

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

Oklahoma

**FY 2018 Application/
FY 2016 Annual Report**

Created on 9/29/2017
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I. General Requirements

I.A. Letter of Transmittal



Oklahoma State Department of Health
Creating a State of Health

July 3, 2017

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, 2015 through September 30, 2016, and the Annual Plan for October 1, 2017 through September 30, 2018.

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

Martha A. Burger, MBA
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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 50 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. Fifty-nine states and jurisdictions have a Title V Block Grant and are required to write annual reports and complete statewide needs assessments every five years. For 2016, 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). This assures 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 CYSHCN (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 eight 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. The 2016-2020 priorities are those most likely to "move the needle" in improving the health of the Oklahoma MCH population (See Table 1).

Table 1. Oklahoma Title V Priorities
Reduce Infant Mortality
Reduce the incidence of preterm and low birth weight births
Reduce the incidence of unintentional injury among children
Reduce the incidence of suicide among adolescents
Reduce health disparities
Improve the transition to adult health care for children and youth with special health care needs
Reduce teen pregnancy
Reduce unplanned pregnancy
Improve the mental and behavioral health of the MCH population
Reduce the prevalence of chronic health conditions among childbearing age women

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 and State Performance Measures which were selected for Oklahoma. The 5-year Action Plan detailing accomplishments and plans for each domain and measure is available in the narrative section of the Block Grant application. Each objective and strategy outlined in the State Action Plan was created to assist the program areas in impacting their designated performance measure.

Table 2. National and State Performance Measures for Oklahoma by Domain	
Population Domain	Performance Measure(s)
Maternal/Women	<ul style="list-style-type: none"> • Percent of women with a past year preventive visit • Rate of Maternal Mortality
Infant/Perinatal	<ul style="list-style-type: none"> • Percent of infants who are A) ever breastfed and B) • Percent of infants breastfed exclusively through 6 months • Percent of infants placed to sleep on their backs • Rate of Infant Mortality
Child	<ul style="list-style-type: none"> • Rate of injury-related hospital admissions per population ages 0 through 19 years
Adolescent	<ul style="list-style-type: none"> • Percent of adolescents, ages 12 through 17 years, who are bullied • Percent of adolescents with a preventive services visit in the last year
CSHCN	<ul style="list-style-type: none"> • Percent of children with and without special health care needs who received services necessary to make transitions to adult health care • Percent of families who are able to access services for their child with behavioral health needs
Crosscutting	<ul style="list-style-type: none"> • A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

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. Although not written into any of the summary information, the budget status for the State of Oklahoma will be monitored across all activities and plans for all domains. State Fiscal Years 2017 and 2018 have projected revenue shortfalls largely unprecedented in state history. This will have an impact on MCH, CSHCN and OFN programs and projects, however the extent for programs is unknown at the time of submission for the grant application and report.

Maternal/Women:

Accomplishments:

- Assisted, through the county health departments, approximately 47,843 women and men with family planning services, linked them to appropriate services or assisted with Medicaid (SoonerCare) enrollment as needed.
- Created and disseminated PRAMS Briefs: *Pre and Post-Natal Stressors Experienced by Oklahoma Mothers* and *Patterns of Postpartum Birth Control Use after an Unintended Pregnancy*.
- Distributed preconception and interconception health information via Farmer’s Markets, March of Dimes walk, Community Baby Showers, and pharmacies.
- Assisted in the development of support groups for women with postpartum depression.

- Recognized those hospitals that established protocols and entered data on Alliance for Innovation on Maternal Health (AIM) activities related to hypertension and hemorrhage.

Plans:

- Continue to work with the Oklahoma Health Care Authority (OHCA) to provide family planning services to low-income females and males of reproductive age not eligible for Medicaid-covered services, and facilitate enrollment in Medicaid for those eligible.
- Encourage family planning providers to treat every visit as a preconception health visit and provide targeted preconception health counseling to every female using the Women's Health Assessment tool.
- Look for partnership opportunities to provide preconception/interconception care and education in the community and increase access to long acting reversible contraception.

Perinatal:

Accomplishments:

- Provided funding and support for the Oklahoma Mothers' Milk Bank (OMMB) and the Oklahoma Breastfeeding Hotline (OBH). Promoted breastfeeding duration and the establishment of Baby-Friendly Hospitals through funding and support of the Oklahoma Hospital Breastfeeding Education (HBEP) and Becoming Baby-Friendly in Oklahoma (BBFOK) Projects.
- Continued to fund and support statewide newborn screening activities, including Zika virus surveillance, for the early detection of birth defects in the state.
- Met with hospitals to ensure all have access to fetal fibronectin testing to help identify women at high risk of preterm labor.
- Distributed 192 cribs to families in need via the crib pilot project for safe sleep.
- Successes included reducing the preterm birth rate to 10.3%, and maintaining a "C" grade on the March of Dimes report card. Oklahoma's hospitals saw a 42% increase in score on the Maternity Practices in Infant Nutrition and Care (mPINC) Survey, from 55 in 2009 to 78 in 2015. Oklahoma currently has 7 Baby-Friendly Hospitals delivering almost 15% of all births statewide.

Plans:

- Continue to partner with and support newborn screening activities in the state.
- Promote breastfeeding initiation and duration through various initiatives. MCH will continue to work with partners to promote the BBFOK and the Baby Café Project, focused on improving access to professional and peer support in African American, Native American, and Hispanic communities.
- Recruit additional delivery hospitals to participate in the Sleep Sack program.
- Continue work with the Oklahoma Perinatal Quality Improvement Collaborative to assist 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:

- Developed a Text4Baby message on infant crying and soothing techniques.
- Added two hospitals to the group of participating hospitals in the Period of PURPLE crying program, which

teaches new parents about infant crying patterns and soothing to prevent abusive head trauma.

- Continued funding for Child Passenger Safety activities, including staff time for the installation of car seats to families in need.
- Provided funding for the Oklahoma Poison Control Hotline for training and technical assistance to families, students, health care providers and child care programs.

Plans:

- Provide leadership on the Infant Injury Prevention Work Group, as part of the statewide infant mortality initiative, *Preparing for a Lifetime, It's Everyone's Responsibility*.
- Maintain a collaborative relationship with Injury Prevention Service (IPS) and Safe Kids Oklahoma, through funding and MCH staff assistance with car seat safety events and seat installations.
- Train and identify partners to provide education in local communities on Graduated Driver Licensing, distracted or impaired driving, seatbelt use, and alcohol use while driving as they relate to children and youth.
- Continue funding Poison Control Center education and outreach activities.

Adolescent:

Accomplishments:

- Reduced state-wide teen birth rates (15-19 year olds) by approximately 40% over the last 15 years.
- Maintained five state-funded adolescent pregnancy prevention projects in local county health departments, and administered the Personal Responsibility Education Program (PREP) grant for Oklahoma City and Tulsa County Health Departments and added a new curriculum which addresses out-of-home youth.
- Supported three Public Health Youth Councils across the state to champion public health issues among youth in their respective communities.
- Provided family planning clinical services to adolescents in county health departments and contract clinics.

Plans:

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

CYSHCN:

Accomplishments:

- Funded Sooner SUCCESS activities, including a provider survey to assess transition processes and policies for primary care and specialty clinics.
- Established a Health Care Transition Subcommittee to strengthen partnership involvement in transition planning activities.

- Funded parent-to-parent support, sibling support, training, and opportunities for family leadership via OFN.
- Continued funding the Oklahoma Infant Transition Program, the Pediatric Sickle Cell Clinic in Oklahoma City, and the Oklahoma Family Support 360^o Center.
- Provided formula, adaptive equipment, medical care, and diapers to CYSHCN with financial need that was not otherwise covered by Title XIX Medicaid funds.
- Provided respite vouchers to families with CYSHCN.

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 OFN and partners to develop an individual health plan template for youth with health and/or genetic conditions on an Individualized Education Plan (IEP) or 504 Plan in school and add to the Transition Care Notebook for CYSHCN.
- Work with partners to identify ways to connect families with services to meet behavioral health needs.

Crosscutting:

Accomplishments:

- Worked with the Center for the Advancement of Wellness and OHCA in promoting tobacco cessation among expectant mothers and their families.
- Disseminated pharmacy bags to pharmacies agreeing to share information on *Preparing for a Lifetime*, Text4Baby, and the Oklahoma Tobacco Helpline (OTH). The bags featured the *Preparing for a Lifetime* logo, as well as a bottle of folic acid, and both sides of the bags display the OTH number.
- Counseled family planning clients and pregnant females seen at county health departments and contract clinics on the impact of smoking during the preconception, interconception, and prenatal periods, and referral to smoking cessation resources, as needed.
- Funded ten rural district school nurses through a contractual agreement with the Oklahoma State Department of Education, with a focus on tobacco prevention and cessation programs.

Plans:

- Continue to provide counseling and OTH referrals to family planning and maternity clients seen at the CHDs and contract clinics.
- Fund up to ten rural school health nurses to continue school-based tobacco prevention and cessation programs.

Comments and Suggestions:

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

For more information about this document, the process, to provide comments, or to partner with Title V please contact: **Joyce Marshall**, MCH Title V Director, OSDH at 405-271-4480 or joycem@health.ok.gov or **Carla McCarrell-Williams**, CSHCN Title V Director, DHS at 405-521-4092 or Carla.McCarrell-Williams@okdhs.org.

II. Components of the Application/Annual Report

II.A. Overview of the State

Overview

Oklahoma, 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 regions: 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 center of the state, transitional prairies and woodlands give way to the Ozark and Ouachita Mountains, which stretch out in an eastward direction towards the border with Arkansas. The diversity of the geography is matched by the diversity of the state's residents and their lived experiences. Health care availability and access, transportation options, and employment opportunities are inconsistent, varying by region of the state.

Demographics

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, a rural state, has three large cities. Oklahoma City, the state's centrally located capitol, is the largest of the three and home to 610,000 residents (15.8%) of the state's population. Approximately 100 miles to the northeast is Tulsa, a city accounting for 10.3% (398,000) of the state's population. Nearly 90 miles to the southwest of Oklahoma City, along Interstate 44, is the city of Lawton, which has a population of 98,000, or 2.5% of the state's total population (approximately 3.8 million).

Approximately 64% of the Oklahoma population resides in the metropolitan statistical areas (MSAs) of Oklahoma City (1,373,000, 36%) and Tulsa (963,000, 25%). A much smaller percentage of the Oklahoma population lives in the Lawton MSA (132,000, 3%). The remainder of Oklahomans resides in rural locales, and smaller cities and towns. The state's metropolitan areas continue to grow.

Oklahoma is home to the largest number of federally recognized American Indian tribal governments (38). According to the American Indian Cultural Center and Museum, there are more languages spoken in Oklahoma than in all of Europe.

Age

Nearly a quarter (24.6%, 961,000) of the Oklahoma population is less than 18 years of age. Persons aged 65 and older comprise 14.7% of the state's population, and roughly 61% of the population is between 18 and 64 years old. The male-female ratio approximately 1:1, with slightly more females (1,974,000) than males (1,937,000). Females of childbearing ages (15-44 years) number 768,000, or about 20% of the Oklahoma population. The number of females ages 15-19 years age has decreased by 2% since 2010, down from 128,000 to 126,000. By size, the fastest growing age group was females ages 30-34, up 12% over the same time period, increasing in absolute terms from 119,000 to 133,000.

Race/Ethnicity

Residential variation by race and ethnicity exists in Oklahoma. While the white population is geographically diffuse, the African American population generally resides in the Oklahoma City and Tulsa metropolitan areas. The American Indian population has greater presence in the northeast corner of the state, a lasting legacy of the U.S. federal government removal programs of the 19th century.

In 2015, just over 73% of the Oklahoma population was classified as white, down marginally from 74% as recorded in the 2010 Census. American Indians and African Americans both account for about 7% of the state's population

according to Census figures released in 2015. Less than 2% of Oklahoma's population was categorized as Asian. The Hispanic population has grown from 8% of the total population in 2010 to 10% in 2015. On balance, these changes are modest.

Poverty

According to data from the U.S. Bureau of Economic Analysis, Oklahoma's per capita personal income was \$45,682 in 2016, ranking 28th among all states, and was about 92% of the national average of \$49,571. U.S. Census Bureau data show that 16.7% (624,000) of Oklahomans were living in poverty in 2015. Females (18%) were more likely to be living below the federal poverty level than were males (15%). For children aged 17 years and younger, 23% lived below the poverty level. Poverty status was more likely among minority populations when compared to whites, particularly among African Americans where 30% of this racial group fell below the federal poverty line.

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 by workforce size for Oklahoma include the Department of Defense (69,000 employees, military and civilian), Walmart Associates, Inc. (33,000) 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 (5,000-6,000).

Oklahoma's real gross domestic product (GDP), the output of all goods and services produced by the economy in current dollars, totaled \$182.9 billion in 2016 according to data from the U.S. Bureau of Economic Analysis, decreasing by 7% from 2014 (\$196.7 billion in current dollars). The private sector comprises 84% of Oklahoma's real GDP, with government making up the remainder (16%). As a percentage of the GDP, industry share in the economy was led by trade (12%), transportation and utilities (12%), financial activities (14%) and mining (11%). Education and health care services contributed 8%.

Gaming (lotteries and casinos) continue to be a major contributor to the state's economy. Oklahoma Tribal Government Gaming output in 2016 amounted to \$4.75 billion, representing 3% of private production in the economy. Moreover, the multiplier effect of indirect economic activity to include construction and operations brought the total impact to \$7.2 billion. In 2016, 31 Oklahoma tribes owned almost 130 gaming operations. Since 2006, tribal gaming operations, as required by state statute, have paid the state a total of \$1.123 billion in exclusivity fees, \$132 million of which were collected in fiscal year 2016. By Oklahoma statute, exclusivity fees are distributed to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS, \$250,000 annually), the Education Reform Revolving Fund (88%), and the General Revenue Fund (12%). ODMHSAS receives funds to address problems arising from gambling.

Data from the U.S. Bureau of Labor Statistics for calendar year 2016 showed that annual average unemployment rates declined for 39 states, remained unchanged for three states, and rose for nine states. Oklahoma was in the latter group with the unemployment rate rising to 4.9%, up from 4.4% in 2015, and equaling the national rate. Of the state's 77 counties, 65 counties experienced an increase in unemployment, 8 counties saw unemployment decrease, while just 5 counties had no change. Oklahoma's employment-population ratio, the number of working age persons who are employed divided by the total population of working age persons, was 58.2 in 2016, compared to the national rate of 59.7.

Budgetary Concerns

The final state fiscal year (SFY) 2017 appropriation for the Oklahoma State Department of Health was \$54,978,498, down 2.5% from final SFY 2016 appropriations. The Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, and the Oklahoma Department of Human Services (DHS) had SFY 2017 appropriations of \$991 million and \$693 million, respectively. The appropriation for the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) was \$325 million. For OHCA, DHS, and ODMHSAS, these appropriations were increases over final FY 2016 funding. The total cabinet-level funding for Oklahoma's Health and Human Services amounted to \$2.22 billion, an increase of approximately 7.3%.

The Oklahoma Governor is required to submit an Executive Budget to the legislature on the first Monday of each regular legislative session. On Monday, February 6, 2017, Governor Mary Fallin submitted her FY 2018 budget to the first session of the 56th Oklahoma Legislature with proposed appropriations of \$7.79 billion. The State Board of Equalization, in December 2016, projected a shortfall in available revenue of \$6 billion for FY 2018 appropriations, \$739.3 million (12.2%) less than was certified in FY 2017. Governor Fallin's budget did not include one-time revenue proposals for FY 2018 and accessing the state's Rainy Day Fund was not proposed. Rather the Governor proposed recurring revenue proposals for sales tax modernization (\$839.7 million), elimination of state sales tax on groceries (-\$234.7 million), elimination of corporate income tax (-\$140.2 million), a Department of Transportation funding reform plan (\$219.7 million), a repeal of motor fuel "eligible purchaser" discount (\$5.8 million), a cigarette tax increase (\$257.8 million), a non-appropriated agency revenue sharing (\$45 million), a wind production tax (\$36.6 million), increasing the reinstatement fee for suspended corporations (\$736,250), and increasing the excise tax rate for commercial trucks (\$1.7 million).

The FY 2018 budget that passed and was signed by the Governor at the close of the legislative session maintained flat funding for 16 state agencies, including Department of Education and OHCA, however it cut funding for all other state agencies by approximately 4%. Uncertainty still exists with the FY 2018 budget, as at least one revenue-raising measure is being contested in court, the \$1.50 cigarette fee increase.

Population Health Ranking

The United Health Foundation (UHF) creates an annual report that ranks each state within the U.S., as well as the U.S. in comparison to other nations. The rankings are based on core measures in the following areas: behaviors, community and environment, policy, clinical care, and outcomes. The UHF's report, American's Health Rankings 2016, has ranked the state of Oklahoma 46th among all U.S. states, down one spot from 45th in 2015. Oklahoma is positioned much lower in state rankings since it reached a high of 32nd in 1990. The UHF report cited three specific challenges that must be addressed if Oklahoma hopes to improve its national standing and the overall health of its population: high prevalence of smoking, high percentage of population without insurance, and high premature death rate. The 2016 report did highlight areas of strength: low prevalence of excessive drinking, small disparity in health status by education, and low incidence of pertussis.

Oklahoma is persistently among the bottom 10 states in the UHF's health rankings. To address the state's position in the national health rankings, the OSDH Board of Health and the State Health Commissioner, in collaboration with many state and local partners, revised the Oklahoma Health Improvement Plan (OHIP) for 2020. OHIP 2020 has 4 flagship issues (tobacco use prevention, obesity reduction, children's health, behavioral health) that must be given priority by OSDH program areas. Additionally, the state recognizes that public and private partnerships must be developed to focus on addressing social determinants of health and the transformation of the health system and their impacts on the flagship issues.

Government

The government of Oklahoma is modeled on the U.S. federal government, a constitutional republic with three branches: legislative, executive, and judicial. Oklahoma has 77 counties, each having local jurisdiction of government functions, and five congressional districts. State officials are elected by plurality voting. The biennial legislature is bicameral with a Senate and House of Representatives. The Senate has 48 members with Senators serving four year terms staggered such that only half of the districts conduct elections in an election year. The House of Representatives 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 congressional chambers.

The Governor of the state is the principal head of government, serving as the chief executive. This office submits a 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 county. Two independent courts, the Court of Impeachment and the Court on the Judiciary, are also part of the judicial branch of government. 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 federally-recognized American Indian tribal governments are based in Oklahoma. Each tribal government has limited powers in defined geographic areas. Indian reservations in the conventional sense do not exist. Tribal governments, recognized by the U.S. federal government 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, yet remain subject to the federal authority held by the U.S. Congress.

As of January 15, 2017, there were 2,161,881 registered voters in Oklahoma, among which 39% were Democrat, 46% were Republican, and 15% were Independent. The Oklahoma delegation to the U.S. House of Representatives represents five congressional districts with all five being registered Republicans. Oklahoma's 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 U.S. Senators from Oklahoma are James Lankford (R) and James Inhofe (R). Mary Fallin (R) is the state's first female governor.

The Oklahoma Legislature convened for the first regular session of the 56th Legislature on Monday, February 6, 2017. A majority (40) of the Senate seats were held by the Republican Party, six seats held by the Democratic Party, and two seats currently are vacant. Likewise, in the House, the Republican Party is in the majority (73) and the Democratic Party, the minority (26).

Legislative Update

Abortion:

SB0030- Provides direction to the Oklahoma State Health Department to require signage at abortion clinics stating coercion is against the law and that agencies exist to help carry the child to term. If funds are appropriated, the State Health Department will be required to develop and update an electronic form with information about agencies and services that can provide help to women through pregnancy, childbirth and childhood. Signed by the Governor April 26, 2017.

Care Coordination:

SB773- Requires the Oklahoma Health Care Authority (OHCA, the State's Medicaid agency) to initiate a Request for Proposals for care coordination models for children in DHS custody. The request must take into consideration and incorporate efforts to continue the implementation of the Pinnacle Plan (mandates from a lawsuit against DHS'

Child Welfare Division). A summary of the responses received must be provided to the Legislature and Governor by January 1, 2018. Signed by the Governor May 3, 2017.

HB1566- Passed by the Oklahoma Legislature and signed by Governor Mary Fallin in April 2015, HB 1566 directed the OHCA to initiate an RFP care coordination model (SoonerCare+) for Oklahoma's Medicaid aged, blind, and disabled (ABD) population. The RFP was issued in November 2016 and revoked June 15, 2017 by OHCA, due to the uncertainty surrounding both federal and state funding.

Child Passenger Safety:

HB1607- Exempts certain parents with physical disability status from the rear-facing child passenger restraints for infants. Vetoed by the Governor May 16, 2017. However, the exemption language was added to another bill on Real ID limits, HB1465, and was signed into law by the Governor on June 6, 2017.

Food Deserts:

SB506- Creates the Healthy Food Financing Act which creates a revolving fund to construct or expand and upgrade existing grocery stores and small food retailers in food deserts for the purposes of bringing healthy foods to underserved communities. Signed by the Governor April 25, 2017.

Public Health Laboratory:

HB2389- Implements a \$58.5 million bond to build a new public health laboratory to maintain accreditation and cost savings for newborn screenings and other public health emergencies and diseases. Signed by the Governor May 25, 2017.

Sickle Cell:

SB652- Directs the Secretary of Health and Human Services to seek funding for identifying disparities in sickle cell disease, utilization of therapies and strategies related to preventing complications, and to promulgate rules to implement. Signed by the Governor May 3, 2017.

Bills of interest to MCH that did not pass or were withdrawn before the end of session include several bills on paid family leave, bills for expanding child passenger safety laws to include safety restraints for children 8-11 years of age and changes to non-medical vaccine exemptions.

II.B. Five Year Needs Assessment Summary and Updates

FY 2018 Application/FY 2016 Annual Report Update

The submission of the FY2016 MCH Title V Block Grant Application and Annual Report, which included the Five-Year Needs Assessment, was the culmination of a two-year process of engaging partners, planning, organizing, and completing grant activities; collecting, analyzing, interpreting, and reporting data; and writing and rewriting grant narratives. These efforts yielded a final product which documented Oklahoma's Title V Program efforts and plans for the fiscal years 2016-2020. The Application/Annual Report included the formulation of 10 priorities and eight state-selected National Performance Measures (NPMs), which were supported by the findings documented in the comprehensive, statewide needs assessment. Following the July 2015 submission of the Application/Annual Report, Oklahoma developed Evidence-Based Strategy Measures (ESMs) and State Performance Measures (SPMs).

The process used in developing the ESMs and SPMs involved multiple MCH staff, as well as MCH and CSHCN leadership, in the review of information prepared in the needs assessment. Staff interpreted the results of a public input survey, listening sessions with tribal health care providers, and analysis of MCH-related data systems to inform decision-making relevant to creation of ESMs and SPMs. In a joint effort, MCH and CSHCN Title V program staff, along with the Oklahoma Family Network (OFN) Executive Director met monthly to discuss results and to identify and create measures. Between monthly meetings, MCH analysts and program staff discussed proposed measures for the purpose of creating measure definitions, documenting data sources, and drafting text to emphasize the importance of the chosen measures for the improvement of the state's MCH population. Measures were selected based on their relevance to state priorities and NPMs, potential impact to health improvement, availability of data, and ease of comprehension. Ultimately, eight ESMs and three SPMs were chosen for performance monitoring and reporting. These measures are consistent with established Title V Block Grant priority areas.

For Oklahoma, the Needs Assessment is an ongoing process, one in which MCH staff continually collect, review, analyze, and interpret a range of data inputs drawn from the Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), the Public Health Oklahoma Client Information System (PHOCIS), and other state and national data systems. Assessment includes monitoring data for changes in behaviors, needs, health status, service utilization, and care availability of Oklahoma's MCH population. For many years the Oklahoma State Department of Health (OSDH) has used Strategic Targeted Action Teams (STAT) to plan and carryout activities directed at positively impacting agency priorities. In part, performance progress is documented by the Oklahoma Health Improvement Plan (OHIP) and OSDH's performance management system.

MCH surveillance activities continue to provide data which are necessary to make informed decisions in program management and strategic planning. In the spring academic semester, MCH administered the 2017 YRBS to public high school students throughout the state. Completed questionnaires have been sent to Westat for data management and the creation of a weighted analysis data set, which we anticipate receiving in August 2017. YRBS data from previous collection cycles have been used to report on risk behaviors of Oklahoma adolescents. MCH staff have developed a data brief (Academic Achievement and Risk Behaviors), a fact sheet (Alcohol and Other Drug Use Among Oklahoma Public High School Students), an infographic focusing on youth not having sex (Don't Believe the Hype), a trend report for selected health indicators, and a journal article (Prescription Drug Misuse and Associated Risk Behaviors among Public Health High School Students in Oklahoma). YRBS data have been used repeatedly by MCH leadership, including in Title V Block Grant reporting, and have been utilized frequently in response to media inquiries.

MCH administered the 2016 Fifth Grade Health Survey (5GHS) in the fall semester of the 2016-2017 academic

school year. Fifty-five schools were randomly selected from the public school enrollment file from Oklahoma State Department of Education, of which 49 schools participated for an 87% school response rate. From those 49 schools, 2,262 students from 97 classrooms were randomly selected to participate. Regrettably, the response from parents of those nearly 2,000 students was inadequate, leading to an overall response rate below the 60% threshold used for preparing weighted data for analysis. Data will be used by MCH internally to inform programs and to improve the 5GHS surveillance project, but will not be distributed publicly. MCH also conducts the First Grade Health Survey (1GHS), a project nearly identical to the 5GHS. Both the 1GHS and the 5GHS have suffered declining response rates which in recent collection cycles have been insufficient, preventing MCH from producing weighted analysis data. Consequently, MCH has suspended the data collection of these surveillance systems to carry out a comprehensive assessment, to determine if remedial action can be taken to address declining survey response or if viable alternatives to observation data collection exist. This assessment will be completed by January 2018.

The CDC released 2014 PRAMS data to Oklahoma in November 2016. These data continue the long series of data that PRAMS has provided the state since 1988. PRAMS data are essential to measuring Oklahoma's progress in improving the health and well-being of the state's maternal and infant populations. Analysts routinely fulfill data requests for MCH staff and partners for use in grant applications, performance reporting, legislative requests, press releases, journal articles, and conference presentations. CDC has yet to release 2015 and 2016 data as CDC statisticians have not begun the data weighting process for these years. The collection cycle for calendar year 2017 began in April.

The Oklahoma Toddler Survey (TOTS) is a follow back survey to the Oklahoma PRAMS. Begun in 1994, this surveillance project collects information from PRAMS mothers at the time their children reach age two. The Senior Biostatistician for MCH Assessment weighted year 2015 data, releasing it for analysis in September 2016. TOTS data are integrated into much of the analysis and reporting that the Oklahoma MCH Service performs on the state's early childhood population. Year 2016 data will become available in July 2017. In response to flagging response rates, MCH Assessment has initiated a comprehensive evaluation of the TOTS Project to assure that the project is functioning optimally. The evaluation includes a revision of the TOTS questionnaire and will conclude by December 2017.

Oklahoma received funds from the Maternal and Child Health Bureau to administer the State Systems Development Initiative (SSDI) grant. MCH uses these funds to staff a SSDI Analyst position which has responsibility for expanding data capacity for the state's Title V programs. The three goals of the Oklahoma SSDI Project include: 1) enhance the ability of Title V programs to access and use data relevant to MCH programming, 2) support the Collaborative Improvement and Innovation Network (CollIN) to Reduce Infant Mortality, and 3) promote the use of the core and minimum data sets. While this position was vacant for greater than two years, in February 2016, an analyst was hired. The prolonged vacancy did hamper MCH's ability to develop analytic data sets and data products but since the hire, data work has been completed. In addition to standard grant reporting requirements (i.e., Performance Progress Reports and Non-Competing Continuation applications), the SSDI Analyst has produced the Oklahoma Infant Mortality County Profiles, which are county-specific reports of infant mortality and related birth and population data, and infant mortality death data sets for years 2004 to 2015. The latter was developed to enable all of MCH analysis staff to have readily available infant mortality data, standardized and uniform such that analysis can be initiated with relative ease and beginning with a data set vetted by consistent data management processes. Subsequent years of data will be added as it becomes available.

MCH Assessment had acquired the public use data file for the hospital inpatient discharge data set for the years 2011-2014. This acquisition acknowledged that Oklahoma had not adequately assessed morbidity issues among the state's MCH populations. The first analysis completed with these data was conducted by MCH's Senior

Biostatistician and focused on cesarean deliveries in the state's birthing hospitals. A report of this analysis, which also included live birth data, has been completed and is currently in the publication process. Release of the report is anticipated in June 2017.

With joint funding from OSDH and the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, MCH employs a Medicaid Analyst with responsibility for analyzing Medicaid administrative data after linking to birth records. The purpose of this analysis work is to inform OSDH and OHCA program efforts aimed at providing health care and improving perinatal, infant, and child health outcomes. The Medicaid Analyst position had been vacant for an extended period; thus, stalling much of the work in this area. In May 2017, an epidemiologist was recruited to fill the position. MCH expects work to resume during the year as the epidemiologist receives training and becomes acquainted with the goals and objectives of the Medicaid Analyst position.

MCH, along with several partners, has initiated a Safe Sleep Cribs Project that provides participants with an infant sleep sack (wearable blanket), a portable crib (Pack-N-Play), and race- or ethnicity-specific educational training materials. Pilot sites for the project include the Oklahoma University Neonatal Intensive Care Unit (OU NICU), OSDH Office of Minority Health community baby showers, state home visiting programs, and the Oklahoma City Indian Health Clinic. Project participants complete 1-month and 6-month surveys which ask about frequency of use of the sleep sack and portable crib, as well as infant sleep practices. Data collected from these surveys are assessed for improvements from baseline and compared to PRAMS statewide data. Preliminary results are encouraging and MCH will look to expand the project to more sites in 2017.

MCH has developed a plan to guide development of data sets, data products, analyses, and reporting. The plan incorporates the needs of each of the MCH program areas – Child and Adolescent Health, Perinatal and Reproductive Health, and Assessment. The strategic plan establishes a schedule for what gets done, by whom, and for what purpose. The intent is to clearly state the goals and objectives for expanding existing and building new data capacity necessary for MCH to be successful in meeting its established priorities. Each year the plan will evolve and be refined to address ongoing and emerging needs of the MCH program area.

Efforts to expand MCH data capacity could not be carried out without the participation and involvement of multiple internal and external partners committed to improving the health and wellbeing of Oklahoma's maternal, infant, and child and adolescent populations. Internal partners, which include staff from Screening and Special Services, Community Epidemiology and Evaluation, the Center for Health Statistics, the Center for the Advancement of Wellness, Immunization Service, WIC, Injury Prevention Service, Family Support and Prevention Service, contribute to data capacity efforts by sharing data, advising on data collection and analysis, staffing data work groups, and supporting the reporting and release of study findings. Much the same can be said of relationships with staff from external agencies and organizations with missions that overlap with the mission of MCH. Staff from the Oklahoma Health Care Authority and the Department of Human Services are members of work groups formed for the purpose of advancing the use of MCH-related data to drive decision-making important to Title V programs.

Further, MCH Assessment staff actively participates in the recently formed American Indian Data Community of Practice, an entity created for the purpose of building data capacity, including that pertinent to MCH populations. MCH Assessment also has developed partnerships with the Southern Plains Tribal Health Board, often collaborating on data and analysis projects exploring health issues among Oklahoma's American Indian population.

FY 2017 Application/FY 2015 Annual Report Update

The submission of the FY 2016 MCH Title V Block Grant Application and Annual Report, which included the Five-Year Needs Assessment, was the culmination of a two-year process of engaging partners; planning and organizing grant activities; collecting, analyzing, interpreting, and reporting data; and writing and rewriting narratives. These efforts resulted in a final product which documented Oklahoma's Title V program efforts and plans for the fiscal years 2016-2020. Included in the application were the ten priorities and eight selected National Performance Measures (NPM) supported through the results of the comprehensive, statewide needs assessment. Following the July 2015 submission of the grant application and annual report, Oklahoma continued with the identification of Evidence-Based Strategy Measures (ESMs) and State Performance Measures (SPMs).

The process for the formulation and selection of ESMs and SPMs involved multiple MCH staff and MCH and CSHCN leadership in review of the information prepared in the needs assessment process. This included the results of a public input survey, MCH listening sessions with tribal health care providers, and analysis of MCH-related data systems. There were 7 listening sessions with more than 150 tribal health care providers in attendance. Attendees included physicians, nurse practitioners, nurses, health educators, agency and program administrators, and administrative staff. In a joint effort, MCH and CSHCN Title V program staff, along with the Oklahoma Family Network (OFN) Executive Director met monthly to discuss results and to identify measures. In between the monthly meetings, MCH analysts and program staff conferred on proposed measures to develop accurate definitions, document sources of data, and prepare text which emphasized the importance of the chosen measures to the improvement of Oklahoma's MCH population. Measures were selected based on their linkage to state priorities, National Performance Measures, potential impact to health improvement, availability of data, and ease of comprehension. Ultimately, eight ESMs and three SPMs were selected for ongoing reporting and monitoring. These measures are consistent with Oklahoma's stated Title V Block Grant priority areas.

The MCH Title V Needs Assessment is an ongoing process and Oklahoma continues to collect, analyze, and report data provided by the Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the First and Fifth Grade Health Surveys, the Youth Risk Behavior Survey (YRBS), and other state and national surveillance systems. These activities include monitoring data for changes in behaviors, needs, health, and safety of Oklahoma's MCH population. The OSDH uses Strategic Targeted Action Teams (STATs) to facilitate activities toward impacting agency priorities. Performance progress is documented in part through reporting for the Oklahoma Health Improvement Plan (OHIP) and the agency's performance management system.

MCH surveillance activities continue to provide the data necessary to make informed decisions for program management and short- and long-term planning. The 2015 YRBS was administered in the spring of 2015. The Centers for Disease Control and Prevention (CDC) prepared weighted data and released those data to the state in August 2015. Since that time the data have been used to create data briefs, fact sheets, and infographics to inform public health practitioners, OSDH leadership, and MCH partners. Preparations for conducting the 2017 YRBS in the spring semester of the 2016-2017 school year are now underway as the questionnaire is in development.

MCH administered the 2015-2016 First Grade Health Survey (1GHS) during the fall of 2015. Fifty-five schools were randomly selected from the public school enrollment file from Oklahoma State Department of Education (OSDE), of which 47 schools participated for an 85% school response rate. From those 47 schools, 1,948 students from 93 classrooms were randomly selected to participate. Regrettably, the response from parents of those nearly 2,000 students was inadequate, leading to an overall response rate below the 60% threshold used for preparing weighted data for analysis. Data will be used internally to MCH to inform programs and to improve the 1GHS surveillance project, but will not be distributed publicly. MCH also conducts the Fifth Grade Health Survey (5GHS), a project nearly

identical to the 1GHS. Currently, the 5GHS is being revised for administration in the fall semester of the 2016-2017 academic year. Assuming response rates are sufficient (i.e., 60%), collected data should be available for analysis and reporting in spring 2017.

PRAMS data for 2013 were released in fall 2015. These data continue the long series of data that PRAMS has provided the state since 1988. PRAMS data are essential to measuring Oklahoma's progress in improving the health and wellbeing of the state's maternal and infant populations. Analysts routinely fulfill data requests for MCH staff and partners with data being used in grant applications, performance reporting, legislative requests, press releases, journal articles, and conference presentations. Data for collection year 2014 should become available in mid to late summer 2016, as CDC statisticians have begun the data weighting process. The collection cycle for calendar year 2016 began in April.

TOTS is a follow back survey to the Oklahoma PRAMS. Begun in 1994, this surveillance project collects information from PRAMS mothers at the time their children reach two years of age. Year 2014 TOTS data became available in June 2015 and, like the data from PRAMS, TOTS data are integrated into much of the analysis and reporting that the Oklahoma MCH Service performs on the state's early childhood population. Year 2015 data will become available in June/July 2016.

Oklahoma has continued to use funds from the State Systems Development Initiative (SSDI) to fund an analyst position which has responsibility for expanding data capacity for the state's Title V programs. The three goals of the Oklahoma SSDI Project include 1) enhance the ability of Title V programs to access and use data relevant to MCH programming, 2) support the CoIIN to Reduce Infant Mortality, and 3) promote the use of the core and minimum data sets. Oklahoma's SSDI Analyst position had been vacant for more than two years. As a result, MCH has been hindered in its capacity to develop analytic data sets and data products that should be used by analysts and program staff to advance MCH priorities. In February 2016, this position was filled with the hiring of an epidemiologist. Analytic and data work long held up due to the vacancy is now proceeding in a positive direction.

In early 2016, MCH Assessment acquired the public use data file for the hospital inpatient discharge data set for the years 2011-2014. This acquisition acknowledges the recognition that Oklahoma has not adequately assessed morbidity issues among the state's MCH population. This information-rich data set will provide an opportunity for Oklahoma to assess health issues from a new perspective which had not been explored in the past. The first analysis underway by the Senior Biostatistician is the review of cesarean births at Oklahoma's birthing hospitals. Results of this study should become available in late 2016.

MCH has contracted with a health economist at the University of South Florida to perform a return on investment (ROI) analysis of two MCH-funded programs. The *Every Week Counts* initiative was a collaborative effort among Oklahoma birthing hospitals and MCH for the purpose of eliminating early elective deliveries in Oklahoma. The MCH Safe Sleep Program has implemented a pilot project seeking to prevent infant sleep-related deaths by providing safe sleep education to parents and caregivers, sleep sacks for newborns delivered at participating birthing hospitals, and pack-n-plays to families of newborns lacking a safe sleep surface. The ROI analyses of *Every Week Counts* and the Safe Sleep Program will be conducted from the perspective of the State of Oklahoma and aim to document the benefits in dollars related to prevention of adverse health outcomes for every dollar expended in implementing and conducting these programs. Economic study results will be finalized in the fall of 2016. The contract with the health economist also included a training on economic impact studies with the intent to train MCH staff in the techniques of economic analysis, which would then permit MCH to perform such analyses independently in the future.

MCH is developing a service-wide strategic analysis plan which will guide development of data sets, data products,

analyses, and reporting. This plan will incorporate input from each of the MCH program areas- Child and Adolescent Health, Perinatal and Reproductive Health, and MCH Assessment. The strategic plan will establish a schedule for what gets done, by whom, and for what purpose. The intent is to state clearly the goals and objectives for expanding existing and building new data capacity necessary for MCH to be successful in meeting its established priorities.

Regrettably, there were projects not completed or fully addressed due to vacancies in MCH Assessment analyst positions. The MCH Medicaid Analyst position, a position jointly funded by MCH and the state's Medicaid agency, the Oklahoma Health Care Authority, has been vacant since October 2013. While recruitment is ongoing, a qualified candidate has not been identified. As a result, projects to electronically link and analyze Medicaid administrative data and birth records have been stalled and has prevented OSDH and OHCA from assessing Medicaid births in a manner beneficial to both agencies. Similarly, although not to the same extent, the SSDI Analyst position located within MCH Assessment was vacant between March 2014 and February 2016. This vacancy impacted MCH Assessment's ability to timely meet SSDI grant deadlines, particularly in relation to quality improvement activities. QI analyses were delayed several months because an analyst was not hired to perform the work. While a hire has been made - Dr. Susan Harman began work as the SSDI Analyst in February 2016 - the SSDI Project is behind schedule on completing grant goals.

Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)

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, socio-economic 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 (CoIIN) to Reduce Infant Mortality: MCH participates in the CoIIN 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

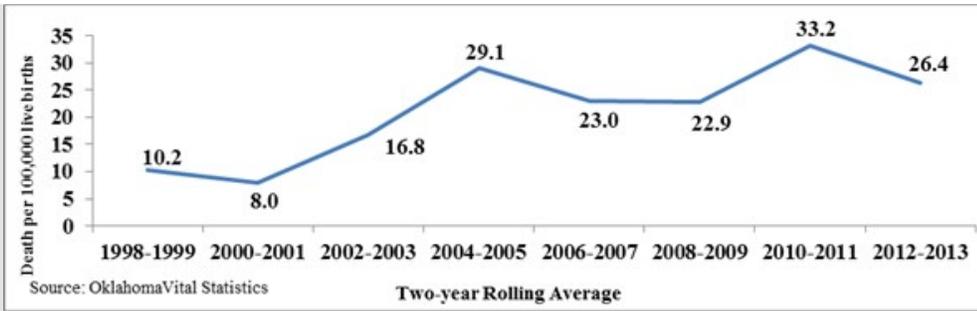
Prenatal Care (PNC): In Oklahoma for 2013, 68.5% of mothers initiated their PNC during the first trimester. Fifty-five percent (55.2%) of mothers that report having received PNC during their first trimester also report having attended 10 or more prenatal visits. A small percentage of mothers, 3.3%, report 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.

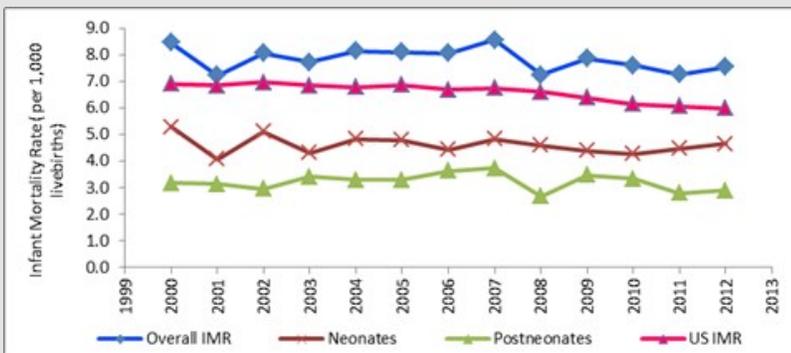
Maternal Mortality: In Oklahoma the two year average of maternal mortality rates (Figure II.B.2.a.1) has shown an overall upward trajectory, like the US maternal mortality rate. Racial disparities in 2013 continue to be a challenge in Oklahoma in relation to maternal mortality, among women of reproductive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

CoIIN to Reduce Infant Mortality: Oklahoma participates in several CoIIN 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 has 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.

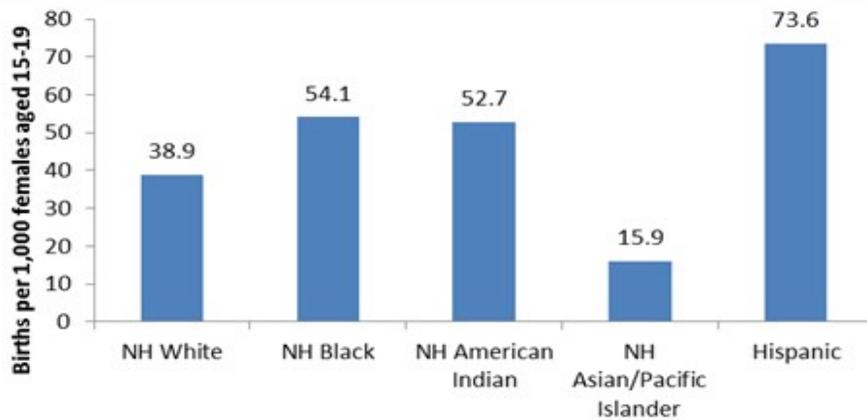
Contributing factors related to intentional self-harm include:

- 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.

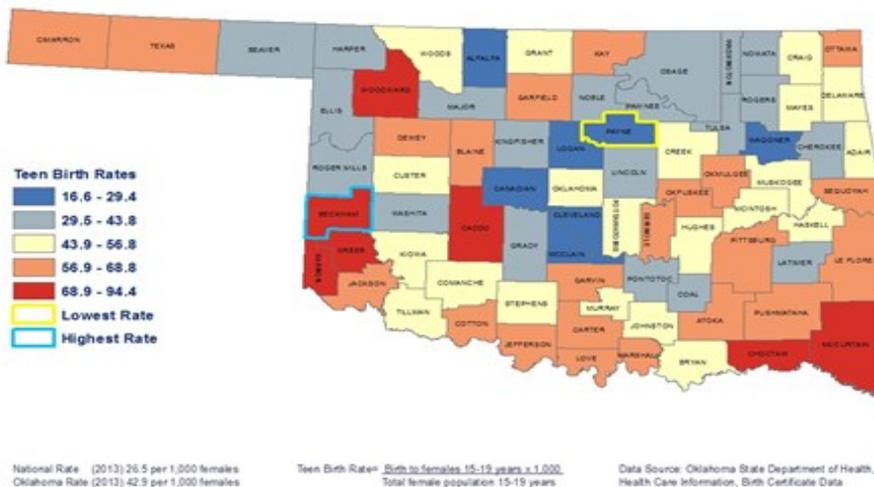
Figure II.B.2.a.3. Birth Rates for Teens aged 15-19 by Race/Ethnicity: Oklahoma, 2011-2013



Source: Oklahoma State Department of Health (OSDH), Center for Health Statistics, Health Care Information, Vital Statistics, OK2SHARE.

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



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

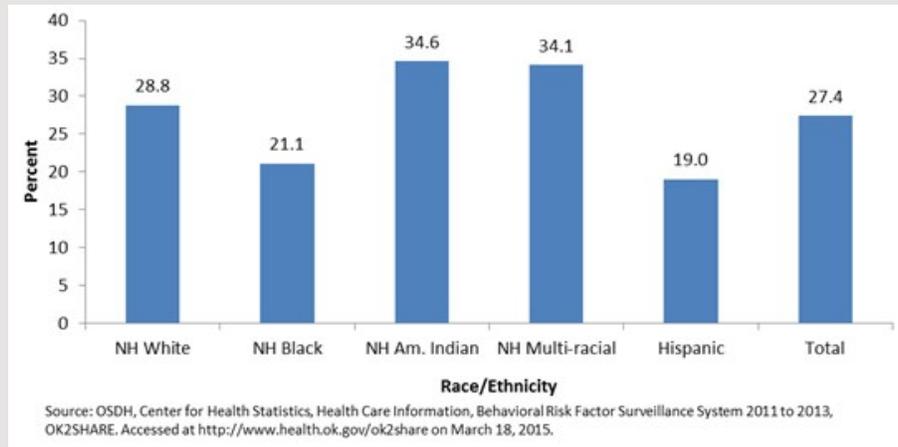
The life course perspective is a useful conceptual framework for understanding and addressing health. This approach helps incorporate the interplay of risk and protective factors and stages of critical development to further explain health outcomes as they occur across the lifespan. It has been particularly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



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.

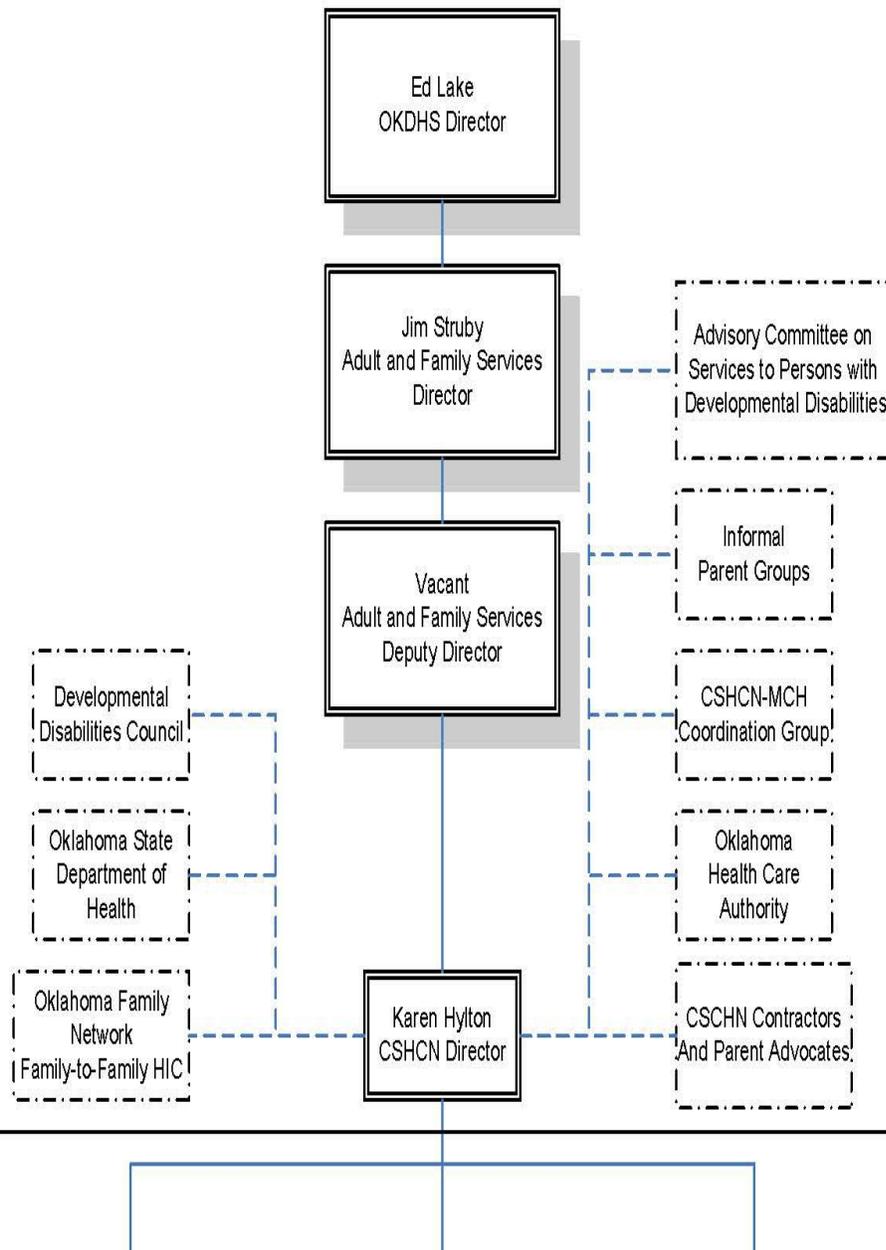
Programs administered in some part with Title V funds include: *Preparing for a Lifetime, It's Everyone's Responsibility*; the CollN Prematurity, Preconception/Interconception, Safe Sleep and Social Determinants of Health national projects; *Every Mother Counts*, the maternal mortality and morbidity 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.

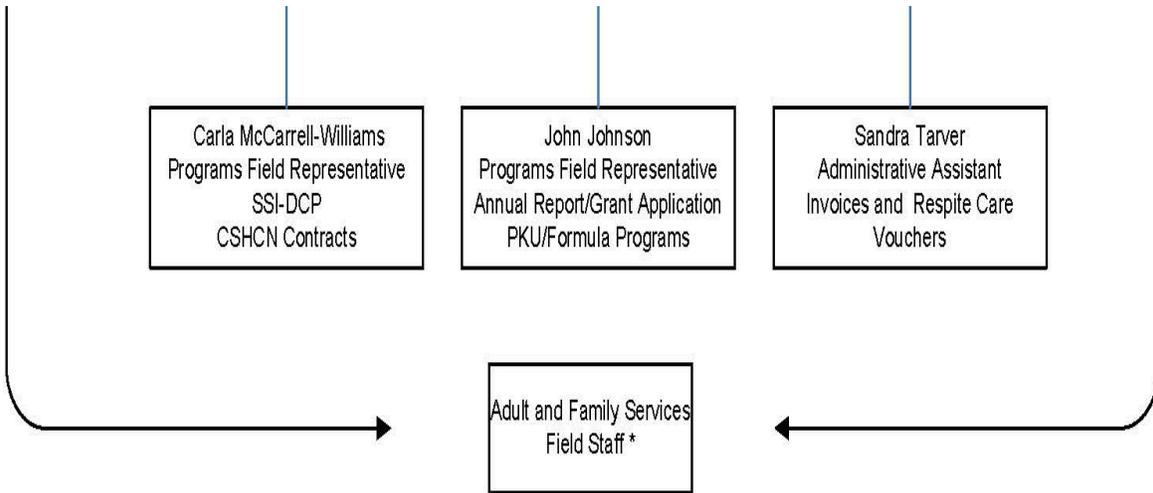
The Title V CSHCN Program is located in the DHS within the Health Related and Medical Services (HRMS) unit. The HRMS is organizationally placed under Adult and Family Services. Karen Hylton is the Director of the CSHCN Program and Program Manager for HRMS. Karen Hylton reports to the Deputy Director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

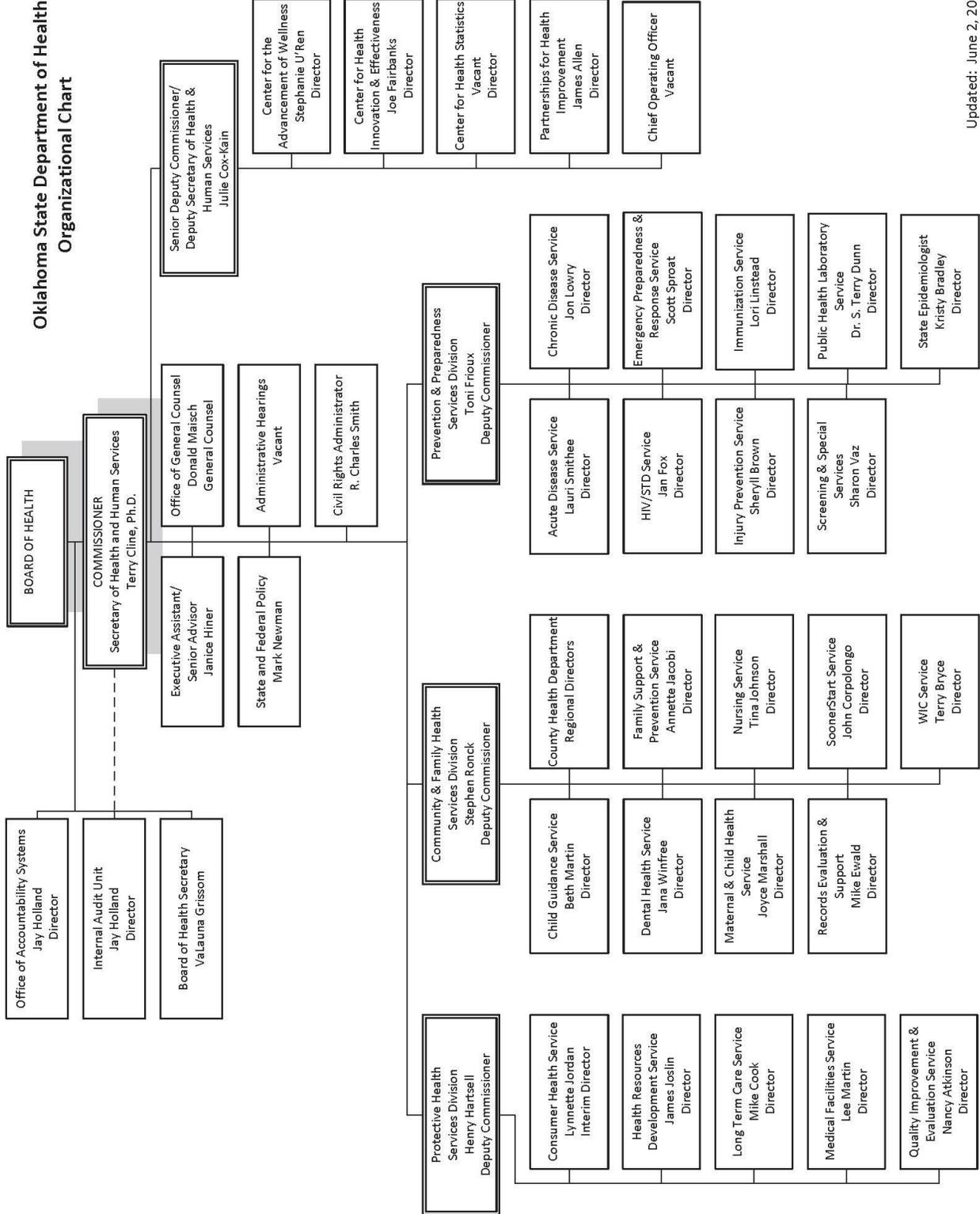
OKLAHOMA DEPARTMENT OF HUMAN SERVICES
CHILDREN WITH SPECIAL HEALTH CARE NEEDS
PROGRAM ORGANIZATIONAL CHART





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

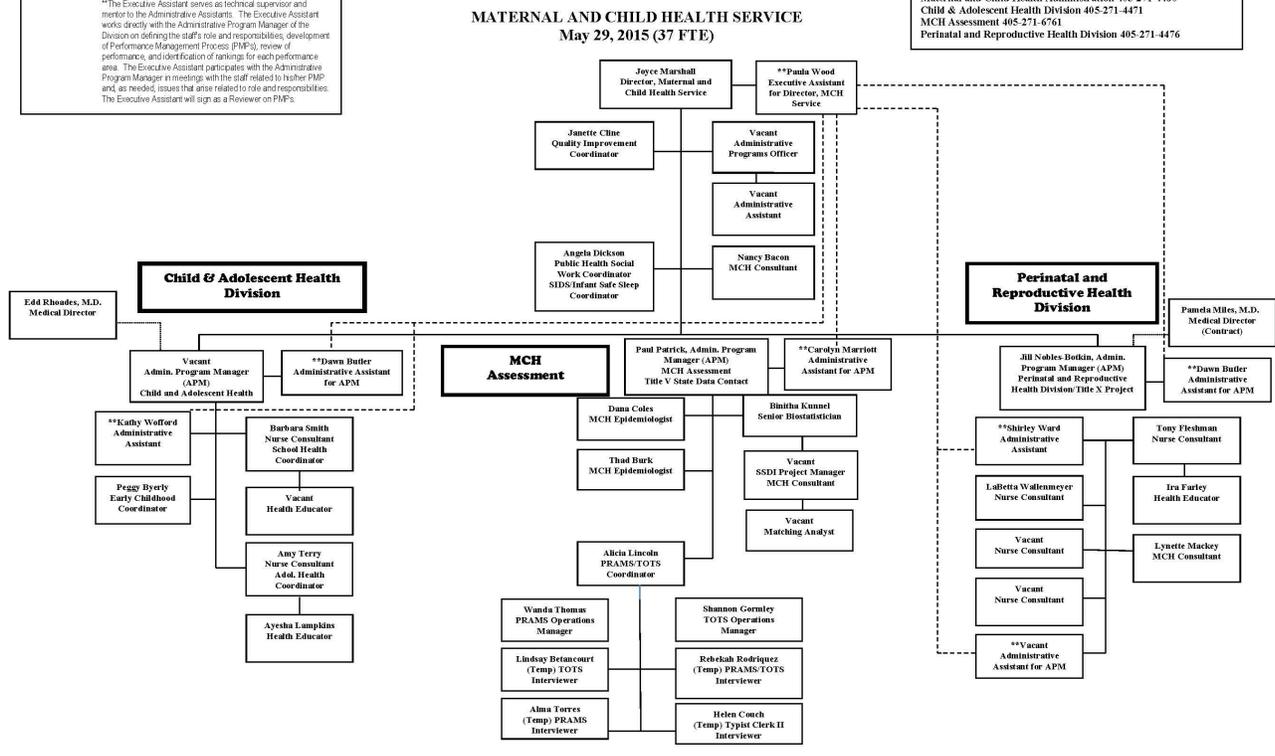
Oklahoma State Department of Health Organizational Chart



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 developing the staff's role and responsibilities, development of Performance Management Process (PMPs), review of performance, and identification of trainings 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 are 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



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 [†]	Challenges [‡]
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

[†] Greater than 80% of respondents indicated capacity for performing service

[‡] Less 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.

Table II.B.2.b.ii.2 Partners Participating in Title V-supported Programs and Activities

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)

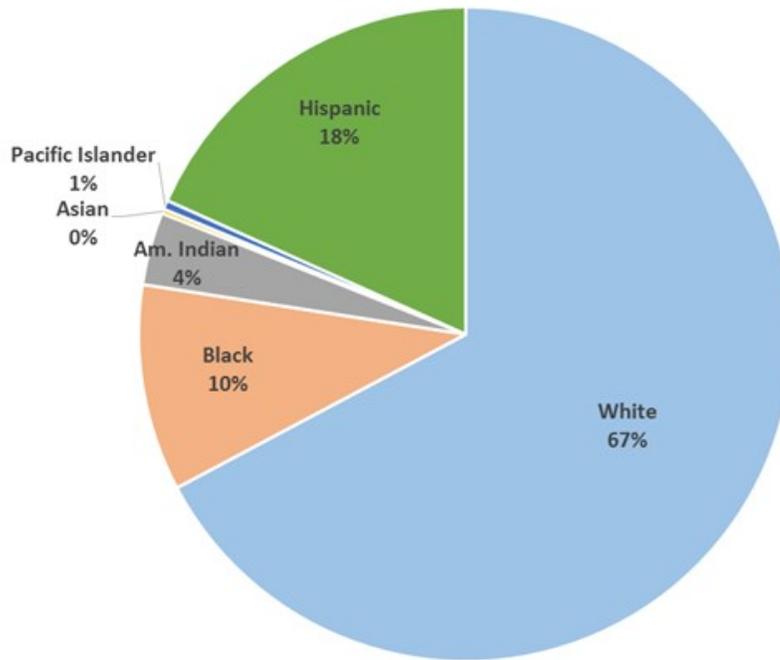
One key aspect of partnership and collaboration for Oklahoma Title V is family participation. The Oklahoma Family Network

(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
1	Reduce infant mortality
2	Reduce the incidence of preterm and low birth weight births
3	Reduce the incidence of unintentional injury among children
4	Reduce the incidence of suicide among adolescents
5	Reduce health disparities
6	Improve the transition to adult health care for children and youth with special health care needs
7	Reduce teen pregnancy
8	Reduce unplanned pregnancy
9	Improve the mental and behavioral health of the MCH population
10	Reduce the prevalence of chronic health conditions among childbearing age women

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 tribal facilities, Indian Health Service facilities and Urban Indian facilities 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 Muscogee (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., National Survey of Children's Health (NSCH)). 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, 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 Work Group, and the Oklahoma Perinatal Quality Improvement Collaborative. Obtaining feedback from members of these groups was essential in understanding analyses findings.

Utilizing 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 the 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 to determine 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 priorities 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/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	Immunization	Substance Use	Family participation in care and services	
Health disparities	Health disparities	Oral health	Health disparities	Physical abuse	
Unintended pregnancy	Congenital anomalies	Unintentional injury	STDs/risky sexual behavior		
	Immunization	Health disparities	Suicide		
	Safe sleep	Child mortality			
	Newborn screening	School readiness			
	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; an estimated half of all live births are 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
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 5 - Percent of infants placed to sleep on their backs
- NPM 7 - Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19
- NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
- NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

The following national performance measures in Table II.D.1. 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.

Table II.D.1. 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>
Perinatal	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>
	Percent of infants placed to sleep	<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</p>

	on their backs	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 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 (<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	<p>MCH Priorities Impacted: Infant Mortality, Chronic Disease, Preterm and LBW, Mental and Behavioral Health, Health Disparities</p> <p>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>).</p>

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

- SPM 1 - Infant mortality rate per 1,000 live births
- SPM 2 - Maternal mortality rate per 100,000 live births
- SPM 3 - The percent of families who are able to access services for their child with behavioral health needs

The following state performance measures in Table II.E.1. 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, Agency Strategic Plan, and Maternal and Child Health (MCH) Service Strategic Priority Areas. Specific rationale is listed in the third column for each state performance measure selected along with the Oklahoma MCH Title V Priorities impacted by each measure.

Table II.E.1. State Performance Measures Selected for Oklahoma, by Population Domain		
Domain	State Performance Measure	Priorities Impacted and Rationale
Perinatal	Rate of Infant Mortality	<p>MCH Priorities Impacted: Health Disparities, Infant Mortality, Preterm and LBW, Behavioral and Mental Health, Teen Pregnancy, Unintentional Injury, Unplanned Pregnancy, Chronic Disease</p> <p>Rationale: Impacts 8 of 10 Title V/MCH Priorities as listed above, 2 agency strategic plan core performance measures (Infant Mortality and Prenatal Care) and 4 statewide Oklahoma Health Improvement Plan priority flagship and goal areas including <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>
Maternal	Rate of Maternal Mortality	<p>MCH Priorities Impacted: Chronic Disease, Health Disparities, Infant Mortality, Behavioral and Mental Health, Teen Pregnancy, Unplanned Pregnancy</p> <p>Rationale: Impacts 5 of 10 Title V/MCH Priorities as listed above, 2 agency strategic plan core performance measures (<i>Infant Mortality and Prenatal Care</i>) and the statewide Oklahoma Health Improvement Plan priority flagship and goal area <i>Children’s Health: Improve Maternal and Infant Health Outcomes</i>.</p>
CSHCN	Percent of families who are able to access services for their child with behavioral health needs.	<p>MCH Priorities Impacted: Transition to Adulthood, Health Disparities, Behavioral and Mental Health, Adolescent Suicide, Unintentional Injury</p> <p>Rationale: Impacts 5 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>

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

II.F. Five Year State Action Plan

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

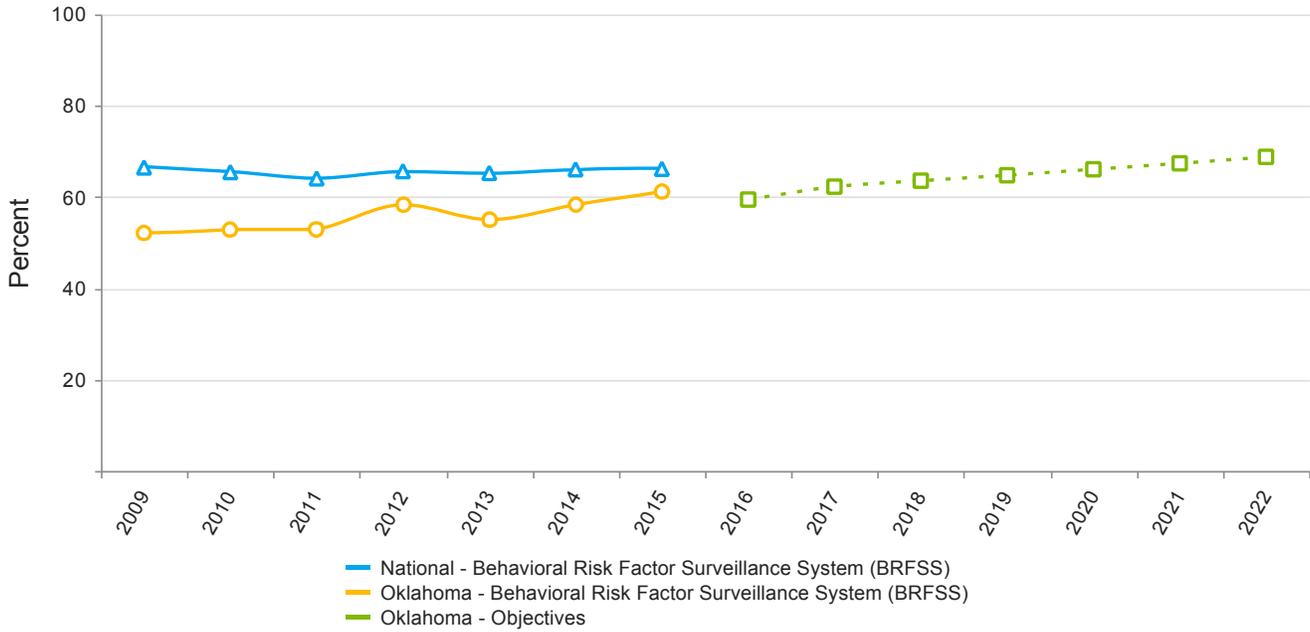
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	171.4	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	23.4	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	7.9 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.4 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	6.5 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	10.3 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.8 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.6 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	27.5 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	7.1	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	8.2	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	5.3	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.9	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	313.1	NPM 1

National Performance Measures

NPM 1 - Percent of women with a past year preventive medical visit
Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	59.4
Annual Indicator	61.0
Numerator	414,257
Denominator	679,075
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	62.2	63.5	64.7	66.0	67.3	68.7

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health or any alternative preconception tool

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

State Provided Data	
	2016
Annual Objective	
Annual Indicator	91
Numerator	
Denominator	
Data Source	PHOCIS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	95.0	100.0	105.0	110.0	115.0	120.0

State Performance Measures

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

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	17.6
Numerator	28
Denominator	158,868
Data Source	Oklahoma Vital Statistics
Data Source Year	2014-2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	17.4	17.3	17.1	16.9	16.8	16.6

State Action Plan Table

State Action Plan Table (Oklahoma) - Women/Maternal Health - Entry 1

Priority Need

Reduce the prevalence of chronic health conditions among childbearing age women

NPM

Percent of women with a past year preventive medical visit

- Objectives**
1. Increase the number of women returning for the postpartum visit from 90.5% in 2014 to 95.0% in 2020.
 2. Improve birth intention by increasing the usage of the most effective methods of contraception among women on Medicaid and at risk for unintended pregnancy from 12.0% in 2014 to 12.6% in 2020.

- Strategies**
- 1a. As part of postpartum/interconception care, partner with home visitation programs (Healthy Start, Children First) to promote the importance of postpartum visits, well woman visits, and early prenatal care for future pregnancies.
 - 1b. Support OHCA as they educate providers on the unbundling of prenatal care and postpartum care visits, and promote postpartum visits among women with recent deliveries.
 - 1c. Continue disseminating the postpartum postcards encouraging new mothers to attend their postpartum visit and follow-up on any health issues. (NEW STRATEGY)
 - 2a. Lead the state team for the national CoIIN Initiative on Pre/ Interconception Health and promote long acting reversible contraception (LARC) usage in family planning clinics and private physician practices.
 - 2b. Educate reproductive age males and females on being healthy before and between pregnancies through community baby showers, health fairs, March of Dimes walks, and public service announcements. Educate health care providers on the importance of preconception health education and screening through Oklahoma Perinatal Quality Improvement Collaborative activities and Maternal Mortality Review.

ESMs	Status
ESM 1.1 - The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health or any alternative preconception tool	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

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

Priority Need

Reduce unplanned pregnancy

NPM

Percent of women with a past year preventive medical visit

Objectives

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

Strategies

Promote the importance of reproductive life planning through utilization of the Women's Health Assessment Tool and My Life. My Plan for adolescents.

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

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

ESMs

Status

ESM 1.1 - The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health or any alternative preconception tool Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

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

Priority Need

Reduce health disparities

NPM

Percent of women with a past year preventive medical visit

Objectives

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

Strategies

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

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

Utilize text4baby messages to develop media effective at reaching African Americans regarding infant mortality and being healthy.

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

ESMs

Status

ESM 1.1 - The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health or any alternative preconception tool Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

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

Priority Need

Improve the mental and behavioral health of the MCH population

NPM

Percent of women with a past year preventive medical visit

Objectives

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

Strategies

Provide education, training and information on the available and appropriate screening tools.

Support the county health department social workers as they work on postpartum depression and other mood disorders in their counties.

ESMs

Status

ESM 1.1 - The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health or any alternative preconception tool

Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

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

Priority Need

Reduce the prevalence of chronic health conditions among childbearing age women

SPM

Maternal mortality rate per 100,000 live births

Objectives

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

Strategies

Continue to facilitate the Maternal Mortality Review Project.

As part of the Alliance for Innovation on Maternal Health (AIM) project, provide technical assistance for hospitals in developing policies for care of patients with postpartum hemorrhage and hypertension to decrease morbidity and mortality, and provide simulation exercises to ensure all staff are familiar with policy and procedures.

Women/Maternal Health - Plan for the Application Year

With the Medicaid Analyst position refilled, MCH will proceed with matching Medicaid claims data with birth certificate data in order to assess more recent data on women who are returning for the postpartum visit and identify ways to reach those who typically are not.

MCH will keep sending postcards to all women delivering a live infant with information on the importance of the postpartum visit. Staff in the county health departments will continue providing postpartum care for those women choosing not to return to their delivering provider for a postpartum visit.

The home visitation programs will educate and encourage new moms to make and attend postpartum appointments and MCH staff will continue to assist in training new parentPro staff.

The OSDH and Oklahoma Health Care Authority (OHCA) will continue to work together to promote long-acting reversible contraception (LARC) utilization with public and private providers. The Association of State and Territorial Health Officials (ASTHO) and Collaborative Improvement and Innovation Network (CollIN) teams will educate providers across the state on client centered counseling and presenting the most effective methods first based on reproductive life plans. Work will also continue on establishing a sustainable education model for providing skills training to current and future health care providers for LARC insertion. The OHCA will work to cover LARC methods for Title XIX and SoonerPlan recipients.

OSDH will continue to support OHCA efforts to modify existing policies decreasing barriers through changes to reimbursement policies for LARCs increasing access/utilization and alignment between private insurance policies and SoonerCare/Medicaid policies.

OHCA benefits will maintain coverage for a broad range of contraceptives including the LARC methods. The OSDH will continue to administer the family planning program through county health departments and contract clinics including assistance with SoonerCare enrollment, reproductive life planning and client centered counseling, and provision of LARC methods. OSDH will maintain family planning services at all county health departments for both insured and uninsured clients. MCH will distribute LARCs purchased with additional funding to ensure same day access in county health departments. MCH will continue to work with OHCA to develop curriculum and train private providers for LARC counseling and insertion and to eliminate barriers to access through Medicaid and private insurance policies.

A minimum of four youth councils will be developed and facilitated by the Adolescent Health Specialists during the 2017-2018 school year. Facilitators trained in both positive youth development and youth-adult partnership frameworks will use this knowledge in the development and implementation of the councils.

County health departments will continue to utilize the Women's Health Assessment tool with clients in the clinic for preventive health check-ups and pregnancy tests to identify potential risk factors and provide a framework for preconception health counseling.

MCH will work with community partners (OHCA, March of Dimes, Oklahoma Perinatal Quality Improvement Collaborative, Federally Qualified Health Centers, etc.) to identify ways to promote preconception health messages.

MCH will look at analyzing Pregnancy Risk Assessment Monitoring System (PRAMS) data and disseminating information through a Pregnancy PRAMS Brief or a PRAMSgram on preconception health and counseling information obtained from the PRAMS surveys. Women will be surveyed through PRAMS regarding utilization of

postpartum visits.

MCH will continue to provide leadership and financial support for the Maternal Mortality Review (MMR). Staff will work to create an annual report with data that is comparable to other states.

MCH will remain active in the Alliance for Innovation on Maternal Health (AIM) activities through the OPQI hospital level interventions to reduce maternal mortality and morbidity, addressing priority activities related to postpartum hemorrhage and hypertension.

MCH will continue to work with the OSDH Office of State and Federal Policy to secure legislative support for MMR activities and review.

The Maternal Mood Disorders Workgroup will continue to promote universal screening for postpartum depression and work to elevate the awareness of providers and families on the impact and symptoms of postpartum mental health issues.

Women/Maternal Health - Annual Report

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

Objective 1. Increase the number of women returning for the postpartum visit from 90.5% in 2014 to 95.0% in 2020.

Data:

According to the most recent PRAMS data (2014), 90.5% of new moms in Oklahoma attended their postpartum visit. The postpartum visit rate did increase almost 5% from a reported 86.4% in 2013. With global billing and reimbursement for obstetric services, claims data are not available to support this high self-reported percentage. Based on anecdotal information, these numbers may be inflated by recall or social desirability bias, as mothers may be aware they are expected to return for the postpartum visit but do not actually attend the visit.

Successes:

MCH continued to send out postcards to all women with a recent live birth reminding them of the importance of returning for their postpartum visit to follow-up on problems that may have developed during pregnancy or delivery (i.e. gestational diabetes, hypertension), talk about birth control, folic acid and continuing to stay quit from smoking.

A PRAMS BRIEF was published in February 2016 on "Pre and Postnatal Stressors Experienced by Oklahoma Mothers". In the 12 months before the birth of their child, 33.4% of mothers reported having 3 or more stressors. Nearly half of the mothers with 3 or more prenatal stressors also had 3 or more postnatal stressors and 22% of the mothers with 3 or more stressors were also diagnosed with postpartum depression. Postpartum visits can be an integral component in the early detection and treatment of postpartum depression.

Another PRAMS BRIEF was published in June 2016 reporting on "Patterns of Postpartum Birth Control Use after an Unintended Pregnancy". In 2012, 36.3% of Oklahoma mothers experienced an unintended pregnancy. Of these mothers, 47% used birth control at the time of conception; however, 83.6% were using some form of birth control at the time of the survey. Nearly 10% of mothers using postpartum birth control were using less effective methods like condoms and withdrawal, indicating a need for more education and awareness about appropriate and effective birth control methods. These data indicate some of the important reasons for continued promotion of attendance at postpartum visits.

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

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

make timely postpartum appointments and provided transportation, if she needed it.

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

Children First, Oklahoma's Nurse-Family Partnership continued to provide a voluntary family support program that offered home visitation services to mothers expecting their first child. Upon enrollment, a public health nurse worked with the mother in order to increase her chances of delivering a healthy baby. The nurses addressed life course development with the client in the prenatal period. During the Children First postpartum visit, the nurse asked when the client's next appointment with the delivery provider was to occur. Mothers were also asked, up to 12 weeks postpartum, if they had returned for a postpartum visit. These questions provided a natural segue way to encourage the client to attend the postpartum exam. Data collection about the postpartum visit attendance for these clients started October 1, 2016.

Challenges:

The Oklahoma HealthCare Authority (OHCA) attempted to change the rate methodology for reimbursement for obstetrical services from the global structure and rate, inclusive of all antepartum, delivery, and postpartum services. The proposed rate methodology would have reimbursed for actual services rendered, splitting out the postpartum visit from the global package. However, in September of 2016, the agency retracted plans for changing the rate methodology and decided to stay with the global reimbursement package. Consequently, it remained difficult to determine how many women actually returned for their postpartum visit and to incentivize providers into more strongly encouraging women to attend this visit.

Objective 2. Improve birth intention by increasing the usage of the most effective methods of contraception among women on Medicaid and at risk for unintended pregnancy from 12.0% in 2014 to 12.6% in 2020.

Data:

Baseline data (fiscal year (FY) 2014) indicate 8.45% of females \leq 18 year olds, 16.27% of 19-24 year olds, and 14.72% of females \geq 25 on Medicaid relied on long acting reversible contraception (LARC) methods. FY 16 data show 4.5% of females \leq 18 year olds, 11.3% 19-24 year olds, and 8.1% of females 25 years or older with SoonerCare used a LARC.

Successes:

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

OSDH continued to support eligibility staff in all county health departments trained to assist clients with the online

enrollment process to help link clients with services (including contraception). Eligibility was determined (for any Medicaid program including Title XIX, SoonerPlan, Insure Oklahoma) at the time of application and clients were immediately provided with a Medicaid ID number to use in covering the cost of services for that day as well as setting up appointments if referrals were indicated. As of September 30, 2016, SoonerPlan provided coverage to 33,701 enrollees accounting for 4.18% of Medicaid enrollment. For state fiscal year 2016, SoonerPlan accounted for 7.04% of all enrollees.

Family planning services were provided through county health departments and contract clinics. Services included medical histories; physical exams; laboratory services; methods education and counseling; provision of contraceptive methods; STD/human immunodeficiency virus (HIV) screening and prevention education; pregnancy testing; immunizations; and preconception health education. OSDH continued promoting the new guidelines for the provision of family planning services released in April 2014 (Providing Quality Family Planning Services,(QFP)) requiring contraceptive counseling to present information on the most effective methods of contraception first. The Family Planning Annual Report for calendar year 2016 indicated a slight increase in clients relying on intrauterine devices/systems (1.6%) and a 13% increase in the number of clients relying on the implant for contraception. However, there was still a waiting list for these methods in county health departments as demand surpassed available funds to purchase the LARCs. Family planning services were provided to a total of 47,843 females and males of reproductive age for calendar year 2016. Of the 47,843 clients, 9,557 relied on public insurance and 30,513 were considered uninsured (SoonerPlan clients were included in the uninsured category for the purposes of FPAR since benefits are limited to only family planning related services).

Staff from the Oklahoma State Department of Health and the OHCA jointly led the Collaborative Improvement and Innovation Network (CollIN) Preconception team with this same goal. Staff from both agencies also provided leadership for the Association of State and Territorial Health Officials (ASTHO) team for improving access to contraception. Activities included participation in monthly network calls and face-to-face meetings. Historically, Title X funds were utilized to purchase LARCs for the OSDH clinics. Additional funding was secured this year from Title V and The Prevent Block Grant to purchase LARCs to eliminate the waiting lists and assist in ensuring availability for all clients on their date of service. The OHCA led efforts to recruit and train health care providers across the state on counseling and insertion for LARCs. The original contractor could not meet funding deadlines and staff worked with the University of Oklahoma Health Sciences Center to identify alternate resources for training.

Challenges:

Three major challenges emerged in relation to reaching this goal. Education, religiously affiliated hospital systems, and financial resources.

Reaching and educating busy physicians and other health care providers remained a challenge. Information on LARCs was provided via U.S. mail and email, electronically through websites and OHCA Provider letters, conferences, and through the Oklahoma Perinatal Quality Improvement Collaborative. However, many providers were still hesitant to counsel on and insert the most effective methods.

Although the OHCA started covering the placement of LARCs prior to hospital discharge after delivery effective 9/1/14, utilization of this benefit remained low. Utilization of immediate postpartum LARCs increased from 62 in CY 2014 to 228 in CY2015. Considering that OHCA covered almost half of the births in Oklahoma, this figure still remained low. Religiously affiliated hospital systems managed a large number of smaller hospitals and physician practices and LARCs could not be provided immediately postpartum in those hospitals and frequently not in the physician offices either for physicians associated with the hospital system. Clients were referred to another provider when they chose a LARC method for contraception erecting significant barriers especially in rural areas of the state.

Smaller hospitals, physician practices, and some Federally Qualified Health Centers faced financial barriers in purchasing LARCs and having them available for same day insertion. Some hospitals and providers were still not aware that LARCs could be placed immediately postpartum and billed separate from the global delivery charge.

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

Data:

Pregnancy Risk Assessment Monitoring System (PRAMS) data were used to monitor unintended pregnancy within Oklahoma. In 2013, 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 versions of the survey. For 2014 births, 48.6% of mothers reported an intended pregnancy, 33.5% reported an unintended pregnancy, and 18% said they weren’t sure what they wanted compared to 49.1%, 32.0%, and 18.9% respectively from 2013 data.

Successes:

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

OSDH continued to support eligibility staff in all county health departments trained to assist clients with the online enrollment process to help link clients with services (including contraception). Eligibility was determined (for any Medicaid program including Title XIX, SoonerPlan, Insure Oklahoma) at the time of application and clients were immediately provided with a Medicaid ID number to use in covering the cost of services for that day as well as setting up appointments if referrals were indicated. As of September 30, 2016, SoonerPlan provided coverage to 33,701 enrollees accounting for 4.18% of Medicaid enrollment. For state fiscal year 2016, SoonerPlan accounted for 7.04% of all enrollees.

Family planning services were provided through county health departments and contract clinics. Services included medical histories; physical exams; laboratory services; methods education and counseling; provision of contraceptive methods; STD/human immunodeficiency virus (HIV) screening and prevention education; pregnancy testing; immunizations; and preconception health education. OSDH continued promoting the new guidelines for the provision of family planning services released in April 2014 (Providing Quality Family Planning Services,(QFP)) requiring contraceptive counseling to present information on the most effective methods of contraception first and to counsel clients on the importance of developing a reproductive health plan. The Family Planning Annual Report for calendar year 2016 indicated a slight increase in clients relying on intrauterine devices/systems (1.6%) and a 13% increase in the number of clients relying on the implant for contraception. However, there was still a waiting list for these methods in county health departments as demand surpassed available funds to purchase the long acting reversible contraception (LARCs). Family planning services were provided to a total of 47,843 females and males of reproductive age for calendar year 2016. Of the 47,843 clients, 9,557 relied on public insurance and 30,513 were considered uninsured (SoonerPlan clients were included in the uninsured category for purposes of the Family Planning Annual Report, as benefits are limited to only family planning related services).

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

MCH continued to receive funding through the federal Personal Responsibility Education Program (PREP) grant to maintain teen pregnancy prevention efforts. PREP funds continued to support projects in the Oklahoma City County Health Department (OCCHD) and Tulsa Health Department (THD). Both projects continued to build connections with schools and expanded their reach in providing the evidence-based curricula, "Making a Difference!", "Making Proud Choices!", and "Reducing the Risk." An additional curriculum option was added this year, "Power through Choices" to assist in reaching out-of-home youth.

Three sites in two 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. MCH staff developed and offered a one-day Public Health Youth Council Facilitator training. One training was conducted during the fiscal year. Facilitators were trained to utilize both positive youth development and youth-adult partnership frameworks in the development and implementation of the youth councils.

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 Life Course Perspective for provision of health care; adolescent health and unplanned pregnancy prevention; intimate partner violence and sexual coercion; using a client centered approach to contraceptive counseling; adolescent health issues (including teen pregnancy prevention); grandparents raising grandchildren; and, fatherhood and male involvement in reproductive health.

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

Challenges:

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.

Lack of funding to adequately meet the demand for LARCs was a major challenge. Although effective at preventing unintended pregnancies, the upfront cost of LARC methods was prohibitive for some health care providers. OSDH health care providers did an excellent job of promoting these methods even though funding was not available to meet the demand until September. The order for additional Nexplanon and Mirena was placed 9/30/16.

In addition, religiously affiliated hospital systems managed a large number of smaller hospitals and physician practices and LARCs could not be provided immediately postpartum in these hospitals and frequently not in the physician offices either, for physicians associated with the hospital system. Clients had to be referred to another provider when they chose a LARC method for contraception erecting significant barriers, especially in rural areas of the state.

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

Data:

The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health (OSDH) or any alternative tool remained constant this year. Every county health department

utilized the Women's Health Assessment with clients being seen for an initial or annual exam and all clients with a negative pregnancy test desiring pregnancy. Plans to expand usage of the tool did not materialize as staff at partnering agencies changed and consequently priorities and partnerships changed.

Successes:

County health departments continued to utilize the Women's Health Assessment tool with more than 38,690 clients in the clinic for preventive health check-ups and pregnancy tests.

Preconception health information was distributed in cloth bags to Farmer's Markets and through community baby showers in the summer and fall of 2015. After October 1, locations included baby showers in Tulsa, Custer County, and at Langston University. Information in the bags included: Prescription for a Healthy Future, information on folic acid and immunizations, and resources for physical and mental health clinical services.

The Oklahoma Health Care Authority (OHCA) and MCH staff distributed pharmacy bags to the Indian Health Care Resource Center, Absentee Shawnee Pharmacy, Li-Si-Wi-Nwi Pharmacy, Chickasaw Nation – Purcell Clinic, Talihina, Eufaula, Ardmore, Ada, Miami, Tishomingo and Wyandotte. The pharmacy bags contained messages on folic acid and tobacco cessation as well as the logo for the statewide *Preparing for a Lifetime, It's Everyone's Responsibility Initiative* to decrease infant mortality. In order to get the bags, pharmacies had to agree to distribute material related to tobacco cessation, Text4Baby, or *Preparing for a Lifetime*.

MCH staff shared preconception health and prematurity information at the annual March of Dimes Walk for Babies on May 14, 2016 including Prescription for a Healthy Future for men and women, folic acid, progesterone therapy for prevention of subsequent preterm births, and tobacco cessation.

Information was shared via social media through Facebook postings during women's and men's health weeks on mental, sexual, reproductive, and cardiovascular health, prostate health for men and breast health for women. Information was also posted on simple steps to take to protect babies from four infections that cause serious health problems: Zika, Group B strep, Cytomegalovirus, and Listeriosis.

The Perinatal and Reproductive Health Division (PRHD) also maintained a web page under the *Preparing for a Lifetime Initiative* page on preconception health entitled "Before and Between Pregnancy" with information on living a healthy lifestyle, making healthy food choices, getting regular health check-ups, emotional wellness and support, knowing health and pregnancy risks and provided a list of free resources.

A public service announcement (PSA) entitled "Measure Up" aired on television and radio between November and September. The PSA promoted the importance of being healthy prior to pregnancy and planning for pregnancy.

Challenges:

A new billing code was added to help track usage of the Women's Health Assessment however, preliminary assessment indicated that the code was not consistently used this year and consequently data was not accurate on actual usage.

Changing the paradigm from reactive to proactive with emphasis on establishing a reproductive health plan and taking steps to ensure reproductive goals are reached resulting in a healthy pregnancy; intended pregnancies remained a challenge. Healthcare providers were busy and often did not have time for counseling and planning. A multitude of resources were available to assist with preconception health counseling; however, busy providers did not have time to review and assess all the resources available in order to choose a resource that would work best for

each of them.

Funding also remained a challenge as federal and state budgets faced repeated cuts and revenue failures.

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

Data:

Maternal death continued to be the international standard by which a nation's commitment to women's status and their health could be evaluated. The Maternal Mortality Rate (maternal deaths within 42 days of termination of pregnancy per 100,000 live births) for Oklahoma from 2013-2015 among women aged 10-59 years was 19.4 maternal deaths per 100,000 live births. The goal of Healthy People 2020 is to reduce the Maternal Mortality rate to no more than 11.4 per 100,000 live births. This measure was changed from a one year rate, which included maternal deaths occurring up to one year from termination of pregnancy, to a three year rate of those occurring within forty-two days from termination of pregnancy. This was done to better assure the availability of comparable data to other state and national rates. MCH policy for reporting Oklahoma maternal mortality rates was also changed so that only three year rolling averages would be released.

Successes:

The Maternal and Child Health Service (MCH) continued to provide leadership for the Maternal Mortality Review. Oversight was provided by the Perinatal and Reproductive Health Division (PRHD) Administrative Program Manager (APM) and the Nurse Manager served as the project manager. The Maternal Mortality Review (MMR) remained an essential community process used to enhance and improve services to women, infants and their families. Qualitative, in-depth reviews investigated the causes and circumstances surrounding each maternal death. Through communication and collaboration, the MMR served as a continuous quality improvement system that resulted in a better understanding of the maternal issues. The overall goal of the MMR was prevention through understanding of causes and risk factors. The list of maternal deaths, obtained from the Vital Records Division, was reviewed by the APM and the PRH Medical Director to determine which cases would be reviewed by the committee. All possible pregnancy related and pregnancy-associated deaths were reviewed for women who died while they were pregnant or within 365 days of the end of the pregnancy. The APM, two nurse practitioners and the nurse manager abstracted cases for review. In Oklahoma, the committee was broadly representative of medical, social and community services and providers. The committee reviewed three to four cases at quarterly meetings to identify gaps in services or possible system level changes to prevent future maternal deaths.

MCH participated in the Every Mother Counts Collaborative with the Association of Maternal and Child Health Programs (AMCHP) and the Centers for Disease Control and Prevention (CDC) from November 2014 to March 2016 to strengthen maternal mortality reviews across the nation. The kick-off event occurred just prior to this reporting period (April 24, 2015). Activities focused on implementing the postpartum hemorrhage and hypertension bundles published by the Patient Safety Council in birthing hospitals in Oklahoma. The University of Oklahoma Health Sciences Center's Office of Perinatal Quality Improvement (OPQI) led efforts with hospital staff to collect data and provided technical assistance for implementing the bundles. After the collaborative ended, MCH continued to work with AMCHP and the CDC in the adoption of a new data base, hosted by the CDC to help states collect and report comparable data. MCH continued to work through technical issues to transition to the Maternal Mortality Review Data System (MMRDS) or the new network based Maternal Mortality Review Information Application (MMRIA) database.

The Council on Patient Safety in Women's Health Care was awarded a four-year, \$4 million cooperative agreement

from the Health Resources and Services Administration (HSRA) Maternal and Child Health Program in 2015. The goal is to prevent 100,000 severe complications during delivery hospitalizations and 1,000 maternal deaths over the course of the funding period. The agreement funds the program “Alliance for Innovation on Maternal Health (AIM): Improving Maternal Health and Safety”. AIM collaborated with public, private, and professional organizations to focus on the areas of **obstetric hemorrhage**, severe hypertension, venous thromboembolism, reduction of primary cesarean births, and reduction of racial disparities during pregnancy contributing to maternal morbidity and mortality. Oklahoma became the first AIM state based on infrastructure and activities put in place through the Every Week Counts Collaborative. In January 2016, the AIM data portal went live and participating hospitals started entering data. All participating Oklahoma birthing hospitals (48/51) worked on postpartum hemorrhage and/or hypertension. Information on outcome measures was entered into the database through the Vital Records Division. Process measure information was entered by individual hospital staff. Hospitals were recognized as “Spotlight Hospitals” for establishing protocols and entering data into the AIM data portal.

Challenges:

Although Oklahoma’s maternal mortality rate was high, the relatively small number of cases each year made it challenging to identify system level interventions to improve morbidity and prevent mortality.

Frequently, case review summaries were missing critical information. Without legislative support for MMR activities requiring entities to provide information, full case review could not be completed and system level changes could not always be identified. MCH tried to work with the OSDH Office of State and Federal Policy to secure an author for a bill defining activities and requiring entities to provide requested information. Unfortunately, an author was not found for the current legislative session.

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

Data:

According to data from the 2015 The Oklahoma Toddler Survey (TOTS), 44.5% of new mothers were screened for postpartum depression. Targets for this objective were adjusted from the previous verbiage of “39.9% in 2012-2014 to 43.1% in 2020” to reflect the met goal. Almost 11% of mothers with toddlers indicated they had been diagnosed with postpartum depression sometime after their toddler was born.

Successes:

MCH continued to provide education and outreach to community partners, to include: health providers, home visitation programs, behavioral health providers, hospital staff; and those families affected by postpartum depression (PPD). MCH staff was interviewed by local media on the effects of PPD on children and parenting for mothers and fathers. The interview came after an incident in Oklahoma where a mother who was postpartum committed a crime which ended in her injuring her infant.

MCH and community partners participated in the NAMI (National Alliance for Mental Illness) walk to raise awareness for PPD. MCH and Child Guidance staff partnered with two community partners to form PPD support groups. They also worked collaboratively with community partners to raise awareness about PPD during Mental Health Awareness Month in May 2016. Social media messaging via Facebook postings went out during the same time and was well-received.

The *Preparing for a Lifetime* Workgroup partnered with Postpartum Progress for the “climb out of darkness walk” in June 2016. The workgroup also collaborated with Calm Waters and the Oklahoma Family Network to bring

awareness about PPD to families who had children in the NICU and to families who had lost a child during pregnancy. The partnership with Calm Waters led to the development of an infant loss support group, as those mothers were at high risk for symptoms of postpartum depression.

In October of 2015, a training sponsored by Postpartum Support International (PSI) was attended by 15-20 professionals. The training provided information and clinical intervention for mental health professionals. Many employees of OSDH attended.

In January 2016, the name of the PPD Workgroup changed to the MMD (Maternal Mood Disorders) Workgroup to encompass other mood disorders during the maternal period. This term has also been adopted nationally by many organizations.

Challenges:

Maternal mood disorders/postpartum depression were not widely recognized or diagnosed by families or providers.

Universal screening implementation was an on-going challenge. The argument most often made was that there were not enough resources for the management of PPD for those with positive screens. There continued to be a significant shortage of licensed behavioral health providers who could or would treat MMD and/or saw it as a priority need in their areas.

Perinatal/Infant Health

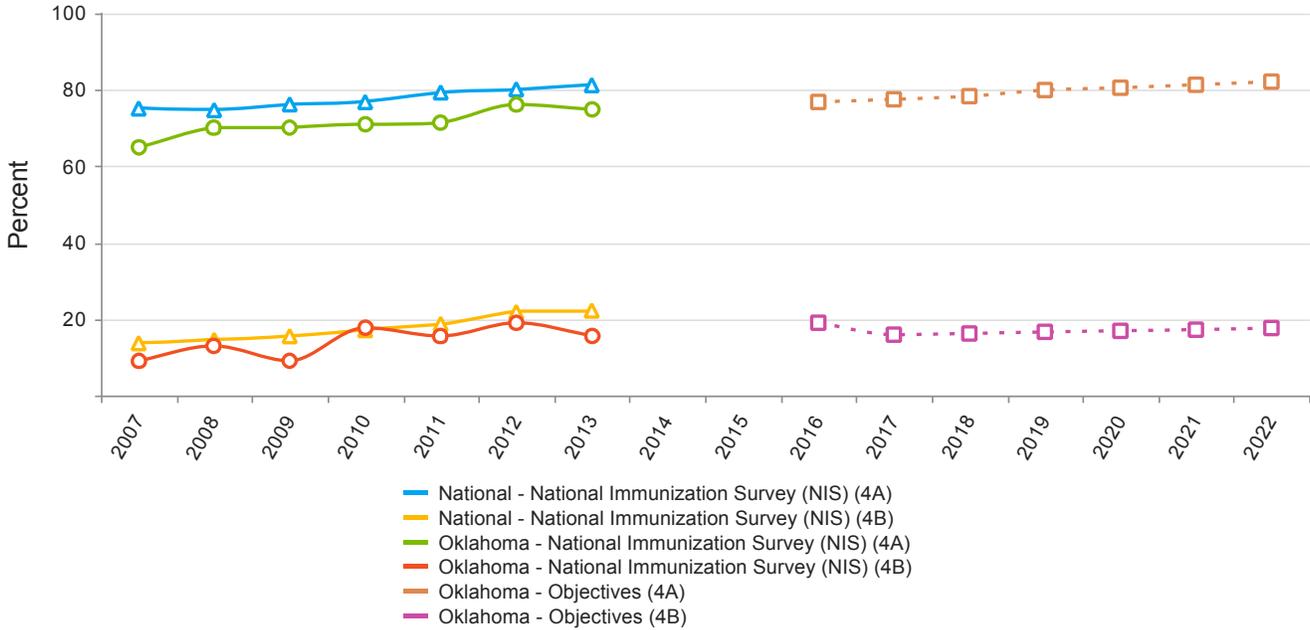
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	8.2	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.9	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	155.6	NPM 4 NPM 5

National Performance Measures

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

Baseline Indicators and Annual Objectives



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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	76.7
Annual Indicator	74.7
Numerator	38,593
Denominator	51,646
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	77.4	78.2	79.8	80.4	81.2	82.0

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	19.1
Annual Indicator	15.7
Numerator	7,715
Denominator	49,145
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	16.0	16.3	16.7	17.0	17.3	17.7

Evidence-Based or –Informed Strategy Measures

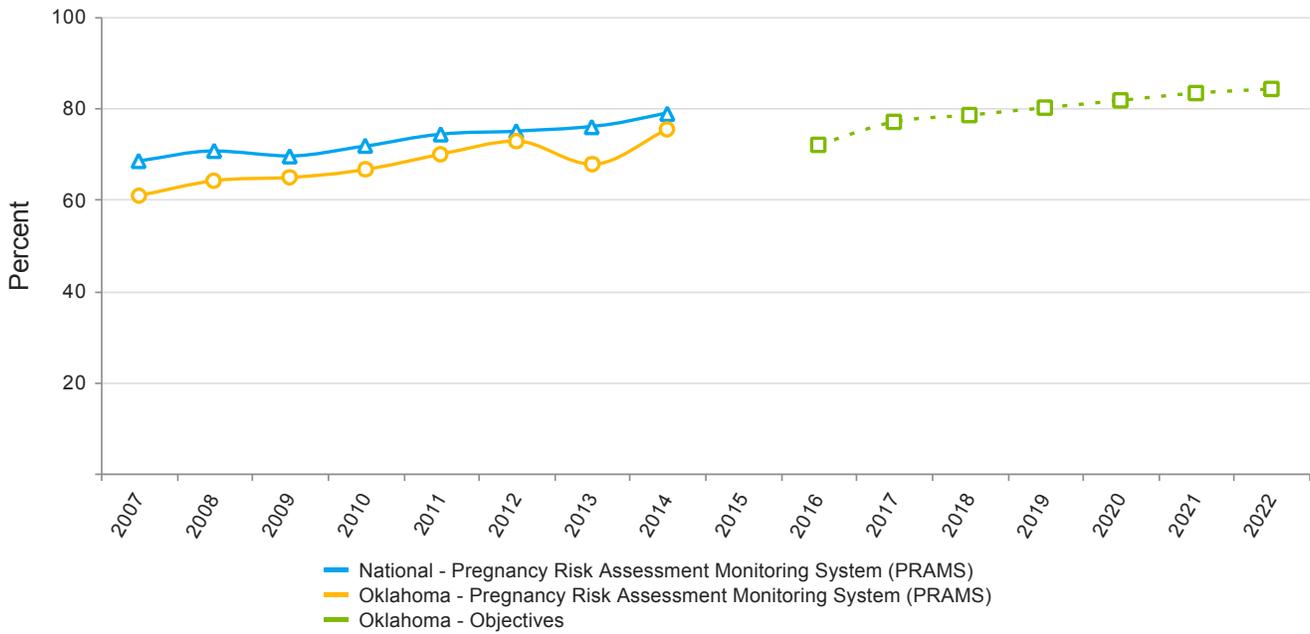
ESM 4.1 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	14.9
Numerator	7,911
Denominator	53,118
Data Source	Oklahoma Vital Statistics
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.6	16.4	17.2	18.1	19.0	20.0

**NPM 5 - Percent of infants placed to sleep on their backs
Baseline Indicators and Annual Objectives**



Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	71.9
Annual Indicator	75.4
Numerator	37,018
Denominator	49,130
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	76.9	78.4	80.0	81.6	83.2	84.1

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	69.2
Numerator	36,743
Denominator	53,118
Data Source	Oklahoma Vital Statistics
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	70.6	72.0	73.4	74.9	76.4	77.9

State Performance Measures

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

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	7.4
Numerator	391
Denominator	52,584
Data Source	Oklahoma Vital Statistics
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.3	7.1	7.0	6.8	6.7	6.6

State Action Plan Table

State Action Plan Table (Oklahoma) - Perinatal/Infant Health - Entry 1

Priority Need

Reduce infant mortality

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

1. Increase the percent of mothers who breastfeed their infants at hospital discharge from 75.0% in 2013 to 78.0% by 2020.
2. Increase the percent of mothers who breastfeed their infants at 6 months of age from 37.0% in 2014 to 38.3% by 2020.

Strategies

- 1a. Coordinate with the WIC Breastfeeding Task Force to develop materials and participate in planning a variety of statewide breastfeeding trainings for WIC, county health department and independent agency staff, and statewide healthcare providers as they are scheduled.
- 1b. Provide support for the Oklahoma Breastfeeding Hotline.
- 1c. Provide support for the Oklahoma Hospital Breastfeeding Education Project.
- 1d. Provide support for the Becoming Baby-Friendly in Oklahoma (BBFOK) Project.
- 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.
- 2a. Partner with the Coalition of Oklahoma Breastfeeding Advocates (COBA) to increase Oklahoma Breastfeeding Friendly Worksites/ Businesses.
- 2b. See also strategies for Objective 1.

ESMs

Status

ESM 4.1 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly Active

NOMs

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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

Priority Need

Reduce health disparities

NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Objectives

Improve breastfeeding duration rates among African American mothers from 16% (2009-2011 NIS data) to 16.8% by 2020.

Strategies

Support COBA's efforts to continue Baby Cafés, with an emphasis on African American mothers/families.

Support COBA's efforts to further expand Baby Cafés, among other racial and ethnic minorities, including American Indian and Hispanic mothers and families.

Partner with WIC to increase the number of ethnically diverse peer counselors.

ESMs

Status

ESM 4.1 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly

Active

NOMs

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Priority Need

Reduce infant mortality

NPM

Percent of infants placed to sleep on their backs

Objectives

1. Increase the number of hospitals participating in the Safe Sleep Sack Program from 21 in 2015 to 30 in 2020.
2. Increase the number of trainings given to providers and professional organizations on infant safe sleep from 2 in 2014 to 4 in 2018.
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 to the Preparing for a Lifetime website and MCH Facebook page from 411 to 495 hits by 2020.

Strategies

1. Provide safe sleep training and technical assistance to birthing hospitals.
2. Provide training and technical assistance to home visiting programs, child care centers, and other community and health organizations that address the needs of newborns and infants.
- 3a. 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.
- 4a. Establish a baseline for the Preparing for a Lifetime website and MCH Facebook postings.
- 4b. Implement social marketing strategies and promote the Preparing for a Lifetime website and MCH Facebook page.
- 4c. Assign a person from the Infant Safe Sleep Work Group to assist with social media projects.

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

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

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

Priority Need

Reduce health disparities

NPM

Percent of infants placed to sleep on their backs

Objectives

1. 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.
2. Reduce infant mortality rate due to unsafe sleep practices for American Indian infants from 9.5 in 2014 to 7.5 by 2018 and from 14.6 in 2014 to 12.6 for African American infants by 2018.

Strategies

- 1a. Provide safe sleep training and technical assistance to birthing hospitals with high numbers of African American and American Indian births.
- 1b. Target specific populations through outreach efforts, including, community baby showers, health fairs, family conference partners (OFN, DHS), and local schools to increase education on safe sleep practices and guidelines.
- 1c. Provide opportunities to train community leaders and educate non-traditional partners, including faith based organizations and non-profit organizations that help women and infants.
- 2a. Work with pilot groups (NICU at OU Hospital, Home visitation program, and Office of Minority Health) to identify and educate families of infants on culturally and racially specific safe sleep practices.
- 2b. Work with pilot groups to identify families eligible for the pilot crib project, which provides a pack-n-play and racially and culturally specific information and training on safe sleep guidelines and practices for families unable to provide a safe sleep surface for their newborns.
- 2c. Evaluate the effectiveness of the crib pilot, by conducting caregiver surveys at one month and six months post distribution.

ESMs

Status

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

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Priority Need

Reduce the incidence of preterm and low birth weight births

SPM

Infant mortality rate per 1,000 live births

Objectives

1. Reduce the rate of preterm births (births < 37 weeks gestation) from 10.8 in 2012 to 9.1 by 2020.
2. Increase the number of women who receive prenatal care in the first trimester of pregnancy from 68.5% in 2013 to 71.9% by 2020.

Strategies

- 1a. Lead state team on the national Prematurity CoIIN Initiative.
- 1b. Increase utilization of progesterone therapy among pregnant women with a previous preterm delivery.
- 1c. Increase the number of hospitals utilizing fetal fibronectin testing to assist in determining the plan of care for women with preterm contractions.
2. 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.).

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

Priority Need

Reduce health disparities

SPM

Infant mortality rate per 1,000 live births

Objectives

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

Strategies

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

Collaborate with Screening and Special Services to offer multi-vitamins to family planning clients to increase folic acid consumption before and between pregnancies. (NEW STRATEGY)

Perinatal/Infant Health - Plan for the Application Year

Breastfeeding rates will be monitored through PRAMS, WIC, TOTS, and National Immunization Survey (NIS) data. Information will be shared with state policymakers, healthcare providers, families, and community groups. The OSDH employee mothers' room and worksite policy information will continue to be shared on the agency intranet, bulletin boards, websites, and through conferences, serving as models for state and community agencies and worksites. Efforts will continue to promote and increase Oklahoma's Recognized Breastfeeding Friendly Worksites.

MCH will work with WIC's Breastfeeding Task Force, participating in efforts to coordinate with Indian Tribal Organization members to plan joint Breastfeeding conferences and trainings. The Task Force will coordinate World Breastfeeding Week activities, review breastfeeding promotion and duration materials for county health departments and area clinics, promote breastfeeding duration through a radio and television public service announcement (PSA) focusing on ways dads, grandparents, employers, and child care workers can support breastfeeding mothers, and help to identify expansion sites for the Breastfeeding Peer Counseling Program.

Breastfeeding duration will be promoted through joint efforts of the OSDH MCH Service and WIC Program, Coalition of Oklahoma Breastfeeding Advocates (COBA), PFLT and COBA Breastfeeding Friendly Worksite Recognition Program, the Turning Point Annual Conference, Oklahoma Healthy Birth Alliance, Oklahoma Breastfeeding Resource Center, websites, and statewide news releases and trainings. The OSDH PFLT Breastfeeding, OK Breastfeeding Resource Center, and COBA websites will serve as statewide breastfeeding resources.

MCH will continue to partner with OUHSC to maintain support for the 24 hour Oklahoma Breastfeeding Hotline. The hotline 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 Oklahoma Mothers Milk Bank as it serves the eight Oklahoma level III Neonatal Intensive Care Units (NICUs), smaller rural level II NICUs and establishes additional milk depots in statewide Oklahoma Blood Institute centers.

Through a MCH contract, the Oklahoma Hospital Breastfeeding Education Program (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 (OHCA), the Oklahoma Hospital Association, the OUHSC Office of Perinatal Quality Improvement (OPQI), the Oklahoma Perinatal Quality Improvement Collaborative (OPQIC), and the HBEP to promote Baby-Friendly designation for Oklahoma hospitals.

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

There will continue to be an emphasis on reducing racial disparities in Safe Sleep by addressing racial and ethnic specific communities, training community leaders, providing cribs and sleep sacks and culturally specific materials.

The Safe Sleep Workgroup will continue working to increase the number of hospitals educated in infant sleep safety and participating in the sleep sack distribution program to meet the goals and objectives of the Infant Safe Sleep Work Plan.

There are plans to purchase more cribs in order to extend the crib distribution project, and additional partners will participate in the distribution of cribs to the families.

Prematurity will remain a priority focus for OSDH and community partners. The Oklahoma State Department of Health, the Oklahoma Health Care Authority, the March of Dimes, and OPQI will continue to support the activities of the Oklahoma Perinatal Quality Improvement Collaborative in addressing perinatal quality of care issues in Oklahoma. Promotion of progesterone therapy to prevent preterm births will continue to be a priority as well as reducing barriers for women with private insurance to access progesterone.

Preconception/Interconception Care and Education and Tobacco Cessation, two workgroups with the *Preparing for a Lifetime, It's Everyone's Responsibility* initiative, will continue activities to impact the number of preterm births by decreasing smoking rates during pregnancy and to promote reproductive life planning to address preconception health risks prior to pregnancy through dissemination of preconception information at health fairs and community baby showers.

MCH will continue to provide contraceptives through the Title X Family Planning Grant. Emphasis will continue to be 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.

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

MCH staff will continue to meet with community prenatal care providers in efforts to identify ways to partner and improve access to prenatal care.

CHD staff will continue assisting clients with a positive pregnancy test in signing up for Text4Baby prior to leaving the clinic. The Oklahoma Health Care Authority (OHCA) will continue texting all women enrolled for prenatal care, offering them the opportunity to enroll in Text4Baby.

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

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

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

MCH will continue to provide partial funding for birth defects screening and the Oklahoma Birth Defects Registry.

Zika screening and surveillance activities will continue across the state.

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

Objective 1: Increase the percent of mothers who breastfeed their infant at hospital discharge from 75.0% in 2013 to 78.0% by 2020.

Objective 2: Increase the percent of mothers who breastfeed their infant at 6 months of age from 37.0% in 2014 to 38.3% by 2020.

Data:

The Oklahoma Toddler Survey (TOTS) provided data to monitor NPM#4. According to 2014 TOTS data, 37.0% of women reported breastfeeding their infants to six months of age, not significantly different from 2010. Maternal and Child Health Service (MCH) monitored breastfeeding initiation, duration, and exclusivity using Pregnancy Risk Assessment Monitoring System (PRAMS), Women, Infants and Children Supplemental Nutrition Program (WIC), TOTS, and the National Immunization Survey (NIS) data. This information was shared with state policymakers, health care providers, families, and community groups.

Successes:

One hundred and fourteen (114) attended the Second Reducing Racial and Ethnic Inequities in Breastfeeding Conference from 13 hospitals and 31 organizations. Featured Speakers and topics were Sherry Payne, MSN, RN, IBCLC, Executive Director of the Uzazi Village in Kansas City, Missouri, *What You Don't Know Hurts Us: Racism, White Privilege, and Breastfeeding Disparities*; Muswamba Mwamba, MPH, IBCLC, from the Dallas Health Department, *What Can We Learn from African Immigrants within the African American Minority Group*; and Kamisha Busby, Oklahoma City Healthy Start Director, *Healthy Start Updates*. A Leadership Panel discussed *What do inequities and racism have to do with me?* Participants also had an opportunity to experience how inequities affect the trajectory of one's life by playing the *Life Course Game*.

One hundred and twenty two (122) attended the 4th Annual *Becoming Baby-Friendly in OK (BBFOK) Summit* with leadership teams from 21 hospitals and 10 organizations. Featured speakers were Alison Stuebe, MD, MSc, from the University of North Carolina School of Medicine and Anne Merewood, MPH, PhD, IBCLC, from Boston Medical Center, Muswamba Mwamba, MPH, IBCLC, Dallas Health Department, and Becky Mannel, IBCLC, FILCA, BBFOK Project Lead & Oklahoma Breastfeeding Resource Center Director. Topics were *Building a Breastfeeding Culture Using the Six Sources of Influence*, *Breastfeeding and Maternal Substance Abuse*, and *The Obstetrician's Role in Promoting and Supporting Breastfeeding/How Baby-Friendly Hospitals Can Improve Your Patient Outcomes*. The Summit also included a Fathers' Panel and Recognition of Oklahoma's newest (third and fourth) Baby-Friendly Hospitals: Cherokee Nation W. W. Hastings Hospital in Tahlequah and Comanche County Memorial Hospital in Lawton. Twelve hospitals continued efforts toward designation and more have indicated interest. Over half of the state's birthing hospitals (28) have stopped providing formula discharge bags, and according to NIS 2013 data, Oklahoma's breastfeeding rates increased in two categories.

Oklahoma's Maternity Practices in Infant Nutrition and Care (mPINC) total rose from 71 in 2013 to 78 in 2015, with increases in all seven areas, five of which were above the national average. Six birthing hospitals received the 2016 Oklahoma Perinatal Quality Improvement Collaborative's (OPQIC) "Spotlight Hospital" recognition (Sept. 16th) in their Pathways to Excellence designation, which included participation in BBFOK. Four of the six were also 2015 Spotlight Hospital Award Recipients.

As part of the WIC Breastfeeding Task Force, MCH participated in planning for the 16th Annual WIC Breastfeeding Symposium, however due to the state's budget/funding issues; plans for the Symposium were cancelled. One hundred and sixty seven (167) Oklahoma Breastfeeding Friendly Worksites including 26 hospitals and healthcare facilities received Gold Star recognition through meetings, conferences, and websites. WIC sponsored a free two-day Lactation Cram Course September 8th and 9th, provided by *Lactation Education Consultants*, Jan Ellen Brown and Pam Allyn with 76 attending. WIC also sponsored the Breastfeeding Educator Course with Alabama's Glenda Dickerson, Women's Support Services Manager at Brookwood Women's Medical Center in Birmingham. WIC Peer Counselors worked in 38 clinics in 24 counties.

The Task Force promoted World Breastfeeding Week (WBW) and National Breastfeeding Month with the theme *Breastfeeding: Building a Brighter Future*, and provided input for state and community news releases. Clinics hosted receptions, shared materials to support mothers and increase breastfeeding rates, distributed *Breastfeeding Laws* cards and *Thank You for Breastfeeding* cards, promoted enrollment in Text4Baby, and shared *the hospital experience* booklets. MCH displayed the theme and offered breastfeeding materials in the Central Office lobby, coordinated with the Coalition of Oklahoma Breastfeeding Advocates (COBA) to provide materials and staff displays for La Leche League Live, Love, and Latch events in Edmond, Mustang/Yukon, and Duncan; for COBA Baby-Cafés in Edmond, Oklahoma City, and Lawton; and for the first annual Lift Every Baby Celebration in Tulsa. An Oklahoma Chocolate Milk Café sponsored a family health fair celebrating Black Breastfeeding Week. MCH and COBA also provided breastfeeding promotion materials for the University of Central Oklahoma's Wellness Day event.

MCH support continued for the Oklahoma Breastfeeding Hotline (OBH), providing information and referrals for 2,713 mothers, their families, and health care providers. Funding was also provided for the 13th accredited Oklahoma Mothers' Milk Bank (OMMB), which celebrated its third year anniversary serving all 8 of the level III Neonatal Intensive Care Units (NICUs). Support also continued for the Hospital Breastfeeding Education (HBEP) and the BBFOK Projects. Participating BBFOK Hospitals began a two-to-three year learning collaborative to make system-level changes to achieve the Baby-Friendly designation. They worked with state breastfeeding and quality improvement experts through in-person sessions and regular education/networking webinars. Project support included reimbursement of the majority of the Baby-Friendly USA phase completion fees, education stipends for attending BBFOK annual summits, ongoing technical support to facilitate policy development/revision, staff/physician education, onsite skills labs and site visits, and mock surveys prior to Baby-Friendly assessments.

MCH continued to promote breastfeeding duration, Baby-Friendly Hospitals and COBA Baby Cafés through a variety of venues; the Oklahoma Health Improvement Plan Children's Health Workgroup, OPQIC and *Preparing for A Lifetime* meetings, the Oklahoma Turning Point Conference and National Nutrition Month activities and displays.

The *Preparing for a Lifetime, It's Everyone's Responsibility* (PFLT) Breastfeeding Workgroup met monthly with members representing the Oklahoma Family Network, Oklahoma Birth Network, Chickasaw Nation, Oklahoma Turning Point, OMMB, SoonerStart, Oklahoma Employee Benefits Department/Human Capital Management, University of Oklahoma Health Sciences Center (OUHSC), MCH, and WIC Services. Workgroup members coordinated with COBA members in quarterly joint meetings to promote breastfeeding friendly worksites. Breastfeeding Friendly Worksite Area Coordinators assisted worksites in creating breastfeeding policies, establishing employee breastfeeding rooms, and in receiving recognition.

With second year Association of State and Territorial Health Officials (ASTHO) funding, COBA opened a COBA Baby Café in the largest of the 7 WIC clinics in Oklahoma City, later moving it to the Oklahoma Mothers' Milk Bank, also in the same zip code area and on the bus route.

COBA partnered with INTEGRIS Health Edmond (IHE) to open a hospital sponsored café in January 2016. IHE achieved Baby-Friendly designation in May 2016. ASTHO grant funding enabled BBFOK Project leaders at the Oklahoma Breastfeeding Resource Center to complete development of an online training course meeting the 15 hours of didactic staff education requirements for Baby-Friendly USA. This training course has been made available to participating BBFOK hospital staffs through the OUHSC online education portal for a minimal fee of \$30.00 per person, and to non-participating hospitals' staff for a \$60.00 per person fee.

Objective 1: Improve breastfeeding duration rates among racial and ethnic minorities.

Successes:

ASTHO funding provided Certified Lactation Counselor (CLC) Training for an additional woman of color, who also attended a WIC sponsored lactation management course. Third year efforts have focused on maintaining and building attendance in three cafés located in Edmond, Oklahoma City, and Lawton. Baby Café facilitators provided peer support for African American and Hispanic families in the three areas with twice monthly meetings in each area. Five bus stop ads promoting the OKC baby café were created and posted in the Oklahoma City target area.

Challenges: More hospitals wanted to participate in the BBFOK project and were challenged to acquire physician and leadership buy-in. Competing priorities continued to contribute to the loss of active workgroup members, and the state's budget issues limited provision and attendance for some trainings. As a new non-profit, the state coalition learned that strong board leadership, good financial accounting/bookkeeping, communication, and an initial pool of funding were necessary to operationalize the Baby Café Project.

NPM: Percent of infants placed to sleep on their backs.

Objective 1. Increase the number of hospitals participating in the Safe Sleep Sack Program from 21 in 2015 to 30 in 2020.

Objective 2. Increase the number of trainings given to providers and professional organizations on infant safe sleep from 2 in 2014 to 4 in 2018.

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

Objective 4. Increase the number of hits for the Preparing for a Lifetime website and MCH Facebook page from 411 in 2016 to 495 hits by 2020.

Objective 5. 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.

Objective 6. Reduce infant mortality rate due to unsafe sleep practices for American Indian infants from 9.5 in 2014 to 7.5 by 2018 and from 14.6 in 2014 to 12.6 for African American infants by 2018.

Data:

Between October 1, 2015 and September 30, 2016 approximately 22,140 sleep sacks were provided to families upon discharge from the 21 participating Oklahoma birthing hospitals. Due to the success of the sleep sack program, Objective 1 has been changed from "Increase the number of hospitals participating in the Safe Sleep Sack

Program from 11 in 2015 to 20 in 2020” to “21 in 2016 to 30 in 2020.”

Infant mortality rate data are the most current available. The percent of infants who were put to sleep on their backs was 75.4% in 2014. This is an increase from 64.9% in 2009. However, 53.0% of African American mothers reported placing their infants to sleep on their backs, compared to 77.2% of white mothers and 74.7% of American Indian mothers.

Successes:

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 Workgroup, led by the Maternal and Child Health SIDS and Safe Sleep Coordinator continued to work toward the goals and objectives in the Infant Safe Sleep Work Plan. Workgroup members included representatives from the Central Oklahoma and Tulsa Fetal Infant Mortality Review (FIMR) programs, Oklahoma MIECHV, Oklahoma Child Death Review Board, Oklahoma SAFE KIDS Coalition, Oklahoma Health Care Authority, the University of Oklahoma Health Sciences' Office of Perinatal Quality Improvement (OPQI), as well as additional community and state agencies. The OK TRAIN modules on Infant Sleep Safety: Risk Reduction and Prevention of Infant Sleep Related Deaths 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, signed the Infant Safe Sleep Hospital Participation Agreement, and began participating in the *Preparing for a Lifetime* Safe Sleep Workgroup's sleep sack distribution program.

The Oklahoma State Department of Health received funding in the fall of 2015 for a Cribs Pilot Project. The Maternal and Child Health Service developed a plan to provide a safe sleep environment for families that were not able to purchase cribs, with a focus on African American and Native American families. The health department worked with four partners: OU Children's Hospital NICU, OSDH Office of Minority Health, OSDH contracted Home Visitation Programs, and the Oklahoma City Indian Clinic to distribute Infant Pack-N-Plays, sleep sacks and culturally specific materials to qualified families beginning in February 2016. One hundred ninety-two cribs were distributed to families as of September 30, 2016.

The Oklahoma FIMR programs, supported by Title V funds, provided safe sleep education in their communities, including providing updated training for home visitors and DHS Child Welfare workers. Central Oklahoma FIMR provided 5 Infant Safe Sleep Train-the-Trainer sessions and had a total of 161 participants from across the state.

In collaboration with the OSDH Office of Minority Health (OMH), *Preparing for a Lifetime* urged communities to continue to host community baby showers at local libraries, community centers, or other venues. 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, breastfeeding, and taking care of oneself during and after pregnancy. Community partners provided free door prizes and light snacks for those attending, and the OMH distributed Pack-N-Plays to qualified families.

As of September 2016, 21 hospitals were participating in the Sleep Sack program. Another six or seven hospitals were in the process of changing their policies to include Safe Sleep Education in order to begin participation. In September 2016 a new bid was written to purchase additional sleep sacks to accommodate the growing need.

Challenges:

The large racial/ethnic disparity for both safe sleep and infant mortality in the state was a continued challenge. 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.

Additional challenges were staff time and resources to meet the needs.

SPM: Infant mortality rate per 1,000 live births

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

Data:

Prematurity remained the second leading cause of infant mortality in Oklahoma at 10.3%, significantly higher than the Healthy People 2020 goal of 8.1%. Disparities still remained evident with Black women having a preterm birth rate of 14.2% compared to American Indian/Alaska Natives women at 10.7%, white women at 10.3%, Hispanic women at 9.6% and Asian/Pacific Islander at 9.3% (MOD 2016 Report Card).

Successes:

Two workgroups of the *Preparing for a Lifetime, It's Everyone's Responsibility* initiative addressed preconception/interconception health and prematurity in Oklahoma. The Preconception/Interconception Workgroup of the *Preparing for a Lifetime* initiative to reduce infant mortality focused on educating women about planning for pregnancy and the importance of early and appropriate prenatal care. Work group members and county health department staff distributed preconception health information at health fairs and community baby showers across the state.

The Preconception Collaborative Improvement and Innovation (CoIIN) team and the Association of State and Territorial Health Officials (ASTHO) team promoted the use of "One Key Question" to assess pregnancy intention and direct interventions to either the most effective form of contraception or preconception health education. Efforts were targeted to increasing access to most effective methods of contraception since unintended pregnancy and adolescent pregnancy significantly impact the preterm birth rate. MCH and the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, promoted immediate postpartum long acting reversible contraception (LARC) for new moms desiring one of these methods prior to hospital discharge. OHCA unbundled the postpartum LARCs in 2014 but utilization of the benefit remained low. The ASTHO team also focused on education for providers. The OHCA put a contract in place with a national organization to train health care providers in the state on LARC insertion. The contractor could not meet the funding time constraints so alternate plans are being made with the University of Oklahoma Health Sciences Center for a more sustainable training program.

The Prematurity Workgroup and the Office of Perinatal Quality Improvement (OPQI) continued promotion of the March of Dimes Preterm Labor Assessment Toolkit. OPQI continued the partnership with a vendor for fetal fibronectin (fFN) testing, meeting with individual hospitals to ensure all hospitals have access to and appropriately utilize fFN testing to help identify women at high risk of preterm labor.

The OHCA agreed to expand the preauthorization for progesterone use to include initiation between 16 and 26 weeks. Efforts to promote the utilization of progesterone to prevent subsequent preterm births included development of a progesterone guideline which includes information on patient identification, prescription initiation and patient management for progesterone use in SoonerCare women. The progesterone road map "SoonerCare Guideline for

Provision of Progesterone Prophylaxis of Preterm Birth” was finalized in September and shared with healthcare providers via social media, the Oklahoma Perinatal Quality Collaborative (OPQIC) website, and the quarterly OPQIC meetings starting in October 2016. OPQI staff are sharing information about this guideline through face-to-face meetings with OB clinicians.

Efforts also focused on creating awareness among women who have experienced a preterm birth of the potential need for progesterone therapy in subsequent pregnancies. Current education is through NICU family support persons in the Oklahoma Family Network, but will potentially expand to WIC and pediatric clinics.

Through a grant from the March of Dimes, OPQI facilitated Cervical Length Education and Review (CLEAR) training to accurately assess cervical length for 71 Oklahoma clinicians at no cost. This program was for practicing clinicians, mainly ultrasonographers and physicians, whose scope of practice included measurement of the cervical length.

OPQI continued work on quality improvement activities with birthing hospitals, including the continued monitoring of elimination of elective, non-medically indicated inductions and scheduled cesarean sections prior to 39 weeks of gestation. The “Every Week Still Counts” initiative provided birthing hospitals with support to maintain reduced rates for elective deliveries prior to 39 weeks. Activities for the “Every Week Counts” collaborative ended 12/31/14 as hospitals transitioned to reporting these numbers to the Centers for Medicare and Medicaid Services for The Joint Commission’s PC-01 measure “Patients with elective vaginal deliveries or elective cesarean sections at ≥ 37 weeks and < 39 weeks of gestation.” Oklahoma saw a 96% decrease from baseline data in Q1 2011 for elective scheduled deliveries prior to 39 weeks. From Q2 2015-Q1 2016, Oklahoma hospitals maintained an average PC-01 rate of 3%. While Oklahoma has sustained the rate of 3% during the last four reporting periods, the national average continued to decline, with the last period reported at 2%.

Between August 2015 and July 2016, 4,600 pregnant women in Oklahoma received a preterm risk assessment and 470 were identified as high risk through the Text4Baby program. Seventy-four percent of high risk moms were identified in the first trimester. High risk moms received 17P education and weekly shot reminders (355 women were asked if they had been prescribed 17P and 500+ weekly shot reminders were sent out). Twelve percent of high risk women reported being prescribed 17P by the 22nd week of pregnancy. Among the high risk women taking 17P, 98% reported receiving a shot each week. Responses were biased as only moms who were compliant responded to the follow-up survey.

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.

The Healthy Start projects in Oklahoma and Tulsa counties and the home visiting programs under the umbrella of parentPro (Maternal, Infant, and Early Childhood Home Visiting programs [MIECHIV], Children First, Parents as Teachers) received technical assistance and support from MCH. These projects and programs provided in-home support to pregnant females and their families. The Fetal and Infant Mortality Case Management project at OHCA provided phone support to decrease infant morbidity and mortality, including education on the signs and symptoms of pregnancy complications and where to seek prompt medical attention.

The OPQIC addressed perinatal issues identified by providers and continued to serve as the link between providers and policy makers. Members were educated on fFN testing, progesterone therapy to prevent preterm births in women with a previous preterm birth, and the availability of CLEAR (Cervical Length Education and Review) training for accurately measuring cervical length. MCH participated in and provided funding for the OPQIC.

Successes included sustaining the preterm birth rate at 10.3% maintaining a “C” grade on the March of Dimes grade card in 2016; maintaining a close collaborative relationship with MCH contractors and community partners; and, ensuring that developed tools and information were available to healthcare providers across the state through the OSDH website, the OPQIC website, the OHCA website, OPQIC quarterly meetings and the annual Summit.

For information on addressing the number of preterm births due to tobacco use, see Objectives and Activities in the Crosscutting Section.

Challenges:

Challenges include competing priorities for hospitals and providers; implementing practice changes for physicians who feel they are being told how to practice; identifying causes of spontaneous preterm birth, especially in the African American population; fiscal impact and current lab policies/procedures related to implementing fFN testing in all hospitals; lack of education or combating misinformation regarding progesterone indications/use for women with a previous preterm delivery; and differences in preauthorization and billing requirements for progesterone between insurance providers.

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

Data:

Data for 2015 shows that 70.2% of all Oklahoma births occurred to females beginning prenatal care during the first trimester of pregnancy. From 2013 to 2015 there was a 2.3% increase in the number of births to Oklahoma females who began prenatal care during the first trimester of pregnancy. Oklahoma experienced a 7.3% increase of women who gave birth and had prenatal care during their first trimester since 2010 (65.4%).

Successes:

In FY 2016, 30,954 or approximately 57.4% of all births in Oklahoma were paid for by the Medicaid programs SoonerCare or Soon-To-Be-Sooners (STBS). The Medicaid program STBS continued to provide health care benefits through the State Children's Health Insurance Program for the unborn children of pregnant females who would not otherwise qualify for SoonerCare benefits due to their citizenship status. The STBS program also continued to cover pregnant women with incomes between 133% of Federal Poverty Level (FPL) and 185% FPL.

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.

MCH staff met with community prenatal care providers in efforts to identify ways to partner and improve access to prenatal care. The Memorandum of Understanding was approved between the Oklahoma State Department of Health (OSDH) and the Warren Clinic in Tulsa. Dr. Stevens began providing prenatal care in April at a county health department in Creek County. Dialogue continued through this grant period regarding possible options for provision of prenatal care at additional county health departments. A model of joint care provided by county health department staff and physicians/nurse-midwives from OU Tulsa Physician should be finalized in the near future.

CHD staff assisted clients with a positive pregnancy test in signing up for Text4Baby prior to leaving the clinic and the Oklahoma Health Care Authority (OHCA) continued texting all women enrolled for prenatal care offering them the opportunity to enroll 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 for the third year in a row.

The Oklahoma Perinatal Quality Improvement Collaborative (OPQIC) addressed issues identified by providers and continued to serve as the link between providers and policy makers.

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

County health departments and contract providers served as safety net providers for maternity clinical services. Clinics served as the point of entry for 26,810 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. Two counties continued to retain the ability to provide maternity services with an active caseload.

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

Challenges:

Although the Soon-to-be-Sooners (STBS) program was expanded last year to accommodate the women who were excluded from full Medicaid benefits due to changes in eligibility requirements, the STBS program offered a limited benefit package which only includes prenatal care and delivery services that benefit the infant. Insurance coverage for this population ends at hospital discharge.

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 28 of the state's 77 counties had hospitals providing delivery services.

Legislation moved forward this year for full practice authority for advanced practice registered nurses, however, it was stopped in the Health and Human Services Committee. This legislation would have removed the requirement for advanced practice nurses to have a physician signature for prescriptive authority. Each practicing physician can only sign for two full-time APRNs creating a significant barrier to accessing services especially in rural areas of the state.

Creating new models of care is time consuming and requires legal interpretation and agency approval. Once a model of care was finally developed by clinical staff to expand access to prenatal care services in county health departments, legal review and agency reviews also took time and consequently, a final agreement still is not in place.

Budget shortfalls continued to impact access to care as Medicaid benefits were threatened or reduced, reimbursement was decreased, physician offices closed, and rural hospitals either closed or stopped providing

obstetric services.

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

Data:

All newborns born in Oklahoma hospitals in 2015 were screened through the Newborn Screening Program (NSP) for the disorders of phenylketonuria (PKU) and other amino acid disorders; congenital hypothyroidism; galactosemia; sickle cell disease; other hemoglobinopathies; cystic fibrosis (CF); congenital adrenal hyperplasia; medium chain acyl-CoA dehydrogenase deficiency (MCAD) and other fatty acid disorders; organic acid disorders; biotinidase deficiency, and severe combined immunodeficiency (SCID). One hundred percent of newborns received short-term follow-up (STFU) services for diagnosis and 100% of affected newborns were referred to long-term follow-up (LTFU) for care coordination services. For 2015, all 646 newborns with sickle cell trait and hemoglobin C trait received educational material regarding trait status and were referred for genetic counseling. Many of the families also received trait counseling from their child's primary physician when seen for well child visits, as both families and physicians on record were sent screening results. The NSP offered families an opportunity to discuss long-term life and family planning issues with a genetic counselor and 155 families received counseling with a board-certified genetic counselor. All newborns identified with an out-of-range CF screen were referred for genetic counseling (62 of the 80 received counseling). All cases of confirmed diagnosis for newborn screening disorders were referred for genetic counseling.

Successes:

Title V funding continued to support the newborn screening activities statewide. The NSP, housed within the Screening and Special Services Division of the 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 NSP expanded the screening panel to include SCID in January 2015. Additionally, due to a growing interest among midwives in Oklahoma to provide Pulse Oximetry (PO) Screening, workgroup meetings were held to plan for the expansion of PO Screening for Critical Congenital Heart Disease to include the homebirth population in Oklahoma.

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) 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 Children First, Healthy Start, Smart Start, Oklahoma Parents as Teachers (OPAT), the Maternal, Infant, Early Childhood Home Visiting (MIECHV) program, the Child Abuse Training & Coordination (CATC) Program, the Home Visitation Leadership Advisory Council (HVLAC), and the Office of Minority Health.

MCH and NSP participated in Zika screening activities in the state. NSP participated in the CDC pregnancy registry for pregnant women who tested positive for the virus. Handouts were created to educate pregnant women and their partners about the risks and symptoms of Zika and county health departments administered a brief screening tool to all pregnant clients. Women identified with risk factors for Zika transmission were referred to the epidemiologist on call through their health care provider to determine if testing was indicated and received directions on testing. OSDH

was proactive in surveillance and in ensuring the public had information on the risks for individuals traveling to areas of the world with active Zika transmission, prevention of Zika transmission through sexual contact, and on safe and effective ways to decrease the risk of bites from mosquitos carrying the Zika virus.

Challenges:

Funding continued to be a barrier to services, especially related to adding disorders recommended by the Advisory Committee on Heritable Disorders in Newborns and Children approved by the HHS Secretary.

Challenges related to pulse oximetry screening 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. Another challenge included linking to birth certificates to capture home births for screening and follow-up activities.

Child Health

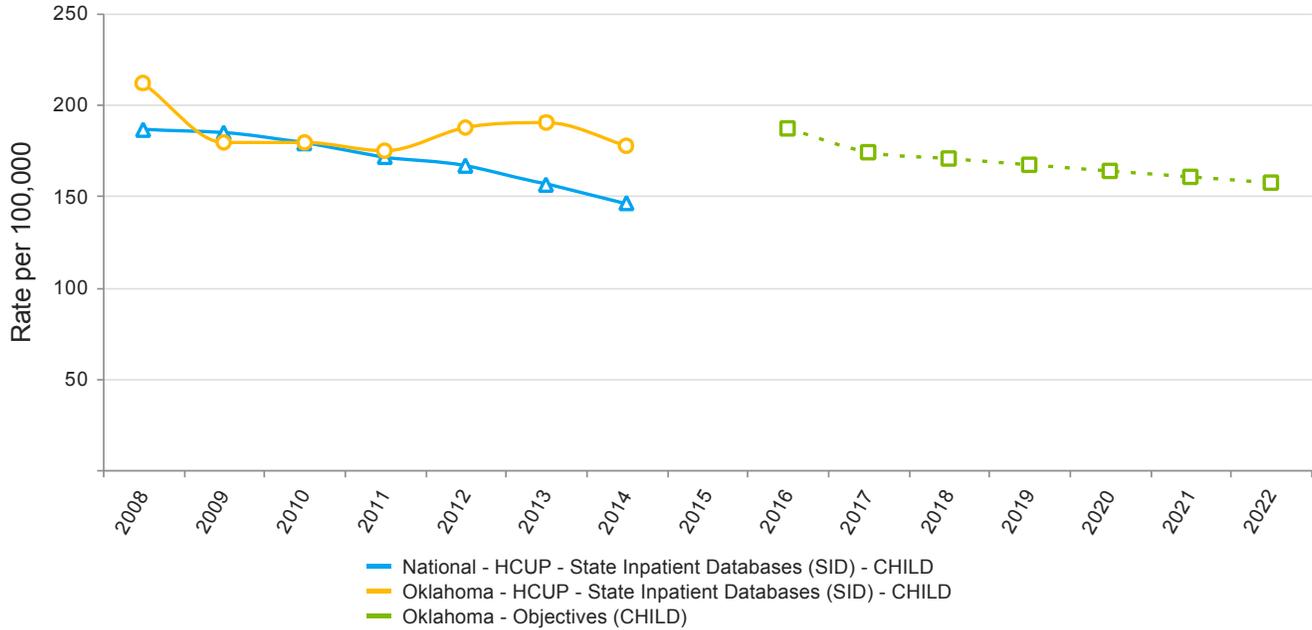
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	NVSS-2015	28.0	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	43.4	NPM 7
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	19.6	NPM 7
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	14.5	NPM 7

National Performance Measures

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

Baseline Indicators and Annual Objectives



NPM 7 - Child Health

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	186.8
Annual Indicator	177.3
Numerator	951
Denominator	536,332
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	173.8	170.3	166.9	163.5	160.3	157.1

Evidence-Based or –Informed Strategy Measures

ESM 7.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	84.8
Numerator	45,031
Denominator	53,118
Data Source	Oklahoma Vital Statistics
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	86.5	88.2	90.0	91.8	93.6	95.5

State Action Plan Table

State Action Plan Table (Oklahoma) - Child Health - Entry 1

Priority Need

Reduce the incidence of unintentional injury among children

NPM

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

Objectives

1. Increase the number of delivering hospitals participating in the Period of PURPLE Crying Abusive Head Trauma curriculum from 39 in 2015 to 42 by 2020.
2. Increase by 5% the number of caps received from community volunteers through the CLICK for Babies campaign from 4,086 in 2015 to 4,290 by 2017.
3. Provide, via Adolescent Health Specialists, a total of 3 trainings in communities on adolescent distracted driving and graduated drivers licensing each year.
4. Reduce nonfatal motor vehicle injuries in children ages 0 to 19 from 394 in 2013 to 366 by 2020.
5. Maintain an average minimum of 3,300 calls per month to the Poison Control Hotline through December 2020.
6. 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.

Strategies

- 1a. Contact delivering hospitals to increase participation in the PURPLE curriculum.
- 1b. Provide training via a webinar and ongoing support as needed to participating hospitals.
2. Utilize existing resources and available partners to distribute materials and provide community education.
3. Train and provide materials to Adolescent Health Specialists for distribution and training in their local communities.
- 4a. Continue to provide funding for car seats to be distributed by county health department and Injury Prevention Service staff.
- 4b. Utilize the MCH staff member who is a Child Passenger Safety Technician to assist Injury Prevention Services with a minimum of two car seat safety checks or installations per month and one safety seat event each year.
5. Continue to provide funding and contract monitoring for the Poison Control Center, to provide educational materials on poisoning prevention and how to access the hotline for possible poisoning incidents, as well as staffing for call response.
- 6a. Provide training on the Good Health Handbook to Early Childhood professionals, including home visitation staff and child care providers, to include topics such as safety, behavior, child abuse and neglect reporting, and resources for families.
- 6b. Continue to participate in various advisory boards, committees and partnerships to promote best practices in early childhood care and education.

ESMs

Status

ESM 7.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum	Active
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NOMs

- NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000
- NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000
- NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000
- NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

State Action Plan Table (Oklahoma) - Child Health - Entry 2

Priority Need

Reduce health disparities

NPM

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

Objectives

Reduce by 2% by 2020 the number of suicide attempts requiring hospitalization among white females less than 25 years of age from 321 attempts in 2014.

Strategies

Increase the number of annual trainings in evidence-based methods of suicide prevention to youth and those that work with youth.
 Ensure at least two Adolescent Health Specialists receive the training-of-trainers for Question, Persuade, Refer.

ESMs

Status

ESM 7.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum	Active
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NOMs

- NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000
- NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000
- NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000
- NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Child Health - Plan for the Application Year

Efforts will continue to increase the number of PURPLE hospitals, relying on partners in those communities to assist in describing the need for the few remaining non-participating hospital administrators to become a partner.

CLICK hats will be tagged and distributed to PURPLE participating hospitals and the 2018 CLICK Campaign will be planned.

Adolescent Health Specialists will host trainings on distracted driving and incorporate youth in their communities, via Public Health Youth Councils, into the information dissemination and training activities. See the Adolescent Health Section for more information on Public Health Youth Councils.

The MCH certified technician will continue to book car seat appointments by entering available dates and times on the Injury Prevention car seat calendar, with a minimum of six appointments per month, and also participate in at least one car seat safety event annually. The MCH certified technician intends to complete the Child Passenger Safety Technician (CPS) Instructor training by September 2018, and will then be available to assist Injury Prevention Service with the CPS Certification training.

Continuing education for child care providers and home visitors will continue to be provided via the Professional Development Collaborative Registry, in partnership with the University of Oklahoma's College of Continuing Education. These trainings include infant safe sleep, diabetes education, and many others.

MCH will continue to contract with the Poison Control Hotline to provide training opportunities for children, child care centers and schools on topics related to poison prevention.

MCH will continue to provide copies of the Good Health Handbook upon request while supplies are available. The Early Childhood Coordinator for MCH will continue to provide training on the utilization of the Good Health Handbook to child care providers, Head Start programs, students, school nurses, and health department staff and strive to have an online version of the training available by June of 2018.

MCH will continue to fund school health programs and school health nurses to address school wellness and bullying prevention. Support for vision screening trainings and diabetes education will continue for school-aged children.

OSDH county health departments will continue to offer well child checks and preventive health services at select sites, utilizing the new Child Health forms which follow the Bright Futures periodicity schedule and provide age-appropriate anticipatory guidance. MCH will continue to provide technical assistance as necessary.

Child Health - Annual Report

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

Data:

The number of participating hospitals was 40 as of September 30, 2016, due to the loss of one hospital and the addition of the two new ones. The hospital lost stopped delivering infants at that location.

Successes:

The Injury Prevention Workgroup of *Preparing for a Lifetime* continued to meet regularly to discuss projects, including the Period of PURPLE Crying. PURPLE provides evidence-based information via a booklet, DVD and nurse education to inform new parents and caregivers about the patterns of infant crying in an effort to reduce abusive head trauma.

Workgroup members developed a text message for the Text4Baby Oklahoma pilot project (messages solely for Oklahoma Text4Baby users) focused on soothing techniques and peak crying. The message went out on August 9th to mothers in Oklahoma who had infants between 4-12 weeks old. The message read as follows: "Crying peaks in baby's 2nd month. Try massage, white noise, holding/baby-wearing, rocking, singing. What worked yesterday may not work today!
 Need a break? Put baby safely in crib and walk away for a few minutes or take baby for a walk/drive. For help call 1-877-271-7611 or visit parentpro.org." Parent Pro helps parents find home visiting programs and other parenting programs in the state. The message went out to 1,091 new mothers in the state, in English and Spanish. A series of Facebook messages for July-September were also developed and posted, on a variety of infant injury prevention topics.

During Workgroup meetings, ideas for recruitment of hospitals were discussed as well as potential partners for expansion. One idea, a webinar on the Period of PURPLE Crying for hospitals who were current participants and those interested in participating, was presented on August 30th and September 7th. More than 20 hospitals participated. The webinar discussed the importance of the PURPLE curriculum, how to implement with families, walked through the training website, highlighted the data on abusive head trauma in Oklahoma, and solicited from hospitals what training and material needs they had to successfully implement the project. A few hospitals mentioned they appreciated the walk-through of the website, to help track staff training and that apps would be useful to show videos and materials to families. Apps are available from the National Center on Shaken Baby Syndrome and the group decided to add apps to the list of options for hospitals to use in-house when showing families the video on the Period of PURPLE Crying.

In September, the Injury Prevention Workgroup created a lobby display for the state health department focused on several aspects of infant and toddler safety, including abusive head trauma prevention. DVDs, booklets, and other educational materials were available in English and Spanish for visitors to review and take home. The table was very successful and items had to be replenished almost daily. Many of the visitors in the lobby area have new babies and have come to the State Health Department to obtain birth certificates.

Two new hospitals were contacted and training began to add them to the list of participating hospitals in September of 2016. A delivery hospital in Clinton and one in McAlester Oklahoma were added after community members saw the news release for Period of PURPLE Crying and the CLICK campaign in September, describing the program and the need for knitted hats. The community members contacted MCH and facilitated communication with Injury Prevention Workgroup members to add the new hospitals to the campaign.

Challenges:

Dedicating staff time to Period of PURPLE can be challenging, particularly as it is a true partnership consisting of four different agencies, the OSDH, Oklahoma Commission on Children and Youth, The Parent Child Center of Tulsa, and the Office of Perinatal Quality Improvement. Due to budget cuts at the state level some partners have lost staff or had their ability to participate in non-mission critical activities limited, which reduces the amount of time they can spend on activities like the Injury Prevention Workgroup and PURPLE.

Objective 2. Increase by 5% the number of caps received from community volunteers through the CLICK for Babies campaign from 4,086 in 2015 to 4,290 by 2017.

Data:

CLICK provides handmade, purple knit hats to participating PURPLE hospitals in an effort to provide parents and caregivers with a visual reminder of the PURPLE crying techniques. The hats are given out during November and December. This year's CLICK Campaign in Oklahoma netted 3,350 knitted caps to send to hospitals. One hospital in Oklahoma City collected hats for their project and the Tulsa Parent Child Center collected hats for participating Tulsa hospitals. Because of the low number of hats collected from in-state donors (about 1,000), several other campaigns in other states such as Kansas, Utah and New Hampshire sent caps to OSDH for distribution to hospitals.

Successes:

In September 2016, after the press release went out, a group of students from McAlester contacted MCH asking to partner and participate in CLICK activities. The students attended the Kiamichi Technology Center and were looking for a health-care related project. The group brought in someone to teach them how to knit, and with the help of MCH, researched the Period of PURPLE Crying, and recruited their local birthing hospital to participate in the PURPLE Crying program. The students were invited to attend the cap tagging in October hosted by the Injury Prevention Workgroup and created a storyboard about their project for a state competition. The partnership was such a success the plan is to continue the partnership in 2017 with the next student cohort and target another hospital in their area for recruitment. The students knitted enough hats to supply their local hospital for both months of CLICK.

Challenges:

The CLICK Campaign was slow to get off the ground this year due in part to staff changes and a late press release (over 300 caps were received in December and January 2016-2017, past the distribution day). Future Injury Prevention Workgroup meetings will focus on ways to improve cap donations statewide. With new partners on-board, including the student group and a sub-committee for the Child Abuse Prevention Workgroup for Family Support and Prevention Services, increasing the number of caps received is attainable.

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

Data:

No trainings were held by AHS in their schools.

Successes:

Training was provided to the AHS on distracted driving in July 2016 to take back to their communities to implement. Materials were distributed to the AHS to hand out in their communities about the graduated driver's license law and distracted driving.

Challenges:

No AHS were able to implement distracted driving training in their county schools before the end of the federal fiscal year.

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

MCH continued to provide funding to Injury Prevention Service (IPS) for car seats and booster seats for distribution by county health department and IPS staff.

The Early Childhood Coordinator in the Child and Adolescent Health (CAH) Division of MCH attended the National Child Passenger Safety Certification Training January 20-22, 2016, and became a certified technician February 1, 2016. The certified technician from MCH worked under the supervision of IPS's CPS Instructor, assisting with a minimum of 3 car seat checks and installations per month through July 2016. In August and September of 2016, the MCH certified technician began handling individual appointments with families at the state office and checked and installed car seats one and two days per week. In addition, the MCH technician helped staff a Safe Kids Oklahoma Car Seat Check at a local DHS office on September 19, 2016.

In June, MCH staff helped with a Safe Kids informational table at an Oklahoma City Dodgers baseball game, providing car seat information and discussion about the changes in the law for booster seats. Participants took a quiz about car seat safety, received feedback on their answers in exchange for a fan donated by the Office of Highway Safety. Over 150 fans were given away.

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

For Calendar Year 2016, the Poison Control Hotline received an average of 3,326 total calls per month. This included calls to address possible human and animal exposures. The objective for this measure was changed to reflect the increased call volume for 2016 from 2,200 calls per month to 3,300 per month.

Successes:

Each month the Oklahoma Center for Poison and Drug Information provided training opportunities for physicians, pharmacy and nursing students, trainings for childcare providers and the children in their programs, as well as radio and television interviews on topics related to prevention of poisonings. They also provided educational opportunities to parent groups, senior citizen clubs and community-based organizations. They provided technical assistance to emergency response personnel on potential poisoning episodes and to hospital emergency rooms treating patients with possible poisonings.

Challenges:

Staff time and funding limits the number of presentations and outreach that can be accomplished for prevention activities.

Objective 6. 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.**Data:**

Final data for this measure have not been released for this measure.

Successes:

The Good Health Handbook: A Guide for Those Caring for Children, Revision 2015 was posted on the OSDH website in December of 2015. MCH printed 410 copies in June 2016 and mailed one to each county health department and to all eight child care resource and referral agencies.

The MCH School Health Coordinator distributed over one hundred copies of the Good Health Handbook to public school nurses at their statewide training in July 2016.

The Oklahoma Department of Human Services (DHS) mailed out a CD of the revised *Good Health Handbook* (GHHB) to all licensed child care programs in Oklahoma in the summer of 2016.

The MCH Early Childhood Coordinator developed a Power Point and training materials for the revised Good Health Handbook and presented to a class of early childhood professionals at OSU-OKC on September 20, 2016.

The Early Childhood Coordinator continued to serve on the Oklahoma Department of Human Services Child Care Advisory Committee. Legislation requires an advisory committee of child care facilities representatives, from a variety of child care programs and related experts from other agencies and various associations, to assist and advise DHS, Child Care Services (CCS) in the development and maintenance of minimum requirements and desirable standards. The Child Care Advisory Committee was additionally directed in 2012 to form a Peer Review Board to participate in the Child Care Services grievance process and mentor child care programs upon request or as referred by Child Care Services. The 25 member committee meets four times a year, listens to suggestions and concerns from the child care field, and acts on their behalf.

In addition, the Early Childhood Coordinator continued to serve on the Oklahoma Head Start Early Childhood Collaboration Advisory Board, the Oklahoma State University-Oklahoma City (OSU-OKC) Early Care and Child Development Advisory Committee, the Home Visitation Leadership Advisory Coalition, and participated in the quarterly Oklahoma Tribal Child Care Association (OTCCA) meetings. OTCCA represents the 36 tribes in Oklahoma that provide subsidized child care.

Staff support was provided for the Oklahoma Partnership for School Readiness (Smart Start Oklahoma) as needed by the Early Childhood Coordinator. The Oklahoma Partnership for School Readiness (OPSR) Board was created by the Oklahoma Partnership for School Readiness Act (Title 10 O.S. § 640). The statewide Board, comprised of relevant state agency heads and private sector leaders appointed by the Governor, was charged to increase the number of children ready to succeed by the time they enter school.

The OPSR Board named its collective school readiness effort Smart Start Oklahoma, with the mission to lead Oklahoma in coordinating an early childhood system focused on strengthening families and school readiness for all children; and the vision that all Oklahoma children will be safe, healthy, eager to learn, and ready to succeed by the time they enter school. The Early Childhood Coordinator of CAH assisted Smart Start with a variety of projects aimed at enhancing professional development for early childhood teachers and caregivers.

Challenges:

With prior versions, DHS gave printed copies of the GHHB to all child care programs, however with budget cuts the decision was made to provide CDs instead. This limited the number of facilities with the GHHB readily available for consultation for staff in classrooms without computers unless they incurred the printing costs themselves.

Objective 7. Reduce by 2% by 2020 the number of suicide attempts requiring hospitalization among white females less than 25 years of age from 321 attempts in 2014.

Data:

Final data for 2015 and 2016 have not been released, so a comparison cannot be made at this time.

Successes and Challenges:

For successes and Challenges for this Objective, please refer to the Adolescent Health Entry 1, Objectives 1-3 under NPM: Percent of adolescents, ages 12 through 17, who are bullied or who bully others.

Adolescent Health

Linked National Outcome Measures

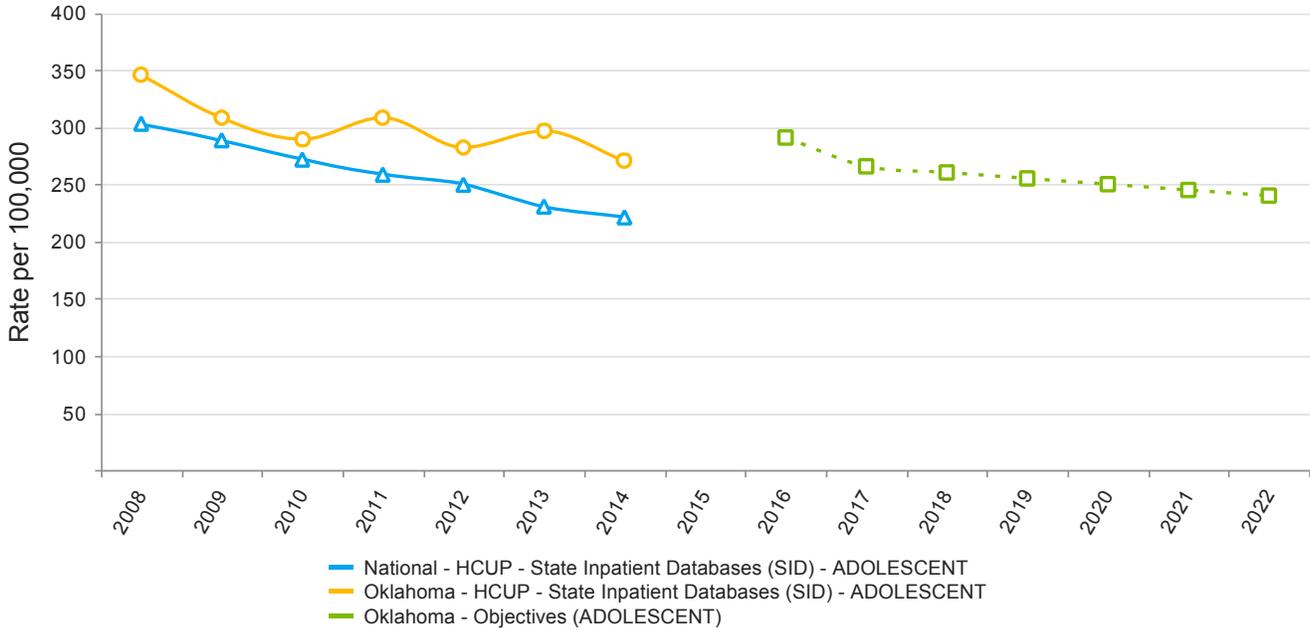
National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000	NVSS-2015	28.0	NPM 7
NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000	NVSS-2015	43.4	NPM 7 NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000	NVSS-2013_2015	19.6	NPM 7 NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	14.5	NPM 7 NPM 9 NPM 10
NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling	NSCH-2011_2012	62.7 %	NPM 10
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	84.4 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	33.9 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	29.6 %	NPM 10
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2015	32.6 %	NPM 10
NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	NIS-2015_2016	52.3 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2015	58.1 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2015	52.9 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2015	84.4 %	NPM 10

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2015	68.1 %	NPM 10

National Performance Measures

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

Baseline Indicators and Annual Objectives



NPM 7 - Adolescent Health

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - ADOLESCENT	
	2016
Annual Objective	290.9
Annual Indicator	271.1
Numerator	1,411
Denominator	520,536
Data Source	SID-ADOLESCENT
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	265.7	260.4	255.2	250.1	245.1	240.2

Evidence-Based or –Informed Strategy Measures

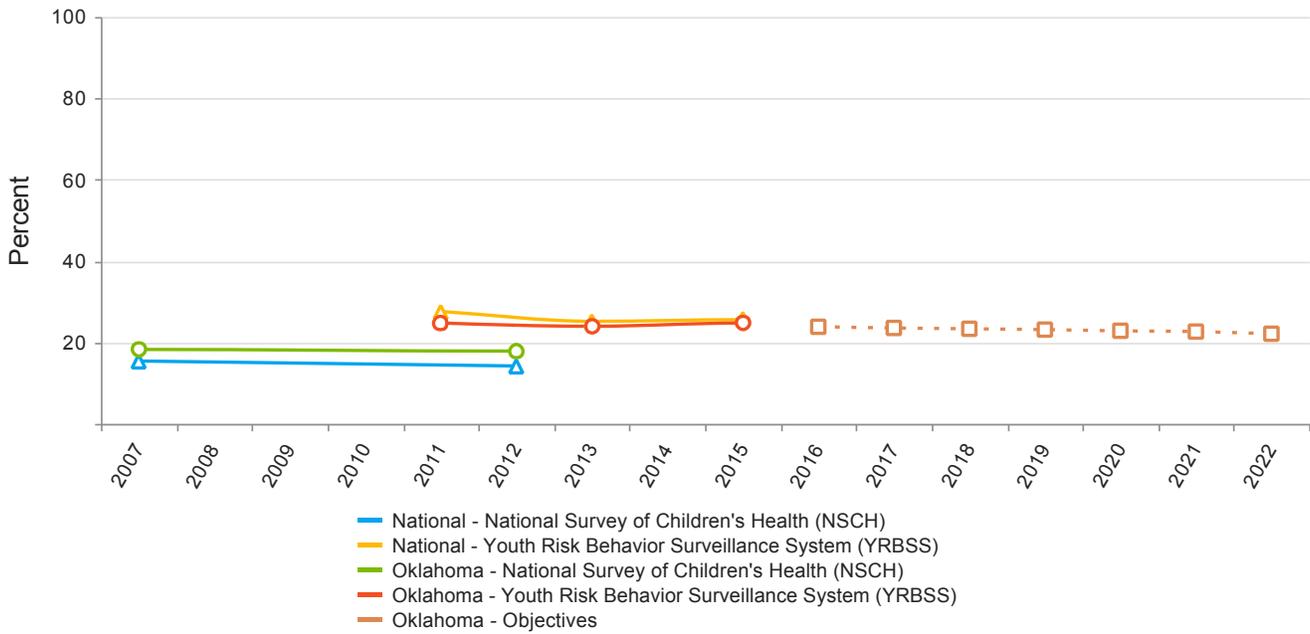
ESM 7.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	84.8
Numerator	45,031
Denominator	53,118
Data Source	Oklahoma Vital Statistics
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	86.5	88.2	90.0	91.8	93.6	95.5

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



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	23.9
Annual Indicator	17.8
Numerator	54,245
Denominator	304,334
Data Source	NSCH
Data Source Year	2011_2012

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	23.9
Annual Indicator	25.0
Numerator	44,898
Denominator	179,440
Data Source	YRBSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	23.6	23.4	23.2	22.9	22.7	22.2

Evidence-Based or –Informed Strategy Measures

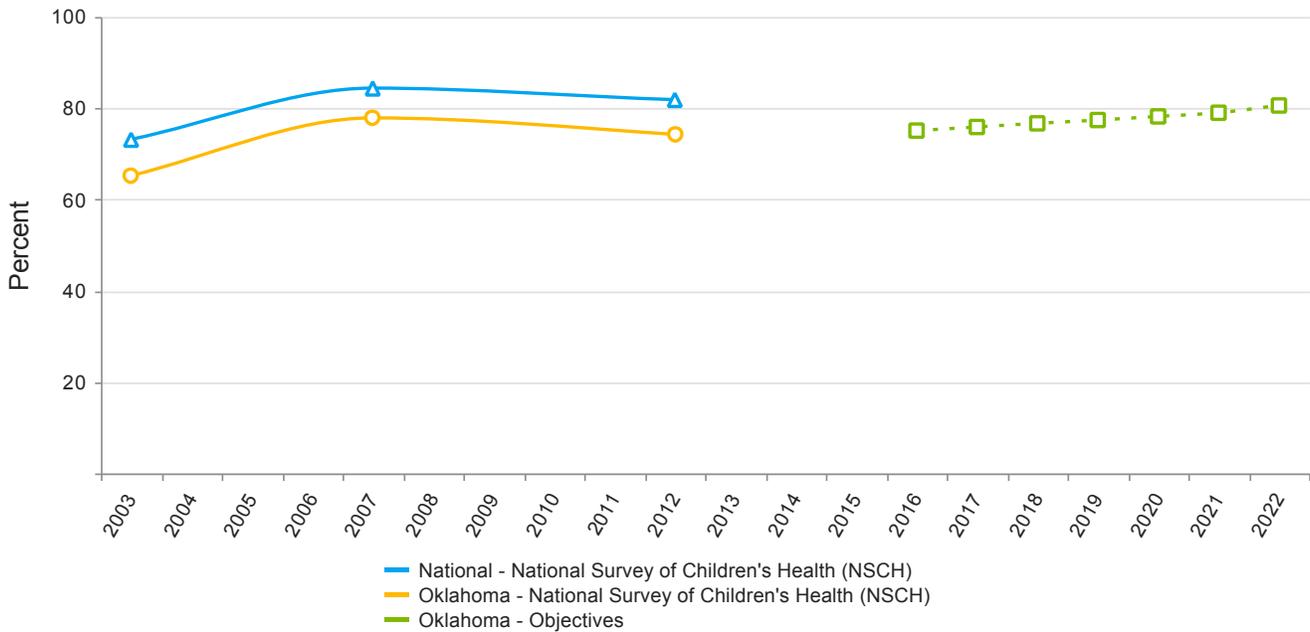
ESM 9.1 - The number of trainings provided by MCH to school staff on bullying prevention

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	3
Numerator	
Denominator	
Data Source	MCH Training Log
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	5.0	6.0	7.0	8.0	9.0

**NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.
Baseline Indicators and Annual Objectives**



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	75
Annual Indicator	74.3
Numerator	225,407
Denominator	303,509
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	75.8	76.6	77.3	78.1	78.9	80.5

Evidence-Based or –Informed Strategy Measures

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

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	3,350
Numerator	
Denominator	
Data Source	MCH PREP Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4,300.0	4,500.0	4,700.0	5,000.0	5,200.0	5,400.0

State Action Plan Table

State Action Plan Table (Oklahoma) - Adolescent Health - Entry 1

Priority Need

Reduce the incidence of suicide among adolescents

NPM

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

Objectives

1. Increase the number of annual trainings provided by MCH staff in evidence-based methods of suicide prevention or positive youth development for individuals that work with adolescents from 1 in 2015 to 3 by 2020.
2. Increase the number of local Public Health Youth Councils across the state from 3 in 2015 to 7 by 2020 that will provide input regarding adolescent health issues, including suicide prevention and bullying, to MCH, CSHCN, as well as other programs within and outside of OSDH.
3. Among county health departments, increase from 5% in 2016 to 50% in 2020 the sites that have the Suicide Prevention Lifeline Number displayed in their lobby.
4. Increase the number of the Safe Schools Committees reported to the Oklahoma State Department of Education mandated by School Safety and Bullying Prevention Act from 1,775 sites to 1,807 sites by 2020.

Strategies

1. Provide training and TA to county health departments and other youth-serving organizations in evidence-based methods following appropriate best practices.

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.

- 3a. Work with county health department directors and local web coordinators to place the Suicide Prevention Lifeline Number and logo on the most appropriate place on their website.

- 3b. Provide county health department directors and staff Suicide Prevention Lifeline materials during Comprehensive Program Review visits.

- 4a. Work with the Oklahoma State Department of Education to determine a data source for the collecting of 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 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.

- 4d. Train county health department health educators in bullying-prevention curriculum to assist in training school staff and communities on this issue.

ESMs

Status

ESM 9.1 - The number of trainings provided by MCH to school staff on bullying prevention

Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

State Action Plan Table (Oklahoma) - Adolescent Health - Entry 2

Priority Need

Reduce teen pregnancy

NPM

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

Objectives

1. Increase by 5% annually the number of adolescents participating in state or federally funded evidence-based teen pregnancy prevention programs (Baseline: 4,145 adolescents for the 2014-2015 school year).
2. Increase the number of adolescent family planning clients aged 15 to 19 who choose Long Acting Reversible Contraception (LARC) methods from 31% in 2013 to 35% by 2020.
3. Maintain the number of available trainers statewide who have completed a training of trainers (TOT) in Oklahoma's selected evidence-based teen pregnancy prevention curricula at 12.
4. Increase the number of local Public Health Youth Councils across the state from 3 in 2015 to 7 by 2020 that will provide input regarding adolescent health issues, including teen pregnancy prevention, to MCH, the CSHCN, as well as other programs within and outside of OSDH.
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 in 2015 to 30 by 2020.
6. Increase the number of trainers statewide for Positive Youth Development from 1 in 2016 to 3 by 2020. (NEW OBJECTIVE)

Strategies

1a. Maintain the number of adolescents participating in state-funded evidence-based teen pregnancy prevention programs by supporting the Adolescent Health Specialists in the counties.

1b. Maintain the current number of adolescents participating in the Personal Responsibility Education Program (PREP) at a minimum of 3,659 students/year (April 1, 2015-March 31, 2016).

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

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

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

3. Coordinate training on evidence-based curricula for new PREP and state-funded teen pregnancy prevention staff and interested partners annually.

4. Train additional council facilitators, recruit for more youth, conduct an 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.

6. Coordinate the Positive Youth Development training for OSDH staff and partners. (NEW STRATEGY)

ESMs

Status

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

Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

NOM 18 - Percent of children with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

NOM 22.2 - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

State Action Plan Table (Oklahoma) - Adolescent Health - Entry 3

Priority Need

Reduce health disparities

NPM

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

Objectives

Identify disparities that exist among suicide attempts and completion percentages by race/ethnicity, gender, geography, and age by January 2017.

Strategies

Analyze most current surveillance systems (Oklahoma Violent Death Reporting System, Injury Inpatient Discharge Data) to detect disparities, identify program targets, and inform interventions.
 Implement interventions to address the populations of highest risk by December 2017.

ESMs

Status

ESM 9.1 - The number of trainings provided by MCH to school staff on bullying prevention

Active

NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

State Action Plan Table (Oklahoma) - Adolescent Health - Entry 4

Priority Need

Reduce the incidence of unintentional injury among children

NPM

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

Objectives

See Child Health for Objectives to impact this measure.

Strategies

See Child Health for Strategies to impact this measure.

ESMs

Status

ESM 7.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum	Active
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NOMs

- NOM 15 - Child Mortality rate, ages 1 through 9 per 100,000

- NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

- NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000

- NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Adolescent Health - Plan for the Application Year

Adolescent 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 12.7 by 2020.

MCH will continue to train school-based staff and health educators in evidence-based teen pregnancy prevention curricula implementation and provide support and guidance as needed.

MCH, state-funded teen 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 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, youth suicide, and bullying and work with public health professionals to implement solutions.

MCH will strengthen interests in Public Health Youth Councils among OSDH leadership at all levels and staff. The Public Health Youth Council Facilitator training will be conducted on a bi-annual basis.

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.

MCH will continue to collaborate with tribal partners and additional stakeholders to strengthen teen pregnancy prevention and positive youth development efforts across the state of Oklahoma.

MCH will rehire the School Health Educator position and ensure staff works closely with the Oklahoma State Department of Education, and the Oklahoma City and Tulsa Anti-Bullying Coalitions on bullying prevention activities across the state.

The School Health Educator and School Health Coordinator will assure bullying prevention programs and activities continue to be undertaken by school health contractors, including the rural school health nurses and *It's all About Kids and Health at School*.

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

The Oklahoma Suicide Prevention Council will continue to promote 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.

MCH will collaborate with partners to write a suicide brief to promote awareness and avenues for prevention activities.

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

Objective 1: Increase the number of annual trainings provided by MCH staff in evidence-based methods of suicide prevention or positive youth development for individuals that work with adolescents from 1 in 2016 to 3 by 2020.

Data:

The suicide death rate among youth 15-19 years old has seen little change over the last 30 years with observed rates of 14.5 deaths per 100,000 youth ages 15-19 in 1986 and 14.9 in 2015. In 2015, disparities were observed by gender as males had a suicide rate three times that of females at 22.3 and 7.1, respectively. Data from the 2015 Youth Risk Behavior Survey (YRBS) indicated that females were significantly more likely than males to have attempted suicide in the past 12 months at 10.2 and 4.5%, 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.

Successes:

The Oklahoma Suicide Prevention Council implemented the 2015-2020 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 Annual Suicide Prevention Conference April 2016.

MCH trained two MCH staff members and three Adolescent Health Specialists in Question, Persuade, and Refer (QPR). Applied Suicide Intervention Skills Training (ASIST), QPR, and suicide awareness presentations were provided statewide with participants receiving the message that suicide is a preventable public health problem. MCH staff provided QPR training to OSDH social workers in October 2016.

MCH, Injury Prevention and Community Development Services staff participated in Tribal Youth Suicide Prevention Pre-Conference planning and attended the event on August 2, 2016.

MCH placed a poster board for suicide prevention month in the lobby of OSDH with materials and resources available to the public throughout the month of September 2016.

MCH and Child Guidance staff participated in the State Advisory Team and the Children's State Advisory workgroup to support and collaborate with mental health providers.

MCH staff attended Suicide Post-vention Training January 2, 2016 to gain additional knowledge on best practices of a community's response following a suicide.

Oklahoma's Youth Suicide Prevention Toolkit was available on the MCH website to assist communities in the development of prevention strategies.

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.

The state's plan to transform the health of Oklahomans, the Oklahoma Health Improvement Plan (OHIP), added

behavioral health as one of the flagship issues. This further supported statewide suicide prevention efforts, and provided a platform for emerging efforts.

Challenges:

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.

The Adolescent Health Consultant position was vacant from April 2016 to July 2016.

Objective 2: Increase the number of local Public Health Youth Councils across the state from 3 in 2015 to 7 by 2020 that will provide input regarding adolescent health issues, including suicide prevention and bullying, to MCH, CSHCN, as well as other programs within and outside of OSDH.

Data:

Three Public Health Youth Councils were active in the state providing input on adolescent health issues in their counties.

Successes:

MCH maintained the same number of Public Health Youth Councils (PHYC) in Lincoln County and Seminole County. In both regions, facilitators trained and empowered council members to be self-advocates and community advocates. Self-advocacy was demonstrated through understanding public health and its impact at various socio-ecological levels; knowing how to identify and access resources in their communities; and learning about careers in public health. Community advocacy was shown by educating their peers and community on various issues including bullying, teen pregnancy and hygiene.

In March 2016, PHYC assisted with an annual county-wide conference, which provided 5th grade boys and girls a network of support as they develop the necessary skills to make positive choices in their own lives. In May 2016, joint efforts were made by two PHYC to promote healthy lifestyles, discuss bullying prevention and bridge the gap between community resources and schools. Facilitators utilize both the positive youth development (PYD) and the youth-adult partnership (YAP) model.

In August 2016, MCH provided a training for Adolescent Health Specialists and other interested community partners on developing Public Health Youth Councils and the importance of the YAP model. The training was developed by MCH in partnership with AHS and current PHYC facilitators. The training had 14 participants. The Adolescent Health Specialists began having goal-oriented monthly video-conferences with the Adolescent Health Consultant and developed concrete plans and activities for recruitment for the following school year.

Challenges:

Turn-over in the Adolescent Health Specialists positions and for the Adolescent Health Consultant (vacant from April

to July 2016) slowed progress in developing more PHYCs.

Objective 3: Among county health departments that have webpages, increase from 3% in 2015 to 85% the sites that have the Suicide Prevention Lifeline Number displayed by 2020.

Data:

Three percent of county health department webpages have the Lifeline number displayed. This objective was modified for future years to state “Among county health departments, increase from 5% to 50% the sites that have the Suicide Prevention Lifeline Number displayed in their lobby by 2020” to more accurately reflect activities.

Successes:

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. Two county health departments added the number to their webpages.

Challenges:

This activity was not a priority for this year, due to staff turnover and uncertainty about the contacts for various webpages. Some staff hung posters in the county health departments with the hotline number, for clients and staff.

Objective 4: Increase the number of the Safe Schools Committees reported to the Oklahoma State Department of Education mandated by School Safety and Bullying Prevention Act from 1,775 in 2016 to 1,807 sites by 2020.

Data:

Currently 32 of the 1,807 sites for fiscal year 2016 do not have Safe Schools Committees, as reported by the Oklahoma State Department of Education.

Successes:

The MCH School Health Coordinator partnered with the Oklahoma State Department of Education (OSDE), Director of Prevention Services to develop a method to account for the number of schools and school districts in Oklahoma meeting the requirement of the establishment of Safe Schools Committees. Beginning with the 2016-2017 school year, the accountability data will be collected by the State Accreditation Standards Division during their annual or semi-annual school site visits on the number of schools and school districts meeting the requirement of establishing a Safe Schools Committee.

The MCH School Health Educator attended the monthly Anti-Bullying Coalition (ABC) meetings in both Tulsa and Oklahoma City. The Health Educator participated in the planning and activities of the ABC-OKC Community Night to educate parents and interested community members on bullying prevention, recognition, and intervention.

The School Health Educator provided one bullying prevention training to foster parents in partnership with the OKC-ABC collaboration and five in-school trainings to students on bullying prevention. The Health Educator partnered with OSDE to present required bullying prevention, recognition, and intervention trainings throughout the state to teachers and school staff members, presenting or co-presenting at least five presentations. The Health Educator worked with the Program Coordinator for the OSDH Health Educators to provide them with training on the mandated school staff training for bullying prevention and district policy development. A presentation on bullying was also provided to Teen Pregnancy Prevention Specialists at the Campaign to Prevent Teen Pregnancy’s Tulsa meeting.

The 12 school nurses working in 10 rural school districts funded by the MCH Title V Block Grant have partnered in their communities with the Cherokee, Choctaw, and Citizen Potawatomi tribes to provide their individual tribal bullying prevention programs to the students attending those schools.

The *Health at School* Program with the Oklahoma City-County Health Department and the *It's All About Kids* program with the Tulsa Health Department, also provided bullying prevention activities, partially funded by MCH Title V Block Grant funds. During this time period, the *Health at School* program made 222 bullying prevention presentations, reaching 2,223 school staff, students, and community resource partners. The *It's All About Kids* program provided 285 classes on bullying prevention for grades Pre-K through 8th grade, reaching a total of 5,400 students.

A paper, *Bullying and Selected Risk Factors among Adolescents in Oklahoma*, was written by MCH and partners which includes data and recommendations for parents and schools to reduce bullying.

Challenges:

Turnover at OSDE made scheduling bullying prevention programs challenging for the School Health Educator, as did competing priorities, as work for the Youth Risk Behavior Survey became more frequent for staff.

Objective 1: Increase by 5% annually the number of adolescents participating in state or federally funded evidence-based teen pregnancy prevention programs (Baseline: 4,145 adolescents for the 2014-2015 school year).

Objective 2: Increase the number of adolescent family planning clients aged 15 to 19 who choose Long Acting Reversible Contraception (LARC) methods from 31% in 2013 to 35% by 2020.

Data:

Teen birth rates for 15-19 year olds are at historic lows in Oklahoma and have declined 40% over the past 15 years from 58 births per 1,000 females aged 15-19 in 2001 to 34.8 in 2015. However, Oklahoma's teen birth rate is declining at a slower pace than the national average, which decreased 51% during the same time span. In 2015, older teens in Oklahoma, aged 18-19 years, had the highest birth rate at 64.2, followed by 15-17 year olds at 15.9. Compared to other states in the nation, including the District of Columbia, Oklahoma was tied with Mississippi for the 2nd highest teen birth rate for 15-19 year olds, the 3rd highest teen birth rate for 18-19 year olds, and the 5th highest teen birth rate for 15-17 year olds. Oklahoma's teen birth rate is significantly higher than the national average; however, it is important to note it is improving. In 2015, there were 4,434 births to females less than 20 years old, comprising 8.4% of all births in Oklahoma. This is a significant decrease from 7,572 teen births, which comprised 15.1% of all births 15 years ago. Among teen births in 2015, 3,166 were to females ages 18-19 years, 1,225 were to females ages 15-17 years, and 43 were to females ages 10-14 years.

Successes:

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, 2015 and September 30, 2016, 5,003 clients ages 15-17 were seen in family planning clinics in county health departments and the two city-county health departments.

MCH provided technical assistance to local county health departments that identified the reduction of teen births as a

quality improvement measure within local family planning community participation plans. On May 13, 2016, MCH held videoconference training for health department staff in all county health departments focusing on teen pregnancy prevention and suicide prevention.

Some county health department County Community Participation Plans included increasing services to adolescents as part of their quality improvement activities.

Challenges:

Funding for LARCS was a challenge, as county health departments reported waiting lists.

Objective 2: Maintain the number of available trainers statewide who have completed a training of trainers (TOT) in Oklahoma's selected evidence-based teen pregnancy prevention curricula at 12.

Data:

Objective has been met-MCH Staff hosted a Making A Difference (MAD) and Making Proud Choices (MPC) Training of Trainers for 12 participants to include staff from MCH, PREP, Teen Pregnancy Prevention Projects, Tulsa Campaign to Prevent Teen Pregnancy, and Muscogee-Creek Nation, ensuring 17 TOTs in the state. As this objective was met, it was modified to read "Maintain the number...at 12" instead of "Increase... from 5 to 12..."

Successes:

MCH staff and staff from partner organizations have been able to train others in the state in curriculum use, including new staff, tribal partners, and schools.

Challenges:

None, for this Objective.

Objective 3: Increase the number of local Public Health Youth Councils across the state from 3 in 2015 to 7 by 2020 that will provide input regarding adolescent health issues, including teen pregnancy prevention, to MCH, the CSHCN, as well as other programs within and outside of OSDH.

Data:

Three Public Health Youth Councils were active in the state providing input on adolescent health issues in their counties.

Successes:

MCH has maintained the number of Public Health Youth Councils (PHYC) in Lincoln County and Seminole County. In both regions, facilitators trained and empowered council members to be self-advocates and community advocates. Self-advocacy by understanding public health and its impact at various socio-ecological levels; knowing how to identify and access resources in their communities; and learning about careers in public health. Community advocacy by educating their peers and community on various issues including bullying, teen pregnancy and hygiene. In March 2016, PHYC assisted with an annual county-wide conference, which provides 5th grade boys and girls a network of support as they develop the necessary skills to make positive choices in their own lives. In May 2016, joint efforts were made by two PHYC to promote healthy lifestyles, discuss bullying prevention and bridge the gap between community resources and schools. Facilitators utilize both the positive youth development (PYD) and the youth-adult partnership (YAP) model.

Challenges:

The expansion of PHYC initiative into other regions did not occur during this fiscal year due to Adolescent Health Specialists having limited time and knowledge to establish a council and the Adolescent Health Consultant position being vacant from April to July 2016.

Objective 4: Expand coverage of state or federally funded, age-appropriate, evidence-based teen pregnancy prevention projects in rural counties with teen birth rates higher than the national average from 24 in 2015 to 30 by 2020.

Data:

Teen pregnancy prevention projects were active in 27 rural counties, including one non-funded county.

Successes:

MCH continued the administration and monitoring of the Personal Responsibility Education Program (PREP) grant from the Administration of Children, Youth, and Families and Family and Youth Services Bureau (FYSB). The \$643,470 in federal funds supported implementation of adolescent pregnancy prevention projects through contractual agreements with Oklahoma City-County Health Department and Tulsa Health Department. 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 2015, both PREP sites held activities associated with *Let's Talk* Month, a national public education campaign encouraging parent and child communication about sexuality.

PREP staff and MCH staff completed activities throughout the month of May 2016 highlighting National Teen Pregnancy Prevention Month and the National Day to Prevent Teen Pregnancy. MCH placed a banner on IRENE (the OSDH internal website) that recognized the month and promoted the National Day to Prevent Teen Pregnancy quiz. 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 maintained the number of state-funded adolescent pregnancy prevention projects in local county health departments in five areas. Three school nurses and one health educator received training in the evidence-based curriculum in October 2015. This additional training expanded the project into non-funded areas. All project areas 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 staff coordinated training for PREP and adolescent pregnancy prevention staff in January and July of 2016. In January, training focused on Responding to the Media, Protocol, and Intimate Partner Violence. In July, training focused on Positive Youth Development. Outside partners were invited to attend and 28 participants were present representing Choctaw Nation, Muskogee Nation Youth Services, Cherokee Nation, Oklahoma Institute for Child Advocacy, PREP, and county health departments.

MCH staff attended the Wellness Now Coalition Adolescent Health Workgroup meetings to collaborate on teen pregnancy prevention efforts in Oklahoma County. MCH staff attended the Clinical Subcommittee meetings to establish guidelines for teen friendly clinics in Oklahoma County.

MCH staff created a Teen Pregnancy Prevention site on the OSDH website which includes materials and resources. The Oklahoma Teen Birth Report was updated and added to the OSDH website May 2016.

MCH staff, PREP educators, and two Adolescent Health Specialists were trained in the *Power through Choices* curriculum in August 2016 to enhance program capacity to reach out-of-home youth.

Challenges:

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.

Two tribal PREP partners did not continue receiving tribal PREP funding which resulted in reduced coverage of teen pregnancy prevention projects in the northeastern part of Oklahoma.

The Adolescent Health Consultant position was vacant from April 2016 to July 2016.

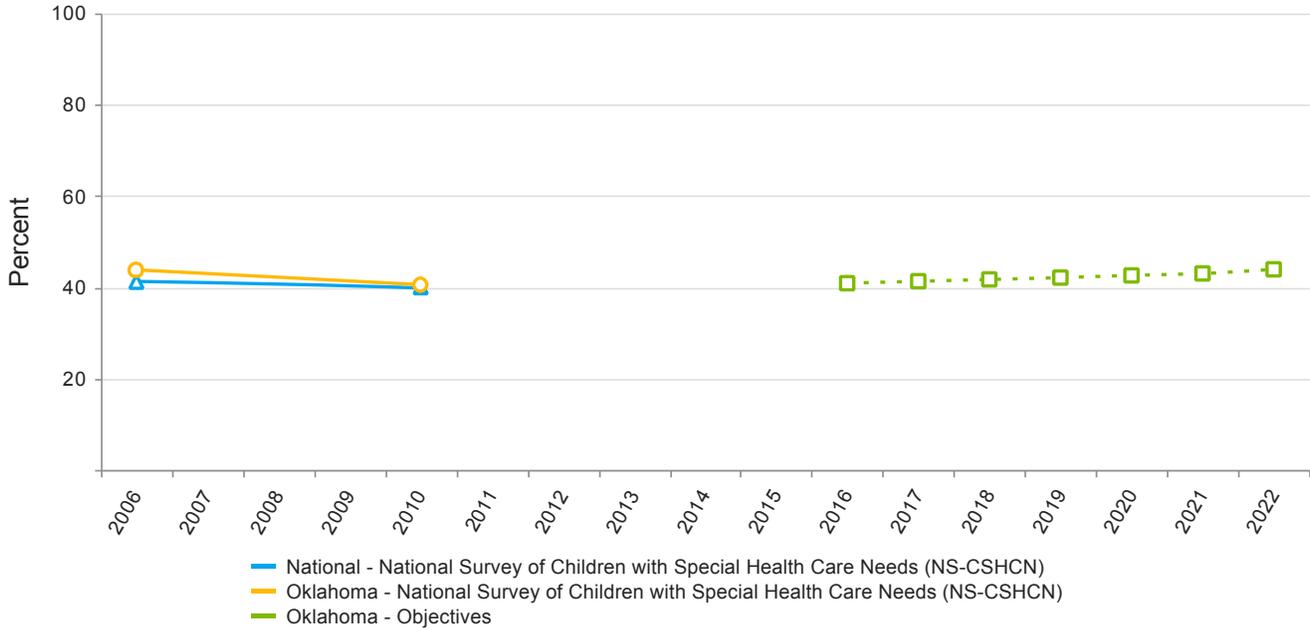
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	16.6 %	NPM 12
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	84.4 %	NPM 12

National Performance Measures

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



Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	40.9
Annual Indicator	40.5
Numerator	22,989
Denominator	56,766
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	41.3	41.7	42.1	42.6	43.0	43.9

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - The number of providers who address transition to adult health care in their practice

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	94
Numerator	
Denominator	
Data Source	Sooner Success
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	105.0	110.0	115.0	120.0	125.0

State Performance Measures

SPM 3 - The percent of families who are able to access services for their child with behavioral health needs

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	60.7
Numerator	
Denominator	
Data Source	National Survey of Childrens Health
Data Source Year	2011/12
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	61.9	63.2	64.4	65.7	67.0	68.4

State Action Plan Table

State Action Plan Table (Oklahoma) - Children with Special Health Care Needs - Entry 1

Priority Need

Improve the transition to adult health care for children and youth with special health care needs

NPM

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

Objectives

1. Develop a toolkit for primary care physicians by 2020.
2. Increase number of families who are aware of need for provision of transition services by 10% by 2020.
3. Increase number of families of CYSHCN who report receiving transition services from 40.5% in 2009/2010 to 44.5% by 2020.

Strategies

- 1a. Access a network of pediatricians and family medicine physicians to gather information on how they provide transition services for patients.
- 1b. Collaborate with the Oklahoma American Academy of Pediatrics (AAP) chapter to get their assistance in engaging pediatricians.
2. Convene a work group of Title V partners and families of CYSHCN to discuss how each can provide input into transition planning.
3. Determine and compile a list of resources available within the state to address transition to adult health care.

ESMs

Status

ESM 12.1 - The number of providers who address transition to adult health care in their practice

Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Oklahoma) - Children with Special Health Care Needs - Entry 2

Priority Need

Reduce health disparities

NPM

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

Objectives

4. Develop a plan to increase healthcare transition awareness among the CYSCHN population, to include addressing health disparities for CYSCHN, by 2020.

Strategies

4a. Identify individuals, families and agencies to help develop plan to address health disparities for CYSCHN.

4b. Identify resources within the state that have data regarding health disparities for CYSCHN, including the Oklahoma Health Care Authority.

ESMs

Status

ESM 12.1 - The number of providers who address transition to adult health care in their practice

Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Oklahoma) - Children with Special Health Care Needs - Entry 3

Priority Need

Improve the mental and behavioral health of the MCH population

SPM

The percent of families who are able to access services for their child with behavioral health needs

Objectives

Increase the number of families who are able to access behavioral and mental health services.

Strategies

Collaborate with all Title V CSHCN partners to connect families with behavioral and mental health services.

Identify all infant and early childhood mental health coalitions and other related activities in the five Oklahoma counties with the greatest need for behavioral and mental health services.

Educate at least 25 families of CYSHCN with behavioral and mental health needs by providing leadership and partnerships skills to ensure a family voice at all levels of their decision making process.

Support families through a Title V CSHCN partner, OITP, to provide neurodevelopmental and psycho-social assessments and referrals connecting families with behavioral and infant mental health services.

Provide support, through a Title V CSHCN partnership with the JD McCarty Center, for families to utilize respite services while accessing opportunities for behavioral and mental health assistance.

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

CSHCN will continue to provide Title V funding to support Sooner SUCCESS' efforts in improving transition to adult healthcare, including efforts to finalize data collection and actions on recommendations arising from the report.

Sooner SUCCESS will continue developing partnerships and collaborations within the infrastructure of the counties in which they operate. Their county and regional resource coordinators will help families and health care providers locate and access services and resources for children and youth with special health care needs. They will also work within communities to identify local needs and then develop and support plans to meet those needs. The long term plan is to have county coordinators servicing all seventy-seven counties in Oklahoma. Counties will be added as funding is found for each position. The continued support of Title V funds to work with families addressing transition from pediatric to adulthood for Sooner SUCCESS is crucial.

The Pediatric Sickle Cell Clinic will continue efforts to adequately staff transitional care coordination coverage for the Eastern Area of the state and in the Oklahoma City Clinic.

The Oklahoma Infant Transition Program (OITP)'s future initiatives will be reviewed as they relate to providing services to children with special healthcare needs. The uncertainty of the program remains unknown. A discussion will be held to determine the plan on how the program will continue working with the parents and guardians on how they can get the needed services in a way that works best for their family.

JD McCarty will continue to increase the physical and emotional well-being of patients and their families through an empowering process of education, training, transitional planning and community respite support via continued funding from the Title V Block Grant.

The Oklahoma Family 360° Center staff will continue to assist families as they are referred and resources are available. They will review their current list of families to determine if their goals have been met and other support networks have been established.

Oklahoma Family Network (OFN) and the MCH School Health Coordinator will develop and present health care transition training which includes health plans for youth in schools to a minimum of 25 participants at the Oklahoma Transition Institute. This will increase the number of healthy students and improve the outcomes for those with health conditions.

OFN will fill three positions ensuring families' access to behavioral health services, in central, northeast and southeast Oklahoma, while maintaining four other regional staff. OFN will add a minimum of ten resources to the OFN web site to improve access to care. All OFN identified and directed support groups will be listed on the OFN web site. Future work will include identifying infant and early childhood mental health coalitions in the remaining priority counties and beginning partnerships with at least one of the following per priority county: early childhood center, Head Start, Early Head Start and Sooner Start (early intervention program). A partnership with a tribal Head Start in one of the priority communities will be pursued.

OFN will host a Family Leader Pre-Institute and the 11th Joining Forces: Supporting Family Professional Partnerships Conference for a minimum of 100 participants and will host a webcast of the 18th Annual Chronic Illness and Disability Conference provided by Baylor University for a minimum of 15 participants.

Children with Special Health Care Needs - Annual Report

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

Objective 1: Develop a toolkit for primary care providers by 2020.

Data:

To address the Oklahoma Title V performance measure to improve health care transition for *children and youth with special health care needs* (CYSHCNs), the Oklahoma Department of Human Services (DHS) Title V program in collaboration with Sooner SUCCESS (State Unified Children's Comprehensive Exemplary Services for Special Needs), developed a five year plan to assess, develop and disseminate Health Care Transition plans. The first phase was implemented to address the baseline assessment of the national performance measure. The ultimate goal remained to provide the essential services required to make the necessary health care transition by the adolescent population and have a toolkit developed for primary care physicians. This tool/resource kit will include a list of family physicians willing to accept adolescents as new patients as they enter adulthood; a list of internists who will take adolescents into adult health care; and, a list of adult specialty physicians involved in long-term care for complex advanced medical conditions.

Data collected by Sooner SUCCESS found that 81.0% of primary care physicians did not have any process for health care transition for patients transitioning from pediatrics to adult health care services. Nearly all providers who did not have a process for health care transition or make referrals to adult health care providers indicated that they maintain adult health care for their patients once these children turn 18. The 19% of primary care providers who did have a process for health care transition reported that the process was informal and unstructured. No providers maintained a transition tracking and monitoring system or conducted a transition readiness assessment with their families.

Successes:

Sooner SUCCESS administered an online provider survey to a list of primary-care pediatricians in collaboration with Oklahoma Chapter of the American Academy of Pediatrics (AAP). The initial phase included reviewing existing literature available on health care transition and obtaining baseline information about the current level of health care transitioning in CSHCN by surveying providers and families. A survey link was first published in the electronic chapter newsletter on April 14, 2016. However, the response was extremely low despite the support of the AAP president. An alternative process was proposed, and a list of pediatricians from the Oklahoma Board of Medical Licensure and Supervision was requested and compared with the members list from the Oklahoma Chapter of American Academy of Pediatrics (164 were surveyed).

In addition, a brief clinical inventory on health care transition was done in June 2016. Approximately 21 clinics were visited. Five specialty clinics either had a formal health care transition process in place or a comprehensive plan for one. Clinics with established health care transition process included: Endocrinology/Diabetes, Urology, Sickle Cell Anemia and Gastroenterology/Hepatology. The Cystic Fibrosis Clinic had a comprehensive plan for transitional health care assistance to adulthood but no process or policy in place.

Most other clinics surveyed were aware of the health care transition process but had not yet implemented it. Only four clinics were unaware of the health care transition process. However, they understood the process once it was explained to them. Some clinics had adolescents who continued with the same physicians once they transitioned into adulthood. For clinics that transferred their patients, they typically did so between the ages of 18-21 years.

Challenges:

Convincing pediatric primary care physicians of the value of the Health Care Transition Process Pediatric to Adulthood as a necessary tool to adapt in their practices has been an ongoing challenge. Personnel available to visit clinical sites to collect the data were limited. Many clinics were unaware of the differences between typical referrals and a standard health care transition process that is recommended to be conducted between 12-18 years of age. Specialty clinics with a tradition or process for health care transition did not necessarily have a structured or written policy.

Objective 2. Increase number of families who are aware of need for provision of transition services by 10% by 2020.**Data:**

Sooner SUCCESS County Coordinators made efforts to reach families of CYSHCNs; via email for a family survey to assess their level of awareness around timely preparation for transition of health care for their adolescents when they turn 18 years old. At the time of grant submission baseline data for this measure was unavailable.

Successes:

A Health Care Transition Subcommittee was established to strengthen partnership involvement and input. This subcommittee consists of many partners that work with families that have a child with special needs: Department of Health and Human Services Title V, Oklahoma Family Network, Oklahoma Pediatric Sickle Cell, Oklahoma LEND (Leadership Education in Neurodevelopmental Disabilities), Center for Learning and Leadership, Oklahoma Department of Education, Oklahoma Infant Transition Center, Department of Rehabilitation Services, Oklahoma Department of Mental Health and Substance Abuse Services and the OU Children's Hospital Volunteer's. The first initial meeting convened on October 2015. Thereafter, the committee has met regularly to both evaluate ongoing transition activities and prioritize their objectives and goals. A representative from each partner was encouraged to attend a local broadcast of the 17th Annual Chronic Illness and Disability Conference sponsored by Texas Children's Hospital on October 27-28, 2016.

Challenges:

Consistent attendance by the subcommittee members varies due to staffing issues within the participating agencies as a result of budgetary cuts throughout the State of Oklahoma for State Fiscal Year (SFY)16.

Objective 3. Increase number of families of CYSHCN who report receiving transition services from 40.5% in 2009/2010 to 44.5% by 2020.**Objective 4: Develop a plan to increase health care transition awareness among the CYSCHN population, to include addressing health disparities for CYSCHN, by 2020.****Data:**

Readiness and timely preparation for the transfer of healthcare for adolescents around age 18, was among the key components identified for accomplishing successful post-transition goals. In between reviewing material on gottransition.org (six-core elements of health care transition, other resources for youth and family) and questions on National Survey for Children with Special Health Care Needs, discussions were held among key stakeholders in the community. Family surveys were then constructed. The purpose was to facilitate group thinking among the intended population from diverse demographics (e.g. family size, age, race, gender, county of residence, socio-economic structure etc.), in order to successfully address demographic-related disparities by 2020. Emphasis was laid on developing and having a transition plan between ages 12 – 18 years with focus on current and future insurance

availability and other concerns.

Successes:

The Oklahoma Family Network (OFN), the state Family-to-Family Health Information Center (F2F HIC), hosted the webcast of the 17th Annual Chronic Illness and Disability Conference with a focus on Transition from Pediatric to Adult-based Care on October 27-28, 2016 in Oklahoma City at the Shephard Mall Training Institute. Six families and seven health care and other providers attended. Participants not only learned from the presenters in Houston, but also received state-specific health care resource information, a health care transition planning tool as well as tools developed by the PACER Center regarding school health plans for children and youth with asthma, diabetes and seizure disorder.

Two OFN staff and one Sooner SUCCESS staff participated on the Oklahoma Transition Council and served on the planning committee for the 11th Annual Oklahoma Transition Institute. Approximately 525 individuals participated. OFN provided six scholarships for families to attend the conference and provided three trainings, one focusing on the use of Life Course tools for youth transitioning from high school. The second session trained families and professionals on how to facilitate sessions to plan future transition activities regionally. The third session covered Community Resources (including behavioral health resources) for an effective transition.

For nine years, OFN has hosted Joining Forces: Supporting Family Professional Partnerships Conference. One hundred sixty families and professionals attended the 2016 conference focused on family/professional partners, thirty percent were family members and about thirty-one percent of all attendees were from rural or frontier areas. The keynote was Mr. Randy Lewis, a former executive with the Walgreens Corporation. He shared his experience with increasing the number of people with chronic health conditions and disabilities working for Walgreens to ensure a good life for all.

The Pediatric Sickle Cell Clinic in Oklahoma City, funded in part with Title V funds, maintained their transition program for adolescents with sickle cell. This program utilized a formal health care transition procedure from pediatric to adulthood, serving youth between the ages of 13 and 25. A Transition Nurse Coordinator oversaw the provision of services. Participants received training in life skills such as goal setting, budgeting, applying for SSI and health insurance, and getting a job. The young person booked their own appointments with medical practitioners, but the Transition Nurse Coordinator attended the first few appointments with each primary care provider (PCP) and hematologist. The coordinator remained available for the participating youth even after he or she graduated from high school. Young people in the program became well versed in making their own appointments with medical professionals and how to communicate problems and concerns with their health to those professionals.

Sooner SUCCESS held "On the Road" conferences to help families learn what services were available through programs such as SoonerCare (the state Medicaid program), Sooner Start (the state early intervention program for children with special needs) and ABLE Tech (an organization that helps families find and acquire technology adapted for CYSHCN) focusing on all aspects of transition. The conferences were held at different times of the year in different communities around the state to allow as many families as possible to attend at least one event. CSHCN program staff participated in these conferences as well as meeting with other parent and professional groups to explain the eligibility requirements of SoonerCare, TEFRA (a medical program for children with significant needs) and the SSI-Disabled Child Program SSI-DCP which continued to be funded by Title V and provided formula and some equipment for accessibility or mobility. Thus far, only one conference was held in Oklahoma City for the

Hispanic population. This conference was well attended, with approximately 60 families.

The Oklahoma Family Support 360⁰ Center continued to serve families with children with developmental disabilities and Medicaid eligibility. The 360⁰ Center maintained an active enrollment of over 80 families, the majority of which were families who spoke Spanish as a primary language. The Center played a unique role in the community by providing assistance to Hispanic families who had no other consistent bilingual support to navigate health, education, medical and social service systems. The Center also supported families to find non-public resources to address the needs of their children and other family members. Over time, families became more self-sufficient and proficient in setting priorities, finding resources and navigating the complexities of health and social service systems.

Challenges:

Pediatric Sickle Cell Clinic transition services to children were limited as a result of two staff vacancies.

Budget cuts continued to place burdens on staff time and limit participation in committees and new programs.

SPM: The percent of families who are able to access services for their child with behavioral health needs

Objective: Increase the number of families who are able to access behavioral and mental health services.

Data:

The 2011-2012 National Survey of Children's Health found that 60.7% of Oklahoma children ages 2-17 with needs for counseling received mental health care.

Successes:

OFN had seven regional staff providing resource referral for families of children and youth with behavioral health conditions. Families of children with behavioral health conditions received parent-to-parent emotional support and assistance with accessing behavioral and mental health services by ten regionally-based staff, all parents of children with special health care needs and disabilities. OFN staff members initiated four new support groups for families of children with behavioral health conditions and began the process for two more. Four of these groups focused on families of children in state custody who were attempting to reunify with their children. All groups focused on families of children with behavioral health concerns and provided emotional support and assistance with accessing services for their family. OFN partnered with Oklahoma Systems of Care and Health Homes to ensure wrap around services for families who have the greatest need for behavioral health services.

Sooner SUCCESS provided resource referral for families of children and youth with behavioral health concerns. They maintained county coordinators who provided one-on-one resource referrals.

The Oklahoma Infant Transition Program (OITP) had one Family Partner and two Social Work staff members who assisted the families of children at OU Medical Center Children's Hospital at greatest risk for long-term health conditions. Families received assistance in transitioning from the NICU to home, ensuring all needed services were identified, including any mental health services for families. These services ensured positive infant and early childhood mental health.

The JD McCarty Center continued to provide a comprehensive program of rehabilitative care to Oklahoma's children (ages 0-21) with developmental disabilities. Specialized services such as respite were designed to give parents needed time off. Children in respite can stay at the McCarty Center for a total of seven days one time per year. Children in respite care did not attend school or receive therapy while they were there, but did participate in

recreational activities, including field trips. The respite program was primarily funded by the Federal Title V MCH Block Grant. The Center also provided evaluations for children who had behavioral and developmental disabilities. The evaluations assisted families in identifying strategies to assist their children in becoming healthier and in accessing all types of services including school-based.

Challenges:

OFN received more than \$110,000 in reduced funds due to state budget cuts for SFY17, resulting in staff reductions and less regional training. In the fall, OFN received two small community grants and hosted an annual appeal campaign. However, this only resulted in raising about 10% of what had been lost. As a result, some staff resigned due to lack of pay increases and benefits, and the increased amount of travel required because of the size of their regions.

OITP faced a variety of staffing issues. Vacancies included the program director, family advocate, and several social worker positions.

JD McCarty respite care services are limited to a seven day per year per child, in part due to funding and staffing limitations.

Cross-Cutting/Life Course

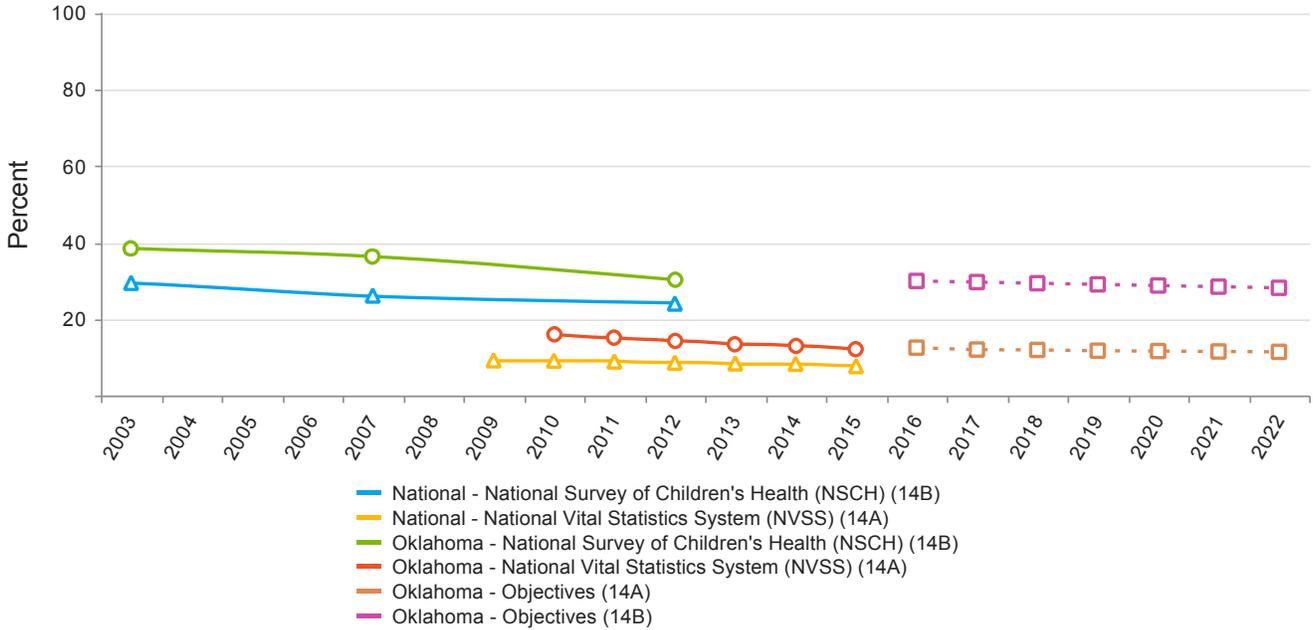
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2014	171.4	NPM 14
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	23.4	NPM 14
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	7.9 %	NPM 14
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.4 %	NPM 14
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	6.5 %	NPM 14
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	10.3 %	NPM 14
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	2.8 %	NPM 14
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.6 %	NPM 14
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	27.5 %	NPM 14
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	7.1	NPM 14
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	8.2	NPM 14
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	5.3	NPM 14
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.9	NPM 14
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	313.1	NPM 14
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	155.6	NPM 14
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	84.4 %	NPM 14

National Performance Measures

NPM 14 - A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Baseline Indicators and Annual Objectives



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

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	12.6
Annual Indicator	12.2
Numerator	6,465
Denominator	53,071
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	12.1	12.0	11.8	11.7	11.6	11.5

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	30
Annual Indicator	30.3
Numerator	281,264
Denominator	927,603
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.7	29.4	29.1	28.8	28.5	28.2

Evidence-Based or –Informed Strategy Measures

ESM 14.1 - The percentage of pregnant women who call the Oklahoma Tobacco Helpline for cessation support

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	5.7
Numerator	417
Denominator	7,362
Data Source	TSET, Oklahoma Tobacco Helpline
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	6.0	6.3	6.6	6.9	7.3	7.6

State Action Plan Table

State Action Plan Table (Oklahoma) - Cross-Cutting/Life Course - Entry 1

Priority Need

Reduce the prevalence of chronic health conditions among childbearing age women

NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objectives

Reduce the percent of women who smoke during the last 3 months of pregnancy from 14.8% in 2014 to 12.6% by December 2020.

Strategies

Encourage pregnant women to quit smoking through referral to the QUIT line.

Air public service announcements at least annually on smoking and pregnancy and the impact of secondhand smoke on infants.

Analyze PRAMS data and BRFSS data on e-cigarette use to determine prevalence and create data briefs, etc.

ESMs

Status

ESM 14.1 - The percentage of pregnant women who call the Oklahoma Tobacco Helpline for cessation support

Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children in excellent or very good health

State Action Plan Table (Oklahoma) - Cross-Cutting/Life Course - Entry 2

Priority Need

Reduce health disparities

NPM

A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Objectives

1. Reduce the number of African American women who smoke during pregnancy from 12.9% in 2012-2014 to 12.0% and the number of American Indian women who smoke during pregnancy from 19.2% in 2012-2014 to 18.0% by 2020.
2. Reduce the percent of children who ride in vehicles where smoking is allowed from 15.1% in 2012-2015 to 14.5% by 2020, with a special focus on rural areas in the state.

Strategies

1. Work with OHCA and other partners to identify ways to effectively use tobacco cessation media messages to reach African American and American Indian mothers.
- 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.
- 2b. Create messages for social media on the prevalence of children riding in vehicles where smoking was allowed, targeting areas of the state and populations where disparities exist.
- 2c. Continue to fund school health nurses in ten rural communities to promote tobacco reduction and health promotion activities.

ESMs

Status

ESM 14.1 - The percentage of pregnant women who call the Oklahoma Tobacco Helpline for cessation support

Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

NOM 5.1 - Percent of preterm births (<37 weeks)

NOM 5.2 - Percent of early preterm births (<34 weeks)

NOM 5.3 - Percent of late preterm births (34-36 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NOM 19 - Percent of children in excellent or very good health

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

MCH will continue to partner with the Center for the Advancement of Wellness within OSDH on the *Preparing for a Lifetime* Tobacco Workgroup, to reduce the prevalence of tobacco use among pregnant and parenting women.

Family planning clients seen at the CHDs and contract clinics will continue to receive counseling and referrals to the Oklahoma Tobacco Helpline (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.

The Center for Advancement of Wellness will continue to partner with statewide organizations to provide health systems change, Health Information Technology (HIT) support and provide training to healthcare providers across the state on the best practices for effective tobacco cessation interventions.

The Center staff will work more closely with the OSDH county health department health system to ensure evidence-based interventions, county referral data dissemination and quality improvement projects to increase innovation and effectiveness in the utilization of the OTH referral program and to increase the billing of Medicaid clients who identify and are assessed for tobacco use.

The MCH-funded school health nurses in rural school districts will continue to provide tobacco prevention education to students pre-kindergarten through twelfth grade and participate on local Health, Fit and Safe School Committees. Each will continue to be required 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, including tribal programs, to provide education and resources to students and community members supporting tobacco prevention and cessation. The MCH School Health Coordinator will provide the school nurses with information on local programs that can be used to enhance their tobacco prevention programs.

Weighted Youth Risk Behavior Survey data for 2017 will be analyzed and reports drafted on the incidence and prevalence of youth tobacco use and exposure.

Cross-Cutting/Life Course - Annual Report

Objective 1. Reduce the percent of women who smoke during the last 3 months of pregnancy from 14.8% in 2014 to 12.6% by 2020.

Objective 2. Reduce the number of African American women who smoke during pregnancy from 12.9% in 2012-2014 to 12.0% and the number of American Indian women who smoke during pregnancy from 19.2% in 2012-2014 to 18.0% by 2020.

Data:

The most recent available data for this measure come from the 2014 Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS); 14.8% of new mothers smoked in the last three months of their pregnancy. Rates for African American women for 2012-2014 were at 12.9% and for American Indian mothers were 19.2%. Targets were reevaluated and adjusted for both Objectives to reflect met goals.

Successes:

The Oklahoma State Department of Health (OSDH) Center for the Advancement of Wellness (Center) restructured the division to incorporate the Chronic Disease Division Service within the Center. The merger allowed the Center to have a greater capacity to reach women and children in Oklahoma through the education, screening and chronic health self-management programs offered by OSDH. The Center also provided oversight of all statewide cessation programs by participating in the monthly Cessation Leadership Team meeting as well as the Health Systems Initiative Workgroup and the Tribal Cessation Workgroup. The Center continued to provide technical assistance and consultation to MCH, the Tobacco Settlement Endowment Trust (TSET) grantees, the Oklahoma Health Care Authority (OHCA), the Oklahoma Department of Mental Health Substance Abuse Services (ODMHSAS) and the Oklahoma Hospital Association (OHA). All of the aforementioned organizations focus on evidence-based practices related to tobacco interventions and work with providers throughout the state.

To address the specific needs of pregnant woman, the Oklahoma Tobacco Helpline (OTH) developed a specific program for pregnant women who use tobacco products. This program offered enhanced services such as coaching sessions specifically related to quitting during various stages of pregnancy, clinical override for nicotine replacement therapy (NRT) during pregnancy and relapse prevention post pregnancy. Pregnant SoonerCare members were also eligible for a 10-call program especially tailored for pregnant tobacco users. SoonerCare participants could also choose the single call program with 2-weeks of NRT, self-help/general questions only, or an array of "individual services" including text messaging and email. The 2-week supply of NRT was intended to be a "starter kit", and SoonerCare members were counseled to access additional smoking cessation benefits available to them through their benefits package. These included additional NRT, prescription medications and counseling sessions with their health care provider. MCH staff and contractors regularly referred pregnant smokers to the OTH during the course of service provision, as appropriate.

The Center continued to work with the OHCA, to promote the statewide cessation SoonerCare insurance benefits and the OTH services. The OHCA utilized TSET funds to focus their efforts on the SoonerQuit™ for Women program, the SoonerQuit Provider Engagement program and the SoonerCare Health Promotion program. These programs focus on provider engagement and education, health promotion and mass media to reach pregnant women. The OHCA SoonerQuit™ for Women program has the long term goal of improving birth outcomes by reducing rates of tobacco use during pregnancy and postpartum. The SoonerQuit™ for Women program connected their members to evidence-based tobacco dependence treatment through a variety of ways. In addition, the Center worked with the OHCA in SYF15 and 16 to reduce barriers to tobacco cessation coverage for SoonerCare members by removing prior authorizations, co-pays on the seven FDA approved tobacco cessation medications and

counseling and duration limits with the exception of Chantix. The policy changes have yielded great results with a 20.3 percent increase in prescription claims two years after the policy change went into effect.

The Center worked with the *Preparing for a Lifetime* Tobacco Cessation Workgroup in conjunction with the OHCA to report on the pregnancy program utilization with the OTH and referrals from healthcare providers, which included OB/GYN and OB/GYN Specialists. In State Fiscal Year (SFY)16, the OTH reported the following for participants registering in the pregnancy program:

- Utilization of the OTH among women with SoonerCare who were pregnant, planning pregnancy or breastfeeding increased 88 percent in SFY16 compared to SFY15 (442 registrants vs. 236)
- In SFY16, of the 442 SoonerCare members who accessed the OTH for assistance quitting tobacco, 315 were pregnant, 65 were breastfeeding and 60 were planning pregnancy.
- 95.4 percent of SoonerCare members utilizing the OTH identified as an ethnicity of non-Hispanic origin
- 12.9 percent of all SoonerCare members identified as Black or African American
- 11.2 percent of all SoonerCare members identified as American Indian or Alaskan Native
- 60 percent of pregnant, planning pregnancy and breastfeeding women received telephone counseling and 29.5 percent received NRT
- During SFY16, 9.5 percent of SoonerCare registrants reported current use of an e-cigarette or other vapor product.

It should be noted that treatment reach (number of tobacco users who accept services and are provided treatment) was slightly higher for African Americans than in American Indians in SFY16, and treatment reach among African American females was two times higher than treatment reach of African American males in SFY16.

The SoonerQuit™ Provider Engagement Program trained 48 prenatal providers in the urban areas of Oklahoma City and Tulsa; these providers oversaw the majority of births within the state. The program ensured that providers were utilizing best practices to help individuals successfully quit tobacco use. The program also focused on health system change to incorporate direct patient referrals to the OTH as well as the utilization of the 5 A's assessment for tobacco cessation.

Additionally, the SoonerQuit™ Health Promotion program, in its ongoing partnership with TSET and the Oklahoma State Department of Health, engaged women of child-bearing ages (18 -34) with digital, social and visual display media platforms. In SFY16, SoonerQuit™ advertising ran 11 months out of the year in both English and Spanish on television, radio and digital media in several markets in Oklahoma. These media campaigns featured the OTH and the “No Judgments, Just Help” campaign, and the “SoonerQuit Coaching” campaign, along with the Clearway Minnesota “Claymation” promotions of the OTH cessation services for women. Moreover, SoonerQuit™ media campaigns extended to Oklahoma City Transit Authority (EMBARK) and Tulsa Transit on bus wrap-arounds and benches to further reach women in the Oklahoma City metroplex and Tulsa markets.

In FY16, the OTH launched a new suite of services which provided more tools and resources for registered participants. These new services were promoted by the OHCA Text4Baby and SoonerQuit™ campaign(s). Text4Baby is a mobile health service that provides timely health information to pregnant women and caretakers of infants and young children. The health information can be about any health issue affecting women who are pregnant, including tobacco use. Having seen good results with the tobacco cessation messaging via Text4Baby, the OHCA launched Quit4Baby™, a subset program of Text4Baby. The Quit4Baby™ program sought to increase enrollment in the Text4Baby program and offered specialized tobacco cessation messaging, resources and program specific information for women who were pregnant and mothers of infants.

The OSDH remained just one of 65 organizations that partnered with Text4Baby to reduce tobacco use among pregnant women and families with young children. From January 1, 2015 through December 2015, an estimated 18,655 SoonerCare recipients enrolled in Text4Baby in Oklahoma, a 166% increase from the SFY13 reporting.

In SFY16, the utilization of provider electronic referrals to the OTH through several large health systems and their electronic health record (EHR) was a priority. The Center worked with the Oklahoma Tobacco Research Center (OTRC) to provide technical assistance for those health systems. This large scale implementation greatly impacted SFY16 OTH utilization. The potential for the increase of referrals from providers through the EHR was the most sustainable option available to healthcare systems and it saved time during the clinical referral process, along with systematically assuring meaningful use and the adherence of best practice standards. The Center and MCH collaborated with the three Cessation Systems Initiatives funded by the TSET, OHA, OHCA and ODMHSAS in an effort to incorporate tobacco screening and referral into electronic medical records (EMR).

In SFY16 there were 10,996 fax referrals and 2,169 electronic referrals received by the OTH from health professionals and health systems across the state. This was a 25% increase in the number of fax referrals and a 113% increase in the number of electronic referrals as compared to SFY15.

The OSDH Family Planning Program saw more than 7,947 unduplicated users, who were pregnant or seeking pregnancy in calendar year 2016. The county health departments (CHD) continued to serve as a primary entry point for low socioeconomic status, pregnant women and women of childbearing age. Family planning clients were provided counseling on the impact of smoking during the preconception, interconception, and prenatal periods. All CHDs in Oklahoma were equipped with the capacity to refer women who identified as a tobacco user during a 5A's assessment or who identified smoking in their home. The CHD fax referral program proactively connected clients to the OTH for support through the specialized pregnancy program.

MCH monitored county health departments' and contract clinics' smoking intervention documentation to ensure appropriate referrals for clients who reported tobacco use. Although SoonerCare billing declined specifically for tobacco cessation intervention from the CHDs, the OSDH has placed greater emphasis on the referrals and service code utilization in SFY16 and SFY17.

Challenges:

Oklahomans continued to have poor health outcomes, higher rates of disease and an overall higher death rate than the national average which was a result of complex interactions with multiple factors. Despite the improvements that have been made across health systems, the capacity of many health systems hinders the cessation referral process through the balancing of multiple system priorities, cost challenges and technology supports.

Objective 3. Reduce the percent of children who ride in vehicles where smoking is allowed from 15.1% in 2012-2015 to 14.5% by 2020, with a special focus on rural areas in the state.

Data:

The rate of toddlers riding in cars with someone who smoked was 15.1% according to 2012-2015 The Oklahoma Toddler Survey (TOTS) data. Targets were reevaluated and adjusted to reflect the met goal for this objective, and the 2020 goal changed from 15.7% to 14.5%.

Successes:

In SFY16, the Center partnered with the City of Oklahoma City, Oklahoma Tobacco Research Center, Oklahoma City County Health Department and TSET to advocate for multi-unit housing ordinances that prohibited the use of

tobacco on the properties of housing authorities across Oklahoma. This move toward smoke-free living could protect the environments of thousands of Oklahomans, reduce the cost to housing authorities and reduce exposure to secondhand smoke. A toolkit for landlords and tenants was created by Center staff in SFY14 and widely distributed in SFY15.

MCH continued to support school health nurses in ten rural school districts. These nurses provided health, nutrition, drug/alcohol/tobacco prevention education to students pre-kindergarten through 12th grade. They worked with community stakeholders to provide programs addressing bullying prevention with the students and how to develop positive relationships with peers, parents, and other adults. They used their community and tribal contacts to provide training and assistance to their school staff members on integrating trauma-based classroom management skills for all students.

These nurses provided technical assistance and training to staff members on the management of chronic health problems in the schools setting such as diabetes, asthma, epilepsy, severe allergies and other chronic conditions and tobacco cessation where necessary. They assisted schools with the development of the Section 504 of the Americans with Disabilities Act plans, individualized education plans (IEP) and the individualized health care plans. These nurses also provided emergency care to students and staff if necessary.

The MCH School Health nurses worked with the local Healthy, Fit, and Safe schools committees by helping the committees work through assessment, planning, implementation, and evaluation of actions taken by the school to promote health. They provided their communities with information on access to health care, tobacco prevention programs, social services through community health fairs, presentations at local service organizations, and direct one-on-one meetings.

MCH posted information about secondhand smoke and infant and child health and data on e-cigarette use among youth on the MCH Facebook page to help increase awareness. Resources such as Text4Baby and the OTH were also provided via social media.

Challenges:

Tobacco cessation and secondhand smoke reduction is a complex issue, requiring multiple partners and avenues for success, including policy. The Oklahoma legislature had an opportunity to increase the tax on cigarettes by \$1.50 per pack, funds that would have been earmarked for mental health and other health care expenditures, in SFY16 but failed to do so. The opportunity to revisit the tax for SFY17 was explored during fall planning meetings.

Other Programmatic Activities

No content was entered for Other Programmatic Activities in the State Action Plan Narrative section.

II.F.2 MCH Workforce Development and Capacity

All new MCH staff members are required to complete the MCH New Employee Orientation and 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, Title X 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.

OSDH has integrated the Life Course Approach into its Strategic Map 2015-2010. As a result, a strategic planning work group has been created which includes senior leadership. The work group has developed a work plan to more intentionally integrate the Life Course Approach into programs and initiatives of the Agency, including training staff. MCH continued to offer a quarterly Life Course training for employees and provide training materials to others upon request. Trainings are at capacity for every session and the material continues to be well received. Nursing students, interns, and partners are also provided the training. OSDH Human Resources has approved the training for three hours of cultural competency and three hours of supervisory credit for OSDH employees who attend the training.

MCH hosts Preparing for a Lifetime, It's Everyone's Responsibility partner meetings quarterly. The Preparing for a Lifetime initiative aims to reduce infant mortality and reduce racial disparities. Professional development opportunities are provided at each meeting. Topics addressed through recent presentations include infant mental health; neonatal abstinence syndrome; infections that affect pregnancy, including the Zika virus, and evidence-based practices to prevent preterm birth.

Annual trainings are provided by MCH to staff in county health departments, OSDH central office, and contract staff. These trainings include required trainings such as child abuse identification and reporting, and sexual coercion, including human trafficking. Trainings for SFY 2017 include culturally competent care; involving family members in adolescents' decisions regarding reproductive health services; prevention and counseling on sexual coercion; child abuse awareness and prevention, including bullying; alcohol, tobacco, and drug abuse; preconception/interconception health and care; unplanned pregnancy; and improving outcomes for Oklahoma's babies.

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 a brief overview of Title V regulations and services relating to the SSI Disabled Children's Program (SSI-DCP). Additional training on how to complete a service plan, and how to request services are available for staff through our online tutorials (QUEST) developed by CSHCN staff.

CSHCN staff is a participant in the Supporting Families Community of Practice Oklahoma Project Team. This team is a group of people that come together to focus on and study, throughout the life course, families with members with special healthcare needs such as intellectual and developmental disabilities. The overall goal is to develop policies that support family networks, provide family-centered support coordination, expand services available in the home and strengthen the role of families in all models of services.

CSHCN also partners with three programs at the University of Oklahoma Health Sciences Center Section on Developmental and Behavioral Pediatrics of the Department of Pediatrics; the Oklahoma Leadership Education in Neurodevelopmental Disabilities (LEND), the Developmental-Behavioral Pediatric Fellowship, and the Sooner State Unified Children's Comprehensive Exemplary Services for Special Needs (Sooner SUCCESS). LEND offers a two-semester interdisciplinary leadership education program for advanced graduate or postgraduate students in

Audiology, Autism Spectrum Disorders (ASD), Child Psychiatry, Genetic Counseling, Nursing, Nutrition, Occupational Therapy, Developmental-Behavioral Pediatrics, Pediatric Dentistry, Physical Therapy, Psychology, Public Health, Social Work and Speech-Language Pathology. In addition, a parent or family member is selected to represent the Parent-Family Perspective and an individual with a disability is selected to represent self-advocacy. Interdisciplinary education experiences are provided through classroom, clinical/community and research activities focused on the core principles of Family-Centered/Person-Centered Care, Cultural Competence, Interdisciplinary Teaming, Life Course and Inclusive Community-Based Practices on behalf of children-youth with Autism Spectrum Disorders (ASD) and other Developmental Disabilities (DD) and their families. Twelve to fifteen trainees are trained annually with plans for expansion to include trainees from the Tulsa area in the coming year.

The fellowship training in Developmental-Behavioral Pediatrics (DBP) is a three year program, accepting one fellow each year. Like the LEND training, it provides interdisciplinary education experiences through classroom, clinical/community and research activities focused on the core principles of Family-Centered/Person-Centered Care, Cultural Competence, Interdisciplinary Teaming, Life Course and Inclusive Community-Based Practices on behalf of children and youth with Autism Spectrum Disorders (ASD) and other Developmental Disabilities (DD) and their families. The number of DBP physicians in Oklahoma has increased from three to five within the past five years.

Sooner SUCCESS works to advance a comprehensive, unified system of health, social and educational services for Oklahoma Children and Youth with Special Needs through community based resource coordination. County coordinators help coalitions identify, plan, and educate key stakeholders to reduce gaps in services in their communities. Recently, the program received a grant from the Oklahoma Developmental Disabilities Council to train providers to provide support to parents with intellectual disabilities.

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. Financial support (financial assistance, technical assistance, travel, and child care) is offered for parent activities, parent groups, and sibling support groups.

Family members are involved in both the CSHCN and MCH elements of the MCH Title V Block Grant application process. OFN participated in the planning, information gathering activities, and prioritization process for the 2016-2020 Title V Needs Assessment. 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. Because the Block Grant Review will be held in Oklahoma in 2017, other family leaders will be able to attend as well.

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 Maternal Mood Disorder Work Group; Screening and Special Services and Newborn Screening Advisory Groups; Children with Special Needs and Child Health Advisories; Oklahoma Perinatal Quality Improvement Collaborative and their leadership team; Oklahoma 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; Oklahoma Health Care Authority Member Advisory Task Force and Medical Advisory Committee; Infant Mental Health; the Governor's task force regarding individuals on the waitlist for DDS services 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 given 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 given 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, Autism Symposiums, and the Oklahoma Health Care Authority Strategic Planning Meetings, various early intervention and school district staff, and other professionals across the state during regional family/professional partnerships institutes.

For ten years, OFN has hosted Joining Forces: Supporting Family Professional Partnerships Conference. One hundred sixty-nine families and professionals attended the conference focused on family/professional partnerships; one-half were family members and approximately one-third were from rural or frontier areas. This year, a pre-conference for emerging family leaders was provided for 61 family members of diverse cultures. OFN staff and other seasoned family leaders will remain connected to these families and provide opportunities for continuing education and partnership activities in their area.

OFN trainings are available in Spanish, and an effort has been made by American Indian staff and families to assure OFN trainings are appropriate for families from their culture. All trainings consider aspects of other cultures, beyond race and ethnicity, such as single moms, military families, rural and urban families, disability-specific, child welfare experience, etc.

II.F.4. Health Reform

The passage and implementation of the Patient Protection and Affordable Care Act (ACA) brought about numerous changes to the way health insurance coverage is provided to Oklahoma residents. While these changes have increased the number of Oklahomans with health care coverage, it has come with increased burden and cost for some individuals, employers, and insurance carriers. Oklahoma continues to face a number of challenges related to providing individuals with access to affordable, quality, and sustainable health care coverage. While the future landscape of health care remains uncertain at both the state and federal level, what is clear is that Oklahoma needs to make significant changes to the way insurance coverage is available and health care services are accessible. The completion of the State Health System Innovation Plan (SHSIP) provided a framework for achieving the state's goals by driving the adoption of value-based payment and delivery system models for Oklahoma. This framework has been modified to allow for greater flexibility in implementation timelines, as well as address available options to implement. The SHSIP is acting as the "Road Map" for how to achieve the Oklahoma Health Improvement Plan (OHIP) Health System Transformation goals.

Value-based models expressly link provider reimbursement with improved quality of care and health outcomes. In order to identify the values, the State of Oklahoma Health and Human Services (HHS) Cabinet has developed work groups around quality and effectiveness and operational improvements. These operational workgroups are striving to streamline the transition of services across state agencies. The workgroups are close to establishing a single sign on portal for the Aged, Blind or Disabled (ABD) population to determine eligibility of multiple services offered among agencies. The Quality and Effectiveness Workgroup is close to finalizing the first phase quality clinical measures that will be integrated into waivers, contracts and programs across the HHS Cabinet to better align investments in health improvement.

In addition, the HHS Cabinet provides leadership and instruction to seek innovative waivers or policy change to improve coverage. The Oklahoma State Department of Health (OSDH) team is leading efforts toward the submission of a 1332 State Innovation Waiver. Although Oklahoma has experienced a reduced number of uninsured following the implementation of the ACA, the overall rate remains high, and the state continues to struggle with high rates of chronic disease and lack of access to health coverage. In fact, Oklahoma had only 31% of its eligible population (those with incomes between 100-400% of the FPL) purchasing coverage through the federally funded marketplace in 2016, relative to an average of 43% among other states similar to Oklahoma. Fortunately, the availability of 1332 State Innovation Waivers, coupled with potential regulatory shifts at the federal level, gives Oklahoma the chance to make significant changes necessary to improve the health of our insurance market and residents.

Oklahoma Senate Bill 1386, enacted during the 2016 legislative session, was created to explore potential methods to increase healthcare coverage in Oklahoma and reduce the financial burden for Oklahoma residents and employers seeking affordable coverage. The goal is to create an alternative pathway for affordable, high quality healthcare coverage in Oklahoma's commercial insurance market that meets the needs of Oklahomans. As a result of this legislation, OSDH, under the direction and leadership of the HHS Cabinet, organized a task force comprised of numerous Oklahoma stakeholders to investigate and analyze the options for Oklahoma pursuing a 1332 State Innovation Waiver.

In working towards achieving a modernized market, Oklahoma will submit a sequential, phased approach over time that starts with the state identifying innovative approaches to address health care needs, continues with changes at the federal level that move our state toward a redesigned individual insurance market, and ends with a state-owned, federally-supported platform that allows Oklahoma to calibrate its market through state-based policies and

procedures. This oversight at the state level will allow the market to evolve with changes in the environment and target specific outcomes related to bending the cost curve of health care, improving the quality of care, and improving population health. Oklahoma plans to submit sequential waivers over the course of the next three years. Although not in direct connection to other waivers, the 1332 Waiver submission will work with other potential waiver opportunities that assist in providing coverage to gap populations such as through an 1115 Delivery System Reform Incentive Payment Waiver to be explored and developed in the near future. This waiver would support hospitals and other providers in changing how they provide care to Medicaid beneficiaries, by focusing on improving coverage through building incentives for preventative care and quality measures that will improve overall health.

II.F.5. Emerging Issues

Neonatal Abstinence Syndrome:

Based on provider report, the use of opioids has increased in prevalence among the state's pregnant population. A question was added to the 2016 PRAMS to measure the use of opioids during pregnancy. According to reports from DHS (Department of Human Services) and ODMHSAS (Oklahoma 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 has identified neonatal abstinence syndrome as a topic of interest and has formed a task force to address the increasing rates in the state. MCH will participate on the task force and work to monitor prevalence and determine programmatic activities, as appropriate.

Infant Mental Health:

Infant mental health is defined by Zeanah and Zeanah as the developing capacity of the child from birth to 3 to experience, regulate (manage), and express emotions; form close and secure interpersonal relationships; and explore and master the environment and learn in the context of family, community, and cultural expectations for young children. To address the issue in Oklahoma, the Infant and Early Childhood Mental Health Strategic Plan was created in 2015 with funding from the Substance Abuse and Mental Health Services Administration (SAMHSA). The plan was formulated with input from workgroups focused on four priority areas. These areas include: 1) promoting awareness of the significance of infant and early childhood mental health, 2) enhancing the competency of the infant and early childhood mental health workforce to effectively meet needs, 3) developing, enhancing, and expanding programs for IECMH promotion, prevention, early intervention, and treatment and 4) establishing infrastructure and developing policies to support the integrated early childhood system of care. The work plan includes specific objectives to meet these goals, with the plan set to be completed by 2020. MCH and OFN participate on several workgroups supporting these objectives and have attended trainings offered by the lead agency in this initiative, ODMHSAS.

Advanced Practice Nurse Supervision:

Oklahoma ranks 49th in the nation for physician to patient ratio which severely limits access to care. The number of advanced practice registered nurses (APRNs) is currently limited in Oklahoma by the requirement of a "supervising physician". A physician can have up to two APRNs attached to his/her license. Physicians in Oklahoma are often working for hospital systems that will not allow the physician to enter into an agreement with an APRN outside of the hospital system.

Sixty-four out of seventy-seven counties in Oklahoma are designated as primary health care Health Professional Shortage Areas and this problem is not likely to be solved by the lower numbers of physicians currently entering into primary care practice. Only 28 counties in the state have a hospital providing delivery services and consequently no physician providing prenatal care. With limited number of physicians in the rural areas of the state, residents have limited access to care from APRNs also. The Oklahoma State Department of Health serves residents in these rural areas but finding a physician willing to agree to serve as "supervising physician" is becoming increasingly difficult.

Currently APRNs in the state need a signed agreement with a physician every two years solely to prescribe medications. The ability to contact that physician, if the need should arise, is as far as this 'supervision' goes. There is no requirement for chart review or regular meetings with the APRN because they have been trained to provide care in a safe and effective manner with evidence based methods. In all reality, the Oklahoma Board of Nursing supervises the practice of APRNs and the "supervising physicians" only sign the documentation. Some physicians require large amounts of compensation just to sign the documentation for an APRN to have prescriptive authority.

Legislation was introduced in this legislative session to eliminate the “supervising physician” requirement allowing full practice authority based on the APRN’s certification. Unfortunately, the bill passed the House of Representatives, but the chair of the Health and Human Services Committee refused to hear it. This issue is becoming a major barrier for OSDH and creating reduced access to services in many areas of the state. OSDH will continue to support this issue with the legislature for the next legislative session.

State Budget:

For FY18, Oklahoma continued to face a budget shortfall. The FY 2018 state budget was signed by the Governor at the close of the legislative session and maintained flat funding for 16 state agencies, including Department of Education and OHCA, however it cut funding for all other state agencies by approximately 4%. Uncertainty still exists with the FY 2018 budget, as at least one revenue-raising measure is being contested in court, the \$1.50 cigarette fee increase. These cuts are in addition to almost 40% reductions in funding that have already occurred in the last five years.

For Adult and Family Services, the \$33 million agency reduction will include another possible cut in staff and in programs. The Department of Human Services (DHS) has closed four local offices at this time and will have to close several more, if no revenue is created. Any state funded programs are at risk of being reduced and/or terminated. Program and staff cuts will most certainly affect CSHCN clients as well as others, as both access to services and the types of services available will be affected. DHS staff will be more limited and processing times for cases and claims will suffer.

At OSDH, the agency received a 2.8% budget reduction which impacted funding for the uncompensated care fund for Federally Qualified Health Centers (FQHCs), colorectal screening, the Child Abuse Prevention Program, the parentPRO Home Visitation Program, and the Oklahoma State Athletic Commission.

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, Title V Program, is found on the MCH web page, https://www.ok.gov/health/Community_&_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 under the active link. A one-page description of the MCH Title V Block Grant and the Title V priorities in the state has also been created and is available on the MCH 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/services/health/Pages/default4.aspx> on the OKDHS website, with a request for public comment. Hard copies and pdfs of the MCH Title V Block Grant are also provided on request to MCH at (405) 271-4480 or via e-mail to ShannonG@health.ok.gov.

Public input via e-mail and telephone calls was received intermittently throughout the year. To date, calls and emails have been received requesting more program information about MCH projects in general and seeking details on the state plan. 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.

The call for public input on the Title V block grant was posted on Facebook five times between January and May 2017 on the MCH and OSDH Facebook pages. Links to the Block Grant and requests for public comments will continue to be distributed several times over the year via social media, including the OSDH Facebook page and Twitter account. Comments, if received, are given to the appropriate program area for response.

The current Title V Executive Summary has been shared at several meetings, including site visits to county health departments. The Executive Summary has been posted online for viewing since January 2017.

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. Survey responses are discussed during all site visits and program review meetings when necessary.

Another mechanism to obtain input on health department materials used for family planning clients is the Information and Education (I&E) Committee. This committee is mandated by Title X and serves MCH by reviewing all materials distributed to clients seen in health department and contract clinics across the state. The I&E Committee is made up of representatives internal and external to the health department, including family representatives. This year the Committee added a youth member, to assure materials are appropriate and relevant to adolescents in the state. The Committee must help ensure materials are appropriate for the educational and cultural backgrounds of the individuals to whom the materials are addressed; consider the standards of the population or community to be served with respect to such materials; review the content of the material to assure that the information is factually correct; and determine whether the material is suitable for the intended population or community.

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 the 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 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

MCH is requesting technical assistance at this time for training on Positive Youth Development (PYD) and trauma-informed care for individuals and families. In the current restrictive budget climate Oklahoma does not have funds to send staff to trainings on these topics and/or purchase appropriate curriculum. MCH staff has been trained in the past on these topics but the individuals who received the training have moved on to other positions in the agency or state. It is imperative for the work that MCH does to have intensive training on these topics that goes beyond awareness, to help staff incorporate PYD and trauma-informed care into their day-to-day activities, within the programs they manage.

MCH Assessment is also seeking technical assistance related to establishing and implementing formal quality standards of data management, reporting and analysis, particularly with respect to developing detailed analysis plans and estimating valid and reliable statistics. Developed standards should provide professionally accepted practice guidelines for developing study designs, summarizing and describing data, testing hypotheses, and reporting study findings. Technical assistance is requested to support the development of such standards which are transparent and replicable, and that produce timely, accurate, and reliable data for the purpose of informing MCH Title V programs.

III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$6,747,316	\$6,903,092	\$6,903,092	\$6,903,092
Unobligated Balance	\$0	\$0	\$0	\$0
State Funds	\$5,060,487	\$5,252,960	\$5,184,379	\$7,498,441
Local Funds	\$0	\$641,942	\$0	\$641,942
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$52,016	\$75,564	\$64,006	\$28,758
SubTotal	\$11,859,819	\$12,873,558	\$12,151,477	\$15,072,233
Other Federal Funds	\$4,980,591		\$4,801,808	\$4,928,539
Total	\$16,840,410	\$12,873,558	\$16,953,285	\$20,000,772

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		2017	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$6,903,092	\$6,967,164	\$6,903,092	
Unobligated Balance	\$0	\$0	\$0	
State Funds	\$5,252,960	\$6,513,130	\$5,280,899	
Local Funds	\$641,942	\$1,163,806	\$0	
Other Funds	\$0	\$0	\$0	
Program Funds	\$52,724	\$4,050	\$5,919	
SubTotal	\$12,850,718	\$14,648,150	\$12,189,910	
Other Federal Funds	\$4,917,594	\$4,922,937	\$4,788,539	
Total	\$17,768,312	\$19,571,087	\$16,978,449	

	2018	
	Budgeted	Expended
Federal Allocation	\$6,967,164	
Unobligated Balance	\$0	
State Funds	\$5,285,582	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$4,050	
SubTotal	\$12,256,796	
Other Federal Funds	\$4,787,937	
Total	\$17,044,733	

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 ensure audit compliance.

It should be noted that the new required breakdown of expenditures by types of services and individuals served, along with specific funding sources has necessitated these numbers to be estimated through the agency's current budgeting system. Beginning with fiscal year 2017, these should move from estimates to actual expenditure numbers.

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 indicates that while Title V federal dollars remained fairly level, a decrease of approximately 13% was expended in state match dollars that included an increase in local funds and decreases in state and program income funds, when comparing 2015 to 2016 numbers. Due to receiving reductions of approximately 30% in state appropriations since 2009, and more revenue failures and budget cuts projected for the new state fiscal year, less state match dollars may be available to support this project. Additionally, program income has continued to significantly decline with children covered by Medicaid and ACA being linked with medical homes and pregnant women being linked with providers accepting Medicaid and/or ACA coverage. Many state funded positions in the central office and county health departments are not being refilled and contracts for both services and products are being decreased. MCH contract providers are also experiencing difficulty in maintaining state and local funds that they have previously shown on budgets as expenditures for MCH services. This climate will be reflected in the lower budgeted amounts from fiscal year 2017 continuing into fiscal year 2018 for state match dollars.

Form 3a documents expenditures by the MCH types of individuals served. For FFY 2016, there were fairly significant decreases in funding for infants, children and CSHCN service population groups due largely to the current state

economic climate and reduced state match funding available. However, there was an increase of over \$273,000 in funding for pregnant women in FFY 2016 due to community support for specific maternal mortality and morbidity reduction initiatives.

Form 3b documents shifts that occurred within the categories of direct health care services, enabling services, and public health services and systems. Direct health care service expenditures were increased to a partnership total of \$3,406,001, enabling services expenditures decreased 13% to \$1,354,982 and public health systems and services decreased by approximately 10% from 2015 to 2016. The largest area of expenditure continues to be in public health services and systems to address the shift in recent years to more population-based services to meet the need of the MCH population in Oklahoma.

With these changes, 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	\$236,644	0	\$236,644
Total	\$8,743,993	\$2,407,068	\$11,151,061

Special consolidated projects:

MCH Title V Block Grant funds continue to be used to carry out safe sleep activities and the CSHCN Supplemental Security Income-Disabled Children's Program (SSI-DCP). Safe sleep activities include public education and technical assistance/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 2018, 45% 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 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.

Federal funds are received from the CDC to support ongoing administration of the Youth Risk Behavior Survey (YRBS). This survey provides Oklahoma with information on risk-taking behaviors of high school youth.

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 \$1,000,000 + 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 continue 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). *Power Through Choices* curriculum is being utilized and PREP staff are being trained to implement this evidence-informed teen pregnancy prevention and positive youth development program with out of home youth.

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 ensure financial awareness within each budgeted area. CSHCN performs yearly onsite reviews with each contracted entity to ensure 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 any time 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 - [MOA between OSDH MCH Service OKDHS 2018.pdf](#)

Supporting Document #02 - [Org_charts2017_oklahoma.pdf](#)

Supporting Document #03 - [Block Grant Bios_OK.pdf](#)

Supporting Document #04 - [Acronyms_2017.pdf](#)

VI. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Oklahoma

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 6,967,164	
A. Preventive and Primary Care for Children	\$ 3,146,155	(45.1%)
B. Children with Special Health Care Needs	\$ 2,090,150	(30%)
C. Title V Administrative Costs	\$ 696,716	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 5,285,582	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 4,050	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 5,289,632	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 4,684,317		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 12,256,796	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 4,787,937	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 17,044,733	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 643,470
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 3,839,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	\$ 65,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 145,093

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 6,903,092		\$ 6,967,164	
A. Preventive and Primary Care for Children	\$ 3,177,985	(46%)	\$ 3,146,155	(45.1%)
B. Children with Special Health Care Needs	\$ 2,070,928	(30%)	\$ 2,090,150	(30%)
C. Title V Administrative Costs	\$ 690,309	(10%)	\$ 696,716	(10%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 5,252,960		\$ 6,513,130	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 641,942		\$ 1,163,806	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 52,724		\$ 4,050	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 5,947,626		\$ 7,680,986	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 4,684,317				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 12,850,718		\$ 14,648,150	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 4,917,594		\$ 4,922,937	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 17,768,312		\$ 19,571,087	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 636,606	\$ 643,470
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 145,093	\$ 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	\$ 140,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 97,495	\$ 95,374
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 3,838,400	\$ 3,839,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior	\$ 60,000	\$ 60,000

Form Notes for Form 2:

Line 4 Local MCH funds were not budgeted due to issues with Medicaid billing

Field Level Notes for Form 2:

1.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2018
	Column Name:	Application Budgeted
	Field Note:	The FY 2018 Budgeted and FY 2016 Expended Program Income are same.
2.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2016
	Column Name:	Annual Report Expended
	Field Note:	State MCH funds are predicted to be less this next fiscal year due to current revenue failures and budget cuts of state dollars.
3.	Field Name:	4. LOCAL MCH FUNDS
	Fiscal Year:	2016
	Column Name:	Annual Report Expended
	Field Note:	Line 4 Local MCH funds were not budgeted due to issues with Medicaid billing
4.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2016
	Column Name:	Annual Report Expended
	Field Note:	The FY 2018 Budgeted and FY 2016 Expended Program Income are same. FY 2016 Program Income includes OSDH MCH Medicaid dollars received and expended for maternity and perinatal services. Funding received this year was reduced due to vacancies and new administrative billing processes and requirements. DHS CSHCN does not currently claim Medicaid dollars as program income for this grant.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: Oklahoma

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	\$ 300,277	\$ 315,126
2. Infants < 1 year	\$ 733,866	\$ 719,017
3. Children 1-22 years	\$ 3,146,155	\$ 3,146,155
4. CSHCN	\$ 2,090,150	\$ 2,090,150
5. All Others	\$ 0	\$ 0
Federal Total of Individuals Served	\$ 6,270,448	\$ 6,270,448

IB. Non Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Pregnant Women	\$ 604,714	\$ 604,714
2. Infants < 1 year	\$ 1,758,989	\$ 2,379,186
3. Children 1-22 years	\$ 1,345,136	\$ 2,716,964
4. CSHCN	\$ 1,576,743	\$ 1,980,122
5. All Others	\$ 0	\$ 0
Non Federal Total of Individuals Served	\$ 5,285,582	\$ 7,680,986
Federal State MCH Block Grant Partnership Total	\$ 11,556,030	\$ 13,951,434

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Form 3b
Budget and Expenditure Details by Types of Services
State: Oklahoma

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	\$ 1,737,084	\$ 1,737,084
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 1,158,870	\$ 1,158,870
B. Preventive and Primary Care Services for Children	\$ 262,800	\$ 262,800
C. Services for CSHCN	\$ 315,414	\$ 315,414
2. Enabling Services	\$ 623,292	\$ 623,292
3. Public Health Services and Systems	\$ 4,606,788	\$ 4,606,788
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		\$ 26,288
Physician/Office Services		\$ 88,302
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 200,824
Laboratory Services		\$ 0
Other		
MCH Direct costs		\$ 1,421,670
Direct Services Line 4 Expended Total		\$ 1,737,084
Federal Total	\$ 6,967,164	\$ 6,967,164

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	\$ 1,056,927	\$ 1,668,917
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 215,286	\$ 431,501
B. Preventive and Primary Care Services for Children	\$ 529,785	\$ 1,002,664
C. Services for CSHCN	\$ 311,856	\$ 234,752
2. Enabling Services	\$ 546,060	\$ 731,690
3. Public Health Services and Systems	\$ 3,682,595	\$ 5,280,379
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 19,832
Physician/Office Services		\$ 65,454
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 149,466
Laboratory Services		\$ 0
Other		
MCH DIRECT SERVICES LESS CSHCN		\$ 1,434,165
Direct Services Line 4 Expended Total		\$ 1,668,917
Non-Federal Total	\$ 5,285,582	\$ 7,680,986

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	Field Name:	IIA. - Other - MCH Direct costs
	Fiscal Year:	2018
	Column Name:	Annual Report Expended
	Field Note:	The "Other MCH Direct Costs" category includes direct cost services that cannot be broken into the subcategories listed in IIA.4 due to agency systemic cost reporting issues. We are currently working to try to address these issues for more complete breakdown of direct costs in the future for subcategories requested.

2.	Field Name:	IIB. - Other - MCH DIRECT SERVICES LESS CSHCN
	Fiscal Year:	2018
	Column Name:	Annual Report Expended
	Field Note:	The "Other" category includes direct cost services that cannot be broken into the subcategories listed in II.B.4 due to agency systemic cost reporting issues. We are currently working to try to address these issues for more complete breakdown of direct costs subcategories in the future.

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated
State: Oklahoma

Total Births by Occurrence: 52,584

1. Core RUSP Conditions

Aggregate Data Not Available

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
Phenylketonuria	52,584 (100.0%)	7	3	3 (100.0%)
Congenital Hypothyroidism	52,584 (100.0%)	68	46	46 (100.0%)
Galactosemia	52,584 (100.0%)	6	0	0 (0%)
Sickle Cell Disease	52,584 (100.0%)	13	13	13 (100.0%)
Congenital Adrenal Hyperplasia	52,584 (100.0%)	7	5	5 (100.0%)
Biotinidase Deficiency	52,584 (100.0%)	15	15	15 (100.0%)
Cystic Fibrosis	52,584 (100.0%)	9	9	9 (100.0%)
Sickle Cell Trait	52,584 (100.0%)	181	181	0 (0.0%)
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	52,584 (100.0%)	10	0	0 (0%)
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	52,584 (100.0%)	6	6	6 (100.0%)
Short-Chain Acyl-CoA Dehydrogenase Deficiency/Glutaric Aciduria Type II	52,584 (100.0%)	12	10	0 (0.0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Citrullinemia/Argininosuccinic Acidemia	52,584 (100.0%)	23	7	4 (57.1%)
Tyrosinemia	52,584 (100.0%)	17	0	0 (0%)
Propionic/Methylmalonic Acidemia	52,584 (100.0%)	6	1	1 (100.0%)
Glutaric Aciduria Type I	52,584 (100.0%)	8	0	0 (0%)
3-Methylcrotonyl-CoA Carboxylase Deficiency/3-Hydroxy-3-Methylglutaryl-CoA Lyase Deficiency	52,584 (100.0%)	3	1	1 (100.0%)
Carnitine Palmitoyltransferase I Deficiency	52,584 (100.0%)	6	1	1 (100.0%)
Carnitine Uptake Defect	52,584 (100.0%)	4	0	0 (0%)
Carnitine Acylcarnitine Translocase Deficiency	52,584 (100.0%)	19	0	0 (0%)
Long-Chain 3-Hydroxyacyl-CoA Dehydrogenase Deficiency	52,584 (100.0%)	0	0	0 (0%)
Isovaleric Acidemia	52,584 (100.0%)	2	2	2 (100.0%)
Maple Syrup Urine Disease	52,584 (100.0%)	6	1	1 (100.0%)
Severe Combined Immunodeficiency (SCID)	52,584 (100.0%)	13	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Oklahoma Newborn Screening Program (NSP) provides contracted services for long-term follow-up for infants identified with a metabolic, endocrine, dietary management and transition for hemoglobinopathies. The NSP collaborates with nurses who provide long-term management for cystic fibrosis and hemoglobinopathies that are funded by other entities. Children diagnosed through newborn screening continue to receive long-term follow-up services until 21 years of age, except for children identified with congenital hypothyroidism who are followed up through age five. Care coordination services include education to families, establishing and maintaining children in a medical home, addressing barriers to care, monitoring morbidity and mortality of referred children. Information collected includes diagnosis, genetic counseling, service referrals, barriers to care, annual performance assessments, growth development, ER visits, and compliance with medication regimen.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	Field Name:	Aggregate Data Not Available
	Fiscal Year:	2016
	Column Name:	Aggregate Data Not Available Notes
	Field Note:	Newborn screening data are entered individually by condition.
2.	Field Name:	Sickle Cell Trait - Positive Screen
	Fiscal Year:	2016
	Column Name:	Other Newborn
	Field Note:	<p>Sickle cell trait individuals are identified as carrier for sickle cell disease therefore they do not exhibit symptoms or have the disease. These results are never considered presumptive results as the result does not indicate possible disease status only carrier status.</p> <p>The count for the number of presumptive cases (181) is entered only to address the data alert issued by the TVIS.</p>
3.	Field Name:	Sickle Cell Trait - Referred For Treatment
	Fiscal Year:	2016
	Column Name:	Other Newborn
	Field Note:	<p>Sickle cell trait individuals are identified as carrier for sickle cell disease therefore they do not exhibit symptoms or have the disease. These results are never considered presumptive results as the result does not indicate possible disease status only carrier status.</p>
4.	Field Name:	Short-Chain Acyl-CoA Dehydrogenase Deficiency/Glutaric Aciduria Type II - Referred For Treatment
	Fiscal Year:	2016
	Column Name:	Other Newborn
	Field Note:	<p>Children identified with SCAD do not require medical intervention, only monitoring during times of illness or stress. A specialist is monitoring these children. Precautions only this condition does not require medical intervention. Treatment usually provided during times of illness or stress.</p>
5.	Field Name:	Citrullinemia/Arginiosuccinic Acidemia - Referred For Treatment
	Fiscal Year:	2016

Column Name:

Other Newborn

Field Note:

Three of the seven cases were diagnosed with very mild citrullinemia variant and "precautions only" was started. No medical treatment indicated.

Data Alerts: None

**Form 5a
Unduplicated Count of Individuals Served under Title V**

State: Oklahoma

Reporting Year 2016

		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	52,584	63.1	0.0	31.5	1.2	4.2
2. Infants < 1 Year of Age	52,584	45.0	0.0	43.6	8.7	2.7
3. Children 1 to 22 Years of Age	69,140	50.4	0.0	38.2	11.4	0.0
4. Children with Special Health Care Needs	2,237	65.1	17.1	14.2	3.6	0.0
5. Others	589	0.0	0.0	0.0	0.0	100.0
Total	177,134					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2016
	Field Note:	Pregnant Women – Enumeration for pregnant women served by Oklahoma Title V programs includes the number of resident women delivering a live birth. These women receive direct and enabling services through the implementation of safety bundles of the Alliance for Innovation on Maternal Health (AIM); the provision of safe sleep education, sleep sacks, and portable cribs; the promotion of breastfeeding in Becoming Baby Friendly hospital program; the reduction of infant injury in the Period of Purple Crying Program; and the reduction of the risk and incidence of preterm birth.
2.	Field Name:	Infants Less Than One Year Total Served
	Fiscal Year:	2016
	Field Note:	Infants < 1 Year of Age – Count of individuals served reflects the number of live births in Oklahoma for 2016. Data are provisional pending final closeout of 2016 annual dataset. All births occurring in the state are subject to newborn metabolic and hearing screening.
3.	Field Name:	Children 1 to 22 Years of Age
	Fiscal Year:	2016
	Field Note:	Children 1 to 22 Years of Age – Count of children reflects those participating in bullying prevention trainings, teen pregnancy prevention education (PREP and TPP), vision screening, diabetes education, and the small number of children receiving child health care in county health departments.
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2016
	Field Note:	Children with Special Health Care Needs – CSHCN count reflects those children served by Sooner Success, the Oklahoma Family Network, the Oklahoma Infant Transition Program, the Sickle Cell Clinic, Family 360, and JD McCarty.
5.	Field Name:	Others
	Fiscal Year:	2016
	Field Note:	Other – This category reflects family planning clients receiving LARCs funded by Title V.

Form 5b
Total Recipient Count of Individuals Served by Title V

State: Oklahoma

Reporting Year 2016

Types Of Individuals Served	Total Served
1. Pregnant Women	78,895
2. Infants < 1 Year of Age	52,584
3. Children 1 to 22 Years of Age	693,710
4. Children with Special Health Care Needs	21,000
5. Others	544,423
Total	1,390,612

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2016
	Field Note:	Pregnant Women: Reflects those reported on Form 5a plus women estimated to have received non-direct care services related to postpartum screening, postpartum visits, and pregnancy tests.
2.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2016
	Field Note:	Infants <1: Reflects the number of Oklahoma resident births.
3.	Field Name:	Children 1 to 22 Year of Age
	Fiscal Year:	2016
	Field Note:	Children 1-22: The number represents the estimated population of Oklahoma children in the state below 250% of FPL. In general, the target population potentially in need of MCH services. Admittedly, a broad canvas of the child population.
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2016
	Field Note:	CSHCN: The number is an estimate of the number of CSHCN residing in the state. Estimate is derived from the National Survey of Children's Health.
5.	Field Name:	Others
	Fiscal Year:	2016
	Field Note:	Others: The number reflects an estimate of the number of men and women (minus those in other categories) at 250% FPL. Again, this is a broad count of individuals potentially served by Title V. As with Children 1-22 we do not have a direct method to count individuals served by Title V programs for each level of service (infrastructure, population-based, enabling, direct).

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Oklahoma

Reporting Year 2016

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	52,584	39,023	5,531	6,186	1,823	0	0	21
Title V Served	52,584	39,023	5,531	6,186	1,823	0	0	21
Eligible for Title XIX	30,593	22,703	3,218	3,599	1,061	0	0	12
2. Total Infants in State	105,716	78,811	10,937	12,278	3,669	0	0	21
Title V Served	61,162	45,630	6,331	7,065	2,124	0	0	12
Eligible for Title XIX	36,412	27,150	3,768	4,230	1,264	0	0	0

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	44,993	7,591	0	52,584
Title V Served	44,993	7,591	0	52,584
Eligible for Title XIX	26,177	4,416	0	30,593
2. Total Infants in State	90,658	15,058	0	105,716
Title V Served	52,445	8,717	0	61,162
Eligible for Title XIX	31,225	5,187	0	36,412

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	2. Total Infants in State
	Fiscal Year:	2016
	Column Name:	Total All Races

Field Note:

Total infants in state reflect the aggregated count of live births to Oklahoma residents for calendar years 2015 and 2016. Enumeration of infants using U.S.

Census Bureau population estimates tends to underestimate this population.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Oklahoma

A. State MCH Toll-Free Telephone Lines	2018 Application Year	2016 Reporting Year
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"		147,944

B. Other Appropriate Methods	2018 Application Year	2016 Reporting Year
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"		79,296
3. State Title V Program Website Address	https://www.ok.gov/health/Community_&_Family_Health/Maternal_and_Child_Health_Service/index.html	https://www.ok.gov/health/Community_&_Family_Health/Maternal_and_Child_Health_Service/
4. Number of Hits to the State Title V Program Website		2,200
5. State Title V Social Media Websites	https://www.facebook.com/Oklahoma-Maternal-and-Child-Health-451472241604992/	https://www.facebook.com/Oklahoma-Maternal-and-Child-Health-451472241604992/
6. Number of Hits to the State Title V Program Social Media Websites		213

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Oklahoma

1. Title V Maternal and Child Health (MCH) Director	
Name	Joyce Marshall
Title	Director, Maternal & Child Health Service
Address 1	Oklahoma State Department of Health
Address 2	1000 NE 10th Street
City/State/Zip	Oklahoma City / OK / 73117
Telephone	(405) 271-4480
Extension	
Email	joycem@health.ok.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Carla McCarrell-Williams
Title	Title V CSHCN Director
Address 1	Oklahoma Department of Human Services
Address 2	2400 N. Lincoln Blvd
City/State/Zip	Oklahoma City / OK / 73105
Telephone	(405) 521-4092
Extension	
Email	Carla.McCarrell-Williams@okdhs.org

3. State Family or Youth Leader (Optional)

Name	Joni Bruce
Title	Executive Director
Address 1	Oklahoma Family Network
Address 2	800 NE 15th Street
City/State/Zip	Oklahoma City / OK / 73104
Telephone	(405) 271-5072
Extension	
Email	jonib@ofn.mobi

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Oklahoma

Application Year 2018

No.	Priority Need
1.	Reduce infant mortality
2.	Reduce the incidence of preterm and low birth weight births
3.	Reduce the incidence of unintentional injury among children
4.	Reduce the incidence of suicide among adolescents
5.	Reduce health disparities
6.	Improve the transition to adult health care for children and youth with special health care needs
7.	Reduce teen pregnancy
8.	Reduce unplanned pregnancy
9.	Improve the mental and behavioral health of the MCH population
10.	Reduce the prevalence of chronic health conditions among childbearing age women

Form 9 State Priorities-Needs Assessment Year - 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, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	74.6 %	0.2 %	38,719	51,929
2014	72.8 %	0.2 %	37,398	51,352
2013	69.1 %	0.2 %	34,413	49,834
2012	68.7 %	0.2 %	34,280	49,900
2011	66.6 %	0.2 %	32,996	49,577
2010	65.5 %	0.2 %	33,170	50,613

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	171.4	6.1 %	799	46,625
2013	190.2	6.4 %	901	47,367
2012	179.8	6.2 %	860	47,841
2011	227.6	7.0 %	1,083	47,578
2010	186.2	6.3 %	900	48,324
2009	178.2	6.0 %	888	49,826
2008	129.3	5.1 %	641	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
2011_2015	23.4	3.0 %	62	264,853
2010_2014	26.0	3.1 %	69	264,969
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
2015	7.9 %	0.1 %	4,172	53,066
2014	8.0 %	0.1 %	4,238	53,307
2013	8.1 %	0.1 %	4,297	53,341
2012	8.0 %	0.1 %	4,200	52,697
2011	8.5 %	0.1 %	4,431	52,242
2010	8.4 %	0.1 %	4,458	53,206
2009	8.4 %	0.1 %	4,558	54,453

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, 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
2015	1.4 %	0.1 %	726	53,066
2014	1.4 %	0.1 %	766	53,307
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
2015	6.5 %	0.1 %	3,446	53,066
2014	6.5 %	0.1 %	3,472	53,307
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
2015	10.3 %	0.1 %	5,485	53,082
2014	10.3 %	0.1 %	5,492	53,284
2013	10.6 %	0.1 %	5,625	53,284
2012	10.9 %	0.1 %	5,710	52,555
2011	10.8 %	0.1 %	5,639	52,121
2010	11.2 %	0.1 %	5,919	53,017
2009	10.9 %	0.1 %	5,907	54,294

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, 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
2015	2.8 %	0.1 %	1,466	53,082
2014	2.8 %	0.1 %	1,482	53,284
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
2015	7.6 %	0.1 %	4,019	53,082
2014	7.5 %	0.1 %	4,010	53,284
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
2015	27.5 %	0.2 %	14,570	53,082
2014	27.6 %	0.2 %	14,699	53,284
2013	27.8 %	0.2 %	14,834	53,284
2012	29.2 %	0.2 %	15,325	52,555
2011	30.1 %	0.2 %	15,702	52,121
2010	31.9 %	0.2 %	16,929	53,017
2009	33.5 %	0.2 %	18,191	54,294

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, 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
2015/Q2-2016/Q1	3.0 %			
2015/Q1-2015/Q4	3.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:
■ 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
2014	7.1	0.4 %	377	53,483
2013	5.8	0.3 %	309	53,519
2012	6.9	0.4 %	363	52,916
2011	6.2	0.3 %	324	52,420
2010	6.0	0.3 %	318	53,388
2009	6.2	0.3 %	341	54,715

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	8.2	0.4 %	438	53,339
2013	6.7	0.4 %	359	53,369
2012	7.5	0.4 %	397	52,751
2011	7.3	0.4 %	380	52,272
2010	7.5	0.4 %	399	53,238
2009	7.9	0.4 %	431	54,553

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	5.3	0.3 %	283	53,339
2013	4.0	0.3 %	212	53,369
2012	4.6	0.3 %	243	52,751
2011	4.4	0.3 %	231	52,272
2010	4.2	0.3 %	223	53,238
2009	4.4	0.3 %	242	54,553

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	2.9	0.2 %	155	53,339
2013	2.8	0.2 %	147	53,369
2012	2.9	0.2 %	154	52,751
2011	2.9	0.2 %	149	52,272
2010	3.3	0.3 %	176	53,238
2009	3.5	0.3 %	189	54,553

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	313.1	24.3 %	167	53,339
2013	211.7	19.9 %	113	53,369
2012	265.4	22.5 %	140	52,751
2011	170.3	18.1 %	89	52,272
2010	174.7	18.1 %	93	53,238
2009	229.1	20.5 %	125	54,553

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - 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
2014	155.6	17.1 %	83	53,339
2013	149.9	16.8 %	80	53,369
2012	164.9	17.7 %	87	52,751
2011	155.0	17.2 %	81	52,272
2010	182.2	18.5 %	97	53,238
2009	154.0	16.8 %	84	54,553

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - 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
2014	7.0 %	1.1 %	3,498	50,017
2013	3.9 %	0.8 %	1,957	50,172
2012	5.6 %	0.9 %	2,817	50,068
2011	5.3 %	1.0 %	2,611	49,664
2010	5.3 %	0.9 %	2,715	50,867
2009	4.6 %	0.8 %	2,365	51,960
2008	6.1 %	0.9 %	3,150	51,928
2007	4.8 %	0.8 %	2,516	51,975

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >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: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	10.2	0.5 %	477	46,628
2013	8.1	0.4 %	385	47,368
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
2015	28.0	2.4 %	136	485,290
2014	26.7	2.4 %	129	482,492
2013	29.1	2.5 %	140	481,170
2012	25.2	2.3 %	120	475,436
2011	29.9	2.5 %	142	474,448
2010	27.4	2.4 %	129	471,513
2009	29.3	2.5 %	136	464,479

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	43.4	2.9 %	228	525,456
2014	42.7	2.9 %	222	520,233
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
2013_2015	19.6	1.6 %	152	774,912
2012_2014	19.8	1.6 %	152	769,486
2011_2013	20.3	1.6 %	157	772,259
2010_2012	22.3	1.7 %	174	780,352
2009_2011	24.3	1.8 %	192	790,954
2008_2010	28.6	1.9 %	228	796,647
2007_2009	30.0	1.9 %	239	797,110

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013_2015	14.5	1.4 %	112	774,912
2012_2014	15.0	1.4 %	115	769,486
2011_2013	14.0	1.4 %	108	772,259
2010_2012	12.8	1.3 %	100	780,352
2009_2011	10.8	1.2 %	85	790,954
2008_2010	10.4	1.1 %	83	796,647
2007_2009	9.9	1.1 %	79	797,110

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs

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
2014	29.6 %	0.3 %	9,686	32,754
2012	31.7 %	0.3 %	11,028	34,770
2010	33.0 %	0.2 %	12,501	37,849
2008	32.3 %	0.3 %	9,148	28,285

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
2015	32.6 %	1.9 %	56,144	172,023
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
2015	8.2 %	0.4 %	78,467	959,160
2014	8.7 %	0.5 %	82,190	950,023
2013	10.5 %	0.5 %	98,940	947,160
2012	9.9 %	0.5 %	92,887	936,722
2011	10.9 %	0.6 %	101,812	934,009
2010	10.4 %	0.5 %	96,671	932,723
2009	11.1 %	0.6 %	102,685	921,695

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width 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 completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	75.4 %	3.7 %	57,220	75,920
2014	73.3 %	3.8 %	55,110	75,222
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) - Flu

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015_2016	52.3 %	2.2 %	463,253	886,608
2014_2015	54.4 %	2.2 %	482,493	886,773
2013_2014	55.2 %	2.1 %	480,374	870,847
2012_2013	50.1 %	2.6 %	438,541	875,876
2011_2012	53.2 %	2.9 %	453,126	851,398
2010_2011	50.4 %	3.1 %	423,271	839,823
2009_2010	43.7 %	2.3 %	379,503	868,427

Legends:

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 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) - Teen (Female)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	58.1 %	5.1 %	74,135	127,538
2014	65.3 %	4.4 %	82,099	125,694
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) - Teen (Male)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	52.9 %	4.5 %	70,683	133,610
2014	43.2 %	4.5 %	57,224	132,446
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) - Teen

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	84.4 %	2.5 %	220,371	261,148
2014	82.6 %	2.4 %	213,323	258,140
2013	78.1 %	2.5 %	200,795	257,188
2012	77.1 %	2.9 %	198,246	257,165
2011	66.0 %	3.2 %	168,949	256,171
2010	54.8 %	3.3 %	135,997	248,051
2009	35.1 %	2.9 %	86,620	246,600

Legends:

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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) - Teen

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	68.1 %	3.3 %	177,924	261,148
2014	70.8 %	2.9 %	182,853	258,140
2013	66.2 %	2.7 %	170,300	257,188
2012	63.8 %	3.4 %	164,130	257,165
2011	55.3 %	3.4 %	141,605	256,171
2010	42.6 %	3.3 %	105,757	248,051
2009	29.5 %	2.8 %	72,731	246,600

Legends:

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	59.4
Annual Indicator	61.0
Numerator	414,257
Denominator	679,075
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	62.2	63.5	64.7	66.0	67.3	68.7

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	76.7
Annual Indicator	74.7
Numerator	38,593
Denominator	51,646
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	77.4	78.2	79.8	80.4	81.2	82.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	19.1
Annual Indicator	15.7
Numerator	7,715
Denominator	49,145
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	16.0	16.3	16.7	17.0	17.3	17.7

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	71.9
Annual Indicator	75.4
Numerator	37,018
Denominator	49,130
Data Source	PRAMS
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	76.9	78.4	80.0	81.6	83.2	84.1

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - CHILD	
	2016
Annual Objective	186.8
Annual Indicator	177.3
Numerator	951
Denominator	536,332
Data Source	SID-CHILD
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	173.8	170.3	166.9	163.5	160.3	157.1

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: HCUP - State Inpatient Databases (SID) - ADOLESCENT	
	2016
Annual Objective	290.9
Annual Indicator	271.1
Numerator	1,411
Denominator	520,536
Data Source	SID-ADOLESCENT
Data Source Year	2014

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	265.7	260.4	255.2	250.1	245.1	240.2

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	23.9
Annual Indicator	17.8
Numerator	54,245
Denominator	304,334
Data Source	NSCH
Data Source Year	2011_2012

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	23.9
Annual Indicator	25.0
Numerator	44,898
Denominator	179,440
Data Source	YRBSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	23.6	23.4	23.2	22.9	22.7	22.2

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	75
Annual Indicator	74.3
Numerator	225,407
Denominator	303,509
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	75.8	76.6	77.3	78.1	78.9	80.5

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	40.9
Annual Indicator	40.5
Numerator	22,989
Denominator	56,766
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	41.3	41.7	42.1	42.6	43.0	43.9

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Vital Statistics System (NVSS)	
	2016
Annual Objective	12.6
Annual Indicator	12.2
Numerator	6,465
Denominator	53,071
Data Source	NVSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	12.1	12.0	11.8	11.7	11.6	11.5

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	30
Annual Indicator	30.3
Numerator	281,264
Denominator	927,603
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	29.7	29.4	29.1	28.8	28.5	28.2

Field Level Notes for Form 10a NPMs:

None

**Form 10a
State Performance Measures (SPMs)**

State: Oklahoma

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

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

State Provided Data	
	2016
Annual Objective	
Annual Indicator	7.4
Numerator	391
Denominator	52,584
Data Source	Oklahoma Vital Statistics
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	7.3	7.1	7.0	6.8	6.7	6.6

Field Level Notes for Form 10a SPMs:

None

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

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

State Provided Data	
	2016
Annual Objective	
Annual Indicator	17.6
Numerator	28
Denominator	158,868
Data Source	Oklahoma Vital Statistics
Data Source Year	2014-2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	17.4	17.3	17.1	16.9	16.8	16.6

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data

Field Note:

The data reported for SPM #2, maternal mortality rate per 100,000 live births, reflect multi-year data for years 2014-2016. Data for year 2016 are provisional pending final closeout of that year's death data.

Annual Objectives have been revised to reflect improvement in the maternal mortality rate.

SPM 3 - The percent of families who are able to access services for their child with behavioral health needs

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	60.7
Numerator	
Denominator	
Data Source	National Survey of Childrens Health
Data Source Year	2011/12
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	61.9	63.2	64.4	65.7	67.0	68.4

Field Level Notes for Form 10a SPMs:

None

**Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)**

State: Oklahoma

ESM 1.1 - The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health or any alternative preconception tool

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	91
Numerator	
Denominator	
Data Source	PHOCIS
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	95.0	100.0	105.0	110.0	115.0	120.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.1 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	14.9
Numerator	7,911
Denominator	53,118
Data Source	Oklahoma Vital Statistics
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	15.6	16.4	17.2	18.1	19.0	20.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data

Field Note:

Data reflect provisional 2016 live births occurring at facilities classified as baby-friendly - Cherokee Nation W.W. Hastings Hospital, Claremore Indian Hospital, Comanche County Memorial Hospital, Integris Baptist Medical Center, Integris Health Edmond, St. Anthony Hospital, Chickasaw Nation Medical Center.

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

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	69.2
Numerator	36,743
Denominator	53,118
Data Source	Oklahoma Vital Statistics
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	70.6	72.0	73.4	74.9	76.4	77.9

Field Level Notes for Form 10a ESMs:

None

ESM 7.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	84.8
Numerator	45,031
Denominator	53,118
Data Source	Oklahoma Vital Statistics
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	86.5	88.2	90.0	91.8	93.6	95.5

Field Level Notes for Form 10a ESMs:

None

ESM 9.1 - The number of trainings provided by MCH to school staff on bullying prevention

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	3
Numerator	
Denominator	
Data Source	MCH Training Log
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	5.0	6.0	7.0	8.0	9.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active
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State Provided Data	
	2016
Annual Objective	
Annual Indicator	3,350
Numerator	
Denominator	
Data Source	MCH PREP Program
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4,300.0	4,500.0	4,700.0	5,000.0	5,200.0	5,400.0

Field Level Notes for Form 10a ESMs:

None

ESM 12.1 - The number of providers who address transition to adult health care in their practice

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

State Provided Data	
	2016
Annual Objective	
Annual Indicator	94
Numerator	
Denominator	
Data Source	Sooner Success
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	100.0	105.0	110.0	115.0	120.0	125.0

Field Level Notes for Form 10a ESMs:

None

ESM 14.1 - The percentage of pregnant women who call the Oklahoma Tobacco Helpline for cessation support

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

State Provided Data	
	2016
Annual Objective	
Annual Indicator	5.7
Numerator	417
Denominator	7,362
Data Source	TSET, Oklahoma Tobacco Helpline
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	6.0	6.3	6.6	6.9	7.3	7.6

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Oklahoma

SPM 1 - Infant mortality rate per 1,000 live births
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active									
Goal:	To reduce the number of infant deaths									
Definition:	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;">Numerator:</td> <td>The number of deaths to infants from birth through 364 days of age</td> </tr> <tr> <td>Denominator:</td> <td>The number of live births</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>1,000</td> </tr> </table>		Numerator:	The number of deaths to infants from birth through 364 days of age	Denominator:	The number of live births	Unit Type:	Rate	Unit Number:	1,000
Numerator:	The number of deaths to infants from birth through 364 days of age									
Denominator:	The number of live births									
Unit Type:	Rate									
Unit Number:	1,000									
Healthy People 2020 Objective:	MICH-1.3 Reduce the rate of all infant deaths (within 1 year) to 6.0 per 1,000 live births. Baseline: 6.7 infant deaths per 1,000 live births (2006)									
Data Sources and Data Issues:	Oklahoma Vital Statistics, Health Care Information, Center for Health Statistics, Oklahoma State Department of Health									
Significance:	<p>The Oklahoma infant mortality rate (IMR) has declined substantially over the last three decades, down from 12.3 in 1980 to 8.1 in 2014. Significant racial disparities persist despite this improvement in the overall infant mortality rate. The non-Hispanic Black IMR (13.3 deaths per 1,000 live births in 2014) is nearly two times the rate for non-Hispanic Whites (7.0), while the IMR in American Indians (12.0) is more than one and a half times the rate of non-Hispanic Whites. The IMR for Hispanic infants was 7.4 in 2014. Infant mortality continues to be an extremely complex health issue with many medical, social, and economic determinants, including race/ethnicity, maternal age, education, smoking and health status.</p>									

SPM 2 - Maternal mortality rate per 100,000 live births
Population Domain(s) – Women/Maternal Health

Measure Status:	Active								
Goal:	To reduce the maternal mortality rate								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of deaths related to or aggravated by pregnancy and occurring within 42 days of the end of the pregnancy</td> </tr> <tr> <td>Denominator:</td> <td>The number of live births</td> </tr> <tr> <td>Unit Type:</td> <td>Rate</td> </tr> <tr> <td>Unit Number:</td> <td>100,000</td> </tr> </table>	Numerator:	The number of deaths related to or aggravated by pregnancy and occurring within 42 days of the end of the pregnancy	Denominator:	The number of live births	Unit Type:	Rate	Unit Number:	100,000
Numerator:	The number of deaths related to or aggravated by pregnancy and occurring within 42 days of the end of the pregnancy								
Denominator:	The number of live births								
Unit Type:	Rate								
Unit Number:	100,000								
Healthy People 2020 Objective:	MICH-5 Reduce the rate of maternal mortality. (Baseline: 12.7 maternal deaths per 100,000 live births in 2007. Target: 11.4 maternal deaths per 100,000 live births.)								
Data Sources and Data Issues:	Oklahoma Vital Statistics, Health Care Information, Center for Health Statistics, Oklahoma State Department of Health								
Significance:	According to CDC data from 2005-2010, the rate of maternal deaths related to childbirth in Oklahoma (29.9 deaths per 100,000 live births) is highest among all states, with the rate increasing in recent years. There are significant racial disparities with Black/African American women being more likely than white women to experience maternal death.								

SPM 3 - The percent of families who are able to access services for their child with behavioral health needs
Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active								
Goal:	To improve the behavioral health of children with special health care needs								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of families who are able to access services for their child with behavioral health needs</td> </tr> <tr> <td>Denominator:</td> <td>The number of families who have a child needing behavioral health services</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The number of families who are able to access services for their child with behavioral health needs	Denominator:	The number of families who have a child needing behavioral health services	Unit Type:	Percentage	Unit Number:	100
Numerator:	The number of families who are able to access services for their child with behavioral health needs								
Denominator:	The number of families who have a child needing behavioral health services								
Unit Type:	Percentage								
Unit Number:	100								
Healthy People 2020 Objective:	MHMD-6 Increase the proportion of children with mental health problems who receive treatment. (Baseline: 68.9 percent of children with mental health problems received treatment in 2008. Target: 75.8 percent)								
Data Sources and Data Issues:	National Survey of Children's Health								
Significance:	Mental health has a complex interactive relationship with a child's physical health and their ability to succeed in school, at work and in society. All children and youth have the right to happy and healthy lives and deserve access to effective care to prevent or treat any mental health problems that they may develop. However, there is a tremendous amount of unmet need, and health disparities are particularly pronounced for children and youth living in low-income communities, ethnic minority youth or those with special needs.								

Form 10b
State Outcome Measure (SOM) Detail Sheets
State: Oklahoma

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Oklahoma

ESM 1.1 - The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health or any alternative preconception tool

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

Measure Status:	Active								
Goal:	Increase the number of service sites utilizing any preconception health tool								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health or any alternative preconception tool</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>NA</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>200</td> </tr> </table>	Numerator:	The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health or any alternative preconception tool	Denominator:	NA	Unit Type:	Count	Unit Number:	200
Numerator:	The number of service sites utilizing the Women's Health Assessment Tool developed by the Oklahoma State Department of Health or any alternative preconception tool								
Denominator:	NA								
Unit Type:	Count								
Unit Number:	200								
Data Sources and Data Issues:	Public Health Oklahoma Client Information System (PHOCIS), Oklahoma State Department of Health and Oklahoma Health Care Authority (OHCA) practice facilitation data								
Significance:	<p>Improved health before conception will improve birth outcomes for both mother and infant. Preconception health care is "the medical care a woman or man receives from the doctor or other health professionals that focuses on the parts of health that have been shown to increase the chance of having a healthy baby. Preconception care seeks to reduce the risk of adverse effects for women and infants by optimizing women's health and knowledge before planning and conceiving a pregnancy."</p> <p>Recommendations to Improve Preconception Health and Health Care - United States. MMWR 55 (RR06); 1-23. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm</p>								

ESM 4.1 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly NPM 4 – A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active								
Goal:	Increase the number of Oklahoma birthing hospitals that are Baby-Friendly								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of births occurring at Baby-Friendly hospitals</td> </tr> <tr> <td>Denominator:</td> <td>The number of resident live births</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The number of births occurring at Baby-Friendly hospitals	Denominator:	The number of resident live births	Unit Type:	Percentage	Unit Number:	100
Numerator:	The number of births occurring at Baby-Friendly hospitals								
Denominator:	The number of resident live births								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Vital Statistics Data, Health Care Information, Center for Health Statistics, Oklahoma State Department of Health and Baby-Friendly USA								
Significance:	<p>Breastfeeding, specifically exclusive breastfeeding, is known to provide immediate benefits to infants and mothers and long-term protection from chronic health problems that lead to morbidity and mortality. Achieving the Baby-Friendly designation is an evidence based practice that has been shown to increase breastfeeding initiation and duration.</p> <p>Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation. 2016 revision. Baby-Friendly USA, Inc.</p>								

ESM 5.1 - The percentage of infants delivered at birthing hospitals participating in the sleep sack program
NPM 5 – Percent of infants placed to sleep on their backs

Measure Status:	Active								
Goal:	Increase the number of birthing hospitals participating in the safe sleep program								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of births occurring at birthing hospitals participating in the sleep sack program</td> </tr> <tr> <td>Denominator:</td> <td>The number of resident live births</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The number of births occurring at birthing hospitals participating in the sleep sack program	Denominator:	The number of resident live births	Unit Type:	Percentage	Unit Number:	100
Numerator:	The number of births occurring at birthing hospitals participating in the sleep sack program								
Denominator:	The number of resident live births								
Unit Type:	Percentage								
Unit Number:	100								
Data Sources and Data Issues:	Vital Statistics Data, Health Care Information, Center for Health Statistics, Oklahoma State Department of Health and MCH Sleep Sack Program								
Significance:	<p>Providing a consistent message about infant sleep safety is essential to reducing sleep-related infant deaths. Hospital-based programs provide opportunities to give accurate and consistent infant safe sleep information to hospital staff and enable modeling of safe sleep practices. Increasing the number of birthing hospitals participating in the safe sleep program will directly increase the number of parents and caregivers receiving infant safe sleep education and the number of babies utilizing sleep sacks. This in turn will lead a reduction in infant deaths related to unsafe sleep conditions.</p> <p>Safe to Sleep Campaign. Eunice Kennedy Shriver National Institute of Child Health and Human Development. U.S. Department of Health and Human Services.</p>								

ESM 7.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum

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

Measure Status:	Active	
Goal:	Reduce the number of infants who experience abusive head trauma	
Definition:	Numerator:	The number of infants delivered in birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum
	Denominator:	The number of resident live births
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Vital Statistics Data, Health Care Information, Center for Health Statistics, Oklahoma State Department of Health and Preparing for a Lifetime Injury Prevention Work Group	
Significance:	The Period of Purple Crying is an evidence-based curriculum shown to have a positive impact on providing new parents with an effective technique for calming the baby and reducing abusive head trauma.	
	The Period of Purple Crying. National Center on Shaken Baby Syndrome. http://dontshake.org/purple-crying	

ESM 9.1 - The number of trainings provided by MCH to school staff on bullying prevention
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active								
Goal:	Increase the knowledge and preparedness of school staff with respect to bullying prevention								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of trainings provided by MCH staff annually on bullying prevention</td> </tr> <tr> <td>Denominator:</td> <td>NA</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The number of trainings provided by MCH staff annually on bullying prevention	Denominator:	NA	Unit Type:	Count	Unit Number:	100
Numerator:	The number of trainings provided by MCH staff annually on bullying prevention								
Denominator:	NA								
Unit Type:	Count								
Unit Number:	100								
Data Sources and Data Issues:	MCH bullying prevention training log								
Significance:	<p>Trainings using the evidence-based curriculum will increase the knowledge of school staff on the recognition of bullying and appropriate intervention measures, assist schools in meeting state regulations, and decrease the number of students feeling unsafe at school as measured by the Youth Risk Behavior Survey.</p> <p>(http://www.cdc.gov/violenceprevention/youthviolence/bullyingresearch/index.html, http://www.cdc.gov/healthyyouth/data/yrbs/index.htm)</p>								

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

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

Measure Status:	Active								
Goal:	To empower adolescents to make responsible, healthy decisions to enable them to better transition into adulthood								
Definition:	<table border="1"> <tr> <td style="background-color: #2e75b6; color: white;">Numerator:</td> <td>The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Denominator:</td> <td>NA</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Type:</td> <td>Count</td> </tr> <tr> <td style="background-color: #2e75b6; color: white;">Unit Number:</td> <td>10,000</td> </tr> </table>	Numerator:	The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum	Denominator:	NA	Unit Type:	Count	Unit Number:	10,000
Numerator:	The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum								
Denominator:	NA								
Unit Type:	Count								
Unit Number:	10,000								
Data Sources and Data Issues:	MCH sessions data recording tool completed by PREP staff, Adolescent Health Specialists, Health Educators, and School Health Nurses								
Significance:	<p>Research has shown that youth who possess a greater number of health assets/protective factors are less likely to engage in high-risk behaviors such as sexual activity, illicit drug use, and alcohol use. Evaluations from the trainings capture each participant’s opinion of the training as it pertains to how well they feel the training prepared them for resisting or saying no to peer pressure, knowing how to manage stress, forming friendships that keep them out of trouble, making health decisions about drugs and alcohol, etc.</p> <p>Goesling B, Colman S, Trenholm C. Programs to Reduce Teen Pregnancy, Sexually Transmitted Infections, and Associated Sexual Risk Behaviors: A Systematic Review, Mathematica Policy Research. ASPE Working Paper. Department of Health and Human Services.</p>								

ESM 12.1 - The number of providers who address transition to adult health care in their practice
NPM 12 – Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

Measure Status:	Active								
Goal:	Increase the number of providers who address transition to adult health care in their practice								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of providers who address transition to adult health care in their practice</td> </tr> <tr> <td>Denominator:</td> <td>NA</td> </tr> <tr> <td>Unit Type:</td> <td>Count</td> </tr> <tr> <td>Unit Number:</td> <td>200</td> </tr> </table>	Numerator:	The number of providers who address transition to adult health care in their practice	Denominator:	NA	Unit Type:	Count	Unit Number:	200
	Numerator:	The number of providers who address transition to adult health care in their practice							
	Denominator:	NA							
	Unit Type:	Count							
Unit Number:	200								
Data Sources and Data Issues:	CSHCN Program, Oklahoma Department of Human Services & SoonerSuccess								
Significance:	Health care transition planning is important as all teens should receive quality health care that is appropriate for their age. Teens should not go through a period of time without a primary care provider. Losing access to primary care, even for a short time, can affect the long-term health of a teen with special health care needs.								
	Center for Health Care Transition Improvement, Maternal and Child Health Bureau and the National Alliance to Advance Adolescent Health.								

ESM 14.1 - The percentage of pregnant women who call the Oklahoma Tobacco Helpline for cessation support
NPM 14 – A) Percent of women who smoke during pregnancy and B) Percent of children who live in households where someone smokes

Measure Status:	Active								
Goal:	Reduce the proportion of women smoking during pregnancy								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of pregnant women who call the Oklahoma Tobacco Helpline for cessation support.</td> </tr> <tr> <td>Denominator:</td> <td>The number of women with a recent live birth who report smoking during pregnancy.</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	Numerator:	The number of pregnant women who call the Oklahoma Tobacco Helpline for cessation support.	Denominator:	The number of women with a recent live birth who report smoking during pregnancy.	Unit Type:	Percentage	Unit Number:	100
	Numerator:	The number of pregnant women who call the Oklahoma Tobacco Helpline for cessation support.							
	Denominator:	The number of women with a recent live birth who report smoking during pregnancy.							
	Unit Type:	Percentage							
Unit Number:	100								
Data Sources and Data Issues:	Oklahoma Tobacco Helpline & Pregnancy Risk Assessment Monitoring System (PRAMS)								
Significance:	<p>Birth weight is the single most important determinant of a newborn's survival during the first year. Maternal smoking during pregnancy has been directly related to low birth weight.</p> <p>CDC. http://www.cdc.gov/tobacco/stateandcommunity/best_practices/index.htm</p>								

Form 11
Other State Data
State: Oklahoma

The Form 11 data are available for review via the link below.

[Form 11 Data](#)

State Action Plan Table

State: Oklahoma

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

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

Abbreviated State Action Plan Table

State: Oklahoma

Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce the prevalence of chronic health conditions among childbearing age women	NPM 1 - Well-Woman Visit	ESM 1.1	
Reduce unplanned pregnancy	NPM 1 - Well-Woman Visit	ESM 1.1	
Reduce health disparities	NPM 1 - Well-Woman Visit	ESM 1.1	
Reduce the prevalence of chronic health conditions among childbearing age women			SPM 2
Improve the mental and behavioral health of the MCH population	NPM 1 - Well-Woman Visit	ESM 1.1	

Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce infant mortality	NPM 4 - Breastfeeding	ESM 4.1	
Reduce health disparities	NPM 4 - Breastfeeding	ESM 4.1	
Reduce infant mortality	NPM 5 - Safe Sleep	ESM 5.1	
Reduce health disparities	NPM 5 - Safe Sleep	ESM 5.1	
Reduce the incidence of preterm and low birth weight births			SPM 1
Reduce health disparities			SPM 1

Child Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce the incidence of unintentional injury among children	NPM 7 - Injury Hospitalization	ESM 7.1	
Reduce health disparities	NPM 7 - Injury Hospitalization	ESM 7.1	

Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce the incidence of suicide among adolescents	NPM 9 - Bullying	ESM 9.1	
Reduce teen pregnancy	NPM 10 - Adolescent Well-Visit	ESM 10.1	
Reduce health disparities	NPM 9 - Bullying	ESM 9.1	
Reduce the incidence of unintentional injury among children	NPM 7 - Injury Hospitalization	ESM 7.1	

Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Improve the transition to adult health care for children and youth with special health care needs	NPM 12 - Transition	ESM 12.1	
Reduce health disparities	NPM 12 - Transition	ESM 12.1	
Improve the mental and behavioral health of the MCH population			SPM 3

Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Reduce the prevalence of chronic health conditions among childbearing age women	NPM 14 - Smoking	ESM 14.1	
Reduce health disparities	NPM 14 - Smoking	ESM 14.1	