

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

Oklahoma

**FY 2019 Application/
FY 2017 Annual Report**

Created on 9/26/2018
at 10:41 PM

Table of Contents

I. General Requirements	4
I.A. Letter of Transmittal	4
I.B. Face Sheet	5
I.C. Assurances and Certifications	5
I.D. Table of Contents	5
II. Logic Model	5
III. Components of the Application/Annual Report	6
III.A. Executive Summary	6
III.A.1. Program Overview	6
III.A.2. How Title V Funds Support State MCH Efforts	11
III.A.3. MCH Success Story	11
III.B. Overview of the State	12
III.C. Needs Assessment	19
FY 2019 Application/FY 2017 Annual Report Update	19
FY 2018 Application/FY 2016 Annual Report Update	23
FY 2017 Application/FY 2015 Annual Report Update	26
Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)	29
III.D. Financial Narrative	59
III.D.1. Expenditures	61
III.D.2. Budget	63
Summary – Federal Fiscal Year (FFY) 1989 Block Grant Expenditures	63
III.E. Five-Year State Action Plan	67
III.E.1. Five-Year State Action Plan Table	67
III.E.2. State Action Plan Narrative Overview	68
<i>III.E.2.a. State Title V Program Purpose and Design</i>	68
<i>III.E.2.b. Supportive Administrative Systems and Processes</i>	70
III.E.2.b.i. MCH Workforce Development	70
III.E.2.b.ii. Family Partnership	72
III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts	74
III.E.2.b.iv. Health Care Delivery System	76
<i>III.E.2.c State Action Plan Narrative by Domain</i>	79
Women/Maternal Health	79
Perinatal/Infant Health	103

Child Health	134
Adolescent Health	146
Children with Special Health Care Needs	170
Cross-Cutting/Systems Building	190
III.F. Public Input	195
III.G. Technical Assistance	197
IV. Title V-Medicaid IAA/MOU	198
V. Supporting Documents	199
VI. Organizational Chart	200
VII. Appendix	201
Form 2 MCH Budget/Expenditure Details	202
Form 3a Budget and Expenditure Details by Types of Individuals Served	207
Form 3b Budget and Expenditure Details by Types of Services	209
Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated	212
Form 5a Count of Individuals Served by Title V	217
Form 5b Total Percentage of Populations Served by Title V	220
Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX	222
Form 7 State MCH Toll-Free Telephone Line and Other Appropriate Methods Data	225
Form 8 State MCH and CSHCN Directors Contact Information	227
Form 9 List of MCH Priority Needs	230
Form 9 State Priorities-Needs Assessment Year - Application Year 2016	231
Form 10a National Outcome Measures (NOMs)	233
Form 10a National Performance Measures (NPMs)	273
Form 10a State Performance Measures (SPMs)	285
Form 10a Evidence-Based or –Informed Strategy Measures (ESMs)	288
Form 10b State Performance Measure (SPM) Detail Sheets	295
Form 10b State Outcome Measure (SOM) Detail Sheets	298
Form 10c Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets	299
Form 11 Other State Data	305

I. General Requirements

I.A. Letter of Transmittal



Oklahoma State Department of Health
Creating a State of Health

June 29, 2018

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 Service Title V Block Grant Annual Report for October 1, 2016 through September 30, 2017, and the Annual Plan for October 1, 2018 through September 30, 2019.

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,

Tom Bates, JD
Interim Commissioner of Health

Board of Health

Tom Bates, JD
Interim Commissioner of Health

Martha A Burger, MBA (*President*)
Robert S Stewart, MD (*Secretary-Treasurer*)
Jenny Alexopoulos, DO

Terry R Gerard II, DO
Charles W Grim, DDS, MHSA
Timothy E Starkey, MBA

Edward A Legako, MD
R Murali Krishna, MD
Ronald D Osterhout

www.health.ok.gov
An equal opportunity
employer and provider



I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2018 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: December 31, 2020.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: December 31, 2020.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Maternal and Child Health Services Block Grant, Title V of the Social Security Act, is the only federal program devoted to improving the health of all women, children, and families. Title V provides funding to state maternal and child health (MCH) programs, which serve 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 receive the Title V Block Grant and are required to write annual reports and every five years complete a statewide needs assessment. For 2017, 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.

Population Needs and Title V Priorities:

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 make the most impact 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

Oklahoma's Progress on National and State Performance Measures:

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

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

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

Maternal/Women:

Accomplishments:

- Assisted through the county health departments, approximately 45,515 women and men with family planning services, and linked them to follow-up services or assisted with Medicaid (SoonerCare) enrollment as needed. Exceeded 2020 goal for long acting reversible contraceptives (LARCs) usage for SoonerCare participants. Selected to participate on new CollIN team for preconception care.
- Continued to staff Maternal Mortality Review (MMR) and promoted via the Alliance for Innovation on Maternal Health (AIM) postpartum hemorrhage and hypertension bundles published by the Patient Safety Council for birthing hospitals in Oklahoma. Severe maternal morbidity has been reduced by 24% since AIM began in 2015.

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.
- Continue work on Maternal Mortality Review.

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.
- Distributed infant safe sleep message and sleep sacks to 70.5% of infants born in Oklahoma.
- Distributed 115 cribs to families in need via the crib pilot project for safe sleep.
- Increased the number of Breastfeeding Friendly Worksites to 178 and Baby-Friendly Hospitals to 7, delivering 15.7% of all births statewide.
- Screened 100% of all newborns in Oklahoma through the Newborn Screening Program and 100% of affected newborns received short-term follow-up and were referred to long-term follow-up care coordination.

Plans:

- Continue 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.
- 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; and encourage birthing hospitals to continue hard stop policies to not permit early elective deliveries (prior to 39 weeks) without a medical indication.

Child:

Accomplishments:

- Added one hospital to the group of participating hospitals in the Period of PURPLE crying program, which teaches new parents about infant crying patterns and soothing techniques to prevent abusive head trauma. Became a Jurisdiction-wide project with over 85% of births born in a hospital implementing PURPLE and was recognized by the National Center for Shaken Baby Syndrome.
- Surpassed goal for CLICK for Babies Campaign receiving over 67,000 knitted hats donated to support Period of PURPLE Crying and Abusive Head Trauma Awareness.
- Continued funding Child Passenger Safety activities, including staff time for the installation of car seats to families in need.
- Provided funding for the Oklahoma Center for Poison and Drug Information 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 Oklahoma Center for Poison and Drug Information education and outreach activities.

Adolescent:

Accomplishments:

- Reduced statewide 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.
- Awarded the Pregnancy Assistance Fund (PAF) grant to support parenting and pregnant youth in Oklahoma City and Tulsa metropolitan statistical areas.
- 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.
- Funded parent-to-parent support, sibling support, training, and opportunities for family leadership via OFN.
- Continued funding the Oklahoma Infant Transition Program (OITP), the Pediatric Sickle Cell Clinic in Oklahoma City, and the Oklahoma Family Support 360⁰ 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 contracts with Sooner SUCCESS, OFN, OITP, Family Support 360⁰, and the Sickle Cell Clinic to further work in the state for the families of children and youth with special health care needs.

- Efforts will be ongoing to develop a transition toolkit for primary care providers by 2020.
- Work with partners to identify ways to connect families with services to meet behavioral health needs.

Comments and Suggestions:

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

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

III.A.2. How Title V Funds Support State MCH Efforts

Title V funding in Oklahoma enables the state MCH program to engage in infant mortality and maternal mortality projects and initiatives to work towards reducing rates in the state. As the only state in the nation with no mandatory health education in schools, Title V monies are utilized to bolster health education programs in the two largest school districts in the state. Funding also supports school and community-based teen pregnancy prevention projects in rural areas identified as high need. Title X program capacity has been expanded due to the ability to use Title V funds to enhance activities for females and males of reproductive age, where otherwise unavailable. In addition, MCH utilizes Title V federal funding to maintain data analytic capacity, to assure that monitoring and health surveillance activities for all key projects are able to continue uninterrupted.

The CSHCN program utilizes federal funds for specialty services to children with special needs and their families. Included services are neonatal services, specialty services for children with sickle cell anemia, durable medical supplies, and respite care.

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

III.A.3. MCH Success Story

CLICK for Babies provides handmade, purple knit hats to participating Period of PURPLE Crying hospitals in an effort to provide parents and caregivers with a visual reminder of the PURPLE crying techniques; to help prevent shaken baby syndrome. A postcard that said “Knit a cap and help save a baby!” with a photo of knitting needles and purple yarn was released August 1, 2017. The message was sent as a press release and put on Facebook and went viral. It was viewed by people from all across the US and the world. People mentioned hearing or reading about CLICK on social media, on national TV, their local news stations, or online news and print magazines.

By mid-August, packages began arriving. Caps came from around the world, and almost every US state, with caps knitted and crocheted by people ages 8-101 years- women, men, youth groups, senior centers, church groups, and a retired couple who were blind. Packages even came from Puerto Rico, while they were dealing with hurricanes. For the next three months hundreds of boxes, packages and envelopes were opened and caps counted. The total number of caps received was 67,488!

One of the unexpected benefits of the packages was the privilege of reading the notes, letters and cards that often accompanied the caps. There were stories that would bring laughter or tears, photos of babies, children, knitters, cards with handmade artwork, but the predominant message was appreciation for the opportunity and well wishes for such important work.

III.B. Overview of the State

Demographics:

Oklahoma, the 28th most populous state, accounts for 1.2% of the U.S. population. The Oklahoma population, estimated in 2017 at 3.9 million persons, has grown by approximately 5% since the 2010 decennial census. A rural state, Oklahoma has three large cities. Oklahoma City, the state's centrally located capital, is the largest of the three and home to 16% (620,000 residents) of the state's population. Approximately 100 miles to the northeast is Tulsa, a city accounting for 10.3% (400,000 residents) of the state's population. Nearly 90 miles to the southwest of the capital, along U.S. Interstate 44, is the city of Lawton, consisting of 97,000 residents, or 2.5% of the Oklahoma population.

Nearly a quarter (24.5%, 962,000) of the Oklahoma population is less than 18 years of age. Individuals aged 65 years and older make up 15% of the state's population, and roughly 61% of the population is between 18 and 64 years old. The male-female ratio is about 1:1, with slightly more females (1.98 million) than males (1.94 million). Females of childbearing age (15-44 years) number 768,000, or about 20% of the total Oklahoma population. The number of females aged 15-19 years has decreased marginally (1%) since 2010, down from 128,600 to 127,100 in 2016. The fastest growing age group was females aged 30-34, up by 12% over the same time period, increasing in absolute terms from 118,800 to 132,900.

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 section of the state, a lasting legacy of the U.S. federal government removal programs of the 19th century. In 2016, nearly 73% of the population was classified as white, down slightly 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 population figures released in 2016. Less than 2% of Oklahoma's population was categorized as Asian or Pacific Islander. The Hispanic population has grown from 8% (302,000) of the total population in 2010 to 10% (381,000) in 2016, representing a growth of approximately 26% over the time period. Oklahoma is home to the largest number of federally recognized Native American tribal governments (38). According to the American Indian Cultural Center and Museum, there are more languages spoken in Oklahoma than in all of Europe.

According to data from the U.S. Bureau of Economic Analysis, Oklahoma's personal income was \$43,449 in 2017, ranking 38th among all states, and about 86% of the national average of \$50,392. U.S. Census Bureau data show that 16.5% (621,000) of Oklahoma residents were living in poverty in 2016. Females (18%) were more likely to be living below the federal poverty level (FPL) than were males (15%). For children aged 17 years and younger, 23% lived below the FPL. Poverty status was more likely among minority population when compared to whites, particularly among African Americans, where 29% of this racial group fell below the federal poverty line.

Oklahoma's birth rate was 13.4 births per 1,000 population in 2016, ranking 42nd among other states, and about 10% higher than the comparable U.S. birth rate (12.2). Since 2010, the birth rate has decreased by 5.6%, with the state averaging about 53,000 births per year. Similarly, the fertility rate has decreased from 72.3 births per 1,000 females aged 15-44 years to 68.4 over the same study period. While Oklahoma has experienced strong declines in the rate of births to teens, the state still ranks poorly when compared to other states. In 2016, Oklahoma's teen birth rate for ages 15-19 was 33.4 births per 1,000 population (females aged 15-19), ranking 2nd for the highest (worst) teen birth rate. This is a consistent result for the state.

Geography:

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

Economy:

Oklahoma is a major producer of natural gas, oil, and agricultural products. The state’s economic base relies on aviation, energy, telecommunications, and biotechnology. The two 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) and Walmart Associates, Inc. (34,000). In the health sector, INTEGRIS Health has 9,000 employees, followed by the University of Oklahoma Health Sciences Center (7,000), Mercy Health (6,500), Saint Francis Hospital (6,000), and St. John Medical Center (4,500).

Oklahoma’s real gross domestic product (GDP), the output of all goods and services produced by the economy in current dollars, totaled \$181.3 billion in 2016, according to data from the U.S. Bureau of Economic Analysis, decreasing by nearly 5% from 2015 (\$190.2 billion). The private sector comprises 84% of Oklahoma’s real GDP, with government making up the remainder (16%). As a percentage of GDP, the industry share in the economy was led by the FIRE sector (i.e., finance, insurance, real estate; 14%), trade (12%), natural resources and mining (12%), manufacturing (10%), and transportation and utilities (8%). Education and health care services comprised 8% of the state’s GDP.

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 2017 showed that annual average unemployment rates declined for 46 states, remained unchanged for two states, and rose for three states. Oklahoma was in the largest group with the unemployment rate falling to 4.3%, down from 4.8% in 2016, and lower than the national rate (4.4%). Of the state’s 77 counties, 73 counties experienced a decrease in unemployment, 1 county saw unemployment increase, while 3 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 61.2 in 2017, compared to the national rate of 62.9.

Urbanization:

Approximately 58% of the Oklahoma population resides in the metropolitan statistical areas (MSAs) of Oklahoma City (1,337,000; 33%) and Tulsa (971,000; 25%), while a much smaller proportion of the state’s citizens lives in the Lawton MSA (131, 000; 3%). The remainder of the Oklahoma population resides in rural cities and towns. The Oklahoma City MSA is made up of seven counties (Canadian, Cleveland, Grady, Lincoln, Logan, McClain, and

Oklahoma) surrounding the principal city located in Oklahoma County. Population growth in the Oklahoma City MSA has been strong, increasing by 6.7% between 2010 and 2016, with growth in the individual counties comprising the MSA ranging from a low of 1.1% (Lincoln County) to a high of 12.1% (Canadian County). Likewise, the Tulsa MSA is comprised of the seven counties (Creek, Okmulgee, Osage, Pawnee, Rogers, Tulsa, and Wagoner) encircling the principal city, Tulsa. Population growth in the Tulsa MSA has been moderate at 3.5%. Changes in the population size among the constituent counties have been mainly positive, ranging from 1.4% (Creek County) to 4.4% (Tulsa County). However, two counties, Okmulgee and Pawnee have seen declines in their population numbers, down 1.9% and 0.8%, respectively. The Lawton MSA, made up of Comanche and Cotton counties, has experienced marginal growth, up only 0.3% since 2010.

Unique Strengths and Challenges Impacting the MCH Population:

Oklahoma's MCH Service has forged close partnerships, both internally to the Oklahoma State Department of Health (OSDH) and externally with other state agencies and community partners. Since 2009 when the *Preparing for a Lifetime, It's Everyone's Responsibility*, the statewide infant mortality reduction initiative, was launched MCH has collaborated with OSDH service areas to staff the initiative, perform analyses, develop public service announcements, formulate strategy, and implement programs. Internal partners include the Center for the Advancement of Wellness, the Office of Minority Health, Office of the Tribal Liaison, the Center for Health Statistics, Injury Prevention Service, Child Guidance, Screening and Special Services, Family and Support Services, and the county health departments (CHDs). These service areas and CHDs have taken part in other state and national efforts as well, including the CoIIN to Reduce Infant Mortality, the Oklahoma Perinatal Quality Collaborative, the Oklahoma Health Improvement Plan Child Health Group, the CLICK Period of Purple Crying Program, the MCH Cribs Safe Sleep Pilot Project, and many others unnamed here.

Joining the internal partners mentioned above are entities external to OSDH, but who contribute in large and meaningful ways. Sister agencies like the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, the Oklahoma Department of Human Services, the Oklahoma Commission on Children and Youth, and ODMHSAS are frequent and routine collaborators on the many efforts to improve and promote health in the maternal, infant, and child populations. Other colleagues in MCH-related work include those from the Oklahoma Hospital Association, the Office of Perinatal Quality Improvement (OPQI), Tulsa Health Department, the Oklahoma City-County Health Department, the Oklahoma Family Network, and the Southern Plains Tribal Health Board (SPTHB). The relationship with the SPTHB, along with the OSDH Office of Tribal Liaison, enabled MCH to establish connections with individual tribes for the purpose of conducting Tribal Listening Sessions which were used to inform the most recent Title V MCH Five-Year Needs Assessment. These partnerships, those internal and external to OSDH and MCH, are how MCH work gets done in Oklahoma.

Oklahoma has experienced a number of successes related to health outcomes and behaviors. The Every Week Counts, a partnership among MCH, OPQI, and state birthing facilities active between 2011 and 2014, brought about a 96% reduction in the number of early elective deliveries. In January 2017, the March of Dimes recognized MCH's achievement of lowering the preterm birth rate by 8% since 2010 by awarding the state with the Virginia Apgar Prematurity Campaign Leadership Award. Despite still having the 2nd highest birth rate among teens aged 15-19, Oklahoma has experienced significant declines in the last two decades. In 2016, the teen birth rate for this population group was 33.4 births per 1,000 female population. While this rate was still much higher than the comparable national rate (20.3), it was a remarkable improvement since the year 2000, when the state rate was recorded at 59.1 (decrease of 43%). Another improvement includes the uptake in the use of long acting reversible contraceptives (LARCs), the result of program emphasis on providing LARCs when indicated for women not seeking to become pregnant.

The United Health Foundation (UHF) creates an annual report which 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 2017, has ranked the state of Oklahoma 43rd among all U.S. states, up three spots from 46th in 2016. 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 percentage of population who are uninsured (ranked 48th), high cardiovascular death rate (ranked 48th), and high infant mortality rate (ranked 47th). The 2017 report did highlight areas of strength: low prevalence of excessive drinking, small disparity in health status by education, and higher number of mental health providers. The AHR 2017 report gave Oklahoma a ranking of 46th for the health of women and children, positioned in the bottom 10 states for obesity in adults (42nd), physical activity in adults (41st), children in poverty (41st), chlamydia rate (41st), childhood immunizations (42nd), diabetes (41st), frequent mental distress (46th), frequent physical distress (44th), and premature death (44th).

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.

As a rural state, Oklahoma continues to be challenged on the availability and accessibility of health care services. Interrelated contributors to these challenges include lack of transportation (public and/or personal), limited number of providers in remote areas, and lack of or inadequate health insurance.

Roles, Responsibilities and Interests of Title V Services:

In Oklahoma, state health and human services are organized under the Cabinet Secretary of Health and Human Services, a position appointed by the governor, and held by Steve Buck, Executive Director of the Office of Oklahoma Juvenile Affairs. Health and Human Services agencies in Oklahoma include the OSDH, Oklahoma Department of Human Services (DHS), ODMHSAS, Department of Rehabilitation Services, Office of Juvenile Affairs, OHCA, and the Oklahoma Commission on Children and Youth (OCCY).

The Oklahoma State Department of Health, created under Oklahoma Statute Title 63 § 1-105, is responsible for protecting and improving the public's health status through strategies that focus on preventing disease. There are three major service branches making up OSDH: Community and Family Health Services (CFHS), Protective Health Services (PHS), and the Office of the State Epidemiologist (OSE). CFHS is home to Child Guidance, Dental Health Service, Family Support and Prevention Service, Maternal and Child Health Service, Nursing Services, Screening and Special Services, SoonerStart, Records Evaluation and Support, and WIC. Oklahoma's county health departments are also supervised through CFHS.

Oklahoma administers the MCH Title V Block Grant through two state agencies, the OSDH and the DHS. OSDH, as the state health agency, is authorized to receive and disburse the MCH Title V Block Grant funds as provided in Title 63 of the Oklahoma Statutes, Public Health Code, Sections 1-105 through 1-108. These sections create the OSDH, charge the Commissioner of Health to serve under the Board of Health (which will change this year as new legislation has made the Board advisory to the Commissioner), 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, Tina Johnson, who is directly responsible to the Interim Commissioner of Health, Tom Bates. 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 maternal mortality and morbidity reduction initiative; Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), and the Youth Risk Behavior Survey (YRBS) surveillance programs; Teen Pregnancy Projects throughout the state; State Systems Development Initiative (SSDI); Fetal and Infant Mortality Review; School Health; Oklahoma Birth Defects Registry; Becoming Baby Friendly Oklahoma; and, other-related programs and initiatives.

The Title V CSHCN Program is located in the DHS within the Health Related and Medical Services (HRMS) unit. The HRMS is organizationally placed under Adult and Family Services. Carla McCarrell-Williams is the Director of the CSHCN Program. 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.

Systems of Care for Underserved and Vulnerable Populations:

a. Population Served

Overall, 2,748 Oklahoma children with special health care needs received direct services from a Title V partner in FFY2017. This is compared to an estimated 210,529 children in Oklahoma with a special health care need.

Note: The number of children served is a conservative estimate intended to reduce the risk of duplication. For FFY2018, steps are being taken to improve partner reporting so as to ascertain a more reflective count of unduplicated children who received Title V services. Additionally, Title V representatives continue to encourage collaboration across partners and to reach out to families in under-served populations by speaking at family support groups and attending local health conferences that address children with special health care needs.

b. Health Services Infrastructure

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

According to the Oklahoma Board of Medical Licensure and Supervision, there are 629 active pediatricians in the

state.

As of February 2018, Oklahoma neither has nor is pursuing a state Medicaid Accountable Care Organization Program.

The Oklahoma Health Care Authority (OHCA) administers two health programs for the state. The first is SoonerCare, Oklahoma's Medicaid program. SoonerCare works to improve the health of qualified Oklahomans by ensuring that medically necessary benefits and services are available. Qualifying Oklahomans include certain low-income children, seniors, the disabled, those being treated for breast or cervical cancer and those seeking family planning services. The second program OHCA operates is Insure Oklahoma, which assists qualifying adults and small business employees in obtaining health care coverage for themselves and their families.

In 2017, OHCA took action to cancel the Request for Proposal (RFP) for SoonerHealth+, the fully capitated, statewide model of care coordination that has been in development for Oklahoma Medicaid's aged, blind, and disabled population. A new statute (SB 773) requires OHCA to initiate an RFP for care coordination models for children in DHS custody.

c. Integration of Services

Oklahoma has 77 counties with 68 county health departments where families of children and youth with special needs can access reproductive health care, vaccines, and, in some cases, mental health and dental services. This allows families affordable access to care, some services at no charge while others have sliding scale fees. Additionally, each county in Oklahoma has at least one health home which integrates medical, behavioral and social supports needed, coordinated in a way that recognizes all of their needs as an individual, not just patients. To be eligible for a Health Home, children and youth must have Medicaid, have either a serious mental illness or a serious emotional disturbance, and one or more chronic health conditions. A Care Manager from the Health Home organization assists patients with coordination and access to necessary medical, mental health, and social services.

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

d. Financing of Services

Medicaid is managed by the Oklahoma Health Care Authority, Oklahoma's Medicaid agency. CHIP funding is blended with other Medicaid dollars to ensure better access for more children. Currently, Oklahoma has 642 children 18 years and under accessing SoonerCare via TEFRA. Additionally, 16,495 children qualify for SoonerCare based on their Aged/Blind/Disability status. Both groups, TEFRA and ABD, have high medical needs and/or significant disabilities and are better able to access needed medical/mental health services because of their access to SoonerCare. The Oklahoma Health Care Authority also manages Insure Oklahoma, which is a premium assistance program for families of low income status. This program provides another mode for families to access insurance for their CYSHCN so they can receive needed services. Several community, state and national programs provide access to grants and other funds to assist youth in receiving needed durable medical equipment, respite, co-pay assistance, etc. These vital funds fill gaps where families cannot afford to meet their child's needs.

Legislative Update:

A number of legislative bills were tracked by OSDH and MCH during 2017 special session and the 2018 regular session of the 56th Legislature. This included 217 active bills, 33 of which were considered high priority for the

agency. A broad set of topics were monitored including abortion, administrative rules, agency funding, agency governance, audits, diabetes, emergency response, employee benefits, employee salary, family planning, health workforce, insurance, immunizations, marijuana, Medicaid eligibility, school wellness, state finance, tobacco tax, the Tobacco Settlement Endowment Trust, and vital records. The passage of a select number of bills was deemed public health wins.

HB1010XX, which established a \$1 tax on cigarettes and little cigars, is considered a step in the right direction, despite not achieving the tax magnitude initially sought. Raising the cigarette tax is considered the most effective way to reduce state smoking rates.

SB1446 implements certain limits on prescribing opioids and requires physicians to receive pain management education and to utilize the central repository. Opioid misuse continues to be a state challenge and efforts to put safeguards against such misuse are supported.

SB1517 creates the Task Force on Trauma-Informed Care to study and make recommendation to the Oklahoma Legislature on best practices with respect to children and youth who have experienced trauma.

SB1600 provides level funding for OSDH in SFY2019. While the bill did not provide an increase to agency funding, it did not put into effect the 15% state appropriation cut that was being considered.

A number of bills impacted agency governance: HB3036 transferred all duties and powers of the Board of Health to the Commissioner of Health. Effective January 14, 2019, the Board is designated as an advisory body to the State Commissioner of Health, a position which will now be appointed by the Governor, with consent of the Senate. HB3096 allows a county Board of Health to create a city-county board of health. HB3581 amends oversight responsibility of the Office of Accountability Systems at OSDH. HB3584 requires that two members of the Board of Health possess at minimum five years of executive leadership experience in a health-related business, along with education and experience in fiduciary, legal, business planning, or operational decision-making authority.

Legislation related to the Medicaid program includes HB2932 which requires the OHCA to seek a Medicaid waiver to pursue modification to eligibility criteria such that receipt of SoonerCare coverage for certain Medicaid populations is conditional upon documentation of education, skills, training, work or job activities. HB1270 creates the Act to Restore Hope, Opportunity and Prosperity for Everyone requiring OHCA and DHS to verify eligibility information prior to awarding assistance under Medicaid.

On June 26, 2018, Oklahoma voters went to the polls to approve the measure, State Question 788 (SQ788), which legalizes medical marijuana in the state. The Oklahoma State Department of Health has established a regulatory office, the Oklahoma Medical Marijuana Authority (OMMA), to oversee the application and licensure process. The OSDH Board of Health will consider emergency rules for governing the OMMA at their meeting on July 10, 2018. Application information and program requirements will be available by July 26. OSDH will begin accepting applications no later than August 25.

III.C. Needs Assessment

FY 2019 Application/FY 2017 Annual Report Update

Ongoing Activities:

For Oklahoma, assessing the needs of MCH populations is a continuing process. State level data are drawn from the Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), the Behavioral Risk Factor Surveillance System (BRFSS), and the Public Health Oklahoma Client Information System (PHOCIS). These systems include data on behaviors, service utilization, health status, and availability and accessibility of care; data compiled from these systems are monitored constantly and are used to inform MCH programs and leadership to ensure the latest information is available for planning and program management purposes.

In January 2017, MCH began administering the YRBS to public high school students throughout the state. The weighted analysis data set was received in August 2017. Since that time, YRBS 2017 data, and previous years' data, have been used by MCH staff to develop a number of data products using these data, including a data brief (Associations between Dating and Sexual Violence and Selected Risk Indicators), fact sheets (Obesity and Tobacco Use), infographics (Unsafe Driving Behaviors, Obesity, and Nutrition), and a trend report for the years 2003 to 2017. YRBS data have been used repeatedly by MCH partners and by MCH leadership, including in Title V Block Grant reporting. The Child and Adolescent Health Epidemiologist responsible for YRBS has responded to numerous media enquiries about project data.

Since the submission of the last Five-Year Needs Assessment in July 2015, MCH has elected to suspend two projects which collected data on young children in Oklahoma. The First Grade Health Survey and the Fifth Grade Health Survey have stopped operations due to low response rates. MCH leadership and supporting analysts determined that response to these surveys was insufficient to yield representative weighted data as response rates fell below the targeted threshold of 60 percent. MCH has initiated an internal review to determine next steps in replacing these projects.

The CDC released 2015 Oklahoma PRAMS data 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 MCH population. 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. MCH published a PRAMS analysis, *Infant Sleep-Surface Sharing and Other Safe Sleep Practices among Oklahoma American Indian Mothers*, in April 2018. This analysis and publication was a collaborative effort with MCH program staff, the American Indian Data Community of Practice initiative (AIDCoP), and staff from the Office of Minority Health and OU Pediatrics contributing to the work. MCH expects to receive 2016 data by August 2018. The collection cycle for calendar year 2018 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 2016 data, releasing it for analysis in September 2017. 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 2017 data will become available in July/August 2018. Throughout 2017, in response to flagging response rates, MCH Assessment initiated a comprehensive evaluation of the TOTS Project, including a revision of the TOTS questionnaire which was implemented in January 2018. The questionnaire is shorter with improvements in survey item construction and literacy level, and is more visually appealing. MCH anticipates better response to the survey for 2018.

Oklahoma received funds from the Maternal and Child Health Bureau to administer the State Systems Development Initiative (SSDI) grant. For more information on SSDI activities please refer to Section III.E.2.b.iii.

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. In 2017, the Medicaid Analyst linked 2016 births to Medicaid administrative data for the same year. Preliminary analyses are underway for neonatal abstinence syndrome, 17P, and the Soon-to-be-Sooners program. Results will be released throughout 2018.

Changes in Health Status and Needs:

The state has made no changes to the list of identified health priorities for its MCH population. MCH remains focused on improving the indicators for these health priorities and continues to identify and implement evidence-based strategies to produce the established goals of Oklahoma's Title V programs.

The state has experienced improvements in certain health measures. Teen birth rates have decreased across all age and racial/ethnic groups, continuing a two decade trend. While Oklahoma teen birth rates do not compare favorably to the nation and other states, for example, ranking 2nd highest for teens aged 15-19 years, MCH programs are heartened to see efforts contributing to this decline. Unintended pregnancy decreased modestly, according to PRAMS project data. Other improvements include the percentage of women receiving an annual preventive medical visit, the percentage of infants who were ever breastfed, and the percentage of infants placed to sleep on their backs.

Regrettably, there are a number of measures for which Oklahoma experienced worsening results. The infant mortality rate increased by nearly 3% between 2016 and 2017, and the disparity between white and minority populations remains large. Moreover, the trend trajectory for American Indians, Asian/Pacific Islanders, and Hispanics are increasing, as well. Related, overall preterm birth increased marginally in Oklahoma, rising to 10.6%, and March of Dimes Premature Report Card conferring a D letter grade (down from a C) for the state's performance on this measure. Another measure that worsened was unintentional injuries among children, with hospitalizations among this group rising sharply between 2016 and 2017.

Changes to Program Capacity:

Oklahoma's Title V program capacity has been affected by staff resignations and the lengthy approval process to refill vacant positions. The Child and Adolescent Health Division (CAH) within MCH has lost two staff due to resignations. The School Health Educator is a key position for implementing bullying prevention activities and for supporting the administration of the YRBS. These responsibilities have been absorbed by other staff to some extent but full dedication to this work is impossible given existing responsibilities and limitations of time. CAH also lost its Adolescent Health Educator, a position responsible for coordinating teen pregnancy prevention efforts through county health departments. Again, these duties were taken on by the Adolescent Health Coordinator, the supervisor of the position.

Given ongoing budget shortfalls due to decreasing state revenues, the state and OSDH has implemented extraordinary review procedures that require close scrutiny and cabinet level approval for refilling vacant positions. At this time, both positions described above remain vacant. Further, in September 2017, the OSDH initiated plans to address budget deficits in the form of staff furloughs and a reduction in force (RIF) of certain positions throughout the OSDH system. Nearly 200 positions were eliminated, hardest hit were county positions, particularly administrative support staff and nurses. This has impacted MCH with respect to its ability to administer teen pregnancy prevention

programs, family planning services and eliminated all capacity to provide well child services in the few remaining counties which had pediatric services.

Partnerships:

Oklahoma's Title V programs have a rich history in developing relationships with partners to carry out mutually beneficial program efforts. MCH staff participate in various state level committees and work groups which have been formed to address MCH-related health issues. Members of the *Preparing for a Lifetime, It's Everyone's Responsibility*, the MCH-led infant mortality reduction initiative, come from other state agencies (e.g., Department of Human Services, Oklahoma Health Care Authority, Department of Mental Health and Substance Abuse Services, Oklahoma Commission on Children and Youth) and OSDH departments (e.g., Family Support and Prevention Services, Screening and Special Services, Child Guidance Service, WIC Service).

The MCH Assessment Division has staff serving as core and auxiliary members of the AIDCoP, a group led by the OSDH Office of the Tribal Liaison, for the purpose of promoting and enhancing the use of data focused on Oklahoma's American Indian population. The AIDCoP has an active membership of public health professionals across academe, tribal membership, state public health agencies, and the Indian Health Service.

MCH participated in the CoIIN to Reduce Infant Mortality (IM CoIIN) from its inception in January 2012. Key MCH personnel served as state leads of the IM CoIIN strategy groups such as Safe Sleep, Prematurity, Social Determinants of Health, and Preconception/Interconception Care. Staff attended routine conference calls, webinars, and national meetings throughout the life of the IM CoIIN, sharing and presenting information, developing projects that have continued beyond the duration of the CoIIN. Oklahoma MCH staff is participating in the currently active Preconception CoIIN, to streamline and improve a woman's preconception health tool.

Operationalizing the Five-Year Needs Assessment:

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

Changes in Organizational Structure and Leadership:

The Oklahoma State Department of Health has experienced significant leadership change since October 2017. Under allegations of mismanagement of agency finances, then Commissioner of Health and Secretary of Health and Human Services, and Senior Deputy Commissioner and Deputy Secretary of Health and Human Services resigned their positions. In response, the OSDH Board of Health appointed then Secretary of Finance, Administration and Information Technology and Director of the Office of Management and Enterprise Services as Interim Commissioner of Health to lead the agency as it dealt with the investigations into the allegations and recruited a new Commissioner of Health. His tenure at the helm of OSDH was short-lived as he resigned in February 2018. At that time the OSDH Director of State and Federal Policy was appointed Acting Commissioner of Health. As agreed, he served temporarily in this capacity, stepping down in March when Tom Bates, former First Assistant Attorney General, was appointed by the Board of Health as the new Interim Commissioner of Health.

In addition to changes in the top leadership, other agency personnel were dismissed or left voluntarily. These include personnel holding essential positions – Chief Operating Officer, Chief Financial Officer, Human Resources Director, General Counsel, Director of Accountability Systems, Director of Internal Audit Unit, and the Board of Health Secretary. The Chief Operating Officer, Human Resources Director and the General Counsel positions have been filled but the other positions remain vacant and/or are being filled on an interim basis.

With the RIF, some service areas of OSDH were heavily impacted, staff sizes being greatly reduced and some departments eliminated altogether. Some of those areas impacted the most were the Center for Health Innovation and Effectiveness, Partnerships for Health Improvement, the Office of Minority Health, the Office of Performance Management, and County Health Departments. New processes and procedures are being developed and implemented to prevent these types of issues in the future.

Emerging Issues:

In 2017, HB2013 was introduced as legislation to grant full practice authority, by removing the requirement for a supervising physician, for the Advanced Practice Registered Nurse in select practice categories – Certified Nurse Practitioner, Clinical Nurse Specialist, and Certified Nurse Midwife – when acting within the scope of employment or contract with the OSDH, Tulsa Health Department, or the Oklahoma City-County Health Department. The proposed policy change would increase and assure continued access to essential public health services through the state health department, city-county health departments, and county health departments. Without passage of this bill, clinical services may cease in clinics where supervising physicians are not available due, at least in part, to physician shortages and practice restrictions by private clinics. Nationally the trend is to permit full practice authority in licensure of an APRN. HB2013 passed out of the House but was not heard by Senate Committee.

Oklahomans experience a high rate of adverse childhood experiences. In an effort to reduce the long term impact such trauma can create, various agencies in the state have begun working on creating trauma-informed practices and procedures. This year, MCH began participating in a work group led by the Oklahoma State Department of Mental Health and Substance Abuses Services focused on creating trauma-informed schools. The work group began developing a tool kit for schools and communities which will provide trauma sensitive information, education and resources to implement a trauma informed culture throughout the state. This work will be complemented with the recently signed Senate Bill 1517, which creates a Trauma-Informed Care Task Force for the state.

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

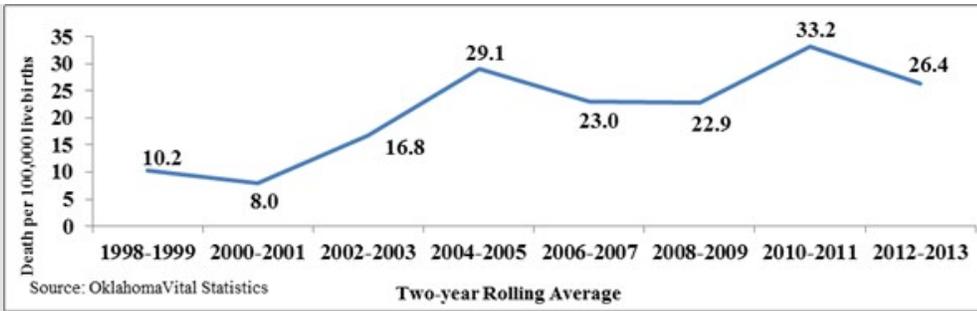
Prenatal Care (PNC): In Oklahoma for 2013, 68.5% of mothers initiated their PNC during the first trimester. Fifty-five percent (55.2%) of mothers that report having received PNC during their first trimester also report having attended 10 or more prenatal visits. A small percentage of mothers, 3.3%, report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

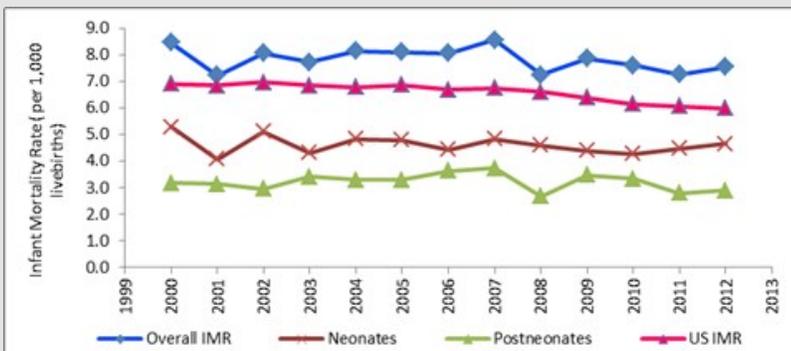
Maternal Mortality: In Oklahoma the two year average of maternal mortality rates (Figure II.B.2.a.1) has shown an overall upward trajectory, like the US maternal mortality rate. Racial disparities in 2013 continue to be a challenge in Oklahoma in relation to maternal mortality, among women of reproductive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

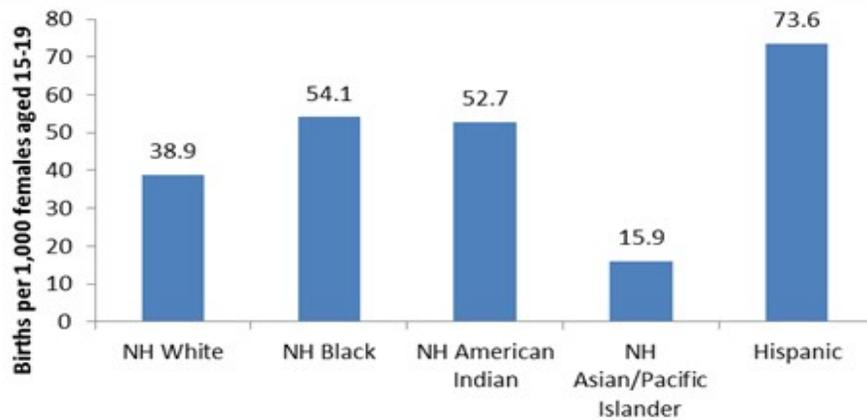
Contributing factors related to intentional self-harm include:

- 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.

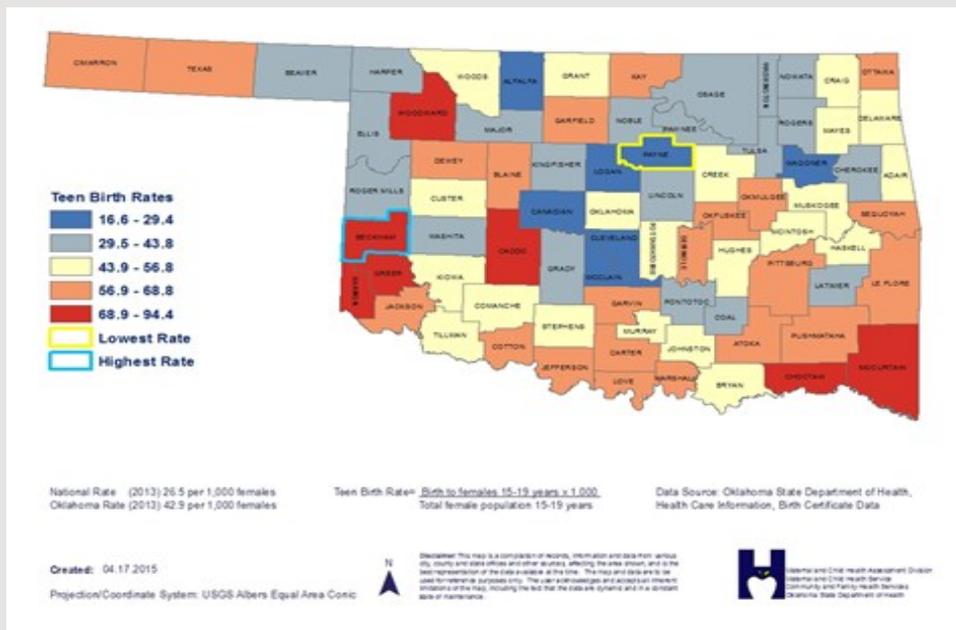
Figure II.B.2.a.3. Birth Rates for Teens aged 15-19 by Race/Ethnicity: Oklahoma, 2011-2013



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

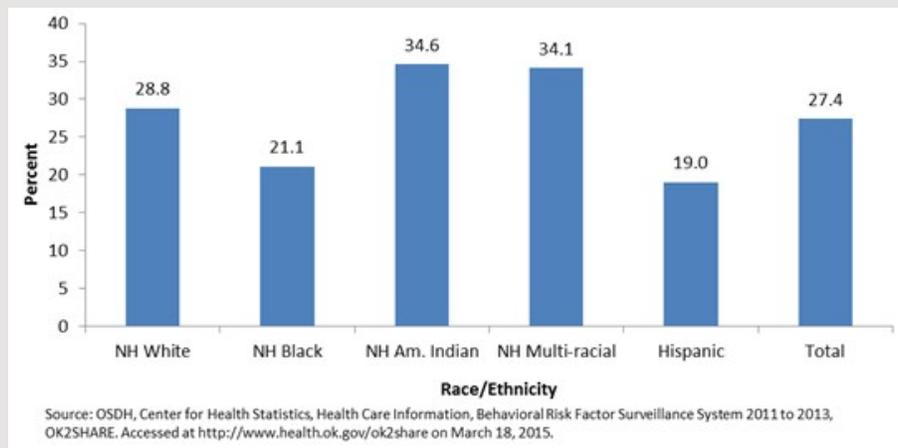
The life course perspective is a useful conceptual framework for understanding and addressing health. This approach helps incorporate the interplay of risk and protective factors and stages of critical development to further explain health outcomes as they occur across the lifespan. It has been particularly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

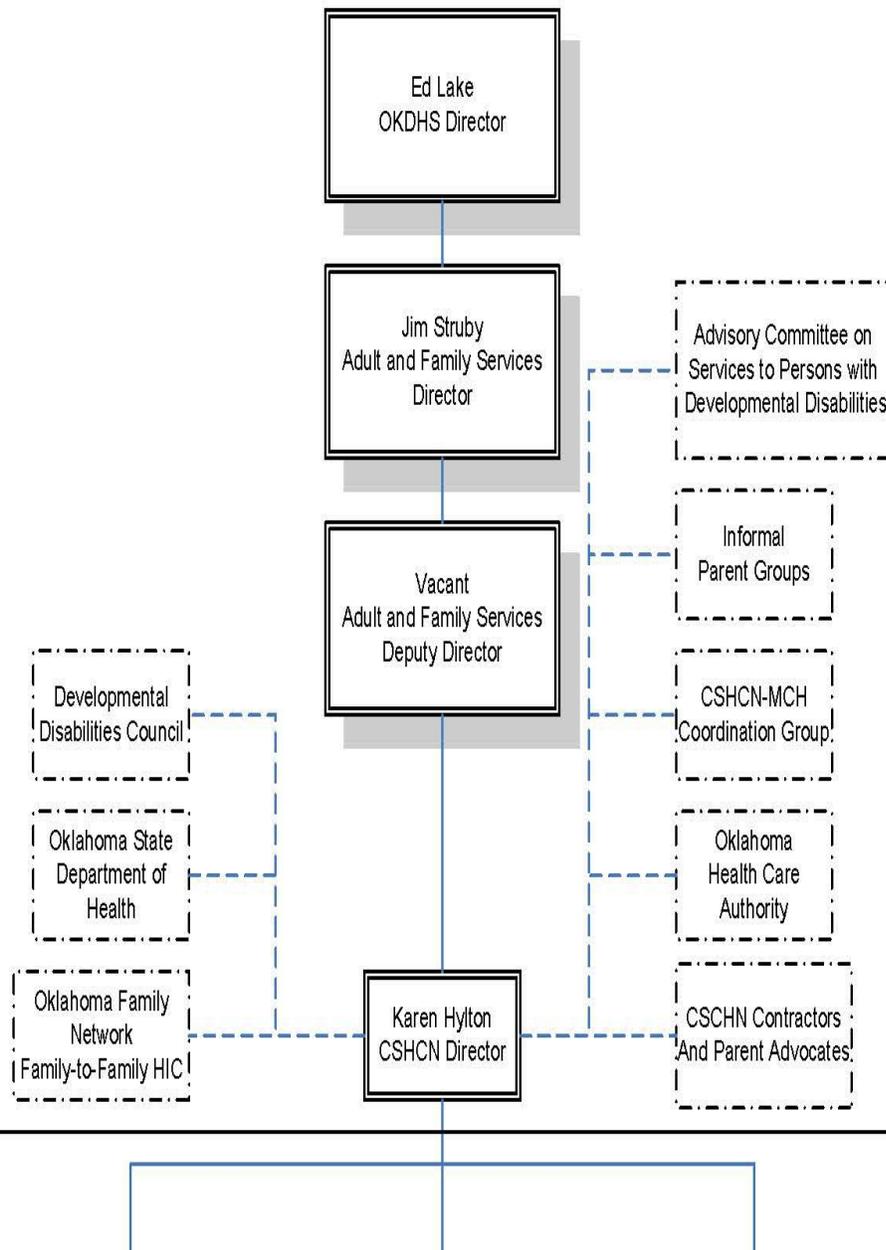
Programs administered in some part with Title V funds include: *Preparing for a Lifetime, It's Everyone's Responsibility*; the CollN Prematurity, Preconception/Interconception, Safe Sleep and Social Determinants of Health national projects; *Every Mother Counts*, the maternal mortality and morbidity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

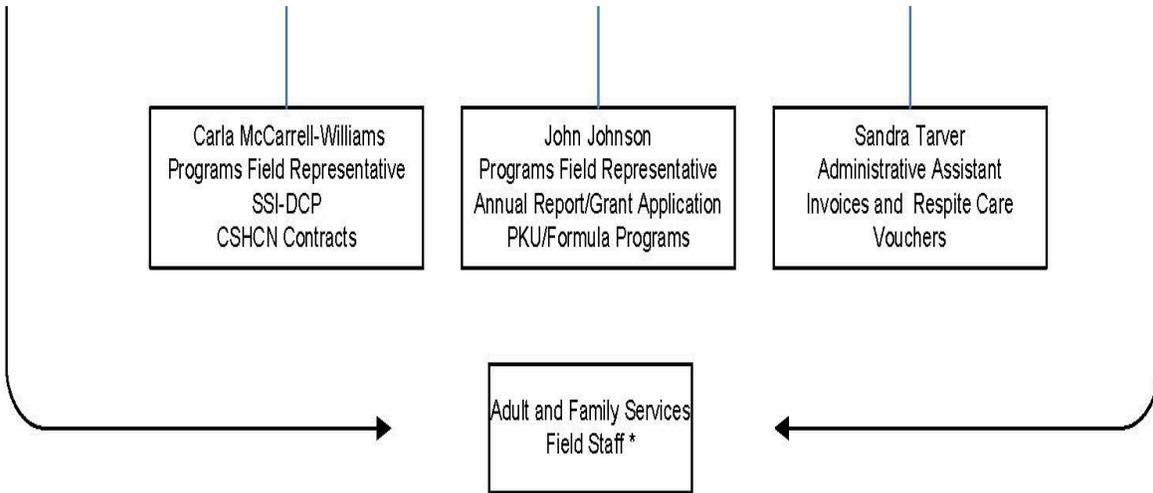
The Title V CSHCN Program is located in the DHS within the Health Related and Medical Services (HRMS) unit. The HRMS is organizationally placed under Adult and Family Services. Karen Hylton is the Director of the CSHCN Program and Program Manager for HRMS. Karen Hylton reports to the Deputy Director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

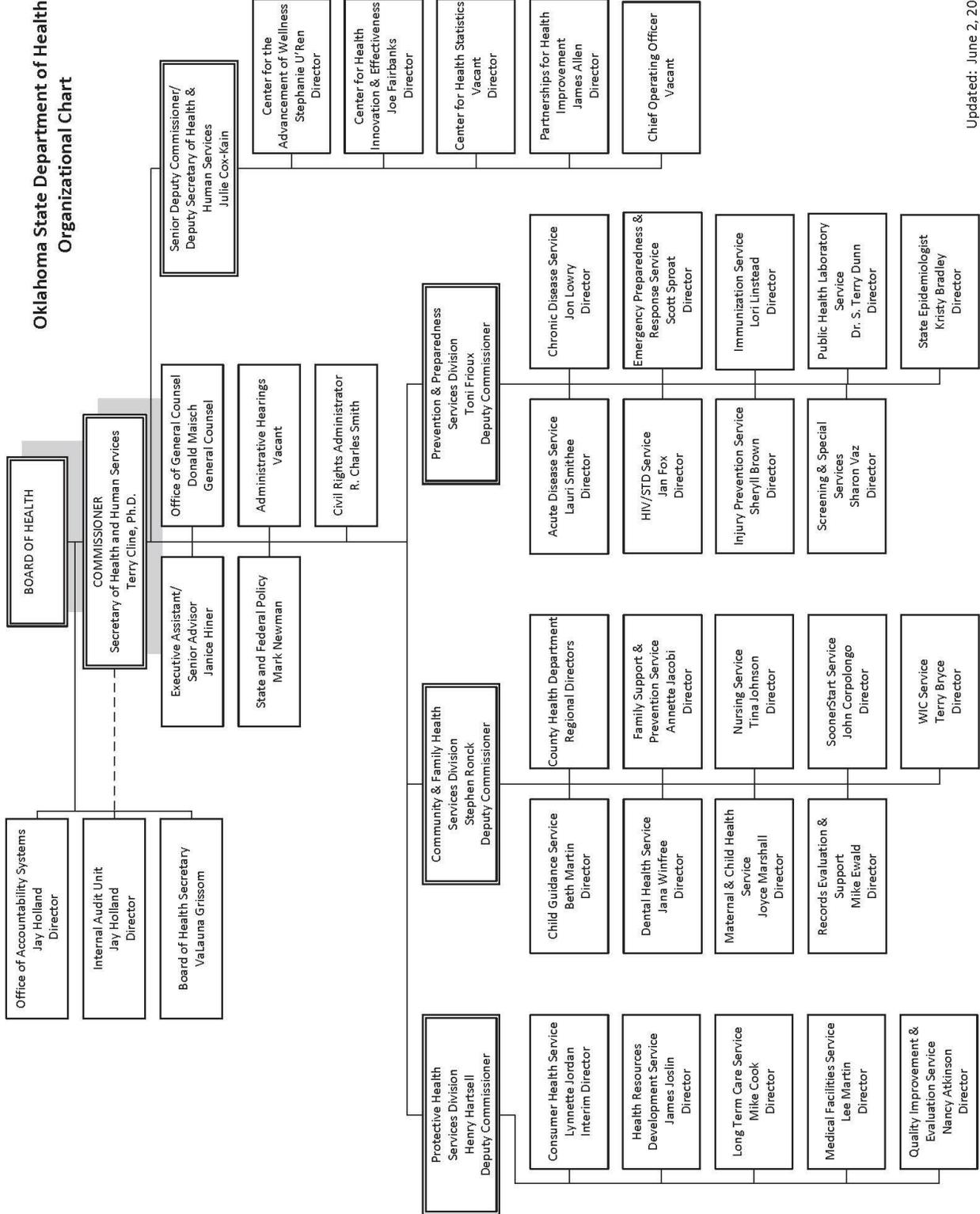
OKLAHOMA DEPARTMENT OF HUMAN SERVICES
CHILDREN WITH SPECIAL HEALTH CARE NEEDS
PROGRAM ORGANIZATIONAL CHART





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

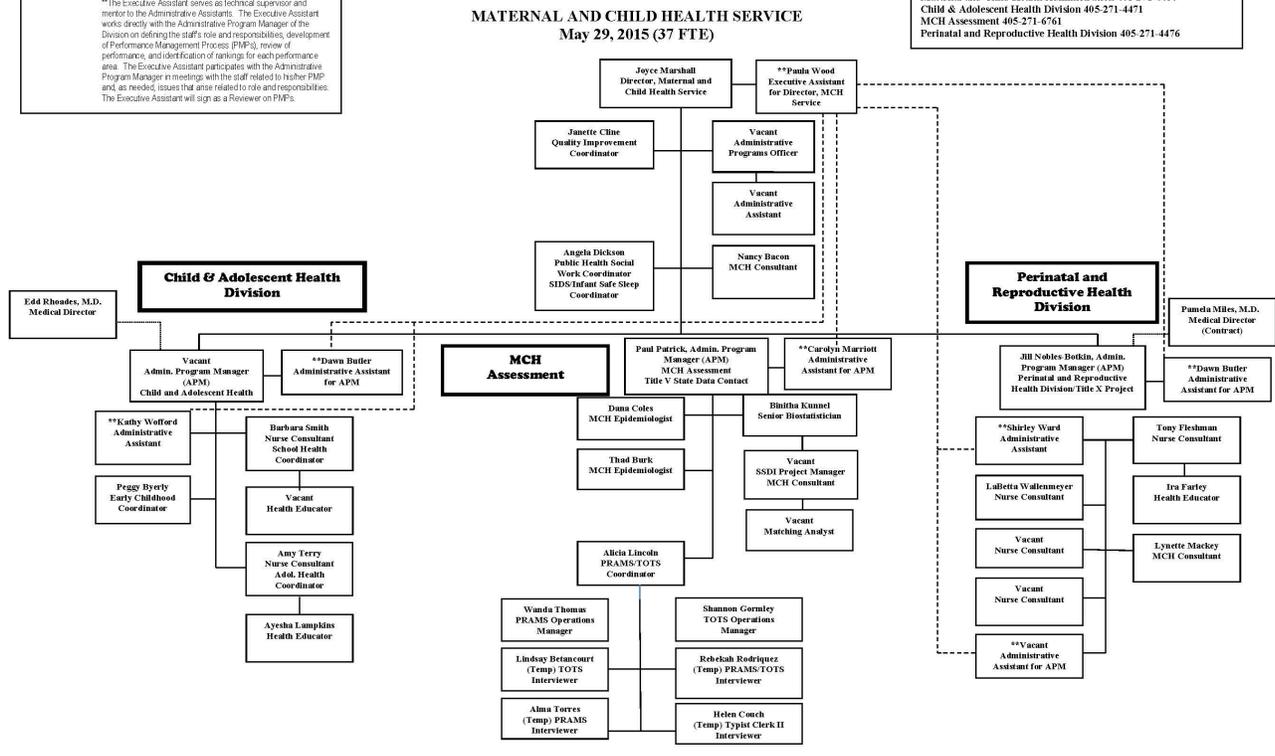
Oklahoma State Department of Health Organizational Chart



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 defining the staff's role and responsibilities, development of Performance Management Process (PMP), review of performance, and identification of openings for each performance area. The Executive Assistant participates with the Administrative Program Manager in meetings with the staff related to the PMP and, as needed, issues that arise related to role and responsibilities. The Executive Assistant will sign as a Reviewer on PMPs.

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



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)

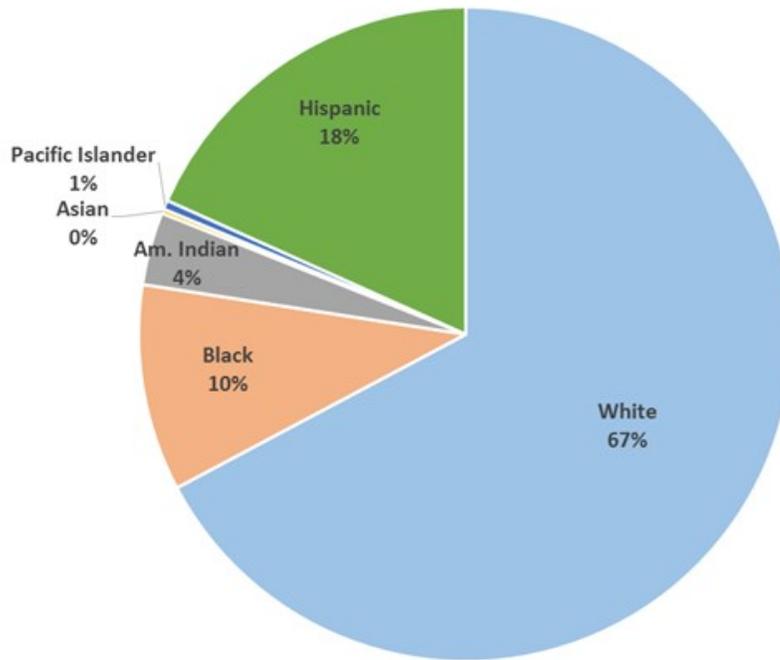
One key aspect of partnership and collaboration for Oklahoma Title V is family participation. The Oklahoma Family Network

(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.

III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$6,903,092	\$6,903,092	\$6,903,092	\$6,967,164
State Funds	\$5,184,379	\$7,498,441	\$5,252,960	\$6,513,130
Local Funds	\$0	\$641,942	\$641,942	\$1,163,806
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$64,006	\$28,758	\$52,724	\$4,050
SubTotal	\$12,151,477	\$15,072,233	\$12,850,718	\$14,648,150
Other Federal Funds	\$4,801,808	\$4,928,539	\$4,917,594	\$4,922,937
Total	\$16,953,285	\$20,000,772	\$17,768,312	\$19,571,087

	2017		2018	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$6,903,092	\$6,956,304	\$6,967,164	
State Funds	\$5,280,899	\$5,849,288	\$5,285,582	
Local Funds	\$0	\$1,802,006	\$0	
Other Funds	\$0	\$0	\$0	
Program Funds	\$5,919	\$65,969	\$4,050	
SubTotal	\$12,189,910	\$14,673,567	\$12,256,796	
Other Federal Funds	\$4,788,539	\$4,834,203	\$4,787,937	
Total	\$16,978,449	\$19,507,770	\$17,044,733	

	2019	
	Budgeted	Expended
Federal Allocation	\$6,956,304	
State Funds	\$5,217,228	
Local Funds	\$219,826	
Other Funds	\$0	
Program Funds	\$32,970	
SubTotal	\$12,426,328	
Other Federal Funds	\$4,890,970	
Total	\$17,317,298	

III.D.1. Expenditures

See Forms 2, 3a, and 3b

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

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 and there was an approximate 10% decrease in state MCH funds, the significant increase in local and program income funds to assist in these critical programs provided us with virtually flat overall funding, when comparing 2016 to 2017 numbers. Due to continued decreases in state funding, including additional program budget cuts throughout this fiscal year that are projected to continue through the new state fiscal year, less state match dollars are available to support this project. Many state funded positions in the central office and county health departments were eliminated in two Reductions in Force in the Fall and Winter of 2017/2018 due to funding being unavailable and are not being refilled. State contracts for both services and products have also been decreased. This climate downturn with the State of Oklahoma and OSDH funding will be reflected in continued lower budgeted amounts for fiscal year 2019 in state match, local, and program income dollars until this trend begins to reverse.

Form 3a documents expenditures by the MCH types of individuals served. For FFY 2017, CSHCN funding was relatively flat, while decreases in funding for pregnant women and infants (7.7% and 15.9% respectively) were noted, and an increase of 11.3% was realized among children aged 1-21 years of age. This increase was due in part to enhanced efforts in regard to teen pregnancy prevention, injury prevention, positive youth development and wellness as further detailed in our action plan.

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 decreased to \$1,591,105, enabling services expenditures increased by 30%, and public health systems and services decreased by approximately 25% from 2016 to 2017. The shift to more population-based enabling services such as health education and working with hospitals and schools in relation to best practices implementation in the areas of maternity, infant mortality reduction, and teen pregnancy prevention to address the need of the Oklahoma MCH population, along with funds being available in state match, program income, and local dollars to attend to MCH public health system necessities were demonstrated in 2017 expenditures.

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.D.2. Budget

Maintenance of effort from 1989:

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

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

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

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

Special consolidated projects:

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

State matching funds:

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

Federal 30/30/10 requirement:

For FFY 2017, 42.8% of the federal Title V Block Grant funds were designated for programs for preventative and primary care services for children, 30% for services for children with special health care needs, and 10% for

administrative costs.

State provides a reasonable portion of funds to deliver services:

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

The OKDHS administers the CSHCN Program through Adult and Family Services (AFS). AFS also administers the SSI-DCP for SSI recipients 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 Assistance Fund (PAF), a grant funded by the Office of Adolescent Health, is a competitive grant program that funds states and tribal entities so they can provide a seamless network of support services to expectant and parenting teens, women, fathers, and their families, with the goal of improving the health, educational, social, and economic outcomes of this special population.

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

State funds, county funds, Medicaid revenue, fees, and Title X federal funds support the provision of family planning services through county health departments and contract clinic sites. These funds are also used to provide a variety of educational programs targeted at decreasing unintended pregnancies; postponing sexual activity in teens; prevention of sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS); and increasing knowledge of human sexuality. The Oklahoma State Department of Health was designated as the state agency to apply for and receive funding from the Administration on Children, Youth, and Families (ACYF), Family and Youth Services Bureau (FYSB) to implement a Personal Responsibility Education Program (PREP). Grant approval has been received and funds are being used to implement projects in the two large metropolitan areas of Oklahoma City and Tulsa through contractual agreements with the two city-county health departments. These projects will focus on educating adolescents on both abstinence and contraception to prevent pregnancy and STDs, including HIV/AIDS, and adulthood preparation (e.g., healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, healthy life skills).

Budget Documentation:

Overall budget preparation and monitoring are provided through administrative support within the OSDH Administrative Services. Agency budgeting, grants, and contract acquisition staff meets 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. Additionally, MCH performs onsite program reviews with county health departments and contractors to assure programmatic compliance for both Title V and Title X.

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

The Title V Grant application documents a proposed budget on Forms 2, 3a, and 3b, inclusive of Title V federal funds, state dollar match, local dollars, and anticipated income to be received from Medicaid. This budget is the

base for services at the beginning of the grant period. As the year passes, the OSDH may make available more state and local funded resources (e.g., staff, supplies, travel) as available for provision of MCH services as an agency priority. This results in increased funding reported as expended on Forms 2, 3a, and 3b, compared to budget requirements. It is understood each year that these additional state and local funded resources are fluid and may be redirected at any time by the Commissioner of Health based on state and/or agency priorities, or in the event of a state health event, emergency or disaster needing to be addressed.

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

III.E. Five-Year State Action Plan

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

State: Oklahoma

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

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

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

Oklahoma administers the MCH Title V Block Grant through two state agencies, the Oklahoma State Department of Health (OSDH) and the Oklahoma Department of Human Services (DHS). The OSDH, as the state health agency, is authorized to receive and disburse the MCH Title V Block Grant funds as provided in Title 63 of the Oklahoma Statutes, Public Health Code, Sections 1-105 through 1-108. These sections create the OSDH, 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 OSDH MCH Service manages programs and services for pregnant women, mothers and infants, and children, while the CSHCN Program oversees those for children and youth with special health care needs. OSDH, as the state health agency, receives federal Title V Block Grant funds and then transfers funds designated for CSHCN to DHS. OSDH and DHS formulate a memorandum of agreement (MOA) which directs the administration and funds for the CSHCN Program. The MOA is attached.

The MCH Title V Program is located in the OSDH within 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, Tina Johnson, who is directly responsible to the Interim Commissioner of Health, Tom Bates. Dr. Edd Rhoades is Medical Director for the Child and Adolescent Health Division and Dr. Pamela Miles is Medical Director for the Perinatal and Reproductive Health Division.

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

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

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

Oklahoma's Title V programs enjoy strong relationships with state and community-based public and private partners, and emphasize through these relationships the goal of promoting and protecting the health of MCH populations. MCH, OFN and CSHCN participate in the Oklahoma Health Improvement Plan Child Health Group. MCH serves as the lead for the state's infant mortality reduction initiative, *Preparing for a Lifetime, It's Everyone's Responsibility*,

with several MCH leadership staff leading topical workgroups (i.e., maternal mood disorders, preconception care, infant safe sleep, breastfeeding, injury prevention) in the initiative. MCH continues to be integrally involved with the work of the Oklahoma Perinatal Quality Improvement Collaborative, which aims to improve 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. There are multiple opportunities 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 Program Managers, as well as the biweekly meeting held by the Deputy Commissioner of the CFHS. Both meetings provide a space for agency updates, sharing program activities, and networking. In the latter, the MCH Title V Director interacts with all CFHS Directors, affording an opportunity to discuss crosscutting activities. MCH routinely collaborates with other OSDH programs to address issues of mutual interest, including preconception care, family planning, maternal depression, breastfeeding, tobacco use prevention, dental care, obesity, injury prevention, immunizations, newborn hearing and metabolic screening, adolescent pregnancy prevention, school health, family resource and support services, child care, and early childhood.

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

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

The CSHCN Program oversees the provision of social services to children receiving Supplemental Security Income (SSI) by providing training and guidance to approximately 70 social services specialists, who are responsible for developing and monitoring service plans for children who receive SSI and other services through the DHS. CSHCN program information can be accessed via the social services specialists and the DHS website. Contracts are in place with the Oklahoma Family Network, Comprehensive Pediatric Sickle Cell Clinic, Family Support 360°, Oklahoma Infant Transition Program, Sooner SUCCESS, and the JD McCarty Center to provide high quality, family-centered services to Oklahoma's CYSHCN.

III.E.2.b. Supportive Administrative Systems and Processes

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

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

MCH maintains a staffing pattern which includes long-term employees, nearly half of whom have served at least ten years with MCH. Employee retention is accomplished through administrative support, professional development and opportunities for transition and advancement. Agency supports such as a generous benefits package, employee assistance program, health and wellness activities, and partnerships with other OSDH programs contribute to employee satisfaction and retention. Staff is encouraged to engage in career enrichment opportunities such as the Oklahoma Public Health Leadership Institute.

All new MCH employees must complete trainings required by OSDH, including data security, HIPAA, cultural competency, ethics, safety and supervisory. In addition, the MCH New Employee Orientation and Checklist must be completed during their first few months, which includes Human Subjects Research Training, MCH Navigator website review and trainings, Title V Block Grant and Needs Assessment Review, Title X 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. To further enhance the orientation experience, a mentor is assigned for a period of six months to provide guidance, encouragement, and opportunities for one-to-one learning. The mentor helps the new employee to achieve professional goals and build capacity to succeed.

Annual trainings are provided by MCH to staff in county health departments, OSDH central office, and contract staff. These trainings include required content such as child abuse identification and reporting, and sexual coercion, including human trafficking. Trainings for SFY 2018 include enhancing the client experience, updates on OSDH programs supporting infant/family wellness, improving outcomes for Oklahoma's babies, community participation, family planning and maternity program update, preconception/interconception health, domestic/interpersonal violence, adolescent health issues, mental health, women's health priorities and fatherhood. These trainings are recorded and distributed to staff in county health departments serving the maternal and child population.

MCH continues to provide the Life Course Approach training for new and current employees, highlighting the significance of adverse childhood experiences as they impact health outcomes into adulthood. Nursing students, interns and partners are also provided the training.

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 trainings 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 families with members with special health care needs,

such as intellectual and developmental disabilities, throughout the life course. 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) Program.

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.

III.E.2.b.ii. Family 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.

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; 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 eleven years, OFN has hosted Joining Forces: Supporting Family Professional Partnerships Conference. One hundred sixty-nine families and professionals attended the conference day focused on family/professional partnerships. About one-half were family members and about one-third were from rural or frontier areas. Last 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 agreeable to families from their culture. All trainings consider aspects of other cultures, beyond race and ethnicity, such as single moms, military families, rural

and urban families, disability-specific, child welfare experience, etc.

III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

In using State System Development Initiative (SSDI) grant awards, the Oklahoma Maternal and Child Health Service (MCH) partially funds a staff position, the SSDI Analyst, which has responsibility for performing the duties required under the SSDI grant. The principal goals of the Oklahoma SSDI Project are 1) to build and expand MCH data capacity to support the Title V MCH Block Grant program activities and to contribute to data-driven decision making as it relates to assessment, planning, and evaluation of MCH programs; 2) to advance the development and utilization of linked MCH-related data systems; and 3) to provide data support in state quality improvement activities. By meeting these goals, MCH will be better positioned to produce improvements in the health and well-being of the women, infants, and children that need and utilize the state's MCH programs.

Within the SSDI Project work plan, each goal is associated with established supporting objectives which require identified activities to be performed according to schedule. In broad terms, the SSDI Analyst serves as the primary position for coordinating the Title V MCH Five-Year Needs Assessment and plays a supporting role in the preparation and submission of the Title V MCH Block Grant Application and Annual Report. Preparation of the grant application and report is done by compiling the necessary data to meet the reporting requirements for the National Performance Measures, Evidence-Based Strategy Measures, and the State Performance Measures. Compilation of these data is carried out by all MCH analysts with the SSDI Analyst having key assignments in this process. For the Five-Year Needs Assessment, the SSDI Analyst has a larger role, one that requires the position to serve as the primary coordinator of all activities related to the needs assessment process. This includes developing data collection tools, identifying and collaborating with key partners, performing data analyses and reporting, drafting and editing written materials, scheduling and facilitating planning meetings, and managing a timeline to assure that milestones are met according to agreed schedules.

Work related to developing, utilizing, and linking of data systems also falls to the SSDI Analyst, but is one that is partially shared with the MCH Medicaid Analyst, a position responsible for linking and analyzing birth certificate records and Medicaid administrative data. Ideally, these positions work in tandem to develop linked data sets that can be standardized and prepared for routine analysis of MCH priority health issues. For the current SSDI project period, federal fiscal years 2018-2022, the SSDI Project will partner with Screening and Special Services to electronically join birth certificate data with newborn hearing and metabolic screening records. Currently, this work is in the planning stage with preliminary discussions held in fall 2017. It is expected that the SSDI Analyst and the MCH Medicaid Analyst will collaborate to develop linking strategies and protocols to perform the targeted linkages and to document the process for repeatability in future years. Another primary linkage to be utilized by the SSDI Project includes linked infant death/birth data, which is prepared by Health Care Information (HCI), an organizational unit within the Center for Health Statistics at the Oklahoma State Department of Health. Through a Data Use Agreement with HCI, the SSDI Project will access these linked data for preparation of a report that explores key maternal and infant birth factors associated with infant mortality.

Throughout the life of the Collaborative Improvement and Innovation Network (CoIIN) to Reduce Infant Mortality, the SSDI Project played, and continues to play, a key role in preparing, analyzing, and reporting data. These efforts continue with the Preconception CoIIN now underway in four states, including Oklahoma. The SSDI Analyst will prepare infant mortality and prematurity data as part of the Preconception CoIIN annual reporting process. On an ongoing, routine basis, these data are shared with MCH leadership for review and incorporated into the program planning process. Along with this work, the SSDI Project has developed an objective to create uniform, standardized data sets for fetal death certificates, a data system that has been largely ignored within the state. The SSDI Project seeks to create analysis data sets that can be used routinely to assess pregnancy outcomes other than those resulting in live birth.

Broadly speaking, the Oklahoma SSDI Project seeks to develop greater data capacity by creating richer, more comprehensive data sets which can be used by MCH to better understand its target population. By developing these data sets, MCH and its partners will have more information and an improved understanding of the health care and health status of the state's women, infants, and children. Ultimately, this information can be used to develop programs and policy to yield health improvements in MCH populations.

III.E.2.b.iv. Health Care Delivery System

Oklahoma Title V has excellent relationships with partners throughout the state and this assists programs in assuring access to quality health care and needed services for the Oklahoma MCH population. A close working relationship with the State's Medicaid Agency, the Oklahoma Health Care Authority (OHCA), is of high value to Title V to the degree that representation and involvement from OHCA can be found in most all Title V initiatives undertaken. Other system partners include: Department of Human Services (DHS), Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma Perinatal Quality Improvement Collaborative (OPQIC), Oklahoma Hospital Association, Oklahoma March of Dimes, Oklahoma American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) Chapters, Oklahoma State Medical Association (OSMA), Southern Plains Tribal Health Board, Indian Health Service, tribal nations, birthing hospitals, universities, county health departments, physicians, and other public health organizations and agencies. Examples of some of these collaborations include:

- *AIM/Every Mother Initiative* to reduce severe maternal morbidity and maternal mortality through evidence-based safety bundles;
- *Focus Forward Oklahoma* to reduce unintended pregnancies and teen births through education, counseling, and increased access to long acting reversible contraceptives;
- *OPQIC Maternal Opioid Use Disorder and Neonatal Abstinence Syndrome Work Group* to decrease maternal opioid use and infants affected with NAS;
- *OPQIC Preterm Birth Initiative* to promote best practices with providers to reduce preterm births;
- *The Child Health Group* to improve overall child health outcomes;
- *Sooner SUCCESS Health Care Transition Team/Advisory Board* to advise on services for CSHCN and transition to adult care services;
- *Child Death Review Board, Fetal and Infant Mortality Review Teams, and Maternal Mortality Review Committee* to review maternal, fetal, infant, and child deaths and make recommendations in relation to prevention and best practices;
- Choctaw Nation Medical Center pilot to improve breastfeeding and safe sleep practices;
- *Preconception CoIIN* to improve Women's Health awareness and assessment during Preconception/Interconception phases; and the
- *Oklahoma Family Network Advisory Committee* to advise the Oklahoma Family Network in relation to services and resources for Oklahoma families.

Other unique collaborative efforts between the OHCA and MCH are the Shared Data Work Group and analyst position. The OHCA and MCH have a leadership team that meets monthly to address shared MCH topics of interest through linked data. The analysis is accomplished by a shared analyst position (paid 50% from OHCA Medicaid and 50% from the MCH) that links both data systems and gathers critical data and information to further inform efforts to critical MCH areas of concern such as Neonatal Abstinence Syndrome and prenatal care.

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

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

Waivers or state plan amendments which influence health care delivery for the MCH population, particularly CSHCN are the 1915 (c) home and community based waivers and the Tax Equity and Fiscal Responsibility Act of 1982

(TEFRA). DHS' medical programs have the responsibility for the operation and allowable OHCA administrative activities of approved 1915 (c) home and community-based waivers. Developmental Disabilities Service Division, a division of DHS, serves individuals who are 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for individuals with intellectual disabilities. OHCA and DHS coordinate all mutual policy issues related to the operation of all waivers and state plan amendments.

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

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

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

- Assisting and informing families regarding online SoonerCare (Medicaid) enrollment and connecting them with their local DHS office in cases of CYSHCN;
- Hosting booths at conferences, trainings, health fairs, etc. to share information regarding access to Medicaid and other services;
- Providing SoonerCare, TEFRA and private duty nursing information and how to access by sharing on social media Facebook pages (public and private), in quarterly OFN newsletters and in *Joining Forces: Supporting Family Professional Partnerships* Conferences;
- Providing training and supporting families attempting to fill out TEFRA applications;
- Partnering with OHCA to assist in identifying barriers and improving access to TEFRA;
- Increasing awareness of lack of Private Duty Nurses for CYSHCN primarily due to reimbursement rates and promoting increases in rate, which was successful with an outcome of many CYSHCN now receiving more hours of nursing so they can remain at home;
- Promoting and sharing information to families and policy makers regarding financing of waivers and state plan services; and
- Hosting Coffee Chats at the Capitol for legislators and their staff to increase awareness of need for services for CYSHCN including behavioral health.

Other services relating to financing and policy decision making include items such as promoting and attending *Medicaid Matters Day* and other disability awareness days to share information with families and policymakers regarding the importance of services for CYSHCN and providing *Telling Your Story* and *Sitting on Boards and Committees* Trainings at Family Leadership Institutes and individually to ensure the family voice and experience is available and valued to improve financing of essential services and better access to health care for CYSHCN and their families. OFN Family Leaders serve as members of the OKDHS Developmental Disability Services Policy Committee, OHCA Member Advisory Task Force, OSDH Preparing for a Lifetime and other Maternal and Child

Health committees, Screening and Special Services Committees, and Mental Health and Substance Abuse Services State Advisory Team for Systems of Care, to name a few. The OFN also provides stipends to family leaders for their involvement in these important decision-making groups.

Finally, two new Medicaid Health Service Initiatives are going through the final approval stages. These will impact two MCH Title V priority areas over the next few years, unintended pregnancy and infant safe sleep. The OHCA would pay for 87-97% of the costs for these projects, once approved, and MCH would fund the remainder. One project would provide additional long acting reversible contraceptive methods to reduce unintended pregnancies and teen births in the counties and the other will expand the Cribs Pilot Project to reduce infant deaths and racial disparities through improvements in infant safe sleep practices.

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

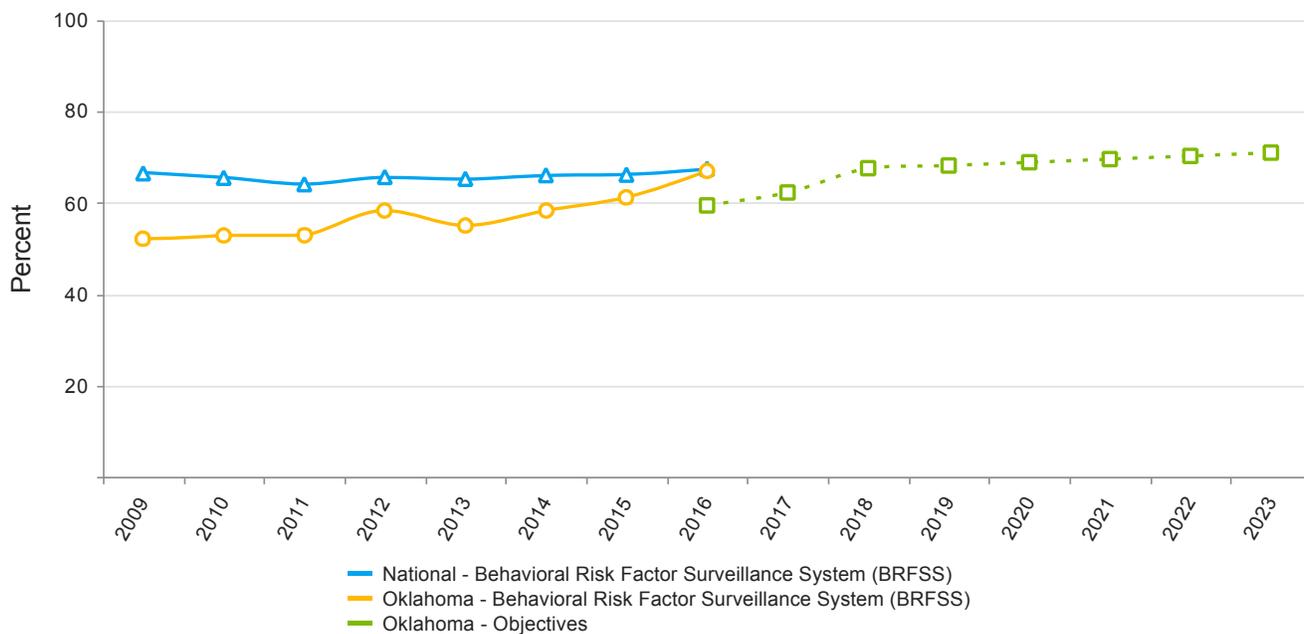
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	156.0	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	21.1	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	7.8 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	10.7 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	28.2 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	6.2	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	7.3	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	4.4	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.9	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	244.7	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2015	5.0 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2015	5.7	NPM 1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	33.4	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2015	16.1 %	NPM 1

National Performance Measures

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



Federally Available Data

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2016	2017
Annual Objective	59.4	62.2
Annual Indicator	61.0	66.8
Numerator	414,257	449,510
Denominator	679,075	672,938
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	67.5	68.1	68.8	69.5	70.2	70.9

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	2017
Annual Objective		95
Annual Indicator	91	90
Numerator		
Denominator		
Data Source	PHOCIS	PHOCIS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	105.0	110.0	115.0	120.0	125.0

State Performance Measures

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

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

State Provided Data		
	2016	2017
Annual Objective		17.4
Annual Indicator	20.1	21.2
Numerator	32	33
Denominator	159,025	155,716
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2014-2016	2015-2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	20.8	20.4	20.0	19.6	19.2	18.8

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

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

Objectives

1. Increase the number of women returning for the postpartum visit from 88.0% in 2012-2014 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 15.5% 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.
- 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.
- 2c. 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 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

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

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

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

Reduce unplanned pregnancy

NPM

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

Objectives

Reduce the rate of unintended pregnancies (mistimed or unwanted) among mothers who have live births from 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 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

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

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

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

Reduce health disparities

NPM

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

Objectives

Create a Communication and Dissemination Plan to educate reproductive age males and females on being healthy before and between pregnancies in areas of the state with the highest infant and maternal mortality rates by December 2020.

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

NOM 5 - Percent of preterm births (<37 weeks)

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

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

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

Improve the mental and behavioral health of the MCH population

NPM

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

Objectives

Increase the percent of 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 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

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

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

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

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

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

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

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy

NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

Reduce the prevalence of chronic health conditions among childbearing age women

SPM

SPM 2 - 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 - 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 88.0% in 2012-2014 to 95.0% in 2020.

Data:

According to the most recent PRAMS data (2013-2015), 88.1% of new moms in Oklahoma attended their postpartum visit with the postpartum visit rate staying relatively stable (88.0% 2012-2014). With global billing and reimbursement for obstetric services, claims data were not available to support this self-reported percentage. Based on anecdotal information, these numbers may be inflated by recall or social desirability bias, as mothers may have been aware they were expected to return for the postpartum visit but did not actually attend the visit.

Successes:

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), and to discuss birth control, folic acid, and continuing to stay quit from smoking.

A PRAMS Brief was published in August 2017 on "Birth Control Practices among Oklahoma Teen Mothers". Based on 2012-2014 data, 36.5% of teen moms and 44.3% of older moms were using a method of birth control at the time of pregnancy. This number increased dramatically to 84.4% of teen moms and 80.5% of older mothers who reported using birth control postpartum. According to PRAMS data, 45.9% of teen moms were relying on condoms at the time of the survey, 28.1% on pills, 17.7% on shots, 17.2% on an IUD, and 15.6% on an implant. This indicated some level of postpartum care for 78.6% of teen moms who were relying on a prescription method of birth control. These data highlighted 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 that the family had a medical home (whether the mother was pregnant or postpartum). This included a primary care provider (PCP) for the mother and baby. In addition, the parent educator helped mothers to understand the importance of maternal health, what to expect during a postpartum visit, and questions she may want to ask her health care provider. The parent educator supported the mother by helping her make timely postpartum appointments and provided transportation, if needed.

The PAT curriculum contained lessons that addressed the postpartum period called "Normal Postpartum Adjustment". In addition, the parent educator had access to handouts that addressed adjusting to the birth of the baby and signs and symptoms of postpartum depression. Parent educators performed the Patient Health

Questionnaire (PHQ9) to screen for postpartum depression which was administered by the 4th home visit or if the mother was pregnant, in her 36th week. It was administered again when the infant was between 4-6 months, and then annually. Also, it could be administered at any time if the parent educator suspected depression.

Children First (C1), Oklahoma's Nurse-Family Partnership, continued to provide a voluntary family support program that offered home visitation services to mothers expecting their first child. Upon enrollment, a public health nurse worked with the mother in order to increase her chances of delivering a healthy baby. The nurses addressed life course development with the client in the prenatal period. During the C1 postpartum visit, the nurse asked when the client's next appointment with the delivery provider was to occur. 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 occurred October 1, 2016 – September 30, 2017 and indicated that 67% of C1 clients attended their postpartum visit.

Challenges:

The Oklahoma State Department of Health, in conjunction with partners with the Oklahoma Health Care Authority (OHCA, the State's Medicaid agency) and private insurers have been unsuccessful in attempts to change the rate methodology for reimbursement for obstetrical services, splitting out the postpartum visit from the global package. Consequently, it remained difficult to determine how many women actually returned for their postpartum visit and to incentivize providers into more strongly encouraging women to attend this visit. Current information on postpartum visits was obtained from PRAMS which relied on the mother's recall and ability to have completed the postpartum visit at the time of the survey.

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

Data:

Baseline data (state fiscal year (SFY) 2014) indicated 8.5% of females \leq 18 year olds, 16.3% of 19-24 year olds, and 14.7% of females \geq 25 with Medicaid-funded health care relied on long acting reversible contraception (LARC) methods. SFY 16 data show 10.3% of females \leq 18 year olds, 17.7% 19-24 year olds, 15.5% of 25-34 year olds, 10.6% of 35-44 year olds and 6.4% of females 45 years or older with SoonerCare used a LARC. This provided an overall LARC utilization rate of 14.1% for SoonerCare members SFY 2016, exceeding the original 2020 goal of 12.6%. The goal has been adjusted to a new target, 15.5% in 2020.

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, 2017, SoonerPlan provided coverage to 32,075 enrollees accounting for 4.0% of Medicaid enrollment.

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 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 (FPAR) for calendar year 2017 indicated 8.7% of clients relied on intrauterine devices/systems and a 10.6% of clients relied on the implant for contraception. Family planning services were provided to a total of 45,515 females and males of reproductive age for calendar year 2017. Of the 45,515 clients, 8,610 relied on public insurance and 29,403 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 (CoIIN) 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, only Title X funds were utilized to purchase LARCs for the OSDH clinics. With additional funding from Title V and The Prevent Block Grant to purchase LARCs, waiting lists were eliminated creating availability for all clients on their date of service.

Through the collaborative Focus Forward Initiative, the OHCA led efforts to recruit and train health care providers across the state on counseling and insertion for LARCs. The State Plan Amendment was changed to remove restrictions on LARC devices for Medicaid members to support better access to the most effective methods of contraception. LARC Provider Training Sessions were held for family planning providers across Oklahoma. Training sessions included: Intro to LARC, patient-centered counseling techniques, mock counseling practice with patient scenarios, hands-on insertion and removal skills using a high fidelity pelvic simulator and pelvic task trainers, and contraceptive implant training provided by the implant manufacturer. During these training sessions, 124 providers were trained - 27% from rural Oklahoma, 58% were MDs/DOs, 27% were APRNs, and 69% were Family Practice Providers. All OSDH staff were previously trained on LARC insertion so did not attend these sessions. With reauthorization of CHIP funds, additional training is being scheduled for next summer.

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 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. Through the ASTHO Team activities, OHCA attempted to collect data from manufacturers and private payers to determine gaps in services and LARC access in the state. This information has proven difficult to obtain. LARC trainings were all provided in Oklahoma City and Tulsa. No training was provided for clinicians in the western half of the state. This was due to financial resources, availability of trainers, and access to simulators for training.

Although the OHCA started covering the placement of LARCs prior to hospital discharge after delivery effective September 1, 2014, utilization of this benefit remained low. Reimbursement for immediate postpartum LARCs became available in CY 2014 with 62 claims submitted during the year. The most recent data available show 173 claims paid in SFY 2016.

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

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

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

Data:

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 2013-2015 births, 49.7% of mothers reported an intended pregnancy (up slightly from the previous reporting period 48.8%), 33.5% reported an unintended pregnancy (previously 33.9%), and 18% reported they weren't sure what they wanted.

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 those 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, 2017, SoonerPlan provided coverage to 32,075 enrollees accounting for 4% of Medicaid enrollment.

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.

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

opportunities.

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

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

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; enhancing the client experience and client centered approach to contraceptive counseling; adolescent health issues (including teen pregnancy prevention); obesity prevention, and, fatherhood and male involvement in reproductive health.

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.

Although effective at preventing unintended pregnancies, the upfront cost of LARC methods was prohibitive for some health care providers. The Focus Forward Program continued to work towards making the methods more accessible through additional providers across the state.

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

Data:

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

Successes:

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

The Preconception Health and Health Care Initiative out of University of North Carolina submitted an application to host the next round of preconception CollN teams with Oklahoma being one of four states included in this new

project. The kick-off for this project was December 2017 and included MCH staff as well as representatives from all four Healthy Start projects, and a Federally Qualified Health Center.

MCH staff shared preconception health and prematurity information at the annual March of Dimes Walk for Babies on May 6, 2017 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 the importance of immunizations prior to pregnancy and during pregnancy (flu and Tdap) and breastfeeding.

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

A public service announcement (PSA) entitled "Measure Up" was available on the website for use on television and radio and was utilized on closed circuit televisions in some locations including the central office this year. The PSA promoted the importance of being healthy prior to pregnancy and planning for pregnancy.

Challenges:

A new billing code was added last year to help track usage of the Women's Health Assessment, however, during Comprehensive Program Review visits, chart audits 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 healthy, intended pregnancies remained a challenge. Health care providers were busy and often did not have time for counseling and planning. A multitude of resources were available to assist with preconception health counseling; however, busy providers did not have time to review and assess all the resources available in order to choose a resource that would work best for each of them.

Changing electronic health records to include a preconception health assessment is frequently too time consuming and costly presenting a barrier for some sites. Federal funding requirements for some programs include lengthy data collection tools, including preconception health questions, leaving little time for education.

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

SPM 2 Maternal mortality rate per 100,000 live births

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

Data:

Maternal death continued to be the international standard by which a nation's commitment to women's status and their health could be evaluated. The Maternal Mortality Rate (maternal deaths within 42 days of termination of pregnancy per 100,000 live births) for Oklahoma from 2014-2016 among women aged 10-59 years was 20.1 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 is based on a three year rate of those deaths occurring within forty-two days from termination of pregnancy to assure the availability of comparable data to other state and national rates. For confidentiality reasons, MCH policy for reporting Oklahoma maternal mortality rates requires only three year rolling averages 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. Activities focused on implementing the postpartum hemorrhage and hypertension bundles (published by the Patient Safety Council) in birthing hospitals in Oklahoma. This year, MCH continued to work with AMCHP and the CDC in the adoption of a new database, hosted by the CDC to help states collect and report comparable data. MCH continued to work through technical issues to transition to 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 national 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 was the first AIM state based on infrastructure and activities put in place through the Every Mother Counts Initiative the previous year. The Office of Perinatal Quality Improvement continued to provide leadership for these efforts providing technical assistance for participating hospitals on data entry, policy development, and emergency drills. The participating Oklahoma birthing hospitals (48 out of 51 hospitals) worked on postpartum hemorrhage and/or hypertension. Information on outcome measures was entered into the database through the Vital Records Division. Process measure information was entered by individual hospital staff. Hospitals were recognized as "Spotlight Hospitals" for establishing protocols and entering data into the AIM data portal during the annual Oklahoma Perinatal Quality Improvement Collaborative held September 29, 2017, in addition to meeting other criteria.

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.

Transition to the new MMRIA database did not occur based on the difficulty of the approval process for IT projects and the cost of hosting the data base. MCH began working to identify alternate options for hosting the database.

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.

Continued challenges related to preconception health and pregnancy intention were identified as contributing factors for many maternal deaths. To date, the MMR has reviewed 105 cases with at least one of the following contributing factors listed for the majority of cases reviewed: obesity (BMI listed as high as 53.5), hypertension, diabetes, (not gestational diabetes), cardiac problems, and asthma/pulmonary issues.

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

Data:

According to data from the 2015 The Oklahoma Toddler Survey (TOTS), 44.5% of new mothers were screened for postpartum depression. Almost 11% of mothers with toddlers indicated they had been diagnosed with postpartum depression (PPD) sometime after their toddler was born.

Successes:

MCH supported efforts into outreach and screening with partners in Tulsa, Oklahoma City, and several rural counties utilizing the Edinburgh postnatal depression scale in most county health department clinics, as well as others utilizing the PHQ-9 patient health questionnaire. In the county offices not a part of the Oklahoma City or Tulsa County catchment areas, there were 2,554 screenings conducted between October 1 2016-September 30 2017. Within Oklahoma County, there were 222 screenings conducted during this time; and within Tulsa County 52 screenings were completed by social work staff and over 100 by nursing staff.

In addition, screenings and brief intervention and treatment has been an ongoing focus with SBIRT (Screening, Brief Intervention, and Referral to Treatment) being implemented at St. Anthony Hospital in Oklahoma City in October 2016, with more partners potentially to follow.

Education and awareness has continued to be a focus, with trainings conducted for the Oklahoma home visitation programs, health care providers, and behavioral health clinicians working with mothers of child-bearing age and their families.

The *Preparing for a Lifetime* Work Group continued to partner with the Oklahoma Family Network to bring awareness about PPD to families with children in the neonatal intensive care unit (NICU) and to families who had lost a child during pregnancy. In addition, a postpartum depression support group was offered in Spanish and English for eight weeks through a Central Oklahoma FIMR partnership with Variety Care (a local FQHC).

There was an increase in membership and diversity of the *Preparing for a Lifetime* Maternal Mood Disorders Work

Group at the Oklahoma State Department of Health. The increased membership reflected several private-practice therapists focused directly on working with mothers diagnosed with postpartum depression and representatives from the Oklahoma Infant Transition Program with the University of Oklahoma Medical Center NICU who were looking into supports for families impacted by postpartum depression.

Challenges:

There continued to be a stigma against disclosure of any mental health diagnosis, and especially PPD or other maternal mood disorder. As a result, many women continued to remain undiagnosed and untreated.

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

Women/Maternal Health - Application Year

With the Medicaid Analyst position refilled, and data matching between Medicaid claims and birth certificate data resumed, analysis will be ongoing. The joint OSDH/OHCA work group will assess more recent data on women who are returning for the postpartum visit and identify ways to reach those who typically are not, and assess barriers to early entry into prenatal care.

MCH will send 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 through the Focus Forward Initiative. Although both the Association of State and Territorial Health Officials (ASTHO) and Collaborative Improvement and Innovation Network (CoIIN) teams will be ending their support, Focus Forward will carry on efforts to educate providers across the state. A sustainable education model has been developed for providing skills training to current and future health care providers for LARC insertion utilizing staff from two major institutions of higher learning in partnership with the OHCA. The OHCA will continue work to decrease barriers to access in relation to LARC methods for Title XIX and SoonerPlan recipients.

OHCA benefits will maintain coverage for a broad range of contraceptives including the LARC methods. 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.

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 also continue to work with OHCA to train private providers for LARC counseling and insertion and to eliminate barriers to access through Medicaid and private insurance policies.

MCH will look at expanding education provided through the Pregnancy Assistance Fund grant utilizing the Love Notes curriculum to additional sites. Through this curriculum, college age youth are educated on healthy relationships, avoiding sexual risk and/or returning to a risk free status, setting and achieving goals, and reproductive health. If funding and staff resources are available, MCH will also work towards expanding the Preconception Peer Education program started at the end of 2017.

Youth councils will be facilitated by the Adolescent Health Specialists during the 2018-2019 school year after vacant positions are refilled. Facilitators trained in both positive youth development and youth-adult partnership frameworks will use this knowledge to provide leadership for the councils.

MCH will continue work with the Preconception CoIIN Team to develop a new patient engagement tool focused on helping reproductive age individuals identify risks and develop goals for improving overall health. It will be used in tandem with the comprehensive Women's Health Assessment tool in pilot sites throughout the state. County health

departments will continue to utilize these tools with clients in the clinic for preventive health check-ups and pregnancy tests.

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 and preconception health issues.

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, hypertension, and opioid use/abuse.

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 work group will work towards the creation of PSA (public service announcement) videos; the goal of which is to showcase the diversity in population and experience of individuals impacted by these diagnoses in the state. In conjunction, efforts will be underway to explore awareness raising events to showcase the "blue dot" symbol, currently used with permission by the organization "2020 mom".

There will also be an effort to bring perinatal mental health certification training to Oklahoma, to increase the number of informed and trained clinicians available to treat these concerns.

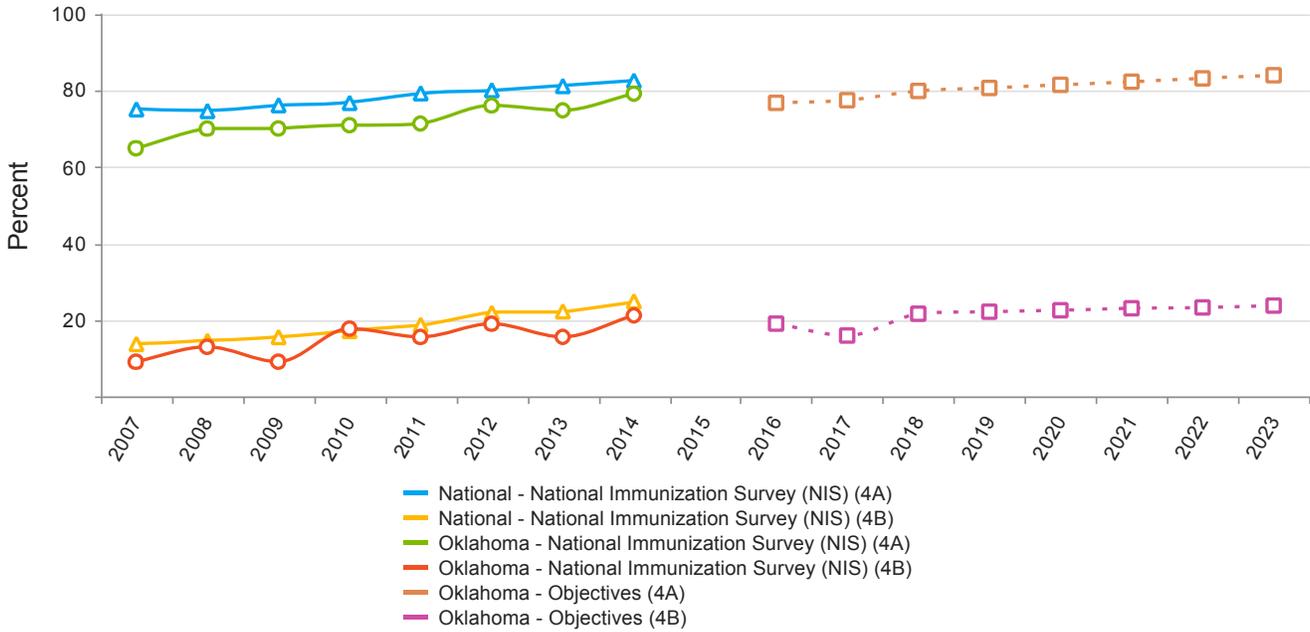
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	7.3	NPM 4 NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.9	NPM 4 NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	148.7	NPM 4 NPM 5

National Performance Measures

**NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months
Baseline Indicators and Annual Objectives**



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	76.7	77.4
Annual Indicator	74.7	79.2
Numerator	38,593	41,230
Denominator	51,646	52,032
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	79.8	80.6	81.4	82.2	83.1	83.9

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	19.1	16
Annual Indicator	15.7	21.3
Numerator	7,715	10,883
Denominator	49,145	51,056
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	21.7	22.2	22.6	23.1	23.3	23.8

Evidence-Based or –Informed Strategy Measures

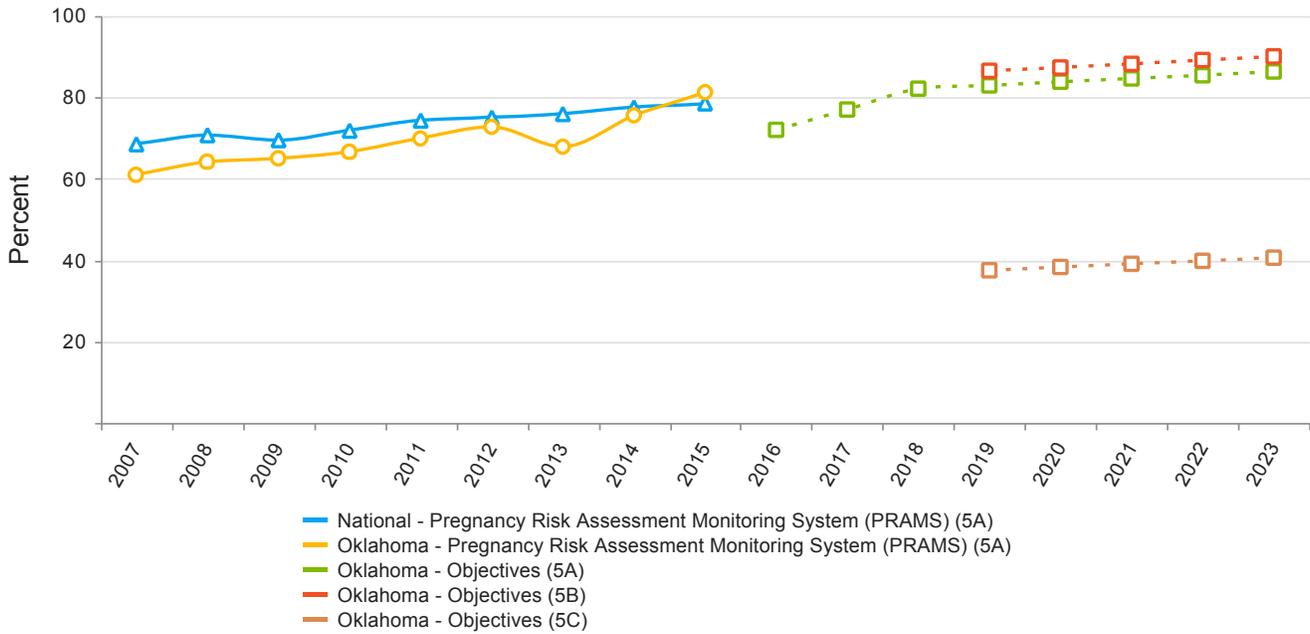
ESM 4.1 - The percentage of births occurring in Oklahoma birthing hospitals designated as Baby-Friendly

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

State Provided Data		
	2016	2017
Annual Objective		15.6
Annual Indicator	14.8	15.7
Numerator	7,767	7,864
Denominator	52,607	50,008
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	16.0	16.3	16.7	17.0	17.3	17.7

**NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Baseline Indicators and Annual Objectives**



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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	2017
Annual Objective	71.9	76.9
Annual Indicator	75.4	81.2
Numerator	37,018	40,173
Denominator	49,130	49,458
Data Source	PRAMS	PRAMS
Data Source Year	2014	2015

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	82.0	82.8	83.7	84.5	85.3	86.2

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

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	85.5
Numerator	
Denominator	
Data Source	Pregnancy Risk Assessment Monitoring System
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	86.4	87.2	88.1	89.0	89.9

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

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	36.8
Numerator	
Denominator	
Data Source	Pregnancy Risk Assessment Monitoring System
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	37.5	38.3	39.1	39.8	40.6

Evidence-Based or –Informed Strategy Measures

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

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

State Provided Data		
	2016	2017
Annual Objective		70.6
Annual Indicator	70.2	70.5
Numerator	36,926	35,244
Denominator	52,607	50,008
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	71.2	71.9	72.6	73.4	74.1	74.8

State Performance Measures

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

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

State Provided Data		
	2016	2017
Annual Objective		7.3
Annual Indicator	7.4	7.6
Numerator	391	379
Denominator	52,607	49,971
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	7.5	7.3	7.2	7.0	6.9	6.7

State Action Plan Table

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

Priority Need

Reduce infant mortality

NPM

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

Objectives

1. Increase the percent of mothers who breastfeed their infants at hospital discharge from 75.0% in 2013 to 85.0% by 2020.
2. Increase the percent of mothers who breastfeed their infants at 6 months of age from 41.4% in 2014-2016 to 44.0% 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 9.1 - 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 2

Priority Need

Reduce health disparities

NPM

NPM 4 - A) Percent of infants who are ever breastfed 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 promote breastfeeding among African American mothers and families.

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

Participate in the National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-IIN). [New Strategy]

Partner with NAPPSS-IIN and the Safe Sleep Work Group to develop an online comprehensive breastfeeding education training for maternal newborn providers which will address best breastfeeding and safe sleep practices. [New Strategy]

ESMs

Status

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

Active

NOMs

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

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

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

Priority Need

Reduce infant mortality

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

1. Increase the number of hospitals participating in the Safe Sleep Sack Program from 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

Priority Need

Reduce health disparities

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

1. Increase the percent of American Indian and African American births in hospitals participating in the Safe Sleep Sack Program, from 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 a caregiver survey between one month and three months post distribution.

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

NOMs
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.5 - 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

SPM 1 - 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.
3. Reduce prevalence of substance-exposed newborns. [New Objective]

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.
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.).
3. Participate in work groups focused on reducing neonatal substance abuse in Oklahoma. [New Strategy]

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

Priority Need

Reduce health disparities

SPM

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

Objectives

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

Strategies

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

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

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

Priority Need

Reduce infant mortality

SPM

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

Objectives

MCH will evaluate and (potentially) revise the Preparing for a Lifetime, It's Everyone's Responsibility statewide infant mortality reduction initiative, as it approaches its 10th year. [New Objective]

Strategies

Review data on key contributors to infant mortality to determine what, if any, changes are necessary to work groups and programs to further address the high infant mortality rate in the state. [New Strategy]

Determine if there are emerging issues that need to be addressed by the initiative. [New Strategy]

Engage new stakeholders in the Preparing for a Lifetime activities and meetings. [New Strategy]

Create new tools for public education and awareness on the factors related to infant mortality in the state. [New Strategy]

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 85.0% by 2020.

Objective 2: Increase the percent of mothers who breastfeed their infant at 6 months of age from 41.4% in 2014-2016 to 44.0% by 2018-2020.

Data:

In 2016, Oklahoma Vital Statistic data showed that 80.0% of new mothers were breastfeeding at hospital discharge, an increase from 75.0% in 2013. As a result, the target for 2020 has been increased from 78.0% to 85.0%. The Oklahoma Toddler Survey (TOTS) provided data to monitor feeding at six months duration. According to 2014-2016 TOTS data, 41.4% of women reported breastfeeding their infants to six months of age, an increase from the 34.7% rate for 2012-2014. 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 seventy individuals attended the 5th *Becoming Baby-Friendly in OK (BBFOK) Summit* with leadership teams from 22 hospitals and 19 organizations. Speakers were Melissa Bartick, MD, MSc, Harvard Medical School; Cynthia Good-Mojab, MS, LMHCA, IBCLC, Life Circle Counseling; and Becky Mannel, IBCLC, FILCA, Oklahoma Breastfeeding Resource Center (OBRC). Topics were *Breastfeeding Disparities and Social Marketing; Bias, Ethics, and the Lactation Specialist; Massachusetts Baby-Friendly Collaborative: Lessons Learned; Effective Counseling Techniques When Time is Limited; and State of the State/Updates*. The Summit included a MiniPanel: *Observations from Lactation Support Providers of Color*, a Mothers' Panel: *Mothers' Experiences with Baby-Friendly Practices*, and recognition of Oklahoma's newest Baby-Friendly Hospitals: INTEGRIS Health Edmond and St. Anthony Hospital in Oklahoma City. Eleven hospitals continued efforts towards designation. Fifteen hospitals enrolled 158 staff in OBRC's 15-hour online Baby-Friendly training.

According to the August 2017 CDC Breastfeeding Rates Update, Oklahoma increased in all five areas and in the Healthy People 2020 goals for initiation, any breastfeeding at twelve months, and exclusive breastfeeding at six months. With the addition of the Chickasaw Nation Medical Center, the number of Baby-Friendly Hospitals in the state increased to seven. Gold Star Breastfeeding Friendly Worksites rose to 178 including 26 health care facilities recognized through meetings and websites. Nine birthing hospitals received the 2017 Oklahoma Perinatal Quality Improvement Collaborative's (OPQIC) "Spotlight Hospital" recognition, which included BBFOK participation. Becky Mannel received the Warren M. Crosby *Champion for Maternal and Infant Health Award* for exemplary efforts to improve local and statewide outcomes for mothers and babies.

The WIC Breastfeeding Peer Counselor (BFPC) Program expanded trainings to Oklahoma County for WIC clinic managers, coordinators, and CEOs from Neighborhood Services Organization (NSO), Variety Care, and Hope Center Clinics. BFPC orientation was offered quarterly. Forty-five WIC BFPCs worked in 30 clinics, covering 25 counties across the state.

WIC sponsored the Breastfeeding Educator Course, led by Alabama's Glenda Dickerson, MSN, RN, IBCLC, and a

five-day Lactation Management Course in Norman, provided by *Lactation Education Consultants*. The WIC Breastfeeding Task Force (WBTF) promoted World Breastfeeding Week (WBW), National Breastfeeding Month, and Black Breastfeeding Week (BBW) with the theme *Supporting Breastfeeding – Together*, through state and community news releases. WIC clinics hosted receptions, held spirit weeks, created displays, promoted Text4Baby, and shared a variety of promotional materials to support mothers and increase breastfeeding rates. MCH, WIC, and *Coalition of Oklahoma Breastfeeding Advocates (COBA)* displayed the theme and offered materials in the Central Office lobby, promoted and staffed displays for *La Leche League (LLL) Live, Love, and Latch events* in Mustang, Duncan, Tulsa, Bartlesville, and Edmond; the Chickasaw Nation Medical Center WBW event in Ada; the *OK Lactation Consultant Association (LCA) WBW Networking Event* in OKC; COBA Baby-Cafés; and the second annual *Lift Every Baby Celebration* in Tulsa.

A statewide MCH Videoconference featuring Breastfeeding included WIC's three new public service announcements (PSAs): *Family/Doctor/Employer-Childcare Center Support*. These were posted on the OSDH *Preparing for a Lifetime, It's Everyone's Responsibility (PFL)* Breastfeeding & COBA websites and ran from August through October. COBA's chair promoted breastfeeding at the University of Central Oklahoma's Wellness Day event.

Trainings were limited due to funding issues, so the *Annual WIC Breastfeeding Symposium* was cancelled. However WIC helped to plan the statewide WIC Conference hosted by the Osage Nation, featuring Jenny Thomas, MD, MPH, IBCLC, Wisconsin pediatrician and breastfeeding medicine specialist.

Support continued for the Oklahoma Breastfeeding Hotline (OBH), providing information and referrals for over 2,200 mothers, families, and health care providers, the Hospital Breastfeeding Education (HBEP) and BBFOK Projects, and the Oklahoma Mothers' Milk Bank (OMMB). Two posters showcasing the OBH and BBFOK Project were presented in the Oklahoma Public Health Association Conference in Tulsa, and in the US LCA Conference in San Antonio, with the OBH voted Best Poster. The OMMB celebrated its fourth anniversary, serving all eight level III Neonatal Intensive Care Units. Expanding to twelve depots, OMMB increased its capacity to serve rural level II NICUs and Special Care Nurseries.

MCH promoted breastfeeding duration through a variety of venues; the Oklahoma Health Improvement Plan Child Health Group, OPQIC and PFL meetings, and National Nutrition Month activities. Work groups representing a variety of partners met quarterly to promote activities and worksite recognition. Area Coordinators assisted in creating policies, establishing mothers' rooms, and receiving recognition.

Objective 3: Improve breastfeeding duration rates among racial and ethnic minorities.

Successes:

Efforts to address disparities focused on featuring communities of color in staff recruitment, training materials, and in selection of topics and speakers. The *BBFOK Summit* featured speakers and a panel depicting and addressing disparities. Several celebrations focused on, and all included information for, communities of color. Tulsa's *Lift Every Baby Celebration*, held during BBW, was led by COBA's Chair; a representative of communities of color, as were many of COBA's leadership and WIC BFPCs. The State's multicultural population was reflected in brochures, websites, posters, and PSA's.

COBA recruited and funded training for African American and Hispanic facilitators to provide peer support in targeted populations. Baby Cafés were located on accessible bus routes and families were welcomed with healthy snacks and activities. Communication occurred through peer counselors, social media, word of mouth, websites,

birthing hospitals, health professionals, and a variety of networks (COBA, OMMB, LLL, and Thrive Mama Collective of Oklahoma City).

Challenges:

Budget issues limited trainings and attendance. More hospitals wanted to join the BBFOK project but were challenged to acquire and maintain physician and leadership buy-in. Changes in hospital priorities, such as implementing electronic documentation, redirected efforts in some hospitals for months. Competing priorities and staff reductions contributed to the loss of active work group members. As a new non-profit, the state coalition worked to recruit and train leaders to develop leadership, communication, and financial skills needed to maintain and promote ongoing and new projects.

NPM 5: A) Percent of infants placed to sleep on their backs; B) Percent of infants placed to sleep on a separate approved sleep surface; C) Percent of infants placed to sleep without soft objects or loose bedding

Objective 1. Increase the number of hospitals participating in the Safe Sleep Sack Program from 22 in 2016 to 30 in 2020.

Objective 2. Increase the number of trainings given to providers and professional organizations on infant safe sleep from 3 in 2017 to 4 in 2018.

Objective 3. Increase the number of community outreach activities by Safe Sleep Work Group 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, 2016 and September 30, 2017 approximately 22,428 sleep sacks were provided to families upon discharge from the 25 participating Oklahoma birthing hospitals.

Infant mortality rate data are the most current available. The percent of infants who were placed to sleep on their backs was 81.2% in 2015. This is an increase from 75.4% in 2014. 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:

Title V continued to support the statewide initiative *Preparing for a Lifetime, It's Everyone's Responsibility*, which remained the umbrella group for a coalition of work groups focused on reducing racial disparities in infant mortality. The Safe Sleep Work Group continued to work on the goals and objectives contained in the group's work plan. These goals met with some significant progress such as a rise in the number of participating Oklahoma birthing

hospitals in the safe sleep sack distribution program from 22 in the beginning of October 2016 to 25 by the end of September 2017. Work Group 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* Work Group's sleep sack distribution program.

The Oklahoma State Department of Health continued a portable crib and sleep sack distribution project into its second year in FFY 2016, with sustained focus on families who were unable to provide safe sleep environments for their new infants. As the African American and Native American families continued to be impacted the most disparately by infant mortality in Oklahoma, they remained the chief focus of the distribution effort. OSDH continued to work with the prior year partners: OU Children's Hospital NICU, OSDH Office of Minority Health, OSDH-contracted Home Visitation Programs, and the Oklahoma City Indian Clinic. The infant Pack-N-Plays were distributed with sleep sacks and culturally specific materials to qualified families. One hundred-fifteen cribs were distributed to families in need as of September 30, 2017.

The Oklahoma FIMR programs, Maternal and Child Health outreach workers in Tulsa County Health Department, and safe sleep work group co-lead provided safe sleep education in their communities, including providing updated training for home visitors and Department of Human Services child care licensing staff, early intervention staff, as well as other child care staff. Central Oklahoma FIMR provided train-the-trainer Infant Safe Sleep sessions that resulted in approximately 3,014 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 women and men, 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.

In regards to awareness and visibility, likely due to an increase in promotional campaigns and posts that was substantially larger than years prior, the *Preparing for a Lifetime* website saw a rise in views to 1,367 in 2017. As well, the Facebook page reached 5,865 individuals in 2017.

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. The Native American community also continues to exhibit disparities in bed-sharing when compared to the statewide population.

The amount of time needed for hospital administrative staff to review safe sleep sack agreements and finalize them

to begin to implement distribution of these to their patients was considerable and resulted in difficulty in adding additional hospitals.

Due to budget constraints, the shipping department at the Oklahoma State Department of Health began operating on a bi-weekly shipping schedule; which resulted in additional lag time between requests for sleep sacks to participating hospitals and distribution. Additional challenges were staff time and resources to meet the needs.

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

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

Data:

Prematurity remained the second leading cause of infant mortality in Oklahoma, rising slightly to 10.6% for 2016 births. This was significantly higher than the Healthy People 2020 goal of 8.1%. Disparities remained evident with Black women having a preterm birth rate of 14.0% compared to American Indian/Alaska Natives women at 10.4%, white women at 10.1%, Hispanic women at 9.4% and Asian/Pacific Islander at 9.2% (MOD 2017 Report Card).

Successes:

Two work groups of the *Preparing for a Lifetime, It's Everyone's Responsibility* initiative addressed preconception/interconception health and prematurity in Oklahoma. The Preconception/Interconception Work Group 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 impacted 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. For state fiscal year (SFY) 2017, Medicaid provided coverage for 28,159 deliveries of which 120 members received an immediate postpartum LARC, 70 received a LARC between 22 and 60 days postpartum, and 2,118 after 60 days postpartum.

The ASTHO team also focused on education for providers through the Focus Forward Initiative. After the national contract fell through for training health care providers in the state on LARC insertion, the OHCA worked with the University of Oklahoma Health Sciences Center to develop a more sustainable training program. Multiple sessions were provided over the summer with 124 providers trained. Seventy-five were from rural Oklahoma, 58% were MDs/DOs, 27% APRNs, and 69% Family Practice providers. The Oklahoma State Department of Health clinics saw a 13% increase in clients relying on Nexplanon for contraception and a 1.2% increase in IUD usage for calendar year 2016 (2017 Family Planning Annual Report).

In October 2016, the American College of Obstetricians and Gynecologists (ACOG) released updated guidelines for the management of preterm labor which no longer supported the use of fetal fibronectin (fFN) testing to determine

clinical management for women presenting with preterm contractions. The March of Dimes withdrew the Preterm Labor Assessment Toolkit based on the ACOG recommendations and the Prematurity Work Group and the Office of Perinatal Quality Improvement (OPQI) worked to ensure all hospitals were aware of the new recommendations.

In 2016, the OHCA agreed to expand the preauthorization for progesterone use to include initiation between 16 and 26 weeks. OPQI staff continued sharing information about the progesterone road map “SoonerCare Guideline for Provision of Progesterone Prophylaxis of Preterm Birth” through face-to-face meetings with OB clinicians, during the Oklahoma Perinatal Quality Collaborative (OPQIC) meetings, and on the Oklahoma OPQIC website. The progesterone guideline included information on patient identification, prescription initiation and patient management for progesterone use in SoonerCare women. Efforts also focused on creating awareness among women who had experienced a previous preterm birth of the potential need for progesterone therapy in subsequent pregnancies. Education was provided through NICU family support persons in the Oklahoma Family Network, through Text4Baby messages, and counseling for women with a positive pregnancy test in OSDH clinics.

OPQI continued work on quality improvement activities with birthing hospitals, including the continued monitoring of elimination of elective, non-medically indicated inductions and scheduled cesarean sections prior to 39 weeks of gestation. The “Every Week Still Counts” initiative provided birthing hospitals with support to maintain reduced rates for elective deliveries prior to 39 weeks. Activities for the “Every Week Counts” collaborative ended 12/31/14 as hospitals transitioned to reporting these numbers to the Centers for Medicare and Medicaid Services for The Joint Commission’s PC-01 measure “Patients with elective vaginal deliveries or elective cesarean sections at \geq 37 weeks and $<$ 39 weeks of gestation.” Oklahoma saw a 96% decrease from baseline data in Q1 2011 for elective scheduled deliveries prior to 39 weeks. From Q2 2016-Q1 2017, Oklahoma hospitals maintained an average PC-01 rate of 2% which equaled the national average.

Between August 2016 and July 2017, approximately 4,600 pregnant women in Oklahoma received a preterm risk assessment and 10% 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 changes in fFN testing recommendations and promoted usage of progesterone therapy to prevent preterm births in women with a previous preterm birth. MCH participated in and provided funding for the OPQIC.

Successes included maintaining a close collaborative relationship with MCH contractors and community partners and ensuring that developed tools and information were available to health care providers across the state through the OSDH website, the OPQIC website, the OHCA website, 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 the rising preterm birth rate at 10.6% and the drop to a “D” grade on the March of Dimes grade card in 2017 despite all the work of OSDH and community partners; 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; communicating changes to recommendations related to implementing fFN testing; 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:

In 2015, the number of births to Oklahoma females who began prenatal care during the first trimester of pregnancy reached 70.2%. The data for 2016 however shows a decline back to 68.3%, comparable to the 2013 rate of 68.5%.

Successes:

In FY 2017, 29,644 or approximately 59.3% 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. MCH continued to have a strong partnership with staff at the Oklahoma Health Care Authority (OHCA), the state agency that administers the Medicaid program.

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

MCH staff met with community prenatal care providers in efforts to identify ways to partner and improve access to prenatal care. Dr. Stevens continued providing prenatal care 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 Physicians was finalized to offer prenatal care to the clients in Lincoln County also. Currently, the Creek County clinic has been very successful but geographical limitations have prevented the Lincoln County clinic from being as successful.

CHD staff assisted clients with a positive pregnancy test in signing up for Text4Baby prior to leaving the clinic and the 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.

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 25,302 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. Canadian County 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. Screening for a history of premature birth was added to the pregnancy test counseling to help educate women with a prior preterm delivery on the importance of early prenatal care for progesterone therapy.

Challenges:

The Soon-to-be-Sooners (STBS) program was created to provide insurance coverage for women who were excluded from full Medicaid benefits due to citizenship status and consequently offers a limited benefit package which only includes prenatal care services that benefit the infant. Insurance coverage for this population ends at hospital discharge. Two years ago, STBS expanded to accommodate the changes in eligibility requirements for full Medicaid benefits and covers those women between 133% and 185% FPL leaving a larger percentage of pregnant women with limited prenatal care coverage.

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

Legislation moved forward last year for full practice authority for advanced practice registered nurses, however, it was stopped in the Health and Human Services Committee. Legislation was once again introduced in this legislative session, however it did not pass. 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. After all approvals were received and the prenatal care program in Lincoln County was initiated, distance from the delivering hospital proved to be a barrier to utilization of the program. Clients are only required to attend one visit with the delivering physician group, however, this still proved to be a barrier.

Budget shortfalls continue to impact access to care as Medicaid benefits are threatened or reduced, reimbursement is decreased, physician offices close, and rural hospitals either close or stop 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 2016 (latest data available) were screened through the Newborn Screening Program (NSP) for the disorders of phenylketonuria (PKU) and other amino acid disorders; congenital hypothyroidism; galactosemia; sickle cell disease; other hemoglobinopathies; cystic fibrosis (CF); congenital adrenal hyperplasia; medium chain acyl-CoA dehydrogenase deficiency (MCAD) and other fatty acid disorders; organic acid disorders; biotinidase deficiency, and severe combined immunodeficiency (SCID). One hundred percent of newborns received short-term follow-up (STFU) services for diagnosis and 100% of affected newborns were referred to long-term follow-up (LTFU) for care coordination services. For 2016, all 606 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 56 families received counseling with a board-certified genetic counselor. All newborns identified with an out-of-range CF screen were referred for genetic counseling (81 of the 92 received counseling). All cases of confirmed diagnosis for other newborn screening disorders were referred for genetic counseling and 12 received genetic counseling.

Successes:

Title V funding continued to support the newborn screening activities statewide. The NSP, housed within the Screening and Special Services Division of the 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 and Public Health Laboratory partnered with the Oklahoma Hospital Association to develop and implement a quality improvement program, "Every Baby Counts," to address delays in newborn screening. The overall goal of the QI program was to improve timeliness of newborn screening through collaboration with birthing hospitals and the contracted courier service to improve transit time (the time it takes for specimens to arrive at the PHL from the time of collect). The QI program included providing educational Web-Ex sessions for all birthing hospitals, development and dissemination of quarterly transit time reports to birthing hospitals and expansion of courier services provided.

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 and Coordination (CATC) Program, the Home Visitation Leadership Advisory Council (HVLAC), and the Office of Minority Health.

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 improving newborn screening timeliness included engagement from every birthing hospital with the QI program and identifying a champion at each facility.

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

Perinatal/Infant Health - Application Year

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

Mothers' room and worksite policy information will be shared on the agency intranet, bulletin boards, websites, and trainings, serving as models for state and community agencies and worksites. Efforts will continue to promote and increase Recognized Breastfeeding Friendly Worksites.

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

MCH will partner with OUHSC to support and promote the 24 hour OBH through a variety of outlets and settings. With others, MCH will continue to fund the OMMB to provide donor human milk for preterm and fragile infants.

Through a MCH contract, the HBEP will offer in-person evidence-based education with staff trainings, train-the-trainer sessions, ongoing technical support, and resources. MCH will collaborate with WIC, COBA, the Oklahoma Health Care Authority (OHCA), the Oklahoma Hospital Association, the OUHSC Office of Perinatal Quality Improvement (OPQI), the OPQIC, and the HBEP to promote Baby-Friendly designation for birthing hospitals.

MCH and partners will promote COBA's community support efforts, including INTEGRIS hospital based *Milk Bars*.

Breastfeeding and Safe Sleep Work Groups will participate in the National Action Partnership to Promote Safe Sleep Improvement and Innovation Network (NAPPSS-IIN). Work will include creating an online training for birthing hospital staff to promote best practices in both areas.

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 the annual March of Dimes walk, county health fairs, and Facebook postings.

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.

There will continue to be an emphasis on reducing racial disparities in Safe Sleep by addressing racial and ethnic specific communities, training community leaders, requesting auditing of the hospital practices as well as the education efforts, providing cribs and sleep sacks and culturally specific materials.

The Safe Sleep Workgroup will continue to increase the number of hospitals educated in infant sleep safety and participating in the sleep sack distribution program. The workgroup will provide continued safe sleep education; and will implement a requirement for the hospitals participating in the sleep sack distribution program to audit their internal practices as well as a conducting twice a year safe sleep education audit. The proposed safe sleep education audit tool specifically will address the new national performance measures with the questions, "What safe sleep options are in the home" with the choices of "checkbox" answers *crib, bassinet, pack n play* (along with a checkbox for 'education provided'); and the question "Will stuffed animals, toys, pillows, quilts, blankets, wedges, positioners, or loose bedding or bumpers be in the infant's sleep environment?" with "checkbox" answers *yes or no* (along with a checkbox for 'education provided').

Regarding the new performance measure *percent of infants placed to sleep on a separate approved sleep surface*, there are plans to purchase more cribs in order to extend the crib distribution project that should positively impact this measure. Additional partners are also being sought to participate in the distribution of cribs to the families. There are ongoing efforts to include the Choctaw Nation as a partner and distributor of portable cribs to the families in need served by the Nation. In discussions around other areas for expansion of portable cribs distribution a concerted effort will be made to target more rural populations in the southeast and southwest portions of the state as well urban centers, as these areas do have disproportionately larger Native American and African-American populations respectively and are the two largest populations impacted by SUID deaths in Oklahoma.

MCH will work with partners to evaluate, revise, and renew interest in the *Preparing for a Lifetime* initiative to further efforts to reduce infant mortality in the state.

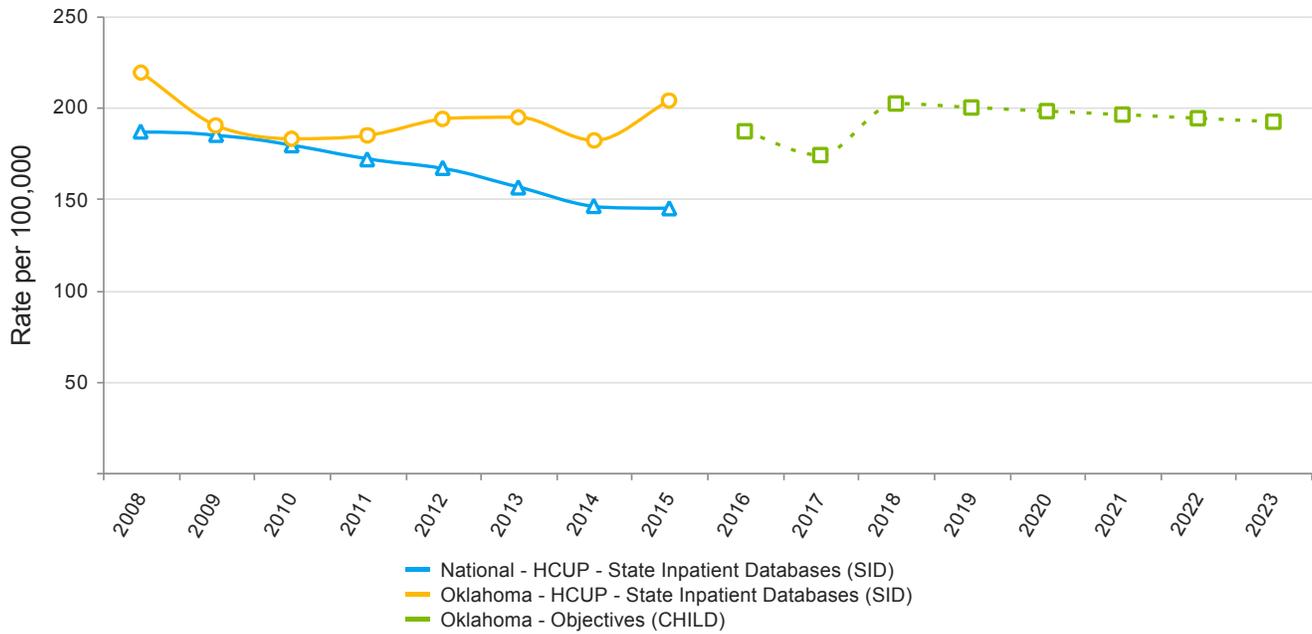
Child Health

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-2016	24.7	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	43.8	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	19.2	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	15.0	NPM 7.1

National Performance Measures

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9
Baseline Indicators and Annual Objectives



Federally Available Data

Data Source: HCUP - State Inpatient Databases (SID)

	2016	2017
Annual Objective	186.8	173.8
Annual Indicator	177.3	203.9
Numerator	951	823
Denominator	536,332	403,600
Data Source	SID-CHILD	SID-CHILD
Data Source Year	2014	2015

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	201.9	199.8	197.8	195.9	193.9	192.0

Evidence-Based or –Informed Strategy Measures

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

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

State Provided Data		
	2016	2017
Annual Objective		86.5
Annual Indicator	86.5	87.1
Numerator	45,490	43,576
Denominator	52,607	50,008
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	88.0	88.9	89.7	90.6	91.5	92.5

State Action Plan Table

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

Priority Need

Reduce the incidence of unintentional injury among children

NPM

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

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. Continue CLICK for Babies outreach activities, and expand project to 2 new community partners by 2020. [Revised Objective]
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 26.6% in 2016 to 23.9% 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 7.1.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum	Active
--	--------

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

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

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

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 - 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 41 as of September 30, 2017; the program added one new hospital in Owasso, Oklahoma.

Successes:

The Injury Prevention Work Group 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.

Hospitals were given the option to request the PURPLE application (or app) for families, in addition to the DVD. The National Center on Shaken Baby Syndrome began updating the app so it would be more appealing to new families.

Several presentations were given by staff and partners during this time on the Period of PURPLE Crying, abusive head trauma and the crying curve experienced by infants. Staff at Child Welfare offices, WIC, and tribal health organizations participated in trainings to encourage awareness and education for new families, including foster parents. DVDs were handed out to all participants to share with clients and help reinforce the message. Community groups in the Tulsa area were provided information via The Parent Child Center, a member of the Injury Prevention Work Group and partner in the PURPLE program.

Oklahoma received a State Jurisdiction Award in April, for outstanding implementation of PURPLE, during the Child Abuse Prevention Day at the Capitol Ceremony. Over 85% of Oklahoma infants were born in a hospital providing education on the Period of PURPLE Crying, to reduce the incidence of abusive head trauma.

The Injury Prevention Work Group also participated in Child Abuse Prevention Month activities in April. Members created a Blue Ribbon Tree with teachers and preschoolers at a local child development center, shared information on the MCH Facebook page, and promoted the month's events with partners.

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 and staff turnover 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 Work Group 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. [Revised for 2019 Action Plan to say "Continue CLICK for Babies outreach activities, and expand project to 2 new community partners by 2020."]

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 over 65,000 knitted caps to send to hospitals.

Successes:

The increase in cap donations was largely due to the success of social media and the new marketing materials created by OSDH Communications staff which prominently displayed the phrase “Knit a cap and save a baby!” on a deep purple skein of yarn with knitting needles. CAH and Injury Prevention staff spent August-October 2017 answering media calls, emails, phone calls and even handwritten letters. Mailroom staff was incredibly patient considering the influx of thousands of unforeseen packages.

MCH and Injury Prevention Work Group staff responded to television, print, and social media news requests, providing information about CLICK, knitting patterns, crying patterns for infants, abusive head trauma, and ways to support new parents. Over 2,700 different donors sent caps to Oklahoma from all over the world. A cap was received from every continent except Antarctica and caps were received from every state except one. Knitters in Puerto Rico responded even in the midst of the hurricanes. For staff it was a joyous, although sometimes overwhelming, experience. The stories and notes enclosed with the caps demonstrated how deeply this subject, crying infants who at times are inconsolable, resonated with families across the nation and the world. At the time it was the most popular social media post the OSDH had ever had (it has since been overtaken by a measles exposure in the state). Opening packages of caps became a source of respite as financial issues at the agency became worse; different divisions requested packages to open during staff meetings, staff in other areas and other agencies participated in washing and tagging the caps.

Perhaps the best summation of the experience can be found in some of the hundreds of letters from knitters. To quote a few: “I was happy to help with the project. I know the stress and concern that a crying baby causes but I also know how short that time seems when they are grown. Hopefully these caps will help.” And, “Both of our children were babies who had three month colic. We tried everything...[changed my diet]...washed their clothes in special organic detergent. We rock[ed], sang, drove them around. We ran the dryer...We prayed. At three months they stopped crying. We hope parents receive these hats with love and the knowledge that time is on their side. This too shall pass. Place the baby in a crib and take a shower. The baby will be fine (probably still crying...but at least you will be clean). With hope...”

Challenges:

This year the primary challenge was having the storage space to keep all the excess caps for subsequent years’ dissemination and finding volunteers to help wash the caps to prepare them for the hospitals. Staff time to do work other than count, sort, and wash caps was also limited during September, when the majority of the caps were received.

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:**

Two trainings on distracted driving were provided during the year. Adolescent Health Specialists (AHS) provided information on Graduated Driver’s License at the Back to School Bash August 2017. AHS held a Distracted Driving presentation at the local community public library as well.

Successes:

Materials were given to the AHS on distracted driving and the graduated driver’s license law in July 2017 to take back to their communities to distribute. Materials were distributed to the AHS to hand out in their communities about distracted driving.

Challenges:

Difficulty scheduling classroom time for distracted driving presentations due to full school schedules and challenges in getting adults to attend community Distracted Driving presentation despite evening time and social media advertisement were noted.

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

The number of hospitalizations for nonfatal motor vehicle injuries for children ages 0-19 in 2015 (latest data available) was 401, a slight increase from 2013.

Successes:

MCH continued to provide funding to Injury Prevention Service (IPS) to support the purchase of car seats and booster seats. These seats were distributed by certified Child Passenger Safety (CPS) technicians at the county health departments and at the Central Office to families who qualified for assistance. The CPS technicians also assisted families who had a car seat but needed help with installation.

The Early Childhood Coordinator in the Child and Adolescent Health (CAH) Division of MCH, a CPS technician, installed car seats for families at the Central Office approximately 2-3 times a week for a total of 148 car seats installed from October 2016 through September 2017. In addition, the MCH technician helped staff a Safe Kids Car Seat Check during Child Passenger Safety Week in September and installed approximately 15 car seats.

MCH staff assisted with the Safe Kids booth at the OKC Dodgers baseball game in June 2017, handing out car seat safety information in an interactive format to approximately 125 individuals. On July 28, 2017 CPS technicians from IPS and MCH helped staff a car seat safety booth at the Annual Health and Wellness Expo at Children's Hospital. Over 100 families with young children learned about correct use of car seats and where to obtain a car seat or booster seat if they needed one.

Challenges:

It was a challenge meeting the needs for car seat installations at the OSDH Central Office with the departure of one of the Injury Prevention CPS technicians in the summer of 2017.

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

For the calendar year 2017, the Poison Control Hotline received an average of 3,092 calls per month, a slight decrease from the anticipated 3,300 calls per month. These calls included both confirmed exposures and confirmed non-exposures to humans and animals and calls requesting information on medications.

Successes:

During this fiscal year the Poison Control Hotline changed their branding and name to become the Oklahoma Center for Poison and Drug Information, to better reflect the work they do and the assistance they can provide to callers and the public. Each month the Oklahoma Center for Poison and Drug Information provided training opportunities for physicians, pharmacy and nursing students, trainings for child care 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 26.6% in 2016 to 23.9% by 2020.

Data:

According to 2016 National Survey of Children's Health, 26.6% of Oklahoma's children 0-17 years experienced two or more adverse family experiences. Because of the change in the survey questions, and therefore the lack of comparable data, the Objective has been changed from the previous 2011/2012 data to 2016 data.

Successes:

The MCH Early Childhood Coordinator mailed out 24 printed copies of *The Good Health Handbook: A Guide for Those Caring for Children, Revised 2015* to child development centers, Head Start programs, public schools and tribal child care organizations as requested from October 1, 2016 through September 30, 2017. The Early Childhood Coordinator conducted three training sessions to early childhood college students and provided them with a printed copy. MCH also supplied the Oklahoma Family Network with 10 copies to share with families as needed.

The MCH Early Childhood Coordinator served on the Oklahoma Head Start Early Childhood Collaboration Advisory Board and attended meetings in October, February, and June. The Advisory Board was established to provide input to and receive updates on the strategic plan of work and activities of the Oklahoma Head Start State Collaboration Office (HSSCO). The Board met according to schedule, three times per year, with ongoing communication between meetings. The membership of the advisory board continued to be composed of representatives of these priority areas: Health and Mental Health Care; Child Care; Education; Professional Development/Higher Education; Welfare (TANF); Child Welfare; Community Services; Family and Financial Literacy Services and Reading Readiness Programs; Activities related to Children with Limited English Proficiency; Activities relating to Children with Disabilities; and Services to Children who are Homeless. The MCH Early Childhood Coordinator also continued to assist the Oklahoma Partnership for School Readiness with kindergarten assessments, attended board meetings, and helped assure health remained a priority area for the group.

The MCH Early Childhood Coordinator began participating in the Oklahoma Tribal Child Care Association (OTCCA) quarterly meetings in March of 2017 and was put on the agenda to report information and updates. The OTCCA is a representative American Indian and Alaska Native organization serving the 36 tribal Child Care Development Fund (CCDF) grantees that represent Tribal communities across Oklahoma. The first half of the meeting consists of the Tribal/State Early Childhood Network which includes reports from agencies, contractors, and additional resources. At the March, June, and September 2017 meetings the MCH Early Childhood Coordinator provided information and resources on safety, health, and nutrition for the tribal child care entities to share with the families they serve.

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. It is of concern that the printed copies of the Good Health Handbook are running low and budget cuts may make it difficult to justify printing more copies.

Child Health - Application Year

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

CLICK hats will be tagged and distributed to PURPLE participating hospitals and the 2019 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.

MCH will continue to provide funding to Injury Prevention Service (IPS) to support the purchase of car seats and booster seats. These will continue to be distributed through the county health departments as well as the state office building, to families that qualify for assistance.

The MCH Early Childhood Coordinator will maintain CPS certification, begin work toward completing the CPS Instructor Candidacy, and assist with teaching the one day child passenger safety training to child care providers and the nurse home visitation program, as well as the full three-day CPS technician course.

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 the *Good Health Handbook: A Guide for Those Caring for Children* and the training sessions on utilizing the 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 2019.

The Early Childhood Coordinator will continue to participate in OTCCA quarterly meetings, bringing information and resources for the tribal child care programs and the families they serve. The Coordinator will also continue to assist the Oklahoma Partnership for School Readiness.

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.

Adolescent Health

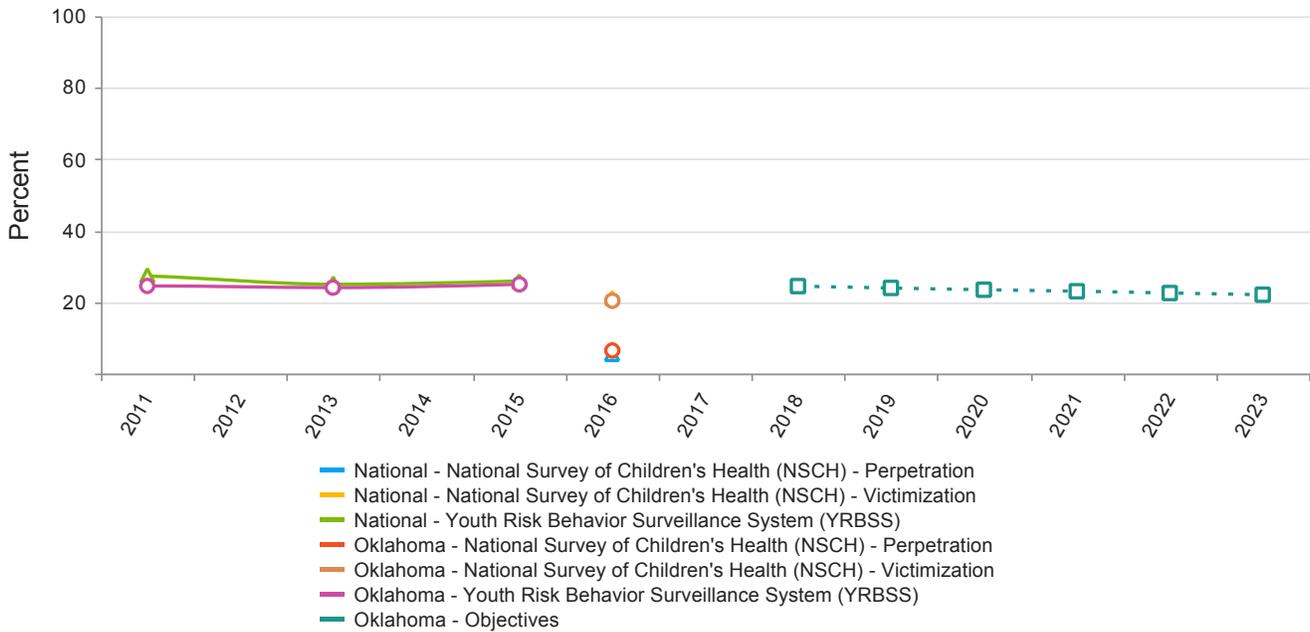
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2016	43.8	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2014_2016	19.2	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2014_2016	15.0	NPM 9 NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	14.5 %	NPM 12
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016	51.9 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	90.5 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	18.1 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	13.8 %	NPM 10
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2015	17.3 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2016_2017	53.6 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISF-2016	63.8 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NISM-2016	50.3 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2016	89.6 %	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-2016	73.6 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	33.4	NPM 10

National Performance Measures

**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: Youth Risk Behavior Surveillance System (YRBSS)

	2016	2017
Annual Objective	23.9	23.6
Annual Indicator	25.0	25.0
Numerator	44,898	44,898
Denominator	179,440	179,440
Data Source	YRBSS	YRBSS
Data Source Year	2015	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2017
Annual Objective	
Annual Indicator	6.7
Numerator	20,257
Denominator	303,088
Data Source	NSCHP
Data Source Year	2016

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Victimization	
	2017
Annual Objective	
Annual Indicator	20.6
Numerator	62,195
Denominator	301,280
Data Source	NSCHV
Data Source Year	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	24.5	24.0	23.5	23.1	22.6	22.1

Evidence-Based or –Informed Strategy Measures

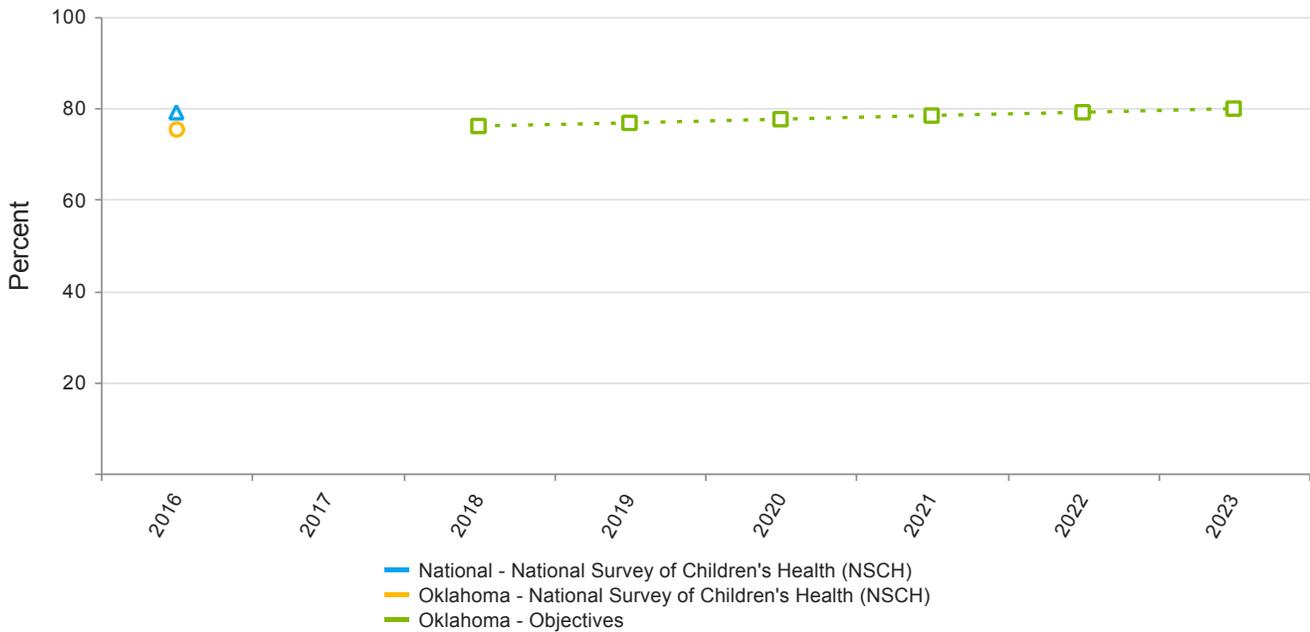
ESM 9.1 - The number of trainings provided by MCH to school staff on bullying prevention

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

State Provided Data		
	2016	2017
Annual Objective		4
Annual Indicator	3	3
Numerator		
Denominator		
Data Source	MCH Training Log	MCH Training Log
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	5.0	6.0	7.0	8.0	9.0	10.0

**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	2017
Annual Objective		
Annual Indicator		75.2
Numerator		229,371
Denominator		304,952
Data Source		NSCH
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	76.0	76.7	77.5	78.3	79.0	79.8

Evidence-Based or –Informed Strategy Measures

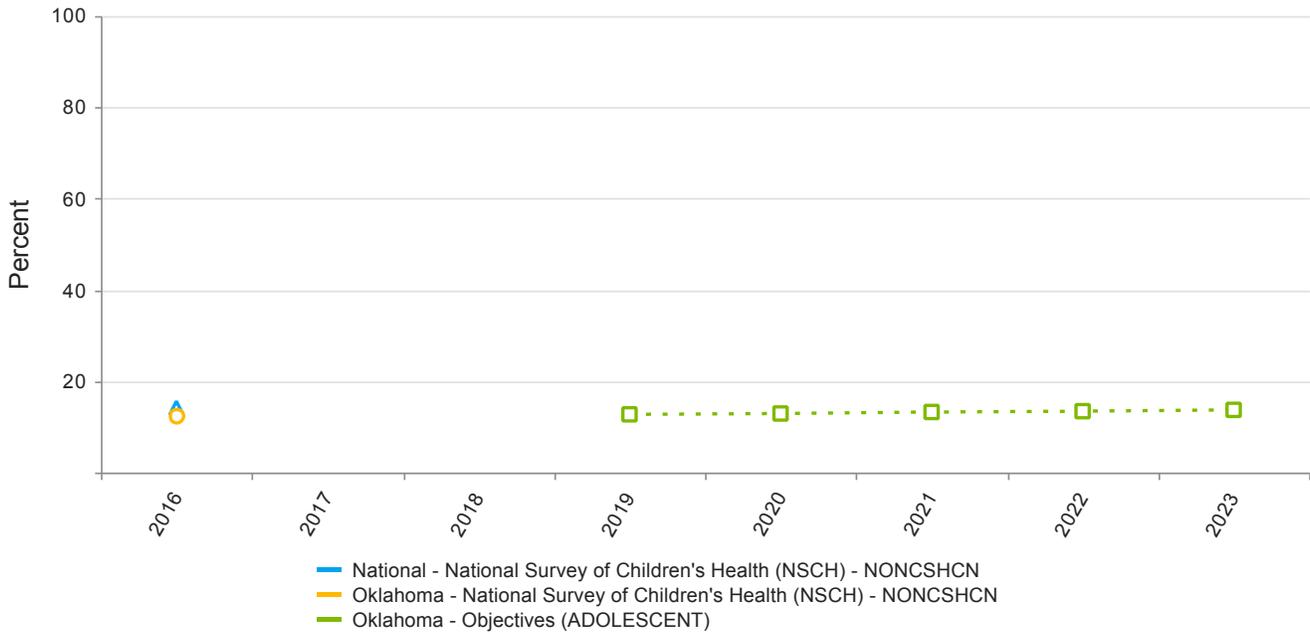
ESM 10.1 - The number of adolescents trained on Teen Pregnancy Prevention/Positive Youth Development curriculum

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

State Provided Data		
	2016	2017
Annual Objective		4,300
Annual Indicator	3,350	4,389
Numerator		
Denominator		
Data Source	MCH PREP Program	MCH PREP Program
Data Source Year	2016	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4,500.0	4,700.0	5,000.0	5,200.0	5,400.0	5,600.0

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



NPM 12 - Adolescent Health - NONCSHCN

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN	
	2017
Annual Objective	
Annual Indicator	12.5
Numerator	26,234
Denominator	210,453
Data Source	NSCH-NONCSHCN
Data Source Year	2016

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	12.8	13.0	13.3	13.5	13.8

Evidence-Based or –Informed Strategy Measures

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

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

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	94	164
Numerator		
Denominator		
Data Source	Sooner Success	Sooner Success
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	170.0	178.0	187.0	197.0	207.0	217.0

State Action Plan Table

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

Priority Need

Reduce the incidence of suicide among adolescents

NPM

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

Objectives

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

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

Objectives

1. Increase by 5% annually the number of adolescents participating in state or federally funded evidence-based teen pregnancy prevention programs (Baseline: 4,145 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 8.0% in 2013 to 10.2% 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. 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.

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.
- 4a. Identify areas of highest need based on most current data available.
- 4b. Partner with county health department regional directors in the areas of highest need to begin targeted prevention efforts.

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

NOMs
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

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

Priority Need

Reduce health disparities

NPM

NPM 9 - 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 2019.

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 2019.

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

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

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

Objectives

Increase activities and public awareness on the topic of transition to adulthood for all youth in Oklahoma. [New Objective]

Strategies

Add information to the MCH webpages and Facebook page on the importance of transition to adulthood, and how to prepare as a parent and a healthcare provider. [New Activity]

Incorporate transition information into presentations, activities of Adolescent Health Specialists and Adolescent Health Coordinator. [New Activity]

ESMs

Status

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

Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

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 14.5 in 2016. In 2016, disparities were observed by gender as males had a suicide rate six times that of females at 24.4 and 3.9, respectively. However, data from the 2017 Youth Risk Behavior Survey (YRBS) indicated that females were significantly more likely than males to have attempted suicide in the past 12 months at 15.7% and 6.2%, respectively.

Four trainings were provided by Title V-funded staff on suicide prevention or positive youth development. However, due to the loss of staff in the counties from budget shortfalls and a reduction in force, the Objective will not change.

Successes:

MCH and Injury Prevention Service (IPS) staff attended the Suicide Prevention Council meetings monthly. MCH staff served on the planning committee for the Annual Suicide Prevention Conference April 2017.

Adolescent Health Specialist (AHS) in the rural area of the state provided Positive Youth Development training to clients in Gateway to Prevention and Recovery October 2016.

MCH collaborated with partners and wrote a suicide brief to promote awareness and avenues for prevention activities.

AHS assisted with Question, Persuade, and Refer (QPR) training to county health department leadership in March 2017 with 17 in attendance. QPR training was provided to Pittsburg County Health Department staff the same month with 40 in attendance. An additional QPR training was held for OSDH nurses in July.

MCH created a banner and television slide for Suicide Prevention Month to display in the lobby of OSDH to the public and on the intranet for employees throughout the month of September 2017.

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

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

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.

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:

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

Successes:

MCH increased the number of Public Health Youth Councils (PHYC) to four in Lincoln County, Seminole County and Atoka County. In all 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 adolescent health issues including suicide prevention, teen pregnancy prevention and wellness. PHYC facilitators utilized both the positive youth development (PYD) and the youth-adult partnership (YAP) models.

The Varnum PHYC participated in Seminole County suicide prevention efforts by distributing over 60 gun locks and medication destruction pouches to the community.

In March 2017, MCH provided training for 13 county/state office staff on developing and facilitating PHYC and the importance of the YAP model.

In April 2017, MCH provided training for Canadian County Health Department staff and other interested community partners on developing Public Health Youth Councils; the training had 12 participants in attendance. MCH staff provided resources and offered technical assistance to all PHYC training participants.

The Adolescent Health Specialists continued to have goal-oriented monthly video-conferences with the Adolescent Health Consultant to formalize plans and report on activities for recruitment for the current and upcoming school year.

Challenges:

One Adolescent Health Specialist (AHS) was on leave during the last quarter of 2016; another AHS only worked part-time due to family needs, and then retired in September 2017. Inability to fill a vacant AHS position in Eastern Oklahoma, due to budget cuts, led to the placement in May of an existing county health department nurse as a part-time AHS in a rural county with high teen birth rates; this position was unable to start a PHYC due to time constraints.

Three AHS actively worked to start PHYCs in their areas. Two did not receive any student applications; however, one started September 2017. Feedback received from participants following the PHYC training was the inability to commit enough time to start and then facilitate a PHYC due to level of current workload and staff reductions due to budget deficits.

Objective 3: Among county health departments, increase from 5% to 50% the sites that have the Suicide Prevention Lifeline Number displayed in their lobby by 2020.

Data:

All AHS staff hung posters with the hotline number in their county health department sites for staff and clients, approximately 39% of sites.

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 AHS actively participated in local suicide prevention coalitions. One MCH staff served on the Oklahoma Suicide Prevention Council.

All AHS staff hung posters in the county health departments that included the hotline number, for clients and staff. AHS kept the county health departments within their region stocked with the Lifeline Wallet Card. Distribution of materials within the AHS regional county health departments was not an issue.

Challenges:

Due to staff turnover and budget cuts the ability to access and distribute posters to counties without AHS was limited.

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:

Thirty-two of the 1,807 sites for fiscal year 2017 (most current data available) did 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 was 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. For the 2017-2018 school year, due to decreased funding to schools, the legislature allowed schools to defer the requirements for Safe Schools Committees and for Healthy and Fit School Committees without penalty.

The School Health Educator provided one in-school training to students on bullying prevention and the Adolescent Health Educator provided one in-school training to educators in Sulphur, Oklahoma.

The MCH School Health Educator and Coordinator attended the monthly Anti-Bullying Coalition (ABC) meetings in both Tulsa and Oklahoma City when schedules allowed. However, in September 2017 the School Health Educator left the agency, and because of budget issues within the agency, MCH was not allowed to refill the position.

The eleven school nurses working in nine rural school districts funded by the MCH Title V Block Grant have partnered in their communities with the Cherokee, Choctaw, Creek, 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 bullying prevention presentations at elementary schools in their area, reaching 345 school staff, students, and community resource partners. The *It's All About Kids* program provided 18 classes and assemblies on bullying prevention for grades Pre-K through 8th grade, reaching a total of 4,474 students.

OSDH provided trauma informed classroom training to school nurses in August 2017, reaching 75. OSDH also presented bullying recognition, intervention, and prevention training to regional school bus drivers during their spring training session in Altus, Oklahoma.

MCH began working with the Oklahoma Department of Mental Health and Substance Abuse Services on developing online resources for schools, communities, and parents on addressing issues of childhood trauma, including bullying recognition, intervention, and prevention.

Challenges:

Turnover at OSDE made scheduling bullying prevention programs challenging for the School Health Educator. Loss of the School Health Educator and loss of the OSDE Prevention Specialist during this time significantly reduced the ability to provide training to school staff as mandated by law.

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

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

Data:

Teen birth rates for 15-19 year olds were at historic lows in Oklahoma and declined 42% over the past 15 years from 57.8 births per 1,000 females aged 15-19 in 2001 to 33.4 in 2016. However, Oklahoma's teen birth rate declined at a slower pace than the national average, which decreased 55% during the same time span. In 2016, older teens in Oklahoma, aged 18-19 years, had the highest birth rate at 63.1, followed by 15-17 year olds at 14.2. In 2016, there were 4,295 births to females less than 20 years old, comprising 8.2% 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 2016, 3,146 were to females' ages 18-19 years, 1,100 were to females ages 15-17 years, and 49 were to females ages 10-14 years. Compared to other states in the nation, including the District of Columbia, Oklahoma had the 2nd highest teen birth rate for 15-19 year olds, the 2nd highest teen birth rate for 18-19 year olds, and the 5th highest teen birth rate for 15-17 year olds.

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 \$601,146 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 with 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. Power through Choices (PTC) curriculum for out of home youth was implemented in two facilities.

Two MCH staff and OCCHD PREP staff attended Love Notes curriculum Training of Educators (TOE) provided by a partner agency. *Love Notes* curriculum was added to options list, and MCH updated the protocol to include the new curriculum.

Throughout the month of October 2016, 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 2017 highlighting National Teen Pregnancy Prevention Month and the National Day to Prevent Teen Pregnancy. MCH placed a banner on IRENE that recognized the month to raise awareness, provide resources and promote steps to take for prevention. 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.

A total of 3,425 students completed curricula in the Oklahoma City and Tulsa MSA through PREP. A total of 807 students completed curricula in the rural areas through Oklahoma Healthy YOUth. During this timeframe a total of 4,232 completed state and federally funded teen pregnancy prevention curricula through MCH in Oklahoma which is an increase from baseline.

Making a Difference (MAD) and *Making Proud Choices* (MPC) Curricula were upgraded to the most recent 5th edition during this timeframe. The 5th edition incorporated more inclusive language and included a trauma informed focus.

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. In March 2017, MCH held videoconference training for health department staff in all county health departments focusing on teen pregnancy prevention and sexually transmitted infections in youth.

MCH applied for and received the Pregnancy Assistance Fund (PAF) grant in the amount of \$1,360,938 to support expectant and parenting youth and families less than 24 years of age in the Oklahoma City and Tulsa MSAs. Family Resource Centers, School-based programs, *Love Notes* curriculum implementation in colleges and alternative schools, and enhanced clinic services for pregnant and parenting youth were projects designated to receive the new funding. MCH staff began administering the grant funds upon receipt.

Objective 2: Increase the number of adolescent family planning clients aged 15 to 19 who choose Long Acting Reversible Contraception (LARC) methods from 8.0% in 2013 to 10.2% by 2020.

Data:

Between October 1, 2016 and September 30, 2017, 10,535 clients ages 15-19 were seen in family planning clinics in county health departments and the two city-county health departments. Of those, 9.2% chose a LARC method, an increase from 2013.

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.

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

Challenges:

Communicating family planning services available to youth in areas where teen pregnancy prevention projects were not active or funded remained a challenge.

Objective 3: Maintain the number of available trainers statewide who have completed a training of trainers (TOT) in Oklahoma's selected evidence-based teen pregnancy prevention curricula at 12.**Data:**

Due to staff turnover, eleven staff from MCH and partner agencies were certified TOT in MAD and MPC.

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. Love Notes curriculum was added to the options staff and partners were able to utilize in the last year.

Challenges:

Challenges included staff turnover and the cost to send new staff to trainings due to budget restraints.

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 counties in Oklahoma.

Successes:

MCH maintained the number of state-funded adolescent pregnancy prevention projects in local county health departments in five areas. Five school nurses received training in the evidence-based curriculum in May 2017. Three clinic nurses received training in the evidence-based curriculum in June 2017. This additional training expanded the project into non-funded areas. All project areas used the same curriculum, upgrading to the 5th edition of MAD and MPC, and the same evaluation tools as the PREP grant recipients. Adolescent Health Specialists were trained on curricula changes as well as reporting logs. 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 Health Specialist (AHS) staff in January and July of 2017. In January, training focused on Risk/Protective Factors and Youth Engagement through a Trauma Lens, Classroom Management, and Family Planning Services training. In July, training focused on Human Trafficking: Supply and

Demand, Domestic Violence, and Protocol/Fidelity.

MCH staff attended the Wellness Now Coalition Adolescent Health Work Group 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 an Oklahoma Teen Pregnancy Fact Sheet which was distributed throughout the agency and posted on the OSDH website. The Oklahoma Teen Birth Report was updated and added to the OSDH website May 2017.

AHS shared materials and gave presentations in their community during Teen Pregnancy Prevention Month of May. The Pittsburg County AHS hosted a teen pregnancy prevention art contest for youth then displayed art work created at all five regional health departments.

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 MCH remained optional for schools. This continued to be a barrier for project implementation in some high need areas. Oklahoma remained the only state in the nation without mandatory health education in public schools.

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.

One Adolescent Health Specialist (AHS) was out on leave September through December 2016; another AHS only worked part-time due to family needs, and then retired effective September 2017. Inability to fill vacant AHS positions led to the placement of an existing OSDH clinic nurse as a part-time AHS in a rural county with high teen birth rates effective in May.

Adolescent Health - Application Year

Adolescent health will continue as a flagship issue 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.

Work with the Pregnancy Assistance Fund grant will continue, pending a new award of funds.

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.

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 and School Health Coordinator position recently vacated 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 rehire the Adolescent Health Educator position and ensure staff works closely with internal and external agency partners to increase PHYC implementation and activities across the state.

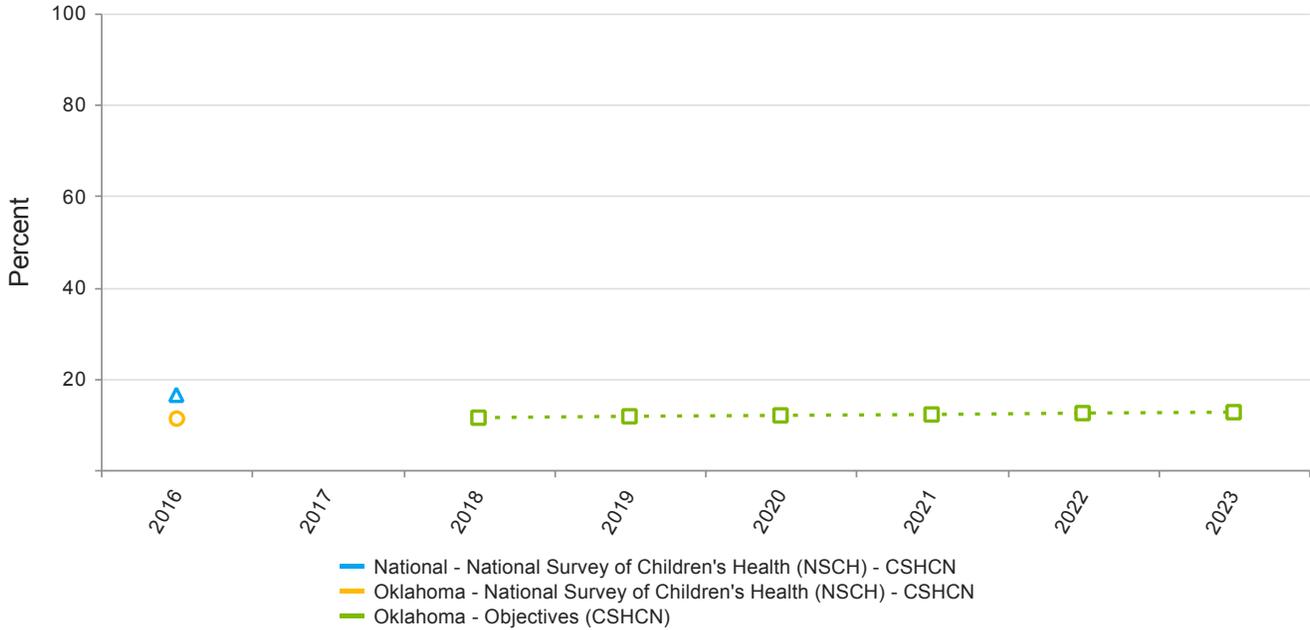
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	14.5 %	NPM 12

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care
Baseline Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		11.3
Numerator		10,795
Denominator		95,220
Data Source		NSCH-CSHCN
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	11.5	11.8	12.0	12.2	12.5	12.7

Evidence-Based or –Informed Strategy Measures

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

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

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	94	164
Numerator		
Denominator		
Data Source	Sooner Success	Sooner Success
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	170.0	178.0	187.0	197.0	207.0	217.0

State Performance Measures

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

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

State Provided Data		
	2016	2017
Annual Objective		61.9
Annual Indicator	60.7	60.7
Numerator		
Denominator		
Data Source	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2011/12	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	63.2	64.4	65.7	67.0	68.4	69.8

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

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

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 from 32% in 2017 to 35% in 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), ages 0 through 17, who receive care in a well-functioning system

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

Priority Need

Reduce health disparities

NPM

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care

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), ages 0 through 17, who receive care in a well-functioning system

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

Priority Need

Improve the mental and behavioral health of the MCH population

SPM

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

Objectives

Increase the number of children who receive behavioral and mental health services from 51.9% in 2016 to 54.9% by 2020.

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 - 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:

A recent provider survey with members of the Oklahoma Chapter of American Academy of Pediatricians conducted by Sooner SUCCESS found that 78% of practices had a process of health care transition for patients transitioning from pediatrics to adult health care services. Most such practices (95%) had procedures that were informal and unstructured. Of those practices that did not have a process, the majority (91%) made referrals for children to adult health care providers when they turn 18 years of age.

SUCSESSES:

The Oklahoma Department of Human Services' (DHS) Title V program continued to collaborate with Sooner SUCCESS (State Unified Children's Comprehensive Exemplary Services for Special Needs) to assess, develop, and disseminate Health Care Transition plans. The ultimate goal of this collaboration is to provide the essential services required to assist the adolescent population with health care transition and to develop a toolkit for primary care physicians. The toolkit, which will be available by 2020, is under development. It will include a list of family physicians and internists who are willing to accept new patients that are entering adulthood and a list of adult specialty physicians who focus on long-term care for complex advanced medical conditions.

Sooner SUCCESS piloted a community needs assessment utilizing an online survey with the Oklahoma Chapter of the American Academy of Pediatrics members. Both policy and system level information was assessed from individual clinical settings and the findings are being used to develop materials and a resource guide. These resources, along with protocol and clinical guidelines and principles, will be provided on the Sooner SUCCESS website in 2018.

A Needs Assessment with Sooner SUCCESS families was conducted. Surveys were distributed to families in Oklahoma through assistance of our partners. Insight gained from families contributed to the development of the tool kit.

The Health Care Transition Subcommittee continued to hold quarterly meetings. The Subcommittee includes partners who work with families who have a child with special needs. Partners to date are the Department of Health and Human Services Title V, Oklahoma Family Network, Family Partners, Oklahoma Pediatric Sickle Cell, Family Support 360°, Oklahoma LEND (Leadership Education in Neurodevelopmental Disabilities), Center for Learning and Leadership, Oklahoma Department of Education, Oklahoma Infant Transition Program, Department of Rehabilitation Services, Oklahoma Department of Mental Health and Substance Abuse Services, and the OU Children's Hospital's Child Life Department.

CHALLENGES:

It was a challenge to increase response rates to the surveys administered by Sooner SUCCESS. In addition, the Sooner SUCCESS family study cannot be generalized to all families of CYSHCNs in the state of Oklahoma. These families were either reached in person or efforts were made to contact them via phone calls and emails. Several families did not respond or opted to not participate. Others did not have an English speaking family member available or the child was no longer living with the family.

For the provider survey, the following were listed as primary barriers to health care transition:

- Finding adult providers who can manage children and youth with special health care needs
- Finding a physician willing to take new patients and accepting certain insurances, such as SoonerCare (Medicaid)
- Convincing patients to work with new providers
- Having female patients who need gynecological services, but may not be comfortable with male physicians
- Not consistently starting transition discussions at an appropriate age
- Transferring of patients to family physicians because families don't want to start over with a new practitioner for adult health care.
- Families having to find providers on their own
- Not having a process for health care transition for children without disabilities
- Encouraging parents to realize the importance of planning for health care transition

Objective 2. Increase number of families who are aware of need for provision of transition services from 32% in 2017 to 35% in 2020.

DATA:

Sooner SUCCESS County Coordinators made efforts to survey families of CYSHCNs in order to assess their level of awareness around timely preparation for transition of health care for their children. Thirty-two percent reported having a plan for transition to adult health care. Over half (56%) reported being concerned about their child's future health care coverage and more than two-thirds (68%) did not have a health care transition plan for their children. Most families indicated that had received limited help on health care transition.

SUCCESSSES:

Oklahoma Family Network (OFN) continued to focus on supporting families of children and youth with special needs via emotional support, resource navigation, and ensuring quality health care for all children and families through strong and effective family/professional partnerships. 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 which had 525 participants. OFN provided six scholarships for families to attend the conference and provided three trainings: one session focused on the use of Life Course tools for youth transitioning from high school, a second session trained families and professionals to facilitate sessions to plan future transition activities regionally, and the third session covered Community Resources (including behavioral health resources) for effective transition.

The Oklahoma Infant Transition Program (OITP) served infants and families in the Neonatal Intensive Care Unit (NICU) at Children's Hospital at OU Medical Center. The program focused on the family's needs for discharge and helped them connect with support services. OITP social workers managed the Tuesday Oklahoma Transition Clinic for infants who were medically fragile after discharged to home. Developmental and behavioral needs of NICU infants were addressed by assessment and discussion with families and the NICU staff. Although their primary focus continued to be centered on infancy, OITP encouraged families to begin thinking about the health care transitioning process from pediatric care to adulthood care.

OITP hosted two successful family activities weekly which included a family lunch with an inspirational or self-help speaker and scrapbooking classes for parents to gather and share NICU experiences, tips for other parents, and/or pictures of their infant. OITP taught families to prepare for the transition home and what to expect once discharged.

The speaker topics focused on transitioning home and parents sharing what they have learned. OITP increased participation in scrapbooking by approximately 15% and participation in the parent lunch by 20% over the last year. This was accomplished with the help provided by OITP's new Family Advocate. The Family Advocate meets all OITP parents and invites them to class and lunch. The addition of this position has allowed OITP to reach many parents who did not respond to professional social workers.

The Oklahoma Family Support 360° Center, serving Medicaid-eligible families with children with developmental disabilities, was limited by funding constraints to maintain acceptance of new families to 28 per year. However, the Center maintained an active enrollment of over 80 families, with the majority of these families being Hispanic and speaking Spanish as the primary language. Family Support 360° provided individualized information about health care transition to each family, depending on their needs. About 14% of the children enrolled in the program are of transitional age.

The Comprehensive Pediatric Sickle Cell Clinic at the University of Oklahoma's (OU) Medical Center's Jimmy Everest Center for Cancer and Blood Disorders in Children continued to be supported in part with Title V CSHCN funds. The Clinic provided treatment for all aspects of sickle cell disease, offering patient care, education, screening, and counseling for affected patients and their families. The clinic also assisted older patients with making the important transition from pediatric to adult sickle cell care. All patients aged 13-21 years with sickle cell disease who attended their sickle cell comprehensive clinic visit met with the transition coordinator to learn about the transition process. Another success was the formal educational lectures with pediatric residents and medical students that were given several times last year. These lectures highlighted the importance of speaking with patients and their families about health care transition.

CHALLENGES:

The Transition Institute was held during the week and many families could not attend due to work and child care concerns. OFN provided registration fees to reduce some of these barriers.

OITP outgrew its space and began looking within the hospital for additional space that is near the NICU.

Transition is a challenge for any youth, more so when that youth has a disability. Oklahoma Family Support 360° has found that this challenge can be magnified when there is a language barrier for families working through health care transition.

For the Comprehensive Pediatric Sickle Cell Clinic, it was difficult to ensure all adolescent patients with Sickle Cell Disease were seen in the Comprehensive Pediatric Sickle Cell Clinic at least once per year. In addition, it was challenging to reach all pediatricians and emergency room physicians throughout the state to discuss Sickle Cell Disease.

Objective 3. Increase number of families of CYSHCN who report receiving transition services from 11.3% in 2016 to 12.4% by 2020.

DATA:

The 2016 National Survey of Children's Health found that 11.3% of adolescents with special health care needs in Oklahoma received the services necessary for making the transition to adulthood care. The objective has been changed to reflect the new survey data results and new goal, based on the new data.

SUCSESSES:

Since October of 2015, Sooner SUCCESS has used LEAD (Listen.Empower.Advocate.Database) reports to support 1,407 Children and Youth with Special Health Care Needs. When asked about health care transition, families expressed concerns with locating practitioners who are local, experienced and trust-worthy, and able to navigate co-existing complex medical conditions and needs. Many families were concerned about affordability of care in the future as well as loss of current services. A large number of families expressed fears about their ability to maintain health insurance as well as a lack of information and referrals.

OITP increased the number of families receiving services from 200 infants in FY2016 to 306 in FY17. OITP also initiated and hosted individual care conferences for infants whose length of stay in the NICU was greater than 90 days. OITP notified the neonatologist and the family to determine what topics needed to be covered and what the barriers were to discharge home. In each care conference, the attending neonatologist, nursing leadership, primary care nurses, specialist, and staff of OITP and other members of the infant's care team were invited to discuss a plan for discharge. The team ensured the family was comfortable with the infant's plan of care and OITP then continued to facilitate a smooth transition home.

OFN provided transition information and resources to 706 individuals through multiple venues: transition care notebook documents, transition fairs in the community, and through one-on-one assistance. OFN provided registration fees for six families to attend the Oklahoma Transition Institute where they received information on how to support their youth as they transition to adulthood. As a part of the institute, families accessed a resource fair that included many types of transition related service organizations. The hope is that this will drive families to understand and access transition related services for their child.

All patients aged 13-21 years with sickle cell disease who attended their Comprehensive Pediatric Sickle Cell Clinic visit continued to meet with the transition coordinator, participated in the transition educational program, and were transitioned appropriately to adult care at the age of 21 years.

CHALLENGES:

Transition was challenging, especially in rural communities where resources and access were limited.

Follow-up with families after discharge from the NICU was difficult for OITP due to the inability to locate parents, as phone numbers were sometimes disconnected without a forwarding number.

Some of the programs or services families needed to successfully transition did not provide the application or materials in the language of the families, nor did they provide translators to assist the families, often due to budget restraints or staffing issues.

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:

This plan was still in development. Sooner SUCCESS continued to utilize Got Transition to identify and distribute existing material to clinical practices within Oklahoma, both to guide awareness of families around the relevance of health care transition and to help practices formulate a standard policy for health care transition. These efforts were further assisted by the Health Care Transition Subcommittee. Sooner SUCCESS also worked to develop a resource guide that will include a current listing of primary care and pediatric practices. Brochures, handouts, posters, and other distribution materials were begun to aid providers and families and to generate awareness and provide guidance on health care transition.

SUCSESSES:

Title V partners used a myriad of approaches to increase awareness of the need for transition related services, although no one formal plan was in place. Several Title V contractors continued involvement with the Oklahoma Transition Council. The council provided training and a quarterly newsletter to an opportunity for teams across the state to develop transition services for their community and to promote awareness of transition related services.

OFN Staff have been involved with the Oklahoma Works for All Advisory Council under the leadership of Ed Long, with Cross Sector Innovations, in partnership with Department of Rehabilitative Services, Oklahoma State Department of Education, Center for Learning and Leadership, Office of Juvenile Affairs, Oklahoma Developmental Disability Council, AbleTech and other partnering organizations. This project was a cross-sector initiative with the shared goals of improving employment outcomes for individuals with intellectual and developmental disabilities and enhancing employer satisfaction using a customized employment model. Although this model focused on employment, health care was recognized as being crucial to obtaining and keeping a job.

There were 108 adolescents that delivered infants at OU Medical Center and approximately one-quarter of these adolescents had their baby admitted to the NICU at The Children's Hospital. These mothers received services from OITP along with education and counseling about transitioning from hospital-based care, to care for themselves and their infant at home. These adolescents were making a developmental transition into adulthood with a medically fragile infant that could add stress and anxiety to their family. OITP taught these adolescents how to use family support systems and how to advocate for themselves and their infant. OITP staff participated as members of the Oklahoma Family Support Focus Group to advise and find appropriate resources for the needs of families in transition from the NICU to a medical home. OITP was also a member of the Children's Health Group for the State of Oklahoma which addressed the disparity of services for CYSCHN.

Part of the health care transition process for children soon to become adults was focused on promoting their independence. This year some of the youth served by Family Support 360° attended the Youth Leadership Forum Camp in June 2017.

CHALLENGES:

A challenge for OFN was the availability of families to attend events and transportation to the events.

A challenge for OITP was adapting information for adolescent use and developing a form of communication that is appropriate for this age group. It was also challenging to reach out and support these mothers while complying with HIPAA rules and regulations.

A challenge for Oklahoma Family Support 360° was the potential language barriers considering that a majority of clients speak Spanish.

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

Objective: Increase the number of children who receive behavioral and mental health services from 51.9% in 2016 to 54.9% by 2020.

DATA:

The 2016 National Survey of Children's Health (NSCH) found that 39.2% of families with children with special health care needs in Oklahoma had difficulties accessing mental health treatment or counseling. According to NSCH,

51.9% of children 3-17 years of age with a mental or behavioral health condition received treatment or counseling.

SUCCESSSES:

OFN maintained eight regions staffed by trained family leaders of CYSHCN who assisted families in accessing mental health and substance abuse services. Close relationships with Oklahoma Department of Mental Health and Substance Abuse Services, the Oklahoma Health Care Authority, Oklahoma Systems of Care sites, and other behavioral health providers allowed OFN staff to connect families and youth to the behavioral health services needed.

OFN provided access to free registrations, hotel rooms, child care stipends, and mileage so that families could attend the 2017 Oklahoma Children's Behavioral Health Conference. Families gathered the evening before for resource information, encouragement, and upcoming training opportunities. Conference sessions included gaining access to educational and health services for children/youth/young adults with behavioral health concerns. A national speaker, Jerry Tello, demonstrated the healing and transformational power of honoring interconnected stories of individuals and how to share personal stories with providers to ensure children receive needed services. Behavioral health interventions for school-aged children were shared as well as effects of youth trafficking in Oklahoma. Families learned of statewide services available to them and their children and gained access to other families for support and information of children and young adults with behavioral health conditions.

Support Groups were provided by OFN in five regions of the state for families of children/young adults with behavioral health and other conditions and birth families attempting to reunify with their children in custody that have behavioral health conditions. Two Sib Shops for siblings of children with behavioral health conditions were provided as well. Both types of groups brought access to emotional support and resources in their region to further support their youth with behavioral health concerns.

OFN provided book parties and other gatherings for groups of families who have children ages 0-5 to encourage attachment and strong relationships with their children, early literacy skills building, and positive infant and early childhood mental health. The gatherings included resource information, a book to take home with handouts on how to engage their child by reading, connections to behavioral health services, if needed, and time for families to encourage one another.

OFN hosted or joined partners to host community events to increase awareness of services and supports available to families of children and young adults with behavioral health concerns at 195 events with an average of 50 community members. Each participant received information regarding Title V and other services. One of those events was a booth at the Behavioral Health Day at the Capitol where OFN provided outreach to approximately 300 individuals.

Sharing stories continued to be an important way to increase awareness about the need and promote access to services. Two staff members shared their stories at the Indian Child Welfare Workers Conference. Three staff shared their story at the CREOKS Behavioral Health Agency all staff training. Two staff members shared their story for three different counties' child welfare workers. Two family leaders received coaching and shared their stories to Oklahoma Health Care Authority staff.

OFN staff have partnered with Systems of Care sites and Child Welfare providers to assist in the reunification of birth families and their children. Most of these children were under five years of age and have serious behavioral issues and often have a developmental delay as well. Assistance with Lifecourse Tools, identifying providers and appropriate placements have been provided. OFN staff and volunteers kept in contact with the families between meetings for encouragement and provided encouraging activities such as preparing Easter baskets and Mother's

Day cards for their children. The long term goal for OFN continued to be to develop a network of volunteer support parents successful in reunification to provide emotional support to other parents who are working toward reunification.

OFN staff and families were involved with the START project with DHS and other stakeholders. START (Systemic, Therapeutic, Assessment, Resources, and Treatment) Services at the Institute on Disability/UCEDD at the University of New Hampshire, a national initiative that works to strengthen efficiencies and service outcomes for individuals with intellectual and developmental disabilities and behavioral health needs (IDD/BH) in the community, contracted with DHS. START Services began conducting an analysis of Oklahoma's current service delivery system specific to dually diagnosed (IDD/BH) individuals including current service availability, what is working, what is not working, and what is missing.

OITP added multiple layers to mental health services for NICU families. OITP began screening for maternal mood disorders in follow-up clinics at one month and at one year post-discharge from the NICU. OITP developed a resource kit for families needing mental health care. OITP staff participated as members of the Maternal Mood Disorder Work Group for the *Preparing for a Lifetime* initiative.

In partnership with WovenLife (formerly Easter Seals), the Family Support 360° Center staff facilitated and interpreted trainings about behavioral teaching strategies to Spanish speaking families who have children with autism and behavioral health needs.

Family Support 360° provided scholarships for Spanish-speaking families to attend the Autism Conference.

The Comprehensive Pediatric Sickle Cell Clinic had psychologists available to meet with their adolescent patients at all the comprehensive clinic visits.

The J.D. McCarty Center for Children with Developmental Disabilities continued to provide care, maintenance, training, treatment, habilitation, and rehabilitation to Oklahoma children afflicted with cerebral palsy and other developmental disabilities. The Center has found that a majority of the families that have recently been screened reported not having had access to behavioral health services.

Jump Start Developmental Clinic continued to help families and providers understand the developmental and behavioral strengths and challenges faced by young children suspected of having developmental delays or Autism Spectrum Disorders. The Clinic's Family Partner position participated in team evaluation/feedback sessions with 72 families in 2017. All families were provided with a diagnosis/diagnoses (e.g. autism spectrum disorder, global developmentally delayed milestones, intellectual disability, mixed receptive expressive language disorder, anxiety, disruptive behavior disorder, ADHD) and with a plan of action, referral recommendations, and resources. The families were encouraged to call back after the appointment with any questions, further explanation, or if additional help was needed. The Family Partner assisted with scheduling a 6-month follow-up with a developmental-behavioral pediatrics physician to check-in to determine if additional assistance was needed in accessing behavioral/mental health, school, medical, and/or other community services and resources.

CHALLENGES:

Statewide there continued to be stigma associated with mental health and acted as a barrier to clients receiving comprehensive care.

The lack of services and supports, especially for families in rural communities and those in crisis who have dual

diagnosis of intellectual disabilities and mental illness, continued to present challenges to programs. Additional barriers included the lack of pediatric psychiatrists for medication management and therapists who feel confident in serving younger children and those with dual diagnoses of mental health and intellectual disabilities. Financial support for underinsured children and youth and transportation to services were concerns as well.

Many NICU families had a knowledge deficit regarding behavioral and mental health and its importance to the health of the family and were unwilling to acknowledge need for services.

The lack of bilingual behavioral specialists continued to create a barrier to care among families for whom English was a second language.

The Family Partner position at Jump Start Developmental Clinic was part-time (20 hours/week) and follow-up with individual families was challenging as it competed with other necessary duties and responsibilities. In addition, there was no dedicated case manager position to follow-up with families.

Children with Special Health Care Needs - Application Year

CSHCN Title V will continue contracts with Sooner SUCCESS, OFN, OITP, Family Support 360°, and the Sickle Cell Clinic to further work in the state for the families of children and youth with special health care needs.

Planning will continue to e-share the SoonerSUCCESS-created resources on soonersuccess.ouhsc.edu website and the Oklahoma Physician Resource Research Network (OKPRN). OKPRN engagement will help involve family physicians and means are being explored to e-share these resources with the network. Oklahoma Chapter of the American Academy of Pediatrics (OCAAP) assistance will help Sooner SUCCESS engage pediatricians and e-share these resources with the network. Tabs will be provided on the websites including OKPRN/OCAAP websites to download these resources. The impact will be measured by analyzing the number of hits on the websites for downloaded materials. Since these resources will be downloaded by practitioners in general, irrespective of the unique children's population they serve (children and youth with or without special health care needs and their families), Sooner SUCCESS will also be able to improve health care transition for children without special health care needs. Sooner SUCCESS county coordinators have been trained to provide material to distribute in the community; both to service providers and clients. Case-managers and SoonerCare personnel will be reached.

In addition, Sooner SUCCESS will add information about health care transition developed by the Center for Learning and Leadership/Family Support 360° for pediatric resident trainings.

The location and practice status of the providers will be continuously maintained on the Sooner SUCCESS website. Changes will be updated on a quarterly basis. While working with families, the Sooner SUCCESS county coordinators will report changes in the providers' location and practice status. These changes will also be identified in-between communication with families or at times county coordinators are navigating health care services with the providers on the Sooner SUCCESS website. Where possible, an opportunity will be provided both for families and providers downloading resources from the websites to report any errors or changes back to hosting websites.

Efforts will be ongoing to develop a toolkit for primary care providers by 2020.

OFN will continue to connect and educate families and professionals on the importance of transition and how to access services by connecting them with other families, resources and trainings (Care Notebook, Transition Care Notebook, Health Care Transition Training and Life Course Tools). OFN will also provide these trainings to the professionals who serve them.

OITP plans to add a discussion group for NICU mothers that will be staffed by LCSWs and a family advocate. This will be a non-judgmental group where mothers can share their experiences in the NICU in a constructive atmosphere and if a mother needs counseling the LCSW can do one-to-one counseling. There will be a curriculum identified, if needed.

OITP will continue to actively participate on the healthcare transition committee hosted by Sooner SUCCESS.

Family Support 360° will develop a one-page bilingual document with "Quick Facts" to help families prepare for their child's health care transition. Topics may include guardianship and alternatives to guardianship, employment, housing, Supplemental Security Income (SSI), Medicaid and the changes that will occur when the child ages out of children's health.

Family Support 360° will continue Hispanic Support groups and provide opportunities for learning by inviting medical providers, and other professionals focused on transition, to train families and youth on successful health care

transition.

The Sickle Cell Clinic will continue current transition program and continue to enroll new patients when they turn 13 years of age. Additionally, the clinic will work to expand educational activities and lectures to pediatricians and ER physicians throughout the state.

Sooner SUCCESS will engage families with children, 12 years and older, on the topic of health care transition and provide them with vital information to help them develop a process. Ongoing efforts will continue to collect and analyze the feedback of families to track changes in the percentage of children with transition plans.

OITP will expand its patient base to include infants with hypoxic brain injuries and infants with complex cardiac disease. This will take additional training and resources for the OITP staff. These families with medically fragile infants need a smooth transition from the hospital to home which will include family dynamic counseling, education on medical needs of infant, depression, and anxiety reducing methods for the entire family. OITP will continue to advocate for families to begin thinking about the healthcare transitioning process from pediatric care to adulthood care.

OFN will provide a webinar that will be recorded to share transition related resources available to families in their areas via their home computer. This will increase availability to transition resources to families and the professionals who serve them as the webinar is watched live or via recording. Other partners will be providing additional training via webinars through OK Transition Council activities.

OFN plans to once again be a host site for the 19th Annual Chronic Illness and Disability Conference Transition from Pediatric to Adult-based Care, October 25-26, 2018. OFN will also provide Transition Care Notebook Trainings for families and youth, webinars to promote transition related services and provide one-to-one support to families of youth needing transition related services by families of CYSHCN. OFN will partner with Screening and Special Services, at the Oklahoma State Department of Health, to host a meeting with all Title V-funded specialty clinics to promote OFN services and to learn how each clinic prepares young adults for adult health care. The hope of OFN is to learn from other partners and implement the best ideas in each specialty clinic.

OITP will add social media to the educational outreach for NICU families with a focus on adolescent mothers. OITP will also encourage these mothers to attend the NICU mothers' discussion group and understand the importance of being a self-advocate for their baby and themselves. Social media groups will also reach out to these families to offer support and resources.

Family Support 360° will continue to assist Hispanic youth with the transition to adult healthcare.

The Sickle Cell Clinic will continue current transition program and will modify educational material to be up-to-date and applicable to the current generation of adolescents.

OFN will continue to work with DHS on the START (Systemic, Therapeutic, Assessment, Resources, and Treatment) project.

OITP is developing discussion groups for parents in the NICU to discuss and receive resources and/or counseling for behavioral health issues that parents may be experiencing as parents of a medically fragile infant. Family education regarding the importance of family behavioral health and maternal mood disorder will be included in the discussion groups.

Family Support 360° will resume its partnership with Wovenlife to continue the trainings for Spanish-speaking families regarding behavioral health teaching strategies. Additionally, the agency will continue to provide information to families about mental health and continue to provide them with scholarships to conferences that will increase their knowledge and support for their children with developmental disabilities and behavioral issues.

Continue to have and potentially expand the psychology services available at all Sickle Cell comprehensive clinics. Community-based referrals to outside resources will be made if deemed appropriate.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Building - 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 11.5% 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 2015 Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS); 13.7% of new mothers smoked in the last three months of their pregnancy. Rates for African American women for 2012-2015 were at 11.8% and for American Indian mothers were 18.9%.

Successes:

The Oklahoma State Department of Health (OSDH) Center for the Advancement of Wellness (Center) provided oversight of all statewide cessation programs by participating in the monthly Cessation Leadership Team meeting as well as the Health Systems Initiative Work Group and the Tribal Cessation Work Group. 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 and Substance Abuse Services (ODMHSAS), the local county health departments 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 ten call program especially tailored for pregnant tobacco users. SoonerCare participants could also choose the single call program with two weeks of NRT, self-help/general questions only, or an array of "individual services" including text messaging and email. The two-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, county health department providers 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 focused on provider engagement and education, health promotion and mass media to reach pregnant women. The OHCA SoonerQuit™ for Women program maintained 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. There was a 5.6 percent increase in tobacco cessation counseling in state fiscal year SFY 2017 when compared to SFY 16. There was also a 15.5 percent increase in prescription claims in SFY17 when compared to SFY16. Additionally, the OHCA continued to provide the member survey to obtain an accurate representation of member behaviors and smoking prevalence.

The Center worked with the *Preparing for a Lifetime* Tobacco Cessation Work Group in conjunction with the OHCA to report on the pregnancy program utilization with the OTH and referrals from health care providers, which included OB/GYN and OB/GYN Specialists. In State Fiscal Year SFY17, the OTH reported the following for participants registering in the pregnancy program:

- In SFY17 there were 393 tobacco users who were also pregnant that accessed the Helpline for assistance quitting smoking
 - This represents a 5.8% decrease over SFY16 (n=417), but a 14.6% increase over SFY15 (n=343)
- An additional 249 women who were planning pregnancy and 109 breastfeeding mothers utilized the Helpline.
- There were over 5,000 Medicaid members who identified as a tobacco user who registered for OTH services

The SoonerQuit™ Provider Engagement Program continued to provide training for providers to ensure they 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 SFY17, 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.

The OHCA promoted the OTH services through the Text4Baby and SoonerQuit™ campaign(s). As a result of the effectiveness of the tobacco cessation messaging via Text4Baby, the OHCA launched Quit4Baby™, a subset program of Text4Baby. The Quit4Baby™ program sought to increase enrollment in Text4Baby 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.

In SFY17, the utilization of provider electronic referrals to the OTH was a primary priority. The Center worked with the Oklahoma Tobacco Research Center (OTRC) to provide technical assistance for those health systems. This large scale implementation impacted SFY17 OTH utilization. The potential for the increase of referrals from providers through the EHR was the most sustainable option available to health care 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 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).

During SFY17, there were 13,731 fax referrals, 3,297 electronic referrals, and 998 online referrals that were received by the Helpline from health professionals and health systems across the state. This reflected a 20 percent increase in the number of fax referrals and a 34 percent increase in the number of electronic referrals as compared to SFY16.

The OSDH Family Planning Program saw more than 7,521 unduplicated users, who were pregnant or seeking pregnancy in calendar year 2017. 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 and The Center monitored county health departments' smoking intervention documentation to ensure appropriate billing and referrals for clients who reported tobacco use. The OSDH placed greater emphasis on the referrals and service code utilization in SFY16. During this reporting period, the Center created CHD Tobacco Cessation Dashboards to provide quarterly updates on tobacco cessation service code utilization, direct OTH referrals, treatment reach and county smoking prevalence. This allows the regional CHD the opportunity to set goals and objectives based on the data. In SFY17 there was a 12 percent decline in tobacco cessation service utilization codes when compared to SFY16. This continued to be a priority for the Center and new training and procedures were beginning development to ensure all CHD staff appropriately document the service codes.

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 14.0% in 2013-2015 to 11.5% 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 12.7% according to 2014-2016 The Oklahoma Toddler Survey (TOTS) data.

Successes:

The Center, in collaboration with the TSET, worked together to develop early childhood education (ECE) voluntary policies that have elements specifically focused on educating parents and staff of the negative health consequences associated with secondhand smoke exposure (SHSE). The policies also have specific elements that address not smoking in vehicles that transport children at any time. Currently, there have been 26 policies adopted by ECE centers throughout the state of Oklahoma. Additionally, during the 2017 legislative session a bill was introduced to implement a cigarette fee and within the bill there were other tobacco control practices that were incorporated. Most of the bill was found unconstitutional; however, there were several elements within the bill that were found constitutional. One specific element that was found constitutional requires the OSDH and TSET to work together to inform the public about the dangers of smoking in motor vehicles when children are present. This specific policy will be addressed by the OSDH and TSET in the upcoming year. The Center staff have started researching current laws and regulations within other states regarding SHSE to children when riding in vehicles. This research will help guide future programmatic and policy initiatives.

The MCH school nurses working in nine rural school districts continued to present tobacco/drug/alcohol prevention programs to students attending their districts in grade pre-kindergarten through high school seniors. They received awards as Certified Healthy Schools, meaning they have worked to make district policies that address tobacco free school campuses, bullying prevention, as well as breakfast programs for the students, recess before lunch for elementary students, food pantries, food backpack programs for students in food insecure homes, management of chronic health conditions to reduce chronic absenteeism, and encourage physical activity and mindfulness activities that have increased student attention and academic performance.

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.

Challenges:

Tobacco cessation and secondhand smoke reduction is a complex issue, requiring multiple partners and avenues for success, including policy. The Oklahoma Legislature passed a fee on cigarettes during the 2017 session which was recalled by the state Supreme Court for procedural difficulties, as the fee was determined to not be different than a tax and a tax increase requires a super majority in the House and Senate, per state law. There continued to be an interest in increasing the tax on cigarettes to \$1.50 per pack earmarked for mental health services, health care expenditures, and a teacher pay raise, but the required supermajority to pass a revenue bill in the Senate and the House did not materialize during this time period.

Cross-Cutting/Systems Building - Application Year

Because much of the agency's work on tobacco cessation is the primary responsibility for our partners in the Center for the Advancement of Wellness, MCH has chosen to discontinue this measure. Tobacco cessation activities in MCH (and funded by Title V) will be addressed under the domains of Women's Health and Children's Health and be included in those narratives in the future. In Women's Health, tobacco cessation will primarily be included in efforts to improve preconception, prenatal and interconception health, via the *Preparing for a Lifetime's Tobacco Cessation* Work Group. For Children's Health, tobacco prevention work will primarily be accomplished through the school health nurses in nine rural counties and the two metropolitan area school health programs, *It's All About Kids* and *Health At School*.

III.F. 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 and several seeking details on teen pregnancy activities, infant mortality, maternal mortality, and neonatal abstinence syndrome from students, parents, and other public health professionals. Questions were answered and contact information was given for follow-up with the appropriate program or data person. MCH and CSHCN use these calls and 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 current Title V Executive Summary has been shared at several meetings, including site visits to county health departments.

The call for public input on the Title V block grant was posted on Facebook four times between January and May 2018 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.

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 continued to include a youth member, to help determine if 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 quarterly 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 engage with parents in the local DHS office or via home visits.

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.

III.G. Technical Assistance

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.

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 - [DHS OSDH MOU - Noll.pdf](#)

Supporting Document #02 - [Block Grant Bios_OK.pdf](#)

Supporting Document #03 - [Acronyms_2018.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [Oklahoma Org Charts_DHS_OSDH.pdf](#)

VII. Appendix

This page is intentionally left blank.

Form 2
MCH Budget/Expenditure Details

State: Oklahoma

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 6,956,304	
A. Preventive and Primary Care for Children	\$ 2,980,183	(42.8%)
B. Children with Special Health Care Needs	\$ 2,086,892	(30%)
C. Title V Administrative Costs	\$ 695,630	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 5,762,705	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 5,217,228	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 219,826	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 32,970	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 5,470,024	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 4,684,317		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 12,426,328	
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)	\$ 4,890,970	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 17,317,298	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
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) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 3,925,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 157,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 643,470

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 6,903,092		\$ 6,956,304	
A. Preventive and Primary Care for Children	\$ 3,200,208	(46.4%)	\$ 2,980,183	(42.8%)
B. Children with Special Health Care Needs	\$ 2,070,928	(30%)	\$ 2,086,892	(30%)
C. Title V Administrative Costs	\$ 690,309	(10%)	\$ 695,630	(10%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 5,961,445		\$ 5,762,705	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 5,280,899		\$ 5,849,288	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 1,802,006	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 5,919		\$ 65,969	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 5,286,818		\$ 7,717,263	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 4,684,317				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 12,189,910		\$ 14,673,567	
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)	\$ 4,788,539		\$ 4,834,203	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 16,978,449		\$ 19,507,770	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
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) > Centers for Disease Control and Prevention (CDC) > Youth Risk Behavior Survey (YRBS)	\$ 65,000	\$ 65,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374	\$ 95,374
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 3,839,000	\$ 3,839,000
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 644,072	\$ 644,072
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens		\$ 45,664

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	At this time, MCH does not anticipate an increase in state match funding for FY19. Amount budgeted is the required 75% match rate.
2.	Field Name:	4. LOCAL MCH FUNDS
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	FY17 Budget did not include local dollars, as these funds were not historically used for Title V programs, i.e. enabling and population-based services.
3.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	Program income fluctuates from year to year and previous year income amounts are used to derive projections for the coming year.

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	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	\$ 292,490	\$ 390,719
2. Infants < 1 year	\$ 901,109	\$ 802,880
3. Children 1 through 21 Years	\$ 2,980,183	\$ 2,980,183
4. CSHCN	\$ 2,086,892	\$ 2,086,892
5. All Others	\$ 0	\$ 0
Federal Total of Individuals Served	\$ 6,260,674	\$ 6,260,674

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	\$ 346,052	\$ 458,670
2. Infants < 1 year	\$ 1,007,359	\$ 1,198,884
3. Children 1 through 21 Years	\$ 1,895,400	\$ 2,221,517
4. CSHCN	\$ 1,968,417	\$ 1,970,217
5. All Others	\$ 0	\$ 0
Non-Federal Total of Individuals Served	\$ 5,217,228	\$ 5,849,288
Federal State MCH Block Grant Partnership Total	\$ 11,477,902	\$ 12,109,962

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Oklahoma

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	\$ 397,151	\$ 397,151
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 19,330	\$ 19,330
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 377,821	\$ 377,821
2. Enabling Services	\$ 1,097,874	\$ 1,097,874
3. Public Health Services and Systems	\$ 5,461,279	\$ 5,461,279
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		\$ 15,942
Physician/Office Services		\$ 170,273
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 207,548
Laboratory Services		\$ 3,388
Direct Services Line 4 Expended Total		\$ 397,151
Federal Total	\$ 6,956,304	\$ 6,956,304

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	\$ 1,417,745	\$ 1,417,745
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 689,561	\$ 689,561
B. Preventive and Primary Care Services for Children	\$ 443,161	\$ 443,161
C. Services for CSHCN	\$ 285,023	\$ 285,023
2. Enabling Services	\$ 1,097,828	\$ 1,342,758
3. Public Health Services and Systems	\$ 2,701,655	\$ 3,088,785
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 1,236,354
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 156,573
Laboratory Services		\$ 24,818
Direct Services Line 4 Expended Total		\$ 1,417,745
Non-Federal Total	\$ 5,217,228	\$ 5,849,288

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Oklahoma

Total Births by Occurrence: 52,607

Data Source Year: 2016

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	52,607 (100.0%)	7	3	3 (100.0%)
Congenital Hypothyroidism	52,607 (100.0%)	67	42	42 (100.0%)
Galactosemia	52,607 (100.0%)	5	3	3 (100.0%)
Sickle Cell Disease	52,607 (100.0%)	13	13	13 (100.0%)
Congenital Adrenal Hyperplasia	52,607 (100.0%)	6	5	5 (100.0%)
Biotinidase Deficiency	52,607 (100.0%)	15	15	15 (100.0%)
Cystic Fibrosis	52,607 (100.0%)	9	9	9 (100.0%)
Sickle Cell Trait	52,607 (100.0%)	247	247	0 (0.0%)
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	52,607 (100.0%)	10	0	0 (0%)
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	52,607 (100.0%)	6	6	6 (100.0%)
Short-Chain Acyl-CoA Dehydrogenase Deficiency/Glutaric Aciduria Type II	52,607 (100.0%)	12	10	10 (100.0%)

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Citrullinemia/Argininosuccinic Acidemia	52,607 (100.0%)	24	7	7 (100.0%)
Tyrosinemia	52,607 (100.0%)	17	0	0 (0%)
Propionic/Methylmalonic Acidemia	52,607 (100.0%)	6	1	1 (100.0%)
Glutaric Aciduria Type I	52,607 (100.0%)	9	0	0 (0%)
3-Methylcrotonyl-CoA Carboxylase Deficiency/3-Hydroxy 3-Methylglutaryl-CoA Lyase Deficiency	52,607 (100.0%)	3	1	1 (100.0%)
Carnitine Palmitoyltransferase I Deficiency	52,607 (100.0%)	6	1	1 (100.0%)
Carnitine Uptake Defect	52,607 (100.0%)	4	0	0 (0%)
Homocystinuria	52,607 (100.0%)	1	0	0 (0%)
Isovaleric Acidemia	52,607 (100.0%)	1	0	0 (0%)
Maple Syrup Urine Disease	52,607 (100.0%)	6	1	1 (100.0%)
Carnitine Acylcarnitine Translocase Deficiency	52,607 (100.0%)	19	0	0 (0%)
Malonic Aciduria	52,607 (100.0%)	3	0	0 (0%)
Severe Combined Immunodeficiency	52,607 (100.0%)	3	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:	Total Births by Occurrence
	Fiscal Year:	2017
	Column Name:	Total Births by Occurrence Notes
	Field Note:	Data reflect all births regardless of state of residence for calendar year 2016. The latest year for which newborn screening data are available for reporting. Source: Oklahoma Vital Statistics.
2.	Field Name:	Data Source Year
	Fiscal Year:	2017
	Column Name:	Data Source Year Notes
	Field Note:	Year 2016 newborn screening data are the latest available for reporting.
3.	Field Name:	Aggregate Data Not Available
	Fiscal Year:	2017
	Column Name:	Aggregate Data Not Available Notes
	Field Note:	Newborn screening data are unavailable in aggregate form. Data are entered individually for each screening condition.
4.	Field Name:	Cystic Fibrosis - Positive Screen
	Fiscal Year:	2017
	Column Name:	Other Newborn
	Field Note:	Two children had borderline results with only one mutation identified on the NBS, however through the diagnostic process they were confirmed to have CF with two mutations. One mutation is not on OK's screening panel.
5.	Field Name:	Sickle Cell Trait - Positive Screen
	Fiscal Year:	2017
	Column Name:	Other Newborn

Field Note:

Sickle cell trait individuals are identified as carrier for sickle cell disease therefore they do not exhibit symptoms or have the disease. These results are never considered presumptive results as the result does not indicate possible disease status, only carrier status.

These numbers are entered here to comply with edit rules of Form 4.

6. **Field Name:** **Sickle Cell Trait - Referred For Treatment**

Fiscal Year: **2017**

Column Name: **Other Newborn**

Field Note:

Sickle cell trait individuals are identified as carrier for sickle cell disease therefore they do not exhibit symptoms or have the disease. These results are never considered presumptive results as the result does not indicate possible disease status, only carrier status.

Data Alerts: None

**Form 5a
Count of Individuals Served by Title V**

State: Oklahoma

Annual Report Year 2017

		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	52,607	31.1	0.0	61.2	7.7	0.0
2. Infants < 1 Year of Age	52,607	52.7	0.0	45.4	1.9	0.0
3. Children 1 through 21 Years of Age	72,643	37.4	0.0	56.0	6.6	0.0
3a. Children with Special Health Care Needs	2,748	48.5	0.0	43.9	7.6	0.0
4. Others	678	10.0	0.0	76.9	13.1	0.0
Total	178,535					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2017
	Field Note:	Figure reflects the number of women delivering a live birth in Oklahoma in the year 2017. Insurance coverage obtained from birth certificate data for year 2016.
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2017
	Field Note:	Figure reflects the number of live births in Oklahoma. Source: Oklahoma Vital Statistics, OSDH. Insurance coverage obtained from birth certificate data for year 2016.
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2017
	Field Note:	Reflects counts of children and adolescents in receiving Title V funded direct and enabling services through school health, teen pregnancy prevention, bullying prevention, injury prevention, Insurance coverage obtained from American Community Survey, 2016.
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2017
	Field Note:	The number of children served is a conservative estimate intended to reduce the risk of duplication. For FFY2018, steps are being taken to improve partner reporting so as to ascertain a more reflective count of unduplicated children who received Title V services. Additionally, Title V representatives continue to encourage across partners and to reach out to families in under-served populations by speaking at family support groups and attending local health conferences that address children with special health care needs. Number reflects those CSHCN served as follows: Sooner SUCCESS (706), Oklahoma Family Network (599), Family Support 360 (321), Sickle Cell Clinic (317), Oklahoma Infant Transition Program (306), Oklahoma Department of Human Services (256), JD McCarthy (171), and JumpStart Clinic (72). Insurance information for primary source of coverage estimated from National Survey of Children's Health, 2016.
5.	Field Name:	Others
	Fiscal Year:	2017

Field Note:

Number reflects family planning clients receiving LARCS funded by Title V and university students participating in PAF project.

Insurance coverage obtained from American Community Survey, 2016.

Data Alerts: None

Form 5b
Total Percentage of Populations Served by Title V

State: Oklahoma

Annual Report Year 2017

Populations Served by Title V	Total % Served
1. Pregnant Women	68
2. Infants < 1 Year of Age	100
3. Children 1 through 21 Years of Age	25
3a. Children with Special Health Care Needs	25
4. Others	1

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2017
	Field Note:	Derived by dividing the number of live births by the estimated number of pregnant women in Oklahoma during the year.
2.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2017
	Field Note:	MCH serves 100% of newborns by funding newborn screening, Preparing for a Lifetime, PRAMS, Period of Purple Crying, FIMR, Becoming Baby Friendly, Infant Sleep Sack and Cribs Pilot Projects, Breastfeeding Hotline, Office of Perinatal Quality Improvement.
3.	Field Name:	Children 1 Through 21 Years of Age
	Fiscal Year:	2017
	Field Note:	Figure reflects the estimated percentage of children receiving MCH/CSHCN services across all levels of the pyramid.
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2017
	Field Note:	Figure reflects a crude estimate of the percentage of CSHCN served by the range of Title V services provided in Oklahoma.
5.	Field Name:	Others
	Fiscal Year:	2017
	Field Note:	Only a minute fraction of the total Oklahoma population, not covered in other population, is covered by Title V services. The figure given here reflects only those served through family planning and PAF programs.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Oklahoma

Annual Report Year 2017

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	52,607	30,472	4,390	7,594	4,939	1,581	0	3,612	19
Title V Served	52,607	30,472	4,390	7,594	4,939	1,581	0	3,612	19
Eligible for Title XIX	34,029	18,498	3,182	6,231	3,258	767	0	2,082	11
2. Total Infants in State	105,739	61,770	8,693	15,069	9,836	3,158	0	7,154	59
Title V Served	79,306	46,328	6,520	11,302	7,377	2,369	0	5,366	44
Eligible for Title XIX	57,935	28,123	6,301	12,364	6,488	1,532	0	3,093	34

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	1. Total Deliveries in State
	Fiscal Year:	2017
	Column Name:	Total
	Field Note:	Numbers reflect live births by race and ethnicity for calendar year 2016, the latest year for which final birth data are available. Source: Oklahoma Vital Statistics
2.	Field Name:	1. Title V Served
	Fiscal Year:	2017
	Column Name:	Total
	Field Note:	MCH funds are used to support newborn screening for all infants delivered in Oklahoma. Numbers reflect live births delivered in the state. Source: Oklahoma Vital Statistics.
3.	Field Name:	1. Eligible for Title XIX
	Fiscal Year:	2017
	Column Name:	Total
	Field Note:	Numbers reflect Medicaid enrollment by race and ethnicity for FY2017. Source: Oklahoma Health Care Authority, the state's Medicaid agency.
4.	Field Name:	2. Total Infants in State
	Fiscal Year:	2017
	Column Name:	Total
	Field Note:	Numbers reflect live births for the years 2015 and 2016, the latest years for which final birth data are available. Census counts of infants < 1 year of age underestimate this population. Birth data used as an approximation of population size. Source: Oklahoma Vital Statistics.
5.	Field Name:	2. Title V Served
	Fiscal Year:	2017
	Column Name:	Total
	Field Note:	Figures estimated based on approximate percentages of populations served.

6. **Field Name:** **2. Eligible for Title XIX**

Fiscal Year: **2017**

Column Name: **Total**

Field Note:

Derived based on Medicaid enrollment figures obtained from Oklahoma Health Care Authority, the state's Medicaid agency.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Oklahoma

A. State MCH Toll-Free Telephone Lines	2019 Application Year	2017 Annual Report 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"	Margi Preston	Margi Preston
4. Contact Person's Telephone Number	(405) 521-6206	(405) 521-6206
5. Number of Calls Received on the State MCH "Hotline"		110,777

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report 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"		65,327
3. State Title V Program Website Address	https://www.ok.gov/health/Community_&_Family_Health/Maternal_and_Child_Health_Service/	https://www.ok.gov/health/Community_&_Family_Health/Maternal_and_Child_Health_Service/
4. Number of Hits to the State Title V Program Website		3,442
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		6,159

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 and Child Health Service
Address 1	1000 NE Tenth St
Address 2	
City/State/Zip	Oklahoma City / OK / 73117
Telephone	(405) 271-4480
Extension	56839
Email	joycem@health.ok.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Carla McCarrell-Williams
Title	Title V Director-Children with Special Health Care Needs
Address 1	2400 N Lincoln Blvd
Address 2	
City/State/Zip	Oklahoma City / OK / 73125
Telephone	(405) 521-4092
Extension	
Email	Carla.McCarrell-Williams@okdhs.org

3. State Family or Youth Leader (Optional)

Name	Joni Bruce
Title	Executive Director, Oklahoma Family Network
Address 1	800 NE 15th Street Suite 316
Address 2	
City/State/Zip	Oklahoma City / OK / 73117
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 2019

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
2016	72.8 %	0.2 %	37,411	51,405
2015	74.6 %	0.2 %	38,719	51,929
2014	72.8 %	0.2 %	37,398	51,352
2013	69.1 %	0.2 %	34,413	49,834
2012	68.7 %	0.2 %	34,280	49,900
2011	66.6 %	0.2 %	32,996	49,577
2010	65.5 %	0.2 %	33,170	50,613

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20, a confidence interval width >20%, 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
2015	156.0	6.6	571	36,615
2014	151.3	5.7	727	48,041
2013	169.8	6.0	821	48,340
2012	157.5	5.7	769	48,842
2011	201.9	6.5	978	48,452
2010	166.4	5.9	820	49,273
2009	158.3	5.6	802	50,677
2008	110.1	4.7	557	50,607

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
2012_2016	21.1	2.8	56	265,173
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 - 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
2016	7.8 %	0.1 %	4,110	52,547
2015	7.9 %	0.1 %	4,172	53,066
2014	8.0 %	0.1 %	4,238	53,307
2013	8.1 %	0.1 %	4,297	53,341
2012	8.0 %	0.1 %	4,200	52,697
2011	8.5 %	0.1 %	4,431	52,242
2010	8.4 %	0.1 %	4,458	53,206
2009	8.4 %	0.1 %	4,558	54,453

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	10.7 %	0.1 %	5,597	52,555
2015	10.3 %	0.1 %	5,485	53,082
2014	10.3 %	0.1 %	5,492	53,284
2013	10.6 %	0.1 %	5,625	53,284
2012	10.9 %	0.1 %	5,710	52,555
2011	10.8 %	0.1 %	5,639	52,121
2010	11.2 %	0.1 %	5,919	53,017
2009	10.9 %	0.1 %	5,907	54,294

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	28.2 %	0.2 %	14,825	52,555
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
2016/Q2-2017/Q1	2.0 %			
2015/Q2-2016/Q1	3.0 %			
2015/Q1-2015/Q4	3.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	3.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	6.0 %			

Legends:
🚩 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
2015	6.2	0.3	329	53,260
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
2015	7.3	0.4	389	53,122
2014	8.2	0.4	438	53,339
2013	6.7	0.4	359	53,369
2012	7.5	0.4	397	52,751
2011	7.3	0.4	380	52,272
2010	7.5	0.4	399	53,238
2009	7.9	0.4	431	54,553

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	4.4	0.3	233	53,122
2014	5.3	0.3	283	53,339
2013	4.0	0.3	212	53,369
2012	4.6	0.3	243	52,751
2011	4.4	0.3	231	52,272
2010	4.2	0.3	223	53,238
2009	4.4	0.3	242	54,553

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.9	0.2	156	53,122
2014	2.9	0.2	155	53,339
2013	2.8	0.2	147	53,369
2012	2.9	0.2	154	52,751
2011	2.9	0.2	149	52,272
2010	3.3	0.3	176	53,238
2009	3.5	0.3	189	54,553

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	244.7	21.5	130	53,122
2014	313.1	24.3	167	53,339
2013	211.7	19.9	113	53,369
2012	265.4	22.5	140	52,751
2011	170.3	18.1	89	52,272
2010	174.7	18.1	93	53,238
2009	229.1	20.5	125	54,553

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - 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
2015	148.7	16.7	79	53,122
2014	155.6	17.1	83	53,339
2013	149.9	16.8	80	53,369
2012	164.9	17.7	87	52,751
2011	155.0	17.2	81	52,272
2010	182.2	18.5	97	53,238
2009	154.0	16.8	84	54,553

Legends:

-  Indicator has a numerator <10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - 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
2015	5.0 %	0.8 %	2,517	50,387
2014	7.0 %	1.1 %	3,498	50,017
2013	3.9 %	0.8 %	1,957	50,172
2012	5.6 %	0.9 %	2,817	50,068
2011	5.3 %	1.0 %	2,611	49,664
2010	5.3 %	0.9 %	2,715	50,867
2009	4.6 %	0.8 %	2,365	51,960
2008	6.1 %	0.9 %	3,150	51,928
2007	4.8 %	0.8 %	2,516	51,975

Legends:

- 🚫 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has an unweighted denominator between 30 and 59 or 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 hospital births

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.7	0.4	210	36,974
2014	5.0	0.3	244	48,638
2013	3.9	0.3	189	48,559
2012	2.8	0.2	136	48,974
2011	2.5	0.2	122	48,454
2010	1.7	0.2	85	49,516
2009	1.2	0.2	62	50,928
2008	1.2	0.2	62	50,506

Legends:

-  Indicator has a numerator ≤10 and is not reportable
-  Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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 year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	13.0 %	1.9 %	115,261	887,430

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	24.7	2.3	120	485,066
2015	28.0	2.4	136	485,290
2014	26.7	2.4	129	482,492
2013	29.1	2.5	140	481,170
2012	25.2	2.3	120	475,436
2011	29.9	2.5	142	474,448
2010	27.4	2.4	129	471,513
2009	29.3	2.5	136	464,479

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	43.8	2.9	231	527,872
2015	43.4	2.9	228	525,456
2014	42.7	2.9	222	520,233
2013	44.1	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
2014_2016	19.2	1.6	150	780,627
2013_2015	19.6	1.6	152	774,912
2012_2014	19.8	1.6	152	769,486
2011_2013	20.3	1.6	157	772,259
2010_2012	22.3	1.7	174	780,352
2009_2011	24.3	1.8	192	790,954
2008_2010	28.6	1.9	228	796,647
2007_2009	30.0	1.9	239	797,110

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	15.0	1.4	117	780,627
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 (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	22.0 %	1.9 %	210,529	957,402

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	14.5 %	3.0 %	30,123	207,744

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	1.9 %	0.5 %	15,058	796,277

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	11.4 %	1.7 %	89,620	787,609

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	51.9 % ⚡	6.3 % ⚡	56,340 ⚡	108,482 ⚡

Legends:

- 🚩 Indicator has an unweighted denominator <30 and is not reportable
- ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	90.5 %	1.4 %	859,741	950,514

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	13.8 %	0.2 %	4,518	32,754
2012	14.8 %	0.2 %	5,158	34,770
2010	15.4 %	0.2 %	5,838	37,849
2008	14.9 %	0.2 %	4,206	28,285

Legends:

- Indicator has a denominator <50 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	17.3 %	1.5 %		
2013	11.8 %	1.0 %		
2011	16.7 %	1.4 %		
2009	14.0 %	1.4 %		
2007	14.6 %	0.9 %		
2005	15.1 %	1.0 %		

Legends:

- Indicator has an unweighted denominator <100 and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	18.1 %	2.9 %	69,168	381,285

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	7.0 %	0.4 %	67,244	962,141
2015	8.2 %	0.4 %	78,467	959,160
2014	8.7 %	0.5 %	82,190	950,023
2013	10.5 %	0.5 %	98,940	947,160
2012	9.9 %	0.5 %	92,887	936,722
2011	10.9 %	0.6 %	101,812	934,009
2010	10.4 %	0.5 %	96,671	932,723
2009	11.1 %	0.6 %	102,685	921,695

Legends:

-  Indicator has an unweighted denominator <30 and is not reportable
-  Indicator has a confidence interval width 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
2016	67.0 %	4.0 %	51,230	76,431
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, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	53.6 %	1.9 %	478,533	892,286
2015_2016	52.3 %	2.2 %	463,253	886,608
2014_2015	54.4 %	2.2 %	482,493	886,773
2013_2014	55.2 %	2.1 %	480,374	870,847
2012_2013	50.1 %	2.6 %	438,541	875,876
2011_2012	53.2 %	2.9 %	453,126	851,398
2010_2011	50.4 %	3.1 %	423,271	839,823
2009_2010	43.7 %	2.3 %	379,503	868,427

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 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
2016	63.8 % ⚡	5.3 % ⚡	81,905 ⚡	128,386 ⚡
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
2016	50.3 %	5.1 %	67,852	134,877
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
2016	89.6 %	2.3 %	235,981	263,262
2015	84.4 %	2.5 %	220,371	261,148
2014	82.6 %	2.4 %	213,323	258,140
2013	78.1 %	2.5 %	200,795	257,188
2012	77.1 %	2.9 %	198,246	257,165
2011	66.0 %	3.2 %	168,949	256,171
2010	54.8 %	3.3 %	135,997	248,051
2009	35.1 %	2.9 %	86,620	246,600

Legends:

- Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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
2016	73.6 %	3.3 %	193,766	263,262
2015	68.1 %	3.3 %	177,924	261,148
2014	70.8 %	2.9 %	182,853	258,140
2013	66.2 %	2.7 %	170,300	257,188
2012	63.8 %	3.4 %	164,130	257,165
2011	55.3 %	3.4 %	141,605	256,171
2010	42.6 %	3.3 %	105,757	248,051
2009	29.5 %	2.8 %	72,731	246,600

Legends:

-  Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval 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

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	33.4	0.5	4,250	127,118
2015	34.9	0.5	4,391	125,886
2014	38.6	0.6	4,802	124,485
2013	42.9	0.6	5,310	123,737
2012	47.3	0.6	5,844	123,473
2011	48.1	0.6	6,025	125,333
2010	50.7	0.6	6,496	128,156
2009	57.4	0.7	7,451	129,709

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	16.1 %	1.4 %	8,098	50,425
2014	16.4 %	1.6 %	8,240	50,128
2013	15.9 %	1.5 %	8,026	50,459
2012	14.9 %	1.5 %	7,494	50,174

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	3.1 %	0.8 %	29,586	951,285

Legends:

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)
State: Oklahoma

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

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	2017
Annual Objective	59.4	62.2
Annual Indicator	61.0	66.8
Numerator	414,257	449,510
Denominator	679,075	672,938
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	67.5	68.1	68.8	69.5	70.2	70.9

Field Level Notes for Form 10a NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	76.7	77.4
Annual Indicator	74.7	79.2
Numerator	38,593	41,230
Denominator	51,646	52,032
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	79.8	80.6	81.4	82.2	83.1	83.9

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	19.1	16
Annual Indicator	15.7	21.3
Numerator	7,715	10,883
Denominator	49,145	51,056
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	21.7	22.2	22.6	23.1	23.3	23.8

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	2017
Annual Objective	71.9	76.9
Annual Indicator	75.4	81.2
Numerator	37,018	40,173
Denominator	49,130	49,458
Data Source	PRAMS	PRAMS
Data Source Year	2014	2015

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	82.0	82.8	83.7	84.5	85.3	86.2

Field Level Notes for Form 10a NPMs:

None

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

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	85.5
Numerator	
Denominator	
Data Source	Pregnancy Risk Assessment Monitoring System
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	86.4	87.2	88.1	89.0	89.9

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

Figure reflects the percentage of infants who are placed to sleep in a crib.

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

FAD for this measure is not available for the State.

State Provided Data	
	2017
Annual Objective	
Annual Indicator	36.8
Numerator	
Denominator	
Data Source	Pregnancy Risk Assessment Monitoring System
Data Source Year	2015
Provisional or Final ?	Final

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	37.5	38.3	39.1	39.8	40.6

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

Figure reflects the percentage of infants who are placed to sleep without blanket.

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Federally Available Data		
Data Source: HCUP - State Inpatient Databases (SID)		
	2016	2017
Annual Objective	186.8	173.8
Annual Indicator	177.3	203.9
Numerator	951	823
Denominator	536,332	403,600
Data Source	SID-CHILD	SID-CHILD
Data Source Year	2014	2015

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	201.9	199.8	197.8	195.9	193.9	192.0

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: Youth Risk Behavior Surveillance System (YRBSS)		
	2016	2017
Annual Objective	23.9	23.6
Annual Indicator	25.0	25.0
Numerator	44,898	44,898
Denominator	179,440	179,440
Data Source	YRBSS	YRBSS
Data Source Year	2015	2015

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Perpetration	
	2017
Annual Objective	
Annual Indicator	6.7
Numerator	20,257
Denominator	303,088
Data Source	NSCHP
Data Source Year	2016

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - Victimization	
	2017
Annual Objective	
Annual Indicator	20.6
Numerator	62,195
Denominator	301,280
Data Source	NSCHV
Data Source Year	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	24.5	24.0	23.5	23.1	22.6	22.1

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	2017
Annual Objective		
Annual Indicator		75.2
Numerator		229,371
Denominator		304,952
Data Source		NSCH
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	76.0	76.7	77.5	78.3	79.0	79.8

Field Level Notes for Form 10a NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		11.3
Numerator		10,795
Denominator		95,220
Data Source		NSCH-CSHCN
Data Source Year		2016

i Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	11.5	11.8	12.0	12.2	12.5	12.7

Field Level Notes for Form 10a NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services necessary to make transitions to adult health care - Adolescent Health - NONCSHCN

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - NONCSHCN	
	2017
Annual Objective	
Annual Indicator	12.5
Numerator	26,234
Denominator	210,453
Data Source	NSCH-NONCSHCN
Data Source Year	2016

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	12.8	13.0	13.3	13.5	13.8

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	2017
Annual Objective		7.3
Annual Indicator	7.4	7.6
Numerator	391	379
Denominator	52,607	49,971
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	7.5	7.3	7.2	7.0	6.9	6.7

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	2017
Annual Objective		17.4
Annual Indicator	20.1	21.2
Numerator	32	33
Denominator	159,025	155,716
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2014-2016	2015-2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	20.8	20.4	20.0	19.6	19.2	18.8

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
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		61.9
Annual Indicator	60.7	60.7
Numerator		
Denominator		
Data Source	National Survey of Childrens Health	National Survey of Childrens Health
Data Source Year	2011/12	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	63.2	64.4	65.7	67.0	68.4	69.8

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

With the 2016 NSCH, there is no comparable survey item to provide a comparable measurement for State Performance Measure #3 as originally defined. For this reporting, the previous indicator from 2011/12 NSCH is carried forward as an estimation. Future reporting will address this gap in timely information.

**Form 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
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		95
Annual Indicator	91	90
Numerator		
Denominator		
Data Source	PHOCIS	PHOCIS
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	100.0	105.0	110.0	115.0	120.0	125.0

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
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		15.6
Annual Indicator	14.8	15.7
Numerator	7,767	7,864
Denominator	52,607	50,008
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	16.0	16.3	16.7	17.0	17.3	17.7

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
Data reflect final 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.
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
Data reflect provisional 2017 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
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		70.6
Annual Indicator	70.2	70.5
Numerator	36,926	35,244
Denominator	52,607	50,008
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	71.2	71.9	72.6	73.4	74.1	74.8

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Data reflect the percent of births delivered at Oklahoma birthing hospitals participating in the sleep sack distribution program. Source of final data is Oklahoma Vital Statistics, 2016.
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Data reflect the percent of births delivered at Oklahoma birthing hospitals participating in the sleep sack distribution program. Source of provisional data is Oklahoma Vital Statistics, 2017.

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

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

State Provided Data		
	2016	2017
Annual Objective		86.5
Annual Indicator	86.5	87.1
Numerator	45,490	43,576
Denominator	52,607	50,008
Data Source	Oklahoma Vital Statistics	Oklahoma Vital Statistics
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	88.0	88.9	89.7	90.6	91.5	92.5

Field Level Notes for Form 10a ESMs:

- Field Name:** 2016

Column Name: State Provided Data

Field Note:
Data reflect the number and percent of births delivered at Oklahoma birthing facilities participating in the Period of Purple Crying program. Source of final data is Oklahoma Vital Statistics, 2016.
- Field Name:** 2017

Column Name: State Provided Data

Field Note:
Data reflect the number and percent of births delivered at Oklahoma birthing facilities participating in the Period of Purple Crying program. Source of provisional data is Oklahoma Vital Statistics, 2017.

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

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

State Provided Data		
	2016	2017
Annual Objective		4
Annual Indicator	3	3
Numerator		
Denominator		
Data Source	MCH Training Log	MCH Training Log
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	5.0	6.0	7.0	8.0	9.0	10.0

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
------------------------	---------------

State Provided Data		
	2016	2017
Annual Objective		4,300
Annual Indicator	3,350	4,389
Numerator		
Denominator		
Data Source	MCH PREP Program	MCH PREP Program
Data Source Year	2016	2016
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	4,500.0	4,700.0	5,000.0	5,200.0	5,400.0	5,600.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

Number reflects the total who initiated or attended at least one session for the 2017 academic year, August 2016 to July 2017.

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

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

State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	94	164
Numerator		
Denominator		
Data Source	Sooner Success	Sooner Success
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	170.0	178.0	187.0	197.0	207.0	217.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data

Field Note:

Rather than providers data reflect the number of practices who address transition. Collecting data at the provider-level has been problematic. Oklahoma may look to change this measure in future reporting.

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"> <tr> <td>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:	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.								

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, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active									
Goal:	Increase the number of service sites utilizing any preconception health tool									
Definition:	<table border="1"> <tr> <td>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>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 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 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 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active								
Goal:	Increase the number of birthing hospitals participating in the safe sleep program								
Definition:	<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 7.1.1 - The percentage of infants delivered at birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum

NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active								
Goal:	Reduce the number of infants who experience abusive head trauma								
Definition:	<table border="1"> <tr> <td>Numerator:</td> <td>The number of infants delivered in birthing hospitals providing the Period of Purple Crying Abusive Head Trauma curriculum</td> </tr> <tr> <td>Denominator:</td> <td>The number of resident live births</td> </tr> <tr> <td>Unit Type:</td> <td>Percentage</td> </tr> <tr> <td>Unit Number:</td> <td>100</td> </tr> </table>	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
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:	<p>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.</p> <p>The Period of Purple Crying. National Center on Shaken Baby Syndrome.http://dontshake.org/purple-crying</p>								

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, ages 12 through 17, 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>300</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:	300
Numerator:	The number of providers who address transition to adult health care in their practice								
Denominator:	NA								
Unit Type:	Count								
Unit Number:	300								
Data Sources and Data Issues:	CSHCN Program, Oklahoma Department of Human Services & SoonerSuccess								
Significance:	<p>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.</p> <p>Center for Health Care Transition Improvement, Maternal and Child Health Bureau and the National Alliance to Advance Adolescent Health.</p>								

Form 11
Other State Data
State: Oklahoma

The Form 11 data are available for review via the link below.

[Form 11 Data](#)