



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

**State Narrative for
Oklahoma**

**Application for 2013
Annual Report for 2011**



Document Generation Date: Monday, September 24, 2012

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section. IA - Letter of Transmittal

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The Assurances Non-Construction Programs, Form 424B, is signed by the Oklahoma Commissioner of Health. The Certifications regarding debarment and suspension, drug-free workplace requirements, lobbying, Program Fraud Civil Remedies Act (PFCR), and environmental tobacco smoke are also signed by the Oklahoma Commissioner of Health. The original signed documents are kept in a central folder in the Maternal and Child Health Service (MCH) at the Oklahoma State Department of Health. Copies are available upon request by contacting MCH at (405)271-4480 or PaulaW@health.ok.gov.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

E. 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.

/2012/ On January 27, 2011, a press release was issued from the Oklahoma State Department of Health (OSDH) seeking public input for the MCH Title V Block Grant Federal Fiscal Year (FFY) 2012 State Plan. The public was invited to provide feedback for the state plan until May 2, 2011. The block grant and news release were posted on the OSDH website with contact information for comments. Several health and family websites and local newspapers throughout the state picked up the news release. From this news release, emails and telephone calls were received providing thoughts and ideas on how to improve health in Oklahoma and soliciting more information about Title V. *//2012//*

/2013/ A press release was issued on January 26, 2012 describing the needs of the Oklahoma State Department of Health (OSDH) for public input for the MCH Title V Block Grant Federal Fiscal Year (FFY) 2013 State Plan. Some partner agencies, such as the Oklahoma Hospital Association and the Oklahoma Family Network, also distributed the call for input via e-mail, newsletters, and Facebook. //2013//

For the Title V 2011-2015 Needs Assessment, public input was sought in a variety of ways. On March 30, 2009, a press release was sent out announcing the State's intent to open up an anonymous, online survey about the health needs for the maternal and child health (MCH)

population in Oklahoma. The press release was picked up by several newspapers and newsletters. The press release explained Title V, its funding source, mission, and directed the potential respondents where and how to access the survey. Postcards were distributed at various meetings and conferences announcing the survey and encouraging participation. Approximately 700 individuals representing stakeholders from various professions, agencies, programs, and consumers participated in the online survey. At the completion of the survey, participants were invited to return to the website for a summary of the findings. Refer to the Oklahoma Title V 2011-2015 Needs Assessment, Appendix A, for a copy of the survey, and Appendix B for a summary of the findings.

/2012/ The Oklahoma Title V 2011-2015 Needs Assessment document continues to provide an avenue for feedback. A survey link is incorporated into the online document with an open comment section provided at the bottom of the survey to communicate recommended changes to the needs assessment or the process for gathering data, and to provide input on the health of Oklahomans.

A revision of the previous online Title V Needs Assessment Survey to determine priorities and needs in Oklahoma is underway. The new version will be specific to the American Indian population in Oklahoma, in an effort to better serve this population. Partners at the Oklahoma City Area Inter-Tribal Health Board Tribal Epidemiology Center are engaged to facilitate this effort. //2012//

/2013/ Due to a ruling by the Oklahoma City Area Inter-Tribal Health Board, Institutional Review Board (IRB) approval was necessary before beginning the assessment. Approval was sought from tribal nations with IRBs (Cherokee, Chickasaw, and Choctaw Nations) and the Indian Health Services (IHS) IRB. IHS approval has been obtained, and currently applications are under review for the Cherokee, Chickasaw, and Choctaw Nations. Once approvals are obtained, the dissemination of the survey will begin. //2013//

Information from the online surveys was used to identify priority needs for all three Title V population groups. In addition two task forces, the Perinatal Advisory Task Force (PATF) and the Child Health Advisory Task Force (CHATF), were presented the top 10 priorities selected from a review of public input and data. These task forces assisted the Title V Program to narrow the focus to the top three-to-five priority needs for each population group. Refer to Appendix C of the Oklahoma Title V 2011-2015 Needs Assessment for a flow chart on stakeholder involvement in the Title V Needs Assessment process. Several Title V funded programs in MCH and Children with Special Health Care Needs (CSHCN) have mechanisms and advisory groups to facilitate public, family, and consumer input addressing specific issues or projects. For example, focus groups are used to gain input into policies and service. The Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS) and The Oklahoma Toddler Survey (TOTS) have a joint Steering Committee which consists of a diverse group of interagency professionals and individuals who offer input on survey methods, survey questions, incentives, and analysis projects. In addition, the First Grade Health Survey, exclusively Title V funded, relies on individuals with experience in children's health, education, as well as family input, to craft and revise the survey questionnaire. 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. CSHCN receives input at monthly meetings with the Sooner SUCCESS (State Unified Children's Comprehensive Exemplary Services for Special Needs) State Interagency Coordinating Council which consists of professionals and family members from numerous agencies that provide services to children with special needs. CSHCN also receives input from several parent groups at various conferences held throughout the year, as well as from surveys and face-to-face interaction. These are but a few examples of how the Oklahoma Title V Program incorporates public input into ongoing activities and programs.

/2012/ Preconception and pregnancy health focus groups conducted in the spring and fall 2010

have provided additional insight into how to better serve women and families in the Oklahoma City and Tulsa areas. See the Needs Assessment Summary for more detailed information about these groups and their findings.

Public input via community partners continues to inform MCH and Children with Special Health Care Needs Program (CSHCN). Title V-funded surveillance projects, such as the First and Fifth Grade Health Surveys, Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), and The Oklahoma Toddler Survey (TOTS) were revised with the assistance of partner agencies, client and participant feedback, and the 2011-2015 Title V Needs Assessment. In addition, MCH receives client input via customer satisfaction surveys at clinics around the state.

CSHCN continues to receive input at monthly meetings with the Sooner SUCCESS (State Unified Children's Comprehensive Exemplary Services for Special Needs) State Interagency Coordinating Council, which consists of professionals and family members from numerous agencies that provide services to children with special needs. CSHCN also receives input from several parent groups at various conferences held throughout the year, as well as from surveys and face-to-face interaction. //2012//

//2013/ No changes were made to the methods employed by MCH or CSHCN for gathering public input and community feedback on programs and projects. Surveys, community forums, conferences, and meetings remained important avenues of communication with the populations served by the Oklahoma Title V programs. //2013//

Oklahoma provides access for public input to the MCH Title V Block Grant throughout the year via an active link to the federal Maternal and Child Health Bureau (MCHB), Title V Information System (TVIS) website. This active link titled, Public Input Sought For Maternal and Child Health Services Title V Block Grant, is found at the bottom of the MCH web page, www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/, on the Oklahoma State Department of Health's (OSDH) website. Information on how the public may forward input on the grant is provided on the MCH web page directly under the active link. The CSHCN, Oklahoma Department of Human Services (OKDHS), has a link to the OSDH MCH web page on the CSHCN web page, <http://www.okdhs.org/programsandservices/health/cshcn/> on the OKDHS website. Hard copies of the MCH Title V Block Grant are also provided on request to MCH at (405) 271-4480 or via e-mail to PaulaW@health.ok.gov.

//2012/ Oklahoma maintains an active link to the federal MCHB, TVIS website. This link titled, Public Input Sought For Maternal and Child Health Services Title V Block Grant, is found at the bottom of the MCH web page, www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/, on the OSDH website. The OKDHS also maintains a link to the MCH web page on the CSHCN web page, <http://www.okdhs.org/programsandservices/health/cshcn/> on the OKDHS website. Hard copies of the MCH Title V Block Grant are also available on request to MCH at (405) 271-4480 or via e-mail to PaulaW@health.ok.gov. //2012//

//2013/ No changes have been made to the active link to the TVIS website. This link titled, Public Input Sought For Maternal and Child Health Services Title V Block Grant, is found at the bottom of the MCH web page, www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/, on the OSDH website. CSHCN also maintains a link to the MCH web page on the CSHCN web page, http://www.okdhs.org/programsandservices/health/cshcn/ on the OKDHS website. Hard copies of the MCH Title V Block Grant are also available on request to MCH at (405) 271-4480 or via e-mail to PaulaW@health.ok.gov. //2013//

Public input via e-mail, letters, and telephone calls is received intermittently throughout the year. MCH and CSHCN use this public input in 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 for submission to the MCHB.

II. Needs Assessment

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Title V Needs Assessment for the years 2011-2015 consisted of an 18-month process that culminated in the setting of ten state priorities as focus areas to improve the health of pregnant women, mothers, infants, children, and children with special health care needs. Through the continuous and ongoing collection, extensive research, evaluation, and analysis of all available data and data sources, along with the attendance of regularly-scheduled meetings, organized focus groups, and survey input, the Title V program (MCH and CSHCN) and the Oklahoma Family Network (OFN) were able to formulate and conclude how best to serve all aspects of Oklahoma's MCH population, taking into account the state's current and anticipated economic climate and system capacity. Over 700 community members, social service and public health professionals, family members, and health care providers participated in the process which began with open-ended comments in a survey and became increasingly more focused as time and efforts progressed.

The process for priority selection differed significantly from the one used for the program years, 2006-2010. Community and family involvement improved significantly with the development of the online survey tools which were widely disseminated through partner networks (See Appendix G of the Title V Needs Assessment). The use of a priority matrix enabled staff to review comments, obtain community input, determine the feasibility of impact, and review data trends in the prioritization of issues. The involvement of task force groups, who specialized in each area of MCH, enabled the MCH, CSHCN, and OFN to identify the top three to five priorities for Parts A, B, and C utilizing a more inclusive methodology.

Agency capacity to address the priorities, performance measures, indicators, and outcome measures has changed somewhat since the previous application period. The greatest change has been reduction in funding due to the economic downturn. This is presenting challenges, yet these challenges are also being viewed as opportunities.

The chosen priorities for the federal fiscal years 2011-2015 are a realignment of the previous needs assessment along with a shift in focus towards reducing infant mortality rates within the state. Several of the state priorities affect all MCH population groups and are therefore considered overarching priority needs: access to care, tobacco prevention, obesity, and preconception care. By enhancing and targeting efforts in these areas, it is theorized that the health among all MCH population groups will be positively impacted. Those more specific state priorities, unintended pregnancies, infant safe sleep, infant mortality, motor vehicle injury, child care for families with CSHCN, and transition to adulthood for CSHCN are targeted more towards groups within the MCH overall population; however, some, such as reducing unintended pregnancy and infant mortality rates have the potential to positively impact all three population groups. Within all of the chosen priorities health equity and reducing health disparities are sentinel to Oklahoma's MCH policy and practice.

The MCH Title V Needs Assessment is an on-going process. MCH continues to monitor 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 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. Progress on performance measures for the identified priorities is documented in Step UP ("Strategies toward

excellent performance-Unlimited Potential"), the Agency's electronic system for monitoring progress on priorities.

Due to an increasing emphasis on preterm birth reduction in Oklahoma, MCH has made the decision to include a new state performance measure to reduce preterm birth (SPM #10). Infants born prior to 39 completed weeks of gestation have greater risks for morbidity and mortality, evidence of which comes from greater number of neonatal intensive care unit (NICU) admissions, more frequent and longer hospitalizations, and considerably higher associated medical costs. In Oklahoma, disorders relating to short gestation and low birth weight are the second most common cause of infant mortality. Recent trend data illustrate a steady increase in the rate of premature birth among infants. This rise in the rate of preterm birth has led to a distributional shift in the average gestational age for Oklahoma births. In the relatively short span of 15 years, the average gestational age has decreased from 40 weeks to 39 weeks of gestation.

However, efforts in the state to affect this issue have shown promise. The Prematurity Workgroup of "Preparing for a Lifetime, It's Everyone's Responsibility" is dedicated to reducing the number of preterm births in the state. Their flagship project is a hospital-based initiative to eliminate non-medically indicated scheduled inductions and caesarian sections prior to 39 weeks. Currently 90% of Oklahoma birthing hospitals are participating affecting approximately 95% of births in the state. The project has been successful at reducing the number of early, elective scheduled births in participating hospitals from approximately 7% to 2% in one year.

MCH surveillance activities continue to provide the data necessary to make informed decisions for program management and short and long-term planning. In the spring of 2011, MCH conducted the statewide 2011 collection year cycle of the Youth Risk Behavior Survey (YRBS). Data from the YRBS represent all public school students in the state. With the completion of the 2011 YRBS, Oklahoma marks the 5th consecutive collection cycle for which weighted data have been achieved. To date, a series of fact sheets based on the key surveillance domains (e.g., sexual behaviors, injuries, obesity, alcohol use, tobacco use, and violence) have been developed and distributed to MCH partners. Additional analyses are underway. Also, MCH recently has administered the First Grade Health Survey for the 2011-2012 school year. Although challenging, survey response was sufficient to achieve weighted analysis data. Currently, data are being prepared for electronic data entry. Analysis of these data will take place once an electronic database has been created and at the time analysis weights have been developed and applied.

Feedback for the current Title V Needs Assessment document continues to be solicited via an online survey. Comments are reviewed periodically to determine if changes are necessary to the assessment, the online display, or the navigational functions of the online documents. Public comments indicate that at this time no changes are necessary to the needs assessment.

The Oklahoma City Area Inter-Tribal Health Board, MCH's partner in the American Indian Needs Assessment project, determined Institutional Review Board (IRB) approval was necessary before beginning the needs assessment. Beginning in August 2011, approval was sought from tribal nations with IRBs (Cherokee, Chickasaw, and Choctaw nations) and the Indian Health Services (IHS) IRB. IHS approval has been obtained, and currently applications are under review for the Cherokee, Chickasaw, and Choctaw nations. Once approvals are obtained the dissemination of the survey will begin.

MCH continues to evaluate current programs and priorities using the Life Course Perspective Theory as a guide. The goal is to enhance existing infrastructure by incorporating the Life Course Perspective, in order to improve the health of generations of Oklahomans - women, children, and their families. Life Course Perspective Training was facilitated by MCH for the Joining Forces Conference on May 7, 2012. Training for all MCH staff on incorporating Life Course Perspective was given on May 18, 2012 and a similar training for county health department staff is scheduled for August 17, 2012. The Oklahoma City Area Inter-Tribal Health Board held a conference centered on Life Course in April 24-25 2012 entitled "Health Across the Life Span." MCH staff

presented on Infant Safe Sleep and "Preparing for a Lifetime, It's Everyone's Responsibility" at this conference. MCH will work with the OSDH's Oklahoma Health Equity Campaign and the Oklahoma Turning Point Initiative (a community-based collaborative to engage local partners in public health) in an effort to expand the concept of Life Course Perspective across the state. In addition, in June 2012, MCH submitted an application to participate in the Life Course Metrics Project sponsored by the Association of Maternal and Child Health Programs (AMCHP). MCH identified a diverse team of public health professionals, both internal and external to the OSDH, to support these efforts. On June 21, 2012 MCH learned that the Oklahoma team was not selected to participate; however, team members will be utilized by MCH to provide comments and feedback to the national team during the public comment period.

III. State Overview

A. Overview

Oklahoma has a diverse geography with a quarter of the state covered by forests and includes four mountain ranges: the Arbuckle, Ouachita, the Ozark Plateau, and the Wichita. Oklahoma is one of only four states with more than 10 distinct ecological regions. To the west, the state has semi-arid plains, while in the central portion of the state transitional prairies and woodlands give way to the Ozark and Ouachita Mountains, which stretch out in an eastward direction towards the Arkansas border. The diversity of the geography is matched by the diversity of the state's people and their life experiences. Health care access and availability, transportation options, and employment opportunities are not always consistent and vary by region of the state.

Demographics

In 2009, Oklahoma had an estimated 3,687,050 residents, an increase of 43,025 (1.1%) from 2008, and ranked as the 28th most populous state. The state's population has increased each year since the year 2000 Census was conducted. Since that time, the population has grown in absolute terms by 236,396 representing relative growth of 6.9 percent. With its 77 counties, the state spans some 69,898 square miles, ranking 20th in land area, with approximately 53 persons per square mile, and ranking 36th among all U.S. states in population density. Roughly positioned in the center of the 48 contiguous states, Oklahoma is bordered by six states: Arkansas, Colorado, Kansas, Missouri, New Mexico, and Texas. Oklahoma, characterized mainly as a rural state, has three larger cities. The largest of which is Oklahoma City, the state's centrally located capitol city, home to 551,789 residents (15.1%). Approximately 100 miles to the northeast is Tulsa, a city that accounts for 385,635 (10.6%) of the state's population. Nearly 90 miles to the southwest along Interstate 44 is the city of Lawton, which has a total population of 90,091, or 2.5 percent of the state's total.

*//2012/ U.S. Census Bureau data collected in the 2010 Census indicate that Oklahoma's total population has increased by 1.7 percent to 3,751,351 from 3,687,050 estimated in 2009. //2012//
//2013/ Oklahoma's population increased by 1.1 percent to 3,791,508 from the 2010 Census estimate. //2013//*

Nearly 60 percent of the Oklahoma population resides in the metropolitan statistical areas of Oklahoma City (1,189,529; 32.9%) and Tulsa (903,868; 25.0%). A much smaller percentage of the Oklahoma population lives in the metropolitan statistical area of Lawton (112,653, 3.1%). The remainder of Oklahomans resides in rural locales, smaller cities, and towns beyond the periphery of the three metropolitan centers. Recent years have seen population shifts to the more urban areas.

Approximately 25 percent of the Oklahoma population is under 18 years of age. Persons aged 65 years and older make up 13.5 percent, leaving about 61 percent of the population between the ages of 18 and 64 years. The male-female ratio is roughly 1:1. In 2008, females of childbearing age (15-44 years) numbered 722,027, or about 20 percent of the Oklahoma population. The white population makes up 78 percent of the total population, while African American/Black and American Indian/Alaska Native citizens both equal about 8 percent. Less than 2 percent of the population is of Asian descent. As a percentage of the total population, Oklahoma's American Indian/Alaska Native population is about 8 times larger than the comparable U.S. population. Oklahoma is home to the largest number of federally recognized tribes, 38 American Indian tribal governments with an additional tribe pending federal recognition. The Hispanic or Latino population comprises 7.6 percent of the total Oklahoma population.

//2012/ Updated 2009 population estimates for the number of females of childbearing age show that in that year there were 729,110 females aged 15 to 44 years residing in the state. No change in the percent of the total population was evident. This population subgroup still represents approximately 20 percent of Oklahoma's overall population. //2012//

//2013/ Population estimates from July 1, 2011, the latest data available, indicate a 1.9 percent increase in the number of Oklahoma females of childbearing age; 742,805 women

between the ages 15-44 reside in Oklahoma. //2013//

Variations exist by race and ethnicity in the primary location of residences. While the white population is spread geographically across the state, the African American population tends to reside in the urban areas of Oklahoma City and Tulsa. The American Indian population has greater presence in the northeast quadrant of the state, a legacy of the U.S. federal government tribe relocation programs of the 19th century. Initially, the Hispanic population growth was isolated in many of the rural farming communities of the state, particularly in the south and southwest regions, as well as the panhandle of the state; however, more recent trends show that this population has begun to merge itself into the larger metropolitan areas.

Oklahoma's per capita personal income was \$35,268 in 2009, ranking 34th among all states, and representing about 90% of the national value. For the general population, nearly 16 percent of Oklahomans live below the federal poverty level. The poverty rate rises when considering only females aged 15-44, the principal childbearing age group. For this group, 1 in 5 live at or below 100% of the federal poverty level. For children aged 24 years and younger, 24 percent are at poverty status. Oklahoma is a poor state and despite relatively low unemployment rates, the state estimates that 14 percent of all Oklahomans do not have health coverage. In 2008, 12.6 percent of children under the age of 19 years were reported to be without health care coverage. ***//2013/ The 2010 American Community Survey estimated that 18.9 percent of all Oklahomans do not have health insurance. Ten percent of children (<18 years) are estimated to be without health insurance. Oklahoma's per capita personal income grew to \$37,277 in 2011, ranking 34th among all states, and representing about 90% of the national value. //2013//***

Economy

Oklahoma is a major producer of natural gas, oil, and agricultural products. The state's economic base relies on aviation, energy, telecommunications, and biotechnology. The two major metropolitan centers, Oklahoma City and Tulsa, serve as the primary economic anchors for the state. The top employers within the state are the State of Oklahoma (38,000), Tinker Air Force Base (24,000), and the U.S. Postal Service (8,700). From the health care sector, Integris Health (6,200), OU Medical Center (3,250), Mercy Health System of Oklahoma (2,426), and SSM Health Care of Oklahoma (2,355) contribute a sizable number of jobs to the Oklahoma economy. *//2012/* Recent data show that the top employers in the state are the State of Oklahoma (35,000), Walmart and Sam's Club (32,500), Tinker Air Force Base (24,200), Fort Sill and U.S. Army Field Artillery Center (19,000), and the University of Oklahoma (12,250). The leading health care sector employers include Integris Health (8,500), St. Francis Hospital (5,250), Marian Health System (6,000), Mercy Health System (4,750), and the Veterans Administration (4,000). *//2012//*

Oklahoma's gross domestic product (GDP), the output of all goods and services produced by the economy, totaled \$146.4 billion in 2008, up 2.7 percent from 2007 in real dollar terms. As a percentage of the GDP, industry share in the Oklahoma economy was led by trade, transportation, and utilities at 17.6 percent, followed by government at 15.7 percent. Mining, financial services, and manufacturing represented 14.3 percent, 12.0 percent, and 10.8 percent, respectively. Gaming (lotteries and casinos) has become a significant contributor to the Oklahoma economy. Behind California, Oklahoma now has the second largest gaming revenue from American Indian gaming ventures. In 2008, Oklahoma tribal casinos brought in almost \$2.9 billion in gaming revenue, an 18 percent growth from the previous year. Tribal gaming fees have contributed \$107.5 million to the state treasury for fiscal year 2010, with the forecast suggesting the amount will rise to \$120 million by fiscal year end. Most of the tribal gaming fees are directed towards funding for public schools, but \$250,000 per year is provided to the Oklahoma Department of Mental Health and Substance Abuse Services for remediation of gambling problems. As of June 2010, there were 110 casinos operating in the state.

//2012/ Oklahoma's real (adjusted for inflation) gross domestic product (GDP) growth was 1 percent in calendar year 2010, ranking the state 47th nationwide. The value of the state's output for all the goods and services produced during 2010 was \$133.5 billion, up from the \$132.1 billion

posted for 2009, but lower by 8.8 percent than that recorded for 2008 (\$145.4 billion). There was a percentage shift in industry trade for the year with state government making up 17.2 percent of Oklahoma's GDP, leading all industries in the contribution to the economy. Trade, transportation, and utilities contributed 16.4 percent of GDP, while financial services and mining accounted for 13.9 percent and 13.8 percent, respectively.

Oklahoma tribal gaming revenues rose by nearly 7 percent in calendar year 2009, outpacing the nation as a whole, which experienced a decline in gaming revenues, a first for the gaming industry. Growth of gaming has been attributed to favorable legislation and regulation that has enabled expansion and replacement of existing gaming operations. This growth continued throughout 2010. //2012//

In general, Oklahoma's economy tends to follow broad national economic trends. According to the National Bureau of Economic Research (NBER), the U.S. economy entered a recession in December 2007. The U.S. economy declined 5.4 percent in the 4th quarter of 2008 and 6.4 percent in the 1st quarter of 2009; these economic contractions represent the largest declines experienced since the early 1980s. More recent data show the national economy expanding with positive growth of 5.6 percent and 3.0 percent in the 4th quarter of 2009 and the 1st quarter of 2010, respectively. State data for GDP lag behind that of the national economy; therefore it is often not a timely indicator of the current economic conditions. However, it can provide valuable signals of the state's economic growth.

Preliminary data from the U.S. Bureau of Labor Statistics for April 2010 show the Oklahoma unemployment rate at 6.6 percent of the available labor force (1,779,708). The unemployment rate is down from a high of 6.9 percent reported in October 2009. As a percentage, Oklahoma's unemployed labor force is smaller relative to the U.S. In April 2010, there were 608,000 first time claimants for unemployed benefits. Total non-farm employment represents approximately 92 percent of Oklahoma employment with the largest contributor being government jobs, 22 percent or approximately 335,800. Employment in "trade, transportation, and utilities" and "education and health services" represents 18.1 percent (276,300) and 13.6 percent (206,500) of Oklahoma jobs, respectively. Overall, non-farm employment over the 12-month period ending in April 2010 showed a decline of 1.7 percent, a pace that has decelerated over the preceding six months. Oklahoma's two largest counties, Oklahoma and Tulsa, account for roughly 50 percent of the state's total employment. Job loss for 2008-2009 has hit industries relatively hard with all sectors except two (Government and Education and Health Services) experiencing a loss in the number of jobs. The heaviest hit industry was manufacturing with more than 20,000 jobs lost during the period. Professional and business services lost another 17,300 positions in the Oklahoma economy. Government and Education and Health Services added 9,200 and 4,000 jobs, respectively.

/2012/ Annual average unemployment rates in 2010 rose in 52 counties in Oklahoma, declined in 21 counties, and remained the same in 4 counties, when compared to 2009 figures, according to data released by U.S. Bureau of Labor Statistics. The state jobless rate for 2010 was reported to be 7.1 percent, significantly different from the U.S. average of 9.6 percent. //2012//

/2013/ The unemployment rate for Oklahoma in 2011 was 6.2 percent, 2 percent less than the national unemployment rate of 8.2 percent. The state unemployment rate has continued to decline with the most recent estimates from March 2012 reporting a rate of 5.4 percent, compared to the national rate of 8.2 percent. //2013//

Budgetary Concerns

Oklahoma had been slower to feel the impact of the national economic situation due to oil and natural gas prices. With the drop in market prices for those energy products, the state has since been faced with budget shortfalls that have approached 18.5 percent of its general fund budget. To end state fiscal year (SFY) 2009, state agencies received a 1.4 percent budgetary cut in June 2009. On July 1, 2009, SFY 2010 began with state funding down \$612 million from SFY2009. A state fiscal budget of \$7.2 billion was approved, an amount similar to previous state budgets, yet, with an important difference; \$631 million of the \$7.2 billion were federal stimulus funds. For SFY

2010, state budgetary shortfalls were closed through a combination of spending cuts and use of federal stimulus dollars.

In response to the state's budgetary situation, the Commissioner of Health, with support of the Board of Health, made the decision in early SFY 2010 to reduce the Oklahoma State Department of Health's state budgets by 7.5%. With this proactive decision, the Oklahoma State Department of Health (OSDH) has been able to move forward with operations and not react monthly to news of continuing state budget shortfalls.

For SFY 2011, the governor and legislative leaders agreed on a \$6.8 billion budget. Budget analysts and negotiators had \$1.2 billion less to work with than was originally appropriated. To address the shortfall, leaders proposed a balanced budget (required by law) using a series of targeted agency cuts, reserve and stimulus funds, cost recovery methods, and other unnamed savings and efficiencies across state government. State agencies again received cuts in state appropriations. The level of cuts differed among the state agencies with the OSDH receiving a 7.5 percent reduction. With this 7.5 percent reduction, combined with SFY 2010 cutbacks, the agency was subject to an equivalent of a 15 percent decrease in budget funds for the two year period. In addition, the OSDH faces approximately \$3 million in additional costs each year due to increasing health care costs and benefits for the current workforce. With the response to a Voluntary Out Benefit Offers (VOBO) by retirement eligible staff, some pressures on agency funds have been relieved. Senior leadership of the agency does not anticipate furloughs of the workforce in SFY 2011, as were necessary in other state agencies.

The downside of the reduction in budget funds and staffing is the elimination of services to the Oklahoma population. Budget difficulties have led to decreases in services to residents, including those who are most vulnerable. Current estimates indicate that 11,000 individuals and families have been affected by the agency budget shortfall. Another consideration with the loss of agency staff to retirement is the concomitant loss of years of experience. Of the 354 eligible for the VOBO, 62 people elected to take early retirement. These individuals represented nearly 1,800 years of service to the state of Oklahoma.

/2012/ In May 2011, the new Oklahoma governor, Republican Mary Fallin, along with House Speaker Kris Steele (R) and Senate Pro Tempore Brian Bingman (R), announced a budget agreement to balance the state's budget without raising taxes. To address the \$500 million budget shortfall, the agreement focused heavily on targeted budget cuts.

Budget cuts to state agencies vary from 1 to 9 percent. The budget cuts for Health and Human Services Agencies are considerably less than reductions to other state agencies. The Departments of Education and Transportation are subject to budget reductions corresponding to 4.1 percent and 7 percent.

The final FY 2012 appropriation for the Oklahoma State Department of Health is \$60 million, down 4.2 percent from \$62.7 million in FY 2011. State appropriation for FY2012 to the Oklahoma Health Care Authority, the state's Medicaid agency, is \$983 million, down from \$993 million (1%). For the Department of Human Services, the allocated funds amount to \$537 million, a result of a decrease of nearly \$6 million (1.1%) from FY 2011. Total state fiscal year 2012 appropriations for the state agencies making up the government functions dedicated to health and human services amount to \$1.97 billion, a decline of \$24 million from the previous fiscal year. //2012//

/2013/ The final FY 2013 appropriation for the Oklahoma State Department of Health is \$61,783,682, a 2.8% increase from FY 2012. The final budget for the Oklahoma Health Care Authority is \$925,063,007, a decrease of over \$58 million (5.9%) from FY 2012. The Department of Human Services FY 2013 budget totals \$586,958,664, a nearly \$50 million (9.3%) increase from FY 2012. Total state fiscal year 2013 appropriations for state agencies making up government functions dedicated to health and human services amount to \$2.1 billion, an increase of \$121.7 million from FY 2012. //2013//

Public Health Workforce

The Oklahoma's Health Care Industry Workforce 2006 Report examined 2005 health care worker vacancies and projected shortages of 1) nurses, 2) lab technicians, 3) physical therapists, 4) surgical technologists, 5) occupational therapists, 6) pharmacists, and 7) radiology and respiratory professionals for 2012. In 2008, a follow-up study, conducted by the Oklahoma Healthcare Workforce Center, identified there were high vacancy rates and predicted shortage concerns for emergency medical technicians and chemical dependency counselors. National studies have shown that the public health workforce has: shortages of key public health personnel (e.g., epidemiologists and public health nurses); trends in insufficient number of experienced public health workers due to many approaching retirement age; inadequate incentives for recruitment and retention of qualified professionals; and insufficient preparation and orientation of students by professional education programs to the public health system.

The United Health Foundation report for 2009 ranked Oklahoma 49th in the nation for primary care physicians per 100,000 population, with five rural counties having only one physician providing primary care services. Migration of rural residents to the metropolitan centers has had a negative impact upon the availability of health care providers. Diminishing populations, rising medical liability costs, and low Medicaid reimbursement rates have influenced physicians to relocate or to restrict their practices. The net result has created a number of significant geographic gaps in obstetric and pediatric medical care across the state.

Awareness of these findings and what they foreshadow led to the development of the public health workforce development workgroup of the Oklahoma Health Improvement Plan (OHIP). This group seeks as its long-term outcome the creation of a private and public workforce that is well prepared, of sufficient size, and distributed geographically such that the health care needs of Oklahoma's population, rural and urban, can be fully met. The rural demographic of the Oklahoma population, its economic challenges, and the lack of primary care providers require that public health leaders identify new ways to assure that those citizens with need for health services have access to those services.

Government

The government of Oklahoma, modeled on the U.S. federal government, is a constitutional republic with legislative, executive, and judicial branches. Oklahoma has 77 counties, each having local jurisdiction over government functions, and five congressional districts. State officials are elected by plurality voting. The biennial Oklahoma legislature is bicameral (having two legislative chambers), consisting of a Senate and House of Representatives. The Oklahoma Senate has 48 members serving four year terms. Senators serve a staggered term; thus, only half of the senate districts have elections in any election year. The House has 101 members, each holding office for two year terms. Term limits restrict elected officials to a total of 12 cumulative years of service between both legislative branches. The Governor of the state is the principal head of government, serving as the chief officer of the executive branch of government. This office submits the budget and assures the enforcement of state law. Term of office is four years. The judicial branch consists of the Oklahoma Supreme Court, the Oklahoma Court of Criminal Appeals, the Oklahoma Court of Civil Appeals, and 77 District Courts, one for each Oklahoma County. Two independent courts, the Court of Impeachment and the Court on the Judiciary, are also included in the makeup of the judiciary branch. Judges sitting on the Supreme Court, the Court of Criminal Appeals, and the Court of Civil Appeals are appointed by the governor upon recommendation of the Judicial Nominating Commission. These judges stand for retention vote on a six year rotating schedule.

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

Voter registration for January 2010 shows that 49 percent of registered Oklahoma voters are registered with the Democratic Party. Republican Party members made up 39 percent of the registered electorate. However, the state is one of the more conservative in the union. Since 1968, the state's electoral votes have gone to the Republican presidential candidate. In 2008, Oklahoma was the only state whose counties voted unanimously for John McCain. The Oklahoma delegation to the U.S. House of Representatives represents five congressional districts with four of the five being registered Republicans. These House representatives are John Sullivan (R-OK1), Dan Boren (D-OK2), Frank Lucas (R-OK3), Tom Cole (R-OK4), and Mary Fallin (R-OK5). The two senators from Oklahoma are Tom Coburn (R) and James Inhofe (R).

The November 2008 election cycle saw for the first time in state history a sweep of both legislative chambers for the Republican Party. In the Oklahoma 52nd State Legislature 2009-2011, the majority (26) of the seats in the Senate is held by the Republican Party. The Democratic Party holds 22 of the Senate seats. Likewise, in the House, the Republican Party holds the majority, accounting for 62 of the 101 House seats. The Office of Governor is currently held by Brad Henry (D), whose second term will end in January 2011. Term limits bar Governor Henry from seeking reelection in November 2010.

//2012/ In November 2010, Oklahoma voters chose the state's first female governor, Mary Fallin (R), in historic elections that saw Republicans gain control of all eleven statewide offices for the first time in state history. Republicans hold the offices of Governor, Lieutenant Governor, State Auditor, Attorney General, State Treasurer, Superintendent of Public Instruction, Labor Commissioner, Insurance Commissioner, and Corporation Commissioner. At the state level, in the Senate, 31 of the 48 Senators are members of the Republican Party. In the House of Representatives, 70 of the 101 members are Republicans. //2012//

//2013/ The state senate is comprised of 32 Republican and 16 Democrat senators. The House of Representatives is now comprised of 67 Republican members, 31 Democrat members and has three vacant seats. //2013//

Legislative Update

MCH serves as a resource and provides education to state legislators and their staff prior to and during the legislative session each year to assist in the setting of state policy and procedure (e.g., this year: access to health care, breastfeeding, injury prevention, school health, child welfare). Analyses of bills are accomplished each year during session to identify issues that may present obstacles to improving the health of Oklahoma's maternal and child health population. These written analyses are shared with legislators and their legislative staff by the Commissioner of Health and the Director of the OSDH Office of State and Federal Policy. MCH also participates in state boards, task forces, workgroups, and committees during and between sessions per request of members of the state Legislature or as appointed by the Governor. MCH is able to provide to the legislative process the latest in national health care policy and practice; information on national, regional, and state health care issues and practices; and the most recent available national, regional, and state data for the maternal and child health population.

Another means afforded to MCH each year for involvement in the legislative process is participation in the Oklahoma Legislative Fall Forum. This annual event sponsored by the Oklahoma Institute for Child Advocacy, brings maternal and child advocates from the state, regional, county, and community levels together to focus on MCH health issues and set a legislative agenda.

During the 2010 legislative session, numerous bills were followed closely by OSDH and MCH: Autism: Senate Bill (SB) 2045 requires insurance companies to provide children with autism the same coverage for non-autism-related illnesses, diseases, and injuries that children without autism are provided, and states that such coverage does not constitute coverage for autism-related treatments. SB2045 was signed by the governor in April 2010.

Women, Infants and Children Supplemental Nutrition Program (WIC): House Bill (HB) 2775,

signed into law by the governor in April 2010, authorizes the OSDH to contract with existing vendors that provide electronic benefit transfer systems to the Oklahoma Department of Human Services to deliver WIC benefits electronically.

Maternal/Infant Care: HB2920 creates the Oklahoma Maternal-Infant Quality Care Act and the Oklahoma Maternal-Infant Quality Care Collaborative until December 2015 to identify and monitor ways to remove barriers to hospitals and providers in providing safe, quality health care for mothers and infants. HB2920 directs the collaborative to submit a report to the governor and legislature each December beginning in 2011. This House bill was approved by the governor in May 2010. SB1817 modifies language related to the treatment of eye diseases in newborns. The bill eliminates language requiring certain medical providers and parents of newborns to provide certain care. Physicians, midwives, and other birth attendants are required to ensure treatment of the eyes of the infant with a prophylactic ophthalmic agent as recommended by the CDC to prevent ophthalmia neonatorum. Under the bill, parents or legal guardian may refuse treatment if it is deemed in the best interest of the child. The health care provider must document refusal in the newborn's medical file. The Oklahoma State Board of Health is charged with promulgating rules to implement the legislation. SB1817 was signed into law in May 2010. /2012/ HB1826 requires every physician or other person permitted by law to attend upon pregnant females at the time of delivery when the female has had no prenatal care to take or cause to be taken under the order of a licensed physician a sample of blood from the pregnant female and submit it to an approved laboratory for HIV serological test. This bill was signed into law in April 2011. //2012//

Injury: SB1700 directs school districts to partner with the Oklahoma Secondary School Activities Association to develop the guidelines and forms to guide coaches, athletes, and parents or guardians about the nature and risk of concussions and head injuries. An information sheet on concussion and head injury must be completed and returned to the school district by the youth athlete and his/her parents before the athlete can return to practice and competition. SB1700 requires that a youth sustaining a concussion or head injury may not return to practice or competition until a licensed health care provider has evaluated and released the athlete. SB1700 was signed into law by the governor in May 2010.

/2013/ SB1882, signed into law April 2012, protects state and/or political subdivisions from liability, except by willful negligence, if a loss or claim results from the use of indoor/outdoor school property and facilities made available for public recreation before or after normal school hours or on weekends and vacations.

SB1316, signed by the governor April 2012, prohibits the state and/or a political subdivision from being liable if a loss or claim results from use of a public facility opened to the general public during an emergency. HB2419 exempts from liability for civil damages any entity or individual that provides access to a safe place in times of severe weather if acting in good faith and the damage or injury sustained was not caused by willful or wanton negligence or misconduct of the individual or entity. This bill was signed by Governor Fallin in May 2012. //2013//

Primary Care: HB1043 creates the Oklahoma Medical Loan Repayment Program to provide educational loan repayment assistance up to \$25,000 per year for five years for up to six Oklahoma licensed primary care physicians per year who agree to set up practice in a community approved by the Physician Manpower Training Commission. The bill was amended in the Senate to add qualifications for physicians participating in the loan program. HB1043 was approved by the governor in May 2010.

/2012/ HB2017 modifies language of the Oklahoma Medical Loan Repayment Program, directing that the program is limited to available funding and removing the six-physician per year limit on repayment assistance. It directs awards to be made at the end of each year, and directs the Physician Manpower Training Commission to establish annual disbursement amounts. Eligibility requirements are modified to permit new primary care residency graduates with preferences to graduates of the OSU College of Osteopathic Medicine and the OU College of Medicine. The bill

affords the ability of the commission to fund new or expanded primary care residency programs in rural and underserved areas of the state. //2012//

/2013/ HB3058 creates the Oklahoma Hospital Residency Training Program with the purpose of establishing new training programs with the Oklahoma State University College of Osteopathic Medicine and the University of Oklahoma College of Medicine focused on meeting the health care needs of medically underserved areas within the state. SB1280 appropriates approximately \$3 million from the General Revenue Fund to financially support the residency training program. //2013//

/2013/ Dental: HB2587, signed by the governor in May 2012, increases from five to 25 the number of Oklahoma licensed dentists per year to be provided education loan repayment under the Dental Loan Repayment Program. It limits the number of years of participation to 5 and also removes language that required the participant to sign a contract to practice in a designated underserved area and see at least 30 percent Medicaid patients. This was modified so that the contract would be in accordance with Oklahoma State Department of Health rules. //2013//

/2012/ Nursing: HB1275, signed by the governor in April 2011, modifies language related to the Oklahoma Nursing Practice Act, creating a process of certification to obtain the title of advanced practice registered nurse. The bill defines penalties, both imprisonment and fines, which can be levied for anyone who assumes the role of an advanced practice registered nurse without receiving proper certification. Language is provided that creates titles for certified nurse practitioner and clinical nurse specialists, listing qualifications for certification of each. //2012//

/2013/ HB2266, signed by the governor in May 2012, authorizes registered nurses to use physician-approved protocols to provide public health services as an employee or contractor of any city-county, county, or the State Health Department. It also allows for a registered nurse to orally submit a prescription prescribed by an advanced practice registered nurse with prescriptive authority to the patient's pharmacy of choice. This bill also prohibits nurses from performing certain acts related to terminating pregnancies. //2013//

Nutrition: HB3015, signed into law by the governor in April 2010, modifies the definitions under the Agricultural Linked Deposit Act by including certified "healthy corner stores" under the definition of "eligible agricultural business." This bill requires eligible healthy corner stores to be certified by the Oklahoma Department of Agriculture, Food and Forestry to market locally grown fruits and vegetables and nutritious foods and for which the sale of beer and tobacco products comprise less than 10 percent of gross sales, excluding gasoline and other non-grocery items. The stores must be located in geographic areas considered underserved by grocery outlets meeting these requirements.

Health Care Reform: House Joint Resolution (HJR) 1054 proposed language prohibiting a state resident from being required to obtain or maintain a policy of health insurance coverage, except as required by a court or the Department of Human Services in a case where the individual is named a party in a judicial or administrative proceeding. HJR1054 sought to prohibit law or administrative rules that made Oklahoma residents liable for penalty or fine due to failure to obtain health insurance coverage. The resolution authorized the Senate president pro tempore and the House speaker to hire legal counsel to file a lawsuit against the U.S. Congress, the President and the Secretary of the U.S. Department of Health and Human Services to prevent the provisions of the Patient Protection and Affordable Care Act from taking effect. The Senate failed to override the governor's veto of HJR1054. Senate Joint Resolution (SJR) 0059 proposes a constitutional amendment prohibiting a law from compelling any person, employer, or health care provider from participating in a health care system and allowing a person or employer to pay directly for health care services without being required to pay penalties or fines. SJR0059 prohibits the purchase or sale of health insurance in private health care systems from being prohibited by law or rule. The conference committee report for SJR0059 has been read into the House as of May 2010.

/2012/ Hospital Offset Payment: HB1381 creates the Supplemental Hospital Offset Payment Program Act, which directs the Oklahoma Health Care Authority to assess hospitals licensed in the state a supplemental hospital offset payment program fee. Certain facilities are exempt: hospitals owned or operated by the state or federal government; facilities of federally recognized tribes or the Indian Health Service; hospitals providing more than 50% of its inpatient days under state contract other than the authority; hospitals with heavy patient load for services related to cardiac, brain injury, cancer, surgical or obstetric services with some exceptions; hospitals certified by Centers for Medicare and Medicaid Services (CMS) as long term acute care (LTAC) or children hospitals; and those facilities certified by CMS as critical access hospitals. The fee is calculated as a fraction of each hospital's net revenue. For state fiscal year 2012, the assessment rate is fixed at 2.5% and is prohibited from exceeding 4% in years afterward. The legislation will sunset on June 30, 2014.

Health Services Payment: HB1397 directs the Oklahoma State Department of Health (OSDH) to perform any and all health-related services within the scope of practice and as prescribed by state law and the Board of Health. The bill states that OSDH has the authority to submit claims for services rendered when those services are covered by a health insurance plan. HB1397 permits city-county health departments to submit claims for payment of services to an insurance provider. This bill was signed into law by the governor in April 2011.

Medicaid Eligibility Fraud: HB1736 authorizes the director of the Department of Human Services to investigate cases of Medicaid eligibility fraud. Any person falsely obtaining benefits can be subject to misdemeanor or felony charges. The bill, signed by the governor in April 2011, creates a misdemeanor or felony for the sale, possession, or use of a medical ID card permitting participation in the Medicaid program for any person not entitled or for attempting to obtain Medicaid benefits by omitting personal assets or other material eligibility factors.

Tort Reform: Several bills on tort reform were signed into law by the governor this year and go into effect November 1, 2011. HB2128 places a cap of \$350,000 on noneconomic damages, with exceptions for gross negligence, fraud, and malicious conduct. SB862 eliminates the "deep pocket" rule where defendants in a tort lawsuit are liable for the entire amount of the plaintiff's damage, regardless of their degree of fault. SB865 requires that juries be instructed that no part of the award for damages is subject to state or federal income tax, so juries should not consider taxes when determining an award. //2012//

Pregnancy Resource Centers: Senate Resolution (SR) 0082 expressed support for pregnancy resource centers, encourages their support and expresses disapproval for opposition to these centers. Resolution went to the Office of the Secretary of State in February 2010.

Abortion: SB1890 prohibits any person, knowingly or recklessly, from performing or attempting to perform an abortion with knowledge that the pregnant female is seeking an abortion solely on the account of the sex of the unborn child. The governor signed SB1890 in April 2010. SB1891 creates the Freedom of Conscience Act, which prohibits an employer from discriminating against an employee by refusing to accommodate the employee's religious views on abortion, uses of cells derived from human embryo, and other experimental or medical procedures defined in the bill. SB1891 states that a health care facility is not required to admit a patient or use its facilities for any of these defined acts. This bill was signed by the governor in April 2010. SB1902 prohibits a person from knowingly or recklessly giving, selling, dispensing, administering, prescribing, or providing RU-486 for the purpose of inducing an abortion in a pregnant female, unless that person is a physician meeting certain qualifications. SB1902 provides requirements for the dispensing of RU-486. This bill was signed by the governor in April 2010. HB2656 prohibits pregnant women and their families from seeking legal damages if physicians knowingly or negligently withhold information or provided information to them about their pregnancy. The state representative who authored the bill said the measure prevents a doctor from being sued based on the opinion after birth that a child would have been better off if s/he would have been

aborted. Governor Henry vetoed this bill. The veto was overturned by a vote in the House of 84-12 and by a Senate vote of 36-12. HB2656 was filed with Secretary of State in April 2010. HB2780 requires an abortion provider to perform an obstetric ultrasound on the female one hour prior to the abortion. Simultaneously, females receiving an abortion must listen to a detailed description of the ultrasound before an abortion can be received. In April 2010, HB2780 was vetoed by the governor, but was quickly overridden by a vote in the Oklahoma legislature. This bill is now law. However, in early May 2010, Oklahoma courts granted a reproductive rights advocacy group, The Center for Reproductive Rights, a temporary injunction, preventing the state from carrying out the law. HB3075 requires facilities performing abortions, other than those performed for the safety of the mother, to post a legal notice in the waiting or consultation room. The legal notice must state that it is illegal to perform an abortion against the female's will or to force a female to get an abortion. This bill was approved by the governor in April 2010. HB3284 creates the Statistical Abortion Reporting Act, requiring the OSDH to make an individual abortion form available to the Complications of Induced Abortion Report for the OSDH website. Women seeking abortions would be required to provide information that would then be posted to the website. Information about marital status; age; race; education; number of live births; miscarriages; abortions; type of abortion; and reasons for abortion would be included in the report. Governor Henry vetoed HB3284 which was then overridden by the House of Representatives on a vote of 81-14 and by a Senate vote of 36-12. The measure was filed with Secretary of State in April 2010.

/2012/ HB1888 creates the Pain-Capable Unborn Child Protection Act, prohibiting an abortion from being performed, induced, or attempted unless the physician had determined the probable age of the fetus. Failure to determine fetus age is considered conduct unprofessional. The bill prohibits a person performing, inducing, or attempting an abortion when it is determined by a physician that the age of the fetus is 20 weeks or more, unless medical judgment indicates a condition necessitating the abortion to avert the woman's death or serious, irreversible impairment. A physician performing an abortion must report to the OSDH if the age determination was made, the female's condition necessitating the abortion, and the method used to perform the abortion. The OSDH must issue a report by June 30 of each year detailing the previous year's abortion statistics. HB1888 was signed by the governor in April 2011.

HB1970 requires a physician prescribing mifepristone or any abortion-inducing drug to first examine the woman to document the gestational age and intrauterine location of the pregnancy in the woman's medical chart. The drug must be administered in the same room and in the presence of the physician providing the drug to the patient. The governor signed this bill in May 2011.

SB0547 prohibits inclusion of elective abortion coverage in any health insurance policy offered by the state's health exchange, established by the federal Patient Protection and Affordable Care Act. This bill prohibits elective abortion coverage in any plan not offered by the exchange but offered in the state, except by supplemental coverage with a separate premium. Any insurer offering a plan must calculate the premium for the coverage such that it covers the estimated cost of elective abortions per enrollee, determined by actuarial schedules. The bill prohibits an insurer from considering any cost reduction in a health plan covering enrollees estimated to result from the provision of abortion coverage to include prenatal care, delivery, or postnatal care. The bill was signed into law in April 2011. //2012//

/2013/ HB2381, signed into law May 2012, requires a physician who provides RU-486, mifepristone, or any other drug or chemical used to perform or induce an abortion to be present in the same room as the patient when the drug or chemical is first provided to the patient. It creates a felony for anyone who knowingly or recklessly violates the act. The bill allows the patient, the father of the unborn child married to the patient, or a maternal grandparent of the unborn child to maintain an action for actual and punitive damages. The bill also provides for civil fines for any person who knowingly or recklessly violates the terms of an injunction issued in accordance with the act. The license of the physician found guilty of violating this act may be suspended or revoked by the State Medical Board of Licensure and Supervision or the State Board of Osteopathic Examiners. The

anonymity of the patient is protected under this law.

HB2561, signed into law May 2012, allows a woman upon whom an abortion has been performed in negligent violation of statutes without voluntary and informed consent, without availability of certain printed materials, without a required ultrasound, and without being provided information about unborn child pain awareness, or the parent or legal guardian of the woman if she is an unemancipated minor, to bring a civil action against the abortion provider, the prescriber of any medicine intended to induce abortion, and against any person or entity which referred the woman to the abortion provider and who is or employs a licensed medical provider.

SB1274, signed into law April 2012, among other provisions, creates the Heartbeat Informed Consent Act, stating that prior to a woman giving informed consent to have an abortion performed or induced if the pregnancy is at least eight weeks after fertilization, the abortion provider may use a Doppler fetal heart rate monitor and make the embryonic or fetal heartbeat of the unborn child audible for the pregnant woman to hear if she requests.

HR1054, signed and filed with the Secretary of State April 2012, states that "person" means a human being at all stages of human development of life, including the state of fertilization or conception, regardless of age, health, level of functioning or condition of dependency. It also states that all persons are created free and have inalienable rights and that the resolution does not apply to in vitro fertilization. //2013//

Emergency Preparedness: SB1295 modifies the membership for the Oklahoma Emergency Response Systems Development Advisory Council (ERSDAC) to include a person with a specialization in pediatric services. HB1888, approved by the governor in June 2010, becomes the Ambulance Service Districts Act requiring local residents of all but the two largest Oklahoma counties submit an Emergency Medical Services (EMS) plan to the legislature and governor by April 1, 2012. With this legislation, county representatives will work with the OSDH to develop plans that assure a coordinated, statewide system to provide emergency medical services. The ERSDAC at the OSDH has responsibility for initiating the planning process and must work with the County Emergency Service Advisory Board to formulate the plan. A Board of local residents will be created to oversee the plan to ensure local control. Licensed ambulance services are required to respond to patients regardless of ability to pay or geographic funding districts.

Information Technology and Services: HB1704 created the Oklahoma Information Services Act and the position of Chief Information Officer (CIO) for the state. This position is appointed by the governor and has authority over the Information Services Division of the Office of State Finance. The CIO serves as the secretary of information technology and telecommunications purchasing director for all state agencies. In March 2010, Alex Pettit became Oklahoma's first CIO as he was named to the position by Governor Brad Henry. Reports estimate that Oklahoma employs approximately 1,500 information technology (IT) staff and spends greater than \$340 million per year on services, not including personnel costs. The legislation directing the appointment of the CIO mandates that there be a net savings within two years of Pettit's hiring.

/2012/ In May 2011, Governor Fallin signed into law HB1304, which centralizes policymaking, procurement and decision making into the CIO's office. Supporters of this legislation have described it as an attempt to streamline the purchase and use of computer technology, IT services, and data storage. A feasibility study found redundancy statewide, including 76 financial systems, 22 unique time and attendance recording systems, 17 separate imaging systems, 48 reporting and analytics applications, and 30 data centers. The study estimated that consolidation and modernization of the state's IT enterprise could significantly reduce the \$233 million in annual IT spending. Initial targets for consolidation include the state's mainframe computer equipment and email systems. //2012//

/2013/ IT consolidation continues in state agencies. The impact on individual programs and activities is largely uncertain. As of February 1, 2012, all IT services and personnel in

individual state agencies were transferred to the oversight of the Office of State Finance (OSF). OSDH was one of the first state agencies to make the transition to OSF. The former Chief of IT Services for OSDH transitioned to OSF in December 2011 becoming the Director-Health Sector for the state. //2013//

Data Capacity: HB3171 mandates that death certificates be filed with the OSDH within three days of the death. Funeral directors must sign the death certificate and are responsible for filing the certificate. The bill requires that the State Registrar of Vital Statistics provide all funeral directors and licensed physicians a system to electronically capture information and to file the death certificate with the OSDH. HB3171 was approved by the Governor in May 2010.

Voluntary Out Benefit Offer (VOBO): HB2363, approved by the governor in April 2010, permits state agencies to offer a voluntary buyout to state workers. This bill allows for \$5,000, coverage of 18 months for health insurance premiums, and a longevity payment. An agency must keep a VOBO position vacant for 36 months and the state employee accepting the VOBO is prohibited from being re-employed by the agency for at least three years. The bill reduces the full time equivalent authorization of an agency for every buyout. It has been estimated that the VOBOs authorized by HB2363 will save the state approximately \$70 million.

/2012/ Safety: SB0324 removes language regarding the operation of watercraft by children under age 12. It decreases from 0.10 to 0.08 the legal limit of blood or breath alcohol concentration for someone operating or in control of a water vehicle. This bill authorizes a law enforcement officer with reasonable suspicion to direct the administration of a test. SB0324 specifies which medical personnel can legally draw blood to determine alcohol concentration. The governor signed the bill into law in May 2011. //2012//

/2013/ Temporary Assistance for Needy Families: HB2388, signed into law May 2012, denies benefits to anyone the department determines to be engaged in the illegal use of controlled substance(s). It establishes guidelines for testing, appeal process, drug treatment program referrals, and reapplication for benefits. Benefits for eligible children of parents not eligible because of illegal substances will remain intact, but administered by an appropriate third party approved by the department.

Appropriations/Budget Bills: SB1980, signed by the governor, requires the University Hospitals Authority to transfer \$500,000 to the University Hospitals Authority Disbursing Fund, directs \$2 million to the Oklahoma Institute for Disaster and Emergency Medicine Revolving Fund, and \$375,000 to the Dental Loan Repayment Revolving Fund. Expenditures of \$356,000 are to be used to provide hearing services for deaf and/or hard of hearing children statewide and \$3 million are to be used for patient care at the University of Oklahoma Wayman Tisdale Specialty Health Clinic.

Child Health: By passage of HB2227, the Child Death Review Board was recreated within the Oklahoma Commission on Children and Youth until July 2, 2014. HB2251 defines a "drug-endangered child" and states that when the Oklahoma Department of Human Services (OKDHS) determines there is a child meeting the definition, the OKDHS must conduct a thorough investigation of the allegation and not to limit the evaluation of the circumstances to an assessment. //2013//

Population Health Ranking

The United Health Foundation's (UHF) "America's Health Rankings 2009" has ranked the state of Oklahoma 49th among all U.S. states, a downward shift of two positions from the UHF rankings published for 2008. The UHF report cited a number of challenges that must be addressed if Oklahoma hopes to improve its national standing. In particular, the report noted, (1) high prevalence of smoking, (2) high prevalence of obesity, (3) limited availability of primary care physicians, and (4) high rate of preventable hospitalizations. The report also identified areas of strength for the state; namely, the low prevalence of binge drinking and the higher funding per

capita for public health. To address the state's slide and position in the national rankings, the Board of Health and OSDH's Commissioner of Health, along with many external partners, launched the Oklahoma Health Improvement Plan (OHIP) in early 2010. The OHIP sets out flagship goals (e.g., tobacco use prevention, obesity reduction, and children's health) that must be given priority by OSDH program areas. Infrastructure goals that reviewed Oklahoma's public health finance, workforce development, access to care, and the effectiveness of health systems were established within the OHIP. In addition, there was review of societal and policy integration that examined social determinants of health and health equity as well as a recognition that the OSDH should pursue and advocate for policies and legislative reforms that maximize opportunities to improve the quality of life of Oklahoma's citizens. Future actions under the OHIP will include the development of a scorecard and reports that measure progress towards goals and objectives, incorporate ongoing community feedback to inform activities and projects, monitor strategies to reduce infant mortality, strengthen Oklahoma's public health workforce, and provide recommendations on improvement of public health financing.

/2012/ Oklahoma's health ranking improved to 46th with the release of the UHF's America's Health Rankings for 2010. Noted strengths included low prevalence of binge drinking, high per capita public health funding, and high immunization coverage. The report identified challenges for the state as well. Areas which continued to pose a challenge for Oklahoma were high prevalence of smoking and obesity, limited availability of primary care physicians, and high rate of preventable hospitalizations. //2012//

/2013/ Oklahoma's health ranking declined to 48th in the 2011 release of the UHF's America's Health Rankings. Strengths and challenges remain unchanged. //2013//

B. Agency Capacity

Oklahoma is one of seven states in the nation that the Maternal and Child Health Services Title V Block Grant Program is administered by two separate state agencies. Under the provisions of Public Law 97-35, Section 509(b), the Oklahoma State Department of Health (OSDH) and the Oklahoma Department of Human Services (OKDHS) share the administration of the Oklahoma Maternal and Child Health Services Title V Block Grant Program. Administration of Part A (preventive and primary care services for pregnant women, mothers, and infants) and Part B (preventive and primary services for children) is provided by the OSDH through the Community and Family Health Services (CFHS), Maternal and Child Health Service (MCH). Part C (services for children with special health care needs) is administered by the OKDHS through the Family Support Services Division (FSSD), Health Related and Medical Services (HRMS). As the state health agency, the OSDH receives the federal MCH Title V Block Grant funds from the Health Resources and Services Administration, Maternal and Child Health Bureau. Funding for the Children with Special Health Care Needs (CSHCN) Program is transferred to the OKDHS upon receipt of federal funds. Since the Omnibus Budget Reconciliation Act (OBRA) of 1981, the OKDHS has received its designated portion of the Title V monies to operate the CSHCN Program. The statutory authority which designates the OKDHS to operate the CSHCN Program is covered in Title 10 of the Oklahoma Statutes 1981, Section 175.1 et. seq. and article XXV of the Oklahoma Constitution.

The OSDH and the OKDHS collaborate to administer the CSHCN Program through a memorandum of agreement. This memorandum of agreement outlines the relationship between the two state agencies to include responsibilities for the MCH Maternal and Child Health Services Title V Block Grant Annual Report and Application. The current memorandum of agreement ends September 30, 2012. Copies of the memorandum of agreement may be obtained by contacting MCH at (405) 271-4480 or by e-mail at PaulaW@health.ok.gov.

/2013/ A new memorandum of agreement is in process and anticipated to be approved and signed by OSDH and OKDHS agency directors by October 1, 2012. A copy of the new agreement will be forwarded to the MCH Project Officer in the Region VI Office in Dallas once signed. Copies of the memorandum of agreement will also be available by

contacting MCH at (405) 271-4480 or by e-mail at PaulaW@health.ok.gov. //2013//

The Oklahoma Family Network (OFN) assures family input is received in the planning, development, and evaluation of Oklahoma Title V policy, procedures, and services. The OFN utilizes a statewide network of families to engage families as partners in Title V work at the individual, community, and policy levels. 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.

//2013/ With the support of OSDH Senior Leadership, MCH entered into a contract this year to provide funding to the OFN. This multi-year agreement will facilitate strengthening family involvement at the state and local levels through family participation and engagement in Title V activities. //2013//

The Oklahoma Title V Program enjoys strong relationships with state and community-based public and private partners. Title V is a strong, consistent voice in these relationships assuring a focus on the goal of promoting and protecting the health of all Oklahoma mothers and children as changes in state and local policy and procedures are explored to ensure and improve the statewide system of services. For example, the Oklahoma Health Improvement Plan (OHIP) Child Health Committee is focused on developing a state plan for improving children's health. The Title V MCH Director and Executive Director of OFN are members of this committee. Another example is the statewide infant mortality reduction initiative, "Preparing for a Lifetime, It's Everyone's Responsibility." MCH provides leadership for this initiative with critical support provided by state and community-based partners to impact preconception and interconception care and education; maternal infections; prematurity; postpartum depression; breastfeeding; tobacco use; infant safe sleep; and, infant injury prevention. Other examples include the Perinatal Advisory Task Force and Child Health Advisory Task Force. The Title V MCH Director co-chairs these task forces with the Director of Child Health from the Oklahoma Health Care Authority, the state's Medicaid agency. The Title V CSHCN Director is a member of the Child Health Advisory Task Force and the OFN assures family representation at meetings of both groups. These task forces have been instrumental in providing input for changes in state Title V and Medicaid policy and procedures (e.g., prenatal diagnostic services, prenatal social work services, lactation support services, perinatal quality improvement activities, child health screening schedules).

//2012/ Keeping Kids Healthy, Oklahoma's five year strategic plan (2011-2014) focused on improving the wellbeing of Oklahoma's children, was released in January 2011. The OSDH is the lead state agency for assuring the plan is moved forward. The Medical Director for Community and Family Health Services and the Chief of MCH lead strategic targeted action teams (STAT) responsible for making successful improvements in identified objectives and core measures. The teams, composed of state and community-based public and private partners, include families as partners. Quarterly reports on progress are submitted to OSDH Senior Leadership and the Oklahoma Health Improvement Plan Team. //2012//

//2013/ Finalization of teams to facilitate work identified in the Oklahoma Children's Health Plan: Keeping Kids Healthy was accomplished this year. The Title V CSHCN Director and Executive Director of the OFN co-lead the Special Health Care Needs team. Goals of this area of the plan are: 1) increase access to health care for children and youth with special health care needs; and, 2) increase community-based services for special populations of children. //2013//

MCH, CSHCN, and OFN schedule monthly meetings to plan and coordinate activities. During these meetings, data are presented to include positive and negative trends, information is shared on state and community-based activities, and discussion occurs about strategies to enhance the effectiveness of Title V in improving the health of mothers and children. In addition, these meetings provide the opportunity to coordinate activities in preparing the MCH Title V Block Grant for submission. MCH coordinates the compilation of all information for submission of the needs

assessment, annual report, and application with CSHCN and OFN providing information to be incorporated into each of the grant areas.

MCH has close working relationships with state level programs and county administration within the OSDH and has multiple opportunities each month to engage in activities with OSDH leadership to communicate about Title V. The Commissioner of Health facilitates a monthly Executive Team Meeting that all Deputy Commissioners, Service Chiefs, and Program Directors are invited to attend. This meeting provides an opportunity for agency updates, sharing of program activities, asking of questions, and informal networking. The Deputy Commissioner of the CFHS has two meetings a month with all CFHS Chiefs. These meetings provide the opportunity for the Chief of MCH to interact with all Chiefs in CFHS and to discuss crosscutting activities. In addition, the Deputy Commissioner of CFHS facilitates a videoconference every other week with CFHS Chiefs and County Health Department Administrators that further allows opportunities for information sharing and discussion of state health issues. Additionally, MCH routinely works with other OSDH programs on MCH issues such as 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.

Services for the MCH population are accomplished through the county health department system (70 of 77 counties have organized systems), professional service agreements (e.g., physician, nurse practitioner), vendor contracts (e.g., ultrasounds, supplies), contracts with other state governmental agencies, requests for proposals (RFPs), and invitations to bid (ITBs). Oklahoma City-County Health Department and Tulsa Health Department, who are administratively separate from the OSDH, are key providers of MCH services in the two large metropolitan areas through direct contracts. Other community-based providers provide MCH services through professional service agreements, vendor contracts, or the RFP process.

//2013/ Integration of the Life Course Perspective into the day-to-day thinking and work remains a priority of OSDH. This is a continual process. See II. Needs Assessment, C. Needs Assessment Summary.

The OSDH submitted an application to the Public Health Accreditation Board (PHAB) in September 2011 and followed with submission of required documentation in January 2012. Oklahoma is one of two states that applied. The PHAB will visit Oklahoma in November 2012. MCH participated in the application process and provided multiple examples to the PHAB. Receipt of accreditation will further document the strength of OSDH's capacity to carry out the Title V Program. //2013//

CSHCN oversees the provision of services to children receiving Supplemental Security Income (SSI) within the state by providing training and guidance to the over 70 social services specialists located in OKDHS county offices across the state. These social services specialists are responsible for writing and monitoring service plans for all children who receive SSI and other services through the OKDHS. All equipment and services available through CSHCN must be pre-approved by the state office. Families of children who receive SSI, but do not receive Medicaid, are also contacted to assure they are informed of services available through CSHCN.

CSHCN initiates and monitors professional service contracts with clinics that provide care to neonates in the Tulsa and Oklahoma City metropolitan areas. CSHCN also contracts with physicians for provision of psychiatric services to children in OKDHS custody. In addition to the state's Family-to-Family Health Information and Education Center, CSHCN contracts with the state's referral and resource network for CSHCN, a respite care facility, and a program that provides integrated community-based services for CSHCN. CSHCN meets with these contractors at least quarterly to ensure goals are being met through these contracts. CSHCN also has a representative on numerous parent advocate groups for CSHCN throughout the state and attends their meetings at least every other month.

MCH and CSHCN seek to assure culturally appropriate services through a variety of activities. Input from families via OFN, individual and group interactions, client satisfaction surveys, and online surveys provide insight to needed changes. Data collected through statewide surveillance (e.g., Pregnancy Risk Assessment Monitoring System, The Oklahoma Toddler Survey, Youth Risk Behavior Survey), vital records, and programs are analyzed by multiple variables such as race, ethnicity, language, age, income, and education, with information used to inform policy and program development and service delivery. Focus groups with culturally diverse groups (e.g., racial, ethnic, faith-based, urban, rural, youth) are conducted to learn how to better provide culturally sensitive service environments. The OSDH specifically requires that each OSDH employee complete a minimum of 3 hours of training on cultural competency each year as part of each employee's annual Performance Management Process (PMP). Interpreter training is also offered for OSDH state office and county employees through the OSDH Office of Minority Health. MCH requires county health departments and contractors to have a written community participation plan for MCH services with input in the development of the plan to be received from diverse populations served. These plans are reviewed on MCH site visits to the county health departments and contractors and technical assistance is provided as requested or identified. CSHCN seeks to insure representation from multiple cultural and ethnic backgrounds when conducting focus groups or gathering input for program operations.

C. Organizational Structure

In Oklahoma, state health and human services are loosely organized under the Cabinet Secretary of Health and the Cabinet Secretary of Human Services who are appointed by the governor. Terry White, Commissioner of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), is the Cabinet Secretary of Health and Howard Hendrick, Director of the Oklahoma Department of Human Services (OKDHS), is the Cabinet Secretary of Human Services. Health and Human Services agencies in Oklahoma include the Oklahoma State Department of Health (OSDH), OKDHS, ODMHSAS, Department of Rehabilitation Services, Office of Juvenile Affairs, Oklahoma Health Care Authority (OHCA) and 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.

//2012/ On November 2, 2010, Oklahoma elected a new governor, Mary Fallin. Shortly after taking office, Governor Fallin named the Oklahoma Commissioner of Health, Terry Cline, PhD., as her Cabinet Secretary of Health and Human Services. Senate confirmation was received in April. Dr. Cline had previously held this position when he was Oklahoma's Commissioner of the Department of Mental Health and Substance Abuse Services in 2004 under then Governor Brad Henry. Dr. Cline left Oklahoma to serve as Administrator for the federal Substance Abuse and Mental Health Services Administration (SAMHSA) from 2006-2008 and, subsequently as the Health Attaché at the U.S. Embassy in Baghdad, Iraq, returning to Oklahoma in June 2009 to begin his tenure as Oklahoma's Commissioner of Health. *//2012//*

As previously described in B. Agency Capacity, Oklahoma administers the MCH Title V Block Grant through two state agencies, the OSDH and the OKDHS. 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 OKDHS.

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. Suzanna Dooley, Chief 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. Organizational charts of the OSDH, the CFHS, and MCH are on file in MCH with electronic versions or hard copy available by contacting MCH at (405) 271-4480 or by e-mail at PaulaW@health.ok.gov.

/2012/ There has been no change in the above organizational structure of the OSDH.

Organizational charts are attached. //2012//

/2013/ Dr. Edd Rhoades was named the State Health Officer in May 2012 in addition to his current responsibilities as the Medical Director for the CFHS and Medical Director for MCH Child and Adolescent Health Division. In this role, he will work closely with the Commissioner of Health and OSDH Senior Leadership. Dr. Rhoades is a pediatrician and brings 34 years of MCH public health experience to his new role. An organizational chart of the OSDH may be obtained by contacting MCH at (405) 271-4480 or by e-mail at PaulaW@health.ok.gov. The MCH organizational chart is attached. //2013//

The Title V CSHCN Program is located in the OKDHS within the Health Related and Medical Services (HRMS). The HRMS is organizationally placed under the Family Support Services Division. Karen Hylton is the Director of the CSHCN Program and Program Manager for the HRMS. Karen Hylton is directly responsible to Jim Struby, Programs Administrator. Jim Struby is directly responsible to Mary Stalnaker, Family Support Services Division Director. Mary Stalnaker is directly responsible to Marq Youngblood, Chief Operating Officer Human Service Centers, who is directly responsible to the Director of the OKDHS, Howard Hendrick. The Medical Director for the CSHCN Program is currently vacant. Organizational charts of the OKDHS, Family Support Services Division, HRMS, and CSHCN Program are on file in MCH with electronic versions or hard copy available by contacting MCH at (405) 271-4480 or by e-mail at PaulaW@health.ok.gov.

/2012/ There has been no change in the above organizational structure of the OKDHS.

Organizational charts are attached. //2012//

/2013/ There have been several retirements within the OKDHS this year. Howard Hendrick retired in January, and Marq Youngblood and Mary Stalnaker retired in June. The OKDHS is undergoing an organizational restructuring. There will no longer be a Chief Operating Officer Human Services Center position; however, the agency director position has been posted. Legislation was passed this year to give the governor the authority to appoint the director of OKDHS, however the state constitution will have to be changed to abolish the Commission for Human Services (the body that currently oversees the OKDHS) before that can happen. This will go to a vote of the people of Oklahoma in November.

The Family Support Services Division and Field Operations Division have been combined into one new division that will be named soon. The CSHCN Program will remain within the Health Related and Medical Services Section of the new division. The organizational chart for CSHCN is attached. //2013//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

Organizationally, MCH consists of Child and Adolescent Health Division, Perinatal and Reproductive Health Division, and MCH Assessment. MCH also has Service level staff to include the Public Health Social Work Coordinator and MCH Nutrition Consultant that work across all MCH programs. The Child and Adolescent Health Division staff are primarily nurses and health educators. Programs and services include clinical services, school health, adolescent health, early childhood, child care, bullying, suicide prevention, teen pregnancy prevention, and injury prevention. The Perinatal and Reproductive Health Division staff are nurses, nurse practitioners,

and health educators. Programs and services include preconception and interconception care, clinical maternity and family planning services, and preventive health education services for females and males of reproductive age. MCH Assessment staff are epidemiologists, biostatisticians, and program analysts. These staff evaluate MCH programs and services. MCH Assessment staff are responsible for carrying out statewide population-based surveillance to include the Pregnancy Risk Assessment Monitoring System (PRAMS), the Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), the Oklahoma Fifth Grade Health Survey (5GHS), and the Oklahoma First Grade Health Survey (1GHS).

Suzanna Dooley is the Title V MCH Director/Chief of MCH. Jim Marks is the Director of the Child and Adolescent Health Division. Dr. Edd Rhoades is the Medical Director for the Child and Adolescent Health Division. Jill Nobles-Botkin is the Director of the Perinatal and Reproductive Health Division. Dr. Pamela Miles from the Department of Obstetrics and Gynecology, University of Oklahoma Health Sciences Center (OUHSC), serves as the Medical Director to the Perinatal and Reproductive Health Division through a contractual agreement. Paul Patrick is the Director of MCH Assessment and is also the State Systems Development Initiative (SSDI) Coordinator. Within MCH Assessment, Robert Feyerharm serves as the Title V Data Contact and Alicia Lincoln assists with the development of the MCH Title V Block Grant Application. Julie Dillard is the Public Health Social Work Coordinator and Nancy Bacon is the MCH Nutrition Consultant. Brief biographies of these key MCH staff are attached. Longevity of these staff working in the field of MCH range from five years for the Title V Data Contact to 32 years for the Child and Adolescent Health Division Medical Director. The MCH Title V Director has over 20 years in the field of MCH and has been the Title V MCH Director for eight years.

//2012/ Jim Marks, Director of the Child and Adolescent Health Division, left MCH the end of January to become the Executive Director of the Oklahoma State Board of Licensed Social Workers. This vacancy has been approved for refill and it is anticipated the position will be filled during the current grant period. Robert Feyerharm, Title V Data Contact, left MCH in early December to pursue personal goals outside Oklahoma. With this change, an administrative decision was made for Paul Patrick, Director of MCH Assessment, to assume the role as the Oklahoma Title V Data Contact. The position vacated by Mr. Feyerharm also had responsibilities as the Senior Analyst for MCH that includes analytic responsibilities for the PRAMS and TOTS. This position has recently been filled. During the year, MCH received support from leadership to fill the SSDI Grant position as a separate position from that of the Director of MCH Assessment. A job announcement was released with the expectation that a new hire will begin by late July. Brief biographies of key MCH staff are attached. //2012//

//2013/ Ann Benson was hired as the Director of the Child and Adolescent Health Division on August 15, 2011. Paul Patrick, Director of MCH Assessment, continued to accomplish responsibilities of the State Systems Development Initiative (SSDI) Grant with delays experienced in filling the Manager/Analyst position after interviews resulted in the need to review the salary. Documentation of the need to increase the salary was provided to OSDH Senior Leadership with approval received to repost the position in December 2011. The SSDI Manager/Analyst position was filled on May 7, 2012. In February 2012, Janette Cline was reassigned from the Perinatal and Reproductive Health Division to work directly with the Chief of MCH on the statewide infant mortality initiative, "Preparing for a Lifetime, It's Everyone's Responsibility." Ms. Cline's duties focus on coordination of the Oklahoma infant mortality summit to occur October 1, 2012 in Oklahoma City and summit follow-up activities, as well as day-to-day responsibilities supporting the overall work of the initiative and it's workgroups. Dr. Edd Rhoades was named State Health Officer in May 2012 in addition to his current responsibilities as Medical Director for Community and Family Health Services and Medical Director for the MCH Child and Adolescent Health Division. In this role, Dr. Rhoades will work closely with the Commissioner of Health and other Senior Leadership to address statewide health issues. Brief biographies of key MCH staff are attached. //2013//

The MCH state office organizational chart currently shows 36 full time equivalent (FTE) positions of which 33 are currently funded for 2010. Of these, 20.62 FTE are funded by Title V Block Grant

funds with the remaining 12.38 FTE funded by state and other federal grant funds. MCH is not anticipating reductions in state office staff during the next state fiscal year though the current numbers do demonstrate a decrease in FTE with a loss of 5 funded FTE from the beginning of the previous five-year period, 2006-2010. With infant mortality an identified priority of the Oklahoma State Department of Health (OSDH), MCH is currently receiving support to fill vacancies. To assist with current state budgetary constraints, the Chief of MCH did make the decision in recent months to combine the responsibilities of the SSDI Coordinator with the Director of MCH Assessment.

/2012/ The MCH state office organizational chart currently shows 34.5 FTE positions funded for 2011. Of these, 19.75 FTE are funded by Title V Block Grant funds with the remaining 14.75 FTE funded by state and other federal grant funds. MCH is not anticipating reductions in state office staff during the next state fiscal year. //2012//

/2013/ With an improved state budget picture and documentation of the negative impact of having the Director of MCH Assessment and SSDI Manager/Analyst positions combined, the Chief of MCH, with support of OSDH leadership during 2011, established a separate position for the SSDI Manager/Analyst which was filled May 7, 2012.

The MCH state office organizational chart for July 1, 2012 will show 35.5 full time equivalent (FTE) positions funded for state federal fiscal year 2013. Of these, 22.315 FTE will be funded by Title V Block Grant funds with the remaining 13.185 FTE funded by state and other federal grant funds. MCH will have the addition of one FTE to assume the previous responsibilities of Janette Cline. //2013//

The Chief of MCH has a routine planning meeting scheduled on Tuesday morning of each week with MCH Directors, the Public Health Social Work Coordinator, the MCH Nutrition Consultant and other MCH staff as identified depending on the area(s) being addressed. The meeting agendas include activities related to setting of priorities and initiating plans of action. These meetings also provide a routine time for MCH to meet with other areas in the agency such as HIV/STD, Public Health Laboratory, Office of Primary Care, and Turning Point as specific issues need to be addressed. Every other Monday morning, MCH has a routine staff meeting scheduled for all staff involved in MCH comprehensive program reviews. These meetings allow for development and revision of program review policy, procedure, and tools as well as coordination of program review schedules. MCH also has a quarterly general staff meeting that brings all MCH staff together for agency updates, training, and Service-wide planning. This year trainings on the MCH Leadership Competencies have been incorporated into these quarterly meetings to facilitate development of leadership skills in all MCH state office staff. In addition, information needing to be shared between these various meetings is accomplished through Division staff meetings scheduled twice a month or through MCH Service-wide e-mail communications.

/2012/ MCH continues to integrate training on leadership competencies into staff meetings. From February 2010 to present, training on the topics of communication; communities and collaboration; self reflection; negotiation; conflict resolution; MCH knowledge base; and developing others through teaching and mentoring has been received. MCH has also reviewed the new staff orientation training for individuals joining MCH in the state office and strengthened components related to family involvement in MCH and onsite observations at county health departments. //2012//

/2013/ Life course has been the focus of staff development this year. Education has been facilitated at the state office, county health departments, and with partners through the sharing of peer-reviewed journal articles, information received from the Maternal and Child Health Bureau, learning sessions at the Association of Maternal and Child Health Programs (AMCHP) annual meeting as well as discussions at MCH meetings and trainings. The CityMatCH Life Course toolbox has been a valuable asset. //2013//

As indicated in B. Agency Capacity, MCH and CSHCN work closely with the Oklahoma Family Network (OFN), Oklahoma's Family Voices and Family-to-Family Health Information Center grantee, to assure family involvement. The OFN assures that families with interest in particular issues are connected with programs and have the opportunity to participate as partners in policy,

program, and services development and evaluation. The Executive Director of the OFN, Joni Bruce, has been accepted to participate in the MCH Public Health Leadership Institute for the next two years. It is anticipated that this opportunity will provide new ideas to strengthen family involvement with both MCH and CSHCN. Joni Bruce is also designated by MCH and CSHCN to be the fifth Oklahoma delegate to the Association of Maternal and Child Health Programs (AMCHP). For the past three years, MCH and CSHCN have partnered with the OFN to provide Joining Forces: Supporting Family Professional Partnerships Conference. During this year's conference held on April 9, MCH and CSHCN partnered with families during breakout sessions to develop strategic plans regarding family input and leadership.

/2012/ On April 1, the annual Joining Forces Conference was held in Oklahoma City. The conference was attended by 136 individuals from across the state, about half were families. Former participants reviewed successes and challenges they had over the past year regarding family involvement in all agencies and discussed ways to remove barriers to family involvement. New participants learned why family/professional partnerships are important and learned skills to assist them in implementation.

All agencies determined goals for the next year to involve more families in meaningful ways. The OFN learned in March that \$50,000 in funding from the Oklahoma State Department of Education would not be continued next state fiscal year. This funding provided income for vital administrative and staff support. The Oklahoma Federation of Families and several state agencies are reviewing their budgets to determine if they are able to assist in filling the financial loss. The OFN received a new contract with the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, which has allowed them to develop a family advisory group for the OHCA. The group began meeting in January and input to leadership at the OHCA has already facilitated changes within the state's Medicaid system. //2012//

/2013/ OFN received a contract from the Oklahoma Federation of Families in May 2011, which allowed for sustaining of current staff and an increase in coverage in the western portion of Oklahoma. Additional funding in January 2012 through a contract with MCH is providing for staff time to focus on family involvement in MCH programs' assessment, planning, and evaluation activities and promotion of "Preparing for a Lifetime, It's Everyone's Responsibility" in rural and urban communities. OFN was included in the "Access For All" grant received by the Oklahoma Department of Mental Health and Substance Abuse Services which will include a five county pilot offering wraparound services to youth and young adults in foster care. The fifth Joining Forces: Supporting Family/Professional Partnerships Conference was held on May 7, 2012, with 142 participants focused on partnership skill development and more meaningful family involvement. Family involvement within Oklahoma agencies has increased significantly over the past five years. //2013//

Karen Hylton, Program Manager for Health Related and Medical Services (HRMS), is the Title V CSHCN Director. Other state office staff includes John Johnson, Programs Field Representative, Family Support Services Division, and Mike Chapman, Supplemental Security Income-Disabled Children Program (SSI-DCP). The Medical Director of CSHCN is currently vacant. Brief biographies of these key CSHCN staff are attached.

/2012/ There have been no changes in CSHCN staff. The Medical Director position remains vacant. CSHCN continues to rely on contracted physicians when issues arise that need medical consultation. Brief biographies of the CSHCN staff are attached. //2012//

/2013/ There have been no changes in CSHCN staff. There are no plans to fill the Medical Director position since the medical expertise needed to administer the state's CSHCN Program has been very capably provided by CSHCN-contracted physicians and other practitioners, as well as the families of children served through the program. //2013//

The system used by the Oklahoma Department of Human Services (OKDHS) to track the number of FTE in the CSHCN Program is different than that used by the OSDH. No FTE within the OKDHS is totally funded by Title V. The OKDHS has over 70 FTE who work in county offices throughout the state and are responsible for ordering equipment and diapers provided through

the Supplemental Security Income-Disabled Children's Program (SSI-DCP) as well as ensuring any other needs that can be met through the CSHCN Program are provided.

CSHCN has parent involvement which includes financial support for parent positions in various CSHCN programs (Oklahoma Areawide Services Information System (OASIS) parent coordinator - 1, OASIS staff - 5, Oklahoma Infant Transition Project - 1 and Tulsa Neonate Follow-up Clinic - 1). In addition, CSHCN also supports parent advocates through contracts with the University of Oklahoma Health Sciences Center (OUHSC) Autism Clinic, the Sooner SUCCESS Project at the OUHSC Child Study Center, and the OFN.

State office CSHCN staff meet at least weekly to discuss training needs, plan site visits, and discuss CSHCN issues. CSHCN state office staff meet with field staff (either individually or collectively) at least monthly to provide training and discuss activities surrounding the provision of services to children receiving SSI.

The OASIS is the statewide toll free information and referral line for MCH and CSHCN (see Form 9). The telephone number for the Hotline is 1-800-OASIS. The OASIS is in operation Monday - Friday from 8:00 AM to 6:00 PM with an answering machine for after-hours calls. Individuals who leave a message after hours are contacted the following workday. TDD/TTY services for the deaf are available and bilingual staff are available to those who speak Spanish. The OASIS also maintains a website (<http://oasis.ouhsc.edu/>) for information and referral services. Oklahoma 211 works closely with the OASIS as 211 relies on the OASIS as their primary information and referral resource for MCH populations, to include CSHCN.

/2012/ OASIS and 211 continue to work together closely with 211 linking with the OASIS behind the scene. The OASIS is a critical piece for information and referrals for the CSHCN population. Further integration of the two continues to be explored with these discussions being fostered this year with the OASIS experiencing a change in leadership.

/2013/ As of July 1, the OASIS moved under the umbrella of Sooner SUCCESS, a program located at the OUHSC that provides integrated community-based services for CSHCN. The goal is to better organize and expand the OASIS database to include more resources in the rural areas of the state. The 1-800-OASIS number will still be publicized and remain the Title V statewide toll free information and referral line for MCH and CSHCN. //2013//

Oklahoma is divided west and east for coverage by 211, a single point of entry to health and human services in all regions of the state. The OKC Heartline 211 serves the western side of the state, and the Tulsa Helpline serves the eastern side of the state. 211 is a free, confidential call from any phone available 24 hours a day, every day. Lines are staffed with professionally trained service specialists. Resources and information can also be obtained by visiting www.211oklahoma.org. //2012//

An attachment is included in this section. IIID - Other MCH Capacity

E. State Agency Coordination

The Oklahoma State Department of Health (OSDH) and the Oklahoma Department of Human Services (OKDHS) coordinate closely with other state health and human services agencies. The Commissioner of Health and Directors of the OKDHS, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), and Oklahoma Health Care Authority (OHCA) actively engage in state planning activities together to improve the health status of Oklahomans. With Oklahoma's poor rankings on many health status indicators, these agency leaders set the tone and expectation for staff from health and social service agencies to partner in their work communicating that it is through our partnerships that addressing the needs of Oklahomans can best be met.

The Oklahoma Health Improvement Plan (OHIP) is one example of these coordinated efforts (www.ok.gov/health). The OHIP is a comprehensive plan to improve the health of all Oklahomans. The OHIP focuses on several key priorities and outcomes to include improving

health outcomes through targeted flagships of children's health, tobacco use prevention, and obesity reduction; increasing public health infrastructure effectiveness and accountability; initiating social determinants of health and health equity approaches to address foundational causes of health status; and, developing and initiating appropriate policies to maximize opportunities for Oklahomans to lead healthy lives. Representatives on the OHIP Team include the key state agency directors as well as legislative leaders, private sector, members of the public health community, professional associations, and academia.

Another example of coordination, much like the OHIP, is the statewide infant mortality reduction initiative, "Preparing for a Lifetime, It's Everyone's Responsibility" (<http://iio.health.ok.gov>). This initiative is not only supported by state health and human services agencies, but has also engaged a multitude of partners at the state, regional, and community levels. The initiative has eight specific focus areas to impact infant mortality: preconception/interconception care and education; prematurity; maternal infections; postpartum depression; tobacco; breastfeeding; infant safe sleep; and infant injury prevention. In addition to workgroups for each of the specific focus areas, there is also a communications workgroup and a data workgroup. Membership of the workgroups is representative of state, regional, and local partners. MCH provides leadership for this initiative.

//2013/ MCH is continuously assessing the effectiveness and efficiency of the workgroups and their work being accomplished in support of "Preparing for a Lifetime, It's Everyone's Responsibility." During this year, the decision was made to integrate the focus area of maternal infections within preconception/interconception care and education given the strong overlap of identified preventive health strategies of the two workgroups. //2013//

The Perinatal Advisory Task Force (PATF), initiated in May 2005, is an effort that has resulted in multiple positive changes to state health policy and health care provider services (e.g., increased benefits for pregnant females, statewide toll-free lactation support services for breastfeeding mothers and health care providers, quality improvement initiatives). The membership of this group includes the state health and human services agencies as well as health care providers, professional medical and nursing organizations, Oklahoma Primary Care Association, Healthy Start projects, academia, advocates, and family representatives. Through routine meetings, issues of concern around perinatal care are openly discussed and proposed strategies to intervene are identified and explored. Changes may be made in state agency policy, but there may also be modifications to health care provider services that PATF members of professional medical and nursing organizations can assume the responsibility for facilitating, or needed changes in curriculum for medical, dental, and/or nursing students that PATF members in academia can take the responsibility for addressing. The PATF meets every odd numbered month on the third Tuesday from 5 p.m. to 7 p.m. The Chief of MCH co-chairs this task force.

With the success of the Perinatal Advisory Task Force, the OHCA Director of Child Health and the Chief of MCH, initiated a Child Health Advisory Task Force in February 2007. The task force meets the third Tuesday of every even numbered month from 5 p.m. to 7 p.m. Members of the Child Health Advisory Task Force include the state health and human services agencies, Oklahoma State Department of Education (OSDE), health care providers, professional medical and nursing organizations, Primary Care Association, Head Start, Smart Start Oklahoma, advocates, and family representatives. This group provided input into the development and structuring of the recently implemented Medicaid medical home model.

A memorandum of agreement between the OSDE and the OSDH provides for a collaborative relationship in facilitating the development and implementation of a comprehensive school health program in Oklahoma. Examples of activities include development of state level standards and protocols, provision of consultation and technical assistance to local school districts and school nurses, and collection of data.

//2013/ A new multi-year memorandum of agreement was entered into after submission of the MCH Title V Block Grant last year. Signed on July 29, 2012 by the Commissioner of Health and the Oklahoma Superintendent of Public Instruction, the agreement ends June

30, 2015.

Bullying and youth suicide prevention are priority focus areas in the work accomplished with the OSDE and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). With bullying playing a more prominent role in youth suicide in the state the past couple of years, MCH is working closely with the OSDE on curriculum schools can implement and partnered this year with the ODMHSAS to have several staff from the Child and Adolescent Health Division become Question, Persuade, and Refer (QPR) trainers. MCH has committed to assist in further building of 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, four trainings over the next two years. //2013//

Another close relationship is with the University of Oklahoma (OU), particularly the University of Oklahoma Health Sciences Center (OUHSC) campus. The OSDH, as the state's public health agency, actively participates in activities of the OUHSC and vice versa. The OSDH provides opportunities for students to complete clinical rotations, internships, and preceptorships. Joint educational activities such as classroom instruction, grand rounds, conferences, and clinical trainings are accomplished in collaboration with the Department of Obstetrics and Gynecology, Department of Pediatrics, College of Public Health, School of Nursing, Child Study Center, and College of Dentistry. The OU Department of Pediatrics and OU Physicians are key partners in supporting SAFE KIDS Oklahoma, a state level coalition focused on prevention of childhood injuries. The OU College of Public Health works with the OSDH to facilitate accomplishment of Public Health Certificates and/or Master and Doctorate of Public Health Degrees for OSDH staff both at the state and local levels.

//2013/ The OSDH has entered into an agreement with the OU College of Public Health this spring to offer employment opportunities to minority students pursuing a graduate degree in health administration and policy, biostatistics and epidemiology, health promotional sciences, or occupational and environmental health. The intent is to provide students with on-the-job training in public health while at the same time using this as a recruitment strategy. Students will be offered the opportunity to work part-time for two years while completing a graduate degree. MCH has expressed an interest in hiring up to two students and developed job descriptions, one for a student pursuing a health administration and policy degree and another for a student pursuing a degree in biostatistics or epidemiology. It is anticipated that MCH will be notified of student interest for employment during the summer. //2013//

In addition to OU, the OSDH and the OKDHS link with colleges and universities across the state to provide students seeking health and human services related degrees with hands-on learning experience. For each experience, a formal written agreement with goals and objectives for the experience and evaluation of the student's progress are outlined between the faculty, agency staff, and student. Students complete assignments by working side-by-side with county and/or state office staff.

The Oklahoma Leadership Education in Neurodevelopmental Disabilities (LEND) Program at the OUHSC Child Study Center is seen as a resource to assure high quality services for the maternal and child health population. The OSDH and the OKDHS along with other health and human services state agencies participate in planning meetings and provision of practicum experiences.

Through support of the Oklahoma Partnership for School Readiness (OPSR), which is also the Early Childhood Advisory Council for Oklahoma, the early childhood plan is being implemented with support of the OSDH and the OKDHS. The outcomes for the state plan are: a statewide comprehensive and coordinated system of early childhood services that meets the needs of families with young children; families nurture, teach and provide for their young children; children will be born healthy and remain healthy; and families with young children are able to find and afford high-quality care and education programs.

Joint activities are accomplished with state medical and nursing associations. These include initiatives to impact the health status of Oklahomans; planning for and evaluation of health services; publishing of data and corresponding recommendations for health systems improvement; and training and education.

The Oklahoma Hospital Association provides critical linkage and credibility to activities needing to be accomplished with hospitals across the state. This relationship has assisted with implementation of important services such as statewide newborn hearing screening; evaluation and restructuring of the emergency medical system; and, state preparedness in the event of a natural or planned disaster. In the coming year, the Oklahoma Hospital Association is a key partner in initiation of the Maternal-Infant Quality Care Collaborative. This Collaborative will bring birthing hospitals together to improve the quality of maternal and infant care.

/2012/ On April 28 the first meeting of "Every Week Counts" was held with 55 of the 60 Oklahoma birthing hospitals participating. Focused on eliminating non-medically indicated (elective) deliveries in women before 39 weeks gestation, the collaborative is using the March of Dimes Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age Toolkit that includes best practice articles and protocol tools (such as checklists and flowcharts) to educate and train obstetric teams from each hospital to improve processes of care and outcomes surrounding appropriate scheduling of inductions and cesarean births. Baseline data have been gathered from each hospital with routine reporting of data occurring to monitor changes. Two additional face-to-face meetings are scheduled (July 22 and October 4) with the hospital teams to provide additional education and support to assure changes in policy and practice are accomplished toward sustaining improvements.

Two additional projects being explored with support of the Oklahoma Hospital Association are state policy changes to formally designate nursery levels based on the recommendations of the American Academy of Pediatrics and a quality project to improve the reporting of data on Oklahoma birth certificates. //2012//

/2013/ The "Every Week Counts" Collaborative moved into its second year. Since the inception of this project, Oklahoma has seen a decline in electively scheduled inductions and c-sections before 39 weeks gestation. Review of birth certificate data is demonstrating an increase in infants delivered at 39-41 weeks and a decrease in births at 36-38 weeks. Currently, 52 of 59 birthing hospitals are participating (note: the overall number of birthing hospitals in Oklahoma and the number participating in the collaborative changes as hospitals make administrative decisions to provide or not to provide obstetrical services as their resources change). The Oklahoma Chapter of the March of Dimes was the first chapter chosen to receive the new "West Wins" award as a result of the partnership of the March of Dimes, OSDH (MCH), Oklahoma Hospital Association, and OU Office of Perinatal Quality Improvement in providing leadership for this project. The award recognizes excellence among the chapters of the West Region.

Work continues on how to establish a more formal system for designation of nursery levels in Oklahoma. Though supported by the Hospital Advisory Council, MCH has decided not to pursue formal rule making at this time but to build on its partnership with birthing hospitals and implement a voluntary procedure for designation. MCH has been gathering information from other states that use this approach and will use this information in partnership with the Oklahoma Hospital Association to develop a procedure over the next year.

The quality project focused on birth certificate data will finish this summer. Using a tool provided by the Centers for Disease Control and Prevention (CDC), MCH made minor revisions to the tool and is using the tool to compare information on birth certificates to information in medical records of the mother and infant. A random selection methodology has been used in selecting hospitals and records for comparison. Birth Clerks at the selected hospitals are also being questioned as to their practices in completion of the

birth certificate. Data will be analyzed this fall and next steps identified to support hospitals in assuring provision of high quality data on birth certificates. //2013//

The OSDH and the OKDHS work closely with Federally Qualified Health Centers (FQHCs) and tribal health care facilities to assure access to health care services. County health departments and local OKDHS offices work with these providers to link clients with needed services not available through the OSDH and the OKDHS. These partners are central to assuring access to primary care services, particularly for the uninsured and underinsured populations.

/2012/ Linkages have been strengthened this year with FQHCs and tribes' participation in activities to impact the three flagship areas of the OHIP. With health disparities seen in the populations served by FQHCs and the Native American population, improvement in health outcomes is dependent on actions of these partners. Tobacco use prevention, nutrition, infant safe sleep, preconception health, and postpartum depression have been areas for focus. Additionally, joint data projects are also being accomplished with the Oklahoma City Area Inter-Tribal Health Board Tribal Epidemiology Center. //2012//

//2013/ An emerging issue resulting in increased coordination currently between state agencies to include the OSDH and OKDHS is substance-exposed newborns. The Oklahoma Commission on Children and Youth (see III. State Overview, C. Organizational Structure) is coordinating meetings with the intended outcome to be the development of guidelines for support and care of pregnant women and newborns impacted by substance abuse. //2013//

F. Health Systems Capacity Indicators

MCH draws on a number of data sources to report on the Health Status Capacity Indicators (HSCI). These sources include the Center for Health Statistics at the Oklahoma State Department of Health (OSDH), the Oklahoma Health Care Authority (OHCA), the Oklahoma Department of Human Services (OKDHS), and the Pregnancy Risk Assessment Monitoring System (PRAMS). These sources are those that have been used with previous reporting of the HSCIs for the MCH Title V Block Grant. With one exception, the ability to provide the data for reporting on a HSCI has been maintained by the data source.

Health Care Information, the organizational unit within the Center for Health Statistics at OSDH having authority over the hospital discharge data, has experienced considerable staff turnover over the course of the last year. To date, a number of positions remain vacant. Staff resignations and the inability to refill positions have hampered that unit's capacity to provide or release data in a timely manner. This has impacted the ability to report on Health Systems Capacity Indicator #1, the rate of children less than five years of age hospitalized for asthma. While the request for the information has been made by MCH, it has not been completed for want of staff to carry out the work. As a result, the rate used in previous Block Grant reporting is carried forward as an estimate for 2011.

The Office of Vital Records (VR), the second division making up the Center for Health Statistics, provides birth certificate data for reporting on HSCI#4, the percent of women of childbearing age who receive greater than or equal to 80% of expected prenatal care visits (Kotelchuck Index), and a portion of HSCI#5, the comparison of health system capacity indicators by Medicaid status. Specifically, VR provides the death certificate data necessary for linking to Medicaid records to determine the rate of infant mortality among the Medicaid and non-Medicaid populations. MCH and VR have standing data use agreements that allow MCH analytic staff to have ongoing, routine access to record-level birth and death data. This provides MCH with considerable data capacity in the analysis and reporting of vital events relevant to MCH priorities. However, reporting has been challenged in recent years as final annual release of birth and death data has

been repeatedly postponed due to delays in the processing of these vital events. At present, in Oklahoma, year 2008 is the latest year for which final birth data are available; for death data, the most recent year of final data is 2009. These delays in closing annual data sets have forced Oklahoma to repeat a previous year's reporting to give estimates for the current year. Moreover, MCH has been hindered by the lack of current data as needed for strategic planning and to gauge the effects of program efforts. Reporting for year 2011 is no exception. Final birth data for 2008 have been repeated as an estimate for HSCI#4. For HSCI#5, currently, MCH does not have linked infant death/Medicaid data more recent than the 2007 data previously reported in the Title V Block Grant.

The OHCA is the source of data for HSCI#2, HSCI#3, HSCI#6A-C, and HSCI#7A-B. In past years, MCH has been required to make a formal data request to OHCA through the Chief of the OSDH Office of Federal Funds Development, who served as an intermediary for acquiring Medicaid data to be used in the Title V Block Grant reporting. This year marked the first time in which data arrived without the necessity of making a formal request. OHCA Reporting and Statistics staff forwarded these data after developing a standard query and production schedule to extract these data for release to MCH. Adopting this proactive posture came about after discussion at the program level between OHCA and MCH staff that these data are needed each year for block grant reporting. As a result, OHCA Reporting and Statistics staff was then able to incorporate data queries into a production schedule that yielded the appropriate data at the time needed for inclusion in the block grant. Rather than submit requests through a liaison, MCH was able to communicate directly with data support personnel at OHCA to assure that data were available as needed for block grant reporting. Direct access to OHCA personnel has improved the timeliness of data receipt, as well as the understanding of data being shared. For 2011 reporting, OHCA has provided data for all measures requiring Medicaid or SCHIP data.

The CSHCN Program at the OKDHS is the source of data for HSCI#8, the percent of Supplemental Security Income (SSI) beneficiaries less than 16 years of age receiving rehabilitation services through the program. Data reported for this measure reflect year 2011 and are easily accessed by MCH through contact with the Director of the CSHCN Program. Year 2011 marks the first year in the last five in which the percent of SSI beneficiaries less than 16 years of age receiving rehabilitation services did not grow over the previous year's reporting. For 2011, the rate fell by approximately 4% to 72.1%.

MCH, through the efforts of PRAMS, the State Systems Development Initiative (SSDI), and the Youth Risk Behavior Survey (YRBS), itself provides data as needed for reporting on HSCI#5 and HSCI#9A-B. The Oklahoma PRAMS Project continues to be an integral part of the analytic and data capacity activities of MCH. Not only does PRAMS provide data for the HSCI, but it also generates data used for performance measures in Title V, as well as those for StepUP (Strategies toward excellent performance- Unlimited Potential) and STAT (Strategic Targeted Action Teams), internal reporting efforts within OSDH. MCH analysts have access to raw, record-level surveillance data from PRAMS. Similarly, MCH is the home of the YRBS, conducting statewide surveillance of Oklahoma public schools biennially in odd-numbered years. YRBS gives MCH data for analysis and reporting of adolescent health-related behaviors including tobacco use as requested for HSCI#9B. Oklahoma's SSDI Project, while being slowed down by the prolonged vacancy in the SSDI Manager/Analyst position, an obstacle recently overcome by the hiring of a master's trained biostatistician, has as its stated goals the use and analysis of linked data. Targeted datasets for linking to birth records include WIC program data, newborn screening records, Medicaid records, and infant deaths. All of which are referenced in HSCI#9A. With the SSDI Manager/Analyst position now filled and the efforts of the Medicaid Matching Analyst, a position jointly funded by the OSDH and OHCA, MCH has the capacity to analyze these linked data systems, thereby, increasing the availability of data needed for decision making.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Performance measures are used to monitor the effect that Title V services have on important health outcomes and processes. These measures in effect are markers of progress in improving health and reducing related risks of our target populations. While many external forces beyond the control of the Title V programs can affect these measures, they still provide direction for Title V services and assure that the focus remains on health improvement. Figure 3 (from the Maternal and Child Health Services Title V Block Grant Program Guidance), Title V Block Grant Performance Measurement System, presents a schematic approach that begins with the needs assessment and identification of priorities and culminates in performance measures leading to improved outcomes for the Title V population (See Attachment).

Every five years, a comprehensive needs assessment is accomplished with state priorities identified. Based on these priorities, state performance measures are developed and resources allocated to impact the priorities. During interim years, needs assessment activities continue to monitor changes and identify gaps that may impact priorities and performance measures. In addition, MCH and CSHCN evaluate the resources assigned to address each priority. Based on the continuing needs assessment process and the annual evaluation of resources and their impact, state priorities may be redefined, performance measures changed, and resources realigned resulting in changes in specific program activities within the four levels of the MCH "pyramid" (direct health care, enabling, population-based, and infrastructure building services).

MCH uses the national and state performance measures in the agency performance and budget report submitted each fall to the state Legislature by the Oklahoma State Department of Health (OSDH). These measures are also part of the OSDH strategic plan for improving the health of Oklahomans.

//2012/ Title V outcome and performance measures have also been incorporated into the Oklahoma Health Improvement Plan (OHIP). The OHIP is focused on general improvement of the physical, social, and mental well being of all people in Oklahoma through a high-functioning public health system. //2012//

The national outcome measures and national and state performance measures are also shared by MCH and CSHCN with internal and external partners so they are aware of Title V priorities and the focus of resources. This assists with planning of collaborative activities and more effective use of limited resources in addressing common priorities.

An attachment is included in this section. IVA - Background and Overview

B. State Priorities

The priorities chosen were selected by MCH and CSHCN to move Oklahoma toward the improved health status of all Title V population groups. Data to highlight areas of need were analyzed from the following sources: population-based surveillance data from the Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the Oklahoma Youth Risk Behavior Survey (YRBS), the Oklahoma First Grade Health Survey (1GHS); Oklahoma vital records; U.S. Census population estimates; the State and Local Area Integrated Telephone Survey (SLAITS); needs assessments of other Oklahoma MCH programs; private, non-profit health-based surveys or studies; agency program data from the OSDH, the Oklahoma Health Care Authority (Medicaid data) and Oklahoma Department of Human Services (OKDHS); and other federal and state surveys.

The process of priority selection for this current Title V Needs Assessment was approached differently from previous Title V Needs Assessments for Oklahoma and included the utilization of newly available electronic resources, such as online surveys and video conferencing during task

force meetings. MCH and CSHCN found a way to better capture what was otherwise considered an inaccessible population. Staff took advantage of available electronic resources through the internet, more specifically, SurveyMonkey, in an attempt to gather more input from all sectors of the state's diverse populations. The survey included both open ended questions about the health needs of the three Title V population groups (A, B, and C) and questions on ranking the importance of selected health conditions. These health conditions were identified during the MCH and CSHCN, Perinatal Advisory Task Force (PATF), and Child Health Advisory Task Force (CHATF) meetings, including discussions with stakeholders and families, prior to developing the online survey. The results from over 700 completed online surveys were received and evaluation and analysis of the input guided MCH and CSHCN to create a smaller subset of priorities for each of the Title V population groups. Part A priorities were then presented to the PATF, and Part B and Part C priorities were presented to the CHATF. These "expert" groups then determined, via a process of organized committee meetings, review of data, and thoughtful discussion, recommendations for Oklahoma Title V priorities for MCH and CSHCN to consider in order to gain the best possible outcomes for the Title V population groups.

MCH, CSHCN, and the Oklahoma Family Network (OFN) explored input from the data collected for the needs assessment, current priorities for the Oklahoma Health Improvement Plan (OHIP), OSDH Strategic Targeted Action Teams (STAT), ongoing work by the OFN, Sooner SUCCESS (State Unified Children's Comprehensive Exemplary Services for Special Needs), and CSHCN Program at OKDHS. The priorities discussed at task force meetings were modified, collapsed, and analyzed to determine what priorities were feasible, could be acted upon at all service levels of the pyramid, and would enact change in the health of Oklahomans. The following were then selected for more in-depth discussion: Part A: Access to Care, Unintended Pregnancy, Infant Safe Sleep; Part B: Access to Care, Depression, Obesity, Tobacco Use; and Part C: Child Care, Transition, Access to Care. It was then decided by MCH, CSHCN, and OFN to combine Access to Care into one overarching priority for all three population groups; Tobacco Use Prevention, Obesity and Preconception Health were also added as overarching priorities for all three population groups. Part A priorities were then selected; unintended pregnancy and infant safe sleep were chosen based on their prevalence and ability to impact infant mortality rates. Part B priorities originally selected were depression and suicide among youth and motor vehicle injuries. Part C priorities were child care and transition to adulthood.

Upon further discussion a decision was made to remove depression and suicide and add infant mortality instead, due to the high profile campaign in the state to combat the issue and the statewide initiative to reduce infant mortality "Preparing for a Lifetime, It's Everyone's Responsibility." Although many of the priorities address some aspect of infant mortality and the overarching goal of Title V is to reduce infant mortality, MCH, CSHCN, and OFN felt it important to be consistent with OSDH, the Oklahoma Health Improvement Plan (OHIP), and state goals and objectives leading to infant mortality being placed on the priority list. The decision was made to consider depression and suicide under the access to care priority.

The priorities were modified slightly, based upon a careful review of the resources available and the relationship of Title V to other services that will partner with the MCH, CSHCN, and OFN efforts: (Note that infant mortality is ranked highest, the others are listed in order of overall impact to all MCH population groups and then by MCH population groups.)

- 1) Reduce infant mortality;
- 2) Improve access to comprehensive health services for the MCH population;
- 3) Reduce the prevalence of tobacco use among the MCH population;
- 4) Reduce the prevalence of obesity among the MCH population;
- 5) Improve preconception health for females and males of reproductive age;
- 6) Reduce unwanted, unplanned pregnancies;
- 7) Improve infant safe sleep practices;
- 8) Reduce motor vehicle injuries among children and youth;
- 9) Improve transition services for CSHCN;

- 10) Improve the system of child care for families of CSHCN.

Next, MCH, CSHCN, and OFN analyzed existing national performance measures and current state performance measures to determine their usefulness in addressing the new priorities. It was noted that national performance measures addressed several of the state priorities. State performance measures no longer pertinent to the priorities were discontinued, and new measures were created to assist the state in monitoring its progress toward impacting the priorities. Five previous state performance measures were retained with two new state performance measures* and two revised** state performance measures developed for 2011:

- 1) The percentage of women who have an unintended pregnancy (mistimed or unwanted) resulting in live birth.
- 2) The percentage of adolescents grades 9-12 smoking tobacco products.
- 3) The number of families with a child with special health care needs receiving respite care provided through the CSHCN Program.
- 4) The percentage of adolescents overweight and obese (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution).
- 5) *The percentage of children with special health care needs who receive child care services at licensed child care facilities and homes.
- 6) *The percentage of women receiving quality [American College of Obstetrics and Gynecology (ACOG) standards] preconception care.
- 7) **The percentage of infants who are put to sleep on their backs.
- 8) The extent to which the MCH program area develops and maintains the capacity to access and link health-related data relevant to targeted MCH populations.
- 9) **The percentage of Medicaid eligible children with special health care needs who report receiving dental services other than for routine dental care.

/2012/ There have been no changes to the identified state priorities or state performance measures for 2012. MCH, CSHCN, and OFN are currently working with the Oklahoma City Inter-Tribal Health Board Tribal Epidemiology Center to conduct a needs assessment specific to Oklahoma's American Indian population. The online survey used for the Title V Comprehensive Needs Assessment is being sent directly to tribal government and health facilities' staff to complete and also share with tribal members for completion. Hard copies of the survey will be available upon request. MCH will analyze the information received to see if it aligns with priorities and performance measures as identified from the broader five year needs assessment or whether there are differences that warrant looking at specific priorities and performance measures for the American Indian population.

State Health Officers in Regions IV and VI have identified infant mortality as a priority focus for the two regions. The use of common outcome and performance measures across the two regions is of interest. Depending on the outcome of these discussions, states in these regions may be adding to or modify existing state performance measures to allow for 2-3 common measures among these states. //2012//

/2013/ MCH has encountered obstacles in accomplishing the needs assessment with Oklahoma tribes. Changes in staff at the Oklahoma City Inter-Tribal Health Board Tribal Epidemiology Center and gaining approval through individual tribe's IRBs (Institutional Review Boards) have slowed the process.

In November 2011, Region IV and Region VI State Health Officials and Title V MCH Directors received an invitation for state teams to attend an Infant Mortality Summit on January 12-13, 2012 in New Orleans, Louisiana from Dr. Wakefield, Administrator, Health Resources and Services Administration (HRSA). The purpose of the meeting was to provide the opportunity to: initiate or maintain networking and collaboration across states; initiate or maintain networking and collaboration within states; share best/promising practices related to infant mortality; and inform a national strategy to reduce infant mortality. The seven member Oklahoma Team (Commissioner of Health;

Title V MCH Director; OSDH Deputy Commissioner of Community and Family Health Services; Vice President of Quality Improvement for the Oklahoma Hospital Association; Director of the Office of Perinatal Quality Improvement, Department of Obstetrics and Gynecology (OB-GYN), University of Oklahoma Health Sciences Center; Deputy Chief Executive Officer for the Oklahoma Health Care Authority; and Director of MCH Assessment/Title V Data Contact) attending the meeting developed action steps to further elevate the priority of infant mortality reduction in Oklahoma. A key action step is the holding of a state infant mortality summit in Oklahoma on October 1, 2012. Invitees are from a diverse audience to include state and local government, private business, medical and nursing, law enforcement, military, tribal, faith-based, community, minority, family, advocacy, and charitable organizations. It is not anticipated that this activity will change identified priorities but will facilitate actions to positively impact several of the priorities and the related national and state performance measures, as well as national outcome measures.

State teams from the January HRSA meeting will be brought together for a follow-up meeting on July 23-24 in Arlington, Virginia to report on progress and begin next steps. Next steps will involve members of each state team working in crosscutting state teams with content and data experts on five areas (reduction of prematurity, infant safe sleep, preconception and interconception health, tobacco cessation, and perinatal regionalization) that have been found to be common priorities from the information reported back to HRSA by the Region IV and VI states. Outcomes of this work may lead to changes in state performance measures in future years to allow for common measures across states and regions.

In April, Dr. Cline, Oklahoma's Commissioner of Health, signed Oklahoma on to support the Association of State and Territorial Health Officials/March of Dimes partnership to work towards reducing premature births thus, ensuring more healthy births. In doing so, Oklahoma committed to reducing prematurity by 8% by 2014. To monitor Oklahoma's progress toward this goal, a new state performance measure has been developed and added to the current nine state measures:

10) The percent of live singleton births delivered before 39 completed weeks of gestation. //2013//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	67	58	492	559	559
Denominator	67	58	492	559	559
Data Source		Screening and Special Services, OSDH			
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

Source: Data were provided by Screening and Special Services, Oklahoma State Department of Health. For reporting year 2011, data for 2010 are used as an estimate. Year 2011 are not available at this time.

Notes - 2010

Source: Data were provided by Screening and Special Services, Oklahoma State Department of Health.

Notes - 2009

Source: Data were provided by Screening and Special Services, Oklahoma State Department of Health.

In 2009, Oklahoma began screening for sickle cell trait, vastly increasing the number of confirmed cases for newborn screening conditions. Last year's reporting was erroneous, whereby sickle cell trait was labeled sickle cell anemia and reported as such with the number recorded as 431 under presumptive positive screens. These cases should have been recorded under confirmed cases. With this reporting, Oklahoma has revised to reflect program practice. As a result, the number of cases with screened conditions has increased considerably.

a. Last Year's Accomplishments

All newborns born in Oklahoma in 2010 were screened through the Newborn Screening Program (NSP) for the disorders of phenylketonuria (PKU) (1) and other amino acid disorders (2); congenital hypothyroidism (26); galactosemia (2); sickle cell disease (11); hemoglobinopathies (3); cystic fibrosis (CF) (6); medium chain acyl-CoA dehydrogenase deficiency (MCAD) (3) and other fatty acid disorders (4); organic acid disorders (0); and biotinidase deficiency (3). 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 2010, all 498 newborns with sickle cell trait and hemoglobin C trait were referred for counseling. Many of the families received trait counseling from their child's primary physician when seen for well child visits, as both families and physicians on record were sent screening results. The NSP offered families an opportunity to discuss long term life and family planning issues with a genetic counselor and 45 families received counseling with a board-certified genetic counselor. All newborns identified with an out-of-range CF screen were referred for genetic counseling (75 of the 81 received counseling). All cases of confirmed diagnosis for newborn screening disorders received genetic counseling.

Activities of the Sickle Cell Association continued to be impacted due to state line item funding

that was eliminated in 2008. Lack of funding continued to hinder advocacy activities such as school individual education plan (IEP) assistance and transition planning for individuals who were identified with sickle cell disease and sickle cell trait, as well as advocacy and support for families.

The Oklahoma Genetics Advisory Council (OGAC) met three times, with a decision made by the Council to reduce meetings to twice a year in future years. Its nine committees met as frequently as needed. The Newborn Screening subcommittees continued to be very active, meeting every quarter.

In May 2011, a Severe Combined Immunodeficiency Syndrome (SCID) Workgroup was developed to review implementation and pilot testing requirements. Families were involved in workgroup activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screened all newborns in Oklahoma for mandated conditions.			X	
2. Provided short-term follow-up for all newborns identified at risk for a disorder or trait.		X		
3. Referred all diagnosed newborns to long-term follow-up care coordination services.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The NSP is currently developing a Critical Cyanotic Heart Disease (CCHD) Workgroup to facilitate implementation of CCHD screening to the Newborn Screening Panel and to develop "Best Practice Guidelines" for birthing facilities. In addition, the NSP will pilot SCID testing this fall.

The NSP maintains comprehensive STFU services to assure all infants with out-of-range screen results are followed until resolution (e.g., diagnosed as normal, affected, or lost to follow-up).

LTFU care coordination services continue to be provided to children and youth with special health care needs and include an Adult Transition Program for adolescents with sickle cell disease and a PKU Formula/Food Program.

The Education Subcommittee of OGAC is currently working with the State Audiology Task Force to increase awareness and education regarding hearing screening. Newborn hearing screening is a mandated test on the American College of Medical Genetics (ACMG) Panel and in Oklahoma.

The NSP is currently participating with the Health Resources and Services Administration (HRSA) and the Association of Public Health Laboratories (APHL) to determine guidelines for LTFU activities and was invited by APHL/HRSA to participate in a workgroup to determine STFU guidelines.

Follow-up staff attended the bi-annual American Public Health Association (APHA) Newborn

Screening Symposium in November 2011. This forum provided staff with training and networking opportunities to improve the current NSP in the state.

c. Plan for the Coming Year

All infants born in Oklahoma will continue to be screened through the NSP for the disorders of PKU and other amino acid disorders, congenital hypothyroidism, galactosemia, sickle cell disease, hemoglobinopathies, CF, CAH, and MCAD and other fatty acid disorder, organic acid disorders, and biotinidase deficiency. The NSP will investigate potential funding in anticipation of adding SCID testing to the current Oklahoma panel, pending results of the pilot tests. The NSP will provide education and "Best Practice Guidelines" to birthing facilities regarding CCHD screening.

The NSP will maintain comprehensive STFU services to assure all infants with out-of-range screen results are followed until resolution (e.g., diagnosed as normal, affected, or lost to follow-up). Affected newborns will be followed until documentation of treatment date (if applicable), referral to a pediatric sub-specialist, a genetic counseling date, and enrollment into available LTFU services. In collaboration with the University of Oklahoma Health Sciences Center (OUHSC) and the Warren Clinic Center for Genetics in Tulsa, the NSP will continue to provide LTFU services to all affected newborns except for those diagnosed with CF. Infants diagnosed with CF will continue to be referred to the CF Center in Tulsa or Oklahoma City (follow-up for CF ceases once the NSP confirms that the infant has been seen by a pediatric pulmonologist).

Three fulltime LTFU care coordinators (Metabolic, Endocrine, and Sickle Cell Disease) and one metabolic dietitian will continue to be supported through contracts with the OUHSC. STFU and LTFU services will be provided in collaboration with the newborn's medical home. Genetic counseling for CF and hemoglobinopathies will continue to be provided in Oklahoma City and Tulsa through contractual agreements.

The NSP will continue to provide education and low-phenylalanine formula to adults and low-protein food to children with PKU.

Implemented activities of the OGAC State Genetics Plan will continue including educational outreach. The Metabolic Workgroup will continue to meet to facilitate implementation of expansion of the ACMG uniform panel. The OGAC will meet two times per year and its nine committees will meet as needed. The Newborn Screening and Pediatrics Committee of OGAC will continue to address newborn screening follow-up.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	50811			
Reporting Year:	2010			
Type of Screening Tests:	(A) Receiving at least one Screen (1)	(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment

					(3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	50811	100.0	7	1	1	100.0
Congenital Hypothyroidism (Classical)	50811	100.0	48	26	26	100.0
Galactosemia (Classical)	50811	100.0	17	2	2	100.0
Sickle Cell Disease	50811	100.0	11	11	9	81.8
Biotinidase Deficiency	50811	100.0	3	3	0	0.0
Cystic Fibrosis	50811	100.0	6	6	6	100.0
Sickle Cell Trait	50811	100.0	0	498	0	0.0
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	50811	100.0	11	1	1	100.0
Organic Acid Disorders	50811	100.0	18	0	0	
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	50811	100.0	19	3	3	100.0
Short-Chain Acyl-CoA Dehydrogenase Deficiency	50811	100.0	9	2	2	100.0
Biopterin Deficiency	50811	100.0	1	1	1	100.0
Glutaric Aciduria Type II	50811	100.0	9	3	3	100.0
Multiple Acyl-CoA Dehydrogenase Deficiency	50811	100.0	1	1	1	100.0
Mild Hyperhomocitrulinemia	50811	100.0	1	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	57.4	58.8	60	60.9	61.5
Annual Indicator	56.9	56.9	56.9	56.9	69.9
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	70.5	71.3	72	72.7	73.4

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2010

Indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM #2 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Annual performance objectives have been left unchanged at this time. Oklahoma will reassess once new data become available from the 2009-2010 CSHCN survey.

Notes - 2009

Source: National Survey of Children with Special Health Care Needs (CSHCN), conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

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

Contracts continued with the Tulsa Neonatal Clinic, part of the Children's Medical Center in the Hillcrest Medical Campus. The clinic remained a resource available to infants who were released from an Oklahoma neonatal intensive care unit (NICU). Families referred to Tulsa Neonatal Clinic were involved in making decisions for their infant at every step. Staff from the referring hospital explained the infant's needs and all the local, regional, and specialty sources that could provide the needed therapies, so the family could make the best possible choices for their infant. If the family decided to use Tulsa Neonatal Clinic, the family's primary care physician (PCP) was contacted to discuss the referral, so she/he could make a preauthorization request to the family's insurance as necessary.

Medical professionals with Tulsa Neonatal Clinic discussed with the family the service they provided to the child, how often it would be provided, and addressed any of the family's questions and concerns. Occupational, physical, and speech-language therapists, as well as nurses, discussed with the family and doctor any further services the child needed. Social workers and nurses coordinated these referrals with the family and other service providers. If the family needed other types of assistance, clinic staff made referrals to private and public agencies such as the Oklahoma Department of Human Services for applying for Medicaid, Child Protective Services, and Supplemental Security Income Disabled Children's Program (SSI-DCP).

Partnership continued with the Oklahoma Family Network (OFN), Oklahoma's Family-to-Family Health Information Center. A Joining Forces Conference was held in April 2011, bringing together family representatives and agency professionals to train family leaders in providing family input into agencies, hospitals, and other organizations.

Support continued for Sooner SUCCESS (State Unified Comprehensive Exemplary Services for Special Needs), part of the pediatric department of the University of Oklahoma Health Sciences Center (OUHSC) in Oklahoma City. Sooner SUCCESS was created to develop resources for families of children with special health needs in communities throughout Oklahoma. The project operated in 11 counties (Blaine, Kingfisher, Major, Logan, Pottawatomie, Cleveland, Garfield, Canadian, Tulsa, Creek, and Rogers) and created plans to spread into all 77 counties, contingent upon the development of additional funding. County Coordinators from the project worked with families to identify needs in that county's communities. The Coordinator then worked to organize agencies, businesses, and other local resources to meet those needs.

Oklahoma participated in the ABCD-3 Project (Assuring Better Child Health and Development Learning Collaborative - Phase Three). The project was designed to help states deliver early childhood services to low-income families. The Oklahoma ABCD-3 Project, "Connecting the Docs", worked on a way to give PCPs a better way to make referrals for services among four communities in Canadian, Garfield, Pottawatomie, and Tulsa counties.

The ABCD-3 Project piloted a web portal developed by the OUHSC. PCPs could go to the web-based Preventive Services Reminder System (PSRS) and enter their referrals. The system then sent an email to the appropriate county specific team. The county teams were composed of individuals with SoonerStart (Oklahoma's Individuals with Disabilities Education Act (IDEA) Part C Early Intervention program), OFN, Sooner SUCCESS, and the Child Guidance Program of the Oklahoma State Department of Health (a program in local county health departments for assessment, intervention, and other services for children ages 13 and younger and their families). The county team chose which agency would best meet the child's need. The selected agency then began working with the child and his/her family. The team sent the PCP an e-mail detailing the result of the referral via the web portal.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Contracted with several organizations in the state that have paid family members on staff to ensure family representation.		X		
2. Supported Sooner SUCCESS through provision of funding and technical assistance for their regional care coordination activities.		X		
3. Supported the Assuring Better Child Health And Development Learning Collaborative Phase Three (ABCD-3) Project to better deliver early intervention services to low-income families.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The goal of the OFN, Oklahoma's Family-to-Family Health Information Center, is to help the connection of CSHCN and families to professionals to receive appropriate services and supports

in their communities. The hub of these activities is matching families with like experiences for encouragement, support, and a roadmap to services preferred by the individuals with special needs and their families.

OFN held the 2012 Joining Forces: Supporting Family Professional Partnerships Conference on May 7, 2012. One hundred forty-two people attended, which included family leaders representing constituents from various family-lead networks and staff members representing eight state agencies that provide services for individuals with special needs. CSHCN had a break out session so contracted partners could discuss how their organization involved families in decision-making.

A toolkit for family-professional partnerships is being completed and shared with each agency and hospital that participated in the Joining Forces Conference to promote more meaningful family involvement. Five new family partners are being identified for coaching and training to prepare them for leadership and partnership opportunities. OFN is supporting the efforts of multiple agencies in developing a speaker's bureau of family and youth leaders who are prepared to share their story.

The ABCD-3 Project is seeking ways to sustain and expand the system when current grant funds are expended.

c. Plan for the Coming Year

The Oklahoma Infant Transition Program (OITP), an arm of the neonatal intensive care unit (NICU) at Children's Hospital at the OUHSC, will be involved in training entry-level and graduate-level health care professionals. OITP will provide a number of classroom lectures related to family-centered developmental care. NICU practicum experiences for several groups of interdisciplinary students will also be offered.

Sooner SUCCESS, operating out of the OUHSC since 2002, will continue to have county and regional resource coordinators in eleven counties in central and eastern Oklahoma. The coordinators will help families and health care providers locate and access services and resources for children and youth with special health care needs. The coordinators will also work with communities to identify local needs then develop and support plans to meet those needs. Expansion into additional counties will occur, if funding becomes available.

The Oklahoma Transition Council (OTC), developed as a partnership of teachers, parents and others with an interest in assisting CSHCN youth, will continue to assist youth with preparing for adulthood and partnering in decision making. The members of the OTC will work with schools, state agencies, and families in developing methods to best help students and their families in preparing for the student's life after his/her secondary education is complete. These transition plans will involve preparing for college or a job depending on the student's abilities. They will also involve helping the student learn how to talk about his/her medical needs and conditions to health professionals.

During fiscal year 2013, OFN and the Oklahoma Department of Rehabilitative Services (OKDRS), the state agency that helps people with disabilities get work training and development, will train others how to use the transition care notebook, a central place for youth with special health care needs to put all their health records and history as well as health care provider information. The transition care notebook was developed through collaboration between OFN, OKDRS, families, and the Oklahoma State Department of Health. This training will be provided at the annual Oklahoma Transition Institute and other venues.

In the spring of 2013, OFN will hold its sixth annual Joining Forces: Supporting Family Professional Partnerships Conference. The toolkit for family-professional partnerships will be updated and shared with each agency and hospital to promote more meaningful family

involvement.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	60.5	60.5	50.2	50.7	51.2
Annual Indicator	49.7	49.7	49.7	49.7	46.1
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	46.5	47	47.4	47.9	48.4

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives have been revised downward due to recent estimates provided by CSHCN survey. Forecasted targets anticipate a 1% relative increase in the annual indicator.

Notes - 2010

Indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM #3 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM #3.

Annual performance objectives have been left unchanged at this time. Oklahoma will reassess once new data become available from the 2009-2010 CSHCN survey.

Notes - 2009

Source: National Survey of Children with Special Health Care Needs (CSHCN), conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

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

The Oklahoma Infant Transition Program (OITP), an arm of the neonatal intensive care unit (NICU) at Children's Hospital at the University of Oklahoma Health Sciences Center (OUHSC) in Oklahoma City, worked with families who had a baby in the NICU. Staff ensured the family understood treatments and options. Additionally, staff facilitated the family's communication with their medical home doctor and organized specialists, equipment, and anything else needed by the infant when released to go home. Family Advocates participated in a number of activities related to and supporting the medical home concept. A Family Advocate was an active participant on the Children's Hospital NICU Family-Centered Developmental Care Committee whose mission remained to provide high quality and compassionate care with expertise in a family-centered environment.

The Fostering Hope Clinic continued as a medical home for children in foster care in Oklahoma and Tulsa counties. This project began in 2005 through a partnership with the OUHSC, Oklahoma Department of Human Services, and Oklahoma Health Care Authority (OHCA), the State's Medicaid agency. Services provided followed American Academy of Pediatrics (AAP) recommendations for children in foster care. The clinic also organized and maintained the medical files of the children, as the medical records of children in foster care can often be lost or not updated when they receive a medical service while in custody. The Fostering Hope Clinic gathered medical records for Medicaid services performed before the children went into foster care and maintained them as long as the children were in foster care. The original clinic was in Oklahoma City, and in September 2007, a clinic was established in Tulsa.

The Oklahoma section of the Medical Home Portal, a project of the University of Utah, continued to operate successfully. Nine other states, including Oklahoma, developed their own sections of the website. The site was created to educate doctors and families about the medical home concept. The website contained sections to help doctors work with children with special health care needs and learn about a variety of diagnoses. Pages were also created for parents to help them find a doctor, learn how to prepare their child for doctor visits, and discuss their child's needs and concerns with the doctor before, during, and after visits.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported the Oklahoma Infant Transition Program at Children's Hospital to facilitate communication and collaboration between families and medical homes for infants in the neonatal intensive care unit.		X		
2. Collaborated with the Fostering Hope Clinic to provide medical home to children in OKDHS custody.		X		
3. Assured continued operation of the Oklahoma section of the Medical Home Portal.		X		
4.				

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Fostering Hope Clinics continue to operate as medical homes for children in foster care in Oklahoma and Tulsa Counties.

The ABCD-3 (Assuring Better Child Health and Development- Phase 3) Project is funded by The Commonwealth Fund and focuses on helping states improve health care systems for young children. The Oklahoma ABCD-3 Project works to improve the delivery of early child development services in a child's medical home for low-income children and their families. A web portal is available for Primary Care Providers (PCPs), designed to make it easy for doctors to make referrals for CSHCN. The system ensures the organization that gets the referral informs the doctor about the outcome of the referral for the child. The National Academy for State Health Policy (NASHP) highlighted Oklahoma's ABCD-3 Project in the February 2012 "State Health Policy Briefing", a NASHP periodical.

c. Plan for the Coming Year

OITP's nurses and social workers will continue working with parents who have newborns in the NICU. OITP will make sure parents understand therapies and treatments given to their infant. The program will also help families access services that are recommended for the infant when the infant leaves the hospital.

The Oklahoma ABCD-3 Project will continue their work to improve the delivery of early child development services in a child's medical home for low-income children and their families. The project will complete developmental assessments and make appropriate referrals to agencies that can meet the child's needs. The project will continue to utilize the online tool for doctors to make referrals and get information back to the doctor from the referring agency or organization. SoonerStart (Oklahoma's Individuals with Disabilities Education Act (IDEA) Part C Early Intervention program), the Oklahoma Family Network (OFN), Sooner SUCCESS (an organization devoted to finding and developing community resources for CSHCN), and the Child Guidance Program of the Oklahoma State Department of Health (a program in local county health departments for assessment, intervention, and other services for children less than 13 years of age and their families) will continue to participate in the project. The Oklahoma ABCD-3 Project will conduct active reviews of the process. Stakeholders will discuss the strengths and weaknesses of the system and make changes as needed. Additional funding sources for ABCD-3 will be sought to ensure the project can continue once grant funds are depleted.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
---------------------------------------	------	------	------	------	------

Annual Performance Objective	64.1	62.9	64.2	65.5	66.8
Annual Indicator	61.6	61.6	61.6	61.6	59.3
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	59.6	60.2	60.8	61.4	62

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives have been revised downward due to recent estimates provided by CSHCN survey. Forecasted targets anticipate a 1% relative increase in the annual indicator.

Notes - 2010

Indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM #4 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Annual performance objectives have been left unchanged at this time. Oklahoma will reassess once new data become available from the 2009-2010 CSHCN survey.

Notes - 2009

Source: National Survey of Children with Special Health Care Needs (CSHCN), conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

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

Medical assistance for children with special health care needs continued to be managed by two agencies in Oklahoma, the Oklahoma Health Care Authority (OHCA), the State's Medicaid agency, and the Oklahoma Department of Human Services (OKDHS). According to statistics from these two agencies, there was a 6.4% increase in the number of CSHCN receiving services through SoonerCare, Oklahoma's Medicaid Program. The number of children in foster care

receiving services through SoonerCare went up slightly (7,973 in 2010 versus 8,801 in 2011). The number of children classified as blind or disabled receiving services covered by SoonerCare went up (21,288 in 2010 versus 22,329 in 2011) as well as the number of children approved for the Tax Equity and Fiscal Responsibility Act (TEFRA) program (385 in 2010 versus 429 in 2011). TEFRA was designed to provide Medicaid services to children who lived at home and were ineligible for SSI (Supplemental Security Income) or SoonerCare because of the income or resources of their families, but have needs that require an institutional level of care.

CSHCN continued to cover specialized formula for a few children with metabolic conditions (such as PKU (phenylketonuria), short gut syndrome, and formula intolerance) who were not eligible for SoonerCare or needed formula that was not covered by SoonerCare.

The Oklahoma Areawide Services and Information System (OASIS) maintained a database of resources for children and adults with special needs. The toll free phone number (1-800-426-2747) was staffed to assist people in finding resources to meet their needs. The OASIS processed 6,330 calls requesting assistance. Approximately 1,743 of these calls were for help getting medical/psychological testing, other medical services, or information about Medicaid/Medicare. The database was also accessible on the OASIS website: <http://oasis.ouhsc.edu/>. The OASIS online directory was used 3,429 times in State Fiscal Year 2011.

The Family Outreach Coordinator from OASIS arranged for one-day conferences called "On the Road" Family Perspective Conferences in Guymon (in the state panhandle), Chickasha (in central Oklahoma), and Okmulgee (in the eastern part of the state) where representatives with the CSHCN OKDHS, Family Support and Developmental Disabilities Division as well as the OHCA provided information to parents and guardians. Presentations included how to get help with children's medical needs through the Supplemental Security Income Disabled Children's Program (SSI-DCP), TEFRA, and SoonerCare, which included EPSDT (Early, Periodic Screening, Diagnosis and Treatment).

The OKDHS maintained at least one office in all of Oklahoma's 77 counties. Individuals went to these offices to apply for Medicaid and other services. When a benefit recipient or applicant had needs that could not be met through a program managed by OKDHS, workers made referrals to local resources.

Every year the Family Support Services Division of OKDHS brings together supervisors from every county office for a conference where attendees learn about policy changes, future agency plans, and other information to help them and their workers do their jobs. At this year's conference, CSHCN had three sessions where they discussed the organizations that receive funding from the MCH Title V Block Grant. Supervisors were given information on what each organization does, as well as contact information and how they could help OKDHS applicants and recipients. The Oklahoma Family Network (OFN), Oklahoma's Family-to-Family Health Information Center, had a booth at the conference to discuss in detail what services they provide for families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Covered specialized formula for a few children with metabolic conditions who were not eligible for SoonerCare or needed formula that was not covered by SoonerCare.	X			
2. Supported OASIS as a resource for families with CSHCN.		X		
3. Participated in one day "On the Road" Conferences through OASIS to help parents understand the process of finding		X		

assistance for needed medical care.				
4. Provided information on Title V to OKDHS county supervisors.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In December 2011, the governor signed an emergency rule that allowed insurance carriers to exclude infants under age one from obtaining health insurance coverage through child-only insurance policies. This was done to encourage insurance carriers to start selling child-only policies again; however, there is concern that families who are ineligible for SoonerCare will have no option for coverage for newborns.

"On the Road" Family Perspective Conferences, held throughout the year in different cities and towns around the state to allow as many families as possible to attend, are being organized in Anadarko (in southwestern Oklahoma) and Muskogee (in eastern Oklahoma). CSHCN participates in these conferences and meets with other parent and professional groups to explain the eligibility requirements and services of SoonerCare, TEFRA, and SSI-DCP.

OFN matches parents who have applied for SoonerCare or TEFRA with families that are newly applying. OFN parents help new families with filling out forms and organizing financial records needed to determine eligibility. If needed, OFN staff calls OKDHS employees to help clarify what the applying family needs or the status of the application.

Developmental Disabilities Services Division (DDSD) of OKDHS continues to deliver services, provided through a Medicaid waiver, to individuals with developmental disabilities. During the 2012 legislative session more funding was provided for DDSD waivers to reduce the waiting list.

c. Plan for the Coming Year

A workgroup, formed last year to address and streamline the issues surrounding determining eligibility for the TEFRA program, will continue to meet. Attendees will include OFN, OKDHS, and SoonerCare staff.

OFN staff will also continue attending the DDSD Waiting List Meetings. DDSD will deliver services, provided through a Medicaid waiver, to individuals with developmental disabilities. Even with additional legislative funding, funding limitations will persist, and the wait list will continue to operate. The monthly waiting list meetings will give the OKDHS an opportunity to discuss how to assist the individuals on the waiting list and provide families and other citizens a chance to discuss their concerns about the waiting list.

OFN will continue its family-centered trainings. The course about programs that provide financial assistance for health issues will be given. This course will explain how to apply for help with the costs of the care for CSHCN from different organizations. OFN will also show families how to put together a care management book, a central place for all documentation affecting a child's care so that it can be accessed and shared easily.

The Children's Health Plan Workgroup, part of the Oklahoma Health Improvement Plan, will continue reporting quarterly on the state's progress in increasing access to health and community-based services for children and youth with special health care needs. This workgroup will consist of individuals from OKDHS, OFN, the Oklahoma State Department of Education, the

Department of Rehabilitation Services, and the Oklahoma State Department of Health.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	75.1	91	92	93	94
Annual Indicator	90.3	90.3	90.3	90.3	65.7
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	66.3	67	67.6	68.3	69

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives have been revised downward due to recent estimates provided by CSHCN survey. Forecasted targets anticipate a 1% relative increase in the annual indicator.

Notes - 2010

Indicator data comes from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering, and the number of the questions used to generate the NPM #5 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for NPM #5.

Annual performance objectives have been left unchanged at this time. Oklahoma will reassess once new data become available from the 2009-2010 CSHCN survey.

Notes - 2009

Source: National Survey of Children with Special Health Care Needs (CSHCN), conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

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

The Oklahoma Infant Transition Program (OITP), an arm of the neonatal intensive care unit (NICU) at Children's Hospital at the University of Oklahoma Health Sciences Center (OUHSC) in Oklahoma City, linked families to a number of home and community-based public and private services. Resources such as SoonerStart (Oklahoma's Individuals with Disabilities Education Act (IDEA) Part C Early Intervention Program), Infant Crisis Center (for baby food, diapers, and age appropriate toys), Oklahoma Areawide Services and Information System (OASIS, a statewide referral network), Latino Community Development Agency, Women, Infants, and Children Supplemental Nutrition Program (WIC), and SoonerCare (the State's Medicaid program) continued to be referral sources for OITP. Social workers from OITP were supported by a family advocate so families had the most up-to-date resource information.

Sooner SUCCESS (State Unified Comprehensive Exemplary Services for Special Needs), a program housed at the OUHSC Child Study Center, remained active in promoting community-based services. Sooner SUCCESS was created in 2002 to bring families and professionals together to meet the needs of children in their communities. Sooner SUCCESS operated in 11 counties in central and eastern Oklahoma (Blaine, Kingfisher, Major, Logan, Pottawatomie, Cleveland, Garfield, Canadian, Tulsa, Creek, and Rogers). Each county had a coordinator who was tasked to either bring together available resources and needy families, or develop resources to meet family needs. Each coordinator also developed a coalition of people concerned with the needs of CSHCN. The coalitions met regularly to discuss issues with the care systems in their communities and solutions, so every child and family had access to what they need.

Sooner SUCCESS coordinators also developed various methods of communicating to the families of CSHCN. The Garfield County Coordinator launched a blog which can be found at <http://soonersuccess.blogspot.com/2010/11/finding-resources-and-programs-you-need.html>. The blog dispensed information on resources and opportunities to learn. Region Two, in the northeastern part of the state, created a Facebook page which it used to announce coalition meetings, training opportunities, and events of interest to families.

The Oklahoma Family Network (OFN), Oklahoma's Family-to-Family Health Information Center (F2F HIC), informed and connected individuals with special health care needs, their families, and professionals to services and supports. The F2F HIC was staffed by parents of CSHCN. As parents, they worked their way through the maze of services and programs to get help for their own children so they could give other families first hand information and advice. The F2F HIC provided assistance in a variety of ways, including support and referral through direct telephone, e-mail, or in-person contact. OFN also offered training through workshops; advocacy for families' resources, and listservs, websites, newsletters, and family-friendly publications.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Supported the efforts of Sooner SUCCESS and the Oklahoma Family Network in their work to ensure communities had organized systems of service.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OASIS organizes the "On the Road" Family Perspective Conferences, which take representatives from public agencies and private organizations to towns around the state. These one-day conferences give families the chance to learn about eligibility requirements for the programs and services offered by these organizations. "Family Connections" is the quarterly newsletter produced by the OASIS and distributed via their website and e-mail. Each newsletter covers a topic of importance to families of people with special needs. Upcoming educational events, such as the next "On the Road" Conference and parent support groups around the state, are listed.

OASIS continues to act as a clearinghouse for resources for individuals with special needs all around the state. It maintains a searchable directory on its website: <http://oasis.ouhsc.edu/>. The directory allows individuals to search for resources by keyword, location, or area served. Searchers can see results by an alphabetical list or a map showing where providers can be found. Clicking on a provider's name or pinpoint on a map will show contact information, hours of service, etc. Individuals without internet access can call OASIS (1-800 426-2747) to access the database.

OFN's annual Joining Forces Conference was held on May 7, 2012. One hundred forty-two (142) families and program representatives attended.

c. Plan for the Coming Year

OFN will continue hosting its annual Joining Forces Conference. The intent of the daylong conference will be to show families and agencies how to partner. Agencies will learn how best to organize their services to serve families. Families will learn how they can give their opinions to agencies in order to have a positive impact on public policy. The conference will act as a starting place for agencies and families to collaborate to improve services throughout the state.

OFN will also continue to be the F2F HIN and will act as a resource for families of CSHCN. OFN will be staffed by parents of CSHCN. As parents, they will have traveled through the maze of services and programs designed to help CSHCN. As OFN staff, they will understand the issues that families face, provide advice, offer a multitude of resources, and tap into a network of other families and professionals to provide support and information.

Sooner SUCCESS coordinators will continue helping families and health care providers locate and access services and resources for children and youth, birth to 21, with developmental disabilities, chronic health care needs, mental health needs, and/or abuse and neglect issues. They will also work with communities to identify local needs and develop and support plans to meet those needs. Sooner SUCCESS will continue following their plan to expand into all of Oklahoma's 77 counties. Staff are presently working to make Sooner SUCCESS a public/private

partnership. This will allow Sooner SUCCESS to pursue more avenues to fund their efforts. The enhanced funding will fuel a multi-year plan to spread Sooner SUCCESS throughout the state by moving into counties adjacent to those in which it already operates.

This year the services provided through OASIS will be placed under the umbrella of Sooner SUCCESS. Sooner SUCCESS will continue and expand on the database that houses the resource and referral information provided to children and youth with special health care needs across the state. OASIS will continue to be publicized as such, but behind the scenes will feed to 211.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	6.2	45	46	47	48
Annual Indicator	43.7	43.7	43.7	40.5	40.5
Numerator					
Denominator					
Data Source		National Survey of CSHCN			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	40.9	41.3	41.7	42.1	42.5

Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Annual Performance Objectives have been revised to reflect targets that are more reasonable given recent surveillance data derived from CSHCN Survey.

Notes - 2010

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

Notes - 2009

Source: National Survey of Children with Special Health Care Needs (CSHCN), conducted by HRSA and CDC, 2005-2006.

a. Last Year's Accomplishments

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

The Oklahoma Transition Council (OTC) was formed in 2004 to improve transition education, planning, and services for students with special needs. The OTC had 34 members from organizations such as the Oklahoma Department of Human Services (OKDHS), the Oklahoma State Department of Education (OSDE), the Department of Rehabilitative Services (DRS), the Oklahoma Family Network (OFN), and local school districts. There were 35 transition teams across the state working on improving transition education at the local level.

The OSDE created the 2011 version of the Oklahoma Transition Education handbook. The handbook gave specific suggestions and requirements in developing a transition plan for students. It cited that federal law requires that transition education begin by the time a child turns 16. Oklahoma procedure stated transition planning should begin the month the child turns 16 or enters the ninth grade. The handbook noted that there are many school districts that have opted to begin transition training at 14, but compelling reasons were given to begin even earlier.

Many youth with special health care needs also received services provided through the OKDHS Developmental Disabilities Services Division (DDSD) waiver program. This waiver program provided assistance to people with developmental disabilities for things such as transportation and help with employment.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated on the multi-agency Oklahoma Transition Council to improve transition education.				X
2. Provided assistance to youth with developmental disabilities for transportation and employment opportunities.		X		

3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

At the Sooner SUCCESS (State Unified Comprehensive Exemplary Services for Special Needs) Region One Fall Workshop which was held on October 25, 2011, the focus was transition and the value of "person-centered thinking" with regard to transition planning. Participants networked with various transition specialists and a youth breakout session provided hands-on activities related to self-advocacy and transition planning.

OTC held its annual Oklahoma Transition Institute in November 2011. The Oklahoma Department of Rehabilitative Services (DRS) presented recommendations for transition preparation for students with special needs. They showed at each stage of a child's education (elementary, middle, and high school) what CSHCN services are available and what educational and training plans should be implemented. A list of state-wide resources was also given. A representative from DRS, along with a Title V staff member, presented on the eligibility criteria for SoonerCare (the State's Medicaid program) and Supplemental Security Income (SSI) for adults with special needs.

Tulsa and Owasso, both in the northeastern corner of the state, are having community transition fairs this year. Representatives from a number of vocational-technical schools, colleges, and universities are scheduled to describe to students the support services available at each institution. Government agencies such as DDSD and OKDHS are going to be available to explain benefits and eligibility criteria.

c. Plan for the Coming Year

The University of Oklahoma, after receiving grant funding through the United States Department of Education, will develop master's level transition experts in special education. The program will have three levels. For certified teachers who already have a master's degree there will be a level for them to do coursework to receive the additional certification. Another level will be for those who are already certified teachers, to complete the necessary work to get the master's degree. The third level will be for participants who need required classes for both teaching certification and the master's degree. The grant will fund fellowships for a limited number of students entering the program. Those who are funded by the fellowship must agree to work with adolescents with special needs in providing transition services for at least two years after program completion.

The OTC, which is made up of representatives from school districts, OSDE, DRS, OFN, parents, and many other organizations interested in helping CSHCN transition to adult life, will continue supporting the 35 teams located across the state. These teams will identify challenges that keep adolescents from successfully transitioning to post-secondary school life. The teams will look for feasible solutions and ways to implement them in their local communities. The OTC will use social media such as Facebook (<https://www.facebook.com/OklahomaTransitionCouncil>) to distribute information on grants, trainings, and personal stories.

The Zarrow Center for Learning and Enrichment at the University of Oklahoma has a mission of facilitating successful secondary and postsecondary educational, vocational, and personal outcomes for people with disabilities. The Center will provide a new website so that transition

teams can learn about the work and projects being accomplished by one another in the state.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	76.4	80.8	82.1	80	72.1
Annual Indicator	80.1	73.6	71.3	71.5	71.5
Numerator	41564	38803	39753	38130	38130
Denominator	51890	52722	55755	53328	53328
Data Source		National Immunization Survey & U.S. Census Bureau			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	73	73.9	74.7	75.6	76.3

Notes - 2011

Source of data: Numerator is estimate from National Immunization Survey, Q1/2010-Q4/2010, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series. Data for year 2011 are not available at this time; year 2010 has been used as an estimate.

Denominator is 2010 population estimate of 2 year olds obtained from the U.S. Bureau of the Census.

95% CI: 71.5% ± 6.3%.

Notes - 2010

Source of data: Numerator is estimate from National Immunization Survey, Q1/2010-Q4/2010, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series.

Denominator is 2010 population estimate of 2 year olds obtained from the U.S. Bureau of the Census.

95% CI: 71.5% ± 6.3%.

Notes - 2009

Source of data: Numerator is estimate from National Immunization Survey, Q1/2009-Q4/2009, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series

Denominator is 2009 population estimate of 2 year olds obtained from the U.S. Bureau of the Census.

95% CI: 71.3% ± 6.3%.

a. Last Year's Accomplishments

The National Immunization Survey (NIS) results for 2010 provided vaccine series completion rates for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B. According to the NIS, 71.5% of Oklahoma's 19-35 month old children completed the 4:3:1:3:3 series compared to 74.9% nationally.

During 2011, the Oklahoma State Department of Health (OSDH) maintained its policy of providing immunizations to any child who presented at a county health department needing immunizations, with priorities for outreach and direct services being the uninsured and underinsured populations. If immunizations were provided to an insured child, county staff worked with the parent/guardian to link the child with his/her primary health care provider for future immunizations. Additionally, county health departments were able to recoup year-round cost reimbursement for services provided to children eligible for Medicaid.

Immunizations continued to be tracked by both private and public health care providers using the Oklahoma State Immunization Information System (OSIIS). This system was supported with Medicaid funds received through a contractual agreement with the Oklahoma Health Care Authority (OHCA). The OHCA provided additional support to OSIIS by maintaining a contractual requirement that all Medicaid practices participating in the Vaccines for Children (VFC) Program report doses administered into the registry.

MCH continued collaboration with the OSDH Immunization Service participating in the OSDH Immunization Advisory Committee meetings and on the OK by One Project. This project, modeled after a similar project in New Mexico, was implemented in 2004 as a strategy to improve vaccine protection levels and particularly that of the fourth Diphtheria, Tetanus, and Pertussis (DTaP), a common problem found in low immunization coverage. The OK by One Project offers a simplified immunization schedule, accepted by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP), that allows completion of the primary vaccination series by the one-year-old well child visit.

Data from the state immunization registry have been used to develop intervention strategies including the OK by One immunization schedule, day care audits, and the intervention called Operation Buzzer Beater (OBB). OBB, a specific reminder intervention, targeted 21 month-old

children who were lacking one or two doses of completing the primary series. Approximately 13% of state children lacked just one dose by 24 months of age to complete the series. The intervention completed its first year of activity in February 2011. An evaluation of the data was conducted in 2011 and demonstrated that OBB activities increased immunization of this population by 9%.

An additional strategy to improve immunization rates included immunization audits conducted by Immunization Service staff in 85% of the state practices enrolled in the VFC Program. Immunization representatives continued to target clinics in both the public and private sectors to be recipients of the CDC's Assessment, Feedback, Incentives and eXchange (AFIX) intervention. AFIX is a proven method of practice level improvement that raises coverage rates and improves standards of care. Child care centers were also audited to improve vaccination rates.

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

The OSDH continued to develop a public health billing plan for fully insured patients receiving vaccines and other preventive health services in a county health department setting. Funding for the development of a private insurance billing plan was provided through a CDC grant. The OSDH assembled a steering committee to guide this process. MCH was represented on this committee and was a vital partner for progress in this area.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained policy of providing immunization to any child presenting at a county health department for immunizations.	X			
2. Assisted families with insurance coverage to link with the child's primary health care provider for immunizations.		X		
3. Supported statewide efforts of the "OK by One" Project to facilitate improvement in vaccine protection levels.			X	
4. Completed first year of Operation Buzzer Beater, which increased immunization completion rates in two-year-olds by 9%.			X	
5. Conducted audits of public and private providers enrolled in the VFC Program as well as child care centers.				X
6. Continued development of a public health billing plan for insured patients receiving services at a county health department, through CDC funding.				X
7.				
8.				
9.				
10.				

b. Current Activities

Oklahoma continues to place a strong emphasis on targeting pockets in need of immunization services and to use population-based immunization data from all 77 counties in seeking improvement. The Immunization Service was without a Data Analyst from May 2011 to June 2012; now that the position is refilled, data analysis and linking projects can resume.

OSDH Immunization Field Consultants (IFC) continue to complete immunization audits in child care centers. Staff is working with centers to raise vaccine protection levels with a follow-up visit to centers falling below the 90% coverage level. Immunization representatives continue to target clinics in both the public and private sectors to be the recipients of CDC's AFIX intervention.

Provider participation in the OSIIS is increasing, from 1,013 to 2,746 this year. Three hundred and thirteen (313) childcare facilities utilize the registry for tracking state immunization requirements. Among the state's population of children less than six years of age, over 90% have multiple vaccinations recorded in the registry.

c. Plan for the Coming Year

The rewrite of OSIIS will be complete and initiated in March of 2013. The updated programming in .Net will result in a more efficient interface for users, heightened security, and will set the foundation for the development of "level three meaningful use and interoperability" per CDC funding guidelines.

MCH will continue to participate as an ex-officio member of the OSDH Immunization Advisory Committee.

MCH will support Immunization Service in efforts to attain the goal of 90% of children who are up-to-date with the primary series of immunizations by their second birthday. Activities will continue to focus on support and evaluation of the OK by One Project, improved vaccination of child care attendees, clinic-level quality improvement, and OBB.

MCH Assessment and the Immunization Service will develop analysis plans to link the 2009-2011 Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS) and The Oklahoma Toddler Survey (TOTS) data with OSIIS data in order to improve vaccine coverage rates at 24 months of age.

The OSDH will maintain its policy of providing immunizations to any child that presents at a county health department needing immunizations, with priorities for outreach and direct services being the uninsured and underinsured populations. If immunizations are provided to an insured child, county staff will work with the parent/guardian to link the child with his/her primary health care provider for future immunizations.

A contractual agreement will remain in place between the OSDH and the OHCA allowing reimbursement for immunization services received through the county health department system for children covered by Medicaid. In addition, a contractual agreement will remain in place allowing reimbursement for Medicaid administrative costs related to the OSIIS.

Oklahoma will implement a public health billing plan. This plan will include broad functionality to cover reimbursement for preventive health services rendered by public health, such as immunizations. The OSDH will use resources generated through this project to offset existing costs and for future public health program expansion.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	27.1	26.8	30	29.8	29.6
Annual Indicator	30.4	30.9	29.5	29.5	29.5

Numerator	2292	2300	2166	2166	2166
Denominator	75486	74346	73516	73516	73516
Data Source		OSDH vital statistics & U.S. Census Bureau.			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	29.4	29.2	29	28.5	28.2

Notes - 2011

Source: Numerator: Health Care Information, Denominator: U.S. Census Bureau. final 2011 data not yet available, provisional data for 2009 are used as an estimate for 2011 reporting.

Annual performance objectives have been left unchanged. The latest final data for births are from 2008. Once more timely data are officially released Oklahoma will reassess annual targets. At that time, it may be necessary to adjust forecasted targets.

Notes - 2010

Source: Numerator: Health Care Information, Denominator: U.S. Census Bureau. final 2010 data not yet available, provisional data for 2009 are used as an estimate for 2010 reporting.

Annual performance objectives have been left unchanged. The latest final data for births are from 2008. Once more timely data are officially released Oklahoma will reassess annual targets. At that time, it may be necessary to adjust forecasted targets.

Notes - 2009

Source: Numerator: Health Care Information, Denominator: U.S. Census Bureau. final 2009 data not yet available, provisional data for 2009 are subject to change.

a. Last Year's Accomplishments

Oklahoma provisional birth data for year 2009 show that the birth rate for teens aged 15-17 years old was 29.5 births per 1,000 females in this age group, a modest decline (4.5%) from the 2008 rate of 30.9. Using the provisional data for 2009 shows that there were 2,166 births to teens aged 15-17. Oklahoma continues to experience high levels of teen pregnancy. Typically, ranking in the top 5 among states for the highest teen birth rates. For teens 15-19 years of age, the birth rate was 58.7 births per 1,000 population, and for the older teens, those aged 18-19 years, the rate was 101.1.

In February 2011, the Oklahoma Health Improvement Plan (OHIP) Children's Health Flagship Workgroup released the Oklahoma Children's Health Plan: Keeping Kids Healthy. The Chief of

MCH and Executive Director of the Oklahoma Family Network served on the 12 member Children's Health Plan Panel, an expert panel identified by the OHIP Children's Flagship Workgroup to develop the plan. The Adolescent Health Coordinator served as a content expert on adolescent health. The document identified adolescent health as one of eight targeted areas of priority with adolescent pregnancy identified as an area to impact in order to improve adolescent health outcomes.

MCH continued to place an emphasis on building infrastructure and supporting adolescent health services statewide. Staff continued a train-the-trainer program, "Parents, Let's Talk", taken from the Advocates for Youth educational campaign. The training emphasized healthy youth development, understanding adolescent brain maturation and what teens need, internet safety, asset building, human immunodeficiency virus and sexually transmitted diseases (HIV/STDs) information, and how to talk to youth about sexuality.

MCH received notification in October 2010 of receipt of the Personal Responsibility Education Program (PREP) grant from the Administration of Children, Youth, and Families. The \$615,320 in federal funds supported implementation of new adolescent pregnancy prevention projects in the Oklahoma City and Tulsa Metropolitan Statistical Areas (MSAs) through contractual agreements with the city-county health departments in Oklahoma City and Tulsa. MCH began development of tools to monitor fidelity in presenting the selected evidence-based curriculum and assess changes in knowledge and attitudes of the youth receiving the curriculum.

During 2011, MCH supported four state-funded adolescent pregnancy prevention projects in local county health departments. Activities of the projects focused on the use of evidenced-based curriculum with the middle school population. Plans were developed to expand in 2012 to four additional administrative areas, based on rates of teen pregnancy, to build infrastructure in those communities.

MCH conducted training for providers on adolescent pregnancy prevention on November 19, 2010, reproductive life planning on May 20, 2011, and sponsored Building Developmental Assets training August 3-4, 2011. MCH, along with partners, hosted a forum focusing on adolescent reproductive health for advanced practitioners on June 3, 2011.

Family planning clinical services continued to be provided to adolescents through county health departments and contract providers. These services included a comprehensive physical examination, preventive education on HIV and STD transmission, education on contraceptive methods (including abstinence), provision of a method when appropriate, and encouragement of parental involvement. Between October 1, 2010 and September 30, 2011, 7,522 clients ages 15-17 were seen in family planning clinics within county health departments and the two city-county health departments.

Special projects in Oklahoma and Tulsa counties designed to provide outreach, education, and family planning clinical services to the African American population continued to be offered as a result of special funding from the Title X Family Planning Region VI Office.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Received the federal Personal Responsibility Education Program (PREP) grant.			X	
2. Provided staff development opportunities on issues related to adolescent health and adolescent pregnancy prevention.				X
3. Supported community-based adolescent pregnancy prevention projects.			X	

4. Provided clinical family planning services through county health departments and contract providers.	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH continues administration and monitoring of the PREP Grant. PREP projects began piloting in community-based locations in December 2011 and began school-based implementation in January 2012. Projects utilize evidenced-based curriculum outlined in the Health and Human Services (HHS) list of 28. The target populations are youth 11-19 years of age in middle, high, and alternative schools in Oklahoma City and Tulsa MSAs.

MCH continues to support adolescent pregnancy prevention projects through the county health department system in areas of the state with the highest teen birth rates (outside the Oklahoma City and Tulsa MSAs). These projects utilize the same evidenced-based curriculum from the HHS list as the PREP projects. Currently, projects are in four administrative areas with the anticipation of expansion to at least four more by September of 2012.

MCH is training both PREP and adolescent pregnancy prevention staff on the HHS evidence-based curriculum. These trainings include one held on November 2-4, 2011 on "Making Proud Choices!", and one November 16-17, 2011 on "Making A Difference!". "Reducing the Risk" will be taught on July 30-31, 2012.

c. Plan for the Coming Year

MCH will work towards establishing a youth advisory board. This board will be used to provide input to MCH, CSHCN, as well as other programs within the OSDH on policy, procedures, and services to youth.

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

MCH will continue work with the Oklahoma Health Care Authority (OHCA) to put a specific focus on adolescent health. The results from the pilot of the "My Life. My Plan." booklet, which encourages adolescents to take better care of their health, set goals, and understand how pregnancy will affect these goals, will be reviewed. OHCA and the University of Oklahoma (OU) will study how effective assigning resident physicians from eight different practices to individual schools was in improving the rate of adolescent preventive health care visits. Plans will be made for training providers and dissemination of the booklet to interested programs and projects.

MCH will continue to offer education, provide resources, and collaborate with external partners to reduce infant mortality and other adverse birth outcomes, as well as reduce racial disparities for such outcomes, through "Preparing for a Lifetime, It's Everyone's Responsibility." MCH will collaborate with other projects that are serving youth in the state, such as tribal PREP projects and Abstinence Education projects, to coordinate efforts to prevent teen pregnancy and reduce associated infant mortality and morbidity. A state summit focusing on reducing the infant mortality rate in Oklahoma will be held in October 2012 with invitees being leadership from state and local government, community-based organizations, education, youth and family advocacy

groups, insurers, foundations, employers, medical associations, tribes, faith-based organizations, minority groups, and military/law enforcement.

MCH will continue to fund and provide oversight and technical assistance to the Oklahoma City-County Health Department and Tulsa Health Department PREP projects. Additionally, MCH will work closely with and provide guidance to the county health departments implementing adolescent pregnancy prevention projects. MCH will have staff trained as trainers for the HHS evidence-based curricula to train others who will be providing adolescent pregnancy prevention projects. Training will also be provided to youth-serving organization staff and school health nurses that will be providing the curriculum.

County health departments and contract providers will continue to provide family planning services to adolescents which include a comprehensive physical examination, prevention education on STDs and HIV, and education on contraceptive methods (including abstinence), coercion, and parental involvement.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	38.7	39.6	40.2	40.7	33.4
Annual Indicator	35.1	39.7	39.7	33.1	33.1
Numerator					
Denominator					
Data Source		Oklahoma Oral Health Needs Assessment			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	33.7	34	34.4	34.7	35

Notes - 2011

Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH. Needs Assessment is completed on a schedule of every third year. As a result, data for 2010 are used as an estimate for 2011 reporting.

Annual Performance Objectives have been revised in line with recent experience. Targets project a 10% growth by 2020 in the percentage of 3rd graders with a protective sealant on at least one molar.

Notes - 2010

Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH.

Annual Performance Objectives have been revised based on data released for CY2010. Oklahoma has surpassed the HP2020 objective of 28.1%. However, following the example of HP2020, Oklahoma has set as an overall target for the 10 years ending in 2020 a 10% relative increase in this measure. That 10% increase is distributed evenly across the years for the period 2011-2020.

New data will become available for NPM#9 in 2013. At that time, annual targets will be assessed for relevance.

Notes - 2009

Source: Statewide Oklahoma Oral Health Needs Assessment, Dental Health Service, OSDH. Needs Assessment is completed on even-numbered years. As a result data for 2008 are used as an estimate for 2009 reporting.

a. Last Year's Accomplishments

In 2010, data from the statewide dental health needs assessment of third grade children revealed that 33.1% of third grade children had protective sealants on at least one permanent molar tooth. This percentage of third grade children with at least one protective sealant has declined by 16.0% when compared to results from the 2008 dental health needs assessment (39.7%). Further, results from the 2010 needs assessment of third grade children show that 58.0% had experience with dental carries, 42.6% had at least one filled primary tooth, and 22.6% had untreated decay in at least one permanent or primary tooth.

MCH funds provided significant support for dental health education and clinical services across the state. Changes with the Oklahoma State Department of Health (OSDH) Dental Health Service's funding resulted in the continued need to realign and prioritize funds for these services.

The Dental Health Service launched the Health Educator Dental Project. Educational materials were developed and training provided to 10 individuals in December 2010. These community educators were equipped to deliver age-appropriate oral health lessons and evaluate effectiveness.

The Oklahoma Dental Loan Repayment Program (ODLRP), created in 2007 to increase the number of dentists serving and caring for Medicaid patients and to make dental care accessible in underserved metropolitan and rural areas, did not receive state fiscal year (SFY) 2011 funding. However, fifteen dentists remained in the program for part of 2011 until preceding funding was depleted. The Dental Health Service administered this program.

The state legislature also eliminated funding to the OSDH for support of the Oklahoma Dental Foundation Mobile Dental Care Program, which provided quality dental services to state Medicaid, gap, and indigent populations, predominantly children.

The second Oklahoma Mission of Mercy (OKMOM) was held in Oklahoma City in February 2011. With help from hundreds of volunteers, 8,964 dental procedures were performed for 2,201 needy Oklahomans. Of this number, 219 were children/adolescents and 752 were women of child-

bearing age (15-44). Dental Health Service staff served in leading roles.

Through work on the Child Health Advisory Task Force, Medicaid policies were developed and trainings provided on fluoride varnish. Reimbursement to physicians for fluoride varnish applications during well child exams began July 1, 2011.

MCH continued to work collaboratively with Dental Health Service to educate children, their parents/guardians, and health care providers on oral health, including the importance of protective sealants. Child health providers assessed teeth during well child exams and referred as indicated. The OSDH School Health Program distributed oral health education material via schools and conferences.

Dental educational services provided by dental health educators included dental health education and tobacco use prevention instruction in 33 counties to 30,220 children, preschool through high school, with an emphasis on reaching those in kindergarten through sixth grades. Topics included appropriate dental hygiene and care of one's teeth, playground safety, the use of mouth guards, dental disease prevention (sealants, fluoridation, regular dental care), and proper nutrition with healthy snacks.

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Launched the Health Educator Dental Project to equip community educators to deliver age appropriate oral health lessons.				X
2. Continued to support the placement of dentists in rural areas of state through educational loan repayment program funded through the Oklahoma Dental Loan Repayment Act.				X
3. Participated on the task force to change Medicaid policy to reimburse physicians for fluoride varnish during well child visits, which went into effect July 1.				X
4. Provided dental health education in schools and at child health clinic visits.			X	
5. Provided dental clinic services through 5 county health department sites.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Funding for the ODLRP was re-authorized and received for SFY 2012 via another state appropriated entity. ODLRP continues to operate with 13 full time equivalent dentists practicing in designated shortage areas treating 30% Medicaid patients, and two faculty members at the University of Oklahoma (OU) College of Dentistry.

The third OKMOM was held in McAlester. With help from hundreds of volunteers, 6,487 dental procedures were performed for 1,733 needy Oklahomans. Of this number, 86 were

children/adolescents and 477 were women of child-bearing age. Dental Health Service staff served in leading roles.

Dental educational services in 35 counties and clinical services in 6 county health department sites are available.

The Governor's Task Force on Children and Oral Health Focus Group is determining program efforts in the areas of Prevention, Education, Access to Care, and the State Disaster Response by Dentistry. The Dental Health Service Chief chairs this group.

Working with Dental Health Service, the Children's Oral Health Coalition is charged with improving the health status of Oklahoma children by progressing with oral health objectives as set forth by the Oklahoma Children's Health Plan.

The Dental Health Service is working with the OU Colleges of Dentistry and Public Health to conduct the Third Grade Oral Health Assessment during the 2012-2013 school year.

c. Plan for the Coming Year

An OKMOM is planned for February 2013 in Lawton, Oklahoma. This will be the fourth statewide event and involve hundreds of volunteers to provide dental services for approximately 1,800 needy Oklahomans, to include children and women of child-bearing age.

Data from the Third Grade Oral Health Assessment will be available in the summer of 2013. Results will be written into a report and posted on the Dental Health Service website.

MCH will assure that oral health is addressed through child health clinics, school health activities, the state plans for early childhood and Head Start.

Dental educational program services and dental clinical services will continue. Educational topics will include appropriate dental hygiene and care of one's teeth, playground safety, the use of mouthguards, dental disease prevention (sealants, fluoridation, regular dental care), and proper nutrition with healthy snacks. Clinical services will include dental sealants, fillings, cleanings, topical fluoride applications, x-rays, extractions, crowns, oral hygiene instruction, and necessary prescriptions for infections.

The Governor's Task Force on Children and Oral Health Focus Group will continue to focus on policies and programming from recommendations presented in the State Oral Health Plan to enhance dental health of children in Oklahoma. Focus areas include community water fluoridation, fluoride varnish and sealant programs, training non-dental personnel on the importance of oral health, advocating for health policies, and addressing access to dental care for children (including those with special health care needs).

The Oklahoma Children's Health Plan: Keeping Kids Healthy is a product of the Oklahoma Health Improvement Plan (OHIP) Children's Health Flagship Workgroup. Working with the Chief of Dental Health Service, the Children's Oral Health Coalition will work to implement identified oral health objectives within the plan of increasing community water fluoridation, reimbursing primary care providers for delivering preventive dental services such as fluoride varnish, modifying rules and laws to enhance the dental workforce, and training others with evidence-based or promising programs addressing oral health. Progress will be reported to the OSDH and to the legislature. Various employees from Dental Health Service will participate as well as representatives from the medical profession, the Oklahoma Health Care Authority, the OU College of Dentistry, Head Start, and other interested stakeholders.

Dental Health Service will also partner with the OU College of Dentistry if it is awarded a Health Resources and Services Administration grant to support oral health workforce activities. Through this grant, opportunities for access to care for the maternal and child health population will be improved and increased.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	5	5	5.7	5.5	5.3
Annual Indicator	6.8	3.4	5.9	5.9	5.9
Numerator	51	26	45	45	45
Denominator	745170	753870	767758	767758	767758
Data Source		Vital records & U.S. Census Bureau			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	5.8	5.7	5.6	5.5	5.4

Notes - 2011

Source for death data: Health Care Information, OSDH for numerator, U.S. Census Bureau for denominator. Finalized 2011 death records not yet available; 2009 data are used as an estimate and are subject to change.

Annual Performance Objectives have been revised to reflect obtainable targets given recently observed mortality rates.

Notes - 2010

Source for death data: Health Care Information, OSDH for numerator, U.S. Census Bureau for denominator. Finalized 2010 death records not yet available; 2009 data are used as an estimate.

Annual performance objectives have been left unchanged. The latest final data for deaths are from 2007. Once more timely data are officially released Oklahoma will reassess annual targets. At that time, it may be necessary to adjust forecasted targets.

Notes - 2009

Source for death data: Health Care Information, OSDH for numerator, U.S. Census Bureau for denominator.

a. Last Year's Accomplishments

In Oklahoma for year 2009, the latest year for which final mortality data are available, there were 45 recorded motor vehicle deaths to children 14 years of age or younger, nearly 46 percent of accidental deaths in this age group. This resulted in a death rate of 5.9 deaths per 100,000 children less than 14 years of age, representing a 1.7% increase since 2004 (5.8 deaths per 100,000), but a sharper increase of 73% from 2008 reporting (3.4 deaths per 100,000). However, this should be interpreted cautiously due to the small number of events in this category of death, which tends to cause volatility in single-year rates. The five-year rate for the period 2003-2007 was 5.2 deaths per 100,000 children aged 14 years and younger.

The Child Death Review Board continued to assess multiple variables leading to the death of children including motor vehicle crashes and made the following legislative and procedural recommendations: mandatory sobriety testing of drivers in motor vehicle accidents resulting in a child fatality and/or a critical or serious injury to a child; banning the use of wireless hand-held telephone or electronic communication devices by drivers; strengthening the booster seat legislation to include use up to age 8; passage of All-Terrain Vehicle (ATV) safety legislation; enforcement of child passenger safety restraint laws; development and dissemination of a campaign promoting the best practices related to booster seat usage; the provision, at no cost, of driver education classes for all high school and career tech students; and increased accessibility and usage of drug courts and drug treatment. The Chief of MCH continued to serve on the Oklahoma Child Death Review Board as Vice Chair, and in July 2011 began serving as Chair.

Safe Kids Oklahoma Incorporated and Safe Kids Tulsa Area worked to improve the number of certified Child Passenger Safety (CPS) trained technicians in Oklahoma. Jointly, they conducted 16 sanctioned certification and re-certification courses, certifying 134 CPS technicians per Safe Kids National Standards. The two organizations held 122 car seat check-up events and distributed 4,542 car seats.

Safe Kids Oklahoma Incorporated continued to collaborate with Oklahoma Child Care Services, Oklahoma Department of Human Services (OKDHS) and offered training statewide in CPS to meet the requirement that child care centers providing transportation for children must have at least one staff member complete the eight-hour CPS course. Safe Kids Oklahoma Incorporated conducted 20 "Introduction to CPS" classes across the state with participation by child care providers, health educators, and home visitation professionals.

Safe Kids Oklahoma Incorporated purchased and distributed 2,486 car seats to county health departments statewide. The Oklahoma State Department of Health (OSDH) Injury Prevention Service provided technical assistance to the county health departments with installation, distribution, and education pertaining to the child safety seats. County health departments continued to conduct car seat checks with 38 certified CPS technicians employed in county health departments across the state.

Joint meetings were held between MCH and Injury Prevention Service to assure awareness of and collaboration on motor vehicle safety activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Participated in Child Death Review Board to contribute to and impact state policy.				X
2. Supported statewide activities of the Oklahoma Safe Kids programs.			X	
3. Partnered with Injury Prevention Service on planning and coordination of injury prevention activities.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oklahoma Children's Health Plan: Keeping Kids Healthy identifies injury prevention, inclusive of child passenger safety, as a priority in addressing the safety and well being of Oklahoma children. Teams and subsequent workgroups are meeting to provide leadership for assuring that strategies are implemented toward reaching targets identified in the plan.

Injury Prevention Service and MCH are working with the Oklahoma Highway Safety Office to finalize an educational brochure on Graduated Driver's License. The brochure's graphic art work is being designed by the Oklahoma Highway Safety Office. When complete, the brochure will be disseminated through community-based vehicle tag agencies.

The Chief of MCH is starting the second year of a two-year term as the Chair of the Oklahoma Child Death Review Board. Of priority is stronger use of data and engagement of partners to broaden the base of support for state level policy changes needed to prevent child deaths.

MCH participates in the statewide Injury Prevention Advisory Council. The Injury Prevention Advisory Council recommends and supports bills introduced during legislative sessions aimed at improving motor vehicle safety on Oklahoma roadways. Senate Bill 182, to prohibit the use of hand held electronic devices while driving for persons less than 18 years of age, was introduced in the 2012 session and supported by OSDH. The bill died early in committee.

c. Plan for the Coming Year

Six of the eight objectives identified for the priority of injury prevention in the Oklahoma Children's Health Plan: Keeping Kids Healthy, focus on policy changes, public education, and services related to motor vehicle safety. One of six objectives is specific to reducing motor vehicle deaths in the state among children and youth. It is anticipated that the Infant Injury Prevention Workgroup, already in place for the statewide infant mortality initiative, "Preparing for a Lifetime, It's Everyone's Responsibility," will expand its focus to include all children 0-18 years old and assume the lead for this priority. The Team Lead for the Infant Injury Prevention Workgroup is the Administrator for the Oklahoma Child Death Review Board.

In the role as Chair of the Oklahoma Child Death Review Board, the Chief of MCH will work closely with the members of the Board and the Executive Committee to use data in a broader manner to educate the public and policymakers of the issues. Recommendations of the Oklahoma Child Death Review Board include mandatory sobriety testing of drivers in motor vehicle collisions resulting in a child fatality and/or critical injury to a child, children transitioning out of custody have access to driver's education and substance abuse education, support of the Office of the Chief Medical Examiner to improve and maintain infrastructure, legislation banning the use of hand-held devices while driving, and enforcement of child passenger safety laws.

Building partnerships and strategically working to engage partners in education and advocacy efforts toward prevention of child deaths will be a priority.

MCH will maintain a supportive relationship with Injury Prevention Service and Safe Kids Oklahoma Incorporated and Safe Kids Tulsa Area. The Injury Prevention Service and Safe Kids Incorporated and Safe Kids Tulsa Area will provide CPS classes and conduct child safety seat checks. Safe Kids Incorporated will continue to provide child safety seats to all county health departments where they will be distributed to families in need. MCH and Injury Prevention Service will provide technical assistance to Safe Kids Incorporated and Safe Kids Tulsa Area, as requested, to support expansion of community-based activities.

MCH will continue to participate in the statewide Injury Prevention Advisory Council.

Joint staff meetings of MCH and Injury Prevention Service will continue. These meetings will continue to provide a forum for discussion related to planning and evaluation of injury prevention activities in the state.

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

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	32.4	33.1	30.7	31.2	35.2
Annual Indicator	30.2	30.5	25.4	34.9	34.1
Numerator	14416	15497	13555	15272	17902
Denominator	47662	50848	53366	43780	52572
Data Source		Oklahoma TOTS survey	Oklahoma TOTS survey	Oklahoma TOTS survey	Oklahoma TOTS survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	35.5	35.9	36.2	36.6	36.9

Notes - 2011

Source: The Oklahoma Toddler Survey (TOTS), 2011.

Annual performance objectives have been revised, based on recent reporting experience, to project a 10% increase by year 2020.

Notes - 2010

Source: The Oklahoma Toddler Survey (TOTS), 2010.

Annual performance objectives have been changed given the latest data available from TOTS. Targets have been revised based on a 10% increase by 2020.

Notes - 2009

Source: 2009 TOTS survey data. Numerator and denominator are weighted population estimates. Oklahoma 2009 TOTS surveyed mothers who completed 2007 PRAMS survey.

a. Last Year's Accomplishments

The Oklahoma Toddler Survey (TOTS) provided data to monitor National Performance Measure #11. According to 2010 TOTS data, 34.9% of women reported breastfeeding their infants to six months of age.

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.

Oklahoma State Department of Health (OSDH) employee breastfeeding room and worksite policy information was shared via new employee orientations, the agency intranet, and agency bulletin boards, serving as models for state and community agencies.

Executive Summaries of the Surgeon General's Breastfeeding Call to Action were offered to Coalition of Oklahoma Breastfeeding Advocates (COBA) members and sent to County Health Department Administrators, tribal health facilities, Federally Qualified Health Centers (FQHCs), and "Preparing for a Lifetime, It's Everyone's Responsibility" partners. These and other breastfeeding updates were shared in the March MCH video conference "What's New in Nutrition."

WIC hosted the Breastfeeding Educator Course in April with 151 attending, the largest number to date. As part of WIC's Breastfeeding Task Force, MCH helped plan and present the 11th Annual WIC Breastfeeding Symposium for Healthcare Providers in June, with 400 attending. The Symposium recognized 17 new and 31 previous Breastfeeding Friendly Worksites. New sites received certificates signed by the Commissioner of Health and were listed on the breastfeeding website.

The Task Force developed Oklahoma's National Breastfeeding Month theme, "Support Breastfeeding: It's Worth It!", and reviewed state and community news releases and public service announcement (PSA) aired before, during, and after World Breastfeeding Week (WBFW), receiving \$425,246 in donated airtime. PSA links were posted on the breastfeeding website. WIC clinics hosted receptions, shared materials to support mothers and increase breastfeeding rates, received germicidal breast pump wipes, and shared legislation cards. COBA members created an insert for the "Breastfeeding Works!" brochure, increasing efforts to educate employers on worksite benefits.

During August, WBFW materials and Oklahoma's theme were displayed in the OSDH central office lobby and discussed in news interviews. The Centers for Disease Control and Prevention (CDC) Vital Signs report on hospital breastfeeding support and a news release were posted on the website. Electronic Benefit Transfer messages were sent to child care centers, and WIC's "Breastfeeding and Returning to Work" brochures were distributed.

WIC's Breastfeeding Peer Counselor Program grew to 32 peer counselors in 21 sites in 14 counties.

In September, MCH created a fiscal year (FY) 2013 legislative budget request through OSDH,

under the umbrella of "Preparing for a Lifetime, It's Everyone's Responsibility." Included in the request was a statewide "Baby-Friendly" hospital training in 2013 to educate maternity care leaders and promote steps toward the Baby-Friendly designation.

The Oklahoma Health Care Authority (OHCA), the State's Medicaid agency, worked with MCH, WIC, and COBA to add 39 contracted International Board Certified Lactation Consultants (IBCLCs) to their website. WIC and COBA increased the listing of IBCLCs to 67 in the updated Oklahoma Lactation Resource Guide, shared at the Symposium and on the breastfeeding website.

The Breastfeeding Workgroup of "Preparing for a Lifetime, It's Everyone's Responsibility" promoted breastfeeding through the website, and provided support for the IBCLC staffed 24-hour hotline, (1-877-271-MILK), for nursing mothers, expecting parents, and health care providers. The hotline, a partnership of MCH, WIC, and the University of Oklahoma (OU) Department of Obstetrics and Gynecology (OB-GYN), increased services to 2,918 calls this year, and created flyers targeting health care providers.

MCH supported the Hospital Breastfeeding Education Project focused on increasing initiation and duration rates through hospital maternity care policy changes. Evidence-based trainings began for 18 targeted hospitals and activity updates were shared in several stakeholder meetings.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided education and data about breastfeeding in Oklahoma to wide audience across the state to promote breastfeeding.			X	
2. Collaborated with WIC and OHCA on breastfeeding training and education activities, including increasing the number of certified lactation consultants contracted with Medicaid.				X
3. Created a FY 2013 budget request through OSDH, which included funding for statewide Baby-Friendly Hospital training as part of infant mortality reduction initiative "Preparing for a Lifetime, It's Everyone's Responsibility."				X
4. Supported the Oklahoma Breastfeeding Hotline for breastfeeding mothers and families and health professionals.		X		
5. Funded Hospital Breastfeeding Education Project to increase initiation and duration rates through hospital maternity care policy changes.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH contracts with the OU Department of OB-GYN to provide breastfeeding education and technical support to healthcare staff in Oklahoma birthing hospitals, clinical practices, and healthcare organizations to promote evidence-based breastfeeding practices and policies in maternity care. The project offers a variety of staff trainings including a train-the-trainer course and books, a one-day class on the basics of breastfeeding support, as well as in-person site visits and training.

A PRAMS Brief, "Duration and Exclusivity of Breastfeeding," is providing current data to share with statewide delivering hospitals and prenatal care providers.

WIC is offering three trainings for WIC staff and healthcare providers: a Lactation Management Course held in March, with 46 clock hours for IBCLCs; a Breastfeeding Educator Course in April; and the WIC Breastfeeding Conference in June, featuring a review of the new American Academy of Pediatrics (AAP) Breastfeeding Policy Statement and laws that affect IBCLCs.

OU Medical Center is working with the Oklahoma Blood Institute (OBI) to establish an Oklahoma milk bank.

Oklahoma's "Baby-Friendly" hospital project, a topic in the July "Every Week Counts" Learning Session, is providing breastfeeding education for hospital leaders and promoting steps toward the "Baby-Friendly" designation, with ten hospitals working to implement four of the Ten Steps. See SPM #10.

Funding was received for the FY 2013 legislative budget request.

c. Plan for the Coming Year

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

MCH will promote the OSDH Breastfeeding Friendly Worksite Initiative through Turning Point's Certified Healthy Business Annual Conference, the OSDH breastfeeding website, the Oklahoma Hospital Breastfeeding Education Project and website, the annual WIC Breastfeeding Conference, the COBA Workplace Breastfeeding Awareness Project, and statewide news releases and trainings.

MCH will continue to partner with OU to maintain support for the 24 hour Oklahoma Breastfeeding Hotline. The support line will be promoted during trainings for health care professionals, through services to pregnant and breastfeeding females, and via different media sources and websites.

MCH will work with WIC to identify sites for expansion of the Breastfeeding Peer Counseling Program.

OU Medical Center, currently a milk depot, will continue to work with the OBI to establish an Oklahoma Mothers Milk Bank to screen and process breastmilk in Oklahoma, with milk depots located in OBI centers across the state.

MCH and the Hospital Breastfeeding Education Project will continue to promote breastfeeding through the development of "Baby-Friendly" hospitals by providing assistance to Oklahoma birthing hospitals in working toward implementing the 10 Steps to Successful Breastfeeding necessary for recognition. Ten hospitals will be recruited to work toward implementing four of the ten steps to achieving the "Baby-Friendly" designation. In the winter of 2013, hospitals will be invited to send a MCH leadership team of up to three participants to a statewide "Baby-Friendly" hospitals training with nationally known speakers to learn ways to implement the Ten Steps.

Through a MCH contract, the Oklahoma Hospital Breastfeeding Education Project leader, working with targeted birthing hospitals, will continue to offer in-person evidence-based staff trainings, individual train-the-trainer sessions, ongoing technical support, and additional staff education and resources. MCH will continue to collaborate with WIC, COBA, and the Hospital Breastfeeding Education Project to address the nine objectives in the United States

Breastfeeding Committee's Vision for the Future.

Discussions with the OHCA, the OU Office of Perinatal Quality Improvement (OPQI), and the COBA will continue to promote the "Baby-Friendly" designation for Oklahoma hospitals. MCH will work with WIC's Breastfeeding Task Force to plan the 2013 annual WIC Breastfeeding Conference. The Task Force will coordinate World Breastfeeding Week activities, review breastfeeding promotion materials for county health departments and area clinics, and plan for upcoming trainings, including breastfeeding education and lactation management courses.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	95.1	95.5	97	97.2	100
Annual Indicator	95.1	98.6	99.0	99.1	99.1
Numerator	52262	52980	52670	51571	51571
Denominator	54946	53735	53185	52055	52055
Data Source		Screening and Special Services, OSDH			
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	100	100	100	100	100

Notes - 2011

Source: Data were obtained from Screening and Special Services, OSDH. Data are not yet available for 2011, hence 2010 data are used as a provisional estimate.

Due to the nature of hearing loss diagnosis, CDC requires that states report one year from the end of the birth year. Therefore, Oklahoma 2011 data will not be available until 2013. That allows time for families to follow-up, audiologists to complete several appointments if needed to obtain diagnosis, and placement in early intervention services as suggested by the CDC/Healthy People goals.

Notes - 2010

Source: Data were obtained from Screening and Special Services, OSDH.

By 2011 auditory screening machines will electronically transmit results from hospital newborn screenings to an OSDH database, which will reduce clerical errors and thus increase the reported % of newborns receiving hearing screenings.

Annual performance objectives have been revised to reflect improvement in the state's capacity to screen newborns. Oklahoma will forecast that 100% of all newborns will be screened annually.

Notes - 2009

Source: Data were obtained from Screening and Special Services, OSDH.

a. Last Year's Accomplishments

Of the 52,055 Oklahoma births in calendar year (CY) 2010 (the most recent data available), 51,571 infants (99%) had hearing screened prior to hospital discharge, while only 484 (1%) were not screened at any time. Of the infants screened, 2,668 (5%) were referred for diagnostic assessment for failing the hospital screen and 84 had confirmed hearing loss. At least 55 infants with a diagnosis of hearing loss born in 2010 were enrolled in Oklahoma's 0-3 early intervention program, SoonerStart, or other related programs.

The Oklahoma Newborn Hearing Screening Program (NHSP) has received federal funds through a Health Resources and Services Administration (HRSA) grant since April 1, 2001. The NHSP was successfully funded through March 2014 to maintain the Universal Newborn Hearing Screening Project and the Follow-up Coordinator position. This position remained responsible for planning, coordinating, and supervising audiology programs and related activities through county health departments in Oklahoma. In addition, the Follow-up Coordinator engaged birthing hospitals, parents, and other interested stakeholders to work towards increased utilization of initial and follow-up screening services and to decrease the percent lost to follow-up. Statewide training at all birthing hospitals and county health departments was completed to enhance screening and follow-up efforts for Oklahoma infants. Training included proper screening techniques, ways to complete equipment checks, resources for trouble-shooting, and the importance of state mandated reporting of all results.

The NHSP was awarded continued funds through a Centers for Disease Control and Prevention (CDC) Cooperative Agreement (July 2011-June 2016). A large portion of the success in this project was due to the employment of a Quality Assurance/Data Coordinator. In efforts to increase statewide reporting of all initial hearing screening results and to reduce the statewide average age of diagnosis with hearing loss, the NHSP continued to focus on three process-based analyses: 1) Not-Performed Rates, 2) Refer Rates, and 3) Not-Reported Rates for each birthing hospital. Not-Performed Rates reports to create baseline data have been piloted and disseminated to nine birthing hospitals over the year. Refer Rates reports have been created and piloted with two of Oklahoma's largest hospitals. These reports also allowed the hospitals and NHSP to determine if there were equipment problems that needed to be addressed.

A data project was completed to improve loss to follow-up/loss to documentation from Oklahoma birthing hospitals. The NHSP piloted safe and secure electronic data linkage with one of Oklahoma's largest hospitals from August 2010-2011 utilizing CDC software called Public Health Information Network Messaging System (PHINMS). Results from this hospital were being sent to the NHSP electronically, effectively reducing their Not-Reported Rate to zero percent. Software for the NHSP Neometrics tracking system was purchased with CDC funds to ensure the needs of the NHSP were met for data tracking, surveillance, and integration.

The Oklahoma Audiology Taskforce (OKAT), under the direction and facilitation of the NHSP, included stakeholders from the public and private sectors. The OKAT continued to expand membership including audiologists, speech-language pathologists, deaf educators, early

interventionists, hospital screening staff, parents/family members, pediatricians, otorhinolarygologists, genetics community members, consumers, representatives from Indian hospitals, Deaf/Hard of Hearing consumers, and family advocates programs. OKAT noted five times more participants than previous years and completed approximately fifteen activities with several ongoing projects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided timely screening for newborn hearing and needed follow-up services statewide.			X	
2. Maintained the Follow-up Coordinator position to increase follow-up services and decrease loss to follow-up by engaging hospitals, parents, and other stakeholders.		X		
3. Completed the pilot for electronic submission of newborn hearing screening data to OSDH with one of the state's largest birthing hospitals to reduce loss to follow-up and improve timely submission rates.				X
4. Expanded membership of the Oklahoma Audiology Taskforce and increased participation in task force activities and projects.				X
5.				
6.				
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9.				
10.				

b. Current Activities

The NHSP is currently working with twelve birthing hospitals to replicate electronic data linkage via PHINMS. Efforts are underway to expand the data linkage project to other birthing hospitals in Oklahoma.

The National Early Hearing Detection and Intervention (EHDI) Conference was held in February 2012. NHSP staff presented two sessions including "Oklahoma Follow-up: See How Far We've Come!!! Changing 1-3-6 months into 1-3-6 weeks" and "Hospital Training Boot Camp." Due to the follow-up coordinator's efforts, new screening equipment, and improved hospital collaboration, Oklahoma is being held up as a model for other states in decreasing the percent lost to follow-up. The NHSP is recording a webinar of the hospital training presentation at the request of the Directors of Speech and Hearing Programs of State Health and Welfare Agencies (DSHPSHWA) for dissemination to all state EHDI programs.

The NHSP was asked to speak on a panel at the EHDI 2012 Conference regarding Part C Early Intervention collaboration. The National Initiative for Children's Healthcare Quality (NICHQ) also invited the NHSP to speak on a national call with 28 other EHDI programs.

The OKAT and NHSP are currently working on School and Early Intervention Hearing Screening Guidelines to be completed by summer 2012.

c. Plan for the Coming Year

Expansion for Not-Performed Rates reports and Refer Rates reports will be completed for all birthing hospitals by December 2012. Baseline Not-Reported Rates reports will be created for all

birthing hospitals and will be distributed in 2013. The NHSP will continue collaborating with all birthing hospitals on electronic data linkage via PHINMS in the next few years as hospital participation allows. Staff will provide technical assistance and consultation to all birthing hospitals as needed to improve rates.

The NHSP will continue to seek ongoing support and assistance from the MCH and CSHCN programs. The collaborative efforts will assure that all Oklahoma newborns meet or exceed the national goals of having their hearing screened within the first month of life, and if hearing loss is suspected, diagnosis and intervention will be provided for the infant in a timely manner. A Follow-up Primary Care Provider (PCP) packet will be finalized. The packet will be sent once a child is reported with hearing loss to assist in continuity of care.

The NHSP will utilize federal funding to assist in the purchase of additional hearing equipment for rural county health departments in Oklahoma. NHSP-created training modules will be disseminated to county health department screening staff. The School and Early Intervention Hearing Screening Guidelines will be combined and disseminated with the Hospital Screening and Pediatric Audiology Diagnostic/Amplification Guidelines.

A previous reorganization of the Child Guidance Program resulted in the elimination of audiology positions at county health departments across the state. Due to limited access to pediatric audiologists in rural Oklahoma, the NHSP will continue to work with county health departments to develop protocols and contracts for private-public partnerships to regain pediatric audiology services in rural areas in an effort to increase proximity of care for families and decrease wait time for follow-up appointments.

The NHSP and the Newborn Metabolic (Bloodspot) Screening Program will continue to explore the web-based data reporting opportunities. Agency-wide initiatives to electronically link programmatic databases are underway, such as the Oklahoma Health Information Exchange (OHIE). The NHSP will be a partner in this process. The NHSP Coordinator will attend monthly OHIE meetings and serve on the Interoperable Public Health Information System (IPHIS) Stakeholder Subcommittee. The IPHIS vision is "Integrating and Sharing Health Data to Enable Partners to Monitor and Improve the State of Health of Oklahomans." A pilot linking project of three OSDH data systems will be explored: Public Health Oklahoma Client Information System (PHOCIS), Vital Records, and the Public Health Investigation and Disease Detection of Oklahoma (PHIDDO). The Oklahoma Newborn Screening Program Neometrics database will be scheduled for linkage following this pilot.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	13.9	12.4	12.5	12.4	12.3
Annual Indicator	12.5	12.6	12.4	11.9	11.9
Numerator	114000	116000	115000	114000	114000
Denominator	913000	920000	928000	954000	954000
Data Source		U.S. Census Bureau	U.S. Census Bureau	U.S. Census Bureau	U.S. Census Bureau
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	11.7	11.6	11.5	11.4	11.2

Notes - 2011

Source: U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic Supplement. Data for year 2011 not yet available.

Table HIB-5. Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2010

Annual performance objectives have been revised to reflect a 1% relative decrease each year.

Notes - 2010

Source: U.S. Census Bureau, Current Population Survey, 2010 Annual Social and Economic Supplement.

Table HIB-5. Health Insurance Coverage Status and Type of Coverage by State--Children Under 18: 1999 to 2010

Notes - 2009

Sources: U.S. Census Bureau, Current Population Survey. Final data for 2009 are not yet available; as a result, 2008 data are used as a provisional estimate for 2009. Data reflect health insurance coverage for children less than 18 years of age.

a. Last Year's Accomplishments

Current survey data collected by the U.S. Census Bureau for 2010 show that 11.9% of Oklahoma children ages 0-18 were uninsured during that year. The national average for the same year was 10 percent, placing Oklahoma 20% higher than the nation as a whole. Approximately 114,000 children were uninsured in Oklahoma for 2010.

The Oklahoma Children's Health Plan: Keeping Kids Healthy, released in February 2011 identified access to primary care, with insurance coverage seen as a major benefit in facilitating access, as a critical component to address the health of children.

The Centers for Medicare and Medicaid Services (CMS) approved the Oklahoma Health Care Authority (OHCA, the State's Medicaid agency) requested state plan amendment to add children with household incomes between 186% and 200% of the Federal Poverty Level (FPL) to the Insure Oklahoma Program effective July 1, 2010. As a result of the amendment 522 children from 0-18 were enrolled by adults participating in Insure Oklahoma.

Through an extension of CMS funding, the OHCA was able to maintain three regional Outreach Coordinators dedicated to increasing the enrollment of children in SoonerCare.

The Electronic Newborn-1 (eNB-1) continued to be implemented in birthing facilities across the state. The electronic process allowed infants to receive an identification (ID) number and be assigned to a primary care provider in SoonerCare before being discharged from the hospital. The ID card and information about the baby's benefits were printed out for the parent to take home.

Online enrollment for SoonerCare became effective in 2010 which allowed potential clients to complete an application from any computer, receive immediate feedback on eligibility, and obtain

a number to access services until a permanent card was mailed. The Oklahoma State Department of Health (OSDH) pilot tested the hiring of eight eligibility staff in 2010, trained to assist county health department clients with the enrollment process. Due to the success of the pilot, additional staff was added in county health departments in 2011.

The MCH Early Childhood Comprehensive Systems (ECCS) Project, Smart Start Oklahoma (SSO), and the SSO communities educated and informed early childhood programs and families on the importance of enrolling children in SoonerCare and the benefits of utilizing SoonerEnroll, the online enrollment form.

The Child Health Advisory Task Force, a partnership of the OHCA and OSDH/MCH established to assist both agencies in developing improved state policy and services for Oklahoma's families, continued to meet on even numbered months. Data on insurance coverage and benefits were part of the discussions.

Clinical child health services were provided as a safety net service through county health department sites and MCH contract providers. Services included the provision of well child exams, immunizations, treatment of minor acute illnesses, follow-up metabolic and newborn hearing screening, and lead screening as needed. These services were provided in accordance with the American Academy of Pediatrics Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Received authorization from CMS for a state plan amendment to add children in households at 186% FPL to 200% FPL to the Insure Oklahoma Program, which is subsidized by Medicaid funds.				X
2. Continued to implement eNB-1 to allow infants to receive an ID number and assigned primary care provider before discharge from the hospital.		X		
3. Piloted the addition of eligibility staff in county health departments to assist clients with the enrollment process for Medicaid.		X		
4. Provided clinical health services as a safety net provider through county health departments and contract providers.	X			
5.				
6.				
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10.				

b. Current Activities

The Oklahoma Health Improvement Plan (OHIP), Children's Health, Access to Primary Care Workgroup is developing a work plan to increase the percent of children with comprehensive health insurance coverage.

The OHIP Children's Health, CSHCN Workgroup is currently working toward increasing the percent of CSHCN receiving coordinated, comprehensive care within a medical home.

The OHCA has three regional outreach coordinators located in Oklahoma City, Tulsa, and Enid,

dedicated to increasing SoonerCare enrollment for children.

On December 28, 2011, the Governor signed an emergency change to Oklahoma's insurance laws allowing insurers to exclude infants from birth to one year from health care coverage. SoonerCare provides coverage to infants born to mothers covered under SoonerCare up to one year and all uninsured infants born less than two pounds, ten ounces, until one month after discharge. In January 2012, the board of the Oklahoma High Risk Pool voted to provide immediate medical insurance for babies younger than one, regardless of health. The Oklahoma High Risk Pool provides coverage for members with a pre-existing condition and denial of coverage by two licensed carriers, but have waived those requirements for infants less than one year of age, as there are no child-only policies for them.

The Child Health Advisory Task Force continues to meet and work toward improved health benefits and services for Oklahoma's low income families with children.

c. Plan for the Coming Year

The OHIP Workforce Workgroup will gather data on active primary care providers and work with the OHCA to identify provider shortage areas for Medicaid expansion.

The OHIP Children's Health, Access to Primary Care Workgroup will finalize its work plan and continue to strive to achieve the objectives: to increase the percentage of children who receive a primary care visit at least one time per year to 90%; increase the percent of children with a medical home to 60%; and, 95% of children will have comprehensive health insurance coverage by December 2014.

The Child Health Advisory Task Force will continue to meet and look at coverage and access to health care. Representation will continue to consist of families; state medical, dental, and nursing organizations; public and private health care providers to include Federally Qualified Health Centers and tribal health; Head Start; Smart Start Oklahoma; and social services and mental health agencies. Content (FQHCs) experts will continue to be brought in as resources during meetings as indicated to assure the most current data and information about standards of care are part of discussions.

Outreach and education activities to facilitate families having information on available coverage and how to access coverage will continue. County health departments and MCH contractors will continue to serve as safety net providers for health care services to children using the American Academy of Pediatrics Bright Futures Guidelines. Both county health departments and MCH contractors will provide information and assistance to families seeking information on health benefits for children.

Tribal nations in the state will continue to work on plans to add to existing clinics or open new clinics. The Absentee Shawnee tribe has a new facility in the rural area of Little Axe with a pediatric department and the Citizens Pottawatomie has opened a clinic for casino employees and their families in Shawnee which also offers pediatric care.

FQHC capacity will continue to expand. Six Oklahoma applicants, awarded more than \$3.6 million in June 2012, will establish new community health center delivery sites. Five of the six new sites will be satellites of existing FQHCs: Great Salt Plains Health Center, Inc. in Medford; Northeastern Oklahoma Community Health Centers, Inc. in Muskogee; Community Health Centers, Inc. in Carney; Stigler Health and Wellness Center in Poteau; and East Central Oklahoma Family Health Center, Inc. in Henryetta. Shortgrass Community Health Centers, Inc., a first-time grantee, will establish a site in Hollis. Oklahoma will have 18 FQHCs with approximately 48 sites. The Oklahoma Primary Care Association estimates these new sites will serve 22,312 Oklahomans, approximately 14,000 of them uninsured.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	53.9	53.3	52.3	17.3	20.6
Annual Indicator	54.4	20.8	20.9	20.9	20.9
Numerator		8621	9538	9707	9707
Denominator		41485	45686	46421	46421
Data Source		Oklahoma WIC	Oklahoma WIC	Oklahoma WIC	Oklahoma WIC
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	20.6	20.4	20.2	20	19.8

Notes - 2011

Source: 2010 Oklahoma WIC data. Year 2011 not yet available; therefore, 2010 data have used to provide an estimate.

Notes - 2010

Source: 2010 Oklahoma WIC data.

Annual performance objectives have been revised. Using HP2020 as a guide, a 10% improvement has been forecast by the year 2020. Annual targets are viewed as incremental steps toward that ultimate goal.

In reporting for the FY2009 application, Oklahoma stated that only WIC data reflecting the 95th percentile were available and henceforth would be reported in the annual grant submission. This statement was inaccurate and based on a misunderstanding of how WIC data are collected and stored. To correct that mistake, Oklahoma has made changes to the percentages previously reported. Data points now show, consistent with the performance measure definition, the percentage of children at or above the 85th percentile for age-gender body mass index (BMI).

Notes - 2009

Source: 2009 Oklahoma WIC data.

a. Last Year's Accomplishments

The Women, Infants, and Children Supplemental Nutrition Program (WIC) reported that the percentage of children ages 2 to 5 years receiving WIC services through the Oklahoma State Department of Health (OSDH) with a body mass index (BMI) at or above the 95th percentile was 20.9% in 2010, the latest data available. Due to changes in the National Survey of Children's Health, data are no longer available for children ages 2 to 5 years receiving WIC with a BMI at or

above the 85th percentile. OSDH WIC captures only those at or above the 95th percentile.

WIC continued to monitor BMI status for children ages 2 to 5 years and required reduced, low, and non-fat milk options for this age group. WIC Food Package options were expanded to include not only fruits, vegetables, and whole grains, but also soy milk and tofu. The new food package aligned with the 2005 Dietary Guidelines for Americans and infant feeding practice guidelines of the American Academy of Pediatrics (AAP). The Oklahoma WIC food package had reduced amounts of milk, cheese, eggs, and juice and eliminated whole milk for participants over two years of age.

Participant education materials continued to be developed. Infant and toddler materials were redesigned to increase appeal and interest among WIC participants, as well as provide more in-depth, detailed nutrition information consistent with AAP Policy and Institute of Medicine (IOM) studies, summaries, and reports. Oklahoma encouraged the development of healthy weights in WIC families through increased intake of fruits and vegetables and the use of reduced, low, and non-fat dairy products in planned meals. Increased active play and physical activity were also emphasized. "Get Your Groove on Mama" DVD lesson plans encouraged healthy nutrition and physical activity among postpartum women. "Cooking with WIC" reinforced positive family nutrition by using video field trips and cooking demonstrations to help WIC participants improve their skills in purchasing, planning, and preparing nutritious meals and snacks to improve the family diet.

WIC promoted the continued expansion of professional development, education, and staff training through various multi-media online instructions, and local, state, and national conferences. The WIC Training Link (www.ok.gov/wic) provided up-to-date online training and information to local, state, and national WIC staff. The Certified WIC Nutrition Technician Training Course was accompanied by activities, quizzes, and assignments to reinforce the course subject matter and to develop skills used in the WIC clinic. Policy, procedure, and additional trainings continued to be developed to expand, train, and educate all WIC staff as well as other OSDH clerical, paraprofessional, and professional staff.

Online nutrition education was implemented as an additional option for participants to complete their nutrition education credits via the website www.wichealth.org. Implementation training was conducted statewide by Oklahoma state office WIC staff in collaboration with University of Michigan staff affiliated with WIChealth.org.

WIC's efforts to promote and support breastfeeding, an evidence-based intervention in reducing the risk for obesity, showed results with almost an 11.3% increase in breastfeeding initiation rates in the last seven years (67.1% in 2004 to 78.4% in 2011). The number of WIC staff with the designation of International Board Certified Lactation Consultant (IBCLCs) increased from 23 in 2010 to 33 in 2011. In addition, the WIC Breastfeeding Peer Counselor Program was expanded to a total of 21 clinics in 14 counties, an increase of three clinics over last year. This succeeded in increasing breastfeeding initiation rates in the counties served by the program. The combined initiation rates in those 14 counties increased from 64.0% in 2004 before implementation to 77.9% in 2011.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitored BMI status of all children ages 2-5 receiving WIC and modified food packages as indicated.	X			
2. Continued to develop and improve quality of participant education materials.			X	
3. Expanded professional development opportunities for WIC				X

staff and other health care professionals.				
4. Offered online nutrition education to WIC clients as an additional option for receiving nutrition education credits.			X	
5. Supported breastfeeding as a priority through the Breastfeeding Peer Counselor Program and state planning and training activities.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Policies and procedures are in place for WIC participants identified with BMIs at or above the 95th percentile. Individualized counseling is done by a Registered/Licensed Dietitian and includes a full dietary assessment addressing family-friendly feeding dynamics.

Original educational materials are developed at the state level to promote and enhance the three types of nutrition education available to WIC participants: individual appointments, group classes, and online nutrition education. Newly designed materials for 2012 include the full color booklets: "Feed Me, I'm Yours" for infants, and "Feeding Your Toddler" for children ages 1-2 years.

WIC produces lesson plans for use in all Oklahoma WIC clinics. New plans for 2012 include: "Cooking with WIC: Kids Cook", and "Feeding with Love and Good Sense", a series of infant and child lessons focusing on the division of responsibility in feeding and family meals. A public service announcement (PSA) is being developed to educate the public on the benefits and availability of WIC services.

Breastfeeding remains a top priority. WIC conducts multiple breastfeeding trainings for staff each year. WIC employs 30 International Board Certified Lactation Consultants. Breast pumps and Breastfeeding Peer Counseling programs encourage and support breastfeeding duration. Breastfeeding education bags are provided to all pregnant participants to help them make an informed choice about feeding their babies.

c. Plan for the Coming Year

WIC will continue to offer nutrition education in three formats to best fit participants' learning styles and needs; individual appointments by a Registered/Licensed Dietitian, facilitated group classes where participants can learn from each other, or online nutrition education which can be completed at the participant's convenience. WIC will produce original lesson plans to be used in all 77 counties. Lessons will focus on healthy foods, the importance of family meals, physical activity, and breastfeeding. A Cooking with WIC recipe booklet will be developed to provide WIC families with multiple recipes utilizing WIC foods right at their fingertips. Video lesson plans will allow staff to demonstrate cooking, meal preparation, and physical fitness classes led by a trainer even when their facilities do not lend themselves to conducting these activities on site.

WIC will continue to focus on outreach and promotion of the availability of services. New PSAs will be developed and WIC will have a presence at local and state conferences, schools, and universities.

Electronic Benefits Transfer (EBT) will be the next new technology to enhance the delivery of WIC benefits. As WIC begins EBT implementation, educational materials and tools will be developed to specifically address the training needs of each particular audience, ranging from participants to WIC staff, the public, and vendors.

Breastfeeding will continue to be a priority and focus area for WIC. Strategies to increase breastfeeding initiation and duration rates among Oklahoma mothers will continue to be pursued, including breastfeeding promotion through the influence of peer support. The Breastfeeding Peer Counseling Program will continue in existing sites with additional plans for expansion.

WIC will continue to provide opportunities for breastfeeding education in 2013. The Breastfeeding Educator Course will be offered in April. In June, the Breastfeeding Symposium will again be combined with the Annual Nutrition/WIC Conference. WIC plans to continue to provide breast pumps to mothers as needed and breastfeeding education bags to all pregnant WIC participants. WIC will also continue to explore additional tools to increase Oklahoma's breastfeeding duration rates by helping women breastfeed their babies longer.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	18.6	18.4	21	20.5	18.3
Annual Indicator	21.3	16.9	18.5	19.3	19.3
Numerator	11101	8797	9576	10001	10001
Denominator	52148	52000	51804	51792	51792
Data Source		PRAMS	PRAMS	PRAMS	PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	18.1	17.9	17.7	17.5	17.3

Notes - 2011

Source: 2010 Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS).

Data for year 2011 have not been released to date, hence PRAMS survey data for 2010 have been used to provide an estimate for this measure.

Notes - 2010

Source: 2010 Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS).

Notes - 2009

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS).

Year 2009 has been updated with PRAMS 2009 data recently released to Oklahoma by the CDC.

Data for year 2009 have not been released to date, hence PRAMS survey data for 2008 have been used to provide an estimate for this measure.

Numerator and denominator consist of weighted counts.

2007 95% CI: (18.3%, 24.6%)

2008 95% CI: (14.3%, 19.9%)

While there was a statistically significant decrease in the maternal smoking rate during pregnancy reported in PRAMS, from 21.3% in 2007 to 16.9% in 2008, there has been considerable variability in this measure in 1996-2008, during which period there is no detectable negative trend in the smoking rate. Hence the current annual performance objectives will not be adjusted. With the launch of the Preparing for a Lifetime initiative in Oklahoma, plus the Tobacco Program's quitline and TV spot, modest improvements for this performance measure are expected in the future.

a. Last Year's Accomplishments

Data for monitoring National Performance Measure #15 were drawn from the 2010 Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). These data show that 19.3% of pregnant females reported smoking during the third trimester of pregnancy. In 2000, the percent of pregnant females reporting third trimester smoking was the same as that reported for 2008, 16.9%, with 2010 marking the second straight year in which the smoking rate during the last trimester of pregnancy has risen among Oklahoma women.

The Tobacco Workgroup of the "Preparing for a Lifetime, It's Everyone's Responsibility" infant mortality reduction initiative met to ensure communication and collaboration across programs, agencies, and organizations on efforts to promote smoking cessation in pregnant females. A Public Service Announcement (PSA) was produced and aired in January 2011 depicting a pregnant woman smoking and an infant in the neonatal intensive care unit. The pregnant woman makes the conscious choice to put down the cigarette and have a healthy baby.

The Oklahoma State Department of Health (OSDH) Tobacco Use Prevention Service (TUPS), the Tobacco Settlement Endowment Trust (TSET), and the Oklahoma Health Care Authority (OHCA, the State's Medicaid agency) continued working on a pilot practice facilitation project in provider offices. The project objectives were to counsel pregnant females on the benefits of smoking cessation, offer incentives to quit smoking during pregnancy, and offer help to stay quit during the postpartum period. Funds were provided through a TSET grant and the OHCA/OSDH Perinatal Advisory Task Force (PATF) served as the advisory body for the project. Over 1,000 Prenatal Quit Kits were distributed to providers and partners statewide. Pregnancy Consumer Cards were developed with pregnancy-specific information for providers and were also disseminated at Community Baby Showers hosted by the OSDH Office of Minority Health.

The PATF, chaired by the OHCA and the OSDH/MCH, moved into its sixth year of facilitating systems changes to improve perinatal care. This year the focus of activities continued to center on quality improvement. Medicaid providers received compensation for completing the Psychosocial Risk Assessment and for counseling clients on the "5 A's" for tobacco cessation. Reminders of this benefit were sent to providers, since relatively few providers were utilizing this resource.

TUPS established a partnership with Cherokee Nation Health Systems to help pregnant women stop smoking and stay quit postpartum and continued to promote the Oklahoma Tobacco Helpline as a strong resource to help pregnant women in their cessation efforts.

The Oklahoma State Plan for Tobacco Use Prevention and Cessation was published with input from key MCH stakeholders. The plan provided detailed information about the effect tobacco use has on reproductive health, including the associations between smoking during pregnancy and low birth weight infants, miscarriages, premature birth, and stillbirth. Discussion began on assuring that the impacts of tobacco use on pregnant women and infants were included in the annual update of the Tobacco Use Prevention Social Marketing Plan.

The OHCA provided training for 123 OSDH staff and partners on smoking and pregnancy.

Family planning clients and pregnant females seen through county health departments and contract clinics were counseled on the impact of smoking during the preconception, interconception, and prenatal periods. Females who smoked or reported family members who smoked were referred to the Oklahoma Tobacco Helpline, 1-800-QUIT-NOW, for support in their efforts to discontinue smoking. MCH monitored county health departments' and contract clinics' smoking intervention documentation to ensure appropriate referrals for clients who reported using tobacco products.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued work on smoking cessation media materials with the Tobacco Workgroup of the "Preparing for a Lifetime, It's Everyone's Responsibility" including a PSA on smoking during pregnancy.			X	
2. Supported the pilot practice facilitation project utilizing Prenatal Quit Kits for tobacco cessation intervention for pregnant women via efforts of the Perinatal Advisory Task Force.			X	
3. Supported OHCA in maintaining their policy to cover tobacco cessation intervention for pregnant women.				X
4. Provided input for The Oklahoma State Plan for Tobacco Use Prevention and Cessation.				X
5. Partnered with OHCA to provide training to OSDH and partners' staff.				X
6. Provided education to family planning and maternity clients seen through county health departments and contract providers; referred to Oklahoma Tobacco Helpline.		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Tobacco Workgroup of the "Preparing for a Lifetime, It's Everyone's Responsibility" meets regularly. Through a partnership between the TSET, TUPS, and OHCA, the practice facilitation project continues to train staff at the local level to conduct practice facilitation with prenatal care providers to implement the 5 A's. Pregnant females are counseled on the benefits of smoking cessation and offered incentives to quit smoking during pregnancy and to stay quit during the postpartum period. Funds are provided through a TSET grant and the OHCA/OSDH Perinatal Advisory Task Force serves as the advisory body for the project.

TUPS has a partnership with Cherokee Nation Health Systems to provide training and consultation to Women, Infants, and Children Supplemental Nutrition Program (WIC) Specialists and lactation nurses on smoking cessation, to help pregnant women stop smoking and stay quit postpartum.

TUPS continues to work with the Children First (Oklahoma's Nurse-Family Partnership) Program on motivational interviewing with clients enrolled in the program in efforts to decrease the number of pregnant women and new mothers who smoke.

The Family Planning Program and TUPS continue to promote the 1-800-QUIT-NOW line to females of childbearing age who smoke.

c. Plan for the Coming Year

The Chief of MCH has been requested to co-lead the Collaborative Improvement & Innovation Network (COIN) Strategy Team on Tobacco Cessation for the Regions IV and VI infant mortality initiative. The work of the COIN will inform future activities for this measure for both regions.

The Tobacco Workgroup will continue to meet. This Workgroup plans to continue a social marketing campaign to educate high-risk populations on effective cessation treatments and provide motivational messages to encourage them to quit (including pregnant women). Plans will include continued collaboration with the OHCA and TSET on the projects in Oklahoma City and Tulsa to help pregnant and postpartum females and their families become tobacco free. Staff will decide if the current framework for the pilot should continue or if adjustments are needed to improve efficiency and effectiveness of interventions. The focus will continue to be tobacco use cessation during pregnancy that is sustained through incentives during the postpartum period.

The OHCA/OSDH Child Health Advisory Task Force will continue to explore policy and budget impacts of extending Medicaid tobacco cessation benefits to mothers who bring infants to child health appointments.

Support will continue for the facilitation of the Obstetric Outreach Program provided by the OHCA to all pregnant SoonerCare members to incorporate tobacco cessation services and referrals to the Oklahoma Tobacco Helpline. TUPS will work with the Oklahoma Insurance Department and TSET to promote the adoption of a core health benefit among private insurers that will reimburse health care providers for tobacco cessation services for pregnant women similar to those provided through the OHCA.

Family planning clients seen through the county health departments and contract clinics will continue to be counseled on the impact of smoking and referred to the Oklahoma Tobacco Helpline. Maternity providers will continue to assess pregnant women for smoking through use of the Psychosocial Risk Assessment and provide counseling and referral to the Tobacco Helpline as indicated.

MCH will continue to promote use of faxed referrals to the Tobacco Helpline in an effort to increase follow-up contact after the initial encounter. By sending the faxed referral, follow-up with the individual will be initiated by a trained smoking cessation counselor and will not be dependent on the individual to call.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	7.9	9.9	11	10.5	10
Annual Indicator	7.9	12.3	10.5	10.5	10.5
Numerator	20	31	27	27	27
Denominator	251911	251880	256841	256841	256841
Data Source		Vital Records &	Vital Records &	Vital Records & U.S.	Vital Records & U.S.

		U.S. Census Bureau	U.S. Census Bureau	Census Bureau	Census Bureau
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	10.4	10.3	10.2	10.1	10

Notes - 2011

Sources: Numerator obtained from Health Care Information, Oklahoma State Department of Health, denominator from U.S. Census Bureau. Death data for year 2011 are not yet available; 2009 data are used as an estimate.

Annual performance objectives have been revised to reflect a 10% reduction by year 2020.

Notes - 2010

Sources: Numerator obtained from Health Care Information, Oklahoma State Department of Health, denominator from U.S. Census Bureau. Death data for year 2010 are not yet available; 2009 data are used as an estimate.

Notes - 2009

Sources: Numerator obtained from Health Care Information, Oklahoma State Department of Health, denominator from U.S. Census Bureau.

a. Last Year's Accomplishments

In 2009, Oklahoma recorded 27 suicide deaths to youth aged 15 through 19, resulting in a suicide death rate of 10.5 deaths per 100,000 population. This is a 12.5% decrease, down from 12.0 deaths per 100,000 population in 2008. Year over year changes in the suicide rate should be viewed with some skepticism given the small number of events in this category of death. The five-year rate covering 2005-2009 was 9.6 suicide deaths per 100,000 youth aged 15-19. Trend analysis from the 2003, 2005, 2007, 2009, and 2011 Oklahoma Youth Risk Behavior Survey (YRBS) indicated no statistically significant change in the percentage of students who made a suicide attempt, who made an attempt plan, or who seriously considered suicide, during the 12 months preceding the survey.

Using YRBS data from 2011, a Youth Suicide and Depression Fact Sheet was developed. Information was included in the fact sheet about selected public schools' efforts and recommended actions. In addition, the Oklahoma State Department of Health (OSDH) Injury Prevention Service created the Oklahoma Violent Death Reporting System (OK-VDRS) Brief Report: Youth Suicide in Oklahoma, 2004-2009. A dissemination plan was developed to ensure these resources reached a broad audience of stakeholders to include school personnel, community coalitions, mental health providers, faith-based communities, and youth-serving organizations.

In February 2011, the Oklahoma Health Improvement Plan (OHIP) Children's Health Flagship Workgroup released the Oklahoma Children's Health Plan: Keeping Kids Healthy. The Chief of MCH and Executive Director of the Oklahoma Family Network served on the 12 member Children's Health Plan Panel, an expert panel identified by the OHIP Children's Flagship Workgroup to develop the plan. The Adolescent Health Coordinator served as a content expert on adolescent health. The document identified adolescent health as one of eight targeted areas of priority and reduction in youth suicide was highlighted as a goal in improving adolescent mental health.

The Adolescent Health Coordinator actively participated on the Oklahoma Suicide Prevention Council, of which youth suicide prevention was a major focus. The Council began working with the Office of Juvenile Affairs to produce suicide prevention plans for youth in crisis. The Council also worked with schools statewide to provide early identification and follow-up for adolescents with a history of suicide ideation and attempts. Resources and assistance were given to various communities for local suicide prevention forums.

Support from the Substance Abuse and Mental Health Services Administration (SAMHSA) Garrett Lee Smith Grant made it possible for the Oklahoma Suicide Prevention Council to continue implementation of the state's suicide prevention plan including community-based suicide prevention training, suicide screening for youth, and improved referral networks for youth at risk for suicide. Oklahomans were able to order or download free materials from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) website, which included a site specifically for adolescents.

Evidence-based programs continued to include Question, Persuade, Refer (QPR) and Applied Suicide Intervention Skills Training (ASIST), Columbia TeenScreen, and the Lifeline's prevention curriculum. Extensive QPR, ASIST, and awareness presentations were provided to a large number of participants to reinforce the message that suicide is a preventable public health problem. QPR instructor trainings were held regionally, adding numerous QPR instructors for agencies, communities, universities, and tribal nations. The Mercy Hospital Project trained physicians and other medical staff to identify suicide warning signs and referral options and techniques.

ODMHSAS's Youth Suicide Prevention Toolkit trainings were held in various Oklahoma communities. The toolkit was provided at conferences, awareness events, and via the ODMHSAS website to assist with developing prevention strategies at a community level.

In July 2011, staff from MCH and Injury Prevention Service were invited to present information concerning internet safety, sexual violence, and bullying at the Annual Suicide Prevention Conference, hosted by ODMHSAS. The conference was attended by educators, mental health professionals, health professional, and youth-serving agencies.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Developed and disseminated fact sheets for 2011 YRBS data on suicide risks and ideation, and 2004-2009 mortality data on youth suicide.			X	
2. Supported implementation of the state suicide prevention plan via a Garrett Lee Smith Grant.				X
3. Maintained involvement with the Oklahoma Youth Suicide Prevention Council.				X
4. Presented information with Injury Prevention Service			X	

concerning internet safety, sexual violence, and bullying at the Annual OSDMHSAS Suicide Prevention Conference.				
5.				
6.				
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10.				

b. Current Activities

The Oklahoma Suicide Prevention Council continues implementation of the state's suicide prevention plan including community-based suicide prevention training, suicide screening for youth, and improved referral networks for youth at risk for suicide. Working in collaboration with the Suicide Prevention Council, Integris Health and Mercy Hospital are printing the National Suicide Prevention Hotline on all client hospital discharge forms. The National Suicide Prevention Hotline, 1-800-273-TALK (8255), is being distributed on posters, billboards, and on gunlocks in communities throughout the state.

Over 381 QPR, ASIST, and awareness presentations have been provided this year throughout the state with over 10,000 participants receiving the message that suicide is a preventable public health problem.

Care Coordination at Mercy Hospital, through a partnership with ODMHSAS, provides those presenting with a mental health crisis or self-inflicted wounds the opportunity to be connected to a mental health professional provided through a referral network.

Two MCH staff, trained as QPR instructors, are conducting trainings with participants who interact with youth ages 10-24. In May 2012, Oklahoma State Parks and Recreation staff were trained. Training for MCH staff is being planned.

Oklahoma's Youth Suicide Prevention Toolkit is provided at conferences, awareness events, and ordered or downloaded by communities to assist with developing prevention strategy.

c. Plan for the Coming Year

MCH will continue to provide staff support and leadership on the Oklahoma Suicide Prevention Council and technical assistance on use of the Oklahoma Youth Suicide Prevention Toolkit.

MCH will continue to assist the ODMHSAS to meet grant requirements of the Garrett Lee Smith Grant from SAMHSA and work towards the project goals of decreasing suicide deaths and attempts among youth age 10-24, increasing the implementation of evidence-based suicide prevention strategies throughout the state, and increasing community and state-level capacity for suicide prevention. The Suicide Prevention Council will work with local media to improve the methods of reporting deaths by suicide and promote the display of the National Suicide Prevention Hotline on all media involving suicide.

Bullying and youth suicide prevention will be priority focus areas in the work accomplished with the Oklahoma State Department of Education (OSDE) and the ODMHSAS. Due to the link between bullying and youth suicide, MCH will continue to work closely with the OSDE on curriculum schools can implement to reduce bullying.

MCH will assist in further building of community level infrastructure for recognizing and intervening to prevent youth suicide across the state by assuring Child and Adolescent Health staff trained in QPR provide the four required trainings requested by the ODMHSAS, over the next two years.

MCH will continue to collaborate with the Injury Prevention Service and the Oklahoma Suicide Prevention Council to utilize the OK-VDRS in conjunction with prevention activities. The Oklahoma Suicide Prevention Council will collaborate again with the Oklahoma City Indian Health Institute in hosting the Oklahoma Suicide Prevention Annual Conference. MCH staff will serve on the Conference Planning Committee.

Support for statewide Crisis Intervention Team (CIT) training for law enforcement officers, in addition to QPR and ASIST efforts, will be ongoing to provide training for public service officers as well as Federally Qualified Health Center (FQHC) staff, public health nurses, school nurses, other school personnel, hospital staff, tribal entities, and faith-based organizations throughout the state.

The YRBS will continue to be utilized in the evaluation of youth risk behaviors related to suicidal thoughts and behaviors.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	77	83	83.5	82	82.5
Annual Indicator	78.7	80.8	81.5	81.5	81.5
Numerator	637	631	423	423	423
Denominator	809	781	519	519	519
Data Source		OSDH Vital Records	OSDH Vital Records	OSDH Vital Records	OSDH Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	83	83.5	84	84.5	85

Notes - 2011

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. Finalized 2011 data are not yet available; provisional 2009 data are used as an estimate and are subject to change.

Notes - 2010

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. Finalized 2010 data are not yet available; provisional 2009 data are used as an estimate and are subject to change.

Notes - 2009

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division. Year 2009 are provisional and are subject to change. Finalized 2009 data are not yet available.

a. Last Year's Accomplishments

Provisional 2009 Oklahoma birth data show that 81.5% of infants born weighing less than 1,500 grams were delivered at high-risk facilities. If final data show a similar result, it will mark the second consecutive year of increase for very low birth weight (VLBW) births delivered at high-risk facilities, as the 2007 rate was 78.7%. Since 2000, the rate has increased by 7.6%, up from 75.7%.

MCH provided data from the Pregnancy Risk Assessment Monitoring System (PRAMS) and vital records through PRAMSGrams, presentations, and trainings to educate the public, health care providers, and policymakers on health issues including access to care, disparities of Oklahoma pregnant women, and prematurity. MCH used this information to make recommendations and facilitate discussion on concerns and changes needed in enhancing the perinatal health care system infrastructure, improving access to care, and reducing prematurity rates.

Two workgroups of the "Preparing for a Lifetime, It's Everyone's Responsibility" infant mortality reduction initiative addressed preconception/interconception health and prematurity in Oklahoma. The Preconception/Interconception Care and Education Workgroup focused on educating women with previous poor pregnancy outcomes about the importance of early and appropriate prenatal care and the Prematurity Workgroup collaborated with the March of Dimes to promote awareness of the March of Dimes 2011 Report Card which gave Oklahoma a "D" for issues related to prematurity.

Support of the Fetal and Infant Mortality Review (FIMR) projects at the Tulsa Health Department (THD) and the Oklahoma City-County Health Department (OCCHD) remained a priority as both projects expanded into their respective metropolitan statistical areas (MSAs) conducting full case review and community action activities. In addition to neonatal deaths, THD expanded reviews to include fetal deaths. MCH staff organized regional calls with FIMR staff to improve communication between projects in Region VI.

The Perinatal Advisory Task Force (PATF) and the Oklahoma Health Care Authority (OHCA) worked together to change Medicaid policy requiring high risk referrals to maternal fetal medicine specialists to facilitate collaboration in care management and delivery at the most appropriate facility.

The Office of Perinatal Quality Improvement (OPQI) and the Oklahoma Hospital Association (OHA), with funding from MCH and the March of Dimes, focused on quality improvement activities with birthing hospitals, including the elimination of elective, non-medically indicated inductions and deliveries prior to 39 weeks of gestation. The evidenced-based toolkit from the March of Dimes, "Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age," served as the basis for Oklahoma's "Every Week Counts" Collaborative. This learning collaborative focused on providing birthing hospitals with education, tools, and support to reduce elective deliveries prior to 39 weeks. Ninety percent of Oklahoma birthing hospitals were participating, affecting 95% of Oklahoma births.

MCH, OPQI, and OHA continued to look at the issue of designated levels of neonatal care in an effort to assure infants are delivered at the most appropriate facility. MCH, OPQI, and OHA met with OSDH staff responsible for hospital regulatory rules and promoted the need to use the American Academy of Pediatrics (AAP) standards in designation of nursery levels. The Chief of MCH presented this information to the Hospital Advisory Board on April 17, 2011 and received approval to move forward with drafting of rules.

Through alternate funding sources, the OPQI trained 299 hospital staff with the Perinatal Continuing Education Program (PCEP) to better recognize and manage obstetrical and newborn emergencies and prepare at risk newborns for transport when indicated. These included physicians, certified nurse midwives, physician assistants, emergency personnel, registered nurses, and licensed practical nurses.

The Healthy Start projects in Oklahoma and Tulsa counties, the Children First Program, and the Office of Child Abuse Prevention (OCAP) Family Resource and Support projects received technical assistance and support from MCH. These projects and programs provided in-home support to pregnant females and their families to decrease infant morbidity and mortality including education on the signs and symptoms of pregnancy complications and where to seek prompt medical attention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided PRAMS data and vital records data through a variety of means to a wide audience to facilitate understanding of the issue.			X	
2. Collaborated with the Prematurity and Preconception/Interconception Care and Education workgroups of the "Preparing for a Lifetime, It's Everyone's Responsibility" to promote interconception care for women with previous poor pregnancy outcomes.				X
3. Supported the FIMR projects in Tulsa and Oklahoma Counties through funding and technical assistance.				X
4. Collaborated with OHCA via the Perinatal Advisory Task Force, to change Medicaid policy requiring high risk referrals to maternal fetal medicine specialists to facilitate collaboration in care management and delivery.				X
5. Supported and helped fund the "Every Week Counts" Collaborative to reduce elective deliveries prior to 39 weeks gestation in the state.				X
6. Provided technical assistance to Healthy Start, Children First, and OCAP programs.				X
7.				
8.				
9.				
10.				

b. Current Activities

Support of the FIMR projects at the THD and OCCHD remains a priority for MCH. Both projects continue expansion into their MSAs and the THD FIMR continues to review fetal deaths.

MCH, the OPQI, and the OHA continue to explore the issue of designated levels of neonatal care in an effort to assure infants are delivered at the most appropriate facility. The decision was made to delay formal rule making at present in lieu of a more collaborative approach based on the AAP standards. Policies and procedures in states with voluntary self-designation by hospitals of levels of neonatal care are being researched and work has begun to develop a similar approach for Oklahoma hospitals.

Two workgroups of the "Preparing for a Lifetime, It's Everyone's Responsibility" initiative continue to address preconception/interconception health and prematurity. A new Women's Health

Assessment Tool was piloted and the Preconception/Interconception Workgroup is working to make indicated revisions. Once finalized, the tool will be available for use in county health department and contractor clinics, by the Family Support and Prevention Service with clients being served through the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grant, and online. The Prematurity Workgroup and the OHA led the third learning session for "Every Week Counts" to reduce elective deliveries prior to 39 weeks. Recent data indicate a 66% decline in these deliveries since the collaborative began.

c. Plan for the Coming Year

Perinatal Regionalization is one of five priority focus areas identified for future work of the Regions IV and VI infant mortality initiative. A Collaborative Improvement & Innovation Network (COIN) Strategy Team on Perinatal Regionalization has been formed that will inform future directions to impact this measure.

Support of the FIMR projects' efforts to expand to the MSAs and to include fetal deaths will continue. MCH will review abstraction tools for the Maternal Mortality Review (MMR), Oklahoma Birth Defects Registry, and FIMR to assess information collected and areas of duplication to improve efficiency and provide more accurate information for use by the projects. Findings and recommendations from these projects will be used to make systems improvements to enhance positive outcomes for mothers and infants.

Currently, Oklahoma's hospital regulatory rules address emergent obstetric care service requirements but fail to provide any recommendations based on the potential needs of the neonate as recommended by AAP guidelines. MCH will continue to work with the OPQI and the OHA to establish and implement a system for self-designation of nursery levels based on the AAP standards including activities to monitor and ensure hospital participation and accurate reporting on the level of care provided at the facility.

The PATF will continue to meet and serve as the link between provider concerns and policy changes to improve collaboration between local prenatal care providers and maternal fetal medicine specialists to increase the number of preterm and low birth weight infants born at the most appropriate facility.

Through "Preparing for a Lifetime, It's Everyone's Responsibility", MCH will continue to partner with the OPQI, the OHA, the Oklahoma Health Care Authority (OHCA, the State's Medicaid agency), and the March of Dimes. This partnership will further develop Oklahoma's "Preparing for a Lifetime, Its Everyone's Responsibility" hospital-based activities in an effort to provide safe, quality, maternal and infant care by providing or linking health care providers to educational tools and best practice resources. The OPQI will continue to be the single point of contact for the hospitals in assuring their needs are identified and technical assistance provided. Face-to-face opportunities will continue to be provided for hospital leadership to emphasize quality improvement and provide tools related to issues impacting infant mortality.

The use of the Women's Health Assessment Tool will be promoted outside the OSDH services (private physician offices, Indian Health clinics, Federally Qualified Health Center clinics) and with home visitation programs (Children First- Oklahoma's Nurse Family Partnership Program and the MIECHV grant).

Technical assistance will continue to the Healthy Start projects in Oklahoma and Tulsa counties, MIECHV, the Children First Program, and the OCAP family resource and support programs.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	80.5	81.7	74.7	77	77.5
Annual Indicator	76.4	76.5	67.2	67.2	67.2
Numerator	41463	41551	34519	34519	34519
Denominator	54281	54290	51360	51360	51360
Data Source		OSDH Vital Records	OSDH Vital Records	OSDH Vital Records	OSDH Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	78	78.5	79	79.5	80

Notes - 2011

Source: Health Care Information, OSDH. Final birth data for 2011 are not yet available; provisional data for 2009 are used as an estimate and subject to change.

Annual performance objectives have been left unchanged until more recent final birth data becomes available. At that time, targets will be reassessed.

Notes - 2010

Source: Health Care Information, OSDH. Final birth data for 2010 are not yet available; provisional data for 2009 are used as an estimate and are subject to change.

Notes - 2009

Source: Health Care Information, OSDH. Birth data for 2009 are provisional and are subject to change; final data are not yet available for this year.

a. Last Year's Accomplishments

In 2009, data for which are provisional, 67.2% of all Oklahoma births occurred to females beginning prenatal care during the first trimester of pregnancy. While subject to change pending final release of 2009 data, if this number holds, it will reflect a relative decrease of 12.1% from 76.5% in 2008. Generally speaking, the rate of receiving first trimester prenatal care by pregnant women in Oklahoma has been unchanged for recent years. Data by race and ethnicity indicate considerable variability: White, 79.4%; Black/African American, 69.4%; American Indian/Alaska Native, 69.7%; and Hispanic, 60.7%.

In 2010, approximately 64% of all births in Oklahoma were paid for by the Medicaid programs SoonerCare or Soon-To-Be-Sooners (STBS). STBS continued to provide health care benefits through the State Children's Health Insurance Program for the unborn child of a pregnant female who would not otherwise qualify for SoonerCare benefits due to citizenship status.

The Oklahoma State Department of Health (OSDH) and the State's Medicaid agency, the Oklahoma Health Care Authority (OHCA), continued to monitor the effectiveness of "Online

Enrollment" allowing members or potential members of SoonerCare to apply and receive eligibility electronically from any computer. Clients received Medicaid eligibility determination and, if qualified, a Medicaid identification (ID) number was assigned prior to leaving the website. The printout with the ID number allowed clients to access care prior to receiving an official card. County health departments served as a primary site in communities with eight staff hired as a pilot project in collaboration with the OHCA to assist individuals with enrollment.

As part of the activities of the MCH Comprehensive Program Review conducted with county health departments and routine site visits to contractors, MCH looked at access issues in communities related to prenatal care. Clinic records were audited to assure females with positive pregnancy tests were counseled on the need to initiate care with a maternity health care provider within 15 days. County health departments and contract providers were expected to keep updated resource lists available to assist in linking 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 28,207 females for pregnancy testing and linkage with appropriate services depending on the results of the pregnancy test. With the continuation of STBS to the Medicaid options for health care coverage, there was a decreased need for safety net providers and only seven counties continued to provide more expanded maternity services, with one of those only providing the initial lab work and exam before linking the clients with providers in the community. Most county health departments and contract clinics reported the ability to initiate care for clients within two weeks of the documented positive pregnancy test or request for prenatal services.

During this time period, MCH continued meetings with the OSDH Health Care Information (HCI), the University of Oklahoma Office of Perinatal Quality Improvement (OPQI), and the Oklahoma Hospital Association (OHA) on quality improvement activities and training of hospital staff on accurate completion of the birth certificate. Abstraction and data collection tools were developed, hospitals were randomly selected, and staff was trained to collect information from hospital medical records, prenatal records, and birth certificate clerks to assess accuracy of data reported on birth certificates regarding entry into prenatal care and number of prenatal visits.

Preconception health information was provided by MCH at 10 Community Baby Showers hosted by the Office of Minority Health to help educate high risk women on the importance of preconception health and early prenatal care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promoted the online enrollment for SoonerCare/STBS applications and electronic eligibility determination by hiring new eligibility staff at county health departments.		X		
2. Provided technical assistance to county health departments and contract providers through MCH comprehensive program reviews.				X
3. Provided clinical maternity services as a safety net provider through county health departments and contract providers.	X			
4. Worked with Health Care Information staff at OSDH, the OPQI, and the OHA to determine the most efficient methods to ensure accurate completion of the birth certificate in all birthing hospitals.				X
5. Provided preconception and benefits of early prenatal care health information at 10 Community Baby Showers throughout the state, hosted by the Office of Minority Health.			X	

6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Women's Health Assessment tool for preconception education is being finalized after completion of a pilot project. The tool will be used in county health department clinics, Federally Qualified Health Centers, Indian Health clinics, and private practices to educate women on the importance of preconception health issues including the importance of early prenatal care when they do get pregnant.

Collaboration continues with the OHCA on the "Online Enrollment" process. OSDH continues to train the 16 staff hired this year to assist clients in the county health departments with Medicaid applications. A contract with the OHCA provides funding support for these staff.

MCH continues to work with HCI, the OHA, and the OPQI on the project evaluating the quality and accuracy of birth certificate data. OSDH and OPQI staff are comparing the information in prenatal records with information on the birth certificate for randomly selected hospitals and interviewing the birth certificate clerks to ascertain sources for information entered. Initiation of this project occurred with pilot sites in November 2011. In March 2012, staff starting abstracting information from client records in the selected hospitals.

Seven Community Baby Showers have been held this year, with five more scheduled before October.

c. Plan for the Coming Year

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

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

The web pages for "Preparing for a Lifetime, It's Everyone's Responsibility" will continue to be updated with information regarding the importance of preconception care and early entry into prenatal care as a method of impacting infant mortality in the state. The web pages will also include updated information on resources including how and where to apply for SoonerCare and STBS. Resource cards identifying practices to promote a healthy pregnancy, to include entry into prenatal care during the first 12 weeks as well as a multitude of resources, have been developed as part of the initiative on infant mortality. These cards, that fold over and are the size of a business card, will continue to be promoted at community events, with health care providers, and in pharmacies as a resource for pregnant females.

MCH will continue comprehensive program reviews with county health departments and routine site visits to contractors and assess access issues in communities related to prenatal care especially in communities without MCH funded maternity clinics. Guidance will be provided to health care providers on strategies to educate women on the importance of receiving early

prenatal care. Clinic records will continue to be audited to assure women with positive pregnancy tests are counseled on the need to initiate prenatal care within 15 days and linked with needed resources.

MCH, HCI, the OPQI, and the OHA will complete the birth certificate quality improvement project and analyze the data. Information obtained will be used to develop training for hospital staff to standardize and improve the accuracy and quality of reported data and to develop a standard definition of entry into prenatal care.

D. State Performance Measures

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	49.8	48	47.8	50	47.2
Annual Indicator	48.0	50.3	47.7	45.6	45.6
Numerator	25073	26233	24491	23638	23638
Denominator	52250	52200	51344	51792	51792
Data Source		Oklahoma PRAMS	Oklahoma PRAMS	Oklahoma PRAMS	Oklahoma PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	45.1	44.6	44.2	43.7	43.3

Notes - 2011

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2010. Data for year 2011 are not available at this time, hence 2010 data are used as provisional estimate.

Annual Performance Objectives for SPM#1 have been revised downward given recent PRAMS survey estimates. Forecasted targets through year 2016 anticipate an annual 1% relative decrease.

Notes - 2010

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2010.

Notes - 2009

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2009.

a. Last Year's Accomplishments

Pregnancy Risk Assessment Monitoring System (PRAMS) data are used to monitor unintended pregnancy within Oklahoma. For collection year 2010, the latest for which final weighted data are available, less than half (45.6%) of Oklahoma live births were the result of an unintended pregnancy, with 31.9% mistimed and 13.7% unwanted at the time of conception. This marks the second consecutive yearly collection cycle for which Oklahoma has experienced a decline in the rate of unintended pregnancy resulting in a live birth. Since 2008, the rate has decreased by

9.3%, down from 50.3%.

The Oklahoma Health Care Authority (OHCA, the State's Medicaid agency) received approval to transition from an 1115A waiver to a state plan amendment (SPA) for family planning services July 1, 2011 with an effective date of August 31. SoonerPlan provided coverage for uninsured males and females 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 (185% of Federal Poverty Level). 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. Enrollment increased 30.3% from January 2011 to December 2011. Nexplanon was added as a covered option for long acting contraceptive methods. The Oklahoma State Department of Health (OSDH) continued to collaborate with the OHCA and the Oklahoma Department of Human Services (OKDHS) to evaluate and improve services provided through SoonerPlan.

Online enrollment for Medicaid became effective in 2010 which allowed potential clients to complete an application from any computer, receive immediate feedback on eligibility, and a number to access services until a permanent card was mailed. OSDH hired eight eligibility staff in 2010 trained to assist clients with the enrollment process to help link clients with services (including contraception).

Family planning services were provided through county health departments and contract clinics. The OSDH finalized steps to add Implanon to the OSDH formulary. Special projects focused on serving the African American population continued in Oklahoma and Tulsa counties. 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 education on smoking cessation, nutrition, and exercise. Services were provided to a total of 59,452 females and males of reproductive age for calendar year 2011.

MCH received funding through the federal State Personal Responsibility Education Program (PREP) grant to expand teen pregnancy prevention efforts. Funds were used to implement teen pregnancy prevention programs through the Oklahoma City-County Health Department (OCCHD) and the Tulsa Health Department (THD). Staff were hired and trained in the "Making a Difference!" and "Making Proud Choices!" curriculum.

The Preconception/Interconception Care and Education Workgroup of the statewide "Preparing for a Lifetime, It's Everyone's Responsibility" infant mortality reduction initiative began piloting the Women's Health Assessment tool in county health departments, physician offices, tribal clinics, and Federally Qualified Health Centers (FQHCs). This tool was designed to assist women in identifying potential preconception health risks and to provide education to improve pregnancy outcomes.

Staff development opportunities were provided throughout the year based on the MCH annual staff development training needs assessment as well as federal MCH Title V and Title X Family Planning priorities and key issues including adolescent pregnancy prevention, preconception health and family planning, and reproductive life planning.

See NPM #8.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Continued support and collaboration with OHCA and OKDHS to assure effective and efficient provision of Medicaid family planning services under state plan amendment.	X			
2. Promoted the new online Medicaid enrollment and hired 16 additional OSDH staff to assist clients with the process to link to services.		X		
3. Provided clinical family planning services through county health departments and contract providers.	X			
4. Received a federal PREP grant to expand teen pregnancy prevention efforts in Oklahoma City and Tulsa.			X	
5. Piloted a Women's Health Assessment tool focused on preconception health in several county health department clinics, FQHC and IHS clinics, and home visiting programs.			X	
6. Provided staff development opportunities.				X
7.				
8.				
9.				
10.				

b. Current Activities

MCH continues working with the OHCA on Medicaid coverage for family planning services. Staff is looking at how to expand services to meet the needs of reproductive age males and females and ensure continued coverage for family planning services through the mandatory transitions dictated by the Affordable Care Act.

SoonerPlan now covers the contraceptive implant Nexplanon. County health department were trained in January to insert the implant which provides contraception for three years.

MCH received 2011 funding through the federal PREP grant to expand teen pregnancy prevention efforts. OCCHD and THD continue to build connections with schools and expand their reach in providing the evidenced-based curriculum, "Making a Difference!" and "Making Proud Choices!" Teen pregnancy prevention projects are also active in four county administrative areas using these evidenced-based curriculum.

The Preconception/Interconception Care and Education Workgroup is evaluating input from the pilot of the Women's Health Assessment tool to determine how to best help women understand and evaluate health risks and behaviors prior to pregnancy and the importance of planning pregnancies to improve birth outcomes. Adolescent and male versions of reproductive health plans are being created to share health information effectively to all males and females of reproductive age.

See NPM #8.

c. Plan for the Coming Year

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

MCH will continue to work with the OHCA to provide family planning services to low-income females and males of reproductive age who would otherwise not be eligible for Medicaid covered services through the SPA. Discussions continue regarding the feasibility of extending coverage to include treatment for STDs and Human Papillomavirus (HPV) reflex testing on Pap smears. MCH will continue working with the OHCA on the possibility of covering preconception education

as a part of physical examinations and/or through an interconception waiver.

Family planning services will be provided through county health departments and contract clinics. Services will include medical histories, physical exams, laboratory services, methods education and counseling, provision of methods, STD/HIV screening and prevention education, pregnancy testing, immunizations, and education on smoking cessation, nutrition, exercise, and healthy weight.

The Preconception/Interconception Care and Education Workgroup will promote use of the Women's Health Assessment tool to help women understand and evaluate health risks and behaviors prior to pregnancy to improve birth outcomes. The adolescent and male versions of reproductive health plans being created will be used to share reproductive health information effectively with all males and females of reproductive age.

Social media options will be explored to promote family planning services and education to all females and males of reproductive age who choose to participate. MCH will work on developing a protocol and initiating social media activities in accordance with the agency social media policy. Messages about pregnancy prevention will be included in social marketing.

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

Family planning providers will continue to be encouraged to treat every visit as a preconception health visit and provide targeted preconception/interconception health counseling to every client.

Long-acting, reversible contraceptives will continue to be offered as an effective strategy to increase the percent of women who have intended pregnancies.

See NPM #8.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	160	168	60	65	80
Annual Indicator	138	62	67	74	75
Numerator					
Denominator					
Data Source		CSHCN Program, OK Dept of Human Services			
Is the Data Provisional or Final?				Final	Final

	2012	2013	2014	2015	2016
Annual Performance Objective	85	90	95	100	105

Notes - 2011

Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services.

Notes - 2010

Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services.

Notes - 2009

Source: Children with Special Health Care Needs (CSHCN) Program, Oklahoma Department of Human Services.

a. Last Year's Accomplishments

The Oklahoma Areawide Services Information System (OASIS) was created in 1987 to provide information, referrals, and assistance to people with disabilities and their families in Oklahoma. Since July of 2000, OASIS has housed the Oklahoma Respite Resource Network (ORRN). ORRN was organized to be the central processing agency for respite care applications in the state. Three divisions of the Oklahoma Department of Human Services (OKDHS) provided funding for respite for the families of children with special needs: CSHCN, which is housed in the Family Support Services Division; the Developmental Disabilities Services Division (DDSD); and, the Children and Family Services Division (CFSD). DDSD served children and adults who had a primary diagnosis of autism, cerebral palsy, Down's syndrome, or other developmental conditions. CFSD administered programs for children in foster care. CSHCN provided vouchers for families of children who were not in foster care or receiving services through DDSD. ORRN received 1,795 first time requests for applications for the respite voucher program. Personnel with ORRN reviewed the applications, decided which funding sources best matched the family's situation, and then determined if the family met that division's eligibility criteria. If a family was eligible, the family's application was sent to that division. The division then sent a set of vouchers to the family. The individual who provided the respite service completed the voucher and mailed it to the issuing division. The issuing division then sent a check to the provider. A total of 275 applications met at least one division's criteria. CSHCN issued 75 vouchers, DDSD issued 151 vouchers, and CFSD issued 49 vouchers. The total number of vouchers issued for children with special health care needs was considerably higher than the previous year. This was due to the fact that DDSD received TANF (Temporary Assistance for Needy Families) grant monies to use for providing respite care.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided funding for respite services.		X		
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

J.D. McCarty Center contracts with CSHCN to provide respite services to any child in the state. Founded in 1946 to treat children with cerebral palsy, the center's focus has changed over the years and currently children are evaluated and treated for many different developmental disabilities. The J.D. McCarty Center provides up to seven days of respite care for a child per year. Children in respite do not receive treatments but they do enjoy a variety of entertaining activities, including field trips.

In Garfield County, located in northern Oklahoma, Sooner SUCCESS (State Unified Comprehensive Exemplary Services for Special Needs) has partnered with the Oklahoma Family Network (OFN) and the Christ United Methodist Church to develop a faith-based respite program. The program is free to families in Garfield County and provides one-on-one respite care once a month for children with special needs and their siblings, ages 6 months to 12 years. Volunteers are recruited from a variety of local service providers, churches, and civic groups and serve as respite "buddies" for the program. The first respite session was held on April 20, 2012 with approximately 30 children served. Funding for the program comes from private donations, with materials donated by the three major partner organizations. Program volunteers have submitted a grant application to 4Imprint to assist with the cost of t-shirts for all the volunteers.

c. Plan for the Coming Year

DDSD, CFSD, and CSHCN will continue to provide respite vouchers to families. TANF funds will continue to support a portion of the DDSD vouchers.

CSHCN will continue to contract with the J.D. McCarty Center to provide respite care to children across the state.

ORRN will continue to process respite applications and be housed with OASIS. The recent organizational changes (OASIS will be placed under the umbrella of the Sooner SUCCESS program) will not affect the respite voucher process. Sooner SUCCESS will continue and expand on the database that houses the resource and referral information provided to children and youth with special health care needs across the state. OASIS will continue to be publicized as such, but behind the scenes will feed to 211.

Sooner SUCCESS, OFN, and the Christ United Methodist Church will continue to offer their faith-based respite program in Garfield County. The program will continue to be based on the Hannah's Promise Model at the Church of the Servant United Methodist Church in Oklahoma City. Once a month Hannah's Promise will offer care to children and youth with special health care needs and their siblings. Parents and caregivers will get a few hours of rest and the children will have an evening of fun. The program will continue to be free and retain enough volunteers that each participant gets his or her own "buddy" (caregiver) for the evening. Attendees will do crafts, indoor and outdoor play, and have a worship time.

The Garfield County program will continue to be free to families residing in Garfield County and will provide one-on-one respite care once a month for children with special needs and their siblings, age 6 months to 12 years. Publicity for the program will be provided by families through their local school districts, parent-to-parent communication, and local children's service providers affiliated with the Garfield County Sooner SUCCESS coalition. Funding for the program will come from private donations. Materials used will be donated by the three major partner organizations.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective		29.6	29.3	29	28.7
Annual Indicator	29.9	29.9	30.2	30.2	33.0
Numerator	45361	53316	50280	50280	54739
Denominator	151710	178316	166489	166489	165875
Data Source		YRBS & OK State Department of Education			
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	32.5	32	31.5	31	30.5

Notes - 2011

Source: Numerator derived from 2011 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted total who gave height and weight measurements.

Annual performance objectives have been revised to reflect recent reporting experience. Forecasted targets anticipate a 10% reduction by year 2020.

Notes - 2010

Source: Numerator derived from 2009 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted total who gave height and weight measurements.

Statewide Oklahoma YRBS administered only in odd-numbered years. For 2010 reporting, 2009 final data are used as an estimate.

Notes - 2009

Source: Numerator derived from 2009 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted total who gave height and weight measurements.

a. Last Year's Accomplishments

According to the Youth Risk Behavior Survey (YRBS) data for 2011, 33.0% of Oklahoma adolescents attending public schools were overweight or obese. This represents a 9.3% relative increase from 2009, at which time the rate was 30.2% for this population, and an increase of 32% since 2003. In 2011, 35.4% of males and 30.7% of females were overweight or obese.

Revisions to the YRBS protocol were completed and approved by the Centers for Disease Control and Prevention (CDC) and Oklahoma State Department of Health (OSDH) institutional review boards (IRBs) in the fall of 2010. The YRBS was administered in late winter through spring of the 2010-2011 school year. Using YRBS data from 2011, MCH began developing a fact

sheet illustrating overweight and obesity among high school students. Work began in August 2011 to prepare for the 2013 YRBS.

In February 2011, the Oklahoma Health Improvement Plan (OHIP) Children's Health Flagship Workgroup released the Oklahoma Children's Health Plan: Keeping Kids Healthy. The document identified adolescent health as one of eight targeted areas of priority with school participation in YRBS and other related surveys identified as an area to impact in order to improve adolescent health outcomes.

MCH purchased the Cooper Institute's FitnessGram data collection utility tool and initiated a pilot of the tool in selected schools across the state as directed by Senate Bill (SB) 519. The pilot of the FitnessGram was to assess the feasibility of the FitnessGram software data collection process. The twelve schools submitted their data to the Child and Adolescent Epidemiologist by email through zip files. It was found that the FitnessGram aggregation utility tool functioned appropriately as a data aggregation tool and worked well on a small scale project such as the one completed. A final report of the pilot, completed in April 2011, contained both pros and cons related to the use of the current system and recommendations should this become a requirement. It was determined that the current software, without upgrading to the newer version, was not adequate for statewide use. The newer version presented financial as well as logistical barriers to purchasing it.

Financial and technical assistance continued to be provided to the Schools for Healthy Lifestyles Program (SHL), an organization that provides preventive, community-based school health education programs for students, their families, and faculty. The program included 61 schools; six were new participants, including the Tulsa and Oklahoma City metropolitan areas. SHL continued to focus on nutrition, physical activity, tobacco, and injury prevention.

MCH continued to provide financial and technical assistance to the Tulsa Health Department's "It's All About Kids Program (IAK)." This program followed the CDC Coordinated School Health Program Model and, along with community collaboration, provided the only coordinated school health program model in Oklahoma reaching more the 8,500 students in the Tulsa County area. Sixteen schools participated in this program.

MCH worked with the OSDH Chronic Disease Service, Fit Kids Coalition (FKC), Action for Healthy Oklahoma Kids (AHOK), and the Oklahoma State Department of Education (OSDE) to update the Healthy Oklahoma Schools Manual in the summer 2011. The Healthy Oklahoma Schools Manual was placed on state and community-based agency websites to provide easy access for individual school site Healthy and Fit Advisory Committees.

MCH provided input on a legislative measure to mandate comprehensive health education sometime between grades six and eight in all Oklahoma public schools. This legislative measure did not pass during the 2011 Legislative Session.

In an effort to better achieve two primary flagship goals set forth by OHIP, obesity reduction and tobacco use prevention, the OSDH reorganized in September 2011 to integrate the Physical Activity and Nutrition Service and the Tobacco Use Prevention Service into the Center for the Advancement of Wellness.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administered the YRBS, which included data on overweight and obesity among adolescents.				X
2. Completed the pilot and final report for the FitnessGram data tool as directed by OK Senate Bill 519.				X

3. Provided financial and technical support to the Schools for Healthy Lifestyles Program and the It's All About Kids Program.			X	
4. Worked with state partners to update the Oklahoma Healthy Schools Manual.				X
5. Provided input on legislation to mandate comprehensive health education in Oklahoma public middle schools.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH continues to provide technical assistance to the Oklahoma Futures Program nurses during the 2011-2012 school year. This multi-year pilot began its second year, involving extensive collaboration between three county health departments (Comanche, Okmulgee, and Oklahoma City-County Health Department), OSDH staff from multiple program areas, and four local high-risk school districts to implement the CDC Coordinated School Health Program model. The primary emphasis is to move Oklahoma students to better academic performance by meeting the needs of students and teachers in the participating schools. This pilot continues to include parent and community components providing a variety of outreach programs in order to gain support for strengthening the bonds between the community stakeholders, parents, students, and the school.

MCH supported legislative efforts to mandate one semester of health education sometime between grades six and eight through House Bill (HB) 1270 which passed out of committee but did not pass a House floor vote. MCH and the Oklahoma Fit Kids Coalition provided support for SB1882 that limits liability to schools for the use of indoor or outdoor school property and facilities made available for public recreation before or after normal school hours or on weekends or school vacations, except those claims resulting from willful and wanton acts of negligence. SB1882 was signed by the governor on April 5, 2012 and is effective November 1, 2012.

c. Plan for the Coming Year

YRBS data will continue to be used to educate school administrators, legislators, and other stakeholders. This information will also be used by the Child and Adolescent Health Division and the Center for the Advancement of Wellness within the OSDH to further policy and interventions to impact overweight and obesity. MCH will seek to more fully engage partners outside the OSDH at the state and community levels in efforts to impact this priority. YRBS data will be collected again in the spring of 2013.

MCH will continue to serve as a resource as state policy is considered for health education in the middle school setting. MCH will continue to work with schools to adopt the CDC Coordinated School Health Program model.

Technical assistance will continue to be provided to the Oklahoma Futures Program as requested. Contracts supporting the SHL, Tulsa Health Department's IAK, and the Oklahoma City-County Health Department's Oklahoma Futures will continue. SHL will work with schools throughout the state to provide programs for students and parents on nutrition education, tobacco and injury prevention, and physical activity. IAK will look to expand their program into additional Tulsa county school districts. The Oklahoma City-County Health Department's Oklahoma Futures will continue to work with school districts in the Oklahoma County area to establish the CDC Coordinated School Health Program model at each site.

The adolescent health tool "My Life. My Plan." includes nutrition and physical activity information to promote wellness. The tool will be made available in print and also on the MCH web page for use in public (health departments, tribal facilities, Medicaid providers, and Federally Qualified Health Centers) and private health care settings.

MCH, along with other OSDH service areas, will develop pilot youth advisory boards in several Oklahoma counties. In future years, with feedback from these pilots, MCH will be expanding the youth advisory boards across the state of Oklahoma, to include youth from urban and rural areas. County health department staff experienced in working with youth will facilitate the groups. The groups will provide leadership skills to a select group of local adolescents who have an interest in health issues. In addition to skills building, feedback from these individuals on adolescent health issues will be used to guide program planning for health department activities and resources.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					4
Annual Indicator				3.0	3.4
Numerator				1260	1389
Denominator				41878	40517
Data Source				CSHCN Program, OKDHS	CSHCN Program, OKDHS
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	5	6	7	8	9

Notes - 2011

Source: CSHCN Program, OKDHS.

Numerator – Number of CSHCN receiving child care subsidy through OKDHS (as reported by Family Support Services Division)

Denominator – Number of children in licensed child care facilities receiving child care subsidy (as reported by the Oklahoma Child Care Resource and Referral Association)

It is intended that this measure show all Oklahoma children rather than be restricted to those children receiving a child care subsidy through OKDHS. However, at this time, data are not available to report in this manner. As a result, Oklahoma is reporting on only those children receiving a child care subsidy. Efforts continue to be made to develop a source of data for this measure as it was intended to be reported.

Notes - 2010

Source: CSHCN Program, OKDHS.

Numerator – Number of CSHCN receiving child care subsidy through OKDHS (as reported by Family Support Services Division)

Denominator – Number of children in licensed child care facilities receiving child care subsidy (as reported by the Oklahoma Child Care Resource and Referral Association, June 2010)

It is intended that this measure show all Oklahoma children rather than be restricted to those children receiving a child care subsidy through OKDHS. However, at this time, data are not available to report in this manner. As a result, Oklahoma is reporting on only those children receiving a child care subsidy. Efforts continue to be made to develop a source of data for this measure as it was intended to be reported.

In June 2010 there were a total of 136,534 slots available throughout the state.

a. Last Year's Accomplishments

The Oklahoma Child Care Resource and Referral Association (OCCRRA) collected and disseminated information and data regarding child care in Oklahoma which was published on their website, www.oklahomachildcare.org. The website also provided information to parents seeking licensed child care.

OCCRRA revised some of their reports to gather more data regarding CSHCN. The definition they used for CSHCN when gathering information from child care providers was "Children who have a physical or mental disability and/or children with a chronic illness." Child care providers self-reported if they had received training and/or were capable of accommodating children with needs in four categories: behavioral, developmental, medical, and physical. A behavioral need was defined as an impairment that affects the child's behavior and may require non-traditional behavioral strategies differing from those used with typically developing children. A developmental need was defined as a child not reaching their expected developmental milestones within the expected time frame. A medical need was defined as an impairment that requires medical intervention in order to carry out regular expected activities by a typically developing child. A physical need was defined as a physical impairment that prevents a child from engaging in regular activities performed by typically developing children. Information from child care providers showed that less than 2% of the available child care facility slots and approximately 10.46% of child care home slots could accommodate CSHCN.

OCCRRA started providing quarterly reports in March 2011 documenting the number of requests received from parents looking for facilities that accepted CSHCN. During the 1st, 3rd, and 4th quarters of the year, the number of requests for CSHCN fluctuated between 52 and 63. However, in the 2nd quarter (which included the beginning of summer vacation for school-age children), the number of requests increased to 94. For the first three quarters, the highest number of requests were for children with behavioral needs (between 30.2-37.2% of requests), but in the 4th quarter, the largest number of requests were for children with physical needs (32.8%).

The procedure for approval of the CSHCN child care reimbursement rate was refined to be somewhat more user-friendly. More complete information was given to the family at the beginning of the process so they would know what the guidelines were to qualify for the special needs rate. In the past, the eligibility worker was the only person who could initiate the request for the special needs rate. The child care licensing worker had to visit the family, gather the necessary information, and send it back to the eligibility worker who then forwarded the request to the Oklahoma Department of Human Services (OKDHS) state office after "scoring" all the information and making sure the child met all the qualifications. This complicated process was revised to allow either the child care provider or the eligibility worker to initiate the request. The request initiator then gathered the necessary medical documentation at the same time the child care licensing worker made the visit to the family, and then sent the documentation to the OKDHS state office. When the child care licensing worker completed the assessment, an e-mail was sent to the OKDHS state office with his or her recommendation. Prior to the revision, there had to be a documented consultation with a health care professional prior to approval of the CSHCN rate. However, the new process gave the family up to 60 days after approval to provide this documentation. Even with this change in processing, there were only about 50 children who were approved for the special needs reimbursement rate in 2011.

In March 2011, the Oklahoma Child Care Services (OCCS) Division of the OKDHS sought input via an online survey from families and child care providers about their experiences locating licensed child care facilities in Oklahoma. Staff from MCH and CSHCN and representatives from parent groups worked with OCCS staff to revise the questions on the 2011 survey so that more useful information could be gathered regarding respondents' experiences. On the parent survey, a question was added asking if the parents were unable to find licensed child care because of the child's special need(s) and five questions, which specifically addressed CSHCN, were added to the provider survey.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reviewed quarterly reports from OCCRRA on parents looking for facilities that will accept CSHCN.				X
2. Revised the procedure for approval of CSHCN child care reimbursement rate to streamline the process for families.				X
3. Solicited input from families and providers via an online survey about their experiences locating/providing licensed child care, including questions specifically about child care services for CSHCN in the state.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Results were released from the OCCS survey. The survey had 57 parent respondents, of which, only one indicated that finding a child care facility for a child with special needs was an issue. On the provider survey, between 43-45% of respondents stated they either serve or would be willing to serve children whose needs required a higher teacher/child ratio than licensing requirements mandate, as well as children who have severe behavior problems or developmental disabilities. A little less than 40% stated they serve or would be willing to serve children with physical disabilities who require equipment for mobility. Only 31% stated they serve or would be willing to serve children whose medical needs require specialized equipment.

MCH funds were utilized, through the Early Childhood Comprehensive Systems (ECCS) Grant, to conduct three all day training sessions to provide support to child care providers in including children with disabilities and special health care needs in their child care settings. The training, called TIC TOC (Training Inclusive Childcare = Terrific Opportunities for Children), was conducted by the Department of Rehabilitation Sciences. The three sessions were held in April and May in Oklahoma City and Tulsa.

OCCRRA continues to collect and disseminate information and data regarding child care in Oklahoma via their website, www.oklahomachildcare.org. The website also provides information to parents seeking licensed child care.

c. Plan for the Coming Year

The Sooner SUCCESS Program at the University of Oklahoma Health Sciences Center is beginning their biennial Community Needs Assessment (CNA) in 2012. The evaluators for the CNA are collaborating with several different agencies and community organizations, including OCCRRA, the Oklahoma Commission on Children and Youth, and staff with CSHCN, to insure they gather useful information for the assessment, which will include the availability of child care for CSHCN. One of the activities for the CNA will be a survey for families and providers. On the family survey there will be at least two new questions. One question will ask if there is any financial assistance available for the unmet need the respondent identifies, and the follow-up question will ask if the financial assistance is adequate to meet the need. On the provider survey, instead of having a long list from which to make a selection of unmet needs (including "Other") there will be at least 10 categories with anywhere from 4-15 examples of service providers in each of the categories; child care will be provided as an example of a service provider. As with the previous surveys, respondents will be asked to choose the three highest unmet needs in their communities as well as the barriers to meeting that need.

Utilizing the child care liaisons, the OCCS will put forth a more concentrated effort to inform families of the availability of the special needs reimbursement rate for child care and make sure that all providers are aware of the new process, which will take much less time and effort. Responses to the new questions on the CNA will hopefully help CSHCN and Sooner SUCCESS identify what counties across the state need more information about the CSHCN child care reimbursement rate.

The OCCS will seek input from families and providers via an online survey in 2013 to determine if changes have been made in the child care system.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					.
Annual Indicator					
Numerator					
Denominator					
Data Source					
Is the Data Provisional or Final?					
	2012	2013	2014	2015	2016
Annual Performance Objective

Notes - 2011

No data are yet available to report for this measure. Data are collected by using a supplementary insert in the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS) survey. Oklahoma began collecting baseline preconception data with the June 2010 PRAMS batch.

Expected availability of the preconception care (PCC) data from the 2010 collection cycle, originally anticipated for spring 2012, has been pushed back so that MCH analysts can aggregate these data with those from the 2011 cycle. This was done with a mind towards improving reliability and robustness of PCC data estimates. Preliminary analyses of 2010 data show that few Oklahoma females receive the full range of PCC as prescribed by ACOG standards. Small cell sizes limit the extent to which data can be interpreted and generalized. Combined 2010 and 2011 PRAMS PCC data should be available for reporting in early 2013. A full year of PCC data will be available with the final release of 2012 PRAMS data in year 2014.

Notes - 2010

No data are yet available to report for this measure. Data are collected by using a supplementary insert in the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS) survey. Oklahoma began collecting baseline preconception data with the June 2010 PRAMS batch.

Expected availability of the preconception care data from the 2010 collection cycle, originally anticipated for spring 2012, has been pushed back so that MCH analysts can aggregate these data with those from the 2011 cycle. This was done with a mind towards improving reliability and robustness of PCC data estimates. Preliminary analyses of 2010 data show that few Oklahoma females receive the full range of preconception care as prescribed by ACOG standards. Small cell sizes limit the extent to which data can be interpreted and generalized. Combined 2010 and 2011 PRAMS PCC data should be available for reporting in early 2013. A full year of PCC data will be available with the final release of 2012 PRAMS data in year 2014.

a. Last Year's Accomplishments

In 2010, Oklahoma developed a seven-item questionnaire insert to the Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire in order to collect data to address this performance measure. PRAMS respondents from June to September for the years 2010 and 2011 were asked to answer preconception care (PCC) questions in order to gather base-line data. Beginning in 2012, these PCC questions were incorporated into the body of the PRAMS questionnaire, rather than appear as an insert. Expected availability of the PCC data from the 2010 collection cycle, originally anticipated for spring 2012, has been pushed back so that MCH analysts can aggregate these data with those from the 2011 cycle. This was done with a mind towards improving reliability and robustness of PCC data estimates. Preliminary analyses of 2010 data show that few Oklahoma females receive the full range of PCC as prescribed by ACOG standards. Small cell sizes limit the extent to which data can be interpreted and generalized. Combined 2010 and 2011 PRAMS PCC data should be available for reporting in early 2013. A full year of PCC data will be available with the final release of 2012 PRAMS data in year 2014.

A press release in February 2011 highlighted the PRAMSgram "Preconception Care and Its Impact in Oklahoma" and television and radio spots released in February entitled "One of These Days" educated men and women of reproductive age on the importance of the lifestyle choices made today and the potential impact on pregnancy outcomes later.

Focus group information on females' attitudes and knowledge about health, pregnancy, and health care was compiled and presented at the "Preparing for a Lifetime, It's Everyone's Responsibility" meeting in January 2011. The full report was finalized May 2011 and was made available online at <http://io.health.ok.gov/> under "Preconception and Pregnancy Health Focus Group Report."

The Preconception/Interconception Care and Education Workgroup of the "Preparing for a Lifetime, It's Everyone's Responsibility" infant mortality reduction initiative started a pilot of the Women's Health Assessment tool July 1, 2011 in seven county health departments, one Federally Qualified Health Center (FQHC), one Indian Health Clinic, and one private physician office.

The Preconception/Interconception Care and Education Workgroup also evaluated existing tools for adolescent reproductive life planning and elicited approval from Delaware to adapt their tool for use in Oklahoma. A small pilot was done with adolescents in Oklahoma and revisions started for adaptation in 2012. Staff started reviewing male reproductive health information to develop a new tool or adapt existing tools for educating males on their role in preconception health.

The Association of Maternal and Child Health Programs (AMCHP) selected Oklahoma to participate in a new Kellogg Foundation funded project to support Title V programs and their key partners in building capacity to promote preconception health throughout the life course for women and girls and ultimately to improve birth outcomes. The five member team, including

representatives from MCH, Oklahoma Health Care Authority (OHCA, the State's Medicaid agency), Turning Point, and a FQHC, attended a kick-off meeting held in conjunction with the National Summit on Preconception Health and Health Care in June 2011. The Oklahoma team presented information on preconception health activities in Oklahoma during a webinar September 23.

MCH staff submitted a competing continuation application for federal Title X funds to continue providing family planning and reproductive health care, including preconception health care, in county health departments and contractor clinics.

Staff development training on preconception health care topics offered to county health department, FQHC, and tribal clinical staff included Teen Pregnancy Prevention (October 2010), STD/HIV Updates regarding screening, treatment, and potential long term effects (January 2011), Preconception Health: Nutrition & Family Planning (March 2011), Reproductive Life Planning (May 2011), and Male Involvement in Contraceptive Decision Making (June 2011).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Created and released television and radio spots and press release on the importance of healthy lifestyle choices and potential impact on future pregnancy outcomes.			X	
2. Finalized and distributed the focus group report on attitudes and knowledge before, during, and after pregnancy in the state.			X	
3. Piloted a Women's Health Assessment tool focused on preconception health in several county health department clinics, FQHC and IHS clinics, and a private physician office.			X	
4. Participated in the Kellogg Foundation's project to build capacity to promote preconception health throughout the life course.				X
5. Provided staff development opportunities.				X
6. Completed and submitted competing continuation application for Title X family planning funds.	X			
7.				
8.				
9.				
10.				

b. Current Activities

The pilot of the Women's Health Assessment tool has been completed in seven county health departments, a private physician office, Indian Health clinic, FQHC, and home visitation program (Children First). Feedback was elicited at three months (December 2011) and at the end of the project (May 2012).

"My Life. MyPlan." a tool to help adolescents plan for their future and improve their overall health, will be piloted by OHCA in eight, residency practices in attempts to increase the rates of adolescent preventive health visits starting July 1. See NPM #8.

Oklahoma continues to participate in the AMCHP project to support Title V programs and key partners in promoting preconception health throughout the life course to improve birth outcomes. In November 2011, the five member team participated in a webinar sharing information with other state teams. Members of the team also attended the Preconception Health Team meeting sponsored by the Kellogg Foundation at the AMCHP Conference in February 2012. On July 25,

members of Oklahoma's team will participate in a face-to-face meeting in Arlington, Virginia where further technical assistance will be received.

Preconception/interconception health is one of five priority focus areas identified by Regions IV and VI in their work toward reducing infant mortality. A strategy team has been formed as part of the Collaborative Improvement and Innovation Network (COIN) that will identify best practices and measures to monitor progress.

c. Plan for the Coming Year

Oklahoma will use the work from the COIN strategy team to inform future activities in preconception/interconception health.

The Preconception/Interconception Care and Education Workgroup will promote use of the Women's Health Assessment tool in county health departments, private physician offices, Indian Health clinics, FQHCs, and home visitation programs across the state.

The Preconception/Interconception Care and Education Workgroup will complete the pilot of the adolescent tool ("My Life. My Plan.") adapted from the Delaware tool promoting reproductive life planning and overall health. Workgroup members will gather input on the proposed tool through a convenience sample of adolescents including church youth groups, health providers, and public school classes. The contract between OHCA and the University of Oklahoma (OU) research group to increase the number of adolescent health care visits and improve the quality of those visits by assigning schools to resident physicians and having the physicians distribute the tool to the students in their assigned school will continue through 2013. MCH will evaluate feedback received from the pilot and make indicated changes to improve the tool.

Additional activities of the Preconception/Interconception Care and Education Workgroup will focus on male involvement in preconception/interconception health and lifestyle choices and promotion of resource cards with state pharmacies.

Conversations will continue with the OHCA to explore coverage of preconception care, as Medicaid covered approximately 64% of deliveries in Oklahoma in 2011. The decision will be made about the feasibility of initiating an interconception waiver addressing specific health issues identified in a previous pregnancy contributing to poor birth outcomes.

MCH will continue working to incorporate the Life Course Perspective into planning for preconception/interconception activities. MCH leadership will continue to promote awareness of this concept and strengthen partnerships focusing on this model of health care and education.

Oklahoma will continue to participate in the Preconception Health Team sponsored by the Kellogg Foundation. Through team activities, Oklahoma team members have the opportunity to communicate with other states in the project and share successes and barriers to promoting the concept and importance of preconception/interconception health and education.

Family planning providers will continue to be encouraged to treat every visit as a preconception health visit and provide targeted preconception/interconception health counseling to every client.

State Performance Measure 6: *The percentage of infants who are put to sleep on their backs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2007	2008	2009	2010	2011
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Performance Data					
Annual Performance Objective			61	67.5	65.5
Annual Indicator	60.9	64.0	64.9	66.4	66.4
Numerator	31201	32844	33070	34405	34405
Denominator	51206	51339	50973	51792	51792
Data Source		Pregnancy Risk Assessment Monitoring System			
Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	67	67.7	68.3	69	69.7

Notes - 2011

Source: 2010 Oklahoma PRAMS. PRAMS data for year 2011 are not yet available, hence 2010 used as provisional estimate.

Annual Performance Objectives have been revised upward to reflect recent surveillance experience. Forecasted targets to 2016 anticipate a 1% relative growth per year.

Notes - 2010

Source: 2010 Oklahoma PRAMS.

Notes - 2009

Source: 2009 Oklahoma PRAMS.

95% CI: (61.2%, 68.3%)

Annual Performance Objectives for 2010-2014 based on 1997-2008 PRAMS trend data for infant sleep position.

a. Last Year's Accomplishments

In 2010, Pregnancy Risk Assessment Monitoring System (PRAMS) data showed that 66.4% of infants were placed on their backs to sleep most of the time. This was a statistically significant increase from 2000 when 54.1% of infants were placed on their backs to sleep. Healthy People 2020 set a goal of 75.9% of all newborns being placed on their backs for sleep.

Bed sharing was also measured. Data from 2010 PRAMS showed that most infants (52.8%) bed shared sometimes, 19.4% of infants always shared a sleep surface with someone else, and 27.8% of infants never shared a sleep surface. Data were not significantly different from 2009. In response to an identified lack of state data regarding infant sleep surface, bedding, etc., the 2012 PRAMS questionnaire was edited to address sleep environment (in addition to sleep position).

In October 2010, a statewide press release written by the Oklahoma State Department of Health (OSDH) was picked up by media across the state of Oklahoma, and generated radio, television, and newspaper interviews.

OSDH's Injury Prevention Service released an Injury Update "Undetermined Manner Deaths among Infants Less than One Year of Age, Oklahoma, 2004-2007" which highlighted sleep-related causes of death.

The Infant Safe Sleep Workgroup of the "Preparing for a Lifetime, It's Everyone's Responsibility" infant mortality reduction initiative continued to meet monthly and focused on increasing infant safe sleep practices in Oklahoma. The workgroup added a family member, and merged with other community-level safe sleep groups including Central Oklahoma Fetal and Infant Mortality Review (FIMR) Safe Sleep Task Force and Tulsa FIMR Safe Sleep Response Team.

Workgroup members conducted presentations on infant safe sleep for statewide conferences (e.g., Oklahoma Indian Child Welfare Association, Oklahoma City Area Inter-Tribal Health Board's Epidemiology Conference), OSDH leadership, parent groups, advisory councils, and OSDH Office of Minority Health's "Community Baby Showers."

Information on infant safe sleep was sent to all Oklahoma birthing hospitals and a joint effort between MCH and Indian Health Service (IHS) allowed for the distribution of infant sleep sacks (wearable blankets) to Indian hospitals.

MCH developed a Fiscal Year (FY) 2013 legislative budget request focused on enhancing infant safe sleep education and providing sleep sacks to delivery hospitals (for distribution to parents of newborns).

MCH continued discussions with the Oklahoma State Medical Examiner's Office regarding Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Infant Death (SUID) data collection. MCH supplied the State Medical Examiner's Office with copies of the Sudden Unexplained Infant Death Investigation Reporting Form (SUIDI-RF) and recommended its use to improve data collection.

MCH, together with Smart Start Central Oklahoma, received a "CJ Foundation for SIDS" mini grant to implement a Lifesaver Patch program with Oklahoma Girl Scouts. Grant funding was used to print brochures and Virginia's infant safe sleep curriculum, and to purchase Girl Scout patches. Seven Girl Scout troops (with 45 scouts) completed the program.

County health department staff were trained through the internet, video conference, and/or live trainings to spread the infant safe sleep message within their communities.

The Infant Safe Sleep Workgroup members continued to promote utilization of model safe sleep policies for child care facilities, neonatal intensive care units, and nurseries as well as the professional education tools available online for nurses, home visitors, social service staff, and child care providers. Collaboration with local birthing hospitals led to hundreds of nurses, nutritionists, lactation consultants, and clerks completing the online safe sleep training.

Infant safe sleep brochures (four culturally-linguistically diverse versions) were made available to partner organizations and the public in print form and via the website.

MCH, along with VI Marketing and Branding, recorded television and radio public service announcements to educate the public about the risks of bed sharing with infants and the American Academy of Pediatrics (AAP) recommendations that infants have their own separate sleep surface.

In recognition of SIDS awareness month (October 2010) and infant mortality awareness month (September 2011), MCH conducted live crib displays and demonstrated how to create a safe infant sleep environment.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Released a news release and PSA on infant safe sleep for print, radio, and television media.			X	
2. Continued and expanded membership base for monthly meetings of the Infant Safe Sleep Workgroup, part of the state's infant mortality reduction initiative, "Preparing for a Lifetime, It's Everyone's Responsibility."				X
3. Presented safe sleep information at meetings, conferences, community events, and partner agencies.			X	
4. Worked on a FY 2013 legislative budget request to provide hospitals with high African American and American Indian birth rates sleep sacks and technical assistance on infant safe sleep.				X
5. Continued to offer online infant safe sleep training for nurses, child care staff, and social services staff.				X
6. Trained county health department staff to carry the infant safe sleep message forward at the community level.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Infant Safe Sleep Workgroup, led by the MCH SIDS/Infant Safe Sleep Coordinator, continues to meet monthly. Safe sleep information is available on the infant safe sleep web pages, which are part of the "Preparing for a Lifetime, It's Everyone's Responsibility" website at <http://iio.health.ok.gov>.

The Infant Safe Sleep Workgroup continues to reach out to various professionals to encourage utilization of the free online training and the model safe sleep policy for hospitals.

MCH is collaborating with the Oklahoma Hospital Association, IHS, as well as the University of Oklahoma Office of Perinatal Quality Improvement on the implementation of hospital-based activities surrounding hospital policy, staff training, and parent education related to infant safe sleep.

The revised PRAMS survey began surveying 2012 births and includes co-sleeping questions as well as questions about bed type, presence of pillows, toys in the bed, and blanket use. The March 2012 PRAMS Brief, "Bed-sharing with Infants in Oklahoma," was disseminated to partner agencies and private providers (www.ok.gov/health/documents/PRAMS%20brief_safe%20sleep_March2012.pdf).

MCH is exploring means of improving data collection and accuracy of coding infant cause and manner of death, coordinating with law enforcement and medical examiners.

The FY 2013 budget request for infant mortality reduction is being funded by the state legislature. Funds will be used to purchase sleep sacks for 10 specific birthing hospitals

c. Plan for the Coming Year

Infant safe sleep is a focus of one of the five strategy teams of the Collaborative Improvement and Innovation Network (COIN), initiated by the Maternal and Child Health Bureau in response to Region IV and VI infant mortality priorities. The work of this strategy team will provide information to inform Oklahoma's future efforts.

The Infant Safe Sleep Workgroup will continue to meet monthly, will update web pages, and will update and promote the online education tools for professionals. Infant Safe Sleep Workgroup members will continue to promote the use of the SUIDI protocol and reporting form. Conversations with the state Medical Examiner's office, as well as local law enforcement agencies will continue to emphasize the importance of consistent data collection at the scene of an infant death.

Co-sleeping and sleep position data from PRAMS will be reviewed annually for the purpose of monitoring adherence to infant safe sleep guidelines.

Public service announcements (in English and Spanish) will remain available for viewing and download on the "Preparing for a Lifetime, It's Everyone's Responsibility" website. MCH will continue to air infant safe sleep public service announcements on radio and television as funding is made available.

Workgroup members will coordinate sending letters to magazines, web pages, and other media that display safe sleep messages. Appropriate and safe photos and messages will be encouraged and education will be provided to those whose photos and/or messages are not consistent with the AAP guidelines for infant sleep safety.

County health department public health nurses, health educators, and other staff will continue to be trained to spread the infant safe sleep message within their communities. Girl Scout troops will continue to receive infant safe sleep education through the Safe Sleep Saves Babies Lives patch program.

The Infant Safe Sleep Workgroup will reach out to medical schools and nursing schools, specifically health promotion and disease prevention classes, to educate professionals on infant safe sleep. The workgroup will also identify and contact social service agencies/professionals, childbirth educators, and home health care agencies with information regarding the availability of online infant safe sleep education tools.

The five hospitals with the highest number of African American births and the five hospitals with the highest number of American Indian births will be targeted for infant safe sleep training and technical assistance. The hospitals will also receive sleep sacks and educational information that will be purchased with funds from the FY 2013 budget request.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	21	18	18	18	19
Annual Indicator	15	15	16	18	18
Numerator					
Denominator					
Data Source		MCH Assessment, OSDH	MCH Assessment, OSDH	MCH Assessment, OSDH	MCH Assessment, OSDH

Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	19	20	20	21	21

Notes - 2011

Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A.

Notes - 2010

Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A.

Annual performance objectives have been revised based on achievement in year 2010.

Notes - 2009

Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A.

Annual Performance Objectives for 2010-2014 have been revised to take into account anticipated future data linking projects with PRAMS, WIC data, hospital discharge, and newborn screening databases.

a. Last Year's Accomplishments

Data used to assess this measure were derived from the reporting on Health Systems Capacity Indicator (HSCI) #09A. State data capacity defined under HSCI #09A was the principal focus of the State Systems Development Initiative (SSDI) Grant which was used by Oklahoma to expand its ability to gather and analyze data important to evaluating the health and well-being of the State's maternal, infant, and child population.

MCH, in partnership with the Oklahoma Health Care Authority (OHCA), the State's Medicaid agency, resumed in April 2011, the work necessary to perform the linkages between vital statistics, primarily live birth records, and the Medicaid administrative records. Resumption of this linking effort began after MCH hired a master's prepared statistician in February 2011 to fill the jointly funded Medicaid Data Matching Analyst position, which had been vacant since January 2010. The interagency Medicaid Matching Workgroup, a group staffed by Oklahoma State Department of Health (OSDH) and OHCA professionals, met monthly between April 2011 and September 2011 to review the results of the work suspended due to the analyst vacancy and to initiate the planning necessary to extend the previous work. Over this six-month period, the Medicaid Data Matching Analyst performed a review of the many computer programs used to extract the data from the OHCA electronic Medicaid data system, the previously linked data sets and accompanying matching algorithms, and the descriptive summary of linked data. Based on this review and related discussions, the Medicaid Matching Workgroup decided that the process should begin anew. To that end, the Medicaid Data Matching Analyst, with considerable support from OHCA personnel, pulled Medicaid eligibility records for the calendar years 2005-2010. The Medicaid Data Matching Analyst performed a data quality review and summarized these findings for the workgroup's appraisal.

The Office of Vital Records at OSDH continued its ongoing efforts to link infant death records to live birth records. This practice has become a routine function of Vital Records staff. Vital Records, upon request, made available to MCH Assessment staff these data in raw record-level form. Furthermore, MCH, via the efforts of the "Preparing for a Lifetime, It's Everyone's Responsibility" infant mortality reduction initiative, partnered with Health Care Information at OSDH to develop and release a linked infant death/live birth module on OK2SHARE (Oklahoma Statistics on Health Available for Everyone, <http://www.ok.gov/health/pub/wrapper/ok2share.html>), the OSDH's web query data system.

MCH continued to operate the Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), the First Grade Health Survey (1GHS), and the Fifth Grade Health Survey (5GHS).

During fiscal year (FY) 2011, PRAMS and TOTS data were linked to the Oklahoma State Immunization Information System (OSIIS), which led to a PRAMSgram publication, an oral presentation at the Maternal and Child Health Epidemiology Conference (December 2010), and poster presentations at the Association of Maternal and Child Health Programs (AMCHP) Conference in February 2011, and the 45th National Immunization Conference in March 2011. MCH partnered with Screening and Special Services at OSDH to gain access to the Oklahoma Birth Defects Registry (OBDR) data. MCH Assessment staff linked PRAMS data for years 2004-2008 to OBDR data for the purpose of assessing the relationship between maternal obesity and the presence of congenital malformations.

New releases of MCH surveillance data during FY 2011 included PRAMS collection year 2009; TOTS collection year for 2010; YRBS 2011, collected in the spring semester of school year 2010-2011, and 5GHS 2010, collected in fall semester 2010-2011.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Resumed the activities of the Medicaid Matching Workgroup to direct the matching and analysis of the linked Medicaid data.				X
2. Maintained access to linked and non-linked birth and death files.				X
3. Continued to operate various surveillance systems, such as PRAMS, TOTS, YRBS and the First and Fifth Grade Health Surveys and presented findings at state and national conferences.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oklahoma PRAMS Project continues to function proficiently. Recent analysis focuses on the disparities in risk for pregnancy outcomes among overweight/obese American Indians, resulting in a poster presentation at the MCH Epidemiology Conference in December 2011.

Progress on linking PRAMS and OBDR data continues. MCH will publish a PRAMSgram in summer 2012 covering the linking process along with a comparison of those infants with and without congenital malformations. In addition, PRAMS data are being linked to the Women, Infants, and Children Supplemental Nutrition Program (WIC) data for analysis.

Another linkage project seeks to bring together birth and PRAMS data with the hospital inpatient discharge data, to review hospitalizations of infants born preterm. Due to recent staff resignations within the Health Care Information, the OSDH organizational unit responsible for hospital inpatient data, MCH is reassessing the timeline and responsibilities to assure the project

moves forward.

The Medicaid/birth linkage continues through FY 2012. These linked data cover the calendar years 2005-2010 and are being used to assess the prenatal care and delivery experience of women who receive Medicaid benefits.

MCH Assessment filled the SSDI Manager/Analyst in May 2012.

MCH submitted an Oklahoma State Team application for the Life Course Metrics Project, which was not accepted. Team members will provide feedback for the national workgroup during the public comment period.

c. Plan for the Coming Year

MCH will identify and develop new channels of access to assure that data are available for interested users. In particular, MCH will explore the possibility of including PRAMS and TOTS surveillance data on the OK2SHARE web portal.

During FY 2013, MCH Assessment will revisit the linkage to OSIIS. MCH Assessment intends to make this linkage a lasting one, a partnership that can be utilized to produce routine publication of linked PRAMS/TOTS/OSIIS data in order to monitor the diverse factors that influence Oklahoma's vaccination coverage of young children. An annual report should be developed to document Oklahoma's progress.

Having resumed the Medicaid Matching Workgroup and with the projected availability of final linked Medicaid/birth datasets for years 2005-2010 in November 2012, analysis plans will be developed to investigate the priority areas of interest within the Medicaid birth population and, by extension, guide the linkage of Medicaid data to PRAMS, TOTS, and other data sources within OSDH. With the recruitment and hiring of the SSDI Manager/Analyst, these activities will be advanced significantly by having a greater number of staff assisting with the efforts. Future steps for data linkage and analysis include joining Medicaid data to the Public Health Oklahoma Client Information System (PHOCIS), the OSDH's database that captures client services for maternity, child health, and family planning visits.

An analysis plan will be developed for the linked WIC-PRAMS dataset. Members of the analytic team will consist of staff from WIC, MCH, and partner agencies. Breastfeeding intention, duration rates, and toddler body mass index (BMI) will be examined to determine analytic potential.

The joint OHCA/OSDH Perinatal Advisory Task Force (PATF) and Child Health Advisory Task Force (CHATF) will be utilized to give input on detailed analyses of the linked data as it is being developed by MCH. The advisory groups are composed of individuals representing academia, professional organizations, providers, advocates, and families. The task forces explore issues pertaining to the delivery of services with a focus on Medicaid clients, including barriers to care and scope of services, among others. In Oklahoma, the Medicaid program covers greater than 60 percent of all deliveries. Having input from PATF and CHATF members is extremely helpful in defining the content and nature of statistical analyses as MCH seeks to understand the health of its target population.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2007	2008	2009	2010	2011
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Performance Data					
Annual Performance Objective					6.8
Annual Indicator				6.4	5.8
Numerator				1829	1556
Denominator				28602	26624
Data Source				OHCA & CSHCN Program	OHCA & CSHCN Program
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	5.9	6	6.1	6.2	6.3

Notes - 2011

Source: Oklahoma Health Care Authority and the CSHCN Program.

Annual Performance Objectives for this measure have been revised downward based on recent reporting experience. Forecasted targets out to 2016 anticipate a 1% relative increase year on year.

Notes - 2010

Source: Oklahoma Health Care Authority and the CSHCN Program.

Notes - 2009

Data not yet available for this State Performance Measure.

a. Last Year's Accomplishments

The Oklahoma Health Care Authority (OHCA, the State's Medicaid agency) reported 1,556 non-routine dental services for Medicaid-eligible children who were classified as disabled or who were in the custody of the state. Services included in this report were crowns, endodontic, and periodontal services.

The Pew Center on the States released its 2011 report on the state of children's oral health. Oklahoma's letter grade went from a "C" in the previous report to a "B." Oklahoma was found to exceed the national average in children on Medicaid receiving dental care (46% compared to 38%, nationally). The study also found 75% of Oklahoma children live in communities that provide fluoridated water. The Pew Center's research found Oklahoma is lacking in dental sealant programs in high-risk schools and dental professionals in underserved areas. A dental sealant is a thin plastic coating applied to teeth to help prevent tooth decay. The Oklahoma Dental Foundation continued to offer classes to train dental professionals in applying sealants.

Since 2006, dental student graduates (up to 5 a year) who signed a contract to serve underserved populations for 2-5 years could have their dental school loans forgiven up to \$25,000 a year. Oklahoma faced a significant budget shortfall in 2010 and most state agencies had to make severe cuts. The loan forgiveness program was suspended as a result. In 2011, the program was taken out of suspension. Students who enter the program must agree to practice in an area that has been designated as underserved and 30% of their patients must be Medicaid recipients. How much of each participant's loans can be forgiven each year is based on how much funding is available.

The Oklahoma Dental Foundation (ODF) continued its mobile dental program. The foundation partnered with local communities and dental professionals to send the mobile dentist to cities around the state. Their recreational vehicle is a fully equipped dentist's office. Children, who did not have a dental home or were unable to travel for dental checkups, could apply to be seen, including CSHCN.

See NPM #9.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Offered, through the Oklahoma Dental Foundation, classes to train dental professionals in applying sealants.				X
2. Continued to support the placement of dentists in rural areas of state through educational loan repayment program funded through the Oklahoma Dental Loan Repayment Act.				X
3. Maintained the Oklahoma Dental Foundation's mobile dental program to provide dental care for children, including CSHCN, who did not otherwise have access to dental care.	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OHCA continues to cover non-routine dental care. Non-routine dental care includes oral health services that go beyond the recommended bi-annual check-ups. These include performing root canals and putting in crowns. Treatments of periodontal diseases (diseases of the gums) such as surgery come under this category as well. Braces are the one of the most common orthodontic treatments that many children need.

The Oklahoma Dental Association (ODA) has a link to their "Oral Health Care for Children with Special Health Care Needs" pocket guide on the Oklahoma Areawide Services Information System (OASIS) website at <http://oasis.ouhsc.edu/>. The guide was developed by the Children's Oral Health Coalition (COHC) to assist caregivers and dental professionals in making dental treatments less frustrating for professionals, caregivers, and CSHCN. The guide describes some of the most common issues with CSHCN, such as seizures, inability to communicate, and aversion to being touched. It also explains ways dental professionals and caregivers can prepare for dental appointments to decrease the chance of problems. The ODA has also put up on its site a list of oral health professionals who are open to serving CSHCN. The list is intended to help families find a dental home. Having a dental home assists to ensure children receive coordinated non-routine dental care.

The ODF continues the mobile dental program.

See NPM #9.

c. Plan for the Coming Year

The Oklahoma State Department of Health will continue to manage the Oklahoma Dental Loan Repayment Program. The program was authorized by the state legislature in 2006. It was created to help insure dental care would be available in areas that do not have a local oral health professional. Dental students accepted into the program must agree to practice in underserved parts of the state in exchange for having part of their school loans covered.

The ODF will purchase another mobile dental unit. This will allow them to reach more people, including CSHCN, in more cities throughout the state.

The ODA is beginning work on its fourth annual Oklahoma Mission of Mercy. The event will occur in Lawton (in the southwestern part of the state) in February 2013. Oral health professionals will be brought together to volunteer at the two-day event. Adults and children can be seen for a variety of treatments including root canals and wisdom tooth extraction. The event will also use non-professional volunteers to help patients fill out paperwork and know where to be. The previous year's event, held in February 2012, saw over 1,700 patients in McAlester (in the southeastern part of the state).

See NPM #9.

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

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	27.7	23	22.7	22.4	22.1
Annual Indicator	23.2	23.2	22.6	22.6	22.7
Numerator	35197	41369	38720	38720	38913
Denominator	151710	178316	171147	171147	171422
Data Source		YRBS	YRBS	YRBS	YRBS
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	22.4	22.2	22	21.7	21.5

Notes - 2011

Source: Numerator derived from 2011 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted frequency of all students who answered the tobacco question on the YRBS.

Data reflect cigarette smoking only.

Annual Performance Objectives have been revised upward to be more in line with recent YRBS survey estimates. Forecasted targets to 2016 anticipate a relative decrease of 1% per year.

Notes - 2010

Source: Numerator derived from 2009 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Statewide YRBS is conducted in odd-numbered years.

Denominator is the weighted frequency of all students who answered the tobacco question on the YRBS.

Data reflect cigarette smoking only.

Notes - 2009

Source: Numerator derived from 2009 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is the weighted frequency of all students who answered the tobacco question on the YRBS.

Data reflect cigarette smoking only.

a. Last Year's Accomplishments

Data from the statewide 2011 Oklahoma Youth Risk Behavior Survey (YRBS) indicate that 22.7% of adolescents in grades 9-12 reported cigarette smoking during the 30 days before the survey, which is the time period used to define a current smoker. The 2011 rate of 22.7% is a statistically significant decrease from the 2003 rate of 26.5%. Smoking rates varied by gender with males (26.9%) smoking at a higher rate than females (18.7%). According to national 2009 YRBS data from the Centers for Disease Control and Prevention (CDC), an estimated 19.5% of U.S. high school students were current cigarette smokers at the time of the survey.

The YRBS was administered in late winter through spring of the 2010-2011 school year. Using YRBS data from 2011, MCH began developing a fact sheet illustrating tobacco use among high school students. The Oklahoma State Department of Health (OSDH) website remained a primary dissemination tool for YRBS data, making it accessible to local county health department staff (e.g., health educators, social workers, child guidance clinicians) and other interested parties.

In February 2011, the Oklahoma Health Improvement Plan (OHIP) Children's Health Flagship Workgroup released the Oklahoma Children's Health Plan: Keeping Kids Healthy. The document identified adolescent health as one of eight targeted areas of priority with school participation in YRBS and other related surveys identified as an area to impact in order to improve adolescent health outcomes.

MCH continued to fund 10 rural district school health nurses through a contractual agreement with the Oklahoma State Department of Education (OSDE). Tobacco use prevention remained a priority within each school health nurse's annual workplan that included a component addressing tobacco use prevention and cessation. The school nurses provided one-on-one, in-class, and group education on tobacco prevention and cessation. MCH provided technical assistance for the development of the school nurses' annual plans, which outlined specific goals, objectives, and activities to be completed within the school year.

Collaboration continued with the Tobacco Use Prevention Service (TUPS) and OSDH Dental Health Service promoting prevention activities and efforts across the state. Strategies to reduce tobacco use included support for comprehensive community-based tobacco prevention initiatives, including work accomplished with schools in the state to develop and adopt policies that would prohibit tobacco use on school grounds 24 hours a day, seven days a week (24/7). Throughout the 2010-2011 school year, Oklahoma schools continued to participate in the 24/7 policies at the K-12 and higher education levels. Moreover, Students Working Against Tobacco (SWAT), a model in which students educate other youth, community members, and policymakers about tobacco use and prevention initiatives, was used to reduce initiation by youth. SWAT teams assisted with the implementation of the Community of Excellence workplans. The workplans included the passage of local youth access ordinances, local clean indoor air ordinances, tobacco free park ordinances, and 24/7 policies, and exposing tobacco industry tactics. Workplans were required through the Communities of Excellence grant, funded by the Tobacco Settlement Endowment Trust (TSET), for tobacco use prevention. The funds were available for three years, renewable with application every year. TSET, approved through constitutional amendment by Oklahoma voters in 2000, is funded by monies obtained from the multi-state lawsuit of the tobacco companies to promote prevention and reduction of tobacco use.

The OSDH General Counsel provided an opinion in spring 2011 that would allow Oklahoma youth to access the Oklahoma Tobacco Helpline. TUPS worked with the Office of General Counsel and the contractor that provided the helpline to put the policy and procedure in place to allow youth access to the Oklahoma Tobacco Helpline, through phone service, text messaging service, and other electronic methods. However, the youth are not eligible for tobacco cessation medications.

In an effort to better achieve two primary flagship goals set forth by OHIP, obesity reduction and tobacco use prevention, the OSDH reorganized in September 2011 to integrate TUPS and the Physical Activity and Nutrition Services into the Center for the Advancement of Wellness.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administered the YRBS, which included data on tobacco use among adolescents.				X
2. Provided funding and technical assistance to 10 rural district school health nurses; tobacco cessation is one of their focus areas.			X	
3. Collaborated with the OSDH Tobacco Use Prevention and Dental Services on youth prevention activities and efforts across the state.			X	
4. Began allowing youth to utilize the free Oklahoma Tobacco Helpline, 1-800-QUIT-NOW, without parental consent, due to revised opinion by the OSDH General Counsel.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

House Bill (HB) 2267 to repeal state laws preventing cities and towns from enacting tobacco use restrictions stricter than the state's received significant support from state and community health leaders in 2012. However, when it reached the Senate Health and Human Services Committee, the committee chair declined to hear the bill. A similar bill could be reintroduced next year, as the language in any bill could potentially be reintroduced in 2013 if there is an author willing to carry it.

SWAT teams in the schools across the state implemented "In The Clear, No Minor Issue," and 24/7 campaigns. Oklahoma currently has 253 school districts that have implemented 24/7 policies as a result of the campaign. Additionally, Oklahoma SWAT has new materials which are available on their website (<http://www.ok.gov/okswat/>).

MCH continues to support the Center for the Advancement of Wellness with implementation of research-based curricula in school districts in the Communities of Excellence service areas across the state. To be eligible to receive curricula, the school district must have a 24/7 No Tobacco Use school policy and commit to the fidelity of the model.

MCH released a 2011 YRBS data brief report, "Tobacco Use," providing an overview of the issue and recommendations to reduce tobacco use among adolescents (http://www.ok.gov/health/documents/TobaccoUse3_YRBS2011.pdf).

c. Plan for the Coming Year

MCH will begin contacting school administrations and developing a YRBS administration schedule in the fall of 2012 and will be administering the YRBS in the spring of 2013. MCH staff will utilize multiple methods of contact to receive a high percentage of participation from the schools and students selected, so as to maximize participation rates and receive weighted data. This data will include information concerning tobacco use within the youth population.

MCH will continue to follow tobacco-related legislation, as it is introduced, to reduce youth access to tobacco products or exposure to second hand smoke. The adoption of preemption in Oklahoma would support the goals and objectives of the Oklahoma State Plan for Tobacco Use Prevention and Cessation and the OHIP. Additionally, MCH will coordinate with the OSDH Center for the Advancement of Wellness on strategically planned and executed meetings with key community leaders and local government to advocate for local youth access ordinances and educate about youth access.

The Prevention Team, a subcommittee of the Tobacco Use Prevention and Cessation Advisory Committee, which serves to advise the TSET Board of Directors and created by TSET, maintains the priority of increasing the reduction of tobacco use among youth. The Prevention Team is hosted by TUPS in the OSDH Center for the Advancement of Wellness and sustains a fluctuating membership from various agencies and individuals including the Oklahoma State Department of Education (OSDE), Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), the Alcoholic Beverage Laws Enforcement (ABLE) Commission, retail business representatives, etc.

MCH will continue to support the TUPS with implementation of research-based curricula in school districts in the Communities of Excellence service areas across the state. To be eligible to receive curricula, the school district must have a 24/7 No Tobacco Use school policy and commit to the fidelity of the model. Moreover, MCH will support the OSDH Center for the Advancement of Wellness in their implementation of Certified Healthy Schools and Communities initiatives.

A contractual agreement with the OSDE to fund school nurses in rural areas of Oklahoma will continue. MCH will work directly with these school nurses to provide technical assistance and support for the development of annual workplans which include goals and objectives related to tobacco use prevention and tobacco use cessation programs at all grade levels.

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

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					
Annual Indicator					43.4
Numerator					23035
Denominator					53044
Data Source					OSDH Vital Records
Is the Data Provisional or Final?					Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	42.2	41	39.9	38.7	37.6

Notes - 2011

Source: Oklahoma Vital Records. Final birth data for year 2008 are reported to establish a baseline for this new State Performance Measure. This baseline number is considered provisional and will be changed once final data for 2011 become available.

Forecasted targets for years 2012-2016 are established using this benchmark as a starting point, assuming a relative decrease of 8% by year 2014, consistent with Association of State and Territorial Health Officials (ASTHO) President's Challenge.

a. Last Year's Accomplishments

This is a new performance measure for this year.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This is a new performance measure for this year.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Prematurity Workgroup, part of the "Preparing for a Lifetime, It's Everyone's Responsibility" infant mortality reduction initiative, provides leadership for the statewide, voluntary collaborative of Oklahoma birthing hospitals called "Every Week Counts" (EWC) to eliminate non-medically indicated, scheduled deliveries prior to 39 weeks. Approximately 90% of Oklahoma birthing hospitals are participating, thus affecting 95% of Oklahoma births. Hospitals participating in the EWC collaborative submit monthly data to the University of Oklahoma Office of Perinatal Quality Improvement (OPQI). A fourth Learning Session is scheduled for July 13, to provide EWC teams with new data, discuss strategies for success, and update them on activities of the "Preparing For a Lifetime, It's Everyone's Responsibility" initiative, particularly the hospital-based activities.

Beginning in July, EWC will partner with the Oklahoma Hospital Association (OHA) Hospital Engagement Network (HEN), who has a goal to improve Oklahoma birth outcomes by eliminating early, elective deliveries. EWC leads are working with hospitals to implement written policies to prevent elective deliveries prior to 39 weeks.

On July 12, staff from OSDH and the OPQI will participate in a national webinar on prematurity reduction sharing EWC activities and accomplishments.

On August 2, staff from OPQI and OHA will present during an American Hospital Association webinar on the efforts of EWC.

c. Plan for the Coming Year

Prematurity is a priority area of focus for the Regions IV and VI infant mortality reduction initiative and the Association of State and Territorial Health Officials (ASTHO); a strategy team has been formed comprised of state staff, data support, and content experts. Information from this team will inform future work in Oklahoma.

The OHA HEN and EWC will continue to work towards eliminating early, elective deliveries. OPQI will continue to collect data from delivering hospitals to help ensure policies put in place to effect the significant decline in elective deliveries will continue to be enforced. Technical assistance and peer mentoring will be offered to those hospitals that have not been successful in implementing policies to reduce elective deliveries. This will include educating hospital administration and physicians who are resistant to changing current practices.

Preconception/Interconception Care and Education and Tobacco Cessation, two additional workgroups with the "Preparing for a Lifetime, It's Everyone's Responsibility" initiative, will

continue activities to impact the number of deliveries prior to 39 weeks.

The Preconception/Interconception Workgroup will continue to promote healthy lifestyles with all males and females of reproductive age. Collaboration will continue with the Oklahoma Health Care Authority, the State's Medicaid agency, to work with physicians in promoting the importance of preventive health care visits for adolescents and the development of a life plan, including reproductive health plans, as adolescent pregnancy continues to be a risk factor for preterm deliveries.

Because smoking is also associated with preterm births, the Tobacco Cessation Workgroup will complete grant-based activities to provide practice facilitation to educate providers on tobacco cessation resources, including the 1-800-QUIT NOW hotline and options for reimbursement for counseling clients to stop smoking using the 5 A's (Ask, Advise, Assess, Assist, and Arrange). The Tobacco Cessation Workgroup will promote the importance of support from local healthcare providers, businesses, educational institutions, etc., that are familiar with the dynamics of the communities they serve and can identify innovative ways to share the message on the importance of tobacco cessation for a healthier, longer life and healthier infants and children.

E. Health Status Indicators

For the Health Status Indicators (HSI), MCH uses several data sources. Some of which are the Center for Health Statistics at the Oklahoma State Department of Health (OSDH), the Oklahoma Health Care Authority (OHCA), the Oklahoma Department of Human Services (OKDHS), the HIV/STD Service at OSDH, the Oklahoma Department of Education, (OSDE), and the U.S. Bureau of the Census. These sources have been reliable, providing key data for reporting on the HSCIs for the MCH Title V Block Grant.

The Center for Health Statistics includes the Office of Vital Records (VR) and Health Care Information (HCI), two important departments at OSDH critical to obtaining vital statistics data. MCH analysts have signed data use agreements (DUAs) with the Center for Health Statistics in order to gain access to record level birth and death data. Only those staff within MCH that has a legitimate need to use record level data completes a DUA. Possessing such access enables MCH to have the ability to analyze birth and death data as needed for the MCH Title V Block Grant and other reporting and analysis activities. For the HSIs included in the block grant, birth and death data are used for HSI#1A-B, HSI#2A-B, HSI#3A-C, HSI#7A-B, and HSI#8A-B. Generally speaking, access to these data is routine and non-problematic. The one issue that has risen in recent years has been the inability of VR/HCI to finalize annual birth and death files in a timely manner. In large part, the delays in closing out annual files have been driven by vital events processing in states that border Oklahoma. States have agreements to share documentation on vital events to residents who give birth or die in other states. In recent experience, Oklahoma has been hampered by the untimely receipt of certificates for the vital events of Oklahoma residents occurring outside its borders.

The most recent data from VR/HCI show that the rates for some HSIs have worsened (HSI#1A, HSI#1B, HSI#2A, HSI#3A, HSI#3B) and others have improved (HSI#2B, HSI#3C). No update for the number of total live births (HSI#7A-B) is provided as the latest final data available remain year 2008. While provisional data for 2009 has been used some in this block grant reporting, it is not used here because of the changes to race with the implementation of the 2003 Revision of the Live Birth Certificate. With the adoption of the 2003 revision, race categories become more complex. At present, Oklahoma does not have bridging algorithms to account for this complexity. HSI#8A-B of Form 21 show that the number of deaths to children aged 0-24 was 1,196 in 2009, up by 1% from 1,184 in 2007. Age categories 10-14, 15-19, and 20-24, all experienced relative increases in the number of deaths. There was a decrease in the number of infant deaths in 2009,

down 4% to 448. By race, the results were mixed. For white, American Indian, and Hispanic children, the number of deaths increased; for Black children the number fell.

Data for nonfatal injuries (HSI#4A-C) are obtained from the Injury Prevention Service at the OSDH. Injury program data are electronically linked to hospital discharge data and used to report on the rate of nonfatal injuries to the key age groups of the Oklahoma child population. New data for years 2010 and 2011 for these indicators are not currently available. In 2009, the rate of nonfatal injury to children less than 14 years of age was 242.5 per 100,000 population, down 8% from the previous year. Similarly, injuries due to motor vehicle crashes for both age groups, 14 and younger and 15-24, dropped between 2008 and 2009, down 14.1% and 18.2%, respectively.

The HIV/STD Service provides the data for the rate of Chlamydia infection among females aged 15-19 and those aged 20-44. Data are provided from an internal database queried by a HIV/STD epidemiologist. There are no known barriers to accessing these data in aggregate form. A simple request is made by MCH with data provided at an agreed upon deadline. For year 2011, the Chlamydia rate for the teen age group was 29.6 cases per 1,000 females aged 15-19 years. This rate has decreased each of the last two reporting years, down 16% from 35.4 in 2009. The Chlamydia rate for adult women has shown variation over the course of the last five years. In 2007, the rate was 9.0 per 1,000 females aged 20-44, it then rose two consecutive years to 10.7 in 2009, fell in 2010 to 10.1, before rising again in 2011 to 10.4. Since 2007, the rate has risen 15.5%.

MCH draws on population data commonly produced by the U.S. Bureau of the Census (Census Bureau) to report on HSI#6A-B, HSI#9A, HSI#10-12. The Census Bureau releases population data at regular, published intervals. These data are critical to producing many of the birth, death, and case rates common to public health reporting. Reporting for the MCH Title V Block Grant is no exception. MCH regularly avails itself of Census Bureau data products to monitor and report on measures important to women, infants, and children. The forms for HSI#6A-B, HSI#9A, and HSI#10-12 have been updated with the latest figures available from the Census Bureau. Child population totals for Oklahoma (HSI#6A-B) indicate that the total child population has grown marginally, 0.42%. Some age groups have grown in number (ages 5-9, ages 10-14, ages 15-19), while others have experienced a reduction (infants, ages 1-4, ages 20-24). Examining the population changes by race and ethnicity shows that only those of Hispanic origin have experienced positive population growth, up 23.3%. All other racial groups experienced declines in their total numbers. Form 21 HSI#10 shows the geographic distribution of the child population and indicates that all geographic entities have experienced population growth in 2010. Changes in the percent of the Oklahoma population living in poverty were evident. In the total population, the proportion of the population in the lowest stratum of poverty (50% of the federal poverty level) declined by 2.9% (6.6% of the total population), while for children the rate rose by 4.2% (9.9% of children). No change was evident for adults living at 100% of the federal poverty level (FPL) but the largest increase occurred among children at this level of poverty (up 10.8%). Both the total population and the child population experienced a decline in the percent living at 200% of FPL.

HSI#9A-B on Form 21 require data from a number of sources. These data elements are the most difficult to obtain in the MCH Title V Block Grant. Principally, this is due to the dependence on external agencies to provide the data. Generally, it takes more time to gather these data than any other reported in Title V forms.

F. Other Program Activities

The Oklahoma Areawide Services Information System (OASIS) is the statewide toll free information and referral line for MCH and CSHCN (see Form 9). The telephone number for the Hotline is 1-800-OASIS. The OASIS is in operation Monday - Friday from 8:00 AM to 6:00 PM with an answering machine for after-hours calls. Individuals who leave a message after hours are contacted the following workday. TDD/TTY services for the deaf are available and bilingual staff

are available to those who speak Spanish. The OASIS also maintains a website (<http://oasis.ouhsc.edu/>) for information and referral services. Oklahoma 211 works closely with the OASIS as 211 relies on the OASIS as their primary information and referral resource for MCH populations, to include CSHCN.

/2012/ The OASIS remains the identified statewide toll free information and referral line for MCH and CSHCN though, as indicated in III. State Overview, D. Other (MCH) Capacity, further integration of the OASIS and 211 is being explored. 211 relies on the OASIS as a critical piece for information and referrals for the CSHCN population. //2012//

/2013/ The OASIS remains the statewide toll free information and referral line for MCH and CSHCN. See III. State Overview, D. Other (MCH) Capacity. //2013//

MCH accomplishes a Comprehensive Program Review in each county health department administrator's area every four years. The MCH Comprehensive Program Review involves a multidisciplinary team traveling to an Administrator's area and assessing infrastructure, population-based, enabling, and direct health services for the MCH population. A report is prepared and forwarded to the Administrator outlining requirements and recommendations as well as timelines for addressing findings. During interim years, technical assistance visits are completed to include annual visits to observe clinical practices of nurse practitioners.

/2013/ Comprehensive program reviews were moved to a three-year schedule this year. Annual visits to monitor family planning clinical services are also being scheduled to address requirements of the federal Title X grant under MCH's administration. //2013//

Contract providers receive a minimum of one required onsite visit each year. At the beginning of the contract year, each contractor completes a risk assessment that assists in developing the annual contract monitoring plan. Depending on the final risk score, the contract monitoring plan is adjusted to reflect any additional onsite visits that must be made beyond the one required visit. Technical assistance visits are also accomplished as identified or requested.

CSHCN continues to provide site visits to all contract providers. The main focus at these visits is to discuss how contractor activities are tied to the national and state performance measures of CSHCN.

Injury prevention activities continue to be a focus. MCH provides technical assistance and state funding for the Oklahoma Poison Control Center. The Poison Control Center operates 24 hours a day, 365 days per year using specially trained licensed pharmacists and nurses who provide emergency poisoning management advice to Oklahoma residents and health care professionals. This year, MCH assumed the lead from the Oklahoma State Department of Health (OSDH) Injury Prevention Service for working with the Oklahoma State Department of Education (OSDE), schools, and families on bullying prevention activities. Routine communications and meetings with the OSDE and meetings with Injury Prevention Service assure ongoing coordination of activities.

MCH funds the Oklahoma Birth Defects Registry (OBDR). The OBDR is a public health surveillance project that monitors the status of children born with birth defects in Oklahoma. Characteristics of the OBDR include: statewide, population based, active surveillance; Oklahoma residents who deliver infants in Oklahoma; age range includes birth to 2 years of age; and, all live births and stillbirths diagnosed with a birth defect (CDC/BPA codes). Activities of the OBDR consist of referral of children with birth defects to the SoonerStart (Oklahoma's zero to three early intervention program), statewide folic acid education campaign for neural tube defect (NTD) prevention, and rapid ascertainment of infants born with NTDs from tertiary hospitals, including recurrence prevention education of NTDs.

/2012/ MCH has initiated discussions with the area within the OSDH responsibility for the OBDR focused on benefits that Oklahomans, more specifically the MCH population, are receiving from activities of the OBDR. Maintenance of the OBDR utilizes a significant amount of federal MCH Title V Block Grant funds. The visibility of the OBDR and use of data to inform state health policy and services has been limited. Discussions are focused on the need for change or

restructuring/eliminating funding if this activity is not to be used to improve the health of the MCH population. //2012//

/2013/ Multiple meetings have occurred this year with OBDR staff and the Deputy of the Service the OBDR is organizationally placed within the OSDH. These meetings have resulted in streamlining the focus of OBDR, data sharing with MCH, and joint analysis and program planning of MCH and the OBDR staff. Title V funds in the OBDR budget have been reduced as a result. MCH maintains a stance of the importance of diversifying OBDR funding if the project is a priority of the OSDH. //2013//

The Oklahoma Vision Screening Advisory Committee for Children created in 2007 through Senate Bill 1795 is staffed by MCH. In addition to assuring activities of the committee are moved forward, MCH also provides training to individuals desiring to become vision screeners.

/2012/ MCH is working with members of the Oklahoma Vision Screening Advisory Committee for Children to prepare an article for publication on the history of the Committee and the impact on vision screening of young children in the public school setting since 2007. MCH continues to work with Prevent Blindness Oklahoma and the College of Optometry, Northeastern State University in Tahlequah on training of vision screeners. //2012//

House Bill 1051, passed in 2007, created the Diabetes Management in Schools Act. This act requires that a diabetes medical management plan be developed for each student with diabetes who will seek care for diabetes while at school or while participating in a school activity. During each school year, the School Health Coordinator in MCH provides diabetes management training for school personnel throughout the state in collaboration with the OSDH Chronic Disease Service and OSDE.

/2012/ Eight trainings are scheduled across the state for the 2011-2012 school year. //2012//

/2013/ Staff in MCH Child and Adolescent Health Division remain the lead for training. //2013//

With the OSDH being designated as the lead agency by Governor Brad Henry to make application for the recently released Funding Opportunity Announcement (FOA) by the Health Resources and Services Administration, Maternal and Child Health Bureau entitled, "Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Program", MCH is working on the required state needs assessment for this FOA due September 1. The OSDH Family Support and Prevention Service, which administers two statewide home visitation program models (the Nurse Family Partnership model and the Healthy Families model), is the lead for the application with MCH providing technical assistance and serving as a resource to assure planning aligns with statewide infant mortality and early childhood activities as well as other Title V priorities.

/2012/ MCH continues to support the OSDH Family Support and Prevention Service in administration of the ACA Maternal, Infant, and Early Childhood Home Visiting Program. MCH provides needs assessment, content, and analytic expertise/support. //2012//

G. Technical Assistance

As MCH partners with the Oklahoma Hospital Association, Oklahoma Health Care Authority, Office of Perinatal Continuing Education at the University of Oklahoma Health Sciences Center, and March of Dimes on implementation of the Maternal-Infant Quality Care Collaborative with birthing hospitals across the state, technical assistance may be requested from other states in the nation who have experience with this type of collaborative. Due to budgetary constraints, funds are not available among any of the partners to implement the collaborative as envisioned. Initial steps will be to attempt to engage birthing hospitals to participate voluntarily by offering tools and technical assistance to develop policies and provide staff education to impact elective deliveries, breastfeeding, infant safe sleep, abusive head trauma, and tobacco use prevention. During an initial meeting earlier this year with representation from approximately half the birthing hospitals in

the state, the concept of a collaborative was introduced and received with positive responses from hospital administration.

A written invitation will be sent this summer to all birthing hospitals under the signature of the Commissioner of Health and the Executive Director of the Oklahoma Hospital Association inviting administration of the hospitals to participate in a one day meeting in September, National Infant Mortality Awareness Month. During the meeting, hospitals will be informed of support to be offered, how the support will assist them in meeting of standard quality indicators, and how to go about obtaining the support. Input will also be requested from the hospitals about how to best provide the offered support. Based on information gained from hospitals during the one-day meeting and issues encountered as the collaborative is implemented, technical assistance may be requested.

/2012/ MCH is working with partners (Oklahoma Hospital Association, March of Dimes, Oklahoma Health Care Authority, the University of Oklahoma Office of Perinatal Quality Improvement and Department of Obstetrics and Gynecology, Child Death Review Board, and multiple programs within the Oklahoma State Department of Health) to assure technical assistance and support of hospital-based activities for infant safe sleep, infant injury prevention (specifically abusive head trauma), breastfeeding, and elimination of non-medically indicated (elective) deliveries. Technical assistance from staff of the California Title V Program via conference calls and e-mail has been particularly helpful as activities related to preconception/interconception health and reduction of premature births have been explored and implemented.

Region VI Title V Directors continue to explore the possibility of a regional performance measure. Related, State Health Officers in Regions IV and VI have come together and identified infant mortality as a priority and are also discussing the potential of the states in these two regions identifying common measures. Currently, reduction of prematurity is a specific interest of the State and Territorial Health Officials. Bringing the Title V Directors and key partners (e.g. Medicaid peers) from Region IV and VI together for technical assistance in developing common measures and exploring evidence-based and promising practices to impact infant mortality would be beneficial. The technical assistance would need to include strategies that take into consideration poverty, health equity, diversity/minority health, and social marketing. //2012//

/2013/ On January 12-13, seven member state teams, composed of the State Health Official, Title V MCH Director, and five other select state leadership staff, from each of the 13 states in Regions IV and VI attended an Infant Mortality Summit in New Orleans per invitation of Mary Wakefield, Administrator, Health Resources and Services Administration (HRSA). The meeting provided the opportunity for states to have focused time to begin to develop a state plan, or if a state already had a plan, to focus on identification of actions to enhance the existing plan. Each state left the meeting with identified steps and related timelines for expected accomplishment. States have since responded back in writing to both HRSA and the Association of State and Territorial Health Officials (ASTHO) on their identified steps and will be brought together for a follow-up meeting on July 23-24 in Arlington, Virginia to report on progress and begin next steps. Next steps will involve members of each state team participating in crosscutting state teams with content and data experts on five areas (reduction of prematurity, infant safe sleep, preconception/interconception health, tobacco cessation, and perinatal regionalization) that have been found to be common priorities from the information reported back to HRSA by the Region IV and VI states. Technical assistance requests for Oklahoma may result from this work.

MCH is providing leadership for a one-day state summit on infant mortality to occur on October 1. This is one of the key actions on Oklahoma's plan from the January HRSA sponsored meeting. Invitees are from a diverse audience to include state and local government, private business, medical and nursing, law enforcement, military, tribal, faith-based, community, minority, family, advocacy, and charitable organizations. At this time, there are no specific technical assistance needs but as the summit takes place and follow-

up occurs, technical assistance needs may be identified and support requested.

With hiring of state program staff from diverse educational and experience backgrounds, an emerging training need is for staff to become knowledgeable and skilled in developing logic models as well as workplans using Specific, Measureable, Attainable, Realistic, and Time-bound (SMART) objectives. MCH will be requesting technical assistance support to bring experienced trainers to Oklahoma to meet this staff development need. //2013//

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation <i>(Line1, Form 2)</i>	7290174	7190901	7290174		7190901	
2. Unobligated Balance <i>(Line2, Form 2)</i>	0	0	0		0	
3. State Funds <i>(Line3, Form 2)</i>	5528288	7182769	5524073		5453690	
4. Local MCH Funds <i>(Line4, Form 2)</i>	0	1063799	0		0	
5. Other Funds <i>(Line5, Form 2)</i>	0	0	0		0	
6. Program Income <i>(Line6, Form 2)</i>	176000	142773	110098		119252	
7. Subtotal	12994462	15580242	12924345		12763843	
8. Other Federal Funds <i>(Line10, Form 2)</i>	4481363	4686629	5276389		5121950	
9. Total <i>(Line11, Form 2)</i>	17475825	20266871	18200734		17885793	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	1672737	1203560	1123738		900283	
b. Infants < 1 year old	1917272	2787976	1678427		2085453	
c. Children 1 to 22 years old	4482939	6352376	5041500		4751682	
d. Children with	3836933	3784686	3831379		3784686	

Special Healthcare Needs						
e. Others	0	0	0		0	
f. Administration	1084581	1451644	1249301		1241739	
g. SUBTOTAL	12994462	15580242	12924345		12763843	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	93713		100000		65357	
c. CISS	0		0		0	
d. Abstinence Education	0		0		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	0		0		0	
h. AIDS	0		0		0	
i. CDC	138173		162496		145093	
j. Education	48635		49592		50000	
k. Home Visiting	0		0		0	
k. Other						
ECCS	140000		140000		150000	
Family Planning	4060842		4203962		4083535	
PREP	0		620339		627965	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	5681802	2402639	2440090		2220972	
II. Enabling Services	917998	1663009	1341765		1330507	
III. Population-Based Services	2690613	6334545	5317093		5068014	
IV. Infrastructure Building Services	3704049	5180049	3825397		4144350	
V. Federal-State Title V Block Grant Partnership Total	12994462	15580242	12924345		12763843	

A. Expenditures

See Forms 2, 3, 4 and 5

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

The Oklahoma Department of Human Services (OKDHS) CSHCN value is determined through the Random Moment Time Study (RMTS) and based on employees' responses specifically related to the CSHCN Program. All Field Operations Division and Family Support Services Division field 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 infrastructure building, population-based, and enabling services 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.

//2012/ There have been no changes to the methods used to document expenditures by the OSDH or OKDHS. However, Forms 3, 4, and 5 do reflect changes, some significant, in expenditure amounts and shifts in expenditures for population groups and categories of service.

Form 3 documents a decrease of 5.8 million dollars expended in comparing 2009 to 2010. The decline in the state's economy has resulted in major reductions in state funding for services. MCH experienced reduced state funds for perinatal health, school health, and adolescent health (specifically teen pregnancy prevention). Many state funded positions in county health departments were not refilled (43 more vacant positions were not approved for refill comparing 2009 to 2010) plus the state deficit led to a voluntary buyout option for early retirement in a specific state funded program that provided MCH services. MCH contract providers also experienced difficulty in maintaining state and local funds that they have historically shown on their budgets as expenditures for MCH services.

Form 4 documents expenditures by the MCH population groups. All population groups served by the OSDH were negatively impacted. Essentially no change was seen in expenditures for CSHCN.

Form 5 documents shifts that occurred within the categories of direct health care services, enabling, population-based, and infrastructure building services. Direct health care services decreased significantly (just over 6 million dollars) with enabling and population-based services also decreased, \$814,209 and \$164,378 respectively. Infrastructure services increased 1.2 million dollars. Reasons underpinning these shifts were multi-factorial: inability to refill county health department positions providing direct health care, enabling, and population-based services; changes in MCH contract provider services; and increased focus on infrastructure building services (needs assessment, data systems, data analysis and dissemination, training, etc.).

With all this change, it needs to be noted that the Oklahoma Title V Program is very thoughtful in its process of looking at the priority needs of the MCH population and realigning funds and resources to meet those needs. As opportunities present with changes in Medicaid policy, state policy, state and county Title V staff, and Title V contractual services, the Title V Program will assure that the funds available are used for appropriate and quality services for mothers, infants, children, and their families. //2012//

//2013/ Late state fiscal year 2011 and into 2012, the economic picture in Oklahoma began stabilizing. State cuts were not requested in Title V programs and as demonstrated on Form 3, total expenditures for 2011 were very similar to 2010.

Form 4 documents changes in 2011 expenditures among MCH populations groups with a shift in resources to the infants <1 year old population from pregnant women and children 1 to 22 years old. This shift demonstrates increased efforts specific to infant mortality in the neonatal and post-neonatal periods.

Form 5 documents changes in 2011 expenditures by types of services. A continued increase in infrastructure services (approximately \$500,000), with shifts of resources from direct health care services and population-based services, is seen in comparing 2010 to 2011. Minimal change is noted in enabling services from 2010 to 2011. //2013//

B. Budget

Maintenance of effort from 1989:

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

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

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

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

Special consolidated projects:

MCH Title V Block Grant funds continue to be used to carry out Sudden Infant Death Syndrome (SIDS) activities and the CSHCN Supplemental Security Income-Disabled Children's Program (SSI-DCP). SIDS 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 SIDS activities. The CSHCN SSI-DCP uses funds to provide diapers, formula, durable medical equipment, supplies and services that would otherwise not be available to children with special health care needs.

State matching funds:

In 2009, the OSDH made a policy decision to provide cost sharing in grant applications based on the requirements in each specific grant. For the MCH Title V Block Grant, cost sharing is based

on the three state dollars for each four federal dollars as well as the requirement to meet the maintenance of effort set in 1989.

Federal 30/30 requirement:

For FFY 2011, 51.59 percent of the federal Title V Block Grant funds are designated for programs for preventive and primary care services for children and 30% for services for children with special health care needs. See Form 2.

/2012/ For FFY 2012, 50.48 percent of the federal Title V Block Grant funds are designated for programs for preventive and primary care services for children and 30% for services for children with special health care needs. //2012//

/2013/ For FFY 2013, 47.31 percent of the federal Title V Block Grant funds are designated for programs for preventive and primary care services for children and 30% for services for children with special health care needs. //2013//

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 the Family Support Services Division (FSSD), Health Related and Medical Services Section. The FSSD also administers the SSI-DCP for SSI recipients to age 18. Other components of the CSHCN Program include two projects that support neonates and their families; support of the state Title V 1-800 toll-free information and referral system; 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; funding for travel, training, and child care for parents of children with special health care needs; 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 FSSD 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 FSSD continues to utilize Title V funding to assure the development of community-based systems of services for children with special health care needs and their families.

Other federal programs or state funds within MCH to meet needs and objectives:

The State Systems Development Initiative (SSDI), a grant funded by the Maternal and Child Health Bureau (MCHB), supports activities to link Women, Infants, and Children Supplemental Nutrition Program (WIC) data with birth certificates and Medicaid eligibility and claims data. This compliments and strengthens MCH's activities to link relevant program services to existing MCH databases including the Pregnancy Risk Assessment Monitoring System (PRAMS) and The Oklahoma Toddler Survey (TOTS) surveillance systems. These linkages enable the state to generalize the results to Oklahoma's population of pregnant women (or new mothers) and young children.

The Early Childhood Comprehensive Systems Initiative (ECCS), a grant funded by the MCHB, provides funds to assist Oklahoma in efforts to build and integrate early childhood services systems that address the critical components of access to comprehensive health services and

medical homes; social-emotional development and mental health of young children; early care and education; parenting education; and family support. Implementation is being accomplished as a collaborative effort of state and community-based public and private partners.

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

The Oklahoma State Department of Education (OSDE) provides federal funds received from the CDC to the OSDH through a contractual agreement. MCH uses these funds to support ongoing administration of the Youth Risk Behavior Survey (YRBS). This survey provides Oklahoma with information on risk-taking behaviors of youth.

State perinatal and general revenue funds are received to support key MCH activities such as gap-filling maternity and child health clinical services; outreach; infant mortality reduction through preconception and interconception care and education, support of mothers and health care providers with breastfeeding information, education, and a statewide 24 hour 7 day a week breastfeeding hotline, Fetal and Infant Mortality Review (FIMR) projects, and Maternal Mortality Review (MMR); adolescent pregnancy prevention efforts; childhood injury prevention; school health to include funding of school nurses in priority areas of the state; Oklahoma's Poison Control Center; public education; and data matching and analysis. Medicaid administrative match funds are received to support FIMR and data matching and analysis.

/2013/ One million dollars in new state funds is being provided to the OSDH by the 2012 Legislature for use in furthering efforts to reduce Oklahoma's infant mortality rate. The funds will be used by MCH to facilitate implementation of evidenced-based models and practices to impact breastfeeding, infant safe sleep, abusive head trauma, and interconception services for high risk women. //2013//

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. Within the federal funds received are specific funds to support special projects in Oklahoma and Tulsa counties targeting the African American population in efforts to impact access to services, use of services, and significant disparities in infant mortality rates. These funds are being used to accomplish family planning outreach, education, and provision of clinical services.

/2013/ Specific funds from Title X for the special projects focused on services for the African American population in Oklahoma and Tulsa counties ended. Given the priority of assuring services to this population, funds for family planning were realigned to assure the contracts to the two city-county health departments were maintained at the level needed to continue these services as part of their family planning programs. //2013//

/2012/ 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 also include education on adulthood preparation subjects (e.g., healthy relationships, adolescent development, financial literacy, parent-child communication, educational and career success, healthy life skills). *//2012//*

Budget Documentation:

Overall budget preparation and monitoring are provided through administrative support within the OSDH Administrative Services. Agency budgeting, grants, and contract acquisition staff meet routinely with program areas to assure program financial awareness. The MCH Chief is responsible for budget oversight and the Chief along with each individual Division Director is responsible for compliance with program standards and federal and state requirements.

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

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

The Title V Grant application documents a proposed budget on Forms 2, 3, 4, and 5 inclusive of Title V federal funds, state dollar match, and anticipated income to be received from Medicaid. This budget is the base for services at the beginning of the grant period. As the year passes, the OSDH makes available more state and local funded resources (e.g., staff, supplies, travel) for provision of MCH services as an Agency priority. This results in increased funding reported as expended on Forms 3, 4, and 5. It is understood each year that these additional state and local funded resources are fluid and may be redirected at anytime by the Commissioner of Health based on state and/or agency priorities, or in the event of a state health event or emergency/disaster needing to be addressed.

/2012/ There are no changes in policy or procedure to report. //2012//

/2013/ There are no changes to report. //2013//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.