



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

**State Narrative for
Oklahoma**

**Application for 2009
Annual Report for 2007**



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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.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

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 Administration 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; expires May 31, 2009.

E. Public Input

Oklahoma provides access for public input to the Title V Maternal and Child Health (MCH) 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 Service Block Grant, is found at the bottom of the Oklahoma Maternal and Child Health Service (MCH) web page, <http://www.health.state.ok.us/program/mchs>, 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 Children with Special Health Care Needs Program (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 Title V MCH Block Grant are also provided on request to MCH Administration at (405) 271-4480 or via e-mail to PaulaW@health.ok.gov.

On February 23, 2007 public input was sought through a statewide press release. The press release was also sent to radio stations and minority newspapers statewide to gain input from various racial, ethnic and cultural groups (Native American/American Indian, Hispanic, Asian, African American/Black, Latino and Chinese).

Public input via e-mail, letters and telephone calls has been 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 Title V MCH Block Grant annual report and application for submission to the MCHB.

Onsite technical assistance is currently being scheduled with Family Voices, Inc. This technical

assistance will focus on strategies to enhance family input in Title V activities to include development of the Title V MCH Block Grant.

//2009/ Access to Oklahoma's Title V MCH Block Grant continues to be provided to the public via an active link to the federal MCHB TVIS website. The Oklahoma MCH web address changed this year as the OSDH website was migrated to the state portal system, www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/. Information on how the public may forward input is provided on the MCH web page directly under the active link. CSHCN continues to maintain an active link on the CSHCN web page, <http://www.okdhs.org/programsandservices/health/cshcn/>, to the OSDH MCH web page. Hard copies of the Title V MCH Block Grant are also provided on request to MCH Administration at (405) 271-4480 or via e-mail to PaulaW@health.ok.gov.

The use of an annual statewide press release is unchanged. The press release for this year was disseminated January 22, 2008. In addition, an article was published in the Oklahoma Hospital Association Newsletter, "Hotline", on January 23, 2008.

MCH and CSHCN use public input received in evaluation, planning and development of policies, procedures and services that are reported and described in the Title V MCH Block Grant annual report and application submitted to the MCHB. //2009//

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Oklahoma Title V 2005-2010 Needs Assessment is available on the Maternal and Child Health Bureau (MCHB) Title V Information System (TVIS) website and may be accessed via an active link titled, "Public Input Sought For Maternal and Child Health Service Block Grant", found at the bottom of the Maternal and Child Health Service (MCH) web page, http://www.ok.gov/health/Child_and_Family_Health/Maternal_and_Child_Health_Service/. On the MCHB TVIS website, click on topic "State Needs Assessments (2005)" then click on "Oklahoma" in the list of states.

/2008/ Oklahoma's infant mortality rate has consistently remained above the national rate since 1992. While some improvements have been observed, the state's infant mortality rate (IMR) of 8.1 deaths per 1,000 live births for 2005 is no better than the national rate of 8.0 achieved over 10 years earlier. The Oklahoma rate has seen little change since 1992 except for a couple of anomalous years, dropping by 10% from 9.0 in 1990 to 8.1 in 2005. In comparison, the U.S. rate dropped by 25% from 9.2 in 1990 to 6.9 in 2003.

Mortality by race reveals a large, persistent disparity between white and African American rates. The African American IMR is more than twice the rate of white deaths, and little has changed for decades. The differences between white deaths and Native American/American Indian deaths are subtler within Oklahoma due to misclassification of mixed race infants. Racial variances in mortality may be due more to cultural and discrimination issues rather than racially genetic differences; more study is needed to separate these effects. Moreover, intervention methods for non-white races have not been sensitive to recognizing the need for culturally different approaches to improving health outcomes. The increasing Hispanic influence in Oklahoma has heightened this disparity. It has actually been easier to address Hispanic cultural difference most likely because the language barrier demands it. This is not a scientific observation; rather, it is observational according to the health care delivery systems with whom the OSDH supports and collaborates.

Hispanic infant mortality in Oklahoma is more difficult to identify due to the immigration of families from non-U.S. locations over the past decade. There is evidence of newly immigrated Hispanic mothers having a greater likelihood of delivering normal weight babies than Hispanic mothers who have been living in Oklahoma for longer periods. The assumption is that acculturation has led to the adoption of poorer dietary practices common among the U.S. population. However, the infant mortality rate for Hispanic babies is not equally low. The data are small and there is not a sufficiently long history to verify true differences. But with the reported data, the IMR for Hispanic infants has been consistently worse than that for whites; the rates have typically been 10% - 20% higher than the white rate. If there are protective factors that allow Hispanic mothers to have healthier babies, the same cannot be said after the infant is born.

From 1990 to 2005, the white IMR was reduced from 8.7 to 7.3, a 16% drop. For African Americans, the rate actually increased by 11% from 13.9 to 15.4. The traditional calculation of Native American IMR also showed an increase of 13% from 6.8 in 1990 to 7.7 in 2005. The rates for minority races in Oklahoma are highly variable due to the relatively small number of deaths each year; however, the lack of a decrease during this 16 year period still reflects problems that need to be addressed among Native Americans and African Americans in Oklahoma.

The OSDH has made the reduction of infant mortality one of its priorities. An intra-agency

workgroup has been convened to study the different aspects of the state's high infant mortality rate. Initial analyses reveals no startling differences among the primary causes of infant deaths than reported for the nation as a whole. The racial disparities also do not reveal any quick answers. Comparing Oklahoma to bordering states reveals that Kansas, Colorado, New Mexico, and even Texas have much lower rates than observed in Oklahoma. The most recent and final data from NCHS shows that Missouri, Arkansas, and Louisiana all have higher rates, but that was for 2003 when Oklahoma reported a questionably low rate of 7.8 that bettered Missouri for that one year. This is not to imply that the rate was incorrect for that year, but rather the year itself did not represent a rate that has been typically reported for the state.

Perhaps some of the most important issues surrounding the state's poor performance in maintaining healthy infants are those social and economic differences that impact health outcomes. These issues will be the greatest challenge for the taskforce to measure, because they are not collected through vital registration records. Therefore, it is equally important to identify mothers and families within the state who do achieve non-fatal outcomes for their infants and determine what factors contribute to those favorable outcomes. //2008//

//2009/A minor decline in the infant mortality rate was observed for 2006, dropping from 8.1 to 8.0 deaths per 1,000 live births. However, the African American infant mortality 2002-2006 averaged annual rate is still 15.5, compared to the white rate of 6.7 for the same five-year period. A review of cases from the two Oklahoma Fetal and Infant Mortality Review projects reveals a high incidence of maternal overweight/obesity and infections among infants who have died. Further review is needed to verify these relationships and determine what interventions are best suited to reduce these prenatal conditions.

The 2007 Youth Risk Behavior Survey was conducted and selected results are incorporated into Performance Measures, Health Status Indicators, and other reports as appropriate.

OSDH conducted a survey of practicing obstetricians providing delivery services in the state from 2003 -- 2005. Nearly 73% of responding physicians reported medical liability premiums as a very important barrier to providing obstetric care. More than one-fourth of respondents rated uninsured clients as a very important obstacle to providing obstetric care, and 46% of those reporting indicated low Medicaid reimbursement to be a very important barrier to providing care to the SoonerCare (Medicaid) clients.

For a status update addressing the Community Needs Assessment (Key Informant Survey) for CHSCN, please see notes on National Performance Measure #2. //2009//

III. State Overview

A. Overview

Oklahoma is a largely rural state with two major metropolitan areas, one located centrally in the state (Oklahoma City) and the other 104 miles to the east (Tulsa). In each of the quadrants and the panhandle of the state, smaller cities provide some of the benefits of the two large metropolitan areas on a lesser scale. Scattered throughout the remainder of the state are rural towns of varying size and population. Population in rural areas is decreasing while the two large metropolitan areas have experienced the most growth over the past five years. Farming continues to shrink and small businesses struggle to survive in a climate of corporate and urban growth. Gaming (lotteries and casinos) is becoming a major contributor to the state's economy with revenue reaching nearly 1 billion this year and expected to increase.

Overall, Oklahoma is primarily Caucasian with other non-white and/or Hispanic populations being less than 22% of the state's population. Larger populations of other non-white and/or Hispanic populations are found in eastern and southeastern Oklahoma. There are 39 federally recognized Native American/American tribal governments with Native American populations integrated into local communities. Oklahoma has no reservations though federally it is considered a reservation state. In recent years, a steady growth in the Hispanic population is occurring, at first in rural farming communities with movement now into growing urban communities. Pockets of predominantly African American/Black communities are found in central and eastern Oklahoma.

The total size of the maternal and child health age-targeted population including children ages 0 through 19 and females ages 20 through 44 stood at 1,572,444 or 44.6% of the total population (3,523,600) for 2004. The population of children and adolescents under the age of 18 dropped 3.6% from 2000-2004.

//2007/ Thirty-one of the state's 77 counties experienced a decrease in population from 2000 to 2004. The continued migration to the two primary metropolitan centers has also had a negative impact upon the availability of health care providers. Population losses, rising medical liability insurance costs and low Medicaid reimbursement rates have forced physicians to move 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. //2007//

//2008/ Oklahoma's population grew by 1.01% from July 1, 2005 to July 1, 2006, gaining 35,000 plus residents for an estimated state population of 3,579,200. With this growth, Oklahoma ranked 22nd in population growth but remained 28th among the states in population. Of the six states in the region, Oklahoma's population growth rate was sixth. //2008//

//2009/ Oklahoma's population grew by 1.01% from July 1, 2006 to July 1, 2007, gaining 38,000 plus residents for an estimated state population of 3,617,300. With this growth, Oklahoma ranked 20th in population numeric growth and 18th in fastest overall growth rate, but remained ranked 28th among the states in population. Of the six states in the region, Oklahoma's population growth rate was fourth.

The two MCH target population groups of children under the age of 20 and females ages 20-44 have changed little in size. The Census estimate for children ages 0 to 19 stood at 998,488 for the year 2007, and it reveals basically no change from the decennial census for 2000. However, some minimal growth is being seen in the younger ages of this population. For females ages 20-44, the 2007 population of 602,273 is approximately 2,000 less than recorded in 2000. With the overall population growing by 4.8% to 3617,316 by 2007, it is evident the state's population is aging. This will present an increasing challenge to maintain or add financial support for healthcare to the younger age groups with the growing health needs for the senior component of the state's population. //2009//

Oklahoma is a poor state even though the state's economy is currently performing well with general revenue fund collections and additional funds being received from gross production tax on oil and natural gas. The 2003 per capita personal income for the state was \$26,719 (85% of

the national value) with only eleven other states reporting lower per capita incomes. Unemployment stood at 4.5% in April 2005. However, even with relatively low unemployment, the state suffers from high rates of uninsured persons. Many jobs are low wage and temporary positions (e.g., call centers, live stock processing, lawn/garden services).

//2007/ Unemployment continues to remain below the national average with a 4.1% unemployment rate for early 2006. However, Oklahoma's median personal income is still well below the national average. Although the general cost of living is less than in other regions, the cost of health insurance is not. As a result, Oklahomans have higher rates of uninsured individuals than the national averages.

Record revenues were reported for the state fiscal year ending June 30. It was the second straight year of record collections. The economy performed well mainly due to oil and gas prices though growth was also being seen in other sectors to include durable goods manufacturing and fabricated metal manufacturing. Questions exist about the economic impact that the closing of the Oklahoma City General Motors Plant earlier this year and the buyout in June of the Kerr-McGee Corporation, with the relocation of its headquarters to the Houston area, will have on the state. //2007//

//2008/ General revenues exceeded official estimates for a third year. Revenue from corporate income taxes, state sales taxes and motor vehicle taxes demonstrated gains with personal income taxes (expected secondary to tax reduction measures passed in previous years) and gross production taxes on oil and gas below estimates. State government ended the fiscal year with \$151.5 million surplus as well as a full "rainy day" fund. //2008//

//2009/ Nationally, Oklahoma ranked 16th in personal income growth. Oklahoma showed a 6.6% rise in personal income for 2007, slightly better than the U.S. national average at 6.2 percent.

Oklahoma's per capita personal income increased in 2007 to \$34,153, up from the state's previous \$32,391 in 2006, though Oklahoma still ranked 33rd among all 50 states. Oklahoma also had the 19th best gain nationwide, reporting a 5.4% rise in per capita income. The most current information from the U.S. Bureau of Labor Statistics shows Oklahoma's preliminary, monthly seasonally adjusted unemployment rate for April 2008 to be 3.2 percent, well below the national average. Oklahoma's labor force population is 1,723,919, its employment numbers are 1,668,426, with 55,493 representing the unemployment population. Historically, Oklahoma's highest unemployment rate was reported in August 1986 at 9.4 percent. Oklahoma's lowest rate to date was recorded to be in January 2001 at 2.7 percent.

In 2007 Oklahoma ranked 23rd, tied with the state of Texas, among all states with its relatively low 4.3 percent annual unemployment rate. However, nationwide Oklahoma ranks 40th for its over-the-year change in unemployment rates, reporting a modest 0.2 percent change over the rate of 4.1 for 2006.

It has been estimated that in 2006 Oklahoma experienced approximately 470 deaths that could be attributed to a lack of health insurance among working aged adults. Between 2000 and 2006 the number of adults aged 25 through 64 that died who lacked health insurance was estimated to be approximately 3,000. //2009//

As indicated earlier, the gaming industry is growing and becoming a significant contributor to the state's economy. In November 2004, Oklahoma voters approved state questions that are expected to create millions more in state revenues. State Question 705 created a state lottery and State Question 712 provided for the creation of the State Tribal Gaming Act. Oklahoma's lottery is slated to begin October 1, 2005 with scratch-off lottery tickets. Electronic lottery games are to begin April 2006 and Powerball games tied to lotteries in other states are to begin October 2006. Proceeds from the lottery are earmarked to support state education. The State Tribal Gaming Act authorizes a limited number of electronic games at three of the four horse race tracks in the state (Remington Park, Blue Ribbon Downs and Will Rogers Park) and provides a model

compact which Indian tribes in the state may enter into to conduct such gaming on Indian lands. Related to approval of these new games under the State Tribal Gaming Act, tribal casinos are expected to continue to expand in Oklahoma. Oklahoma Indian tribes currently operate more than 80 casinos throughout the state.

/2007/ Oklahoma Instant Games went on sale October 2005. Pick3/Daily Game was introduced in November 2005. Powerball sales began in January 2006. Net proceeds of all lottery games are to support improvements and enhancements for educational purposes and programs. Net proceeds are to supplement rather than replace existing funding for education. Lottery proceeds are divided: 52% - prizes; 30% - education; 12% - operations and vendor fees; and, 6% - retailers. At least quarterly, the Oklahoma Lottery Commission transfers 30% of all net proceeds to the Oklahoma Education Lottery Trust Fund. The Office of the State Treasury administers this Trust Fund. These funds are to be distributed: 45% - kindergarten through 12th Grade Public Education, including but not limited to compensation and benefits for public school teachers and support employees, and early childhood development programs; 45% - tuition grants, loans and scholarships to citizens of the state to enable such citizens to attend colleges and universities located within the state, construction of educational, capital outlay programs and technology for all levels of education, endowed chairs for professors at institutions and programs and personnel of the Oklahoma School for the Deaf and the Oklahoma School for the Blind; 5% - Teachers' Retirement System Dedicated Revenue Revolving Fund; and, 5% - School Consolidation and Assistance Fund. Current net proceeds for education are projected to be at least \$110 million a year.

Oklahoma's casino growth is reported to be second in the nation. Tribal gaming revenues topped \$1.4 billion dollars in 2005 with 90 gaming centers divided among 28 tribes. Revenue grew by 39% from 2004. It is projected that similar growth will be seen in 2006 with several new casinos scheduled to open. This year is also the first full year of operation for the nation's first two tribal-owned racetrack casinos, Blue Ribbon Downs in Sallisaw and Will Rogers Downs in Claremore. //2007//

/2008/ Education received \$86.3 million from lottery proceeds, short of the projected \$110 million a year. Questions have been raised as to whether Oklahoma's casino industry is impacting the lottery's success.

Oklahoma experienced its fourth straight year for casino growth in 2006 accounting for the three largest Indian casinos and seven of the 15 total new casinos that opened nationally in 2006. Total Indian casinos in Oklahoma number 94. The state government's share of revenue received from the tribes more than doubled in 2006 (\$30.2 million) from 2005 (\$11 million). It is anticipated that the casino industry will continue to see growth with the addition of new electronic games and poker and blackjack tables in addition to the ability to draw customers from two bordering non-gambling states, Texas and Arkansas. //2008//

/2009/ 2006 revenues from Oklahoma's lottery games (the latest figures available) totaled \$204,843,618. Oklahoma Education Lottery Trust Fund received \$68,948,959 from the aforementioned lottery revenues. //2009//

Oklahoma's political climate is shifting. Marked changes, attributed largely to constitutional term limits, occurred in the Oklahoma Legislature with elections in November 2004. Thirty-nine new legislators were elected to the House and fifteen new members to the Senate. For the second time in state history, Republicans gained control of the House (57 to 44) and are optimistic that they will gain control of the Senate (currently Republicans hold 22 of the 48 seats) in November 2006 when several Democratic Senators cannot seek re-election due to term limits. Democrats are a minority in the House for the first time since 1921-22 when Republicans dominated the House for one term. The House elected a Republican speaker 84 years to the day that the only other Republican was elected to the post. The House also elected the state's first female speaker pro tempore, also a Republican. These Republican House leaders work with a Democratic controlled Senate and a Democratic Governor.

/2007/ In 1990, Oklahoma became the first state in the nation to enact a legislative term-limit law. It allowed incumbent legislators to continue serving until 12 years had passed from the law's

effective date in 1992. The first wave of term limits occurred in 2004. As a result of term limits after this session, more Democrats than Republicans will term limit in both the House and Senate. As a result, Republicans are looking to gain control of both the House and Senate after elections in November 2006. The elections in November will also determine the Governor of Oklahoma for the next four years with Brad Henry, the current Governor and a Democrat, to run for re-election.

New this year is the ability of the general public to more readily access information on Oklahoma's lawmaking process via a new, free website, <http://www.okinsider.com/>, a partnership between Oklahoma Publishing Today and NewsOK.com. Features of the site include: explanation of the legislative process in simple terms; real-time updates and live audio feeds during legislative sessions; a complete list and summary of all bills before the state Legislature; full-text versions of all bills; and, children's content. //2007//

/2008/ The November 2006 elections saw Brad Henry, the current Governor and a Democrat, re-elected as Governor of Oklahoma. The Senate, Democratic since statehood, was split with 24 Democrats and 24 Republicans. This set the stage for both parties to have an equal share of power in the Senate for the first time in the state's history. Each party had its own co-floor leader. The co-floor leaders shared the responsibility for scheduling the daily legislative calendar and rotated management of floor activities on a daily basis. Presiding duties were also shared, when one party's co-floor leader was managing floor activities, the other party presided in the chair. All Senate committees had equal numbers of Democrats and Republicans and co-chairs from each party shared the responsibility of running the committees. The House remained in Republican control with 57 of the 101 members. //2008//

During this year's legislative session, several key bills were passed and signed by the Governor targeting positive outcomes for Oklahoma's maternal and child health population. These include legislation to promote good health and nutrition in the school setting, Senate Bill (SB) 265 requires healthy choices in school vending machines and SB 312 requires physical education in grades K-5 with physical education to be offered as an elective in middle and high school. With a focus on reducing child and youth automobile related morbidity and mortality, SB 799 increases the fine for violation of the Child Passenger Restraint Law from \$25 to \$50 plus all court costs and House Bill (HB) 1653 provides for graduated driver licenses for drivers younger than 18. It is expected with the graduated driver licenses that accidents and fatalities among drivers younger than 18 will be reduced by at least 15%. SB 435 and HB 1547 both lower state taxes. SB 435 lowers taxes by raising the standard deduction on state income taxes. HB 1547 includes a reduction in the income tax rate from 6.65% to 6.25%. In efforts to provide ongoing support for Oklahoma's youngest populations, HB 1094 ensures current levels of child care funding in the Oklahoma Department of Human Services (OKDHS) by increasing the state's share as federal funds decrease, HB 1080 provides funding to the Oklahoma State Department of Education (OSDE) for full-day kindergarten and HB 1020 provides an additional \$1 million in funding for SoonerStart, Oklahoma's early intervention program for 0 to 3 year olds. To assist with liability concerns and curb the loss of health care providers in rural areas of the state providing services through the Oklahoma State Department of Health (OSDH) system, SB 983 amends the Maternal and Infant Care Improvement Act to provide coverage under the Government Tort Claims Act for licensed health care providers contracting with the OSDH.

/2007/ 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 through the OSDH Legislative Liaison. MCH also participates in state boards, task forces, work groups and committees during and between sessions per request of members of the state Legislature or as appointed by the Governor. MCH is able to provide to the legislative process the latest in national health care policy and practice; information on national, regional and state health care issues and practices; and, the most recent available national, regional and state data for the maternal and child health population.

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. MCH has worked with the Oklahoma Institute for Child Advocacy to include CSHCN in the planning of this year's Fall Forum to include developing a section focused on the needs of children with special health care needs and their families.

In 2006, for the first time in over 80 years, the Oklahoma Legislature adjourned without appropriating funds for the operations of state government. The Oklahoma Legislature closed its regular session at 5 p.m. the last Friday of May as required by state constitution without resolving state budget issues. Governor Henry called a special session to allow for a state budget to be approved before the new fiscal year started July 1 and avoid shut down of state agencies. Lawmakers were at odds over budget issues related to tax cuts, increased funding for education and a state employee pay raise. On Friday, June 23, the last day of the special session, lawmakers approved a \$7.1 billion budget, the largest in state history, that includes the largest tax cut in state history and changes the state's tax structure. Lawmakers approved reducing the state income tax from 6.25% to 5.25% within four years, eliminating the inheritance tax in three years and increasing the state's standard deduction to the federal level in four years. As part of the state budget, teachers received a \$3,000 pay increase, higher education received \$130 million and state employees received a 5% pay increase.

Despite disagreement between the House and Senate over how to deal with budgeting of state revenue, the Oklahoma Legislature passed multiple bills before the end of the regular session to improve outcomes for the maternal and child health population. The Governor has signed all these bills.

SB 1737, the Dental Loan Repayment Act, creates a program designed to increase the number of dentists serving and caring for those dependent upon the state for dental care and to make dental care accessible to underserved metropolitan and rural areas. Educational loan repayment assistance will be provided for up to five Oklahoma licensed dentists per year, for a two to five year period per dentist. HB 2358 provides guidelines for employers to create a positive environment for mothers who wish to continue breastfeeding their babies after returning to work. This legislation builds upon positive changes made in prior years to state statute on breastfeeding. SB 990 creates the Oklahoma Genetics Counseling Licensure Act that provides a means for the OSDH Board of Health to set standards and requirements for genetic counselors. With advances in genetics helping physicians identify and treat genetic disorders in newborns in order to ensure optimal healthy outcomes and with all newborns born in Oklahoma receiving screening for metabolic and hearing disorders in order to provide early and comprehensive follow-up services, the complexity of genetic issues has emerged as a discipline to help educate individuals, families and physicians so that better informed decisions may be made regarding health care.

Strategies to reduce risk-taking behaviors and injuries include HB 3056 and SB 1495. HB 3056 creates the Prevention of Youth Access to Alcohol Act and puts stiffer penalties in place to help curb youth access to beer. All three parties involved - the minor, the server and the owner of the store - will receive meaningful penalties, from minors losing their driver license to store owners losing their license to sell beer. SB 1495 specifically addresses boating safety. This bill prohibits children under age 16 from operating large boats or personal watercraft without first completing a course in boating safety and requiring children ages 12-16 to always have an adult present when boating or operating a personal watercraft.

Measures targeting ways for schools to be more involved in improving the health of children include SB 1459 that requires school districts to establish school wellness and fitness policies that meet specified minimum requirements. The measure directs the OSDE, in consultation with the OSDH, to make information and assistance available to schools on request. The bill requires

districts to provide annual reports to the OSDE on the district's wellness policy, goals, guidelines and progress in implementing the policy and attaining the goals. HB 2655 establishes the Oklahoma Farm to School Program within the Oklahoma Department of Agriculture to connect local schools to fresh produce provided by local farmers. It is anticipated that this approach will improve the nutrition and health of Oklahoma school children, while at the same time provide new markets for Oklahoma farmers. SB 1795 requires children in grades K, 1 and 3 to pass a vision screening prior to entry to school and recommends that children who fail the screening undergo a comprehensive eye exam. The OSDH Board of Health is to develop and approve rules to facilitate implementation of this law.

Bills to improve the child welfare system in protecting the health and safety of children include: HB 2840 enacts a number of measures to bring more accountability to the child welfare and judiciary systems; HB 2126 recreates the Child Death Review Board until 7/1/2012; SB 1800 establishes the Child Abuse Response Team (CART) within the Oklahoma State Bureau of Investigation to assist in the investigation of child abuse cases; and, HB 2097 provides annual training for teachers in the recognition and reporting of child abuse and neglect. //2007// /2008/ On Friday, May 25, the 2007 regular session of the Oklahoma Legislature adjourned. The 2007 Oklahoma legislative session experienced the impact of term limits with over two-thirds of the members having less than three years experience. The four-month session (February-May) was also dominated by a power struggle between the Republican-dominated Legislature and Democratic Governor over the state budget. After vetoing in March a general appropriations measure Governor Henry said was negotiated without his input, Governor Henry and the Legislature reached agreement on a state budget May 14 that will fund state government agencies and programs in the fiscal year starting July 1. The budget, just over \$7 billion, is approximately 1% less than the 2007 state fiscal year budget.

Cuts in state tax continued for a third straight year. Record level tax cuts were seen in 2005 and 2006 for Oklahomans. 2007 legislation, SB 861, was passed to speed up implementation of the tax cuts provided in 2006. It reduces the state's top income tax rate from the current 6.65% down to 5.25% by 2009, a year ahead of the previously identified 2010 date. The new law also provides a tax credit for stay-at-home parents creating equal footing with those parents who use day care. Because the current oil and gas income has increased to offset the recent tax cuts, the state has not experienced as significant an impact on lost revenues as would have occurred if oil prices had dropped or production had declined. These changes are again making the state's economy more petroleum-dependent.

Differences between the Legislature and Governor impacted tort reform. Efforts to put forth acceptable changes in the way lawsuits involving personal injury, "torts", in Oklahoma are handled were hampered by disagreement over capping non-economic damages, damages awarded for "pain and suffering" over and above an award for actual economic damages. Governor Henry vetoed the bill put forth by the Legislature, indicating a need to look at a measure that allowed the jury and the judge upon certain findings to lift the cap when appropriate and justified by the injuries. A compromise was unable to be reached before the end of the legislative session setting the stage for tort reform to be listed as a top priority for the 2008 legislative session as it has been each year since 2004.

A significant measure signed into law was HB 1804, an immigration reform bill that creates barriers for undocumented residents to receive public benefits and jobs. The "Oklahoma Taxpayer and Citizen Protection Act" passed in the House, 88-14, and the Senate, 41-6. This state law, signed by the Governor, takes effect November 1 and includes criminal penalties for knowingly and willingly harboring illegal immigrants; prohibits public benefits to individuals 14 years of age or older in the state illegally, except the provision of immunizations, treatment of communicable diseases and treatment of medical emergencies; and, requires businesses to check the background of all workers through a federal verification system or risk penalties and legal action. Health care providers statewide are expressing concerns about the consequences this law will have on Oklahoma's public health. This legislation is considered to be the most

restrictive of any current state law in the United States (U.S.).

Other key bills passed impacting the MCH population include HB 1686, HB 1078, HB 1895 and SB 0639. HB 1686 requires persons under age 18 to wear a crash helmet while operating or riding as a passenger on an all-terrain vehicle (ATV) on public lands. The measure prohibits passengers on ATVs unless the vehicle was designed to carry passengers. The measure also creates penalties for non-compliance with the law. HB 1078 provides for penalties to adults providing liquor or a controlled substance to a minor when great bodily injury occurs not just when death occurs. HB 1895 establishes the Oklahoma Youth and Gang Violence Coordinating Council to coordinate Oklahoma's response to gang activity by reviewing and assessing the current suppression, intervention and prevention efforts to reduce gang activity and violence. SB 0639 allows the OSDH and city-county health departments, in order to maintain public health infrastructure and preparedness, to enter into contracts for professional services with physician assistants, registered nurses, advanced practice nurses, nurse midwives, registered dietitians, occupational therapists, physical therapists and speech language pathologists who have retired from state services without any waiting period. //2008//

//2009/ November 1, 2007, the OSDH Office of General Counsel distributed a memorandum identify programs or services of the OSDH that were determined to be free of the lawful presence verification requirement (Section 8 of HB 1804). Programs under the administration of Maternal and Child Health Service were on this list.

On Friday, May 23, the 2008 regular session of the Oklahoma Legislature adjourned. A \$7.1 billion general appropriations bill was approved, a standstill state budget. State agencies are facing growing financial constraints with increasing costs for services, flat state budgets and cuts in federal program budgets.

Multiple bills were passed focusing on maternal and child health. All four bills addressing childhood obesity passed; SB 1186 doubles the number of minutes of physical activity for students in grades K-5, from 60 minutes per week to 120 minutes per week; HB 1612 creates a grant program for after-school programs to incorporate obesity-reduction components; SB 519 directs the State Health Department to develop fitness testing software to pilot in several elementary schools to acquire a baseline of data; and, HB 3395 establishes a school health coordinator pilot program to assist schools to implement health and wellness programs. Additional bills targeting school health included SB 923 that requires school districts to have automated external defibrillators at each school and HB 2239 that directs schools to allow the self-administration of anaphylaxis medication to a student.

SB 551 Forget-Me-Not Vehicle Safety Act was passed which prohibits parents and guardians from leaving children six years of age or younger, or vulnerable adults, unattended in a motor vehicle if the conditions, including, but not limited to, extreme weather, present a risk to the health or safety the child or vulnerable adult.

In efforts to enhance the health care workforce, SB 1729 creates a scholarship program to attract more faculty and students into the health care profession. Parts of 58 of Oklahoma's 77 counties are designated as medically underserved, especially related to prenatal and delivery services. Current information indicates that Oklahoma will be faced with added shortfalls in nursing and allied health professionals by 2012. //2009//

Additional good news is the multiple opportunities presented to increase access to health care services for the maternal and child health population. Through HB 1088, an additional \$63 million in state funds has been appropriated to the Oklahoma Health Care Authority (OHCA), the state's Medicaid agency, to gain a federal match to place nearly \$200 million total into the Oklahoma Medicaid system to increase provider and hospital reimbursement rates. Over the next year, it is anticipated that the OKDHS and the OHCA will finalize and implement plans to move from a six-month eligibility period to a 12-month eligibility period to facilitate continuity of care for Medicaid

recipients.

//2007/ Governor Henry signed the Medicaid Reform Act, HB 2842, on June 9, 2006. This legislation is the result of a bipartisan task force that met over the past year on Medicaid reform. Though the bill was the subject of intense debates throughout the legislative session and concerns were voiced by a host of advocacy groups, the bill was passed 93-1 in the House and 46-0 in the Senate before going to the Governor. The bill allows the OHCA to seek waivers to create a statewide program to provide for a more efficient and effective service delivery system that enhances quality of care and client outcomes in the Oklahoma Medicaid Program. The bill includes expansion of state funding for Medicaid reimbursement for doctors and hospitals as well as outlines the framework for a new program to be phased in that will facilitate a change in the Medicaid system from a one size fits all program to one that is tailored to each client's needs. Phase one of this new program is to be implemented within a contiguous area of the state with rural and urban characteristics. The OHCA will be required to evaluate and expand the program within two years after the rural and urban program becomes operational. Upon completion of the evaluation and, if found effective, the OHCA would be required to request a waiver for statewide expansion of the program from the Centers for Medicare and Medicaid Services. Legislative intent is that components of the program be phased in across the state within five years from the time the measure becomes law. Other key pieces of the legislation impacting the maternal and child health population include a provision for the OHCA to apply for a waiver to extend Medicaid benefits to persons up to age 23 who are enrolled full-time in an Oklahoma college or university, implementation of a new e-prescribing system and implementation of a disease management program.

The OKDHS revised its policy on review of Medicaid eligibility for children, and adults with children, from every 6 months to every 12 months. It is anticipated that this policy change will assist in continuity of care for these populations receiving services paid by Medicaid. //2007//
//2008/ The OHCA is placing a strong emphasis on communicating to Oklahomans its shift in policies and perception of its services out of the welfare system and into the health care system. Programs through the OHCA are no longer referred to as Medicaid. Programs, of varying names and benefits packages, fall under the umbrella of "SoonerCare".

July 1, 2007 policies for citizenship verification in determining eligibility for receipt of Medicaid were implemented. The OHCA has been working closely with other state agencies and providers of Medicaid funded services as state policy has been developed and training provided to lessen the impact of this new federal requirement. //2008//

//2009/ Citizenship verification continues to present a barrier with a negative impact in numbers of individuals covered by Medicaid, particularly related to children. Since implementation July 1, 2007, total enrollment has dropped 13,000 and continues to drop monthly. //2009//

On January 1, 2005, an expansion of the state Medicaid program began allowing breast and cervical cancer treatment for Oklahoma women less than 65 years of age. This expansion is made possible due to Governor Henry signing the Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund Act in May 2004 enabling the state to exercise the federal option under the State Medicaid Plan to provide breast and cervical cancer services for an expanded eligibility group of Oklahoma women. Women who meet eligibility criteria and have received an abnormal screen for either breast or cervical cancer are eligible for the full scope of Medicaid services through SoonerCare, the state's Medicaid program. Each woman will choose a primary care provider and receive needed specialty referrals through the primary care provider. In addition, she will have available care management services, transportation through SoonerRide, the SoonerCare Helpline and Nurse Advice Line. Eligible women will continue to receive services through SoonerCare until they are determined to no longer be in need of cancer treatment.

//2007/ The OHCA, the OKDHS, the OSDH (Chronic Disease Service and MCH), the Cherokee Nation and the Kaw Nation continue their partnership to provide services for low income and uninsured women between the ages of 19-65 with an abnormal screening result or in need of treatment for breast or cervical cancer. Through this partnership, 739 screening network

providers have been designated across the state and 3,074 women have received services through Oklahoma Cares. //2007//
/2008/ From January 1, 2005-December 31, 2006, Oklahoma Cares served 9,155 women, who met federal poverty level (FPL) guidelines and were between the ages of 19-65, with an abnormal screening result or in need of treatment for breast or cervical cancer. There are currently 768 screening network providers. //2008//
/2009/ From January 1, 2006-December 31, 2007, Oklahoma Cares served 15,447 women, who met federal poverty level (FPL) guidelines and were between the ages of 19-65, with an abnormal screening result or in need of treatment for breast or cervical cancer. There are currently 866 screening network providers. //2009//

On April 1, 2005 the Oklahoma Medicaid Family Planning Waiver was implemented. This 1115(a) research and demonstration waiver allows for family planning services to be provided to individuals who would otherwise not be eligible for Medicaid. Eligible individuals are uninsured women and men ages 19 and older with family income at or below 185% of the federal poverty level (FPL). This category includes women who gain eligibility for Title XIX (Medicaid) reproductive health services due to a pregnancy but whose eligibility ends 60 days postpartum. Medical benefits are limited to reproductive services currently covered under the state Medicaid plan.

/2007/ The OHCA, the OKDHS and the OSDH (MCH) continue to work closely on activities of the Section 1115(a) Medicaid Family Planning Research and Demonstration Waiver (SoonerPlan). MCH participates in routine meetings with the OHCA and the OKDHS to assure ongoing communications/coordination among the partners. MCH also participates in regularly scheduled conference calls the OHCA has with the Centers for Medicare and Medicaid Services related to the waiver. As of the end of March, individuals approved for SoonerPlan numbered 26,226. //2007//

/2008/ Oklahoma completed its second full year of SoonerPlan, the Section 1115(a) Medicaid Family Planning Research and Demonstration Waiver, March 31, 2007. The family planning waiver is maintaining a statewide caseload of around 20,000 serving uninsured women and men ages 19 and older with family income at or below 185% FPL. The OHCA, OKDHS and MCH continue to meet routinely to coordinate administration of SoonerPlan. Current activities are focused on developing/implementing outreach activities to promote the program and exploring a Medicaid policy change to facilitate a smoother transition to SoonerPlan when Medicaid eligibility comes to an end for women 60 days post-partum. The Centers for Medicare and Medicaid Services completed an onsite program visit in June 2006 with several components of the program identified as best practice models. //2008//

/2009/ As of May 2008, Oklahomans currently enrolled in SoonerPlan numbered 16,617, down 3,500 individuals since implementation of citizenship verification July 1, 2007. //2009//

Disabled children who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of their parent's income or resources may be eligible for services under Section 143 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (P.L. 97-248). This option allows children who are eligible for institutional services to be cared for in their homes. Only the child's income and resources are used in determining financial eligibility. The cost of care at home compared to the cost in an institutional setting is also used in determining eligibility. Children who meet eligibility requirements may be eligible for the full range of Medicaid covered services. The program implementation date is set for October 1, 2005 with income from the new tobacco tax that took effect on January 1, 2005 to provide state funds for this expansion.

/2007/ Approximately 148 families have applied for the TEFRA Program since it was implemented in November 2005 with a little over one-third of the applications approved. To be eligible for this program the child must meet the medical criteria for institutional or hospital level of care but be able to have their needs met in their own home. The most common reason children have been denied eligibility was for not meeting the medical criteria. //2007//

/2008/ Since the inception of the TEFRA Program 178 children have been approved with 149 children currently receiving services. The OHCA reports that the most common medical needs

being provided under TEFRA are pharmacy, durable medical equipment and supplies, speech and hearing services and private duty nursing. //2008//
//2009/ During the past year 220 children received services through the TEFRA Program. //2009//

Funds generated from the new tobacco tax are also to be used to support implementation of the Premium Assistance Program. Pending Centers for Medicare and Medicaid Services approval, October 1, 2005 is the target date the OHCA has identified for initiating the first phase of the Premium Assistance Program that is being implemented under a Health Insurance Flexibility and Accountability (HIFA) Waiver. This first phase of the Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC) allows persons who work for employers with less than 25 employees to become Medicaid eligible if household income is less than 185% FPL. Both the employee and the employer will have to pay a portion of the insurance premium. The state plans to devote an average of \$50 million per year to the initiative.

//2007/ As of May, 671 individuals were enrolled in the O-EPIC. HB 2842, the Medicaid Reform Act previously described, will increase the number of Oklahomans that may be provided with health insurance coverage through Medicaid by further expanding the O-EPIC eligibility to businesses with up to 50 workers. Another initiative to be implemented under O-EPIC at the end of this year is the provision of insurance coverage through Medicaid to individuals who do not work for a qualified employer (e.g., are self-employed or unemployed but seeking work). This option will benefit some young adults who were in the CSHCN population but are now over 18, no longer eligible for traditional Medicaid and do not meet the SSI disability definition. //2007//

//2008/ Legislation passed during the 2007 session that is anticipated to improve access to health care for the MCH population were SB 424 and HB 1225, both efforts to increase health insurance coverage statewide. SB 424, also known as the "All Kids Act", expands health coverage to children 18 years of age and younger whose family income is between 185% and 300% FPL. The measure requires the OHCA to provide assistance to families in gaining health care benefits for children in the program by offering subsidies toward the cost of privately sponsored health insurance, including employer-sponsored health insurance provided through the state's Premium Assistance Program, O-EPIC. If privately sponsored health insurance is not available, the OHCA would allow applicants to purchase access to the state administered health care benefit under the state's Premium Assistance Program. There is the potential to provide health insurance coverage for an additional 42,000 children presently uninsured. The new program will be administered by the OHCA with plans to use a voucher system to encourage participation in the private market place. The OHCA would be authorized to offer partial coverage to children who are enrolled in a high-deductible private health insurance plan or to offer a limited package of benefits to children in families who have private or employer-sponsored health insurance coverage that does not cover benefits, including dental or vision benefits. HB 1225 expands the opportunity for working Oklahomans to obtain insurance through their employment. HB 1225 expands eligibility for the O-EPIC by increasing the employee cap from 50 to 250 and the minimum income eligibility to include employees whose family's income does not exceed 250% FPL. //2008//

//2009/ The Centers for Medicare and Medicaid Services has not approved Oklahoma's request to expand health coverage to children 18 years of age and younger whose family income is between 185% and 300% FPL. In efforts to expand health care coverage, HB 2713 allows foster parents to qualify for the Insure Oklahoma Program (O-EPIC, Oklahoma's premium assistance program) and SB 1404 authorizes the OHCA to seek waivers or amendments to expand the premium assistance program to include non-profit employers with 500 employees or less. //2009//

Given the many positive changes occurring with health care services for the maternal and child health population, Oklahoma still faces significant challenges. These include the need to improve its system of emergency/trauma care; the continuing influx of the undocumented Hispanic population and a system of care not fully prepared to deal with absorbing the additional costs of serving this population, as well as differences in culture and language; loss of physicians providing obstetric care due to high malpractice premiums; closure of obstetric units in rural

hospitals due to loss of physicians and inability to meet standards of care for the provision of emergency obstetric care; and, inadequate reimbursement for health care services.

Oklahoma is working to improve its emergency medical system with the expected outcome of a fully implemented trauma system to save one in five lives currently lost. Trauma is the leading cause of death for Oklahomans ages 1 to 44 and costs Oklahomans more years of productive life than all diseases combined. Oklahoma is being divided into eight regions to pinpoint ambulance services and levels of emergency care available at each hospital within the region. Oklahoma trauma victims, classified as Priority 1, Priority 2 or Priority 3, depending on the type and severity of their injuries, will be triaged to the most appropriate hospital emergency room for treatment. The University of Oklahoma is currently the state's only Level 1 trauma center managing all types of trauma. Tulsa's St. John's and St. Francis hospitals have the state's only Level 2 trauma units. All other hospital emergency rooms are classified as either Level 3 or Level 4. On July 1, 2005, Oklahoma City and Tulsa began operating trauma triage and transfer call centers to help direct trauma victims and personnel to the most appropriate hospital emergency room. It is anticipated that this regionalization will also assist with and provide a model for addressing concerns currently faced by the state in relation to emergency obstetric and newborn care.

//2008/ In January, the new Children's Hospital opened on the University of Oklahoma Health Sciences Center (OUHSC) Campus in Oklahoma City. The opening concluded a two-year \$43 million construction and renovation project that was part of a \$100 million construction project to consolidate pediatric and women's services in the new Children's Hospital, and adult services and the Trauma Center at Presbyterian Tower. The new Children's Hospital has all private rooms; a women's and newborn pavilion; 88-bed neonatal intensive care unit; a neonatal "village" where parents can room-in with their newborns; a 25-bed pediatric intensive care unit that provides the state's only acute care pediatric dialysis; an emergency department; pediatric stem cell transplant unit; pediatric catheterization lab; and, surgery and radiology departments.

Saint Francis Health System in Tulsa anticipates the completion in January 2008 of their new \$72.6 million, 104-bed Children's Hospital. The new Children's Hospital will have specialized units for general pediatrics, oncology/hematology, pediatric surgery, pediatric intensive care and pediatric cardiology services. The hospital will also provide services including x-ray, computed tomography (CT) scan, pharmacy and outpatient and inpatient infusion therapies. Rooms for families to stay on-site with children in the intensive care unit will also be available. //2008//
//2009/ Rural ambulance service in Oklahoma has been a focus of ongoing concern with health care providers and the Legislature. Rural counties are losing residents yet still need emergency medical services available. Many ambulance services have been financially unable to continue operation. The Legislature did provide state funding toward relief with planning to continue on restructuring to a regional system.

In February 2008, the University of Oklahoma Regents approved plans for a \$50 million gift from the George Kaiser Family to establish a School of Community Medicine in Tulsa. The goal, to improve the health status of underserved Oklahomans. Funds will be used to recruit and hire new faculty members, for scholarships and financial aid for medical students and residents and for startup and infrastructure. //2009//

Discussion is currently underway between the OHCA, the OKDHS and the OSDH regarding Medicaid expansion of health coverage for uninsured and underinsured pregnant women under the State Children's Health Insurance Program (SCHIP). This expansion would allow Medicaid to cover services for these pregnant women for the benefit of the health of the unborn child. Currently these women are receiving their health care primarily through the statewide county health department system which includes contracted services through community clinics in Oklahoma and Tulsa counties; the University of Oklahoma and Oklahoma State University's teaching environments (clinical and hospital); and, the state's federally qualified community health centers (FQHCs).

//2007/ The OHCA, the OKDHS and the OSDH continue to work collaboratively on strategies to address the perinatal health care system and will be exploring options that may be taken as a

result of the Medicaid Reform Act passed this year. The OHCA and the OSDH (MCH) conducted six regional meetings across the state February through May with public and private perinatal health care providers, rural and urban, primary to tertiary, to gain information on ideas for changing Medicaid policy as well as state health care systems to improve access and delivery of perinatal services. //2007//
/2008/ A Medicaid policy revision that would have provided the ability to offer prenatal care to women using the unborn child option under the SCHIP was not taken forward due to lack of support from the Legislature and Governor.

Other changes in Medicaid policy have occurred this year resulting from input received from the regional meetings held in the spring of 2006 and ongoing routine meetings of the OHCA/OSDH (MCH) Perinatal Advisory Task Force, an advisory group of medical providers, professional medical and nursing organizations and interested advocates that is co-chaired by the Chief of MCH. Ultrasound and other diagnostic benefits have been expanded, dental care benefits have been implemented and a psychosocial assessment has been developed and implemented. Policy changes for restructuring fees to allow for co-management of high risk maternity clients, coverage for licensed clinical social work services, and coverage for genetic counseling and certified lactation consultant services are being explored. An electronic application that will automatically add a newborn to its mother's existing SoonerCare (Medicaid) case is also being developed. This will facilitate provision of medical benefits to the newborn as the mother will leave the hospital with a printout showing the infant's full eligibility and assigned client identification number. The infant will receive a permanent client identification card through the mail in three to five days.

Abortion was a highly debated issue among the Legislature, Governor and health care providers. Governor Henry vetoed an anti-abortion bill prohibiting use of state funds and resources to perform abortions in the state. The Oklahoma State Medical Association and other professional medical and nursing groups also opposed this bill. A second bill, SB 139, will become law without the Governor's signature. Under the Oklahoma Constitution, a bill approved by the Legislature automatically becomes law after five days if the Governor declines to take action on it. SB 139 provides for exemptions for cases of rape and incest, and includes language that allows for a physician to discuss options with his or her patients, language not in the vetoed bill. Health care providers remain concerned that uninsured and underinsured women with troubled pregnancies will not receive medically qualified abortions. Of specific concern is the bill fails to provide exemptions for instances of a lethal birth defect. //2008//

/2009/ Soon to be Sooners (STBS), a Medicaid policy revision that provides the ability to offer prenatal care to women using the unborn child option under the SCHIP, went into effect April 1, 2008. This allows all qualified women to receive prenatal benefits without respect to citizenship.

Medicaid policy has also been revised for reimbursement of co-management of high risk maternity clients, licensed clinical social work services, genetic counseling and certified lactation consultant services.

The electronic application (NB1) that will add a newborn to its mother's existing SoonerCare (Medicaid) case is being piloted. This change will facilitate the newborn having full Medicaid eligibility before being discharged from the hospital.

A law requiring that women receive an ultrasound prior to an abortion, SB 1878, passed in April 2008. The health provider must allow the mother to view the ultrasound if she chooses. //2009//

The public health system in Oklahoma includes the OSDH, county health departments in 67 of 77 counties with 87 service sites in these organized counties, and contract community providers. The city-county health departments in Oklahoma and Tulsa counties have their own personnel systems and are administratively separate from the state system. The remaining county health

departments are administrative units of the OSDH. The CSHCN Program provides services in all 77 counties in the state. In addition, two medical schools are located in Oklahoma, one in Tulsa and the other in Oklahoma City, which also maintains a Tulsa campus. The College of Public Health within the University of Oklahoma Health Sciences Center (OUHSC) campus in Oklahoma City also contributes significantly to the advancement of public health in Oklahoma through its education and training programs.

/2007/ Oklahoma received \$2,730,000 this year as part of a \$14.7 million five-year award from the Substance Abuse and Mental Health Services Administration (SAMSHA). Through this cooperative agreement, the Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS) will provide leadership in facilitating the transformation of Oklahoma's mental health service delivery system into a system driven by consumer and family needs that focuses on building resilience and facilitating recovery. //2007//

/2009/ Oklahoma added an additional county health department to its organizational structure. Osage County residents are receiving services at a temporary location with plans to expand services when the new county health department is completed. //2009//

There are currently eight FQHCs in Oklahoma operating 17 access sites: Central Oklahoma Family Medical Center (Konawa); Family Health Center of Southern Oklahoma (Tishomingo); Kiamichi Family Medical Center (Battiest); Mary Mahoney Memorial Health Center (Langston, 2 Oklahoma City sites); Morton Comprehensive Health Services (Nowata, 3 Tulsa sites); Oklahoma Community Health Service, Inc. (Oklahoma City, Ft. Cobb, Tipton); Northeastern Oklahoma Community Health Centers (Hulbert, Tahlequah, Muskogee); and, Stigler Health and Wellness Center (Stigler). During the 2005 legislative session, over two million dollars were appropriated to support existing FQHCs and expand Oklahoma FQHCs. Just over a million of these funds is to be used for the reimbursement of care provided to uninsured clients. Another million is to be used for enhancing and developing FQHCs in Oklahoma (e.g., contracting for grant writing services, providing transitional operational assistance for new FQHC organizations). Oklahoma also received \$2.85 million this year for four new community health centers (Clayton, Fairfax, Idabel and Tulsa) from the Health Resources and Services Administration, Bureau of Primary Health Care.

/2007/ Federal and state funding currently supports 11 community health centers with 20 access sites across Oklahoma. Central Oklahoma Family Medical Center (Konawa); Mary Mahoney Memorial Health Center (2 Oklahoma City sites, Langston); Community Health Connections (Tulsa); Fairfax Medical Facilities (Fairfax); Family Health Center of Southern Oklahoma (Tishomingo); Kiamichi Family Medical Center (Battiest, Idabel); Morton Comprehensive Health Services (3 Tulsa sites, Nowata); Oklahoma Community Health Service, Inc. (Oklahoma City, Ft Cobb, Tipton); Northeastern Oklahoma Community Health Services (Hulbert, Tahlequah); Stigler Health and Wellness Center (Stigler); and, Pushmataha Family Medical Center (Clayton). //2007//

/2008/ There has been no change in the number of community health centers and access sites this year. The Oklahoma Primary Care Association continues to work with multiple communities as steps are being taken for submission or resubmission of federal funding applications to support development or enhancement of service delivery systems in Oklahoma City, Lawton, Alfalfa County, Sequoyah County and Tulsa. //2008//

/2009/ Federal and state funding currently supports 13 community health centers with 26 access sites across Oklahoma. New sites include Great Salt Plains Health Center (Cherokee); Mary Mahoney Memorial Health Center (1 new Oklahoma City site); Fairfax Medical Facilities (Hominy); Lawton Community Health Center (Lawton); and, Stigler Health and Wellness Center (Sallisaw, Eufaula). //2009//

Native Americans are increasing their visibility related to investments being made toward improving Oklahoma's health. Newspaper stories and paid television spots depict the services and changes occurring. Access to health care for tribal members in the rural areas of the state is through tribe specific health facilities. Intertribal urban clinic facilities are found in Tulsa and Oklahoma City and hospitals operated by Indian Health Services are located in Claremore, Tahlequah and Lawton.

/2007/ Tribal 2-year colleges are expanding in Oklahoma. The Comanche Nation College

(Lawton) was chartered in 2002 and the Muscogee (Creek) Nation College was chartered two years later in 2004. The Cheyenne-Arapaho Tribal College (Weatherford) and the Pawnee Nation College (Pawnee) will open in 2006. The goal of the educational institutions is to preserve tribal history, culture and language. //2007//

Given the changing culture, economics, political climate and health care systems in Oklahoma, creative and flexible prevention and intervention approaches are required to adequately address the health needs of the maternal and child health population. Maternal and child health leaders and other state health leaders are continuously challenged to enhance existing health systems to assure a comprehensive quality system of health care. Ongoing collaborative partnerships are key to their success.

B. Agency Capacity

Under the provisions of Public Law 97-35, Section 509(b), the OSDH and the OKDHS share the administration of the Oklahoma Title V Program. Administration of services to women, infants, children and adolescents is provided by the OSDH through MCH. Administration of services to children with special health care needs is administered by the OKDHS. 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 agencies to include responsibilities for the Title V Block Grant annual report and application. Copies of the memorandum of agreement may be obtained by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.

/2007/ The memorandum of agreement between the OSDH and the OKDHS is reviewed annually, edited as mutually agreed upon by both agencies and signed by the Commissioner of Health and the Director of the OKDHS. A copy of this year's agreement may be obtained by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.

Meetings to discuss strategies to improve collaboration on planning, development and evaluation of state CSHCN services to include support of the OSDH programs providing services for the CSHCN population have been initiated by the OSDH with the OKDHS. The outcomes of these meetings are to enhance the existing infrastructure services for the CSHCN population, assure the needs of the CSHCN population are being routinely monitored to identify changes and facilitate needed adjustments in CSHCN services based on identified state needs. //2007//

/2008/ The memorandum of agreement between the OSDH and OKDHS for the 2008 grant period has been signed and is on file in MCH Administration. A copy of this year's memorandum of agreement is attached. Copies of the signed agreement may be obtained by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. //2008//

/2009/ The memorandum of agreement for 2009 has been signed with both MCH and CSHCN maintaining a copy of the agreement on file. A copy of the agreement is attached. Electronic or hard copy is available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. //2009//

MCH and CSHCN schedule monthly meetings to plan and coordinate activities. During these meetings, staff share updates on services and collaborate on strategies to improve services. In addition, these meetings provide the opportunity to coordinate activities in preparing the Title V Block Grant for submission. MCH coordinates the compilation of all MCH and CSHCN information for submission of the needs assessment, annual report and application with CSHCN providing MCH with its written responses to be incorporated into each of the grant areas. These

meetings also provide a forum to engage other OSDH programs such as Newborn Metabolic Screening, Genetics, Early Intervention (SoonerStart), Dental and the Women, Infants and Children Supplemental Nutrition Program (WIC) in discussions and collaborative planning. ***/2009/ MCH and CSHCN have rescheduled these planning meetings and now meet every other month. In the past year, staff from the Oklahoma Family Network have been engaged in these meetings and provide input from the parent and family perspective. //2009//***

MCH partners with all Services in the Family Health Services (FHS): Child Guidance; Screening, Special Services and SoonerStart; Family Support and Prevention; Dental; and, WIC. MCH funds directly support services provided by Dental Service (statewide dental needs assessment of third grade children in public schools, community-based dental clinics and dental health education) and Screening, Special Services and SoonerStart (newborn metabolic and hearing screening, and birth defects registry).

/2007/ Additional MCH funds are being prioritized to maintain critical infrastructure services in newborn metabolic and hearing screening due to reductions in other federal funding sources. //2007//

MCH maintains a strong relationship with the OSDH Community Health Services (CHS). The CHS receives MCH funds for direct, enabling, population-based and infrastructure services delivered through the statewide county health department system. The county health department system consists of 67 county health departments with 87 service sites. Monthly meetings occur between MCH and the CHS to coordinate budget and health care service issues that arise.

/2009/ With the addition of a county health department in Osage County, there are now 68 of 77 counties with county health departments increasing services sites to 88. //2009//

MCH works closely with all areas within the OSDH. 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. MCH also participates on key agency committees and work groups that focus on data systems, analysis, and utilization; retention of personnel; personnel budgeting; cultural respect; agency forms; and, compliance with the Health Insurance Portability and Accountability Act (HIPAA). The Deputy Commissioner of the FHS has two meetings a month with Chiefs of all Services administratively organized under the larger FHS. These meetings provide the opportunity for the Chief of MCH to interact with all Chiefs in FHS and to discuss collaborative activities. MCH works closely with FHS Services on health issues such as dental care of mothers and children, nutrition, childhood obesity, injury prevention, newborn hearing screening, newborn metabolic screening, genetics, prevention of birth defects, teen pregnancy prevention, school health, family resource and support services, child care and early childhood.

In addition to ongoing collaborative activities and meetings throughout the year, MCH facilitates annual meetings each year with the CHS, Dental Service, Public Health Laboratory and Screening, Special Services and Soonerstart to discuss activities to be accomplished in the next state fiscal year and budgeting of Title V MCH funds within these Services' budgets to support planned activities. These meetings occur in the spring of each year to better coordinate establishment of annual state fiscal year budgets (July 1 - June 30).

Services for the maternal and child health population are also accomplished through professional service agreements (e.g., physician, nurse practitioner), vendor contracts (e.g., ultrasounds, supplies), contracts with other state governmental agencies and invitations to bid (ITBs). Oklahoma City County Health Department and Tulsa City County 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 or the ITB process.

/2007/ To enhance the capacity of the OSDH to provide culturally appropriate services, the OSDH

requires that each OSDH employee complete a minimum of 3 hours of training on cultural competency/respect each year as part of each employee's annual Performance Management Process (PMP). In addition, the OSDH Office of Minority Health provides leadership in collaboration with the Oklahoma State University and the University of Oklahoma Medical Center in the provision of the Health Service Interpreter Certification Program available to public and private health care providers across the state. This training, implemented in early federal fiscal year (FFY) 2006, is the first ever certified interpreter program in Oklahoma. It consists of 20 hours of direct contact instruction in language and cultural aspects of communication, followed by a written exam in English and a verbal exam in the target language selected. The training covers medically specific terminology, linguistic accuracy, legal and ethical role of health service interpreters, client safety and HIPAA regulations on confidentiality. //2007//

CSHCN oversees the provision of services to children receiving SSI within the state by providing training and guidance to the 45 social services specialists located in OKDHS county offices across the state. These social services specialists are responsible for writing and monitoring services plans for all SSI children who receive benefits through the OKDHS. All equipment and services available through Title V CSHCN must be pre-approved by the state office. /2007/ The OKDHS now has 77 social services specialists across the state who complete and monitor service plans and oversee the provision of services to children who receive SSI and Medicaid. Families of children who receive SSI but do not receive Medicaid are also contacted to assure they are informed of services available through CSHCN. //2007//

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 contracting with a respite care facility, the state's referral and resource network for CSHCN, and a program that provides integrated community-based services for CSHCN, CSHCN also meets with these contractors at least quarterly to ensure CSHCN 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. /2007/ CSHCN funds a parent advocate position in one of the neonate clinics and will be providing funding to the Developmental Disabilities Services Division (DDSD) within the OKDHS this year to support a family network which trains and certifies individuals to be mentors to families of children with autism. //2007//

An attachment is included in this section.

C. Organizational Structure

In Oklahoma, state health and human services are loosely organized under the Cabinet Secretary for Health and the Cabinet Secretary for Human Services who are appointed by the Governor. Terry Cline, Commissioner of the DMHSAS, is the Cabinet Secretary for Health and Howard Hendrick, Director of the OKDHS, is the Cabinet Secretary for Human Services. Health and human services agencies in Oklahoma include the OSDH, OKDHS, DMHSAS, Department of Rehabilitation Services, Office of Juvenile Affairs, OHCA and Oklahoma Commission on Children and Youth. The Department of Corrections and the OSDE are under different cabinet secretaries. The Oklahoma Commission on Children and Youth 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 Oklahoma Commission on Children and Youth.

Oklahoma administers the Title V Program through two state agencies, the OSDH and the OKDHS. The OSDH, as the state health agency, is authorized to receive and disburse the Title V MCH 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 Title V MCH Program is located in the OSDH within the FHS. The FHS is organizationally placed under the Commissioner of Health. Suzanna Dooley, M.S., A.R.N.P., Chief of MCH, is directly responsible to the Deputy Commissioner of the FHS, Edd Rhoades, M.D., M.P.H., who is directly responsible to the Commissioner of Health, James M. Crutcher, M.D., M.P.H. Organizational charts of the OSDH, the FHS and MCH are on file in MCH Administration with electronic versions or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov.

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, B.A., is the Director of the CSHCN Program and Program Manager for the HRMS. Karen Hylton is directly responsible to Jim Struby, B.A., Programs Administrator. Jim Struby is directly responsible to Mary Stalnaker, M.S.W., Family Support Services Division Director. Mary Stalnaker is directly responsible to Farilyn Ballard, M.S.W., Chief Operating Officer Human Service Centers who is directly responsible to the Director of the OKDHS, Howard Hendrick, J.D. Organizational charts of the OKDHS, Family Support Services Division, HRMS and CSHCN Program are on file in MCH Administration with electronic versions or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. /2007/ Organizational charts are attached. The organizational structure for MCH and CSHCN is unchanged. //2007//

/2008/ Terry Cline, PhD, resigned as Commissioner of the Oklahoma DMHSAS and Cabinet Secretary for Health and accepted the position of Administrator for SAMHSA. Dr. Cline was nominated by President George W. Bush on November 13, 2006 and confirmed by the U.S. Senate on December 9, 2006. In February 2007, Governor Brad Henry appointed the Commissioner of Health, James M. Crutcher, M.D., M.P.H., as the new Oklahoma Cabinet Secretary of Health.

Organizational structure of the OSDH changed in October 2006 with Rocky McElvany, M.P.H., named Chief Operating Officer. This position assists the Commissioner of Health with day-to-day organizational executive issues and complex administrative issues; advises the Commissioner of Health on health planning, policy analysis and agency opportunities; and, represents the Commissioner of Health and OSDH as needed. Organizational charts of the OSDH and the FHS are on file in MCH Administration with electronic versions or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. The MCH organizational chart is attached.

Two positions in the OKDHS organizational structure changed this past year. Frank Gault, who was on the CSHCN Program staff for many years and was responsible for various aspects of the CSHCN contracting process as well as block grant reporting, retired after 34 years of service to the OKDHS. John Johnson, MEd, has been named as his replacement. Farilyn Ballard, Chief Operating Officer for the Human Services Centers, also retired and was replaced by Marq Youngblood, MHR. Organizational charts of the OKDHS, Family Support Services Division and HRMS are on file in MCH Administration with electronic versions or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. The CSHCN organizational chart is attached. //2008//

/2009/ There have been no changes to agency structure of significant impact to MCH or CSHCN. Organizational charts of the OSDH and the OKDHS are on file in MCH Administration with electronic or hard copy available by contacting Paula Wood at (405) 271-4480 or by e-mail at paulaw@health.ok.gov. MCH and CSHCN organizational charts are attached. //2009//

An attachment is included in this section.

D. Other MCH Capacity

MCH consists of MCH Administration and three Divisions: Child and Adolescent Health, Women's Health and MCH Assessment. MCH Administration consists of Service level administrative support staff as well as the Public Health Social Work Coordinator, MCH Nutrition Consultant and MCH Family Advocate who work across all MCH programs. The Child and Adolescent Health Division staff are primarily nurses and health educators. Programs and services include child health clinical services, school health, adolescent health, early childhood, child care, suicide prevention, teen pregnancy prevention and injury prevention. The Women's Health Division staff are nurses, nurse practitioners and health educators. Programs and services include maternity, family planning 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 also responsible for carrying out statewide population-based surveillance to include the Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the Youth Risk Behavior Survey (YRBS), the Middle School Risk Behavior Survey, the Oklahoma Fifth Grade Health Survey and the Oklahoma First Grade Health Survey.

/2007/ The MCH Family Advocate position was renamed MCH Family Specialist. With the resignation of this staff person in December, MCH has taken the opportunity to explore with other programs in the FHS and state partners options for restructuring the position. Based on input received, two half-time positions are being established as Family Specialists. The parents in these positions will not only be a resource to MCH but to all FHS programs and other state partners, as needed, participating in development, implementation and evaluation of state policy and services for the maternal and child health population. //2007//

/2008/ MCH has been unsuccessful in recruiting parents into the part-time Family Specialist positions. Discussions with family organizations have led MCH to reconsider these positions and to explore alternative ways of using these funds to support involvement of parents/guardians involved with Oklahoma family organizations in MCH planning and services development. As indicated under Public Input, onsite technical assistance from Family Voices Inc. is being planned. This technical assistance will focus on identifying strategies to enhance family input in MCH and CSHCN activities. //2008//

/2009/ Technical assistance was received from Family Voices Inc., on September 25, 2007. A specific strategy resulting from the technical assistance was the planning and presenting of a family/professional partnerships conference, Joining Forces: Supporting Family/Professional Partnerships, in Oklahoma City on April 26, 2008. This conference provided families and state professionals with information on the importance of family/professional partnerships to help increase family participation in development, implementation and evaluation of state programs serving the MCH (inclusive of CSHCN) population. MCH and CSHCN linked with additional families and family organizations during this conference and plan to utilize these resources in program planning and evaluation activities. //2009//

Suzanna Dooley, M.S., A.R.N.P., is the Title V MCH Director and Chief of MCH. Beth Ramos, M.P.H., is the Director of the Child and Adolescent Health Division. Cedar Jackson, M.S., A.R.N.P., is the Director of the Women's Health Division. Dick Lorenz, M.S.P.H., is the Director of MCH Assessment. Jim Marks, M.S.W., Public Health Social Work Coordinator, Nancy Bacon, M.S., R.D./L.D., C.D.E., MCH Nutrition Consultant, Lyn Thoreson, MCH Family Advocate, and Paul Patrick, M.P.H., MCH Data Contact, are also part of MCH leadership. The Child and Adolescent Health Division is currently in the process of identifying a new medical director as the previous medical director resigned June 30, 2005 to pursue other interests. Pamela Miles, M.D., from the Department of Obstetrics and Gynecology, OUHSC campus, serves as the Medical Director to the Women's Health Division through a contractual agreement. Brief biographies of the leadership for MCH are attached.

/2007/ Beth Ramos, M.P.H., the Director of the Child and Adolescent Health Division passed away unexpectedly in October 2005. Suzanna Dooley, M.S., A.R.N.P., Title V MCH Director and

Chief of MCH, has served as the Interim Director for the Child and Adolescent Health Division as staff have adjusted to the loss and decisions made as to refill of the position. A new Director is to be hired this summer. As previously indicated, the MCH Family Advocate position was renamed MCH Family Specialist. Lyn Thoreson resigned from this position in December 2005. As a result of exploring restructuring of the position, two half-time MCH Family Specialist positions have been established with plans to fill both positions this summer. Jim Marks, M.S.W., Public Health Social Work Coordinator, has resigned his position as of the end of July. The position is to be refilled this summer. Edd Rhoades, M.D., M.P.H., Deputy Commissioner of the FHS, is currently serving as the Medical Director for the Child and Adolescent Health Division. Brief biographies of the leadership for MCH are attached. //2007//

/2008/ August 1, 2006, Jim Marks, M.S.W., was hired as the Director of the Child and Adolescent Health Division. December 14, 2006, Margaret DeVault, M.S.W., was hired as the Public Health Social Work Coordinator. As previously indicated, the MCH Family Specialist positions have been reconsidered and MCH is now exploring use of the funds from these positions to support involvement of parents/guardians from Oklahoma family organizations in MCH planning and service development activities. On June 22, 2007 Cedar Jackson, Director of the Women's Health Division, resigned to pursue other personal work goals. This position will be posted with the intent to refill this fall. There have been no other changes in MCH administrative structure. Brief biographies of the leadership for MCH are attached. //2008//

/2009/ Paul Patrick, MCH Data Contact, resigned September 2008. Dick Lorenz, Director, MCH Assessment assumed responsibilities as the MCH Data Contact during an interim period until Robert Feyerharm M.A., was hired as the MCH Senior Biostatistician February 4, 2008 and assumed this responsibility. Jill Nobles-Botkin, M.S.N., C.N.M., accepted the position of Director, Women's Health Division on March 1, 2008. Alicia Lincoln M.S.W, M.S.P.H., began assisting with development of the Title V Block Grant Annual Report and Application. There have been no other changes. Brief biographies of the leadership for MCH are attached. //2009//

The MCH central office organizational chart currently shows 40 full time equivalent (FTE) positions of which 38 are currently funded for 2006. Of these, 27.05 positions are funded on Title V Block Grant funds with the remaining 10.95 positions funded on state and other federal grant funds.

/2007/ MCH currently has 41.5 FTE positions funded for state fiscal year (SFY) 2007. Title V funds 25.4 of these FTE with the remaining 16.1 FTE funded on other state and/or other federal funds. //2007//

/2008/ For SFY 2008, MCH has 41.75 FTE positions funded. Title V funds 26.65 of these FTE with the remaining 15.1 FTE funded on other state and/or federal funds. //2008//

/2009/ For SFY 2009, MCH has 41.6 FTE funded. Title V funds 24.95 of these FTE with the remaining 16.65 FTE funded on other state and/or federal funds. //2009//

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, the MCH Family Advocate and other MCH staff as identified depending on the area(s) being addressed. These meetings assist MCH to accomplish 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. On every other Monday morning, MCH has a routine staff meeting 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 general staff meeting every other month that brings all MCH staff together for agency updates, training and Service-wide planning.

Karen Hylton, B.A., Program Manager for HRMS, is the Title V CSHCN Director. Other state office staff includes Frank Gault, M.S.W., Programs Field Representative, Family Support Services Division and Mike Chapman, B.A., Supplemental Security Income-Disabled Children

Program (SSI-DCP). Robert Brown, M.D., is the Medical Director for the OKDHS and also the CSHCN Program. Brief biographies of the CSHCN Program leadership are attached.

/2007/ There have been no changes to staff for the CSHCN Program. Brief biographies are attached. //2007//

/2008/ Frank Gault retired this past year after 34 years of service with the OKDHS. He was replaced by John Johnson, MEd, who formerly supervised local OKDHS county staff who had responsibility for determining eligibility and providing case management for the aged, blind and disabled population, including children who receive SSI. Brief biographies of the leadership for CSHCN are attached. //2008//

/2009/ There have been no changes to staff for the CSHCN Program. Brief biographies are attached. //2009//

The system used by the 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.

Approximately 48 FTE were involved with the CSHCN Program during the last fiscal year.

/2007/ The OKDHS now has over 70 FTE who work in county offices throughout the state and are responsible for ordering equipment and diapers provided through the SSI-DCP as well as ensuring any other needs that can be met through the CSHCN Program are provided. //2007//

CSHCN has parent involvement to include 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).

/2007/ In addition to continuing to provide support for parent positions with the OASIS, the Oklahoma Infant Transition Project and the Tulsa Neonate Clinic, CSHCN also supports parent advocates through contracts with the OUHSC Autism Clinic and the Sooner SUCCESS Project at the OUHSC Child Study Center. //2007//

/2008/ CSHCN is contracting with the Oklahoma Family Network (OFN), a parent organization that provides mentoring services to other parents of children with special health care needs. Joni Bruce, Executive Director of OFN, was designated by MCH and CSHCN to be the fifth Oklahoma delegate to the Association of Maternal and Child Health Programs (AMCHP). //2008//

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

MCH and CSHCN meet monthly with the State Interagency Coordination Council, which was set up by Sooner SUCCESS, a CSHCN contractor. This Council consists of representatives from parent organizations, the Medical Home Program and other state agencies.

/2007/ 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 Spanish speaking callers. The OASIS also maintains a website (<http://oasis.ouhsc.edu/>) for information and referral services. //2007//

An attachment is included in this section.

E. State Agency Coordination

The OSDH and the OKDHS coordinate closely with other state health and human services agencies. The Commissioner of Health and the Director of the OKDHS coordinate state planning and activities for shared priorities on a regular basis with Directors of other state agencies. Meetings occur more frequently at particular times of the year, such as when the state Legislature

is in session, than at other times of the year.

The OSDH and the OKDHS enjoy a particularly close and supportive relationship with the OHCA, the state Medicaid agency. These relationships have been instrumental in facilitating the development and implementation of services to benefit the maternal and child health population (e.g., breast and cervical cancer treatment, family planning waiver, TEFRA). Staff from the three agencies work together daily using each other's expertise as resources. Communication is continuous with input openly sought from each of the agencies as they accomplish their responsibilities.

//2008// The OSDH will continue to work with the OHCA this coming year as the OHCA changes Medicaid policy to move the OSDH from a clinic provider type to a public health provider type, a more appropriate designation for services of the OSDH. The Chief of MCH has been involved in these meetings and will continue to have the opportunity to provide input as this change continues.

The OHCA/OSDH (MCH) Perinatal Advisory Task Force, initiated in May 2005, has seen several accomplishments during this current grant period as a result of ongoing input received from health care providers, professional medical and nursing organizations, advocates and family representatives. Medicaid policy had been changed to include expansion of ultrasound and other diagnostic testing benefits, provision of dental benefits and development and reimbursement of a psychosocial assessment. The task force will continue to meet through the next year as additional changes to improve perinatal services are explored. These meetings will occur every odd numbered month on the third Tuesday from 5 p.m. to 7 p.m. at the OHCA. The Chief of MCH co-chairs this task force.

With the success of the OHCA/OSDH (MCH) Perinatal Advisory Task Force, the OHCA Director of Child Health and the Chief of MCH, with support from leadership of the two state agencies, 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. at the OHCA. Members of the Child Health Advisory Task Force include representatives from the two university medical centers; state medical, nursing and other health care associations; Head Start; Smart Start Oklahoma; family organizations; and, other state health and human services organizations. Seven priority topics have been identified by task force members for focus: utilization of primary care; mental health; obesity; reimbursement structure; oral health; immunizations; and, accessing specialty care.

A multi-year (2004-2010) memorandum of agreement between the OSDE and 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. Currently an orientation manual for new school health nurses is being finalized. MCH is also working with the OSDE to develop a training manual for school fitness testing and a database for local public schools to enter school fitness data into for use by the local school and in aggregate form by the state. //2008//

//2009/ Changes to Medicaid facilitated through work of the OHCA/OSDH Perinatal Advisory Task Force have included reimbursement for social work services, genetic counseling, certified lactation consultant services and policy changes to the Medicaid reimbursement structure to facilitate co-management of high-risk prenatal clients (e.g., community-based family practice or obstetric physician collaboratively managing client's care with a physician specialized in maternal-fetal medicine at a tertiary center).

MCH supported travel to Oklahoma on March 18-19, 2008 of the Medical Director, Curtis L. Lowery M.D., and Program Director, Tina Benton B.S.N., R.N., of the Arkansas ANGELS (Antenatal and Neonatal Guidelines, Education and Learning System) Program to provide an overview of this program and consultation to the Perinatal Advisory Task Force members on next steps to consider in developing similar components in Oklahoma. As a

result of the visit, the Perinatal Advisory Task Force formed two workgroups, one to explore implementation of standard perinatal guidelines and the other to explore expansion of telemedicine. MCH and OHCA staff are planning a trip to Arkansas July 16 and 17, 2008 to observe the ANGEL Program.

The OHCA/OSDH Child Health Advisory Task Force has met routinely every other month with a focus on exploring efforts to increase the number of children with Medicaid having routine health check-ups. A related priority topic is looking at strategies to increase the number of young children receiving lead screening.

The OSDH has been collaborating closely with the OHCA on a multi-year grant received by the OHCA from the Centers for Medicare and Medicaid Services to transform Oklahoma's Medicaid procedure to apply for and establish Medicaid eligibility. The focus is to establish an online enrollment process that allows members or potential members of SoonerCare to apply and receive eligibility electronically. Changes are expected to eliminate many of the barriers that prevent potential members from applying for coverage by: increasing access to and enrollment in SoonerCare coverage by creating an online enrollment process; reducing stigma associated with obtaining and completing SoonerCare applications; improving the availability of hours a potential member can access and complete the SoonerCare application; and, reducing the amount of time required to complete and submit the SoonerCare application, resulting in timelier eligibility determinations. Efficiency of the enrollment process will be increased through decreasing overall administrative costs associated with the current paper application process. In addition, data integrity and timeliness of reporting will improve.

Collaboration is ongoing with the OSDE regarding fitness testing. Senate Bill (SB) 519 was signed by Governor Brad Henry May 23, 2008 directing the OSDE and OSDH to facilitate development and implementation of a pilot in at least 15 elementary schools during the 2008-2009 school year. //2009//

Another close relationship is with the University of Oklahoma, particularly the 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 training 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 Department of Pediatrics and University of Oklahoma (OU) Physicians are key partners in supporting the SAFE KIDS Oklahoma, a state level coalition focused on prevention of childhood injuries. The 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.

//2007/ The OSDH and the OUHSC College of Medicine have partnered to provide medical students the opportunity to gain public health experience. Beginning in the summer of 2005 and continuing this summer, medical students between their first and second year of medical school, who have an interest in learning more about public health, apply and are selected for summer employment at the OSDH. The medical students are matched with program areas of interest. The Chief of MCH has mentored a medical student each of these years. //2007//

//2009/ A medical student began with MCH June 2, 2008 and will work through the end of July. The student will assist with activities focused on reduction of infant mortality, safe sleep and mystery calling, a quality improvement activity of the family planning program. //2009//

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 receives support from both state agencies. The OSDH and the OKDHS along with other health and human services state agencies participate in planning meetings and provision of practicum experiences. The MCH Family Advocate is an Oklahoma LEND Family Mentor and assures students gain exposure to the issues faced by families in accessing and maintaining needed services for a child with special needs.

/2007/ The MCH Family Specialists will be linked with the Oklahoma LEND Program once hired. //2007//

/2008/ As indicated previously, MCH has been unsuccessful in recruiting for the part-time Family Specialist positions and has been exploring with family representatives of other organizations alternative ways to support involvement of parents/guardians in MCH planning and services development. The parent on staff with the Oklahoma Lend Program is one of the family representatives providing input to MCH and will be participating as part of the technical assistance visit being planned with Family Voices, Inc. //2008//

/2009/ As a result of the technical assistance received from Family Voices, Inc., in September 2007, the Joining Forces: Supporting Family/Professional Partnership Conference was held in Oklahoma City on April 26, 2008. The conference was a first step in development of a statewide network of families who are interested in partnering with state agencies and organization to provide input on the development, implementation and evaluation of programs. The conference presented the opportunity for state agencies/organizations and families to learn from each other and to link with one another based on needs and interests. //2009//

Early childhood is a priority area of the state for which both agencies are providing leadership through collaborative partnerships. Through support of the Oklahoma Partnership for School Readiness (OPSR), a legislatively established public-private partnership, Oklahoma is finalizing a state plan for early childhood to be implemented in SFY 2006. Partnerships with the OSDE, Head Start, local 4-year old programs and child care providers are facilitating establishment of full day kindergarten, early Head Start programs and improved requirements and guidelines for licensed child care facilities.

/2007/ The state plan for early childhood developed with support from a Maternal and Child Health Bureau (MCHB), Community Integrated Services System (CISS) Grant was implemented this year. 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. //2007//

/2009/ The Early Comprehensive Childhood Systems (ECCS) Grant entered its third year of activities. The grant continues to provide critical infrastructure support to state and community-based activities. Eighteen Smart Start community-based initiatives are currently active. Plans to expand to additional communities have been hindered by anticipated state budget deficits. Private funding is being explored. //2009//

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 presentations.

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.

The OSDH and the OKDHS work closely with 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. Support of the Oklahoma Primary Care Association and the OSDH Office of Primary Care's efforts to expand FQHCs in Oklahoma is a priority.

/2007/ MCH has been invited and is participating in the quarterly meetings of the Oklahoma City Area Inter-Tribal Health Board. In addition, MCH has also been invited and is having staff from MCH Assessment participate in the routine meetings of the Indian Health Services (IHS) Epidemiology Center Advisory Council. //2007//

/2009/ PRAMS collaborated with staff from the Southern Plains Intertribal Epidemiology Center and Oklahoma City Area Indian Health Service to write a PRAMSGRAM on Native American Perinatal Health Disparities. The news release from this PRAMSGRAM created several articles in print and online media sources, in both mainstream media and Native American media sources. As a result PRAMS and IHS staff were asked to present the findings at the American College of Obstetrics and Gynecology Oklahoma City Area Indian Health Service Team Meeting in June 2008. //2009//

The OSDH and the OKDHS are two of 11 state agencies and programs participating in the Joint Oklahoma Information Network (JOIN), a data-sharing project with goals of helping state agencies provide services more efficiently and helping Oklahomans find community resources and programs and determine their eligibility for them. It is available at www.join.ok.gov. Other participating organizations include the OHCA, Oklahoma Commission on Children and Youth, Office of Juvenile Affairs, OSDE, Oklahoma Employment Security Commission, Oklahoma State Finance Office, Oklahoma Commerce Department, Oklahoma Rehabilitation Department and DMHSAS. The JOIN is being developed in phases. The first phase, a statewide information and referral system/resource database, is active. The second phase, a de-identified aggregate database for research, service planning and quality assessment is currently being compiled. The third phase, individual client information for single point of entry and case management, is in the planning stage.

/2007/ The JOIN website now includes an Eligibility Questionnaire to assist individuals and families in identifying government services for which they may be eligible to receive by answering a few questions. //2007//

/2008/ JOIN completed a pilot project matching client data across six participating agencies in the spring of 2007. Analysis included the number of persons served by multiple agencies and a special analysis focused on pregnant female clients. //2008//

/2009/ JOIN now includes a total of 14 participating agencies that in addition to those listed previously include the Department of Mental Health and Substance Abuse Services, Department of Corrections, and the University of Oklahoma Health Sciences and Infectious Diseases. The Web-Enabled Data Repository has been in pilot mode since inception in 2000. The application is web-based and written in IBM's Visual Age Java. The user administration piece is written as a Windows thick client running on a DB2 database. The OCCY has engaged a consultant to provide project management and IT technical support services in finalizing and deploying the JOIN application. The intent is to convert the existing DB2 database to either a Microsoft SQL or Oracle database. Once converted, the contractor will then develop a new user interface using either Microsoft .net or Oracle Forms and Reports. The next step will be to automate the transfer of data from the various end users to the JOIN database. The contractor will then develop the standardized reports users may require from the JOIN system. //2009//

F. Health Systems Capacity Indicators

Introduction

See Forms 17, 18 and 19.

Data are received from multiple sources for these indicators: the OSDH Center for Health Care Information, the OHCA, the PRAMS, the OKDHS and national data sets. Examples of data used are vital statistics, Medicaid enrollee data, Medicaid claims data, SCHIP enrollee data, SCHIP claims data and census data.

The OSDH continues to develop its Public Health Oklahoma Client Information System (PHOCIS). This system provides clinical information on maternity, child health and family planning clients and services. Modules continue to be refined for enabling, population-based and infrastructure services. This system has a link with the Oklahoma State Immunization Information System (OSIIS), the immunization statewide registry, and WIC, the supplemental nutrition program for women, infants and children.

With the improved data, retrieval is more complex because the focus has been on ease of documentation and on the collection of funds. The Health Insurance Portability and Accountability Act (HIPAA) has been used inappropriately to prevent data from being used for legitimate research purposes. Fear sustained from the World Trade Center attack has also negatively affected data access and utilization. Staff time is limited for analyzing all of the information in-depth; the epidemiologic and analytic staff must focus on specific measures, develop extraction methods for those specific data, and monitor and interpret the results of those measures.

//2009/OSDH has begun the linking process with Medicaid data to enhance the analytic capabilities of the MCH program. //2009//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	42.4	49.2	34.2	33.7	33.7
Numerator	996	1156	857	858	858
Denominator	234935	234935	250522	254718	254718
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

Notes - 2007

Sources: 2007 data is not yet available. 2006 discharge data from Health Care Information, OSDH used for numerator, Census Bureau 2006 population estimate for denominator.

Notes - 2006

Sources: No. of discharges in 2006 from Health Care Information, OSDH used for numerator, Census Bureau 2006 population estimate for denominator.

Notes - 2005

Sources: Health Care Information, OSDH used for numerator, Census Bureau population estimate for denominator.

Narrative:

Data used to track HSCI #01 are obtained from the OSDH Center for Health Statistics, Health Care Information (HCI) and its hospital discharge dataset. Typically, a formal request, submitted via email, is sent to the analyst responsible for the hospital discharge database. Response to the request is timely. MCH does not have routine access to raw electronic data; rather, data are provided in summary form to be incorporated into the Title V MCH Block Grant. The Health Care Information Advisory Committee determines access to the data, and many of the non-OSDH representatives have strongly supported the perspective that such data could be inflammatory and thus detrimental to the state's hospital system. The resulting lack of access to raw data prohibits detailed examination and understanding of the particularities of the data. Any concerns or questions regarding data quality or reliability are submitted to the analyst of hospital discharge data for comment. In addition, the Director of the OSDH Center for Health Statistics takes a strongly conservative position regarding the release of health information, even if assurances can be documented that the information will remain in aggregate form and never identify an individual. *//2009/ No changes to the HCI policy. //2009//*

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	70.7	84.1	85.8	88.4	87.9
Numerator	23819	28666	30192	31690	33539
Denominator	33709	34074	35197	35862	38156
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

Notes - 2007

Source: Oklahoma Health Care Authority.

Notes - 2006

Source: Oklahoma Health Care Authority.

Notes - 2005

Source: Oklahoma Health Care Authority.

Narrative:

Medicaid data are obtained through an indirect channel. Requests for data are sent through the OSDH Chief of the Office of Federal Funds Development, who serves as the liaison for data sharing between the OSDH and the OHCA, the State's Medicaid agency. This arrangement for communication has both advantages and limitations. To cite one benefit, it ensures that requests to OHCA for data are transmitted through a single point of contact, therefore, limiting the potential for scattershot requests coming from multiple initiation points with the increased likelihood of unfulfilled requests. A downside to this approach is loss of personal and professional contact with persons best equipped to answer important questions about data reliability and availability. Concerns about data are lost through the mediated communications currently used by the agencies. Gaining access to Medicaid data, e.g., obtaining summary measures for Medicaid data, is a lengthy process of submitting requests and waiting for a response. The process is fraught with uncertainty. This includes the ambiguity about the validity and reliability of the data,

but also the uncertainty about the timeliness of response to the data request.

//2009/ MCH has acquired new staff who has begun the process of linking Medicaid data with vital records. This will provide more timely access and more comprehensive evaluation of Medicaid information. The staff position is jointly funded by the OHCA and the OSDH, assuring a collaborative process for analyzing the linked data. //2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	82.9	82.9	69.5	72.3	70.9
Numerator	1230	1230	1637	1826	1728
Denominator	1483	1483	2355	2527	2436
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

Notes - 2007

Source: Oklahoma Health Care Authority.

Notes - 2006

Source: Oklahoma Health Care Authority.

Notes - 2005

Source: Oklahoma Health Care Authority.

Narrative:

As with Medicaid data, SCHIP data are obtained indirectly by way of the OSDH Chief of the Office of Federal Funds Development. The same concerns cited for HSCI#02 above apply for HSCI#03; foremost among them are lack of direct contact with data professionals and uncertainty surrounding data quality.

//2009/ MCH has acquired new staff who has begun the process of linking Medicaid data with vital records. This will provide more timely access and more comprehensive evaluation of Medicaid information. The staff position is jointly funded by the OHCA and the OSDH, assuring a collaborative process for analyzing the linked data. //2009//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	77.8	70.8	71.5	76.1	76.1
Numerator	38223	36219	37019	41334	41334
Denominator	49126	51157	51775	54305	54305
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

Notes - 2007

Source: Health Care Information, OSDH. Year 2007 are not available. Year 2006 repeated to provide an estimate.

Notes - 2006

Source: Health Care Information, OSDH.

Notes - 2005

Source: Health Care Information, OSDH.

Narrative:

Data for HSCI #04 are obtained directly from the raw birth certificate files. MCH has established a working relationship with the OSDH Center for Health Statistics that permits access to raw vital statistics data. This access allows MCH to gain a richer understanding of the birth data. Specific to this measure, by having direct access to data, MCH analysts can explore issues surrounding prenatal care in depth, rather, than relying on summary measures produced by analysts external to MCH.

//2009/ Access to prenatal care has been a focus of the Commissioner's Action Team on Infant Mortality. Work is underway to identify ways the state can improve access to preconception and prenatal care, build awareness for early and comprehensive pregnancy-related care, and improve systems to provide care for all Oklahoma women. //2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	78.2	77.4	84.3	85.7	86.8
Numerator	343243	385620	403023	421001	439252
Denominator	438700	498031	478007	491517	506252
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

Notes - 2007

Source: Oklahoma Health Care Authority.

Notes - 2006

Source: Oklahoma Health Care Authority.

Notes - 2005

Source: Oklahoma Health Care Authority.

Narrative:

Requests for Medicaid data are sent through the OSDH Chief of the Office of Federal Funds Development, who serves as the liaison for data sharing between the OSDH and the OHCA, the State's Medicaid agency. This arrangement for communication complicates a greater understanding of Medicaid data. Gaining information via a third party blocks personal and professional contact with persons best equipped to answer important questions about data reliability and availability. Concerns about data are lost through the mediated communications currently used by the State agencies. Receiving Medicaid data is a lengthy process of submitting requests and waiting for a response. The process is fraught with uncertainty. This includes the ambiguity about the validity and reliability of the data, but also the uncertainty about the timeliness of response to the data request.

//2009/ The OHCA is implementing a program called the NB1. This new service assures infants immediate enrollment into Medicaid upon birth to Medicaid-eligible mothers at delivery. Implementation is occurring on a hospital-by-hospital basis. //2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	26.2	40.4	47.3	51.0	53.6
Numerator	22661	36862	45222	51019	55408
Denominator	86606	91164	95686	100011	103319
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

Notes - 2007

Source: Oklahoma Health Care Authority, the State's Medicaid agency.

Notes - 2006

Source: Oklahoma Health Care Authority, the State's Medicaid agency.

Notes - 2005

Source: Oklahoma Health Care Authority, the State's Medicaid agency.

Narrative:

Similar to Medicaid and SCHIP data, requests for EPSDT data are sent through the OSDH Chief of the Office of Federal Funds Development. Communication through third party contact is blunted, leading to inhibited understanding of the intricacies of EPSDT data. Concerns about data are lost through the mediated communications. Retrieving data from the OHCA is a drawn-out process of submitting requests, followed by long periods of no contact while waiting for a response. Data are obtained for the grant, but no real insight is gained about its quality and meaning.

//2009/ The addition of MCH Assessment staff to link and analyze matched Medicaid-vital records-PRAMS data will provide a new avenue to more fully analyze dental services provided by Medicaid. //2009//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	73.0	70.2	69.0	68.2	69.1
Numerator	6643	7217	7772	8251	8843
Denominator	9100	10282	11258	12102	12805
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

Notes - 2007

Source: Oklahoma Department of Human Services, CSHCN Program.

Per CSHCN Program - Denominator data for 2007 is an estimate based on the known number of SSI recipients under 18 years of age.

Notes - 2006

Source: Oklahoma Department of Human Services, CSHCN Program.

Per CSHCN Program - Denominator data for 2006 have not been published to date; therefore, a projection, which reflects a 7.5% increase from previous year's reporting, has been used.

Notes - 2005

Source: Oklahoma Department of Human Services, CSHCN Program.

Narrative:

Monitoring data for HSCI #08 come from CSHCN. Data are requested through routine contact with CSHCN Program staff. The State Data Contact does not access raw data; rather, aggregate data are provided so that it can be included in the Title V Block Grant Annual Report. Questions regarding the source of this information should be directed to the CSHCN Program and the Oklahoma Department of Human Services.

//2009/ No change. //2009//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid,</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

non-Medicaid, and all MCH populations in the State					
Percent of low birth weight (< 2,500 grams)	2006	other	8.3	6.1	7.6

Notes - 2009

Source: Data derived from linked 2006 PRAMS and 2006 birth certificate records.

Narrative:

Monitoring data for this measure are extracted from PRAMS population-based surveillance. The PRAMS surveillance system is a joint project of the CDC and MCH. In Oklahoma, the MCH Assessment staff carries out PRAMS surveillance. As a result, PRAMS survey data can be accessed on a routine basis. However, there are often considerable delays in obtaining timely data sets for weighted analyses. This is due to the manner in which weighted data sets are generated for State use. After a surveillance year is closed out, MCH Assessment forwards data to the CDC for data cleansing and weighting. Return of the weighted analysis data set is based on the scheduling of all PRAMS states as they submit surveillance data for weighting. Protracted delays are common. For example, surveillance data for the year ending December 2006 may not be available for analysis until mid-year 2008.

/2009/ MCH has acquired new staff who has begun the process of linking Medicaid data with vital records. This will provide more timely access and more comprehensive evaluation of Medicaid information. The staff position is jointly funded by the OHCA and the OSDH, assuring a collaborative process for analyzing the linked data. In addition, an analyst was added to the MCH Assessment staff, enhancing the capacity for more comprehensive analyses. Prenatal care is a priority for analyses of the linked Medicaid-vital records-PRAMS data./2009//

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	other	7.6	7.6	7.6

Notes - 2009

Source: Data derived from 2006 death certificate records. Information regarding infant mortality by Medicaid population currently not available.

Narrative:

Infant death data by Medicaid participation are unavailable. The Oklahoma death certificate does not contain any information about Medicaid status. To tabulate infant death rates by Medicaid participation, an electronic link must be established between the death certificate file and Medicaid program data. At present, this link has not been created. The Oklahoma State Systems Development Initiative (SSDI) Project has planned to develop this link in order to enhance data capacity, but to date this information is not available.

/2009/ MCH has acquired new staff who has begun the process of linking Medicaid data

with vital records. This will provide more timely access and more comprehensive evaluation of Medicaid information. The staff position is jointly funded by the OHCA and the OSDH, assuring a collaborative process for analyzing the linked data. In addition, an analyst was added to the MCH Assessment staff, enhancing the capacity for more comprehensive analyses. Infant mortality is a priority set by the Commissioner of Health and MCH and is a key component of the analyses of linked Medicaid-vital records-PRAMS data.//2009//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	other	81.3	94.2	86.4

Notes - 2009

Source: Data derived from linked 2006 PRAMS and 2006 birth certificate records. PRAMS data is used as an estimation since Medicaid claims data and birth records have not been linked yet.

Narrative:

Tracking data for this health indicator come from the PRAMS surveillance project. The PRAMS is a joint project of the CDC and MCH. As a result, PRAMS data are readily available to MCH analysts. However, there can be delays in receiving weighted analysis data sets. After a surveillance year is closed out, MCH Assessment forwards data to the CDC for data cleansing and weighting. Return of the weighted analysis data set is based on the scheduling of all PRAMS states as they submit surveillance data for weighting. Protracted delays are common. For example, surveillance data for the year ending December 2006 may not be available for analysis until mid-year 2008.

//2009/ Access to prenatal care has been a focus of the Commissioner's Action Team on Infant Mortality. Work is underway to identify ways the state can improve access to preconception and prenatal care, build awareness for early and comprehensive pregnancy-related care, and improve systems to provide care for all Oklahoma women. //2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

State					
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	other	79.1	84.5	80.5

Notes - 2009

Source: Data derived from linked 2006 PRAMS and 2006 birth certificate records. PRAMS data is used as an estimation since Medicaid claims data and birth records have not been linked yet.

Narrative:

The Oklahoma PRAMS surveillance project provides data for tracking this health indicator. The PRAMS is a collaborative project of the CDC and MCH. MCH analysts can easily access PRAMS data. Delays in receiving a weighted analysis data set for the most recent data collection year do occur. Once a surveillance year is closed, data are sent to the CDC for cleaning and weighting. Return of a final analysis data set is determined by the scheduling of all PRAMS states as they submit surveillance data for weighting. Protracted delays are common.

/2009/ Access to prenatal care has been a focus of the Commissioner's Action Team on Infant Mortality. Work is underway to identify ways the state can improve access to preconception and prenatal care, build awareness for early and comprehensive pregnancy-related care, and improve systems to provide care for all Oklahoma women. //2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	185

Narrative:

Poverty level criteria for Medicaid and SCHIP eligibility are obtained from the OHCA, the State's Medicaid agency. A request for information is sent through the OSDH Chief of the Office of Federal Funds Development. Because of the nature of HSCI #06A, data for this measure are not confounded by the manner of communication between the State agencies. It is a rather straightforward reporting of the various eligibility requirements for certain MCH populations.

/2009/ No changes to date. //2009//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and	YEAR	PERCENT OF POVERTY LEVEL Medicaid
--	-------------	--

pregnant women.		
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2007	185 185 185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 5) (Age range 6 to 12) (Age range 13 to 18)	2007	185 185 185

Narrative:

Poverty level criteria for Medicaid and SCHIP eligibility are obtained from the OHCA, the State's Medicaid agency. A request for information is sent through the OSDH Chief of the Office of Federal Funds Development. Because of the nature of HSCI #06B, data for this measure are not confounded by the manner of communication between the State agencies. It is a rather straightforward reporting of the various eligibility requirements for certain MCH populations.

/2009/ No changes in 2008. //2009//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2007	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	185

Narrative:

Poverty level criteria for Medicaid and SCHIP eligibility are obtained from the OHCA, the State's Medicaid agency. A request for information is sent through the OSDH Chief of the Office of Federal Funds Development. Because of the nature of HSCI #06C, data for this measure are not confounded by the manner of communication between the State agencies. It is a rather straightforward reporting of the various eligibility requirements for certain MCH populations.

/2009/ The OHCA has expanded Insure Oklahoma in 2008, enabling workers and their spouses employed in businesses with up to 50 employees to be eligible for Medicaid-supported, private insurance covered through the employer. This insurance expands eligibility up to 200% of poverty for those enrolled in the new program. //2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy	Does your MCH program have Direct access to the electronic database for
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	purposes in a timely manner? (Select 1 - 3)	analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	2	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	1	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:

Access to databases not under the direct authority of MCH remains largely unchanged. An exception is the annual data linkage of birth and infant death records. MCH, via work performed under the SSDI Project, has access to linked birth/infant death files. Plans are to maintain this linkage as routine for the MCH programs. Despite some progress on data availability, electronic linkages to other external data for Medicaid or WIC continue to be unfulfilled. MCH has limited access to registry data from hospital discharge and birth defects by means of agency partnerships established over time. The PRAMS data are collected and maintained within MCH Assessment, providing direct access to survey data and linkages to birth records. The Oklahoma SSDI Project is still active and continues to pursue access to these data. The SSDI Project is working with the OSDH Chief of the Office of Federal Funds Development, who collaborates with representatives from the OHCA to ensure data sharing between agencies. The SSDI Project anticipates and will persist in gaining access to Medicaid data. Projected timelines for access to Medicaid, WIC and newborn screening data have been incorporated into the current SSDI Project that began 1 December 2006. In addition, the inappropriate application of HIPAA rules and the nation's heightened concerns regarding terrorism over the past four years have contributed to policies intended to protect personal information. There appears to be limited understanding about what data are truly protected and what are already available through business transactions that have no protection.

/2009/ MCH has been able to fill vacant positions, providing an enhanced capacity to analyze multiple data systems. This includes a position jointly funded by OSDH and OHCA

to link and analyze Medicaid data to OSDH datasets and a State Systems Development Initiative (SSDI) manager dedicated to enhancing analysis capacity for MCH. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2009

Narrative:

The Youth Risk Behavior Survey (YRBS) is conducted within the MCH program area. As a result, MCH analysts have direct access to data collected by the YRBS surveillance activities. The concern with HSCI #09B is ensuring that response rates with YRBS reach a level that produces a sample size sufficient for data weighting and estimation. It is intensive work to persuade schools to participate in the statewide YRBS. Experience indicates that school participation in YRBS will be a continuing challenge. Schools have a high volume of extracurricular activities that moderate their willingness to participate in surveys like YRBS. The statewide survey is conducted once every two years in accordance to the Centers for Disease Control biennial survey.

//2009/ See State Performance Measure #3 for the status of activities and collaboration. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Government Performance and Results Act (GPRA), enacted in 1993, requires federal agencies to establish standards measuring their performance and effectiveness. 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, 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.

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 part of the OSDH strategic plan for improving the health of Oklahomans.

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.

//2007/ MCH and CSHCN use the monthly MCH/CSHCN Collaboration Meeting to accomplish review of national and state performance measures and related activities. As needed change to a performance measure or activity is identified and agreed upon, steps to accomplish the change, identification of the responsible individual(s) to assure the steps are taken and timelines for progress are established to facilitate accomplishing the identified change. Participation of families and other key partners is critical in assuring input is received to guide decision-making.

//2007//

//2009/ The OSDH is implementing an electronic performance management system, Step UP ("Strategies toward excellent performance---Unlimited Potential"). Staff from MCH participated in development of the system and MCH is currently participating in the pilot phase. MCH national and state performance measures have been input into the system and will be updated annually as is done with the federal Title V MCH Block Grant. The goal of the system is to "optimize human potential within the OSDH by increasing alignment of strategic initiatives toward the defined organizational goals and objectives and providing accountability to stakeholders."

MCH and CSHCN have moved to meeting every other month. Meetings continue to be focused on collaborative planning related to state priorities, outcome measures and performance measures. //2009//

B. State Priorities

The selection of Oklahoma priorities began with a new needs assessment process that assured input from a broad group of individuals from across the state rather than just Title V staff. Three teams were organized to assist the Title V Program in identifying needs from the perspectives of service providers, consumers, advocates and other state and community-based agencies. The three teams represented the three MCH population groups: women and infants, children and adolescents and children with special health care needs. Individuals were identified to represent the broad scope of Title V services and activities and invited to participate in a planning meeting followed by subsequent separate meetings to identify needs for their respective populations. MCH and CSHCN program staff strictly limited their participation to being group facilitators to avoid unnecessary influence from an internal perception of issues and problems.

The initial planning meeting was held for all participants to provide them with a background of Title V, an explanation of the legislation mandating performance-based planning and expectations of each group to provide useful feedback for setting state priorities. The three groups worked independently June through October 2004 and were given wide latitude in determining their recommendations. They were offered access to any available data to support their identification of needs. Upon completion of their work, a list of priorities was submitted by each group that identified the highest needs of their respective population groups of women and infants, children and adolescents and children with special health care needs.

MCH and CSHCN leadership reviewed these recommended priorities to assess and compare them to the mission of Title V and the scope of the MCH and CSHCN programs. A preliminary set of priorities was then selected that best fit the highest priorities of each of the three groups; consideration was given to overlap, mandated services and historical priorities.

An analysis of data was accomplished to determine what needs could be quantified. Data were analyzed from the following sources: population-based surveillance data from the Pregnancy Risk Assessment Monitoring System (PRAMS), The Oklahoma Toddler Survey (TOTS), the Centers for Disease Control and Prevention (CDC) weighted Oklahoma Youth Risk Behavior Survey (YRBS), the Oklahoma First Grade Health Survey, and the Oklahoma Fifth Grade Health Survey; Oklahoma vital records; 2000 U.S. Census and 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 and the Oklahoma Health Care Authority (Medicaid data); and, other federal and state surveys. These data were reviewed and analyzed to assess need and to compare with the qualitative assessments provided initially by the three groups.

A final examination of the initial priorities was then made by MCH and CSHCN to assure that the identified issues remained consistent with their own experiences as well as the priorities of the respective agencies. 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 and CSHCN efforts (note that no one priority is ranked higher than another):

- 1) Reduce the prevalence of obesity among the MCH populations
- 2) Reduce substance abuse behaviors in the MCH populations
- 3) Improve access to dental health services by pregnant women and children
- 4) Increase access to prenatal care
- 5) Improve the system of respite care for CSHCN families
- 6) Improve transition services for adolescents with special health care needs
- 7) Reduce unwanted, unplanned pregnancies
- 8) Increase the proportion of fully immunized children entering school
- 9) Increase the proportion of mothers who breastfeed their infants
- 10) Improve data access and file linkages of public health databases

Next, MCH and CSHCN 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. Four previous state performance measures were retained with three new state performance measures* developed for 2006:

- 1) The percent of women who have an unintended pregnancy (mistimed or unwanted) resulting in live birth.
- 2) The percent of mothers who smoke during the third trimester of pregnancy.
- 3) The percent of adolescents grades 9-12 smoking tobacco products.
- 4) The number of families with a child with special health care needs receiving respite care provided through the CSHCN Program.
- 5)* The percent of first grade students at risk for overweight (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution).
- 6)* 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.
- 7)* Percent of children with special health care needs that receive timely and appropriate transition services.

/2007/ Two state performance measures have been discontinued and new measures identified as a result of comparison of state performance measures with new and revised 2006 national performance measures. State performance measure #2 "The percent of mothers who smoke during the third trimester of pregnancy" was found to be duplicative of the new 2006 national performance measure #15 "Percentage of women who smoke in the last three months of pregnancy" recently identified in the updated Maternal and Child Health Services Title V Block Grant Program Guidance and Forms for the Title V Application/Annual Report released in May 2006. State performance measure #7 "Percent of children with special health care needs that receive timely and appropriate transition services" was found to be very similar to the revised national performance measure #6 "The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence."

MCH and CSHCN reviewed written documentation of input received from stakeholder groups during the five-year needs assessment process completed in 2005 as well as identified state priorities. The following new state performance measures have been established using this information: state performance measure #7 "The percent of Medicaid eligible children with special health care needs who report receiving routine dental care" and state performance measure #8 "The percent of adolescents grades 9-12 not using alcohol during the past 30 days." //2007// /2008/ There are no new state performance measures identified by MCH and CSHCN. //2008// ***/2009/ In April 2007, MCH was requested by the Commissioner of Health to provide leadership in facilitating an OSDH intra-agency strategic planning process to strengthen collaboration among all OSDH programs with common activities targeted toward improving infant outcomes in a overall agency focused effort to reduce Oklahoma's unchanging infant mortality rate (though the overall focus is reduction of infant mortality, within this is the concern of the ongoing disparity with the African American population). In May 2007, the first meeting of the intra-agency workgroup occurred with subsequent meetings continuing on a monthly basis to date. Efforts of the workgroup have focused on review of data, current crosscutting program activities and gaps needing to be addressed to include activities targeting specific racial and ethnic groups. Over the year, smaller workgroups to focus on identified areas of priority have been formed: breastfeeding; childhood injury; data; maternal infections; preconception/interconception care and education; postpartum depression; safe sleep; and, tobacco. The leads of these small workgroups report planned activities back to the large workgroup with a strategic plan being developed for use in OSDH 2009-2010 budgetary, policy and program services decision-making. The 2009-2010 strategic plan is the first step in an expected ongoing***

strategic process that will look to not only strengthen internal OSDH efforts in reducing infant mortality but also strengthen linkages with OSDH state partners in statewide interagency efforts.

The infant mortality reduction strategic planning process has not resulted in changes to the identified Title V state priorities as the MCH priorities identified have a direct impact on the already identified Title V outcome of infant mortality. The process has provided an opportunity to further educate and reinforce MCH priorities (1. Reduce the prevalence of obesity among the MCH population; 2. Reduce substance abuse behaviors in the MCH populations; 3. Improve access to dental health services by pregnant women and children; 4. Increase access to prenatal care; 7. Reduce unwanted, unplanned pregnancies; 9. Increase the proportion of mothers who breastfeed their infants; and, 10. Improve data access and file linkages of public health databases) and their relationship to impacting infant mortality with other OSDH programs. Work from the small workgroups is being incorporated in the planned activities of currently identified national and state performance measures that focus on these priorities.

State performance measure #5 The percent of adolescents at risk for overweight (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution) is being discontinued for 2009 with a new state performance measure #9 The percent of adolescents overweight and obese (greater than or equal to 85th percentile of gender-specific body mass index [BMI] distribution) being added. This change is being made as MCH found on review of state performance measure #5 data that previous reporting included only those adolescents at risk for overweight and not those who were overweight. In addition, CDC now uses the terms overweight and obese; the term "at risk" is no longer used. //2009//

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	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	36	31	54	50	67
Denominator	36	31	54	50	67
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
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

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

Notes - 2006

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

Notes - 2005

All newborns delivered in Oklahoma are screened for congenital hypothyroidism, galactosemia, phenylketonuria (PKU), sickle cell disease, cystic fibrosis, hemoglobinopathies, and congenital adrenal hyperplasia (CAH). Oklahoma began screening for cystic fibrosis and CAH on February 14, 2005. 100% of sickle cell traits and hemoglobin C traits referred for counseling by the Sickle Cell Association (SCA), with 40% of those counseled by the SCA.

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

a. Last Year's Accomplishments

All newborns born in Oklahoma were screened through the Newborn Screening Program (NSP) for the disorders of phenylketonuria (PKU), congenital hypothyroidism, galactosemia, sickle cell disease, hemoglobinopathies, cystic fibrosis (CF), congenital adrenal hyperplasia (CAH) and medium chain acyl-CoA dehydrogenase deficiency (MCAD). The number of disorders identified in calendar year (CY) 2007 included: PKU (2); congenital hypothyroidism (15); classic galactosemia (2); sickle cell disease (21); hemoglobin disease (0); CF (16); CAH (4); MCAD (6); hemoglobin C trait (140); and sickle cell trait (483). 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 CY 2007, 100% of the sickle cell traits and hemoglobin C traits were referred for counseling and 49 (out of 492) families received counseling from a board certified genetic counselor. 100% of newborns identified with an out-of-range CF screen were referred for genetic counseling (86 of the 88 received counseling). Seven newborns identified with a disorder other than CF received genetic counseling from a board certified genetic counselor and 9 newborns received genetic counseling from a board certified geneticist.

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. Provided long-term follow-up for all diagnosed newborns except CF; linked all infants with CF to CF Center		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Expansion to adopt uniform panel recommended by the American College of Medical Genetics (ACMG) is underway. Current Oklahoma screening includes 10 of the 29 core disorders. The Oklahoma State Department of Health (OSDH) Board of Health has mandated through Rules an expansion to the uniform panel of screenings. Current activities include acquiring follow-up staff, developing follow-up protocols and lab validation studies.

Long-term follow-up care coordination services are being provided to children/youth with special health care needs and include an Adult Transition Program for adolescents with sickle cell

disease and a PKU Formula/Food Program.

c. Plan for the Coming Year

All newborns born in Oklahoma will continue to be screened through the NSP for the disorders of PKU, congenital hypothyroidism, galactosemia, sickle cell disease, hemoglobinopathies, CF, CAH and MCAD. It is anticipated that of the 29 core disorders recommended by the ACMG, Oklahoma will screen for 28 by the end of 2008. Additional equipment will need to be purchased to screen for Biotinidase deficiency; state funding has been budgeted for this by the OSDH Public Health Laboratory.

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 pediatric sub-specialist, genetic counseling date and enrollment into available LTFU services. In collaboration with the University of Oklahoma Health Sciences Center (OUHSC), 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 NSP confirms that the baby has been seen by a pediatric pulmonologist). Currently three fulltime LTFU care coordinators (Metabolic, Endocrine, and Sickle Cell Disease) and one metabolic dietitian are supported through contracts with the OUHSC. STFU and LTFU services are provided in collaboration with the medical home.

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

An evaluation of the state genetics plan is in progress in collaboration with the Evaluation Committee of the Oklahoma Genetics Advisory Council (OGAC). Implemented activities of the 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 continue to meet three times a 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.

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	2003	2004	2005	2006	2007
Annual Performance Objective	52	53.8	54.9	56	57.4
Annual Indicator	50.4	50.4	50.4	50.4	56.9
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	58.8	60	60.9	61.5	62.7

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The 2005-2006 Survey of Children with Special Health Care Needs (SLAITS) showed 56.9% of families, with a member who was a child under 18 with special health care needs, were partners in decision making at all levels, and were satisfied with the services they received. This is an increase from the 2001 survey, which found 50.4% of families were satisfied.

Sooner SUCCESS, a program dedicated to improving the services available and utilized in communities for CSHCN, expanded its efforts in developing an infrastructure in served counties to assist families in finding services to meet their needs. Sooner SUCCESS served nine counties, each with a county coordinator who worked one-on-one with families. All nine counties also had their own county coalition. Sooner SUCCESS staff worked together with at least one family member in these coalitions to identify available services and explore ways to bring new services to their communities. Family members were reimbursed for their participation in the coalitions.

The Sooner SUCCESS State Interagency Coordinating Council had four family members who represent families as well as other organizations (Oklahoma Family Network, the University Center for Excellence in Developmental Disabilities Family Faculty, and the Family Support 360 Project). During three of the council's monthly meetings the Oklahoma Family Network (OFN) was assisted with its proposal for a Family-to-Family Health Information and Education Center (F2F HIC) Grant.

The Key Informant Survey was field tested with family members. It was distributed across the state through family networks. The survey was to evaluate how effective Sooner SUCCESS is in each county and provide input for a county needs assessment.

The action plan developed by the Children's Oral Health Coalition (COHC), created in 2003 as a partnership between various state and non-profit agencies with a special emphasis on dental care access and care for CSHCN, focused in part on education for parents and professionals on how to develop a greater degree of empathy, understanding and respect for one another in order to increase partnerships. One recommendation stated that oral health providers should schedule consultations with families before appointments with CSHCN. This would allow both the family and the professional to get to know each other and learn what to expect during the appointment.

As a result of the technical assistance provided by the national Family Voices office, in September 2007, CSHCN learned of other groups in the state who routinely involve parents in their decision-making, such as the Oklahoma Parent Training and Information Center (OPTI). CSHCN was encouraged to continue identifying and communicating with as many parent groups as possible in an effort to be informed of what is being done throughout the state to address

CSHCN issues.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported SoonerSUCCESS through provision of funding and technical assistance for their regional care coordination activities.				X
2. Identified and communicated with parent groups in the state to learn about services in state that involve the family in decision-making for CSHCN.			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Capacity development projects are ongoing in the Sooner SUCCESS local coalitions. Projects include: establishing a teen recreation center in Watonga, implementing a support group for families of CSHCN, providing training to local childcare about providing childcare to CSHCN, and sponsoring trainings on various topics including mental health, infant safety and finance.

Changes were made to the Key Informant Survey. The survey is now available online as well as in hard copy format.

The Oklahoma Infant Transition Program (OITP) staff continues to work with the families of newborns treated in the neonatal intensive care unit (NICU) at the OU Medical Center in Oklahoma City. OITP social workers, family advocates, and other staff help families in the transition from NICU to home. Assistance with navigating medical and therapy appointments and referrals to available provider agencies are given.

CSHCN continues to contract with OFN through the Developmental Disabilities Services Division (DDSD) of the Oklahoma Department of Human Services (OKDHS). OFN provides information, education, emotional support and parent-to-parent mentoring training to families raising CSHCN.

Family involvement is an important focus area for MCH and CSHCN. OFN held a family and professionals conference called "Joining Forces" on April 26, 2008. The conference helped families learn where government agencies need family input, what is expected of them and how to best present their issues at meetings.

c. Plan for the Coming Year

Data from the Key Informant Survey will be analyzed by Sooner SUCCESS to determine necessary improvements in the nine counties they serve. The analysis will also examine data from counties where Sooner SUCCESS does not have a presence in an effort to review program effectiveness. The information will be available in December 2008.

The Autism Clinic (also called Family Partners) at the OU Medical Center, which began in 2004 and is partially funded through CSHCN, will continue to provide direct family contact and plans to develop a database to assist practitioners in understanding which suggestions are helpful and

which are not. Based on the database findings the clinic will modify the way evaluations are done and make recommendations to staff.

OFN will host a second "Joining Forces" conference. Agency representatives will be able to meet interested families and discuss their committees and focus groups.

At yearly CSHCN site visits, input is provided by parents who are paid staff members at the Autism and Sickle Cell clinics at the OU Medical Center, the Oklahoma Areawide Services and Information System (OASIS), OITP, and the Tulsa Neonate Program. The family input will continue to be utilized by CSHCN to identify and address both new and ongoing issues for families of children with special needs on a statewide level.

The COHC will educate caregivers, professionals and the public about the recommended pre-visit consultations through brochures, educational videos and the development of dentist websites.

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	2003	2004	2005	2006	2007
Annual Performance Objective	54	56.7	57.8	59.3	60.5
Annual Indicator	53.3	53.3	53.3	53.3	49.7
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	60.5	61	61.5	62	62.5

Notes - 2007

Indicator data comes from the National Survey of 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 NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The 2005-2006 National Survey of Children with Special Health Care Needs (SLAITS) found that 49.7% of children 18 or younger receive coordinated, ongoing, comprehensive care within a medical home in Oklahoma. This has declined since 2001 when 53.3% of families received care in a medical home.

Fifty children received care in the third year of the Family Support 360 Center, a medical home model in the Children's Hospital Pediatric Practice Clinic focused on increasing the number of CSHCN receiving care within a medical home. The Oklahoma UCEDD (University Center for Excellence in Developmental Disabilities), in partnership with the Oklahoma Department of Human Services (OKDHS), OU Child Study Center (OU CSC) and Community Pediatric Section, Department of Pediatrics was awarded a grant from U.S. Department of Health and Human Services, Administration on Developmental Disabilities, to implement the Family Support 360 Center Medical Home Project to serve families with low income whose children have developmental disabilities.

The Fostering Hope Clinic, a medical home for youth in foster care, completed its second year. This clinic remained a collaboration between the Oklahoma Health Care Authority (OHCA), OKDHS and the University of Oklahoma Health Sciences Center (OUHSC). The clinic followed the Standards for Health Care Services for Children in Out-of-Home Care developed by the American Academy of Pediatrics and the Child Welfare League of America. Fifteen pediatric residents received training on medical home concepts and five primary care providers obtained support to implement medical home concepts in their practices.

The Sooner SUCCESS state coordinator provided training to 42 new special education teachers on how to collaborate with primary care physicians who provide services within a medical home in late fall of 2006. In addition, a statewide training on collaborating with primary care physicians who provide services within a medical home was conducted for early intervention staff.

The OU CSC entered into a three-year contract with the OHCA to adapt national medical home curricula and develop a plan to train primary care practitioners and family members across the state on medical home concepts. The contract is exclusive to children and youth who are SoonerCare (Medicaid) eligible and those practices providing services through SoonerCare.

OU CSC began working with the Utah Collaborative Medical Home Projects to develop Oklahoma Med Home Portal pages within their website. The Utah Med Home Portal (located at <http://www.medhomeportal.org>) was developed to give primary care providers as well as families the tools they need to give the best care and treatment to children with chronic conditions. It provides information on what a medical home is, useful information put together by families to help other families, listings of school and education resources and personnel, modules on conditions and their diagnoses, information about transition issues and extensive lists of resources. OU CSC staff searched for contributors to author the Oklahoma pages. CSHCN staff were able to connect OU CSC with OKDHS web management and Oklahoma 211/JOIN. The Joint Oklahoma Information Network (JOIN) is an online tool designed to help the public learn what government programs are available in Oklahoma. JOIN, working with Oklahoma 211, provided test data to the University of Utah and determined that the Oklahoma specific resources could be easily incorporated into the Med Home Portal web site.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided support to the Fostering Hope Clinic, Sickle Cell Clinic, Infant Transition Program, SoonerSUCCESS, and Family Support 360 Project in their ongoing effort to provide services using the medical home model.				X

2. Collaborated with the University of Oklahoma Child Study Center and Utah Collaborative Medical Home Projects to begin development of Oklahoma Med Home Portal				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Medical Home Program for Medicaid-eligible children and youth at the OU CSC serves as the primary facilitator in developing an integrated system of medical home care. The Medical Home Program is developing recommendations for OHCA on specific criteria for a medical home. The goal is to integrate these criteria into practices and incentives for primary care practices.

CSHCN continues collaboration with the Family Support 360 Medical Home Project. Training provided by the project promotes best practices and partnerships. Tools from this project are utilized in statewide medical home dissemination activities.

The Medical Home Project hosted a technical assistance visit by Vermont Child Health Improvement Project in November 2007. As a result, six practitioners now meet regularly to share ideas, determine community priorities for shared resources and problem solve.

Planning continues for the Oklahoma Med Home Portal Project. The Utah partners are updating the website to increase utility and capacity. Currently a launch date for an Oklahoma version has not been set. 211/JOIN and OKDHS Web Management staff are providing technical expertise to transfer information specific to Oklahoma to the Med Home Portal server.

The Fostering Hope Clinic, a medical home for children in child welfare custody supported by CSHCN, is in its third year. Clients are seen two days each week. A Ph.D. psychologist will screen every child seen at the clinic and assess as needed.

c. Plan for the Coming Year

OU CSC's Medical Home Project will continue working with the nine primary care practices in Canadian and Garfield Counties who have agreed to implement medical home concepts in their practices. The long-term goal of this project is to develop, promote and support health care improvements for SoonerCare eligible children and youth with complex medical conditions and their families by strengthening the capacity of primary care providers throughout the state of Oklahoma to provide them with a high quality medical home.

The Med Home Portal site will have peer-reviewed descriptions of specific health conditions in a tiered format. The initial tier will contain general information, and each subsequent tier will increase in technical content. As the Utah site is able to accept Oklahoma content, submissions will be sought from Oklahoma sources. Contributors to the Oklahoma content for condition-specific descriptions will be identified. 211/JOIN will continue to provide technical assistance to transfer information for the Med Home Portal System.

The OU CSC will continue their collaboration with the Access Health Care Project. Access Health Care Project began in 2006, and supports a community-based care coordinator in Canadian County to assist primary care practices in improving their Early Periodic Screening,

Diagnosis and Treatment Program (EPSDT) rates.

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	2003	2004	2005	2006	2007
Annual Performance Objective	58	59.5	61	62.5	64.1
Annual Indicator	56.4	56.4	56.4	56.4	61.6
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	62.9	64.2	65.5	66.8	68.1

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The State and Local Integrated Telephone Survey (SLAITS) Children with Special Health Care Needs (CSHCN) survey data for 2005-2006 reported that 61.6% of children 18 or younger with special health needs have adequate levels of insurance coverage to provide for required health services. This is an improvement from the 2001 survey when 56.4% of CSHCN had adequate levels of insurance coverage.

CSHCN and the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, continued to work toward the goal of having Medicaid cover metabolic formulas. A new report on formulas presently covered by CSHCN was presented to OHCA. The final work to have metabolic formulas and supplements covered by Medicaid was not completed in time for inclusion in OHCA's 2008 budget.

The OHCA reported a 6% increase in the number of children covered by Medicaid who are classified as disabled or blind. Children continued to be approved for and received services through the Tax Equity and Fiscal Responsibility Act (TEFRA) Program, which provides Medicaid

services to children who are ineligible for Supplemental Security Income (SSI) but meet nursing home or hospital level care and are able to reside at home. Enrollment in the TEFRA Program steadily increased from 120 children at the beginning of the year to 164 by year's end.

All families receiving supports and services through Sooner SUCCESS received assistance with identifying the appropriate mechanism for paying for the services they need. The model incorporated this aspect into the routine resolution of the service requests. County coordinators responded to 350 families. Some of the 586 supports that were identified for those families involved identifying funding mechanisms for needed services. While some of the referrals were for publicly funded services, other payment options included private foundation, faith-based sources, self-pay and private insurance.

The OHCA/Oklahoma State Department of Health (OSDH) Child Health Advisory Task Force was initiated in February 2007. CSHCN was a part of this advisory group to ensure that this population was included in task force activities and plans.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Explored coverage of metabolic formula with OHCA				X
2. Supported SoonerSUCCESS in their efforts to link CSHCN to appropriate resources				X
3. Participated as part of OHCA/OSDH Child Health Advisory Task Force			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OHCA reports Medicaid enrollment increased by 1.7% in 2007 and Medicaid remains the primary source of insurance coverage for children in Oklahoma. CSHCN continues to work with OHCA to ensure services that are compensable under the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) are covered through Medicaid.

Family Perspective conferences are held across the state to help families learn what services and programs are available through SoonerCare and Title V and to encourage families to apply for services. CSHCN staff attends these conferences and holds meetings with other parent and professional groups to explain the eligibility requirements and services of SoonerCare, TEFRA and the SSI-Disabled Children's Program.

At the Fall Forum, sponsored each year by the Oklahoma Institute for Child Advocacy (OICA), professionals and families from across Oklahoma convene to discuss child and adolescent needs in the state. Participants then decide what specific legislation regarding children's issues will be presented at the next legislative session. In October 2007, CSHCN participated in the CSHCN focused session. Participants in this session voted to support legislation to mandate treatment coverage by health insurance companies for children with autism. This legislation was drafted (HB 2531, "Nick's Law") but not heard by the House of Representatives during this year's legislative session.

c. Plan for the Coming Year

The Family Perspective Committee, a component of the Oklahoma Areawide Services Information System (OASIS), is made up of parents and family members of individuals with disabilities. The purpose of the committee is to improve the lives of children and youth in Oklahoma with disabilities throughout their lifespan by bringing issues, recommendations and action steps to the attention of the Oklahoma Commission on Children and Youth. The committee will finalize and disseminate a survey to identify barriers to families accessing the healthcare they need through public and private healthcare insurance companies.

The OHCA/OSDH Child Health Advisory Task Force will continue efforts to identify better policy, benefits and services for children who rely on public support for healthcare. The task force will discuss and make recommendations to OHCA for further analysis, service development, and benefit and process changes. The overall goal is to improve services and make them more accessible for all children using Medicaid and all other public funding.

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	2003	2004	2005	2006	2007
Annual Performance Objective	68	69.7	71.4	73.2	75.1
Annual Indicator	67.6	67.6	67.6	67.6	90.3
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	91	92	93	94	95

Notes - 2007

Indicator data comes from the National Survey of 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 NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The 2005-2006 National Survey of Children with Special Health Care Needs determined that the services of 90.3% of children under the age of 18 with special health care needs were organized so that families could easily use them. The data are not comparable to 2001 due to major revisions to the wording and ordering of this question.

CSHCN staff attended numerous events around the state to inform families of available programs. Two new meetings attended this year were the Oklahoma Mothers of Multiples and the Metro disABILITY Resource Conference, an annual meeting of professionals who serve disabled people across the state. CSHCN staff also held training sessions to educate OKDHS staff on Title V programs and how best to help families access them. CSHCN continued to contract with the Children and Family Services Division to provide medical services to children and youth in the temporary custody of the Oklahoma Department of Human Services (OKDHS) who reside in children's shelters throughout the state to insure they have access to comprehensive care.

The Oklahoma Family Network (OFN) collaborated with Sooner SUCCESS to share resource information. OFN provided training, mentorship and information to families with children who have special needs.

Sooner SUCCESS reported that 350 children and youth with special health care needs received service coordination supports that eased access to community-based services. These families requested assistance in four broad categories of service: health, mental health, education and social services. Sooner SUCCESS staff disseminated information to and acquired information about available services from individuals as well as groups, both large and small. Information disseminated through Sooner SUCCESS utilized direct mail, telephone communications, presentations at statewide and national conferences, discussion at community-based meetings and encounters with individuals. Through these various mechanisms, approximately ten thousand individuals were contacted throughout the year.

The Children's Oral Health Coalition (COHC), as part of its action plan, worked to ensure that community oral health services were organized in such a way that families could easily use them.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreached to families with CSHCN to inform them of available state benefits and programs		X		
2. Provided funding for medical services to children and youth in the temporary custody of the Oklahoma Department of Human Services (OKDHS)	X			
3. Supported the efforts of SoonerSUCCESS, Oklahoma Family Network and the Children's Oral Health Forum in their work to ensure communities had organized systems of service			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

OKDHS continues to make contact with and offer services to every individual under age 18 who is approved for Supplemental Security Income (SSI). More families are being reached due to collaborations throughout the state that include OFN, SoonerStart, the Family Support 360° Project, the Statewide Training and Regional Supports (STARS) project and the Oklahoma Health Care Authority (OHCA), the state Medicaid agency.

CSHCN staff attends the "On the Road Family Perspective Conferences" sponsored by the Oklahoma Areawide Service Information System (OASIS) for families of CSHCN and professionals who provide care to these children.

OFN was notified on April 21, 2008 that they were awarded a Family-to-Family Health Care Information and Education Center (F2F HIC) grant.

The STARS program and OFN continue to work together. Together they are working to develop a cadre of highly skilled individuals prepared to work with people with disabilities and their families and empower families to function as confident and competent team members by providing them with technical information, procedural information and access to training. STARS provides the location for OFN trainings and sends one staff member to assist with trainings. STARS also provides a small amount of funding each year for OFN to provide mentorship to SoonerStart families.

c. Plan for the Coming Year

As part of its action plan, the COHC will continue working to ensure that community oral health services are organized in such a way that families can easily use them.

The organizations that comprise the COHC, such as OHCA, Oklahoma Dental Association (ODA) and Oklahoma Dental Foundation (ODF), will work together to create a system to track CSHCN. A database and referral system for dentists who treat CSHCN will be developed. A separate database will also be created to track the care and treatment of CSHCN. Training will be made available for dentists to learn effective care coordination. In addition, COHC plans to simplify Medicaid processes and language, develop a "tool kit" for parents and providers and provide education for families having dental coverage through Medicaid.

OFN through the Family-to-Family Health Care Information and Education Center (F2F HIC) grant will be planning numerous grant activities during the year.

OFN will continue working with the Family Support 360 Project. An employee of the 360 Project assists OFN by translating training and resource materials into Spanish and providing translation services to families.

OFN will continue their collaborations with the Child Study Center, the Oklahoma State Department of Education, and the University Center for Excellence by assisting them and other agencies in finding staff, committee members and families to speak to professionals, parents and students. The University Center for Excellence and Center for Learning and Leadership provides funding for one staff member to work with mentor/mentee families and provides funding for another staff person to attend various meetings with other family networks or hospitals.

OFN is planning a series of "Joining Forces" conferences based on feedback from the April 2008 conference.

OFN will also continue collaboration with the Oklahoma Parent Training and Information Center (OPTI), referring when families call and need assistance with school supports or school training. The OPTI will refer families to OFN for mentorship, non-education training and assistance.

CSHCN will continue funding the Oklahoma Infant Transition Program (OITP), which assists the families of newborns in the neonatal intensive care unit (NICU) at the OU Medical Center on connecting to existing resources and navigating through the neonatal intensive care unit (NICU). CSHCN plans to also continue funding Tulsa Neonate Program, which provides the same services in the Tulsa metropolitan area.

Sooner SUCCESS will continue to identify and secure state funding to extend their model throughout the state.

With approximately half of Oklahoma's children not receiving needed mental health services, CSHCN will continue work with OHCA, the Oklahoma State Department of Health (OSDH) and the Department of Mental Health and Substance Abuse Services to address the issue of access to mental health services for children in Oklahoma.

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	2003	2004	2005	2006	2007
Annual Performance Objective	7.8	8.2	8.2	6	6.2
Annual Indicator	5.8	5.8	5.8	5.8	43.7
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	45	46	47	48	49

Notes - 2007

Indicator data comes from the National Survey of 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 NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Objectives for 2007-2011 have been revised to reflect more plausible targets given data from CSHCN survey.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The 2005-2006 Survey of Children with Special Health Care Needs (SLAITS) reports that 43.7% of children under the age of 18 received the services necessary to make appropriate transitions to adult health care, work and independence. Comparisons cannot be made to 2001 data due to a change in the questions from the previous version of the survey.

Multiple State agencies collaborated to develop an infrastructure for a coordinated interagency transition approach for youth. The Oklahoma Transition Council membership includes Oklahoma State Departments of Education, Human Services, Mental Health and Substance Abuse, Rehabilitation Services, Sooner SUCCESS, advocacy group representation, private organizations, family members and youth. This group conducted the second annual Oklahoma Transition Institute in June 2007 with approximately 200 participants in community teams attending. Facilitators supported teams as they identified existing resources and needs and made plans to build their team on return to their communities. These teams disseminated information about the statewide transition initiative and encouraged people to participate on their local teams. Plans were made for the teams to reassemble to report on their progress, access facilitators and one another for technical assistance, and to refine their strategic plans. Breakout sessions at the institute included Creating and Using Community Teams, Health Issues in Transition, Transition Assessment, Model Work Adjustment Strategies, Job Readiness, Career Tech Centers, Rural Work Study and Transition into Higher Education.

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 which hosted the second annual "Transition Institute" for training community-based teams				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oklahoma Transition Council (OTC) is conducting regional meetings to update their local plans and share successes and strategies to overcome barriers. Each of the Transition Council members contributes funding to support the Oklahoma Transition Institute. OTC has established an inter-agency statewide financial commitment for the transition component of a comprehensive community-based integrated system for CSHCN.

The Oklahoma Transition Council plans to host the third annual Oklahoma Transition Institute (OTI) in June 2008. The OTI provides facilitators to support teams as they identify existing resources and needs and work to build their team within their communities. These teams disseminate information about the statewide transition initiative and encourage people to participate at the local level.

The Oklahoma Department of Rehabilitation Services (DRS) is now a member of the transition

council to help provide job development, job sampling, job coaching, assistive technology and center-based employment.

c. Plan for the Coming Year

The Oklahoma Transition Council support teams will get back together in Fall 2008 through regional meetings to report their progress, access facilitators and each other for technical assistance and refine their strategic plans. Follow-up meetings will be held to provide technical assistance support for implementing the plan.

The Children's Oral Health Coalition (COHC), acting on a transition component in the action plan developed last year at the Oral Health Forum, will lobby the legislature for more services and public coverage for adults. COHC will promote writing adequate transition plans into children's Individualized Education Programs (IEP) at school. Education materials will also be developed on transition and referral services in regard to oral health.

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	2003	2004	2005	2006	2007
Annual Performance Objective	79	82	83.6	74.2	76.4
Annual Indicator	70.5	72.0	75.7	80.4	79.5
Numerator	33502	34215	37087	40268	41253
Denominator	47521	47521	48992	50085	51890
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
	2008	2009	2010	2011	2012
Annual Performance Objective	80.8	82.1	83.4	84.7	86

Notes - 2007

Source of data: Numerator is estimate from National Immunization Survey, Q3/2006-Q2/2007, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series

Population data in denominator were obtained from the U.S. Bureau of the Census.

Annual Performance Objectives for 2008-2012 have been revised to reflect expected increase in % of 19-35 month olds receiving vaccinations. OSDH will be launching Operation Buzzer-Beater to ensure vaccinations of 24 month-olds who have not received sufficient immunization shots.

Notes - 2006

Source of data: Numerator is estimate from National Immunization Survey, Q1/2006-Q4/2006, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series

Population data in denominator were obtained from the U.S. Bureau of the Census.

Objectives for 2007-2011 have been revised to reflect more plausible targets given data from NIS survey.

Notes - 2005

Source of data: Numerator is estimate from National Immunization Survey, Q1/2005-Q4/2005, of percent of Oklahoma children aged 19-35 months who have received 4:3:1:3:3 vaccination series

Population data in denominator were obtained from the U.S. Bureau of the Census.

a. Last Year's Accomplishments

National Immunization Survey (NIS) results for the third quarter of 2006 through the second quarter of 2007, the latest data available, showed a coverage rate of 79.5% for children less than two years of age who had received these immunizations. This represents an increase from 2005, in which the coverage rate was estimated by NIS at 76%.

The Oklahoma State Department of Health (OSDH) maintained its policy of providing immunizations to any child that 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 Medicaid eligible children for the third consecutive year.

A contractual agreement remained in place with the Oklahoma Health Care Authority (OHCA) allowing reimbursement for Medicaid administrative costs related to the Oklahoma State Immunization Information System (OSIIS), Oklahoma's statewide immunization information registry.

MCH continued collaboration with the OSDH Immunization Service 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 4th 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. In 2007, 75% of Oklahoma Vaccines For Children (VFC) providers indicated use of OK By One in their practice. It is anticipated that some of the improvement in coverage rates seen in the state's 2006 NIS is a result of the 2004 OK By One cohort beginning to be included in the NIS samples.

Additional strategies to improve immunization rates included Immunization staff conducting immunization audits in 557 child care centers and providing 270 clinics in both the public and private sectors with the CDC's Assessment, Feedback, Incentive and eXchange (AFIX) intervention. Additionally, a new requirement for pneumococcal conjugate vaccine for children attending a licensed child care facility was instituted in July 2007.

MCH continued to review immunization status during site visits to county health departments and contractors as well as participate in the OSDH Immunization Advisory Committee meetings held during the year.

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. Maintained contract with the OHCA, the state Medicaid agency, for reimbursement of immunizations and support of the electronic state immunization registry				X
4. Supported statewide efforts of the "OK by One" Project to facilitate improvement in vaccine protection levels		X		
5. Monitored immunization services provided through site visits to service providers to assure children receiving immunizations on schedule				X
6.				
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 surveys conducted in all 77 counties to enhance rates. County and state survey results consistently identify issues of getting infants vaccinated on time and on schedule. The OK by One Project, day care audits and increased emphasis on AFIX are being used to impact this finding. State preliminary results for 2007 show the proportion of children completing the 4th DTaP by 15 months of age has tripled since the implementation of OK By One.

OSDH Immunization Field Consultants (IFC) continue to complete immunization audits in child care centers. Staff are 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 OSIS registry is increasing. Seven hundred sixty eight of the state's estimated 1200 public and private clinics currently use the system to record immunizations. Additionally, 1,046 schools and 88 child care centers utilize the registry for tracking state immunization requirements. Among the state's population of children <6 years of age, 81% have multiple vaccinations recorded in the registry. Since OSIS began in 1995, the system has recorded over 19 million vaccinations.

c. Plan for the Coming Year

MCH will continue its close partnership with Immunization Service and support activities targeted toward attaining the goal of 90% of children 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 and clinic-level quality improvement. Efforts will continue to expand private sector partnerships with business and medical communities to promote the health of children. MCH will additionally provide support in the development of an adolescent platform for newly introduced vaccines, establishing standing orders in hospitals and provider offices for Tdap administration to post-partum women, and support efforts by the Immunization Service to establish a pilot program for billing private insurance companies for children served by public health clinics.

The OSDH Immunization Service will implement a pilot program called Operation Buzzer Beater to decrease the proportion of children who need just one vaccine to complete the primary 4:3:1:3:3:1 vaccination series. Protocols are still under development for this project.

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 OSIS.

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

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	2003	2004	2005	2006	2007
Annual Performance Objective	29	28	27.3	31.4	27.1
Annual Indicator	29.7	31.9	27.4	30.6	30.6
Numerator	2118	2145	2020	2297	2297
Denominator	71309	67198	73677	75177	75177
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
	2008	2009	2010	2011	2012
Annual Performance Objective	26.8	26.6	26.3	26	25.7

Notes - 2007

Source: Health Care Information, OSDH. Data for year 2007 are not available. Year 2006 repeated to provide an estimate for 2007.

Notes - 2006

Source: Health Care Information, OSDH.

Objectives for 2007-2011 have been revised to reflect more plausible targets given recent data from Oklahoma vital statistics.

Notes - 2005

Source: Health Care Information, OSDH.

a. Last Year's Accomplishments

Oklahoma experienced a reduction in teen births over the last several years, however in 2006 there was an 11.7% increase in the birth rate for adolescents 15-17 years old, to 30.6 live births per 1,000 females aged 15-17. For the most recent year that the National Center for Health Statistics (NCHS) final birth data is available, Oklahoma's 2005 birth rate of 27.1 for 15-17 year olds is 26.6% higher than the national rate of 21.4. Of the 7,320 babies born in 2006 to females 19 and younger, 2,376 babies or 32.5% were born to mothers 17 years of age or younger and 4,944 babies or 67.5% were born to mothers eighteen and nineteen years of age. Sixty-three of Oklahoma's 77 counties have teen birth rates higher than the national average of 41.9 per 1,000 females age 15 to 19.

Teen birth statistics were reported and utilized by statewide media and the Interagency Coordination Council (ICC) for Prevention of Adolescent Pregnancy and Sexually Transmitted Diseases (STDs), a legislatively appointed interagency group, which met routinely to develop a written state plan that was submitted to the Legislature and Governor on November 1st.

The Maternal and Child Health Bureau approved technical assistance through MCH for the ICC for Prevention of Adolescent Pregnancy and STDs that resulted in an increased capacity of key state and community agencies, organizations, and coalitions to identify, select, use, and evaluate science-based approaches for adolescent pregnancy prevention. The MCH Chief and Adolescent Health Coordinator continued to serve as members of the ICC for the Prevention of Adolescent Pregnancy and STDs.

MCH realigned the responsibilities of the Adolescent Health Coordinator. Historically this position focused on contract monitoring of the adolescent pregnancy prevention projects, however, the focus moved to building infrastructure supporting adolescent health services statewide. The Adolescent Health Coordinator attended the National Network of State Adolescent Health Coordinators Annual Meeting in March, an opportunity to network with other states adolescent health coordinators and learn more about the role.

A health educator (supervised by the Adolescent Health Coordinator) was hired to monitor the adolescent pregnancy prevention projects contracts, seven state-funded projects with four administered through county health departments and three through community-based private, nonprofit organizations. Research-based curricula were used to reach over two thousand middle school age adolescents within culturally diverse communities. In addition, these projects provided parent education for effective communication with adolescents.

One hundred twenty five thousand dollars (\$125,000) of Title X Family Planning funds supported a special project focused on increasing male involvement in family planning services. Located in three counties where some of the highest rates of teen pregnancy are reported, the project focused on outreach, education and clinical services to Native American and African American males of reproductive age, to include adolescents. Title X funds also supported health education and clinical services in Tulsa County for hard-to-reach/at-risk youth.

Family planning services specific to adolescents continued to be provided through county health departments and contract providers. These services included a comprehensive physical examination, information on sexually transmitted infections (STI), human immunodeficiency virus (HIV) prevention, education on contraception methods (including abstinence) and encouragement of parental involvement.

Five hundred thousand dollars (\$500,000) in new funds were appropriated to the Oklahoma State Department of Health in the 2007 legislative session. These monies were targeted to fund community or faith-based organizations to implement Postponing Sexual Involvement (PSI) curriculum to geographical areas within the state of greatest need due to unfavorable combination of economic, social, environmental and health factors where the teen birth rates are higher than the state average.

Teen parenting projects that provided clinical and population-based services in both Oklahoma City and Tulsa continued to be funded by MCH. The projects focused on healthy birth outcomes, school completion and delay of subsequent pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Disseminated teen birth data for use by statewide media for public education			X	
2. Provided teen birth data to ICC for Prevention of Adolescent Pregnancy and STDs for use in development of the annual state plan				X
3. Facilitated provision of technical assistance to the ICC for Prevention of Adolescent Pregnancy and STDs to promote state systems/policy changes				X
4. Restructured duties of Adolescent Health Coordinator and Health Educator to enhance effectiveness in impacting adolescent health				X
5. Provided funding and technical assistance to teen pregnancy prevention projects, teen parenting programs, hard-to-reach/at-risk youth and male involvement project				X
6. Provided clinical family planning services through county health departments and contract providers	X			
7.				
8.				
9.				
10.				

b. Current Activities

Technical assistance (TA) was given by Konopka Institute for Best Practices in Adolescent Health, University of Minnesota through the Maternal and Child Health Bureau in November 2007. This TA will assist MCH in completion of the Systems Capacity Tool for Adolescent Health in June 2008.

MCH continues to provide TA to the adolescent pregnancy prevention projects. In July, these seven projects will enter the fourth year of the five-year contract.

The OSDH issued a Request for Proposal (RFP) in February 2008 for funding up to five community-based projects up to \$100,000 each to implement PSI. Four projects have been awarded funding with implementation to occur starting July 1, 2008.

c. Plan for the Coming Year

MCH will gather information to complete the Systems Capacity Tool for Adolescent Health from the Konopka Institute for Best Practices in Adolescent Health. The information gained will be used to develop a state adolescent plan that will prioritize prevention efforts and provide a set of critical markers for ongoing system evaluation.

The Title X Family Planning special project on male involvement will continue to promote clinical services for males of reproductive age and provide adolescent males with health education including a variety of family planning and related male health issues such as unwanted pregnancies, sexually transmitted infections (STI's), testicular health, the need for routine

preventive health care and male responsibility related to reproductive health to include pregnancy prevention.

The hard-to-reach/at-risk youth (comprised of those youth identified as low-income, alternative lifestyle, uninsured and/or at-risk of poor health outcomes) Title X project in Tulsa will continue to increase the availability, access, and awareness of reproductive health care services, information and education related to the unique needs of hard-to-reach/at-risk youth.

Teen parenting projects will play a role in the statewide training and technical assistance provided through the CDC and ICC for the Prevention of Adolescent Pregnancy and STDs project.

TA and contract monitoring will continue to be provided to the Title X male involvement and hard-to-reach/at-risk youth projects, the adolescent pregnancy prevention projects, and the teen parenting projects located in Oklahoma City and Tulsa.

The ICC for Prevention of Adolescent Pregnancy and STDs will continue to receive technical assistance and participation from MCH staff to support state and local adolescent pregnancy prevention efforts.

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	2003	2004	2005	2006	2007
Annual Performance Objective	26	40	41.2	37.7	38.7
Annual Indicator	37.2	32.9	36.8	34.2	35.1
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	39.6	40.6	41.6	42.4	43.2

Notes - 2007

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

Notes - 2006

Source: Statewide Oklahoma Oral Health Needs Assessment, 2006 - Dental Health Service, OSDH.

Objectives for 2007-2011 have been revised to reflect more attainable targets given data from the dental needs assessment.

Notes - 2005

Source: Statewide Oklahoma Oral Health Needs Assessment, 2005 - Dental Health Service, OSDH.

a. Last Year's Accomplishments

The fifth annual statewide dental health needs assessment of third grade children was conducted. The Oklahoma State Department of Health (OSDH) Dental Health Service contracted with the University of Oklahoma (OU) College of Dentistry to administer the dental needs assessment and worked with the OU College of Public Health's Department of Biostatistics and Epidemiology to determine the sample design and to perform the data analysis. Data from the 2007 dental survey revealed: the percent of third grade children having protective sealants on at least one permanent molar tooth was 35.1%; the percent of third grade children having dental caries experience was 67.5%; and, the percent of third grade children having untreated dental decay was 30.8%.

The Oklahoma Dental Loan Repayment Program became effective in November 2006 with permanent rules adopted by the Board of Health in March 2007. This program was designed to increase the number of dentists serving and caring for those dependent upon the state for dental care and to make dental care accessible to underserved metropolitan and rural areas. The program provided educational loan repayment assistance for up to four Oklahoma licensed full-time dentists and one full-time equivalent faculty dentist per year, for a 2 to 5 year period per dentist. Eight practicing dentists and one faculty dentist were participating in the program during this period. The OSDH Dental Health Service administered this program.

The state Legislature appropriated \$100,000 to OSDH to help support the Oklahoma Dental Foundation Mobile Dental Care Program. Using this mobile dental unit, comprehensive dental treatments were provided to clients who could not afford dental care and/or who lived in underserved areas of the state. These funds were administered through the Dental Health Service. Between October 1, 2006 and September 30, 2007, 47 trips were made to locations within Oklahoma, 972.5 volunteer hours were provided to treat 464 patients, and the value of the care provided was estimated to be \$93,271. Of those 464 patients, approximately 82% were children under the age of 18; 40% of those were children eight years old or younger.

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

Dental educational services included dental health education and tobacco use prevention instruction in 37 counties to 39,797 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.

Six county health department clinic sites provided dental services to children and pregnant women. Procedures and services included dental sealants, fillings, cleanings, topical fluoride applications, x-rays, extractions, crowns, oral hygiene instruction and prescriptions for infections. MCH continued to provide funding for dental clinical services as well as partial funding for the statewide dental needs assessment.

The Guthrie Smart Start initiative collaborated with community health and early childhood professionals to hold a comprehensive system of early enrollment for children entering school for the first time. The children received vision, hearing, and dental screenings and parents were provided with a checklist of skills to work on with their children. Guthrie also implemented an oral health education program for young children called Tiny Teeth. Smart Start Kay County collaborated with community partners to implement a mobile dental care program and provide dental education materials.

The Governor's Task Force on Children and Oral Health was established by an Executive Order

in August 2007 to determine ways to infuse oral health education, dental care and dental disease prevention into existing programs that address the health of children, youth and families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted the fifth annual statewide dental health needs assessment of third grade children				X
2. Supported the placement of dentists in rural areas of state through educational loan repayment program funded through the Oklahoma Dental Loan Repayment Act				X
3. Provided comprehensive dental care to children who could not afford care and/or live in underserved areas of the state through partnership with Oklahoma Dental Foundation	X			
4. Participated in state planning activities to improve dental services				X
5. Provided dental health education in schools and at child health clinic visits			X	
6. Provided dental clinic services through 6 county health department sites	X			
7. Supported the provision of dental health activities through community-based early childhood initiatives		X		
8.				
9.				
10.				

b. Current Activities

A written report of the 2007 statewide dental health needs assessment of third grade children is being finalized. The 2008 survey is currently being conducted. Dental Health Service is working with the OU Colleges of Dentistry and Public Health to complete this project. Information obtained from this survey includes dental caries and dental sealant data.

The Oklahoma Dental Loan Repayment Program continues to be successful. Applications are under consideration for participation in the program for the next state funding cycle. It has been funded for state fiscal year 2009 (SFY 09) with state appropriated money.

The Governor's Task Force on Children and Oral Health is in the process of making member appointments.

Between October 1 and December 31, 2007, the Oklahoma Dental Foundation Mobile Dental Care Program made 17 trips to locations within Oklahoma, 52 dental providers donated their time, 183 patients were treated, and the value of the care provided is estimated to be \$33,761. Activities are continuing and the program has been funded again for SFY 09.

Dental educational services in 38 counties and dental clinical services in seven county health department clinics continue in the state.

c. Plan for the Coming Year

The dental health needs assessment of third grade children will not be conducted in 2009, but will resume in 2010 and be conducted during the even years. This is due to several reasons including staff constraints, time needed for data analysis and evaluation, and the fact that OSDH has six

consecutive years of data to evaluate.

Appointments to the new Governor's Task Force on Children and Oral Health will be completed and activities begun.

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

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.

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	2003	2004	2005	2006	2007
Annual Performance Objective	6.5	4.5	3.7	5.5	5
Annual Indicator	3.8	5.8	4.9	6.7	6.7
Numerator	28	41	36	49	49
Denominator	733102	712680	727415	735666	735666
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
	2008	2009	2010	2011	2012
Annual Performance Objective	5	4.9	4.9	4.9	4.9

Notes - 2007

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

2007 data for numerator not available. Year 2006 is repeated to provide estimate.

Despite the increase in the death rate of children <15 years of age to motor vehicle crashes in 2006, future rates are expected to remain closer to 5 deaths per 100,000.

Notes - 2006

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

Notes - 2005

Source for numerator data: Health Care Information, OSDH.

Source for population data: American Community Survey, US Census Bureau

a. Last Year's Accomplishments

In 2006, the latest year for which final mortality data are available, there were 49 recorded motor vehicle deaths to children 14 years of age or younger. This resulted in a death rate of 6.7 per 100,000 children in this age group and an increase over the previous year's rate of 5.1 per 100,000. This should be interpreted cautiously due to the small number of events, which tends to cause volatility in single-year rates. Single-year rates for this measure have varied considerably, making interpretation difficult. The five-year average removes some of this variability. The rate for 2002-2006 was 4.5 per 100,000.

The Child Death Review Board continued to assess multiple variables leading to the death of children including motor vehicle crashes and to make legislative and administration recommendations as a result of deaths reviewed. The Chief of MCH continued to serve on the Child Death Review Board.

The Oklahoma State Department of Health (OSDH) continued to be the lead agency for the Safe Kids Worldwide partnership for Oklahoma efforts. Safe Kids Oklahoma (Safe Kids) continued as a collaboration between the OSDH, University of Oklahoma (OU), Children's Physician's, Children's Hospital at OU Medical Center, Oklahoma Highway Safety Office, and Safe Kids Inc., the private non-profit fund-raising arm of Safe Kids Oklahoma.

MCH continued to provide in-kind support to Safe Kids by assigning a staff person to their program to assist, administer, and provide oversight of injury prevention activities. In April 2007, the MCH staff person resigned her position; however, MCH continued to partner with Safe Kids, working with their Board of Directors to review infrastructure and the need for administrative and fiscal policy development. Conversations with the Board of Directors led to a mutual agreement that Safe Kids would be best served by hiring their own Executive Director and contracting with MCH for fiscal support. A contractual agreement was put into place in July 2007 to provide support for the success of statewide childhood injury prevention activities.

Safe Kids continued to work with the Child Care Licensing Division, Oklahoma Department of Human Services (OKDHS), in the requirement of child passenger safety (CPS) training for all child care centers that transport children. Each center is required to have at least one staff member who transports children complete the eight-hour CPS course. Safe Kids provided oversight for this regulation and worked with OKDHS to produce a video for child care providers explaining the transportation requirements.

Safe Kids continued to offer training statewide in CPS, primarily targeting health professionals, child care professionals, law enforcement and firefighters. Sixty "Introduction to CPS" classes were conducted for 844 participants across the state. Three update classes were conducted for 67 participants and one four-day certification class was held for 17 participants. In addition, two CPS re-certification classes were conducted for 19 participants. This class allowed previously certified CPS technicians to renew their certification without re-taking the entire 32-hour course. The Please Be Seated Project allowed concerned citizens to report, via postcard, vehicles carrying unrestrained children. More than 1,300 reported violators were contacted by mail and provided information on car seats. Safe Kids conducted 45 child safety seat checks across the state, checking a total of 548 seats. An additional 158 safety seat checks were conducted through individual appointments. Safe Kids provided 40 discounted car seats, 449 subsidized car seats and 363 free car seats to the public. The loaner program for children with special health care needs served 102 children.

Quarterly meetings continued to occur between MCH and Injury Prevention Service. All staff from the two areas attended the meetings, which were co-facilitated by the Chiefs of the two areas. The meetings provided a forum for discussion of common interests and collaboration to increase opportunities for effective results. One such collaboration developed was the partnership between MCH, the Oklahoma Highway Safety Office and Injury Prevention Service in the 2M2L (Too Much To Lose) Project in the effort to address underage drinking.

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/impact state policy				X
2. Supported statewide activities of Safe Kids Oklahoma through provision of funding and technical assistance				X
3. Developed partnership with Oklahoma Highway Patrol and ODSH Injury Prevention Service to reduce underage drinking				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Executive Director position with Safe Kids was filled January 22, 2008.

Safe Kids continues to offer trainings statewide in CPS, targeting health professionals, child care professionals, law enforcement and firefighters. One four-day certification class was conducted in May 2008, for approximately 20 participants.

The Please Be Seated Project allows concerned citizens to report, via postcard, vehicles carrying unrestrained children. Safe Kids continues to conduct child safety seat checks across Oklahoma. Safe Kids continues to provide discounted car seats, subsidized car seats and free car seats to the public. Safe Kids continues to loan car seats to parents of children with special health care needs.

MCH and Injury Prevention Service continue to participate in joint quarterly meetings involving all staff from the two areas with the Chiefs of both areas serving as co-facilitators. The meetings provide a forum to discuss common areas of interest and ways to increase collaboration for more efficient operations and effective results.

The MCH Adolescent Health Coordinator serves on the Governor's Task Force on Prevention of Underage Drinking; efforts include prevention of motor vehicle crashes and subsequent injury and death for youth as a result of alcohol.

As part of the Commissioner's Action Team on Infant Mortality an intra-agency work group was formed to focus on the reduction of injuries to infants up to one year, to include those resulting from motor vehicle crashes.

c. Plan for the Coming Year

Safe Kids will begin focusing their efforts on the expansion of local chapters across the state. The goal for this next year is to increase the number of local chapters from 13 to 17.

In addition to regularly scheduled events, Safe Kids will establish monthly car seat safety checks supported through State Farm Insurance and the Oklahoma Metropolitan Auto Dealers

Association. Additionally, Safe Kids will diversify training for Child Passenger Safety by looking to increase support given to rural technicians.

MCH will continue to participate in the Child Death Review Board.

MCH and Injury Prevention Service will continue meeting quarterly to facilitate improved collaboration. These meetings will provide MCH with the opportunity to gain input for Title V childhood injury prevention activities, to include motor vehicle crashes.

The intra-agency workgroup on injury prevention will continue to meet and develop a strategic plan to reduce infant mortality and morbidity due to injuries, including those resulting from motor vehicle crashes.

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

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				31.8	32.4
Annual Indicator			31.2	29.6	29.6
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	33.1	33.8	34.4	34.7	35

Notes - 2007

Data for NPM#11 were obtained from the National Immunization Survey, 2004.

Notes - 2006

Data for NPM#11 were obtained from the National Immunization Survey, 2004.

Notes - 2005

Source: National Immunization Survey 2004. Data reflect Oklahoma-specific estimate generated from NIS 2004.

a. Last Year's Accomplishments

Data from the National Immunization Survey (NIS) for 2005 (the latest data available), which provides state-specific information on breastfeeding at six months postpartum, revealed 29.6% of Oklahoma mothers breastfed their infants to at least 6 months of age. This is a decline from 31.2% reported in 2004 using data from the NIS.

MCH monitored breastfeeding initiation and duration at 10 weeks postpartum through the Pregnancy Risk Assessment Monitoring System (PRAMS), Women, Infants and Children Supplemental Nutrition Program (WIC) and NIS data. This information was shared with state policymakers, health care providers, women, families and community groups.

MCH continued to provide leadership for the Oklahoma State Department of Health (OSDH) initiative to recognize breastfeeding friendly employers and worksites through planning meetings with other OSDH Services (WIC, Chronic Disease Service, Office of Communications and Community Health Services) and others interested in promoting and supporting breastfeeding efforts in the workplace (Healthy Mothers Healthy Babies Coalition, Coalition of Oklahoma Breastfeeding Advocates (COBA), University of Oklahoma (OU) Medical Center, Oklahoma Certified Healthy Business Program, and a breastfeeding mother from the community). To promote recognition an employer brochure with minimum criteria for recognition and benefits; a decal indicating that nursing mothers and babies are welcome in businesses and public establishments; legislation cards for the public summarizing Oklahoma's Breastfeeding Laws including a mechanism for reporting supportive or unsupportive businesses; and a ten page OSDH Breastfeeding Information Website providing the previous information as well as the benefits of breastfeeding for mothers, infants, and children; recommended duration and benefits; employer benefits; suggestions for setting up a lactation room; breastfeeding policy and position statements; and, links to other resources were developed.

MCH and WIC continued to collaborate with the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, to develop policy for reimbursement of certified lactation consultants. In addition, MCH supported WIC in a proposal to OSDH leadership for a skill-based pay incentive for employees who obtain certification and/or recertification as an International Board Certified Lactation Consultant (IBCLC).

MCH continued to work with OSDH Human Resources to integrate information about the availability of the OSDH breastfeeding room into new employee orientation. In addition MCH collaborated with the OSDH Breastfeeding Friendly Workplace Recognition Workgroup, and led efforts to expand and improve the current "Mothers Room" for OSDH breastfeeding employees. MCH facilitated the development and approval of the OSDH Worksite Breastfeeding Policy.

MCH continued to participate in COBA activities, which included finalizing a model hospital breastfeeding policy draft to be sent to other Oklahoma professional groups for endorsement.

MCH participated in the WIC Breastfeeding Task Force to plan the Breastfeeding Educator Training in April, the June Breastfeeding Symposium focusing on Kangaroo Mother Care "Skin-to-Skin" with Dr. Nils Bergman from South Africa, the August World Breastfeeding Week activities whose theme was "Hold Me, Feed Me, Love Me" and included the development of radio and television public service announcements (PSAs), which aired a total of \$234,092.00 worth of airtime this year. WIC and the OSDH Office of Communications won two awards from National Public Health Communicators for the Skin-to-Skin PSAs; a Silver Award for the Television PSA , and the Gold Award for in-house creation for the Radio PSA.

The WIC Breastfeeding Peer Counseling Program expanded to include McIntosh, Haskell and Canadian counties, in addition to Lincoln, Logan, Kingfisher and Blaine for a total of ten breastfeeding peer counselors providing services in seven counties. The program offered one-on-one counseling services over the phone and in person and facilitated breastfeeding support groups.

MCH continued to collaborate with WIC and Chronic Disease Services to provide breastfeeding education and promotion efforts. During National Nutrition Month in March, breastfeeding information and activities were provided statewide for the public and OSDH staff.

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 multiple OSDH programs and other stakeholders on breastfeeding friendly business initiative and OSDH breastfeeding website				X
3. Developed with WIC and OHCA a policy for Medicaid reimbursement of lactation consultant services				X
4. Developed a breastfeeding policy for OSDH employees and expanded the worksite breastfeeding room				X
5. Collaborated in development of model hospital breastfeeding policy				X
6. Collaborated with WIC on expansion of Breastfeeding Peer Counseling Program			X	
7. Collaborated with WIC and Chronic Disease Service on breastfeeding training and education activities				X
8.				
9.				
10.				

b. Current Activities

Oklahoma's Breastfeeding Friendly Worksite Initiative is active and was launched during the February Board of Health meeting, and through statewide news releases, television and radio interviews. MCH continues to promote the new "Mothers Room" in Employee Orientation.

The Breastfeeding Information Website was launched around Mother's Day, through news releases and Turning Point's Certified Healthy Business e-mail. MCH, WIC and Chronic Disease Services are working with COBA to obtain endorsements for the Model Hospital Breastfeeding Policy, and to distribute the policy.

World Breastfeeding Week activities are being shared through press releases and incentives for WIC clients.

The OHCA is reimbursing for IBCLCs with Oklahoma licenses.

Breastfeeding information is offered statewide during National Nutrition Month, and ten peer counselors continue to provide services in seven counties.

As part of the Commissioner's Action Team on Infant Mortality an intra-agency work group was formed to focus on additional breastfeeding measures to impact infant mortality.

MCH and WIC have partnered to provide funding for the initiation and the on-going support of a 24-hour statewide breastfeeding support line that will be housed within the department of OB-GYN, University of Oklahoma Medical Center. It is anticipated that the support line will be implemented this summer and will be promoted to all Oklahoma breastfeeding mothers as a resource for support.

c. Plan for the Coming Year

MCH will continue to monitor breastfeeding rates through PRAMS, WIC and NIS data, sharing information with state policymakers, healthcare providers, women, families and community groups to promote and foster the success of breastfeeding.

MCH will promote the OSDH Breastfeeding Friendly Worksite Initiative, showcasing qualifying

worksites in Turning Point's Certified Healthy Business e-mails and annual conference, the HMHB annual meeting, the website and statewide news releases.

The Breastfeeding Information Website will be updated regularly with plans to add the Centers for Disease Control and Prevention's (CDC) Business Case for Breastfeeding Toolkit. MCH will continue to promote agency-wide use of the OSDH "Mothers' Room", and the establishment of work place lactation rooms statewide.

MCH, WIC and Chronic Disease Services will work with COBA on several initiatives including: a task force to monitor compliance with HB 2358 (breastfeeding working mothers); statewide distribution of the Model Hospital Breastfeeding Policy; development of a standard protocol/tools for COBA to provide technical assistance to hospitals implementing the policy; promotion of outpatient lactation services by listing IBCLCs providing services in Oklahoma on the OHCA website and others; continued collaboration with OHCA to provide outpatient lactation service benefits for all breastfeeding infants older than 60 days; and continued collaboration with OHCA on a plan to reward hospitals who receive Baby-Friendly designation.

MCH will work with WIC's Breastfeeding Task Force to plan the 2009 Ninth Annual WIC Breastfeeding Symposium for Healthcare Providers. The task force will coordinate World Breastfeeding Week activities, review breastfeeding promotional materials for county health departments and area clinics and plan for upcoming trainings including the Breastfeeding Educator and the Lactation Exam Preparation Courses for health professionals.

The peer-counseling program will work on plans to expand to additional counties.

MCH and WIC will contract with the Department of OB-GYN, OU Medical Center Lactation Center for development of a 24-hour support line for breastfeeding women and health care providers with problems, concerns or questions about breastfeeding. Promotion and outreach activities will be explored.

MCH will work with the Perinatal Continuing Education program (PCEP) to offer continuing education to physicians and nurses providing perinatal services in statewide hospitals. Consistent messages regarding breastfeeding and breastfeeding benefits will be an emphasis.

MCH will participate in and offer lactation trainings and technical assistance for health professionals in county health departments and contract clinics. Focus areas will center on promoting prenatal preparation for breastfeeding, initiating and continuing breastfeeding and managing common problems.

The intra-agency breastfeeding work group will implement their plan for the reduction of infant mortality.

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	2003	2004	2005	2006	2007
Annual Performance Objective	90	93.5	96.6	97.2	95.1
Annual Indicator	96.2	93.8	94.6	95.1	95.1
Numerator	48928	47989	49001	51352	51352
Denominator	50874	51157	51775	54010	54010
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
	2008	2009	2010	2011	2012
Annual Performance Objective	95.5	96	96.5	96.9	97.4

Notes - 2007

Source: Data were obtained from Screening and Special Services, OSDH. Year 2007 data are not yet available. Therefore, year 2006 is repeated to provide an estimate.

Notes - 2006

Data were obtained from Screening and Special Services, OSDH.

Notes - 2005

Source: Screening and Special Services, OSDH.

a. Last Year's Accomplishments

Of the 54,010 Oklahoma births in calendar year (CY) 2006, 51,352 infants (95.1%) had hearing screened prior to hospital discharge; 2,658 were not screened. Of the infants screened, 1,927 were (3.7%) referred for diagnostic assessment because they did not pass the hospital screening. Of the infants who were referred, 91 had confirmed hearing loss. The average age at diagnosis was less than three months of age. Because of the presence of hearing "risk indicators," 3,438 infants who passed screening at birth were referred for additional hearing screening when they reached six months of age. At least 75 infants with a diagnosis of hearing loss born in 2006 and 27 infants born in 2007 were enrolled in Oklahoma's 0-3 early intervention program, SoonerStart, or other early intervention programs for infants with hearing loss as of September 30, 2007.

On October 1, 2006, sixty-six (66) Oklahoma birthing facilities were providing physiologic hearing screening. All Oklahoma hospitals with a census of fifteen or more births per year were providing physiologic hearing screening on September 30, 2007.

MCH and CSHCN continued to partner in support of the Newborn Hearing Screening Program (NHSP). MCH provided Title V federal and state funding to support ongoing statewide newborn hearing screening activities. Both MCH and CSHCN provided technical assistance as needed.

With the hearing screening equipment purchased with CSHCN funds in 1999 now at the end of its useful life, the NHSP, MCH and CSHCN continued efforts started last year to obtain funding to replace hospital hearing screening equipment. Initially, CSHCN evaluated its budget as a possible revenue source, however, such funding was not available. The Oklahoma State Department of Health (OSDH) provided funds for nine hospital hearing screeners in March 2007 and an OSDH legislative request for funding of twenty additional screeners was realized in July 2007. Nine units were distributed to those hospitals experiencing the most frequent breakdowns in August and September 2007. The twenty additional units were expected after October 1, 2007.

The NHSP taskforces continued their ongoing activities. The Screening Taskforce supported efforts of the NHSP to provide hearing screening in-service training at birthing facilities across the state. For facilities that participated in the training, the number of errors on hospital reported hearing screening results was reduced significantly. In a continuing effort to increase the number of pediatric audiologists providing services for Medicaid-eligible deaf and hard of hearing infants and toddlers, the Audiology Taskforce continued its efforts with the Oklahoma Health Care Authority (OHCA) to institute Medicaid reimbursement fees commensurate with those in the private sector. While new fees were not implemented by September 30, 2007, considerable progress had been made with a revised fee scale anticipated to be in place by the second quarter

of 2008.

The Early Intervention Taskforce developed outcome measure protocols for deaf /hard of hearing infants and toddlers enrolled in intervention programs. This taskforce also was instrumental in making updated Ski-Hi training available to SoonerStart and other OSDH clinicians working with deaf and hard of hearing clients.

With support through the Health and Human Resources Administration (HRSA) funded Universal Newborn Hearing Screening Project (4/05-3/08), a Follow-up Coordinator was employed by the NHSP. The Coordinator enabled the NHSP to move toward reaching the national goal that every newborn is screened within their first month of life, that infants with loss are diagnosed by three months and that infants with documented loss are enrolled in intervention by six months of age. HRSA funding also provided diagnostic oto-acoustic emission (OAE) equipment at the three remaining health department audiology locations that did not have such units and provided diagnostic tympanometers with high-frequency probe tones at two health department sites. Trainings in using hearing screening/diagnostic equipment and updates on screening and assessment techniques were offered to health department clinicians and other interested health care professionals across the state.

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. Secured funds for replacing 29 hearing screening units approaching the end of useful life				X
3. Supported ongoing activities of the NHSP task forces				X
4. Provided education and training to health care providers				X
5. Advocated for a new fee schedule for Medicaid reimbursement for pediatric audiologists				X
6. Employed a Follow-up Coordinator		X		
7. Purchased and placed diagnostic oto-acoustic emission equipment and tympanometers at county health departments				X
8.				
9.				
10.				

b. Current Activities

Twenty replacement hearing screening units were received in October 2007. These screeners are provided to the hospitals that are experiencing the most frequent breakdowns of old equipment and to hospitals with the highest birthrates; two of Oklahoma's Native American hospitals are receiving replacement units. Training in the use of the new equipment is being provided to each facility. The OSDH again submitted a formal request for similar funding for SFY 09 to replace hearing screening equipment and the legislature chose to increase the amount of funding so that NHSP will have the means to replace all of the remaining original hospital hearing screening equipment during SFY 09.

In January 2008 the National Center for Hearing Assessment and Management (NCHAM) invited a representative from the NHSP, a representative from Oklahoma's Part C program (SoonerStart) and an Oklahoma pediatrician to a meeting to assist in developing guidelines compliant with confidentiality regulations for sharing information between screening programs and intervention programs. The working document is available at the NCHAM web site.

The HRSA Universal Newborn Hearing Screening Project originally funded through March 2008 has been re-funded for an additional three years (4/08 - 3/11). HRSA grant funding is providing new OAE screeners and a follow-up coordinator for case management for infants with suspected hearing loss.

Expanded audiology services for infants and toddlers are now available in Tulsa.

c. Plan for the Coming Year

The statewide NHSP will continue to seek ongoing support and assistance from the MCH and CSHCN programs. As in the past, the three programs working together will assure that all Oklahoma newborns have hearing screened within the first month of life, and if hearing loss is suspected, diagnosis and intervention are provided for the infant in a timely manner. Oklahoma will continue to meet or exceed the national newborn hearing screening follow-up goal of screening by one month of age, diagnosis by three months and enrollment in appropriate intervention by six months.

With SFY 09 legislative funding of \$620,000 available to the NHSP, the program will purchase hearing screening equipment to replace all of the remaining 1999 hospital hearing screening equipment. The new equipment will be distributed to the birthing sites and training in the operation of new screeners will be provided by a representative of the manufacturer and by NHSP staff.

With funding from the HRSA grant, additional hearing screening equipment will be made available to health departments in rural areas. More than 60 sites including health departments and early intervention locations will be equipped to provide follow-up screening for infants who did not pass the hospital screen, were not screened prior to discharge and/or have conditions warranting the need for hearing re-screening at specific intervals. Training in the use of screening equipment will be provided to clinicians as needed by health department audiologists.

The HRSA grant-funded follow-up coordinator will continue case management activities to assure infants with suspected hearing loss receive timely follow-up evaluation and treatment.

The NHSP taskforces (Screening, Audiology, and Early Intervention) will meet regularly to address changing needs. The Screening Taskforce will be examining ways to ascertain the accuracy of the newborn's demographics. Steps are being taken to place the serial number of the hospital bloodspot/hearing screening form on the infant's birth certificate beginning in January 2009. The Audiology Taskforce will be recommending changes to the present Oklahoma infant diagnostic assessment protocol; with guidance from the Joint Committee on Infant Hearing's 2007 Statement, the new Oklahoma diagnostic protocol will be approved and in place by early 2009. The Early Intervention Taskforce continues to explore ways that the early intervention program can better serve infants/toddlers with hearing loss and their families who reside in rural areas. The group will investigate the possibility of using the OSDH videoconferencing system, an IP based video-teleconferencing network between the state office and most of Oklahoma's county health departments. A family in a rural area will be able to travel just a few miles to a local health department and using the system, take advantage of the therapy skills of a master clinician who is at location in another part of the state.

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	2003	2004	2005	2006	2007

Annual Performance Objective	19.5	14	13.7	17.8	13.9
Annual Indicator	14.1	15.3	14.0	12.5	12.5
Numerator	130150	141860	127190	114000	114000
Denominator	926120	924670	910660	913000	913000
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
	2008	2009	2010	2011	2012
Annual Performance Objective	12.4	12.3	12.2	12.1	12

Notes - 2007

Sources: U.S. Census Bureau, Current Population Survey. Current 2007 data not yet available, therefore 2006 numbers used as an estimate.

The 2008-2012 future annual performance objectives have been revised to a conservative estimate of the % uninsured children given current economic conditions in Oklahoma.

Notes - 2006

Sources: U.S. Census Bureau, Current Population Survey.

Notes - 2005

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2005 and 2006 Current Population Survey (CPS: Annual Social and Economic Supplements).

Year 2005 data were revised with updated information. Year 2006 data are not available; therefore, 2005 is repeated as an estimate.

Health Insurance Coverage of Children 0-18, states (2004-2005), U.S. (2005)

a. Last Year's Accomplishments

Data published by the Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimate the uninsured rate for Oklahoma children aged 18 and younger at 12.5% for 2006. These data are based on the Census Bureau's 2006 Current Population Survey. In 2004, the Oklahoma uninsured rate for children was reported at 15.3%. A decline of 2.8 real percentage points has been observed since 2004.

The MCH Early Childhood Comprehensive Systems (ECCS) Project continued to work collaboratively with Smart Start Oklahoma and the Oklahoma Partnership for School Readiness (OPSR) Board to implement the Early Childhood System Model. Working at the local level, eighteen Smart Start Oklahoma communities addressed two of the goals that focus on health insurance: 1) services promoting health are available and accessible to all children; and 2) children have a source of comprehensive, family-centered primary health care. The MCH ECCS Coordinator continued providing staff support to Smart Start Oklahoma in the implementation of the state early childhood plan. The MCH ECCS Coordinator also organized and conducted a child care health consultant training session which included a component on assisting families and child care providers with enrolling in the state children's health insurance program (SCHIP).

Child health services were provided as a safety net service through the county health

departments and MCH contract providers. These services were provided in accordance with the American Academy of Pediatrics Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents. The guidelines include family and individual medical and psycho-social histories, physical examination, lead screening, newborn metabolic and hearing screening, treatment of minor illnesses and anticipatory guidance.

During the 2007 legislative session, Senate Bill (SB) 424 was passed requesting the Oklahoma Health Care Authority (OHCA), the state Medicaid agency, to establish and maintain a program to provide medical coverage assistance to children 18 years of age and below in families whose income falls between 185% and 250% of the federal poverty level on or before January 1, 2011.

MCH continued to work closely with the OHCA and the Oklahoma Department of Human Services (OKDHS) to develop policy and procedure to expand health services to children. County health departments and contract providers provided families with information on health related benefits and assisted families with benefit application completion. MCH continued to partner with the OHCA to facilitate the Child Health Advisory Task Force with its emphasis on the seven priority topics: primary care utilization, mental health, obesity, reimbursement structure, oral health, immunizations and accessing specialty care.

Collaboration continued to occur with other state agencies to support actions to expand Federally Qualified Health Center (FQHC) coverage in the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Linked families with needed Medicaid services		X		
2. Provided clinical health services as a safety net provider through county health departments and contract providers	X			
3. Continued implementations of ECCS state plan				X
4. Collaborated with OHCA to facilitate a task force focused on improving policy for child health services				X
5. Continued state agency collaborations to expand FQHCs in the state				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH has provided input to the OHCA on the electronic NB-1 form as it has been developed and field-tested this year. Once implemented, newborns will leave the hospital already having eligibility for Medicaid determined and a Medicaid number assigned.

Child health services are available as a safety net service through the county health departments and MCH contract providers. These services continue to follow the American Academy of Pediatrics Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents. The guidelines include family and individual medical and psycho-social histories, physical examination, lead screening, newborn metabolic and hearing screening, treatment of minor illnesses and anticipatory guidance.

With expansion of SCHIP declined by the Centers for Medicare and Medicaid (CMS), the Child Health Advisory Task Force will explore alternatives to increasing coverage.

On April 1, 2008, the Soon-To-Be-Sooners (STBS) program was implemented. The program is federally approved through Title 21 of the Social Security Act and is focused on providing medical services on behalf of the unborn child. In order to qualify for the STBS program, a pregnant woman must meet all SoonerCare eligibility requirements (income, etc.) other than those for citizenship. Over 400 applications were received within three weeks of implementation. Infants are automatically eligible for SoonerCare.

c. Plan for the Coming Year

MCH will continue to work closely with the OHCA and the OKDHS to develop policy and procedure to expand health services to children.

County health departments and contract providers will continue to provide families with information on health related benefits and assist families with benefit application completion.

MCH will continue to co-chair the Child Health Advisory Task Force with emphasis on the seven priority topics of primary care utilization, mental health, obesity, reimbursement structure, oral health, immunizations, and accessing specialty care.

Child health clinical services will continue as a safety net service through the county health departments and contract providers for uninsured and underinsured children. Services will be provided in accordance with the American Academy of Pediatrics Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents.

Collaboration will continue to occur with other state agencies to support actions to expand FQHC coverage in the state.

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	2003	2004	2005	2006	2007
Annual Performance Objective				50.2	53.9
Annual Indicator			51.3	54.4	54.4
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	53.3	52.3	51.2	50.2	50

Notes - 2007

Source: Data were obtained from the NCHS SLAITS dataset for the National Survey of Children's Health. This national survey provides state-specific estimates for the proportion of children aged

2-5 receiving WIC benefits. Numerator and denominator data are unavailable. 2007 data not available, hence 2006 numbers used as an estimate.

Notes - 2006

Source: Data were obtained from the NCHS SLAITS dataset for the National Survey of Children's Health. This national survey provides state-specific estimates for the proportion of children aged 2-5 receiving WIC benefits. Numerator and denominator data are unavailable.

Notes - 2005

Source: National Survey of Children's Health, 2003. Data reflect Oklahoma-specific estimate.

a. Last Year's Accomplishments

Data from the National Center for Health Statistics (NCHS) created from the State and Local Integrated Telephone Survey (SLAITS) National Survey of Children's Health 2005 are available at the NCHS SLAITS website, <http://www.cdc.gov/nchs/about/major/slaits/nsch.htm>. Oklahoma-specific data from this survey reveal that 54.4% of children ages 2 to 5 years fall at or above the 85th percentile of the body mass index (BMI)-for-age. This compares to the national average of 57.0%. The proportion of Oklahoma children overweight or obese has increased by 3.1 percent in absolute terms. The Women, Infants, and Children Supplemental Nutrition Program (WIC) reported that the percent of children ages 2 to 5 years, receiving WIC services through the Oklahoma State Department of Health (OSDH) with a BMI at or above the 95th percentile, was 13.5% in 2007.

WIC continued to monitor BMI status for children ages 2 to 5 years, and required low fat food options for those with a BMI at or above the 95th percentile.

WIC worked to revitalize quality nutrition services to focus on Value Enhanced Nutrition Assessment (VENA) implementation and childhood obesity prevention. Oklahoma encouraged the development of healthy weights in WIC participants through increased intake of fruits and vegetables and the use of reduced fat dairy products in planned meals. Increased active play and physical activity were also emphasized. Oklahoma WIC nutrition assessment shifted the focus from eligibility determination to a participant centered outcome-based process and improved the program's integrity. "Cooking with WIC" was a continuous series 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.

In support of the 2002 Institute of Medicine (IOM) report and the United States Department of Agriculture (USDA) Memorandum 98-9, WIC focused on a new direction for nutrition assessment and participant nutrition education with an emphasis on lifelong healthful eating and physical activity.

WIC promoted the continued professional development, education and training of staff through web-based training, online training and local, state and national conferences. The WIC Training Link (www.teletrain.com/wic) provided up-to-date online trainings and information to local, state and national WIC staff. The Certified WIC Nutrition Technician (CWNT) training program was accompanied by activities, quizzes and assignments to reinforce the subjects of the course and to develop skills used in the WIC clinic.

WIC also participated in breastfeeding promotion and education activities to combat childhood obesity (See NPM #11).

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			X	
2. Required low fat/kcal options for all WIC clients at or above the 95th percentile BMI	X			
3. Developed and disseminated materials for families and health care providers			X	
4. Provided trainings for health care providers				X
5. Supported breastfeeding as a priority through state planning and training activities				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Children ages 2 to 5 years, receiving WIC, identified with BMIs = 95th percentile are referred to a registered/licensed dietitian for individual counseling.

WIC plans to require reduced/lowfat milk package for all children two years of age and older [based on American Academy of Pediatrics (AAP) policy, for 100% of all WIC participants (except infants)]. Additional reduced fat options are required for those over two with a BMI = 95th percentile.

Nutrition education for families receiving WIC incorporates MyPyramid and Dietary Guidelines information provided in groups or individually. Decreasing total/saturated fat and simple sugars, choosing appropriate portions and eating behaviors and incorporating regular activity are required nutrition education protocols for all clients.

MCH works closely with WIC to assure consistency of tools used to measure growth and weight. Staff from both programs work collaboratively on trainings for service providers.

WIC nutritionists developed and shared educational materials focusing on VENA and WIC staff minimum competencies. Seven new lesson plans were also presented during the State WIC and Clerical Conference held February 6 - 8, 2008.

c. Plan for the Coming Year

The state plan to address obesity and physical activity will be completed and initial steps for implementation taken. The plan will focus on improving the overall health of Oklahomans by initiating cultural change related to nutrition and physical activity behaviors. MCH and WIC will specifically focus on strategies to impact the maternal and child health population.

Education materials will continue to be created and disseminated to health care providers, individuals and families that incorporate balanced nutrition and activity guidelines, identify and track overweight WIC children and offer targeted balanced nutrition and activity education.

Reduced and/or non-fat/kcal food packages will continue to be provided to WIC children identified at risk of or with increased BMI. Future plans are to require reduced and/or non-fat milk, fruit, vegetables and whole grains for all WIC participants older than 2 years of age.

Staff development through distance learning opportunities and the annual WIC conference will be provided based on identified training needs of staff.

Collaborative planning meetings between WIC and MCH will occur quarterly to facilitate

coordination and development of services (e.g. breastfeeding, preconception counseling, nutrition education).

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	2003	2004	2005	2006	2007
Annual Performance Objective				18.8	18.6
Annual Indicator			19.6	19.3	19.3
Numerator			10027	9953	9953
Denominator			51157	51500	51500
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
	2008	2009	2010	2011	2012
Annual Performance Objective	18.4	18.3	18.1	17.9	17.7

Notes - 2007

Data for this performance measure are drawn from the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data for year 2007 have not been released to date. Therefore, PRAMS survey data for 2006 have been used to provide an estimate for this measure.

Notes - 2006

Data for this performance measure are drawn from the Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS) for the year 2006.

Notes - 2005

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS). Data for year 2005 are not available. Reported data represent PRAMS 2003. Measure will be updated when more timely data become available.

a. Last Year's Accomplishments

Monitoring data provided by the Oklahoma State Department of Health (OSDH) Pregnancy Risk Assessment Monitoring System (PRAMS, 2006) show that 19.3% of pregnant women report smoking during the third trimester of pregnancy. This is a slight decrease compared with PRAMS data for year 2005 in which 19.6% of pregnant women reported smoking in the last three months of pregnancy. Overall, since year 2000, when it was 16.9%, the rate of smoking during pregnancy has increased in relative terms by 14.2%. This increase has not been monotonic over this seven-year period and the upward trend is not statistically significant. In 2001, the rate rose to 20.3%, then dropped to 16.2% in 2003, and finally rose again to 19.3% in 2006.

The Oklahoma Health Care Authority (OHCA)/OSDH Perinatal Advisory Task Force continued to meet every other month to look at systems changes to improve perinatal care. The task force provided input to the OHCA regarding the importance of continued health coverage for tobacco cessation intervention for pregnant women.

In October 2007, the Second Annual Prematurity Conference was held. Priority topics covered smoking behaviors contributing to prematurity, low birth weight and infant mortality in Oklahoma.

OHCA reported the approval of expanded benefit coverage to include smoking cessation 5A's counseling for pregnant women. This conference was held in collaboration with the March of Dimes and the University of Oklahoma (OU) College of Nursing.

MCH collaborated with the OSDH Chronic Disease Service on Women's Health Week, May 14-20, 2007. Activities included information on preconception health including smoking behaviors in the preconception, prenatal and postnatal periods. County health departments were provided with packets outlining these topics for the week that included a sample press release to facilitate local activities.

Family planning clients and pregnant women seen through the county health departments and contract clinics were provided with information on the impact of smoking during the preconception, interconception and prenatal periods. Women who smoked or reported family members who smoked were referred to the Tobacco Helpline 1-800-QUIT-NOW for support in their efforts to discontinue smoking. MCH monitored county health department and contract clinics documentation of smoking intervention for clients who use tobacco products.

The Psychosocial Risk Assessment was developed in collaboration with the OHCA. This tool was created to assess all psychosocial aspects of the woman's life, to include smoking, a coping mechanism for mental health problems, stress, unstable family dynamics, etc. OHCA providers received compensation for completing this assessment in association with the ACOG antepartum record.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supported OHCA in maintaining their policy to cover tobacco cessation intervention for pregnant women			X	
2. Provided training and education for health care providers on smoking cessation				X
3. Provided education to family planning and maternity clients seen through county health departments and contract providers; referred to Oklahoma Tobacco Helpline		X		
4. Monitored referrals of clients through review of medical documentation during site visits to county health departments and contract providers				X
5. Developed with OHCA a Psychosocial Risk Assessment to assess all psychosocial aspects of the woman's life, to include smoking. OHCA providers received compensation for completing this assessment			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OHCA/OSDH Perinatal Advisory Task Force continues to meet every other month.

OHCA continues to reimburse providers for tobacco cessation counseling.

MCH is collaborating with the OSDH Chronic Disease Service on Women's Health Week, May 12-16, 2008. A tool kit is being provided to county health departments and communities including

information regarding the effects of substance abuse on women and the effects of smoking on pregnant women and infants.

Family planning clients and pregnant women seen through the county health departments and contract clinics are provided with information on the impact of smoking during the preconceptual/interconceptual and prenatal periods. Women continue to be referred to the Tobacco Helpline for support in their efforts to discontinue smoking.

The Psychosocial Risk Assessment was placed on the OHCA website for their providers and adopted for use in OSDH clinics in December 2007. Smoking is assessed for the client and other members of the household and referrals are provided to help clients and family members quit.

An interactive videoconference training for county health departments was provided in February 2007 on Tobacco Use Cessation: Interventions, Counseling, and Treatment during Pregnancy.

In an effort to impact infant mortality an intra-agency workgroup focused on tobacco prevention and cessation has been implemented and is in the process of developing a strategic plan for state fiscal year (SFY 09).

c. Plan for the Coming Year

The OHCA/OSDH Perinatal Advisory Task Force will continue to meet and work toward improving the health of mothers and babies and decreasing the infant mortality rate. Smoking will continue to be a topic for discussion in this group as protocols are established to provide continuity of care between all health care providers. Protocols will address issues that place pregnant women and babies at risk. Low birth weight and prematurity are risk factors related to smoking and will be addressed in the protocols when developed.

In SYF 09 the strategic plan developed by the intra-agency workgroup to reduce tobacco use and improve OSDH efforts in cessation will be implemented.

MCH will continue to collaborate with Chronic Disease in monthly meetings to discuss factors that impact the health of Oklahoma women and infants, including tobacco use.

Family planning clients seen through the county health departments and contract clinics will continue to be provided with information on the impact of smoking during the preconception and interconception periods. MCH will continue to monitor county health department and contract clinics documentation of smoking intervention for clients who use tobacco products.

MCH maternity providers will continue to assess pregnant women for smoking through the use of the Psychosocial Risk Assessment Form and provide counseling and referral as indicated to assist women in quitting.

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	2003	2004	2005	2006	2007
Annual Performance Objective	9	9	8.9	10.1	7.9
Annual Indicator	11.4	12.2	8.0	10.3	10.3
Numerator	30	27	19	26	26
Denominator	264101	221613	236697	252288	252288

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
	2008	2009	2010	2011	2012
Annual Performance Objective	9.9	9.5	9.1	8.7	8.3

Notes - 2007

Source: Data were obtained from the Health Care Information, Oklahoma State Department of Health. Year 2007 vital statistics data for deaths have not been released at this time. As a result, the indicator for Year 2006 is repeated for 2007 to provide an estimate.

The 2008-2012 annual performance objectives have been revised to reflect current data.

Notes - 2006

Source: Data were readily obtained from the Health Care Information, Oklahoma State Department of Health.

Objectives for 2007-2011 have been revised to reflect more attainable targets given data from Oklahoma vital statistics.

Notes - 2005

Data were readily obtained from the Health Care Information, Oklahoma State Department of Health.

a. Last Year's Accomplishments

In 2006, Oklahoma recorded 19 suicide deaths to youth aged 15 through 19, resulting in a suicide death rate of 10.3 deaths per 100,000 population. This is an increase from 8.0 in 2005. 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 2002-2006 was 10.6 suicide deaths per 100,000 youth aged 15-19.

Latest available data do not indicate 2007 statistics with regard to reported suicide deaths for youth aged 15 through 19; however, trend analysis from the 2005 and 2007 Oklahoma Youth Risk Behavior Survey (YRBS) indicate no linear change in percentage of students who made a suicide attempt during the past 12 months, made an attempt plan or seriously considered suicide.

The MCH Adolescent Health Coordinator continued to provide representation on the Oklahoma Youth Suicide Prevention Council. The Suicide Prevention Council, Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), Oklahoma Commission on Children and Youth, Integris Mental Health and Oklahoma Systems of Care partnered with The Revolution, an Oklahoma state youth organization to present the first Statewide Listening Conference on May 11, 2007. This event grew out of Youth Listening Conferences held annually for several years at the local community level and served as a network of youth and multiple agency advocates in the area of health and safety. Youth presentations included teen depression and suicide, gang violence, Indian youth culture and dating violence.

Three contracts to communities for suicide intervention and training were in place through the ODMHSAS with consultation from MCH. Oklahoma Turning Point (a health coalition established in 2003, that creates collaborations between individuals and communities for education, planning and action) assisted in providing these \$20,000 contracts.

Mercy Hospital, through the support of the Oklahoma Youth Suicide Prevention Council, has provided training for more than 1,082 hospital staff, including training for emergency room medical staff in suicide assessment and intervention. Developed by ODMHSAS, MCH and Mercy Hospital, the training is based on the QPR (Question, Persuade, Refer) model. The MCH Adolescent Health Coordinator presented the QPR training to 11 MCH school nurses in August 2007.

Results for the 2007 Oklahoma YRBS were released to the Oklahoma State Department of Health (OSDH) on August 27, 2007. Fact sheets illustrating trends dating back to 2003 were drafted. MCH developed plans to release six volumes of fact sheets, highlighting the six key areas identified in the survey, including suicide risk among youth.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintained involvement with the Oklahoma Youth Suicide Prevention Council				X
2. Collaborated with ODMHSAS to provide three contracts for suicide prevention and intervention services				X
3. Provided training and education for health providers on the QPR (Question, Persuade, Refer) model				X
4. Developed fact sheets highlighting YRBS data on suicide risks and ideation among high school students				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Oklahoma Youth Suicide Prevention Council is pursuing established goals of the current state plan, which includes increasing community capacity to address suicide through delivery of prevention trainings targeting partnership boards including local Turning Point coalitions. The Adolescent Health Coordinator continues to represent MCH on the Council. Revision of the state plan to include suicide prevention across the lifespan, promote evidence-based strategies and include updated research findings on suicide and suicide prevention is proposed. Increasing awareness of the Council and its mission among youth-serving agencies is underway. Issue briefs have been developed and articles have been distributed for use in community/agency newsletters, church bulletins, employee newsletters, etc.

Numerous QPR trainings continue to be offered and completed throughout the state to school personnel, hospital staff, CHD staff, tribal entities and faith based organizations.

The Oklahoma Hospital Association is currently considering recommending that the Youth Suicide Prevention training for emergency room (ER) staff be implemented statewide.

Through the State Team for the Prevention of Suicide (STOPS), a lifespan suicide prevention effort with representation from MCH, the third annual Oklahoma Suicide Prevention Conference, Journey from Boyhood to Manhood, was held November 5-7, 2007.

Fact sheets featuring 2007 YRBS data related to suicide ideation and depression are being

drafted.

c. Plan for the Coming Year

A proposal by the Oklahoma Youth Suicide Prevention Council for continued funding of the Oklahoma Suicide Prevention Initiative will be submitted to increase the implementation of evidence-based suicide prevention strategies throughout the state and to provide training to local community partnerships to increase community capacity. ODMHSAS will be the lead agency. The overall goals will be to reduce the number of suicide deaths and to reduce attempts among youth ages 10-24, currently the second leading cause of death for Oklahoma youth and young adults.

The MCH Adolescent Health Coordinator will remain active on the Council and represent MCH in collaborations with the ODMHSAS for the implementation of the state plan. This plan will facilitate the translation of youth suicide related data into comprehensive public policy directed toward reducing the number of attempted suicides and suicides in Oklahoma.

The Adolescent Health Coordinator will also collaborate with OSDH Injury Prevention Service and the Council to utilize the Oklahoma Violent Death Reporting System (OK-VDRS) in conjunction with prevention activities.

The 5th Annual Oklahoma Suicide Prevention Conference is scheduled for November 2008 and the target audience will include youth service agencies, counselors, social workers, physicians, nurses and Area Prevention Resource Center personnel.

Collaboration between MCH, the Council and Mercy Hospital will continue in an effort to recognize warning signs of a suicidal individual and establish an efficient referral process. Efforts will be ongoing to provide targeted training for OSDH advance practice nurses, public health nurses and school nurses in public schools throughout the state.

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	2003	2004	2005	2006	2007
Annual Performance Objective	77.6	79.1	80.3	75.5	77
Annual Indicator	78.8	74.0	73.4	82.1	82.1
Numerator	473	481	545	724	724
Denominator	600	650	743	882	882
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
	2008	2009	2010	2011	2012
Annual Performance Objective	83	83.5	84	84.5	85

Notes - 2007

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division.

Year 2007 data are not available at this time; therefore, 2006 repeated as an estimate.

Objectives for 2008-2012 have been revised to reflect more plausible targets given data from Oklahoma vital statistics.

Notes - 2006

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division.

The increase from 73.4% in 2005 to 82.1% in 2006 reflects an increased number of Level III hospitals with NICU facilities in Oklahoma. In addition, an increase in telemedicine consultations and Medicaid referrals is expected to maintain annual indicators above 80%. Therefore, Objectives for 2008-2012 have been revised to reflect more plausible targets given data from Oklahoma vital statistics.

Notes - 2005

Source: Oklahoma State Department of Health, Center for Health Statistics, Vital Records Division.

a. Last Year's Accomplishments

In Oklahoma for 2006, 82.1% (724/882) of infants born weighing less than 1,500 grams were delivered at high-risk facilities. This is an increase in the rate reported for 2005 (73.4%). In 2000, approximately three-fourths (75.7%) of very low birth weight births occurred at high-risk facilities.

MCH provided data from the Pregnancy Risk Assessment Monitoring System (PRAMS) Project and Vital Records through a variety of means (PRAMSgram, presentations, trainings, etc.) to educate the public, health care providers and policymakers on health issues to include health care access of Oklahoma pregnant women. MCH used this information to make recommendations and facilitate discussion on concerns and changes needed in enhancing the perinatal health care system infrastructure between rural and urban areas as well as primary and tertiary health care providers in the state.

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 for MCH. The THD FIMR Project continued into its third year of conducting full case review and community action activities. The OCCHD initiated its first year of conducting case reviews and engaging community partners for action. MCH redefined a position to coordinate state level FIMR activities and maternal mortality review.

The Perinatal Advisory Task Force, a collaborative project of the OSDH and the Oklahoma Health Care Authority (OHCA), continued to meet every other month. These meetings, co-chaired by the Chief of MCH and the OHCA Director of Child Health, included medical providers, health care agencies and most importantly, consumers. Given the fact that over half of all births in Oklahoma were covered by Medicaid, strategies for implementing a tiered system of reimbursement for the provision of prenatal care were approved to facilitate co-management of clients. OHCA also approved coverage for additional tests to help identify high-risk clients and determine appropriate care.

The Perinatal Continuing Education Program (PCEP), University of Oklahoma Health Sciences Center (OUHSC), continued to receive state funding through MCH to provide education and training to medical and nursing staff in rural hospitals. The PCEP provided rural hospital staff with the knowledge and tools to better recognize and manage obstetrical and newborn emergencies. The PCEP was active in 22 hospitals in state fiscal year 2007. Fifteen of the

hospitals participated in all program activities. Seven other hospitals purchased books to provide training to new staff. Three hundred ninety-nine perinatal health care providers participated in the PCEP, including 35 medical staff members (physicians, certified nurse midwives, physician assistants and emergency personnel) and 364 nursing staff members (registered nurses, licensed practical nurses and respiratory therapists).

MCH continued to provide technical assistance and served as a resource to 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. These projects and program provided in-home support to pregnant women and their families and facilitated pregnant women and their families being aware of the signs and symptoms of pregnancy complications and where to seek prompt medical attention.

Due to Oklahoma's unchanging infant mortality rate and the racial disparities associated with this mortality rate, the Commissioner of Health requested MCH take the lead in convening an OSDH intra-agency team focused on reducing infant mortality. The Commissioner's Action Team on Infant Mortality began developing a strategic plan to enhance cross-collaboration across OSDH programs in identifying current activities, gaps in service and needed changes in policy and services to decrease infant morbidity and mortality in Oklahoma.

MCH Assessment administered a physician survey in August 2007 to 809 obstetric providers in the state to explore barriers to practice in Oklahoma. Three common barriers to obstetric practice for the 40.9% who responded to the survey were medical liability premiums, uninsured patients and low Soonercare (Medicaid) reimbursement.

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. Supported the FIMR Projects in Tulsa and Oklahoma Counties through funding and technical assistance				X
3. Collaborated with OHCA to co-chair a task force focused on improving policy for perinatal care			X	
4. Supported the PCEP through funding and technical assistance to provide continuing education to hospital-based physicians and nurses				X
5. Provided technical assistance to Healthy Start, Children First, and OCAP programs				X
6. Initiated intr-agency (OSDH) workgroup focused on reducing infant mortality				X
7. Conducted statewide physician survey to gain information on obstetric care (barriers to provision)				X
8.				
9.				
10.				

b. Current Activities

MCH continues to provide data from PRAMS and vital records through a variety of means to educate and make recommendations on concerns and changes needed in enhancing the perinatal health care system infrastructure between rural and urban areas as well as primary and tertiary health care providers in the state.

Support of the FIMR projects at the THD and the OCCHD remains a priority for MCH. Additional Title V funds are being identified for expansion of the projects to the metropolitan statistical areas.

The OHCA/OSDH Perinatal Advisory Task Force continues to meet every other month.

A subcommittee of the OHCA/OSDH Perinatal Advisory Task Force was created to look at improving the quality of care for pregnant women in Oklahoma by developing standard protocols for providers across the state to follow regarding high-risk obstetric conditions. MCH facilitated onsite technical assistance provided to the task force by the Medical Director and Project Director of the Arkansas Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS) Program, a statewide high risk perinatal effort. As a result, two work groups were formed, one focused on development and implementation of high-risk obstetric protocols and the other on exploring telemedicine.

A \$2.2 million budget request was sent to the Oklahoma legislature to improve the emergency management system (EMS), specifically in rural areas where shortages are severe.

Analysis of the obstetric physician survey is ongoing.

c. Plan for the Coming Year

Funding will be provided to assist the THD FIMR Project to begin expansion to the greater metropolitan statistical area. The OCCHD FIMR Project will enter its second full year of case review and begin to make recommendations for system changes to positively impact the infant mortality rate.

MCH will continue to provide technical assistance and serve as a resource to the Healthy Start Projects in Oklahoma and Tulsa counties, the Children First Program and the Office of Child Abuse Prevention (OCAP) and family resource and support projects. A priority focus for these interactions will center on identifying ways to address racial disparities seen in infant mortality.

The OSDH intra-agency team focused on reducing infant mortality will continue to build upon its strategic plan for improving infant outcomes in Oklahoma.

The Perinatal Advisory Task Force will move forward with the development of protocols to standardize care for women with high risk perinatal conditions to help assure that prenatal care providers across the state provide the same standard of care in consultation with maternal fetal medicine specialists and transfer care as soon as appropriate to insure the best infant outcome. Work will progress on developing a telemedicine network to help improve access to appropriate care for pregnant women across the state.

MCH will continue to support the PCEP program to provide education and training to medical and nursing staff in hospitals across the state to prepare them for obstetrical and neonatal emergencies. This work will be shared with EMS to gain support and input.

Analysis of the physician survey will be completed and presentations and reports will be made identifying barriers to obstetric practice in Oklahoma and making recommendations to improve this situation in areas where the need is greatest.

Data gained from the physicians survey and through data linkage of systems such as PRAMS, Vital Records, and Medicaid will be used in evaluation and planning activities of the Commissioner's Action Team on Infant Mortality and the OHCA/OSDH Perinatal Advisory Task Force.

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	2003	2004	2005	2006	2007
Annual Performance Objective	83.5	83.5	84.8	79.3	80.5
Annual Indicator	77.8	78.1	75.5	73.9	73.9
Numerator	38449	38758	39085	39927	39927
Denominator	49426	49623	51775	54010	54010
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
	2008	2009	2010	2011	2012
Annual Performance Objective	81.7	82.9	84.1	84.9	85.7

Notes - 2007

Source: Health Care Information, OSDH. Data for year 2007 are not yet available. Year 2006 is repeated as an estimate.

Higher future annual performance objectives reflects the expectations of the Soon-To-Be-Sooners Medicaid program which will expand prenatal care available to pregnant women who are non-citizens.

Notes - 2006

Source: Health Care Information, OSDH.

Notes - 2005

Source: Health Care Information, OSDH.

a. Last Year's Accomplishments

In 2006, the most recent year for which data are currently available, 73.9% of all Oklahoma births occurred to women initiating prenatal care (PNC) during the first trimester of pregnancy. This is a slight decline from 75.5% reported in 2005. Generally, the rate for receiving first trimester prenatal care among Oklahoma women has been unchanged in recent years. Racial and ethnic variability in receipt of first trimester PNC did exist in 2006, the rates were as follows: White 75.4%, African American/Black 68.1%, Native American/American Indian 68.4%, and Hispanic 63.3%. These data were readily obtained from Health Care Information, Oklahoma State Department of Health (OSDH).

Time of initiation of prenatal care continued to be a priority topic of discussion within OSDH, specifically MCH, and in interactions with the Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS). With passage of HB 1804, concerns were raised immediately to all three agencies by health care providers about the impact on care of maternity clients. The OSDH legal department determined that proof of citizenship was not required to receive maternity services through OSDH Title V funded clinics although it was required to qualify for coverage of services by Medicaid.

The Perinatal Advisory Task Force, initiated by OHCA and MCH, continued to meet. A tiered system of reimbursement was approved by the OHCA to facilitate more appropriate care of high-risk clients. This change was to allow co-management of high-risk clients between the primary

care physician and a maternity specialist allowing clients to continue care near their home while alleviating the burden on tertiary care centers. By allowing all clients, including high-risk clients, to access and continue care in their community, OHCA and MCH hoped to improve the number of women receiving early and appropriate prenatal care.

A work group of the OSDH Commissioner's Action Team on Infant Mortality was formed around the issue of preconception and interconception care in Oklahoma. The workgroup met monthly to identify activities to assure that women of reproductive age receive needed information and care before becoming pregnant, to include the importance of early entry into prenatal care.

As part of the activities of the MCH Comprehensive Program Review conducted with county health departments and contractors, MCH looked at access issues in communities related to prenatal care. Guidance was provided to health care providers on strategies to educate women on the importance of family planning and receipt of early prenatal care. Clinic records were audited to assure women 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 encouraged to keep updated resource lists available to assist in linking clients with maternity providers.

Maternity clinical services continued to be provided through county health departments and contract providers as needed with 4,809 women served during calendar year 2007. These services ranged from providing the initial visit (risk assessment, history, and physical) and transitioning care to a local provider to providing care throughout the entire pregnancy to time of delivery. 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 services. County health department and contract staff continued to assist women with the completion of Medicaid applications to facilitate the approval process.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborated with OHCA to facilitate a task force focused on improving policy for perinatal services				X
2. Formed first sub-workgroup out of Commissioner's Action Team on Infant Mortality to focus on preconception/interconception care and education				X
3. Provided technical assistance to county health departments and contract providers through MCH comprehensive program reviews				X
4. Provided clinical maternity services as a safety net provider through county health departments and contract providers	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The OSDH worked with the OHCA to secure approval of "Soon-To-Be-Sooners" (STBS). Implemented April 1, this program provides health care benefits for unborn children. Soonercare coverage of pregnancy related medical services will be available for pregnant women who would not otherwise qualify for Soonercare benefits due to their citizenship status.

The Perinatal Advisory Task Force initiated by OHCA and MCH is currently focused on the development of protocols to standardize care for women with high-risk perinatal conditions and exploring the use of telemedicine.

The Preconception Work Group of the Commissioner's Action Team on Infant Mortality is working on the development of a risk assessment tool and a media campaign to promote awareness of the importance of preconception health and seeing a health care provider early.

A PRAMSgram was released in April with information for providers on preconception health care in Oklahoma. PRAMS found that only 13.8% of Oklahoma women sought advice or counseling from a health care provider to prepare for becoming pregnant.

OSDH is working with OHCA on a project called "No Wrong Door" that will establish an online enrollment process that allows members or potential members of SoonerCare to apply and receive eligibility electronically at county health departments. Once in place clients will have a Medicaid eligibility determination and, if qualified, a Medicaid ID number before they leave the clinic.

c. Plan for the Coming Year

OSDH will encourage all staff in maternity and family planning (for positive pregnancy tests) to help women apply for Medicaid (Title 19 or STBS) upon initial contact to improve access to prenatal care for all women as soon as possible.

The OHCA/OSDH Perinatal Advisory Task Force will continue to work toward standardizing protocols and establishing a telemedicine network to help women access early and appropriate prenatal care.

The Preconception Work Group of the Commissioner's Action Team on Infant Mortality will complete development of a risk assessment tool and a plan for a media campaign to promote awareness of the importance of preconception health and the importance of seeing a health care provider early in pregnancy.

OSDH will continue to work with OHCA towards the implementation of "No Wrong Door". March 2009 is the expected date online applications will be accessible for enrollment.

MCH will continue the Comprehensive Program Reviews conducted with county health departments and contractors and look at access issues in communities related to prenatal care. Guidance will be provided to health care providers on strategies to educate women on the importance of family planning and 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 care with a maternity health care provider within 15 days. County health departments and contract providers will be encouraged to keep updated resource lists available to assist in linking clients with maternity providers.

Maternity clinical services will continue to be provided through county health departments and contract providers as needed. With the implementation of STBS, many women may seek care with private Medicaid providers. MCH plans to continue providing gap-filling direct maternity clinical services as long as there is a demonstrated need.

D. State Performance Measures

State Performance Measure 1: *The percent 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	2003	2004	2005	2006	2007
Annual Performance Objective	42	41.5	40.9	50.8	49.8
Annual Indicator	48.4	51.9	48.8	48.4	48.4
Numerator	24623	26550	25266	24950	24950
Denominator	50874	51157	51775	51545	51545
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	48	47.8	47.6	47.4	47.2

Notes - 2007

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2006. Data for year 2007 are not available at this time. Year 2006 data repeated as an estimate for 2007.

Despite having exceeded the Annual Performance Objective for 2006, the objectives for 2008-2012 have not been revised for lack of evidence of a significant decrease in the percent of pregnancies which are unintended.

Notes - 2006

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2006.

Objectives for 2007-2011 have been revised to reflect more plausible targets given data from PRAMS. Objectives are targeted to a step-wise decline in the unintended pregnancy rate.

Notes - 2005

Source: Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS), 2005.

a. Last Year's Accomplishments

MCH continued to monitor unintended pregnancy through data from the Centers for Disease Control and Prevention (CDC) Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance system that provides health information on women who delivered a live birth in Oklahoma. In 2006, the latest PRAMS data available, approximately 48.4% of Oklahoma live births were the result of an unintended pregnancy, with 38.0% mistimed and 10.4% unwanted. This finding is consistent with previous years reporting of the PRAMS data, which has seen the unintended pregnancy rate among live births fluctuate slightly from year-to-year but remain at nearly half of all live births.

The Oklahoma Medicaid Family Planning Waiver, implemented April 15, 2005, completed its second year April 15, 2007. This Section 1115(a) Medicaid waiver provided services to uninsured men and women 19 years of age or older who were United States citizens or qualified aliens, residents of Oklahoma, not eligible for regular Medicaid and who met the income standard (185% of Federal Poverty Level). Services provided included office visits and physical exams related to family planning; birth control information, methods and supplies; laboratory tests including pap smears and screening for sexually transmitted infections; pregnancy tests; tubal ligations for women age 21 and older; and, vasectomies for men age 21 and older. The implementation, follow-up and evaluation of this waiver continued to be a collaborative process of the Oklahoma State Department of Health (OSDH) with MCH the lead for the agency, the Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS). The monthly number of enrollees has averaged approximately 20,000.

MCH Comprehensive Program Reviews were used as an opportunity to provide technical

assistance on the development of community participation plans, to include addressing of unintended pregnancy.

Numerous staff development opportunities were provided throughout the year with topics based on federal Title X family planning priorities/key issues.

MCH continued to fund the male involvement project in Bryan, Choctaw and McCurtain counties, which worked to promote individual and community health by emphasizing clinical family planning and related preventive health services to males. The project collaborated with community partners and area coalitions in each of the three counties to promote community involvement. Male reproductive health education and information about STI, HIV/AIDS prevention, abstinence, delay of sexual activity, and making the decision to parent was provided to more than 500 males of reproductive age at local health fairs, public school presentations and male only health clinics.

A marketing campaign, via local radio interviews and public service announcements, quarterly newsletters and cable television public service announcements, was utilized to create a standard message targeting men of reproductive age. The health departments in each of the target counties also offered male only clinic hours at least 1/2 day per week. The project partnered with Southeastern College in Durant, OK, to outreach to male students. The on-campus health clinic saw an increase in male clients as a result of the project's presence on campus and in the community. The physical environment of the clinics, in the lobby and exam rooms, was modified to create a more male friendly environment by hanging pictures promoting positive male body images, providing magazines that were male specific, and providing illustrations of the male reproductive system in the exam rooms.

Family planning services were provided through county health departments and contract clinics. Services included comprehensive histories, physical exams, laboratory services, methods education and counseling, provision of contraceptive methods, sexually transmitted disease (STD)/human immunodeficiency virus (HIV) screening and prevention education, pregnancy testing, immunizations, smoking cessation and education on nutrition and exercise. Services were provided to a total of 85,524 clients in calendar year 2007.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Shared PRAMS data on current status of unintended pregnancies in the state to support policy and health care systems				X
2. Coordinated with OHCA and OKDHS to assure effective and efficient provision of Medicaid family planning waiver services				X
3. Conducted MCH comprehensive program reviews and used reviews as opportunities for technical assistance				X
4. Provided staff development (training) opportunities				X
5. Funded a Male Involvement Project, including health services, media campaigns, and community involvement projects in 3 counties in Southeast Oklahoma			X	
6. Provided clinical family planning services through county health departments and contract providers	X			
7.				
8.				
9.				
10.				

b. Current Activities

MCH comprehensive program reviews are used as an opportunity to provide technical assistance. Improvement of clinic efficiency and the provision of quality services is an area of focus. Due to the high rate of unintended pregnancies in teens, county health department staff is encouraged to schedule adolescents as soon as possible, the same day if possible. Three OSDH employees have been trained to conduct patient flow analysis (PFA). PFA is a tool for examining the flow of clinic operations and determining how to improve clinic efficiency and reduce gaps in service.

The Male Involvement Project continues to be funded. MCH has applied for another Male Involvement grant to help promote the expansion of services to males in three additional counties in the central eastern area of the state.

MCH has received supplemental funding from the regional Title X office to target racial disparities in Oklahoma County's African American population. Plans are being developed to resume services in a predominantly African American neighborhood and outreach workers are being hired to help identify low income, at-risk, and uninsured men and women in the area and promote the expanded services of the county health department. An additional grant has been applied for through Title X to expand services to the African American population in Oklahoma and Tulsa counties with the goal of reducing unintended pregnancies and infant mortality, and improving the overall health of this population.

c. Plan for the Coming Year

Family planning services will continue to be provided through county health departments and contract clinics. Services include clinical exams, preconception/interconception care and counseling, STI/HIV testing and counseling, pregnancy testing, immunizations, preventive health screenings and referrals, and counseling on numerous topics including smoking, nutrition, exercise and healthy weight.

The Family Planning Waiver will continue in its fourth year. Current enrollment is down related to verification of citizenship status requirements and MCH is partnering with the Oklahoma Health Care Authority (OHCA) to explore ways to assist clients in obtaining the proper documentation. OSDH and OHCA are also working to expand services covered by the waiver to include treatment for sexually transmitted infections.

The Commissioner's Action Team on Infant Mortality is working to develop a strategic plan to decrease the unintended pregnancy rate and the infant mortality rate. A subgroup of this workgroup is creating a tool to promote preconception health and behavior assessment in family planning clinics across the state. Additional subgroups are identifying ways to promote Safe Sleep, breastfeeding, assessment for postpartum depression, smoking cessation and ways to decrease the incidence of infant mortality due to accidents and injuries. Plans are also underway for a media campaign to promote healthy behavior in all men and women of reproductive age if funding becomes available.

Plans are to write and disseminate a PRAMSGRAM about pregnancy outcomes and the relationship to preconception care in Oklahoma with a focus on encouraging interconception care in an attempt to reduce unintended pregnancies among women with one or more children.

The staff trained to assess and promote clinic efficiency will complete the scheduled PFA in 20 randomly chosen OSDH clinics and recommendations will be made for individual clinics as well as statewide changes to improve the quality of services provided.

Numerous staff development opportunities will be provided throughout the year with topics based on federal Title X family planning priorities and key issues, like unintended pregnancy and

preconception care. Training on male involvement this year will include hands on clinical exam training for clinicians who are not comfortable with male exams. Training will continue to be available to all staff on Creative Methods for Including Males in Clinic Services and Contraceptive Decision Making.

If additional funds are approved to expand the Male Involvement grant, the monies will be used to promote sexual health and responsible contraceptive decision-making among males in these additional counties as well as outreach and clinical services to the males at the Central Oklahoma Juvenile Correctional facility in Pottawattomie County.

State Performance Measure 3: *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	2003	2004	2005	2006	2007
Annual Performance Objective	28.2	24.8	24.4	28.2	27.7
Annual Indicator	26.5	26.5	28.6	28.6	23.2
Numerator	69200	69200	42781	42970	35197
Denominator	261131	261131	149585	150246	151710
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	23	22.7	22.4	22.1	21.8

Notes - 2007

Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2006-2007 season.

Notes - 2006

Source: Numerator derived from 2005 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2005-2006 season.

Objectives for 2007-2011 have been revised to reflect more plausible targets given data from the Oklahoma YRBS. Objectives are targeted toward a step-wise decline in adolescent smoking rates.

Notes - 2005

Source: Numerator derived from 2005 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2004-2005 season.

a. Last Year's Accomplishments

Data from the statewide 2007 Oklahoma Youth Risk Behavior Survey (YRBS) reveal that 23.2% of adolescents in grades 9-12 report cigarette smoking in the past 30 days, which is the time period used to define a current smoker. This finding is a slight decrease in the current smoking rate in this age group reported as 28.6% from the 2005 Oklahoma YRBS. According to national 2007 YRBS data from the Centers for Disease Control and Prevention (CDC), an estimated 20% of high school students are current cigarette smokers.

The percentage of students who had ever tried smoking declined in 2007 from 2005. The 2007 results indicate 54.8% of students had ever tried smoking, compared to 2005 where 62.3% had ever tried smoking. The percentage of students who smoked on a daily basis was also down from 2005, 17.8% to 13.3%.

MCH completed administration of the 2007 statewide YRBS. Efforts were coordinated with

Oklahoma State Department of Health (OSDH) Tobacco Use Prevention Service and the Cherokee Nation STEPS to a Healthier U.S. Native American Grant to minimize the impact on schools. The YRBS and Youth Tobacco Survey (YTS) were administered simultaneously.

The YRBS was administered to 2,612 students in 51 public high schools across Oklahoma in the spring of 2007. Oklahoma's participation rate was such that weighted data were achieved for the third straight survey. Several challenges staff met with during the administration of the 2007 survey included: inclement weather which required staff to re-schedule many of the schools, No Child Left Behind and concerns expressed by metropolitan schools regarding the formula used to determine the selection of schools. Oklahoma continued to work closely with the CDC for a determination of the formula.

Results for the 2007 Oklahoma YRBS were released to the OSDH on August 27, 2007. Fact sheets illustrating trends dating back to 2003 were drafted highlighting the six key areas identified in the survey, including tobacco use. The intended audience was legislators, school administrators and key personnel who influence strategic planning opportunities for the reduction of tobacco use among teens.

Collaboration continued with the OSDH Tobacco Use Prevention and Dental Services promoting prevention activities and efforts across the state. Strategies to reduce tobacco use included support for community-based initiatives, classroom programs and youth cessation programs. The focus for these activities continued to be on elementary and middle school students. In addition, information was provided to all schools in the state to encourage development and adoption of policy that would not allow smoking on school grounds 24 hours a day seven days a week.

State dollars continued to fund 13 rural district school health nurses through a contractual agreement with the Oklahoma State Department of Education (OSDE). The school health nurses focused a portion of their time on tobacco prevention activities. The school nurses completed their transition to MCH for oversight and administration. The school health coordinator in MCH provided technical support and assistance. Tobacco use prevention remained a priority.

Tobacco use prevention and cessation information was shared via resource packets to schools, a school nurse listserv through the OSDE and the quarterly School Health Newsletter (a collaborative project between MCH and the OSDE).

A Healthy and Fit School Advisory Committee Manual was drafted as a collaborative partnership of the Governor's Office, the OSDE, the Fit Kids Coalition and the OSDH to give schools more guidance about what programs and resources are available to help them. Emphasizing the CDC Coordinated School Health Program, this manual provided information to schools on how to initiate a local Healthy and Fit School Advisory Committee, wellness policies, resources and examples of school success stories.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administered the 2007 statewide Youth Risk Behavior Survey (YRBS). Shared trend data (2003-2007) with stakeholders for policy and program development				X
2. Collaborated with the OSDH Tobacco Use Prevention and Dental Services on youth prevention activities and health education efforts across the state			X	
3. Provided funding and technical assistance to 13 rural district school health nurses; tobacco cessation is one of their focus areas				X

4. Drafted a Healthy and Fit School Advisory Committee Manual as a collaborative partnership of the Governor's Office, the OSDE, the Fit Kids Coalition and the OSDH to give schools more guidance about available programs and resources				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MCH has finished the administration of the self-select YRBS to schools with data to be returned to individual schools by mid-August.

During the summer of 2008, MCH plans to collaborate with Tobacco Use Prevention Service to begin coordination efforts for the 2009 YRBS and Youth Tobacco Surveys. By September 30, 2008, MCH will contact Westat with information regarding the sample for the 2009 YRBS statewide survey.

MCH plans to make presentations to education leadership groups during the summer of 2008 on the background and benefits of participating in the statewide survey. MCH is completing YRBS fact sheets and other materials to educate the public on tobacco use among state teens.

The state funded school nurses coordinate with county health departments and other community organizations to organize educational opportunities for students in the schools they serve.

MCH coordinated efforts with Tobacco Use Prevention Service to provide training at the OHCA/OSDH Child Health Advisory Task Force in June of 2008. Training included education about data, the impact of tobacco on fetal, newborn and infant development, and tips for providers on how to educate their patients about cessation (focused on 5 A's).

Legislation was proposed in the 2008 session to allow communities to reduce access to tobacco by youth. The proposed legislation was not passed out of committee, but has the opportunity to be reintroduced in the 2009 legislative session.

c. Plan for the Coming Year

Meetings between MCH and Tobacco Use Prevention Service will be routinely held, in efforts to coordinate the administration of the YRBS and YTS. By May 30, 2009 MCH will complete the statewide YRBS. By June 30, 2009 MCH will submit the YRBS surveys to Westat for evaluation. Tobacco Use Prevention Service will complete and submit their survey results within this same time period.

MCH will continue to provide technical support and resources to the state funded school nurses in rural Oklahoma. MCH staff will provide technical assistance and support for the development of their annual plans, which outline specific goals, objectives and activities to be completed within the 2008-2009 school year. Each annual plan submitted by the tobacco nurses must include a component addressing tobacco use prevention and cessation.

MCH will follow closely any legislation put forward to limit access to tobacco products by youth in the 2009 legislative session. MCH will coordinate with Tobacco Use Prevention Service to provide education to policy and lawmakers promoting reduced access of tobacco by youth.

State Performance Measure 4: *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	2003	2004	2005	2006	2007
Annual Performance Objective	75	130	134	144	160
Annual Indicator	127	120	142	152	138
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	168	176	185	194	200

Notes - 2007

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

Notes - 2006

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

Notes - 2005

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

a. Last Year's Accomplishments

The Oklahoma Area-wide Services Information System (OASIS) remained the central processing agency for respite care applications in the state. The OASIS staff handled 10,222 calls in 2007 related to the respite voucher program. Of these, 2,561 were requests for applications and 2,744 were reapplications. Two hundred and ninety-two children received respite care. OASIS determined each family's eligibility then routed their application to the proper funding source. CSHCN issued vouchers for 138 families, the OKDHS Developmental Disabilities Services Division (DDSD) issued 118 vouchers and the OKDHS Children and Family Services Division (CFSD) issued 36 vouchers. CSHCN experienced a decline in issued vouchers of 9.2% from 2006.

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

CSHCN continues working with Oklahoma Family Network (OFN) and OASIS to do outreach regarding the availability of respite vouchers for families of children with special health care needs, as well as identifying resources and individuals in the community who can provide care. The OFN staff refers families to OASIS for respite vouchers and other resource information. OFN staff also email all newsletters and notices from OASIS to OFN families.

At the annual Governor's Conference on Developmental Disabilities in April, CSHCN included information about respite in their presentation to those in attendance, focusing on the availability of vouchers to pay for respite and encouraging families to communicate with CSHCN about the availability of caregivers in their communities.

c. Plan for the Coming Year

CSHCN will continue working with the Oklahoma Respite Resource Network (ORRN) to identify additional sources of funding and trained providers who can provide respite care. CSHCN will also focus on more outreach to communities and agencies that provide services to children with special health care needs and insure they are making appropriate referrals to ORRN.

CSHCN will continue serving on the Children with Special Health Care Needs committee at the Oklahoma Institute for Child Advocacy's (OICA) Fall Forum. In the past CSHCN has proposed more state funding for respite but did not receive enough votes from other committee members to get the proposal moved forward for consideration for placement on the Children's Legislative Agenda. CSHCN intends to propose more state funding for respite again at the October 2008 Fall Forum.

State Performance Measure 5: *The percent of adolescents at risk for overweight (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	2003	2004	2005	2006	2007
Annual Performance Objective				15.6	15.3
Annual Indicator			15.9	15.9	15.3
Numerator			23784	23889	23257
Denominator			149585	150246	151710
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	15	14.7	14.4	14.3	14.2

Notes - 2007

Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2006-2007 season.

Notes - 2006

Source: Numerator derived from 2005 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2005-2006 season.

Notes - 2005

Source: Numerator derived from 2005 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2004-2005 season.

a. Last Year's Accomplishments

Oklahoma conducted the Youth Risk Behavior Survey (YRBS) in 2007 and obtained a weighted state dataset. This is the third time Oklahoma has been able to collect weighted data from the YRBS. According to the latest data there have been no significant changes in the percent of adolescents at risk for overweight. In 2007, 15.3% of adolescents in grades 9-12 were at risk for overweight compared to approximately 16% in 2005. Percent of female adolescents at risk for overweight was 16.8% as compared to 13.7% of male adolescents at risk for overweight.

There was no change in the percent of students who reported eating fruits and vegetables less than 5 times per day during the past 7 days (2007 84.3% compared to 2005 84.1%). The percent of students who were physically active for at least 60 minutes per day on 5 or more of the past 7 days rose from 38.2% in 2005 to 49.6% in 2007. The percent of students who attended physical education (PE) classes one or more days in an average week while in school rose minimally from 35.9% in 2005 to 39.7% in 2007.

MCH helped in the development of state policy by providing information and education to legislators and their staff on childhood obesity and physical activity. House Bill (HB) 1601 clarified that recess does not count toward the required 60 minutes per week of physical education in grades K-5. The bill also required school districts to provide parents with an annual report summarizing the physical activity opportunities and to give them suggestions for encouraging physical activity in their children. As a result of the bill a Task Force was established to formulate recommendations regarding physical education requirements in Oklahoma public schools.

MCH provided input into an appropriations request to provide funds to implement pilots of the Center for Disease Control and Prevention's (CDC) Coordinated School Health Program Model (CSHP) in schools across the state. This request was not funded by the legislature. The MCH School Health Program provided support to schools and school nurses throughout the state as policies and activities were developed related to the requirements of the new state laws regarding diabetes management in schools (HB 1051 and HB 1601).

MCH continued to provide input on nutrition and physical activity for children and adolescents through expanded support of the CDC's CSHP Model to the "Governor's Call To Action" through the OSDH Commissioner's Call to Action Team on Nutrition and Physical Activity. The Commissioner's Action Team met monthly to develop and refine the agency's strategic plan that integrates into the Governor's plan.

MCH continued to provide financial and technical support to the Schools for Healthy Lifestyles Program (SHL). This program expanded to 40 schools in 11 counties including the metropolitan area. The expansion added 11 new schools. SHL continued to focus on nutrition and physical activity for 2 of the 4 components of the program.

MCH worked closely with the Fit Kids Coalition (FKC), a statewide coalition focused on promoting positive, rapid change in the fight against childhood obesity and inactivity. MCH, with the FKC, the Oklahoma State Department of Education (OSDE), and the Action for Healthy Oklahoma Kids (AHOK) worked together to complete and distribute to schools statewide the Strong and Healthy Oklahoma Schools Manual, which addressed recent legislative requirements on nutrition and physical activity for schools and provided examples of successful school programs that increased nutrition and physical activity.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided information and education to legislators and their staff on childhood obesity and physical activity for new policy				X

2. Provided information for an appropriations request to provide funds to implement pilots of the CDC Coordinated School Health Program Model (CSHP) in schools across the state				X
3. Provided input on nutrition and physical activity to the OSDH Action Team on Nutrition and Physical Activity				X
4. Continued to provide financial and technical support to the Schools for Healthy Lifestyles Program (SHL).				X
5. Partnered with the FKC, OSDE, and the Action for Healthy Oklahoma Kids (AHOK) to complete and distribute to schools statewide the Strong and Healthy Oklahoma Schools Manual				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During the 2008 legislative session, an unfunded mandate (SB 519) was passed, directing the Oklahoma State Department of Health to development physical fitness assessment software. The bill authorized the OSDH to pilot test the software in 15 elementary schools for students in grades 3-5.

MCH with FKC, OSDE, and AHOK coordinates efforts to provide statewide trainings to school personnel and partners on how to use the Strong and Healthy Oklahoma Schools Manual and the CDC's School Health Index to guide their schools in needs assessment and program development in the areas of nutrition and physical activity.

The self-select YRBS is offered by MCH to local schools during even numbered years when the statewide YRBS is not conducted. MCH completed the administration of the self-select YRBS during the spring semester of the 2007-2008 school year. MCH is completing the analysis of the data for the schools. Upon request, MCH provides technical assistance and educational support about the data collected.

The Oklahoma State legislature recently passed Senate Bill 1186, which increases the current physical education requirement for grades K-5 from 60 minutes to 120 minutes per week. Senate Bill 1612 creates a mini-grant program with the OSDH to assist out-of-school-time programs to incorporate elements to reduce childhood obesity. MCH is providing resources and technical assistance to schools and organizations to assist in the implementation of these bills.

c. Plan for the Coming Year

This state performance measure is being discontinued for 2009. This change is being made as MCH found on review of data for this performance measure that previous reporting included only those adolescents at risk for overweight and not those who were overweight. In addition, the CDC now uses the terms overweight and obese, the term "at risk" is no longer used. Having this information, a new state performance measure, SPM #9, has been added for 2009.

State Performance Measure 6: *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	2003	2004	2005	2006	2007
--	-------------	-------------	-------------	-------------	-------------

Annual Performance Objective				21	21
Annual Indicator			14	14	15
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	18	18	18	18	18

Notes - 2007

Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A. Future annual performance objectives have been adjusted to more realistically reflect MCH data capacity.

Notes - 2006

Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A.

Notes - 2005

Source: MCH Assessment, OSDH. Score derived from Form 19 HSCI #09A.

a. Last Year's Accomplishments

Linkage between the OSDH vital records and the Medicaid eligibility and paid claims was the largest challenge. However, MCH obtained approval and announced a position jointly funded by both the OSDH and the OHCA. This position description focused on the electronic linkages of agency databases and verifying the accuracy of those linkages. The State Systems Development Initiative (SSDI) biostatistician resigned, leaving the project suspended temporarily.

Enhancing the need for linking data was accomplished through building awareness of its benefits in the OHCA/OSDH Perinatal Advisory Task Force and the Child Health Advisory Task Force. That awareness improved the support for creating and sustaining the interagency data linkage project. Interpretations of various laws continued to restrict the inability of areas within each agency to access confidential information.

Work on joining datasets began within another unit of the agency with the intended purpose of enabling clients to enroll in public assistance programs external to OSDH (No Wrong Door, See NPM#18). The Public Health Oklahoma Client Information System (PHOCIS) linked information for all direct services provided by OSDH, including WIC, Maternity, Child Health, Family Planning, Immunization and other MCH-related services. Once Medicaid information is linked with vital records, MCH will begin the process of joining other datasets into the linked file.

Birth and infant death certificates were routinely linked within the OSDH Office of Vital Records. The past three years has seen a significant improvement in the completeness of these matched records, which resulted in a match rate of over 98% each year.

Hospital discharge data were completed except for a few very small hospitals across the state. The data represented well over 95% of hospitalizations in Oklahoma.

Oklahoma continued to maintain one of the more comprehensive active birth defects surveillance systems in the country. The primary complication was access to this confidential dataset.

The Oklahoma Pregnancy Risk Assessment Monitoring System (PRAMS) Project continued to operate within MCH. This permitted analyses on demand, and a number of PRAMSGRAMS were produced over the past year. These include father's pregnancy intention, infant sleep position, and Native American health disparities. In addition to prepared reports and presentations, data from PRAMS were utilized by multiple groups within the OSDH as well as external partners. Uses included building awareness, documentation of need, support for grant applications and general information.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Obtained approval and announced a position jointly funded by both the OSDH and the OHCA to link agency databases			X	
2. Maintained one of the more comprehensive active birth defects surveillance systems in the country				X
3. Built awareness of benefits of data linkages in the OHCA-OSDH State Perinatal Advisory Task Force and the Child Health Advisory Task Force				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Data used to assess this measure are derived from the reporting on Health Systems Capacity Indicator (HSCI) #09A. State data capacity defined under HSCI #09A is the principal focus of the SSDI grant defined by Oklahoma to expand its ability to gather and analyze data important to assessing the maternal and child health population.

PRAMS continues to operate efficiently and is committed to producing routine publications of topics considered important to the MCH public audience as well as the MCH field of practice.

Limited access to hospital discharge data and the Oklahoma Birth Defects Registry (OBDR) continues to be a challenge, since these data sources have strict confidentiality rules and are maintained by OSDH units outside MCH.

Direct annual data linkages include those targeted (listed on Form 19) for births/infant deaths, births to Medicaid program data, births to WIC program data and births to newborn screening data. A Medicaid matching analyst has been hired to begin linking Medicaid data to the live births and the infant death vital records. Linkages between live births and infant deaths are now being performed annually by the OSDH Center for Health Statistics, Office of Vital Records (score=2 on Form 19), while linkages between births and the other databases are now under development (score=1 on Form 19). In addition, a plan is underway within OSDH to build client and registry database linkages on a routine basis; it is unclear what access MCH will have to the data.

c. Plan for the Coming Year

Efforts are underway to make more of the data available to providers and the general public. Outlets for the use of linked data will be maintained and expanded to enhance the awareness of the health status and need of the MCH populations.

Future steps for data linkage will include linking matched Medicaid data to the PHOCIS, the OSDH's database that includes clients served in Maternity, Child Health, Family Planning, Immunization, WIC, and Children First, the nurse-family partnership program for the state.

Analyses of the Medicaid linked data will begin and will be analyzed for inclusion of the five-year needs assessment that will begin development this year.

The joint OHCA/OSDH Perinatal and Child Health Task Forces will be utilized to provide input into 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. These two task forces are charged with looking at issues surrounding the delivery of Medicaid services, including barriers, scope and other concerns. Because Medicaid covers more than 50% of all deliveries in Oklahoma, their interests are very useful in providing an external perspective for analyzing these large databases.

More emphasis will be made in utilizing and releasing data from The Oklahoma Toddler Survey (TOTS), with the addition of a biostatistician available to review the data, analyze it, and release reports of toddler health status and healthcare utilization.

State Performance Measure 7: *The percent of Medicaid eligible children with special health care needs who report receiving routine dental care.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				20	39.4
Annual Indicator				38.3	41.5
Numerator				10908	10758
Denominator				28496	25921
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	42	42.5	43	43.5	44

Notes - 2007

Source: CSHCN program, OKDHS. Medicaid claims data, OHCA.

Notes - 2006

Source: CSHCN program, OKDHS. Medicaid claims data, OHCA.

Objectives for 2007-2011 have been revised to reflect more plausible targets given recent data from CSHCN Program. Targets reflect step-wise upward trend in the percent of CSHCN receiving dental care.

Notes - 2005

Source: CSHCN program, OKDHS. Medicaid claims data, OHCA. Data are not currently available, but will be later this year.

a. Last Year's Accomplishments

This year OHCA reported an average of 10,758 monthly encounters for routine dental services for Medicaid-eligible children who were classified as disabled or who were in the custody of the state. This was a decrease of approximately 248 encounters per month, however it is felt this is due to a more accurate count of unduplicated recipients. Statistics showed the average number of children receiving Medicaid benefits in any given month was approximately 25,921. Data indicate 45.1% of these children reportedly received routine dental care. A few counties did show a slight gain in the number of dental encounters for this year.

The Children's Oral Health Coalition (COHC) completed development of their five-point action plan. Their first point involved increasing the number of Medicaid providers in the state. Some success has been made on this point. Through the Oklahoma Dental Loan Repayment Act, five dentists per year, for two to five years, would each receive \$25,000 for school loan payments if

they agree to both practice full time in a designated shortage area and have at least 30% of their total patients be on SoonerCare (the state's Medicaid program; See NPM #9). The Oklahoma Dental Association was able to purchase vans so their mobile dental program could go to underserved areas to see children, including children with special needs.

COHC committees worked to implement the remaining four points of the action plan. The second point of the plan is to encourage SoonerCare and private insurance carriers to change their policies to create a greater emphasis on prevention. The third point will consider ways to develop greater empathy, understanding and respect between caregivers and professionals. The fourth point has two parts: educating parents and/or caregivers on the importance of including oral health in transition plans and finding funds for dental programs for adults with special needs. The fifth part of the plan also has two parts: reducing confusion about the eligibility of CSHCN for Medicaid and tackling inefficiencies created by the lack of centralization and coordination of efforts in the care of CSHCN.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participated with the Children's Oral Health Coalition (COHC) to help complete development of their five-point action plan				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

All counties in the state report children being seen for routine dental care by Medicaid providers, however some children travel quite a distance from their home for care. It is expected that since the mobile dental program was able to purchase more vans, this will be ameliorated to some extent.

The COHC continues organizing sub-committees to implement the statewide action plan to address oral health issues for CSHCN in Oklahoma. CSHCN continues to work with the COHC to address the points of action relevant to CSHCN including increasing the number of providers statewide, educating parents and providers on oral health care for special health needs patients and transitioning oral health care into adulthood. Plans include reducing confusion about the eligibility of CSHCN for Medicaid and tackling inefficiencies created by the lack of centralization and coordination of efforts in the care of CSHCN as it relates to dental health.

Another component of the five-part plan, increases in Medicaid rates to build up the number of SoonerCare providers, is seeing results. Approximately seven doctors are now working in underserved areas and have agreed that at least 40% of their practice will be SoonerCare patients.

c. Plan for the Coming Year

CSHCN will continue working with the COHC in implementing their five-point action plan. The COHC plans to address the need for continuous screening by supporting legislation that would require dental check-ups before a child can enroll in school. Further, this group will work to implement clinical training in serving CSHCN with CEU credit for dentists, doctors and dental staff.

COHC will continue to work toward increasing Medicaid rates or providing other incentives to increase the number of SoonerCare providers.

Another COHC committee will focus on ensuring adequate public and private financing of needed services. They will lobby for Medicaid and insurance carriers to change their present policies to put more of an emphasis on prevention. Efforts will also be made to recruit more providers for CSHCN through organizing more free dental clinics and the creation of private scholarships and loan forgiveness programs.

The development of family and professional partnerships committee in COHC will make the recommendation to providers to schedule consultations with families before appointments with CSHCN. This would allow both the family and the professional to get to know each other and learn what to expect during the appointment. This committee will also be educating caregivers, professionals and the public about the importance of family partnership through brochures, educational videos and the development of dentist websites.

The COHC committee for accessibility will lobby for the simplification of SoonerCare processes and language so families will find it easier to get care for their children. A "tool kit" will be created and distributed to families and providers. A database and referral system for dentists who treat CSHCN will be developed. A separate database will also be created to track the care and treatment of CSHCN. Training will be made available for dentists to learn effective care coordination.

Assisting CSHCN in the successful transition to all aspects of adult health care, work and independence will continue in the COHC. Committee members will lobby the legislature for more services and publicly funded coverage for adults. They will promote the writing of adequate transition plans into Individualized Education Programs (IEP). Educational materials will also be developed on transition and referral services in regards to oral health.

State Performance Measure 8: *The percent of adolescents grades 9-12 not using alcohol during the past 30 days.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				60.7	61.9
Annual Indicator			59.5	59.5	56.9
Numerator			89003	89396	86323
Denominator			149585	150246	151710
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	63.1	64.4	65.7	66.4	67.1

Notes - 2007

Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2006-2007 season.

Notes - 2006

Source: Numerator derived from 2005 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2005-2006 season.

Notes - 2005

Source: Numerator derived from 2005 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2004-2005 season.

a. Last Year's Accomplishments

The statewide Oklahoma Youth Risk Behavior Survey (YRBS) collects data from students in grades 9-12 to track this measure. Data from the 2007 YRBS showed that 43.1% of Oklahoma adolescents had used alcohol in the 30 days prior to the administration of this survey. A higher percentage of male adolescents (46.2%) reported alcohol use during the last 30 days compared to females (40.2%). The most recent national data, 2007, shows 55.3% of United States (U.S.) students grade 9-12 reported no alcohol use in the previous 30 days.

The percentage of students in Oklahoma who had their first drink of alcohol (other than a few sips) before thirteen years of age significantly decreased from 25.2% in 2005 to 23.3 percent in 2007. Females had a much lower percentage at 19.2% than males at 27.2%. There was a significant increase in the percentage of students who had five or more drinks of alcohol in a row (within a couple of hours) one or more times in past thirty days from 26.6% in 2005 to 27.9% in 2007.

MCH continued to partner with the Oklahoma State Department of Health (OSDH) Injury Prevention Service and the Oklahoma Department of Mental Health and Substance Abuse Services (DMHSAS). The team consisted of the MCH Adolescent Health Coordinator, SAFE KIDS Coordinator, OSDH Injury Prevention Service staff, and Oklahoma Highway Safety Office staff. Discussions were begun to establish consistent meeting times for the development of recommendations for action and strategies over the coming year. Team activities were delayed due to the SAFE KIDS Coordinator resigning and the unexpected staff changes in MCH, Injury Prevention Service and the Oklahoma Highway Safety Office.

Social Host Ordinances have passed in 32 communities across Oklahoma since The Prevention of Youth Access to Alcohol Bill was signed by Governor Brad Henry on May 25, 2006. With help from grassroots efforts such as Turning Point, city officials have gained an understanding and knowledge of how this ordinance can assist with preventing underage drinking parties by holding the "host" of the party liable for allowing underage drinking to occur on their property.

Results for the 2007 Oklahoma YRBS were released to the OSDH on August 27, 2007. Fact sheets illustrating trends dating back to 2003 were drafted, highlighting the six key areas identified in the survey, including alcohol use.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partnered with the OSDH Injury Prevention Service, Oklahoma Highway Safety Office and DMHSAS for the development of strategies to reduce adolescent alcohol use				X
2. Drafted YRBS fact sheets illustrating trends dating back to 2003, including alcohol use				X
3.				
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

MCH is working with Injury Prevention Service to revive Teen Driving Roundtable by expanding the committee, inviting new members and schedule meetings to present committee goals and activities. Routine quarterly meetings between MCH and Injury Prevention Service assist in the development and implementation of these activities.

The MCH Adolescent Health Coordinator represents OSDH on the Governor's Task Force on Prevention of Underage Drinking. Activities of the Task Force include hosting Rear Admiral Steven K. Galson, M.D., M.P.H., Acting Surgeon General of the United States, and his talk entitled "Start Talking So They Don't Start Drinking" in January 2008. A town hall meeting, a breakfast for current and potential partners and a "Grand Rounds" held at the University of Oklahoma College of Public Health were events in which the Surgeon General spoke on the issue of underage drinking and its implications.

Through Turning Point partnerships and information and technical assistance by MCH, approximately 30 local town hall meetings have taken place or are scheduled throughout Oklahoma for Spring 2008.

The MCH Adolescent Health Coordinator served on the steering committee for the Fetal Alcohol Spectrum Disorders and Underage Drinking Prevention Conference: Cultivating Healthy Pregnancies, Growing Healthy Youth which took place April 7-8, 2008. MCH assisted in sponsoring the conference.

c. Plan for the Coming Year

Trend data comparing results from the 2003, 2005 and 2007 YRBS will be compiled related to teen alcohol use in the past 30 days. This information will be distributed to school leaders, county health departments, local and statewide media outlets, and Turning Point and community coalitions.

The fourth statewide YRBS will be completed in May 2009 by MCH. This will provide Oklahoma with statewide data that can be generalized to the high school population for years 2003, 2005, 2007 and 2009.

The MCH Adolescent Health Coordinator will continue to provide representation on the Governor's Task Force on Underage Drinking. Program efforts will include consistent information and educational resources on negative health outcomes related to underage drinking via trainings and written materials provided for community outreach, school health efforts and for applicable areas in the OSDH whose programs may have an adolescent focused component.

MCH Adolescent Health program has tentative plans to assist with the Oklahoma Highway Safety Office's 2M2L (Too Much to Lose) underage drinking prevention program, including the 2M2L Camp held each summer. Specific ways of assistance are to be explored as planning occurs.

MCH plans to develop further strategies to impact underage alcohol use with partners such as OSDH Injury Prevention Service, Oklahoma Turning Point, SAFE KIDS, Oklahoma Highway Safety Office, Oklahoma State Department of Education, and DMHSAS. MCH will explore further efforts to support state and local initiatives to prevent and reduce underage drinking.

State Performance Measure 10: *The percent 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	2003	2004	2005	2006	2007
Annual Performance Objective					
Annual Indicator			31.1	31.1	29.9
Numerator			46521	46727	45361
Denominator			149585	150246	151710
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	29.6	29.3	29	28.7	28.4

Notes - 2007

Source: Numerator derived from 2007 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2006-2007 season.

Notes - 2006

Source: Numerator derived from 2005 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2005-2006 season.

Notes - 2005

Source: Numerator derived from 2005 Oklahoma Youth Risk Behavior Survey (YRBS), MCH, OSDH. Denominator is average daily high school attendance during 2004-2005 season.

a. Last Year's Accomplishments

This is a new state performance measure for 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. This is a new performance measure for 2009				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

This is a new state performance measure for 2009.

c. Plan for the Coming Year

Collaboration will continue with FKC, AHOK, OSDE, and other partners to plan and implement strategies that will promote positive nutrition and physical activity for school age children. This includes Action for Healthy Kids (AHOK) taking the lead on the statewide campaign to decrease screen time through awareness and education resources through childcare centers, schools, clinicians, faith-based organizations and after-school programs.

MCH will continue to participate on the Commissioner's Call to Action Team on Nutrition and Physical Activity. MCH will continue to have representatives on the three sub-committees (Where We Work, Where We Learn and Where We Live) that make up the "Commissioner's Call to Action Team."

MCH will continue to provide technical assistance to school nurses and encourage schools to move toward the Centers for Disease Control and Prevention (CDC) Coordinated School Health Program (CSHP) model. MCH will continue to work with schools statewide to promote the use of the CDC's School Health Index self-assessment tool including the physical activity and nutrition modules at each school site. "Tools for Schools" trainings offered by the OSDH State Physical Activity and Nutrition Director, Community Health Service, MCH and Oklahoma City-County Health Department are currently being scheduled for school personnel and county health department health educators with MCH conducting the School Health Index component.

MCH will begin during the summer 2008 to promote the random select CDC statewide YRBS. MCH will complete the random select CDC YRBS by May 2009 and submit weighted data to Westat for evaluation.

The contract with the Schools for Healthy Lifestyles (SHL) will remain in place. MCH will continue to provide technical support to SHL throughout the year and participate in the summer training institute for those schools participating in the program.

MCH will continue to provide support to the Oklahoma Afterschool Network as it encourages the development of out of school programs that include education on nutrition and provide additional physical activity to all participating school age children during the of school times.

MCH will serve as technical support for the fitness-testing software program and assessment.

E. Health Status Indicators

See Forms 20 and 21.

Title V designated health status indicators are reviewed regularly by the Oklahoma Title V Program as an integral assessment of program monitoring throughout each year. These indicators are a limited representation of the issues that must be tracked routinely to learn of important changes in health status that may be the result of system changes, including health care access, changes in the population or socio-economic shifts of sub-populations. These changes are dynamic and MCH receives relatively rapid feedback from local providers when significant changes impact the MCH health care structure. Moreover, MCH encourages local communities and local public health providers to monitor these same issues to better address changing needs and to assist the Title V administration staff in adjusting programs and funding as needs indicate.

Some health status indicators are not recognized as being strong indicators for Oklahoma MCH programs. For example, the number of TANF families is not that useful for planning due to the program restrictions placed by the state. Also, the number of high school dropouts is of limited value because of known issues allowing local school districts to provide information that may not be truly representative of the number of school-aged children who have been lost to the education system. In lieu of these limitations, the state frequently locates other data that can be used as a proxy for these important issues. These alternate resources also frequently provide more detailed data that allows assessment to the county level.

Others, such as those specific to low birth weight, mortality and morbidity due to unintentional injury, provision of demographic information related to live births to women and deaths to infants and children are used by MCH in planning and evaluation of services and are linked with national and state performance measures and related activities. MCH also receives data requests and provides these data to governmental agencies, state medical and nursing organizations, legislators, health care providers, advocates and others for their use in planning.

Depending on the degree of changes in health status indicators, further exploration is conducted to identify causative factors leading to the change and potential interventions to impact. A specific example is reported cases of chlamydia. MCH participates with HIV/STD Service and the Public Health Laboratory on a regional infertility prevention project funded with Centers for Disease Control and Prevention (CDC) funds. These data are used to target screening and services for chlamydia in the state as well as activities for the region.

HSI#01 A-B

A) The percent of live births weighing less than 2,500 grams.

B) The percent of live singleton births weighing less than 2,500 grams.

The low birth rate for all live births was unchanged from 2004 to 2005 at 8.0 percent. The percentage of singleton births declined only slightly from 6.6% in 2004 to 6.4 in 2005, a relative decrease of 3%. In the main, the percent of Oklahoma births born weighing less than 2,500 grams has shown little variation over the last five years.

//2009/ The low birth rate for all live births rose slightly from 2005 to 2006 from 8.0 percent to 8.4 percent. The percentage of singleton births increased somewhat from 6.4% in 2005 to 6.8 in 2006, a relative increase of 6.3%. //2009//

HSI#02 A-B

A) The percent of live births weighing less than 1,500 grams.

B) The percent of live singleton births weighing less than 1,500 grams.

The percent of all births that are born weighing less than 1,500 grams increased from 1.3% in 2004 to 1.4% in 2005. This continues a run up in the percentage of all live births delivered weighing less than 1,500 grams, and it represents an absolute increase from 649 very low weight births in 2004 to 743 in 2005. The most recent low occurred in 2003 (1.2%). Among singleton live births, the percent of births born at very low birth weight rose from 1.0% in 2004 to 1.2% in 2005.

//2009/ The percent of all births that are born weighing less than 1,500 grams increased from 1.4% in 2005 to 1.6% in 2006. This continues the upward trend of births less than 1,500 grams, and it represents an absolute increase from 743 very low weight births in 2005 to 866 in 2006. Among singleton live births, the percent of births born at very low birth weight rose from 1.2% in 2005 to 1.3% in 2006. //2009//

HSI#03 A-C

A) The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

B) The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

C) The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.

The unintentional death rate among children less than 15 years of age dropped by 5.4% to 12.3 per 100,000 population in 2005 from 13.0 in 2004. Generally speaking, this measure tends to vary from year-to-year, oscillating yearly from increases to decreases of moderate change. This is due to the small number of events used to compute the death rate.

//2009/ The unintentional death rate among children less than 15 years of age increased by 13.7% to 15.8 per 100,000 population in 2006 from 13.9 in 2005. Due to the small number of events this measure tends to vary from year-to-year. //2009//

The death rates due to unintentional motor vehicle crashes declined for each of the age groups. The death rate for children 14 years and younger climbed to 4.9 per 100,000 population in 2005,

a reduction of 12.5% over 2004. Likewise, the death rate for youth aged 15-24 was off by 3.6%, dropping from 38.5 per 100,000 population in 2004 to 37.1 in 2005. The death rates in this category tend to vary year-to-year; thus, these findings should be interpreted cautiously, given the small number of events that are used in the computation of these rates. Single-year rates that include small counts of events are subject to wide variability.

//2009/ The death rate for children 14 years and younger climbed to 6.6 per 100,000 population in 2006, a significant increase from 2005, with a rate of 4.6 per 100,000. Likewise, the death rate for youth aged 15-24 increased by 7.2%, increasing to 38.6 per 100,000 population in 2006 from 37.1 in 2005. //2009//

HSI#04 A-C

- A) The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.
- B) The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.
- C) The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

The latest nonfatal injury rate for 2003 among children less than 15 years of age was 340.7 per 100,000 population. New data for this measure are not presently available. The nonfatal motor vehicle crash rates for age groups 14 and younger and ages 15-24 have declined 13.9% and 2.8%, respectively. In each case, the nonfatal MVC injury rate has dropped in three consecutive time periods for which new data were available.

//2009/ New data for this measure are not presently available. //2009//

HSI#05 A-B

- A) The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.
 - B) The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.
- The chlamydia case rates for both age groups tracked by HSI#05 A-B saw slight increases in year 2006. For ages 15-19, the rate rose 4% to 31.5 per 1,000 women from 30.3 in 2005 while the rate for women aged 20-44 increased 1.1% to 9.2 from 9.1. The chlamydia rate among teenage women has remained relatively flat during the period 2002-2006, averaging 30.9 cases per 1,000. The chlamydia rate among the older age group rose sharply (19.7%) between 2002 and 2003, leveled off between 2003 and 2004, increased again by 15.2% between 2004 and 2005, before rising at a more moderate rate in the year between 2005 and 2006.

//2009/ New data for this measure are not presently available. //2009//

HSI#06 A-B

- A) Demographics (Total Population) Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race.
- B) Demographics (Total Population) Infants and children aged 0 through 24 years enumerated by sub-populations of age group and ethnicity.

Data for this indicator are drawn from the American Community Survey (ACS) conducted by the U.S. Census Bureau and provided to MCH by the Oklahoma Department of Commerce. In 2005, the latest for which detailed race/ethnicity data are available, the ACS data reveal that there were an estimated 1,236,343 children in Oklahoma between the ages 0 and 24. Four percent were infants and 15% were children ages 1-4. Approximately 18% were children ages 5-9, with another 19% aged 10-14 years and 20% aged 15-19. Roughly 22% of the 1.2 million children were aged 20-24.

//2009/ According to the ACS, in 2006, the latest for which detailed race/ethnicity data are available, there were an estimated 1,271,287 children in Oklahoma between the ages 0 and 24. Four percent were infants and 16% were children ages 1-4. Approximately 19% were children ages 5-9, with another 19% aged 10-14 years and 20% aged 15-19. Roughly 21% of the 1.3 million children were aged 20-24. //2009//

More than three quarters (76%) of Oklahoma children are classified as White, with another 12%

considered American Indian/Native Alaskan and 11% African American. Less than 2% of Oklahoma children are classified as Asian race. More than 9% of Oklahoma children are of Hispanic origin.

//2009/ Nearly three quarters (73%) of Oklahoma children are classified as White, with another 10% considered American Indian/Native Alaskan and 10% African American. Less than 2% of Oklahoma children are classified as Asian race. More than 10% of Oklahoma children are of Hispanic origin. //2009//

HSI#07 A-B

A) Demographics (Total live births) Live births to women of all ages enumerated by maternal age and race.

B) Demographics (Total live births) Live births to women of all ages enumerated by maternal age and ethnicity.

In 2005, the latest year for which final birth data are available, there were 51,775 births to Oklahoma residents. This represents a negligible change over the number of births in 2004 (n=51,683). Nearly 8 in 10 births (77%) in Oklahoma occur to white mothers. African American and Native American births make up 9.3% and 11.3%, respectively, of all Oklahoma births. Just 2% of Oklahoma births are births occurring to women of Asian descent. Just over 12% of births are of Hispanic origin. Hispanic births are the fastest growing race/ethnic birth group in Oklahoma.

//2009/ In 2006, the latest year for which final birth data are available, there were 54,010 live births to Oklahoma residents, a 4.3% increase over the number of births in 2005 (n=51,775). Nearly 8 in 10 births (77%) in Oklahoma occur to white mothers. African American and Native American births make up 9.3% and 11.2%, respectively, of all Oklahoma births. Just 2% of Oklahoma births are births occurring to women of Asian or Pacific Islander descent. Just over 13% of births are of Hispanic origin.

The Oklahoma crude birth rate increased by 3.1% from 2005 to 2006, from 14.6 live births per 1,000 to 15.1 live births per 1,000. Much of this increase may be attributed to the growing Hispanic population in Oklahoma. Hispanic births are the fastest growing race/ethnic birth group in Oklahoma. The crude birth rate in the Hispanic population was 28.5 births per 1,000 in 2006, twice the crude birth rate of 14.0 births per 1,000 for Non-Hispanics. Aside from the Asian/Pacific Islander racial group, all racial groups have seen an increase in birth rates from 2005 to 2006. The Hispanic birth rate increased by 6.8% from 2005 to 2006, compared with only a 2.2% increase among the Non-Hispanic population. //2009//

Approximately 13% of Oklahoma births are to women under the age of 20, resulting in no real change in the proportion of all births occurring to this age group. Another 8% of births occur to women 35 or older, with the remaining births occurring to women aged 20-34 years.

//2009/ The Oklahoma birth rate among adolescents ages 17 or under has increased by over ten percent from 2.4 births per 1,000 in 2005 to 2.7 births per 1,000 in 2006. The 2006 birth rates in the African American and Native American population ages 17 or under were 4.2 births per 1,000 and 4.3 births per 1,000, respectively, considerably higher than the White birth rate of 2.5 births per 1,000. The Hispanic population showed the highest birth rate among teens of ages 17 or under at 4.9 births per 1,000 in 2006, compared with the Non-Hispanic birth rate of 2.4 births per 1,000. //2009//

HSI#08 A-B

A) Demographics (Total deaths) Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race.

B) Demographics (Total deaths) Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and ethnicity.

In 2004, there were 1,139 deaths to children 0 to 24 years of age. This is a slight increase of 2% from 1,113 in 2004. Thirty-seven percent of the child deaths occur to infants. Young adults aged

20-24 make up the second largest proportion (27.4%) of deaths to children 0-24. Another 20% of child deaths occur to the adolescent age group 15-19 years.

/2009/ In 2006, there were 1,235 deaths to children 0 to 24 years of age. This is an increase of 8.4% from 1,139 in 2005, yet is only a minor rate increase of 0.9 deaths per 1,000 in 2005 to 1.0 deaths per 1,000 in 2006 among children 0 to 24 years of age. Thirty-seven percent of the child deaths occur to infants. Young adults aged 20-24 make up the second largest proportion (26.7%) of deaths to children 0-24. Another 18.2% of child deaths occur to the adolescent age group 15-19 years. //2009//

Nearly 3 in 4 (72.4%) child deaths occur to White children. African American and Native American children make up 13.7% and 12.4% of the Oklahoma child deaths in 2005. About 9% of child deaths occur to children of Hispanic origin.

/2009/ Sixty four percent of child deaths occurred to White children in 2006. African American and Native American children make up 14.0% and 13.6% of the Oklahoma child deaths in 2006. About 8% of child deaths occur to children of Hispanic origin. African American and Native American children in Oklahoma had mortality rates of 1.4 deaths per 1,000 and 1.3 deaths per 1,000 in 2006, respectively, significantly higher than White mortality rate of 0.9 deaths per 1,000. //2009//

HSI#09 A-B

A) Demographics (Miscellaneous Data) Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race.

B) Demographics (Miscellaneous Data) Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by ethnicity.

In 2005, there were 957,722 children 0 to 19 years of age in Oklahoma, 27.9% of the population. Three in four (75.6%) children in this age range are White, with African American and Native American children making up 10.9% and 11.7%, respectively. Less than 2% of the child population in this group is classified as Asian. Ten percent of the child population is considered Hispanic.

/2009/ In 2007, there were 998,488 children 0 to 19 years of age in Oklahoma, 27.6% of the population. Over seven in ten (72.3%) children in this age range are White, with African American and Native American children each making up 9.9%. Less than 2% of the child population in this group is classified as Asian. Ten percent of the child population is considered Hispanic. //2009//

Nearly 1 in 4 (23.6%) of Oklahoma children aged 0 to 19 live in a single-parent household. Rates differ rather dramatically by race: white 19.7%, African American 49.3%, and Native American 25.4%. The Hispanic rate (23.3%) of single-parent households does not differ from the overall race proportion.

/2009/ Nearly 1 in 3 (32.9%) of Oklahoma children aged 0 to 19 live in a single-parent household in 2006. Rates differ rather dramatically by race: white 26.9%, African American 67.0, and Native American 36.2%. The Hispanic rate (33.8%) of single-parent households does not differ significantly from the overall race proportion.//2009//

Approximately 33% of Oklahoma children in this age group are enrolled in the Medicaid program, while 10.7% are enrolled in the Oklahoma SCHIP program. Roughly 62% of the children enrolled in the Medicaid program are white. African American and Native American children comprise 20% and 16%, respectively, of child Medicaid enrollees. The primary groups in the racial distribution for SCHIP enrollees are 70% White, 12% African American, and 17% Native American. Hispanic children make up 14.0% of the child Medicaid enrollees and 15% of SCHIP enrollees.

/2009/ Approximately 33% of Oklahoma children in this age group were enrolled in the Medicaid program in 2007, while 10.6% are enrolled in the Oklahoma SCHIP program. Roughly 62% of the children enrolled in the Medicaid program are white. African American and Native American children comprise 20% and 16%, respectively, of child Medicaid enrollees. The primary groups in the racial distribution for SCHIP enrollees are 69% White,

12% African American, and 17% Native American. Hispanic children make up 16% of the child Medicaid enrollees and 16% of SCHIP enrollees.

Over forty percent (42.4%) of children 0 to 19 years of age in Oklahoma were enrolled in a food stamp program during 2007, and nearly 19% were enrolled in WIC. The juvenile crime rate in Oklahoma stood at 2,421 juvenile crime arrests per 1,000 among this age range. The juvenile crime rate among white children is 2,191 arrests per 1,000, while the crime rate for African-American youth is over three times higher, at 6,850 arrests per 1,000. Juvenile crime rates among Native American and Hispanic youth are significantly lower, at 1,462 arrests per 1,000 and 1,864 per 1,000, respectively.

The percentage of Oklahoma children in grades 9-12 that drop out of school was 3.9% in 2006, with whites showing a 3.3% dropout rate, African-Americans 5.4%, and Native Americans 4.0%. Hispanic children have the highest dropout rate of 6.4% for grades 9-12, compared with 3.7% for Non-Hispanic children. //2009//

HSI#10

Demographics (Geographic Living Area) Geographic living area for all resident children aged 0 through 19 years old.

Data for this Health Status Indicator were provided by the Oklahoma Department of Commerce, which extracts the information from the American Community Survey conducted by the U.S. Census Bureau. In 2005, there were an estimated 964,459 children aged 0-19 in the state of Oklahoma, a decline of less than 1% from 965,850 children in 2004. Approximately 64% of these children reside in metropolitan areas. This percentage is unchanged from 2004. Sixty-five percent of Oklahoma children live in urban areas, with the remainder living in rural (34.4%) and frontier (0.7%). Overall, there was no observed shift in the percentage of children living in these defined geographic areas.

//2009/ In 2006, ACS data estimated 990,667 children aged 0-19 lived in Oklahoma, a growth of 2.7% from 964,459 children in 2005. Approximately 65% of these children reside in metropolitan areas. Sixty-four percent of Oklahoma children live in urban areas, with the remainder living in rural (35.1%) and frontier (1.1%). Once again there was no significant shift in the percentage of children living in these defined geographic areas. //2009//

HSI#11

Demographics (Poverty Levels) Percent of the State population at various levels of the federal poverty level.

The Oklahoma Department of Commerce provided these Health Status Indicator data. The U.S. Census Bureau through the American Community Survey (ACS) collected this information. In 2005, there were an estimated 3,420,671 individuals residing in Oklahoma, a slim decline of less than 1% from 2004. Changes in Oklahoma poverty levels were mixed in 2005. The percent of Oklahomans under 50% of the federal poverty level (FPL) dropped to 7.0% from 7.4%. The percent of Oklahomans at or below 100% rose from 15.3% to 16.5% and those at or below 200% rose from 37.5% to 38.1% of FPL between 2004 and 2005.

//2009/ According to the ACS in 2006, there were an estimated 3,488,814 individuals residing in Oklahoma, an increase of 2.0% from 2005. Oklahoma showed an improvement in poverty levels during 2006. The percent of Oklahomans under 50% of the federal poverty level (FPL) dropped to 6.8% from 7.0%. The percent of Oklahomans at or below 100% dropped from 16.5% to 15.2% and those at or below 200% decreased from 38.1% to 37.5% of FPL between 2005 and 2006. //2009//

HSI#12

Demographics (Poverty Levels) Percent of the State population aged 0 through 19 at various levels of the federal poverty level.

Data were provided by the Oklahoma Department of Commerce, which extracted the information from the U.S. Census Bureau through the American Community Survey. In 2005, the percent of Oklahoma children less than 20 years of age under 50% of the federal poverty level (FPL) rose to

11.0% from 10.2% in 2004. Likewise, the percent of children in Oklahoma at or below 100% and 200% of FPL increased between 2004 and 2005, from 21.1% to 23.5% and 48.7% to 52.7%, respectively.

//2009/ ACS data indicate that in 2006 the percent of Oklahoma children less than 20 years of age under 50% of the federal poverty level (FPL) dropped to 8.9% from 11.0% in 2005. Likewise, the percent of children in Oklahoma at or below 100% and 200% of FPL decreased between 2005 and 2006, from 23.5% to 22.2% and 52.7% to 50.0%, respectively. //2009//

F. Other Program Activities

MCH continues to provide MCH comprehensive program reviews to county health departments and contract providers. Each health department site is on a four-year rotating schedule to receive a comprehensive program review. Technical assistance visits and a self-assessment by each site are completed in interim years. Contract providers receive a comprehensive program review every four years with routine contract monitoring visits conducted in each interim year. The MCH Comprehensive Program Review involves a multidisciplinary team traveling to an Administrator's area or a contract provider's clinical site(s) to assess infrastructure, population-based, enabling and direct health services. A comprehensive report is prepared and forwarded to Administration of the county health department or contract agency outlining requirements and recommendations as well as timelines for addressing findings. MCH provides ongoing technical assistance in addressing areas of concern.

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. MCH will work closely with Safe Kids, Inc. to facilitate growth of local Safe Kids coalitions. MCH and CSHCN actively participate on the Traumatic Brain Injury (TBI) Advisory Committee. MCH and CSHCN will assure ongoing involvement with TBI activities accomplished through a Maternal and Child Health Bureau (MCHB) Grant received by the Oklahoma State Department of Health (OSDH) Injury Prevention Service. Recently implemented quarterly MCH and Injury Prevention Service meetings will also facilitate interaction/support of TBI activities.

//2009/ Planning continues with Safe Kids Oklahoma as it pursues strengthening and expanding local injury prevention coalitions. Collaboration with Injury Prevention Service continues on crosscutting injury prevention activities to include TBI activities. //2009//

Activities targeted toward prevention of Sudden Infant Death Syndrome (SIDS) remain a priority. The Public Health Social Work Coordinator coordinates these activities out of MCH working closely with intra and interagency groups as well as families who have been impacted by a SIDS death.

//2009/ MCH is focusing on infant safe sleep with the increased number of deaths occurring due to unsafe sleep conditions that might have contributed to the deaths. In collaboration with the Oklahoma Child Death Review Board and the Oklahoma Department of Human Services (OKDHS), a media campaign is being developed regarding infant safe sleep. In collaboration with OKDHS, an educational display has been developed and is being used to educate the general public and policy makers on infant safe sleep. Work is in process to complete a hospital survey of all nursing staff working labor and delivery, postpartum, nursery and neonatal intensive care units. The survey will explore their knowledge of their facilities written policies on safe sleep, staff training provided on infant safe sleep to include placing infants on their backs to sleep and education provided to parents prior to discharge. MCH is also developing, in collaboration with the Perinatal Continuing

Education Program at the University of Oklahoma Health Sciences Center, a model hospital infant safe sleep policy and nursing curriculum. //2009//

MCH will continue to provide funding to ongoing activities of the Oklahoma Birth Defects Registry (OBDR). The OBDR is a public health surveillance program 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 babies in Oklahoma; age range includes birth to 2 years of age; 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 babies born with NTDs from tertiary hospitals, including recurrence prevention education of NTDs.

In addition to administering the statewide-randomized Centers for Disease Control and Prevention (CDC) Youth Risk Behavior Survey (YRBS) in odd numbered years, MCH continues to offer, in even numbered years, the YRBS to local schools who request the survey. This provides the local school with information to use in planning for activities and programs to impact youth risk-taking behaviors.

MCH is currently working with the CDC on revisions to the Phase VI Pregnancy Risk Assessment Monitoring System (PRAMS) questionnaire. The revised PRAMS questionnaire will be used beginning January 2009.

//2009/ The Phase VI Oklahoma PRAMS survey has been finalized. Several new topics were added, such as reasons for caesarian section births and emergency room use for prenatal care. Revisions to The Oklahoma Toddler Survey (TOTS) will begin in April. //2009//

Revisions are also being accomplished on Oklahoma's First Grade Health Survey. Plans are to administer the survey to parents/guardians of children in first grade in public schools statewide in the fall of this upcoming 2007/2008 school year.

//2009/ The First Grade Health Survey was administered this spring with analysis of data to occur during the summer 2008. Results will be released through topical reports that address specific priorities for the health of early school-age children. Reports will be distributed to elementary schools across the state to inform teachers and school leaders of the health concerns of young public school children. Also, the data will be shared with health partners to provide a status report specific to the needs of Oklahoma's first graders. The Fifth Grade Health Survey is under revision and will be administered fall 2008. Results will be disseminated in a similar fashion as planned for the First Grade Health Survey. //2009//

MCH is providing support to the Oklahoma Vision Screening Advisory Committee for Children created last legislative session through Senate Bill 1795. MCH has provided leadership in development of OSDH Board of Health rules this year. Currently training and education to facilitate statewide implementation of vision screening of kindergarten, first and third grade children in public schools during the 2007/2008 school year is occurring.

//2009/ MCH provided vision screening training to over 100 school nurses across the state during this school year and will conduct vision screening training as requested during the 2008-2009 school year. MCH will continue to work with the Oklahoma Vision Screening Advisory Committee for Children to provide technical assistance during the 2008-2009 school year. //2009//

House Bill 1051, passed this year by the 2007 Legislature and signed by the Governor, creates 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. MCH will be working with state partners and stakeholders to develop policy and procedure to implement the provisions of this law over the current state fiscal year.

/2009/ During the school year, MCH collaborated with Chronic Disease and OSDE to provide diabetes management training for school personnel throughout the state. Eight trainings were held with over 1,000 school personnel trained in the state standards for the management of the diabetic student in schools. MCH will provide training to school staff across the state during the 2008-2009 school year on the management of the diabetic student in schools. //2009//

G. Technical Assistance

MCH and CSHCN are currently in discussion with Family Voice, Inc. regarding planned technical assistance to occur before the end of September. MCH and CSHCN will be inviting representatives of Oklahoma family organizations and family advocates from state and community-based organizations to participate in a one to two day technical assistance visit to be facilitated by Family Voices, Inc. The outcome of the technical assistance is to identify strategies to more actively involve families in MCH and CSHCN activities as well as other Oklahoma State Department of Health (OSDH) and Oklahoma Department of Human Services (OKDHS) activities as opportunities present. It is also anticipated that MCH and CSHCN will learn more about support that is needed to enhance/sustain a viable statewide family network that can have a strong voice in state and community level policy and services.

/2009/ On April 26, 2008 the Joining Forces: Supporting Family/Professional Partnership Conference was held in Oklahoma City. This conference was a result of the technical assistance received from Family Voices, Inc. in September 2007. Goals of the conference were to: 1) increase the awareness of the importance of family/professional partnerships; 2) increase family participation in the development, implementation and evaluation of programs; 3) increase leadership and partnership skills; and, 4) identify opportunities for family leadership. The conference was a first step in development of a statewide network of families who are interested in partnering with state agencies and organization to provide input on the development, implementation and evaluation of programs. The conference presented the opportunity for state agencies/organizations and families to learn from each other and to link with one another based on needs and interests. //2009//

MCH requested and received approval in June from the Maternal and Child Health Bureau for technical assistance in developing this year's annual state plan for the reduction of adolescent pregnancy and sexually transmitted diseases (STDs). More specifically, MCH made this request on behalf of the Interagency Coordinating Council for the Prevention of Adolescent Pregnancy and STDs (ICC), a legislatively appointed interagency group on which the Chief of MCH and Adolescent Health Coordinator participate. David Knapp, a consultant from North Carolina, will be facilitating a one and a half day strategic planning meeting of the council on September 26-27, 2007. The outcome of the strategic planning meeting will be development of a written state plan that MCH and the Chair of the ICC look to set a strong foundation for the future direction of prevention activities for the state for next several years.

/2009/ The technical assistance received from David Knapp was instrumental in development of a written state plan that the ICC has implemented and is being used as the basis for action. The technical assistance also provided the opportunity to restructure some of the internal operations of the ICC facilitating more active and effective involvement of council members. //2009//

MCH and CSHCN are also currently involved with a state review being conducted by the Region VI Health and Human Resources Services Administration (HRSA) Office of Performance Review (OPR). Staff from the Dallas Regional Division met with staff from MCH, CSHCN, OSDH Primary Care and Rural Health Development, OSDH HIV/STD Service, Oklahoma Primary Care Association and Oklahoma Office of Rural Health initially in Oklahoma on May 14. The HRSA OPR is working with these HRSA grantees to identify a common crosscutting health issue and providing technical assistance as the state HRSA partners move through this performance review process. Routine communication is occurring via e-mail and conference calls with a final face-to-

face meeting to occur in Oklahoma in August.

//2009/ The final meeting of the Region VI HRSA OPR occurred August 8, 2007 with a commitment made by the Oklahoma HRSA funded programs to continue with their existing ongoing collaboration and within this to look for additional opportunities for collaboration. //2009//

Technical assistance will be requested during the 2008 grant year from the Konopka Institute for Best Practices in Adolescent Health at the University of Minnesota through the Maternal and Child Health Bureau. This technical assistance will assist MCH and CSHCN in completion of the System Capacity Tool for Adolescent Health. Information gained will be used to develop a strategic plan for adolescent health in Oklahoma.

//2009/ Currently, the Adolescent Health Coordinator is working closely with staff from the Konopka Institute to conduct a systems capacity assessment that will be used in identifying next steps to strengthen the infrastructure in addressing adolescent health needs. //2009//

At this time, no additional technical assistance request(s) is planned. As technical assistance activities described move forward, MCH and CSHCN will look to utilize the process for requesting technical assistance for 2008 as the need(s) arises.

//2009/ Technical assistance is being requested of Brian Woods, Contract Linking Epidemiologist, for consulting and training to assist with probabilistic linking of Medicaid claims records with birth records and PRAMS survey records. Linking with Medicaid claims records will allow Oklahoma to more confidently evaluate birth outcomes among Medicaid recipients, track Medicaid related Health System Capacity Indicators, and confirm Medicaid status of PRAMS respondents.

MCH and CSHCN will look to utilize the process for requesting additional technical assistance for 2009 as the need(s) arise. //2009//

V. Budget Narrative

A. Expenditures

See Forms 2, 3, 4, and 5

The Oklahoma State Department of Health (OSDH) and Oklahoma Department of Human Services (OKDHS) continue to improve verification and reporting of how resources are actually budgeted and spent. Both the OSDH and OKDHS have participated in designing and implementing better methods of defining resource allocation and expenditure. Prior to the 2002 report and 2004 application, all Children With Special Health Care Needs (CSHCN) resources were reported as direct services because no method had been devised to allocate these resources differently. This resource allocation was revised beginning with the 2002 annual report and 2004 application to more accurately reflect true occurrence. The same is true for parts A and B, but with a lesser impact.

OSDH Maternal and Child Health (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 Title XIX. Only one contract agency currently uses fee schedules for maternity and child health services. These fee schedules are reviewed and approved by MCH. The fee schedules are based on federal poverty level (FPL), family income and family size. Clients below 100% FPL are not charged for services and no one is refused services based on inability to pay. The agency is audited each year by the state auditor's office following the federal guidelines applicable to the Title V Block Grant. All appropriate fiscal records are maintained to insure audit compliance.

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.

Within the overall federal portion of MCH Block dollars committed to Maternal and Infant Health, Preventative and Primary Care for Children, and Children with Special Health Care Needs (CSHCN), efforts continue as opportunities present to realign funding for core infrastructure, population-based and enabling services and less towards direct health care services (see Figure 2 attached).

B. Budget

Maintenance of effort from 1989:

For 1989, the OSDH administered 77.5% of the Title V MCH Block Grant funds and the OKDHS administered 22.5% 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 Title V MCH 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 -- FY1989 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 consideration for funding pre-1981 projects:

Prior to the Title V MCH Block Grant, MCH funded a combined Maternal and Infant Care, Children & Youth and Dental Project in an urban area. Title V MCH Block Grant funds continue to fund these programs although they have evolved from the "program to projects" scope. Additionally, an Adolescent Project in place prior to 1981 continues to receive a share of Block Grant funds (\$89,400) originally earmarked.

Special consolidated projects:

Title V MCH 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 support for SIDS education and follow-up services. 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 provides a reasonable portion of funds to deliver services:

The OSDH will continue to use MCH funds towards programs of priority for state and local needs. Assistance will continue to be 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) 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.

MCH continues to support a statewide Title V 1-800 toll-free information and referral system. MCH funds, in addition to federal funds from the Centers for Disease Prevention (CDC) and state general revenue funds, provide critical infrastructure services in newborn metabolic, hearing screening and birth defects surveillance.

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.

Anticipated federal MCH dollars, state matching funds:

Based on a federal fiscal year (FFY) 2008 preliminary Title V Block Grant allocation of \$7,399,286, a minimum of 30% (\$2,219,786) must be designated for programs for prevention and primary care services for children and 30% for services for children with special health care needs. It is understood that the combined components must also meet the required match of three state dollars for each four federal dollars. These requirements will be met with estimated budgets reflecting the following as estimated validated program costs:

Budget	Title V	Cost Sharing	Total
Prevention and Primary Care for Children	\$3,205,739 (43.32%)	\$6,002,662	\$9,208,401
Children with Special Health Care Needs	\$2,219,786 (30.0%)	\$1,665,033	\$3,884,819
Maternal & Infant Care	\$1,233,833 (16.68%)	\$4,532,381	\$5,766,214
Administration	\$739,928 (10.0%)	\$735,152	\$1,475,080
Total	\$7,399,286	\$12,935,228	\$20,334,514

/2009/ Based on a federal fiscal year (FFY) 2009 preliminary Title V Block Grant allocation of \$7,401,402, a minimum of 30% (\$2,220,421) must be designated for programs for prevention and primary care services for children and 30% for services for children with special health care needs. It is understood that the combined components must also meet the required match of three state dollars for each four federal dollars. These requirements will be met with estimated budgets reflecting the following as estimated validated program costs:

<i>Budget</i>	<i>Title V</i>	<i>Cost Sharing</i>	<i>Total</i>
<i>Prevention and Primary</i>			

Care for Children	\$3,261,190 (44.06%)	\$2,073,080	\$5,334,270
Children with Special Health Care Needs	\$2,220,421 (30.0%)	\$1,675,052	\$3,895,473
Maternal & Infant Care	\$1,179,651 (15.94%)	\$1,903,294	\$3,082,945
Administration	\$740,140 (10.0%)	\$88,111	\$828,251
Total	\$7,401,402	\$5,739,537	\$13,140,939

//2009//

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), continues activities to link Women, Infants and Children Supplemental Nutrition Program (WIC) data with birth certificates and Medicaid eligibility and claims data. This is a continuation of Oklahoma's goal 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 for assisting in infrastructure building to facilitate implementation of the comprehensive state system plan for early childhood to include integration of child care activities. Implementation is being accomplished as a collaborative effort by multiple state agencies as well as community agencies.

The PRAMS, funded by the Centers for Disease Control and Prevention (CDC) with additional funds provided by MCH, continues to provide 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 changes.

State line item funding continues for use in conjunction with Mott Foundation dollars to provide technical assistance in support of a sustainable structure (Oklahoma Afterschool Network) for high quality after school programs for Oklahoma children and youth. This structure has a priority of ensuring programs are available and accessible for low-income and hard-to-reach populations.

State line item funding continues for the Perinatal Continuing Education Program (PCEP) located on the University of Oklahoma Health Sciences Center campus. PCEP provides continuing education for medical and nursing staff providing perinatal services across the state.

State line item funding continues to support two adolescent parenting projects, one in Oklahoma City and one in Tulsa. These projects provide maternity services to pregnant adolescent females as well as educational services to facilitate completion of high school and prevention of subsequent pregnancy.

State line item funds were provided to the OSDH this year to implement Postponing Sexual Involvement (PSI) projects in targeted areas of the state to impact adolescent pregnancy. These funds will be distributed through an invitation-to-bid process.

/2009/ Four projects were awarded through a statewide Request For Proposals (three in

Oklahoma County and one in Pittsburg County). //2009//

State funds will continue to fund adolescent pregnancy prevention projects in targeted areas of the state to include evaluation of the projects. Eight projects (four in county health departments and four in private non-profit agencies) will continue to provide health education services to youth in grades 6-8 and their parents/guardians. Evaluation of the projects will continue through the University of Oklahoma, College of Public Health.

//2009/ One private non-profit requested to end its contract this state fiscal year due to inability to provide match funds (one local dollar for every five state dollars). The remaining seven projects enter the fourth year of a five-year contract beginning July 1, 2008. //2009//

State funding continues for the OUHSC, College of Pharmacy, Poison Control Center. Funds are used to support staffing of a toll free information line and for educational activities to prevent poisonings.

State tobacco funds continue to be provided to the OSDH to fund school health nurses in priority areas of the state. The OSDH contracts with the OSDE for these services. The funds will be administered through MCH. MCH will work with the OSDE to provide support to the schools and school health nurses as they implement the eight interactive components of the CDC Coordinated School Health Model (health education; physical education; health services; nutrition services; counseling; psychological and social services; healthy school environment; health promotion for staff; and, family/community involvement).

State perinatal monies continue to be legislatively appropriated to the OSDH and are utilized by MCH to provide services for pregnant women and infants. These funds are used to support services such as the Healthy Mothers Healthy Babies Coalition, fetal and infant mortality review (FIMR) projects and maternity and infant clinical services.

State funds, Medicaid funds and Title X federal funds continue to provide 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) and human immunodeficiency virus (HIV), and increasing knowledge of human sexuality. April 1, 2007 began the third full year of the Oklahoma Medicaid Family Planning Waiver (Sooner Plan). **//2009/ The fourth year of the approved five year Medicaid Family Planning Waiver (Sooner Plan) began April 1, 2008. //2009//**

The Oklahoma Health Care Authority will provide federal administrative funds through a contractual agreement to support data matching and analysis of Medicaid data with OSDH data. This information will be used for joint planning and evaluation of policy and services impacting the MCH population.

//2009/ In April, a shared staff position was filled. This position is housed and supervised within MCH. Expectations are that the individual will work with staff from both agencies in linking and analyzing Medicaid and OSDH data for sharing with policy and program staff to improve health systems and services. //2009//

The Oklahoma State Department of Education (OSDE) continues to provide 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. This survey provides Oklahoma with information on risk-taking behaviors of youth.

Budget Documentation:

Overall budget preparation and monitoring are provided through administrative support within the OSDH Administrative Services. Agency budgeting, grants and contract acquisition staff meet routinely with program areas 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 Commissioner 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.

//2009/ 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 a redirection of priorities, or in the event of a state health event or emergency/disaster needing to be addressed. //2009//

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.