

State Action Plan Table (Oklahoma)

Women/Maternal Health

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

			<p>Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <hr/> <p>Infant mortality rate per 1,000 live births</p> <hr/> <p>Neonatal mortality rate per 1,000 live births</p> <hr/> <p>Post neonatal mortality rate per 1,000 live births</p> <hr/> <p>Preterm-related mortality rate per 100,000 live births</p>			
<p>Reduce the prevalence of chronic health conditions among childbearing age women</p>	<p>1. Increase the number of women who receive prenatal care in the first trimester of pregnancy from 68.5% in 2013 to 71.9% by 2020</p> <hr/> <p>2. Reduce maternal mortality rate from 29.1 per 1,000 live births in 2012 to 26.2 by 2020</p> <hr/> <p>3. Increase the number of women returning for the postpartum visit by 2020</p> <hr/> <p>4. By July 2016, improve birth intention by increasing the usage</p>	<p>1a. Work with OPQIC to determine barriers to women accessing early prenatal care (physician preference, lack of access either geographically or lack of provider, insurance coverage, etc.)</p> <hr/> <p>1b. As a part of postpartum / interconception care, partner with home visitation programs (Healthy Start, Children First) to promote the importance of postpartum visits and</p>	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <hr/> <p>Maternal mortality rate per 100,000 live births</p> <hr/> <p>Percent of low birth weight deliveries (&lt;2,500 grams)</p> <hr/> <p>Percent of very low birth weight deliveries (&lt;1,500 grams)</p> <hr/> <p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <hr/> <p>Percent of preterm</p>	<p>Percent of women with a past year preventive medical visit</p>		

of the most effective methods of contraception among women on Medicaid and at risk for unintended pregnancy by 5%

early prenatal care for future pregnancies.

2a. Continue participation in Association of Maternal and Child Health Programs Every Mother Initiative and continue to facilitate the Maternal Mortality Review Project

2b. As part of Every Mother Initiative, disseminate tool kits to all birthing facilities with information on evidence-based practices, provide technical assistance for hospitals in developing policies for care of patients with postpartum hemorrhage and hypertension to decrease morbidity and mortality, and provide simulation exercises to ensure all staff are familiar with policy and procedures

3. Partner with a physician clinic and Central Oklahoma Healthy Start to educate

births (<37 weeks)

Percent of early preterm births (<34 weeks)

Percent of late preterm births (34-36 weeks)

Percent of early term births (37, 38 weeks)

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

Infant mortality rate per 1,000 live births

Neonatal mortality rate per 1,000 live births

Post neonatal mortality rate per 1,000 live births

Preterm-related mortality rate per 100,000 live births

women on the importance of the postpartum visit and assist in ensuring they attend the visit

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

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

		and Maternal Mortality Review				
Reduce unplanned pregnancy	Reduce the rate of unintended pregnancies (mistimed or unwanted) among mothers who have live births by 5% by 2020	<p>Promote the importance of reproductive life planning through utilization of the Women’s Health Checklist and My Life. My Plan for adolescents</p> <p>Promote long acting reversible contraception to prevent unintended pregnancies and closely spaced pregnancies in county health departments and Medicaid recipients</p> <p>See activities to reduce teen pregnancy in the Adolescent Health Plan</p>	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <p>Maternal mortality rate per 100,000 live births</p> <p>Percent of low birth weight deliveries (&lt;2,500 grams)</p> <p>Percent of very low birth weight deliveries (&lt;1,500 grams)</p> <p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <p>Percent of preterm births (&lt;37 weeks)</p> <p>Percent of early preterm births (&lt;34 weeks)</p> <p>Percent of late preterm births (34-36 weeks)</p> <p>Percent of early term births (37, 38 weeks)</p> <p>Perinatal mortality rate per 1,000 live births plus fetal deaths</p>	Percent of women with a past year preventive medical visit		

			<p>Infant mortality rate per 1,000 live births</p> <hr/> <p>Neonatal mortality rate per 1,000 live births</p> <hr/> <p>Post neonatal mortality rate per 1,000 live births</p> <hr/> <p>Preterm-related mortality rate per 100,000 live births</p>			
Reduce health disparities	Create a Communication and Dissemination Plan to educate reproductive age males and females on being healthy before and between pregnancies in areas of the state with the highest infant and maternal mortality rates by December 2015	<p>Continue to assist all clients visiting a county health department for a preventive health visit with development of a reproductive life plan</p> <hr/> <p>Distribute preconception / interconception health materials at community events (Farmer's Markets, Community Baby Showers, etc.)</p> <hr/> <p>Create and provide targeted preconception health information to populations in need the information as identified by PRAMS and other data sources</p> <hr/> <p>Utilize Text4 Baby</p>	<p>Rate of severe maternal morbidity per 10,000 delivery hospitalizations</p> <hr/> <p>Maternal mortality rate per 100,000 live births</p> <hr/> <p>Percent of low birth weight deliveries (&lt;2,500 grams)</p> <hr/> <p>Percent of very low birth weight deliveries (&lt;1,500 grams)</p> <hr/> <p>Percent of moderately low birth weight deliveries (1,500-2,499 grams)</p> <hr/> <p>Percent of preterm births (&lt;37 weeks)</p> <hr/> <p>Percent of early preterm births (&lt;34 weeks)</p>	Percent of women with a past year preventive medical visit		

		<p>messages to develop media effective at reaching African Americans regarding infant mortality and being healthy</p>	<p>Percent of late preterm births (34-36 weeks)</p> <hr/> <p>Percent of early term births (37, 38 weeks)</p> <hr/> <p>Perinatal mortality rate per 1,000 live births plus fetal deaths</p> <hr/> <p>Infant mortality rate per 1,000 live births</p> <hr/> <p>Neonatal mortality rate per 1,000 live births</p> <hr/> <p>Post neonatal mortality rate per 1,000 live births</p> <hr/> <p>Preterm-related mortality rate per 100,000 live births</p>		
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State Action Plan Table (Oklahoma)

Perinatal/Infant Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Reduce infant mortality	<p>1. Increase the percent of mothers who breastfeed their infants at hospital discharge from 75.0% in 2013 to 78.0% by 2020</p> <p>2. Increase the percent of mothers who breastfeed their infants at 6 months of age from 34.8% in 2013 to 38.3% by 2020</p>	<p>1a. Coordinate with the WIC Breastfeeding Task Force to develop materials and participate in planning a variety of statewide breastfeeding trainings for WIC, county health department and independent agency staff, and statewide healthcare providers</p> <p>1b. Provide support for the Oklahoma Breastfeeding Hotline</p> <p>1c. Provide support for the Oklahoma Hospital Breastfeeding Education Project</p> <p>1d. Provide support for the Becoming Baby-Friendly in Oklahoma (BBFOK) Project</p> <p>1e. Provide support for the Oklahoma Mothers' Milk Bank (OMMB)</p>	<p>Post neonatal mortality rate per 1,000 live births</p> <p>Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>	<p>A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months</p>		

		<p>efforts to provide safe, pasteurized milk donated by healthy, screened breastfeeding mothers to ensure that vulnerable babies can receive human milk to promote growth and development and help fight infections</p> <hr/> <p>2a. Partner with the Coalition of Oklahoma Breastfeeding Advocates (COBA) to increase Oklahoma Breastfeeding Friendly Worksites / Businesses</p> <hr/> <p>2b. See also strategies for Objective 1</p>				
Reduce health disparities	Improve breastfeeding duration rates among racial and ethnic minorities	<p>Support COBA's efforts to establish Baby Cafés and Chocolate Milk Cafés targeting African American and American Indian breastfeeding mothers and families</p> <hr/> <p>Support COBA's efforts to further expand Baby Cafés, targeting Hispanic mothers / families</p>	<p>Post neonatal mortality rate per 1,000 live births</p> <hr/> <p>Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months		

		<p>Partner with WIC to increase the number of ethnically diverse peer counselors</p> <hr/> <p>Partner with WIC to encourage involvement of peers as co-facilitators in Baby Cafés</p>				
Reduce infant mortality	<p>1. Increase the number of hospitals participating in the Safe Sleep Sack Program from 11 in 2015 to 20 in 2020</p> <hr/> <p>2. Increase the number of trainings given to providers and professional organizations on infant safe sleep by 50% by 2017</p> <hr/> <p>3. Increase the number of community outreach activities by Safe Sleep Work Group members from 10 in 2015 to 20 in 2020</p> <hr/> <p>4. Increase the number of hits by 20% to the Preparing for a Lifetime website and MCH</p>	<p>1. Provide safe sleep training and technical assistance to birthing hospitals</p> <hr/> <p>2. Provide training and technical assistance to home visiting programs, child care centers, and other community and health organizations that address the needs of newborns and infants</p> <hr/> <p>3a. Create a presentation and / or training for community members on the safe sleep guidelines</p> <hr/> <p>3b. Provide presentations to community organizations and coalitions to increase awareness of infant</p>	<p>Infant mortality rate per 1,000 live births</p> <hr/> <p>Post neonatal mortality rate per 1,000 live births</p> <hr/> <p>Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>	Percent of infants placed to sleep on their backs		

	Facebook page by 2020	<p>mortality and safe sleep practices</p> <hr/> <p>3c. Provide community outreach and education to non-traditional partners, including faith-based organizations and non-profit organizations that help women and infants</p> <hr/> <p>3d. Create an event during safe sleep awareness month to educate the public on infant mortality rates and safe sleep guidelines</p> <hr/> <p>4a. Establish a baseline for the Preparing for a Lifetime website and MCH Facebook postings</p> <hr/> <p>4b. Implement social marketing strategies and promote the PFL website and MCH Facebook page</p> <hr/> <p>4c. Assign a person from the Infant Safe Sleep Work Group to assist with social media projects</p>			
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<p>Reduce health disparities</p>	<p>Increase the percent of American Indian and African American births in hospitals participating in the Safe Sleep Sack Program, from 52.6% in 2013-2014 to 60.5% in 2020</p>	<p>Provide safe sleep training and technical assistance to birthing hospitals with high numbers of African American and American Indian births</p> <hr/> <p>Target specific populations through outreach efforts, including, community baby showers, health fairs, family conference partners (Oklahoma Family Network, DHS), and local schools to increase education on safe sleep practices and guidelines</p> <hr/> <p>Provide opportunities to train community leaders and educate non-traditional partners, including faith based organizations and non-profit organizations that help women and infants</p>	<p>Infant mortality rate per 1,000 live births</p> <hr/> <p>Post neonatal mortality rate per 1,000 live births</p> <hr/> <p>Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births</p>	<p>Percent of infants placed to sleep on their backs</p>		
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State Action Plan Table (Oklahoma)

Child Health

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

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

State Action Plan Table (Oklahoma)

Adolescent Health

State Priority Needs	Objectives	Strategies	National Outcome Measures	National Performance Measures	ESMs	SPMs
Reduce the incidence of suicide among adolescents	<p>1. Increase the number of annual trainings provided by MCH staff in evidence-based methods of suicide prevention or positive youth development for individuals that work with adolescents from 1 to 3 by 2020</p> <p>2. Increase the number of local Public Health Youth Councils across the state from 3 in 2014 to 12 by 2020 that will provide input regarding adolescent health issues, including suicide prevention and bullying, to MCH, CSHCN, as well as other programs within and outside of OSDH</p> <p>3. Among county health departments that have webpages, increase to 85% the sites that have</p>	<p>1. Provide training and TA to county health departments and other youth-serving organizations in evidence-based methods following appropriate best practices</p> <p>2. Train additional council facilitators, recruit for more youth, conduct asset inventory survey of council members, provide education to council members on adolescent health issues, and prepare some members to be peer facilitators</p> <p>3. Work with county health department directors and local web coordinators to place the Suicide Prevention Lifeline Number and</p>	<p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p>	Percent of adolescents, ages 12 through 17, who are bullied or who bully others		

	<p>the Suicide Prevention Lifeline Number displayed by 2020</p> <p>4. Increase the number of the Safe Schools Committees reported to the Oklahoma State Department of Education mandated by School Safety and Bullying Prevention Act by 5%</p> <p>5. Participate in the development and updating of curriculum for use by public schools Pre-K through 12th grade on bullying prevention, recognition, and intervention to help reduce the incidence of bullying which contributes to the incidence of suicide by students</p>	<p>logo on the most appropriate place on their website</p> <p>4a. Work with the Oklahoma State Department of Education to determine a data source for the collecting information on the number of schools and school districts in Oklahoma that have Safe Schools Committees that meet the requirements mandated by the School Safety and Bullying Prevention Act</p> <p>4b. Work with the agency members of the Anti-Bullying Collaboration to provide training to school staff and administrators on the requirements of the School Safety and Bullying Prevention Act</p> <p>4c. Work with the Oklahoma Department of Mental Health and Substance Abuse, the Department of Human Services, and the</p>			
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		<p>Oklahoma State Department of Education to provide training to parents and community members to understand the pervasiveness and the damaging effects of bullying, learn the signs of bullying and how to help schools and communities implement effective strategies to prevent the continuation of bullying in the community</p> <hr/> <p>5. Continue to staff the Oklahoma State Department of Education Executive Committee to rewrite and update health curricula for use in public schools to present for the approval of the Oklahoma State Board of Education in December 2015 and legislative approval by February 2016</p>				
Improve the mental and behavioral health of the MCH population	Reduce the percentage of children 0-17 years experiencing two or	Partner with home visitation programs, child guidance, early	Adolescent mortality rate ages 10 through 19 per 100,000	Percent of adolescents, ages 12 through 17, with a preventive		

more adverse family experiences from 32.9% in 2013 to 30.6% by 2020

childhood initiatives, or other programs achieving best practices to provide education, counseling, and referrals to families

Leverage existing and developing networks such as Systems of Care to identify and locate referral and resource information

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

Adolescent suicide rate, ages 15 through 19 per 100,000

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

Percent of children in excellent or very good health

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

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

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

Percent of adolescents,

medical visit in the past year.

			<p>ages 13 through 17, who have received at least one dose of the Tdap vaccine</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</p>			
Reduce teen pregnancy	<p>1. Increase by 5% annually the number of adolescents initiated in state or federally funded evidence-based teen pregnancy prevention programs</p> <hr/> <p>2. Increase the number of adolescent family planning clients aged 15 to 19 that choose Long Acting Reversible Contraception (LARC) methods from 31% in 2013 to 35% by 2020</p>	<p>1a. Increase by 5% the number of adolescents initiated in state funded evidence-based teen pregnancy prevention programs from a baseline of 486 students / school year (August 1, 2014-May 31, 2015)</p> <hr/> <p>1b. Maintain the current number of adolescents participating in the Personal Responsibility Education Program</p>	<p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <hr/> <p>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</p> <hr/> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p> <hr/> <p>Percent of children with a mental/behavioral condition who receive treatment or counseling</p>	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

<p>3. Increase the number of available trainers statewide who have gone through a training of trainers (TOT) in Oklahoma's selected evidence-based teen pregnancy prevention curricula from 5 to 12 by 2020</p>	<p>(PREP) at a minimum of 3,750 students / year (April 1, 2014-March 31, 2015)</p>	<p>Percent of children in excellent or very good health</p>
<p>4. Increase the number of local Public Health Youth Councils across the state from 3 in 2014 to 12 by 2020 that will provide input regarding adolescent health issues, including teen pregnancy prevention, to MCH, the CSHCN, as well as other programs within and outside of OSDH</p>	<p>1c. Establish or leverage existing networks of administrators, principals, teachers, school nurses, health educators, adolescent health specialists, community leaders, and parents that are advocates for evidence-based education</p>	<p>Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</p>
<p>5. Expand coverage of state or federally funded, age-appropriate, evidence-based teen pregnancy prevention projects in rural counties with teen birth rates higher than the national average from 24 to 30 by 2020</p>	<p>1d. Increase capacity for curriculum instruction by providing or coordinating evidence-based trainings</p>	<p>Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza</p>
	<p>2a. Continue to educate on the most effective methods of contraception first</p>	<p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</p>
	<p>2b. Increase adolescent education in the community about available methods</p>	<p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</p>
	<p>3. Identify individuals that could best reach the target population of</p>	<p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</p>

		<p>trainers</p> <hr/> <p>4. Train additional council facilitators, recruit for more youth, conduct asset inventory survey of council members, provide education to council members on adolescent health issues, and prepare some members to be peer facilitators</p> <hr/> <p>5a. Identify areas of highest need based on most current data available</p> <hr/> <p>5b. Partner with county health department regional directors in the areas of highest need to begin targeted prevention efforts</p>				
Reduce health disparities	Identify disparities that exist among suicide attempts and completion percentages by race / ethnicity, gender, geography, and age by August 2015	<p>Analyze most current surveillance systems (OKVDRS, Injury Inpatient Discharge Data) to detect disparities, identify program targets, and inform interventions</p> <hr/> <p>Implement interventions</p>	<p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <hr/> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p>	Percent of adolescents, ages 12 through 17, who are bullied or who bully others		

		to address the populations of highest risk by December 2016				
Reduce health disparities	Identify gaps in points of referrals, access, and utilization of mental and behavioral health services among the adolescent population to establish baseline data by January 2016	Analyze data from proven systems to identify program targets, inform interventions, and develop referrals	<p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <hr/> <p>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</p> <hr/> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p> <hr/> <p>Percent of children with a mental/behavioral condition who receive treatment or counseling</p> <hr/> <p>Percent of children in excellent or very good health</p> <hr/> <p>Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)</p> <hr/> <p>Percent of children 6 months through 17 years who are vaccinated annually against seasonal</p>	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.		

			<p>influenza</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine</p> <hr/> <p>Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine</p>			
Reduce the incidence of unintentional injury among children	See Child Health for Objectives to impact this measure	See Child Health for Strategies to impact this measure	<p>Child Mortality rate, ages 1 through 9 per 100,000</p> <hr/> <p>Adolescent mortality rate ages 10 through 19 per 100,000</p> <hr/> <p>Adolescent motor vehicle mortality rate, ages 15 through 19 per 100,000</p> <hr/> <p>Adolescent suicide rate, ages 15 through 19 per 100,000</p>	Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9 and adolescents 10 through 19		



State Action Plan Table (Oklahoma)

Children with Special Health Care Needs

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

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

State Action Plan Table (Oklahoma)

Cross-Cutting/Life Course

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

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

weight deliveries  
(<1,500 grams)

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

Percent of preterm  
births (<37 weeks)

Percent of early preterm  
births (<34 weeks)

Percent of late preterm  
births (34-36 weeks)

Percent of early term  
births (37, 38 weeks)

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

Infant mortality rate per  
1,000 live births

Neonatal mortality rate  
per 1,000 live births

Post neonatal mortality  
rate per 1,000 live  
births

Preterm-related  
mortality rate per  
100,000 live births

Sleep-related Sudden  
Unexpected Infant

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

		smoking was allowed	per 1,000 live births plus fetal deaths			
			Infant mortality rate per 1,000 live births			
			Neonatal mortality rate per 1,000 live births			
			Post neonatal mortality rate per 1,000 live births			
			Preterm-related mortality rate per 100,000 live births			
			Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births			
			Percent of children in excellent or very good health			