OKLAHOMA CHILDREN'S HEALTH PLAN

KEEPING KIDS HEALTHY · 2011-2014

*Wisdom is to the mind what
    health is to the body.*
        - Francois De La Rochefoucauld

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Oklahoma Children's Health Plan online: <http://ohip.health.ok.gov>

*Happiness lies,
    first of all, in health.*

- Henri Frederic Amiel

EXECUTIVE SUMMARY

In 2009 the Oklahoma Health Improvement Planning (OHIP) team, composed of local and state health leaders developed an Oklahoma Health Improvement Plan based on their concern that Oklahoma ranked near the bottom of all states in important health status indicators. A key OHIP flagship workgroup on children's health realized that although the state had a number of major children's initiatives there was no comprehensive plan covering the health of children one to 18 years of age.

Moreover, indicators about the wellbeing of Oklahoma's children are sobering. Some specifics include data from the 2010 Oklahoma KIDS Count Factbook that shows for 2008, there were 195,823 poor children representing 22 percent of the children in the state. This report also cites: that "the leading causes of death for children and teens are changing from natural causes such as illness and birth defects to preventable causes, including injury and violence." Also of concern is data from the 2007 National Survey of Children's Health showing close to 33 percent of children in the state lacking access to both medical and dental care. Data from the 2009 Oklahoma Factbook and the 2007 Youth Risk Behavior Survey show close to 90,000 children age 9 through 17 suffer from mental or behavioral impairments and one out of every 10 young Oklahomans may have a substance abuse disorder. These and other indicators coupled with the lack of a comprehensive plan led to the formation of the Children's Health Plan Panel.

The panel was charged with developing a plan that included the following issues: access to care; primary health care; dental health; mental health; injury reduction; child abuse and neglect; self esteem improvement; and parent education. Panel members included health care professionals working in primary care, neonatology, pediatrics, dental care, public and mental health. Consumers of services participated as did state agency program and policy staff from health and social service agencies in the state. Starting in January, 2010, panel members met monthly listening to experts in areas identified in the OHIP plan as well as additional issues that included children with special health care needs and health equity in order to ensure their findings were considered in development of the comprehensive plan. At the conclusion of meetings in August, 2010, panel recommendations were vetted with the Children's Health Flagship Workgroup and the OHIP team. Final recommendations reflect an endorsement by these entities.

Both teams recognized the importance of strategies directed at tobacco use and obesity. Tobacco kills more Oklahomans than alcohol, auto accidents, AIDs, suicides, murders and illegal drugs combined. Sixty-seven (67) percent of Oklahoma adults are either overweight or obese, and 29.5 percent of Oklahoma youth are either overweight or obese. Comments also stressed the need to continue an emphasis on reducing infant mortality in the state. The Oklahoma State Department of Health's 2008 State of the State's Health Report indicated Oklahoma lags behind the nation in its infant mortality rate. In light of these and other findings, recommended actions were incorporated in the OHIP plan issued in 2009 by the Children's Health, Tobacco Use Prevention, and Obesity Reduction flagship workgroups. They can be found at <http://ohip.health.ok.gov>.

Oklahoma Children's Health Plan Goals

Access to Primary Care

Assure all Oklahoma children have access to comprehensive primary care services that include oral, physical and mental health services consistent with the Joint Principles for the Patient-Centered Medical Home.

Injury Prevention

Reduce preventable injuries in Oklahoma children.

Immunizations

Increase the 4:3:1:3:3:1 immunization coverage rates of children 19-35 months.

Increase immunization rates of adolescents for recommended vaccines.

Oral Health

Improve the health status of Oklahoma children by reducing the amount of dental cavities.

Adolescent Health

Improve adolescent health outcomes.

Mental Health & Substance Abuse

Infant and Early Childhood Mental Health

Develop and expand programs for early identification and treatment of infants, toddlers and children under six exhibiting mental health concerns.

Children/Youth Mental Health and Substance Abuse

Develop and expand programs for early identification and treatment of substance abuse problems.

Expand evidence-based community mental health and substance abuse services statewide.

Develop and expand community-based programs for prevention of injuries among children and youth.

Abuse & Neglect

Reduce child abuse and/or neglect.

Improve the physical and mental health status of children in state custody for child abuse and/or neglect.

Special Health Care Needs

Increase access to health care for children and youth with special health care needs.

Increase community-based services for special populations of children.

Cross-cutting Goals

Promote awareness/improve communication about available services and use data to direct planning and implementation of effective children's health programs.

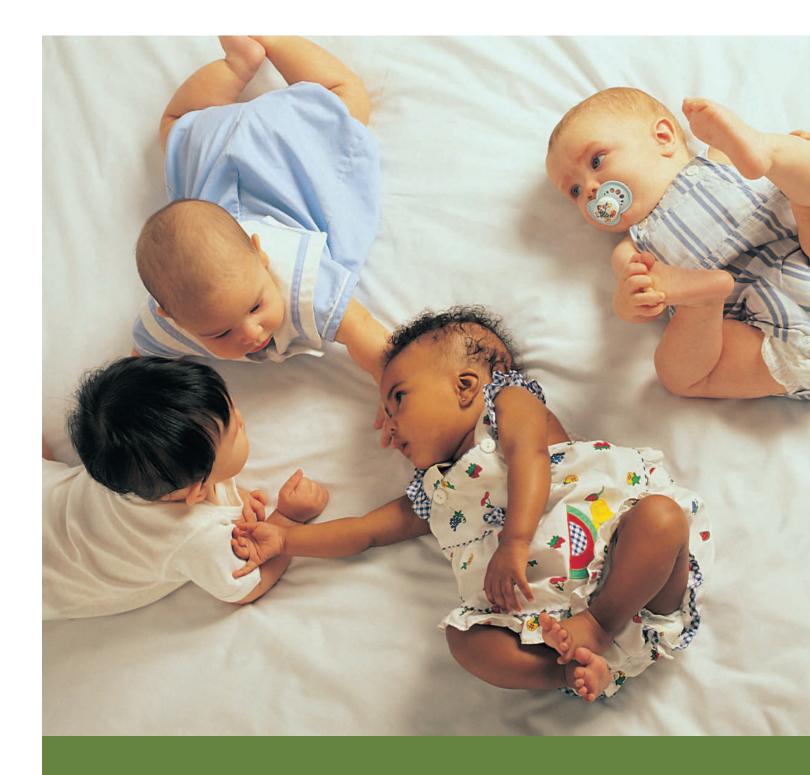Adopt policies and legislation that improve children's health.

Future Actions

It is exciting to present state leaders a comprehensive children's health plan for the State of Oklahoma. These recommendations reflect near and long term priorities that encompass all developmental phases of children and youth. Strategies also incorporate all levels of prevention activities. The *Keeping Kids Healthy* plan is a living document that will be monitored on a regular basis to ensure the active engagement of stakeholders in addressing recommended goals and objectives. OHIP will provide a scorecard by which the goals and objectives referenced in this plan can be measured.

Get Involved

Implementation of this plan is contingent on the active support and engagement of the many stakeholders involved in its development. Legislative involvement as well as community engagement is also critical to its success. OHIP leaders look forward to working with all these groups to achieve progress in improving health outcomes for the children of our state. Without the active involvement of local and state stakeholders, the goals of the *Keeping Kids Healthy* plan will not become a reality.

*Health is the core
 of human development.*

- Gro Harlem Brundtland

INTRODUCTION & BACKGROUND

In 2008, the Oklahoma State Board of Health, concerned about the state's low ranking on important health status indicators, convened a strategic planning retreat to chart a course of improvement. An Oklahoma Health Improvement Planning (OHIP) team emerged as an outgrowth of this effort which included key workgroups targeted on three flagship initiatives: 1) children's health improvement, 2) obesity reduction and 3) tobacco use prevention. The team developed an Oklahoma Health Improvement Plan in 2009 which included recommendations from each of the flagship groups as well as recommendations covering the state's health care infrastructure, related to the areas of 1) public finance; 2) workforce development; 3) access to care; and 4) health system effectiveness. [1]

The Children's Health Flagship Workgroup during its deliberation realized the state had a number of major children's initiatives covering specific issues. They include:

• Improving the quality of early childhood development in educational and child care settings;

• Expansion of evidence-based models used for child abuse prevention;

• Improving immunization rates for children;

• Adoption of certification programs for schools and communities that promote wellness, healthy behaviors and safe and supportive environments;

• Increasing the excise tax on tobacco products to deter teen use;

• Investment by the Oklahoma Tobacco Settlement Endowment Trust (TSET) to fund community-based tobacco cessation and obesity prevention programs and research to improve Oklahoma's health status;

• Expansion of wrap around community-based mental health services using an evidence-based system of care model; and

• Implementation of a statewide 2-1-1 telephone information and referral system to serve as a single point of entry for health and human services in Oklahoma.[2]

However, the Flagship Workgroup recognized there was no comprehensive plan covering the health of children one to 18 years of age. This acknowledgement led to the formation of the Children's Health Plan Panel which was charged with developing a plan that included the following areas of concern: access to care; primary health care; dental health; mental health; injury reduction; child abuse and neglect; self-esteem improvement; and parent education. Panel members included health care professionals working in primary care, neonatology, pediatrics, dental care, public and mental health. Consumers of services participated as did state agency program and policy staff from health and social service agencies in the state. Starting in January, 2010, panel members met monthly listening to experts in areas identified in the OHIP plan as well as additional areas that included children with special health care needs and health equity in order to ensure their findings were considered in development of the comprehensive plan. Presenters identified key issues under each topic area followed by recommendations to address them. As part of the background information, the panel also heard about the top maternal and child health needs in the state. Identified issues included asthma, bullying, child abuse and neglect, depression, motor vehicle injury and death, obesity, sexually transmitted diseases, risky sexual behavior, suicide, access to care, teen pregnancy and tobacco use. At the conclusion of meetings in August 2010, panel recommendations were vetted with the Children's Health Flagship Workgroup and the OHIP team. Final recommendations reflect an endorsement by these entities. The monthly meetings provided more information regarding services available to Oklahoma children and youth and their families than could be included in this plan. A list of web links that provide additional information about various children's programs in the state is included in the appendices.

The Children's Health Plan Panel and Flagship Workgroup assumed a broad definition of children's health to guide their deliberations consistent with language used by the Institute of Medicine that "Children's health is the extent to which individual children or groups of children are able or enabled to (a) develop and realize their potential, (b) satisfy their needs, and (c) develop the capacities that allow them to interact successfully [and responsibly] with their biological, physical and social environments." [3,4] This definition of health must embody a family perspective. The foundations of child health are: 1) a stable and responsive environment of relationships; 2) safe and supportive physical, chemical and built environments; and 3) sound and appropriate nutrition. It is also contingent on the ability of family and other community members to play a major supportive role in strengthening the foundations of child health.[5]

Child well-being is also tied to families having healthy lifestyles. Oklahoma's SoonerCare program supports this behavior through incentives to SoonerCare families that include: 1) patient-centered medical homes; 2) care management; 3) nutritional counseling; and 4) early screenings for children that specifically include developmental and behavioral health.

The panel considered all levels of influence on children's health. The socio-ecological model recognizes there is an interrelationship between the individual and their environment. While individuals are responsible for instituting and maintaining the lifestyle changes necessary to reduce risk and improve health, individual behavior is determined to a large extent by the social environment, including community norms and values, regulations, and policies.[6] The developing child must receive the appropriate resources from his or her environment at the right time in order to optimize his or her biologic potential.

Health equity is the realization by all people of the highest attainable level of health.[7] Health inequity relates to those differences in population health and the unequal economic and social conditions that are systemic and potentially avoidable.[8] Modifiable social factors, including income, education, and childhood and neighborhood socioeconomic conditions may be more important in explaining health differences by race or ethnicity.[9] Inequities exist across the state in such areas as access to health services and health insurance, healthy foods including fresh fruits and vegetables, safe places for physical activity, and available transportation. Major social determinants of health such as poverty, lack of insurance, inadequate prenatal care along with risky health behaviors associated with these determinants contribute to the poor health status of our children.[10] The most effective approach to healthy behaviors is a combination of efforts at all levels: individual, interpersonal, organizational, community, and public policy. Various strategies will be identified in this report from this model's perspective.[11,12,13,14,15]

The panel consistently heard recommendations centering on:

• *Promoting awareness of key children's health issues from primary to tertiary programs* – **Several presenters recommended issue-specific public awareness campaigns, community-based training activities, web-based parent education and legislative strategies. Presenters also recommended promoting awareness about available local and state programs and services using the statewide 211/JOIN information and referral system as well as other resources targeted to special populations of children.**

• *Access to high quality primary health care* - **Several presenters as well as panel members discussed areas where there were needs for additional primary care services, either by a) geographic location due to health inequities, b) payer source where different insurance coverage limits provision of some services or c) targeted populations such as children with special health care needs or those with mental health and substance abuse issues. Presenters and panel members stressed the need for coordinated, ongoing comprehensive care within a medical home. The group recognized the need for sufficient numbers of primary care providers to cover all children in the state.**

• *Prevention focus on children's health care* - **The panel adopted a comprehensive definition of prevention incorporating primary, secondary and tertiary levels as part of the plan's intervention strategies. Primary prevention is actions performed to preclude the development of a disease with strategies focused on the general public. Secondary prevention is actions performed to take care of early symptoms of a disease and preclude the development of possible irreparable medical conditions; it targets individuals and families with risk factors. Tertiary prevention encompasses treatment.[16,17] Recommendations ranged from comprehensive school health education incorporating oral, physical and mental health, as well as child abuse, violence and injury prevention; access to healthy foods; parent education about wellness and behaviors that can reduce entry into the child welfare system; to physical and mental health services needed for children.**

HEALTH DETERMINANTS MODEL

Adapted from the Dahlgren-Whitehead Model[11]

• *Enhancing the capacity of the workforce to effectively meet the health care needs of children* - Recommendations covered incentives to increase Oklahoma's primary care provider supply, increasing the number of providers knowledgeable about adolescent health needs as well as provider- specific training.

• *Developing and expanding quality child health programs* - Recommendations covered primary prevention, special populations, and mental health programs.

• *Utilizing research, evaluation and performance measurement data to drive planning and implementation of effective child health programs* – Recommendations included data linkages between programs; development of registries; development of Oklahoma-specific data on prevalence of children's mental health needs; and data analysis to improve immunization rates.

• *Policy recommendations that can improve child health and well being* - Recommendations included school health education and treatment interventions which mirrored input heard at listening sessions held in the spring and summer of 2009 and spring of 2010. Other presenters identified policy recommendations in the areas of oral health and immunizations.

Obesity rates in the U.S. have increased dramatically over the last 30 years, and obesity is now epidemic in the United States. Data for 2003-2004 and 2005-2006 indicated that one fifth of U.S. children were either obese or overweight. [18] Approximately 30 percent of Oklahoma's youth are obese or overweight. These conditions are associated with many health risks. The panel heard recommendations by partners with the Oklahoma Health Equity Campaign about improving both food security and nutrition for our state's children. These recommendations include making fresh affordable locally-grown produce more available by: 1) schools adopting nutrition education curriculum that promotes gardening, healthy cooking and eating more fruits and vegetables; 2) increasing the affordability of nutritious foods by eliminating sales tax on fruits and vegetables; 3) supporting initiatives similar to the "Farm to School Act" that supports farmers' markets and healthy corner stores; and 4) establishing local food policy councils to increase production, consumption and availability of healthy local foods as well as other initiatives. These recommendations will be forwarded to the OHIP flagship workgroup focusing on obesity reduction to determine the extent that they have been implemented or to receive further consideration. Recommendations covering children's health are included in the flagship workgroups on tobacco use prevention and obesity reduction at <http://ohip.health.ok.gov>. Further, the objectives of these workgroups are covered in the appendices.

The results of the Children's Health Plan Panel and Flagship Workgroup culminated in the formation of comprehensive goals and objectives to improve health outcomes for children. Recommendations cover the following issues: 1) access to primary care; 2) injury prevention; 3) immunizations; 4) oral health; 5) infant and early childhood mental health; 6) mental illness and substance abuse among children and youth; 7) child abuse/neglect prevention; and 8) improving the health status of children in state custody due to child abuse/neglect. Issues related to adolescents and children with special health care needs were viewed as two population groups deserving specific recognition.

This plan also includes cross-cutting goals covering issues that span multiple subject areas. These are 1) communication strategies to inform Oklahomans about available children's health issues as well as available services and 2) specific policy/legislative proposals.

Wellness is a connection of paths:
Knowledge and Action.
- Josh Welch

STRATEGIC GOALS

Access to Primary Care

Provision of primary health care services is a critical component to address the health and well-being of children. Timely access to the right type of provider who is well trained is critical to improving the health outcomes of all children. Of concern is the 2010 United Health Foundation America's Health Rankings Report showing Oklahoma 49th in primary care physicians per 100,000. One also finds that only 48% of all medical school graduates remain in Oklahoma. For graduates completing a residency in the state the number is higher at 56%.[19] By 2012, Oklahoma is projected to have shortages in various categories of health care providers including nurses and other allied professionals.[20] For 2009, the percentage of Oklahoma children who are uninsured is 13.3%.[21] For 2007, only 67.6% of children had access to both medical and dental care, ranking the state 37th in the nation.[22]

There is evidence that adequacy of the supply of primary care providers (PCP) is associated with the prevalence of conditions like cancer, heart disease, strokes, infant mortality, low birth weight, and life expectancy as well as how individuals rate their own care. Research suggests that children who have continuity with a regular practitioner are more likely to adhere to prescribed medications, receive preventive care and well-coordinated, resource-efficient, and family centered care, and less likely to visit the emergency department and be hospitalized. In addition, their practitioner is more likely to recognize their health problems and track their progress.[23,24,25,26,27,28] The patient-centered medical home is an evidence-based approach endorsed by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA) and reflected in the Title V, Maternal and Child Health Block Grant performance measures and the Nation's Healthy People 2010 objectives. A medical home may be especially important to children and youth with special health care needs and their families, who often need help to access and integrate services from a complex web of providers and programs.[29,30]

A major endorsement of this approach in Oklahoma was implementation in January of 2009 of the patient-centered medical home by the SoonerCare program. Entry level requirements include coordination of medically-necessary primary and preventive services, patient education, participation in vaccine and immunization programs, medication reviews, and organization of clinical data with systems in place to track test results and referrals. Following implementation of this approach, the SoonerCare program added 244 primary care providers to the network and the Early Periodic Screening Diagnosis and Treatment (EPSDT) screening rate

increased from 73% in 2008 to 83% in 2009. There has also been a statistically significant improvement in member's satisfaction of their child's health plans and families getting care quickly. Outreach efforts to children who are currently eligible for SoonerCare but not enrolled are critical to further improvements in access to health care. It is within our grasp to achieve coverage for 95% of Oklahoma's children.

Goal & Objectives

Assure all Oklahoma children have access to comprehensive primary care services that include oral, physical and mental health services consistent with the Joint Principles for the Patient-Centered Medical Home.[31]

• By December 2014, 95% of children will have comprehensive health insurance coverage. (Source: 2009 US Census; Baseline: 87.4%)

• By December 2014, the percentage of children who have at least one primary care provider visit in a year will increase to 90%. (Source: 2007 National Survey of Children's Health; Baseline: 83.5%)

• By December 2014, increase to 60% the percent of children provided care through a medical home as defined by the American Academy of Pediatrics. (Source: 2007 National Survey of Children's Health; Baseline: 55.7%)

In lieu of specific recommendations regarding sufficient numbers of primary care providers serving Oklahoma's children, the Children's Health Flagship Workgroup endorses recommendations made by the OHIP Workforce Workgroup to increase the number of providers who practice in the state. Comprehensive access cannot be achieved without addressing workforce shortages. The Workforce Workgroup has formed a data collection/analysis committee to quantify shortages by specific geographic areas, a first step in assessing the needs for the state.

Additionally, the Workforce Workgroup has made recommendations that call for: 1) expansion of primary care residency programs in rural Oklahoma; 2) funding for training of primary care specialties for physical, oral, and behavioral health needs; 3) funding for health professional scholarships; 4) mechanisms for loan repayment and retention of health care professionals; and 5) expanded use of telemedicine for training, supervision and extending the availability of health care professionals in rural areas.

Injury Prevention

Each year, about 170 Oklahoma children ages 1-18 die from an unintentional injury. Many more children sustain nonfatal injuries that take an emotional and financial toll and may lead to lifelong disabilities. Homicides and suicides are also a leading cause of death among children and young adults.

The leading causes of injury deaths for children and youth are motor vehicle crashes (38%), followed by drowning (9%), poisoning [includes prescription and/or illicit drugs](7%), and fires/burns (5%). In addition, homicides account for 13% of injury deaths and suicides for 8%.[32] OHIP recommendations focus on the three areas shown to have the largest impact with proven prevention strategies available: 1) motor vehicle crashes; 2) drowning; and 3) violence prevention.

The number of motor vehicle crash deaths among young children was highest among children under one year of age and among five and six year olds. The overall number of deaths among children increased dramatically among teens 15 years and older. Each year an observational survey is conducted in Oklahoma that assesses car/child safety seat use or seat belt use. In 2009, overall usage for children 0-6 years of age was 86%. Use among infants was 75%. Small children were much more likely to be restrained properly if the driver was wearing a seat belt (90% vs. 68%). Child safety seat use varied by regions of the state. The highest usage was in metropolitan Oklahoma City followed by northwest Oklahoma and Tulsa. The lowest usage was in the southern part of the state, especially in the southeast. Recommendations build on legislation covering age requirements for use of a motor vehicle child passenger restraint system.

There is evidence that teen deaths decline following implementation of graduated driver licensing laws. These laws gradually phase in driving privileges for new drivers ensuring that early driving experiences are in lower-risk conditions. Oklahoma currently has a graduated driver licensing law that restricts driving during nighttime hours and limits the number of passengers teen drivers can have in their vehicle. In addition, persons with a learner's permit or intermediate license are prohibited from using a cell phone while driving for texting or talking.

All-terrain vehicles (ATV) are very popular in the U.S. and Oklahoma and are used for recreation, competition racing, and as work tools. They can weigh up to 800 pounds and travel at highway speeds. They are designed to be off-road vehicles and require interactive riding with operators shifting their weight freely in all directions. Young riders are at the highest risk of injury. The most common mechanisms of injury are falls from the vehicle, collisions with a stationary object and rollovers. Safety training and riding experience are critical to staying safe on an ATV. Recommendations build on prior policy changes requiring helmets for children and youth under the age of 16.

The incidence of drowning is greatest among children age 5 years and younger, especially toddlers. It occurs mainly in swimming pools, bathtubs and ponds. Effective interventions include proper supervision, pool barriers, and an increase in swimming skills. The number of drowning deaths decrease after age 5 but increase again at age 17 or 18, with teen occurrences mainly in recreational waters. Effective interventions include use of personal flotation devices and restricting alcohol use by teens.

Data from the Oklahoma Youth Risk Behavior Survey (YRBS) for 2003-2009 on the percent of students grades 9-12 that are hit, slapped or physically hurt on purpose by their boyfriend or girlfriend in the past 12 months show: 1) the percentage is slightly higher for males and 2) the rate is declining for females, with a recent increase for males. These rates are similar to national trends. Women tend to be more seriously injured by the physical violence than men. Data on the percent of students physically forced to have sex show the rates of sexual assault among high school girls are higher than the rates for high school boys. Rates of sexual assault self-reported by high school boys in the YRBS are higher than those reported by adult males in the Behavioral Risk Factor Surveillance System (BRFSS). The sexual assault survey conducted by the Oklahoma Public Opinion Learning Laboratory found 74% of women 18-34 years of age who had been sexually assaulted were less than 18 years of age when the first sexual assault occurred.

Goal & Objectives

Reduce preventable injuries in Oklahoma children.

- By June 2011, enact legislation to strengthen the graduated driver's license law to prohibit the use of a hand held electronic device while driving except for "life threatening emergency purposes" for all drivers under age 18.

- By June 2012, require safety training for ATV drivers under age 16.

- By December 2012, implement a campaign that promotes best practices related to child safety seat usage including information on correct installation of child safety seats in public service spots.

- By June 2013, require use of child safety seats, appropriate for the child's height and weight, up to age 8.

- By June 2013, enact legislation to strengthen the graduated driver's license law to increase the ages for a learner's permit to age 16 and an unrestricted license to age 18.

- By December 2014, reduce from 75 to 67 motor vehicle deaths per year in the state among children and youth using multiple strategies involving child safety seat distribution, education, and technical assistance. (Source: 2009 Office of Highway Safety)

- By December 2014, reduce from 24 to 22 drowning deaths per year of children and youth in the state through life jacket loaner programs and parent/retailer education strategies. (Source: 2009 Office of Vital Statistics)

- By December 2014, increase to 50% the number of schools that implement evidence-based strategies addressing teen dating and/or sexual violence prevention. (Source: 2010 OU Poll Survey)

Immunization

One-in-four of Oklahoma's children are inadequately protected against the basic series of vaccine preventable diseases, as defined by the Centers for Disease Control and Prevention (CDC). In 2010, the United Health Foundation ranked Oklahoma 18th among the 50 states for the percentage of children ages 19 to 35 months with full immunization coverage. [33] Coverage rates of the basic vaccine series at 24 months of age is 77.9% for Caucasians, 73.1% for African-Americans, 80.3% for Native-Americans and 81.9% for other racial groups. Coverage rates for African-Americans are approximately 5 percent lower than other races. Hispanic coverage rates at 24 months are 82.8% versus non-Hispanics at 75.5%.[34] With the advent of new vaccines and recommendations of the Advisory Committee on Immunization Practices (ACIP), adolescents represent a new age group for immunizations. Barriers for this age group include: 1) fewer health maintenance visits; 2) adolescents being unaware of the need for immunization; 3) underestimating the risk of vaccine-preventable disease; 4) difficulty verifying prior immunizations; and 5) noncompliance with multiple vaccine doses and misperceptions about vaccine safety.[35]

An analysis of Oklahoma's immunization data reveals that just one more dose of DTaP in the recommended vaccine regimen for children to receive by 24 months of age would have a significant impact on the coverage rate of our children. For most Oklahoma counties, the 2006 birth cohort coverage rate is at 70-79%. The impact of one more dose of DTaP by 24 months of age would raise the coverage rate to over 80% for the entire state and over 90% for half of the counties.

Public health agencies and private providers must have the capacity to assess and respond to immunization needs. Immunization programs require health professionals to be competent in cross-cutting and technical skills. There are now 25 doses of vaccine recommended between birth and two years of age, excluding influenza. This represents a 200% increase in immunization volume and workload since 1994.

The OSDH Immunization Strategic Targeted Action Team (STAT) created in January 2010 is charged with developing objectives and an action plan to improve immunization coverage rates among children 19-35 months of age. The team, in conjunction with the Oklahoma State Immunization Advisory Committee, developed a strategic plan to increase immunizations among children 19-35 months of age. The plan addresses the following components: 1) improving legislative and state agency policies to streamline processes that lead to improved outcomes; 2) creating a redesigned Oklahoma state immunization registry (OSIIS); 3) improving parental outreach and access to immunization services; 4) ensuring an adequate workforce to deliver immunization-related services and training/education; 5) engaging communities with the lowest immunization rates to initiate improvement strategies; and 6) improving public education and marketing. The plan takes into consideration the specific needs of vulnerable populations.

Goals & Objectives

Increase the 4:3:1:3:3:1 immunization coverage rates of children 19-35 months.

- By December 2012, develop a new immunization information system (OSIIS) that has full capacity for electronic data exchange.

- By January 2013, implement strategies identified by community and state partners that optimize vaccinations by providers in both private and public settings.

- By June 2013, enact legislation for statewide mandatory reporting of all childhood vaccinations to OSIIS.

- By June 2013, improve state policies related to childhood immunizations for children served in the major child serving state agencies in Oklahoma.

- By July, 2013, identify and implement community-based intervention strategies to increase immunization coverage.

Increase immunization rates of adolescents for recommended vaccines.

- By December 2012, increase the proportion of Oklahoma adolescents aged 13-17 years that have completed one dose of Tdap to 60%. (Source: CDC National Immunization Teen Survey 2009; Baseline: Oklahoma 35.1%, U.S. average = 55.6%)

- By December 2013, increase the proportion of Oklahoma adolescents aged 13-17 years that have completed one dose of meningococcal vaccine to 55%. (Source: CDC National Immunization Teen Survey 2009; Baseline: Oklahoma 29.5%, U.S. average = 53.6%)

- By December 2013, increase the proportion of Oklahoma adolescent females aged 13-17 years that have completed three doses of HPV vaccines to 35%. (Source: CDC National Immunization Teen Survey; Baseline: Oklahoma 16.2%, U.S. average = 26.7%)

Oral Health

According to the CDC, tooth decay is the most common chronic childhood infectious disease in the United States. Although oral diseases are considered highly preventable with knowledge and proper oral healthcare, families with untreated oral disease face serious health problems and a diminished quality of life. According to the first Oral Health Needs Assessment conducted in 2003 by the University of Oklahoma Colleges of Dentistry and Public Health, the state's overall performance is poor. The state prevalence for dental caries (cavities) in Oklahoma third graders is 69.4%, higher than any other state reported. The rate of untreated tooth decay (40.2% in Oklahoma third graders) was also higher than other reported states. For 2007-2008, the rate of untreated decay improved to 32.3%. However the percentage of cavities is 71.5%. These measures are higher than objectives set out in the Healthy People 2010. The greatest barrier to oral health is poverty. Nationally, children and adolescents living in poverty suffer twice as much tooth decay as more affluent peers. Unfortunately, their disease is likely to go untreated. This correlates with race where one finds Oklahoma Hispanics, African-Americans and Native Americans having the highest rates of poverty. Poverty correlates with lack of education which creates barriers to the adoption of good oral health practices.

These sobering conditions led concerned constituencies to petition Governor Henry for formation of a Governor's Task Force on Children and Oral Health. Specifically the task force was charged with: 1) studying the existing state, federal, and private sector-funded programs that address the health of children, youth and families and to avoid duplication of efforts and resources; 2) determining ways to infuse oral health education, dental care and dental disease prevention into these programs; 3) identifying the need for new programs; and 4) developing a State Oral Health Plan.

Goal & Objectives

The Governor's Task Force on Children and Oral Health Report (2009) provided a comprehensive set of recommendations in the areas of prevention, education, workforce and access to care to address oral health needs in the state.

Improve the health status of Oklahoma children by reducing the amount of dental cavities.

- By June 2012, establish a state fluoridation plan that identifies strategies that will result in 75% of the population on public water systems receiving optimally fluoridated water. (Source: 2006 National Oral Health Surveillance System (NOHSS); Baseline: 73.4%)

- By June 2012, reimburse primary care providers for delivery of preventive dental services such as fluoride varnishes.

- By June 2013, modify laws and rules to expand the types of providers who can deliver preventive dental services such as sealants and fluoride varnishes in public settings.

- By December 2012, develop strategies to have the capacity to provide technical assistance, consulting, and training in the integration, coordination, and implementation of evidence-based or promising programs addressing oral health and the prevention of dental diseases to professionals, parents and caregivers.

Adolescent Health

An estimated $700 billion is spent annually in the United States on preventable adolescent health problems such as adolescent pregnancy, sexually transmitted diseases (STDs), substance abuse, and mental health issues. Adolescents are more likely to be uninsured than younger children and have the lowest rate of utilization of primary care in the United States.[36] There are over 462,241 adolescents between the age of 13-21, representing 12.5 % of the state's population.[37] Oklahoma's 2007 teen birth rate for 15 to 19 year olds is 61.8 live births per 1,000 population compared to 42.5 per thousand for the United States. For 2006, Oklahoma's rate was 6th highest in the nation.[38] Teen birth rates are highest for African American and Native American youth. The three leading causes of death for adolescents 15 through 19 years old are unintentional injury, suicide and homicide.

The health needs of adolescents are unique and bridge the gap between pediatric and adult internal medicine with areas that address non-medical factors. There are no subspecialty training programs in Adolescent Medicine in Oklahoma. Pediatric residency programs have a requirement for a one month block of Adolescent Medicine but the requirements are less defined for the Internal Medicine and Family Medicine programs. Risk factors for adolescents include poverty, poor academic achievement, disturbed sleep patterns and suicide. Doing well in school is a major protective factor against risky behavior. The Search Institute, a nonprofit organization committed to creating healthy communities for young people, has identified 40 developmental assets which are common sense experiences that positively influence young people's choices and help make them caring, responsible adults.[39] Factors promoting positive youth development include a positive relationship with parents, engagement in school and community activities and a sense of spirituality.[40] One sees a reduction in youth problems tied to the following factors: physical health; vocational readiness and success; social and emotional health; educational attainment; and civic engagement.[41] Some of the state challenges to serving youth include the lack of: 1) comprehensive health education; 2) access and utilization to preventive care; 3) confidentiality; 4) adequate insurance coverage; and 5) training of providers in adolescent health.

Goal & Objectives

Improve adolescent health outcomes.

• By June 2012, initiate evidence-based medically accurate, age appropriate teen pregnancy prevention curriculum, including evaluation in middle and high schools.

• By December 2013, increase school participation in state youth behavior survey data collection [YRBS, Oklahoma Prevention Needs Assessment (OPNA), Youth Tobacco Survey (YTS)] through a coordinated state-level approach that reduces burden and improves health outcomes for schools. (Source/Baseline: YRBS 2009- 86% school response rate, OPNA 2010-52% public school districts, YTS - 80% middle school response rate and 74% high school response rate)

• By December 2014, establish resources for all 77 Oklahoma counties to provide expertise and technical assistance to communities in evidenced-based models on positive youth development and holistic adolescent health needs.

• By December 2014, the percentage of adolescents aged 12-17 who have at least one primary care provider visit in a year will increase to 80%. (Source: 2007 National Survey of Children's Health; Baseline: 77.9%)

Mental Health & Substance Abuse

Close to 90,000 children ages 9 through 17 suffer from mental or behavioral impairments and one out of every 10 young Oklahomans may have a substance abuse disorder. Information from the 2009 and 2007 Oklahoma YRBS, respectively, indicate: 1) for 2009 39% of students in grades 9-12 report current alcohol consumption and 2) for 2007 Oklahoma high school students were more likely to report driving after drinking alcohol than U.S. students. According to the National Survey on Drug Use and Health (NSDUH) Oklahoma has been consistently above the national average among persons 12 and older reporting the use of any illicit drug other than marijuana. The 2008 OPNA shows 23% of OPNA participants in 12th grade, 21% of OPNA participants in 10th grade, and 13% of OPNA participants in 8th grade reported taking prescription drugs during their lifetime without a doctor's prescription. For 2002-2006 the suicide rate in Oklahoma for ages 15 through 19 was 10.4 per 100,000 population versus 7.6 per 100,000 in the United States. For the same time period and age group, the homicide rate was 6.6 per 100,000 in Oklahoma versus 9.7 per 100,000 in the United States.[42] Suicide and homicide rates were highest for Native American and African American youth respectively. Close to 14% of Oklahoma adolescents have seriously considered attempting suicide during the last 12 months and 5.9% have actually attempted suicide one or more times in that time period.[43]

Adverse childhood experiences (ACE) have a strong influence on adolescent health, teen pregnancy and mental health. A history of adverse childhood experiences is associated with a significant increase in the prevalence of attempted suicides. Each additional adverse experience increases risk by about 60%.[44] Adverse experiences also increase one's risk for many chronic diseases as well as the risk of death. The National Survey of Children's Health shows that in Oklahoma 26.2% of children aged 4 months to 5 years were at moderate or high risk of developmental or behavioral problems. Only 53.6% of children aged 2-17 years with problems that require counseling received mental health care compared to the national average of 60%.[45]

Nationally, the majority of lifetime mental illnesses begin in youth. One in 5 children has a diagnosable mental disease with 1 in 10 having a severe enough condition to impair functioning at home, school or in the community. Nationally, one finds that of the small number of youth classified as needing treatment for alcohol use or substance abuse, only 7.2% and 9.1% respectively received specialty treatment.[46] Half of the youth that receive mental health services have co-occurring disorders. Eighty percent of individuals with multiple mental health and substance abuse disorders report onset before the age of 20.[47] Children and youth from low-income households or in child welfare and juvenile justice systems are high risk. However even with the above description of problems in this area, Oklahoma experts indicate a significant gap exists in Oklahoma-specific data on the incidence and prevalence of mental illness and substance abuse.

Public health principles suggest a new approach to children's mental health, one that balances a focus on reducing mental health problems among children for whom a problem has been identified and helping all children optimize their mental health. Optimization employs strategies around 1) promotion of health by addressing determinants of positive health and 2) prevention which reduces mental health problems by addressing their determinants. Reduction approaches focus on 1) treating problems to diminish their effects and 2) reclaiming one's health by optimizing positive health while recognizing the existence of a mental health problem.

These principles point to adoption of a population perspective in providing and improving children's health services which recognizes that mental health resides in a web of interactions that connect the child, family and school, health and other child service systems, the neighborhood and the community in which the child lives. There is the need to work collaboratively across a broad range of formal and informal systems and sectors that impact children's mental health. Providers interested in enhancing mental health services need to form partnerships with mental health advocates, schools, human service agencies, and developmental and health care specialists to provide care coordination and fill gaps in care. A population perspective necessitates understanding mental health needs of children and youth in their communities, thereby allowing adaptation to local contexts and settings.[48,49,50] An example of such an approach is Oklahoma's system of care which incorporates a comprehensive spectrum of mental health and other support services organized into coordinated networks to meet the needs of children and adolescents with serious emotional disturbances and their families. It accomplishes this by providing community-based, family driven, youth guided and culturally competent services.[51]

Another statewide collaborative is Smart Start Oklahoma which provides leadership and coordination to early childhood systems through the Oklahoma Partnership for School Readiness. One of Smart Start's key strategies is community initiatives that leverage local support and resources to respond to the needs of young children and their families. Each community addresses local needs which can include gaps in health and mental health services.[52]

There is evidence of a window of opportunity for prevention of mental health disorders that can emerge later in adolescence or adulthood. Scientific understanding about the brain development of infants and young children points to the critical influence of parenting attachment and early childhood education on emotional, social and cognitive development of young children. It also points to the role of attachment disturbances in many children and adult disorders.[53,54] The science of early childhood development emphasizes the link between brain development, early environments and children's mental health.

Goals & Objectives

Infant and Early Childhood Mental Health

Develop and expand programs for early identification and treatment of infants, toddlers and children under age six exhibiting mental health concerns.

- By December 2014, increase by 10% annually the number of health care providers that are provided with effective interventions on infant and early childhood mental health development to assist them in identifying infant and early childhood concerns. [Source: Documented number of health care providers at Infant and Early Childhood Mental Health (IECMH) and OSDH Child Guidance (CG) sessions; Baseline: 10]

- By December 2014, increase the number of developmental/behavioral screenings in primary care practices by 10%. (Source: 2011 TOTS survey; Baseline: number available in 2012)

- By December 2014, identify and implement strategies to increase by 25% the number of mental health providers serving infants, young children, their families and caregivers who achieve the Oklahoma Association for Infant Mental Health endorsement. (Source: FY 2010 OKAIMH; Baseline: 11 endorsed)

- By December 2014, increase the percent of women screened for postpartum depression up to one year after the end of pregnancy by 25%. (Source: 2010 TOTS survey; Baseline number available in 2011)

Children/Youth Mental Health and Substance Abuse

Develop and expand programs for early identification and treatment of mental health and substance abuse problems.

- By December 2011, identify strategies to increase the number of community-based services for detection and counseling for children/youth with substance abuse problems.

- By December 2012, develop school and other community-based early intervention programs for detection and counseling for children/youth with substance abuse problems.

- By June 2013, collect Oklahoma-specific data on the prevalence and unmet needs of children with mental health and substance abuse problems.

Expand evidence-based community mental health and substance abuse services statewide.

- By December 2014, expand by 10% the number of children and youth in the state receiving out-patient substance abuse treatment services. (Source: 2010 data from ODMHSAS decision support system; Baseline: 3,638 for both Medicaid and ODMHSAS funding)

- By December 2014, expand by 10% the number of children and youth receiving residential and inpatient substance abuse treatment services in the state. (Source: 2010 data from ODMHSAS decision support system; Baseline: 363 from ODMHSAS funding)

- By December 2014, provide resources to expand the systems of care network statewide.

Develop and expand community-based programs for prevention of injuries and substance abuse among children and youth.

- By June 2014, reduce suicide deaths among youth age 13-18 by 5%. (Source: 2008 Oklahoma Violent Death Reporting System; Baseline: 25 deaths, Rate 8.3)

- By June 2014, reduce the percentage of youth who report at least one suicide attempt by 5%. (Source: 2009 YRBS; Baseline: 7%)

- By June 2014, decrease the percent of youth who report current use of alcohol (in the last 30 days) by 3%. (Source: 2009 YRBS; Baseline: 39%)

Child Abuse & Neglect

The ACE Study[55] provides insight into how childhood experiences evolve into risky behaviors which can result in disease and death. Child maltreatment leaves children vulnerable, disrupting the normal development of the brain. The more trauma experienced, the greater the likelihood that children and youth adopt multiple risky behaviors such as alcohol and drug abuse, smoking, overeating or promiscuity. Prevention, intervention, and treatment methods need to address the whole family and provide support while the adults seek services. Parents or caregivers, who are impaired and unable to care for themselves, are not equipped to provide adequate care and support for a child.[56] Children with disabilities are vulnerable, with a national study finding children with disabilities being 1.7 times more likely to be maltreated than children without disabilities.[57] Low socioeconomic status has been identified as a risk factor associated with parents who abuse and/or neglect their children. A childhood history of maltreatment has also been linked to poverty in adulthood. Adults who were physically abused, sexually abused, or severely neglected as children were significantly more likely to be unemployed, living below the poverty line, and using social services than people without a history of maltreatment.[58] There is a high correlation between domestic violence and child abuse and neglect. The Avon Foundation for Women found, "in cases where victims experience severe forms of domestic violence, their children are also in danger of suffering serious physical harm."[59] Finally, adults who suffer from poor mental health or substance abuse may be less able to nurture and provide reliable or effective parenting for their children.

For state fiscal year (SFY) 2009, 53,394 children and their families were assessed or investigated for an allegation of abuse and/or neglect with 8,605 children confirmed as victims. For that same year, the "threat of harm"(19.69%) surpassed the category of substance abuse by a caretaker (19.27%) as the leading cause of neglect. For the third year in a row, the child abuse and neglect rate declined. Approximately 3,100 less children were alleged to be victims of child abuse and neglect in SFY 2009 than in SFY 2008. Neglect is the most common form of abuse in Oklahoma as well as the nation. In SFY 2008, 41 children died in Oklahoma due to child abuse and/or neglect. The most common age of Oklahoma children that died from abuse or neglect was under one followed by one to two years of age. Over the last three years, deaths due to neglect are declining while deaths due to abuse or both abuse and neglect are on the rise.[60,61,62]

There is not a clear single factor responsible for the decline in child abuse and neglect; rather, those involved in the field point to a combination of policies, practices, and economic circumstances:[63]

- On the policy side, the state has invested heavily over the past decade in front-end prevention programs, such as the Children First Program and Start Right Initiative, aimed at providing at-risk parents the resources and skills to avoid engaging in abusive behaviors.

- Within the Oklahoma Department of Human Services (OKDHS), a newer program, Safe Care, specifically targets families identified at the highest risk for abuse.

- The OKDHS Child Protective Services also has implemented a new practice model that reflects: 1) family centered practices and engagement around safety; 2) home-based interventions with children; as well as 3) concurrent planning and achieving permanency for children.

- During fiscal year 2008, the state had an extended stretch of strong economic growth and low unemployment which may have contributed to the drop in abuse by providing a greater measure of economic security for children and their families. With the state facing revenue shortfalls in fiscal years 2009-2011 and one projected for 2012, this security may have eroded. However, OKDHS also points to higher adoption rates, increasing child support payments to single parents and linking low-income parents to work supports such as food stamps and child care as reducing the financial and psychological stress on families.

There has been extensive research around interventions that correlate with prevention or reduction in child abuse and neglect. Prevention strategies exist at three levels: 1) primary prevention that focuses strategies on the general public through awareness of child maltreatment, laws to reduce risks and enhance protective factors for families; 2) secondary prevention targets families with risk factors for abuse and neglect which include early identification; and 3) tertiary intervention which encompasses treatment for families identified as having committed abuse or neglect.[64]

There are many programs in the state that address prevention at all three levels of engagement. A sampling of primary prevention activities includes parent websites; parent warmlines that provide advice to parents; child guidance services; parent education groups such as Oklahoma Parents as Teachers; some sex abuse prevention education for parents/adults

and children; and quality early childhood education (e.g., Head Start, Educare, prekindergarten, and child care centers). Secondary prevention activities include child guidance, home visitation programs, respite care, family expectations program for couples and alternative schools for pregnant and parenting teens. Tertiary prevention includes home visitation for high risk parents, early intervention services for children with developmental delays, trauma services, parent child interaction therapy (PCIT), Comprehensive Home-based Services (CHBS) targeted at children at risk of removal from their homes, mental health and substance abuse services, domestic violence services, and multidisciplinary child abuse and neglect teams (MDTs) and child advocacy centers (CAC) that respond to child abuse.

Children First is a secondary prevention evidence-based nurse home visitation program administered by the OSDH. Outcomes include improved prenatal health, fewer childhood injuries, fewer subsequent pregnancies, increased intervals between births, and increased maternal employment. Data analysis showed fewer Oklahoma children would have been confirmed child abuse maltreatment victims if the confirmation rate of the general population matched confirmation rates for children in the Children First program. A 2005 Rand Corporation analysis found a $5.70 return per dollar invested in Nurse Family Partnership programs like Children First.[65,66]

The Start Right program is an evidence-informed secondary prevention program also administered by the OSDH. The program is based on the nationally recognized Healthy Families America home visitation program and utilizes the Parents as Teacher curriculum. Outcomes show that between 1997-2007, 70% of Oklahoma Start Right participants were not named in a child maltreatment report and 90% did not have a confirmed case of child maltreatment.

The OKDHS's Oklahoma Children's Services (OCS) contracts include evidence-based tertiary prevention services. Comprehensive Home-Based Services (CHBS) is a component of OCS where professionals conduct comprehensive assessments and treatment planning with families to address issues that resulted in child welfare and/or court-involvement.[67] CHBS providers educate families using an evidence-based eco-behavioral model called Safe Care. Outcomes show between 2007-2009 Safe Care participants reported improved competence in: 1) meeting children's basic health needs; 2) managing behavioral problems; 3) parent – child interactions; 4) knowledge of home safety hazards; and 5) problem solving.[68]

Goals & Objectives

Reduce child abuse and/or neglect.

- By January 2012, implement an abusive head trauma/ shaken baby educational program, guided by parental involvement, for new parents through partnering with 20 hospitals.

- By June 2012, implement a statewide multi-media campaign focusing on primary prevention of child abuse and neglect.

- By December 2012, provide 10 evidence-based community trainings (e.g., Strengthening Families and Front Porch) to engage nontraditional partners in creating a safe, stable and nurturing environment for children and families.

- By December 2012, increase the number of families served in evidence-based home visitation programs/teams across the state by 10% {e.g. Children First , Start Right, and Comprehensive Home- Based Services (CHBS)}. (Source: SFY 2009 Children First; Baseline: 4,590; Source: SFY 2010 Start Right; Baseline: 1,247; Source: SFY 2010 CHBS program; Baseline: 2,057 families)

Improve the physical and mental health status of children in state custody for child abuse and/or neglect.

- By December 2011, implement a medical health passport that electronically provides a custody child's health and education related information to placement and medical providers and allows for portability between service providers.

- By December 2011, develop a strategic plan for a "trauma-informed" Child Welfare System.

- By December 2011, implement procedures for a single statewide screening and intake process for behavioral health services.

- By December 2011, offer targeted interventions to 200 health care professionals and 300 individuals (i.e., case workers, foster parents, teachers, judges, etc.) at the community level about health care for children in foster care.

Special Health Care Needs

Over 12 million children in the United States have a special health care need. The overall prevalence of Oklahoma's children and youth with special health care needs (CSHCN) is 16.5% compared to 13.9% in the United States. When the percentage of children and youth with special health care needs is compared with the number of CSHCN by race, some groups appear to fare worse. Multi-racial children and youth at 23.3% are more likely to have a special health care need than other groups. That is followed by Native Americans at 19.4%, African Americans at 17.8%, Caucasians at 16% and Hispanics at 9.3%.[69]

For 2007-2008, the number of children ages 3 to 21 served in school special education programs was 95,323. This represented 14.8% of public school enrollment.[70] The most frequent diagnoses in the program were specific learning disabilities at 44.2%, developmental delay at 15.6% and speech or language impairments at 12.8%. [71]

CSHCN are children or youth who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that generally required by children. Funds for this OKDHS program are from Title V of the Maternal and Child Health Block Grant.[72] Eighty percent of the health care dollars spent annually on all children are spent on CSHCN.[73] Data from the National Survey showed that 12.3% of Oklahoma's CSHCN were without insurance at some point in the last year, and 18.5% had an unmet need for a specific health care service; both of which exceed the national rates. For Oklahoma families interviewed, 19.8% reported they had difficulty getting referrals and 9.0% reported spending 11 or more hours weekly coordinating care for their children; both higher than the national average. Close to 75% of participants in the program are in families at or below 400% of poverty. The top conditions for CSHCN as reported in the National Survey for 2005 and 2006 include but are not limited to allergies, asthma, attention deficit disorder, emotional problems, intellectual disability, autism, seizure disorder, cerebral palsy, diabetes, down syndrome, muscular dystrophy and cystic fibrosis.

A state community assessment conducted by the Sooner State Unified Children's Comprehensive Exemplary Services for Special Needs (SUCCESS) program identified the top needs as: 1) improving access to day care and health care; 2) increasing knowledge by the public, provider and county health departments; 3) assisting youth in developing skills and abilities; and 4) providing more family support including respite care for families. The provider survey cited the need for more foster home and family counseling. Day care, extended after school programs and respite care were common needs identified by both providers and families.

SoonerStart is Oklahoma's early intervention program for infants and toddlers (birth to 36 months) who have disabilities or developmental delays and their families under Part C of the Individuals with Disabilities Education Act (IDEA) and the Oklahoma Early Intervention Act. The goal of the SoonerStart program is to minimize the adverse impact of developmental delays and to reduce the long-term educational costs through early intervention. High quality early intervention programs have been shown to contribute to improved outcomes related to school success, workplace productivity and responsible citizenship.[74]

SoonerStart program eligibility is determined by the state for infants and toddlers through 36 months of age who have developmental delays or have a physical condition which will most likely cause a developmental delay. Oklahoma's eligibility standard is considered conservative when compared to other states. In state fiscal year 2009, 13,534 infant and toddlers received screening, evaluation and services.[75]

The OKDHS Developmental Disabilities Services Division (DDSD) offers a wide array of community services for individuals with developmental disabilities and their families. Services are individualized to meet each person's needs. DDSD services are funded through Medicaid Home and Community Based Services (HCBS) Waiver and through State funds. The Division has two home and community-based waivers under 1915c of the Medicaid program to serve children with intellectual disabilities: 1) community; and 2) in-home supports for children. It is important to point out that all of these programs are limited to persons with intellectual disabilities leaving a major gap for children with other types of developmental disabilities.

There are currently 3,720 children age 21 and under on the waiting list. Medicaid eligibility is a prerequisite requirement for waiver service eligibility. Seventy-nine percent of the children on the waiting list receive some type of service through the Medicaid state plan. There is recognition of the need to develop alternative, lower cost strategies to continue meeting the needs of children on the waiting list, given current state budget constraints.

Goals & Objectives

Increase access to health care for children and youth with special health care needs.

- By June 2011, enact legislation to amend the Oklahoma Early Intervention Act to allow family cost participation.

- By January 2012, evaluate the feasibility of integrating the SoonerStart data systems.

- By December 2014, increase to 51% 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. (Source: 2005/2006 National Survey of CSHCN; Baseline: 43.7%)

- By December 2014, increase the percentage of children with special health care needs receiving coordinated, ongoing comprehensive care within a medical home by 20%. (Source: 2005/2006 National Survey of CSHCN; Baseline: 49.7%)

Increase community- based services for special populations of children.

- By December 2013, expand the number of counties that provide comprehensive coordinated services for CSHCN including dental, behavioral health and medical services. (Baseline: 10 counties)

- By December 2014, provide services that support families caring for children on the DDSD waiting list.

Cross-cutting Goals

Each of the following goals influences many of the topics mentioned earlier in this plan. Because these goals are cross-cutting in nature, they are being identified separately in this section. Implementation of these goals will benefit many children in the state.

Goal & Objectives

It is important to have good communication and public awareness in regard to children's health resources available to the public to improve access and utilization of needed services. Oklahoma is one of few states with a statewide information and referral system differentiated by geographic area that is available to all Oklahomans by dialing 211.

In order to better serve Oklahoma's children around the topics identified in this plan, it is incumbent on policy makers to use data for research, analysis and evaluation on effective and efficient interventions. Data analysis identifies areas in which to focus as well as interventions that may be addressed from both short and long range perspectives.

Improve communication about available services and use data to direct planning and implementation of effective children's health programs.

- By June 2011, assure child health-related communication campaigns incorporate information about statewide community resource systems available through 211, the Joint Oklahoma Information Network (JOIN) and the Oklahoma Areawide Services Information System (OASIS) as part of health-related public awareness and communication campaigns.

- By December 2014, establish an early childhood data system which includes data from the major child serving state and federal programs in Oklahoma.

Goal & Objectives

Laws and policies can have a dramatic effect on the health of many Oklahomans. Improving policy is often a very effective way of streamlining processes that lead to improved outcomes. Policies and state laws can originate from many levels including national, state, or local sources.

Adopt policies and legislation that can improve children's health.

- By December 2014, promote comprehensive health education in Oklahoma public schools grades K-12 in accordance with Priority Academic Student Skills (PASS) guidelines utilizing state adopted health education curriculum.

- By December 2014, promote the CDC's Coordinated School Health Program model for grades K-12.

Prevention is better than cure.

- Desiderius Erasmus

FUTURE ACTIONS

It is exciting to present state leaders *Keeping Kids Healthy: The Oklahoma Children's Health Plan.* These recommendations reflect near and long term priorities that encompass all developmental phases of children and youth. Strategies also incorporate all levels of prevention activities. Similar to the OHIP plan, released in 2009, the *Keeping Kids Healthy* plan is a living document that will be monitored on a regular basis to ensure the active engagement of stakeholders in addressing recommended goals and objectives. Outcomes will include regular progress reports by the Children's Health Flagship Workgroup. OHIP will also provide a scorecard by which the goals and objectives referenced in this plan can be measured.

Implementation of this plan is contingent on the active support and engagement of the many stakeholders involved in its development. Legislative involvement as well as community engagement is also critical to its success. OHIP leaders look forward to working with all concerned organizations and citizens throughout the state to achieve progress in improving health outcomes of the children of our state. Without the active involvement of local and state stakeholders, the outcomes of the *Keeping Kids Healthy* plan will remain a dream rather than the culmination of the state's vision for the health of its children and youth.

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Health, the greatest of all
we count as blessings.
- Ariphron

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Acronyms & Key Terms

211	State Information and Referral System
AAFP	American Academy of Family Physicians
AAP	American Academy of Pediatrics
ACP	American College of Physicians
ACE	Adverse Childhood Experiences
ACIP	Advisory Committee on Immunization Practices
AMA	American Medical Association
AOA	American Osteopathic Association
ATV	All Terrain Vehicle
BRFSS	Behavioral Risk Factor Surveillance System
CAC	Child Advocacy Centers
CDC	Centers for Disease Control and Prevention
CG	Oklahoma State Department of Health Child Guidance
CHBS	Comprehensive Home-Based Services
CSHCN	Children with Special Health Care Needs
Children First	Oklahoma Nurse Home Visitation Program
DDSD	Developmental Disabilities Services Division
DTaP	Diphtheria, Tetanus and Pertussis
EPSDT	Early Periodic Screening Diagnosis and Treatment Program
GDL	Graduated Driver's License
HCBS	Home and Community-Based Services
HEDIS	Health Effectiveness and Data Information Set
IDEA	Individuals with Disabilities Education Act
IECMH	Infant and Early Childhood Mental Health
JOIN	Joint Oklahoma Information Network
MCH	Maternal and Child Health
NS-CSHCN	National Survey of Children with Special Health Care Needs
NSCH	National Survey of Children's Health
NSDUH	National Survey on Drug Use and Health

OASIS	Oklahoma Areawide Services Information System
OCCY	Oklahoma Commission on Children and Youth
OCS	Oklahoma Children's Services
ODMHSAS	Oklahoma Department of Mental Health and Substance Abuse Services
OHCA	Oklahoma Health Care Authority
OHEC	Oklahoma Health Equity Campaign
OHIP	Oklahoma Health Improvement Plan
OKAIMH	Oklahoma Association for Infant Mental Health
OKDHS	Oklahoma Department of Human Services
OPNA	Oklahoma Prevention Needs Assessment
OSDE	Oklahoma State Department of Education
OSDH	Oklahoma State Department of Health
OSIIS	Oklahoma State Immunization Information System
OYRBS	Oklahoma Youth Risk Behavior Survey
OVS	Office of Vital Statistics
PASS	Priority Academic Student Skills
PCP	Primary Care Providers
PCIT	Parent Child Interaction Therapy
SFY	State Fiscal Year
SoonerCare	Oklahoma Medicaid Program
SoonerStart	Oklahoma Early Intervention Program
SoonerSuccess	Sooner State Unified Children's Comprehensive Exemplary Services for Special Needs
Start Right	Oklahoma Child Abuse Prevention Program
STAT	Strategic Targeted Action Team
STD	Sexually Transmitted Diseases
TOTS	Oklahoma Toddler Survey
TSET	Tobacco Settlement Endowment Trust
YRBS	Youth Risk Behavior Survey

Web Links of Oklahoma Children's Services & Programs

Injury Prevention Service
www.ok.gov/health/Disease,_Prevention,_Preparedness/Injury_Prevention_Service

Graduated Driver's License Law
www.dps.state.ok.us/dls/gdl.htm

Immunization Service
www.ok.gov/health/Disease,_Prevention,_Preparedness/Immunizations

Dental Health Service
www.ok.gov/health/Child_and_Family_Health/Dental_Health_Service

System of Care
www.ok.gov/odmhsas/Consumer_Services/Children,_Youth_and_Family_Services
Systems_of_Care/index.html

Children First
www.ok.gov/health/Child_and_Family_Health/Family_Support_and_Prevention_
Service/Children_First_Program

SoonerCare
www.okhca.org

Smart Start Oklahoma
www.smartstartok.org

Comprehensive Home Based Services (CHBS)
www.okdhs.org/programsandservices/ocs

Start Right
www.ok.gov/health/Child_and_Family_Health/Family_Support_and_Prevention_
Service/Office_of_Child_Abuse_Prevention/Start_Right_Programs/index.html

SoonerStart
http://sde.state.ok.us/Curriculum/SpecEd/pdf/SoonerStart/Presentations/Program_
Presentation.pdf

Children with Special Health Care Needs
www.okdhs.org/programsandservices/health/cshcn

Home and Community-based Waivers for Children with Intellectual Disabilities
www.okdhs.org/NR/exeres/1C216011-A2B1-4CD7-A4EF-B5D9B1DF8562.htm

OHIP Obesity Reduction Objectives

By May 2010, mandate utilization of the School Health Index for assessment and action planning by each public school's site-based Healthy and Fit School Advisory Committee.

In order to implement the recommended strategies of Oklahoma's Physical Activity and Nutrition State Plan, OSDH will have available an online searchable inventory database identifying evidence-based or promising programs that address physical activity, nutrition, and obesity issues by June 2010.

By July 2010, develop and facilitate a multi-level surveillance and evaluation system to monitor implementation of the plan.

By October 2010, the Strong and Healthy Oklahoma Division of OSDH, in collaboration with Oklahoma Fit Kids Coalition and other stakeholders, will have developed the capacity to provide technical assistance, consulting, and training in the integration, coordination, and implementation of evidence-based or promising programs addressing physical activity, nutrition, and obesity in an effort to reduce cost and increase accessibility to those programs for schools and communities.

By May 2011, mandate health-related fitness testing in all public schools for all students.

By May 2012, pass legislation to provide financial incentives for grocery stores or farmers markets to locate in underserved communities.

By May 2013, pass legislation to ensure that the safety and mobility of all users of all transportation systems (pedestrians, bicyclists, drivers) are considered equally through all phases of state transportation projects and that not less than one percent of the total budget for construction, restoration, rehabilitation or relocation projects is expended to provide facilities for all users, including but not limited to, bikeways and sidewalks with appropriate curb cuts and ramps so that even the most vulnerable (children, those with disabilities, the elderly) can feel and be safe with the public right of way.

Note: Implementation dates set out in initial 2010-2014 Oklahoma Health Improvement Plan. Quarterly updates are posted at <http://ohip.health.ok.gov>.

OHIP Tobacco Use Prevention Objectives

By May 2010, extend state law to eliminate smoking in all indoor public places and workplaces, except in private residences; currently, Oklahoma state laws contain exceptions for certain workplaces.

By September 2010, fully implement evidence-based health communications mass media campaigns targeting youth and young adults according to Best Practices for Comprehensive Tobacco Control Programs.

By December 2011, increase compliance with laws and ordinances to prevent illegal sales of tobacco to youth to 90% from 82% (December 2008).

Increase utilization of the Oklahoma Tobacco Helpline from 35,000 to 70,000 registered callers in State Fiscal Year 2014. (Baseline FY 2009).

Between 2010 and 2014, enact key public policy measures including repeal of all pre-emptive clauses in state tobacco control laws, prohibiting use of state driver's license information scans for marketing of tobacco products, and increasing taxes on tobacco products (indexed to at least the national average); Anticipate consequences and opportunities of new Food and Drug Administration (FDA) regulation of tobacco products as related to state-level legislative initiatives.

By January 2015, increase the number of hospitals, health care professionals, and community-based clinics that effectively implement the Public Health Service Clinical Practice Guideline for treating tobacco dependence.

By January 2015, increase tobacco-free properties at all workplaces including private businesses, state agencies (10% to 100%), tribal governments (from 5% to 50%), local governments (75%), hospitals (38% to 100%), school districts (from 29% to 100%), universities and colleges (16% to 100%), career tech centers (7% to 100%) and faith-based organizations (Baseline June 2009).

By January 2015, increase the number of tribal nations that voluntarily adopt laws to eliminate commercial tobacco abuse in tribally-owned or -operated worksites, including casinos; currently no tribal nations in Oklahoma have adopted such 100 percent smoke-free workplace laws.

By January 2015, increase the proportion of multi-unit housing facilities (from 1% to 25%), homes (from 74% to 90%) and motor vehicles (from 69% to 80%) with voluntary smoke-free policies.

Note: Implementation dates set out in initial 2010-2014 Oklahoma Health Improvement Plan. Quarterly updates are posted at <http://ohip.health.ok.gov>.