MATERNAL, INFANT AND EARLY CHILDHOOD

HOME VISITING PROGRAM

Supplemental Information Request for the Submission of the Statewide Needs Assessment Update

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Oklahoma State Department of Health

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INTRODUCTION

Oklahoma, which is located in the South Central region of the contiguous United States, has an extremely diverse geography including forests covering a quarter of the state and four mountain regions, the Arbuckle, the Ouachita, the Ozark Plateau, and the Wichita. Additionally, Oklahoma contains ten distinct ecological regions. Western Oklahoma has semi-arid plains, which transition to prairies and woodlands which are centrally located, and then give way to the Ozark and Ouachita Mountains which stretch eastwardly to the Arkansas border. This diverse geography is matched by the diversity of people and their living experiences. Health care availability and access, transportation options, and employment opportunities are not consistently located throughout the state, and vary by region of the state.

OKLAHOMA DEMOGRAPHICS

According to 2018 Census data estimates, Oklahoma has a population of 3,943,079,[1] and ranks 20th in area among the 50 states, spanning nearly 70,000 square miles (69,898). Oklahoma is comprised of 77 counties, with a population density of 56.4 persons per square mile. There are five metropolitan statistical areas (Oklahoma City, Tulsa, Enid, Lawton and Ft. Smith, AR) containing 18 counties, with an additional 19 counties designated as micropolitan statistical areas (Figures 1 and 2).[2] Youth (under 18 years of age) are 24.3% of the population in Oklahoma. Females comprise 50.5% of the population. The census estimates show that 7.4% of Oklahoma's population is African American/Black, 7.8% American Indian, 2.1% Asian, 0.1% Pacific Islander, 72.0% white, 2.7% other race, and 7.7% two or more races. Additionally, 10.3% of Oklahoma's population is Hispanic. Of note is Oklahoma's American Indian population, which is the second largest within the nation, and includes 39 federally recognized tribes. Oklahoma's median household income for 2018 is $51,924, compared to the U.S. median income of $61,937, and the percentage of persons living below poverty level is 15.6%, which is greater than the national level of 13.1%.[1]

Figure 1

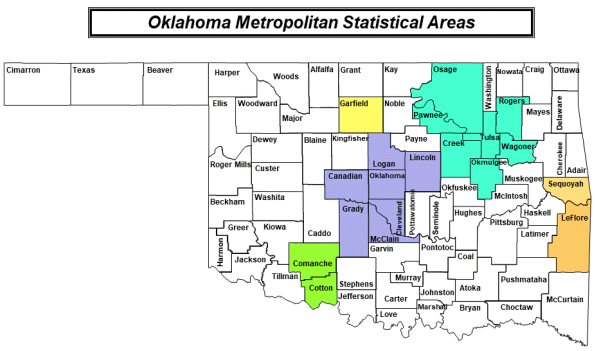
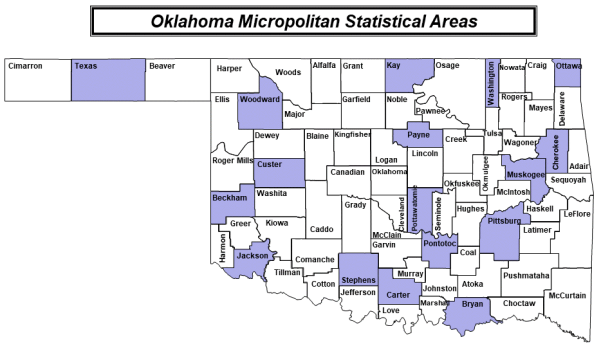


Figure 2



Family Support and Prevention Service

Within the Oklahoma State Department of Health (OSDH), home visiting programs are housed within the Family Support and Prevention Service (FSPS). FSPS promotes the health, safety and wellness of Oklahoma's children by providing:

- Funding, training, technical assistance, and oversight to local organizations and agencies that serve families with young children
- Training for professionals that work in the areas of child maltreatment prevention and intervention
- Infrastructure for family support/child maltreatment prevention efforts

Programs housed within FSPS include:

- Children First Program – Oklahoma's Nurse-Family Partnership Program, which is a family support program that offers home-based services for mothers expecting their first child
- Community-Based Child Abuse Prevention (CBCAP) – established by the Child Abuse Prevention and Treatment Act (CAPTA), the key federal legislation addressing prevention of child abuse and neglect
    - Supports community-based efforts related to preventing child abuse and neglect as well as coordination of resources and activities to better strengthen and support families to reduce the likelihood of child abuse and neglect
    - Fosters understanding, appreciation, and knowledge of diverse populations in order to effectively treat child abuse and neglect
- The Office of Child Abuse Prevention – an office housed within the FSPS that is statutorily charged with developing *The State Plan for the Prevention of Child Abuse and Neglect,* funding child abuse prevention services such as Parents as Teachers state funded home visiting services, and reporting on the effectiveness of those services
- Maternal, Infant, Early Childhood Home Visiting Program (MIECHV) – the program related to this Needs Assessment
- Child Guidance Clinic Program – coordinates behavioral health, child development, and speech language pathology staff providing services in Oklahoma county health departments for families and children ages birth to 13 years
- Child Care Warmline – provides telephone consultation for Oklahoma child care providers with a nurse or child behavioral specialist regarding issues arising from children in their care

FSPS staff have a history of strong collaboration with other OSDH programs and other agencies at both the state and local levels. Staff have also taken steps to ensure that professionals

working with infants, young children and their families, and other caregivers are knowledgeable and skilled in promoting infant mental health and social-emotional development.

Purpose of the Needs Assessment

The 2020 Maternal, Infant and Early Childhood Home Visiting (MIECHV) Needs Assessment is being conducted to identify and describe the needs of families and the current communities that face greater risks for adverse outcomes within Oklahoma. Additionally, gaps and barriers to using home visiting services and to accessing substance use disorder services, if needed, for families that are pregnant, or have infants and/or young children will be identified. Efforts will be focused on these communities for home visiting services.

Identifying Communities with Concentrations of Risk

Data and information provided by the Health Resources and Services Administration (HRSA) determined the following domains, and the indicators that make up the domains, be utilized for determining at-risk communities.

- Socioeconomic Status
  - Poverty
  - Unemployment
  - High school dropout
  - Income inequality
- Adverse Perinatal Outcomes
  - Preterm Birth
  - Low Rate Birth
- Substance Use Disorder
  - Alcohol use
  - Marijuana use
  - Illicit drug use
  - Pain relievers nonmedical use
- Crime
  - Crime reports
  - Juvenile Arrests
- Child Maltreatment

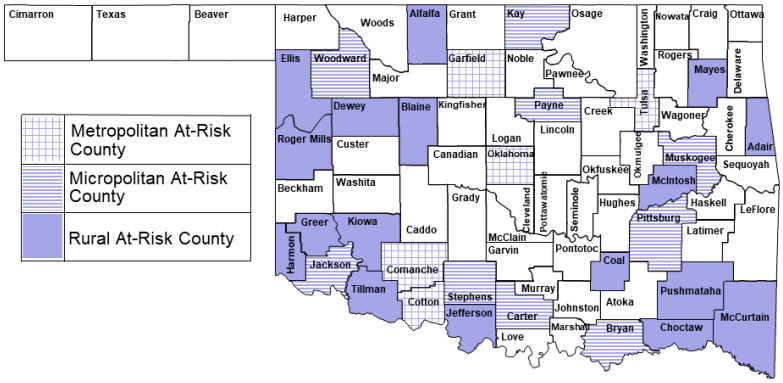
Rates and percentages of these indicators were used to assess Oklahoma's 77 counties, with 31 counties being identified as at-risk, which constitutes the Simplified Method. After reviewing this information, it was determined that using this simplified method with a few modifications would be best way to proceed. Modifications made include unintentional drug overdose death rates added as a risk factor domain and poverty rates for sub-county geographic data added for two Oklahoma counties. These modifications increased the number of counties with larger child populations that are considered at-risk.

By using the unintentional drug overdose death rate as an additional domain, it meets the statutory goals by accurately identifying the number of at-risk counties, thus the number of at-risk families, that may receive the much needed home-visiting services provided through MIECHV funding. Consideration was made to include this data into the Substance Use Disorder domain; however, adding a fifth indicator to the four currently within that domain would not have made an impact on the number of counties identified as at-risk. The four indicators did not completely reflect Oklahoma's substance abuse problem, especially for the counties with larger populations. The data underscore that many young children throughout Oklahoma are living in families that are characterized by poverty and involvement in multiple service systems including mental health, substance abuse and child welfare.

Because Oklahoma has experienced epidemic levels of unintentional drug overdose deaths, and in an attempt to accurately locate areas of risk due to these deaths, this rate was added as a risk factor domain. Oklahoma ranked number one in the abuse of painkiller drugs in the nation in 2014 and with 500 Neonatal Abstinence Syndrome infants being born to those on the state's Medicaid system it seemed apropos to ensure that an indicator examining the impact of opioid abuse be included. [5, 6,] Devastating losses have occurred to families with young children living in specific areas that are most in need of services.

Many of the counties that were included in the at-risk group due to the Simplified Method modifications are adjacent to counties with low child population that are identified as having the greatest risk. Plans are to encourage programs applying for MIECHV grant funds to serve more than one county, including residents of smaller population counties in receiving needed home visiting services. Figure 3 shows the at-risk counties and their designation as a metropolitan, micropolitan, or rural county.

Figure 3 ***Oklahoma At-Risk Counties***



Unintentional Drug Overdose

According to the 2018 National Survey on Drug Use and Health there are an estimated 2.1 million persons in the United States with opioid use disorder.[4] Common reasons for these high numbers include the perception, especially among youth and young adults, that prescription drugs are safer and less harmful to the body than street drugs, that Americans tend to not lock up nor dispose of their medications after use making them vulnerable to theft and misuse, and extensive advertising and marketing used by pharmaceutical companies[7, 8, 9].

In Oklahoma, among people aged 12 years and older, during 2015-2017, 7.3% (~233,000 persons) experienced a substance use disorder, and 4.4% (~140,000 persons) misused prescription pain relievers in the past year.[10] During 2014 to 2018, 3,307 Oklahomans died of unintentional drug overdose. Prescription painkillers were the most common class of drugs involved in overdose deaths, with four of the five most common medications being opioids. Unintentional poisoning is the leading cause of injury death in Oklahoma, surpassing motor vehicle crashes. [11, 12]

Concentrated Poverty

When looking at county level data, areas of concentrated poverty can be masked within metropolitan and micropolitan counties. Census data shows that over half of all poor children live in areas with poverty rates above 20%, and that Blacks and Hispanics account for larger shares of those living in poverty areas.[13] Poverty is not distributed evenly across counties, therefore, poverty data at the zip code level for Carter and Oklahoma counties were added to identify areas at risk.

Quality and Capacity of Existing Programs

In Oklahoma, there is a continuum of evidence based home visiting services with an extensive history. The three models primarily funded throughout the state are Nurse Family Partnership known as Children First in Oklahoma, Parents as Teachers, and SafeCare Augmented. Each of the respective models has its own training and competencies for home visitors and is complemented by additional trainings to bolster home visitors' professional development on topics such as motivational interviewing, mental health issues, safe sleep, child passenger safety, and grief. New trainings are added as new issues arise in the field and an example has been provided in Appendix B.

Additionally:

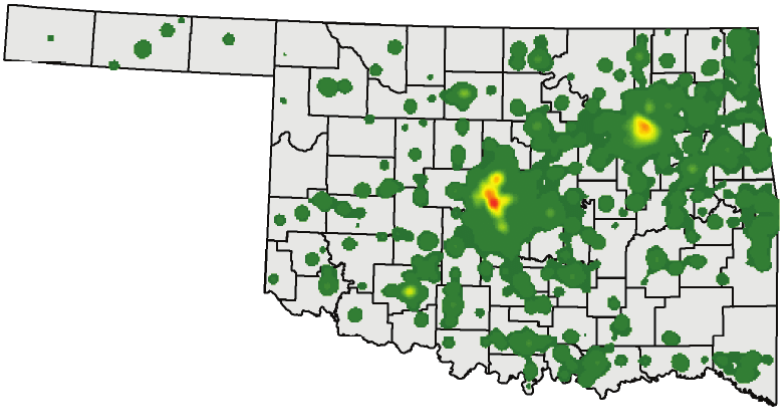
- Oklahoma home visiting programs have served over 6,566 families in 2019 according to the National Home Visiting Yearbook

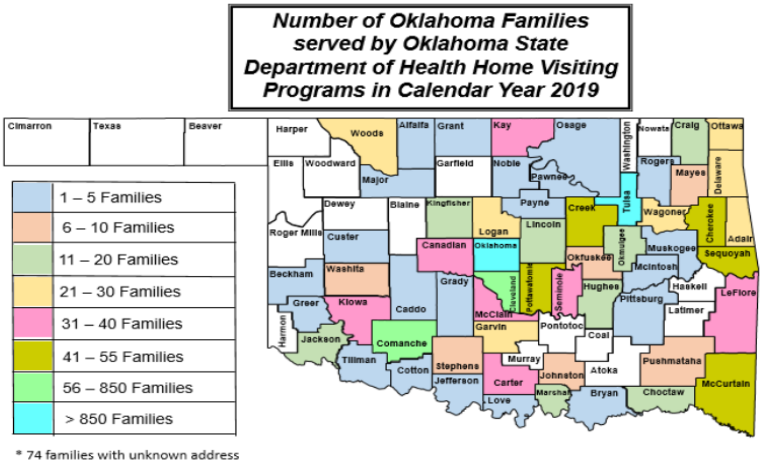
- Serving close to one third of participants were of Hispanic origin with the general population only being ten percent Hispanic
- Thirteen percent of primary caregivers were teen parents
- A report in 2016 showing that home visiting services are serving counties with the highest Oklahoma School Readiness Index, which determines the number of students who are highest risk of not entering kindergarten with the skills needed to succeed.[14]
- Four Oklahoma Parents as Teacher affiliates have reached blue ribbon status, which indicates that these programs are delivering high quality services to families.
- Oklahoma State Department of Health was designated state lead for the Parents as Teachers, which will increase support and resources for parent educators across the state.
- Buy in across the two major cities in Oklahoma has been seen as private funders have funded multiple home visiting programs within recent years and support has been shown throughout the state with coalitions such as Resilient Payne County which has championed for the need for prevention services in their county.[15]
- Four home visiting supervisors are part of a pilot introducing Facilitating Attuned Interactions training from the Erikson Institute to assist home visitors in their abilities to build relationships with their families

The gaps in services for early childhood home visiting services are those commonly seen across the country and include the following:

- 311,800 Oklahoma children could still benefit from home visiting based off the National Home Visiting Yearbook, with half of the families being identified as meeting one high-risk criteria. The population density of children below the age of 5 from 2012-2016, is seen in the figure below as well as the counties served by home visiting programs which highlights the need in the panhandle region where no families were served and other rural areas that are underserved.

Figure 4. Areas with Highest Concentration of Children under 5 years of age [16]





- Health Professional Shortage Areas in 72 of 77 counties in Oklahoma, which is significant factor since home visitors, need to have a place to refer families to ensure healthcare needs are met.
- Oklahoma has a ranking of 44th in internet access with the ever-evolving need for telehealth and also virtual home visits this will play significant factor in service delivery and access if not addressed.[17]
- Oklahoma has a high need for Burmese translators especially in Tulsa with over 5,000 Burmese refugees resettling primarily in that area.[18]
- Geographical disparities make it difficult for those in rural Oklahoma to access services due lack of transportation options.
- Interviews with parents, providers, and stakeholders confirm the extreme difficulty that past needs assessments have documented in families' ability to access mental

health and substance abuse screenings and services, particularly in rural areas, because of a lack of service providers, high costs, and judgment and stigma around using these types of services.[26]

- The struggle to pay the early childhood workforce fairly continues to makes it difficult to retain staff

Table 1. Oklahoma Home Visiting Services Provided, 2019

Program Name	Number of Families Served	Counties Served by Programs	Funders
C1-Adair CHD	22	Adair	STATE
C1-Caddo CHD	4	Caddo	STATE
C1-Canadian CHD	43	Canadian	STATE
C1-Carter CHD	30	Carter	STATE
C1-Cherokee CHD	37	Cherokee	STATE
C1-Choctaw CHD	19	Choctaw	STATE
C1-Cleveland CHD	141	Cleveland	STATE
C1-Comanche CHD	85	Comanche	STATE
C1-Cotton CHD	3	Cotton	STATE
C1-Craig CHD	5	Craig	STATE
C1-Creek CHD	30	Creek	STATE
C1-Custer CHD	5	Custer	STATE
C1-Delaware CHD	7	Delaware	STATE
C1-Grady CHD	5	Grady	STATE
C1-Hughes CHD	10	Hughes	STATE
C1-Jefferson CHD	3	Jefferson	STATE
C1-Johnston CHD	7	Johnston	STATE
C1-Kingfisher CHD	15	Kingfisher	STATE
C1-Leflore CHD	40	Le Flore	STATE
C1-Lincoln CHD	19	Lincoln	STATE
C1-Logan CHD	34	Logan	STATE
C1-Love CHD	2	Love	STATE
C1-Marshall CHD	23	Marshall	STATE
C1-Mayes CHD	2	Mayes	STATE
C1-Mcclain CHD	18	McClain	STATE
C1-McCurtain CHD	41	McCurtain	STATE
C1-McIntosh CHD	2	McIntosh	STATE
C1-Muskogee CHD	1	Muskogee	STATE
C1-Oklahoma CCHD	413	Oklahoma	STATE, MIECHV
C1-Ottawa CHD	23	Ottawa	STATE
C1-Payne CHD	1	Payne	STATE
C1-Pittsburg CHD	15	Pittsburg	STATE

C1-Pottawatomie CHD	41	Pottawatomie	STATE
C1-Pushmataha CHD	8	Pushmataha	STATE
C1-Rogers CHD	1	Rogers	STATE
C1-Seminole CHD	15	Seminole	STATE
C1-Sequoyah CHD	8	Sequoyah	STATE
C1-Stephens CHD	3	Stephens	STATE
C1-Tulsa CCHD	418	Tulsa	STATE, MIECHV
C1-Wagoner CHD	2	Wagoner	STATE
Family Connects-Parent Child Center of Tulsa	1704	Tulsa	Private
HFA- Parent Promise	25	Oklahoma	Private
PAT-Bethany Public Schools	41	Oklahoma	MIECHV
PAT-CAP Tulsa	158	Tulsa	MIECHV
PAT- Center for Children and Families	12	Cleveland	Private
PAT- Choctaw Nation	228	Atoka, Bryan, Coal, Haskell, Hughes, Pittsburgh	Tribal MIECHV
PAT-CREOKS	95	Adair, Cherokee, Creek, Okfuskee, Okmulgee, Muskogee, Pawnee, Sequoyah, Tulsa, Wagoner	STATE, MIECHV
PAT-Frontline	56	Comanche, Cleveland, Garvin, McClain, Oklahoma	STATE, MIECHV
PAT-Great Plains	64	Beckham, Greer, Jackson, Kiowa, Tillman, Washita	STATE
PAT-Hughes and Seminole	25	Cleveland, Hughes, Seminole	STATE
PAT-Latino Community Development Agency	203	Oklahoma	STATE, MIECHV
PAT- Norman Public Schools	47	Cleveland	STATE
PAT-Northwest Family Services	44	Alfalfa, Grant, Logan, Major, Oklahoma, Woods	STATE

PAT-Northern Oklahoma Youth Services	81	Kay, Noble, Osage	STATE
PAT-OKC Public Schools	157	Oklahoma	MIECHV
PAT-Parent Child Center of Tulsa	162	Tulsa	STATE, MIECHV
PAT-Parent Promise	177	Oklahoma	STATE, MIECHV
SC-Latino Community Development Agency	62	Oklahoma	MIECHV, Private
SC-NorthCare	47	Oklahoma, Canadian	MIECHV
SC-Parent Child Center of Tulsa	112	Tulsa, Wagoner	MIECHV, Private

Substance Use Disorder Treatment and Counseling Services

Description of Services in Oklahoma

The state agency responsible for oversight of substance use disorder treatment and counseling services in Oklahoma is the Department of Mental Health and Substance Abuse Services (ODMHSAS). Their core mission is to provide prevention and treatment services for Oklahomans experiencing medical issues associated with mental illness or addiction. Limited agency resources require services predominantly target the needs of the most seriously ill. ODMHSAS provides services to both adults and children. In a single-day count on March 31, 2017, 14,466 Oklahomans were enrolled in substance use disorder treatment.[19]

Oklahoma has 164 treatment facilities providing substance use disorder treatment services (Figure 5). Of these, 99 provide substance abuse services to women and/or pregnant women. Within these 99 facilities, additionally provided are detox services in 12 facilities, halfway house services in 8 facilities, and both detox and halfway house services in 1 facility. Also within these 99 facilities, 43 provide services to pregnant/postpartum women, and 2 facilities provide services only to pregnant/postpartum women.[20]

Currently, Oklahoma has five family-based residential treatment facilities located throughout the state (Figure 6) that provide residential substance use disorder services for parents with children. These facilities can provide services for more than 154 family units. While four facilities have a set number of rooms available for family units, one facility adjusts rooms according to family size, therefore, the number of families that can be served varies as families check in and out for services.[21]

Figure 5

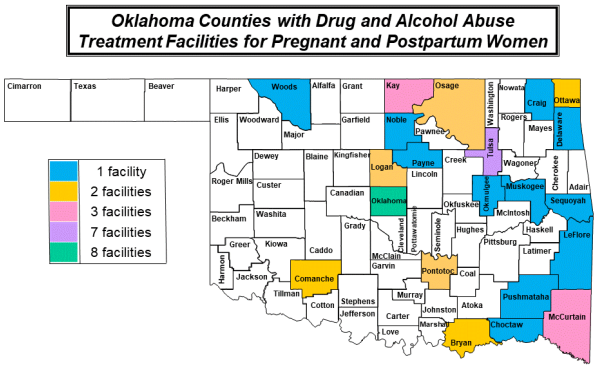
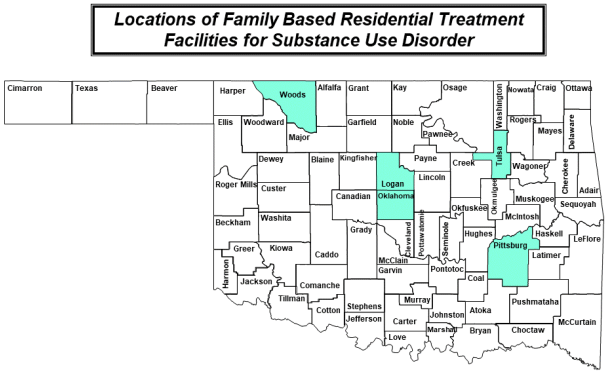


Figure 6



Substance use disorder service settings most commonly used within Oklahoma include inpatient rehabilitation facilities, both short and long term drug and alcohol rehabilitation programs, outpatient day treatment, as well as outpatient detox centers. Treatment modalities include trauma therapy and trauma related counseling, contingency management, motivational incentive, relapse prevention, behavior modification, and brief intervention approaches as well as family and play therapy and parenting skills.[22]

Gaps in Current Level of Services

Like most other states, Oklahoma is experiencing a dramatic increase in the misuse of prescription drugs. While opioid abuse has increased in all states, the largest increases in opioid mortality and injury occur in rural states.[23] Along with the increase in opioid abuse is the parallel increase of opioid exposed neonates.

For families with young children in Oklahoma, a gap exists in available residential family units for treatment of substance use disorder. The map in Figure 4 shows there are currently no facilities providing these services located in the southwest and far northeast portions of the state. Also, within Oklahoma's two major metropolitan areas, there is only a single facility with 80 family units located in Oklahoma City and a single facility with 30 family units located in Tulsa. Additional services of this type would benefit families within the home visiting services population.

States with large rural areas, such as Oklahoma, face unique challenges related to treatment of substance use disorder and mental health care in general. Wait times for patients needing services are prolonged due to lack of services. Concerning specifically opioid use disorder, SAMHSA has identified a shortage of and lack of support for rural physicians providing Medication Assisted Treatment (MAT), which is the preferred method for treating pregnant women addicted to opioids (see map in Attachment A).[6, 24]

Home visiting services provided through MIECHV programs provide an opportunity to support families dealing with substance abuse and with neonatal abstinence syndrome.

Barriers to Receipt of Services

There are many barriers to receiving treatment for persons experiencing substance use disorder. For Oklahomans, two of these barriers are the lack of insurance coverage and service wait times. Many people needing these services either have no health insurance or their insurance plan does not cover treatment or counseling services. If a person cannot pay out of pocket, they are entered onto a waiting list for treatment, which can contain between 600-800 names. Often by the time a spot is available, motivation for treatment has decreased or relapse has occurred. While pregnant women are exempt from having to wait for treatment, there still remains the inadequate availability of bed.[25]

Stigma related to addiction is a very common barrier to treatment. Symptoms of drug addiction, such as erratic behavior or impaired judgement may result in many negative consequences, including relationship impairment, job loss, or legal consequences. Brain changes in addiction are also influenced by factors outside an individual's control, such as genetics, or the home environment when one was raised. These behaviors can cause shame and embarrassment for the individual and stigmatized perceptions among the general public; consequently, many families try to keep these issues private.

Alleviating stigma is difficult. When comparing public attitudes toward stigma related to drug addiction with that of mental illness, respondents held significantly more negative views toward persons with drug addiction.[26] Home visiting providers receive training provided by professional staff from the National Alliance on Mental Illness (NAMI). Staff strive to build positive relationships with their clients, and acknowledge the feelings and emotions that clients experience surrounding the assistance they seek.

Collaboration Opportunities with State and Local Partners

The OSDH has the opportunity to collaborate with ODMHSAS on their Strategic Prevention Framework – State Incentive Grant project, which addresses the prevention of mental, emotional, and behavioral disorders. This opportunity will include collaboration with various partners at the local level. A strategic plan has been developed and will address; assessment of current issues, capacity building, planning, training, and evaluation. The following are the state goals of this project:

- Prevent the onset and prevent/reduce the problems associated with the use of alcohol, tobacco, and other drugs across the lifespan as identified and measured using epidemiological data

- Prevent the onset and prevent/reduce the problems associated with mental and emotional disorders as identified and measured using epidemiological data
- Use the Strategic Prevention Framework process to create prevention-capable communities where individuals, families, schools, workplaces, communities, and the state have the capacity and infrastructure to prevent substance abuse and mental illness
- Develop systematic processes to collect and analyze data regularly to accurately assess the causes and consequences of alcohol and other drug use
- Develop data-driven decision methods to use prevention resources effectively
- Increase the use of prevention services that are evidence-based, implemented with fidelity, and evaluated for effectiveness
- Increase the capacity of prevention providers to meet the behavioral health prevention needs of diverse individuals and communities in a timely, culturally competent manner
- Actively seek opportunities to collaborate and coordinate prevention efforts and resources across sectors to achieve significant, population-level behavioral health outcomes

Optional Considerations

Oklahoma's Pharmaceutical Company Lawsuit

On August 26, 2019, an Oklahoma judge ruled in the favor of the state in the case of Johnson & Johnson vs. Oklahoma. The pharmaceutical company has been ordered to pay a judgement to the state for helping to intensify the state's opioid crisis through false and misleading marketing of painkillers. This was the conclusion of the first state trial against a pharmaceutical company that holds them accountable for one of the worst drug epidemics. Judge Thad Balkman stated that "the defendants caused an opioid crisis that is evidenced by increased rates of addiction, overdose deaths, and neonatal abstinence syndrome in Oklahoma".[27] The judgement, originally set at $572 million but later reduced due to a calculation error, was set at $465 million, with funds set aside for programs treating neonatal abstinence syndrome.[28] Before this ruling, Oklahoma's Attorney General had reached a settlement with Teva Pharmaceuticals, and since this ruling, has reached a settlement with Endo Pharmaceuticals and has filed a lawsuit against three other opioid pain medication distributors.[29]

Oklahoma's Medicaid Expansion

On June 30, 2020, Oklahomans voted to approve a ballot measure to expand Medicaid to eligible adults under the Affordable Care Act, with coverage beginning on July 1, 2021. Medicaid plays a significant role in providing treatment for substance use disorders, and the expansion will help to fill some of the gaps in services that currently exist. For residents in rural areas of the state, where disparities are significant, Medicaid expansion will bring meaningful change.

Coordination with Others Conducting Needs Assessments

OKFutures Needs Assessment

The Oklahoma Partnership for School Readiness Foundation (OPSR) received a Preschool Development Grant Birth through Five Initiative (PDG B-5). FSPS staff were part of the OPSR steering committee, and contributed to the grant application. After securing grant funding, the first goal was to create a Needs Assessment, which was entitled OKFutures, related to Oklahoma's early childhood mixed delivery system. The vision of this needs assessment was to create the most effective early childhood mixed delivery system by building seamless connections between existing resources, using an understanding of current gaps and inefficiencies to ensure low-income and disadvantaged children have equitable access to early learning opportunities. Workgroups were created to address specific needs assessment sections, which were Family & Community Engagement, Quality Improvement, Professional Development, and Evaluation.

Key findings from the OKFutures Needs Assessment[30] include:

- Oklahoma is home to over 317,000 children that are birth through 5 years of age. These children and racially and ethnically diverse, roughly one-third live in rural areas, and many face substantial economic need.
- Approximately 140,000 Oklahoma children may be served by one of the state's three primary ECCE programs, which include Universal Pre-Kindergarten, Head Start/Early Head Start, and licensed child care.
- Roughly 124,000 Oklahoma children may not be served by one of the three primary ECCE programs. Some of these children may not need care, while others are on waiting lists or would make use of care if there were available openings.
- Unmet need varies between rural and urban communities, and is most pressing for infants and young children, families needing care during nontraditional hours, families of low and lower-middle income, and families with limited access to transportation.
- Select ECCE programs offer quality models that are affordable and collaborate with health and family support programs, and with transition supports.

These key findings show that home visiting services fill a need for Oklahoma's families that are pregnant or have infants and young children.

Title V MCH Block Grant Needs Assessment

Maternal and Child Health staff, who are completing the MCH Block Grant Needs Assessment, and MIECHV staff are both part of the Oklahoma State Department of Health. These groups are physically located within the same building, and are able to meet and discuss various issues on

a monthly basis, at a minimum. Sharing information on issues affecting both programs has been instrumental in completing both needs assessments. Topics of mutual concern for Needs Assessment inclusion include substance use disorder, tribal needs, and child abuse prevention.

MIECHV staff assisted MCH staff in collecting both quantitative and qualitative data to determine needs of Oklahoma women and children. The MCH Assessment Survey targeted two populations, parents with children under 18 years and professionals that provide services to families with children. Different surveys were conducted with each group, although the surveys were similar. MIECHV staff assisted with distribution and collection of these surveys. Tribal Listening sessions were conducted to capture more in-depth responses on topics affecting Oklahoma's American Indian families and children. MIECHV staff assisted with notes and coding during these sessions. Data collected was used to ensure that issues Oklahomans believed to be the most important were used to determine at-risk counties.

Table 2. Alignment of Home Visiting Intended Outcomes with MCH Goals

Home Visiting Intended Outcomes	Maternal Child Health Goals
Decrease child injuries, abuse, neglect, and maltreatment and emergency room visits.	Reduction incidence of deaths due to child maltreatment. Reduce incidence of nonfatal child maltreatment.
Improved maternal and newborn health. Decrease child injuries, abuse, neglect, and maltreatment and emergency room visits.	Reduce the rate of fetal deaths at 20 or more weeks of gestation. Reduce the rate of fetal and infant deaths during perinatal period (28 weeks of gestation to 7 days after birth). Reduce the rate of all infant deaths (within 1 year). Increase the proportion of infants who are put to sleep on their backs.
Improved maternal and newborn health.	Reduce the total preterm birth rate. Reduce the late preterm birth rate (34-36 weeks gestation). Reduce the percent of live births at 32 to 33 weeks gestation. Reduce the very preterm birth rate (less than 32 weeks gestation).
Improved maternal and newborn health.	Increase the proportion of children and youth aged 17 years and under who have a specific source of ongoing care.

	Improve the percentage of children who have at least one primary care provider visit for preventive medical care in the past year.
Improved maternal and newborn health	Increase the proportion of infants who are breastfed. Reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life.

Oklahoma Head Start Collaboration Office

Beginning in 1965, Head Start has followed federal standards to serve preschool children living below the federal poverty level with a comprehensive program which includes meeting their emotional, social, health, nutritional, and psychological needs. In 1995, Early Head Start extended these services to pregnant women and children under 3 years of age. Within Oklahoma, the Oklahoma Association of Community Action Agencies (OKACAA) houses the Oklahoma Head Start State Collaboration Office (OKHSSCO) which provides oversight for Head Start/Early Head Start. Additionally, 15 American Indian Tribal organizations in Oklahoma receive Head Start/Early Head Start federal funds. Currently, 5% of Oklahoma's child population (ages 0-5 years) are enrolled in Head Start/Early Head Start (see Table 3).

Community Action Agencies that receive Head Start grant funding must have board members who are parents of children enrolled in Head Start, or with expertise in finance, early childhood education, or the law. Additional board members are selected for expertise in education, business administration, or community affairs.[31]

Table 3. Enrollment in Head Start/Early Head Start, by Age and Type

	Estimated # of Children, Ages 0-5 Years	Total Number of families	% children receiving home based services	% children receiving homelessness services	% children in foster care	% children with IEP
Head Start	12,821	11,870	0.0%	5.9%	4.5%	13.7%
2 years	546					
3 years	7,404					
4 years	4,848					
5 years	23					
American Indian Alaska Native Head Start	2,578	2,405	0.4%	3.7%	4.2%	14.4%
2 years	72					
3 years	1,286					
4 years	1,217					
5 years	3					

Early Head Start	4,242	3,575	6.5%	7.1%	7.9%	13.4%
Pregnant Women	152					
Less than 1 year	1,152					
1 year	1,358					
2 years	1,478					
3 years	101					
American Indian Alaska Native Early Head Start	805	711	4.1%	12.4%	10.3%	3.2%
Pregnant Women	31					
Less than 1 year	255					
1 year	264					
2 years	236					
3 years	19					

Table 4. Alignment of Home Visiting Intended Outcomes with Head Start Goals

Home Visiting Intended Outcomes	Head Start Goals
Improvement in school readiness and achievement.	Promoting and facilitating inclusion of Head Start in the state's early childhood systems and transitions to schools.
Increased coordination and referrals for other community resources and supports. Improvement in school readiness and achievement.	Facilitation of building the best possible linkage, alignment, and inter-operability of common elements found in diverse early childhood programs.
Increased coordination and referrals for other community resources and supports. Increased family economic self-sufficiency.	Fostering and enhancing effective participation in state level coalitions and multi-agency public and private partnerships involved in supporting low-income family services.

Child Abuse and Prevention Treatment Act (CAPTA) Needs Assessment

Collaboration efforts with CAPTA included FSPS staff attending the State Team Planning Meeting in Washington DC during April 2019. This meeting was hosted by the Children's Bureau, with the purpose of providing support to states in jointly creating the next Child and Family Service Plan. Additionally, the meeting included the annual Court Improvement Program

Meeting, the Child Welfare Directors meeting, and a component of the Community-Based Child Abuse Prevention (CBCAP) grantee meeting. Focus included reshaping Child Welfare within the US and creating a shared vision across the broader child welfare system. Participation in the state team process has allowed for more collaboration at the state level. Representatives from CBCAP have participated in state level Child Family Service Plan development activities as well as the Family First Steering Committee. Oklahoma Department of Human Services (DHS) representatives continue to participate with the Child Abuse Prevention Action Committee and assist with planning the annual Child Abuse Prevention Day at the Capitol and Mini-Conference.

Collaboration between DHS and OSDH staff also include the ongoing efforts of the Oklahoma State Plan for the Prevention of Child Abuse and Neglect, providing feedback throughout the process, and participating in two biannual meetings per year. OSDH staff, including the FSPS Director and the MCH Director, are included in the Family First Steering Committee, and also participated in early planning for the Title IV-E Prevention and Family Services and Programs application.

Table 5. Alignment of Home Visiting Intended Outcomes with DHS Outcomes and CAPTA Goals.[30]

Home Visiting Intended Outcomes	DHS Outcomes	CAPTA Goals
Decrease child injuries, abuse, neglect, and maltreatment and emergency room visits. Reduction in crime or domestic violence	Children are first and foremost protected from abuse and neglect. Children are safely maintained in their homes whenever possible and appropriate.	Decrease the number of unnecessary family disruptions by increasing prevention efforts in order to strengthen families, prevent child maltreatment, and keep children safely in their own homes.
Decrease child injuries, abuse, neglect, and maltreatment and emergency room visits.	Children have permanency and stability in their living situations. The continuity of family relationships is preserved for children.	Decrease trauma experienced by a child who enters the child welfare system by ensuring stability of placement, enhancing family engagement and decision-making, decrease maltreatment in care, and enhancing efforts to achieve timely permanency.
Increase coordination and referrals for other community resources and supports.	Families have enhanced capacity to provide for their children's needs. Children receive appropriate services to	Enhance capacity for children, families, and resource parents to receive adequate and timely assessments to ensure access to appropriate and evidence-based and/or evidence-informed services to achieve case plan goals.

Improvement in school readiness and achievement Improved maternal and newborn health	meet their educational needs Children receive adequate services to meet their physical and mental health needs.	

Home visiting intended outcomes are in alignment with the goals and objectives of the Oklahoma agencies listed above, and have provided essential information for this needs assessment. This is critical for the long term sustainability of efforts to improve outcomes for the vulnerable populations (pregnant women, young children) being provided these services. Communication and collaboration across agencies and programs is vital to achieving desired outcomes.

Convene Stakeholders

Stakeholders from several state agencies, non-profit organizations, including Head Start, and private groups convened to participate in the creation of the OKFutures Needs Assessment. Due to these individuals being brought together, an opportunity was recognized that this group could share and obtain data and information for other needs assessments that were also being created/updated. This served as the workgroup for MIECHV's Needs Assessment. Groups not participating with OKFutures were able to participate through conference call or on an individual basis.

Dissemination plan

The MIECHV Needs Assessment will be posted on the FSPS web page of the OSDH website. It will also be announced on social media sites used by the OSDH. A notification regarding the updated needs assessment and a link to its website location will be emailed to all Oklahoma home visiting programs, to all Oklahoma County Health Departments, and to all organizations providing collaboration for this needs assessment. The updated needs assessment, along with the posted link, will be presented to the Home Visitation Leadership Advisory Coalition. The list of at-risk counties will be included in the Request for Proposal information provided to organizations planning to submit applications for home visiting services funding.

CONCLUSION

This needs assessment process and findings offer a strong foundation on which to build a more focused approach to providing appropriate support to pregnant women and parents with young children. The process confirmed and, in some instances, enhanced the recommendations and findings that have emerged in other statewide needs assessments, including those conducted as part of CAPTA, Head Start, and the Title V MCH Block Grant Program. Major findings include locating areas of concentrated poverty within cities, and the extent of Oklahoma's unintentional drug overdose problem. At-risk communities were identified that could receive the most benefit from MIECHV funding for their vulnerable populations. This needs assessment indicates 8 rural counties which currently have no evidence based home visiting programs as being at risk with a need for services. Additionally OSDH will need to continue to partner and collaborate with old and new partners especially those in the mental health arena to ensure children and families reach the akin goals outlined in the varying plans across the health and human services agencies in Oklahoma. Lastly, Oklahoma's home visiting programs will need to continue to adapt and be provided with evolving trainings as the needs and demographics of Oklahomans continue to change.

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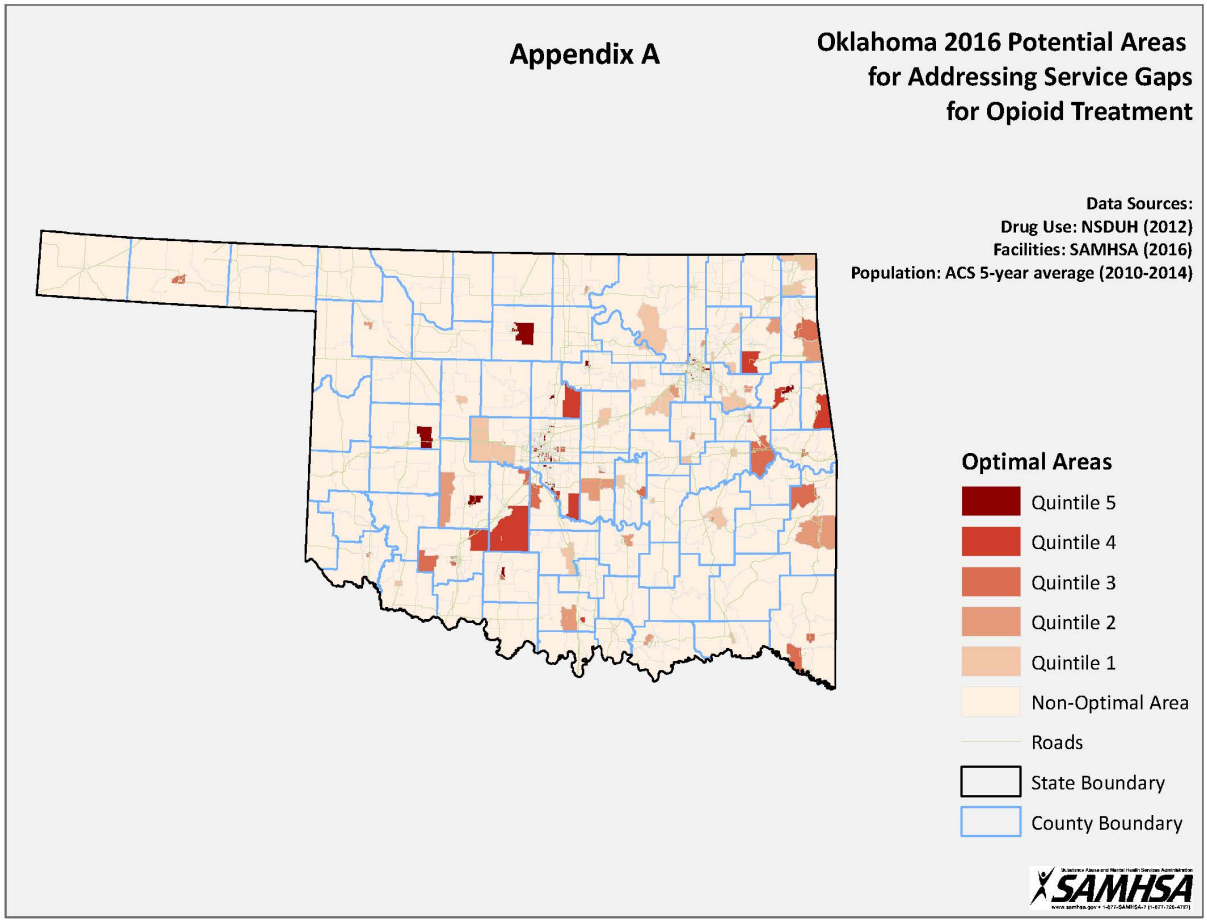
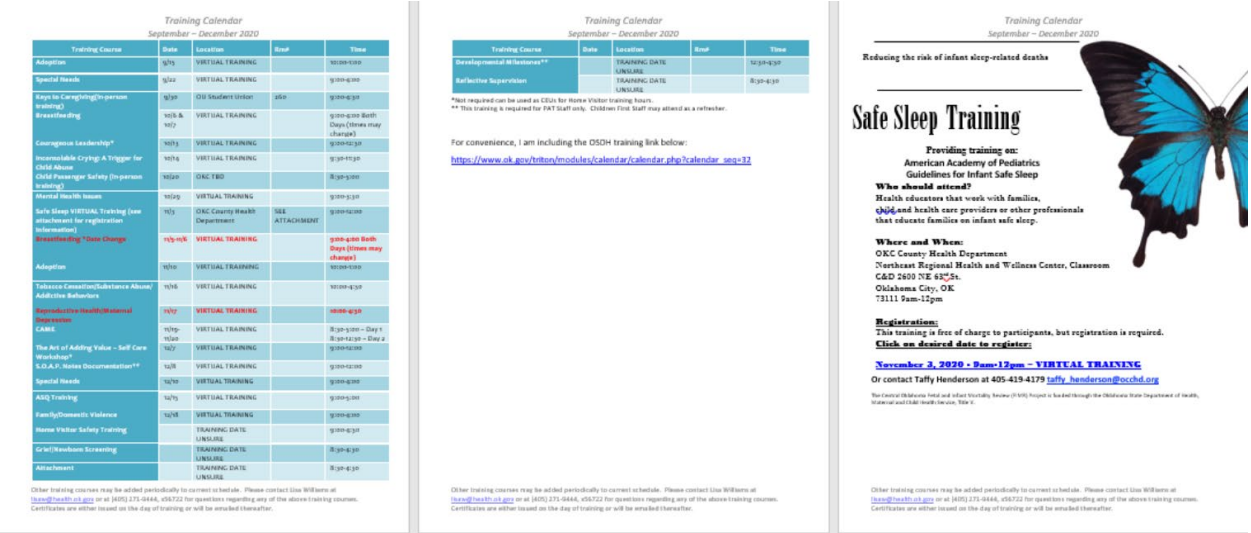


Appendix B:



Training Calendar
September – December 2020

Training Course	Date	Location	Rsvp	Time
Adoption	9/15	VIRTUAL TRAINING		10:00-1:00
Special Needs	9/22	VIRTUAL TRAINING		9:00-4:00
Keys to Caregiving(In-person training)	9/30	OU Student Union	260	9:00-4:30
Breastfeeding	10/6 & 10/7	VIRTUAL TRAINING		9:00-4:00 Both Days (times may change)
Courageous Leadership*	10/13	VIRTUAL TRAINING		9:00-12:30
Inconsolable Crying: A Trigger for Child Abuse	10/14	VIRTUAL TRAINING		9:30-11:30
Child Passenger Safety (In-person training)	10/20	OKC TBD		8:30-5:00
Mental Health Issues	10/29	VIRTUAL TRAINING		9:00-5:30
Safe Sleep VIRTUAL Training (see attachment for registration information)	11/3	OKC County Health Department	SEE ATTACHMENT	9:00-12:00
Breastfeeding *Date Change	11/5-11/6	VIRTUAL TRAINING		9:00-4:00 Both Days (times may change)
Adoption	11/10	VIRTUAL TRAINING		10:00-1:00
Tobacco Cessation/Substance Abuse/ Addictive Behaviors	11/16	VIRTUAL TRAINING		10:00-4:30
Reproductive Health/Maternal Depression	11/17	VIRTUAL TRAINING		10:00-4:30
CARE	11/19-11/20	VIRTUAL TRAINING		8:30-5:00 – Day 1 8:30-12:30 – Day 2
The Art of Adding Value – Self Care Workshop*	12/7	VIRTUAL TRAINING		9:00-12:00
S.O.A.P. Notes Documentation**	12/8	VIRTUAL TRAINING		9:00-12:00
Special Needs	12/10	VIRTUAL TRAINING		9:00-4:00
ASQ Training	12/15	VIRTUAL TRAINING		9:00-5:00
Family/Domestic Violence	12/18	VIRTUAL TRAINING		9:00-4:00
Home Visitor Safety Training		TRAINING DATE UNSURE		9:00-4:30
Grief/Newborn Screening		TRAINING DATE UNSURE		8:30-4:30
Attachment		TRAINING DATE UNSURE		8:30-4:30

Other training courses may be added periodically to current schedule. Please contact Lisa Williams at lhaw@health.ok.gov or at (405) 271-9444, x56722 for questions regarding any of the above training courses. Certificates are either issued on the day of training or will be emailed thereafter.

Training Calendar
September – December 2020

Training Course	Date	Location	Rsvp	Time
Developmental Milestones**		TRAINING DATE UNSURE		12:30-4:30
Reflective Supervision		TRAINING DATE UNSURE		8:30-4:30

*Not required can be used as CEUs for Home Visitor training hours.
** This training is required for PAT Staff only. Children First Staff may attend as a refresher.

For convenience, I am including the OSDH training link below:

https://www.ok.gov/triton/modules/calendar/calendar.php?calendar_seq=32

Other training courses may be added periodically to current schedule. Please contact Lisa Williams at lhaw@health.ok.gov or at (405) 271-9444, x56722 for questions regarding any of the above training courses. Certificates are either issued on the day of training or will be emailed thereafter.

Training Calendar
September – December 2020

Reducing the risk of infant sleep-related deaths

Safe Sleep Training

Providing training on:
American Academy of Pediatrics
Guidelines for Infant Safe Sleep

Who should attend?
Health educators that work with families, child and health care providers or other professionals that educate families on infant safe sleep.

Where and When:
OKC County Health Department
Northeast Regional Health and Wellness Center, Classroom
C&D 2600 NE 63rd St.
Oklahoma City, OK
73111 9am-12pm

Registration:
This training is free of charge to participants, but registration is required.
Click on desired date to register:

November 3, 2020 - 9am-12pm – VIRTUAL TRAINING

Or contact Taffy Henderson at 405-419-4179 taffy_henderson@occhd.org

Other training courses may be added periodically to current schedule. Please contact Lisa Williams at lhaw@health.ok.gov or at (405) 271-9444, x56722 for questions regarding any of the above training courses. Certificates are either issued on the day of training or will be emailed thereafter.