MATERNAL HEALTH TASK FORCE
OPQIC QUARTERLY MEETING

OCTOBER 19, 2021

OKLAHOMA
State Department
of Health

OPQIC

Agenda

- OSDH Updates
- OMHTF Work Groups
- OHCA Updates
- OPQIC Updates
- TeamBirth in Oklahoma – Cohort 1 Update
- OMNO/ OK SAFER IDTA
- Family Care Plans
- Other Business

UPDATES FROM THE OKLAHOMA STATE DEPARTMENT OF HEALTH

OKLAHOMA
State Department
of Health

Joyce Marshall, MPH
Director, Maternal Child Health Service

OPQIC

SPEAK UP E-Learning

Racial Disparity, Health Equity and Birth Equity Education

These 30-45 minute web-based programs, developed by the Institute for Perinatal Quality Improvement (PQI), provide interactive education designed for healthcare workers who care for people who are or may become pregnant.

THE SPEAK UP PROGRAM INCLUDES THREE MODULES

Module 1	Module 2	Module 3
Why Everyone Must SPEAK UP	Pledging to SPEAK UP	How to SPEAK UP
Trends and Racial Disparities in Maternal Mortality and Morbidity	Recognizing Bias, Inequities, and Racism in Perinatal Care	Against Racism in Perinatal Care

CNE/CME credit available. (.75 credit for each module)
All learners will receive a certificate of completion at the conclusion of the training.

This nursing continuing professional development activity was approved for 0.75 CNE credits each by Northeast Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. Released on May 1, 2020.

Boston University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Boston University School of Medicine designates this live activity for a maximum of 0.50 AMA PRA Category 1 Credit[s]™ each. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

To access the training, please register at
opqic.org/speakup/

PERINATAL QUALITY IMPROVEMENT

OPQIC

OKLAHOMA State Department of Health

For more information visit: www.perinatalqi.org

OMHTF Work Groups

John Stanley, MD
Maternal Fetal Medicine
The Perinatal Center

UPDATES FROM THE OKLAHOMA HEALTH CARE AUTHORITY

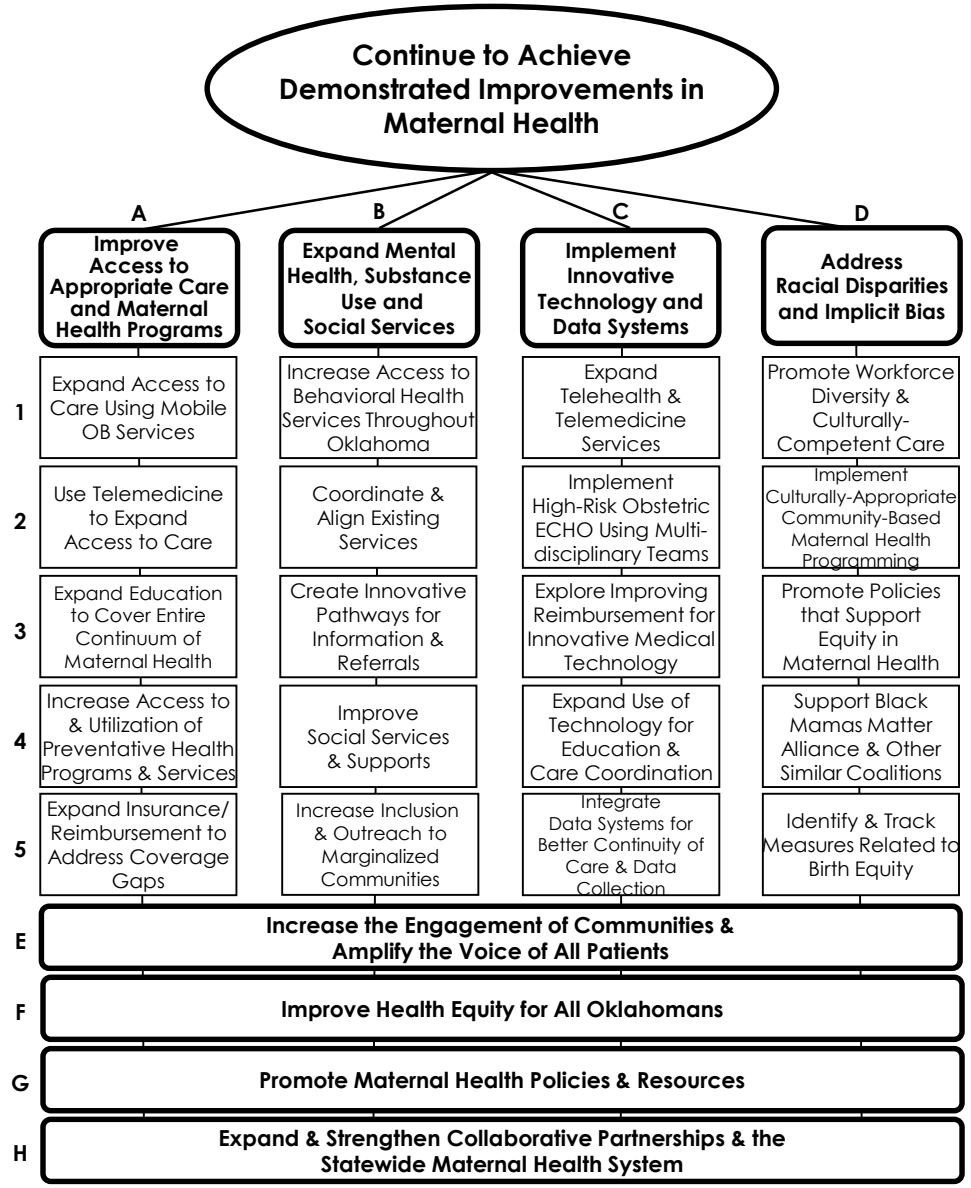
Traylor Rains,
Deputy State
Medicaid Director

Oklahoma HealthCare Authority

Oklahoma Maternal Health Task Force
Strategic Map: 2020-2024

09/09/20

Maternal health encompasses all aspects of a woman's physical, mental, emotional and spiritual health and well-being. It is optimized by comprehensive health care, both preventative and reactive, for women of childbearing age – including preconception, pregnancy, childbirth, postnatal and inter-conception care.



UPDATES FROM THE OKLAHOMA HEALTH CARE AUTHORITY

Traylor Rains
Deputy State Medicaid Director

Oklahoma HealthCare Authority

MEDICAID EXPANSION UPDATE

Traylor Rains

Deputy State Medicaid Director

Oklahoma Health Care Authority

TOTAL ENROLLMENT: 193,616

EXPANSION ENROLLMENT

- 185,449 - Total enrollment through expansion.
- 125,928 - New members through expansion.
- 67,688 - Members who were previously enrolled in other programs, now eligible for more benefits through expansion.

This data is accurate as of October 19, 2021.

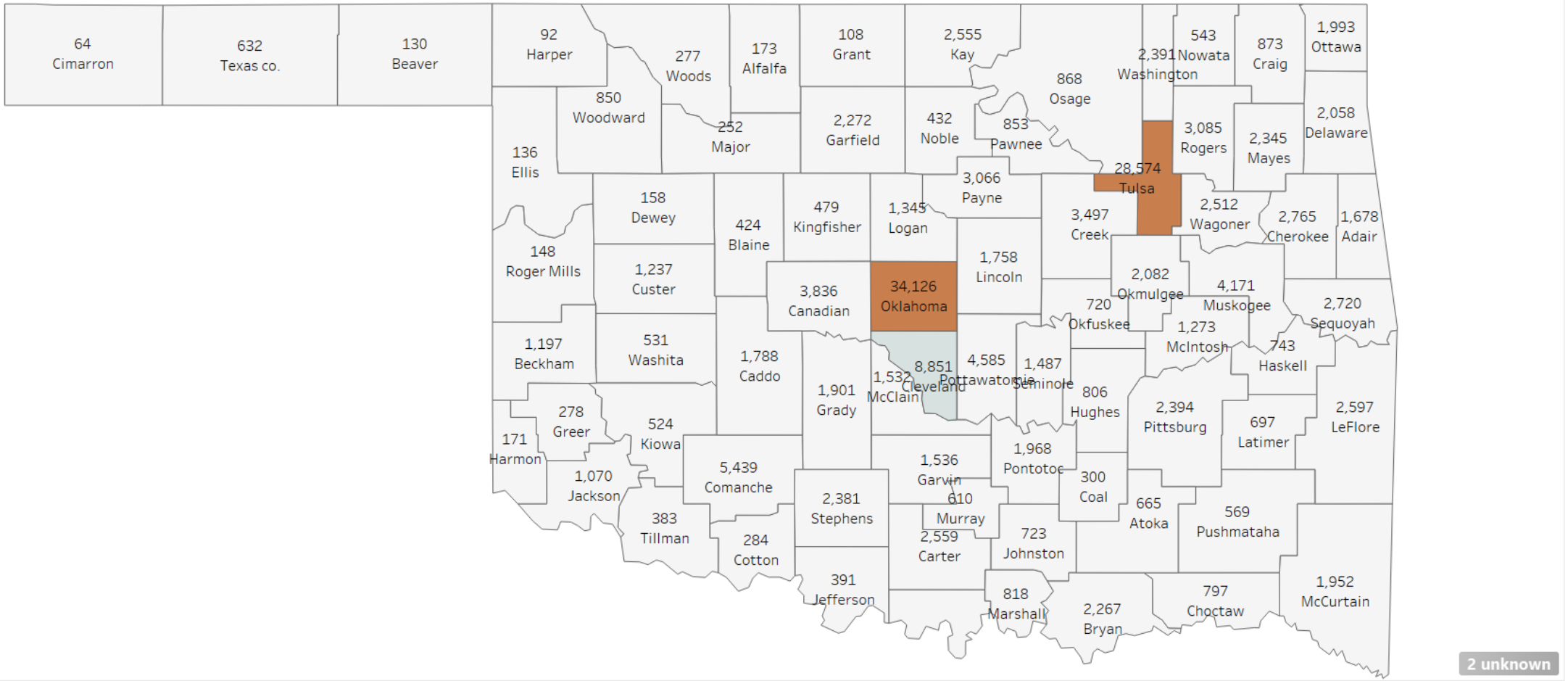
Member Type

Expansion Members

Members

1 34,126

SoonerCare and Expansion Enrollment - August 2021. Uninsured CY2019.



ENROLLMENT AND CLAIMS

Members Served	Total Expansion Served	Total Reimbursement Amount	Average Per Member	Percent of Total Enrolled Members Served
Total (Unduplicated):	**69,204**	**$47,582,856**	**$688**	37%

Sex Code	Total Expansion Served	Total Reimbursement Amount	Average Per Member	Percent of Total Enrolled Members Served by Gender
F	44,677	$26,765,619	$599	40%
M	24,527	$20,817,237	$849	33%
Total (Unduplicated):	**69,204**	**$47,582,856**	**$688**	

Client Age As Of Specified Date+	Total Expansion Served	Total Reimbursement Amount	Average Per Member	Percent of Total Enrolled Members Served by Age
24 & Under	12,189	$5,646,025	$463	28%
25 to 34	16,763	$9,867,518	$589	33%
35 to 44	16,063	$10,724,045	$668	37%
45 to 54	13,314	$11,860,878	$891	49%
55 and Older	10,875	$9,484,390	$872	53%
Total (Unduplicated):	**69,204**	**$47,582,856**	**$688**	

ENROLLMENT AND CLAIMS

Race Group	Total Expansion Served	Total Reimbursement Amount	Average Per Member	Percent of Total Enrolled Members Served by Race Group
American Indian	10,806	$11,218,951	$1,038	42%
Asian or Pacific Islander	1,151	$491,667	$427	26%
Black or African American	6,557	$3,933,828	$600	34%
White	42,429	$26,058,270	$614	38%
Two or More Races	3,786	$2,673,810	$706	35%
Declined to Answer	4,475	$3,206,331	$716	36%
Total (Unduplicated):	**69,204**	**$47,582,856**	**$688**	

Urban/Rural	Total Expansion Served	Total Reimbursement Amount	Average Per Member	Percent of Total Enrolled Members Served by Urban/Rural
URBAN	41,302	$27,962,977	$677	37%
RURAL	27,902	$19,619,880	$703	38%
Total (Unduplicated):	**69,204**	**$47,582,856**	**$688**	

Top 10 Categories of Service by Spend
Prescribed Drug Services
Inpatient Services
Outpatient Services
Physician Services
Behavioral Health Services
Clinic Services
Dental Services
Laboratory Services
Behavioral Health Services
Psychiatric Services

OKLAHOMA
Health Care Authority

GET IN TOUCH

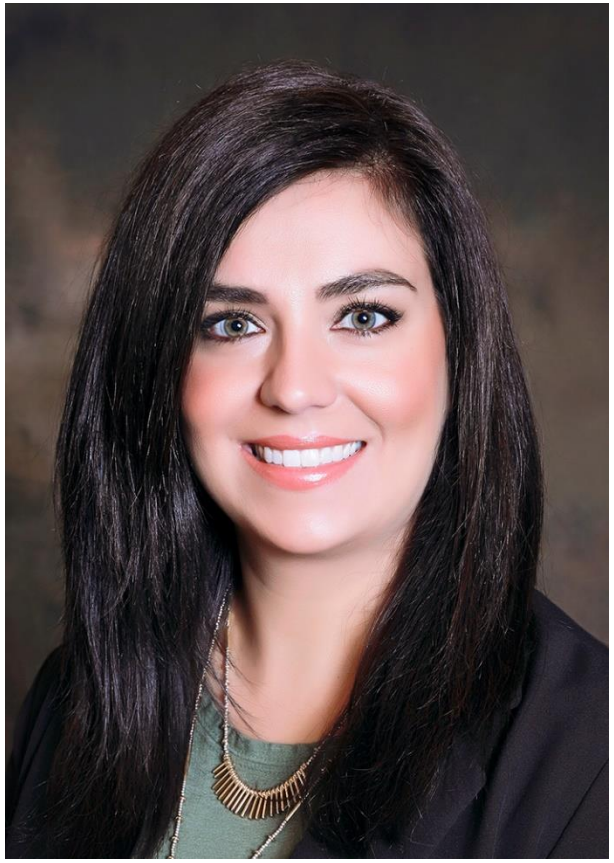
4345 N. Lincoln Blvd.
Oklahoma City, OK
73105

oklahoma.gov/ohca
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767

OPQIC Updates

CMS Maternal Morbidity Structural Measure
in the
Hospital Inpatient Quality Reporting (IQR) Program



Sarah Johnson
OPQIC Maternal Peer Navigator

OPQIC UPDATE: EMPOWERING PREGNANT AND POSTPARTUM PATIENTS

OPQIC

TOOLKIT OVERVIEW

Empowering Pregnant and Postpartum Patients

For use with Empowering Pregnant and Postpartum Patients Implementation Guide.

1 Urgent Maternal Warning Signs

Prenatal Care Visit

- Engage patients and support persons by educating on **Urgent Maternal Warning Signs** and how to seek care.
- Place Urgent Maternal Warning Signs posters in clinic exam rooms and waiting areas. Give patients and support persons written materials to keep as a reference. Provide explanations and review with patient and support persons.
- Urge patients to ask questions and seek help when they have concerns. Offer real-time provider and after hours contact information. Document these conversations.

2 AWHONN POST-BIRTH Warning Signs

Postpartum Hospitalization

- Educate patients and support persons on the **AWHONN POST-BIRTH Warning Signs** and how to seek care.
- Use the AWHONN POST-BIRTH Warning Signs handout as tool. Provide a hard copy to patients and support persons.
- Urge patients to ask questions and seek help when they have concerns. Offer real-time provider and after hours contact information. Document this conversation.

3 Helpful Post-Birth Resources

Postpartum Hospitalization

- Review **OPQIC Helpful Post-Birth Resources** with all patients and support persons. Encourage to use for non-emergent needs.
- Urge patients to send questions to **patientsupport@opqic.org**. Document this conversation.

4 Post-Birth Clinical Summary

Postpartum Hospitalization

- Educate all patient and support persons on the clinical circumstances of their birth using the **Clinical Summary** as a tool, particularly those with complications. Provide written summary to patient.
- Urge patient to ask questions and seek help when they have concerns. Offer real-time provider and after hours contact information. Document this conversation.

All handouts can be found by visiting https://opqic.org/patienthandouts/

https://opqic.org/wp-content/uploads/2021/04/Post-Birth-Support-Resources-OPQIC-V2-FINAL.pdf

OPQIC

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WHAT'S THE LATEST? INITIATIVES COURSES CALENDAR FOR PROFESSIONALS FOR PATIENTS ABOUT US

PATIENT RESOURCES

Please select from the topics below to view the resources.

Oklahoma Patient Resources | Advocacy/ Awareness Campaigns | Birth Trauma Support

Grief & Loss Support | Medical Condition Specific Support | Postpartum Mental Health Support

Social Media Support Groups | Reading Suggestions

OPQIC Patient Handout

- Post-Birth Support Resources - English
- Post Birth Support Resources - Spanish
- Post-Birth Clinical Summary (for provider use)

Oklahoma Based Support Resources

- Oklahoma Breast Feeding Hotline
- Oklahoma Family Network
  - NEST
- OSDH Resource Directory
- Oklahoma Mother's Milk Bank
- Postpartum Support International (PSI) trained mental health providers

https://opqic.org/forpatients/patient-resources/

SEARCH THIS WEBSITE

RECENT POSTS

Pediatrics: Beyond Statistics: Uncovering the Roots of Racial Disparities in Breastfeeding

Pediatrics: Intrapartum Group B Streptococcal Prophylaxis and Childhood Allergic Disorders

Newborn Screening Tip of the Month April: New Disorders

Save the Date for OPQIC's 8th Annual Summit, September 24, 2021

OPQIC 2021 Recognition of Areas of Perinatal Excellence Released

ARCHIVES

Archives

Select Month

CATEGORIES

AAFP (1)

AAP (50)

ACNM (7)

ACOG (205)

AIM (9)

AJOG (36)

TEAMBIRTH IN OKLAHOMA

Amber Weiseth, DNP, RNC-OB
Director, Delivery Decisions Initiative
at Ariadne Labs

OMNO

Oklahoma Mothers and Newborns
Affected by Opioids

OMNO Update

Denise Cole, MS, RNC-NIC

Program Manager, OPQIC

OMNO Data – Q2 2021

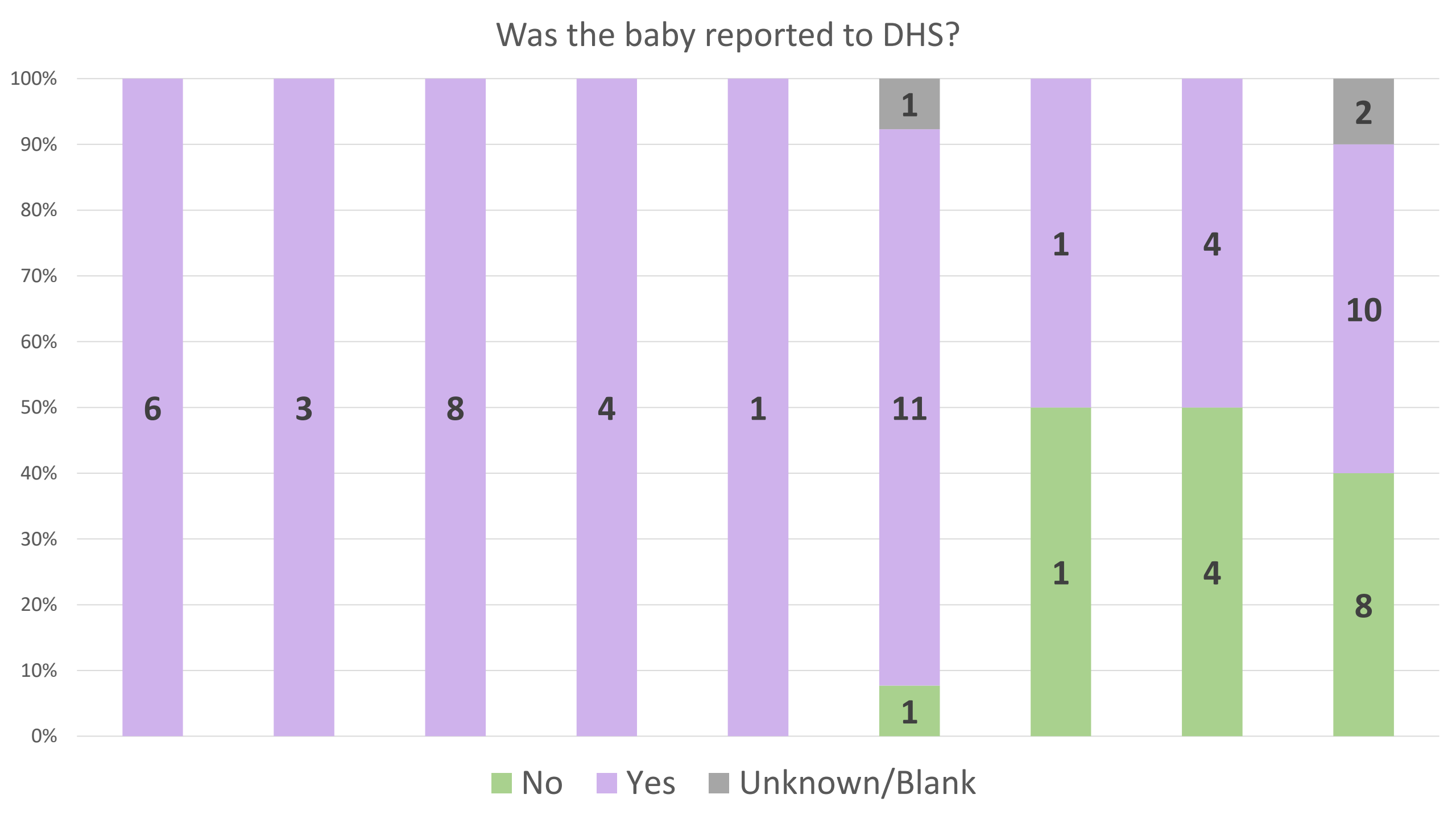
- Total Records: 81
- Women with OUD: 78
- Total Newborns: 80
- Opioid-exposed newborns **≥ 35 weeks** (OEN): 69
  - 11 < 35 weeks
- Hospitals reporting cases: 9
- Hospital reporting no cases: 2

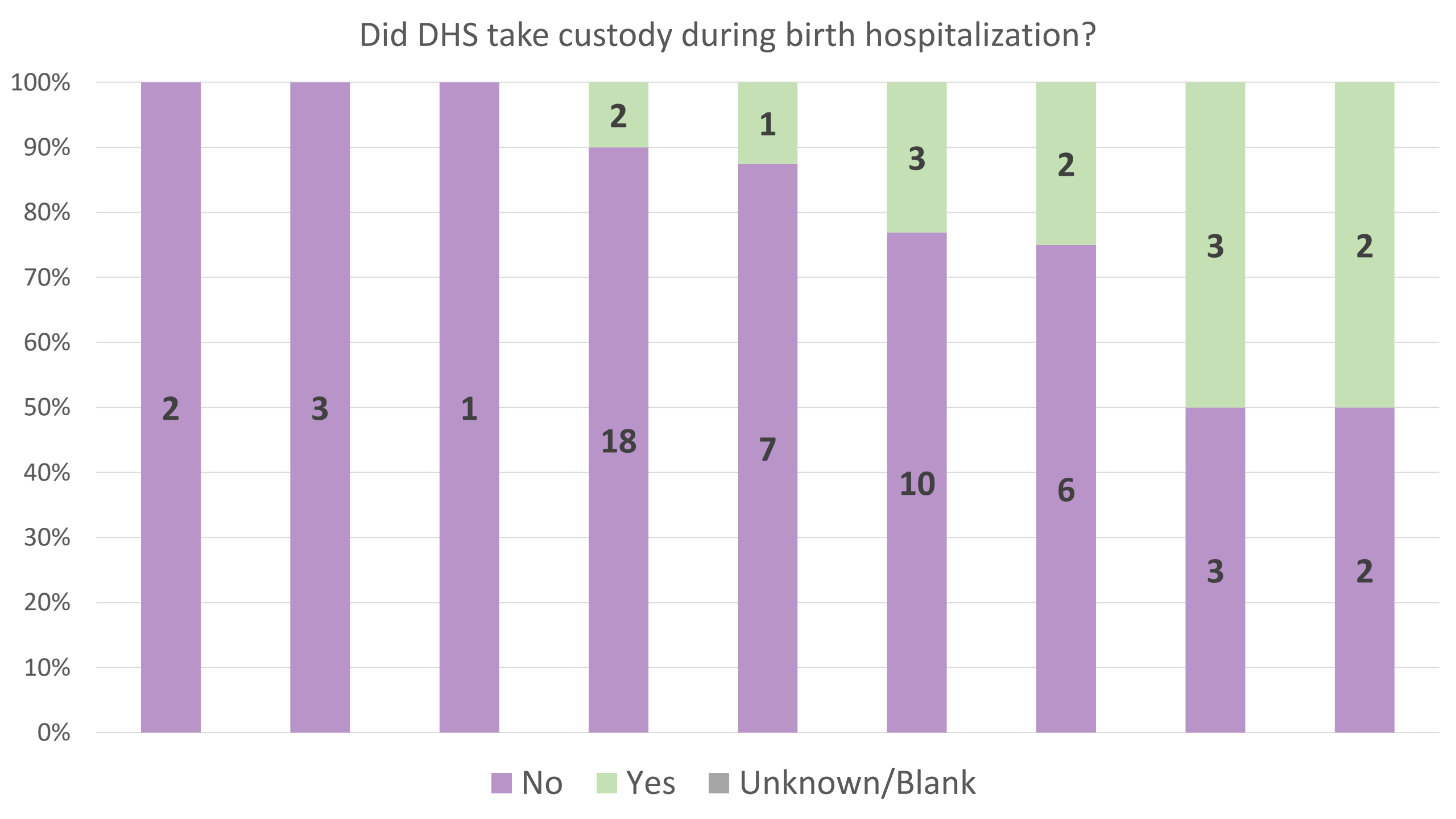
Insurance Status

Insurance	Moms		Baby	
SoonerCare (Medicaid)	54	69.2%	64	80.0%
Private insurer	14	17.9%	5	6.3%
Unknown	1	1.3%	0	0.0%
Other	2	2.6%	2	2.5%
Tricare or military	3	3.8%	1	1.3%
Uninsured / self-pay	1	1.3%	6	7.5%
Indian Health Service (IHS)	3	3.8%	2	2.5%
Total	**78**		**80**	

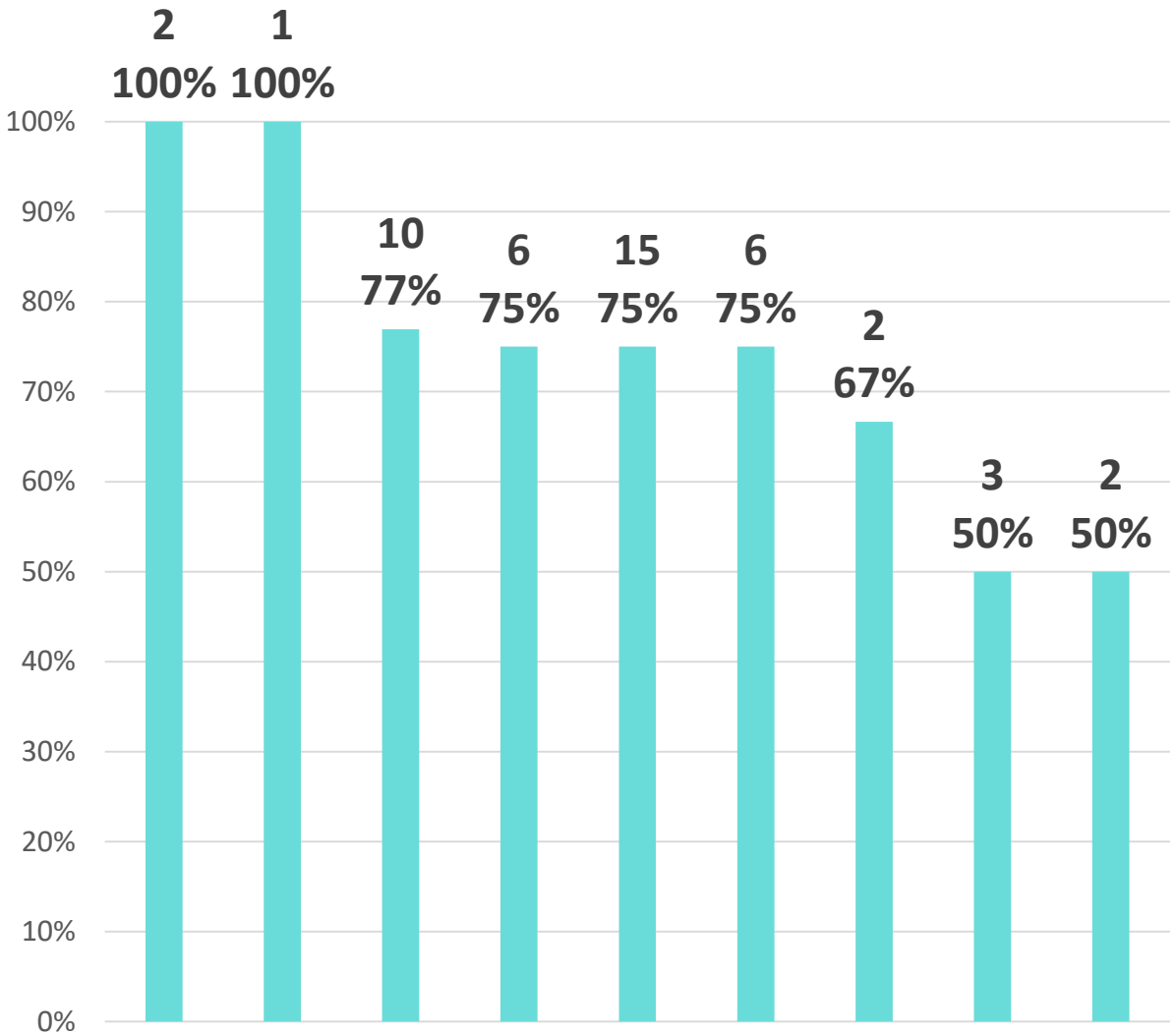
Race/Ethnicity

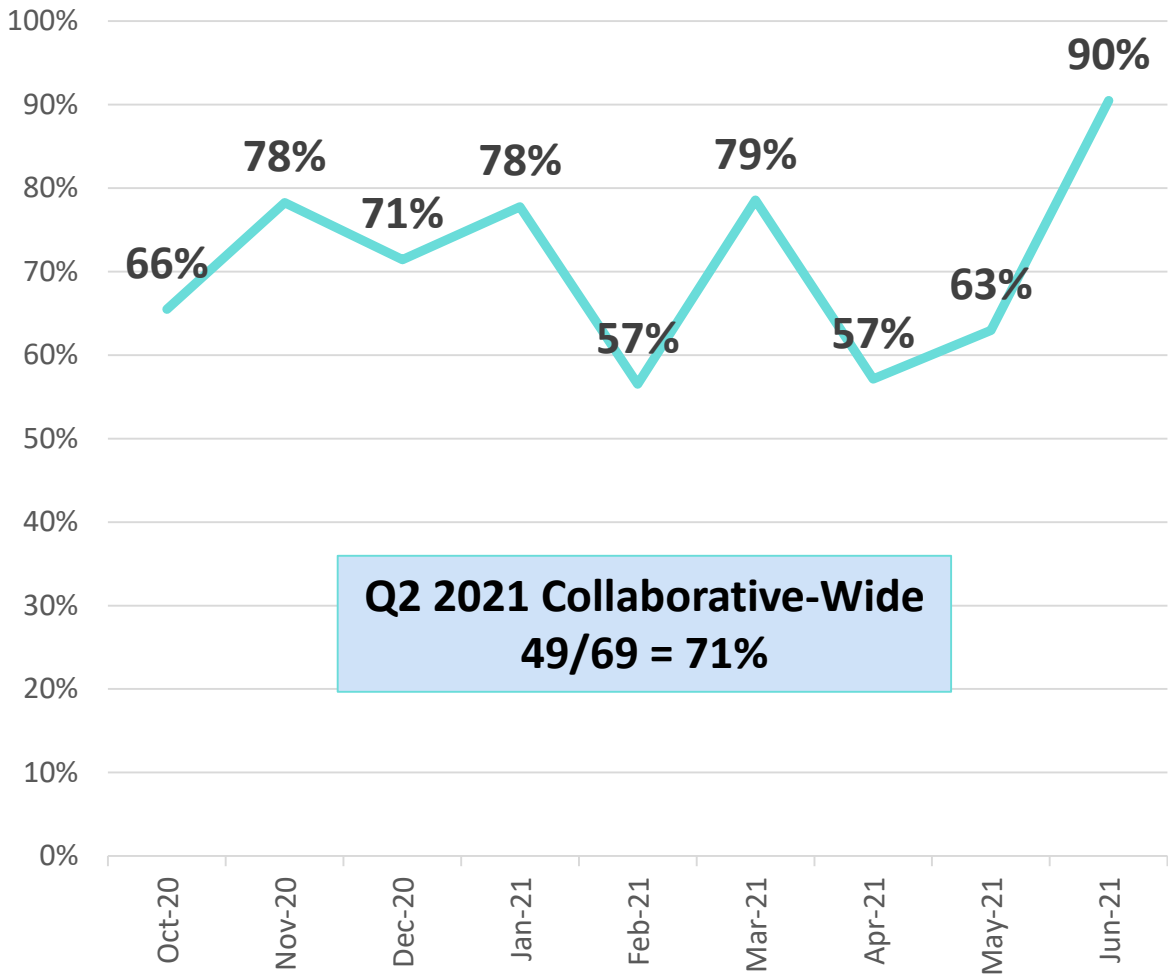
Race/Ethnicity	Moms (78)		Baby (80)	
White or European descent	56	71.8%	59	73.8%
Native American or Alaskan Native	13	16.7%	17	21.3%
Black or African descent	7	9.0%	8	10.0%
Hispanic/Latino	3	3.8%	3	3.8%
Unknown	2	2.6%	3	3.8%
Other	1	1.3%	1	1.3%
Asian	1	1.3%	0	0.0%
Hawaiian or other Pacific Islander	0	0.0%	0	0.0%


Was the baby reported to DHS?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
6
3
8
4
1
1
11
1
1
4
4
2
10
8
No
Yes
Unknown/Blank

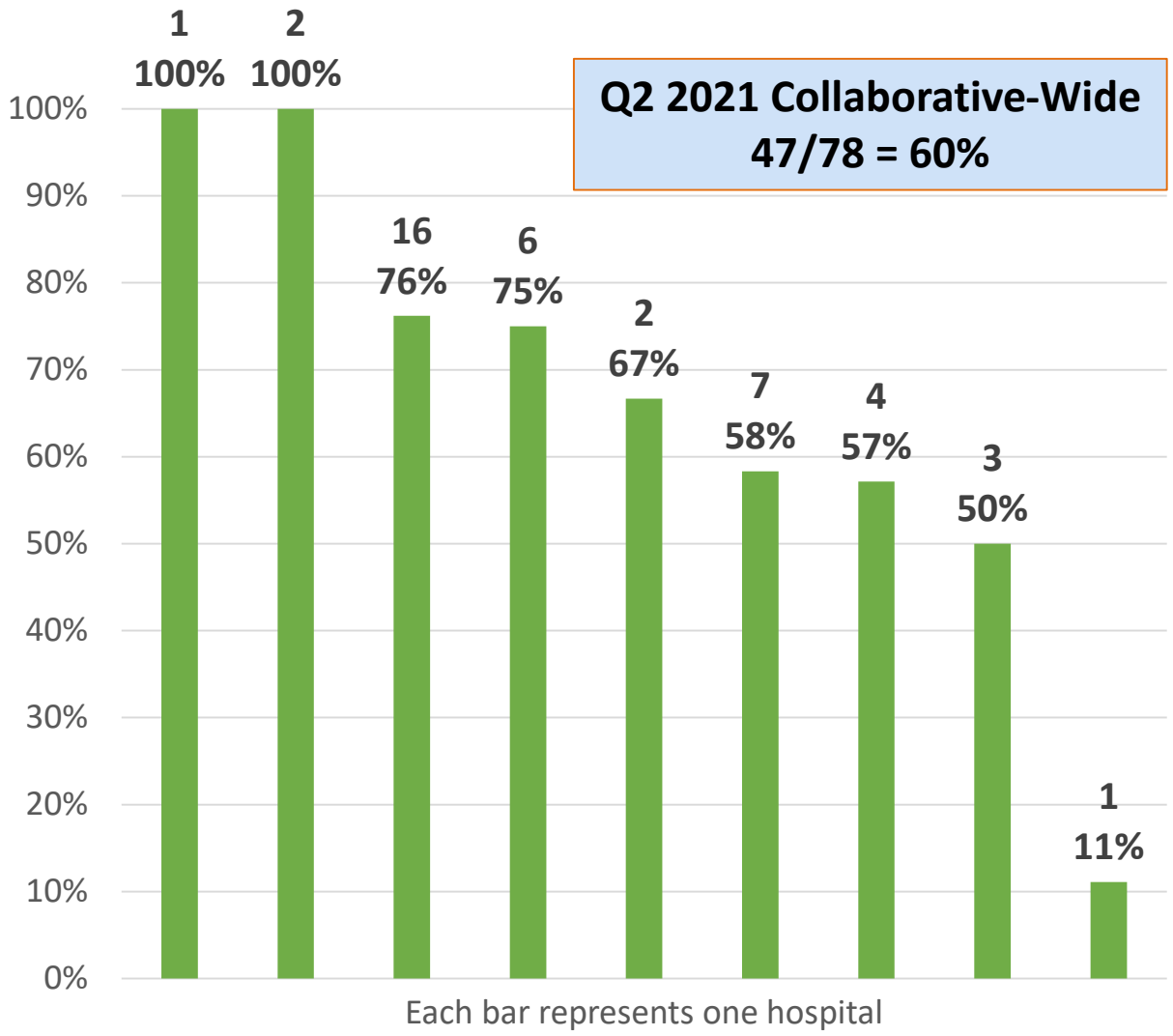

Did DHS take custody during birth hospitalization?
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2
3
1
18
2
7
1
10
3
6
2
3
3
2
2
No
Yes
Unknown/Blank

Percent of OEN who go home to biological mother

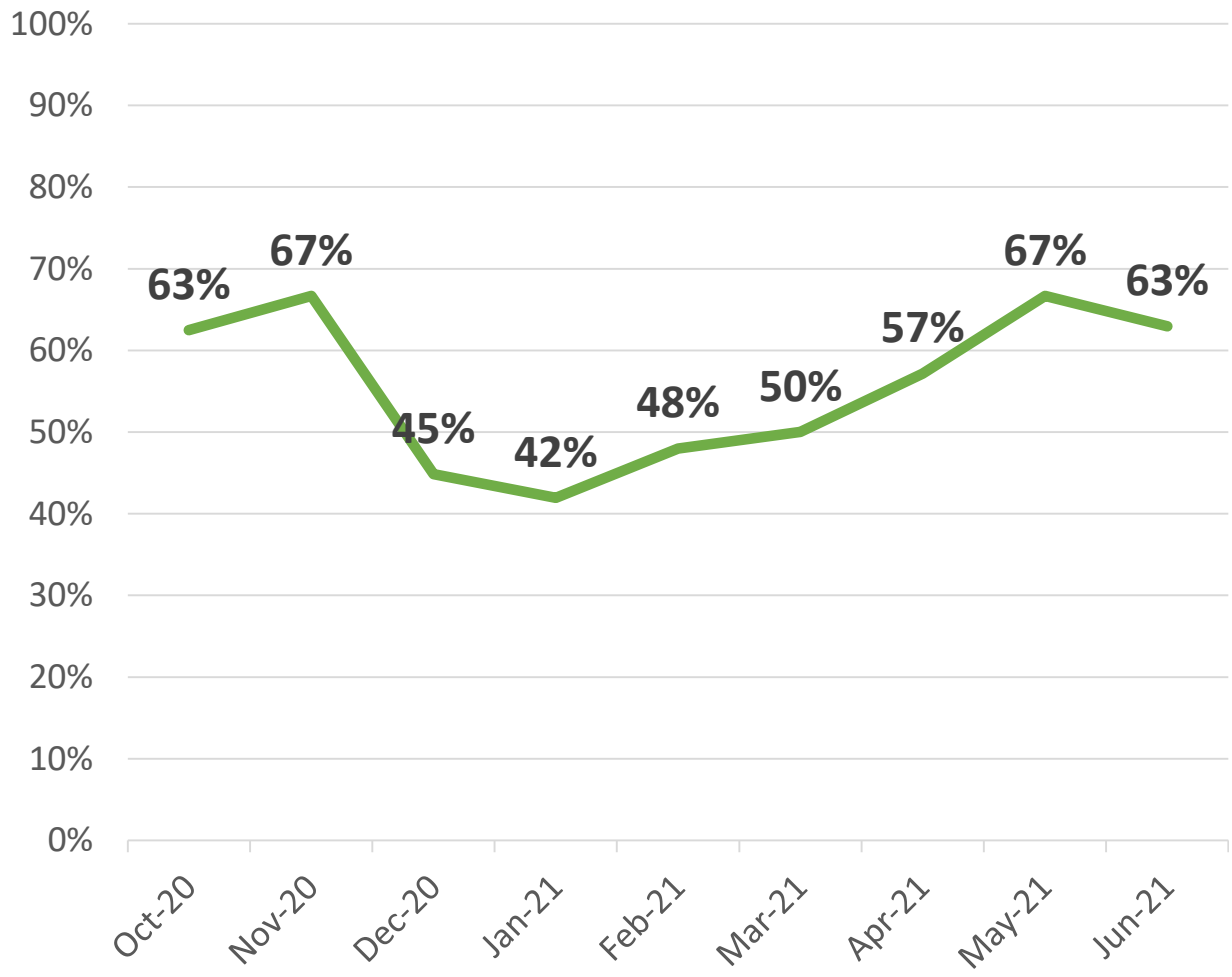




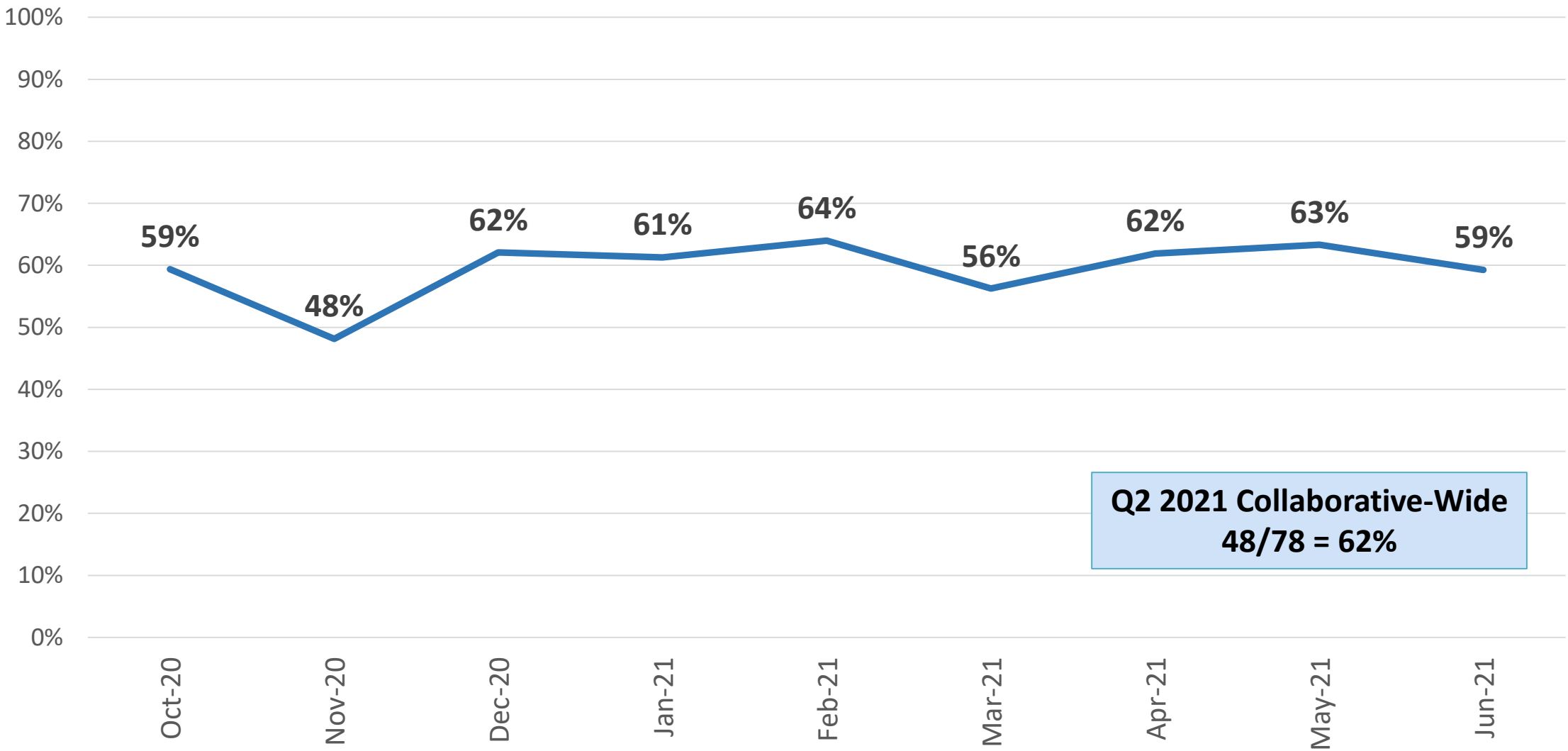
Percent of Women with OUD During Pregnancy who receive medication-assisted treatment OR behavioral health treatment



Q2 2021 Collaborative-Wide
47/78 = 60%



Percent of pregnant women with OUD tested for HCV during pregnancy



OK SAFER/In Depth Technical Assistance (IDTA)

OPQIC Quarterly Meeting

Teri Kook, MSW
Senior Program Associate
Children and Family Futures, Inc.

October 19, 2021

Agenda

REVIEW IDTA RECOMMENDATIONS TO DATE

DISCUSS IMPLICATIONS

NEXT STEPS

Recommendations to date & implications

What needs to change in order to create flexible options for families with SUD in Oklahoma?

Lack of upstream options to increase recovery during pregnancy and reduce prenatal substance exposure

The definition of an “infant affected by substance abuse”

A different option than a child abuse and neglect report for every infant with prenatal substance exposure

Why does the definition of “infant affected by substance abuse” need to change?

- The current “substance affected infant” definition limits who receives a Family Care Plan to infants with NAS and FASD
- Many infants that have experienced prenatal substance exposure and their families are not receiving ongoing care coordination and supports

The current definition of an “infant affected by substance abuse” in Oklahoma

Every physician, surgeon or other health care professional including doctors of medicine, licensed osteopathic physicians, residents and interns or any other health care or midwife involved in the prenatal care of expectant mothers or the delivery of care of infants shall promptly report the Department instances in which an infant tested positive for alcohol or a controlled dangerous substance. This shall include infants who are diagnosed with Neonatal Abstinence Syndrome or Fetal Alcohol Spectrum Disorder.

DHS Policy: Plan of Safe Care

When an Infant alleged to be born substance-exposed or affected, Child welfare staff will:

(1) When an infant is alleged to be born substance-exposed or affected, the CW specialist obtains the infant's test results. Cord blood is the preferred testing method. When cord blood is not available, meconium is the preferred testing method.

(2) An infant who tests positive is referred to services to alleviate the effects of the substance on the child's development. Whenever the infant is diagnosed with Neonatal Abstinence Syndrome (NAS), commonly referred to as withdrawal, or Fetal Alcohol Spectrum Disorder (FASD), the CW specialist develops a plan of safe care for the infant and mother or caregiver.

DHS PLAN OF SAFE CARE DATA: SFY 2020

Accepted Children	2740
# of Assessments & Investigations	2645
# of Infants with Withdrawal Symptoms	151
# of Infants with Fetal Alcohol Syndrome (FAS)	2
# of Infants with Fetal Drug Addiction (FDA)	9
Of the Accepted Children, # with Plan of Safe Care (1b)	73
# with Plan of Safe Care with Service Referral (1c)	68
# with Service Referral and No Plan of Safe Care	1602
# of Accepted Referrals with Infant Removal (3b)	540

KEY DATA

- Infants with prenatal substance exposure: 2645
- In prior year, 57% of cases were marijuana +
- Infants w withdrawal, NAS or FASD: 162
- Plans of safe care: 73
- Infants with prenatal substance exposure and NO POSC: 1602

Implications

2645 children with prenatal substance exposure accepted for assessment and investigation

POSC/ Family Care Plans are only required for withdrawal, NAS/FASD, N=162

Of those 162 infants, 73 received a POSC from DHS

1602 received a referral for services but no POSC/Family Care Plan

What if?

Instead of, for most infants, closing the CPS case at intake or closing with a referral for services…

In alignment with FFPSA: Instead, partner agencies step forward to provide a Family Care Plan and care coordination during pregnancy and postpartum for infants with prenatal substance exposure and their families

Guiding Principles for OK Family Care Plans

Early

Family Care Plans created as early as possible in the prenatal period

Empower

Empower pregnant individuals to lead their own plan

Encourage

Holistically encourage pregnant people seeking services and support

Include

Include dads

Share

Share the plan with providers, to support care coordination

Start Strong

Get infants and their families off to a strong start

Reduce

Reduce stigma

Instill Hope:

Create viable pathways to a successful family future

Eliminate Disparity

Identify and eliminate health disparities

How?

Step 1	Initiate prenatal Family Care Plans for pregnant individuals
Step 2	Change definition of infant affected by substance abuse to include all substance exposed newborns
Step 3	For lower-risk cases create a CAPTA notification pathway and Family Care Plan that is initiated and overseen by a partner agency

How do we prevent infants with prenatal substance exposure overwhelming the child welfare system?

Step One:

Initiate prenatal Family Care Plans for pregnant individuals

Partners have already stepped forward and piloted prenatal Family Care Plans

- OKDMHSAS
- STARS Clinic

Family Care Plan: ODMHSAS Contract Changes

In an effort to better serve pregnant individuals with a substance use disorder (SUD), Contractor shall provide the services, supports, and resources needed to develop a foundation and assist the rollout of the prenatal Plan of Safe Care (Family Care Plan) as a part of the statewide Safely Advocating for Families Engaged in Recovery (SAFER) In Depth Technical Assistance (IDTA) Initiative. To accomplish this Contractor agrees to:

Family Care Plan: ODMHSAS Contract Changes 7/1/21

Develop a plan to begin implementing the Family Care Plan (FCP) within 6 months of contract initiation in order to help support the treatment and recovery of the family unit experiencing SUD. This could include:

- Sending staff to infant and early childhood mental health (IECMH) foundational training approved by ODMHSAS in order to establish basic knowledge in the rapidly growing area of infant mental health.
- Receiving training to ensure there is an awareness and beginning understanding of the core concepts of IECMH and the effects substance exposure has on newborns and the services that will be needed in developing the Family Care Plan (FCP) when working with families experiencing substance use disorders (SUD).
- When available, attend the ODMHSAS SAFER FCP online training to prepare for implementation of the FCP.
- Offer a FCP to individuals wanting to become pregnant within the year, are pregnant, or who are in the 4th trimester (post-natal period).

This has been included in: CW Contracts, TANF Contracts, PPW Grant Women and Women with Children Residential Contracts, OFFP Grant PPW Outpatient Women's Treatment Grant, all FTC contracts

Lack of upstream options to increase recovery during pregnancy and reduce prenatal substance exposure

Proposed Solution: Family Care Plans

SBIRT at prenatal visits and other points of contact with pregnant individuals

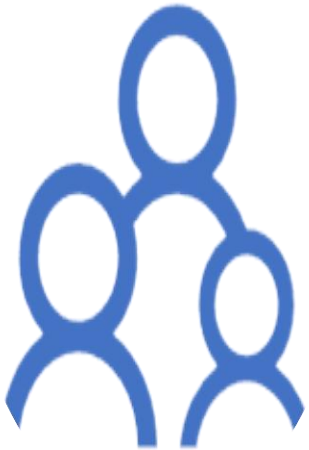
Referral to SUD treatment agency for assessment/treatment

Treatment agency or other provider develops the Family Care Plan; parent is the holder of the plan.

Parent shares plan with additional providers

Family Care Plan is shared with hospital prior to birth event

Family Care Plan informs discharge planning and evolves to a postpartum Family Care Plan for up to a year



Prenatal Family Care Plans: Outcomes

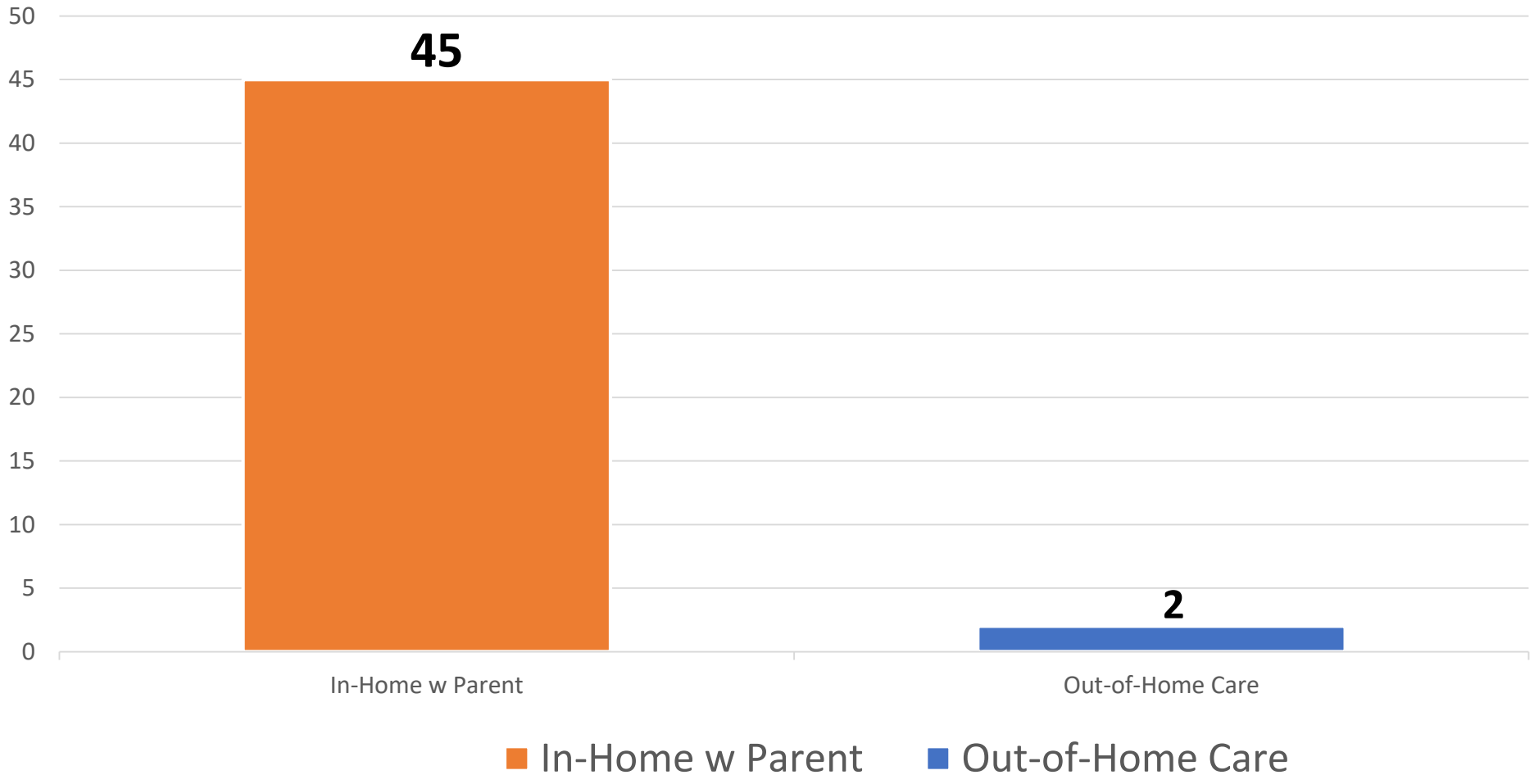
Impressive results of two pilot projects

The Center for Therapeutic Interventions

S.A.F.E.R. PROJECT

Prenatal Family Care Plans Infant **Discharge Outcomes**

Data: October 2019-Sept 2021



OU STARS Clinic Updates (Prenatal FCP initiated by OB/GYN)

*(Data from October 2019-July 2021)

91% of infants are discharged home with parents

Number of pregnant individuals served: 119
Number of infants delivered: 79*
Number of deliveries: 77 (2 sets of twins)
Number currently pregnant: 42
Number of individuals on MAT at time of delivery: 63 (82%)
Percentage of infants placed in DHS custody: 9% (7 out of 78, 2 of the 7 were due to mother's current incarceration)

The Core Team recommends a **change in the definition of "an infant affected by substance abuse"** to ensure that all infants with prenatal substance exposure and their families receive supports and services

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Step 2:

Change definition of infant affected by substance abuse to include all substance exposed newborns

Proposed new definition of “Infant affected by substance abuse” for Oklahoma

An infant diagnosed with Neonatal Abstinence Syndrome or determined to have experienced intrauterine (prenatal)substance exposure.

This definition aligns with ICD 10 coding instructions

Further definition of “Infant affected by substance abuse:

- **Neonatal abstinence syndrome**: A baby has prenatal exposure to a neuroactive substance and exhibits clinical signs/symptoms of withdrawal, regardless of whether or not pharmacological treatment is required.

- **Intrauterine (Prenatal) Substance Exposure**: Exposure is when there is known maternal use of neuroactive substances at any time during the pregnancy.
  - There is known maternal use of neuroactive substances during pregnancy (biological test or self-reported)
  - and/or confirmation of baby’s biological specimen for any neuro-active substance(s),
  - and/or confirmation of baby’s withdrawal symptoms (if biological specimen is not collected/available or there is a false negative test result).

This definition aligns with ICD 10 coding instructions

Implications

2645 children with prenatal substance exposure accepted for assessment and investigation

POSC/ Family Care Plans are only required for withdrawal, NAS/FASD, N=162

Of those 162 infants, 73 received a POSC from DHS

1602 received a referral for services but no POSC/Family Care Plan

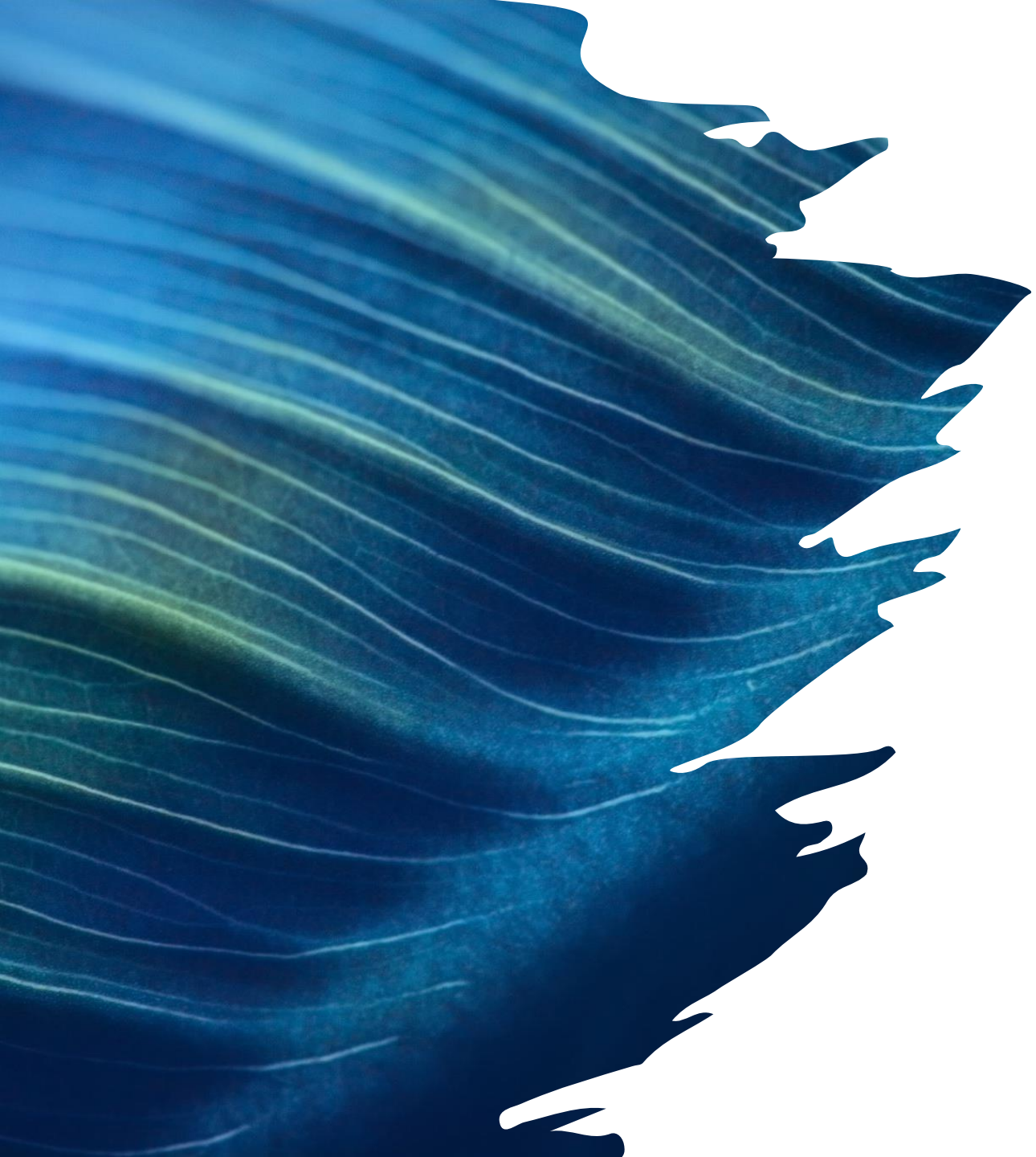
The 1602 infants and their families would be offered Family Care Plans from community partners to coordinate care and supports

How can we spread improved outcomes from Prenatal Family Care Plans to all infants with prenatal substance exposure?

Dilemma: Currently all infants with prenatal substance exposure result in a child abuse and neglect report

Step 3:

For lower-risk cases create a CAPTA notification pathway and Family Care Plan that is initiated by a partner agency



OK Notification and Reporting Options

Current:

All infants with prenatal substance exposure are mandated reports of child abuse or neglect to DSS. Yet, few are substantiated for abuse and neglect.

What if:

A CAPTA notification option for families with a lower risk profile were created. (AND)

Family engagement, Plan of Safe Care development and ongoing tracking were provided by a community partner (such as a treatment provider, health care provider or home visitor)

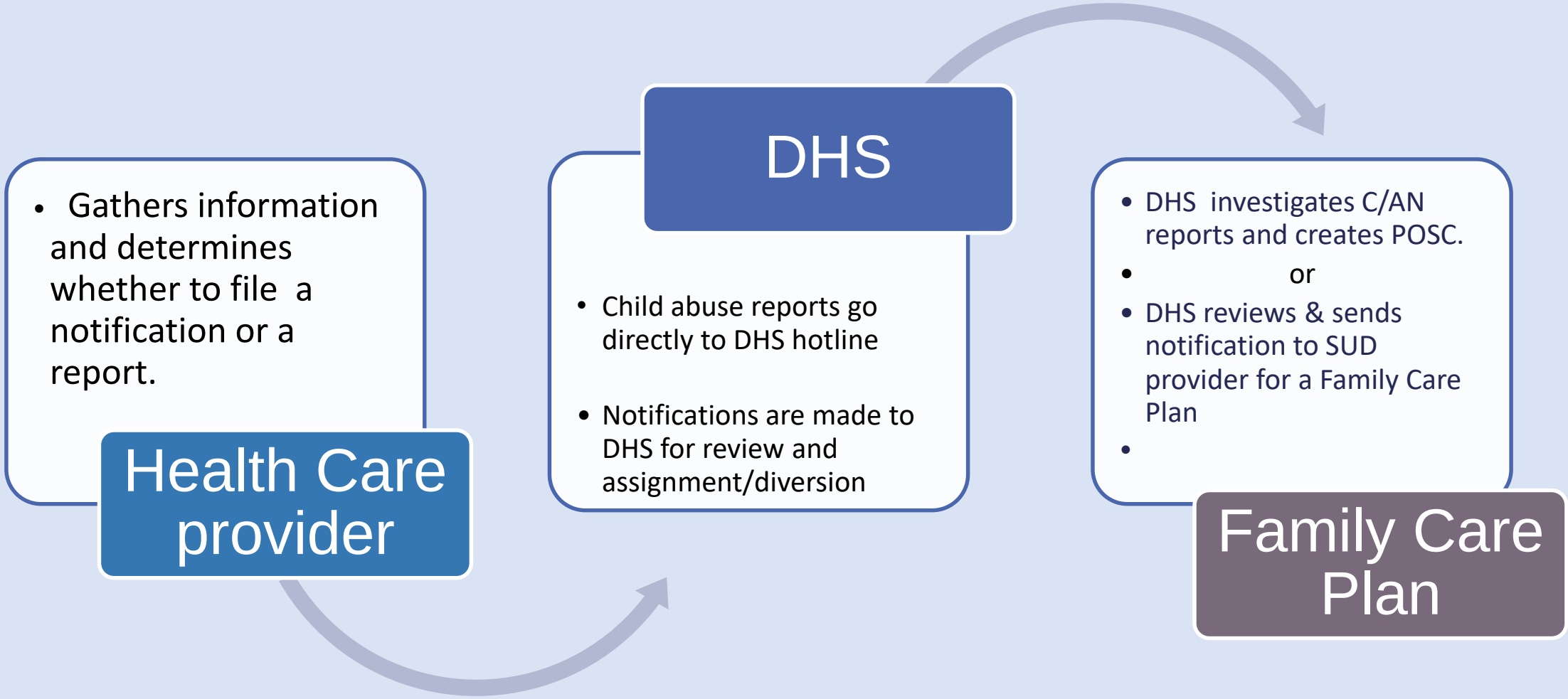
CAPTA Notifications: 3 Key Points

1. Healthcare providers involved in the delivery of care of an infant born "affected by substance abuse" **must notify** CPS. The reports on their own, are not grounds to substantiate child abuse or neglect.

2. A plan of safe care is required for "infants affected by substance abuse" whether or not the circumstances constitute child maltreatment under state law.

3. CAPTA does not specify which agency or entity (such as hospitals or community-based organizations) must develop the plan of safe care.

OK'S PROPOSED CAPTA NOTIFICATION PATHWAY



PROPOSED: CAPTA NOTIFICATION TO DHS HOTLINE

- Hot line staff will refer the notifications to an SUD treatment provider for creation of a Family Care Plan/POSC
- If CAPTA notification, but then additional high-risk indicators are identified, convert to a child abuse report, screen in for investigation and inform referring party.
- Electronic portal to be created to provide decision tree for CAPTA notifications and child abuse neglect reports
- Exploring DHS social services staff embedded at birthing hospitals to provide coaching to help the health care provider discern between notification and report options

Strengths and Risk Factors to determine CAPTA Notification or Child Abuse Report

Risk factors

Likely to be a child abuse/neglect report

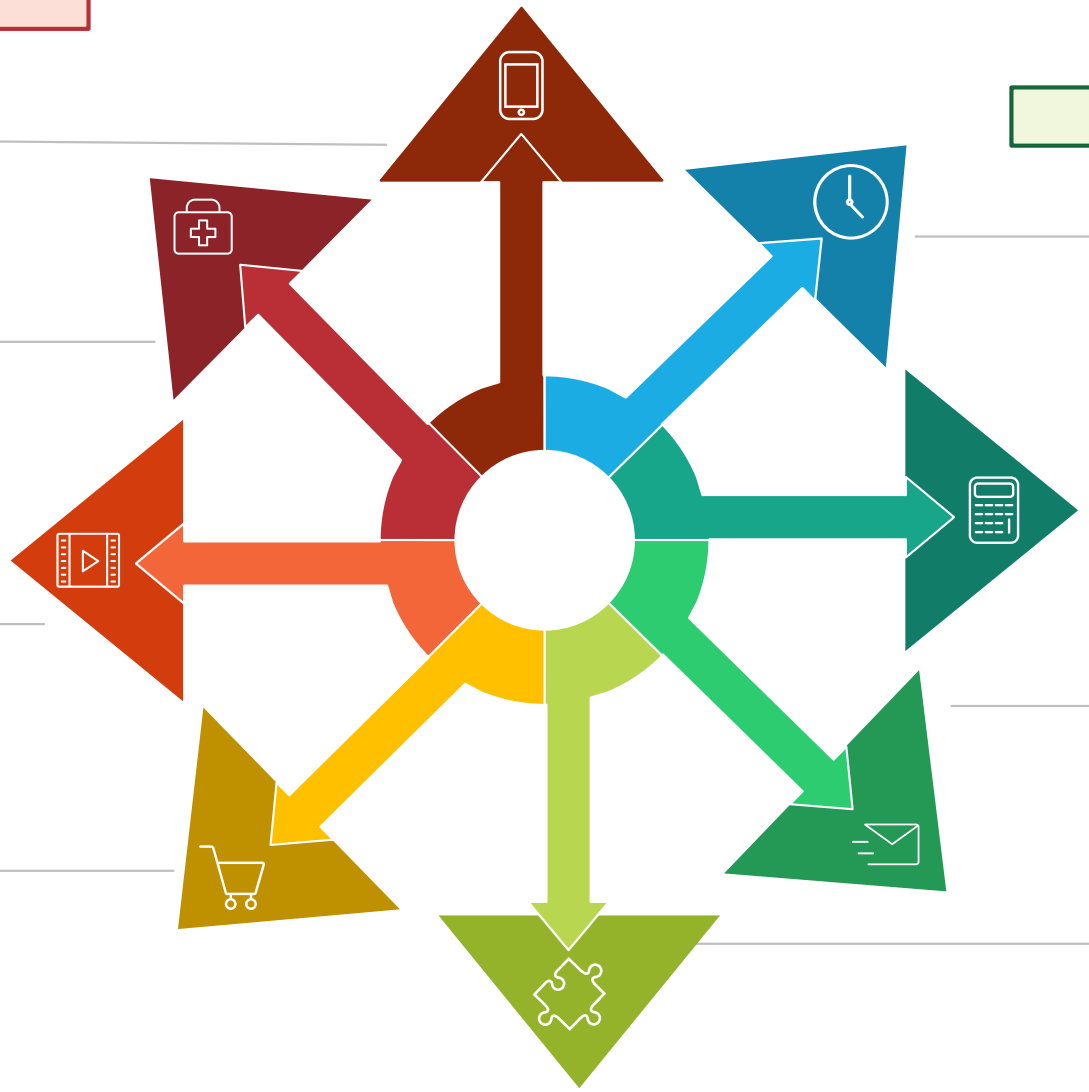
Preparations for Newborn
Parent has not planned for safe sleep, does not have car seat, items for infant care…

SUD & Co-Occurring Disorder
Recent entry to SUD treatment and/or untreated co-occurring mental health disorder that impairs parenting

Family and Community Supports

Not utilizing family or community supports

Infant Care/Medically complex
Significant difficulty with care of the infant (e.g., not visiting or participating in care) and/ or infant has complex medical needs and parent hasn't received training or demonstrated caretaking capacity



Strengths

Likely to be a CAPTA notification

Preparations for Newborn
Parent has a safe sleep plan, has obtained car seat and items for infant care

SUD & Co-Occurring disorder
Parent stable in SUD treatment and/or receiving treatment and supports for co-occurring disorder

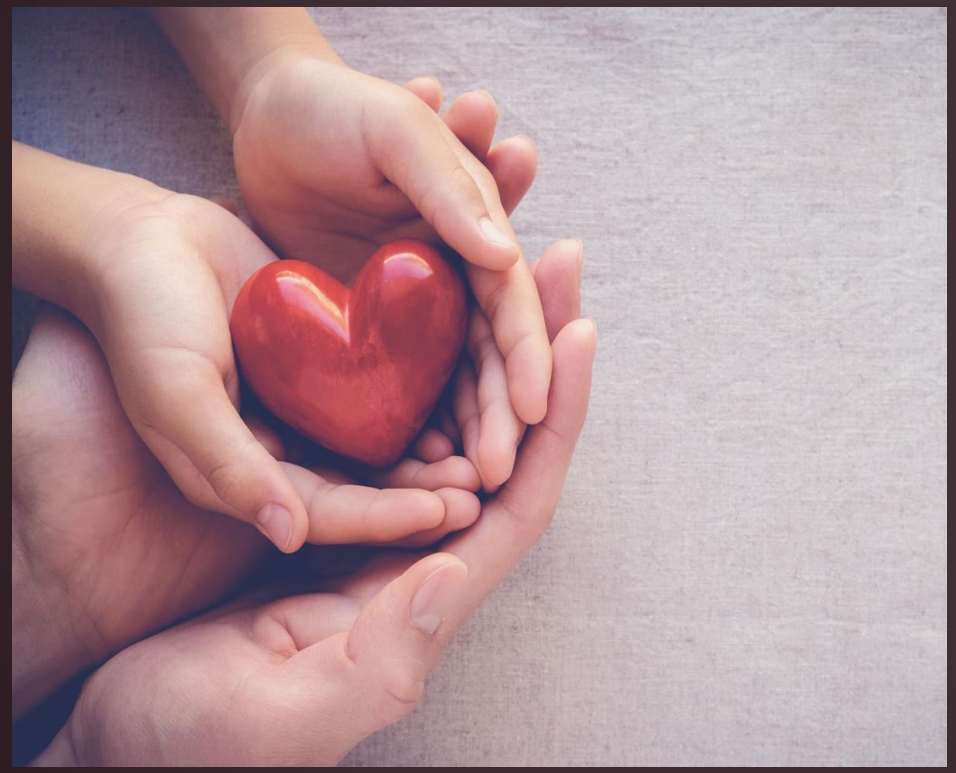
Family and Community Supports
Family and community supports intact and actively providing support

Infant Care/Medically complex
Attentive care to infant, frequent visiting and/ or infant has complex medical needs, parent has received training and demonstrated capacity

Thoughts/Feedback?

- What sounds good?
- Any components that concern you?
- What do you anticipate to be opportunities or barriers for this approach?

THE OKLAHOMA FAMILY CARE PLAN



Sean Couch, Project Manager,

Substance use Treatment And Recovery

STAR Clinic

OKLAHOMA'S

FAMILY CARE PLAN ROLLOUT

Oct.2021
update

As of Oct 15, 2021

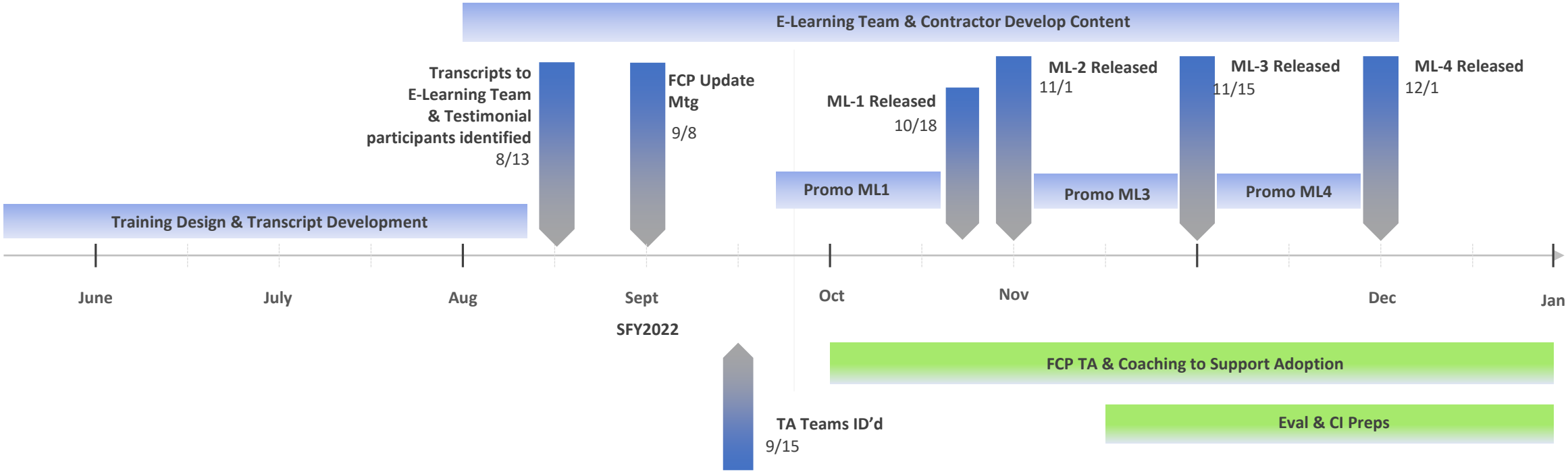
- Creation of statewide Family Care Plan initial document
- Formed Content Teams to developed training design, structure, and learning objectives.
- Reviewed & approved E-Learning Template
- Developed transcripts for each learning session
- Identified participants for each testimonial video and shot videos

Where we've been

In a little under 6 months, SO MUCH has happened!

Current Implementation Timeline

Education, equipping, and creating a culture shift!



1: FCP Foundations

- The need for FCPs
- Values and Beliefs that drive the FCP

2: Initial Walkthrough

- Initial form walkthrough
- How the form facilitates initial discussion

3: Practical Application

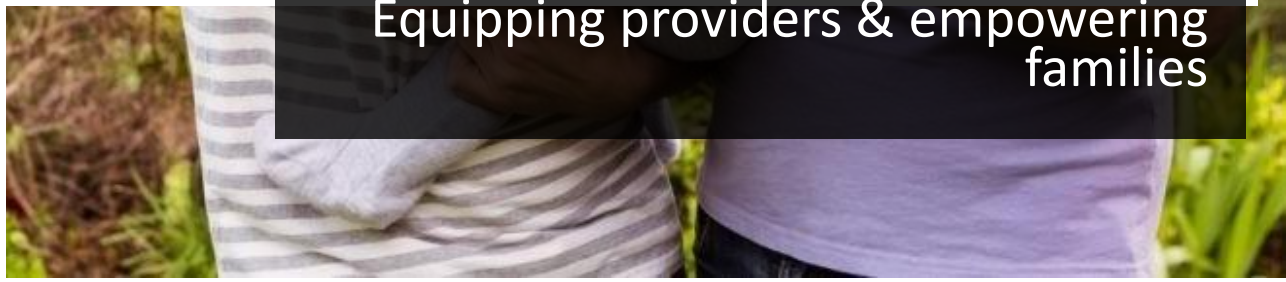
- Witness an in-person initial session
- Learn how to facilitate sessions

4: Organizational Integration

- How to infuse FCP values throughout your organization
- Hear lessons learned from FCP champions

Family Care Plan Modules

Equipping providers & empowering families



Where we are now

What big rocks are moving us towards implementation

- Finalizing Testimonial Videos
- Promoting sessions
- Technical assistance and coaching
- Manual/ documentation support

Session 1 coming this week!

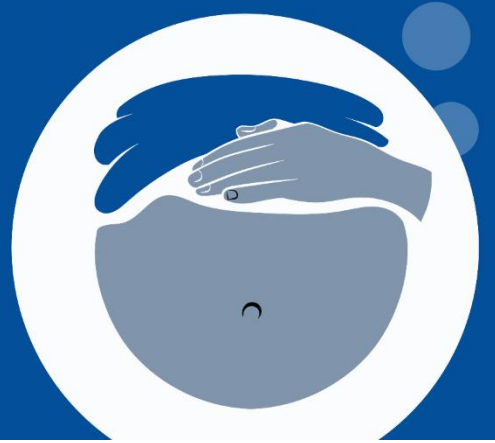
FAMILY CARE PLAN

eLearning

COMING OCTOBER 2021

PROVIDE Early and effective care
PROMOTE Healthy intact families
PREVENT Child out-of-home placements
SUPPORT A person's recovery journey

OKLAHOMA Mental Health & Substance Abuse



QUESTIONS/OTHER BUSINESS?

- You may unmute to ask any questions or address any other business items
- If joining on a phone, press *6 to unmute

Upcoming Events

To Register, visit https://opqic.org/opqic-upcoming-events/

- **TeamBirth Cohort 1 Monthly Learning Sessions**

  Wed. November 3, 9:00a-10:30a

  Fri. November 5, 1:30p-3:00p

- **OMNO Pilot Hospitals Learning & Sharing Session**

  Fri. November 12, 11:00a-1:30p

- Oct.26: COBA Fall Virtual Conference
- Nov. 3: ODMHSAS Keeping Babies in Mind While Working with Parents
- Nov. 4: Safe Sleep Train the Trainer (virtual)
- Nov. 6: Free LARC Provider Training (OKC)
- Nov.10: ODMHSAS: Looking at Diversity through the Lens of Trauma and Resilience while Supporting Parents and Babies

Future OPQIC/MHTF Meeting Dates

January 18, 2022
April 19, 2022
July 19, 2022

- 5:00pm – 7:00pm

THANK YOU FOR YOUR PARTICIPATION!

https://opqic.org

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