NURTURE OREGON PROGRESS

for Oregon Health Authority

December 2021

Oregon Health Authority

Comagine Health

nurture oregon

CONTENTS

EXHIBITS

EXECUTIVE SUMMARY

This report summarizes the first year of implementation of Nurture Oregon, a rural integrated care model for pregnant families that includes peer support, prenatal care, substance use and mental health treatment, care coordination, and other services.

Implementation Progress

Sites hired new staff and worked to **develop partnerships** to offer core program elements and address additional needs

Sites worked to create **team structures,** delineating staffing roles and workflow

Sites **laid the groundwork for integration** through case coordination huddles and shared information systems, and arranging physical space toward colocation

Infrastructure Support

Learning Collaborative and convenings such as cross-site meetings and huddles

Guidance documents, **online repository of resources,** and online message board

Technical assistance from a member of the original Project Nurture Team

Participants Served

85 participants served; almost two-thirds were not stably housed, **60% used multiple substances**, 77% used methamphetamine

81% of participants engaged in **peer services**, **60%** engaged in **SUD treatment**

88% received **prenatal care**, **96% of infants** had at least **1 well-child check**

34% of participants— all of whom had prior child welfare involvement— had a **Nurture Oregon child removed**, and **half were reunited**.

PROGRAM OVERVIEW

BACKGROUND

Nurture Oregon is an integrated care model providing pregnant people who use substances with peer recovery support services, prenatal and postpartum care, substance use and mental health treatment, and service coordination. Oregon Health Authority Health (OHA) Systems Division is building on a 2015 Multnomah County pilot to expand and adapt the program around the state. The pilot Project Nurture model was associated with increased prenatal visits, reduced placement of children in foster care, and cost savings.

The Oregon legislature mandated the expansion of the pilot Project Nurture to focus on rural areas and sites reaching underserved families. The expansion funded 5 rural and frontier counties, and sites began services in 2021.

MISSION & GOALS

Nurture Oregon's mission is to keep families healthy and unified by providing quality, integrated care. Nurture Oregon envisions a state where pregnant people who use substances receive safe, supportive, stigma-free care.

CORE PROGRAM ELEMENTS

The core program elements of Nurture Oregon include:

- Clinicians who can provide prenatal and postpartum care
- Substance use disorder treatment, including access to medications
- Peer recovery support
- Community outreach to engage families
- Pediatric care for infants
- Case management team
- Trauma-informed mental health counseling and services
- Facilitated support groups with Nurture Oregon pregnant participants
- Other available services such as doula care, housing support, or home visiting nurse
- Partnership in developing Plans of Care

Nurture Oregon teams are expected to develop relationships in the community:

- Transparent relationship with local DHS Child Welfare
- Coordination with hospitals for maternity stay
- Supported access to social services
- Community outreach to develop referral pathways and engage participants directly

FUNDED COUNTIES

Nurture Oregon funded 5 counties: 4 rural, 1 frontier. The prime grantee organization in each county issued subcontracts to partners as needed.

County	Nurture Oregon Prime Grantee	Prime Grantee Type	Participating Organizations
Deschutes	Best Care Treatment Center	Behavioral health services	St Charles Center for Women's Health
Jackson	Oasis Center of the Rogue Valley	Primary care clinic with integrated behavioral health services	OnTrack Rogue Valley, Addiction Recovery Center (ARC)
Lincoln	ReConnections Counseling	Behavioral health services	Lincoln County Health & Human Services, Integrity Women's Health, Samaritan House, Community Doula Program
Malheur	Malheur County Health Department	Public health department	Valley Family Treasure Valley Women's Clinic, Altruistic Recovery
Umatilla	Oregon Washington Health Network	Health care network, owns and operates behavioral health services	Independent Doula & Independent Midwife, St Anthony Hospital, Good Shepherd Hospital

IMPLEMENTATION PROGRESS

The first year of Nurture Oregon focused heavily on startup activities, including identifying partners and building partner relationships, delineating roles and responsibilities, developing workflows, and brainstorming steps toward service integration.

BUILDING PARTNERSHIPS & COMMUNITY RELATIONSHIPS

Sites spent substantial time identifying and approaching potential partners, designing workflows for streamlining and coordinating care across organizations and working towards integrated services for Nurture Oregon. Historically, most organizations have worked in silos or with modest levels of communication, so Nurture Oregon sites devoted time and effort to building trusting relationships with partnering organizations to lay the foundation of a collaborative model of care for Nurture Oregon. Additionally, sites spent time strengthening relationships in the community to foster referrals and educate community providers about the needs of pregnant people who use drugs.

CREATING SITE TEAM STRUCTURE

The OHA and Comagine implementation team met with site teams weekly during the first six months to support role delineation and creation of program structure. The implementation team created a Launch Checklist (Appendix 1) to assist sites in identifying gaps in existing teams.

Team Members

The prime grantee organization in Jackson County is a primary care clinic; the other 4 funded counties needed to identify a clinician to provide prenatal/postpartum care. Sites initially worked to identify and partner with OB/GYN clinicians but are now also working to identify family practitioners who provide prenatal care.

Peer Support Specialists and Certified Recovery Mentors play a critical role Nurture Oregon. The peer often initiates communication with new patients, bringing the skills and experiences to build trust and connection. Peers maintain regular contact with participants, checking in and providing peer services between appointments and providing transportation to appointments as needed.

Other roles participating in Nurture Oregon teams include certified alcohol and drug counselors (CADCs), doulas, home visiting nurses, a housing expert, registered nurse coordinators, a licensed midwife, an internal medicine physician, community health workers, and administrative support positions.

Team Workflows

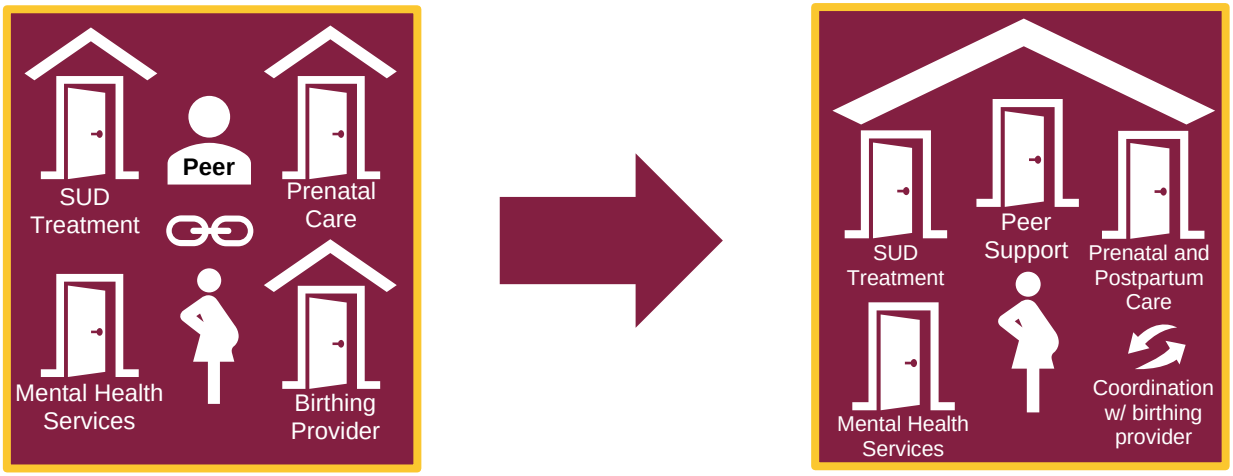
The implementation team created a packet of Workflow Documents (Appendix 2) to assist sites in specifying what services would be provided, by whom, in what location, and how frequently; and how services would be coordinated across organizations. Sites set regular case staffing meetings, 15-minute bi-weekly huddles, and shared documentation systems with the intent of coordinating services. Sites also removed historical barriers such as requiring a faxed referral form to initiate services and shifted to using a unified Nurture intake form across participating organizations.

MOVING TOWARD INTEGRATION

Integrating physical and behavioral health care is a challenge in rural areas, and only one site had an existing integrated care approach. Comagine Health and OHA developed documents that described a continuum of integration to assist sites in identifying baseline levels of integration and highlighting areas for growth in developing a functional integrated team.

Physical Integration/Colocation

One Nurture Oregon site (Jackson County) has successfully integrated physical and behavioral health care in the same space. In Deschutes County, care takes place on two distinct floors in the same building. Sites have laid plans to further physical integration in the coming months, for example by designating a day of the week for a prenatal provider to serve Nurture Oregon participants within a behavioral health setting; or a day of the week for the peer and CADC to serve participants within a physical health setting. In the interim, peer specialists are providing transportation to appointments.



Integrating Services Information

Other dimensions of integration include creating mechanisms for sharing participant information, streamlining the intake process, creating shared treatment plans, collaborating to address participant needs; and aligning values, goals, and policies related to Nurture Oregon participants.

While Nurture Oregon sites have been unable to share electronic health records across organizations, sites have implemented varied strategies to increase service integration. Sites have implemented standing huddles at least once a week for team members to share participant information, and some are using a shared intake form. One site created a secure cloud-based platform to house Integrated Care Plans for participants. Two sites have implemented 15-minute meetings 2 to 3 times a week to communicate about emergent needs of participants and ensure team members share information about the status of services in real time.

CARA PLAN OF CARE

In 2016, the Comprehensive Addiction and Recovery Act (CARA) was enacted, amending Child Abuse Prevention and Treatment Act (CAPTA) legislation to establish a comprehensive, coordinated strategy focusing on the impacts of legal and illegal substance use on infants and their families.

CAPTA/CARA requires the development of a Plan of Care and subsequent service referrals to address the health and safety needs of substance exposed infants, and the health and substance use disorder treatment needs of the infant's family. Oregon Department of Human Services (ODHS) Child Welfare provided Nurture Oregon sites with a draft Plan of Care guidance document to pilot development of the plans and provide feedback to ODHS. The guidance document encouraged Nurture sites to work as a team and with collaborators to develop Plans of Care prenatally and with active involvement of participants.

DESCHUTES COUNTY

BEST CARE TREATMENT SERVICES | ST CHARLES CENTER FOR WOMEN'S HEALTH

Nurture Oregon in Deschutes County builds on an existing program at Best Care Treatment Services, Mothers Outreach to Mothers (MOMs). Best Care, a residential and outpatient SUD treatment program, provides peer support, SUD treatment, group and individual therapy, and care coordination for Nurture Oregon. Best Care partners with St. Charles Center for Women's Health for prenatal services. The Best Care team lead and peer attend weekly meetings at the St. Charles clinic to discuss Nurture participants and identify new potential participants, although service coordination is minimal. Best Care is working to build a relationship with East Cascades Women's Group, the largest obstetrics care provider in Central Oregon.

Strengths & Successes

- Experienced Best Care team (CADC, peer), established relationship with St. Charles Women's Center
- Best Care and St. Charles Women's Center share a building
- Best Care team joins St. Charles case staffing meetings weekly to share information
- History of effective peer outreach and engagement

Challenges & Barriers

- Minimal service coordination between physical and behavioral health at Best Care and St. Charles
- Inability to share EHR data between Best Care and St. Charles
- High staff turnover at Best Care, including the peer and team lead; workforce burnout and retention concerns
- Low engagement in online support group during COVID-19

Goals Moving Forward

Integrate services more fully with St. Charles prenatal provider and/or Identify alternative prenatal provider

Implement an incentive program for participants

Explore additional local housing options for participants

JACKSON COUNTY

OASIS CENTER OF THE ROGUE VALLEY | ONTRACK | ADDICTION RECOVERY CENTER

Jackson County's Nurture Oregon program is led by Oasis Center of the Rogue Valley, a family-centered primary care clinic serving patients with substance use disorder. Oasis opened in January 2019 and provides health care for adults and children, medications for opioid use disorder (MOUD), family support services, and care coordination. Oasis provides space for all Nurture Oregon services. The Medical Director has provided MOUD in Jackson County for years and has strong commitment to this work. The peer doula attends deliveries with participants. The CADC is employed by OnTrack treatment agency and is physically housed at Oasis. Historically, most patients have been involved with DHS Child Welfare or criminal justice systems. Nurture Oregon peer outreach provides an opportunity to reach more non-mandated patients.

Strengths & Successes

- All services are provided on site at Oasis Center
- Team communicates regularly about participant needs and services
- Recovery peer is experienced, does effective outreach, and has trained as a doula and can attend hospital deliveries with participants

Challenges & Barriers

- Participant experiences of stigma in interactions with hospital labor and delivery staff
- Certified Nurse Midwife provides prenatal care only; Pediatric Nurse Practitioner provides postpartum care. CNM burnout is a risk in lack of continuity model (Sidhu et al., 2020)
- Sustainability of peer support in a physical health setting when unable to bill for services
- Workforce burnout and retention concerns

Goals Moving Forward

Create more flexibility for CNM to provide or assist with postpartum care

Conduct trainings for hospital staff to reduce stigma

Advocate with CCO to implement billing codes for peers in physical health setting

LINCOLN COUNTY

RECONNECTIONS COUNSELING | LINCOLN COUNTY HHS | COMMUNITY DOULA PROGRAM

Lincoln County's Nurture Oregon program is led by ReConnections Counseling, which provides behavioral health treatment and peer support services. Lincoln County's program prioritizes linking clients to supportive housing and offers home visiting nursing and doula care. Nurture Oregon partners include Samaritan House (housing), Lincoln County HHS Maternal Child Health (home visiting nursing), Integrity Women's Health (consultation), and the Community Doula Program. ReConnections coordinates with prenatal and pediatric care providers at Samaritan Hospital's women's clinic. Nurture Oregon services are currently provided in separate locations, though space is now available to host all services at ReConnections. The Nurture team has regular standing meetings to discuss cases, check in about participant appointments, and coordinate care.

Strengths & Successes

- Passionate multidisciplinary team consistently engaging in meetings
- Successful information-sharing across partners through cloud-based access to Integrated Care Plans
- Physical space available at ReConnections to house all services
- History of effective peer outreach and engagement

Challenges & Barriers

- Lack of a dedicated prenatal provider as part of team
- Samaritan Hospital Women's Health Center providers have engaged, but leadership has not yet endorsed a partnership to integrate services
- Samaritan Hospital submitted a HRSA grant for similar services; Nurture team will need to seek opportunity to integrate

Goals Moving Forward

Leverage Samaritan Hospital's HRSA grant application to forge a relationship with Nurture Oregon

Identify dedicated prenatal care provider

Create regular schedule for Nurture Oregon services in one location, the ReConnections Annex

MALHEUR COUNTY

MALHEUR COUNTY HD | VALLEY FAMILY HEALTH CARE | ALTRUISTIC RECOVERY

Malheur County is the most vulnerable county in the state and in the top 10% in the nation according to the CDC's social vulnerability index. The need is high, and organizations involved in Nurture Oregon do not bring a history of collaboration in service provision. Malheur's program is led by the Malheur County Health Department, which provides peer services and home visiting nurses. Valley Family Health Care, an FQHC with a women's clinic, provides prenatal and postpartum care, mental health services, and care coordination. Altruistic Recovery provides SUD treatment services. Due to staff turnover, contractual delays, and challenges reaching agreement about structure and leadership, Nurture Oregon has been slow to ramp up in Malheur County.

Strengths & Successes

- Health Department brings history of effective peer outreach and engagement
- Valley Family team brings experience providing prenatal care, medications for opioid use disorder, mental health services, and care coordination
- Starting in December 2021, Valley Family will provide space for the Nurture peer and SUD counselor to serve participants one day per week

Challenges & Barriers

- To date, services offered in three distinct physical locations and with minimal coordination
- Need for greater clarity across organizations about structure, leadership, and services approach
- High staff turnover at Health Department and Valley Family; workforce burnout and retention challenges

Goals Moving Forward

- **Fill open positions (peer, SUD counselor)**
- **Offer space at Valley Family for peer and SUD counselor to physically sit one day per week**
- **Create shared policies across organizations to ensure Nurture participants receive trauma informed care**

UMATILLA COUNTY

OREGON WASHINGTON HEALTH NETWORK | INDEPENDENT DOULA & MIDWIFE

Umatilla County's program is led by the Oregon Washington Health Network (OWhN), whose mission is to integrate physical, mental, behavioral, and public health services. OWhN provides SUD treatment and medications for opioid use disorder, mental health services, and peer support for Nurture Oregon. OWhN contracts with an independent doula and a licensed midwife for the project. The OWhN team is seeking a Family Nurse Practitioner (either internal staff or contracted partner) to provide dedicated prenatal care for Nurture Oregon. In the meantime, OWhN coordinates services with the women's clinics at both local hospitals, each with a designated RN acting as the Nurture contact. Umatilla's Nurture team has also created a relationship with a local dentist to provide dental care for Nurture Oregon participants.

Strengths & Successes

- Physical space available to house all services
- In-house MOUD prescriber
- History of effective peer outreach and engagement
- Hospital women's clinic RN Case Managers join huddles periodically (though case information is shared informally)

Challenges & Barriers

- High staff turnover in key positions and workforce retention challenges; Nurture support groups paused
- Lack of a dedicated prenatal provider as part of team
- Participant experiences of stigma in interactions with hospital labor and delivery staff

Goals Moving Forward

Fill open positions (CADC, peer supervisor), restart support groups

Designate in-house FNP as prenatal provider or identify external prenatal provider

Conduct trainings for hospital staff to reduce stigma

NURTURE PARTICIPANTS

Oregon Health and Science University is conducting a formal evaluation of the project. Comagine Health and Oregon Health Authority collaboratively developed indicators for program improvement and monitoring, which are reported here.

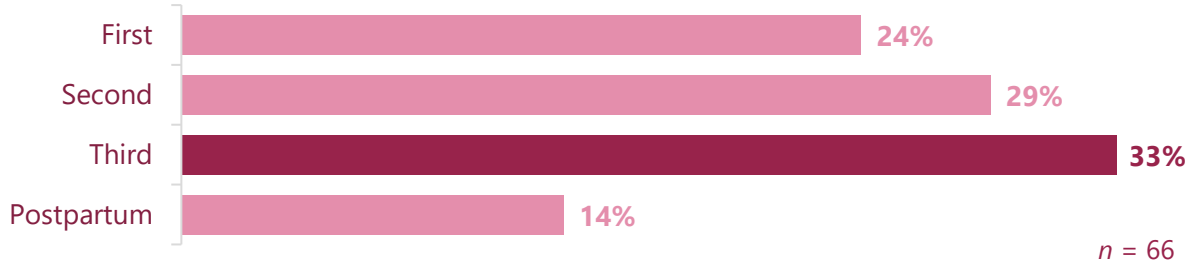
One site (Jackson County) had the programmatic infrastructure to begin serving participants soon after receiving funding September 1, 2020. Other sites worked on partnerships, hiring, and executing subcontracts, and began serving clients after the cross-site kickoff in March 2021. Services reported occurred from September 1, 2020 – November 30, 2021.

PARTICIPANTS REACHED

Of the 111 individuals who were referred to Nurture Oregon, 91 engaged in services. Six participants engaged in services more than 30 days after giving birth and are excluded from the current cohort. The remaining **85 participants** comprise the final cohort for this period.

Participants were fairly evenly distributed across the three trimesters of pregnancy with slightly more participants in the third trimester (33%) than the other two trimesters.[1] A smaller proportion of participants (14%) engaged with the program after giving birth.

Exhibit 1: Participants' Trimester at Engagement
86% of participants engaged prenatally.



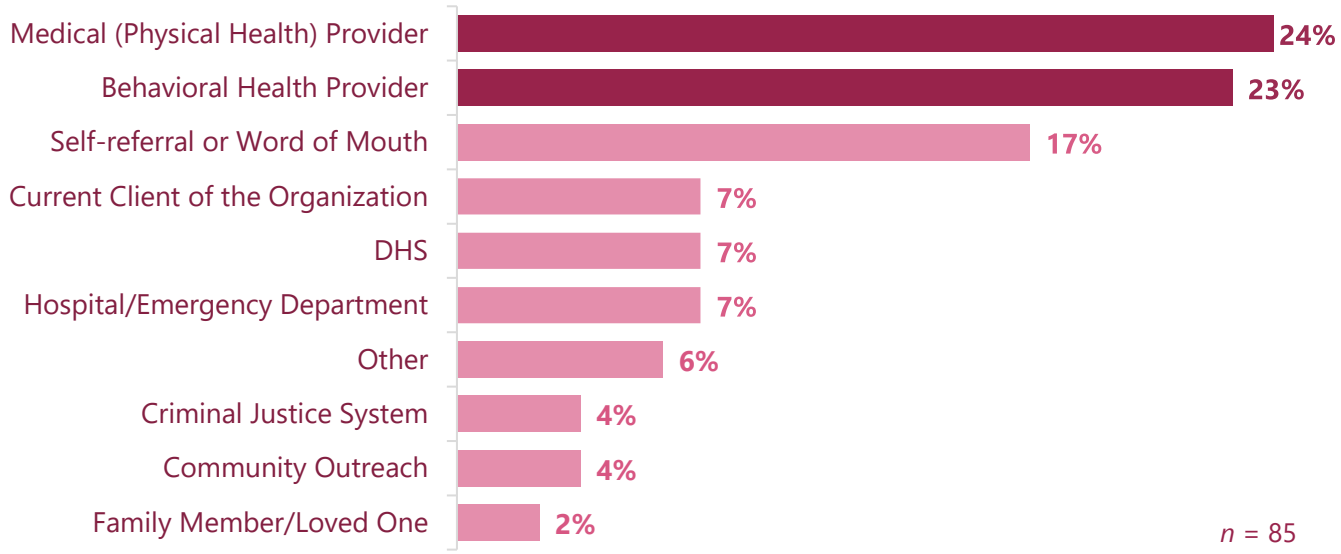
[1] Either the pregnancy due date or the date engaged with the program were missing for 19 participants

REFERRAL SOURCES & ENGAGEMENT PATHWAYS

Nurture Oregon sites developed relationships with a wide variety of community partners to create referral pathways into the program.

> Nearly half of participants were referred by a physical or behavioral health provider
>
> Informal engagement pathways were important: self-referral or word of mouth, direct outreach by peers, or referral from family or loved one
>
> Referral pathways included Department of Human Services (DHS), hospitals or emergency departments, and the criminal justice system

Exhibit 2: Referral Sources and Engagement Pathways
Nearly half of participants were referred by a medical or behavioral health provider.



PARTICIPANT DEMOGRAPHICS

Age, Gender, Race, Ethnicity

The majority of participants were between the ages of 20 and 34. All participants identified as female, though gender was missing for one participant.

Exhibit 3: Participant Age
More than three-quarters of participants were aged 20-34.

Thirteen percent of Nurture Oregon participants identified as Multiple Races/Other, a category differing slightly from the Census' "two or more races" category (https://www.census.gov/quickfacts/OR). Nationally, American Indian/Alaskan Native and people reporting two or more races have higher prevalence of illicit drug use disorder than other groups, though no groups have rates above 5% (https://www.samhsa.gov/data/sites/default/files/reports/rpt35326/2021NSDUHSUChartbook.pdf).

> 6% were Black/African American, compared to 2% of Oregonians
>
> 13% were Multiple Races/Other, while 4% of Oregonians are more than one race
>
> 22% were Hispanic/Latinx, compared to 13% of Oregonians

Exhibit 4: Participant Race
Twenty percent of participants identified as a race other than White alone.

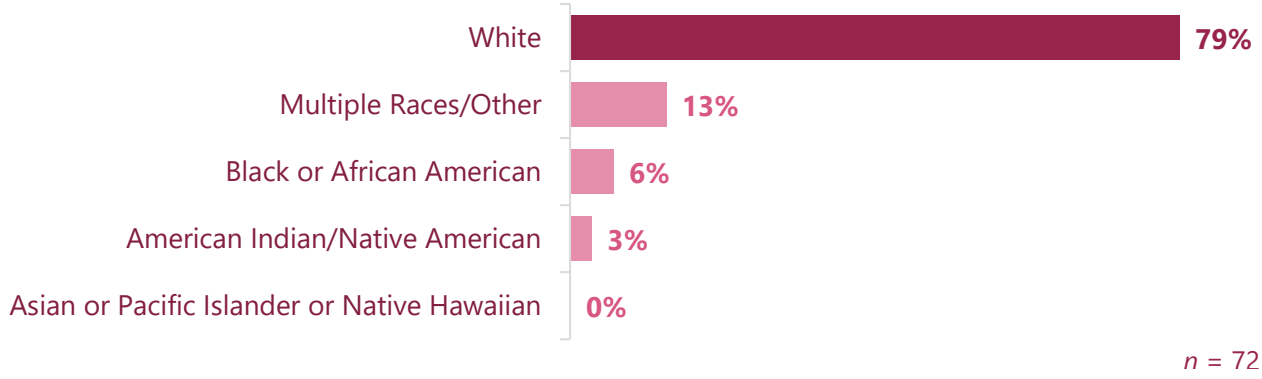
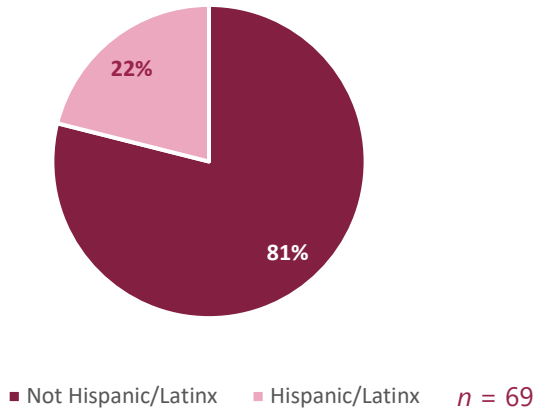


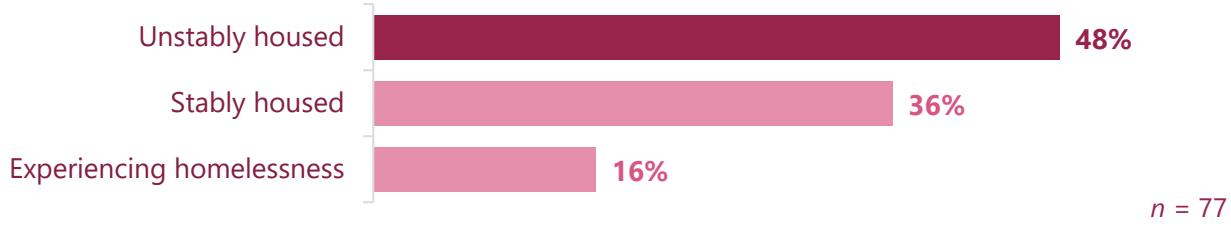
Exhibit 5: Participant Ethnicity
Nearly a quarter of participants were Hispanic/Latinx.



Housing Status

The majority of participants (64%) did not have stable housing at the time they engaged with the Nurture Oregon program: Approximately half were unstably housed and 16% were experiencing homelessness.

Exhibit 6: Housing Status at Engagement
Roughly two-thirds of clients were not stably housed.

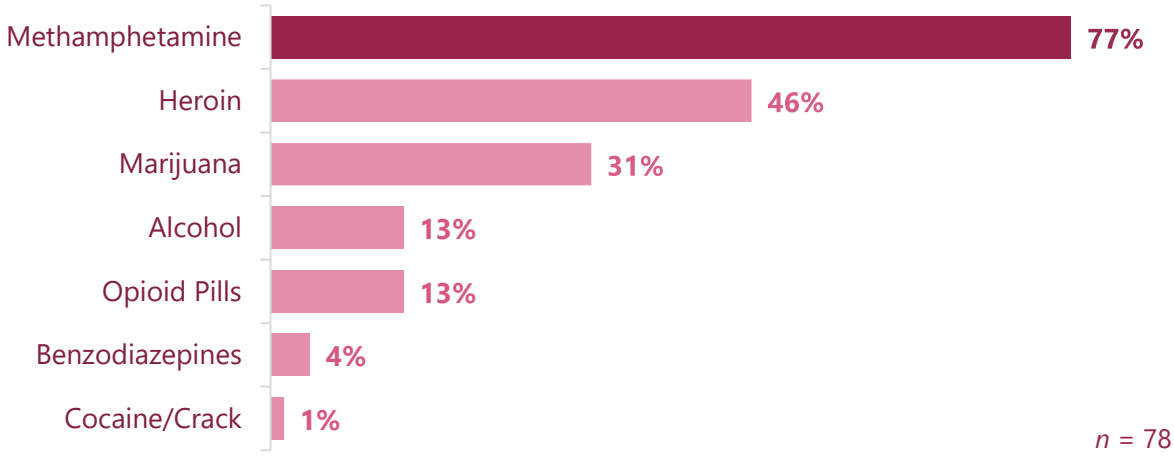


SUBSTANCE USE AT TIME OF ENGAGEMENT

> 60% of participants used multiple substances at engagement
>
> 77% of participants used methamphetamine
>
> 46% used heroin

Sixty percent of participants used multiple substances, and methamphetamine was the most common substance used (77%). Nearly half (46%) of participants used heroin and 31% used marijuana.

Exhibit 7: Substances Used at Engagement
The most commonly used substances were methamphetamine and heroin.



SERVICES PROVIDED

81% of participants engaged in peer services

60% engaged in SUD treatment; 51% received medications for SUD

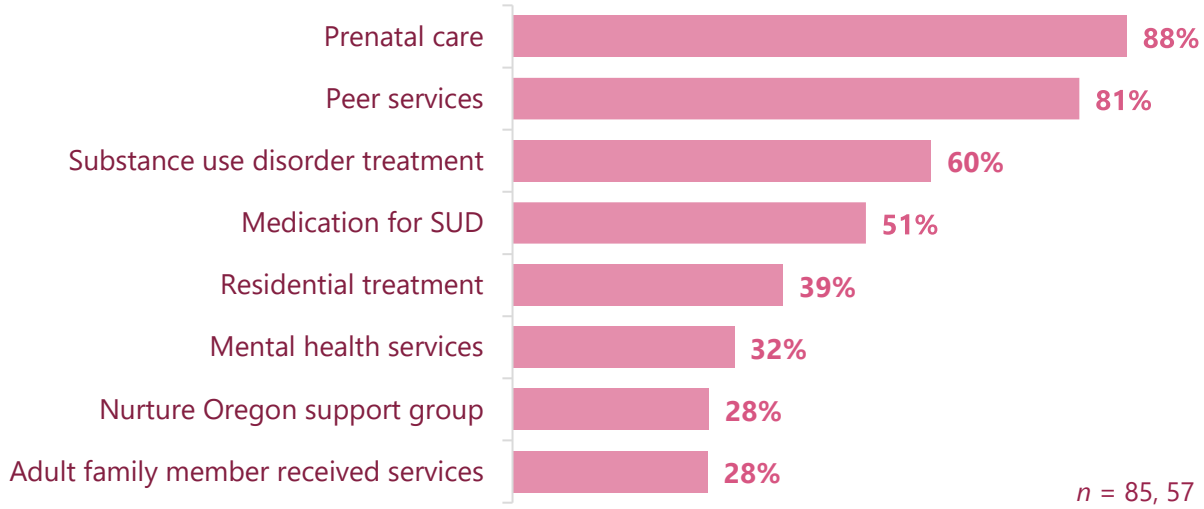
88% received prenatal care

Behavioral Health and Prenatal Care

The majority of participants (81%) engaged in peer support services. Three-fifths of participants engaged in any type of substance use disorder (SUD) treatment and half received a medication for SUD (i.e., buprenorphine, methadone). A third received mental health services and just over a quarter (28%) engaged in a Nurture Oregon support group.

Among participants who engaged with Nurture Oregon prior to giving birth, 88% received prenatal care. Just over a quarter (28%) of participants had adult family members who received Nurture Oregon services to complement the services received by the participants themselves.

Exhibit 8: Behavioral Health and Prenatal Care
Participants engaged in a variety of behavioral health services.

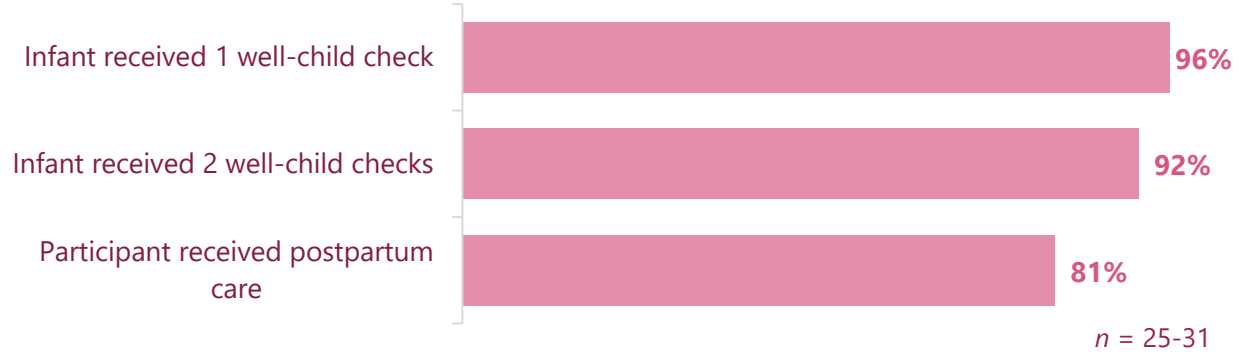


Postpartum and Postnatal Care

> 96% of infants born to participants had at least 1 well-child check and 92% had at least 2 well-child checks in their first year of life
>
> 81% of participants received postpartum care

Of the 36 participants who had given birth by the end of the reporting period, all but one was a live birth. Two participants gave birth to twins. Nearly all infants born to Nurture Oregon participants (92%) received at least 2 well-child checks in their first year of life.

Exhibit 9: Postpartum and Postnatal Care
Nearly all Nurture Oregon infants received 2 well-child checks within 12 months of birth.



CARA PLANS OF CARE

> 46% of participants had a Plan of Care developed to date
>
> 70% of Plans of Care were developed prenatally
>
> 67% of participants contributed to the development of the Plan of Care
>
> Plans of Care were most often led by prenatal clinicians; peer specialist were involved for half of participants; behavioral health providers, child welfare case workers, hospital social workers, and family members contributed

Just under half of Nurture participants had a Plan of Care developed at the time of this report.

Exhibit 10: Plan of Care
About half of participants had a Plan of Care developed.

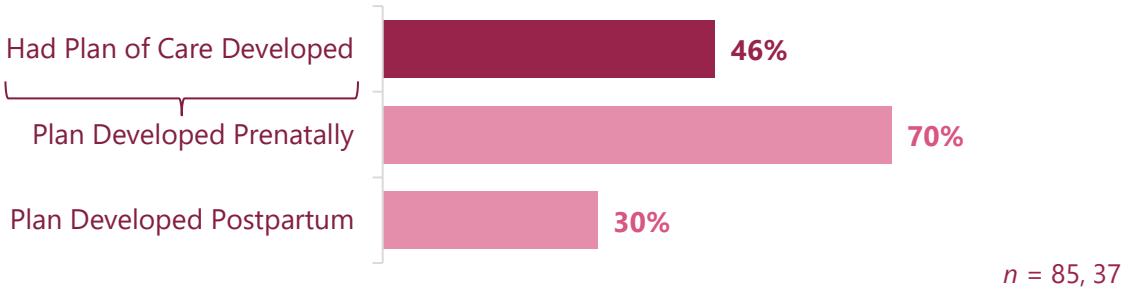


Exhibit 11: Plan of Care Development Leadership
Prenatal clinicians most commonly led the development of Plans of Care.

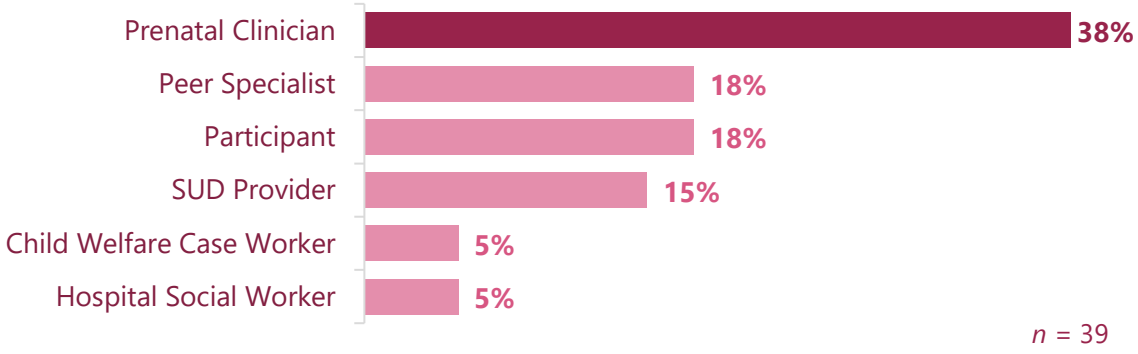
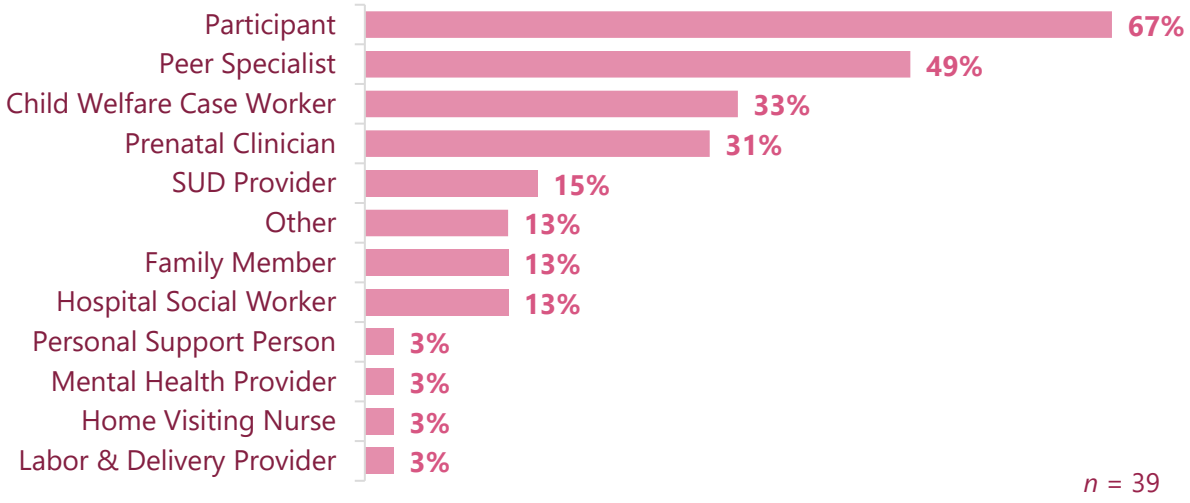


Exhibit 12: Other Plan of Care Contributors
Two-thirds of participants contributed to the development of their own Plan of Care.



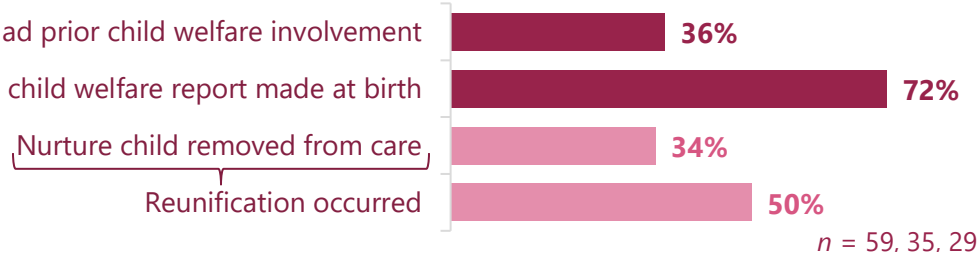
ODHS also provided Safe Sleep materials to Nurture Oregon sites to distribute to participants. Of the 11 participants for whom data was available, three-quarters (73%) were given Safe Sleep materials.

CHILD WELFARE INVOLVEMENT

> 36% of participants had prior involvement with child welfare
>
> 72% had a child welfare report made at the birth of their Nurture Oregon child
>
> 34% of participants— all of whom had prior child welfare involvement— had a Nurture Oregon child removed, and half were reunited.

Of the 35 participants who had a live birth by the end of the reporting period, a third had a child removed from their care after birth. All 11 of these participants had involvement with child welfare prior to their engagement with Nurture Oregon. Half of these participants were reunited with their child by the end of the reporting period.

Exhibit 13: Child Welfare Involvement
Three-quarters of participants had a child welfare report made at the time of birth.



STATE-LEVEL INFRASTRUCTURE

CONVENINGS AND LEARNING COLLABORATIVE

Comagine Health and OHA convened the following Nurture Oregon meetings:

Meeting	Frequency	Attendees
Site Case Coordination Huddles	Weekly	Site team staff
Site Implementation Reflection Huddles	Monthly	Site team staff
Cross-Site Meetings	Monthly	Site team staff
Learning Collaborative	1 – 2 times/month	Site team staff
Peer Huddles	Monthly	Peers
Database Drop-Ins	Monthly	Site database leads

Convenings

Nurture Oregon convenings support site-level progress, cross-site learning, and communication with the state implementation team. Comagine Health and OHA implementation team attend all meetings except the site case coordination huddles; the implementation team joined the coordination huddles for approximately the first six months as teams organized the work, then stepped back as sites shifted to participant case discussions.

- **Site case coordination huddles.** Each site team meets to discuss general coordination and participant-specific issues and needs.
- **Site implementation reflection huddles.** Each site team meets to reflect on implementation progress. Discussion topics typically include:
    - Community partnership updates, site progress, questions, and barriers
    - Staffing updates
    - Implementation and integration progress and next steps
- **Cross-site meetings.** Sites convene to brainstorm strategies to overcome barriers. Topics have included case staffing, participant retention, developing referral pathways into Nurture Oregon, and service integration.
- **Peer huddles.** Discussion topics typically include:
    - Successes and challenges in reaching and engaging participants
    - Strategies for wellness, self-care, and maintaining recovery
- **Database drop-ins.** Comagine Health provides a space for site database leads to ask questions.

Trainings and Learning Collaborative

Nurture Oregon staff participated in (or watched a recording of) an orientation training that addresses Nurture Oregon values and core elements, the pilot Project Nurture model, referral and engagement pathways, introduction to integration, and other topics.

Nurture Oregon staff receive ongoing learning through Learning Collaborative sessions organized by OHA and Comagine Health, often in response to team experiences or requests for training, featuring state and national subject matter expert speakers. The Nurture Oregon leadership team provided 12 Learning Collaborative sessions from January 1, 2021 – November 30, 2021.

11 Learning Collaborative Sessions

Topic	Presenter
Nurture Kickoff Meeting	OHA & Comagine
Startup and Building a Team	Kerri Hecox & Rick Treleaven
Child Welfare & CARA/CAPTA Plans of Care	ODHS Child Welfare Team
Project Nurture Pilot Model	Julia Vance
Trauma Stewardship with	Laura van Dernoot Lipsky
Making Harm Reduction Inclusive: Cultural Approaches to LGBTQI+ Harm Reduction and Recovery Services	Dharma Mirza
Dental Care, Oral Health, and People Who Use Drugs	Dr. Beverlee Cutler
Peer Outreach & Engagement	Telia Anderson & Jamie Myers
Support Group Participation, Process, Approach	Dr. Kathy Tomlin
Child Welfare Part 1: General Walkthrough & Revisit CARA Implementation	ODHS Child Welfare Team
Child Welfare Part 2: Lived Experience Parent Panel	Parents with child welfare history

RESOURCES

Documents

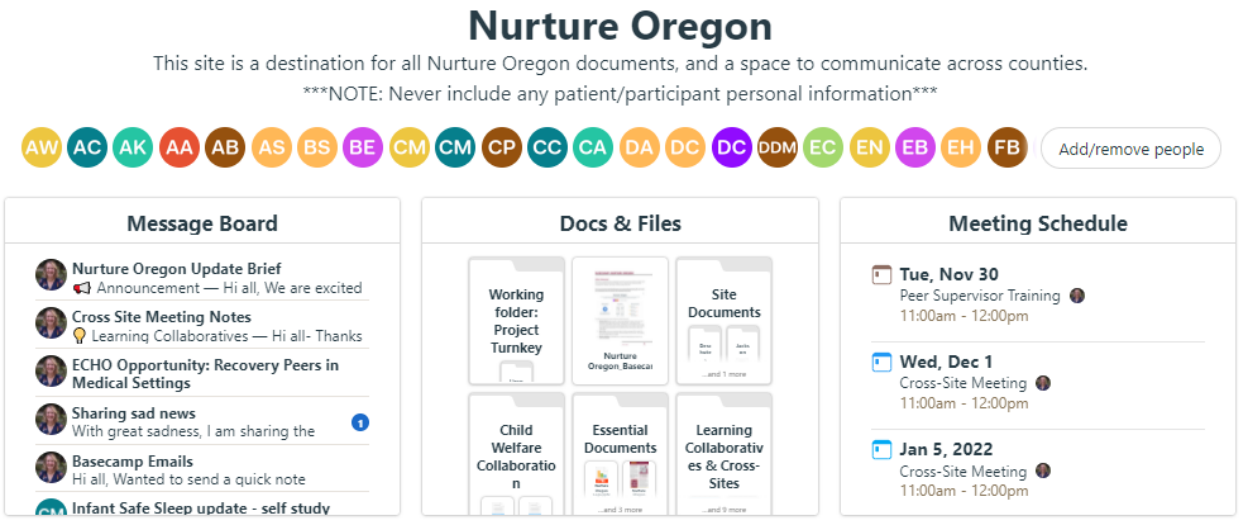
Comagine Health and OHA created a living library of resources for Nurture Oregon sites. The documents are continuously updated and include the following:

- **Orientation and Launch Documents**: agenda, checklist, contact sheet

- **Promotional templates** for Nurture Oregon sites: trifold brochure, flyer for potential participants; and a promotional handout aimed at community partners
- **Procedural documents**: Nurture Oregon Program Manual, peer supervision resources, peer services informational tools, Nurture Oregon database user documents
- **Quarterly Briefs:** Began October 2021, highlighting implementation status and successes to share with community partners

Basecamp Repository and Message Board

Nurture Oregon teams use Basecamp, an online collaboration site used as a repository and communication tool. The repository on Basecamp includes the document library and training and Learning Collaborative recordings and slides.



Sites use the message board to communicate across teams, for example to identify available specialty treatment beds, locate providers, share resources and trainings, share successes, and ask for advice or ideas about addressing service needs. The message board aids in facilitating a statewide communication network.

TECHNICAL ASSISTANCE

Along with structured meetings, learning opportunities, and creation of guidance documents, Comagine Health contracted with a Certified Nurse Midwife who worked on the original Project Nurture to provide technical assistance to sites. Dr. Julia Vance provided cross-site trainings on integration and provided in-person support to multiple sites to assist in troubleshooting barriers to implementation and integration. Given the challenges in integrating services, hands-on practice facilitation is recommended.

CHALLENGES

COVID-19

Delayed start. The grant period of the Nurture Oregon expansion is September 2020 to September 2022. Due to contractual elements delayed by COVID-19, sites did not receive funding until early 2021. The official kickoff for Nurture Oregon occurred in March 2021.

Relationship-building. During key infrastructure-building periods, organizations were unable to meet with community partners in person, and statewide infrastructure support occurred online. The transition to virtual communication affected levels of engagement from site teams and collaborators.

Workforce. Some Nurture Oregon site team members contracted COVID-19 or faced challenges related to childcare, sick family members, and deaths of loved ones. These challenges took an emotional toll and affected availability of services and implementation progress. The vaccine mandate that went into effect in October 2021 resulted in partner hospitals losing a substantial number of nursing staff (in one case 20%).

Services. Hospital restrictions on peer visits affected many sites, and peer teams navigated shifting state, local, and organizational policies related to engaging with and transporting participants as COVID-19 conditions changed. All sites struggled with providing services virtually during periods of COVID-19 lockdowns, striving to find creative ways to engage and retain participants. Recovery support and treatment groups in particular presented challenges, and some sites shifted to individual services only while others opted to have vaccinated/tested and masked groups.

Sites also struggled to combat misinformation about the COVID-19 vaccine and pregnancy. Nurture Oregon sites are working with primarily unvaccinated participants, adding to stress and anxiety of teams.

Integration in Rural/Frontier Oregon

The key challenge for Nurture Oregon was the integration of physical and behavioral health care. In most participating counties, behavioral health and physical health providers have no history of collaboration, and effort was required to build trusting relationships and address practical and logistical hurdles.

Prenatal care integration. Nurture Oregon sites have faced a limited prenatal provider pool and limited capacity among prenatal providers. Nurture Oregon sites focused initially on building relationships with OB/GYNs due to limited primary care provider capacity, but are now reaching out to other potential prenatal providers (family nurse practitioners, certified nurse midwives) who may be able to dedicate time to Nurture participants and service coordination with Nurture partners. With a slow trickle of participants in the early days of Nurture, prenatal

providers were unable to commit substantive time to offer co-located Nurture services, as clinical staff were already overburdened due to rural provider shortages and COVID.

Physical integration or colocation. One of the 5 sites has physical and behavioral health care integrated in the same space and one is collocated in the same building though on different floors and with limited coordination. Sites have to overcome organizational barriers such as agreement around where collocated services can take place; for example, designating space and a day per week for behavioral health team members to offer services on site at a physical health clinic, or for a prenatal provider to offer care at the behavioral health agency.

Information sharing. Tracking and sharing client information across partner organizations has been challenging due to a lack of a standardized platform or electronic health record that can be used by all partners. Sites have used verbal case staffing and in one site, a cloud-based platform for Integrated Care Plans.

Workforce Challenges

Turnover among Nurture Oregon staff (including of project leads and peers) interrupted momentum at times for most sites. Sites that have lost peers have struggled to hire new peers due to workforce shortages, particularly in areas where the cost of housing has increased at a dramatic rate. Turnover has created challenges for Nurture Oregon sites in building and maintaining relationships with local hospitals, as rural hospitals faced COVID-19 surges and reduced staffing due to vaccine mandates.

Due to workforce shortages of peer supervisors in rural/frontier areas, OHA is arranging to offer contracted peer supervision from an experienced peer recovery organization for sites in need of additional support. OHA will also offer additional peer supervision trainings in 2022.

Negative or Stigmatizing Experiences with Systems

Nurture Oregon participants bring past experiences of enacted stigma and at times have experienced stigmatizing responses from hospitals and child welfare staff during their Nurture involvement. Experiences include inadequate pain and withdrawal management, exclusion of the patient from infant care, blaming and biased language and interactions, and other negative experiences. Nurture Oregon team members have worked to lessen the burden of past experiences and intervene when faced with current stigma toward participants. System-level interventions such as education for hospital and child welfare staff are needed.

Lack of Housing and Residential Treatment

An important gap reported by Nurture Oregon teams was a lack of low barrier housing and available treatment beds in most counties. Abstinence requirements for housing made temporary and transitional options unavailable to many unhoused participants or caused repeated instability when participants experienced a recurrence of use. Some housing options do not permit children, requiring participants to vacate once they gave birth. Displacement

increased challenges in maintaining contact with participants, often disrupting participant progress toward goals. Camp sweeps presented similar obstacles.

The lack of availability of treatment beds was also a major struggle for sites, as many participants were interested but unable to secure a bed to support participants in attaining stability during pregnancy.

RECOMMENDATIONS

Nurture Oregon sites are in the early stages of integration. Cross-site collaboration and shared learning provided space for sites to learn from one another and connect on strategies for implementation. To continue to support these efforts, OHA should consider the following recommendations:

- Extend **funding timeframe** to allow sites time to create a sustainable model
- Provide **in-person coaching and practice facilitation** to aid in colocation and integration approaches
- Expand **supportive infrastructure** for sites, such as external/remote peer supervision when needed, a supervisor buddy system, and peer team respite services
- Support development of **video clips and presentations** describing the work of Nurture Oregon and the experiences of pregnant people who use drugs to expand partnerships and reduce stigma and bias
- Consider state-level education and quality improvement for **hospitals** around best practices related to pregnancy and substance use
- Support relationship building with and expanded education for **local DHS Child Welfare**
- Engage **CCOs** in support for Nurture Oregon, such as encouraging prenatal providers to partner and discussing sustainability through payment systems for various peer roles
- Support use of **contingency management** to engage and retain pregnant participants who use methamphetamine
- Prioritize **low barrier housing** options for pregnant people
- Expand outreach to **engage people who are Black, indigenous, and people of color**, as individuals in these groups experience disparities in systemic consequences of drug use; continue learning collaborative sessions on health equity topics such as cultural competence/humility

APPENDIX 1: LAUNCH CHECKLIST

INDIVIDUAL SITE EXPECTATIONS

The following list is intended to organize and capture site commitment to Nurture Oregon program expectations and deliverables. OHA & Comagine will work with each team will complete the details/actions required.

Area	Expectations	Details/Action required
Meetings	☐ 1:1 Launch Site meeting with OHA, Comagine, OHSU	Date:
	☐ Attend cross-site Kickoff meeting with all sites	***Date: 3/12/21 11am-1pm PST***
	☐ 1:1 Site meeting with all affiliated staff, and implementation partners	[day, time, frequency]
Staffing: identify and onboard your services team (internal and external)	☐ Team supervisor/Project Manager	[name, agency, contact]
	☐ Peer recovery support (PSS/CRM)	[name, agency, contact]
	☐ Prenatal medical provider(s)	[name, agency, contact]
	☐ Postpartum medical provider(s)	[name, agency, contact]
	☐ Pediatric care provider(s)	[name, agency, contact]
	☐ Substance use disorder (SUD) treatment counselor/agency	[name, agency, contact]
	☐ Prescriber for medications for SUD (e.g., buprenorphine, methadone)	[name, agency, contact]
	☐ Mental health counselor	[name, agency, contact]
	☐ Other core staff?	[name, agency, contact]
	☐ OPTIONAL: Doula or peer recovery doula	[name, agency, contact]
	☐ OPTIONAL: Home Health Nurse	[name, agency, contact]

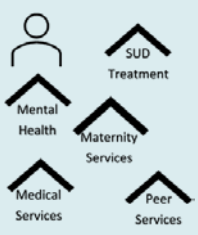
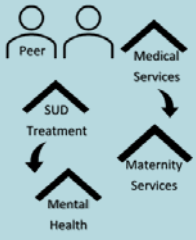
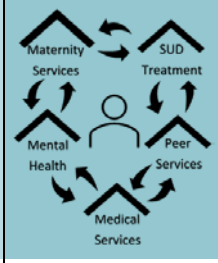
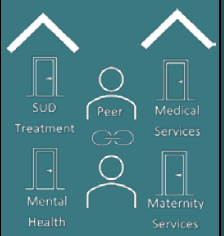
Key services and structures	☐ Start date for beginning services:	For teams/groups, list start date and frequency
	☐ Case management team	For teams/groups, list start date and frequency
	☐ Multidisciplinary team	For teams/groups, list start date and frequency
	☐ Facilitated support groups provided: List type(s)	For teams/groups, list start date and frequency
Role clarity & expectation of team participation	☐ Role clarity related to mission and key program goals	Review mission, vision, values and key program goals
	☐ Team members have allotted time to participate in: o Planning meetings o Learning collaboratives o Cross- site meetings	
Key relationships identified	☐ Local Hospital contact(s)	[Agency/organization, name, contact]
	☐ Child Welfare contact(s), including regional DHS team leaders	CW ART Team Member: CW Case Worker: CW Manager:
	☐ CCO connection made	[CCO contact]
	☐ Other referral sources and community partners (list)	
Documentation, service goals, and reporting and evaluation	☐ Set targets for clients/families served, by quarter o GPRA goals (Lincoln/Jackson):	[Target #s} [#s] Documentation record:
	☐ Plan for service documentation	How do you currently document services?
	☐ Designate person to submit monthly reports to OHA/Comagine **Core Team will report back quarterly*	[Person at site responsible for submitting]

APPENDIX 2: INTEGRATION AND WORKFLOW

LEVELS OF INTEGRATION

Nurture Oregon sites are striving toward integration of physical and behavioral health services. The tables below display a continuum of informational and physical integration, from no integration to full integration.

	Participant led Communication	Referral Based Communication	Verbal Information Sharing	Collaborative Information Sharing	Full Informational Integration	
Information Sharing	Information is not shared across organizations.	Organizations request information from each other through ROIs at time of referral.	One organization takes responsibility of tracking participant info and updating other team members.	Organizations are updating a shared protected tracking sheet.	Multi-discipline access to participant information (ex: shared EHR or database)	Information & Policy Integration
Communication	No consistent communication across organizations. Sporadic referrals may be made, but organizations are largely not aware of community services.	Communication – ad hoc communication among individuals at participating organizations.	Communication – ad hoc huddles, weekly clinical staffing, and MDT meetings.	Regular communication – each organization sends a representative to attend daily huddles, all members attend weekly clinical staffing and MDT meetings.	Regular communication – team attends daily huddles, weekly clinical staffing, and hosts MDT meetings.	
Intake Process	Separate intake and assessments for each service.	Separate intake and assessments for each service, minimal shared information makes this process slightly shorter.	Intakes are funneled through one organization, assessments are separate.	Single intake process through any organization, assessments are separate appointments for each service area.	Single streamlined intake and assessment process.	
Treatment Planning	Treatment planning happens independently, plans and goals may or may not align with each other.	Treatment planning happens separately, shared if requested.	Treatment planning happens separately but is verbally communicated to team (could be sent via secure fax/email).	All providers share treatment plans and consolidate them in a shared protected location.	All providers assume shared treatment plan of participant. Participants don't repeat the same information, everyone on the team has shared knowledge of participant status, goals, plans, etc.	
Team Collaboration	No collaboration across organizations.	Minimal, if any, collaboration across organizations.	Minimal collaboration to distance-based collaboration.	Consistent collaboration across organizations. Organizations that are co-located have more seamless collaboration.	Collaboration and coordination is seamless from participant perspective.	
Shared Values, Goals, and Policies	No shared values or policies across organizations.	Organizations may share goals, but still operate largely independently.	Values and polices are developed separately, but goals may be developed across organizations.	Shared values, culture, and vision is developed across organizations.	Policies, rules, and regulatory frameworks are shared across organizations.	

	Non-Integrated Care	Referral-Based Care	Coordinated Care	Co-Located or Linked Care	Fully Integrated Care	
						Physical Integration
	Participant soley coordinates their care. Services are housed at separate locations and agencies do not communicate. Participant responsible for shuttling from place to place.	Participant primarily coordinates their own care. Participant enrolls in services and then is referred to additional services based on their needs. Peer assists participant with transportation to services.	Care is coordinated through separately housed agencies. Agencies share information as needed to wrap services around participant. Participant still must physically be many places, but there is less repetition of participant needs.	Most services take place at one or two physical locations. Peers link the physical spaces by accompanying participant across all services. For example, all services occur within a behavioral health program except OBGYN, which has set aside an hour per day for program participants but are available at other times as well.	Care is fully integrated, with all services housed at the same location. Participant is able to access all services regardless of which "door" they enter through.	

CLARIFYING SERVICES AND ROLES

- **Who** is your Core Nurture Oregon Team?
    - Identify roles and clarify individual responsibilities, as well as collaborative crossover
    - Identify point person/people for tracking Nurture Oregon participants, reporting to Comagine/OHA, and scheduling services for
    - How do team members communicate – identify potential challenges in language and communication across disciplines.
- **Where** will services take place for Nurture Oregon?
    - Are you able to offer services in one location?
    - If no, where will services take place and how will you coordinate travel between sites?
- **When** will Nurture Oregon services take place?
    - The original pilot Project Nurture laid out dedicated days of the week where all services would take place.
- **What** is the referral process for potential Nurture Oregon participants?
    - What local organizations will you develop relationships with, in order to create referral pathways?
    - Who will be the point of contact for incoming referrals (what is the phone number/email address to list on promotional materials)?
- **How** will you coordinate/integrate care across agencies?
    - How will point person coordinate across sites/disciplines to schedule appointments for clients?

- How will the Nurture Oregon team track client information; including general contact information, demographics, physical health, behavioral health, and goals?
- Will you provide participants with any tangible assistance for scheduling?
    - Ex: Oasis clinic provides clients with a planner with updated appointments, responsibilities, and goals throughout their participation in the program.
    - Who will follow up with participants after missed appointments?
- What tangible support will Nurture Oregon provide?
    - How will Nurture Oregon assist in addressing SDOH within this program? Ex: Transportation, food, housing assistance, clothing, post-natal supplies, financial support, etc.
    - How can you make the program fun? Ex: incentive programs!

BREAKING DOWN WORKFLOW

Nurture Executive Tasks

Executive Tasks
Develop relationships and partnerships with community organizations and agencies to expand referrals into Nurture Oregon, raise awareness of the program, and identify potential partners.
Inform and train all members of site organizations on Nurture Oregon and ensure team members are using destigmatizing language and creating a safe space for all program participants
Create a stigma-free, safe environment for pregnant people
Approach work with hope and optimism

Specific Nurture Project Tasks

Project Tasks
Create a stigma-free, safe environment for pregnant people
Approach work with hope and optimism
Direct program outreach to pregnant people who are using substances within your community
Orient new participants to services and completing intake form
Distribute safe sleep materials and information
Transport participants and attending appointments with them
Facilitate support groups and psychoeducational groups using anti-oppressive practice
Lead clinical huddles and/or multi-disciplinary staff meetings
Attend all clinical huddles, multi-disciplinary staff meetings, and trainings
Facilitate development of the Plan of Care with participants and their support people
Communicate with local child welfare offices as needed

Update and maintain participant files and notes

Maintain and update Nurture Oregon data tracking sheet and submit monthly to Comagine/OHA

Distribute and monitor program feedback from participants

Onboard and train new staff members

Roles and Responsibilities

Review the table of roles and responsibilities with your team, insert your titles, names, and organizations. Discuss and assign specific tasks for each person to clarify roles and expectations. Be sure to include the tasks outlined above and indicate which tasks are shared among multiple team members or the entire team.

Nurture Oregon Team

Role	Title	Name	Organization	Tasks
Nurture Oregon CORE ROLES				
Team Supervisor				▶
Project Coordinator				▶
Peer Recovery Support				▶
Prenatal Medical Provider				▶
Postpartum Medical Provider				▶
Substance use disorder (SUD) treatment counselor				▶
Prescriber for medications for SUD				▶
Mental Health Provider				▶
Other Core Team Members [EXAMPLES]				

Pediatric Medical Provider	▶
Doula	▶
Home Health Nurse	▶
Housing specialist	▶
Other	▶
Other	▶
Tasks Shared Across Team	
▶	
▶	
▶	
▶	
▶	

Minimum Services Offered

At a *minimum*, Nurture Oregon participants should expect to have **once weekly** contact with someone from the Nurture Oregon team.

Service	Specifics	Frequency
	Type/Intensity	
SUDS Treatment		
	Withdrawal Management	
	Outpatient	Based on ASAM Assessment
	Intensive Outpatient	Based on ASAM Assessment
	Inpatient/Residential – not explicitly part of Nurture Oregon	
	Trimester	
Prenatal and Postpartum Care	First Trimester	3+ visits
	Second Trimester	3+ visits
	Third Trimester	10+ visits
	Post-Partum	Contact within 3 weeks of giving birth Ongoing care as needed Postpartum check-up within 12 weeks of giving birth

	Infant Age	
Pediatric Care	0-2 months	3+ visits
	3-6 months	2+ visits
	7-9 months	1+ visit
	10-12 months	2+ visits
	Counseling Type	
Mental Health Services	Individual	As needed
	Group	As needed
	Family – not explicitly part of Nurture Oregon	
	Couple– not explicitly part of Nurture Oregon	
	Topics	
Support Groups	*Recovery Support*	As needed
	Practical Support	As needed
	Process Support	As needed
	Other Support	As needed
Peer Services	Outreach	Weekly
	In-Person Visits	As needed
	Virtual Communication	2+ weekly
	Transport and Accompany Participants to appointments	As needed
Harm Reduction Services	*See Nurture Oregon Workbook for detailed information on harm reduction specific to pregnancy*	As needed

Intake Process

To streamline the intake process for Nurture Oregon, sites are encouraged to use the intake form created by OHA & Comagine Health.

Schedule of Services

The goal of integrating care for Nurture Oregon is primarily based on patient experience. To provide continuity of care, a set schedule is recommended for Nurture Oregon services. While there will be ad hoc time for appointments to be scheduled, it is beneficial to set aside time each day, or multiple times a week, where Nurture Oregon participants get priority in scheduling, of providers are regularly available for discussion with team members, etc. Below is an example of what a weekly service provision schedule may look like. Please take the time to work with your team to create a service schedule for your site.

Weekly Services Provided Example

Monday	Tuesday	Wednesday	Thursday	Friday
▶ Peer at SUD Treatment Center ▶ Coordination of care within the Nurture OR team	▶ OB visits ▶ MOUD/SUD Treatment visit ▶ Group session: Recovery Support Group ▶ Peer visits	▶ Peer at OB office	▶ OB visits ▶ MOUD/SUD treatment visit ▶ Group session: Process Group ▶ Peer visits	▶ Peer Outreach in Community

List your site's weekly services below:

[SITE NAME] Weekly Services Provided

Day	Services	Time	Location	Provider/Facilitator
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday/Sunday				

Meetings and Communication

Similar to scheduled service provision, setting a schedule for meetings is crucial to have consistent and accurate communication within the Nurture Oregon team and external partnering organizations and agencies.

Meeting Type	Purpose	Attendees	Frequency
Implementation Huddle	Check-ins with each site to share implementation progress, barriers and needs. A time to collect information on overall site progress, concerns, questions, or barriers to implementation.	Core Site team, OHA, Comagine, ODHS CW, OHSU	Weekly or Bi-Weekly
Daily Huddle	Huddles are typical in medical models of care. Huddles are brief (10-30 min.), typically daily meetings where team members review patients, needs for the day, and divide tasks to be accomplished (i.e. transportation support, doing outreach to find a participant, etc.). Medical providers may or may not be present.	Core Site Team	Daily
Clinical Staffing	Program staffing meetings include medical providers and allows for case presentation and review of more in-depth issues or challenges. Length could be 30-60 minutes. These could be in place of huddles, allowing for more dedicated time to discuss the basics (from the huddles), client progress or successes, and client challenges.	Core Site Team	Weekly
Multidisciplinary Team (MDT)	Multidisciplinary Team (MDT) meetings involve outside partner agencies like Child Welfare or criminal justice/parole or probation. They typically are at least 60 minutes. Some sites are already involved in MDT meetings in their community – these can be important places to ensure referral pathways into Nurture Oregon.	MDT members	Weekly to Monthly

Weekly Team Communication Example

Monday	Tuesday	Wednesday	Thursday	Friday
▪ Weekly Clinical Staffing Meeting (1 hr) ▪ Monthly Project Update with Partners (1 hr)	▪ Daily Huddle (15 mins)	▪ Daily Huddle (15 mins)	▪ Daily Huddle (15 mins)	▪ Daily Huddle (15 mins)

List your site's weekly communication/meeting schedule below:

[SITE] Weekly Team Communication

Monday	Tuesday	Wednesday	Thursday	Friday
▪	▪	▪	▪	▪

This report was prepared by Comagine Health (Gillian Leichtling, Sara Magnusson, Kyn Kappesser) under contract number 167605 for the Oregon Health Authority (OHA). Nurture Oregon site teams generously shared their efforts and experiences, and dedicated time to data collection and entry. Nurture Oregon leadership team collaborates with Oregon Department of Human Services (ODHS) Child Welfare and the evaluation team at Oregon Health and Sciences University.

The Nurture Oregon leadership team consists of Gregory Bledsoe and Samantha Byers of OHA; Julia Vance of the pilot Project Nurture; the authors and Christi Hildebran of Comagine Health.

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