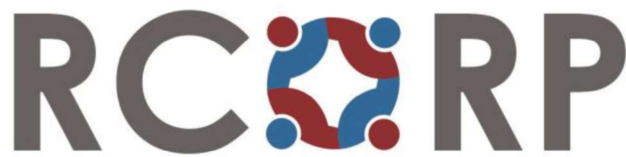

Template: Behavioral Health Disparities Impact Statement

Last Updated June 20, 2023

This guidance is to assist in the development of the Behavioral Health Disparities Impact Statement (DIS), as outlined in the RCORP Notice of Funding Opportunities. The DIS will describe how the consortium plans to reduce behavioral health disparities in the target rural service area(s) and to continuously monitor and measure the project's impact on health disparities in order to inform process and outcome improvements. Grantees will report annually the consortium updates and progress made in the service area.

Grantee Organization Information		
Consortium Name	HIWAY Consortium Awardee/Fiscal Agent: Samaritan North Lincoln Hospital	
Grant Number	GA1RH45981-01	
Address	Street:	3043 NE 28th St.
	City, State:	Lincoln City, OR
Service Area	Lincoln County	
Project Director	Name:	Jolynn Meza Wynkoop
	Title:	Project Director/Data Coordinator
	Phone Number:	541-971-9786
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Contributing Consortium Members and Stakeholders	ReConnections Counseling	
	Northwest Coastal Housing	
	Samaritan House	
	Samaritan North Lincoln Hospital	
	Samaritan Pacific Communities Hospital	
	Faith, Hope and Charity	
	Olalla Center	
	Confederated Tribes of Siletz Indians	
	Partnership Against Alcohol and Drug Abuse (PAADA)	

STEP 1–ASSESSMENT

Identify subpopulations vulnerable to behavioral health disparities within the service area and the specific behavioral health disparities experienced by these subpopulations.

- List the subpopulations in your service area vulnerable to behavioral health disparities. Subpopulations may be based on race, ethnicity, tribal entities and organizations, language, age, socioeconomic status, gender identity, sexual orientation, people who are pregnant, adolescents and youth, veterans, older adults, individuals with special needs, and other relevant factors (e.g., literacy).
- Identify the behavioral health disparities in access, use, and outcomes that currently exist within identified subpopulations.
- Select one subpopulation from your data on which to focus your work.

Subpopulations	Health Disparities
Pregnant people with SUD	**Access** • Inaccessibility to affordable health care • Inaccessibility to local providers due to workforce shortages • Inaccessibility to transportation to services • Mental health barriers (related to guilt and shame associated with being pregnant and having SUD/OUD) **Use** • Stigma faced by healthcare providers • Discrimination in the hospitals • Unsupportive partners or family **Outcomes** • Neonatal Abstinence Syndrome • Neonatal Opioid Withdrawal • Higher mortality rates • Poorer mental health • Babies taken from parent at birth to be placed in foster care
Enrolled tribal members with SUD	**Access** • Inaccessibility to affordable healthcare • Inaccessibility to affordable housing due to having an SUD • Historical distrust of authority or surveillance type organizations/systems **Use** • Shame associated with accessing services • Multigenerational belief/values that health system will not understand needs • Cultural related stigma • Fear of breach of confidentiality • Stigma influences the decision to access treatment services **Outcomes** • Mental illness

	• Suicide • Overdose • Loneliness/isolation
Adolescents and youth with SUD	**Access** • Limited access to services specific for youth • Limited access to transportation • Limited knowledge on what is provided in the community (not only in the schools) • No SUD residential treatment in Lincoln County for youth (or adults) • Inappropriate parentified behavior among youth – causes youth to miss out on opportunities • High deductibles for youth with private insurance make SUD services not feasible for families. **Use** • Having to have parents' consent to receive certain services • Long wait times for behavioral health and mental health services • Workforce shortages cause limited supply of workforce to serve youth • Stigma associated with accessing services • Treatment for SUD becomes more informal/temporary (related to crisis) vs related to lifestyle/behavioral changes **Outcomes** • Poor mental/behavioral health • Disassociation • Loneliness • Anxiety • Depression • Suicide • Overdose
LGBTQIA2S+ population with mental & behavioral health needs & SUD	**Access** • Inaccessibility to organizations with gender-affirming care • Inaccessibility to providers with non-binary related health knowledge • Inaccessibility to trusted providers who are welcoming and compassionate (first impressions are important) **Use** • Feelings of unsafety related to their identity • Living with different identities to different groups of people due to fear of acceptance • Unhealthy use as coping mechanism or escapism **Outcomes** • Depression • Trauma • Loneliness • Increase in substance use that can then become disorder

<table>
<tr>
<td>Latinx/o/a population with SUD</td>
<td>Access
• Shame associated with admitting there is a problem present, living in denial
• Lack of knowledge related to mental health or substance use
• Communication barriers (not being able to express what they are truly feeling)
• Trust issues with authority
• Generational/cultural barriers that are rooted in family history
• Immigration related barriers
• Being undocumented brings fear related to accessing services (Oregon Health Plan, public charge)
• Limited access to information related to services that are available to them
• Lack of services offered in native languages
Use
• Protective of their perception by others
• Fear of being unheard even they are being open and sharing
• Monetary impact on families
• Eligible clients/patients self-select away from needed services and resources
• Behavioral or physical health symptoms are minimized or ignored

Outcomes
• Poor mental health
• Increase in substance use</td>
</tr>
<tr>
<td colspan="2">Selected Subpopulation of Focus:</td>
</tr>
<tr>
<td colspan="2">The Helping Impact Women and Youth (HIWAY) Consortium serving Lincoln County, OR, has selected pregnant people with substance use disorders (SUD) as the subpopulation of focus for the Disparities Impact Statement. In selecting this subpopulation, we plan on serving a diverse group of individuals who also encompass the other subpopulations mentioned above: enrolled tribal members, adolescents and youth, those who identify as LGBTQIA2S+ and the Latino/a/x populations. Partners have made pregnant individuals with SUD a priority since Project Nurture began in 2021. During this first year, the project reached 13 individuals with SUD. In 2022, the project reached 13 more individuals. With the start of the HIWAY grant in September 2022, this population continued to remain a focus and we anticipate being able to serve more pregnant people through services offered. This population was also chosen as the subpopulation of focus for the DIS due to it being a key area of focus for the region with the goal of seeing an increase in pregnant people with SUD served through the HIWAY grant efforts.</td>
</tr>
</table>

STEP 2 –CAPACITY

Explain how you will build the capacity of the consortium, partners, and community stakeholders to address behavioral health disparities.

- Describe the overall capacity and history of collaboration in the service area to meet the behavioral health care needs of the identified subpopulation.
- What resources currently exist in your service area to address behavioral health disparities?
- What is the readiness of the consortium, partners, and community stakeholders to address behavioral health disparities in selected identification (e.g., Is there any related stigma, lack of resources, or challenges that the consortium or stakeholders will face)?
- How will you reach out to subpopulations experiencing behavioral health disparities and involve them in community-level, capacity-building efforts?

- The twelve member Helping Impact Women and Youth (HIWAY) Consortium was created out of the identified need to address the lack of services for pregnant women and youth in Lincoln County. The Lincoln County HIWAY Consortium is comprised of organizations from treatment, prevention and recovery organizations including Samaritan North Lincoln Hospital (SNLH), Samaritan Pacific Community Hospital (SPCH), Samaritan Medical Group (SMG), Confederated Tribes of the Siletz Indians (CTSI), ReConnections Counseling, Samaritan House, Partnership Against Alcohol and Drug Abuse (PAADA), Lincoln County Health and Human Services (LCHHS), Olalla Center, Faith Hope and Charity (FHC), Lincoln County Sheriff's Office, (LCSO) and Northwest Coastal Housing – Coastal Phoenix Rising (NWCH-CPR).

  The HIWAY Consortium is supported and overseen by the Coast to the Cascades Wellness Network (CCCWN). Established in 2009, the CCCWN is a mature consortium of 24 organizations, including hospitals, health departments, schools, and a range of community-based organizations, working together to develop and sustain local health-related programs and initiatives in Lincoln, Linn and Benton counties. In 2017, CCCWN members voted to prioritize mental health, with a focus on the opioid epidemic and created a Mental Health Substance Use Disorder Subcommittee (CCCWN/MHSUD). The twelve members of the HIWAY project consortium are all members of the CCCWN/MHSUD and many are also members of the regional CCCWN. The CCCWN provides guidance and support as the HIWAY project implements project activities. This focused Consortium includes members from prevention, treatment, recovery, and the lived experience community and has a history of supporting member activities.

  The CCCWN has extensive experience implementing collaborative projects in rural communities. The HIWAY consortium members have been working together for many years, collaborating on projects well before the HIWAY grant began on September 1, 2022. While all consortium members provide services to pregnant individuals, three organizations provide more specific services to pregnant individuals through a project called Project Nurture. Project Nurture, piloted as Nurture Oregon in 2015, is a rural integrated care model for pregnant families. It includes peer recovery support services, prenatal and postpartum

care, substance use and mental health treatment and service coordination. After the Oregon Health Authority (OHA) piloted this project in 2015 in Multnomah County and saw an increase in prenatal visits, reduced placement of children into foster care and overall cost savings, the Oregon legislature mandated the expansion of the project into rural counties specifically focusing on underserved families. Funding was awarded to five counties in Oregon with Lincoln County being one of them. ReConnections Counseling was the grantee recipient for Lincoln County and has been working on this project since 2021.

- Through the growth of Project Nurture, pregnant individuals are served in a variety of ways. Individuals receive care coordination, mental health services, opportunities to attend support groups, substance use treatment, medication assisted treatment, prenatal and postpartum care, and many other services. Some organizations who are currently working with Project Nurture to reduce health disparities of pregnant people with SUD include ReConnections Counseling (behavioral health treatment and peer support services), Samaritan House (supportive housing and childcare program), Lincoln County Health and Human Services Maternal Child Health (home visiting nursing program), Integrity Women's Health (consultation services), the Community Doula Program, SNLH – Women's Clinic and SPCH. Additional resources targeting behavioral health disparities are listed below.[1]

- The HIWAY consortium and partners are ready and have already been providing services to the target subpopulation, pregnant people with SUD. Partnerships amongst organizations can always be improved and more service availability is needed. We plan to continue serving pregnant people with SUD and expand our reach over the next few years with our RCORP Implementation IV grant funding. Of the health disparities experienced by people with SUD, the largest is due to shame and stigma associated with being pregnant and using (or used in the past) drugs or alcohol. The goal of the work associated with the HIWAY grant and Project Nurture is to empower pregnant individuals to take back their health and to realize that they are worthy of receiving services, no matter their substance use, or substance use history. It's also a goal to have babies being born healthy, not placed into foster care, and engage in services throughout their first year of life. Stigma can be faced by the pregnant individuals from family members, community members and healthcare professionals. This can lead to individuals not seeking care for themselves and their child, such as accessing treatment services for substance use. If services are not accessed, this could lead to poor health outcomes for the parent and baby such as miscarriage, preterm labor, birth defects, stillbirth, neonatal opioid withdrawal syndrome, neonatal abstinence syndrome, a higher risk of sudden infant death syndrome (SIDS), poor fetal growth rate, and cognitive and behavioral problems.

  One success that has already been identified is the increase in communication and referrals from SNLH to ReConnections Counseling for pregnant women with SUD seeking Project Nurture services. In 2021, 8% of referrals to Project Nurture occurred via hospitals/emergency departments/healthcare providers. After an increase and education within the hospitals in 2022, this increased to 46%. The goal is to continue seeing an increase in referrals as healthcare providers see the advantages and successful outcomes of their patients who are involved with Project Nurture. Healthcare providers have reported feeling "burnt out" when interacting with repeat hospital emergency department admittees with substance use concerns. Having a program such as Project Nurture, which shows positive health outcomes in providing compassionate support for someone with SUD, can be very impactful in influencing the stigmas that healthcare providers have towards people

with SUD. We hope that those working with Project Nurture to support pregnant women can continue to help remove stigmas associated with individuals who use substances.

- Outreach to pregnant people with SUD occurs through a variety of pathways. As mentioned above, many organizations are involved with connecting individuals to services. As the individual engages in services, they are involved in the decision making and planning for their care. After a year of giving birth, the individuals have the opportunity to engage with Project Nurture supports to continue on a path of recovery and healing. As the project progresses, we can invite these individuals to be a part of our committees as we are open to individuals with lived experience with SUD. Additionally, we are in the process of developing a stigma reduction media campaign and we will reach out to these clients to see if they have interest in helping to plan the campaign. We will also need key messengers and people with lived experience to share their voices and stories. This in turn gives hope to other pregnant people with SUD who might be considering reaching out for support.

Lincoln County SUD/OUD Services and Programs

General health services: Lincoln County is served by Samaritan North Lincoln Hospital (SNLH), a 16-bed Critical Access Hospital located in Lincoln City and Samaritan Pacific Communities Hospital (SPCH), a 25-bed Critical Access Hospital, located in Newport. Mental health services are integrated into all eight clinics, as well as one Community Health Center and four school-based health centers.

SUD/OUD treatment services: Opioid treatment services are extremely limited in Lincoln County. Lincoln County Health and Human Services (LCHHS), along with Samaritan Health Services (SHS) and Samaritan Medical Group (SMG) are working to increase services in the region. They are working together to recruit and retain providers who specialize in substance abuse treatment. These partners have identified priority areas of need for psychiatrists, psychologists, and clinical social workers to support uninsured and underinsured patients. The partners are also identifying ways to share space as well as electronic health records to promote continuity of care for patients.

Al-Anon, Ala-Teen (District 2): Various churches in Lincoln City and Newport host support groups for people affected by someone else's SUD. There is a mix of in-person meetings, online meetings, and hybrid in person/online meetings.

Alcoholics Anonymous (District 2): Meetings in Depoe Bay, Lincoln City, Newport, and Waldport. Daily 12-step recovery meetings are available.

Medication Assisted Treatment Prescribers:

- Jason Brown, Samaritan Toledo Clinic
- Jamey Burris-Fish, Lincoln County Bridges to Recovery Office Based Addition Treatment Program in Newport and Lincoln City
- Jason VanErickson, Lincoln County Bridges to Recovery Office Based Addition Treatment Program in Newport and Lincoln City
- David Long, Lincoln County Jail in Newport
- Lisa Taylor, Siletz Clinic
- Randall Kelly, Equinox Clinics in Newport and Lincoln City
- Rio McWilliams, Equinox Clinics in Newport and Lincoln City
- Christine McCambridge, Changing Tides in Depoe Bay
- April Castillo, Changing Tides in Depoe Bay

The Confederated Tribes of Siletz Indians (CTSI): CTSI provides SUD and Opioid Use Disorder (OUD) treatment. There are limited MAT services available at the Siletz Clinic. The Tribe also provides peer mentor support services for MAT clients, group counseling and community outreach. The Tribe is working to expand MAT services to address the growing need among the CTSI community.

Equinox Clinics: Equinox Clinic is a medical practice located in Newport and Lincoln City that provides outpatient substance use and opioid use disorder treatment including MAT, counseling, 12-step facilitation, and group therapy.

Faith, Hope and Charity (FHC): FHC provides peer support services to all individuals specifically targeting those who identify as Black, Indigenous, People of Color.

Integrity Coastal Health & Wellness (ICHW): ICHW is an independent multi-specialty practice in Newport, OR. They provide primary care and gynecologic services, including office/clinic-based services. They also provide specialty health services for trans, non-binary, and genderfluid individuals, seeking to maintain a respectful and welcoming space for the LGBTQIA2S+ community.

Lincoln County Health and Human Services (LCHHS): LCHHS provides outpatient substance use and opioid use disorder screening and treatment that is affordable and available to all. Limited MAT services are available. Health Navigators and Promotoras are available to assist Spanish speakers.

Northwest Coastal Housing – Coastal Phoenix Rising (NWCH – CPR): NWCH-CPR provides transitional housing, case management and transportation to pregnant and childbearing age women in SUD/OUD treatment and recovery.

Olalla Center: The Olalla Center for Children and Families is a community-driven, community-based organization that provides mental health services to heal children and families and has been approved as an emerging Family Relief Nursery. The Olalla Center provides a range of individual, group, and family therapy programs and outpatient services ranging from nature-based mental health programming to equine-assisted therapy. Relief Nursery services include wrap-around support for families overcoming SUD/OUD. All services are available in English and Spanish.

Partnership Against Alcohol and Drug Abuse (PAADA): PAADA is a grassroots community coalition working to empower youth and adults to make healthy decisions and to reduce the use or abuse of alcohol, tobacco, and other drugs. PAADA strives to increase community collaboration and reduce youth substance use. Primary focus areas include community education and outreach through events such as Drug Task Force Summits, Youth Leadership Academies and Restorative Justice trainings.

Phoenix Wellness Center: Phoenix Wellness Center provides substance use counseling services both one-on-one and in group settings. Additionally, they host culture groups, wellness groups, dialectical therapy, family support, parenting classes, case management, peer support services, youth specific services, and DUII A&D rehabilitation and education.

Power House Detox: Power House is a voluntary, 24-hour, inpatient, medically supervised substance detox center location in Otis, OR. The center is staffed by nurses 24/7 and a local PA-C or MD provides daily visits to clients. They help in personalizing services and the detox course of treatment. Power House offers Suboxone for acute withdrawal symptoms and assistance in setting up MAT on an out-patient basis.

ReConnections Counseling: ReConnections Counseling provides regular and intensive outpatient SUD services that are culturally relevant and language responsive; individual and group therapy; women's transitional housing; case management and transitional services; peer services; and DUII services provider to people in Lincoln County. ReConnections targets uninsured, underinsured, unhoused, racially and ethnically diverse, LGBTQIA2S+, veterans and immigrant people in Lincoln County.

Samaritan House: Samaritan House is a non-profit organization that serves families with children experiencing homelessness. Samaritan House provides transitional housing, emergency shelter, parenting education, resident education, and childcare.

Regional Initiatives and Organizations

Coast to the Cascades Community Wellness Network (CCCWN): The CCCWN provides leadership and support for community partnerships to improve community health in Benton, Lincoln, and Linn counties.

Family Tree Relief Nursery (FTRN): FTRN, based in Albany, OR, is a private nonprofit that supports and strengthens families experiencing stress as a result of poverty, domestic violence, SUDs, mental health issues and other challenges. SUD recovery support services include alcohol and drug outreach, family treatment court and peer mentorship. They serve communities across the region, including Lincoln County.

Opioid Task Force: The Opioid Task Force is a tri-county task force that brings together medical professionals, public health officers, and law enforcement to increase public education on opioid use, reduce the number of pills in circulation, and foster leadership from across the community.

Community Harm Reduction Mentors and Allies (CHRMA): CHRMA is a tri-county collaboration between health and social service partners to promote use of evidence-based harm reduction practices. The coalition sponsors special trainings for professionals and community members.

Samaritan Health Services (SHS): SHS is a nonprofit network of five hospitals, clinics and health services caring for more than 250,000 residents in mid-Willamette Valley and central Oregon Coast. SHS hospitals are in an ideal position to influence professional education, workforce development, prescribing, treatment and recovery services as well as community education on SUD.

Samaritan Treatment and Recovery Services (STARS): STARS, located in Lebanon, OR, is a 16-bed co-ed residential treatment center. Services provided include outpatient SUD treatment, MAT and peer-delivered recovery support.

STEP 3–PLANNING

Provide a plan for addressing behavioral health disparities in the identified subpopulation, including incorporating effective strategies to increase access to care. Please note how many individuals in the subpopulation you will reach and how you will measure that reach.

Access:

Describe:

- Current access to care for your identified subpopulation (e.g., Are substance use disorder services providers available in the service area to treat your identified subpopulation, or do individuals have to travel for treatment? Are services affordable? Are individuals in the identified subpopulation aware of available services?)
- Current quality of care for your identified subpopulation (e.g., Are providers available to your identified subpopulation who have shared language, race, ethnicity, gender identity, and sexual orientation? Are providers engaged in ongoing educational opportunities and continuous quality improvement?)
- Strategies and culturally and linguistically appropriate services (CLAS) standards that you will use to address behavioral health disparities and to increase access to care among your identified subpopulation (Please see Attachment B.)

- The HIWAY consortium aims to reach 20 pregnant people with SUD and connect them to SUD services between September 1, 2022 – August 31, 2023. In 2021, Project Nurture served 13 pregnant people with SUD and in 2022, Project Nurture served 13 additional pregnant people with SUD. Measurements for our DIS will take place through Project Nurture data collection and SNLH & SPCH data collection. One goal the consortium has is to reduce the number of babies being born with neonatal abstinence syndrome (NAS) or neonatal opioid withdrawal syndrome (NOWS). In 2020, 12 babies were born in Lincoln County with NAS/NOWS. In 2021, this number rose to 14 and in 2022 there were 13. As of today, there has been one baby born in Lincoln County with NAS/NOW in 2023. We anticipate the number of babies being born with NAS/NOW to decline due to the efforts in place through Project Nurture and the HIWAY grant.

- Access to care is a focus of our consortium as many of our partner organizations are committed to assisting individuals seeking services. As mentioned in Step Two, there are a variety of substance use providers in Lincoln County and organizations work together to find the best fit for the client seeking services. MAT is available for clients and can be accessed easily as there are many providers available in Lincoln County. Within the last three months, Changing Tides in Depoe Bay hired one new Family Nurse Practitioner who can prescribe MAT. Residential treatment is one area in which Lincoln County is lacking, however, SHS plans on opening the first residential treatment center on the coast in Newport in 2025. There is one 24-hour detox center, but it is located in the north part of the county and is not easily accessible. Most services are covered under the Oregon Health Plan, and SHS does

not refuse services to anyone regardless on their ability to pay. With Project Nurture being the current largest capture point for pregnant individuals with SUD, people are becoming more educated about the services that are available in Lincoln County.

- As mentioned in Step Two, there are providers in Lincoln County who are open to serving pregnant people with SUD who have diverse languages, races, ethnicities, gender identities and sexual orientations. One organization in particular, Integrity Coastal Health & Wellness, specifically notes on their website that they are the "only medical provider on the Oregon coast who offer specialty health services specifically to trans, non-binary & genderfluid individuals and they are committed to providing a safe, respectful and welcoming space to the LGBTQIA2S+ community." Additionally, ReConnections Counseling has a bilingual staff who is working on the HIWAY grant and Project Nurture and she provides services in Spanish and English. She has been working as a peer support specialist and is getting her medical interpreter license and Doula certification to work in the hospitals. She has specifically been doing outreach among the Latino/a/x populations to build trust in the community. Another large population within Lincoln County is the Confederated Tribes of the Siletz Indians. In Siletz, there is a community health clinic located there and native Siletz individuals work there and are able to provide services to other enrolled tribal members. The Olalla Center is a mental health treatment provider and a great partner on the HIWAY grant. They work to provide safe spaces for members of the LGBTQIA2S+ community and have been actively doing outreach within the community. They are involved with the schools and attend youth LGBTQ+ meetings and have been involved in the formation of Lincoln County Pride events. Finally, continuing medical education (CME) across the SHS system is always available to all providers and staff. Recently, on March 21, 2023, members of the SHS community attended a CME opportunity on gender affirming care. Participants learned about the healthcare needs of transgender and gender diverse patients and learned about methods to improve communication with these patients. They also learned about resources and references to consult when looking up clinical information about providing gender transition services. Providers have also recently attended SHS CME opportunities on managing acute pain in patients with opioid use disorder, new & trending marijuana products, empathetic communication, cannabis and cannabinoids, increased engagement in SUD treatment, human trafficking and much more! SHS is committed to continuing to provide new and up to date information and seminars to their staff and the community.

- One strategy that will be utilized amongst the CLAS standards to address behavioral health disparities for pregnant people with SUD is the principal standard: "Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs." This will occur through two methods. The first will involve the continued strengthening of partnerships between behavioral health providers, SHS & SMG staff, medication treatment providers, and wraparound community support services. As partnerships continue to grow and strengthen, and stigma begins to be reduced amongst healthcare professionals, more pregnant people with SUD will be empowered to receive

treatment and care. The second will involve continued education amongst providers. Many OBGYN providers attend CME opportunities and are eager to learn more about substance use and how it affects people who are pregnant. Not only is it important for providers to receiving trauma informed and compassionate training on how to interact with this population, but it is also important to expand this training to support staff, nurses, front desk workers, etc. It only takes one person to say something negative or judgmental for a pregnant individual with SUD to have an experience that makes them not want to return. Additionally, individuals might have had previous experiences feeling shame or stigma related to their SUD and have the perception that staff at the hospital are not going to be supportive.

Reach:

- *In Attachment A*, identify the number of individuals in the subpopulation your strategies anticipate reaching during the award period. Identify the data source/tool you will use to gather your data.
- *Below*, explain how you will monitor the implementation of the DIS and the reach of your strategies to decrease health disparities among the identified subpopulation.
- Describe your process for continuously collecting the Performance Improvement Management System (PIMS) demographic data on the identified subpopulation reached by your efforts and how you will work with your consortium to collect these data. Include data sources and the frequency of data collection (e.g., annual, biannual).
- How will you reach out to subpopulations experiencing behavioral health disparities and engage them in the planning process?

- The number of pregnant people with SUD that will be reached are estimated to be 20 individuals between September 1, 2022 – August 31, 2023. During year two (September 1, 2023 – August 31, 2024), we plan on providing services/receiving referrals for 22 pregnant people with SUD. In year three (September 1, 2024 – August 31, 2025), we plan on providing services/receiving referrals for 24 pregnant people with SUD.

- Monitoring of the implementation of the DIS will be through routine data collections from Project Nurture and SNLH & SPCH. The project director/data coordinator for the HIWAY grant will also receive monthly updates from HIWAY grant partners on the progress of providing services to pregnant individuals with SUD. The project director/data coordinator also anticipates working directly with the state Project Nurture directors to collect data surrounding demographics of the people served.

- Currently, data specific to pregnant individuals with SUD is not collected specifically through PIMS. PIMS does collect individuals screened and diagnosed with SUD, so those numbers will overlap with individuals being served through the DIS. Additionally, all those screened

and diagnosed for SUD include demographic data. For future PIMS reporting periods, the project director/data coordinator can include the number of referrals to Project Nurture under the "Referrals" metric in PIMS. This data will be collected biannually from partners and will be collected through individualized Excel Spreadsheet PIMS reporting forms.

- Pregnant people with SUD are targeted with outreach activities each week by a group of peer support specialists that meet with the Project Nurture team. The team decides which peer will make the initial contact with the potential client. Referrals from the hospital and other partners come in through a Google form. Peers can then reach out via phone to have the first engagement with the client. Since Project Nurture has been a program that has been in place since 2021 in Lincoln County, there isn't a need to begin a new planning process. We will continue to monitor progress and augment the program with RCORP HIWAY funds. We plan on partnering with pregnant people with SUD by inviting them to trainings, to speak as a person with lived experience, and to give voice to the media campaign that was mentioned in Step Two.

STEP 4–IMPLEMENTATION:

Implement programs, policies, and practices that focus on the identified subpopulation vulnerable to and/or experiencing behavioral health disparities. Describe:

- How you will you engage, support, and communicate with the identified subpopulation throughout implementation
- Your approach for ensuring that evidence-based programs, policies, and practices are adapted and/or tailored to meet the needs of these identified subpopulations
- How each approach (program, policy, or practice) links to an appropriate CLAS standard

- The current Project Nurture community team includes SHS, ReConnections Counseling, Samaritan House, Northwest Coastal Housing – Coastal Phoenix Rising, home health nurses and the community doula program. Participants in the Project Nurture program receive communication from a peer on a weekly basis. Depending on the stage of their pregnancy will determine the number of engagements that individual has with a peer. Peers accompany clients to doctor's appointment and help monitor treatment process. Additionally, clients participate in group sessions both before and after the baby is born.

- Project Nurture has been operating since 2021 and has given time to the Lincoln County Project Nurture team to adapt and make changes to processes. Project Nurture staff will continue to receive feedback from clients and state agencies and make changes where necessary. It's also important to note that not every client that is a part of Project Nurture has the same plan, timeline, or needs. Some clients may need more mental health support while others might need more support with their withdrawal management. Some might want to participate in group counseling sessions while others might like a one-on-one format

better. It's important to note that the experience for each client can be tailored and changed based on the clients needs. Additionally, if there is a specific language request, staff will work to meet that request either through translation services or in finding a peer support specialist who speaks the client's language.

- This approach of serving pregnant people with SUD with needs-specific services allows for all people to be seen in their uniqueness. Every client is different and its important to treat each and every person with respect and care that is individualized. Again, referring back to the Principal Class Standard, it's important to point out that diversity in cultural health beliefs and practices is a key aspect. Every person has their own culture, their own set of beliefs, and their own experiences in how they have received healthcare in the past. Project Nurture and HIWAY grant members are committed to making people feel comfortable and that their beliefs and culture are being respected while receiving services. The goal is to send a healthy new parent home with their new child and for them to be set up to make healthy decisions in their recovery journey. Language, health literacy and communication are prioritized by allowing for a peer support specialist to attend all the client's health appointments with them and to provide interpretative services when necessary. The peer support assists in communication with setting up appoints with also explaining information to the client when needed.

Enhanced National CLAS Standards:

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care is a tool to advance health equity, improve quality, and help eliminate health care disparities (*please see* *Attachment B*).

Please check ***two (2)*** *of the CLAS standards listed below appropriate to your identified subpopulation and to the health disparities to which they are vulnerable or experiencing.*

Principal Standard:

☒ Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

Governance, Leadership, and Workforce Standards:

☐ Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resource.

☐ Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area

☐ Educate and train governance, leadership, and workforce in CLA policies and practices on an ongoing basis

Communication and Language Assistance Standards:

☐ Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

☐ Inform all individuals of the availability of language assistance services clearly and in their preferred language, orally and in writing.

☐ Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

☐ Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area

Engagement, Continuous Improvement, and Accountability Standards:

☐ Establish CLA goals, policies, and management accountability and infuse them throughout the organization's planning and operations

☐ Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities

☐ Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

☒ Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area

☐ Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness

☐ Create conflict and grievance resolution processes that are CLA to identify, prevent, and resolve conflicts or complaints

☐ Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public

Describe a plan to ensure adherence to the two (2) identified CLAS standards with the grant program for the provision of effective services. Examples include, but are not limited to:

- Increasing participation from subpopulations experiencing behavioral health disparities on advisory boards and workgroups
- Developing strategic partnerships and collaborations with the goal of preventing behavioral health disparities among identified subpopulations
- Increasing the capacity and readiness of subrecipient communities to prevent behavioral health disparities among identified subpopulations
- Improving the readability level of educational materials

- Providing materials in a language easily accessible by the community

Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

- Improving the readability level of educational materials
- Providing materials in a language easily accessible by the client
- Providing services in Spanish and English
- Continuing to build trust in the Latino/a/x community
- Sharing pronouns and addressing someone by their pronouns
- Learning about cultural beliefs by fostering an environment that is open and welcoming
- Creating an environment where people want to share about their culture
- Creating an environment where people feel comfortable asking questions
- Responding to questions in a way that is reflective and respectful – never judging someone for a question they might ask
- Asking for clarification, restating questions

Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area

- Share community health assets and needs during monthly CCCWN MH/SUD meeting
- Review Lincoln County Community Health Improvement Program to determine assets and needs
- Review recent community health needs assessments
- Review data shared by SHS OBGYN department
- Collect demographic data and ensure demographic data is being collected and analyzed amongst other health coalitions in Lincoln County
- Engage with culturally specific groups in Lincoln County to determine what their unique needs are

STEP 5–EVALUATION:

Data coordinators should use PIMS and program data to assess process and/or outcomes, with the goal of understanding if the project is having the intended impact on reducing health disparities among the identified subpopulation. Describe:

- How you will involve the identified subpopulation in the assessment process
- How you will use program and PIMS data on access, use, and outcomes to evaluate processes, make programmatic adjustments, and demonstrate your impact on behavioral health disparities experienced by the identified subpopulation
- Other ways that you intend to use programmatic data to demonstrate the impact of your efforts on behavioral health disparities among the identified subpopulation.
- If the strategies you have implemented are resulting in increased access to services for the subpopulation. If so, how, and, if not, why not?

- The subpopulation will be identified through partner referrals to Project Nurture and they will be involved in the assessment process through verbal communications with Project Nurture staff.

- Data will be analyzed to measure the overall impact that Project Nurture has on Lincoln County. Project Nurture data has been collected from 2021-2022 and has been analyzed/summarized. New data from January 2023-present will be collected and analyzed to determine if there has been an increase in services and an increase in diversity amongst the target population. From 2021-2022, 26 individuals were served with Project Nurture services. Of those served, the average age was 28 years old and all identified as female. 85% identified as White (22 individuals), 4% as Black/African American (1 individual), 4% as American Indian/Native American/Alaska Native (1 individual), and 4% as Multiple-Race/Something Else (1 individual). In terms of ethnicity, 15% identified as Hispanic or Latino/a/x (4 individuals), 77% as Non-Hispanic or Latino/a/x (20 individuals), and 4% as Don't Know/Not Sure (1 individual). Project Nurture does a programmatic evaluation every year and we will partner with them to determine how Lincoln County compares to other counties in Oregon who are implementing Project Nurture. Testimonials will also be received from clients to determine how Project Nurture has impacted them during and after their pregnancy. Although PIMS data collects demographics for people receiving SUD services, these demographics are not specific to pregnant people with SUD. PIMS data will not be used to identify the demographics of our subpopulation. Instead, our partnership with ReConnections Counseling will allow us to obtain data related to Project Nurture, which is the data specific to our subpopulation.

- Data will also be shared amongst the CCCWN & MH/SUD regional coalition. Discussions will take place on methods in which the target population is being reached and how efforts can be improved to reach more pregnant people with SUD. Additionally, data will be used to help inform future stigma reduction media campaign planning. All HRSA-RCORP funding that has been received in Lincoln County has included an aspect of stigma reduction

through a local campaign. We expect to use this data to help inform the direction of our future campaigns to reduce stigma among pregnant people with SUD.

- Project Nurture successes will include the following: an increase in referrals from healthcare providers to the program, clients maintaining their meetings with peer support specialists, clients sticking to their path of recovery, clients maintaining their prenatal and postnatal appointments, and less babies being born with NAS/NOWS. One final large success will be the removal of stigmas associated with people with SUD, especially among health care providers, staff, and community members.

STEP 6–CULTURAL COMPETENCE:

Describe how you will ensure that you are implementing each step of the DIS to reflect the culture, needs, and capacity of the subpopulations experiencing behavioral health disparities.

To ensure adherence to the DIS, the HIWAY grant consortium will maintain their quarterly meetings to discuss this deliverable and all the steps that are included. With oversight from the MH/SUD coalition and CCCWN, we anticipate success in ensuring cultural competency.

STEP 7–SUSTAINABILITY:

Describe the main barriers to sustainability of services to the identified subpopulation and provide a brief explanation of how you will ensure sustainability of services remains a high priority for this subpopulation. If applicable, grantees can reference their RCORP sustainability plan.

The main barrier to sustainability of services is the funding of the programs. Funding for Project Nurture began in 2021 with funding from the Oregon Health Authority is not guaranteed to be available in subsequent years. Additionally, funds were delayed in being dispersed to organizations in 2022 and this can often be a barrier in paying for services. The HIWAY grant pays for peer support services that support Project Nurture clients, and this funding will end in August 2025. To ensure sustainability of services, both ReConnections Counseling (fiscal agent for Project Nurture) and SNLH (fiscal agent for the HIWAY grant) continue to identify funding opportunities that support SUD/OUD prevention, treatment and recovery services in Lincoln County. Additionally, partnerships that were developed through the HIWAY grant and Project Nurture have been instrumental in caring for pregnant people with SUD. With the CCCWN and MH/SUD regional coalition, there are partnerships that can be leveraged to continue to prioritize this population.

ATTACHMENT A: DIS REACH TABLE

In the table below, identify the number of individuals in the subpopulation your strategies will reach during the award period. Identify the data source/tool you will use to gather your data. Categories marked with an asterisk (*) are optional to respond.

	Total Population	FY 1		FY 2		FY 3		Total	
		Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
Number to Be Reached	198	20	Enter #	22	Enter #	24	Enter #	66	Enter #
By Race and Ethnicity									
African American	2	0	Enter #	0	Enter #	0	Enter #	0	Enter #
American Indian/Alaska Native	5	1	Enter #	1	Enter #	1	Enter #	3	Enter #
Asian	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
White (non-Hispanic)	171	17	Enter #	19	Enter #	21	Enter #	57	Enter #
Hispanic or Latino/a/e	18	2	Enter #	2	Enter #	2	Enter #	6	Enter #
Native Hawaiian/Other Pacific Islander	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
*Two or More Races	13	1	Enter #	1	Enter #	1	Enter #	3	Enter #
Unknown	7	1	Enter #	1	Enter #	1	Enter #	3	Enter #
By Gender Identity									
Cisgender Woman, Girl, or Female	196	10	Enter #	11	Enter #	12	Enter #	33	Enter #
Cisgender Man, Boy, or Male	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
*Transgender Woman, Girl, or Transfeminine (MTF)	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
*Transgender Man, Boy, or Transmasculine (FTM)	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
*Nonbinary, Gender Nonconforming, or Genderfluid	1	0	Enter #	0	Enter #	0	Enter #	0	Enter #
Two-Spirit	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #

	Total Population	FY 1		FY 2		FY 3		Total	
		Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual
Intersex	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
Other (*Please specify.*)	1	0	Enter #	0	Enter #	0	Enter #	0	Enter #
Unknown	0	10	Enter #	11	Enter #	12	Enter #	33	Enter #
By Sexual Orientation									
Heterosexual or Straight	0	10	Enter #	11	Enter #	12	Enter #	33	Enter #
Lesbian	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
Gay	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
Bisexual	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
*Same Gender Loving (SGL)	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
*Queer	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
*Asexual	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
*Pansexual	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
Other (*Please specify.*)	0	0	Enter #	0	Enter #	0	Enter #	0	Enter #
Unknown	198	10	Enter #	11	Enter #	12	Enter #	33	Enter #

Data Source/Tool

SHS Epic Database: Reports 198 patients.
Criteria for data:

- Individuals living in Lincoln County (per Epic address on file)
- Who were pregnant at any point between 9/1/2021 and 8/31/2022 and either:
  1) Had a positive lab result for cocaine, amphetamines, barbiturates, MDMA, ethanol, heroin, or PCP between 12/1/2020 and 8/31/2022

  <u>OR</u>

  2) Had any of the below diagnoses coded as a billing diagnosis, hospital diagnosis, or encounter/visit diagnosis between 12/1/2020 and 8/31/2022:
     a. Alcohol related disorders (ICD-10-CM: F10.*)
     b. Opioid related disorders (ICD-10-CM: F11.*)
     c. Cannabis related disorders (ICD-10-CM: F12.*)
     d. Sedative, hypnotic, or anxiolytic related disorders (ICD-10-CM: F13.*)
     e. Cocaine related disorders(ICD-10-CM: F14.*)
     f. Other stimulant related disorders(ICD-10-CM: F15.*)
     g. Hallucinogen related disorders(ICD-10-CM: F16.*)

	Total Population	FY 1		FY 2		FY 3		Total	
		Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual

h. Nicotine dependence(ICD-10-CM: F17.*)
i. Inhalant related disorders(ICD-10-CM: F18.*)
j. Other psychoactive substance related disorders(ICD-10-CM: F19.*)

Project Nurture Data: Reports 50,862 as total population of individuals in Lincoln County with 51.7% of them being Female.

Lincoln County Census Facts	
Race	**Percent**
White, alone	89.6%
Black or African American, alone	0.9%
American Indian and Alaska Native alone	4.0%
Asian or Pacific Islander or Native Hawaiian, alone	1.6%
Two or more races	3.9%
Ethnicity	**Percent**
Hispanic or Latinx	9.5%

Attachment B: Enhanced National Standards for Culturally and Linguistically Appropriate Services (CLAS)

National CLAS Standards in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

Governance, Leadership, and Workforce Standards:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area
4. Educate and train governance, leadership, and workforce in CLA policies and practices on an ongoing basis

Communication and Language Assistance Standards:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, orally and in writing
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area

Engagement, Continuous Improvement, and Accountability Standards:

9. Establish CLA appropriate goals, policies, and management accountability and infuse them throughout the organization's planning and operations
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery

12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness
14. Create conflict and grievance resolution processes that are CLA to identify, prevent, and resolve conflicts or complaints
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public

Think Cultural Health

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