Comprehensive Statewide Plan to Prevent Child Maltreatment Fatalities

Child Fatality Prevention and Review Program

OREGON DEPARTMENT OF HUMAN SERVICES | CHILD WELFARE DIVISION | APRIL 2023

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Child Fatality Prevention and Review Program Overview

While child deaths are rare events, Oregon Department of Human Services, Child Welfare invested in the creation of the Child Fatality Prevention and Review Program (CFPRP) to review and learn from our most tragic outcomes and use this learning to propel necessary system changes and prevention efforts with cross-system collaboration in mind.

The formation of this focused program has allowed for time and space to consider new ways of thinking about preventing child fatalities, including all child fatalities that come to the attention of Child Welfare, child maltreatment fatalities, and more broadly preventable child fatalities. Such work requires attention to both workforce support and infrastructure to improve tertiary and secondary prevention as well as identifying and elevating primary prevention efforts to support children and families in their communities. CFPRP has coordinators dedicated to various aspects of this work, including the Critical Incident Review Team (CIRT), Safe Systems/Safety Culture, Chronic Neglect Response, Suicide Prevention, Safe Sleep, and the Comprehensive Addiction Recovery Act (CARA). Additionally, a CFPRP coordinator is co-chair of the State Child Death Review and Prevention Team, which includes state level focus on prevention as well as support for county death review teams. Coordinators for CFPRP are responsible for tracking recommendations resulting from critical incident reviews, using data to identify potential trends including in demographics and casework practice, leading select system improvement efforts and prevention opportunities, and advancing a safety culture in Child Welfare.

National Partnership for Child Safety (NPCS)

In early 2020, CFPRP joined the National Partnership for Child Safety (NPCS) which is now a collaborative of 38 jurisdictions focused on applying safety science and sharing data to develop strategies in child welfare to improve safety and prevent child maltreatment fatalities. Safety science provides a framework and processes for child protection agencies to understand the inherently complex nature of the work and the factors that influence decision-making. It also provides a safe and supportive environment for professionals to process, share, and learn from critical incidents to prevent additional tragedies. For more information, please visit the NPCS website.

Members of the NPCS have a shared goal of strengthening families, promoting innovations and a public health response to reducing and preventing child maltreatment and fatalities. This concept integrates a broad spectrum of partners and systems to identify, test, and evaluate strategies to provide upstream, preventative, and earlier intervention supports and services that can strengthen the building blocks of healthy families. It represents a system that is focused less on a child protection response to abuse and more on building the wellbeing of all children.

Through membership in the NPCS, Child Welfare participates in the sharing and analysis of data across jurisdictions. Data from each jurisdiction will be housed in a central database at the National Center for Fatality Review and Prevention, allowing for analysis across the partnership to inform strategies to address children and families at risk and reduce maltreatment and fatalities. Jurisdictions began sharing data in late

2022 and Oregon uploaded our first round of data in March 2023. Data will be uploaded quarterly going forward.

The aim of CFPRP is to facilitate a robust critical incident review process that builds safety and trust with the professionals working directly with families and opens the door to true introspection and learning. Through safe systems analysis, an accurate story is provided, common casework problems identified, and more meaningful solutions that improve conditions for the workforce and outcomes for children and families are developed. As members of the NPCS, CFPRP receives technical assistance from the Safe Systems Team at the University of Kentucky Center for Innovation in Population Health. This technical assistance has been ongoing since 2019 and includes a broad array of training and support (see attachment "NPCS Resource Guide 2024").

- Training for CFPRP and other Child Welfare programs on safety culture and systems-focused critical incident reviews
- Skill building labs for CIRT/Safe Systems Coordinators on drafting improvement opportunities, using the SSIT, conducting safe systems debriefings, as well as facilitating safe systems mapping.
- AWAKEN training for CIRT/Safe Systems Coordinators (AWAKEN is a framework for identifying and addressing bias in decision-making)
- Upcoming AWAKEN Bias training for Oregon Child Abuse Hotline (ORCAH) staff in Fall 2024
- Technical support to maintain a REDCap database which houses SSIT and NPCS Data Dictionary information.
- Peer support for Critical Incident Review Leaders
- Support facilitating safe systems mapping
- NPCS Affinity Group, Safely to their First Birthday: Upstream Prevention and Compassionate, Equitable Screening, Safety Threat Identification, and Maltreatment Classification after Sudden Unexpected Infant Deaths (SUID)
- NPCS Affinity Group, Advancing Safety Science in the Workforce: Integrating learning from Systems-Focused Critical Incident Reviews and Safety Culture Surveys to implement new innovations through Workforce Development
- NPCS Affinity Group, Identity, Intersectionality and Safety Culture
- SSIT review and support on a case-by-case basis
- Facilitation of cross-jurisdiction communication to support continued learning and improvement in different areas of the work.
- Development and creation of Safe Systems Debriefing Introduction video
- Access to the Reframing Childhood Adversity Toolkit
- Drop-in office hours for technical support questions
- Other technical assistance as requested.

As early adopters of a systems-focused approach to reviewing critical incidents, Oregon has become a leader in the NPCS and is regularly sought out to provide support and learning opportunities for other jurisdictions.

In 2023, CFPRP's systems mapping exercise for father engagement was highlighted in the NPCS quarterly newsletter. Additionally, CFPRP members applied to the 2024 TCOM Conference and the National Family Support Network 2024 Virtual Conference to share learning from the mapping. A CFPRP member and a mapping participant with lived experience would co-facilitate the presentations.

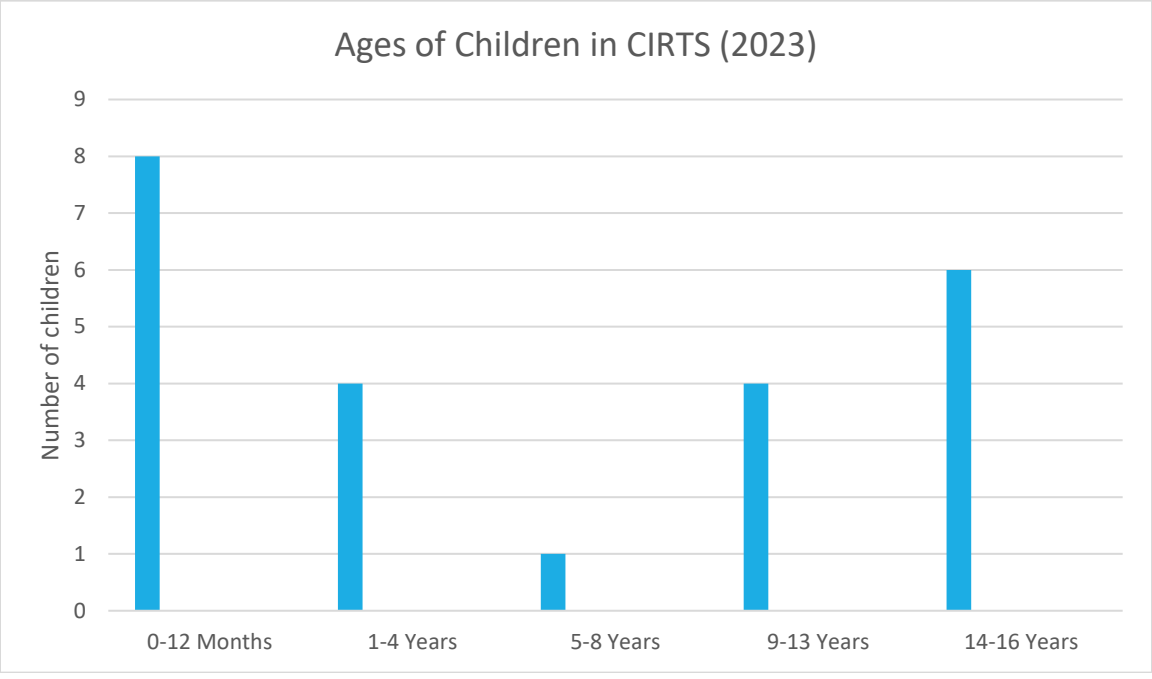
Critical Incident Review Team (CIRT)

The Critical Incident Review Team (CIRT) process has been an integral continuous quality improvement process for Oregon's Department of Human Services Child Welfare Division since 2004. Created as an important and unique tool to help protect Oregon's children from abuse and to prevent future child maltreatment fatalities. Initially this work was in the Central Office Child Safety Program, however the CIRT work moved to the new Child Fatality Prevention and Review Program (CFPRP) in February 2020. This has provided a unique opportunity for Oregon Department of Human Services to have a Child Welfare program that both provides an objective review process for child fatalities along with researching, developing recommendations, and leading and implementing innovative strategies and efforts focused on child maltreatment prevention at primary, secondary, and tertiary levels (see attachment "CIRT FAQ").

CFPRP has team members referred to as CIRT Coordinators who are assigned specifically to the CIRT work that involves leading with a non-punitive, systems focused approach. The CIRT Coordinators facilitate meetings, engage, and prepare CIRT members for the review process which include child welfare professionals, community partners as well as CPS, Permanency, Screening and Foster Care program experts. In addition, the CIRT Coordinators complete the case file review and associated public report once the review is complete. Lastly, the CIRT Coordinators assist in the development of system improvement recommendations resulting from actions or inactions of ODHS or Law Enforcement leading up to or surrounding the critical incident. A CFPRP System Improvement Coordinator is dedicated to tracking CIRT and fatality data and facilitating regular cross program meetings to ensure the completion of all system improvement recommendations (see attachment "CIRT Process Map"). There remains a separate pathway for personnel related issues through the human resources department.

2023 Critical Incident Data

During the calendar year of 2023, 23 child fatalities met the criteria for a mandatory CIRT review. The chart below reflects the age ranges for the children whose deaths resulted in the assignment of these 23 CIRTs.



Details related to and surrounding the fatalities:

- Out of the 8 children ages 0–12-months, when 6 of these infants died, high risk sleep practices were present.
  - 4 of the sleep environments included bed sharing
  - 5 of the infants experienced prenatal substance exposure
- 3 children died as a result of an injury from a firearm
- 2 children died from a medical condition or complication, both noted substance exposure at the time of the critical incident (methamphetamine)
- 3 children died from motor vehicle accidents, 2 of those included substance use at the time of the critical incident (alcohol)
- 3 children died from physical abuse
- 4 children died from poisoning/overdose (fentanyl and/or multiple substances)

For more information regarding CIRTs please refer to the ODHS CIRT Website.

As a result of the CIRT process, numerous system improvement recommendations are implemented each year by CFPRP and other Child Welfare Programs (ORCAH, Safety, Permanency, Well-Being, Equity, Training & Workforce Development, etc.). Some system improvement efforts implemented since 2023 include: Statewide presentations about Plans of Care, associated funding, and safe sleep practice strategies; Local office level Infant Safety Staffing enhancements and support; Infant Safety Logic Model; ODHS participation within Oregon Alliance for Suicide Prevention; Safe Systems Analysis to enhance local office continuous quality improvements utilizing Safety Science Data; Rush toxicology guidance; Safe Systems Mapping for system improvements around father engagement in casework practice; Honoring tribal culture during child death investigations; Workforce trainings on CPS dispositions and considerations involving Domestic Violence; Intersection of Substance Use Disorder and Domestic Violence practice guidelines; Motivational Interviewing Training for Child Welfare Professionals; ORKIDS redesign to increase access to information necessary for child safety; Modified administrative rule to remove restrictions on the funds available for covering funeral expenses to better assist families coping with the loss of a child; Environmental Safety Enhancement Guidelines for Child Welfare Professionals; Karly's Law refresher training; Fentanyl Practice Guide; Substance Use Disorder workforce development, training and guidelines; and Protective Action Planning Guidance involving tribal families provided by the Office of Tribal Affairs.

CFPRP recognizes the hard work and collaboration of the child welfare professionals who facilitated or participated in each of these efforts. CFPRP would also like to recognize the efforts of the local offices to enhance the knowledge and skills of the workforce and improve operations as a result of learning from the CIRT.

Professional Development and Supporting the Workforce

As CIRT criteria has shifted over time, so has the number of child fatalities reviewed through the CIRT process. With the substantial change in CIRT legislation in 2019, multiple full-time staff continue to be needed to manage the CIRT workload. Recently, in winter 2024, CFPRP added a rotational full-time Assistant Manager. The primary role of this position is overseeing the CIRT workload, including supervising CIRT Coordinators, and serving as the contact for the National Partnership for Child Safety. Added positions, even short-term

professional development positions, create opportunities for CIRT Coordinators to take a larger role in the prevention and safe systems work occurring within the team, to pursue professional development goals, and has resulted in less exposure to the secondary trauma experienced when reviewing tragic child fatalities. Additionally, these short-term positions allow CFPRP to continue efforts to share and promote the concepts of safety science and safety culture used in the CIRT process and by the CFPRP team. Any staff returning to their local office can become culture carriers and promote positive shifts in agency culture.

As part of a continuous quality improvement effort, CFPRP offers an opportunity for one-on-one feedback to understand the experience of any caseworker, supervisor, manager, or partner who participates in a CIRT or a Safe Systems debriefing. The feedback received informs what is working well and where there are opportunities for improvement. The feedback opportunities are conducted through a trauma informed lens, are voluntary, and participants are assured the focus is on the process and does not include discussion about the family or circumstances.

Internal Discretionary Reviews

CFPRP is responsible for leading Internal Discretionary Reviews which are directed by the ODHS Director when Child Welfare receives a report of abuse that resulted in a fatality, near fatality, or other serious physical injury of a child and the incident does not meet the criteria for a critical incident review team (CIRT). These reviews are an important opportunity for system learning and the development of system improvement recommendations and actions similar to the CIRT process.

CFPRP team members are assigned to complete the work surrounding the Internal Discretionary Review process such as engaging and preparing participants, facilitating meetings, partnering with other child welfare programs to conduct case reviews, and developing and assisting in the implementation of system improvement recommendations. Two cases were reviewed through this process in 2023 and three cases are in the process of being reviewed as of April 2024. Safe systems analysis from each of these cases is included in the aggregate data set.

Near Fatalities/Serious Physical Injuries

In addition to the data collected by CFPRP on child fatalities, CFPRP gathers data from near fatalities and serious physical injuries. CFPRP is in the early stages of collecting this specific data and understands it is critical to understanding system factors and to developing child abuse and child fatality prevention strategies. In addition, new fatality/near fatality procedure is in the process of being developed to provide further guidance to Child Welfare professionals.

Safe Systems Analysis

Safe systems analysis is a critical extension of Oregon's child fatality review process. Through file review, participation in the CIRT or internal discretionary review, and follow-up supportive inquiry debriefs, CFPRP gathers important information about what influences the casework or system challenges that may be identified in cases with tragic outcomes. See attachment "Safe Systems Analysis Frequently Asked Questions".

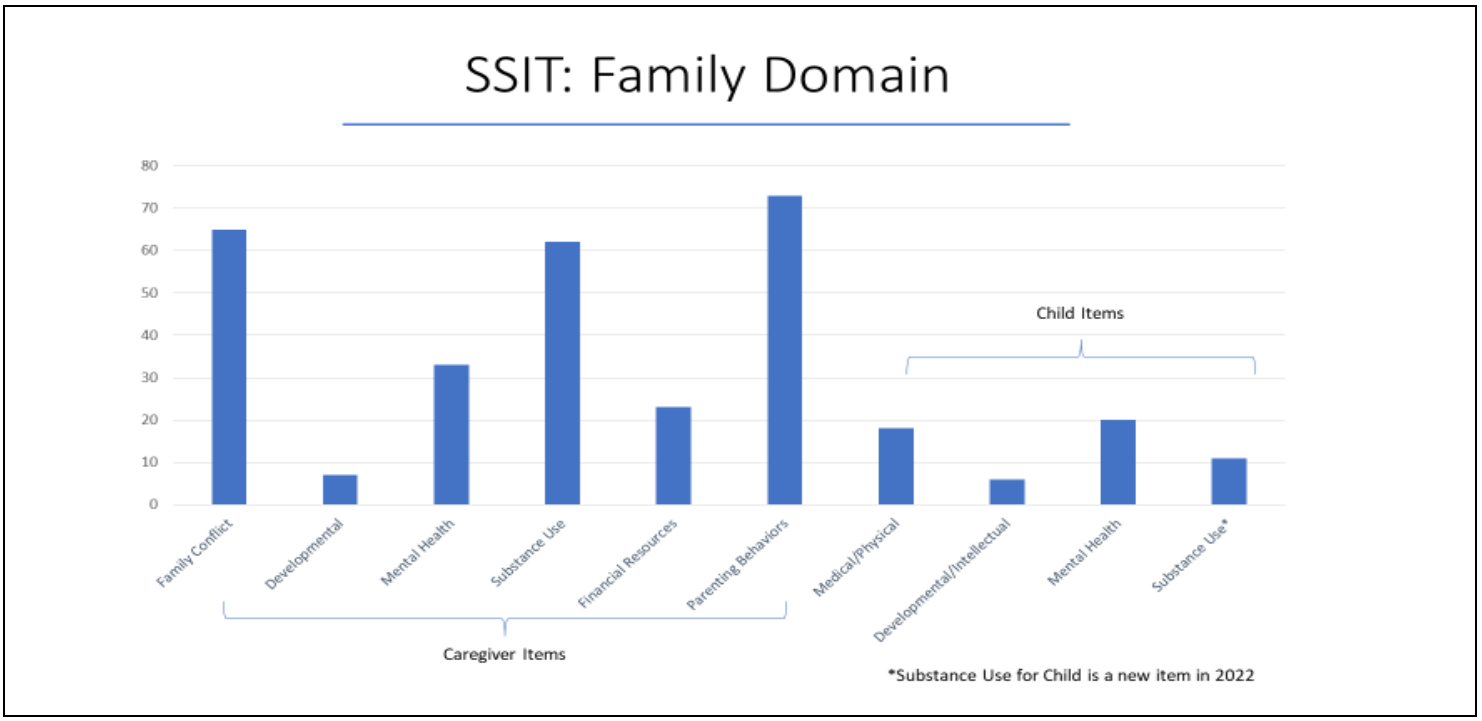
These challenges are known as Improvement opportunities (IOs) and they represent the gap between what the child or family needed and what they received. More technically, IOs are case-specific actions or inactions

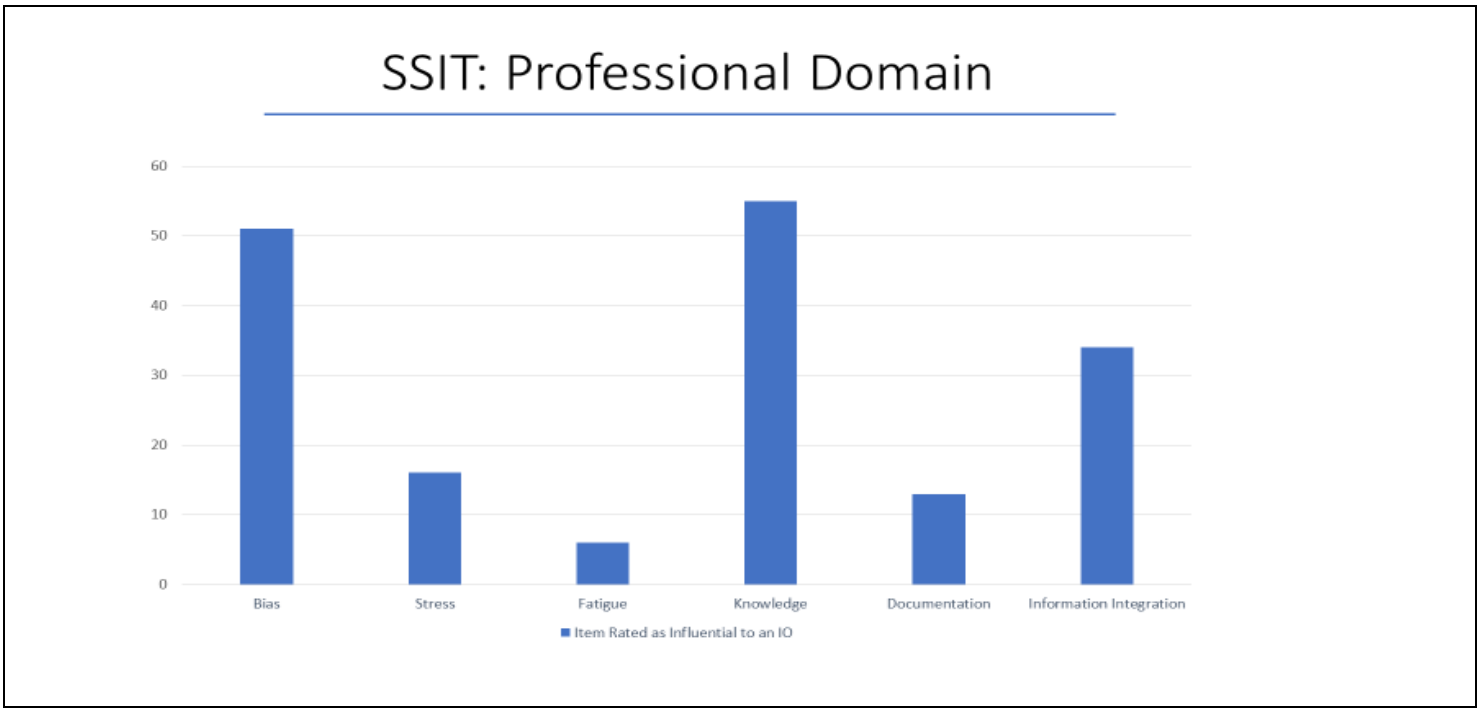
relevant to the outcome or industry standards and are often representative of relatively common casework problems. While emphasis is given to those IOs within Child Welfare, IOs also consider the actions/inactions of other entities within the macro child-serving system (e.g., courts, human service providers, law enforcement, schools). In the safe systems analysis process, IOs are first identified through the CIRT or discretionary review and those IOs are then explored by a Safe Systems Coordinator through use of the Safe Systems Improvement Tool (SSIT) (see attachment "2022 NPCS SSIT Reference Guide"). At times, additional IOs are identified by the Safe Systems Coordinator and added to the exploration. Since implementing safe systems analysis in July 2019, the SSIT has been completed on 116 cases including Internal Discretionary Reviews. Of those 116 cases, 107 had IOs identified, some cases having multiple, for a total of 226 IOs.

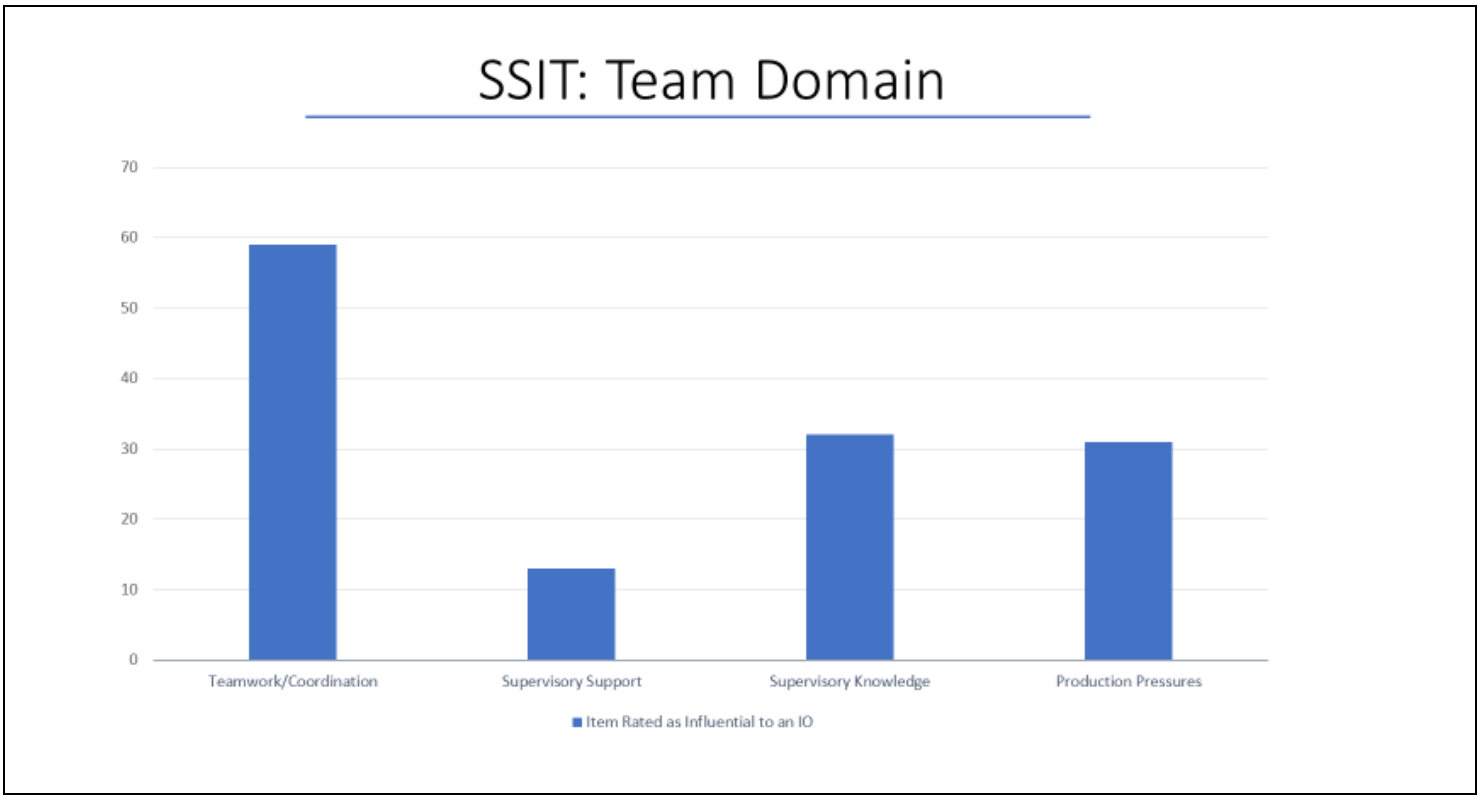
In some cases, the safe systems analysis includes individual debriefings. These debriefings are the mechanism for gathering the "second story" from those who experienced the outcome in the specific case. Debriefings are voluntary and trauma responsive and use supportive inquiry to support child welfare professionals in sharing their experiences. While debriefings are not completed in every case, they lend important detail and reliability to the overall information gathered and rated in the SSIT. Since 2019, Safe Systems Coordinators have engaged 43 child welfare professionals across 28 cases in individual debriefings.

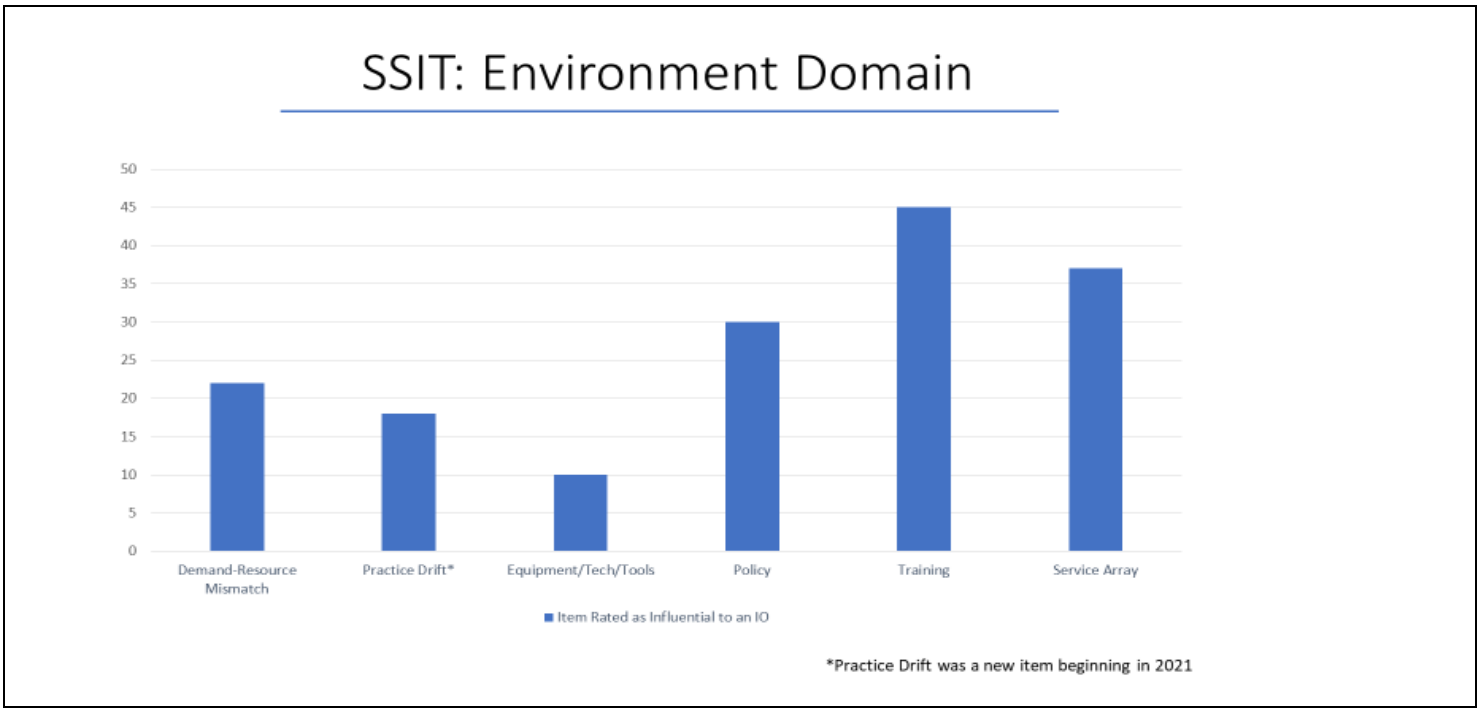
SSIT results and the standardized NPCS dataset are captured in a REDCap[1] database (see attachment "NPCS Data Dictionary"). REDCap is a secure web platform for building and managing online databases and allows for exporting data to excel as well as ad hoc reporting. REDCap allows CFPRP to efficiently organize SSIT data for reporting and guiding system improvement efforts. CFPRP members participate in the partnership's Data Sharing Workgroup. Additionally, as a member of the NPCS, Oregon has access to the NPCS Data Warehouse via the Michigan Public Health Institute (MPHI) and held at the nationally recognized Nation Center for Fatality Review and Prevention. Oregon, along with other jurisdictions around the country upload de-identified SSIT and demographic data on a quarterly basis into the NPCS Data Warehouse. This data sharing exists to improve child, family, and workforce-level outcomes by accelerating a family centered, workforce informed, systems-focused approach to learn from critical incidents. The SSIT contains four nested domains for rating. The first domain is the family domain and is rated independent of any Improvement Opportunities and functions similar to the CANS. These items are important for considering the needs of the family at the time of the critical incident. The remaining three domains capture influences at the professional, team and environment levels. These items are important for considering what factors contributed to any identified challenge, or IO, in the case. The charts below depict information gathered by Safe Systems Coordinators through the SSIT since July 2019.

[1] https://www.project-redcap.org/


SSIT: Family Domain
80
70
60
50
40
30
20
10
0
Family Conflict
Developmental
Mental Health
Substance Use
Financial Resources
Parenting Behaviors
Medical/Physical
Developmental/Intellectual
Mental Health
Substance Use*
Child Items
Caregiver Items
*Substance Use for Child is a new item in 2022


SSIT: Professional Domain
60
50
40
30
20
10
0
Bias
Stress
Fatigue
Knowledge
Documentation
Information Integration
Item Rated as Influential to an IO





Since quality improvement resources are finite, considering the frequency and proximity of an IO is important to balancing if, when, and to what degree an agency advances a system improvement effort. In each safe systems analysis, IOs are evaluated for their proximity (i.e., closeness) to the outcome. Proximity is not intended to imply causality or severity of an action or inaction but rather describes how close the IO was in time or distance *and* with relationship to the incident. Of the 107 cases with identified IOs, 55 had at least one

IO determined to be proximal. Through safe systems analysis CFPRP has been able to identify themes across the IOs and consider how to tailor improvement efforts based on the influences identified through the SSIT items.

One notable way CFPRP explores IO themes is through safe systems mapping. The purpose of safe systems mapping is to discuss in a group of experienced professionals their perceptions of what factors influence IOs. In safe systems mapping, these IOs are evaluated at all levels of the system, from the local team level to the legislative/government level. Every participant has an equal voice in the process and all perspectives are valuable to understanding more clearly how the system is operating and what gets in the way of successful work with families. See attachments "Systems Mapping Facilitator Tips Sheet" and "Participant Guide".

In 2021, CFPRP partnered with the Child Safety Program to map IOs related to assessing safety when parent/caregiver substance use is present. Participants included a CPS caseworker, CPS Supervisor, Addiction Recovery Team (ART) lead worker, ART outreach worker, contracted provider for ART services, county-level Family Nurse Partnership supervisor, county-level child abuse pediatrician, ODHS district manager, Tribal Affairs senior ICWA manager, Child Welfare alcohol & drug specialist, Safety Program manager and assistant manager, Child Welfare executive director and deputy directors, and others. The group's diverse experience and expertise allowed for a robust discussion of what factors impact effective assessment and intervention in cases involving parental substance use at all levels of the system.

The team met several times to complete the mapping activity and brainstorm strategies for system improvement. In total, eight recommendations were presented to Child Welfare Division Executive Leadership for review during the summer of 2021:

1. Restructure and expand Addiction Recovery Team and corresponding contracted services
2. Develop comprehensive casework practice guidelines for cases involving substance use
3. Develop a process for referring reports closed at screening to community-based supports or services
4. Develop statewide staffing guidance for cases involving infants (see attachment "logic model" created to provide framework for recommendation)
5. Enhance knowledge and skill through creative education for caseworkers and supervisors
6. Actively promote partnerships with local prevention organizations
7. Identify and support culturally appropriate paid respite, child-care programs, and safety service providers
8. Develop a smart phone application to provide information and guidance to child welfare professionals

All the recommendations together are instrumental in creating a robust child welfare response to families impacted by substance use disorder and each has a specific role in equipping the child welfare workforce with the tools, skills, and resources necessary to support families and children and promote both secondary and tertiary prevention. The recommendations are in various stages of exploration and implementation and a project manager has been assigned to support and track progress and identify intersections with other initiatives. In addition, Child Welfare sought support from the National Center for Substance Abuse in Child Welfare (NCSACW) to identify similar efforts across the country for reference by Oregon. For a detailed overview of the mapping process and the resulting recommendations see attachments "Safe Systems Map" and "Systems Mapping Overview and Recommendations".

In the winter of 2022, CFPRP and Child Safety Program initiated safe systems mapping to explore the factors related to a common improvement opportunity, insufficient comprehensive CPS safety assessment follow-up.

The mapping team was comprised of child welfare professionals from across the state and with various levels of experience and expertise. The group concluded their mapping sessions and CFPRP and Child Safety Program finalized recommendations and presented to program leadership. See attachment "Mapping 2022" for a detailed overview.

CFPRP initiated another safe system mapping exercise in 2023 related to an overarching improvement opportunity for father and noncustodial caregiver engagement in child welfare practice. The mapping team developed five recommendations to improve child welfare practice, which are in the early stages of implementation. The 2023 mapping was highlighted in the National Partnership for Child Safety's quarterly newsletter for efforts in centering and honoring the voices of both people with lived expertise and professionals working directly with families. More information related to the recommendations can be found in the "Other Prevention Efforts" section of this document. See attachments "2023 Systems Map Father Engagement" for the finalized map from the 2023 process, and "Safe Systems Mapping 2023-24 Final report" for a detailed overview.

SSIT results are also used to inform development of improvement efforts related to recommendations stemming from the CIRT. Both individual case and aggregate SSIT results will be shared with central office programs when relevant to a specific recommendation. In addition, beginning in 2023, results are shared with local district leadership to support planning and improvement at the local level. So far interactive presentations have occurred in three counties.

As the safe systems analysis process matures and CFPRP develops a deeper understanding of how to share about the system learning, regular data reporting and topical briefs will be developed.

Advancing a Safety Culture

Since its inception in 2020, CFPRP has strived to advance safety culture in Oregon's Child Welfare Division. This occurs through the application of safety science in the Critical Incident Review and Safe Systems Analysis processes but also as a specific body of work within the program.

A workplace culture in which mistakes are seen as opportunities to learn and child welfare professionals at all levels are engaged in problem-solving without shame or blame is critical to improved outcomes for families and enhanced satisfaction for the workforce. Building a safety culture is central to Child Welfare's transformation efforts. When teams feel connected and supported, they are better able to embrace change and fully engage with families.

The work of CFPRP to advance safety culture in child welfare has continued to grow over the past year. CFPRP coordinators have engaged with a variety of groups across Child Welfare to educate and coach leaders around advancing a safety culture in their own teams. CFPRP coordinators actively promote safety culture when interacting with external partners as well as internal colleagues during participation in workgroups and committees.

Activities to build knowledge and skill:

- CFPRP staff participated in ongoing National Partnership for Child Safety (NPCS) trainings to support knowledge and skills in advancing safety culture. Trainings were offered to other Child Welfare program areas as well to support development of culture carriers. These trainings included: Safety

Culture in Critical Incident Reviews, Writing Improvement Opportunities, SSIT: Skilled Practitioner Training, Systems Mapping, Data Aggregation, and Debriefing Professionals.

- New CFPRP Coordinators participate in 15 hours of training on the AWAKEN framework (see attachment "AWAKEN Infographic") for building awareness around bias and developing a practice for conscious decision-making. CFPRP continues to explore opportunities to bring the training more broadly to child welfare in Oregon and is in the early stages of coordinating this training for ORCAH staff.

Activities to educate about and promote a safety culture across child welfare:

- In 2023 and continuing into 2024, CFPRP CIRT Coordinators started presenting a "CIRT Roadshow" to local child welfare offices across the state. This presentation includes information regarding the importance of safety culture in CIRT reviews and the Safe Systems debriefing process, in addition to creating a safety culture in the local offices. The goal is to bring this presentation to every local child welfare office in the state.
- In September 2022, CFPRP began facilitating Safety Culture Hour, a virtual drop-in style micro-learning opportunity, twice monthly available to all of Child Welfare staff. Attendance regularly includes participation from program managers, office managers, supervisors, direct service staff, administrative support staff, and Coaching and Training Specialists, from all program areas within Child Welfare to cultivate culture carriers. Safety Culture Hour covers topics including psychological safety, the intersection of psychological safety and anti-racism, healthy team habits, and other safety culture concepts and practices to build skills and increase staff knowledge. CFPRP also launched a Microsoft TEAMS Safety Culture channel where safety culture resources are regularly posted to encourage learning.
- In 2023 and early 2024, CFPRP members have done several targeted presentations/skill-building labs for teams working to advance safety culture. Examples from 2023-2024 include the new supervisor's cohort, Hood River management team, and Clackamas County Family Time Team. Key concepts from the TeamFirst Field Guide, tailored for the audiences were shared with the teams.
- In 2024, CFPRP established a monthly virtual call with representatives of Office of Equity and Multicultural Services (OEMS) for purposes of collaboration in advancing safety culture in local offices as appropriate in district service equity plans/action plans.
- Developing a curriculum of adaptable spaced education on key learning topics for use by jurisdictions across the partnership In October 2023, in honor of Domestic Violence Awareness Month, CFPRP in coordination with the ODHS Domestic & Sexual Violence Intervention Coordinator and the NPCS provided one month of spaced education training to child welfare staff on the subject of domestic violence. A new round of spaced education training around domestic violence is scheduled to occur in June 2024.
- CFPRP participates in the NPCS Affinity Group, focused on Identity, Intersectionality and Safety Culture

Workforce Supports

Fatality/Near Fatality Procedure

As a result of various program efforts, CFPRP determined additional attention was needed regarding the guidance provided to Child Welfare professionals when engaged in the work of responding to child fatalities and near fatalities. Given the unique activities and considerations required for this challenging work, CFPRP began the development of child fatality and near fatality procedure to provide support and direction to staff. This ongoing effort is led by CFPRP and will benefit from the insight of Child Welfare professionals, tribal partners, community-based child, and family serving professionals, and the voice of those with lived experience. CFPRP believes this procedure will support Child Welfare professionals in navigating these tragic outcomes and allow for increased consistency of practice and an improved experience for families engaged with Child Welfare.

Fatality/Near Fatality Toolkit

In 2022 CFPRP initiated the development of a trauma-sensitive toolkit for our Child Welfare professional workforce, with the goal of providing support and guidance to professionals responding to child fatalities and non-fatal serious injuries to assess the safety of the home. Contents of the toolkit include definitions and clarity of trauma-sensitive care, culturally responsive engagement with families, sample local office workflows to ensure trauma-informed management of staff and case activities, multiple domains of trauma-sensitive question and engagement prompts to support staff in speaking with grieving families, local, regional and statewide resources for grief and loss support, trauma-sensitive initial contact prompts, and well-being resources for staff and leadership involved in assessing critical injuries. The Trauma-Sensitive Toolkit Workgroup (Toolkit), consisting of staff in various classifications from multiple districts and programs, completed an initial draft of the Toolkit in early 2023. Currently the draft remains under refinement and review for content, approved Oregon Department of Human Services communications style compliance as well as review for diversity, equity, and inclusion standard metrics. Currently CFPRP and the Child Safety Program along with local office leadership are exploring the feasibility of regional fatality assessment specialty teams who would respond to fatality and near fatality/serious physical injury reports of abuse following recommendations from a Critical Incident Review Team. Consideration is currently being given to the distribution of the finalized and approved Toolkit to these specialty teams upon implementation of the service structure.

Staff Support for Critical Incident Stress Management

Several CFPRP team members are certified to administer Critical Incident Stress Management (CISM.) These certified team members, are resources to facilitate and support CISM sessions for ODHS professionals, including child welfare professionals. There is a range of stressful events where a CISM response is helpful, such as the death of a child or adult served by ODHS or the death of an ODHS employee.

Certificate Program in Implementation Science

Two CFPRP team members participated in the inaugural cohort of the Certificate Program in Implementation Practice offered by the University of North Carolina's School of Social Work's Collaborative for Implementation Practice. This certificate program was developed for professionals working in health and human services and is focused on bolstering competencies related to the implementation of initiatives and sustaining change. The three competencies are: co-creation and engagement, ongoing improvement, and sustaining change.

State Child Death Review and Prevention Team

The State Child Death Review and Prevention Team (state team) is mandated by Oregon Revised Statute 418.748 and is co-chaired by ODHS and OHA. The ODHS co-chair is filled by a CFPRP member creating opportunity for communication and collaboration across the CIRT, the state team, and the 36-county child death review teams.

The National Partnership for Child Safety (NPCS) continues to support multiple states in exploring a path for improving communication and collaboration between state and county child death review teams and the Critical Incident Review Team. This exploration occurs through CFPRP's active engagement in the National Partnership for Child Safety affinity group: Connecting internal death review to state and county child fatality review teams.

The mission, purpose, objectives, and guiding principles of the state team closely align with and support the work of CFPRP. See attachment "State Child Death Review and Prevention Team Charter".

Mission: The mission of the state team is to serve Oregon by reducing preventable child deaths.

Purpose: The purpose of the state team is to better understand the circumstances surrounding child fatalities occurring in Oregon to prevent future child deaths and serious injuries. The team accomplishes this through:

- Reviewing data gathered from collaborative, multidisciplinary, comprehensive case reviews.
- Supporting county teams where the reviews primarily occur.
- Tracking data-driven trends, improvement opportunities, and recommendations.
- Advocating for equitable prevention strategies at the community, local, state, and national levels.
- Informing continuous quality improvement within Oregon's larger child death review system.

Objectives:

- Support accurate identification and uniform reporting of the cause and manner of child deaths.
- Promote cooperation, collaboration, and communication across the child and family serving system and enhance coordination of efforts.
- Achieve quality, equitable investigation of child deaths consistent with national standards.
- Design and implement cooperative, standardized protocols for the review of child deaths.
- Ensure accurate, complete, and timely data entry in the National fatality Review - Case Reporting System.
- Review county team prevention recommendations and support prevention efforts.
- Identify needed changes in legislation, policy, practices, and recommend expanded efforts in child health and safety to prevent child deaths and serious injuries.

The CFPRP co-chair leads the efforts to implement the Child Death Review Resource and System Improvement Plan. As part of these efforts the Child Death Review and Prevention website was developed and implemented. See attachment "Child Death Review Resource and System Improvement Plan".

Prevention Strategies

CFPRP strategically selects prevention measures based on data trends. By analyzing data from CIRTs, SSITs, and other sources, CFPRP identifies emerging issues. Recently, CFPRP has developed a system to monitor the impact of fentanyl on families in the child welfare system. Efforts are underway to ensure accurate data entry into the fentanyl data tracker. Furthermore, text analysis techniques enable CFPRP to extract insights and identify patterns from narrative data in OR-Kids, enhancing our ability to address evolving challenges in child welfare. Highlighted below are some prevention efforts coordinated by CFPRP:

Suicide Prevention

In 2017, the Critical Incident Review Team (CIRT) saw an increase in reports of deaths by suicide and a comparison of state fatality data and child welfare records of suicides for the fiscal year 2017 confirmed almost half of the children who died by suicide had some previous history with child welfare. Data collected from CIRTs since 2017, which includes data on child and young adult deaths, shows progress in suicide prevention and intervention efforts in ODHS and across Oregon. This data also highlights the ongoing need for suicide prevention and intervention initiatives in Oregon's Child Welfare Program.

Calendar Year	Total Critical Incident Reviews	Suicide Deaths
2017	7	3
2018	18	0
*2019	29	4
2020	34	2
2021	16	1
2022	30	1, 1 Discretionary Review
2023	23	0

*CIRT rule governing criteria for assigning a CIRT changed in 2019, resulting in an increase in CIRT assignments

According to the Suicide-related Public Health Surveillance Update, dated April 2024, the number of suicide deaths in Oregon in 2023 are similar to previous years, as are suicide-related visits to Emergency Departments and Urgent Care Centers. Demand for crisis support related to suicide in 2023 is increasing as expected, mirroring trends seen in previous years since the establishment of the nationwide 988 crisis hotline.

According to the 2021-2025 Youth Suicide Intervention and Prevention Plan (YSIPP) Annual Report, child suicide numbers decreased in 2021 compared to 2020. For young persons age 18-24, suicide numbers in 2021 were similar to 2020. Suicide numbers decreased overall for young persons age 24 and under in 2021 compared to 2020. According to the YSIPP 2021 Annual Report, this is the first time since 2001 that Oregon has had a three-year decrease in suicide fatalities for young persons age 24 and under. While preliminary data for 2022 will not be official until spring 2024the data shows Oregon suicide rates among young persons, despite the three-year decrease, remain high and above the national average. In response to the ongoing need to reduce young persons suicide deaths in Oregon, CFPRP is committed to continuing and expanding

efforts to enhance suicide prevention and intervention knowledge and practice among Child Welfare professionals. Some of these efforts include:

In collaboration with the Oregon Health Authority, Garrett Lee Smith grant funds continue to provide Question, Persuade, Refer (QPR) training for the greater Child Welfare workforce. To date, over 950 Child Welfare direct service professionals have been trained in a facilitated QPR training for casework staff. Moreover, throughout ODHS over 9500 staff have been trained in computer based QPR to date. Pre- and post-training survey data show that QPR training enhances staff knowledge and preparedness to assist individuals showing suicide risk (see attachment "Oregon DHS QPR Suicide Prevention Training Pre- and Post-Training Survey Data Report July 1, 2020 through December 31, 2023"). ODHS remains committed to the training of QPR and requires participation in QPR for all employees. To assess the continuous efficacy of QPR training long term for Child Welfare professionals, CFPRP has developed and implemented a 6-month post-QPR training survey and begun providing the survey to training cohorts in March 2023. To date survey sample size remains too small to complete substantive data analysis, but with subsequent provisions of the training it is expected survey sample size increases will allow for meaningful data analysis to assess the utility and use of QPR skills within the workforce.

Additionally, a specially designed QPR for Resource Parents also continues to be offered throughout the year to support families caring for children and young persons in ODHS custody. The CFPRP Suicide Prevention Coordinator currently supports additional information and resource provision efforts for Resource Parents through collaboration with Child Welfare's Equity, Workforce Development and Training Program.

- In collaboration with OHA, the Garrett Lee Smith grant was used to provide handgun and medication lockboxes to local offices for distribution to families. Also,

- A CFPRP member attended the Oregon Counseling on Access to Lethal Means (OCALM) Training with the goal of offering this training more widely to the Child Welfare workforce beginning in late 2024.

- The CFPRP Suicide Prevention Coordinator previously developed and completed a Young Persons Mental Health and Suicide Prevention training in collaboration with the Oregon Child Abuse Hotline (ORCAH), with the aim of providing additional risk assessment knowledge and skill to ORCAH screening and intake staff. The completion of the 90-minute recorded training occurred in September 2022, with provision to ORCAH staff beginning in November 2022. All current and incoming ORCAH staff are provided the training as well as follow up opportunities with the CFPRP Suicide Prevention Coordinator to address additional questions or needs.

In January 2023 CFPRP, in partnership with the Oregon Health Authority and Oregon Pediatric Society, commenced development of the ODHS Child Welfare YouthSAVE training. The curriculum development was completed in late 2023. This training, a modified version of the widely available YouthSAVE (Suicide Assessment in Various Environments) Training, has been developed to support the child welfare professional workforce in identifying, assessing, and safety planning for suicide risk within the unique context child welfare engaged with young people and families. Due to extenuating external circumstances, delays in the curriculum development completion and Training for Trainers have been experienced. However, as of Spring 2024 it is expected that Train the Trainers modules will be offered no later than Fall 2024 with broader workforce offerings beginning no later than Winter 2024.

- In Spring 2023, the CFPRP Suicide Prevention Coordinator partnered with the ODHS Mobile Child Safety team from District 3 for a demonstration initiative for including mental health and suicide risk screening in all child safety assessments. The team used questions from the Patient Health Questionnaire-Adolescent (PHQ-A) (see PHQ-A adolescent suicide risk screening tool) and ASQ (see ASQ suicide risk screening tool) as standard screening tools for young persons ages 8 and above as validated through the measures. The conclusion of the demonstration project indicated successful suicide risk assessment and screening can occur without the use of scales and that a prompt within the current Oregon electronic case management system may help the workforce. Continued consideration of the feedback obtained from the demonstration project is occurring.

- The CFPRP Suicide Prevention Coordinator engages with Child Welfare professionals to provide behavioral health and suicide prevention/intervention resources and learning activities. This includes child welfare professionals engaged with Temporary Lodging and Resource Management to support complex needs of young persons transitioning between levels of behavioral health care and placement, including support for brief, non-clinical safety planning until longer term clinical interventions can be established.

Responding to Neglect and Promoting Protective Factors

Promoting responsive relationships, bolstering protective factors, and connecting families with supportive resources sooner is essential to preventing maltreatment and maltreatment related fatalities.

Neglect can be difficult to understand and impact as it is influenced by factors at all levels of the social ecology. An approach rooted in community care and connection can help build collective responsibility for children and promote safety and well-being for families. CFPRP has a unique role in supporting prevention and the work described throughout this plan is reflective of the ways the program works to promote primary, secondary, and tertiary efforts. In this section, we will discuss efforts to enhance child welfare professionals' ability to understand and respond to neglect and promote protective factors for families.

Training

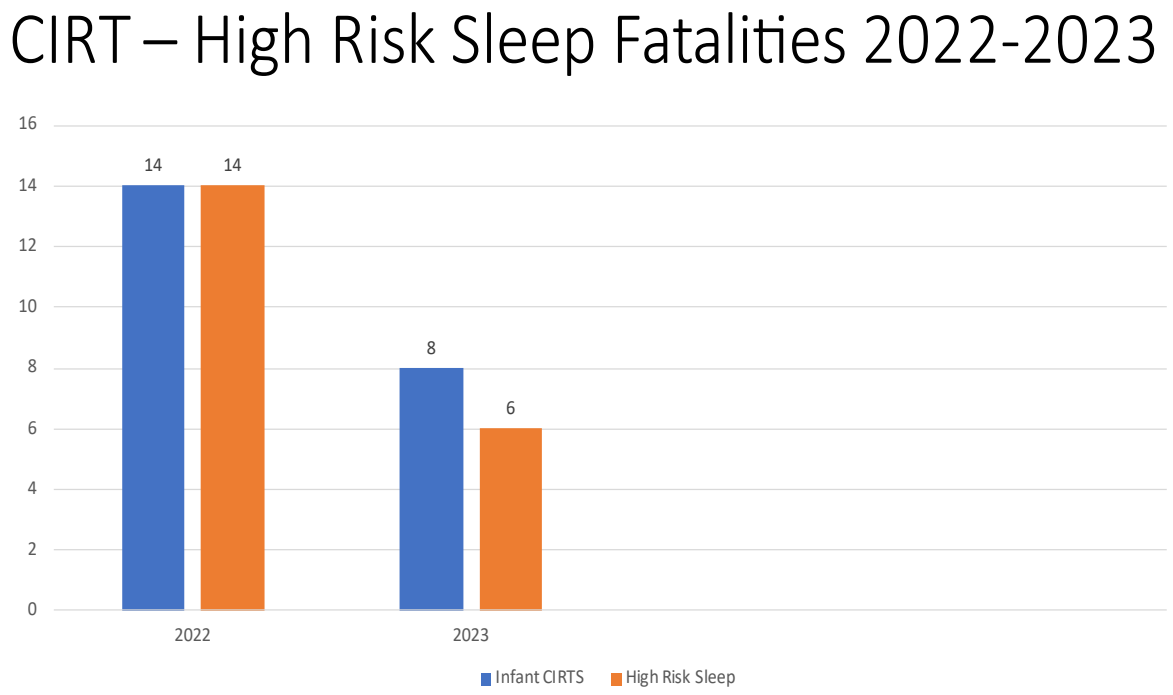
Since launching a virtual version of the 2-day Oregon Assessing Patterns and Behaviors of Neglect training (see attachment "OAPBN Executive Summary 2023", for a description of the course) in 2021, fifteen sessions have been offered. In total 203 child welfare professionals have completed the course virtually. Additionally, the Confederated Tribes of Grand Ronde Children and Family Services Program professionals were invited to attend sessions alongside ODHS child welfare professionals in the second half of 2023. This creates an opportunity for shared learning and networking across the two workforces. Prior to the virtual version, an in-person version was available which trained over 250 child welfare professionals in a variety of roles such as Coaching and Training Specialists, Consultants, and Supervisors.

Training evaluations indicate enhanced understanding in each of the four areas of knowledge (personal experiences/bias/judgments and influence on decision-making, protective factors, consequences of neglect and contributing factors, and long-term impact of chronic neglect on child development) and comments continue to reflect a positive learning experience for participants. Areas for improvement have been related to virtual delivery challenges (breakout rooms and use of cameras) and a desire for in-person learning

opportunities. Continued feedback will be gathered and incorporated as the training facilitation team works with the Child Welfare Equity, Training and Workforce Development program to update the curriculum and delivery plan for 2024.

In addition to classroom training, CFPRP is continuously exploring avenues to enhance the knowledge and skills of child welfare professionals in responding to the needs of families and preventing future maltreatment. A knowledgeable workforce with the skills and resources to do their jobs is a workforce that can have significant positive impacts on the families they encounter. To that end, CFPRP has trained eight additional facilitators from CFPRP, Child Safety, and Reunification programs who can both support the training effort and champion the application of learning across the state.

Infant Safe Sleep



In 2023, of the 23 child fatalities reviewed by the CIRT, 8 were infants. Of the 8 cases involving infants, 6 had high risk sleep practices present at the time of the critical incident. These numbers are a notable decline compared to 2022 when 14 infants were reviewed by the CIRT and all of them had high risk sleep practices present at the time of the critical incident. While the decline in critical incidents with high-risk sleep practices present is encouraging, the need to educate and engage caregivers about reducing sleep related risks remains. Meaningful caregiver engagement and education strategies require an ongoing community response from all family serving systems, including child welfare, which CFPRP is proud to support. Below are some examples of

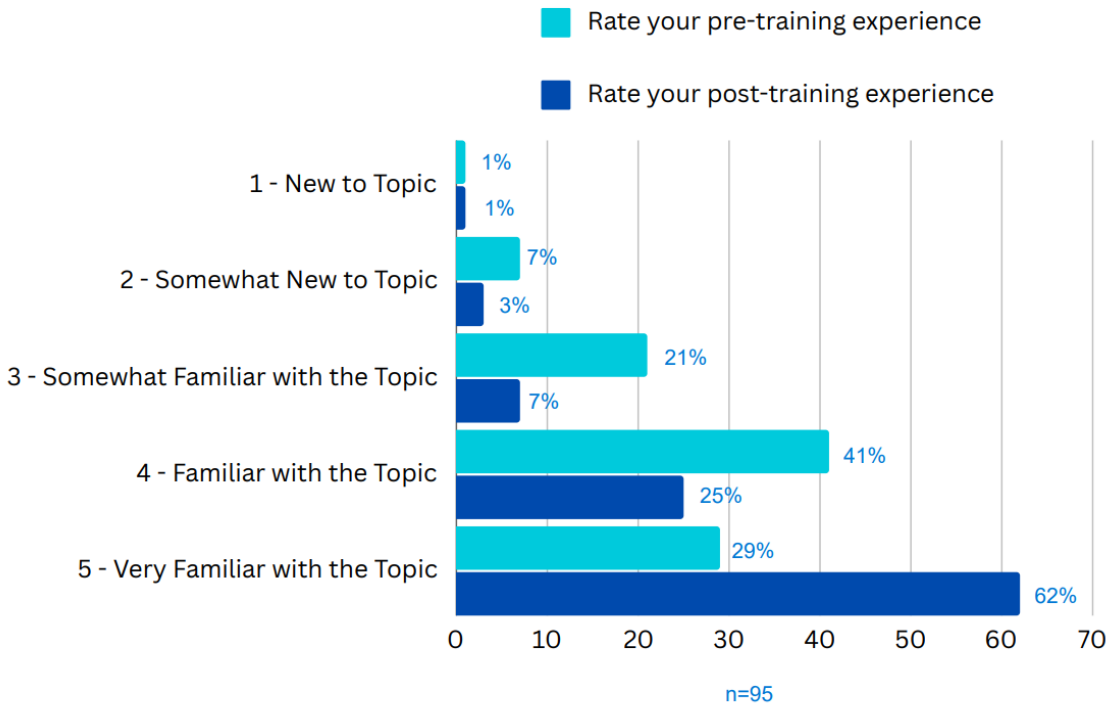
current program efforts to support this important cause.

Education and Training

As a critical part of the child safety community, Child Welfare professionals have a role in supporting families to reduce risk of sleep related death through education and engaging families in conversations about their infant's sleep practices. To effectively have these conversations, Child Welfare professionals need to be educated on safe sleep practices and have the necessary resources available to them.

Self-study trainings tailored to a Child Welfare professional's role, opportunities to practice having safe sleep conversations with families alongside community partners, and access to tangible resources are all a part of the plan to prepare Child Welfare professionals to support families in safely caring for infants. Child Welfare is collaborating with other state agencies and community partners to ensure consistency in messaging received by families.

Self-study trainings are available for Social Service Specialists in screening, safety, permanency, certification, and adoption. Versions for certified resource families and other family-serving professionals were released in 2021 and continue to be promoted. Ongoing updates to the self-study curriculums are made based on learning and input from case reviews, Child Welfare professionals in the local offices, as well as Oregon Tribal members, and other community partners. Input was actively sought through multiple methods from parents of infants and a variety of family serving systems throughout the development of the safe sleep self-studies. Over 2300 child welfare professionals have completed the trainings. Due to a technology issue the feedback results for all the studies, except the family serving professionals version, were lost. Some of the positive impact is evident in the graph below which represents results from 95 family serving professionals who chose to complete the evaluation. These professionals represent a variety of roles including Self-Sufficiency professionals, WIC employees, substance use disorder treatment providers, and mental health professionals.



Sleep practices promoted in the self-study are consistent with the American Academy of Pediatrics safe sleep guidelines. These self-paced educational materials take approximately one hour and by the end professionals should be able to:

- Identify actions that increase and decrease the risk factors of SUIDS and sleep-related infant deaths.
- Recognize safe and high-risk sleep environments.
- Communicate safe sleep practices to pregnant and parenting individuals with a strength based, trauma aware approach that honors their values and needs.

Each self-study includes a knowledge check and opportunity to provide feedback which has been overwhelmingly positive from all audiences.

SAFE SLEEP TOY DISPLAY

To emphasize the importance of safe sleep practices and assessing safe sleep environments for infants, all Child Welfare and Self-Sufficiency offices were offered safe sleep environment displays which consist of a toy doll, wearable blanket, a toy version of a safe sleep surface, and safe sleep educational materials (see photo to left). These were set up in high traffic areas within offices so Child Welfare professionals and members from the community have a visual reminder of what a safe sleep space should look like and can access safe sleep related educational materials.

Partnership and Engagement

Strong partnership and engagement between Child Welfare and other state agencies and community-based providers is critical to ensuring Child Welfare's role in the community response is proportionate and supportive. Below are some examples of partnership and community engagement efforts involving CFPRP to promote infant safe sleep awareness.

Raise Up Oregon: A Statewide Early Learning System Plan for 2019-2023 (see attachment, "Raise Up Oregon – A Statewide Early Learning System Plan") identified prevention of sleep related infant deaths as a priority for Oregon's early learning system. A workgroup tasked with developing recommendations for a statewide coordinated effort was formed in 2020. Participants from a wide range of family serving systems, including culturally specific organizations and CFPRP members, met to develop the recommendations which were presented to the Raise Up Oregon Agency Implementation Coordinating Team. The workgroup recommended the development of a statewide coordinated effort to improve infant safe sleep practices, decrease sleep-related infant deaths, and reduce relative disparities in sleep-related deaths between White and Black and American Indian/Alaska Native infants (See Safe Sleep Workgroup Report and Recommendations). Upon completing the recommendations report, the workgroup elected to continue meeting on a quarterly basis and further explore ways to reduce sleep related infant death in Oregon. This group is known as Oregon's Safe Sleep Coalition. As highlighted in the recommendations, sleep related infant deaths for African American/Black and Native American/Alaska Native infants are two to three times greater than white infants. These disproportionate rates demand a different approach and the need for culturally specific efforts are at the forefront of the Safe Sleep Coalition's efforts as well as CFPRP's strategies.

During National SIDS Awareness Month each September the CFPRP, in coordination with the ODHS communication team, undergoes an effort to educate and engage parents and providers via social media using the toolkit provided by the National Institute of Health (NIH).

To facilitate feedback from providers and parents, CFPRP is coordinating a safe sleep pilot within the Nurture Oregon, Plan of Care Pilot. In this pilot, safe sleep conversations begin as part of prenatal care with a trusted professional and continue while the participant remains within the program. As part of the Plan of Care, safe sleep will also be addressed by the pregnant or parenting individual and their care team. Nurture Oregon professionals were provided the Safe Sleep for Oregon's Infants self-study to develop or enhance their knowledge of safe sleep practices. In addition to the education, each parent receiving services through Nurture Oregon is offered a safe sleep kit, including a portable crib, wearable blanket, and some educational materials. According to the 2023 Nurture Oregon Progress Report, 63% of the 166 participants for whom data was available received some sort of safe sleep materials whether that be a sleep surface, educational materials, or both (see attachment "2023 Nurture Oregon Progress Report").

Members from CFPRP as well as ORCAH and Child Safety Program are participants in the National Partnership for Child Safety Affinity Group: Safely to Their First Birthday. The focus of this group is upstream prevention, compassionate, equitable screening, safety threat identification, and CPS assessment disposition after sudden unexpected infant deaths (SUID)**.**

CFPRP members continue to meet with local child welfare offices and other family serving systems as requested to discuss efforts to reduce sleep related risk and promote harm reduction messaging consistent with AAP guidelines. An example of this partnership is seen in the ongoing work with the Willamette Health Council's (WHC) Prevention, Education, and Outreach group who has made promoting safer infant sleep their focus area for 2023. The WHC requested a presentation from ODHS on SUID data and ODHS efforts to ensure consistent and effective messaging for families. This presentation was completed by members from CFPRP and local office leadership in Marion County.

Concrete Support

Local Child Welfare offices continue to express the urgent need for immediate resources to ensure safe sleep environments for infants. Between 2020, when CFPRP began providing portable cribs to local Child Welfare offices, and 2023, over 2000 sleep surfaces have been distributed to ODHS offices and community partners statewide. This includes the 780 sleep surfaces and wearable blankets, commonly known as sleep sacks, distributed in 2023. These resources can also be shared with other ODHS programs, community partners, and Oregon Tribes. In partnership, a county level public health department has hosted multiple safe sleep classes in the community and distributed CFPRP provided sleep surfaces to participants. The most recent event in spring 2024 engaged 40 caregivers, including those from multi-generational families, with representation from three languages.

Supporting Infants Exposed to Prenatal Substance Use and Their Families

In 2022 and 2023, 53 Critical Incident Reviews Teams (CIRTs) were assigned by the ODHS Director. All 53 CIRTs involved the review of a critical incident that resulted in a child fatality, 22 of which involved an infant fatality, and of those 22 infant fatalities reviewed by the CIRT, 21 had familial substance use concerns identified in the family's child welfare case record, and 12 were identified as infants with prenatal substance exposure. With this data in mind, Child Welfare's continued implementation of the Comprehensive Addiction and Recovery Act (CARA) is under the umbrella of CFPRP and has been incorporated into the comprehensive plan to prevent child maltreatment fatalities. Two CARA coordinator positions were hired in April of 2021 to continue efforts

to develop, implement, and monitor Plans of Care, and further advance efforts related to infant safe sleep in cases requiring a Plan of Care. The CARA coordinators continue to collaborate with the Oregon Health Authority (OHA) in efforts to move all aspects of implementation forward.

Oregon is making a concerted effort to address barriers to engagement and improve the implementation and reach of evidence-based strategies including coordination of care, medication for opioid use disorder, contingency management, resource navigation and support through peer doulas, and non-punitive policies. These efforts to date have included:

- Monthly collaborative meetings between Oregon Department of Human Services, Oregon Health Authority, and Comagine Health to create a plan for implementing Plans of Care (including data reporting infrastructure) to improve access to and coordination of care for pregnant and postpartum people with substance use disorders.
- An emphasis on non-punitive approaches to care includes prioritizing family unity, removal prevention, and limiting reporting to Oregon Child Abuse Hotline (ORCAH) only when a safety concern is present at or after the time of delivery but not during pregnancy or for substance use exposure during pregnancy alone. In contrast with some states, Oregon does not include prenatal substance exposure in the statutory definition of child maltreatment.
- Piloting Plans of Care with a subset of community-based organizations through Nurture Oregon sites to understand barriers and facilitators to implementation and consider how to create and refine systems. The Nurture Oregon demonstration kicked off in August of 2021. 225 Nurture Oregon participants gave birth by the end of the reporting period (December 2023) and had data on child welfare involvement. Of those who gave birth, 60% had a Plan of Care developed and 63% had their Plan of Care developed prenatally. 66% of participants went home from the hospital with their Nurture Oregon child and did not experience a removal at birth.

See attachment “2023 Nurture Oregon Progress Report”.

Statewide Implementation

ODHS Child Welfare and the Oregon Health Authority (OHA) have contracted with Comagine Health to facilitate statewide implementation of the Comprehensive Addiction and Recovery Act (CARA), including Plans of Care. Representatives from ODHS Child Welfare, OHA and Comagine Health have met monthly as part of an interdisciplinary Planning Team since 2022. These meetings are facilitated by Camille Cioffi, PhD. Dr. Cioffi is a consultant with Comagine, Research Assistant Professor at the University of Oregon, and Research Scientist at Influents Innovations. Dr. Cioffi’s research centers community voices through mixed methods approaches and equitable implementation and focuses on supporting pregnant and parenting people, particularly people with substance use disorders. Through these monthly meetings and information gathering with early adopters of Plans of Care, namely Nurture Oregon sites, and Health Information Technology representatives, the Planning Team has developed a statewide implementation plan rooted in the goals of improving access to coordinated care, reducing stigma and increasing engagement, maintaining infants with families, and eliminating or reducing Child Welfare involvement.

Comagine Health and the Oregon Perinatal Collaborative (OPC) plan to reduce maternal mortality and severe maternal morbidity related to Substance Use Disorder (SUD) in Oregon through a comprehensive implementation of the Alliance for Innovation on Maternal Health (AIM) Care for Pregnant and Postpartum

People with SUD Patient Safety Bundle. Bundle implementation will be supported and enhanced by partnerships with key organizations including Oregon Health and Sciences University, Project Nurture & Nurture Oregon, providers, and peer support specialists. Comagine has established a Maternal Health Task Force (MHTF) comprised of public health professionals, providers, payers, and consumers to support this work. Two members of the CARA Planning Team, representing OHA and ODHS, are also members of the MHTF. Oregon intends to focus on perinatal SUD, with aims of using (and making available) the data to drive OPC planning to implement quality improvement efforts within hospitals and birthing centers, beginning with facilities located in service areas with a Nurture Oregon site.

Quality improvement efforts will be rooted in the SUD AIM patient safety bundle which includes several elements focused on CAPTA notifications and Plans of Care development. The planning team has identified the need for a community-driven process for identifying the optimal elements of a Plan of Care, destigmatizing the instructions, and emphasizing the birthing person as the change agent of their own lives and the lives of their family members. To date, they define a team model that proposes the Planning Team as an Implementation Team and a new decision-making body composed of individuals with lived experience navigating pregnancy and postpartum with Substance Use Disorder (SUD) and community professionals. To support this effort, Comagine Health established and facilitates a Lived Experience Community Board to gather essential input on the Plan of Care and Notification systems processes. Meeting topics include orienting members to the purpose of the Plan of Care, providing input on the current Plan of Care document and guidance, and providing input on the hospital notification system. The Maternal Health Taskforce will serve as the decision-making body for community professionals. See attachment “Family Care Plans in Oregon by Comagine Health”.

Child Welfare Policy and Practice

Within Child Welfare, continued education, support, training, and mutual learning through feedback has occurred with CPS and permanency consultants and Child Welfare professionals in the local offices (screeners, caseworkers, Coaching and Training Specialists, Addiction and Recovery Teams, supervisors, and management). The following are examples of specific workforce support and development efforts pertaining to CARA and Plans of Care:

- CARA Coordinators developed and delivered trainings to Child Welfare professionals across the state to reinforce Child Welfare’s responsibilities with the development of Plans of Care. In addition, local Child Welfare offices were allotted funding to support the concrete needs of child welfare involved families with a Plan of Care in place. The process to utilize the funding was also shared during these trainings.
- To offer ongoing support a CARA specific Microsoft Teams channel was created for Child Welfare professionals statewide to give real time access to CARA specific information and ask questions as they arise.
- Child Welfare is developing staffing guidelines for cases involving infants and substance use that emphasizes developing Plans of Care and referrals to community-based services and recovery supports. Since substance use disorder is not the only complicating factor associated with infant fatalities, the staffing guidelines will highlight other factors including safe sleep and responsive relationships. Work is underway to enhance Child Welfare procedure and practice when a report is closed at screening on an open CPS assessment to ensure timely communication occurs between ORCAH and CPS caseworkers and supervisors. Additional procedure is being developed for CPS assessments where multiple reports are received in a short period of time involving infants aged 0-12 months, whether they are assigned or closed at screening. The procedure will require direct contact

between an ORCAH supervisor and a CPS supervisor to communicate information contained in the report(s) and ensure appropriate screening and CPS assessment decisions are made.

- In consultation with the Child Safety Program and CFPRP, the Oregon Child Abuse Hotline (ORCAH) is taking steps to support early identification of assigned reports with infants in the home. Beginning 3/7/2023, ORCAH flags reports by adding "INFANT" to the subject line for local office notification. Child Welfare has implemented several strategies to account for the increased vulnerability of infants on CPS assessments and open permanency cases, including assessing the safe sleep environment, ensuring the development of Plans of Care for infants with prenatal substance exposure, and encouraging the utilization of infant safety staffings. These strategies are intended to support engagement with families around topics specifically related to infant safety and wellbeing. Adding the infant flag to the assignment email will help alert workers and supervisors to consider these strategies when engaging with a family who has an infant.
- Child welfare professionals have received additional practice guidance promoting the development of prenatal Plans of Care for cases involving pregnant individuals using substances including Expectant and Parenting children and young adults in foster care and pregnant people associated with cases open for ongoing services or CPS assessment.
- Several family serving systems in Oregon conduct strengths and needs assessments and develop plans that incorporate content that is also included in a Plan of Care. CARA coordinators are guiding Child Welfare professionals developing Plans of Care to collaborate with other family serving professionals like family coaches and nurse home visitors to identify the underlying strengths and challenges families may be experiencing. CFPRP and Child Safety Program have partnered with the Health and Wellness Services Program to bring Resource Nurses into the CPS assessment phase when certain criteria apply, one of the criteria being an infant identified as a participant on the CPS assessment. The Resource Nurses are prepared to help caseworkers develop Plans of Care on cases where the infant was exposed to substances during the prenatal period. In addition to support with the development of Plans of Care, the Resource Nurses will assist with a variety of tasks including but not limited to safe sleep and tummy time education, developmental assessments, and identifying potential referrals for the caregivers.

Changes to Policy or Practice, and Lessons Learned

To center the needs of the entire family, the statewide CARA Planning Team is shifting to using the term 'Family Care Plan', rather than 'Plan of Care'. Until rules, procedures, and forms are updated the term Plan of Care will be used for clarity and consistency. As Oregon moves toward statewide implementation, the opportunity exists to revise the Plan of Care template and instructions to ensure it supports families as intended and is user friendly for providers.

The term and definition in Oregon Administrative Rule for 'substance affected infant' was updated to 'infant with prenatal substance exposure'. This promotes person centered language when talking about families in need of a plan of care. The definition now reads:

"Infant with prenatal substance exposure" means an infant, regardless of whether abuse is suspected, for whom prenatal substance exposure is indicated at birth. This includes any of the following circumstances:

(a) There is credible information the birthing parent used substances during the pregnancy or at the time of birth;

(b) Prenatal substance exposure is determined by a positive toxicology screen from the infant or the birthing parent at delivery; or

(c) An infant whose health care provider has identified signs of substance withdrawal, a Fetal Alcohol Spectrum Disorder diagnosis, or detectable physical, developmental, cognitive, or emotional delay or harm associated with prenatal substance exposure.

Challenges & Technical Assistance

Nurture Oregon sites identified the following challenges and barriers in 2023:

- Nurture Oregon sites and participants face stigma from other agencies as it relates to serving pregnant people with substance use disorder.
- Limited housing options in rural and frontier counties, and limited access due to restrictive eligibility criteria.
- Lack of central electronic platform to share Plans of Care with hospitals and other external community partners.

See attachment “2023 Nurture Oregon Progress Report”.

Other Prevention Efforts

Child Maltreatment Prevention Collaborative

CFPRP initiated a collaborative partnership with OHA, Public Health, to address primary, secondary, and tertiary child maltreatment prevention. As a result, CFPRP representing Child Welfare and OHA, Public Health, finalized a memorandum of understanding supporting this collaboration. The two agencies have a significant amount of cross over in work efforts, individuals served, and the values driving how the work is done (see attachment “Child Maltreatment Prevention Collaboration Visual”).

Therefore, the purpose of this agreement is to:

- Document existing activities and areas of collaboration and coordination between CP&HP and Child Welfare.
- Describe a structure of communication and collaboration that will support the identification of new activities and initiatives that promote our shared intent.
- Increase coordination and collaboration between these entities to enhance family support and prevent child maltreatment.
- Describe methods and forums for regular and consistent communication, collaboration, and information exchange.

The implementation of this agreement shall be guided by the following objectives:

- Programmatic, Policy, and Relationship Building
    - To prevent duplication and fragmentation of effort and services.
    - To promote long-term planning.
    - To collaborate on policy and systems initiatives for and with the shared population.
    - To promote equitable, culturally, and linguistically appropriate, family centered, and trauma informed systems and services that are responsive to community needs.
    - To support collective approaches to responding to statutory requirements, such as CARA/CAPTA Plans of Care, State Child Death Review and Prevention Team and State Technical Assistance Team.
    - To collaborate on outreach and increase public awareness of services and supports for safe, stable, and nurturing families and to prevent child maltreatment.

- Assessment, evaluation, surveillance, and data sharing
    - To establish a systematic process for the timely sharing of programmatic and surveillance data.
    - To enhance collaboration on statewide needs assessment, evaluation, and surveillance to support the health and safety of the shared populations we serve.
- Resource Sharing
    - To explore and support opportunities to share and/or align resources (e.g., funds, systems, staff time) across the agencies to support joint initiatives.

Prevention Kits

CFPRP purchased prevention kits from Oregon Health Sciences University, Tom Sargent Safety Center to prevent child fatalities and serious injuries by improving home environment safety. These kits were shipped to local Child Welfare and Self Sufficiency offices to provide families with items that improve household safety by reducing risk. Examples of items include window locks, firearm locks, and medication storage items. These kits arrived in late 2022 and many items have already been distributed to families across the state. An additional order for more items were placed in the summer of 2023 which included the items listed above as well as bicycle helmets. Lifejackets in a variety of sizes were also delivered to local offices to provide to any family in need.

Community Needs Assessment – Social Determinants of Health

Child Welfare recognizes the need to ensure pregnant individuals and families can access supports and services further upstream from CPS. To support this effort, CFPRP is reviewing and gathering data from statewide plans developed by other family serving systems and Community Health Assessments developed by CCO's and public health agencies in each of Oregon's 36 counties. Child welfare hopes to gain a better understanding of the socioeconomic conditions, health disparities and the array of existing services available to children and families in local communities. Additionally, CFPRP is currently researching and reviewing evidence-driven strategies for incorporating Social Determinant of Health considerations formally into the Critical Incident Review Teams. CFPRP plans to incorporate a minimum of one identified strategy no later than Winter 2025 to support the thorough and equitable consideration of the totality of a family's circumstances in the CIRT process.

Enhanced Early Learning Partnership

Collaboration with the Early Learning council (ELC) and Oregon Department of Education (ODE) to support the development and implementation of strategies that increase access to culturally responsive, targeted supports; promote wellbeing; and prevent child welfare involvement. Initial conversations with the ELC and ODE have focused on Early Intervention referrals made by Child Welfare on behalf of children aged 0-3. The reality is many children in Oregon who are identified with developmental delays at screening never receive services due to limited funding and only 34% of infants and toddlers who are identified and enrolled in Early Intervention receive the recommended level of services[2]. Child Welfare and ELC have already identified opportunities to enhance communication and engagement with families navigating the Early Intervention referral and evaluation process. Child Welfare is exploring opportunities to partner with the ELC to support the strategies identified in Raise Up Oregon: A Statewide Early Learning System Plan (see attachment "Raise Up

[2] https://www.oregon.gov/ode/students-and-family/SpecialEducation/earlyintervention/Documents/govreport.pdf

Oregon - A Statewide Early Learning System Plan") that align with the Comprehensive Addiction and Recovery Act. Some efforts include building the connection between local early intervention referral coordinators and child welfare offices to improve the referral process for both mandatory CAPTA referrals and voluntary referrals when there are no substantiated allegations of abuse at the conclusion of a CPS assessment.

Substance Use Disorder Workforce Support

In 2023, 78% of CIRTS identified substance use concerns present in case history (prior to the critical incident) involving abuse or misuse with alcohol, legal or illegal drugs and/or prescription drugs regarding the parent(s) and/or caregiver(s) of the child involved in the critical incident. In addition, a statewide safe systems analysis identified the assessment of parental substance use as the top system improvement opportunity and training (either ineffective or lack of), as one of the top five most influencing factors proximal to poor outcomes for children and families.

Given the high prevalence of substance use concerns present in not only CIRTS but child welfare cases in general, it is critical to have a workforce who feels confident and capable of engaging families in conversations about substance use so they can accurately assess impacts of substance use on child safety. To achieve this goal, a cross program effort involving CFPRP, Child Safety Program, Permanency Program, and the Equity, Workforce, Training, and Development Team is exploring ways to streamline statewide training expectations for all child welfare professionals on topics related to substance use, introduce an evidence-based screening tool for substance use concerns, and provide centralized coordination for the 25 child welfare professionals who are specifically tasked with connecting caregivers with substance use concerns to appropriate supports. These efforts also align with several system mapping recommendations.

Foster America: Fiscal Leadership Circle 2024

In April 2024, Oregon Child Welfare in partnership with Dr. Tiffany Lindsey of the NPCS applied to be part of a national fellowship of leaders within a public child welfare system or family-focused community organization to advance fiscal strategies in the child welfare sector. This 12-month hybrid fellowship aims to help finance professionals to imagine and implement new ways to direct funding toward prevention programming that keeps children safely at home with their families, reducing the need to place children in foster care. Oregon will collaborate with Dr. Lindsey to develop funding pipelines aimed at preventing family separation in the case of a substance exposed newborn and provide opportunity to share the results with the 38 jurisdictions involved in the National Partnership for Child Safety.

Oregon Opioid Settlement Prevention, Treatment and Recovery Board

ODHS Child Welfare is represented on the state Opioid Settlement Prevention, Treatment and Recovery Board. ORS Chapter 63, Sections 5-10 mandates that an 18-member Board will determine how to allocate the State's portion of the opioid settlement funds for statewide and regional opioid prevention, treatment, and recovery initiatives. These funding decisions will be in alignment with Oregon's Strategic Plan for Substance Use Services. As a member of the Board, the CFPRP program manager maintains awareness of the related support needed by the Child Welfare workforce and the families served by Child Welfare. See 2020-2025 Oregon Statewide Strategic Plan.

Father and Noncustodial Caregiver Engagement

CFPRP conducted system mapping in fall 2023 to better understand barriers to engaging noncustodial caregivers in child welfare practice, with emphasis on fathers. Fathers have a societal bias as being secondary caregivers which is reflected in child welfare practice. A need for enhanced father and noncustodial caregiver engagement emerged as a trend in child fatality cases. Father engagement and participation in case planning often results in improved child welfare outcomes. The safe systems mapping team consisted of 42 child welfare, and broader child and family serving professionals, including individuals with lived experience.

The mapping sessions highlighted pervasive barriers fathers experience across the Child Welfare system and the broader child and family serving system. Five recommendations were developed to improve child welfare practice:

- Explore development of regional assignments, such as existent structure in Child Welfare "champions," which focus on fathers and parents who are not primary custodians of their children.
- A section of training specific to father engagement in new employee training, and exploration of available training opportunities to infuse elements of implicit bias, secondary trauma, and their impact to individual casework practice.
- Develop a tool which maps father-specific services available in the state. This tool must be developed in collaboration with lived experts of child welfare involvement.
- Evaluate areas in policy, procedure, and databases (such as OR-Kids database used by caseworkers) where "hard stops" may be implemented for identifying and purposely engaging fathers.
- In consultation with ODHS Office of Tribal Affairs and Oregon Tribes, support development of specialized advocate role(s) for Indigenous father engagement, including but not limited to ICWA/ORICWA, and explore additional prevention efforts.

In 2024, a work charter is being formed to strategize and carry out implementation of these recommendations. Additionally, the mapping highlighted deficits in the broader child and family serving system outside of ODHS. The mapping team recommended the development of an interagency council to address the wide-reaching barriers. See attachment "Recommendations addendum" for more information about this. There is no current plan to implement this broad recommendation, though CFPRP has shared it with several statewide partners.

Collaboration

Collaboration is part of the CFPRP mission and integral to ensuring community voice in all work. Some of the collaborative efforts are detailed below and demonstrate how the work is aligned with the Vision for Transformation, including supporting families and promoting prevention, enhancing our staff and infrastructure, and enhancing the structure of our system by using data with continuous quality improvement. For more information on how the work of CFPRP aligns with the Vision (see attachment "CFPRP Vision for Transformation").

- Depending on the circumstances, CFPRP includes the Office of Tribal Affairs within the ODHS Director's office, law enforcement agencies, probation and parole officers, Self Sufficiency Programs, Oregon Health Authority, medical professionals, Oregon Youth Authority, Alcohol and Drug Policy Commission, the Oregon Tribes or other federally recognized Tribal Nations, service providers, subject matter experts, or others with specific information related to the family or the larger family serving system as members of a Critical Incident Review Team (CIRT).
- CFPRP seeks the expert insight of the Office of Tribal Affairs in the Critical Incident Review Process. Child Welfare's commitment to Oregon Tribes and other federally recognized Tribal Nations having voice in the work of CFPRP remains central to the work. CFPRP ensures the Office of Tribal Affairs is involved in the CIRT process at the earliest possible juncture when the fatality of a child with Native ancestry meets review criteria.
- CFPRP received expert consultation and guidance from ODHS Tribal Affairs about reducing traumatic impact when a child dies and ensuring Tribal Nation engagement and voice. The guidance is incorporated into the Fatality Protocol revisions and the plan remains for future partnership to draft procedures on the topic.
- CFPRP engaged in and continued to develop communication and connection with multiple community partners to open and maintain lines of communication and be responsive regarding their needs and concerns surrounding young persons suicide. This included:
    - Actively participating in local and regional statewide suicide prevention coalitions throughout Oregon.
    - Sharing activities, initiatives, and strategies for suicide prevention and intervention.
- CFPRP was represented through membership in the Oregon Alliance to Prevent Suicide and included participation in sub-workgroups related to equity in the continued support of diverse and underrepresented communities to access suicide prevention and intervention supports.
- CFPRP supported workforce and community suicide prevention and postvention programs through ongoing collaboration with the Oregon Health Authority public and behavioral health Suicide Prevention Coordinators as well as collaboration with ODHS Trauma Aware.
- CFPRP continues collaboration with ODHS Shared Services, Oregon Health Authority, and REAP in the development and implementation of the Oregon Child Welfare YouthSAVE training module with full implementation slated for Fall 2024. CFPRP continues collaboration with the ODHS Child Welfare Equity, Training, and Workforce Development Program to provide enhanced Question, Persuade, Refer for Resource Parent training and additional information and guidance to support resource parents in caring for children and young adults in their care.
- CFPRP continues collaboration with Oregon Health Authority and Oregon Department of Education as part of the State Agency Partnership to share and develop best practice strategies for suicide prevention and intervention for Oregon's young people.
- In response to increasing Fentanyl related overdoses, CFPRP is collaborating with other state agencies in furthering education and treatment options related to young persons substance use. CFPRP is currently conducting an evaluation of ODHS' current efforts to address child substance use by consulting with experts to determine whether additional intervention strategies are indicated.

- CFPRP, as part of the CIRT process, continues to lead the creation and oversee the implementation of system and practice recommendations developed in response to child fatalities through collaboration with numerous and varied system partners.
- Through the National Partnership for Child Safety (NPCS), CFPRP collaborates with 38 state, county and Tribal child and family serving agencies and technical assistance advisors in support of safety science implementation.
- CFPRP continues collaboration with the interdisciplinary State Child Death Review and Prevention Team and all 36 multidisciplinary county child death review teams to enhance Oregon's death review system, death review data collection, and resulting prevention efforts. Some of the collaborative efforts include:
    - Ongoing implementation of the Child Death Review Resource and System Improvement Plan which was informed by the county child death review team needs assessment. All 36 county multidisciplinary teams had voice in the assessment and the plan.
    - Outreach to each county death review team when a prevention recommendation is entered into the National Fatality Review – Case Reporting System. The outreach includes acknowledgement of the effort, an offer of support, and follow through with supporting the prevention work in the manner requested by the county.
    - Establishing a workgroup of external partners whose role is impacted by death investigation to address equity in child death investigation across Oregon counties.
    - Initiated and participated in a listening and education session with county child death review teams related to overdose prevention.
- CFPRP initiates and engages in extensive collaboration statewide with child and family serving professionals and organizations and those they serve in efforts to support infant safe sleep practices. This includes:
    - Partnership with health care providers to strategize community messaging efforts to promote safer infant sleep environments.
    - Continued promotion of self-study document on infant safe sleep education for Oregon Family Serving Processionals which includes input from parents of infants and a variety of family serving professionals and organizations. This was developed in response to a community voiced desire to improve consistency of infant safe sleep education across family serving systems (see attachment "Safe Sleep for Oregon's Infants").
    - Support of Safe Sleep Awareness month activities for The Confederated Tribes of Grande Ronde by providing data, talking points, and resources regarding safe infant sleep practices.
- Continued engagement with child formerly in foster care for consultation on the work of CFPRP.
- CFPRP continues collaboration with individuals, professionals, and organizations impacted by or essential to implementing the Comprehensive Addiction and Recovery Act and specifically Plans of Care with the objectives of increasing engagement, maintaining infants safely with their families, eliminating or reducing child welfare involvement, mitigating the impact of substance use, and supporting parents diagnosed with substance use disorder with their recovery. CFPRP continues to engage the following groups throughout the statewide implementation process:
    - Oregon Health Authority (OHA) Public Health Division
    - Maternal and Child Health

  - Health Promotion and Chronic Disease Prevention
  - Injury and Violence Prevention
  - OHA Health Systems Division
  - Addiction Services
  - Behavioral Health Policy and Planning
  - OHA Health Policy and Analytics Division
  - Transformation Center
  - Patient-Centered Primary Care Home Program
  - Quality and Health Outcomes Committee (QHOC)
  - Coordinated Care Organizations
  - Every Step Clinics
  - Project Nurture
  - Nurture Oregon
  - Substance Use Disorder Treatment providers and programs
  - Health Care Professionals (doctors, nurses, midwives)
  - Community Health Workers (traditional health workers, peer support specialists, doulas)
  - Oregon MothersCare Program
  - Family Connects Oregon
  - Babies First!
  - Healthy Families Oregon
  - Nurse Family Partnership
  - Healthy Birth Initiative
  - Help Me Grow
  - Oregon Association of Relief Nurseries
  - Northwest Portland Area Indian Health Board
  - Office of Tribal Affairs
  - Raise Up Oregon
  - Connect Oregon (Unite Us)
  - Prevent Child Abuse Oregon
  - Oregon Sexual Assault Taskforce
  - Morrison Child and Family Services
  - Families Actively Improving Relationships (FAIR) Program
  - Comagine Health
  - WA State Department of Children Youth and Families
  - Early Learning Council
- Ongoing collaboration with health care providers across the state to discuss caring for infants with prenatal substance exposure and supporting their families by way of Plans of Care.
- CFPRP has active engagement and collaboration with numerous ODHS and OHA programs. At ODHS this includes the following: Tribal Affairs, Child Welfare Programs, Office of Program Integrity, Office of Contracts and Procurement, Office of Reporting, Research, Analytics, and Implementation, Office of Equity and Multicultural Services, Self-Sufficiency Program, Communications, ODHS Director's Office, Trauma Aware ODHS, Office of Training, Investigations and Safety, and Developmental Disabilities

Services. At Oregon Health Authority this includes the following: Behavioral Health, Zero Suicide, Youth Suicide Prevention Intervention & Postvention Program, Oregon WIC, Injury and Violence Prevention Program, Public Health, Maternal and Child Health, Youth and Runaway Program, Addiction Services Program, Youth and Young Adult Substance Use Collaborative, and the Center for Prevention and Health Promotion.

- CFPRP has active engagement and collaboration with external partners to develop data-informed and innovative strategies for prevention. This includes the following: Community Health Nurses, Oregon Tribes, Oregon Judicial Department, Oregon Department of Justice, local law enforcement agencies, Oregon Association of Chiefs of Police, District Attorneys, Oregon State Child Death Review and Prevention Team, 36 county child death review teams, Oregon Child Abuse Solutions, Oregon Parenting Education Collaborative parent coordinators and trainers, health care professionals, Relief Nurseries, Birthing Hospitals, Jackson Care Connect, Home Visiting Programs, Child and Family Futures, Oregon Perinatal Collaborative, Overdose Response Strategy, Doulas, Traditional Health Workers, Peer Support Specialists, Certified Recovery Mentors, Raise Up Oregon, Child Advocacy Centers, Designated Medical Professionals, Substance Use Disorder treatment professionals, YouthSAVE, YouthLine/Lines for Life, County Suicide Prevention Coalitions, Oregon Liquor and Cannabis Commission, REAP, Oregon Alliance to Prevent Suicide, Oregon Social Learning Center, State Medical Examiner's Office, Connect Postvention, Association of Oregon Community Mental Health Programs, Portland State University, Trauma Aware Oregon, Hospital Social Workers, National Center for Substance Abuse in Child Welfare, Early Intervention, Oregon Health Sciences University Safety Center, QPR Institute, Affinità Consulting, NPCS Innovation and Implementation Learning Community, NPCS Peer Leaders, NPCS Data Sharing Workgroup, NPCS Affinity Group: Safely to Their First Birthday, and the University of Kentucky Center for Innovation in Population Health.
- Ongoing collaboration with Oregon's Early Learning Division and Department of Education to improve Early Intervention referral and engagement as required by CAPTA.
- Continued communication with various Coordinated Care Organizations to develop and streamline local processes for Child Welfare professionals to connect families to community-based resources.
- CFPRP continued to develop partnerships with fathers with lived experience from diverse communities. CFPRP regularly attends and assists the Father's Advisory Board (FAB), which is supported by District 10 Child Welfare. FAB advocates for improved outcomes for fathers in Child Welfare, and the broader family serving system. CFPRP developed partnerships with numerous other partners for improved outcomes with fathers including Casey Family Programs, Washington Department of Children, Youth & Families, Washington Tribal Affairs, Oregon Department of Corrections, Multnomah County Health Department: Health Birth Initiatives Father Involvement Program, Self Enhancement Inc., Relief Nursery of Lane County, We Are 4 Fathers, Unity Our Tool, Painted Horse Recovery, and Morrison Child & Family Services.

Building Partnerships and Learning from Oregon Tribes

CFPRP is committed to building a strong partnership with Oregon Tribes to collaborate on child maltreatment and fatality prevention opportunities through listening and learning. CFPRP efforts to build this relationship during the past year include:

- CFPRP continues to seek the expert insight of Tribal Affairs in the Critical Incident Review Process. Our commitment to Oregon Tribes having voice in the work of CFPRP will remain central to our efforts. With humility, we look forward to continuing to develop relationships and doing better each year.
- Developed and provided Suicide Prevention training for Oregon Child Abuse Hotline staff containing information specific to enhanced impact factors for suicide, including increased impacts for Tribal/ Indigenous young persons.
- Collaborated with the Confederated Tribes of Grand Ronde Children and Family Services to provide free life jackets to have available for distribution when a need is identified in the community. CFPRP members participated in and completed the DOJ-led ORICWA training to enhance understanding of ORICWA in the Court System.
- Developed new internal data dashboard to improve understanding of infant safety and well-being with ability to filter by Race/Ethnicity and ICWA status. This data will provide new opportunities to share data, partner with Oregon Tribes and community at all levels of prevention.
- Provided information on *Building Psychological Safety to Advance a Safety Culture* at the Tribal Affairs Unit Quarterly meeting.
- Provided information on Critical Incidents, Plans of Care and CFPRP's current child maltreatment prevention strategies at ICWA Advisory.
- Provided information on CAPTA supplemental funding available through the American Rescue Plan Act at the ODHS Directors and Oregon Tribes Quarterly Convening.
- CFPRP members presented on Innovations in Infant Safety and Wellbeing at the 2023 Tribal State ICWA conference where culturally specific resources and data were shared regarding Plans of Care. This presentation included an overview and dissemination of printed materials from the Northwest Portland Area Indian Health Board's Family Wellness Plan toolkit.
- CFPRP collaborated with Confederated Tribes of Grande Ronde, Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians, Klamath Tribes, and numerous Indigenous fathers with lived expertise for purposes of improving outcomes for fathers and families.
- CFPRP members engaged with residents of Celilo Village, representatives from Tribal Affairs, the ODHS Directors office, the Office of Resilience and Emergency Management (OREM), the Columbia River Inter-Tribal Fish Commission (CRITFC) and leadership from District 9 to implement a project using child welfare funds to replace the floor and various appliances at the Celilo Village Longhouse.

Acknowledgement

To Child Fatality Prevention & Review Team members:

Thank you to this amazing team of caring, passionate, and professional human beings who took a chance to be part of this program and who are sharing details about their work in our Comprehensive Statewide Plan to Prevent Child Maltreatment Fatalities. Each one of you show up every day, and through your dedication to this difficult work, you honor Oregon's most vulnerable and precious beings; the children whose lives have been lost too early, and their families and communities who grieve the immense loss of a child. Your work is important; your passion, commitment, and innovation have the power to change and improve an imperfect system that doesn't always work in the way it was intended. The work of this team strives to provide an objective and thorough review of our most tragic outcomes in order to better understand what systems and communities must have in place for children and their families to live and thrive in all Oregon communities. I value your commitment to the work of ensuring all children and their families get what they need when they interact with our systems and within their own communities. It makes me proud and humbled to work alongside each of you. Thank you for all you give of yourselves and all you have taught me.

And one final thank you goes out to our amazing technical advisors at the National Partnership for Child Safety – University of Kentucky Center for Innovation in Population Health. Your inclusivity and never-ending support to Oregon and this team has truly sowed the seeds for each of us to grow individually but also grow as a Child Welfare program. Thank you for taking us under your wings and teaching us how to fly. We appreciate you all so very much.

Child Fatality Prevention and Review Program Manager

NATIONAL PARTNERSHIP FOR CHILD SAFETY

Partnership Activities Resource Guide

2024

Center for Innovation in Population Health

NATIONAL PARTNERSHIP FOR CHILD SAFETY

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NATIONAL PARTNERSHIP FOR CHILD SAFETY

Membership Benefits

NPCS Membership Benefits:

Critical Incident Review technical support from the leading national experts on the applications of **safety science/safety culture to public child welfare work**, including:

- Skilled and Advanced Trainings and Practice Labs
- Peer-to-Peer and Affinity Groups for Community and QI work
- Critical Incident Review Process Development
- Coaching and Certification in the Safe Systems Improvement Tool -- *the most widely used tool for understanding critical incidents in child welfare*
- Policy Development Support
- Stakeholder Engagement and Communications Support
- Co-facilitation of High-Profile Reviews
- Data Analysis and Support
- Customized Database Creation and Management via REDCap

Support with **broader safety science/safety culture** paradigm work, such as:

- Annual Safety Culture Survey Administration and Data Analysis
- Coaching and curating a library of NPCS Spaced Education and Safety Notices
- Workforce Development and Implementation of the TeamFirst Field Guide for Safe, Reliable and Effective Child Welfare Teams

The Safe Systems Team, led by Dr. Michael Cull at University of Kentucky's Center for Innovation in Population Health, is the founding and lead technical support for the NPCS. With a national reputation and commitment to excellence, the Safe Systems Team organizes **peer-to-peer learning at executive and program levels**, leads **NPCS data analysis**, and customizes **site-specific work to meet every jurisdiction where they are at and personally respond to emerging needs**.

NATIONAL PARTNERSHIP FOR CHILD SAFETY

Membership Benefits

NPCS Membership Benefits:

Access to the **NPCS Data Warehouse** via the Michigan Public Health Institute (MPHI) and held at the nationally recognized National Center for Fatality Review and Prevention. The Partnership's data-sharing exists to improve child, family, and workforce-level outcomes by accelerating a **family-centered, workforce-informed, systems-focused approach to learning from critical incidents**.

Crisis Management and Communications Support from former White House Communications Director Jennifer Devlin, such as:

- Coaching and press-related technical assistance to individual partners to highlight local NPCS involvement and manage crisis communications after a high-profile critical incident
- Access to communications training, customized NPCS Communications Toolkits, Reframing Childhood Adversity Toolkit, press release and op-ed templates, and related resources

Public listing on the NPCS Website as well as access to the **NPCS' internal sharing site on Basecamp**

The Partnership maintains three primary Basecamp sites: General Communications, Critical Incident Review, and Communications Workgroup. Basecamp is a platform for small and large group peer-to-peer connection and resource sharing. To be added to Basecamp, email Tiffany Lindsey.

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Governance and Community Technical Assistance

Governance

Executive Committee*
Executive Advisory Group (nomination-only, closed invitation)
Data Sharing Workgroup*
Data Advisory Group (nomination-only, closed invitation)
Communications Workgroup*

Community Technical Asistance (varied cadence)

Systems-focused Critical Incident Review (SCIR) Peer Leader's Meeting
Quarterly SCIR Practitioner Community Calls
Affinity Groups

Technical Assistance: Drop-in Office Hours

Safe Systems Drop-in with the UKY Team (biweekly)

Jurisdiction-specific TA scheduled upon request.
**Denotes a committee or workgroup with participation from every Partnership jurisdiction.*

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Committees and Community Forums

Committees

Executive Committee

The Executive Committee meets for one hour every other month to maintain governance and foster collegiality and shared leadership across senior leaders in the Partnership. The Partnership is member-owned and member-directed, so this key governance approves major decisions and celebrates milestone achievements. Every agency within the Partnership has senior leadership representation on this committee.

Email Tiffany Lindsey for more Information about this group

Executive Advisory Group

The Executive Advisory Group is a nominated subgroup of leaders from the Executive Committee. This small team of leaders explores issues related to governance, sustainability and focus of the partnership in greater depth than is feasible with the larger Executive Committee. When decisions need to be made, they make recommendations to the Partnership's Executive Committee.

Email Tiffany Lindsey for more Information about this group

Communications Workgroup

The Communications Workgroup is comprised of public information officers and other staff directly involved in communications from every partner jurisdiction. The workgroup meets for 60 minutes every other month and focuses on media engagement, partnership communication, both nationally and locally, sharing of communication resources and peer learning.

The Partnership's past press releases and related news articles may be viewed here. Additional communication resources and toolkits are accessible through Communications Workgroup members.

Email Jennifer Devlin for more information about this group.

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Committees and Community Forums

Committees

Data Sharing Workgroup

The Data Sharing Workgroup meets every other month for 90 minutes to advance the collaboration, accessibility and quality of data sharing within the Partnership.

Each NPCS jurisdiction is asked to assign a representative for this workgroup, generally a program leader or data analytic professional within the agency's critical incident review process. This group centers around peer exchange and technical assistance.

Email Santana Jones for more information about this group.

Data Advisory Group

The Data Advisory Group is comprised of a nominated subgroup of leaders from the Data Sharing Workgroup. This smaller group of highly experienced critical incident reviewers and data analysts are able to respond nimbly to data sharing requests and opportunities to advance strong analytics within the Partnership's work.

Email Elizabeth Riley for details about this group.

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Community Forums Committees and

Community Forum

Systems-Focused Critical Incident Review Peer Leaders

Monthly meeting for critical incident review program leaders to come together and ask questions, brainstorm challenges, and celebrate successes.

Fourth Thursday of the month from 2:00pm - 3:00pm ET

Click here to join

Email Santana Jones for information about this group

Tiffany Lindsey (She/Her)

Jordan Constantine (He/They)

Christina Rosato, (She/Her)

Santana Jones (She/Her)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Community Forums Committees and

Community Forum

Systems-Focused Critical Incident Review Practitioners

Quarterly meeting for all critical incident review practitioners to connect with their peers across the Partnership, ask questions, share challenges and celebrate successes.

Join us on the first Friday of every quarter

April 5	2.00 - 3.00 ET
July 5	2.00 - 3.00 ET
Oct 4	2.00 - 3.00 ET

Register for the call series and get a calendar invitation using this link

Email Santana Jones for information about this group

Tiffany Lindsey (She/Her)

Jordan Constantine (He/They)

Christina Rosato (She/Her)

Santana Jones, (She/Her)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Drop-in Technical Assistance

Safe Systems Drop-in Office Hours

Safe Systems Drop-in Technical Assistance is offered to all Partnership teams on the first Monday (3-4 ET) and last Friday (11-12 ET) of each month. Drop ins are an opportunity to ask questions, discuss challenges and receive UKY assistance and support.

Click link to Join

TA Drop-ins are facilitated by the Systems Focused Review Technical Assistance Team

Tiffany Lindsey
(She/Her)

Jordan Constantine
(He/They)

Christina Rosato
(She/Her)

Santana Jones
(She/Her)

Communications Technical Assistance

Along with technical assistance provided in bi-monthly Communications Workgroup meetings, partner specific communications technical assistance is also available. Topics might include assistance developing a local press release or op-ed, utilization of available communication resources and toolkits, managing crisis communications, or messaging around critical incidents. Technical assistance is provided by Jennifer Devlin, the NPCS communications consultant.

Jennifer Devlin
(She/Her)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Committees and Community Forums

Community Forum

Affinity Group*

Safely to their First Birthday:
Upstream Prevention and Compassionate, Equitable Screening, Safety Threat Identification, and Maltreatment Classification after Sudden Unexpected Infant Deaths (SUID)

This new affinity group focuses on:

- Upstream practices for a multi-factorial approach to infants safely reaching their first birthday with their families.
- Consistency in screening child abuse hotline calls on unexpected infant deaths.
- Consistency in identifying safety threats and making dispositional findings regarding and, in light of, an infant's unexpected death.

Email Tiffany Lindsey for more information.

Facilitators:

Tiffany Lindsey, (She/Her)

Santana Jones (She/Her)

*Affinity groups provide a space for jurisdictions experiencing similar challenges to collaborate, learn, and generate solutions. Affinity groups have an ongoing, open invitation to all Partnership members, but all participants are asked to provide their agency's policies, campaigns, etc. as requested for the group's benefit.

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Committees and Community Forums

Community Forum

Affinity Group*

Advancing Safety Science in the Workforce:

Integrating learning from Systems-Focused Critical Incident Reviews and Safety Culture Surveys to Implement new innovations through Workforce Development

This affinity group will bring together critical incident review, safety culture survey and workforce development leaders to focus on:

- Integrating key learnings from SCIR data into workforce development efforts
- Developing strategies and workflows for integrating key learnings into existing agency training, such as new and experienced casework professionals training
- Curating and creating best practice learning resources
- Developing a curricula of adaptable spaced education on key learning topics for use by jurisdictions across the partnership

Email Elizabeth Riley for more information.

Facilitators

Jordan Constantine (He/They)

Elizabeth N. Riley, (She/Her)

*Affinity groups provide a space for jurisdictions with shared experience to come together, learn, and generate innovative solutions. Affinity groups are open to partnership members at any time. Partnership jurisdictions are asked to share policies, campaigns, etc. with the group as requested for the benefit of all members

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Committees and Community Forums

Community Forum

Affinity Group*

State Oversight Agencies within County Administered Systems: Peer-to-Peer

This affinity group is for state agencies operating within county-administered systems. As most states are state-administered, this small group of state agencies within county-administered systems have unique challenges and considerations. This affinity group is a forum for state oversight agencies to connect and share with one another. This group usually meeting every other month.

Facilitators

Michael Cull
(He/Him)

Tiffany Lindsey
(She/Her)

Email Tiffany Lindsey for more information.

*Affinity groups provide a space for jurisdictions with shared experience to come together, learn, and generate innovative solutions. Affinity groups are open to partnership members at any time. Partnership jurisdictions are asked to share policies, campaigns, etc. with the group as requested for the benefit of all members

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Committees and Community Forums

Community Forum

Affinity Group*

Identity, Intersectionality and Safety Culture

Based on feedback from partnership jurisdictions, we are working to create an affinity group titled Identity, Intersectionality, and Safety Culture. We anticipate that this will be an open group for ongoing conversation and brainstorming around the integration of safety culture and a variety of topics related to identity/intersectionality including racial justice, ability status, and diverse sexual orientation/gender identity work. This Affinity Group will likely be a helpful space for DEIA leadership and culture change leadership in partner jurisdictions, and we hope to have many sessions led or co-facilitated by partner jurisdiction members.

The interest call on 1/25/24 is an opportunity for interested members to discuss what they are looking for in terms of structure and content for this space.

REGISTER FOR INTEREST CALL
January 25 1.00 - 2.00 ET

*Affinity groups provide a space for jurisdictions with shared experience to come together, learn, and generate innovative solutions. Affinity groups are open to partnership members at any time. Partnership jurisdictions are asked to share policies, campaigns, etc. with the group as requested for the benefit of all members

Facilitators

Elizabeth Riley
(She/Her)

Santana Jones
(She/Her)

Christina Rosato
(She/Her)

Jordan Constantine
(He/They)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Skills Labs

Completion of the Skilled Practitioner Training Pathway is a pre-requisite for both data skills labs

Data Analysis Skills Lab

In this skills lab, we will go over best practices for cleaning and organizing data for analysis, then review how to create an analytic plan. We will discuss the importance of defining the purpose/audience of a data presentation and what goes into choosing what data to present. Finally, we will talk about the format and techniques for presenting data, pros and cons of multiple approaches. This skills lab will focus on the analysis and presentation of systems-focused critical incident review data. This lab will not involve the actual analysis of data and is open to anyone working with or considering presenting this data.

July 9, 2024 1.00 - 4.00 ET

Data Analysis Practice Lab

This is a companion practice lab following the skills lab. This lab will involve bringing and working with your jurisdictions actual critical incident review data and will focus on creating a specific analytic plan and presentation plan/format for your data. If you would like some consultation on cleaning/organizing data prior to this practice lab, please don't hesitate to reach out!

November 19, 2024 1.00 - 4.00 ET

Facilitator

Elizabeth Riley (She/Her)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Skills Labs

Safety Culture Survey Skills Lab

In this skills lab we will take a deep dive into safety culture survey work, with the purpose being for participants to build expertise in talking about the survey data and presenting it to teams within your jurisdiction. We'll go over three main pieces of the survey: why the data is useful and what it tells us, in-depth conversations about the standard scales (i.e., emotional exhaustion, mindful organizing, psychological safety), and how to support offices/teams in having data-driven conversations about where and how to shift their culture. This lab will likely be most useful for individuals working in jurisdictions who have done, or are imminently planning, an implementation of the safety culture survey.

Facilitator

Elizabeth Riley
(She/Her)

Links, Dates, and Times:

April 9, 2024 - 1.00 - 4.00 ET

September 24, 2024 - 1.00 - 4.00 ET

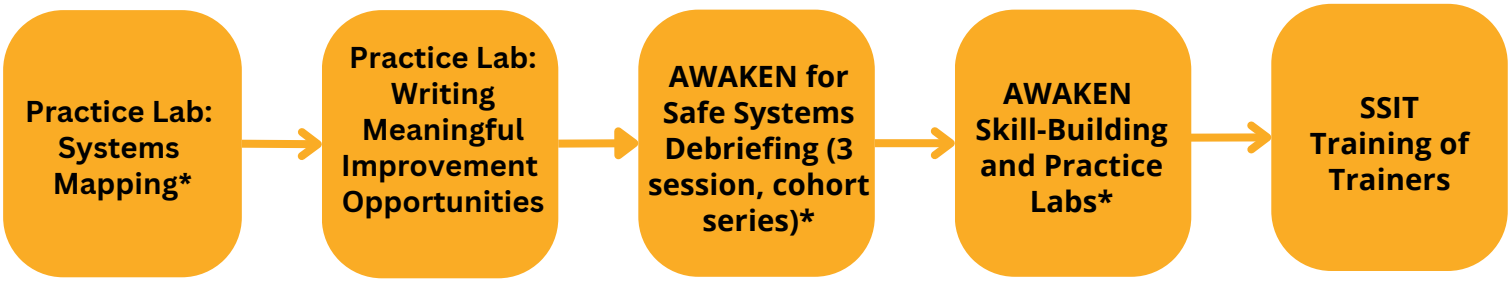
NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Safe Systems Practitioner Training

Safe Systems Skilled Practitioner Courses (offered quarterly)

The Skilled Practitioner Courses can be taken in sequence or stand alone. It is recommended that Safe Systems Critical Incident Reviewers complete the training sequentially.

Safe Systems Advanced Practitioner Courses (offered at varied cadence)



***Skill-Building Labs** provide a content refresher, deeper skill-building, and interactive activities focus on taking a deeper dive into to content. **Practice Labs** focus on skill and value application. Registered participants are invited to share redacted current/completed case summaries, quarterly/annual reports or short scenarios in advance. The Practice Lab orients around the shared practice examples. In addition to participant redaction, UKY further removes potential jurisdiction identifiers.

All courses delivered by
Center for Innovation in Population Health

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Skilled Practitioner

Skilled Practitioner Training Pathway

Skilled Practitioner Trainings are delivered by the Systems Focused Review Technical Assistance Team

Tiffany Lindsey
(She/Her)

Jordan Constantine
(He/They)

Christina Rosato
(She/Her)

Santana Jones
(She/Her)

CEUS OFFERED

Safety Culture in Systems Focused Critical Incident Reviews
This module focuses on foundational safety science and safety culture concepts in the context of family serving systems, specifically child welfare and a systems approach and best practices to learning from critical events (e.g, deaths and near deaths).

Safe Systems Improvement Tool (SSIT)
The SSIT is the most widely used tool nationally to learn from critical incidents in child welfare. This module instructs how to use the SSIT and its role in guiding a family centered, workforce-informed, systems-focused review. This course is the pre-requisite to online certification in the SSIT.

Writing Meaningful Improvement Opportunities
Improvement Opportunities are a crucial anchor for high-quality, actionable reviews. This module focuses on how to craft objective, relevant, meaningful Improvement Opportunities that honor families and the professionals who serve them.

Debriefing
Speaking to direct care professionals who served the family during or before a critical incident is an important culture carrier, and an opportunity for restorative and reflective conversation, focused on learning and systems change. This module shares foundational values and best practices.

Systems Mapping
Systems maps (AcciMap) can structure systems change opportunities and help multi-disciplinary groups visualize gaps or complexities within systems that contribute to families and professionals needs not being met and help generate alignment and elevate quality improvement priorities. This module focuses on how to read and facilitate a systems map.

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Advanced Practitioner

Advanced Practitioner Training Pathway

Tiffany Lindsey (She/Her)

Jordan Constantine (He/They)

Christina Rosato (She/Her)

Santana Jones (She/Her)

Advanced Practitioner Trainings are delivered by the Systems Focused Review Technical Assistance Team

Writing Meaningful Improvement Opportunities: Practice Lab

In this Practice Lab, participants will provide redacted case summaries, trouble spots, or brief scenarios for use in the group activities. There will be no teaching content in this session – it's all practice! We use a mixture of small and large group activities to identify and hone Improvement Opportunities. *Note: Upon registration, please provide your redacted materials at least one week in advance of the Lab.*

- **March 26 11 - 1.00 ET**
- **September 19 11 - 1.00 ET**
- **June 26 11 - 1.00 ET**
- **December 12 11 - 1.00 ET**

Prerequisite Required:
Safe Systems Skilled Practitioner Course

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Advanced Practitioner

Advanced Practitioner Training Pathway

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Systems Mapping Practice Lab

There's always something to be said for understanding the complexity of a problem before jumping to solutions. Systems Mapping is a great, flexible, visual way to represent a systems-focused discussion. Mapping is relatively simple and intuitive, yet the facilitation can feel very constant. It can be hard to facilitate and map at the same time... Practice helps!! In this lab, participants will provide an Improvement Opportunity with and without a Systems Story for use in real-time mapping practice. All mapping platforms (e.g., Miro, Mural, Visio) are accepted. Miro will be used in the Lab. *Once registered, please provide your redacted materials at least one week in advance of the Lab.*

Prerequisite Required:
Safe Systems Skilled Practitioner Course

- **March 12 11 - 1.00 ET**
- **July 24 11 - 1.00 ET**
- **June 24 11 - 1.00 ET**
- **November 20 11 - 1.00 ET**

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Advanced Practitioner

AWAKEN A PRACTICE FOR CONSCIOUS DECISION-MAKING

CEUS OFFERED

AWAKEN for Safe Systems Debriefing teaches participants to apply the AWAKEN framework to the complexity of identifying improvement opportunities and debriefing individuals following a critical incident. Over three sessions, participants will explore how their unique perspective and automatic thinking inform their decision-making and practice strategies to disrupt bias-based thinking and bring forward the values integral to the AWAKEN framework and system-focused reviews.

***It is recommended that critical incident review teams complete AWAKEN as a jurisdiction team.**

Prerequisite Required:
All Skilled Practitioner Courses
*Must be able to attend all 3 dates

Facilitators

Christina Rosato (She/Her)

Jordan Constantine (He/They)

AWAKEN is delivered in partnership with:

affinità CONSULTING

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Advanced Practitioner

AWAKEN A PRACTICE FOR CONSCIOUS DECISION-MAKING

Prerequisite Required:
All Skilled Practitioner Courses
*Must be able to attend all 3 dates

Cohort 9 Schedule and Registration

Wednesday, February 21, 2023 - 11:00 am to 5:00 pm ET

Wedneday, February 28, 2023 - 11:00 am to 5:00 pm ET

Wednesday, March 6, 2023 - 11:00 am to 5:00 pm ET

Cohort 10 Schedule and Registration

Tuesday April 30, 2023 11:00 am - 5:00 pm ET

Wednesday May 1, 2023 11:00 am - 5:00 pm ET

Wednesday May 8, 2023 11:00 am - 5:00 pm ET

Cohort 11 Schedule and Registration

Tuesday October 15, 2023 11:00 am - 5:00 pm ET

Wednesday October 16, 2023 11:00 am - 5:00 pm ET

Wednesday October 23, 2023 - 11:00 am to 5:00 pm ET

AWAKEN is delivered in partnership with affinità CONSULTING

Contact Christina Rosato with questions

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Advanced Practitioner

AWAKEN A PRACTICE FOR CONSCIOUS DECISION-MAKING

Skills Lab

AWAKEN Skill-Building Labs take a deep dive into aspects of the AWAKEN framework. Participants will learn skills to enhance skills in one or more areas of AWAKEN. The labs are designed to challenge our own thinking by connecting with other perspectives to generate new ideas and ways of addressing challenges facing the child welfare system.

Prerequisite Required:
AWAKEN for Safe Systems Debriefing 3-Part Series

- **March 20, 12-2 ET**
- **May 22, 12-2 ET**
- **September 11, 12-2 ET**

Facilitators

Christina Rosato
(She/Her)

Jordan Constantine
(He/They)

AWAKEN is delivered in partnership with affinità CONSULTING

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Advanced Practitioner

AWAKEN A PRACTICE FOR CONSCIOUS DECISION-MAKING

Practice Lab

AWAKEN Practice Labs take a redacted/anonymous case example from a participating jurisdiction and provide participants with an opportunity to practice AWAKEN skills to examine the opportunities for improvement and prepare for debriefing. Participants will generate new learning by sharing perspectives across jurisdictions.

Prerequisite Required:
AWAKEN for Safe Systems Debriefing 3-Part Series

April 17, 12-2.30 ET

July 17, 12-2.30 ET

November 6, 12-2.30 ET

Facilitators:

Christina Rosato
(She/Her)

Jordan Constantine
(He/They)

AWAKEN is delivered in partnership with affinità CONSULTING

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Advanced Practitioner

SSIT: Training of Trainers

In this 2-day experiential course, critical incident review practitioners will create their own exemplars, materials and vignettes, so they can become a certified instructor in the Safe Systems Improvement Tool. This course will prepare practitioners to serve as a team or agency's lead coach in the SSIT for use in critical incident review and broader human services' applications.

Participant materials will be submitted and approved by the facilitators prior to awarding certification.

Prerequisite Required:
All Skilled and Advanced Practitioner Courses (including AWAKEN for Safe Systems Debriefing
On-line SSIT certification

Links, Dates, and Times:

December 2, 2024 - 10.30 - 4.30 ET

December 3, 2024 - 10.30 - 4.30 ET

SCIR Program Leaders can register Interest by contacting Jordan Constantine.

Facilitators

Tiffany Lindsey
(She/Her)

Jordan Constantine
(He/They)

Registration will be capped at 10 - Limit of two practitioners per jurisdiction.

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Skilled Practitioner

Quarter One (January - March)

Links, Dates, and Times

Safety Culture in Systems Focused Critical Incident Reviews
January 30th, 11.30 - 4.30 ET

Safe Systems Improvement Tool (SSIT)
February 6th, 11.30 - 4.30 ET

Writing Meaningful Improvement Opportunities
February 12th, 11.00 - 1.00 ET

Debriefing
February 13th, 11.00 - 1.00 ET

Systems Mapping
February 13th, 2.00 - 4.00 ET

Practice Lab: Writing Meaningful Improvement Opportunities
March 26th 11.00 - 1.00 ET

Click link to register

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Skilled Practitioner

Quarter Two (April-June)

Links, Dates, and Times

Safety Culture in Systems Focused Critical Incident Reviews
May 14, 11.30 - 4.30 ET

Safe Systems Improvement Tool (SSIT)
May 21, 11.30 - 4.30 ET

Writing Meaningful Improvement Opportunities
June 3, 11.00 - 1.00 ET

Debriefing
June 4, 11.00 - 1.00 ET

Systems Mapping
June 4th, 2.00 - 4.00 ET

Practice Lab: Writing Meaningful Improvement Opportunities
June 26, 11.00 - 1.00

Click links to register

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Skilled Practitioner

Quarter Three (July-Sep)

Links, Dates, and Times

Safety Culture in Systems Focused Critical Incident Reviews
August 20, 11.30 - 4.30 ET

Safe Systems Improvement Tool (SSIT)
August 27, 11.30 - 4.30 ET

Writing Meaningful Improvement Opportunities
September 9, 11.00 - 1.00 ET

Debriefing
September 10, 11.00 - 1.00 ET

Systems Mapping
September 10, 2.00 - 4.00 ET

Practice Lab: Writing Meaningful Improvement Opportunities
September 18, 11.00 - 1.00

Click links to register

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2024 Learning and Development Opportunities

Safe Systems Skilled Practitioner

Quarter Four (Oct - Dec)

Links, Dates, and Times

Safety Culture in Systems Focused Critical Incident Reviews
October 29, 11.30 - 4.30 ET

Safe Systems Improvement Tool (SSIT)
November 5, 11.30 - 4.30 ET

Writing Meaningful Improvement Opportunities
November 11, 11.00 - 1.00 ET

Debriefing
November 12, 11.00 - 1.00 ET

Systems Mapping
November 12, 2.00 - 4.00 ET

Practice Lab: Writing Meaningful Improvement Opportunities
December 10, 11.00 - 1.00

Click links to register

NATIONAL PARTNERSHIP FOR CHILD SAFETY

Center for Innovation in Population Health

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Critical Incident Review Team (CIRT) FAQ

What is a CIRT?

The CIRT is a team assigned by the ODHS Director to conduct the executive review of an incident that resulted in a child fatality when maltreatment is suspected and criteria are met related to contact with Child Welfare, as outlined in ORS 418.806 to 418.816 and OAR Chapter 013, Division 017.

What is the purpose of a CIRT?

- To convene a team to evaluate and learn from cases designated as critical incidents
- To increase the Department's ability to address and recommend necessary changes to systems

What are the criteria for a CIRT assignment?

The Department reasonably believes the death was the result of child abuse ***and*** the deceased child was in the custody of the Department at the time of the fatality ***or*** the deceased child, the deceased child's sibling, or any other child living in the household with the deceased child:

- was the subject of a CPS assessment within the 12 months preceding the fatality ***or***
- had a pending child welfare or adoption case with the Department within the 12 months preceding the fatality ***or***
- was the subject of a report of abuse made to the department within the 12 months preceding the fatality

How is the local office informed of a CIRT being assigned?

- When the Department is informed through the Sensitive Issue Report procedure (Chapter 1, Section 4) that a child fatality occurs and the fatality appears to meet criteria for a CIRT, the Child Fatality Prevention and Review Program manager will be in contact with leadership for the district in which the critical incident and/or fatality occurred.
- The CIRT Coordinator will attend the 3-day Fatality Staffing, per the fatality protocol, to listen to the information shared about the circumstances surrounding the fatality and provide introductory information regarding the CIRT process should the case meet criteria.
- After the 3-day Fatality Staffing and once the ODHS Director assigns the CIRT, the CIRT Coordinator from the Child Fatality Prevention and Review Program will be in contact with leadership, informing them of the assignment and providing an outline of next steps.

Who attends the CIRT meeting(s)?

The CIRT law requires certain members and allows for others at the discretion of the ODHS Director. There are a number of standing CIRT members, including the ODHS Director, Child Welfare Deputy Director, ODHS Communications representative, ODHS Tribal Affairs (if applicable), Central Office Program Managers, Oregon Child Abuse Hotline Continuous Quality Improvement Manager, as well as

consultants and coordinators. In each case the local office leadership is also asked to participate. The CFPRP encourages local office leadership to consider including caseworkers who were involved in decision making on the case to participate in the CIRT process.

In addition to the typical participants, depending on the specific circumstances, a CIRT may include ODHS subject matter experts (e.g., Alcohol and Drug coordinator, Domestic and Sexual Violence coordinator, or Suicide Prevention coordinator), ODHS Self Sufficiency Program, or external partners with specific information related to the family or the larger family serving system (e.g., law enforcement, medical providers, or service providers).

What is the timeline associated with a CIRT?

The CIRT Final Report is required to be submitted to the Department no later than the 100th day following the CIRT assignment. Local office leadership is asked to complete the CPS assessment within 90 days to ensure that all available information can be included in the CIRT Final Report.

What is available to the public regarding a CIRT?

The Department is required to immediately post information about the critical incident on the Department's public website. This includes:

- The date of the critical incident
- Age of the deceased child
- Whether the child was in the custody of the Department at the time of the critical incident or fatality
- Whether there was an open CPS assessment regarding the child at the time of the critical incident or the fatality
- The date the Department assigned the CIRT
- The due date for the CIRT's final report

In addition, the Department is required to share the CIRT Final Report on the Department's public website. This report includes non-identifying information regarding the critical incident, the fatality and the family's relevant Oregon Child Welfare history.

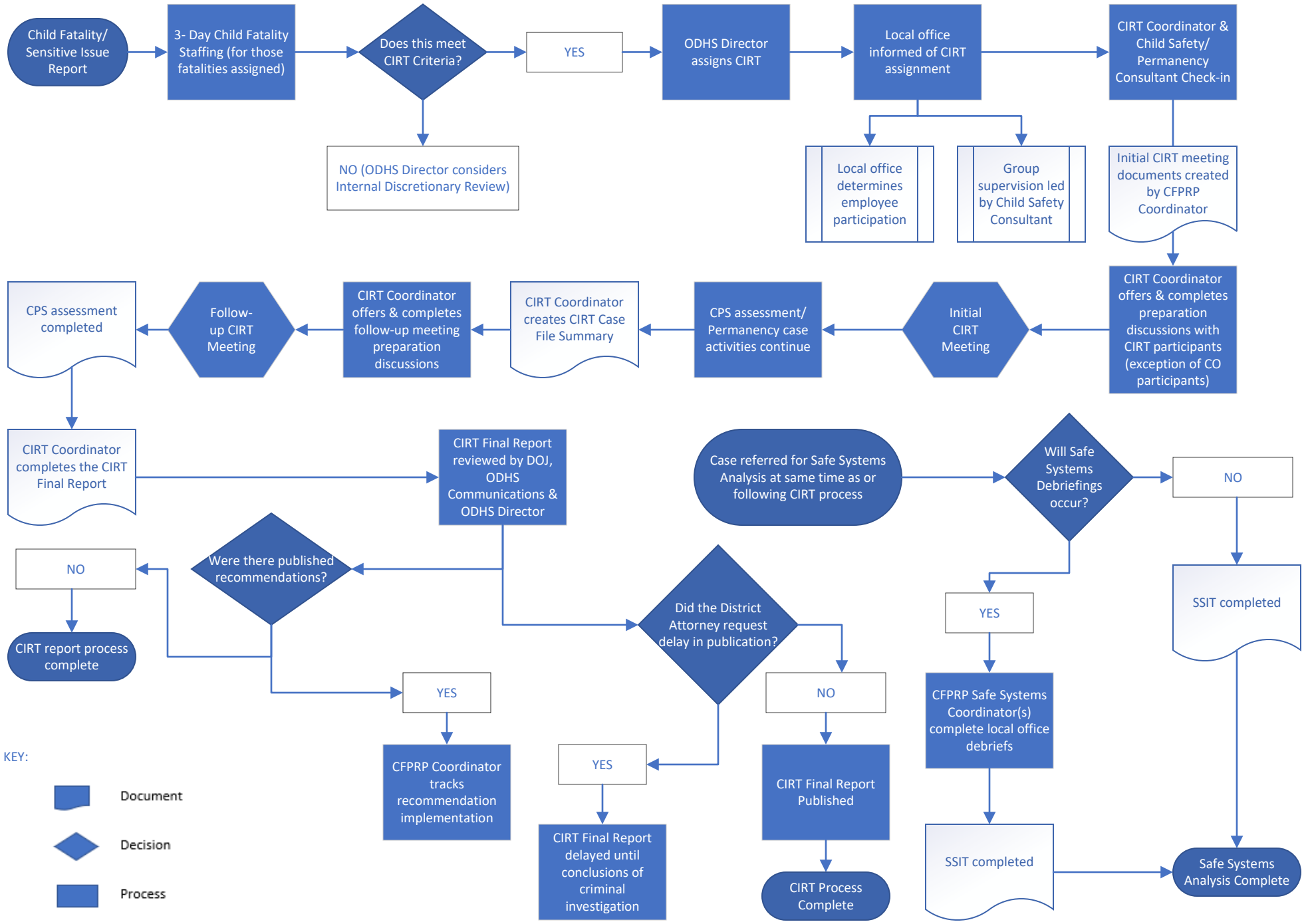
What is a Discretionary Review?

During 2021, the CFPRP began facilitating Internal Discretionary Reviews. An Internal Discretionary Review is convened by the ODHS Director when Child Welfare becomes aware of a fatality, near fatality, or other serious incident involving a family that has had contact with ODHS and the incident does not meet the criteria for a critical incident review team (CIRT) however an opportunity for system learning has been identified. The reviews are called by the ODHS Director to analyze ODHS actions in relation to the incident and to ensure the safety and well-being of all children being served by Child Welfare.

All the work surrounding the Internal Discretionary Review, such as engaging and preparing participants, facilitating meetings, partnering with other child welfare programs to conduct case reviews, and tracking data, is the responsibility of the CFPRP.

For more information, contact the Child Fatality Prevention and Review Program at cw.prevention@dhsoha.state.or.us.

CIRT Process Map



Safe Systems Analysis FAQ

The Child Fatality Prevention & Review Program (CFPRP) joined the National Partnership for Child Safety (NPCS) in early 2020. The NPCS is a collaborative focused on applying safety science and sharing data to develop strategies in child welfare to improve safety and prevent child maltreatment fatalities[1]. In Oregon Child Welfare, this work happens through safe systems analysis.

What is safe systems analysis?

Safe systems analysis is a critical extension of Oregon's child fatality review process and is conducted by the CFPRP Safe Systems Coordinator(s). Through case file review, participation in the Critical Incident Review Team (CIRT), and follow-up supportive inquiry, the coordinator is able to gather important information about what influences common casework problems, also known as improvement opportunities. The information is then synthesized and rated using the Safe Systems Improvement Tool (SSIT).

What is the SSIT?

The Safe Systems Improvement Tool (SSIT) [2] is a multi-purpose information integration tool designed to be the output of an analysis process. The purpose of the SSIT is to support a culture of safety, improvement, and resilience. The SSIT is an effective assessment tool for use in critical incident reviews and provides structure to the output of a review process. It organizes the reviewers' learnings, shares the "system's story" of a critical incident, and advocates for targeted system reform efforts to lessen the likelihood of the problem occurring again in casework (Cull, Lindsey, & Epstein, 2019).

The SSIT is organized into four domains. The family domain is rated similar to the CANS and captures family and child characteristics around the time of the critical incident. The other three domains are nested to measure influencing factors at the professional, team, and environment levels.

When is safe systems analysis conducted?

Safe systems analysis is conducted in all cases reviewed by the CIRT and in some discretionary reviews. Safe systems analysis explores improvement opportunities (IOs) identified through the review processes. In cases where no improvement opportunities are identified, the safe systems

[1] National Partnership for Child Safety Charter: NPCS Charter

[2] SSIT Reference Guide: 2022 SSIT Reference Guide

analysis is brief and only involves documenting family characteristics in the family domain of the SSIT. When improvement opportunities are identified, all four domains of the SSIT are completed.

What are improvement opportunities?

Improvement opportunities (IOs) represent the gap between what the child or family needed and what they received. More technically, IOs are case-specific actions or inactions relevant to the outcome or industry standards and are often representative of relatively common casework problems. While emphasis is given to those IOs within ODHS-CW, IOs also consider the actions/inactions of other entities within the macro child-serving system (e.g., courts, human service providers, law enforcement, schools). In the safe systems analysis process, IOs are first identified through the CIRT or discretionary review. Those IOs are then explored in safe systems analysis. At times, additional IOs are identified through the process and added to the exploration.

In each safe systems analysis, IOs are evaluated for their proximity (i.e., closeness) to the outcome. Proximity is not intended to imply causality or severity of an action or inaction but rather describes how close the IO was in time or distance *and* with relationship to the incident. Since quality improvement resources are finite, considering the frequency and proximity of an IO is important to balancing if, when, and to what degree an agency advances a system improvement effort.

Who is involved in safe systems analysis?

The Safe Systems Coordinator reviews the file, participates in CIRT follow-up meeting, and consults with the CIRT coordinator in order to gather relevant information and determine whether or not to offer safe systems debriefings before completing the SSIT. If debriefings are to be offered, the caseworker(s) and supervisor(s) with recent or substantial contact with the family may be involved. Program managers, MAPS and other child welfare professionals may also be invited to participate. Occasionally external partners may be invited to participate as well.

What are safe systems debriefings?

Safe systems debriefings are the mechanism for gathering more individualized information from those who experienced the outcome in the local office/community.

Debriefings are completely voluntary, one-on-one meetings, lasting about 90 minutes. The coordinator uses supportive inquiry to engage with the child welfare professional. It is the goal of debriefings to promote healing and learning at both the individual and system level.

Are safe systems debriefings completed in every case?

Debriefings are not completed in every case. When improvement opportunities are identified through the CIRT or discretionary review process, the safe systems coordinator evaluates the circumstances of the case and may offer debriefings if there was an open CPS assessment or case with the family in the year prior. Because resources are somewhat limited, whether or not to

offer debriefings depends on availability of the coordinator as well as nature of the IO and its relevance to system challenges currently under exploration.

What happens to the information gathered during debriefings?

The information gathered during debriefings is evaluated along with all other information gathered through the CIRT or discretionary review process and then synthesized through the SSIT. The results of SSITs are aggregated, utilizing frequency and proximity of improvement opportunities as well as frequency of influencing factors in the professional, team, and environment domains to shape strategies for both system improvement and prevention efforts. Recommendations resulting from safe systems analysis may be presented to ODHS executive leadership for review and approval.

For more information, contact the Child Fatality Prevention and Review Program at cw.prevention@dhsoha.state.or.us.

Safe Systems Improvement Tool:
National Partnership for Child Safety Version (SSIT-NPCS)

2022
REFERENCE
GUIDE

ACKNOWLEDGEMENTS

A large number of individuals have collaborated in the development of the Safe Systems Improvement Tool (SSIT). This information integration tool is designed to support system improvement activities. The SSIT is an open domain tool. The copyright is held by the Praed Foundation to ensure that it remains free to use. Training and certification is expected for appropriate use.

For specific permission to use please contact the Praed Foundation. For more information on the SSIT contact:

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http://TCOMConversations.org

Table of Contents

1. INTRODUCTION

SAFE SYSTEMS IMPROVEMENT TOOL

The pursuit of learning is the characteristic that distinguishes high-quality service delivery systems. Organizations with a well-developed culture of excellence find ways to successfully identify improvement opportunities, implement strategies for change, evaluate change over time, and hardwire what they learn.

The following is a multi-purpose information integration tool designed to be the output of an analysis process. The purpose of this instrument is to support a culture of safety, improvement, and resilience. As such, completion of this instrument is accomplished in order to allow for effective communication at all levels of the system. Since its primary purpose is communication, this instrument is based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure that apply to understanding this instrument.

SIX KEY PRINCIPLES

1. Items are included because they are relevant and inform system change opportunities.
2. Each item uses a 4-level rating (0-3) system. Ratings translate into action levels designed to support quality improvement (QI) activities. For a description of these action levels please see below.
3. Ratings are made to identify an opportunity for improvement independent of a current intervention. If interventions are in place that are masking a need/opportunity, the underlying need/opportunity is described, not its status as a result of the intervention. For example, if a work-around has been created to overcome an equipment failure, the underlying equipment failure should be rated.
4. Item-level ratings are designed to promote objectivity and avoid bias. The potential for implicit and explicit biases should always be considered when rating an item.
5. Ratings use the influences' proximity to the incident as an organizing principle to support communication. If there was closeness in time or distance, and with relationship to the incident, a rating of "proximal" (i.e., 3) is appropriate.
6. It is about the "what and how," not the "who and why." Items are organized into domains to engage rich discussion on the complexity of factors affecting casework practice. Items are about *relationship and influence* and avoid the controversy of causal assumptions.

This is an effective assessment tool for use in critical incident review (e.g., child fatalities, child near fatalities) but may be used more broadly to understand systemic influences to other outcomes (e.g., youth in foster care being trafficked, children experiencing a long-length of stay in care, maltreatment recurrence). In short, the SSIT provides structure to the output of a review process. It organizes the reviewers' learnings, shares the "system's story" of a critical incident, and advocates for targeted system reform efforts to lessen the likelihood of the problem occurring again in casework. To administer the instrument found at the end of this manual, the reviewer should read the anchor descriptions for each item and then record the appropriate rating on the assessment form.

REFERENCE GUIDE STRUCTURE

This reference guide is divided into the following four parts:

Section One: origins, overarching purpose, and the general structure of how items are rated

Section Two: domains and items, item definitions, descriptive rating anchors, and guidance (i.e., "Questions to Consider") in assessing the items.

Section Three: scoresheet as a template for case reviews

Section Four: sharing the "system's story" of a critical incident and advocating for strategic quality improvement work to support safe, effective, and reliable care of children and families.

HISTORY AND BACKGROUND

The SSIT was first developed for use in Tennessee's Department of Children's Services' (TN DCS) critical incident reviews (i.e., Child Death and Near-Death reviews). During critical incident reviews, professionals assigned to work with the family, both past and present, are requested to participate in debriefing. These debriefings are voluntary, supportive, facilitated opportunities for professionals to process their casework, identify barriers and improvement opportunities, and highlight learning. SSIT provides both a guide in facilitating these debriefings (e.g., questions to consider) and an efficient means to capture the complex information provided as a result of debriefings. After debriefings, critical incident reviews are presented to a multi-disciplinary team who dissects the case and relevant findings from a systemic perspective. SSIT is used to facilitate these conversations and to capture rich discussion. SSIT is only completed once, at the closing of every case review. SSIT's scores are aggregated and analyzed on at least a quarterly basis to review findings and discuss trends. In a similar way to how a barometer measures pressures in the atmosphere, SSIT measures pressure existing within organizations and provides a frame for targeted quality improvement work.

Since 2015, the SSIT has been successfully used to support the analysis of deaths and near deaths, reports made to TN DCS' Confidential Safety Reporting System, and critical incident reviews that do not involve death or near death (e.g., staff injuries, incidents where custodial children absconded and were subsequently exploited).

In 2019, Casey Family Programs led a pioneering team of twelve child-welfare jurisdictions to form the National Partnership for Child Safety. Their aim to reduce maltreatment-related fatalities, enhance system safety through the lens of safety science, and advance the child welfare system into the 21st century—a place where technology, community-based family supports, and partnership with public health would effectively reduce the presence of social determinants to poor outcomes and promote holistic health. The SSIT-NPCS was designed with the input of all NPCS jurisdictions as a way to communicate the learnings from their respective critical incident reviews and provide a foundation for informed data-sharing. In 2021, the National Partnership for Child Safety had grown to 26 public child welfare jurisdictions and tribes.

WHAT IS THE SSIT?

IT IS AN IMPROVEMENT STRATEGY

When items are rated with a 2 or 3, they indicate a need for improvement. The SSIT helps a system identify and prioritize systems improvement opportunities. The structure of the SSIT allows a system to uncover those threats/opportunities that are most proximal to adverse events. Quality improvement resources can then be directed efficiently to mitigate risk and support safe, reliable, and effective care.

IT FACILITATES OUTCOMES MEASUREMENT

Ratings on items can be aggregated across cases. The SSIT standardizes critical incident review data for use in quality improvement. SSIT data contributes to professional learning at the individual case level and can be aggregated at any level of the system to support improvement and evaluate change over time.

IT IS A COMMUNICATION TOOL

Classifying complex systems findings into a common language supports improvement discussions at all levels of the organization. SSIT domains, items, and anchors derive from research in human factors and safety science. The SSIT supports organizational learning and an improvement approach focused on human interaction in complex systems.

IT IS A CULTURE CARRIER

The SSIT becomes an important organizational artifact. Use of the SSIT in critical incident reviews reinforces important organizational values and shifts focus away from discussions of blame-worthy acts and simple cause and

effect relationships. It supports efforts to create a culture of safety by increasing understanding of complex interactions in tightly-coupled systems.

SSIT BASIC STRUCTURE

The SSIT is organized into four domains to facilitate learning and improvement. While each item is unique and not replicated in other items, the domains are nested. In other words, a family working with a professional, who works within a team, who all work within an environment. For example, a professional may have experienced trouble interpreting external assessments (e.g., medical records) about a child with complex needs, which may have been exacerbated by the availability and case direction given by the supervisor. These factors may be further affected by the absence of helpful policy, training, and internal professionals to support the interpretation of medical records. In summary, while the domains provide structure to learning, they are not intended to suggest exclusivity. The intention is of the domains is to guide the reviewer into assessing all system levels.

Child/Family Domain		
Family Conflict	Substance Use	Child Medical/Physical
Developmental	Economic Stability	Child Developmental/Intellectual
Mental Health	Parenting Behavior	Child Mental Heath
Professional Domain	**Team Domain**	**Environment Domain**
Cognitive Bias	Teamwork/Coordination	Demand-Resource Mismatch
Stress	Supervisory Support	Equipment/Technology/Tools
Fatigue	Supervisory Knowledge Transfer	Policies/Rules/Statutes
Knowledge Base	Production Pressure	Training
Documentation		Service Array
Information Integration		Practice Drift

RATING ITEMS

The SSIT is easy to learn and use in critical incident reviews. It provides structure to organizational learning. The SSIT assesses the underlying factors that influence casework problems. For example, if a critical incident review about a child's unsafe sleep-related death discovers the child welfare professional assigned to the family did not educate on safe sleep practices, the SSIT is designed to support an understanding of the factors that influenced that problem. To use the same example, it is possible the professional co-bedded with his/her own children and therefore undervalued safe sleep practices (SSIT item: Cognitive Bias), had no policy, training or supervision to support the provision of safe sleep information (SSIT items: Policy/Rules/Statutes, Training, Supervisory Support), and/or did not have external or internal resources to provide the family with a safe sleeping environment (SSIT items: Service Array, Demand-Resource Mismatch).

Improvement Opportunities

It is important to note the SSIT does not identify the problems in the case under review. In this Reference Guide, problems identified in the case under review are called Improvement Opportunities (IOs). These are defined as actions or inactions in the case under review that are either relevant to the outcome (e.g., a child dies abusively at the hands of a caregiver unassessed by the child welfare agency prior to the death) or an important industry standard (e.g., meeting response timeframes for assessing an alleged victim, speaking to collaterals). The most important Improvement Opportunities are family-centered and describe what the family needed vs. received from the helping system. Since the goal is system transformation to advance family well-being and meaningful

transformational help is what professionals intend and want for those they serve, families' needs are at the center of any critical incident review. For this reason, the Family Domain exists to point reviewers to consider potential IOs for further exploration. The SSIT's System Domain ratings are organized around IOs. In order to rate a SSIT as a 2 or 3, the item must be affecting an identified IO.

The SSIT should be used by someone who is well-versed in their system and current industry standards, acknowledging of the high-risk and complex sociotechnical nature of human service work, appreciative of the professional's goal to achieve the best outcomes, and with personal experience serving families. Someone with lived experience in the child welfare system is a highly valued contributor for these reviews.

Like all Transformational Collaborative Outcomes Management (TCOM) tools, the ratings translate into action levels. The SSIT has one retrospective set of action levels for the Family domain, and a prospective set of action levels for the remaining domains.

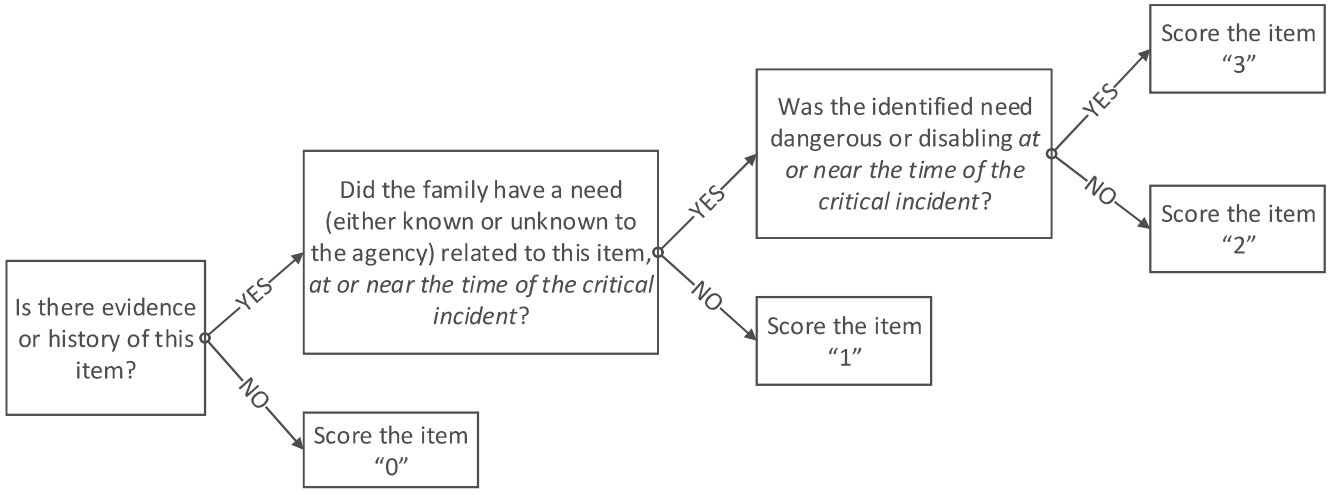
Scoring the Child and Family Domain

For the Family Domain, the items are rated based on the family's status at the time of the critical incident (Table 1). Consistent with the National Partnership for Child Safety's Data Dictionary, caregiver is defined as the adult(s) living in the household who is legally obligated and entitled to provide for the safety and well-being of the child, and a household is a group of people who have frequent contact with the child leading up to the time of the critical incident. It is recommended the Family Domain be tentatively scored prior to debriefing professionals who worked with the family, in the interests of identifying unmet family needs as potential IOs.

Table 1: Child Family Domain Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	No evidence	No action was needed
1	History	Watchful waiting/prevention was indicated
2	Need interfered with functioning	Action/intervention was needed
3	Need was dangerous or disabling	Immediate action/intensive action was needed

Figure 1: Decision Scoring Tree for Family Domain



A scoring of '2' or '3' denotes an item as retrospectively actionable. Whether known or unknown to helping professionals at the time of the critical incident, scoring these items actionably means the family had a need for

support (e.g., intervention, formal/informal help, services) at or near the time of the critical incident, actionable items are accompanied by a narrative description to support the rating.

Scoring the System Domains: Proximity

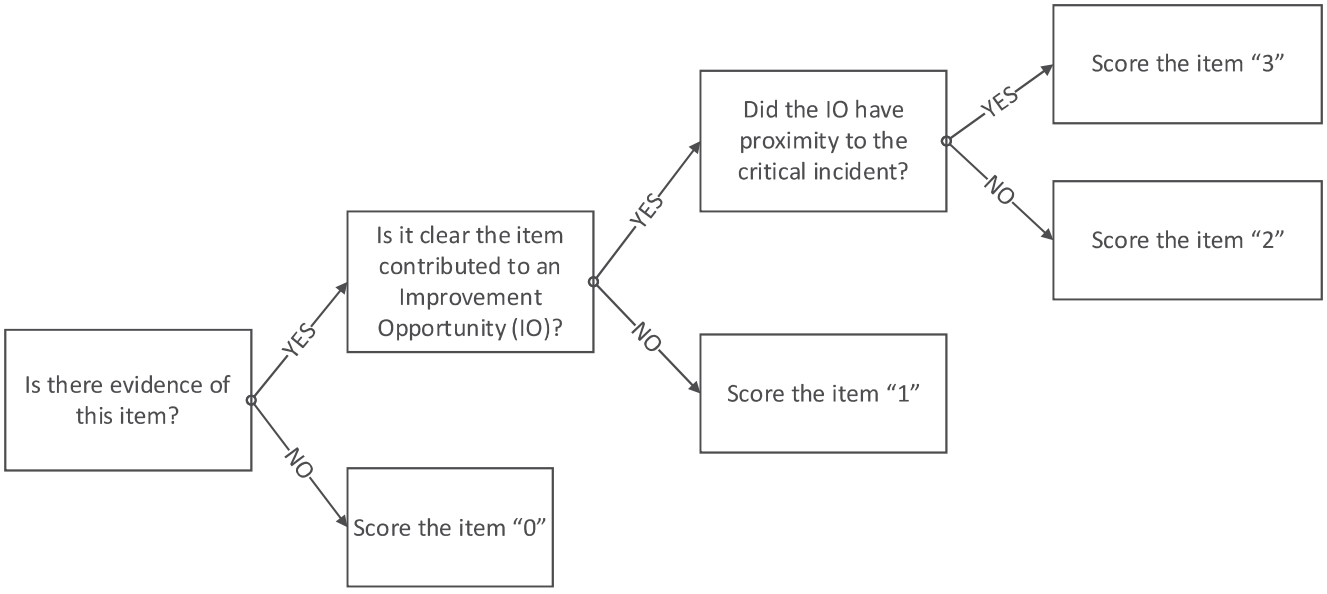
Proximity is used to differentiate between ratings of 2 and 3 (Figure 2) in the 3 system domains – Professional Team, and Environment. Proximity is a Gestalt Principle about how the human mind naturally organizes items. If an IO identified in a case was close in time or distance and with relationship to the critical incident, then a rating of proximal (3) is appropriate. For example, if an infant dies in an unsafe sleep environment, and the child welfare agency did not provide safe sleep education and/or timely access to needed safe sleep resources, then SSIT items related to that IO are all scored as proximal (3). Conversely, if an infant dies from a congenital heart condition, yet historical engagement with the household did not include a private interview with all children in the home, all SSIT items related to the IO are scored as non-proximal (2).

Table 2: System Domains Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	No evidence	No action needed
1	Latent factor	Watchful waiting/prevention
2	Influence to Improvement Opportunity **without** proximity to the outcome	QI action may be needed to promote best practices in casework. IOs should be tracked over time and/or compared with other quality data before being considered for system-level improvement projects.
3	Influence to Improvement Opportunity **with** proximity to the outcome	QI action to protect against recurrence of critical incidents may be needed. Response could include: providing case-level or system-wide education, forming a local ad hoc QI team, developing system-level improvement projects.

Scoring in this way promotes rating reliability and secures an understanding of the system-level needs most proximal to critical incidents (Figure 1). While human service agencies are not solely responsible for prevention of critical incident, such organizations are still invested in reducing any and all adverse outcomes as much as possible, in pursuit of the best outcomes for every family.

Figure 2: Decision Scoring Tree for System Domains



A scoring of ‘2’ or ‘3’ denotes an item as actionable; it means the item affected an IO. Actionable items should be accompanied by a narrative description to support the rating. This combination of quantitative and qualitative data facilitates simple and structured communication on every case but also creates a rich database of information over time—allowing for dissection of themes.

2. SSIT DOMAINS AND ITEMS

FAMILY DOMAIN

This section focuses on factors present in the family at the time of the critical incident. It provides an opportunity to document the family, caregiver and child/youth's needs during the time the critical incident occurred, even if they were unknown to the agency prior to the incident occurring. This domain can be useful in drawing correlations between systems-level items and certain family items (e.g., if service array challenges are often scored actionably when families identify with developmental/intellectual diagnoses). Unmet family needs identified in this domain are potential Improvement Opportunities to explore during the review. Consistent with the National Partnership for Child Safety's Data Dictionary, caregiver is defined as the adult(s) living in the household who is legally obligated and entitled to provide for the safety and well-being of the child, and a household is a group of people who have frequent contact with the child leading up to the time of the critical incident.

For the **FAMILY DOMAIN,** the item ratings translate into the following categories and action levels, *as they existed at the time of the critical incident* (e.g., death or near death):

0	No evidence; there was no need for action at the time of the critical incident
1	History; there was a need for "watchful waiting" at the time of the critical incident
2	Action was needed at the time of the critical incident
3	Dangerous or disabling problem required immediate and/or intensive action at the time of the critical incident

FAMILY/CAREGIVER ITEMS

FAMILY CONFLICT

This item refers to how much fighting and arguing occurred between family members. Domestic violence refers to physical fighting in which family members might get hurt.

Questions to Consider	Ratings & Descriptions	
• Did members of the family get along well? • Did arguments escalate to physical altercations?	0	Family had minimal conflict, got along well and negotiated disagreements appropriately.
	1	Family generally got along fairly well, but when conflicts arose, resolution was difficult or there was a history of significant conflict or domestic violence.
	2	Family was generally argumentative and significant conflict was a fairly constant theme in family communications.
	3	Family experienced domestic violence. There was threat or occurrence of physical, verbal, or emotional altercations. If the family had a current restraining order against one member, then they would be rated here.

CAREGIVER DEVELOPMENTAL

This item refers to developmental disabilities including autism and intellectual disabilities. A formal diagnosis is not required to rate this item.

Questions to Consider	Ratings & Descriptions	
• Had the caregiver been identified with any developmental or intellectual disabilities?	0	There was no evidence that the caregiver had developmental needs.
	1	The caregiver had developmental challenges, but they did not currently interfere with parenting or there was a history of those challenges interfering with parenting.
	2	The caregiver had developmental challenges that interfered with their capacity to parent.
	3	The caregiver had developmental challenges that made it very difficult or impossible for them to parent.

CAREGIVER MENTAL HEALTH

This item refers to mental health needs only (not substance abuse). A formal mental health diagnosis is not required to rate this item.
Note: Mental Health Disorders would be rated '2' or '3' unless the individual was in recovery.

Questions to Consider	Ratings & Descriptions	
• Did the caregiver have any mental health needs? • Were the caregiver's mental health needs interfering with their functioning?	0	There was no evidence that the caregiver had mental health needs.
	1	The caregiver was in recovery from mental health difficulties or there was a history of mental health problems.
	2	The caregiver had mental health difficulties that interfered with their capacity to parent.
	3	Caregiver had mental health difficulties that made it very difficult or impossible for them to parent.

CAREGIVER SUBSTANCE USE

This item includes problems with alcohol, marijuana, illegal drugs and/or prescription drugs. A formal diagnosis is not required to rate this item.
Note: Substance-Related Disorders would be rated '2' or '3' unless the individual was in recovery.

Questions to Consider	Ratings & Descriptions	
• Did caregivers have any substance use needs that made parenting difficult? •	0	There was no evidence that the caregiver used alcohol or drugs.
	1	The caregiver may have had mild problems with work or home life that result from occasional alcohol or drug use or there was a past history of substance use problems.
	2	The caregiver had substance use that interfered with their life; caregiver had a diagnosable substance-related disorder near the time of the critical incident.
	3	Caregiver had substance use that made it very difficult or impossible for them to parent.

CAREGIVER ECONOMIC STABILITY

This item rates the caregivers' ability to consistently have met daily needs, such as affordable and safe housing, childcare, adequate income, healthy food, and reliable transportation. A family may have had adequate living stability via government and non-governmental assistance. If the government or non-governmental assistance was temporary or at-risk of being lost, this is a reason to rate the item a 2 or 3.

Questions to Consider:	Ratings & Descriptions	
	0	No current need; no need for action or intervention. This may have been a resource for the child. Caregivers had sufficient resources to raise the child.

• Did the caregiver ever struggle financially? • Did the caregiver ever worry they won't enough money to meet needs? • How stable was the family's life at the time of the critical incident?	1 Caregivers had limited resources but usually had daily living needs met for the child. History of struggles with sufficient resources would be rated here as would the presence of ongoing governmental (e.g., subsidized housing) or non-governmental (e.g., food pantries, low-income medical clinics) supports that create economic sufficiency and are not at known risk of being lost (e.g., closing program, family at risk of not meeting eligibility criteria)
	2 Caregiver needed help stabilizing their economic situation. The caregiver may have been at risk of losing economic supports, such as losing reliable transportation or housing or childcare. Daily living needs were sometimes unmet for the child.
	3 Caregiver needed urgent help, perhaps due to homelessness, inadequate food, income, or no transportation. Child's daily living needs were often unmet.

CAREGIVER PARENTING BEHAVIORS

This item rates the caregiving behaviors of the primary caregivers. The item rates if the caregiver gave developmentally-appropriate care and followed the care-based recommendations of professionals (e.g., physicians)

Questions to Consider	Ratings & Descriptions
• Did caregivers provide developmentally appropriate supervision? • Did caregivers meet the basic caregiving needs of the child, following through on the recommendations of professionals (e.g., physicians, counselors)?	0 Caregiver(s) were involved with the child and provided appropriate levels of expectations and supervision for the child.
	1 Caregiver(s) were involved and generally provided appropriate levels of expectations and supervision for child. There were some concerns about caregiving behavior, but they were mild or historical and unrelated to child safety.
	2 Caregiver(s) did not follow through with professional recommendations or provide developmentally-appropriate care. Caregivers often did not provide appropriate levels of expectations and supervision.
	3 Caregiver(s) did not provide adequate developmentally-appropriate care and deficits in caregiving resulted in serious safety concerns.

CHILD/YOUTH ITEMS

CHILD/YOUTH MEDICAL/PHYSICAL

This item is used to describe the child/youth's medical/physical health.
Note: Most transient, treatable conditions would be rates as a '1'. Most chronic conditions (e.g., diabetes, severe asthma, HIV) would be rated a '2'. The rating '3' is reserved for life threatening medical conditions. A formal diagnosis is not required to rate this item.

Questions to Consider	Ratings & Descriptions
• How was the child/youth's health? • Did the child/youth have any chronic conditions or physical limitations?	0 No evidence that the child/youth had any medical or physical challenges, and/or they were healthy.
	1 Child/youth had transient or well-managed physical or medical challenges. These include well-managed chronic conditions like juvenile diabetes or asthma.
	2 Child/youth had serious medical or physical challenges that required medical treatment or intervention or child/youth had a chronic illness or a physical condition that requires ongoing medical intervention.
	3 Child/youth had life-threatening illness or medical/physical challenges. Immediate and/or intense action was needed due to imminent danger to child/youth's safety, health, and/or development.

CHILD/YOUTH DEVELOPMENTAL/INTELLECTUAL

This item describes the child/youth's development as compared to standard developmental milestones, as well as rates the presence of any developmental (motor, social and speech) or intellectual disabilities. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning. A formal diagnosis is not required to rate this item.

Questions to Consider

- Did the child/youth's growth and development seem age appropriate?
- Had the child/youth been screened for any developmental problems?

Ratings & Descriptions

0	No evidence of developmental delay and/or child/youth had no developmental delay or intellectual disability.
1	There were concerns about possible developmental delay. Child/youth may have low IQ, a documented delay, or documented borderline intellectual disability (i.e. FSIQ 70-85). Mild deficits in adaptive functioning were indicated.
2	Child/youth had developmental delays (e.g., deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability/Intellectual Disability Disorder. (If available, FSIQ 55-69.) IDD affected communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.
3	Youth had severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social participation and independent living across multiple environments.

CHILD/YOUTH MENTAL HEALTH

This item is used to describe the child/youth's mental health (not substance use or dependence). A formal mental health diagnosis is not required to score this item.

Questions to Consider

- Did the child/youth have any mental health needs?
- Were the child/youth's mental health needs interfering with their functioning?

Ratings & Descriptions

0	There was no evidence or signs the child/youth was experiencing mental health challenges.
1	The child/youth had mild challenges with adjustment, may have been somewhat depressed, withdrawn, irritable, or agitated. A history of mental health challenges would be scored here.
2	The child/youth had moderate mental health challenges that interfered with their functioning in at least one life domain (e.g., school).
3	The child/youth had significant challenges with their mental health, affecting two or more life domains (e.g., school, neighborhood community). The child/youth may have had a serious psychiatric disorder.

PROFESSIONAL DOMAIN

This section focuses on factors primarily present within professionals. Largely intrapersonal in focus, this domain centers on the experience, knowledge, perceptions, and skills of professionals assigned to the family's care or experiencing the problem under review. This domain focuses on behaviors as well as the presence of psychological factors within professionals, like fatigue and stress. Neither this domain nor any domain is created to assign individual blame for a problem's existence; rather this domain offers an organized way to deconstruct perspectives before, during, and after decision-making.

For the **PROFESSIONAL DOMAIN,** the item ratings translate into the following categories and action levels:

0	No evidence, no need for action.
1	Latent factor.
2	QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.
3	A priority for QI action to prevent recurrence of proximal influences.

COGNITIVE BIAS

A faulty understanding of a situation or person(s) due to basic human limitations (e.g., confirmation bias, cognitive fixation, focusing effect, transference) as well as unconscious or conscious bias, including microaggressions. Identity-based biases are rated here, such as racism, sexism, genderism, and ableism. Undervaluing culturally-normative traditions or caregiving behaviors is also rated here.

Questions to Consider

- What were your thoughts when you received the referral/case? About the family? Perpetrators? Children?

Ratings & Descriptions	
0	No evidence of bias(es).
1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but bias was present).
2	Bias(es) contributed to an Improvement Opportunity without proximity to the outcome.
3	Bias(es) contributed to an Improvement Opportunity with proximity to the outcome.

STRESS

Psychological strain or tension resulting from adverse or demanding circumstances. Professionals express or exhibit difficulty managing the strains of casework and/or other life circumstances (e.g., divorce).

Questions to Consider

- What were the pressures you faced, professionally and personally? How did that impact casework? How do you know when you are stressed?

Ratings & Descriptions	
0	No evidence of stress.
1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but stress was present).
2	Stress contributed to an Improvement Opportunity without proximity to the outcome.
3	Stress contributed to an Improvement Opportunity with proximity to the outcome.

FATIGUE

Extreme tiredness as a result of casework and/or other life circumstances (e.g., single parent, personal illness).

Questions to Consider

- What were the pressures you faced, professionally and personally, that contributed to fatigue? How did that impact casework? How much sleep had you received in the days preceding this incident?

Ratings & Descriptions

0	No evidence of fatigue.
1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but fatigue was present).
2	Fatigue contributed to an Improvement Opportunity without proximity to the outcome.
3	Fatigue contributed to an Improvement Opportunity with proximity to the outcome.

KNOWLEDGE BASE

An absence of knowledge or difficulty activating knowledge (i.e., putting knowledge into practice).

Questions to Consider

- Was there anything you learned from this case that you previously had not known? Were there items you felt unequipped to assess or address? Were any records (i.e., medical records) difficult to interpret?

Ratings & Descriptions

0	No evidence of knowledge gaps.
1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but knowledge gaps were present).
2	Knowledge gaps contributed to an Improvement Opportunity without proximity to the outcome.
3	Knowledge gaps contributed to an Improvement Opportunity with proximity to the outcome.

DOCUMENTATION

Absent or ineffective official, internal records. *Note: Sometimes an Improvement Opportunity is about Documentation but only score this item if Documentation contributed to an Improvement Opportunity – not if Documentation was the Improvement Opportunity.*

Questions to Consider

- If someone only read the notes, would they know what was going on?

Ratings & Descriptions

0	No evidence of documentation concerns.
1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but documentation concerns were present)
2	Documentation contributed to an Improvement Opportunity without proximity to the outcome.
3	Documentation contributed to an Improvement Opportunity with proximity to the outcome.

INFORMATION INTEGRATION

Challenges with externally-sourced information (e.g., obtaining or using medical records, school records/assessments, criminal records, formal assessments). *Note: Sometimes an Improvement Opportunity is about Information Integration but only score this item if Information Integration contributed to an Improvement Opportunity – not if Information Integration was the Improvement Opportunity. Also, if knowledge gaps contributed to misunderstanding external records, this would be scored under Knowledge Base.*

Questions to Consider

- How did you decide what records to request in this case? Were historical records on previous services requested? How were assessments used to plan services?

Ratings & Descriptions

0	No evidence of difficulties in obtaining or synthesizing external records.
1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but difficulties were present).
2	Difficulties obtaining or synthesizing external records contributed to an Improvement Opportunity without proximity to the outcome.
3	Difficulties obtaining, or synthesizing external records contributed to an Improvement Opportunity with proximity to the outcome.

TEAM DOMAIN

This section focuses on factors primarily present within teams. The pressures, communication, and climate of the team are considered in this domain, with specific attention given to the supervisor's unique role in supporting the professional. This domain is not exclusive to factors only present among internal teams; collaboration with relevant community partners is assessed as well.

For the **TEAM DOMAIN,** the item ratings translate into the following categories and action levels:

0	No evidence, no need for action.
1	Latent factor.
2	QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.
3	A priority for QI action to prevent recurrence of proximal influences.

TEAMWORK/COORDINATION

Ineffective collaboration between two or more internal and/or external entities (e.g., agencies, people and teams). Notably, this item does not encompass the family's willingness or cooperation but rather the team of family-serving professionals.

Note: Ineffective teamwork between a supervisor and supervisee is captured under "Supervisory Support."

Questions to Consider

- What barriers existed in communicating with outside partners during this case? How often did you communicate? What barriers existed in internal communication while working this case?

Ratings & Descriptions

0	No evidence of issue with teamwork/coordination.
1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but teamwork/coordination concerns were present).
2	Teamwork/coordination problems contributed to an Improvement Opportunity without proximity to the outcome.
3	Teamwork/coordination problems contributed to an Improvement Opportunity with proximity to the outcome.

SUPERVISORY SUPPORT

Supervisor provides ineffective support, communication, teamwork, and/or is unavailable.

Questions to Consider

- What support was received from supervisors during this case? What is supervision generally like on this team? What was the supervisor's leadership style?

Ratings & Descriptions

0	No evidence of problems with supervisory support.
1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but supervisory support concerns were present).
2	Supervisory support problems contributed to an Improvement Opportunity without proximity to the outcome.
3	Supervisory support problems contributed to an Improvement Opportunity with proximity to the outcome.

SUPERVISORY KNOWLEDGE TRANSFER

Case direction from supervisor was inconsistent with best practice.

Questions to Consider	Ratings & Descriptions	
• What case direction was received from supervisors during this case? Was case direction aligned with best practice?	0	No evidence of problems with supervisory case direction.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but supervisory case direction concerns were present).
	2	Supervisory case direction contributed to an Improvement Opportunity without proximity to the outcome.
	3	Supervisory case direction contributed to an Improvement Opportunity with proximity to the outcome.

PRODUCTION PRESSURE

Demands on professionals to increase efficiency.

Note: This is distinctive from Demand Resource Mismatch (DRM) as Production Pressure describes pressures within casework (e.g., overdues, extensive court involvement, child removals in other assigned cases). Though not exclusively, the presence of DRM may impact the presence of Production Pressures.

Questions to Consider	Ratings & Descriptions	
• How pushed were you by deadlines in this case? How many other cases did you have? What was happening in other cases during the time of this incident?	0	No evidence of problems with production pressures.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but production pressures were present).
	2	Production pressures contributed to an Improvement Opportunity without proximity to the outcome.
	3	Production pressures contributed to an Improvement Opportunity with proximity to the outcome.

ENVIRONMENT DOMAIN

This section focuses on factors present in the team's environment. This domain fosters an appreciative inquiry of the team's internal and external access to resources, policies, services, training, and technologies needed to support safe and reliable care delivery. Items in this domain refer to the child/family-serving macrosystem. These items can have positive, negative, or mixed impact to vulnerable populations, such as Black Indigenous People of Color (BIPOC) and Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Two Spirit (LGBTQ2S).

For the **ENVIRONMENT DOMAIN,** the item ratings translate into the following categories and action levels:

0 No evidence, no need for action.

1 Latent factor.

2 QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.

3 A priority for QI action to prevent recurrence of proximal influences.

DEMAND-RESOURCE MISMATCH

A lack of internal resources or programs (e.g., inadequate staffing, limited access to drug testing supplies, insufficient funding for services) to carry out safe work practices. *Note: The absence of equipment/technology and external resources/programs are scored in separate items.*

Questions to Consider	Ratings & Descriptions	
• What was the staffing pattern at the time of this case? How long has it been that way? What problems did it cause in this case? What is the barrier to having adequate staffing?	0	No evidence of problems with demand-resource mismatch. Assigned case professionals appeared to have needed resources to carry out work practices.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but demand-resource mismatch was present).
	2	Lack of resources to carry out safe work practices contributed to an Improvement Opportunity without proximity to the outcome.
	3	Lack of resources to carry out safe work practices contributed to an Improvement Opportunity with proximity to the outcome.

PRACTICE DRIFT

A widely-accepted, often gradient, departure from work-as-prescribed. Practice Drift usually occurs as a result of experienced success and as a means of managing production pressures and/or complex interpersonal decisions. Practice Drift uniquely describes an environmental (e.g., system-wide, county-wide, office-wide) departure from work-as-prescribed and may involve a single or multiple child serving agencies.

Questions to Consider	Ratings & Descriptions	
• Were workarounds present at the time of the case? Did these workarounds potentially affect the family in a positive or negative way? Was the workaround widely-used in the county or across the state?	0	No evidence of Practice Drift.
	1	Evidence of latency (i.e., no known impact an Improvement Opportunity, but Practice Drift was present).
	2	Practice Drift contributed to an Improvement Opportunity without proximity to the outcome.
	3	Practice Drift contributed to an Improvement Opportunity with proximity to the outcome.

EQUIPMENT/TECHNOLOGY/TOOLS

An absence or deficiency in the equipment and technology (e.g., electronic records management system like SACWIS, communication devices, electronics) used to carry out work practices. Tools refers to the structured assessments (e.g., CANS, FAST, SDM), predictive analytics, and related algorithms (e.g., algorithms may perpetuate systemic bias toward underrepresented populations).

Questions to Consider	Ratings & Descriptions	
• What equipment would have been helpful in this case? Were there any difficulties in acquiring or using certain equipment or technology?	0	No evidence of problems with equipment, tools or technology.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but issues with equipment/technology/tools were present).
	2	The absence or deficiency of equipment, tools or technology contributed to an Improvement Opportunity without proximity to the outcome.
	3	The absence or deficiency of equipment, tools or technology contributed to an Improvement Opportunity with proximity to the outcome.

POLICIES/RULES/STATUTES

The absence, poor clarity, or ineffectiveness of an internal written practice or procedure. Conflicting policies would also be rated here, as well as other written rules, statutes, and procedures detailing work-as-prescribed.

Questions to Consider	Ratings & Descriptions	
• What policies, protocols, or forms affected this case? How did it impact decisions? What would have been more helpful?	0	No evidence of absent or ineffective policies.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but the absence of ineffectiveness of a policy was present).
	2	The absence or ineffectiveness of one or more policies contributed to an Improvement Opportunity without proximity to the outcome.
	3	The absence or ineffectiveness of one or more policies contributed to an Improvement Opportunity with proximity to the outcome.

TRAINING

The absence, poor clarity, or ineffectiveness of an internal formal instruction. This may include a variety of learning modalities, such as: web-based, classroom, independent study, formal mentoring or coaching, etc.)

Questions to Consider	Ratings & Descriptions	
• What trainings affected decision-making in this case? Were needed trainings helpful and available? What trainings would have been useful?	0	No evidence of absent or ineffective trainings.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but the absence of ineffectiveness of a training was present).
	2	The absence or ineffectiveness of one or more trainings contributed to an Improvement Opportunity without proximity to the outcome.
	3	The absence or ineffectiveness of one or more trainings was contributed to an Improvement Opportunity with proximity to the outcome.

SERVICE ARRAY

The unavailability or ineffectiveness of a particular external and/or community-based service. These services include provider agencies as well as county and state child-service partners (e.g., school, court, law enforcement).

Questions to Consider	Ratings & Descriptions	
• What services are available in the area? How accessible are those services? How effective do services appear to be?	0	No evidence of problems with service array.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but service array concerns were present).

SERVICE ARRAY The unavailability or ineffectiveness of a particular external and/or community-based service. These services include provider agencies as well as county and state child-service partners (e.g., school, court, law enforcement).		
	2	Problems with service array contributed to an Improvement Opportunity without proximity to the outcome.
	3	Problems with service array contributed to an Improvement Opportunity with proximity to the outcome.

3. SSIT SCORESHEET

CASE ID:	

Improvement Opportunities (IOs)
1
2
3
4
5

Abbreviated Rating Summary for Family Domain

0=No Evidence	1=Minimal Problem or History	2=Problem affected Functioning	3=Severely Disabling or Dangerous Problem

Abbreviated Rating Summary for Professional, Team, and Environment Domains

0=No Evidence of Influence	1=Latent Factor	2=Evidence of Influence	3=Evidence of Proximity to Poor Outcomes

Family Domain	**Influence**				**Narrative**
	0	**1**	**2**	**3**	***Required if rating is 2 or 3***
1. Family Conflict (Caregiver)	○	○	○	○	
2. Developmental (Caregiver)	○	○	○	○	
3. Mental Health (Caregiver)	○	○	○	○	
4. Substance Use (Caregiver)	○	○	○	○	
5. Economic Stability (Caregiver)	○	○	○	○	
6. Parenting Behaviors (Caregiver)	○	○	○	○	
7. Medical/Physical (Child)	○	○	○	○	
8. Developmental/Intellectual (Child)	○	○	○	○	
9. Mental Health of (Child)	○	○	○	○	
Professional Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
10. Cognitive Bias	○	○	○	○	
11. Stress	○	○	○	○	
12. Fatigue	○	○	○	○	
13. Knowledge Base	○	○	○	○	
14. Documentation	○	○	○	○	
15. Information Integration	○	○	○	○	
Team Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
16. Teamwork/Coordination	○	○	○	○	
17. Supervisory Support	○	○	○	○	
18. Supervisory Knowledge Transfer	○	○	○	○	

19. Production Pressure	○	○	○	○	
Environment Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
20. Demand-Resource Mismatch	○	○	○	○	
21. Practice Drift	○	○	○		
22. Equipment/Technology/Tools	○	○	○	○	
23. Policies/Rules/Statutes	○	○	○	○	
24. Training	○	○	○	○	
25. Service Array	○	○	○	○	

4. QUALITY IMPROVEMENT ADVOCACY

In this final section we provide strategies for using SSIT data to share the "system's story" of a critical incident and support advocacy for system improvement actions. A primary purpose of measurement is to cultivate shared language and inform decision-making. For this reason, item ratings within the Professional, Team, and Environment domains translate into the following action levels:

Table 2: System Domains Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	No evidence	No action needed
1	Latent factor	Watchful waiting/prevention
2	Influence to Improvement Opportunity **without** proximity to the outcome	QI action may be needed to promote best practices in casework. IOs should be tracked over time and/or compared with other quality data before being considered for system-level improvement projects.
3	Influence to Improvement Opportunity **with** proximity to the outcome	QI action to protect against recurrence of critical incidents may be needed. Response could include: providing case-level or system-wide education or forming an ad hoc QI team.

SSIT action levels are not intended to be prescriptive. They are a steady and reliable guide for targeting system reform in the areas most likely to prevent a future critical incident. Items scoring "3" translate into a priority for action because the item influenced an IO proximal to a critical incident. Nesting the domains serves as a prompt to direct QI resources as deep into the system as possible, so—if a review yields proximal scores in the Professional, Team, and Environment domains—resources can be directed to improve the Environment, rather than merely providing professionals with directives.

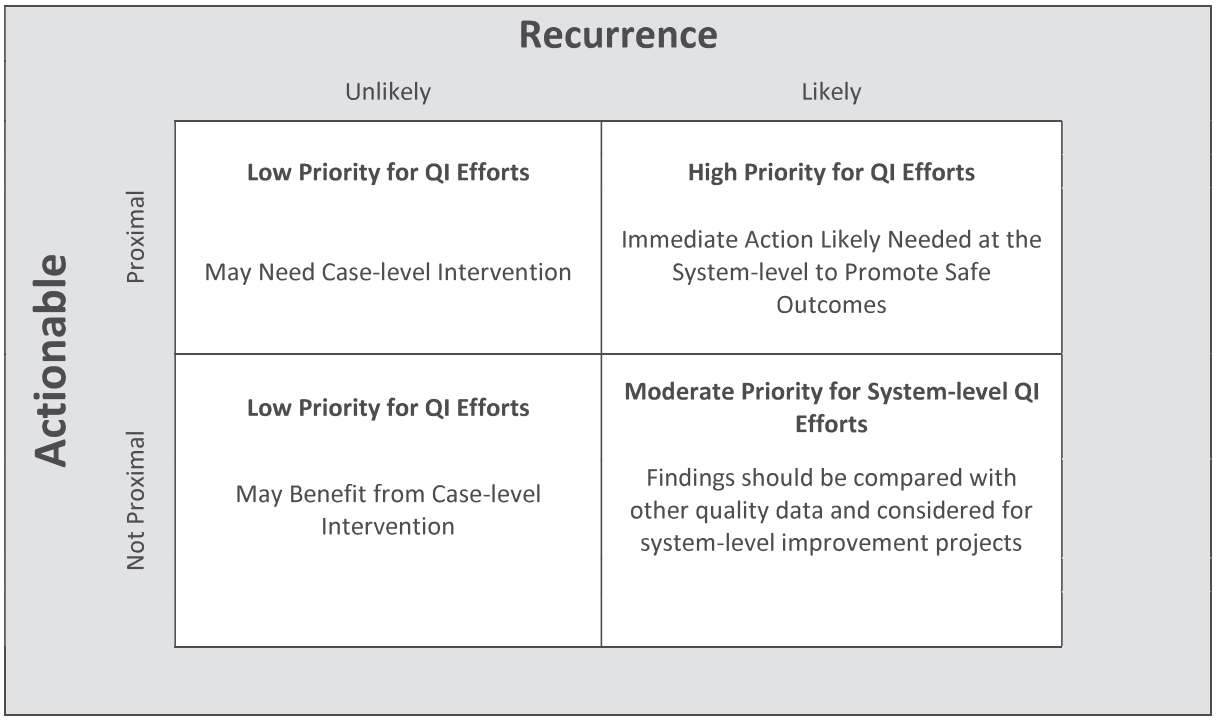
SSIT data can be aggregated and reviewed to inform system-focused quality improvement opportunities. SSIT data should be viewed alongside the IOs from reviewed cases. For example, IOs may reveal inconsistent engagement of all caregivers in a home, allegation/incident-focused casework practice, or barriers in reviewing all applicable case history. Prior to review of SSIT data, it is useful to consider how likely these IOs are to recur in the system. While this can be done through content analysis of IOs as well as a review of other QI data (e.g., Child and Family Service Review findings), the following anchors (table 3) may be helpful in thinking through the likelihood for IOs to recur within a system:

Table 3: Recurrence Rating Structure

ORGANIZATIONAL RECURRENCE	
Questions to Consider • Is this finding already known to be part of a systems issue? • Are effective procedures in place to address? • Have system changes already been in effect since the problem last occurred?	Ratings & Descriptions 0 Minimal or no likelihood of recurrence; problem appears a rare outlier. 1 There is a history of recurrence that appears to have been successfully addressed through organizational improvement(s). 2 There is a likelihood of future recurrence. Though some organizational constructs (e.g., policy, supervision practices, trainings, technology, resource allocation) exist to address the problem, it is unproven or disproven if these will successfully reduce recurrence. 3 Minimal or no organizational constructs currently exist to address the problem.

When considering where to focus finite QI resources, the QI Advocacy Matrix (figure 2) may support decision-making. After establishing recurrence likelihood - and with proximity established by the SSIT - QI professionals can use the matrix to identify and advocate for those IOs that should be prioritized. IOs that are both proximal and likely to recur may require more immediate action form the system (see top right quadrant in table below). IOs likely to recur but not proximal to critical incidents may benefit from system-level QI resources, but it is prudent to compare such findings with other system data so as to make the most informed decision (see bottom right quadrant). IOs unlikely to recur may be suitable for case-level intervention (see left side). For example, a region may have experienced an isolated and/or unusual problem that can be improved by collaborating directly with local region's personnel. The following table is a graphic depiction of this concept:

Figure 2: QI Advocacy Matrix



Advocating for System Change

Those tasked with reviewing critical incidents rarely have formal authority to move systems to change. More often, their success lies in their ability to effectively use data to tell a story and influence communities with such formal authority to move to action. These traits—accurate story-sharing and influence-- are the hallmarks of an effective advocate. QI advocacy, like all forms of advocacy, requires dedicated, experienced individuals armed with information. The SSIT allows a system to standardize important information about its system and to support QI advocacy.

Statewide implementation of Comprehensive Addiction and Recovery Act (CARA)

Child Fatality Prevention and Review Program

Goal: Implementation of an equitable, coordinated statewide early intervention program that meets the health and substance use disorder treatment needs of people who are pregnant, substance affected infants, and their families*.

***A family includes parents, partners, relatives, and other caregivers in the household**

Inputs	Activities		Outcomes/Metrics		
What Oregon Child Welfare invests	*What Oregon Child Welfare does*	*Who Oregon Child Welfare reaches*	*Why this project: short-term results*	*Why this project: intermediate results*	*Why this project: long-term results*
• Time • Commitment • Relationship building and community engagement • Technical assistance • Technology • Funding • Data tracking and evaluation • Research • CW staff • CW leadership support • CW expertise • Continuous learning • Implementation infrastructure • CFPRP equity tool • Evidence Based Practices • Upstream thinking	• Use a culturally responsive, strengths based, trauma informed, multi-generational, family focused approach • Apply equity tool early and throughout • Seek out technical assistance • Gather and track data • Analyze data to inform efforts • Report data as required • Share data across family serving systems • Identify safe strategies that utilize natural / community supports and eliminate or reduce CW involvement • Collaborative coordination of community led effort to identify quality practices • Educate family serving systems on plan of care best practices • Collaborate with OHA to educate healthcare professionals re: report vs. notification • Collaborate to develop tools for notification, and tools that support best practice • Create mutual learning opportunities to facilitate continuous quality improvement	• Substance affected infants • Pregnant and parenting people • Other caregivers, household members, family members • CW professionals • Tribal partners • SUD treatment providers • Peer mentors • People with lived experience • ART / FIT team • Health care professionals • Prenatal care providers • Midwives, doulas, hospital social workers • OHA • Maternal mortality death review • Home visiting nurses • Family Connects • Early Intervention • Child Development Specialists • Birthing hospitals • Juvenile court and partners • Probation and parole • WIC • Food pantries • Domestic Violence Shelters • Lactation specialists • Housing resources • Mental Health providers • Oregon Parenting Education Collaborative • Self Sufficiency Program • Developmental Disabilities • Oregon Alcohol and Drug Policy Commission • Coordinated Care Organizations • Safe Families • FFPSA Preservation Unit pilot?	• Family serving professionals have increased understanding of their role and best practices in development and maintenance of Plans of Care • Healthcare providers have increased understanding of notification process • Family serving professionals know how to access technical assistance and tools • Family serving professionals have increased awareness of need to collaborate • Members of CARA implementation infrastructure have shared understanding of the goal	• The Plan of Care is developed during pregnancy. • The Plan of Care is initiated during pregnancy and updated following delivery. • Health care, substance use treatment, and other service providers involved in caring for the family initiate development of the Plan of Care. • The pregnant/new parent is actively engaged in developing the plan. Other family members or caregivers are involved if the parent desires. • The Plan of Care includes multidisciplinary service supports. • The Plan of Care is active for a year post-delivery. Ongoing support is offered beyond one year if desired. • Birthing hospitals have policies in place that support development and maintenance of Plans of Care • SUD treatment programs have policies in place that support the development and maintenance of Plans of Care • Peer mentors are utilized to support Plans of Care • Policies, laws or rules in place to require notification by healthcare providers • Development of notification portal • A Public health website is available with CARA resources for professionals and families	• Reduced number of substance-affected infants in foster care • Reduced duration of child welfare intervention with substance affected infants and their families • Reduce reoccurrence of maltreatment rate among families with a Plan of Care • Reduced number of reports of maltreatment on substance affected infants • Reduced number of reports assigned to CPS involving substance affected infants • Plans of Care are perceived as a supportive, not punitive, response • Pregnant people are consistently connected to a health care provider and receive post-partum follow up care • Decreased number of missed pediatric appointments for substance affected infants • Decrease in stigma associated with pregnant and parenting people with a SUD • Plans of Care and progress updates are shared regularly across systems • Eliminate racial and ethnic disparate outcomes for substance affected infants, including mortality rates • Eliminate racial and ethnic disparities in maternal mortality rates with use of a prenatal Plan of Care • Improved outcomes for families with Plan of Care • Increased job satisfaction and decreased turnover for family serving professionals • Statewide use of Plans of Care results in healthier communities

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Assumptions

- Early identification and intervention improve outcomes for substance affected infants and their families
- Community led efforts support a culturally responsive approach
- Coordination across systems improves connection to and delivery of services
- Education can reduce bias and stigma
- Child Welfare can be effective in prevention efforts
- SUD is a complex medical condition
-

External Factors

- (-) HIPPA (and similar laws) impact cross system communication and data sharing
- (-) Family serving professionals have varied levels of experience and skill
- (-) Stigma associated with SUD
- (+/-) Funding
- (+/-) Access to SUD treatment services
- (+/-) Insurance
- (-) Structural racism in health care and social service systems and service delivery
- (-) Lack of data on SUD trends for CW involved families
- (-) Workload
- (-) Turnover

Outcomes	Metrics
Why this project: short-term results:	
• Family serving professionals have increased understanding of their role and best practices in the development and maintenance of Plans of Care • Healthcare providers have increased understanding of the process for notification • Family serving professionals know how to access technical assistance and tools • Family serving professionals have increased awareness of the need to collaborate • Members of the CARA implementation infrastructure have shared understanding of the goal	• Increase in the number of Plans of Care developed – (look at ORKIDS data at screening) • Increase in notifications – (look at ORKIDS data, Nurture Oregon pilot – notification forms, decrease in reports that meet the criteria for a notification) • The number of notifications received from healthcare providers is greater than the number of infants with a diagnosis code of FAS, neonatal withdrawal and infant has affect of maternal substance use • CARA coordinator is utilized by family serving professionals for technical assistance, metrics regarding forms/publications access and website access • Information contained in Plan of Care shows multiple family serving professionals and family members were involved in the development of the Plan of Care • Members involved in implementation will have opportunities to provide input and will ultimately be in agreement regarding charters
Why this project: intermediate results: • Increase in the number of Plans of Care developed during pregnancy • Increase in the number of Plans of Care developed in hospital prior to discharge • The pregnant/post-partum individual is actively engaged in developing the plan. • The Plan of Care is active for a year post-delivery. • Increase in the number of Birthing hospitals that have policies for development and maintenance of Plans of Care • SUD treatment programs have policies in place that support the development and maintenance of Plans of Care • Peer mentors are utilized to support Plans of Care • Policies, laws or rules in place to require notification by healthcare providers • Development of notification portal • A Public health website containing CARA resources for professionals and families is developed and implemented	• Increased number of notifications indicate a Plan of Care was developed prior to delivery (consider modifying Notification form to include question about if plan developed prenatally • Increased number of notifications indicate a Plan of Care was developed in hospital prior to discharge • The following two Nurture Oregon pilot assessment questions will be answered by pilot sites: who do families want to take the lead on developing the Plan of Care and Who do families request to participate in the development of the Plan of Care? • Plan of Care forms (1394) available in ORKIDS capture increased number of pregnant/post-partum individuals engaged in developing the Plan of Care • The answer to the following Nurture Oregon pilot assessment question reflects Plans of Care remain active for a year: When does ongoing review of the Plan of Care occur? • The Oregon Perinatal Collaborative list serve will be used to confirm birthing hospitals have policies/protocols in place for the development of Plans of Care • Survey SUD treatment programs to determine strengths and challenges associated with their Plan of Care procedures and/or process • Plan of Care forms (1394) available in ORKIDS capture increased number of Peer Mentors participate and/or provide support • Requirements for healthcare providers have been established • Notification portal is operable • Families and professionals can access CARA resources and information on OHA's website

Why this project: long-term results	
• Reduced number of substance affected infants in foster care • Reduced duration of child welfare intervention with substance affected infants and their families • Reduce reoccurrence of maltreatment rate among families with a Plan of Care • Reduced number of reports of maltreatment on substance affected infants • Reduced number of referrals assigned to CPS involving substance affected infants • Plans of care are perceived as a supportive, not a punitive response, that is: preventive, destigmatizing and strength based • Pregnant people are consistently connected to a health care provider and receive post-partum follow up care • Decrease in number of missed pediatric appointments for substance affected infants • Plans of care are shared with all providers working with the family • Eliminate racial and ethnic disparate outcomes for substance affected infants, including mortality rates • Eliminate racial and ethnic disparities in maternal mortality rates for pregnant people with a prenatal Plan of Care • Family serving professionals experience increased job satisfaction and decreased turnover • Statewide use of Plans of Care results in healthier communities	• Pull ORKIDS data - number of substance affected infants placed in foster care • Pull ORKIDS data - number of months cases involving substance affected infants remain open for in home or foster care services • Pull ORKIDS, ORRAI, data from Nurture Oregon pilot – number of parents who had a Plan of Care developed that are founded for CA/N for a second time within 12 months of an original substantiated report of maltreatment. • Pull ORKIDS data - number of reports received by ORCAH regarding substance affected infants • Stigma training self-report pre/post survey's reflect increased understanding of how SUD related stigma poses a barrier to better outcomes (1 year well child check Plan of Care survey pediatric/parent survey) • Medicaid claims – number of pregnant people with SUD who access prenatal care AND SUD tx during prenatal period • Medicaid claims – number of pregnant people with SUD who participate in follow up care appointments post partum • Medicaid claims – number of substance affected infants that participate in post natal follow up care appointments. • 1 year well child check Plan of Care pediatric and parent survey • OHA, vital stats data, March of Dimes data to track race/ethnicity re infant/maternal fatalities in OR • Consider feedback from child welfare exit interviews

4. The use of comparison in assessing aspects of parental substance use negatively impacted child safety decisions. This comparison ultimately conflated “least unsafe” with “safe” when evaluating caregivers or the risk to child safety based on types of substances being used.

Mapping Process and Results

The safe systems mapping team met a total of five times throughout April and May 2021. The first two meetings were focused on mapping the improvement opportunities and all of the information was captured on a visual map. The next three meetings focused on brainstorming strategies for improvement. One theme that was clear throughout the mapping process was the need to equip child welfare professionals with information and professional support to engage and make sound safety decisions with families. Child welfare caseworkers are tasked with the responsibility of being knowledgeable about many topics (SUD, mental health, domestic violence, child development, etc.) often all in one day and sometimes all in one interaction. Oregon has long supported a teaming model in SUD cases, but shortcomings exist due to insufficient funding and position allocation. Caseworkers need support and perspective from individuals with lived experience as well as professional experience in the field of SUD assessment, treatment, and recovery. Addiction Recovery Teams with diverse knowledge and expertise support caseworker growth and professionalism and provide supportive and equitable service to families.

Recommendations

After thorough review of the map and the brainstorming session notes, recommendations for system improvement could be organized into four categories; ART/FIT and contracted services, practice/procedure, training/workforce development, and family/community supports. In each of these categories, a variety of strategies were discussed among mapping participants. The Safe Systems Coordinator then compiled all of the team’s good thinking into a table of recommendations for consideration.

The CFPRP and the Child Safety Program have identified eight recommendations we would like to elevate for executive leadership consideration:

1. Restructure and expand ART/FIT and corresponding contracted services

The team discussed in depth the limitations of the current structure and allocation of ART/FIT resources across the state and the negative impact to casework practice and service delivery for families experiencing SUD. A number of recommendations were identified to address internal staffing, contracts, as well as access to services.

ART/FIT ODHS Child Welfare Positions

- Centralization of ART Leads (coordination or management)
- Reclassification of ART Leads to SSS-2’s
- Position description for ART leads (consider professional development aspects, such as CADC)

- Develop a workload model to determine adequate staffing levels for ART/FIT Leads across the state

ART/FIT Contracted Services

- Right-size contracts with ART providers, increase access to outreach for up-front engagement with families
- Diversify pool of support/resources available (peer mentors, contracted nurses, outreach, navigators, CADCs)

Access to Services

- Clarify current contract requirements – remedy barriers to immediate access
- Increase front-end services to be accessed from initial contact
- Look for opportunities to pool resources - there is a benefit of having services co-housed (home visiting programs, outreach, navigators, peer mentors, etc.) with financial resources to meet concrete needs and the ability to be nimble in level of supports offered

2. Develop comprehensive SUD case practice guidelines

Throughout the conversations with the mapping team, it became clear the improvement opportunities were impacted by the limited guidance provided to caseworkers and supervisors when engaging with families experiencing SUD. There are detailed guidelines and toolkits available for cases involving sexual abuse and domestic violence, yet a similar resource does not exist for cases involving substance use.

3. Develop a process for referring to community-based supports or services on reports that are closed at screening

Over the course of the mapping exercise, prevention efforts were discussed time and again, including mechanisms to provide support to families before formal child welfare involvement. The team identified a need to develop specific criteria for referrals to community based supports or services on reports not assigned but documented as a Closed at Screening report, which has long been a requirement of CAPTA (*Ensuring children's safety and making referrals to other services*: A state must have procedures to refer children not at risk of imminent harm to a community organization or voluntary preventive service). This level of preventative work is phase two of Oregon's FFPSA plan, but it is highlighted as a pressing need by the mapping team. Formation of a workgroup to clarify CAPTA requirements and develop a process for referral to community-based supports and services when a report is closed at screening, is recommended.

4. Develop statewide staffing guidance for infant cases

In the majority of cases reviewed, the children most gravely impacted were infants. Development of staffing guidance for cases involving infants and substance use, with emphasis

on plans of care and incorporating community-based supports early and often is recommended. This guidance could be embedded in the overall SUD guidelines or called out more specifically in guidelines for any case involving a child under the age of one year. SUD is not the only complicating factor in infant fatalities and any staffing guidelines should also consider safe sleep and responsive relationships.

5. Enhance knowledge and skill through creative education for caseworkers and supervisors

While training has a place in system improvement efforts, it alone is not the most effective system improvement strategy. In an environment where training is widely available but bandwidth for retention is limited and application even more so, it is important to identify methods for targeted learning that support direct application and pull from knowledge and experience staff already possess. It must also be applicable to child welfare professionals with varying experience levels and specific to current trends in the subject area. Spaced education is a method that uses spacing, repetition and testing to increase knowledge about a specific topic. Administered on-line, spaced education is a novel approach in the current work environment. Oregon can receive support in development and administration of spaced education from the University of Kentucky through our participation in the National Partnership for Child Safety.

6. Actively promote partnership with local prevention organizations

Communities often have an array of service options for families that are rooted in prevention, supporting responsive relationships, and promoting protective factors. At times, child welfare professionals do not effectively refer or partner with prevention organizations, who may have existing relationships with families or would be an effective provider. The team recognizes an opportunity to intentionally connect with local prevention agencies, in particular Nurse-Family Partnership and other early home visiting programs, to better understand how families can access programs and how best to partner on behalf of families to support safety and well-being.

7. Identify and support culturally appropriate paid respite, child-care programs, and safety service providers

Access to safe and reliable respite and child-care remains a challenge in many communities. For families that become involved with child welfare, comprehensive assessment, safety decision-making, and case planning can be negatively impacted when there is limited availability of safety service providers or other options for safe child-care. During the mapping discussions, the challenges related to safe and reliable respite and child-care surfaced a number of times. Parenting young children, in particular infants, is a significant lift for anyone and support to manage the exhaustion is important, especially for parents struggling with SUD. The team agreed access to respite for families struggling with SUD and parenting young children could be life-saving. The team considered both scenarios where families require formal child welfare

intervention as well as scenarios where children are safe, but families may still need support in their community. There are recommendations related to each scenario.

- Identify respite programs in local districts and secure funding streams to pay culturally appropriate respite/safety service providers during protective actions as well as initial and ongoing safety plans - CBCAP funding may be available to support paid respite in Oregon communities
- Partner with our ODHS Self-Sufficiency Program to identify funding for respite care and clarify requirements for high-quality subsidized child-care programs families could be connected with outside of child welfare intervention

8. Develop an application to provide information and guidance to child welfare professionals

Child welfare professionals are tasked with the responsibility of knowing a lot of information about a lot of different topics, which can take years to acquire, sometimes changes, and can be difficult to apply in the moment. That is why the development of a smart phone application, which would provide information on SUD as well as child development, mental health, domestic violence, and other subject matter at the touch of a screen, could be incredibly useful in ensuring child welfare professionals have the information they need to engage effectively with children and families. It is recommended research begin on the development of such and application for Oregon.

Conclusion

With any recommendation that is moved forward, it will be critical to keep close track of other efforts happening around the state to improve practice and/or promote prevention. Nurture Oregon, Family Treatment Court and Family Connect are all examples of innovative programs to follow and learn from as internal efforts are carried forward. It is also critical to build connections between existing department efforts to make the best use of resources available. Oregon's Family First Prevention Services plan and Comprehensive Addiction Recovery Act efforts are likely to highlight opportunities for connecting families back to the community in lieu of formal child welfare interventions. It is the hope of the mapping team that the influencing factors identified through the mapping process and the resulting recommendations provide a solid starting place for meaningful system improvement.

Oregon Safe System Mapping

Spring 2022

Overview

In the spring of 2022 the Child Safety Program, in partnership with the Child Fatality Prevention and Review Program (CFPRP), facilitated safe systems mapping sessions for Oregon Child Welfare. This process was facilitated with the much-appreciated support of Dr. Tiffany Lindsey from the University of Kentucky Center for Innovation in Population Health.

The purpose of safe systems mapping is to discuss the perceptions held by a group of experienced professionals regarding the factors they believe influence identified improvement opportunities. Improvement opportunities are defined as actions or inactions in cases reviewed by the CIRT/Safe Systems Coordinator that are either relevant to the outcome or an important industry standard. In safe systems mapping, these improvement opportunities are evaluated at all levels of the system – from the local team level to the legislative/government level. Every participant has an equal voice in the process and all perspectives are valuable to understanding more clearly how the system is operating and what gets in the way of successful work with families.

Improvement Opportunities

During this safe systems mapping process, the team explored improvement opportunities regarding the comprehensiveness of CPS assessments. The improvement opportunity identified was representative of the ten cases reviewed through the CIRT and Safe Systems Analysis processes from 2019 through 2021.

In a number of cases reviewed through the CIRT/Safe Systems Review processes, child safety was not well understood, and additional necessary assessment activities did not occur in CPS assessments open at the time of the critical incident.

In all of the cases reviewed, the children involved in critical incidents were participants in an active child protective service assessment. In most cases, a single contact with the family occurred and while the assessment frequently remained open for a significant amount of time prior to the critical incident, limited additional assessment activities occurred. While a number of barriers in assessing and understanding child safety beyond that of the caregiver's report or presentation were noted, in the majority of cases the CPS worker's primary focus appeared to be determining present danger at the time of initial contact thereby forgoing necessary actions required to fully assess child safety as the family and child's circumstances evolved over the course of the assessment. In several of the cases reviewed, it was determined that information essential to child safety was available through collateral contacts and evaluation of case history, which did not occur prior to the critical incident.

Oregon Safe System Mapping

Spring 2022

Additional barriers to ensuring child safety identified through case reviews were challenges in communication during CPS case transfers and difficulty with accurately determining child safety at the caseworker and supervisory level. As is common in many offices, three of the assessments reviewed were transferred between workers and a larger number were touched by multiple workers for various reasons. Due to turnover, extended absences, or work schedules, when cases were transferred between workers, a sense of urgency seemed to be lost and many times the expectations regarding follow-up actions needed to ensure child safety were unclear. Case reviews also indicated an inconsistent understanding of the Department's responsibility in assessing child safety when a family or Department plan is in place or after initial contact has been made. Additionally, case reviews revealed an inconsistent understanding regarding the level of information needed to come to a child safety decision.

The improvement opportunity presented to the mapping team for discussion was as follows:

Families need a child protective services system that seeks thorough understanding of child safety through diligent follow-up and information gathering, and clear communication and planning.

Mapping Process and Recommendations

The safe systems mapping team met twice during February and March 2022. The first meeting focused on mapping the improvement opportunity and all of the information was captured on a visual map. The second meeting focused on brainstorming strategies for improvement. The team recognized the interdependent nature of the numerous factors which impact the improvement opportunity. Staff turnover resulting in increased workloads and less experienced staff, additional training and support needed for CPS staff as well as the need for improved supervisory support and availability interact to create the current circumstance where barriers exist to conducting comprehensive assessments and thoroughly understanding child safety.

Recommendations

After thorough review of the map and brainstorming session notes, recommendations for system improvement could be organized into three categories: supervision, casework practice support and worker retention. With any recommendation that is moved forward, it will be critical to keep close track of other efforts happening around the state to improve practice and/or promote prevention.

It is the hope of the mapping team that the influencing factors identified through the mapping process and the resulting recommendations provide a solid starting place for meaningful

system improvement. The Safe Systems Coordinator then compiled all of the team's good thinking into a table of recommendations.

The CFPRP and the Child Safety Program have identified seven recommendations we would like to elevate for executive leadership consideration:

1. Reduce supervisor burden in the hiring process

The team discussed in depth the barriers that prevent supervisors from engaging in regular and comprehensive supervision with CPS staff. A challenge which was consistently identified was the time-consuming process of hiring which falls on supervisors to manage. Given the ongoing turnover and the associated administrative requirements, the hiring process has greatly impacted the amount of time supervisors are available to support workers and ensure comprehensive assessment occur. Creating alternative hiring processes which remove the burden from supervisors would improve their ability to provide meaningful and timely supervision of CPS assessments. Some proposed process changes identified by the group include a Human Resource led hiring process and the creation of designated district or area specific hiring teams which manage the hiring process. These changes may also allow for changes in the hiring process and additional attention to the screening of applications to ensure they have realistic understanding of job duties.

2. Strengthen requirements for the frequency and content of supervision

Over the course of the mapping exercise, the mapping team clearly identified the critical role that regular and thorough supervision plays in the completion of comprehensive CPS assessment follow-up. While some guidance has been provided regarding the frequency of clinical supervision, additional direction and support are necessary. The team suggested the creation of mandatory supervision frequency and supervision topics to include discussions of worker safety, prioritization of cases, identifying and addressing bias, sufficiency of information/evidence as well as requiring additional staffing supports to manage CPS assessment transfers and assist with understanding and monitoring sufficiency of information.

The recently completed CPS Supervisor Toolkit can be an important support for CPS supervision. The CPS Supervisor Toolkit was developed to be a practical guide to provide additional recommendations and resources that have been used successfully to support the ongoing efforts being made across the state to meet the expectations to complete safety assessments timely while also making sound safety decisions. One important area of the CPS Toolkit is specific to the identified improvement opportunity and need to address a lack of urgency and clarity around expectations for assessments transferring between workers is the CPS Worker Transition Guide & Unattended Caseload Section 6 in the Toolkit. Safety Program has considered creating a protocol and transmittal to formalize a process that supports the

review, analysis, and timely response to these caseloads using the information contained in the Toolkit.

CPS Supervisor Toolkit.pdf

3. Expand the tiered Social Service Specialist classification

In the course of our time together the team identified the need to employ new strategies to address worker retention due to the negative consequences turnover has on workload and subsequently casework practice. Mapping team members identified limited casework promotional opportunities and recommended the creation of promotional openings within the Social Service Specialist classification as used by other states. For example, Washington State provides promotional opportunities to casework staff which include financial incentives based on length of service and education.

4. Provide clarification and training regarding critical case practice challenges

In the cases reviewed for the mapping exercise, CPS workers appeared to lack a clear framework for understanding the information needed to develop a comprehensive understanding of child safety and family functioning rather than solely determine if present danger existed. While training has a place in system improvement efforts, it alone is not the most effective system improvement strategy but in combination with additional supervisor availability, field support and improved worker retention, the team believed that providing additional information to staff regarding sufficiency of information and assessment beyond present danger would aid in the completion of more comprehensive CPS assessments.

Child Safety Program is contracting with Tiffany Carr who is in charge of workforce development for Nevada Child Welfare. Ms. Carr is trained by Action for Child Protection who implemented the Safety Model in Oregon. Ms. Carr is partnering with Oregon to provide technical assistance to support gathering and documenting sufficient information during a CPS assessment as well as share a rubric for consultation and coaching. The goal is to continue to support the workforce around gathering sufficient information to determine the presence or absence of present and impending danger safety threats and improve safety outcomes for children in Oregon. This information could be formatted in such a manner as to be allow for statewide dissemination so that staff may activate their professional knowledge for use in comprehensive assessment of allegations of maltreatment. Additionally, the team believes that further support and training for supervisors and case worker staff in understanding assessment beyond present danger would be beneficial and could be provided by Child Safety Consultants as needed.

5. Designate Lead Workers for CPS Units

As part of our mapping conversations, the group determined that increasing the hands-on support of staff during CPS assessment field contacts is critical for professional development and supports improvement in the skills and knowledge needed for conducing comprehensive assessments. As it was determined that supervisory support during field contacts is unrealistic in most situations, the team believes that this could be addressed through unit level Lead Workers. These lead work staff would have slightly reduced caseloads and would carry the expectation of teaming with newer workers or with any worker assigned a complex CPS case, would provide real time mentoring during assessments and ensure the completeness of CPS assessment. The team recognized that existing MAPS positions, while incredibly valuable, do not meet the need for ongoing support for CPS related field contacts, frequently have limited availability due to a wide range of job duties and may not always have expertise in CPS practice. Staff holding lead worker duties would also be able to relay information to Supervisors and supplement the supervisor's knowledge and understanding of staff strengths and needs. Lastly, Lead Work positions also provide promotional opportunities to staff which can improve worker retention.

6. Expand the Mobile CPS Unit

Throughout mapping team discussions, the group repeatedly identified how staffing shortages and high workloads negatively impact the ability of staff to complete comprehensive assessments. The Mobile CPS Unit, while initially created to support offices in the completion of overdue assessments, has become a meaningful support for critically understaffed CPS units. As the Department continues work to stabilize CPS staffing around the state, additional positions within the existing Mobile CPS Unit would provide needed support to local offices during staffing challenges or unexpected workloads which overwhelm existing local office resources. This additional support for CPS units would provide the space and time for the comprehensive assessment of child safety and family functioning and minimize the challenges that result from overwhelming workloads.

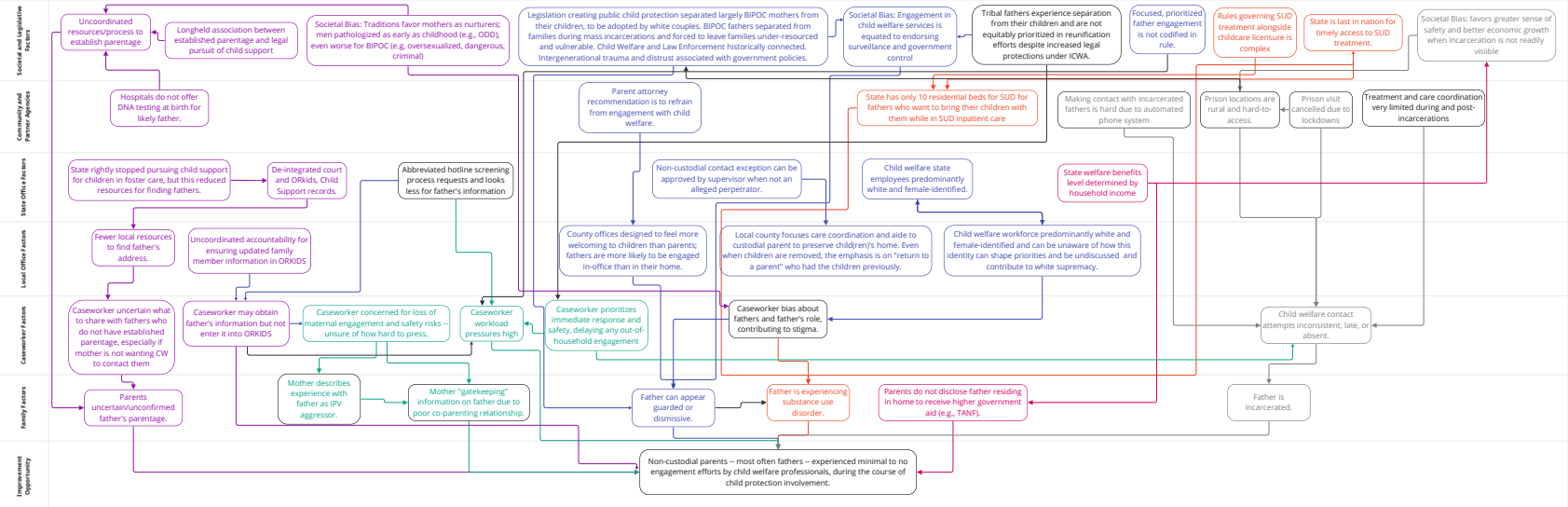
7. Develop and Require Consistent Post-Essential Elements Training and Support

Benefitting from the experience of mapping participants from around the state, when discussing onboarding new CPS staff and related training, the team determined a vast difference between districts regarding the training and support workers receive when returning from Essential Elements training. Developing and requiring a comprehensive training and support plan for new staff upon completion of Essential Elements training would provide for increased consistency in practice. This additional measure, currently under consideration with the Child Welfare Equity, Training and Workforce Development team, would support staff in

activating their learning and provide experience applying concepts to active assessments thereby improving overall comprehensiveness of CPS assessments.

Conclusion

With any recommendation that is moved forward, it will be critical to keep close track of other efforts happening around the state to improve practice and/or promote prevention. It is the hope of the mapping team that the influencing factors identified through the mapping process and the resulting recommendations provide a solid starting place for meaningful system improvement.


Societal and Legislative Factors
Community and Partner Agencies
State Office Factors
Local Office Factors
Caseworker Factors
Family Factors
Improvement Opportunity
Uncoordinated resources/process to establish parentage
Longheld association between established parentage and legal pursuit of child support
Societal Bias: Traditions favor mothers as nurturers; men pathologized as early as childhood (e.g., ODD), even worse for BIPOC (e.g, oversexualized, dangerous, criminal)
Legislation creating public child protection separated largely BIPOC mothers from their children, to be adopted by white couples. BIPOC fathers separated from families during mass incarcerations and forced to leave families under-resourced and vulnerable. Child Welfare and Law Enforcement historically connected. Intergenerational trauma and distrust associated with government policies.
Societal Bias: Engagement in child welfare services is equated to endorsing surveillance and government control
Tribal fathers experience separation from their children and are not equitably prioritized in reunification efforts despite increased legal protections under ICWA.
Focused, prioritized father engagement is not codified in rule.
Rules governing SUD treatment alongside childcare licensure is complex
State is last in nation for timely access to SUD treatment.
Societal Bias: favors greater sense of safety and better economic growth when incarceration is not readily visible
Hospitals do not offer DNA testing at birth for likely father.
Parent attorney recommendation is to refrain from engagement with child welfare.
State has only 10 residential beds for SUD for fathers who want to bring their children with them while in SUD inpatient care
Making contact with incarcerated fathers is hard due to automated phone system
Prison locations are rural and hard-to-access.
Prison visit cancelled due to lockdowns
Treatment and care coordination very limited during and post-incarcerations
State rightly stopped pursuing child support for children in foster care, but this reduced resources for finding fathers.
De-integrated court and ORkids, Child Support records.
Abbreviated hotline screening process requests and looks less for father's information
Non-custodial contact exception can be approved by supervisor when not an alleged perpetrator.
Child welfare state employees predominantly white and female-identified.
State welfare benefits level determined by household income
Fewer local resources to find father's address.
Uncoordinated accountability for ensuring updated family member information in ORKIDS
County offices designed to feel more welcoming to children than parents; fathers are more likely to be engaged in-office than in their home.
Local county focuses care coordination and aide to custodial parent to preserve child(ren)'s home. Even when children are removed, the emphasis is on "return to a parent" who had the children previously.
Child welfare workforce predominantly white and female-identified and can be unaware of how this identity can shape priorities and be undiscussed and contribute to white supremacy.
Caseworker uncertain what to share with fathers who do not have established parentage, especially if mother is not wanting CW to contact them
Caseworker may obtain father's information but not enter it into ORKIDS
Caseworker concerned for loss of maternal engagement and safety risks -- unsure of how hard to press.
Caseworker workload pressures high
Caseworker prioritizes immediate response and safety, delaying any out-of-household engagement
Caseworker bias about fathers and father's role, contributing to stigma.
Child welfare contact attempts inconsistent, late, or absent.
Parents uncertain/unconfirmed father's parentage.
Mother describes experience with father as IPV aggressor.
Mother "gatekeeping" information on father due to poor co-parenting relationship.
Father can appear guarded or dismissive.
Father is experiencing substance use disorder.
Parents do not disclose father residing in home to receive higher government aid (e.g., TANF).
Father is incarcerated.
Non-custodial parents -- most often fathers -- experienced minimal to no engagement efforts by child welfare professionals, during the course of child protection involvement.

Oregon Safe Systems Mapping, 2023-2024

Overview

For the third consecutive year, the Child Fatality Prevention and Review Program (CFPRP) coordinated and facilitated Safe Systems Mapping sessions for Oregon Child Welfare. This process was facilitated with the support of Dr. Tiffany Lindsey from the University of Kentucky Center for Innovation in Population Health.

The purpose of safe systems mapping is to discuss perceptions of factors influencing identified systemic improvement opportunities, in a group of experienced professionals and individuals with lived experience. The group shares their perceptions of which factors influence identified improvement opportunities. Improvement opportunities are defined as actions or inactions in cases reviewed through the Critical Incident Review Team (CIRT)/Safe Systems Analysis process, that are either relevant to the outcome or an important industry standard. In safe systems mapping, improvement opportunities are evaluated at all levels of the system – from the local team level to the societal level. Every mapping team participant has an equal voice in the process and all perspectives are valuable to understanding more clearly how the system is operating and what gets in the way of successful work with families.

Improvement Opportunity: Why Dads?

In this round of safe systems mapping, the team explored one over-arching improvement opportunity regarding quality engagement and casework practice with fathers and non-custodial parents. This improvement opportunity was representative of themes across fifteen cases reviewed through the CIRT and Safe Systems Analysis process between 2019 and 2022. Of the fifteen cases reviewed, fourteen had opportunities for improvement specific to ODHS Child Welfare's work with fathers or non-custodial caregivers. The cases demonstrated a trend where the non-custodial caregiver had key insights into the family condition which were not considered until after the critical incident. There were inequitable documented engagement efforts with the fathers and non-custodial caregivers when compared to mothers and custodial caregivers, such as a single phone call or a letter to the parent's last known address. Several cases had abuse allegations by the father which were coded as founded, but they were not contacted during the CPS assessment period. This case review suggests the existence of bias towards fathers as secondary caregivers in Oregon Child Welfare practice.[1] For more information about the improvement opportunity, click the file below.

2023 Safe Systems Mapping Improvem

Research suggests that fathers, custodial or non-custodial, are an important part of child welfare provision and planning. When child welfare agencies *identify* non-custodial fathers, children are more likely to be reunified with a parent and are less likely to be adopted. When child welfare agencies *contact* non-custodial fathers, it can lead to shorter case duration.[2]

However, available research and the insights from the CIRT/Safe Systems analysis demonstrates fathers are not engaged equitably.

In nationwide Child and Family Service Reviews (CFSR) measurements, fathers' needs were accurately assessed in 47% of child welfare cases compared to 64% of mother's needs.[3] CFSR conducted in Oregon in 2016 showed 56% of fathers involved with Oregon Child Welfare had their needs assessed accurately. Child welfare agencies often identify fathers at a high rate (88%), but only contacted them in 55% of the cases from the same sample.[4] Most children who are placed with a resource family are removed from, and returned to the mother's home where their biological father does not live.[5] Child welfare caseworkers are mandated to identify and involve nonresident fathers, though it is more common for children to be placed with a relative than with their nonresident father. [6]

Child welfare agencies are less likely to identify the fathers of Black and Multiracial children, compared to White fathers. Engaging fathers in child welfare practice could be a concrete means of affecting the disproportionate number of Black and Indigenous children placed in resource care. Because fathers of BIPOC identities are engaged at a lower rate, this leaves unconsidered resources, and potentially unaddressed risks in the family condition.[7]

Research highlights numerous barriers fathers face when involved with child welfare agencies which aligns with observations from the systems mapping team. Child welfare caseworkers may display rigid thinking towards fathers and can be affected by the societal norms about gendered parenting. Fathers can be viewed as intimidating or dangerous by caseworkers, and fathers themselves may present as reluctant to engage.[8] [9] When men are perpetrators of child abuse or interpersonal violence, services tend to be tailored towards mothers, placing onus on the mother while denying fathers' chances at rehabilitation and reunification.[10] Fathers who are incarcerated also are significantly less likely to be contacted by child welfare caseworkers.[11]

These factors, and the observations from the CIRT/Safe Systems Analysis process outline the need for further exploration into system improvement for fathers in Oregon Child Welfare practice.

The Mapping Process and Results

The safe systems mapping team met three times in August and September 2023. The first two sessions were focused on mapping the improvement opportunity and the last session was focused on developing strategies for improvement. The safe systems mapping team was composed of 42 child and family-serving professionals including ODHS CW Executive Leadership, managers and caseworkers from multiple CW programs, substance use disorder and domestic violence subject matter experts, and ODHS Office of Tribal Affairs. Also included were partners from West Virginia and Washington, Casey Family Programs, Spark Learning, Oregon Health Authority, and local treatment and outreach programs. The mapping sessions were facilitated with an emphasis on centering and honoring the voices of those with lived experience, and perspectives of participants who worked directly with families.

The mapping sessions highlighted pervasive barriers fathers experience across the ODHS Child Welfare system, and the broader child and family-serving system. Unintentional, reinforced

caseworker bias towards men and fathers, which is magnified for fathers of BIPOC identities, was an underlined theme in the discussion. The availability of resources specific to fathers, caseworker knowledge of services, barriers to documenting a father's contact information, and custodial parents' "gatekeeping" information about the father's whereabout or behaviors were other highlights of the discussion. Additionally, the mapping team identified numerous other child and family-serving systems that interface with ODHS Child Welfare impacting fathers. Throughout the mapping sessions it became apparent the broad reach of this improvement opportunity was significant and beyond what can be addressed by ODHS.

A visual map of the problem was developed based on discussion in the two mapping sessions. For more information about the content of the conversations, see the attachment below.

Oregon Systems Map_Father Engage

Recommendations

After a thorough review of the map and brainstorming session notes, recommendations for system improvement could be organized into four different categories: staff training and development, staff tools and communications, practice guidance, and additional resources needed to address father engagement.

The Prevention Coordinator compiled the team's inspired thinking into a table of recommendations, which is attached below.

2023 Mapping Recommendations T

A draft of the recommendations was shared with the mapping team for purposes of prioritizing efforts. Five strategies were identified for elevation to ODHS CW Executive Leadership for consideration.

1. Explore development of regional assignments, such as existent structure in ODHS CW "champions," which focus on fathers and parents who are not primary custodians of their children.
2. A section of training specific to father engagement in new employee training, and exploration of available training opportunities to infuse elements of implicit bias,

secondary trauma, and their impact to individual casework practice.[a]

3. Develop a tool which maps father-specific services available in the state. This tool must be developed in collaboration with lived experts of CW involvement.
4. Evaluate areas in policy, procedure, and databases (such as ORkids database used by caseworkers) where "hard stops" may be implemented for identifying and purposely engaging fathers.
5. In consultation with ODHS Office of Tribal Affairs and Oregon Tribal Nations, support development of specialized advocate role(s) for Indigenous father engagement, including but not limited to ICWA/ORICWA, and explore additional prevention efforts.

The Need for Broad System Response

As mentioned, the mapping team highlighted deficits in the child and family-serving system impacting fathers and their children. The mapping team would be remiss not to address these cross-system barriers. To encapsulate the additional recommendations from the mapping team, ODHS CFPRP developed an addendum to the CW system improvement recommendations. Much more information can be found in the attachment below.

The mapping team recommends the development of an interagency collaborative specific to father engagement, which spans the child and family serving system.

Recommendations Addendum. Fathers

Conclusion

The mapping team hopes these recommendations lay foundations for meaningful system improvement for engagement of fathers and non-custodial caregivers and provide direction to current and future Oregon Child Welfare efforts. The need for equitable, non-biased and holistic family reunification efforts cannot be underscored emphatically enough. As with any efforts aimed at improving outcomes for children and families, it will be critical to monitor other efforts around the state to align practice that improves outcomes for children, fathers, and families.

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[a] Caseworkers who received training about father engagement are much more likely to share case plans with a father, consider fathers as placements for their children and fathers are more likely to express interest in having their children live with them.

Coakley, T. M. (2013). The influence of father involvement on child welfare permanency outcomes: A secondary data analysis. *Children and Youth Services Review*, *35*(1), 174–182. Elsevier. https://doi.org/10.1016/j.childyouth.2012.09.023

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[6] Arroyo, J., Zsembik, B., & Peek, C. W. (2019). Ain't nobody got time for dad? Racial-ethnic disproportionalities in child welfare casework practice with nonresident fathers. *Child Abuse & Neglect*, *93*, 182–196. https://doi.org/10.1016/j.chiabu.2019.03.014.

[7] Arroyo, J., Zsembik, B., & Peek, C. W. (2019). Ain't nobody got time for dad? Racial-ethnic disproportionalities in child welfare casework practice with nonresident fathers. *Child Abuse & Neglect*, *93*, 182–196. https://doi.org/10.1016/j.chiabu.2019.03.014.

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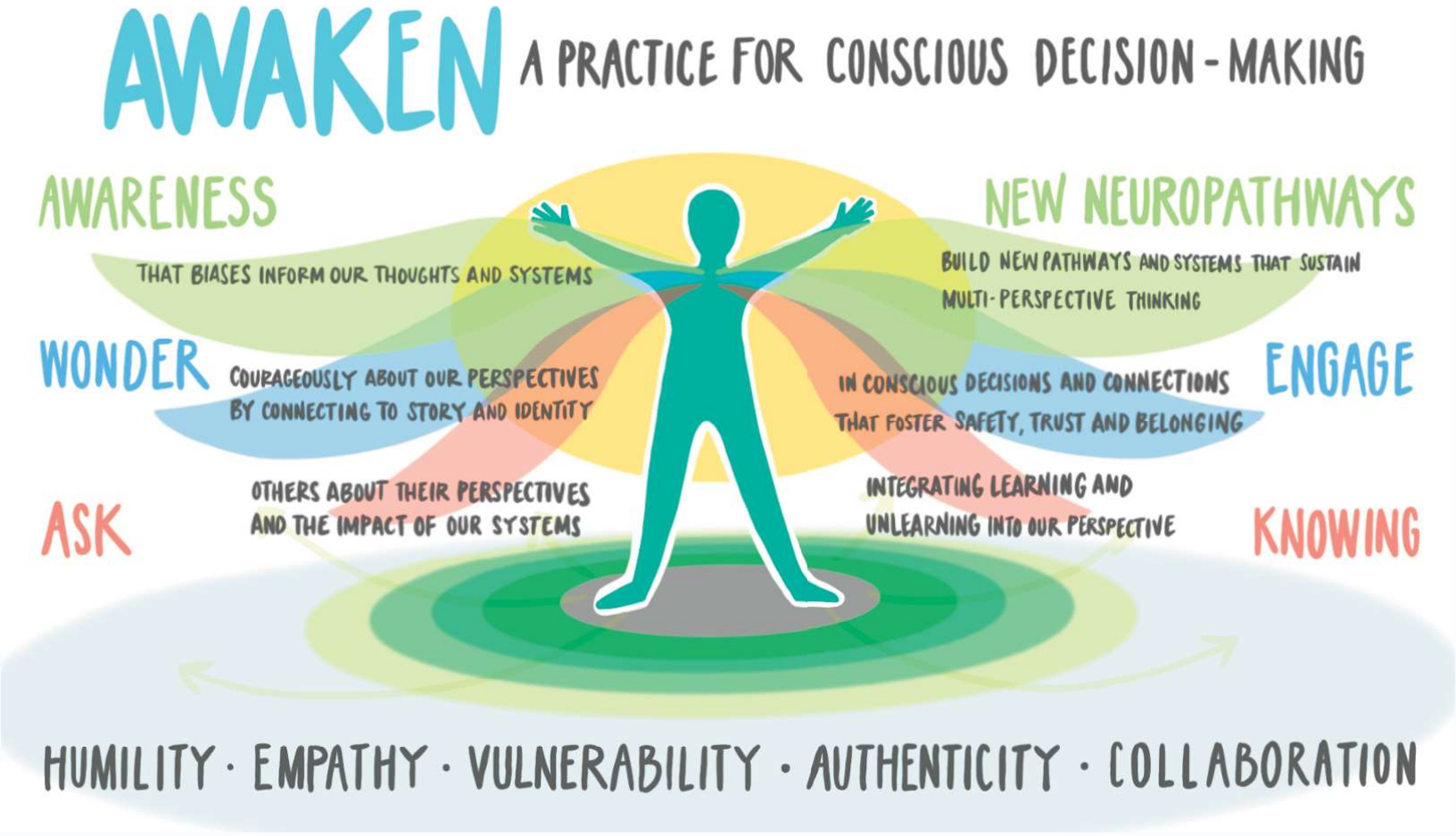

AWAKEN is a value-based framework providing actionable steps that take us from automatic, bias-based thinking to intentional decisions and behaviors. It identifies when bias is activated and provides teams with mindful organizing strategies to co-conspire against biases in ourselves and our systems. It also awakens the critical consciousness needed to make equitable decisions that foster safety, trust, and belonging. **AWAKEN** can be used as a quick self-check-in or a deeper dive anytime we notice a response to a situation, person, or decision.

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Bias and Safety Culture

Bias lives everywhere, in all of us and in the teams, organizations, and systems where we work and live. Understanding different types of cognitive bias enable us to identify better when bias may be at play and how it influences our decision-making. Identifying systemic bias allows us to advocate for social justice and system improvements. Cognitive biases, such as hindsight bias and severity bias, can significantly impact safety culture. How agencies navigate bias affects organizational culture, and that's where mindful organizing comes In.

Mindful Organizing

Mindful organizing Is a team-based practice that allows teams to manage complexity and bias In decision-making (Sutcliffe, 2011). **AWAKEN** Is a mindful organizing strategy that can be used individually or collaboratively within teams to plan forward proactively or reflect back retrospectively anytime decisions are made.

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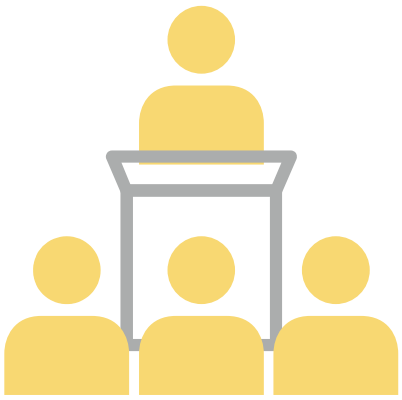
Target Audience

Anyone seeking to address bias in teams and systems, strengthen collaboration and workplace connectedness to reduce bias in assessment and decision making, primarily to address equity, inclusion, and belonging for diverse populations served.



Demand

Disparity and disproportionality have long been a focus for child welfare organizations. In addition, addressing systemic bias and racial injustice on individuals and communities has become a priority to transforming child welfare.

Teaming is a core tenet of safety culture. As jurisdictions integrate safe systems approaches into their practice, the value of workplace connectedness and collaboration Is a crucial feature.

Innovation

By operationalizing the AWAKEN framework in teams, we are interested in exploring whether sharing and understanding diverse perspectives and stories strengthens team relationships, trust, and workplace connectedness.

Implicit bias training alone has not been shown to be effective in reducing bias over time. Therefore, we are interested in exploring how collaborative decision-making might support teams in identifying systemic biases and advocating for system improvements.

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Competency

Teams will learn to engage in conscious decision-making, both independently and together, by recognizing and counteracting unconscious bias to foster safety, trust, and belonging in safe systems debriefings.

Learning Objectives

- Know how to practice empathy, humility, vulnerability, authenticity, and collaboration as foundational values in perspective taking, trust, and relationship building.
- Recognize the types of cognitive bias seen in child welfare serving systems and apply strategies to counteract them.
- Recognize signifiers of when bias might be present. (AWARENESS)
- Explore one's perspective to understand how individual and system biases are shaped. (WONDER)
- Demonstrate foundational values and skills to encourage participation and gain new perspectives. (ASK)
- Demonstrate the ability to synthesize new knowledge gained from different perspectives. (KNOWING)
- Know how to engage in conscious decision-making. (ENGAGE)
- Know how to develop and sustain new conscious decision-making habits. (NEW NEUROPATHWAYS)

Implementations

South Carolina Department of Social Services has integrated AWAKEN into their new child welfare certification and entire direct service workforce. It is used as foundational decision-making support for casework, including addressing during assessment and planning throughout the life of a case.

The Safe Systems team at the Center for Innovation in Population Health has integrated AWAKEN into an advanced training for systemic critical incident reviewers from child welfare jurisdiction members of the Casey Family Programs National Partnerships for Child Safety. Implementation is supported by team PDSAs, coaching calls, and self-assessment surveys for the six months following the formal training.

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How we implement AWAKEN

Collaborate to Identify a targeted area (or areas) of focus in your organization to implement **AWAKEN.**

Customize **AWAKEN** to your organization's needs and areas of focus.

Partner to identify metrics to measure the effectiveness of **AWAKEN** in your organization.

Deliver the **AWAKEN** training and provide coaching to your organization's workforce

Establish sustainability by training trainers within your organization on how to deliver training and coach **AWAKEN**.

Provide ongoing support to your organization's **AWAKEN** journey.

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What people are saying about **AWAKEN**

I'm thinking about bias all the time, I feel like. In a different way than I previously thought about it. That tells me that I've learned something and how I'm responding to it.

It strengthened our team in lots of ways. Experiencing it together creates something powerful. The shared experience created trust and we shared emotions.

It doesn't always feel good when we're having these conversations [about bias]. Our outcome in the end might still be what we think. But we're truly making sure that we are asking questions and posing other hypotheses. It's been challenging for my staff, but I've been using some of the tools from the [AWAKEN] training and I think it's been helpful in navigating the conversations.

I'm more understanding and trusting of my colleagues. Deeper relationships, knowing they will support.

I see things differently now I am tuned into my bias. It's impossible not to use that lens now. The film has been lifted from my eyes.

We've really expanded our conversations about our biases. I've found that as a leader, I've really challenged my workers on biases. We're making sure that we're challenging ourselves.

Oregon's State Child Death Review and Prevention Team

CHARTER

2022

CONTENTS

INTRODUCTION

This Charter was developed by and for the State Child Death Review and Prevention Team. Within this document, the State Child Death Review and Prevention Team will be referred to as the state team and the County Child Death Review Teams will be referred to as county teams.

MISSION

The mission of the state team is to serve Oregon by reducing preventable child deaths.

STATUTORY AUTHORITY

ORS 418.748 states:

"The Oregon Health Authority, in collaboration with the Department of Human Services, shall form a statewide interdisciplinary team to meet twice a year to review child fatality cases where child abuse or suicide is suspected, identify trends, make recommendations, and take actions involving statewide issues.

The statewide interdisciplinary team may recommend specific cases to a (county) child fatality review team for its review under ORS 418.785.

The statewide interdisciplinary team shall provide recommendations to (county) child fatality review teams in the development of protocols. The recommendations shall address investigation, training, case selection and fatality review of child deaths, including but not limited to child abuse and youth suicide cases."

PURPOSE

The purpose of the state team is to better understand the circumstances surrounding child deaths occurring in Oregon to prevent future child deaths and serious injuries. The team accomplishes this through:

- Reviewing data gathered from collaborative, multidisciplinary, comprehensive case reviews.
- Supporting county teams where the reviews primarily occur.
- Tracking data-driven trends, improvement opportunities, and recommendations.
- Advocating for equitable prevention strategies at the community, local, state, and national levels.
- Informing continuous quality improvement within Oregon's larger child death review system.

OBJECTIVES

1. Support accurate identification and uniform reporting of the cause and manner of child deaths.

2. Promote cooperation, collaboration, and communication across the child and family serving system and enhance coordination of efforts within the family serving system.
3. Achieve quality, equitable investigation of child deaths consistent with national standards.
4. Design and implement cooperative, standardized protocols for the review of child deaths.
5. Ensure accurate, complete, and timely data entry in the National Fatality Review - Case Reporting System.
6. Review county team prevention recommendations and support prevention efforts.
7. Identify needed changes in legislation, policy, and practices, and recommend expanded efforts in child health and safety to prevent child deaths and serious injuries.

BACKGROUND

Oregon's State Child Death Review and Prevention Team (state team) is an interdisciplinary team. The state team exists within a larger child death response system comprised of professionals working to understand and prevent unexpected child death in Oregon and across the nation. The state team is charged with supporting county child death review teams (county teams) and collecting and analyzing child death information to support local and statewide prevention efforts.

Oregon Revised Statute (ORS) established the state team in 1989, county teams in 1991 and the state technical assistance team in 1995. The technical assistance team supports both the state and county teams and is housed in the Injury and Violence Prevention Program in Oregon Health Authority's Public Health Division.

GUIDING PRINCIPLES

EQUITY

The state team acknowledges generations-long social, economic, and environmental inequities result in adverse health outcomes. Systematic oppressions affect communities differently and may have a greater influence on health outcomes than either individual choices or one's ability to access health care. Some of the reviewed child deaths are not the result of the actions or behaviors of those who died, or their parents or caregivers. Social factors such as where they live, how much money or education they have and how they are treated because of one or more of their identities can also contribute to a child's death. When reviewing individual cases and interpreting the data, it is critical not to lose sight of these systemic, avoidable, and unjust factors. These factors perpetuate the inequities we observe in child deaths across populations in Oregon. It is critical that state team members and the system's, members represent, including state data systems, identify and understand the life-long inequities that persist across groups to eradicate them. Reducing health disparities through policies, practices, and organizational systems can help improve opportunities for all Oregonians.

The interdisciplinary state team commits to:

- Review and support the review of all death cases from a health equity lens and engage in difficult discussions that arise. Structural racism, interpersonal racism, and discrimination will be noted as findings.
- Regularly review data to identify populations with disproportionate outcomes.
- Make ongoing efforts to have state team membership reflect the diversity in Oregon communities.
- Evaluate our own biases and prejudices and engage in ongoing equity trainings.
- Support and promote equitable child death investigation.

HEALTH

The state team recognizes social determinants of health, including but not limited to poverty, food insecurity, housing instability, a lack of access to medical care (physical and mental health care), parental educational status, and systemic racism play a role in child deaths in Oregon. The state team commits to bringing social determinants of health to the forefront of team discussions and recommendations.

RIGHTS OF CHILDREN

The state team embraces a child rights-based approach to death investigation, review, and prevention. This includes (1) the basic rights to life, survival, and development of one's full potential; (2) protection from harm; and (3) having an active voice. Consistent with the United Nations Convention on the Rights of the Child, the state team, "respects and promotes the human dignity and the physical and psychological integrity of children as rights-bearing individuals, rather than perceiving them primarily as victims" (https://www.unicef.org/child-rights-convention/convention-text).

TRAUMA-INFORMED

The death of any child is a tragedy. The state team seeks to honor the trauma that results from the death of a child for the family and the community through all the activity and output of the team. As part of the work of the state team, the team will mindfully consider and seek to improve (1) how systems are, or are not, addressing the trauma of child death; and (2) the supports available to caregivers, community members, and county teams in managing trauma related to child death.

The state team recognizes the impact participation in child death reviews has on the emotional wellbeing of team members. To remain trauma-informed and responsive, the team will continue to take steps to support wellness of team members, which may include:

- Training opportunities regarding trauma and responding to secondary trauma.

- Taking intentional breaks during team meetings to engage in activities which support managing the impact of exposure to traumatic material.
- Actively working to create a safe culture focused on learning that encourages open communication and emotional support among team members without judgment.

SAFETY CULTURE

The state team values open communication, curiosity, continuous learning and improvement, and each team member's perspective, professional knowledge, lived experience, and expertise. The state team seeks to create an environment and culture that is free of blame and shame, where mistakes are opportunities for improvement, and individual accountability is balanced with systems accountability.

While disagreements between members are sometimes unavoidable, if navigated with care, they may help the team to function effectively and support quality work. It is the responsibility of the state team co-chairs to support and foster productive exchanges and dialogue between team members.

ORGANIZATIONAL STRUCTURE

The state team acts as the center of the child death review system in Oregon. This includes serving as support and oversight for Oregon's county teams.

While the state team's effectiveness depends on its membership forming a statewide interdisciplinary team, ORS 418.748 provides responsibility for the state team to the Oregon Heath Authority (OHA) and Oregon Department of Human Services (ODHS). As a result, co-chair positions are assigned to representatives of OHA and ODHS.

The state technical assistance team as outlined in ORS 418.706, provides staff support for the state team and technical assistance to the county teams. The state technical assistance team operates out of Oregon Health Authority, Public Health Division, Injury Violence and Prevention Program.

MEMBERSHIP

RECRUITMENT

The state team commits to ongoing recruitment of team members with a focus on team diversity and representation and seeks the support of active members in identifying and recruiting individuals who may bring value to the work of the team through their professional associations, personal experience, and expertise.

ONBOARDING

When a new team member is identified, the co-chairs will initiate the onboarding process with the assistance of the state technical assistance team. State team onboarding activities include but are not limited to:

- Dissemination of orientation materials to include team charter, recent annual reports, meeting minutes for two prior meetings, the National Center for Child Death Review Program Manual for Child Death Review, and a link to the Oregon Child Death Review and Prevention website.
- An initial onboarding virtual meeting with one or both co-chairs to discuss team member roles and responsibilities including active participation requirements, associated time commitment, and the onboarding timeline. If the onboarding member is replacing an existing member, the existing member will also participate.
- Co-chairs will create and send an email to the state team introducing the new team member.
- Observing a state team and county team meeting prior to team membership, whenever possible.
- Completion of a voluntary diversity questionnaire.
- A post-meeting check in between the co-chairs and the new team member after the new team member attends their first state team meeting.

ROLES AND RESPONSIBILITIES

The state team is comprised of individuals who hold one of three roles: co-chair, core team member or designee, and state technical assistance team member. Roles and responsibilities may shift over time and with agreement of the team member and co-chairs. However, all members regardless of role share the following responsibilities:

- Review and abide by the state team charter.
- Actively uphold the guiding principles, mission, and purpose of the state team.
- Actively and consistently engage with the team during state team meetings.
- Adequately prepare for state team meetings by completing necessary activities, such as document review, research, communication with county teams, completion of action items from prior meeting, or any other work required to support state team efforts.
- Participate in recommended trainings independently and during team meeting. Team members are encouraged to participate in and share learnings from training offered through their parent agency. When training relevant to child death review and prevention is available, the training information will be shared with the team.
- Share information openly and honestly within the state team.
- Share information with and from others in represented role.

- Protect the confidentiality of information by not sharing identifying information of the family and any law enforcement, health care, child protective services, or other protected information with anyone outside the child death review process.
- Use respectful, strengths-based, person-centered language when discussing children and families whose experience is shared through the child death review process, as well as when conversing with other team members. This includes the ongoing critical self-reflection necessary for the recognition of team members' individual biases and privileges.
- Understand that team membership is a long-term commitment with an associated workload and time commitment.
- Continuously work to strengthen relationships and improve communication with county teams.

DESIGNEES

Effective child death review requires a variety of perspectives. As such, state team members are asked to identify a designee should they be unable to attend a team meeting. When a designee cannot be identified, it is the member's responsibility to ensure alternative means for contributing to the agenda items. When possible, communication from the member to co-chairs informing of the need for a designee should occur at least one week prior to the team meeting. Team members may also choose to provide the co-chairs a letter authorizing an individual to serve as a permanent designee.

REPRESENTATION IN MEMBERSHIP

To support the commitment to policy and system improvement, state team members should have an ability to impact statewide change through role, connections, or access to and support from their represented group. When a permanent designee is assigned, the designee may represent a local connection to the work but will maintain a statewide connection through the member. Members will be selected for their subject matter expertise gained through education, work experience, and/or lived experience.

The state team is committed to diversity among team members and utilizes a voluntary diversity questionnaire as an assessment tool to inform recruitment efforts. The state team will continue to utilize this tool annually or as needed to fulfill the goal of ongoing reflection and growth toward creating a diverse team that represents perspectives and lived experiences of the Oregonians served by the broader child and family serving system.

The state team recognizes the sovereignty of Oregon Tribal Nations and continues to seek out opportunities to engage tribes in child death review and prevention efforts in a manner determined by the Oregon Tribal Nations.

The state team will at a minimum seek to include members representing the following perspectives and roles:

- Oregon Health Authority, Public Health Division, Injury and Violence Prevention Program, co-chair
- Oregon Department of Human Services, Child Welfare, Child Fatality Prevention and Review Program, co-chair
- Sheriff's Association
- Chiefs of Police
- Oregon State Police
- Department of Public Safety Standards and Training
- Office of the State Fire Marshall
- Oregon District Attorneys Association
- State Medical Examiner
- Oregon Child Abuse Solutions
- Oregon Pediatric Society
- Early Learning Division, Office of Childcare (Department of Early Learning and Care)
- Oregon Department of Education
- County Team Lead
- County Team Coordinator
- Oregon Department of Justice, Child Abuse Multidisciplinary Intervention (CAMI) Fund Coordinator
- Oregon Department of Justice, Child Advocacy Division
- Oregon Youth Authority
- Oregon Health Authority, Public Health Division, Maternal and Child Health
- Oregon Health Authority, Health Systems Division, Behavioral Health
- Oregon Health Authority, Public Health Division, Emergency Medical Services
- Oregon Department of Human Services, Office of Developmental Disabilities Services
- County Health Department medical provider
- Oregon Tribal Nations
- Oregon Council Against Domestic and Sexual Violence
- Safe Kids
- Oregon Child Development Coalition
- Oregon Association of Hospitals and Health Systems
- Faith Leader
- Oregon Health & Science University, Office of Rural Health
- Oregon Infant Mental Health Association

- Toxicologist
- Oregon Health & Science University, Doernbecher's Children's Hospital, Tom Sargent Safety Center
- Legacy Health Systems, Injury Prevention
- Family Support and Connections
- Oregon Council for Behavioral Health
- Pediatrician
- Coordinated Care Organizations
- Child and Adolescent Psychiatry
- Oregon Medical Board
- Oregon State Board of Nursing
- Oregon Board of Naturopathic Medicine
- Mental Health and Addiction Certification Board of Oregon
- Oregon Vital Records
- Oregon Department of Transportation

The state technical assistance team members, although not state team members, support the work of the state and county teams, and participate in the state team meetings.

EXITING THE TEAM

A state team member may end their membership for a variety of reasons, including change in role, and inability to meet the roles and responsibilities of a team member.

It is expected that any team member exiting the team will participate in an offboarding process as follows:

- When possible, if a team members become aware of their need to exit the team, they will communicate this to the co-chairs prior to their final meeting.
- The co-chairs provide an opportunity to receive feedback from the exiting team member.
- The exiting team member will work with the co-chairs to identify a possible replacement.
- When a replacement has been approved, the exiting team member will work with the co-chairs to develop a transition plan to support onboarding of a replacement. The transition plan will include:
    - Conversation regarding team responsibilities and time commitments will occur between the co-chairs and the exiting and onboarding team members.
    - Determination of when the transition between exiting and onboarding team members will occur.
    - Communication with any counties assigned to the exiting team member to inform them of the change.

- Exiting team member to participate in an exit interview with a co-chair to gather information to support overall program improvement.
- Removal of exiting member from future communications and confirmation the exiting member has disposed of all state team review materials or information not relevant to their job duties at their parent agency.

LOGISTICS

MEETING SCHEDULE

The state team will have half day meetings that occur at least quarterly.

MEETING LOCATION

To ensure inclusivity and access to statewide experts, the state team will be held virtually for the foreseeable future. The co-chairs will communicate any change in meeting format.

GUESTS/INTERNS

Periodically, the state may consider inviting guests to participate in or present at a state team meeting. Guests may include individuals with a particular expertise, case specific knowledge, or those for whom the experience would provide educational or professional development. Guests at state team meetings will be oriented to the team's purpose and guiding principles and must complete a statement of confidentiality prior to participation.

DECISION-MAKING PROCESS

The state team uses a consensus-based decision-making model where the co-chairs identify decision-making junctures, encourage open dialogue, and facilitate the decision-making process. Should the team fail to reach consensus, all members are provided an opportunity to provide feedback to the co-chairs, who weigh information and come to a final decision on behalf of the team.

CONFIDENTIALITY

State team members will sign and return a statement of confidentiality. Members will periodically be asked to provide a new signed statement.

The state technical assistance team will obtain and maintain the confidentiality agreements, ensuring no individual attends the state team meeting without a signed and returned confidentiality agreement. State team guests are required to complete a statement of confidentiality prior to participation in meetings.

ACCESSIBILITY

For the benefit of the state team and each member and guest, it is imperative all members and guests can fully participate in the state team process. The state team is committed to ensuring the accessibility needs of team members and guests are met during team meetings and with team communication. Prior to meetings members and guests will be asked what can be done to make participation easier. Actions taken may include but are not limited to:

- Including an accommodation statement in meeting invitations.
- Holding meetings via a virtual platform that provide a variety of means of participation including audio, visual, and dial-in via conference phone number.
- Co-chairs will ensure the chat box is monitored, read aloud the author and questions/comments to be addressed, and offer use of the chat box as an alternative method of communication during meetings.
- Providing captioning or live sign language or translation services as needed.
- Distributing communication in a minimum of 14-point font.

CASE REVIEW

SCOPE OF REVIEW

Child deaths which come under the purview of the state team include unexpected deaths of individuals under the age of 18 years including deaths as the result of maltreatment, suicide, or unexpected injury. Any questions or disagreements regarding the appropriateness of a child death review will be addressed by state team co-chairs.

CASE SELECTION

While review of individual child deaths occur at the county level, the state team may conduct a formal child death review in the following circumstances:

- A county is requesting assistance in reviewing a death due to insufficient resources to conduct a review.

- When the co-chairs determine an additional review is necessary to understand system improvement opportunities.
- When the co-chairs determine the review will serve as a learning opportunity for state team members.

To ensure access to a review, the state team will prioritize requests for review from counties with insufficient resources to conduct their own.

REVIEW PROCESS

Any state team member bringing forward a death for team review will do the following to ensure a quality death review occurs:

- Utilize the child death case summary abstract and disseminate to team members at least two weeks prior to the review.
- Identify individuals whose participation would provide value to the review and inform co-chairs and technical assistance team members at least 10 business days prior to the review.
- Review and utilize quality practice guidelines for conducting child death reviews available through the National Center for Child Fatality Review and Prevention.
- Present case information with a strengths-based, person-centered framework that seeks to identify opportunities for improvement while considering the totality of the family's experience with the broader child and family serving system rather than focusing on individuals or specific actions.

COUNTY TEAMS

COMMUNICATION WITH COUNTY TEAMS

Communication between county teams and state team primarily occur through regular contact resulting from the technical assistance team duties, administration of the Child Abuse Multidisciplinary Intervention funds, and co-chair contact.

COUNTY SUPPORT

State team members are strongly encouraged to participate in the critical work of supporting county teams.

County Support Goals:

- Enhance communication between the county and state death review teams.
- Support and encourage the county in the completion of death reviews.

- Increase the understanding of the purpose and value of the death reviews.
- Remove barriers to completing death reviews.
- Ensure Oregon has data on child deaths to inform prevention and intervention.

DATA

DATA COLLECTION

Data collection will occur through regularly scheduled data imports from the National Fatality Review-Case Reporting System (NFR-CRS), the data system supporting Child Death Review and Fetal and Infant Mortality Review teams across the country. Collection of data through the NFR-CRS is facilitated by the state technical assistance team. The County Support Program will serve as an additional means to ensure the timely and accurate entry of information into NFR-CRS by county teams.

DATA SHARING

The state team members will engage in data sharing with other Oregon child death review professionals and national partners as needed to fulfill the objectives of the state team and pursuant to ORS 418.747(13).

IDENTIFICATION OF TRENDS

Using their unique expertise and connection with county teams, state team members are responsible for identifying trends in Oregon child deaths using available data and through discussion with county teams.

PREVENTION

PREVENTION RECOMMENDATIONS & SUPPORT OF PREVENTION EFFORTS

A foundational purpose of the state team is the creation of child death prevention strategies based on data obtained during child death reviews occurring throughout Oregon. The state team addresses the status of current statewide prevention efforts, identifies gaps in child death prevention, and develops additional plans and strategies as needed as part of the team's core work pursuant to ORS 418.748.

ENGAGEMENT OF COUNTY TEAMS IN PREVENTION

County teams are vital partners in the work of child death prevention in Oregon. Using available data, the state team will make efforts to partner with county teams to identify, develop, and implement prevention efforts occurring both at a local level and statewide level.

LEGISLATION AND PUBLIC POLICY

The state team recognizes the limitations placed on some team members, such as their ability to participate in lobbying activities, because of their employment. The state team co-chairs, along with impacted team members, will ensure that state team actions are not in violation of such restrictions.

Despite restrictions, there are opportunities for many members to impact legislation and public policy through legislative concepts, policy option packages, and other means. Members are encouraged to reach out to the state team for potential partnership and support for such opportunities.

COORDINATION WITH OTHER REVIEWS

The state team will continue to explore opportunities to coordinate child death reviews with county teams and death reviews occurring as part of the ODHS Child Welfare's Child Fatality Prevention and Review program.

Additionally, the state team will make efforts to engage and learn from other death reviews in Oregon, including but not limited to domestic violence, sex trafficking, overdose, suicide, firearm, and maternal mortality and morbidity.

OUTPUTS

ANNUAL REPORT

The state team publishes an annual report regarding child death reviews conducted in Oregon. This report focuses on child death reviews known to the state team that occurred during the prior calendar year and is issued no later than 6 months after the end of the year. The annual report is provided to the Governor's Office and ODHS and OHA leadership. The report is published on the Oregon Child Death Review and Prevention web pages.

The report contains but is not limited to the following:

- The number of known child deaths for the applicable year.
- The manner and/or cause of death in such deaths.
- The age, gender, race, ethnicity, and geographic areas of child deaths for the applicable year.
- Identified local and statewide trends.
- The status of local and statewide prevention efforts stemming from current and previous annual reports.

ANNUAL CONFERENCE

The state team will host an annual (virtual or in-person) conference to enhance the work of the county teams and to offer an opportunity for networking and sharing of expertise between individuals conducting child death reviews within Oregon.

WEBSITE

The state team will maintain a webpage on the OHA website with child death review and prevention information and resources.

Resource and System Improvement Plan

Below is a list of resources and system improvements developed by the State Child Death Review and Prevention Team (state team) to address the needs identified by Oregon's county child death review teams (county teams) through participation in the county team needs assessment.

I. Resources

Resource	Done
Model job and task descriptions for County Team Lead and Coordinator	In process
Implement onboarding process for new team leads and coordinators.	Done
Onboarding packet and/or checklist for new county team members	In process
Set up role specific peer groups for (1) leads and coordinators and (2) based on team member professional role to: • share information about roles and responsibilities across counties • support onboarding of new members • provide peer support	In process
Procedural guide for preparing for and conducting child death review • Procedure for assigning and creating cases. Done • NCFRP guidance posted on website. Done • Add guidance about required reviews and contacting technical assistance if case does not meet criteria. Done • Add guidance on data quality/consistency controls. • Explore video of mock review. • Develop and post model protocol template.	In process
Information sharing and confidentiality quality practices and tools • Post confidentiality statutes on website. Done	In process

• Post links to major hospitals record request forms in toolkit on website.	
Training in multiple modalities • Post link to NCFRP trainings on website. Done • Create training calendar on website. Done (resources needed to keep current) • Consider accessibility and unique needs of audiences when rolling out trainings. Ongoing	Done
Trauma informed death review tools, training, and support • Designate section of in toolkit on website for trauma informed resources. Done • Post breathing exercise in toolkit on website. Done • Ensure link to Trauma Informed Oregon is on website. Done • Link to NCFRP trauma informed resources on website. Done	Done
Equitable death review tools, training, and support • Designate section in toolkit on website for equity resources. Done • Post grounding statement in toolkit on website. Done • Link to NCFRP trainings on website. Done • Roll out equity training for leads and coordinators. In process • Post resources in toolkit on website focused on equitable death review, including specific to American Indian and Alaska Native communities. Done	In process
Resources to support prevention efforts identified most by county teams • Acknowledge counties that complete prevention efforts. Ongoing • Discuss and document the state team response to all prevention recommendations documented in the case reporting system. Ongoing • Follow through with documented state team response. Ongoing	Done
Create opportunities for county team members to observe other county reviews. • Post county contact information on website. Done	In process

• Send a communication to county teams encouraging cross participation. • Encourage connection through peer support groups.	
Create opportunities to participate in state team meetings	Done
Virtual one-on-one or group support for county team members • State Technical Assistance Team member to offer support to county teams. Ongoing • Contact information for technical assistance detailed on website. Done	Done
State team contact assigned to each county team to provide support.	Done

II. System enhancements

Enhancement	Done
Re-develop OHA hosted Child Death Review and Prevention website to be a comprehensive resource hub for Oregon child death review, including connecting to National Center for Child Fatality Review and Prevention resources.	Done
Improve the data import from the State of Oregon Vital Statistics to the National Fatality Review Case Reporting System.	In process
Increase frequency of notifications to county teams regarding cases needing review.	Done
Make current contact list of county team leads and coordinators to county team leads accessible to county teams.	Done
Set up role specific peer groups for (1) leads and coordinators and (2) based on team member professional role to: o share information about roles and responsibilities across counties o support onboarding of new members o provide peer support	
Encourage and support county teams to convene regular meetings outside of case review to provide opportunities for learning, information sharing, and communication.	Done

Improve collaboration with and access to state level experts for consultation and support such as suicide, sleep related infant death, and overdose experts.	In process
Host annual statewide convening of county teams.	
Form implementation team comprised of community members and legislators for the purpose of implementing statewide improvement opportunities and prevention recommendations.	
Revise focus of state team to providing support to county teams, using county team death review data to identify patterns and opportunities for reducing preventable child deaths statewide, and providing information and recommendations to an implementation team. Clarify state team's role in Oregon's child death review and prevention system through creation of a state team charter.	Done

Oregon DHS QPR Suicide Prevention Training

Pre- and Post-Training Survey Data Report

July 1, 2020 through December 31, 2023

Highlights *(see following pages for more detail)*

Trainee Details

+ This quarter[1], **233 people** have completed either QPR[2] or QPR-CW[3]:
  - QPR – **233** completed
  - QPR-CW – **0** completed

+ Overall, **9,864 people** have completed either QPR or QPR-CW:
  - QPR – **8,905** completed
  - QPR-CW – **959** completed

+ **Districts** with the largest total numbers of trainees:

QPR[4]
- District 2 (Multnomah)– **922**
- District 8 (Jackson, Josephine) – **532**
- District 3 (Marion, Polk, Yamhill) – **499**

QPR-CW
- District 5 (Lane) – **112**
- District 16 (Washington) – **104**
- District 2 (Multnomah) – **101**

+ **Divisions** with the largest numbers of trainees:

QPR
- Office of Self Sufficiency Programs – **3,029**
- Office of Child Welfare – **1,701**
- Aging and People with Disabilities – **1,561**

QPR-CW
- Office of Child Welfare – **867**
- CW_SS District Administration – **45**
- Office of Self Sufficiency Programs – **14**

Knowledge of Suicide and Suicide Prevention Increased this Quarter[1]

+ An average of **72.6%** of respondents rated their knowledge of suicide and suicide prevention as "high" after the training, compared with **21.8%** before.
+ On average, **0.4%** of respondents rated their knowledge of suicide and suicide prevention as "low" after the training, compared with **23.3%** before.
+ **Every DHS program** represented in the survey data reported an **increase** in their knowledge of suicide and suicide prevention in all seven areas:
  - Facts concerning suicide prevention
  - Warning signs of suicide
  - How to ask someone about suicide
  - Persuading someone to get help
  - How to get help for someone
  - Information about resources for help with suicide
  - Understanding of suicide and suicide prevention

[1] July 1 thru December 31, 2023
[2] QPR Gatekeeper Training
[3] QPR Computer-Based Training for CW
[4] A total of 3,819 (39%) QPR trainees did not specify which district(s) they were affiliated with.

Comfort and Likeliness of Helping to Prevent Suicide this Quarter[5]

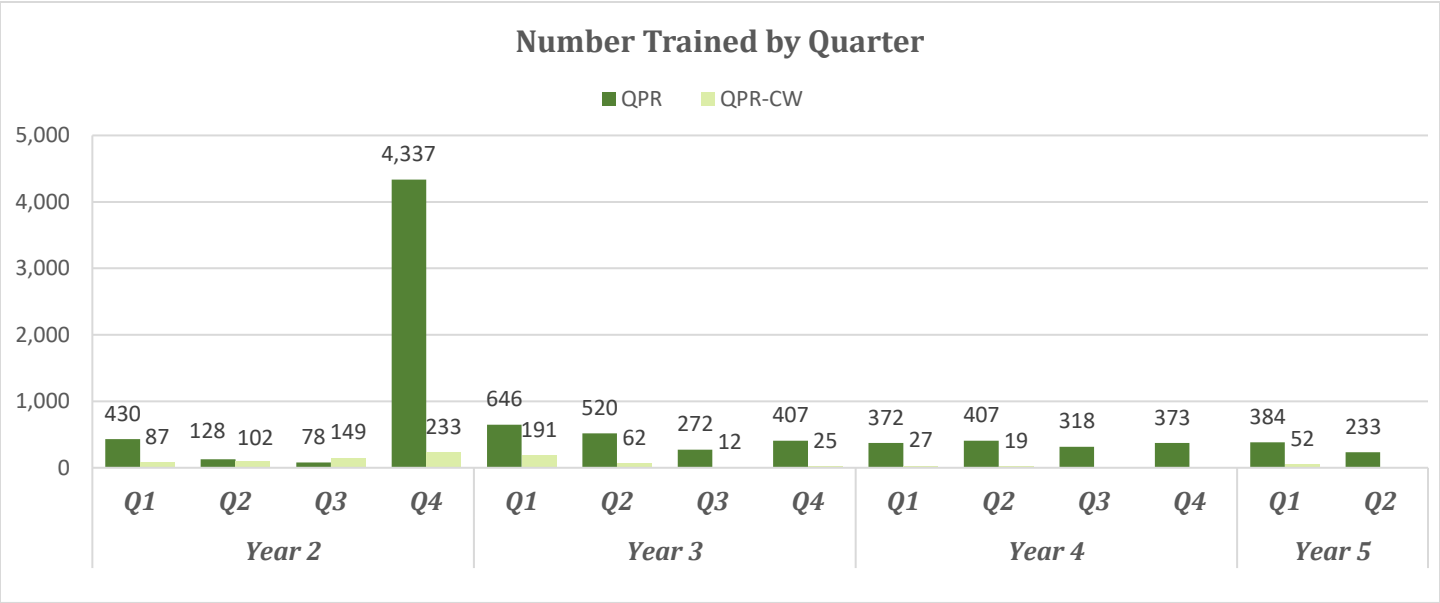
+ The percentage of trainees who **strongly agree** that *suicide is preventable* increased **66.7%**
+ Trainees who reported being **very comfortable** with *asking a person about suicide* increased **93.8%**
+ The percentage of trainees who are **very likely** to *ask someone exhibiting signs of suicide risk if they are thinking of suicide* increased **56.9%**
+ Trainees who reported being **very likely** to *intervene when someone is exhibiting signs of suicide risk* increased **4.2%**
+ The percentage of trainees who were **very likely** to *refer someone exhibiting signs of suicide risk to mental health or related services* increased **0.9%**

Trainee Impressions

+ A total of **85.3%** of respondents believe that this training will be very valuable to their work with children, adults, and families
+ Nearly three-quarters of trainees (**71.5%**) would be interested in a more comprehensive suicide prevention training

[5] July 1 thru December 31, 2023

Trainee Details



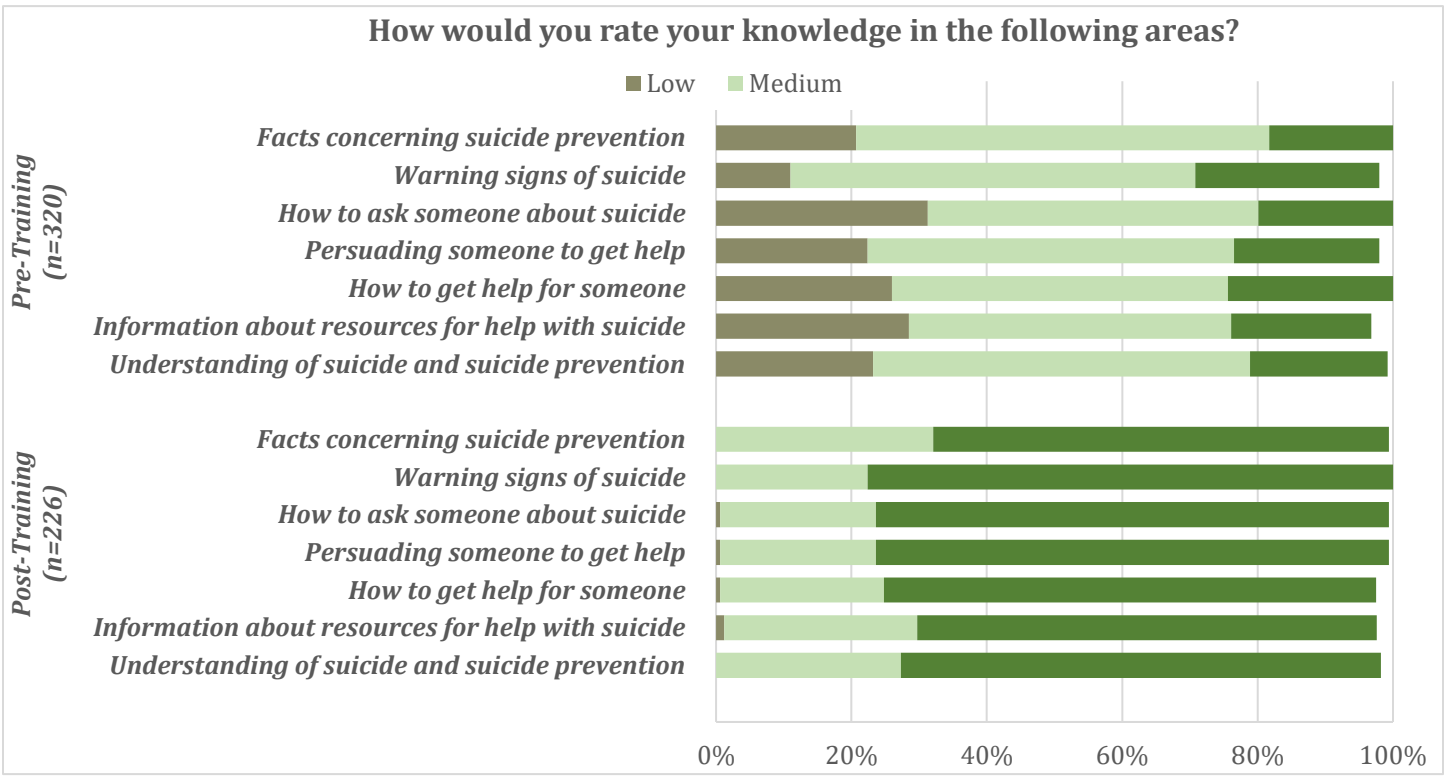
Total Number Trained

District	QPR Trainees		QPR-CW Trainees		Total Trainees	
1	159	1.8%	39	4.1%	198	2.0%
2	922	10.4%	101	10.5%	1,023	10.4%
3	499	5.6%	93	9.7%	592	6.0%
4	264	3.0%	55	5.7%	319	3.2%
5	300	3.4%	112	11.7%	412	4.2%
6	261	2.9%	29	3.0%	290	2.9%
7	237	2.7%	25	2.6%	262	2.7%
8	532	6.0%	94	9.8%	626	6.3%
9	82	0.9%	24	2.5%	106	1.1%
10	282	3.2%	51	5.3%	333	3.4%
11	210	2.4%	42	4.4%	252	2.6%
12	198	2.2%	10	1.0%	208	2.1%
13	132	1.5%	19	2.0%	151	1.5%
14	216	2.4%	44	4.6%	260	2.6%
15	316	3.5%	45	4.7%	361	3.7%
16	476	5.3%	104	10.8%	580	5.9%
Not Specified	3,819	42.9%	72	7.5%	3,891	39.4%
Total	***8,905***		***959***		***9,864***	

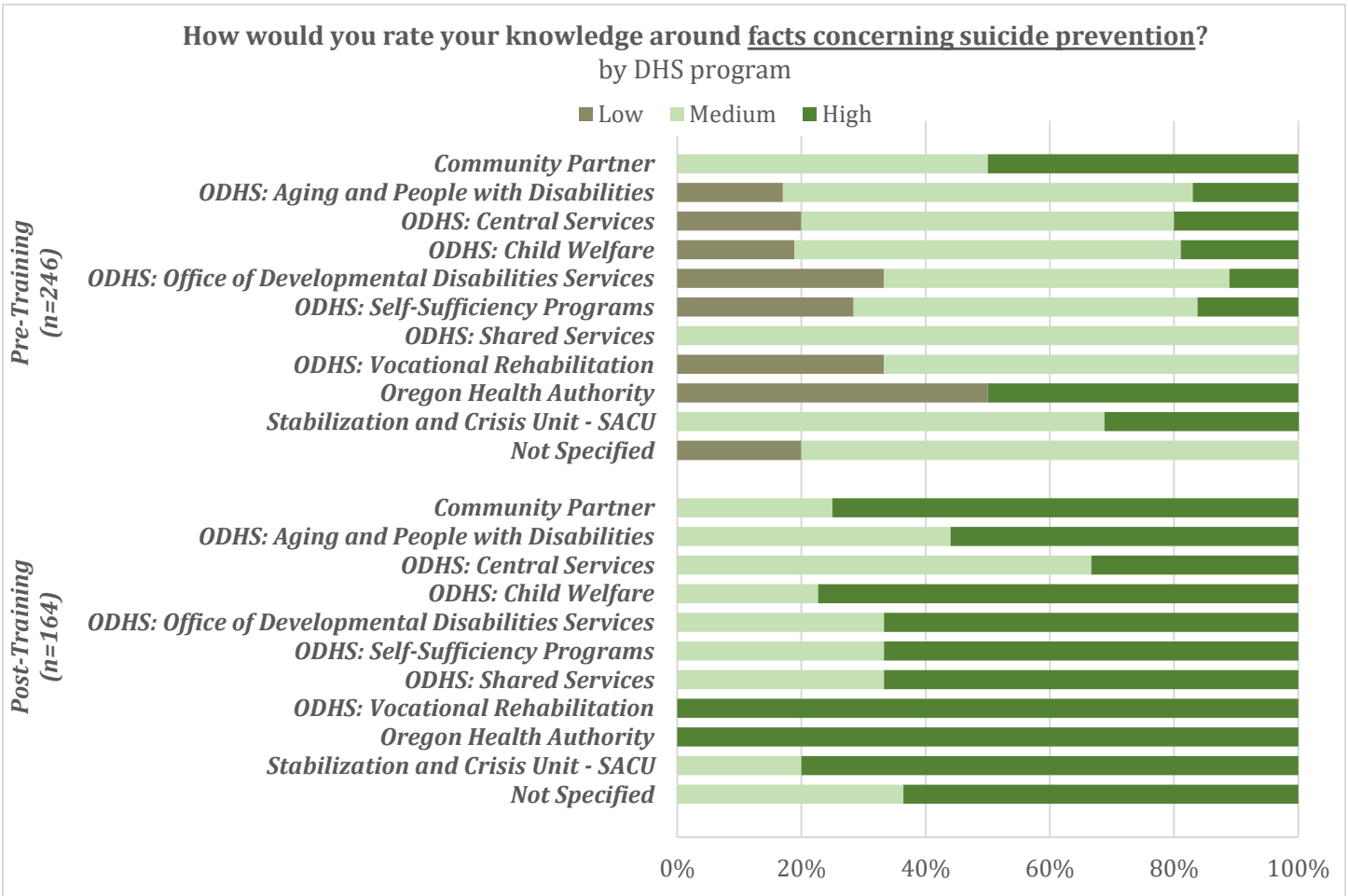
Division Title *Sorted in descending order by Total Trainees*	QPR Trainees		QPR-CW Trainees		Total Trainees	
Office of Self Sufficiency Programs	3,029	34.0%	14	1.5%	3,043	30.8%
Office of Child Welfare	1,701	19.1%	867	90.4%	2,568	26.0%
Aging and People with Disabilities	1,561	17.5%	2	0.2%	1,563	15.8%
Developmental Disabilities Services	780	8.8%	1	0.1%	781	7.9%
ODHS/OHA Shared Services	622	7.0%	5	0.5%	627	6.4%
DHS Central Services	255	2.9%	4	0.4%	259	2.6%
Office of Vocational Rehabilitation Services	231	2.6%	3	0.3%	234	2.4%
Not Current	163	1.8%	9	0.9%	172	1.7%
CW_SS District Administration	112	1.3%	45	4.7%	157	1.6%
Oregon Eligibility Program	43	0.5%	0	0.0%	43	0.4%
OHA Central Services	11	0.1%	0	0.0%	11	0.1%
Volunteer Program	4	0.0%	0	0.0%	4	0.0%
External Relations	1	0.0%	0	0.0%	1	0.0%
Juvenile Justice Information System	1	0.0%	0	0.0%	1	0.0%
Public Health	2	0.0%	0	0.0%	2	0.0%
DOJ Child Support	1	0.0%	0	0.0%	1	0.0%
Oregon State Hospital	0	0.0%	1	0.1%	1	0.0%
Oregon Youth Authority	0	0.0%	0	0.0%	0	0.0%
Unspecified	388	4.4%	8	0.8%	396	4.0%
Office of Self Sufficiency Programs	3,029	34.0%	14	1.5%	3,043	30.8%
Office of Child Welfare	1,701	19.1%	867	90.4%	2,568	26.0%
Total	***8,905***		***959***		***9,864***	

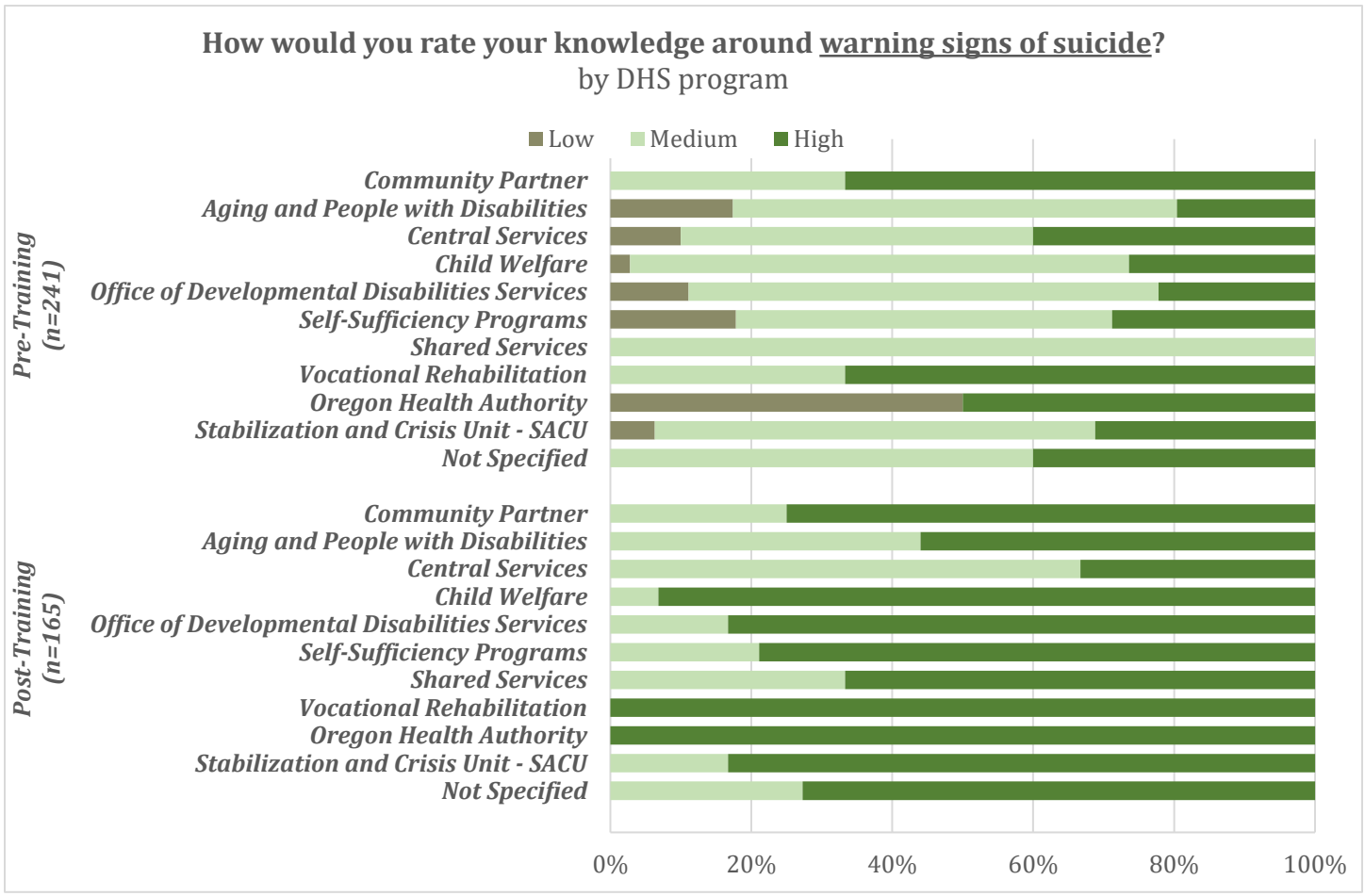
Knowledge of Suicide and Suicide Prevention this Quarter[6]

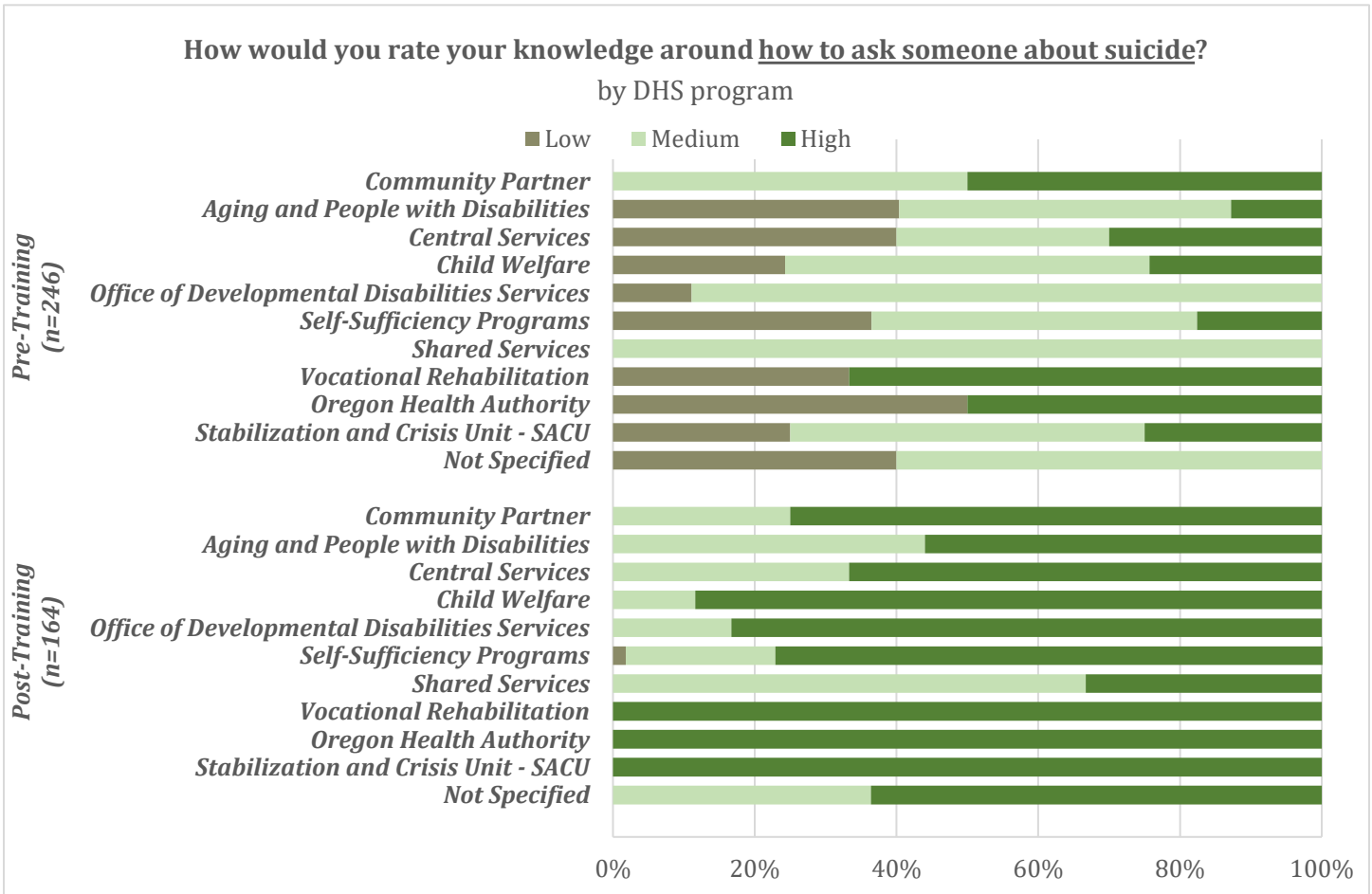
Overall



By DHS Program




How would you rate your knowledge around warning signs of suicide?
by DHS program
Low
Medium
High
Pre-Training (n=241)
Community Partner
Aging and People with Disabilities
Central Services
Child Welfare
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Vocational Rehabilitation
Oregon Health Authority
Stabilization and Crisis Unit - SACU
Not Specified
Post-Training (n=165)
Community Partner
Aging and People with Disabilities
Central Services
Child Welfare
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Vocational Rehabilitation
Oregon Health Authority
Stabilization and Crisis Unit - SACU
Not Specified
0%
20%
40%
60%
80%
100%


How would you rate your knowledge around how to ask someone about suicide?
by DHS program
Low
Medium
High
Pre-Training (n=246)
Community Partner
Aging and People with Disabilities
Central Services
Child Welfare
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Vocational Rehabilitation
Oregon Health Authority
Stabilization and Crisis Unit - SACU
Not Specified
Post-Training (n=164)
Community Partner
Aging and People with Disabilities
Central Services
Child Welfare
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Vocational Rehabilitation
Oregon Health Authority
Stabilization and Crisis Unit - SACU
Not Specified
0%
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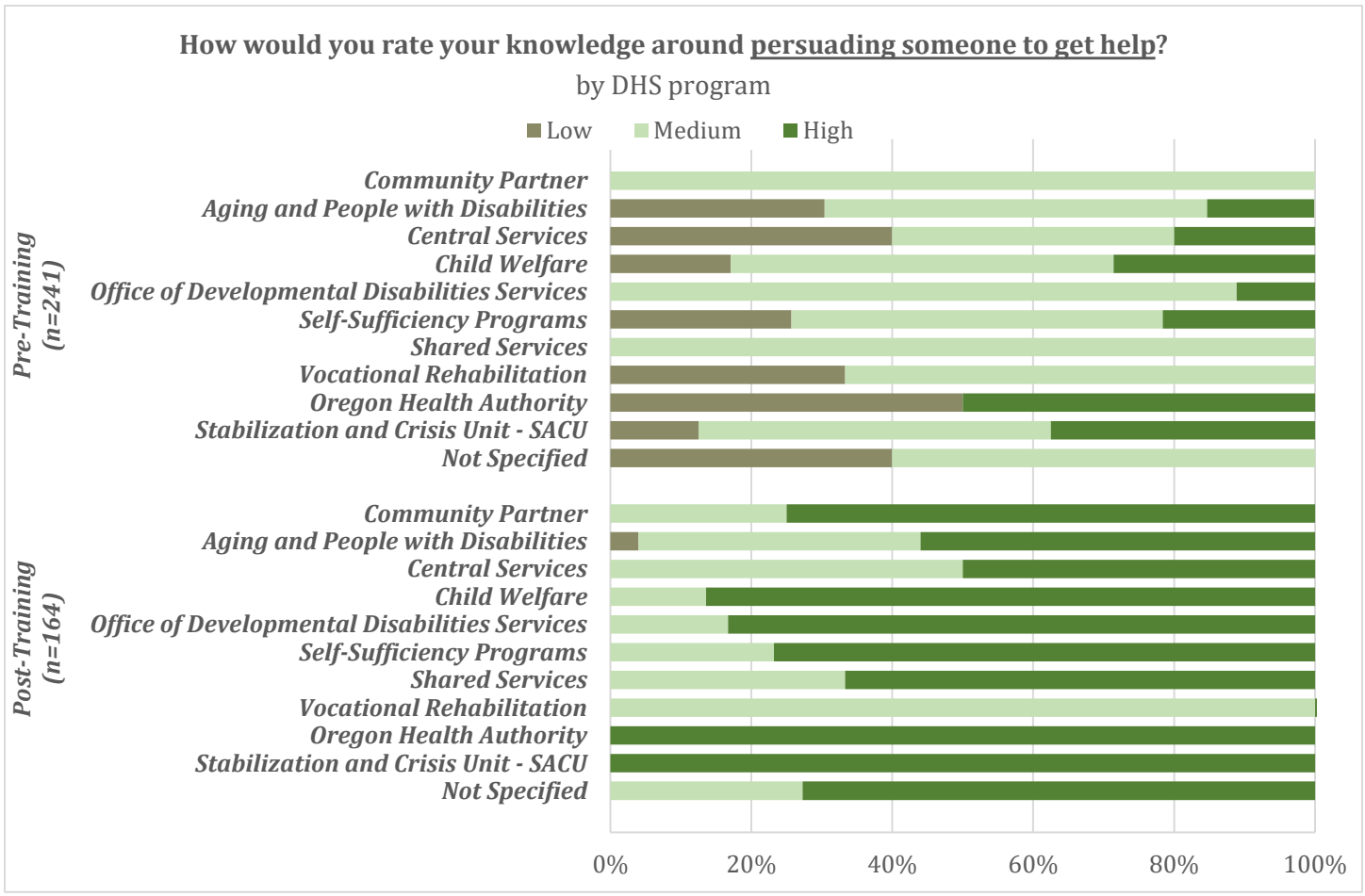
How would you rate your knowledge around persuading someone to get help?
by DHS program
Low
Medium
High
Pre-Training (n=241)
Community Partner
Aging and People with Disabilities
Central Services
Child Welfare
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Vocational Rehabilitation
Oregon Health Authority
Stabilization and Crisis Unit - SACU
Not Specified
Post-Training (n=164)
Community Partner
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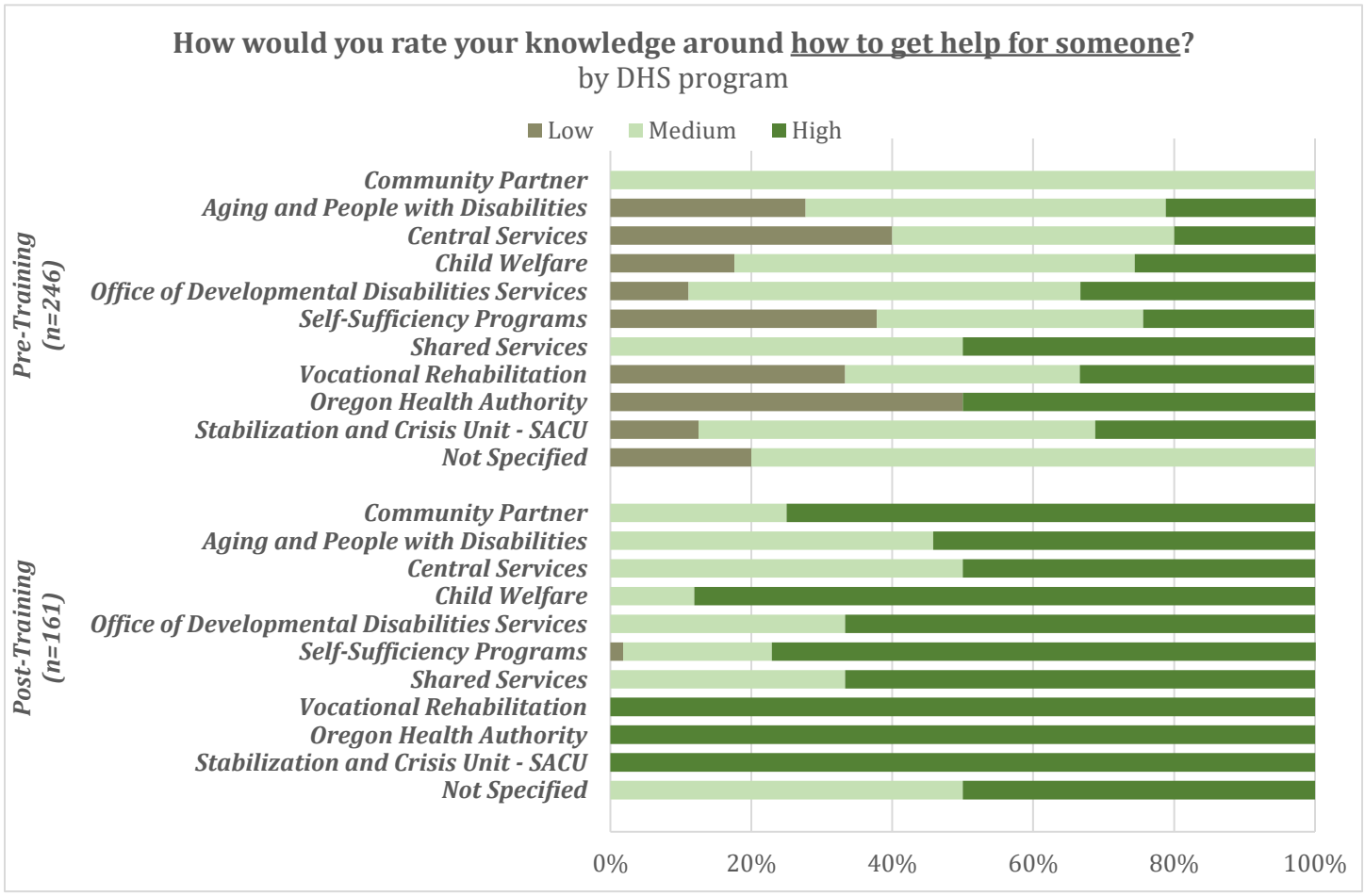
80%
100%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by DHS program
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Medium
High
Pre-Training (n=246)
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Child Welfare
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Vocational Rehabilitation
Oregon Health Authority
Stabilization and Crisis Unit - SACU
Not Specified
Post-Training (n=161)
Community Partner
Aging and People with Disabilities
Central Services
Child Welfare
Office of Developmental Disabilities Services
Self-Sufficiency Programs
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Vocational Rehabilitation
Oregon Health Authority
Stabilization and Crisis Unit - SACU
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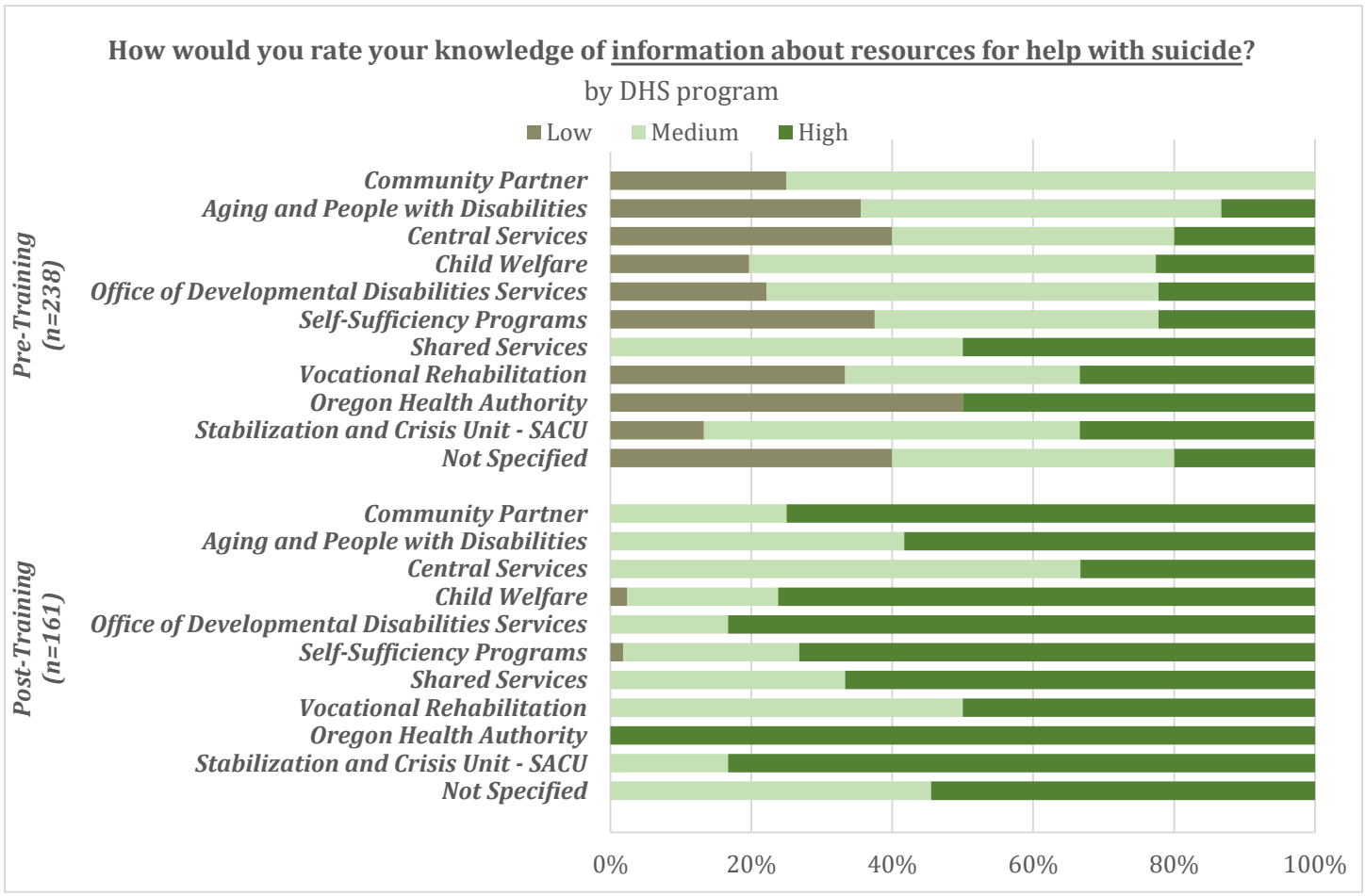
60%
80%
100%


How would you rate your knowledge of information about resources for help with suicide?
by DHS program
Low
Medium
High
Pre-Training (n=238)
Community Partner
Aging and People with Disabilities
Central Services
Child Welfare
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Vocational Rehabilitation
Oregon Health Authority
Stabilization and Crisis Unit - SACU
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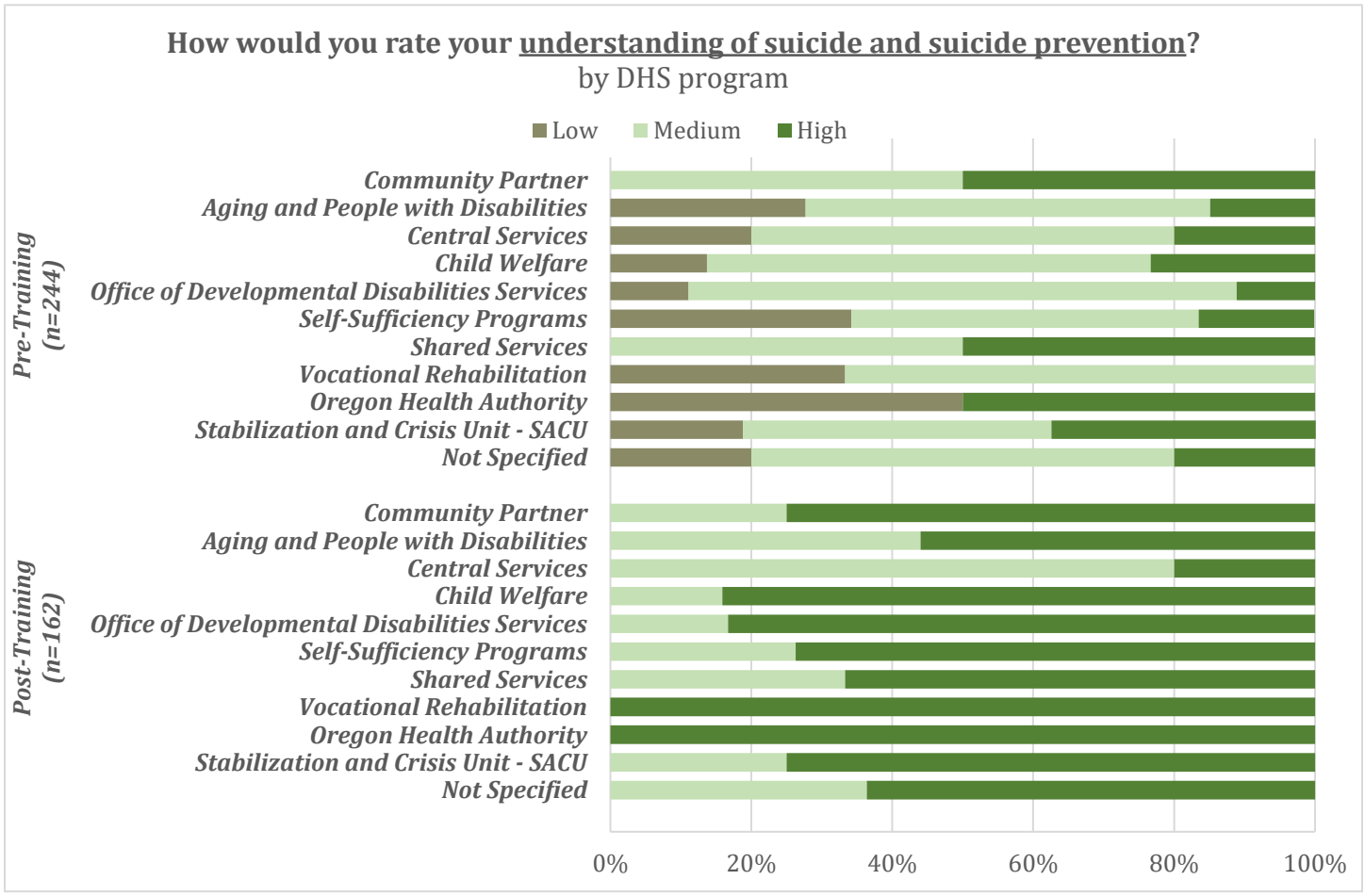
20%
40%
60%
80%
100%


How would you rate your understanding of suicide and suicide prevention?
by DHS program
Low
Medium
High
Pre-Training (n=244)
Community Partner
Aging and People with Disabilities
Central Services
Child Welfare
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Vocational Rehabilitation
Oregon Health Authority
Stabilization and Crisis Unit - SACU
Not Specified
Post-Training (n=162)
Community Partner
Aging and People with Disabilities
Central Services
Child Welfare
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Vocational Rehabilitation
Oregon Health Authority
Stabilization and Crisis Unit - SACU
Not Specified
0%
20%
40%
60%
80%
100%

Comfort and Likeliness of Helping to Prevent Suicide

How much do you agree or disagree that suicide is preventable?	Pre-Training		Post-Training		Percent Change
Strongly Agree	51	21%	85	52%	67%
Agree	131	54%	61	37%	-53%
Neutral	53	22%	15	9%	-72%
Disagree	2	1%	1	1%	-50%
Strongly Disagree	4	2%	1	1%	-75%
Total	***241***		***163***		

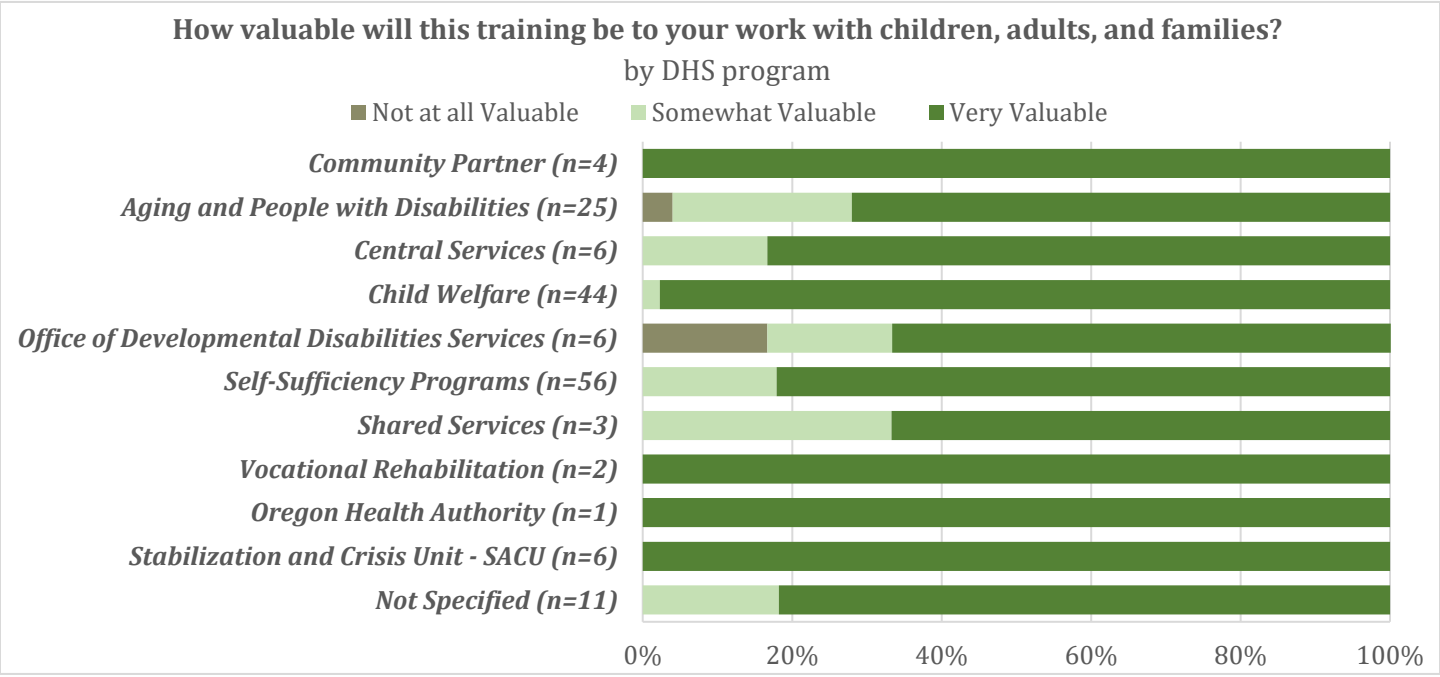
How comfortable are you with asking a person about suicide?	Pre-Training		Post-Training		Percent Change
Very Comfortable	32	13%	62	38%	94%
Comfortable	130	53%	88	54%	-32%
Uncomfortable	76	31%	13	8%	-83%
Very Uncomfortable	6	3%	0	0%	-100%
Total	***244***		***163***		

How likely are you to ask someone exhibiting signs of suicide risk if they are thinking of suicide?	Pre-Training		Post-Training		Percent Change
Very Likely	58	24%	91	56%	57%
Likely	155	64%	68	42%	-56%
Unlikely	29	12%	3	2%	-90%
Very Unlikely	2	1%	0	0%	-100%
Total	***244***		***162***		

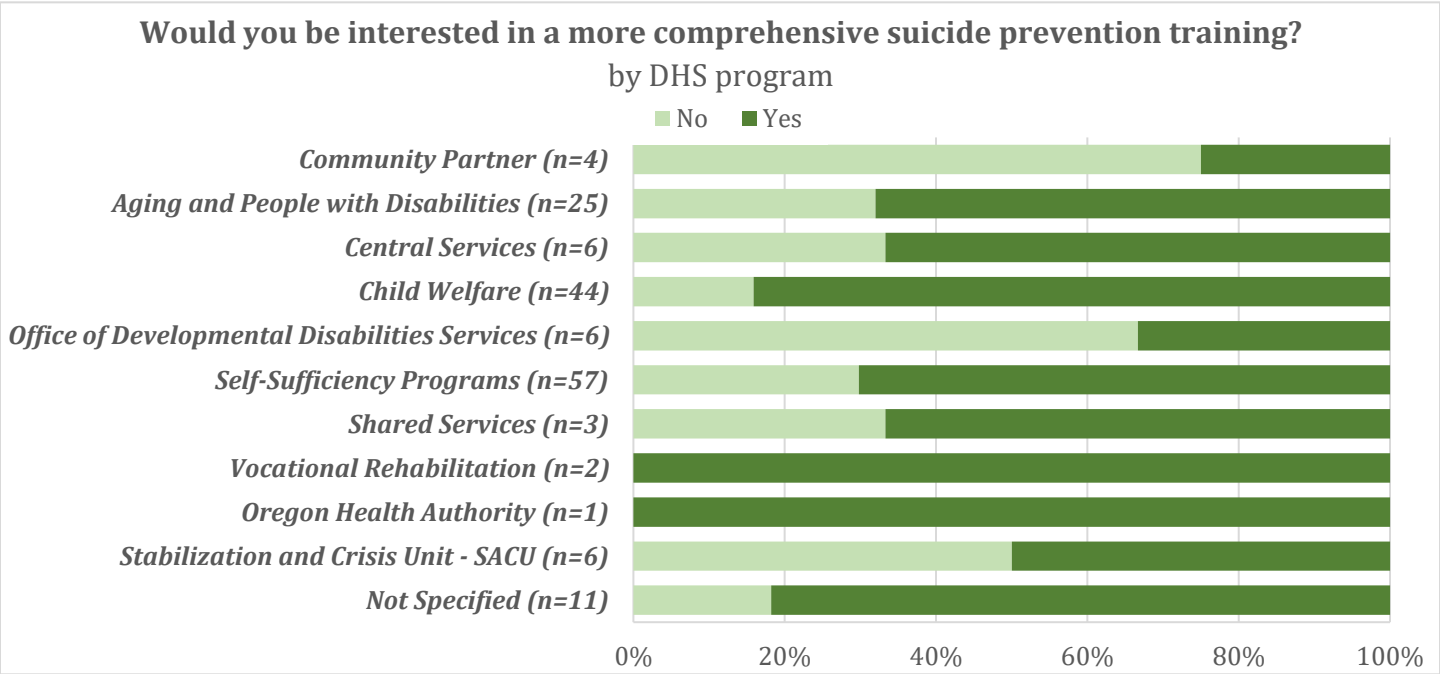
How likely are you to intervene when someone is exhibiting signs of suicide risk?	Pre-Training		Post-Training		Percent Change
Very Likely	96	39%	100	61%	4%
Likely	138	57%	62	38%	-55%
Unlikely	9	4%	1	1%	-89%
Very Unlikely	1	0%	1	1%	0%
Total	***244***		***164***		

How likely are you to refer someone exhibiting signs of suicide risk to mental health or related services?	Pre-Training		Post-Training		Percent Change
Very Likely	113	46%	114	70%	1%
Likely	121	49%	47	29%	-61%
Unlikely	10	4%	3	2%	-70%
Very Unlikely	1	0%	0	0%	-100%
Total	***245***		***164***		

Training Value



Interest in More Comprehensive Training



Child Fatality Prevention & Review Program
Executive Summary (Updated Dec. 2022)

Course Title: Assessing Patterns and Behaviors of Neglect

Target Audience: Child Welfare Supervisors, CTS, Regional ICWA Specialists and SSS1s with one or more years of casework experience

Outline of Training:
This advanced course was adapted for Oregon in partnership with the Butler Institute for Families[i]. The course uses Problem-Based Learning[ii] to guide participants toward a deeper understanding of the circumstances that give rise to neglect as well as strength-based approaches to addressing neglect. This course compels learners to explore their own life experiences and how those experiences influence perceptions of neglect and decision-making. Participants are introduced to the decision-making ecology and the socio-ecological framework, both of which help identify how bias and systemic oppression play a role in the ways we respond to families and how families access support and resources in their communities. The course is two days with some pre-class work. Each session is limited to 30 participants and is facilitated by two Child Welfare consultants or coordinators. The course uses Padlet[iii] to engage learners through technology.

- Pre-Class Work: One week prior to the session, a facilitator organizes the participants into four groups and sends each group an email with reading and activities to complete in preparation for the course. The work consists of reading about and completing a personal ACEs questionnaire, as well as reading case study materials. Learners are also provided a link to the course Padlet, which is a virtual learning library that participants have access to even after they complete the course.
- Day 1: The first day of the course will introduce the decision-making ecology and engage learners in exploring the factors that impact practice with families. This lays the groundwork for expanding conversations throughout the course about the intersection of race, socio-economic status and gender in child welfare work and in particular reports of neglect. The course then introduces the protective factors[iv] and the learners have an opportunity to apply learning to their case studies. The afternoon transitions to identification of risk factors for neglect and concludes with a timelining activity.
- Day 2: The second day guides learners through identification of the impacts of neglect on children, relating examples from the case study to understand the chronicity of neglect and increasing developmental impacts to children. In the afternoon, the course pivots to identifying coaching in cases of neglect as a means to support self-reflection and skill development. Learners then participate in group supervision using their case study. The day finishes with exploration of supports and resources to engage families.

Learning Objectives for Participants:

1. Learners will know how the decision-making ecology manifests in practice with families.

- Explain how personal experiences, biases, judgments, and other preconceived notions may influence decision-making.
- Describe the decision-making ecology.
- Explain the impact of cultural factors on decision-making.
- Describe the impact of differences in safety thresholds.

2. Learners will be able to identify and assess for protective factors with families and will understand how they minimize the likelihood of maltreatment.
   - Identify the protective capacities domains.
   - List the 6 protective factors.
   - Explain how Oregon's six assessment domains within Oregon's safety model are embedded in the protective factors as part of Oregon's safety assessment.
   - Explain how protective capacities and factors minimize the likelihood of maltreatment.
   - Explain strategies workers can use to assess protective capacities and factors and identify risk factors for neglect.
   - Demonstrate techniques for engaging family members about issues related to neglect.
   - Explain factors that contribute to determining if a finding is warranted in a case.

3. Learners will develop an understanding of the consequences of neglect and the contributing factors.
   - Explain how neglect manifests in families involved in Oregon's child welfare system.
   - Explain the intersection of race, gender and socio-economic status and how systemic oppression impacts reports of neglect.
   - Demonstrate techniques for engaging family members about issues related to neglect.
   - Demonstrate how to time-line a case using a case example.

4. Learners will be able to describe the consequences of neglect and contributing parental factors increasing the likelihood of neglect.
   - Describe types of parental behaviors that are a risk factor for neglect.
   - Identify the long-term impact of chronic neglect on child development.
   - Examine cultural factors and their impact on parenting behaviors in a case scenario.
   - Differentiate between chronic and escalating neglect.
   - Identify and assess for increasing impact of neglect on child development in case scenario.

5. Learners will be able to demonstrate and utilize coaching strategies to be used across settings.
   - Describe how coaching skills can be used to support self-reflection and skill development.
   - Differentiate powerful coaching questions within supervision and for use with families.
   - Reflect issues of racial equity in coaching conversations.

6. Learners will be able to demonstrate how to conduct a group supervision based upon a case scenario.
    - Explain the structure of a group supervision to maximize the collective thinking of a team.
    - Demonstrate facilitation techniques to promote critical thinking from the group.
    - Demonstrate how to use coaching questions to prepare workers for presenting cases in group supervision.
    - Describe approaches for drawing out cultural issues when engaging families.

7. Learners will demonstrate how to determine the most appropriate set of supports and interventions to engage the family to mitigate safety concerns and/or reduce ongoing risk to the children.
    - Select community resources and/or natural supports to strengthen the family.
    - Describe culturally relevant services for the family.
    - Demonstrate how to identify resources with the family.
    - Demonstrate crucial conversations with the family to promote the safety of the children.

Ways that the Participants can support Transfer of Learning from the classroom to the job:

BEFORE the training:

- Think about how you are willing to show up differently these two days.
- Review materials and learning objectives and identify ways you would like this experience to enhance your skills.
- Ensure you have coverage and will not need to be contacted during the training hours.

AFTER Days 1 and 2:

- Bookmark and set aside time to review the materials provided through the Padlet to support continued learning.
- Work with others in your unit to expand your examination of ways in which history, culture, laws and policies, economics, and power impact marginalized groups through the accumulation of disadvantages that affect experience and service opportunities for children and families.
- Practice timelining, using different methods of information gathering and engagement.
- Work with a consultant or CTS to arrange group supervision, utilizing tools provided in the course and setting an intention to focus on protective factors.
- Practice intentional documentation that is rooted in identification of protective factors and evaluation of developmental impacts to children.

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[i] https://socialwork.du.edu/butler

[ii] Marra, R., Jonassen, D. H., Palmer, B., & Luft, S. (2014). Why problem-based learning works: Theoretical foundations. Journal on Excellence in College Teaching, 25(3&4), 221-238.

[iii] https://padlet.com/OregonDHS_CW_SafetyProgram/OAPBN

[iv] https://www.childwelfare.gov/pubs/issue-briefs/protective-factors/

Acknowledgements

A special thanks to the team from the Oregon Early Learning Division and the BUILD Initiative for their work in support of *Raise Up Oregon*, particularly those who served as primary planners, developers and authors of the plan: Alyssa Chatterjee, David Mandell, Sara Mickelson, Carey McCann, and Harriet Dichter.

Suggested citation

Oregon Early Learning Council. (2019). *Raise Up Oregon: A Statewide Early Learning System Plan 2019-2023*. Salem, OR: Oregon Early Learning Division.

For more information

Raise Up Oregon: A Statewide Early Learning System Plan 2019-2023,
https://oregonearlylearning.com/raise-up-oregon

https://oregonearlylearning.com/

Contact us

early.learning@state.or.us

OREGON DEPARTMENT OF EDUCATION
EARLY LEARNING DIVISION

CONTENTS

EXPLANATION OF SYMBOLS

This symbol is next to strategies with a focus on infants and toddlers.

Existing state plans and *Raise Up Oregon* have shared strategies, as indicated by the following symbols:

Aligns with Department of Human Services 2016-2019 Self Sufficiency Programs (SSP) Strategic Plan, SSP Fundamentals Map and Child Welfare Action Plan

Aligns with Oregon Department of Education 2017-2019 Strategic Plan.[i]

Aligns with Early Learning Division's Child Care Supply and Quality; Preschool and Kindergarten Readiness; Community-based and Family Supports; and Workforce Quality, and with ELD Policy Option Packages (POP) and Legislative Concepts (LC) 2019-2021.

Aligns with Oregon Health Authority State Health Improvement Plan,[ii] the Public Health Division Maternal and Child Health Section 2018 Strategic Plan,[iii] and CCO 2.0 Recommendations of the Oregon Health Policy Board.[iv]

Aligns with Oregon Housing and Community Services 2019 Statewide Housing Plan.

Aligns with Governor's Agenda, e.g., Health Care for All: Sustaining the Oregon Model of Health Care Coverage, Quality, and Cost Management; Education Policy Agenda: Every Oregon Student Engaged, Empowered, and Future Ready; Housing Policy Agenda: Housing Stability for Children, Veterans, and the Chronically Homeless and Increased Housing Supply for Urban and Rural Communities; Child Welfare Policy Agenda: Protecting Children, Supporting Families and Ending the Cycle of Poverty; and The Children's Agenda: Pathways Out of Poverty for Children to Achieve Their Full Potential.[v]

KATE BROWN
GOVERNOR

January 1, 2019

Dear Early Learning Stakeholders:

As you know, the first few years of a child's life have a powerful impact on their future, and, as a result, the future of our state. It is essential for the state and local communities to do all that we can to provide support for the more than 43,000 children born each year in Oregon and their families.

That is why, over a year ago, I asked Miriam Calderon, Early Learning System Director, and Sue Miller, Early Learning Council Chair, to prepare a statewide prenatal to age five early learning plan. I envisioned this plan as a roadmap to ensure all children enter school ready to learn, especially those children who have been historically underserved, including those living in rural areas, communities of color, and low-income communities.

I am pleased to share that plan with you today, entitled *Raise Up Oregon: A Statewide Early Learning System Plan*. To create this plan, the Early Learning Council engaged hundreds of diverse stakeholders over the past year. Council members listened to families and received input from professionals working in early learning across our state. They have delivered a plan that demonstrates a solid understanding of our challenges and the best path forward to ensure a brighter future for our youngest Oregonians. This plan responds to what we know from science, economics, and experience about how to best address root causes and meet the needs of Oregon's youngest children and their families.

Raise Up Oregon: A Statewide Early Learning System Plan builds on our successes, calls for bolder action in the areas where we must do more, and, importantly, it recognizes that it takes collaborative problem solving across sectors to do better by our youngest children. The plan is bolstered by the expertise and commitment of families and of those working in early care and education, health, housing and community development, human services, and K-12 education, and its solutions engage all of these sectors to take action.

I commend the members of the Early Learning Council for the development of this plan. In addition, the development of this plan would not have been possible without the support of key philanthropic partners in early learning. My thanks to The Ford Family Foundation, Bill & Melinda Gates Foundation, Lora and Martin Kelley Family Foundation, Oscar G. & Elsa S. Mayer Family Foundation, Meyer Memorial Trust, James F. and Marion L. Miller Foundation, Oregon Community Foundation, J.B. and M.K. Pritzker Family Foundation, and Thrasher Family Fund of the Oregon Community Foundation for their financial support and for their ongoing commitment to early childhood.

I am proud to share this plan with you, and I look forward to working together to move it from plan to reality.

Sincerely,

Kate Brown

Governor Kate Brown

254 STATE CAPITOL, SALEM OR 97301-4047 (503) 378-3111 FAX (503) 378-8970
WWW.GOVERNOR.OREGON.GOV

RAISE UP OREGON AT-A-GLANCE

SYSTEM GOAL 1: CHILDREN ARRIVE READY FOR KINDERGARTEN

OBJECTIVE 1: Families are supported and engaged as their child's first teachers.

Strategy 1.1 Expand parenting education and family supports.

Strategy 1.2 Scale culturally responsive home visiting.

OBJECTIVE 2: Families have access to high-quality (culturally responsive, inclusive, developmentally appropriate) affordable early care and education that meets their needs.

Strategy 2.1 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable infant-toddler early care and education that meets the needs of families.

Strategy 2.2 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable preschool that meets the needs of families.

Strategy 2.3 Strengthen child care assistance programs.

Strategy 2.4 Build the state's capacity to ensure children are healthy and safe in child care.

Strategy 2.5 Improve the essential infrastructure for high-quality early care and education.

OBJECTIVE 3: The early care and education workforce is diverse, culturally responsive, high quality and well compensated.

Strategy 3.1 Improve professional learning opportunities for the full diversity of the early care and education workforce.

Strategy 3.2 Build pathways to credentials and degrees that recruit and retain a diverse early care and education workforce.

Strategy 3.3 Compensate and recognize early childhood educators as professionals.

Strategy 3.4 Improve state policy to ensure early care and education work environments guarantee professional supports.

OBJECTIVE 4: Early childhood physical and social-emotional health promotion and prevention is increased.

Strategy 4.1 Ensure prenatal-to-age-five health care services are comprehensive, accessible, high quality, and culturally and linguistically responsive.

Strategy 4.2 Increase capacity to provide culturally responsive social-emotional supports for young children and their families.

Strategy 4.3 Increase and improve equitable access to early childhood oral health.

Strategy 4.4 Strengthen coordination among early care and education, health, and housing to promote health and safety for young children.

OBJECTIVE 5: Young children with social-emotional, developmental, and health care needs are identified early and supported to reach their full potential.

Strategy 5.1 Ensure adequate funding of and access to a range of regional and community-based services, including Early Intervention/Early Childhood Special Education services.

Strategy 5.2 Continue to prioritize screening through the health system and build pathways from screening to a range of community-based services and supports for children and families.

Strategy 5.3 Prevent expulsion and suspension by strengthening state policies and supports to early care and education programs.

OBJECTIVE 6: Children and families experience supportive transitions and continuity of services across early care and education and K-12 settings.

Strategy 6.1 Establish shared professional culture and practice among early care and education and K-3 that supports all domains, including social-emotional learning.

Strategy 6.2 Improve the Oregon Kindergarten Assessment to better support decision-making between early learning and K-12 stakeholders.

SYSTEM GOAL 2: CHILDREN ARE RAISED IN HEALTHY, STABLE, AND ATTACHED FAMILIES

- **OBJECTIVE 7: Parents and caregivers have equitable access to support for their physical and social-emotional health.**

  Strategy 7.1 Increase equitable access to reproductive, maternal, and prenatal health services.

  Strategy 7.2 Improve access to culturally and linguistically responsive, multi-generational approaches to physical and social-emotional health.

- **OBJECTIVE 8: All families with infants have opportunities for connection.**

  Strategy 8.1 Create a universal connection point for families with newborns.

  Strategy 8.2 Provide paid family leave.

- **OBJECTIVE 9: Families with young children who are experiencing adversity have access to coordinated and comprehensive services.**

  Strategy 9.1 Expand and focus access to housing assistance and supports for families with young children.

  Strategy 9.2 Provide preventive parenting support services to reduce participation in the child welfare system.

  Strategy 9.3 Improve the nutritional security of pregnant women and young children, particularly infants and toddlers.

  Strategy 9.4 Link high-quality early care and education, self-sufficiency, and housing assistance programs.

SYSTEM GOAL 3: THE EARLY LEARNING SYSTEM IS ALIGNED, COORDINATED, AND FAMILY CENTERED

- **OBJECTIVE 10: State-community connections and regional systems are strengthened.**

  Strategy 10.1 Ensure family voice in system design and implementation.

  Strategy 10.2 Ensure family-friendly referrals.

  Strategy 10.3 Further develop the local Early Learning Hub system.

- **OBJECTIVE 11: Investments are prioritized in support of equitable outcomes for children and families.**

  Strategy 11.1 Ensure resources are used to reduce disparities in access and outcomes.

  Strategy 11.2 Align and expand funding opportunities for culturally specific organizations.

- **OBJECTIVE 12: The alignment and capacity of the cross-sector early learning workforce is supported.**

  Strategy 12.1 Support consistent, high-quality practice among all professionals in the family- and child-serving early learning workforce.

  Strategy 12.2 Improve cross-sector recruitment, retention, and compensation.

- **OBJECTIVE 13: The business and philanthropic communities champion the early learning system.**

  Strategy 13.1 Educate business leaders on the economic value of early care and education to the Oregon economy.

  Strategy 13.2 Introduce business leaders to the science of early childhood development and the impact of public investment.

- **OBJECTIVE 14: The data infrastructure is developed to enhance service delivery, systems building, and outcome reporting.**

  Strategy 14.1 Strengthen data-driven community planning.

  Strategy 14.2 Integrate early learning data into the Statewide Longitudinal Data System.

  Strategy 14.3 Develop and implement a population survey to track the well-being of children and families across Oregon.

  Strategy 14.4 Create and use an early learning system dashboard to create shared cross-sector accountability for outcomes for young children and their families.

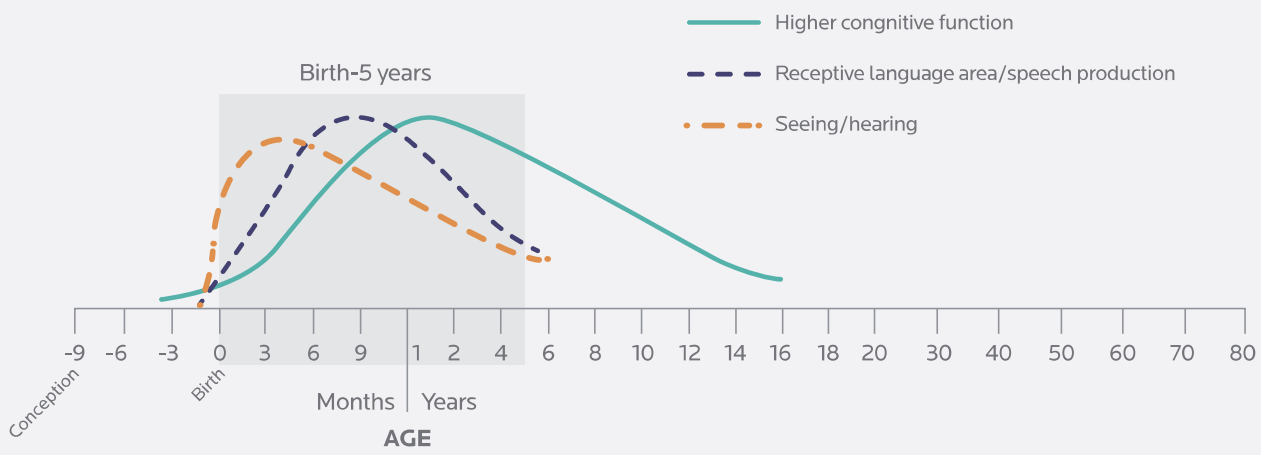
INVESTING IN OREGON'S YOUNG CHILDREN: MULTI-SECTOR SOLUTIONS GROUNDED IN SCIENCE AND EQUITY

Oregon is home to over 275,000 children, birth to kindergarten entry.[vi] Our state has an opportunity to change how it supports these children and their families and, in doing so, put itself on the path to an even brighter future. Overwhelming evidence tells us that investing in young children and their families has a lasting, positive impact across their lifetime. *Raise Up Oregon: A Statewide Early Learning System Plan* is grounded in the science of child development, equity, and a firm understanding that it takes leaders from early care and education, K-12, health, housing, and human services—together with families, communities, and the public and private sectors—to work together during this critical period of children's lives.

Brain science makes clear that the first 2,000 days of a child's life – the time between birth and kindergarten entry – represent the most consequential period in human development. From birth to age three, a child's brain makes one million new neural connections every second. The rapid pace of synapse formation in the brain sets the architecture for future health and learning. During this time, children are establishing critical attachment to caregivers as well as learning to communicate with others and regulate their emotions. The quality of their relationships, experiences, and interactions matters greatly.

The science of child development underscores the importance of the first 2,000 days of childhood.

Figure 1. Synapse formation in the developing brain[vii]

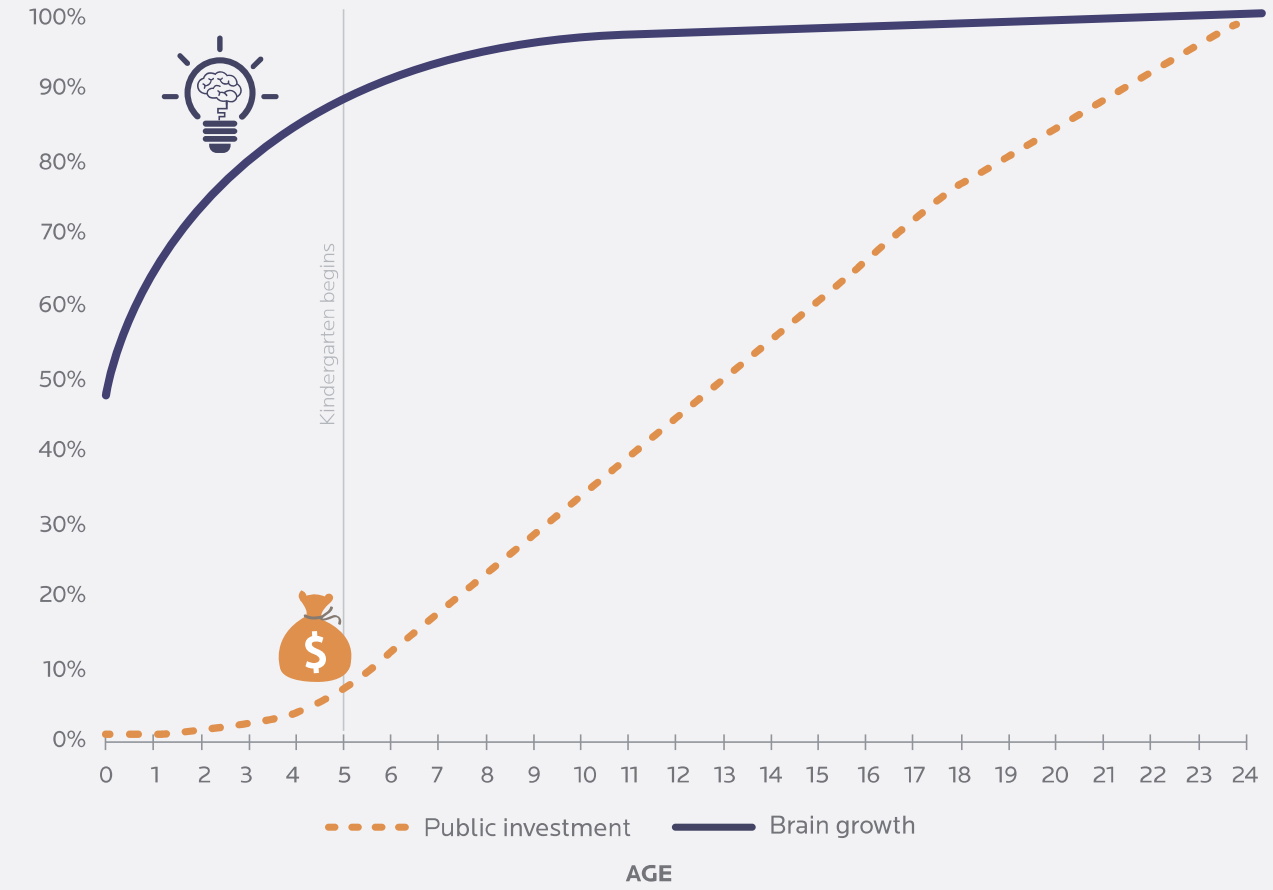


When we address the learning and development needs of young children, the economic returns not only benefit children and families, but society at large. Scientists at the RAND Corporation reviewed 115 early childhood programs, and 102—or nearly 90%—had a positive effect on at least one child outcome, such as behavior and emotion, language, cognitive achievement, child health, and kindergarten readiness. Researchers also found a reduction in child welfare involvement and crime-related behaviors.[viii] The RAND review showed that among programs with an economic evaluation, the typical return is $2 to $4 for every dollar invested. These findings are associated with improved adult outcomes, including higher likelihood of high school and college completion, increased earnings and workforce participation, and better health.

The evidence notwithstanding, less than 10% of Oregon's combined federal and state investment in children's education occurs before age five. The state investments from cradle to career accrue gradually in the first five years and increase rapidly once a child enters kindergarten. This is the antithesis of an approach that would be consistent with the brain science. By kindergarten entry, the brain has matured, reaching 90% of its adult size; however, most of the public investments in education are made after this point.

Invest early to get the best return on public investment.

Figure 2. Oregon's cumulative per child public education investment compared to child brain growth[ix]



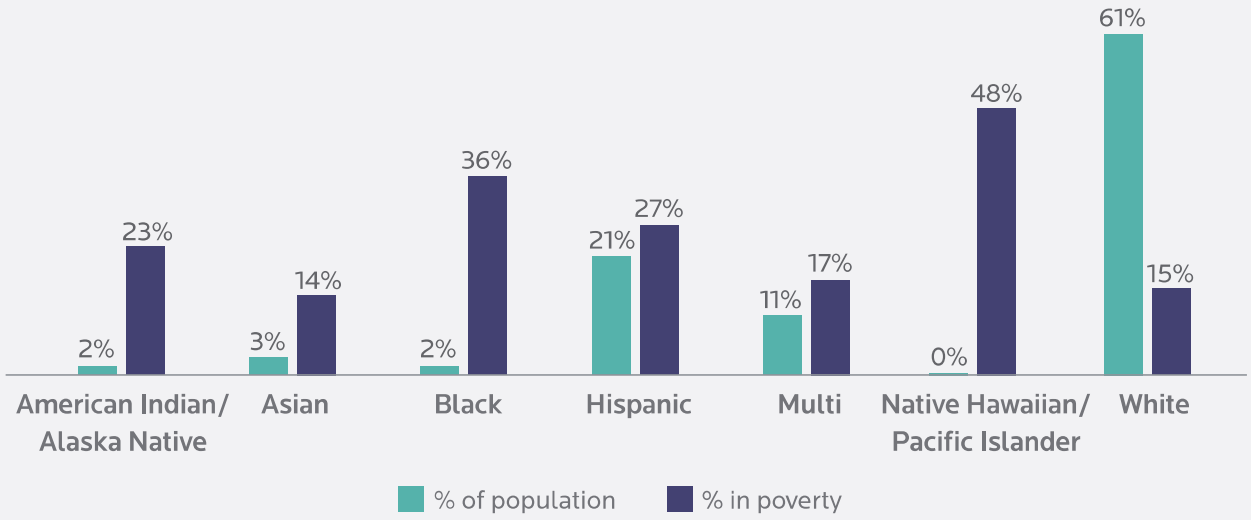
While these years represent a remarkable period of opportunity, they are also a period of intense vulnerability. Adverse conditions, such as inadequate nutrition and housing, exposure to toxic substances, poor maternal health, or a lack of appropriate early experiences and nurturing relationships have a lasting detrimental effect on the developing brain, even if a child's circumstances are improved later in childhood.

Oregon's equity lens helps us understand that adversity in early childhood is rooted in chronic and persistent opportunity gaps. Income, race, and zip code are powerful predictors of whether children and their families experience the conditions that are optimal for young children's development, including access to high-quality child care and preschool. Breaking the link between these inherited factors and life outcomes can only happen if we change the circumstances of families, which means changing the distribution of opportunities in those years.

This will require addressing the economic well-being of families with young children, and recognizing that income is closely linked with race and geography. Nearly 50,000 young children in Oregon live in poverty, which means their families earn below $20,780 for a family of three. More than one in five children in rural Oregon live in poverty, with children of color disproportionately represented among them.

Racial and economic disparities emerge early.

Figure 3. Oregon children under 5: percent of population and percent in poverty by racial/ethnic groups[x]



In order to address early adversity and opportunity gaps, we must develop comprehensive solutions that recognize that the lives of young children and families are influenced by many factors, including stable housing, consistent health care, and affordable, high-quality early care and education. We must also find new ways to work with community partners and – particularly – communities of color, as well as adequately fund the programs in our state that are designed to support these communities that have been historically marginalized and underserved. Early care and education, K-12, health, housing, and human services—together with families, communities, and the public and private sectors—are all needed to drive positive change for Oregon's youngest children and families.

DEVELOPING *RAISE UP OREGON:* THE APPROACH TO STRATEGIC PLANNING

The Early Learning Council serves as the governing body for Oregon's comprehensive early learning system at the state level. Its composition includes the directors of the five state agency partners and key early learning professionals representing the diversity of the state. The Early Learning Council is statutorily charged with overseeing the early learning system and the services it delivers for children and families in order to make progress toward three system goals outlined in statute:

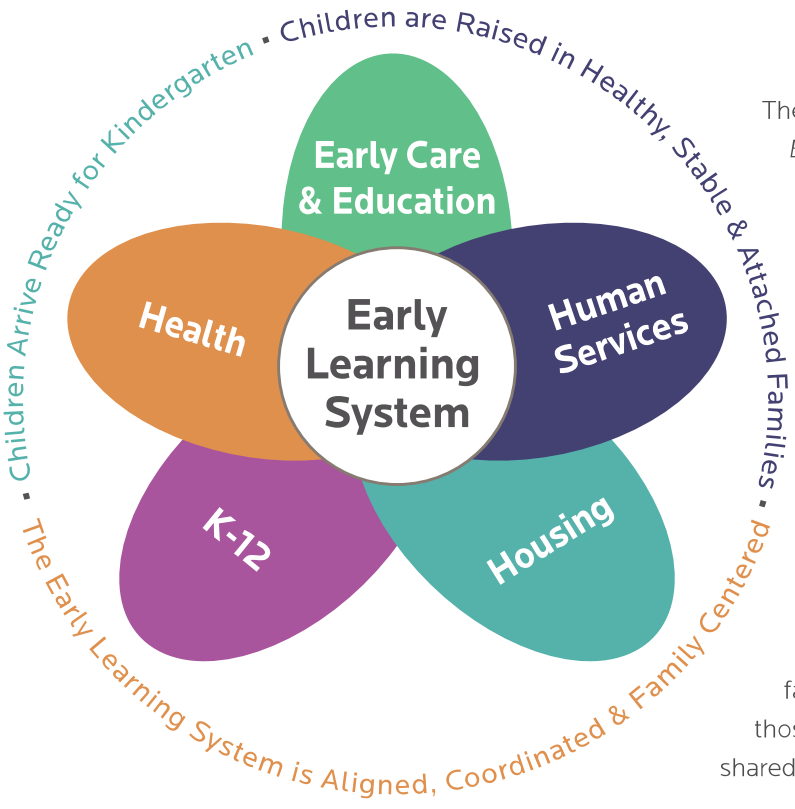
Children Arrive Ready for Kindergarten

Children are Raised in Healthy, Stable, and Attached Families

The Early Learning System is Aligned, Coordinated, and Family Centered

In developing *Raise Up Oregon: A Statewide Early Learning System Plan*, the Early Learning Council focused on the most strategic ways to make progress over the next five years (2019-2024) toward the vision embodied by the three system goals. The Council spent a year working with cross-agency partners— Department of Human Services, Oregon Department of Education, Oregon Early Learning Division, Oregon Health Authority, and Oregon Housing and Community Services– and hearing from communities, partners, parents, and providers.

Figure 4. *Raise Up Oregon* goals and sectors



The Council framed *Raise Up Oregon: A Statewide Early Learning System Plan* using the Council's guiding principles, which are rooted in equity, community and family engagement, and evidence-based practices in all decision-making processes within the early learning system. In order to engage diverse voices throughout the state, outreach included partners and providers representing children and families in historically underserved communities. The Council was particularly interested in: parents' and providers' experiences with services during the early childhood years; each sector's key goals and priorities for children prenatal to five and their families; strengths for and barriers to reaching those goals and priorities; and opportunities for shared interests and work across sectors.

The purpose of the five-year *Raise Up Oregon: A Statewide Early Learning System Plan* is to share a vision of where we as a state intend to go and to identify actionable, concrete strategies for working together across traditional boundaries to make this vision a reality. All of Oregon's young children deserve the best start. Zip code, race, and family income should not predict the health, educational, and life outcomes of Oregon's children.

Implementing *Raise Up Oregon: A Statewide Early Learning System Plan* requires that all five sectors are connected to the early learning system. This plan aligns with the governor's agenda and the strategic plans of cross-agency state partners, and provides an opportunity to intervene early and be more successful in the individual missions of each agency. This systems approach will make certain that children and families are receiving the services and supports they need to ensure that children enter kindergarten learning, thriving, and healthy.

DEVELOPING *RAISE UP OREGON: A STATEWIDE EARLY LEARNING SYSTEM PLAN*

OVER 200 PEOPLE

including state agency representatives, program administrators and providers, families, and all four Early Learning Council committees engaged in the development of *Raise Up Oregon*.

7 EARLY LEARNING COUNCIL MEETINGS

Presentations and discussions with state agency leadership, program administrators, Early Learning Hubs and other regional entities, providers and families across early care and education, health, housing and community supports, human services, K-12, and public health.

12 PARENT ENGAGEMENT SESSIONS

Parent discussions throughout the state.

16 EARLY LEARNING HUB Governance Board Meetings

Early Learning Hub Governance Boards discussed the strengths and barriers within each Hub community, provided input on cross-sector strategic planning themes, and explored the potential role for Hubs.

4 EARLY LEARNING COUNCIL COMMITTEES

All four Council committees—Best Beginnings, Equity Implementation, Child Care and Education, and Measuring Success—contributed to plan development.

VIA SURVEY

60 PEOPLE

Partners representing Child Care Resource & Referral entities, Early Learning Hubs, Early Learning Division staff, local Public Health offices, and members of the nine federally recognized tribes of Oregon provided feedback on the objectives and strategies most related to their work.

8 CHILDREN'S CABINET MEETINGS

4 Meetings with top state AGENCY LEADERSHIP

The Department of Human Services, Oregon Department of Education, Oregon Health Authority, and Oregon Housing and Community Services met with the Early Learning Council chair and the Early Learning System Director.

SYSTEM GOAL 1:
CHILDREN ARRIVE READY FOR KINDERGARTEN

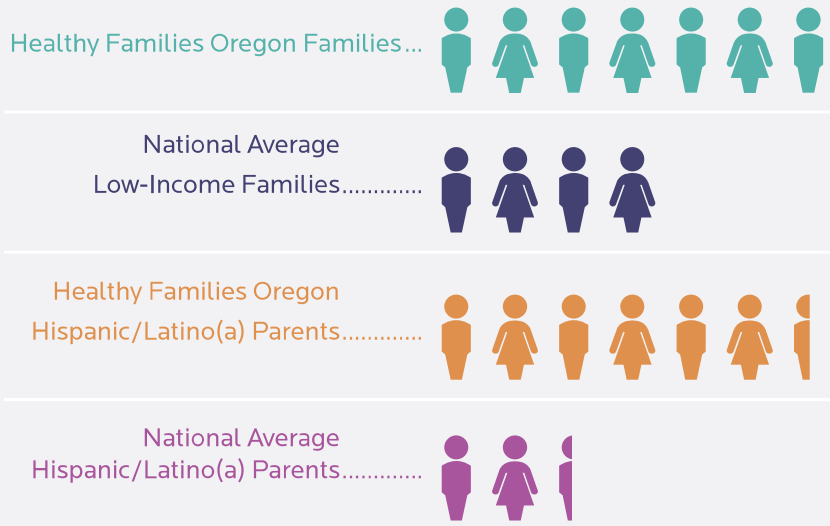
OBJECTIVE 1: Families are supported and engaged as their child's first teachers.

Parents have the greatest impact on their children's learning and development, especially when they can access programs that support them. For example, 70% of parents who participated in the Healthy Families Oregon (HFO) home visiting program for at least six months reported reading to their children on a daily basis, compared to the national average of just 40%.

Yet, only 20% of eligible families in Oregon have access to a home visiting program[xi] and only 3% have access to parenting education programs.[xii]

Furthermore, culturally specific organizations that have some of the strongest and most trusting relationships with families often lack access to available public resources needed to serve their communities.

Figure 5. Percentage of parents reading to children 0-5 daily[xiii]



Strategy 1.1 Expand parenting education and family supports.

- Expand availability and access to community-based parenting education by building on the philanthropic investment in the Oregon Parenting Education Collaborative (OPEC).
- Create an Equity Fund to support community-based, culturally specific organizations to extend their reach in providing culturally specific parenting and early learning supports in their communities.

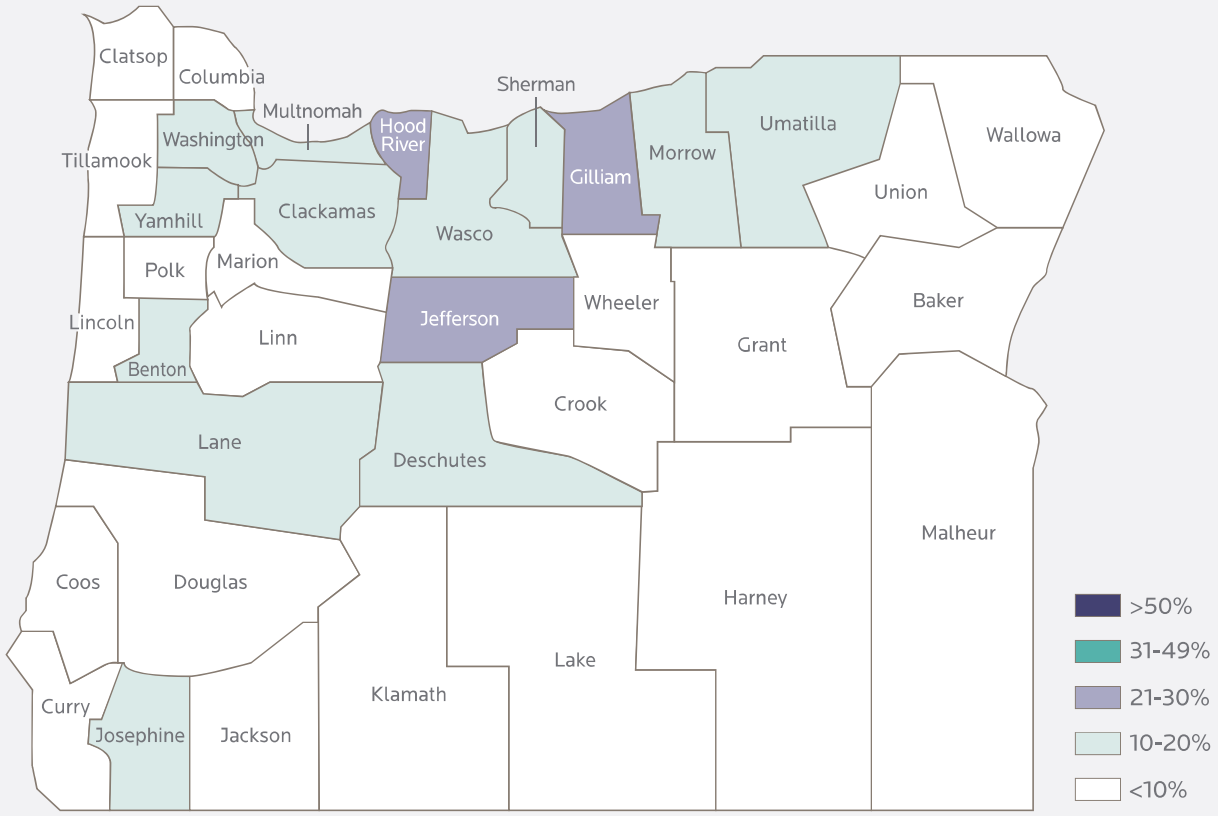
Strategy 1.2 Scale culturally responsive home visiting.

- Expand access to Oregon's current array of evidenced-based and evidence-informed targeted home visiting programs so that more families have access to these supports, prioritizing those families in historically underserved communities.
- Expand access to professional learning opportunities and address compensation for home vsitors in order to build a strong, culturally diverse workforce and increase retention.

OBJECTIVE 2: Families have access to high-quality (culturally responsive, inclusive, developmentally appropriate) affordable early care and education that meets their needs.

Oregon families face significant barriers to accessing early care and education (ECE), including finding programs that are high-quality, affordable, culturally or linguistically responsive, and meet their scheduling needs. All but one of Oregon's counties are infant and toddler child care "deserts"[xiv] and over 30,000 three to five year olds in low-income families lack access to publicly funded preschool.[xv] A national report ranking states on infant child care affordability lists Oregon in the bottom three for center-based care.[xvi] Achieving a supply of accessible, affordable, high-quality ECE takes sound policy, resources, and the engagement of families and communities.

Figure 6. Percent of Oregon young children 0-3 with access to regulated child care[xvii]



Strategy 2.1 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable infant-toddler early care and education that meets the needs of families.

- Create, scale, and sustain a statewide, high-quality infant and toddler child care program with a focus on children in historically underserved communities.
- Create shared service networks within rural and urban communities to better scale infant and toddler care.
- Increase state investments in Early Head Start by expanding Oregon Prekindergarten as a prenatal-to-five program.

Strategy 2.2 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable preschool that meets the needs of families.

- Expand preschool programs (i.e. Oregon Prekindergarten, Preschool Promise, Early Childhood Special Education) to serve more children, especially those in historically underserved communities.
- Align policies across Oregon's three state preschool programs (Early Childhood Special Education, Oregon Prekindergarten, and Preschool Promise) to facilitate blended funding models.
- Expand use of child care assistance contracts for wraparound care for preschool programs so they meet the needs of working families.
- Support Early Learning Hubs to create coordinated preschool enrollment processes.

Strategy 2.3 Strengthen child care assistance programs.

- Unify policymaking and policies across all child care assistance programs (Employment-Related Day Care (ERDC), Temporary Assistance for Needy Families (TANF) child care, and contracted child care assistance).
- Increase resources for child care assistance programs so that: 1) reimbursement rates meet the cost of delivering quality care across all types of care and ages, and 2) participating families pay no more than 7% of their income on care.
- Ensure child care assistance policy results in continuity of care, particularly for infants and toddlers.
- Ensure child care assistance policy reflects the scheduling needs of families.

Strategy 2.4 Build the state's capacity to ensure children are healthy and safe in child care.

- Improve child care licensing standards.
- Improve child care licensing implementation by strengthening technical assistance and monitoring.
- Coordinate investigations into serious violations in child care at the state and local level.
- Identify and address gaps in current licensing authority, including who is subject to licensing.

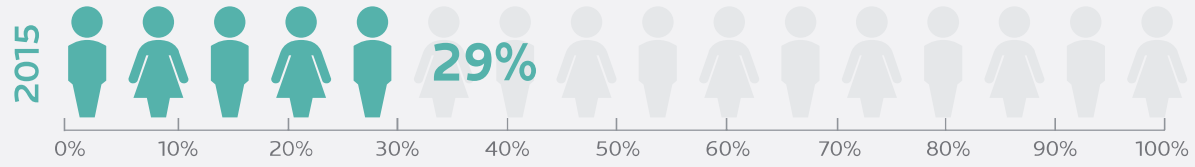
Strategy 2.5 Improve the essential infrastructure for high-quality early care and education.

- Conduct a statewide facilities needs assessment to identify communities with a dearth of ECE facilities and invest accordingly.
- Identify how to open high-quality family child care and child care centers within affordable housing units and housing developments.
- Create a regional plan for expanding access to and supply of high-quality infant, toddler, and preschool early care and education, available at times that meet the needs of families, especially to infants, toddlers, and preschoolers in historically underserved communities, under the leadership of the Early Learning Hubs.
- Use the state's licensing and Spark programs to recruit and support providers, especially in rural communities and communities of color, to become licensed and implement foundational health, safety, and quality practices.
- Expand resources for Spark to support additional ECE providers, including family, friend, and neighbor caregivers, in implementing best practices in ECE.

OBJECTIVE 3: The early care and education workforce is diverse, culturally responsive, high quality and well compensated.

A supply of high-quality, culturally responsive ECE programs requires a diverse, knowledgeable, skilled, and fairly compensated workforce. Yet Oregon's early childhood educators typically make between $25,000 and $35,000 annually.[xviii] In addition to fair compensation, educators also need pathways to early childhood degrees, ongoing professional learning supports, and positive, supportive work environments in order to implement best practice. These conditions can ensure that Oregon retains the workforce it needs, rather than continue to see a quarter of the workforce leaving the field each year.

Figure 7. Oregon ECE teacher and provider annual workforce turnover[xix]



Strategy 3.1 Improve professional learning opportunities for the full diversity of the early care and education workforce.

- Implement a competency-based professional learning system that is culturally and linguistically relevant for educators, educational leaders, professional development, and training personnel.
- Tailor and scale supports for family, friend, and neighbor caregivers, especially for those participating in child care assistance programs.
- Create competencies and professional learning opportunities that speak to the unique role of infant and toddler educators.
- Ensure communities have data needed to design and evaluate effectiveness of professional learning for the diversity of the workforce – including across different settings.
- Increase the relevance and effectiveness of professional learning through job-embedded supports and the inclusion of culturally responsive pedagogy.

Strategy 3.2 Build pathways to credentials and degrees that recruit and retain a diverse early care and education workforce.

- Fully implement all steps in the career pathway.
- Partner with higher education institutions to ensure degree programs reduce barriers to higher education and meet the needs of the current workforce, equitably addressing cultural, language, learning, and access needs.
- Partner with higher education institutions to ensure degree programs include curriculum that addresses the prenatal-to-5 continuum.
- Build upon existing scholarship programs to support more educators in entering the field and existing educators in attaining AA and BA degrees in early childhood.
- Increase the number of educators entering the field by expanding opportunities for early care and education preparation in high school that can be leveraged in higher education.

Strategy 3.3 Compensate and recognize early childhood educators as professionals.

- Create educator compensation requirements that align with kindergarten educator compensation across publicly funded ECE programs (i.e. Oregon Prekindergarten, Preschool Promise, contracted slots) and increase public investment to implement those requirements.
- Create financial incentives for ERDC and TANF child care providers to support compensation that is aligned with kindergarten educators and increase public investment to support implementation.
- In collaboration with Early Learning Hubs and other partners, create understanding of the role and impact of early childhood educators among policymakers and the public.

Strategy 3.4 Improve state policy to ensure early care and education work environments guarantee professional supports.

- Incorporate professional supports (e.g., paid planning time, paid professional development time, compensation, wellness and health benefits) into program standards.
- Collect and use data to improve professional supports (e.g., paid planning time, paid professional development time, compensation, wellness and health benefits).

OBJECTIVE 4: Early childhood physical and social-emotional health promotion and prevention is increased.

Physical and emotional health provide the foundation for school readiness. More remains to be done to leverage Oregon's significant commitment to children's health care coverage. While Oregon is a leader in providing health insurance for children, access alone cannot eliminate health disparities that inhibit the ability of young children to learn and flourish. For example, there are significant racial disparities in Oregon's infant mortality rate – Native American and African American children are nearly twice as likely to die before their first birthday as their white counterparts.[xx] Health equity must be addressed.

Strategy 4.1 Ensure prenatal-to-age-five health care services are comprehensive, accessible, high quality, and culturally and linguistically responsive.

- Improve access to patient-centered primary care homes for all young children.
- Strengthen the early childhood focus of Coordinated Care Organizations (CCOs) by adding Early Learning Hub representation on CCOs' governing boards or using other tools to improve relationships and coordination.
- Increase the integration of physical, behavioral, and oral health for young children.
- Incentivize high-quality, evidence-based pediatric care, including rural communities.

Strategy 4.2 Increase capacity to provide culturally responsive social-emotional supports for young children and their families.

- Increase access to culturally responsive mental health services by ensuring there are diverse providers with expertise in children birth through age 5.
- Train home visitors, mental health professionals, and early care and education providers in relationship-based infant mental health and equity approaches.
- Focus on children whose families are affected by substance abuse and family separation, including by ensuring access to community health workers.

Strategy 4.3 Increase and improve equitable access to early childhood oral health.

- Increase access to and address disparities in prevention and treatment dental services for young children.
- Advance provider trainings such as First Tooth and Maternity Teeth for Two.
- Continue integration of oral health services in early care and education settings.

Strategy 4.4 Strengthen coordination among early care and education, health, and housing to promote health and safety for young children.

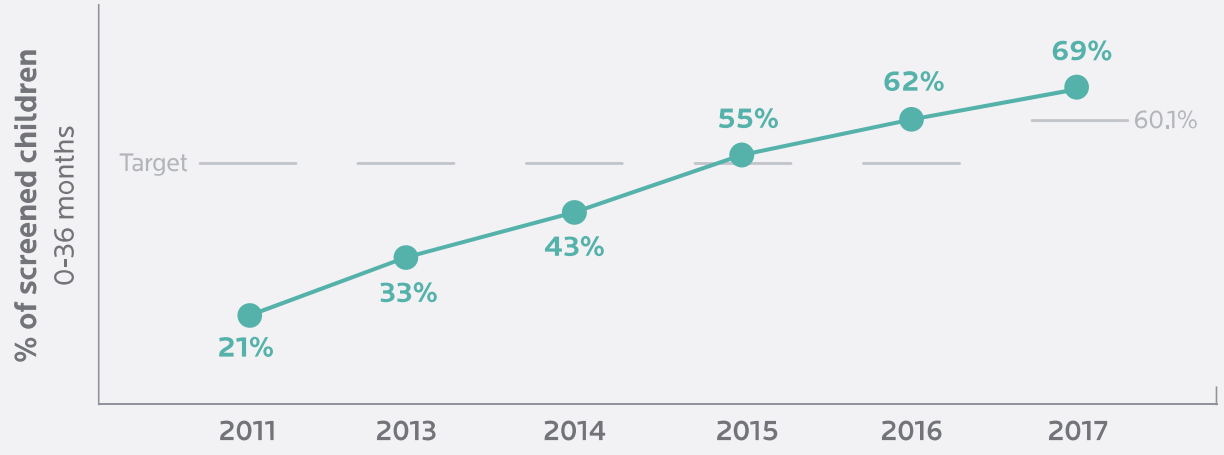
- Provide health consultation across ECE settings.
- Collaborate to support families and ECE providers in implementing safe sleep practices.
- Identify areas of shared accountability across housing, health, and ECE, and expand joint activities that promote environmental health, injury prevention and safety, physical activity, and healthy foods.

OBJECTIVE 5: Young children with social-emotional, developmental, and health care needs are identified early and supported to reach their full potential.

Oregon has made significant progress in ensuring that children with social-emotional, developmental, and health care needs are identified early. The rate of developmental screening for children enrolled in the Oregon Health Plan in the first thirty-six months of life has increased from 21% in 2011 to 69% by 2017.

However, too many children in Oregon who are identified with developmental delays at screening never receive services. Building local community-based systems that ensure early learning detection and a family-friendly process of referral to the supports that best address the needs of the individual child and family is essential to achieving that end. Services for children who are identified and enrolled in Early Intervention and Early Childhood Special Education (EI/ECSE) remain too limited due to funding, with only 34% of infants and toddlers currently enrolled in Early Intervention receiving the recommended level of services.[xxii]

Figure 8. Oregon developmental screenings in the first thirty-six months of life[xxi]



Strategy 5.1 Ensure adequate funding of and access to a range of regional and community-based services, including Early Intervention/ Early Childhood Special Education services.

- Increase funding so that Early Intervention/ Early Childhood Special Education services are at an adequate level to support the positive development of children with special needs as defined by the 2010 report to the Oregon Legislature.
- Review the criteria used to determine whether a child is eligible for Early Intervention/Early Childhood Special Education services and make and implement recommendations regarding the appropriate eligibility thresholds to ensure that all children needing these services are able to access them.
- Provide resources for communities to expand the array of services available to infants, toddlers, and families that need additional supports.
- Enable integration of Early Intervention and Early Childhood Special Education with other funding streams so that children are served in inclusive early care and education settings.

Strategy 5.2 Continue to prioritize screening through the health system and build pathways from screening to a range of community-based services and supports for children and families.

- Improve screening.
- Scale successful approaches to build community-based referral systems from screening to services that meet the diverse needs of young children and families.

Strategy 5.3 Prevent expulsion and suspension by strengthening state policies and supports to early care and education programs.

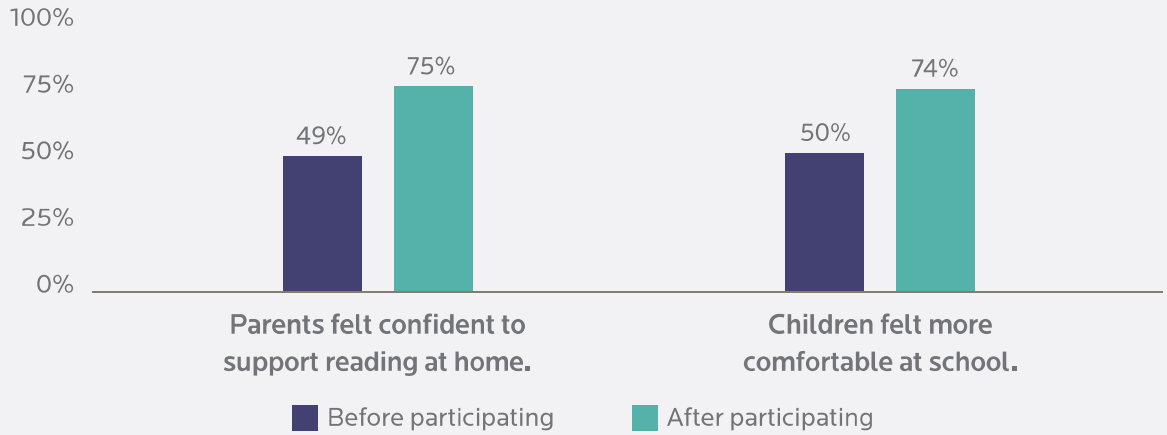
- Align policies across ECE programs and K-12 regarding suspension and expulsion.
- Improve data systems to track suspension and expulsion across the birth-to-five early learning system and early grades, disaggregated by race and other critical indicators.
- Provide culturally responsive mental health consultation to ECE providers.
- Increase access to anti-bias early childhood education training for ECE providers.

Children who arrive at kindergarten with strong social-emotional skills, as measured by Oregon's Kindergarten Assessment, are more likely to be on track in third grade reading and math.

OBJECTIVE 6: Children and families experience supportive transitions and continuity of services across early care and education and K-12 settings.

Oregon has made meaningful strides in supporting kindergarten transitions over the last several years, particularly in relation to the implementation of summertime transition camps and parenting education programs. After participating in family engagement and kindergarten transition activities supported by the Kindergarten Readiness Partnership and Innovation Fund (KPI), parents felt more confident in supporting their children's learning in reading and math, and children and parents felt more comfortable and welcomed in school.

Figure 9. Benefits of Kindergarten Readiness Partnership and Innovation fund (KPI) programs[xxiii]



However, significant work remains to be done to scale culturally responsive, developmentally appropriate transition practices across the state, and to achieve greater alignment across early care and education and K-12 settings.

Strategy 6.1 Establish shared professional culture and practice between early care and education and K-3 that supports all domains, including social-emotional learning.

- Support Professional Learning Teams, consisting of both early learning and kindergarten to grade 3 (K-3) educators, with participation in shared statewide and regional professional development activities on the part of both early learning and K-3 educators, including elementary school principals and ECE directors.
- Support school districts in aligning attendance, curriculum, instructional, and assessment practices across the prenatal-to-third-grade continuum with a focus on high-quality (culturally responsive, inclusive, developmentally appropriate).
- Scale and expand the work of Early Learning Hubs and local communities through KPI and local funding sources, to support social-emotional learning across the P-3 continuum.

Strategy 6.2 Improve the Oregon Kindergarten Assessment to better support decision-making between early learning and K-12 stakeholders.

- Enhance the Kindergarten Assessment (KA) process for children whose home language is not English and who are emerging bilingual children, focusing first on children whose home language is Spanish.
- Provide sufficient support to school districts to ensure that the assessment is administered properly and in ways that are developmentally appropriate.
- Improve the communications and data analysis/interpretation tools for the KA so policymakers, Early Learning Hubs, providers of early learning services, school districts, and elementary schools have access to timely, accessible, and actionable data that supports regional and local decision-making.
- Develop a Kindergarten Entry Family Survey that enables families to provide information about their children's experiences and provides a more holistic picture of children's development.

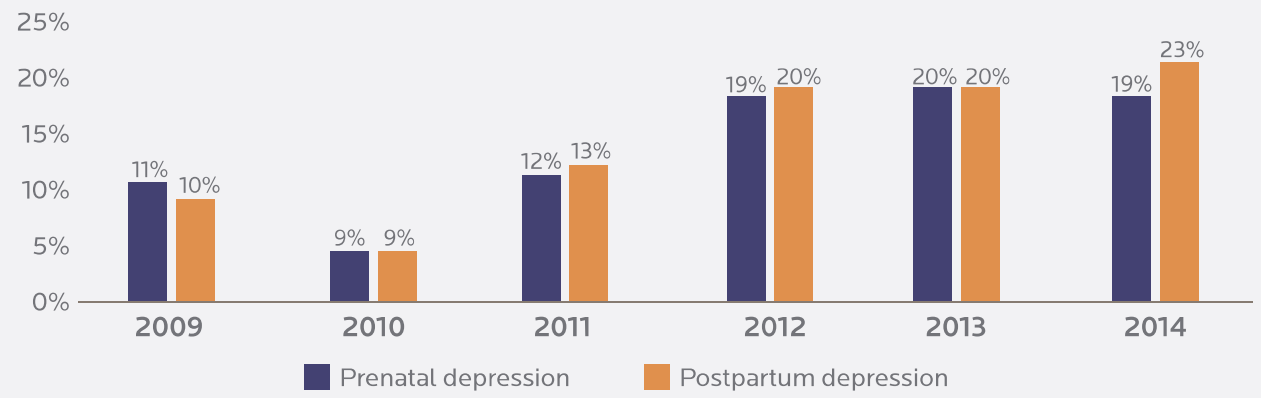
SYSTEM GOAL 2:
CHILDREN ARE RAISED IN HEALTHY, STABLE, AND ATTACHED FAMILIES

OBJECTIVE 7: Parents and caregivers have equitable access to support for their physical and social-emotional health.

Children's healthy development depends to a large extent on the health and well-being of their parents and caregivers. But parent and caregiver health and well-being in Oregon is compromised by various factors including health care costs, disparities in prenatal care, the cross-generational transmission of trauma through their own adverse childhood experiences (ACEs), and the chronic disease of substance use disorder (SUD). These factors have a large impact on children, with SUD alone leading to nearly 75% of Oregon's foster care placements.[xxiv]

Maternal prenatal and postpartum depression is also on the rise in Oregon, with one in five women in the state suffering from it. Optimizing parental mental health is critical for disrupting the transgenerational impact of maternal depression, and improves children's social-emotional development, secure attachments, and kindergarten readiness.

Figure 10. Perinatal depression in Oregon[xxv]



Strategy 7.1 Increase equitable access to reproductive, maternal, and prenatal health services.

- Increase access to traditional health workers (e.g., doulas) and home visiting services.
- Address the needs of women impacted by substance use disorder (SUD), such as through integrated prenatal care and SUD treatment, as well as those of infants affected by neonatal abstinence syndrome.

Strategy 7.2 Improve access to culturally and linguistically responsive, multi-generational approaches to physical and social-emotional health.

- Reduce the financial burden of health care costs to families.
- Expand accessible and culturally responsive systems that support family unity while addressing parent co-occurring health, mental health, addiction, and/or parenting strategies.
- Improve access to health care for families who are pregnant or have young children.
- Ensure a continuum of services for children and their caregivers when families are affected by mental health conditions and substance use disorders (SUD).
- Handle the cross-generational transmission of trauma by identifying and addressing adverse childhood experiences.
- Increase partnerships between Coordinated Care Organizations (CCOs) and community health workers to enable access.

OBJECTIVE 8: All families with infants have opportunities for connection.

A nurturing, supportive relationship between a caregiver and child is an essential ingredient for positive child development, and the bond formed between parent and child during the first few months of a child's life sets the foundation for healthy development. But economic necessity often forces parents to return to work shortly after the birth or adoption of a child when critical bonds and attachments are forming. Families with newborn children also often lack a non-stigmatizing and accessible point of contact to help them address the challenges of parenting a newborn and connect with additional support and services when needed.

Strategy 8.1 Create a universal connection point for families with newborns. Health

- Build, in partnership with local communities, Early Learning Hubs, Coordinated Care Organizations, and public health agencies, a system to deliver home visits for all families with newborn children that provides parenting information and helps families with deeper needs connect to additional services.

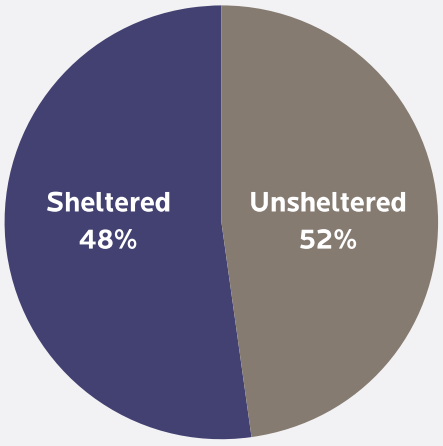
Strategy 8.2 Provide paid family leave. Health

- Provide paid family leave to all families with a newborn or newly adopted child to support the development of bonding and attachment during this critical window.

OBJECTIVE 9: Families with young children who are experiencing adversity have access to coordinated and comprehensive services.

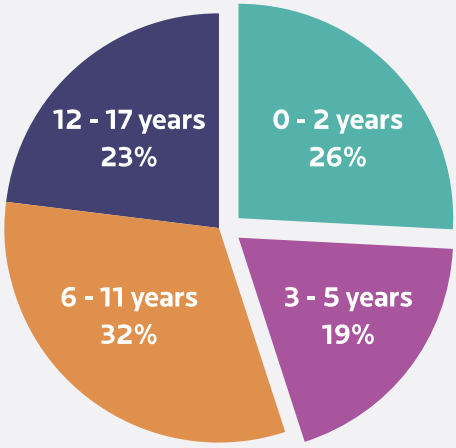
Homelessness, housing-cost burdens, food insecurity, employment instability, and the high cost of child care can create severe or chronic stress within families that, in turn, can affect children. Recent studies show strong correlations between housing stability and child outcomes, thereby pointing to the pressing need for addressing housing as part of an early childhood agenda.[xxvi] In 2017, Oregon had the second highest rate of homelessness among people in households with children in the United States. According to the 2017 Point-in-Time Count, 3,519 of the 13,953 Oregonians experiencing homelessness were families with children.[xxvii]

Figure 11. Homeless familes in Oregon with children[xxviii]



When families experience stressors, including not being able to meet their material needs, they are at an increased risk of involvement with the child welfare system. Oregon's high rate of families with young children involved in the child welfare system is cause for concern. In 2017, 11,077 children in Oregon experienced abuse and neglect. Almost half of these children were under the age of six and more than a quarter were under the age of three. Reducing the number of children who enter into the child welfare system must be a priority for all Oregonians. Doing so will require strong relationships across sectors and with communities and families.

Figure 12. Abused and neglected Oregon children, 2017[xxix]



Approximately 5,000 young children under age six every year are abused or neglected.

Strategy 9.1 Expand and focus access to housing assistance and supports for families with young children.

- Expand and focus housing subsidy for families with young children, starting with families with children prenatal to 12 months of age who are experiencing unsheltered homelessness.
- Expand the supply of affordable housing and rental assistance for families with children by exploring new programs and working with providers to establish priorities for assisting families with young children.
- Strengthen relationships between Early Learning Hubs, Community Action Agencies, Department of Human Services (DHS) field offices, and local housing authorities to focus on families with infants and toddlers.

Strategy 9.2 Provide preventive parenting support services to reduce participation in the child welfare system.

- Increase access to evidence-based early learning programs (e.g., Relief Nurseries, parenting education, home visiting programs) proven to reduce abuse and neglect for families at imminent risk of entering into the child welfare system.
- Expand access to family coaches for local parenting support organizations, including community-based, culturally responsive organizations.
- Collaboratively develop community-based early childhood child abuse and maltreatment prevention plans.

Strategy 9.3 Improve the nutritional security of pregnant women and young children, particularly infants and toddlers.

- Promote breastfeeding.
- Improve connections between the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and primary care medical homes and other community services.

Strategy 9.4 Link high-quality early care and education, self-sufficiency, and housing assistance programs.

- Implement strategies such as waitlist prioritizations and incentives.
- Develop innovative child care networks, connected to affordable housing complexes, to deliver high-quality early care and education.

SYSTEM GOAL 3: THE EARLY LEARNING SYSTEM IS ALIGNED, COORDINATED, AND FAMILY CENTERED

OBJECTIVE 10: State-community connections and regional systems are strengthened.

In order for Oregon's children to arrive ready for kindergarten and live in healthy, stable, and attached families, comprehensive solutions and greater coordination with every sector – early care and education, health, human services, K-12, housing, and the business community – will be required. State-community connections must be deepened and regional systems strengthened, with Early Learning Hubs playing a unique role as they build coherent local systems through which families with young families can easily connect with needed supports and services. Families must be engaged, with their voices guiding the development of policies and programs.

Strategy 10.1 Ensure family voice in system design and implementation.

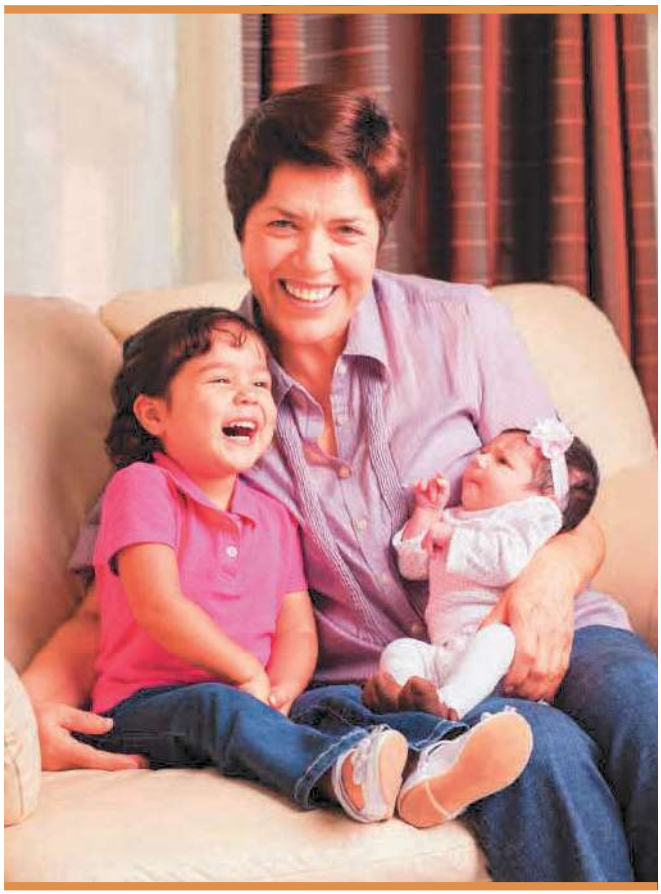
- Increase authentic input of family voice in the design and implementation of state policy and programming that welcomes all families.
- Establish a mechanism, in collaboration with Early Learning Hubs, for authentic leadership in parent voice to inform Early Learning Council systems-building work.
- Work with Early Learning Hubs and their partners in developing local capacity to facilitate culturally responsive family engagement activities across their communities, prioritizing communities that have not yet been engaged.

Strategy 10.2 Ensure family-friendly referrals.

- Develop centralized systems locally to coordinate eligibility and enrollment of services across sectors, starting with early care and education (ECE).
- Develop shared principles for building a community-level, family-friendly, respectful, and easy-to-navigate referral system so that families can easily access services and supports.

Strategy 10.3 Further develop the local Early Learning Hub system.

- Incentivize active participation across sectors on the Early Learning Hub Governance Boards to ensure investment in shared goals, policy, and programming as well as coordinated implementation across a region.
- Strengthen the Early Learning Hub role in informing community needs assessments that meet the requirements of each sector, supporting coordinated and aligned community planning and shared problem solving.
- Create ongoing feedback loops between the state sectors and communities to improve communication, policy implementation, and collaboration, and address barriers in order to make progress toward the three systems goals.



OBJECTIVE 11: Investments are prioritized in support of equitable outcomes for children and families.

All of the work in this plan must be guided by a deep commitment to equitable outcomes for children and families in historically underserved communities. This means taking action to address the avoidable conditions that impact those who have experienced socioeconomic disadvantage or historical injustices, and using data to evaluate the impact of policies and services that eliminate race as a predictor of a child's success. All sectors must come together on a regular basis to analyze disparities in access and outcomes to achieve the goals of this plan.

Strategy 11.1 Ensure resources are used to reduce disparities in access and outcomes.

- Collect, analyze, and consolidate data, across agencies and committees, on disparities in access and outcomes related to the goals of this plan.
- Share the results and recommendations for further improvement, including cross-sector funding opportunities.

Strategy 11.2 Align and expand funding opportunities for culturally specific organizations.

- Develop a coordinated state approach to increasing the capacity of culturally specific organizations to seed and scale promising culturally responsive practices and programs in early childhood.
- Expand funding of culturally specific organizations to implement early childhood programming and build partnerships with other programs.

Objective 12: The alignment and capacity of the cross-sector early learning workforce is supported.

Despite working in different settings, the early learning workforce – consisting of health, human services, K-12, and the early care and education sector – serves young children and their families largely toward the same end: ensuring that children's health and development is on track. This requires some common knowledge and skills, as well as collaboration with one another. In order to support families and children in a consistent way, key areas of shared knowledge and competency must be identified and supported across the entire system.

Strategy 12.1 Support consistent, high-quality practice among all professionals in the family- and child-serving early learning workforce.

- Analyze existing core knowledge and competency frameworks or standards across disciplines for the family- and child-serving workforce to identify commonalities and gaps across sectors.
- Create and implement opportunities for shared professional learning across sectors in established areas of need (e.g., trauma-informed practices and family-centered referral pathways).
- Collaborate with the Higher Education Coordinating Commission and professional learning partners to incorporate identified areas of shared knowledge into curriculum.

Strategy 12.2 Improve cross-sector recruitment, retention, and compensation.

- Through the Children's Cabinet, require state agencies to report on the diversity of race/ethnicity, language, compensation, and working conditions of front-line staff within each sector.
- Analyze data across the early learning workforce to determine common strengths and shared challenges regarding diversity, compensation, turnover, qualifications, and professional learning pathways in each sector.
- Use data analysis to create and implement a plan based on common strengths and shared challenges.

OBJECTIVE 13: The business and philanthropic communities champion the early learning system.

A strong early learning system is inextricably linked with Oregon's economy and workforce. Just as no one sector alone can achieve the state's early learning system goals, Oregon needs the support and partnership of the private sector to finance an early learning system for the state. This will require that Oregon build on its existing partnership with philanthropy and cultivate champions from the business community, deepening their understanding of financing strategies and the return on investment of high-quality early learning programs.

Strategy 13.1 Educate business leaders on the economic value of early care and education to the Oregon economy.

- Engage business leaders in addressing the lack of ECE programs necessary to support Oregon's workforce, including the availability of high-quality, affordable child care.
- Demonstrate the value of early educators to leading businesses and business associations.
- Share information on the return on investment of ECE in contributing to Oregon's economy.

Strategy 13.2 Introduce business leaders to the science of early childhood development and the impact of public investment.

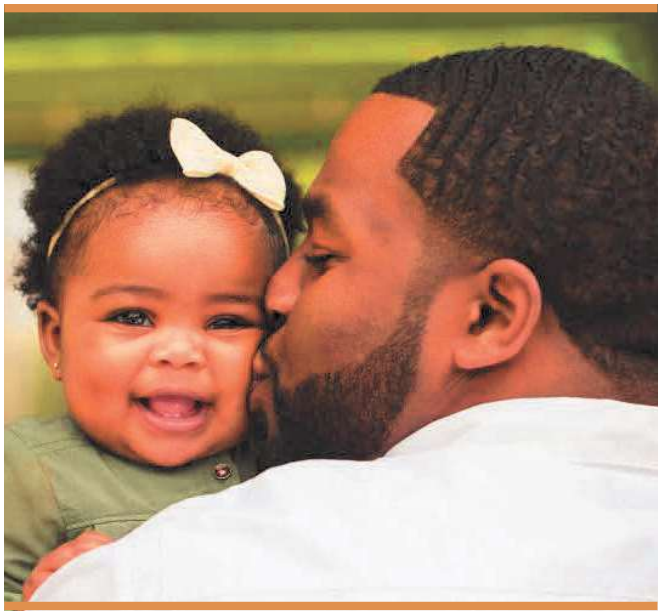
- Share information on early childhood brain development and the impact of adverse childhood experiences.
- Include business leaders as members of the Early Learning Council.

OBJECTIVE 14: The data infrastructure is developed to enhance service delivery, systems building, and outcome reporting.

The success of all these strategies will depend on the effective use of data to drive decision-making and ensure that disaggregated data is used to assess impacts of policies and investments on children in historically underserved communities. In order to realize this goal, Oregon needs to increase its capacity to collect, integrate, analyze, and disseminate data to inform decisions at the state and local levels of the early learning system.

Strategy 14.1 Strengthen data-driven community planning.

- Increase access to state and local data, and resources, to improve Hub capacity to use data in its planning to ensure the highest needs are met and that the greatest impact for children and families is achieved.
- Address data sharing and data governance barriers, while protecting family privacy, that limit community access to data needed for decision-making.
- Incorporate specific data on children of color and children from historically underserved communities.
- Bring state and community leaders together to better understand data in order to track the well-being of children and families in communities, guide a process of continuous quality improvement, and facilitate collaboration across sectors and partners.



Strategy 14.2 Integrate early learning data into the Statewide Longitudinal Data System.

- Build state and program capacity to collect, monitor, and analyze data from early care and education programs in order to support quality improvements in the delivery of early care and education services and programs for children prenatal to kindergarten entry and their families.
- Use integrated data from the Statewide Longitudinal Data System to determine impacts of early childhood investment and identify the most effective strategies for supporting positive outcomes for children and their families.
- Incorporate specific data on children of color and children from families in historically underserved communities.

Strategy 14.3 Develop and implement a population survey to track the well-being of children and families across Oregon.

- State agencies collaborate to finance, develop, and implement a population survey of Oregon families with young children that provides holistic information on their well-being.
- Ensure that the survey is developed and implemented so as to provide accurate and holistic information on the well-being of families from historically underserved populations.

Strategy 14.4 Create and use an early learning system dashboard to create shared cross-sector accountability for outcomes for young children and their families.

- Create and regularly monitor an early learning system dashboard that fosters collective impact and shared cross-sector, cross-agency accountability for population-level outcomes for children prenatal to five and their families.
- Incorporate specific data on children of color and children from historically underserved communities.

NEXT STEPS

Moving from this plan to action requires many partners working together as we strive to do more and better for young children and their families. Within state government, key systems partners will create implementation plans with measurable outcomes and timelines. The Early Learning Council will maintain an active role in overseeing, disseminating, and championing the plan, and supporting the state's early learning system in moving it forward.

APPENDIX A:
MEMBERS OF THE EARLY LEARNING COUNCIL

Sue Miller ..... Chair, Early Learning Council

Patrick Allen ..... Director, Oregon Health Authority

Martha Brooks ..... Western States Regional Director, Fight Crime: Invest in Kids and ReadyNation

Miriam Calderon ..... Early Learning System Director, Early Learning Division

Donalda Dodson ..... Executive Director, Oregon Child Development Coalition

Colt Gill ..... Deputy Superintendent of Public Instruction, Oregon Department of Education

Holly Mar ..... Vice President of Community Impact, United Way of Lane County

Fariborz Pakseresht ..... Director, Department of Human Services

Eva Rippeteau ..... Political Coordinator, Oregon AFSCME

Shawna Rodrigues ..... Oregon Head Start Collaboration Director, Early Learning Division

Donna Schnitker ..... Director of Early Childhood Programs, Harney ESD

Teri Thalhofer ..... Director, North Central Public Health District

Kali Thorne Ladd ..... Executive Director and Co-Founder, KairosPDX

Bobbie Weber ..... Research Associate, Family Policy, College of Public Health and Human Sciences, Oregon State University

Agency Advisors

Kim Fredlund ..... Director, Self-Sufficiency Programs, Department of Human Services

Candace Pelt ..... Assistant Superintendent, Office of Student Services, Oregon Department of Education

Cate Wilcox ..... Maternal and Child Health Manager, Title V Director, Public Health Division, Oregon Health Authority

APPENDIX B: GLOSSARY

The following glossary was originally published by the Oregon Child Care Research Partnership, Corvallis, Oregon, August 2016 and updated by the Early Learning Division. This glossary presents a list of terminology and definitions used to discuss state support, regulation, and involvement in early care and education services in Oregon. Oregon-specific terms are interspersed with terms used both within Oregon and nationally, as reflected in Research Connections' Child Care and Early Education Glossary.

Affordability
The degree to which the price of child care is a reasonable or feasible family expense. States maintain different definitions of "affordable" child care, taking various factors into consideration, such as family income, child care market rates, and **subsidy** acceptance, among others.

At Risk
A term used to describe children who are considered to have a higher probability of non-optimal **child development** and learning.

Attachment
The emotional and psychological bond between a child and adult, typically a parent or caregiver, that contributes to the child's sense of security and safety. It is believed that secure attachment leads to psychological well-being and Resilience throughout the child's lifetime and is considered a key predictor of positive **child development** and learning.

Child Care Access
Refers to the ability of families to find quality child care arrangements that satisfy their preferences, with reasonable effort and at an affordable price. **See related: Child Care Availability.**

Child Care Assistance
Any public or private financial assistance intended to lower the cost of child care for families. **See related: Child Care Subsidy.**

Child Care Availability
Refers to whether quality child care is accessible and available to families at a reasonable cost and using reasonable effort. **See related: Child Care Access.**

Child Care Desert
A community with more than three children for every regulated **child care slot**.

Child Care Provider
An organization or individual that provides early care and education services.

Child Care Resource & Referral (CCR&R)
Child Care Resource and Referral services promote the health, safety and development of young children in child care settings as part of Oregon's Early Learning System. They are responsible for providing a wide variety of program services which include recruiting, training, and promoting retention of a **high-quality**, diverse early learning workforce through professional development and collaboration with community partners to align and coordinate local early learning systems.

Child Care Slots
The number of openings that a child care setting has available as dictated by its **licensed capacity.** The desired capacity of a facility is often lower than its licensed capacity. Child care slots may be filled or unfilled.

Child Care Subsidy
A type of **child care assistance** primarily funded by the federal Child Care and Development Fund program. **See related: Employment-Related Day Care (ERDC).**

Child Development
The process by which children acquire skills in the areas of social, emotional, intellectual, speech and language, and physical development, including fine and gross motor skills. Developmental stages describe the expected, sequential order of gaining skills and competencies that children typically acquire.

Child Welfare System
A system that includes preventive, protective and foster care, as well as adoption services for children who have experienced or at risk of experiencing maltreatment. Oregon's Child Welfare system is part of the Department of Human Services.

Children of Incarcerated Parents
Refers to children who have a parent or parental figure(s) involved in the criminal justice system from arrest through parole.

Children's Cabinet
The Governor's Children's Cabinet involves the major sector partners involved with ensuring young children enter kindergarten ready to succeed. It includes the agency leadership from the Department of Human Services, Oregon Department of Education, Early Learning Division, Oregon Health Authority and Oregon Housing and Community Services.

Coaching
A relationship-based process led by an expert with specialized knowledge and adult learning competencies that is designed to build capacity for or enhance specific professional dispositions, skills, and behaviors. Coaching is typically offered to teaching and administrative staff, either by in-house or outside coaches, and focuses on goal-setting and achievement. See related: Technical Assistance.

Collective Impact
A commitment to a common agenda for solving a complex social problem by a group of actors from different sectors. A collective impact model provides a foundation for the work of Oregon's Early Learning Hubs.

Communities of Color
Four communities are traditionally recognized as being of color – Native American, African American, Asian, and Latino. Additional groups that have been impacted by racism in a given community can be added.

Community-Based Child Care/Community-Based Organization (CBO)
A nonprofit organization that provides educational or related services to children and families within their local community. CBOs that provide child care may be associated with faith-based organizations or other nonprofit organizations. CBOs are subject to section 501(c)(3) of the Internal Revenue Code.

Competencies (refers to Workforce Knowledge or Core Competencies)
Refers to the range of knowledge and observable skills that early childhood practitioners need to provide effective services to children and families. Competencies, sometimes referred to as "core competencies," are typically linked with states' early learning guidelines and provide a framework for professional development at various career stages.

Comprehensive Services
An array of coordinated services that meet the holistic needs of children and families enrolled in a given program, from health and developmental screenings to family literacy trainings and parent education.

Continuity of Care
Refers to the provision of care to children by consistent caregivers in consistent environments over a period of time to ensure stable and nurturing environments. Research shows that maintaining continuity and limiting transitions in a child's first few years of life promotes the type of deep human connections that young children need for optimal early brain development, emotional regulation, and learning.

Contracted Slots
Contracted slots are an agreement made between a state and a child care provider prior to service delivery that the provider will make available a certain number of child care slots, which will be paid for by the state as long as contracted state program or attendance conditions are met.

Coordinated Care Organization (CCO)
A network of all types of health care providers (physical health care, addictions, mental health care, and dental care providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs focus on prevention and helping people manage chronic conditions, such as diabetes. This helps reduce unnecessary emergency room visits and supports people in being healthy.

Core Body of Knowledge
The Core Body of Knowledge for Oregon's Childhood Care and Education Profession is the basis for training and education essential for on-going professional development in the childhood care and education profession, a foundation for both the Oregon Registry and the Oregon Registry Trainer Program. It embodies what professionals should know and be able to do to effectively care for and educate Oregon's young children, ages 0-8, with special consideration for children 9-12 years old. Ten core knowledge categories make up the Core Body of Knowledge. Three sets of knowledge constitute a progression of increased depth and breadth of knowledge within each core knowledge category.

Cost of Care
The monetary cost of providing early care and education services. Major contributors to the cost of care include staff wages and salaries, benefits, rent, supplies, professional development, and training. The cost of care can be different from the actual price of care charged by the provider.

Cultural Responsiveness
A term that describes what happens when special knowledge about individuals and groups of people is incorporated into standards, policies, and practices. Cultural responsiveness fosters an appreciation of families and their unique backgrounds and has been shown to increase the quality and effectiveness of services to children.

Curriculum
A written plan that includes goals for children's development and learning, the experiences through which they will achieve the goals, what staff and parents should do to help children achieve the goals, and the materials needed to support the implementation of the curriculum.

Department of Human Services (DHS)
DHS is Oregon's principal agency for helping Oregonians achieve well-being and independence through opportunities that protect and respect choice and preserve dignity, especially for those who are least able to help themselves. DHS manages Employment-Related Day Care (ERDC), Oregon's major child care subsidy program.

Developmental Screening and Assessment
The practice of systematically measuring a child's development across multiple domains and looking for signs of developmental delays. Screening and assessment tools are typically administered by professionals in health care, community, or school settings with children and families and can consist of formal questionnaires or checklists that ask targeted questions about a child's development.

Developmentally Appropriate
Practices, behaviors, activities, and settings that are adapted to match the age, characteristics, and developmental progress of a specific group of children.

Developmentally Appropriate Practice (DAP)
DAP in early learning settings reflects knowledge of child development and an understanding of the unique personality, learning style, and family background of each child.

Early Childhood Mental Health Consultation
A strategic intervention geared towards building the capacity of early childhood staff, programs, families, and systems to prevent, identify, treat, and reduce the impact of mental health problems in children from birth to age six. In a child-focused consultation, the consultant may facilitate the development of an individualized plan for the child. In a classroom-focused consultation, the consultant may work with the teacher/caregiver to increase the level of social-emotional support for all the children in the class through observations, modeling, and sharing of resources and information. In a program-focused consultation, the consultant may help administrators address policies and procedures that benefit all children and adults in the program.

Early Childhood Special Education (ECSE)
Specialized instruction that is provided by trained early childhood special education professionals to preschool children with disabilities in various early childhood settings such as preschool, child care, Oregon Prekindergarten and Head Start, among others and requires the development of an Individualized Education Plan. ECSE is authorized by the federal Individuals with Disabilities Education Act (IDEA), Part B.

Early Head Start

A federally funded program that serves low-income pregnant women and families with infants and toddlers to support optimal child development while helping parents/families move toward economic independence. EHS programs generally offer the following core services: (1) high-quality early education in and out of the home; (2) family support services, home visits, and parent education; (3) comprehensive health and mental health services, including services for pregnant and postpartum women; (4) nutrition; (5) child care; (6) ongoing support for parents through case management and peer support. Programs have a broad range of flexibility in how they provide these services.

Early Intervention (EI)

Services that are designed to address the developmental needs of infants and toddlers with disabilities, ages birth to three years, and their families. Early Intervention services are generally administered by qualified personnel and require the development of an Individualized Family Service Plan (IFSP). Early Intervention is authorized by the federal Individuals with Disabilities Education Act (IDEA), Part C.

Early Learning Council (ELC)

In 2011 the Oregon Legislature created the ELC to provide policy direction and oversee and coordinate Oregon's comprehensive early learning system. The Council also serves as the policy rulemaking body for all programs administered by the Early Learning Division. Council members are appointed by the governor for a term of four years.

Early Learning Division (ELD)

In 2013, the Oregon Legislature created the Early Learning Division to oversee the early learning system, including policies and programs within the early care and education sector. The Division is overseen by the governor-appointed Early Learning System Director.

Early Learning Hubs

The 2013 Legislature authorized creation of 16 regional and community–based Early Learning Hubs to make support more available, accessible, and effective for children and families, particularly those from historically underserved communities. Hubs bring together the following sectors in order to improve outcomes for young children and their families: early education, K-12, health, human services, and business.

Early Literacy

Refers to what children know about and are able to do as it relates to communication, language, reading, and writing before they can actually read and write. Children's experiences with conversation, books, print, and stories (oral and written) all contribute to their early literacy skills.

Education Cabinet

The Education Cabinet is convened to include all major sector partners in supporting the P-20 education continuum. The Cabinet includes agency leadership from the Chief Education Office, Early Learning Division, Oregon Department of Education and Higher Education Coordinating Commission.

Emerging Bilingual Learners

Refers to children under the age of five who are in the process of learning more than one language, and is used to recognize and communicate the value of knowing and being able to communicate in multiple languages.

Employment-Related Day Care (ERDC)

Oregon's major form of financial assistance for child care for low-income families is funded by a combination of federal Child Care and Development Fund and Oregon General Fund dollars. The program is managed by DHS.

Equity

Equity is the notion that each and every person will receive the necessary resources he/she needs individually to thrive, regardless of national origin, race, gender, sexual orientation, first language, or differently abled or other distinguishing characteristics.

Equity Lens

Oregon's Chief Education Office (formerly, the Oregon Education and Investment Board) works to ensure that the Equity Lens it adopted guides education policy. The Lens articulates a set of beliefs. It is intended to "clearly articulate the shared goals we have for our state and the intentional investments we will make to reach our goals of an equitable educational system, and create clear accountability structures to ensure that we are actively making progress and correcting where there is no progress. This lens was created to propel the educational system into action to shift policies, procedures, and practices in order to move from our commitment to an equitable system into actively pursuing an equitable system."

Evidence-Based Practice
A practice, regimen, or service that is grounded in evidence and can demonstrate that it improves outcomes. Elements of evidence-based practice are standardized, replicable, and effective within a given setting and for a particular group of participants.

Family Coach
Assists families transitioning into a state of independence through collaboration and partnership within the community.

Family Friend and Neighbor Care (FFN)
Child care provided by relatives, friends, and neighbors in the child's own home or in another home, often in unregulated settings.

Family Engagement
Refers to an interactive process of relationship-building between early childhood professionals and families that is mutual, respectful, and responsive to the family's language and culture. Engagement in the early years prepares families to support their children's learning throughout their school years and support parent/family-child relationships that are key to healthy child development, school readiness, and well-being.

Head Start
A federal program that provides comprehensive early childhood education, health, nutrition, and parent involvement services to low-income families. The program is designed to foster stable family relationships, enhance children's physical and emotional well-being, and support children's cognitive skills so they are ready to succeed in school. Federal grants are awarded to local public or private agencies, referred to as "grantees," that provide Head Start services. Head Start is administered by the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS). See related: Oregon Head Start PreKindergarten and Early Head Start.

Healthy Families Oregon
Healthy Families Oregon is an accredited multi-site state system with Healthy Families America (HFA) that provides family support and parenting education through home visiting, and is Oregon's largest child abuse prevention program.

High-Quality
Refers to the characteristics of early learning and development programs and settings that research has demonstrated are associated with positive child outcomes. These programs identify and support the needs of children from diverse cultures, children who speak a language other than English, and children with emerging and diagnosed special needs. These programs and settings seek out and use their resources in an equitable manner to ensure developmentally appropriate, culturally, and linguistically responsive communication, activities, and family engagement. They create a dynamic relationship between the family and the educator that works to define what the physical, social, emotional, and cognitive needs are for that child to ensure an optimal learning environment for that individual.

Historically Underserved Communities
Refers to communities that the Early Learning Council Equity Implementation Committee identified as African American, Asian and Pacific Islander, English Language Learners, Geographically Isolated, Immigrants and Refugees, Latino, Tribal Communities, and Children with Disabilities, Economic Disparities, or of Incarcerated Parents/Parental Figures.

Home Visiting Programs
Programs that aim to improve child outcomes by helping high-risk parents who are pregnant or have young children to enhance their parenting skills. Most home visiting programs match trained professionals and/or paraprofessionals with families to provide a variety of services in families' home settings. Examples of home visiting services can include health check-ups, developmental screenings, referrals, parenting advice, and guidance with navigating community services.

Housing/Oregon Housing and Community Services (OHCS)
Oregon Housing and Community Services is Oregon's housing finance agency, providing financial and program support to create and preserve opportunities for quality, affordable housing for Oregonians of lower and moderate income.

Inclusion
The principle of enabling all children, regardless of their diverse backgrounds or abilities, to participate actively in natural settings within their learning environments and larger communities.

Individualized Education Program (IEP)
The Individualized Education Program (IEP) is a written document that is developed for each child who is eligible for special education services. The IEP is created through a team effort and reviewed at least once a year and is required by the federal Individual with Disabilities Education Act (IDEA). See related: Early Childhood Special Education; IEP Team.

Individualized Education Program (IEP) Team
The members of the multidisciplinary team who write a child's IEP.

Individualized Family Services Plan (IFSP)
A written plan that outlines the special services children ages birth through two years and their families will receive if found eligible for Early Intervention services. The plan is mandated by the federal Individuals with Disabilities Education Act (IDEA), Part C. See related: Early Intervention.

Infant/Toddler Mental Health (ITMH)
Defined as the healthy social and emotional development of young children, birth to three years of age. ITMH builds on responsive relationships with primary caregivers (parents, family, child care) that build healthy attachment and foundations for life.

Kindergarten Assessment (KA)
Assessment developed by Oregon and aligned with the state's early learning and development standards to assess what children know and are able to do as they enter kindergarten.

Kindergarten Transition
Refers to a process or milestone in which a child moves from a preschool setting to kindergarten.

Licensed Child Care
The care and supervision of a child, on a regular basis, unaccompanied by his/her parent or guardian, in a place other than the child's own home, with or without compensation.

License Exempt Child Care
Child care that is not required to be licensed based on a series of exemptions in the state of Oregon. See related: Regulated Subsidy Child Care Provider

Mentoring
A form of professional development characterized by an ongoing relationship between a novice and an experienced teacher or provider to deliver personalized instruction and feedback. Mentoring is intended to increase an individual's personal or professional capacity, resulting in greater professional effectiveness. See related: Coaching.

Monitoring
The process used to enforce child care providers' compliance with licensing rules and regulations. States may use "differential monitoring" as a regulatory method for determining the frequency or depth of monitoring based on an assessment of the child care facility's compliance history and other quality indicators.

Office of Child Care
A public office located within the Early Learning Division responsible for child care licensing, compliance, background checks, and monitoring.

Oregon Department of Education (ODE)
ODE is responsible for implementing the state's public education policies. The department is overseen by the governor, acting as state superintendent of public instruction, with an appointed deputy superintendent acting as chief administrator.

Oregon Health Authority (OHA)
OHA is the state agency at the forefront of work to improve the lifelong health of Oregonians through partnerships, prevention, and access to quality, affordable health care. It includes most of the state's health and prevention programs such as Public Health, Oregon Health Plan, and Healthy Kids, as well as public-private partnerships.

Oregon Parenting Education Collaborative (OPEC)
Oregon Parenting Education Collaborative (OPEC) was founded to help parents along on their parenting journey. The OPEC initiative provides access to regional Parenting Education Hubs that provide high-quality (research-based) resources and parenting education classes in Oregon.

Oregon Head Start PreKindergarten and Early Head Start

Oregon Head Start PreKindergarten (OHSPK) and Early Head Start (EHS) are comprehensive high-quality early childhood development programs offering integrated services. OHSPK and EHS programs receive funding from the federal Office of Head Start, the **Early Learning Division**, or both. All OHSPK programs follow the same guidelines for providing services.

Parent Choice

Refers to families' ability to access child care that they choose. The term is often used to refer to the federal Child Care and Development Fund that parents receiving **child care subsidy** should be able to use all legal forms of care.

Parenting Education

Instruction or information directed toward parents and families to increase effective parenting skills.

Preschool

Programs that provide early education and care to children in the two or three years before they enter kindergarten, typically from ages 2.5-5 years. Preschools may be publicly or privately operated and may receive public funds.

Preschool Promise

A high-quality state preschool program serving 3- and 4-year old children living in families at or below 200% of the federal poverty guidelines. It was created by the 2015 Oregon Legislature with a commitment to supporting all of Oregon's young children and families with a focus on equity and expanding opportunities to underserved populations. The program is administered by **Early Learning Hubs** throughout the state, bringing together early learning programs operated by **Head Start**, K-12, **licensed child care**, and **community-based child care** in a mixed-delivery model.

Professional Development (PD)

Refers to a continuum of learning and support activities designed to prepare individuals for work with, and on behalf of, young children and their families, as well as ongoing experiences to enhance this work. Professional development encompasses education, training, and **technical assistance (TA)**, which leads to improvements in the knowledge, skills, practices, and dispositions of early education professionals.

Regulated Subsidy

Regulated subsidy refers to federal child care funds offered through the state to qualifying families to support care that is provided to their children. **See related: Subsidized Child Care.**

Regulated Subsidy Child Care Provider

A Regulated Subsidy Provider is a non-relative who cares for children whose families are eligible for child care assistance through the **Department of Human Services** (DHS), but who is not required to be licensed. A Regulated Subsidy Provider (sometimes referred to as a **License-Exempt Child Care** provider) is required to be listed with DHS and to follow new federal regulations for training and allow a visit by the Office of Child Care.

Relief Nurseries

A public-private partnership program that offers families at high risk for abuse and neglect the intensive trauma-informed support they need.

Retention (of Staff)

Refers to the ability of programs to retain their employees over time. Staff retention is a well-documented problem in early childhood programs that affects program quality.

Risk Factors

Refers to circumstances that increase a child's susceptibility to a wide range of negative outcomes and experiences. Risk factors for low school readiness may include parental/family characteristics such as low socioeconomic status and education, children's characteristics, such as whether the child has **special needs**, or community conditions and experiences, such as whether the child has access to **high-quality** early care and education.

Self-Sufficiency Programs (SSP)

Self-Sufficiency Programs serves Oregonians of all ages through a variety of programs and partnerships with the goal to reduce poverty in Oregon, help families create a safe, secure environment through careers and housing, and stop the cycle of poverty for the next generation.

Social-Emotional Development
Refers to the developmental process whereby children learn to identify and understand their own feelings, accurately read and comprehend emotional states in others, manage and express strong emotions in constructive manners, regulate their behavior, develop empathy for others, and establish and maintain relationships.

Spark
Spark, formerly known as Oregon's Quality Rating and Improvement System (QRIS), is a statewide program that raises the quality of child care across the state. Spark recognizes, rewards, and builds on what early childhood care and education professionals are already doing well.

Special Needs
A term used to describe a child with an identified learning disability or physical or mental health condition requiring special education services, or other specialized services and supports. See related: Early Intervention (EI); Individualized Education Plan (IEP); Individualized Family Services Plan (IFSP).

Statewide Longitudinal Data System (SLDS)
The Oregon State Legislature charged the Chief Education Office with providing an integrated, statewide, student-based longitudinal data system that monitors outcomes to determine the return on statewide educational investments. This data system will provide secure, non-identifiable educational data to enhance the ability of policy makers, educators, and interested parties to improve educational outcomes for students.

Subsidized Child Care
Child care that is at least partially funded by public or charitable resources in order to decrease the cost to families. See related: Regulated Subsidy.

Subsidy
Private or public assistance that reduces the cost of child care for families.

Supply Building
Efforts to increase the quantity of child care programs in a particular local area.

Technical Assistance (TA)
The provision of targeted and customized supports by a professional(s) with subject matter expertise and adult learning knowledge and competencies. In an early education setting, TA is typically provided to teaching and administrative staff to improve the quality of services and supports they provide to children and families. See related: Coaching; Mentoring; Professional Development.

Trauma Informed Care
Refers to an approach used in working with children exposed to traumatic events or conditions. Children exposed to trauma may display heightened aggression, poor social skills, and impulsivity; they also may struggle academically or engage in risk-taking or other challenging behaviors. Service providers and family members that are trained in TIC learn effective ways to interact with these children, such as helping them cope with traumatic "triggers," supporting their emotion regulation skills, maintaining predictable routines, and using effective behavior management strategies.

Workforce
The broad range of individuals engaged in the care and education of young children. Members of the early childhood workforce may include teaching, caregiving, and administrative staff, as well as consultants, learning specialists, and others that provide professional development, training and technical assistance to programs.

Wrap-Around Services
A team of providers collaborate to improve the lives of the children and families they serve by creating, enhancing, and accessing a coordinated and comprehensive system of supports. Supports might include formal services and interventions, such as enrichment and academic supports outside of regular child care programming; community and health services, such as doctor visits; and interpersonal assistance, such as family counseling.

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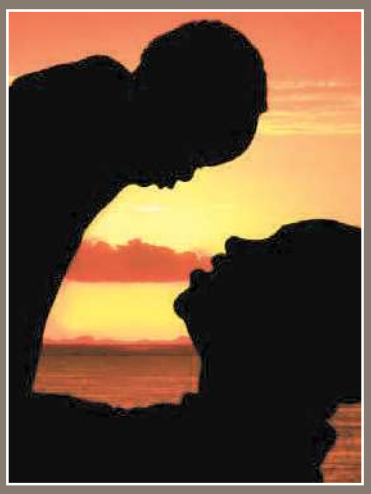

RAISE UP OREGON:
A STATEWIDE EARLY LEARNING SYSTEM PLAN
2019 -2023

The report is issued by the Oregon Early Learning Council

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oregonearlylearning.com/raise-up-oregon

NURTURE OREGON PROGRESS

For Oregon Health Authority

December 2023

Oregon Health Authority

Comagine Health

nurture oregon

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This report summarizes the third year of implementation of Nurture Oregon (NO), 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.

Participants Served

341 participants served; **58% were not stably housed**, 63% used multiple substances, 76% used methamphetamine

90% of participants engaged in **peer services**, **55%** engaged in **SUD treatment** (counseling) and **70%** of participants who used opioids received **medications for opioid use disorder**

65% received **prenatal care**, and among those who gave birth, **93% of infants** had at least **1 well-child check**

Among those who gave birth, 66% of participants went home from the hospital with their baby after birth

Infrastructure Support

Learning Collaborative and convenings such as cross-site meetings, monthly team huddles, and in-person site visits

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

Technical Assistance

Sites received support from technical assistance providers to further develop in the areas of medical and behavioral service integration, peer support and infrastructure, and CCO connections

PROGRESS ON PREVIOUS RECOMMENDATIONS

In the previous annual report, we provided recommendations based on the challenges and barriers experienced by Nurture Oregon sites. The following table describes actions that were taken by the implementation team and NO sites in 2023 related to these recommendations.

Recommendations made in 2022	Actions taken in 2023
Assist sites in **developing site procedures documents** to institutionalize internal team processes and coordination with community partners and continue **enhanced peer supervision** and coaching to address high staff turnover on NO teams	✓ Supported NO site peers in developing their own workflow documents tailored to their specific needs as well as the sites ✓ Peer/Doula technical assistance (TA) provider conducted regular one-on-one supervision and check-ins for peers, and began a quarterly peer/doula process group
Continue to support sites in **creative solutions** such as cross-training existing agency staff who are in other roles, reaching out to clinicians in diverse specialties, etc. to address difficulty identifying qualified and available staff and providers at some NO sites	✓ Some NO peers obtained doula certification ✓ Some NO peers obtained CADC certification
Support sites in **meeting with hospital staff** to increase collaborative care for pregnant and postpartum people with drug use and provide resources and guidance in **addressing stigma** within hospitals	✓ NO teams conducted presentations and lunch and learns to provider groups to try to establish relationships & provide education to help reduce stigma toward pregnant people using substances ✓ Conducted Overcoming Alienation cross-site meeting for NO peers and other staff
Assist sites with ways to **streamline communication** across providers, e.g., exploring a Deschutes pilot with Unite Us to address lack of shared EHR systems across physical & behavioral providers	✓ Met with Unite Us/Connect Oregon, hospital system leaders (Oregon Health Leadership Council), and local CCOs around options to get plans of care in Unite Us and Epic
Continue to support sites to **develop on-site housing** and/or advocate for local organizations to **expand housing eligibility**	✓ Several sites created housing options specifically for the NO population ✓ Conducted cross-site meetings on housing solutions for rural communities and exploring master leasing to deal w/ affordable housing crisis

Continue to **support sites to develop childcare resources** within their agencies and explore state or CCO funding for childcare	✓ Two NO sites obtained grant funding to open up free or low-cost childcare programs (i.e., preschool and daycare)
Continue to support work with CCOs to develop **value-based payment models** and assist sites in examining billing options and outlining essential nonbillable costs to promote program **sustainability**	✓ Finalized and fully implemented NO value-based payment contract between one CCO and one site ✓ Conducted breakout rooms at cross-sites for questions on working with CCOs or VBP models ✓ Made presentations to CCO clinical directors at the Quality and Health Outcomes Committee to support the development of value-based payment options for Nurture ✓ On-going communication w/ NO site CCOs to advance and refine NO prenatal VBP

CHALLENGES & RECOMMENDATIONS

The following table describes recommendations for 2024 in response to challenges and barriers experienced by Nurture Oregon sites in 2023. These challenges were derived from conversations with NO site teams through site visits, cross-site meetings, and monthly site huddles.

Challenges in 2023	Recommendations for 2024
Workforce Challenges	
High staff turnover among Nurture Oregon teams and external partners, presenting challenges to maintaining community relationships	▶ Continue enhanced supervision and coaching by peer technical assistance (TA) provider
Staff burnout from a heavy work burden and emotional fatigue working with a population with complex needs	▶ Continue enhanced supervision and coaching by peer TA provider ▶ Recommend that peer-to-participant ratio for Nurture should be lower than other peer programs, and encourage site leadership to assist peers in attending the peer mutual support group offered through the PRIME+ TA provider
Stigma	
Nurture sites and participants face stigma from other agencies (e.g., police driving around the parking lot of a site) as it relates to serving pregnant people with substance use disorders	▶ Provide community-facing materials and ideas for partner outreach (e.g., lunch and learns, presentations) to inform and reduce stigma
Integration Challenges	
Limited co-location of services in most sites burdens peers with linkage responsibilities and affects participant ease of access	▶ Support sites in identifying opportunities to expand co-location of Nurture services
Inconsistent Engagement of Site Leadership	
At some sites, leadership changes or disengagement led to inattention to program struggles	▶ Institute quarterly leadership meetings ▶ Develop a roles/responsibilities form for sites to complete when changes in staff occur
Lack of Available Community Resources	
Limited housing options in rural and frontier counties, and limited access due to restrictive eligibility criteria	▶ Continue to elevate this issue within OHA ▶ Continue to support cross-site coordination/sharing of ideas for creative housing solutions

Central Platform for Plans of Care	
Lack of a central electronic platform to share Plans of Care with hospitals and other external community partners	▶ Encourage sites to explore opportunities on Unite Us or Connect Oregon
Planning for Sustainability	
Competing priorities within Quality and Health Outcomes Committee leadership hampered expansion of value-based payment (VBP) models at state level	▶ Leverage the Jackson Care Connect VBP contract to move other CCOs within NO service areas

PROGRAM OVERVIEW

BACKGROUND

Nurture Oregon (NO) 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. The original model (Project Nurture), launched by Health Share of Oregon, was piloted in three sites in Portland, Oregon beginning in 2015 and was associated with increased prenatal visits, reduced placement of children in foster care, and cost savings.

The Oregon legislature mandated that the Oregon Health Authority expand Project Nurture to focus on rural areas and sites reaching underserved families. The expansion, Nurture Oregon, 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 journey map below is the ideal Nurture Oregon participant journey in a Nurture program, highlighting the core program elements. Nurture services ideally take place within a single, integrated location. Many sites have identified gaps in the community, particularly around housing and childcare, and have expanded their services to offer additional resources beyond the core program elements.

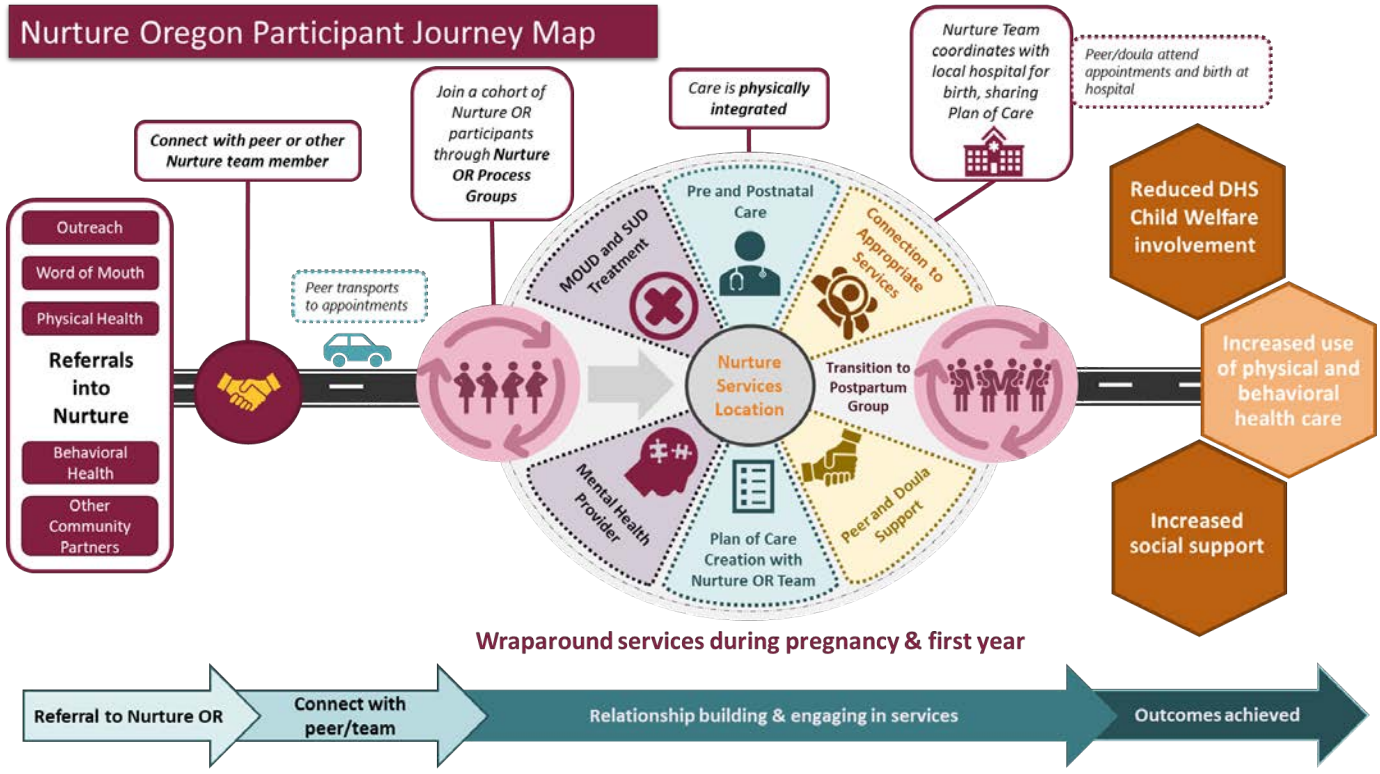
The core program elements of Nurture Oregon include the following:

- 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
- Trauma-informed mental health counseling and services
- Facilitated support groups with Nurture Oregon participants, including prenatal and postpartum groups that include the Nurture Oregon infant
- Other available services such as doula care, housing support, or home visiting nurse

- Partnership in developing Plans of Care

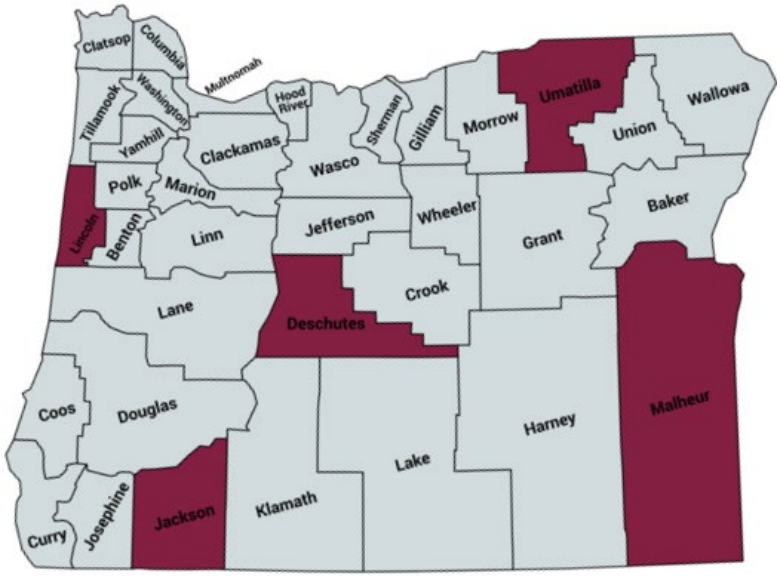
Nurture Oregon teams are expected to develop relationships in the community:

- 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. Note: Funding for the Nurture Oregon program in Malheur County ended June 30th, 2023. OHA and the Nurture core team did not see a path to achieving the Nurture model in the short term in Malheur County due to infrastructure and staffing challenges and gaps in cross-service institutional partnerships.



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, Samaritan Health Services, ODHS Child Welfare, 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	St Anthony Hospital, Good Shepherd Hospital, ODHS Child Welfare, Nurse Family Partnership -UCoHealth

Nurture Database

On a monthly basis, Nurture Oregon sites submit deidentified participant-level process data into an Excel file template created by the Comagine team and upload the data to a secure file transfer protocol site. Participant identifiers are stored separately in each site organization's EHR systems. Nurture Oregon sites track participants who are referred to their site and who engage in services, intake information, and demographics; and plan of care, safe sleep, and child welfare information. Sites track visit frequency and participant utilization of Nurture services including prenatal care, substance use disorder treatment (counseling), medications for opioid use

disorder (MOUD)—also known as medications for addiction treatment (MAT), Nurture Oregon support group attendance, peer services, and postpartum and pediatric care. The Nurture data reporting tool includes an auto-calculated report that gives sites real-time access to site-level information on the number of new people reached each month, cumulative numbers and percentages for all data points, and comparison of participant demographics to county Census statistics. Comagine uses the data to prepare a Site Matrix **(see Appendix 1)**, that displays comparisons of key service data points across Nurture Oregon sites. Every month, sites also receive a Quality Control document **(see Appendix 2)**, that highlights missing data so that sites can ensure that they are collecting and maintaining up-to-date information on all participants. Nurture Oregon sites have been reporting data in the database since August 2021.

SITE IMPLEMENTATION PROGRESS

Progress Towards Integrated Care

Physical health, behavioral health and peer services are the cornerstones of Nurture Oregon and true integration of these services is a long-standing program goal in these rural counties. Integrated care facilitates immediate entry into care and leads to improved health outcomes cost-effectively. Integrating physical and behavioral health care, however, is a challenge in rural areas due to services workforce shortages, health care provider shortages, geographical barriers, and economic and technological constraints, in addition to bias and systems-level stigma around mental health or substance use issues. Only one Nurture Oregon site, a primary care clinic with behavioral health services, has an integrated approach. The other four funded Nurture Oregon sites, consisting of three behavioral health sites and one public health department, were required to build relationships in their community to bridge the health care provider gap. In these cases, finding ways to co-locate services with close collaboration might be the most attainable goal.

Utilizing the Six Levels of Collaboration/Integration (see Table 1) from SAMHSA-HRSA serves as a conceptual framework to better understand and differentiate Nurture Oregon implementation across sites. One Nurture site (Jackson County) offers integrated care; the other Nurture sites offer highly coordinated care. In Deschutes, Umatilla, and Lincoln, the peers regularly transport and attend prenatal and postpartum visits alongside Nurture participants. Nurture teams meet weekly to review participant needs and coordinate care. The Lincoln Nurture weekly meetings include a consortium across multiple community sectors (e.g. Public Health nursing, transitional housing, OB-GYN providers, Community Doula and others), and the clinics that provide most of the prenatal care in Lincoln City and Newport have the Nurture peers on speed dial. In mid-2023, the Lincoln site opened a new Nurture location in Benton County called Monarch on 4th, offering co-located services.

Table 1: SAMHSA Six Levels of Collaboration/Integration[1]

COORDINATED		CO-LOCATED		INTEGRATED	
LEVEL 1 Minimal Collaboration	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed/ Merged Integrated Practice

Implementation Progress in 2023

In the first year of implementation (2021), Nurture Oregon sites focused heavily on startup activities, including identifying partners and building partner relationships, delineating roles and

[1] From Heath B, Wise Romero P, and Reynolds K. A Standard Framework for Levels of Integrated Healthcare. Washington, D.C. SAMHSA-HRSA Center for Integrated Health Solutions. March 2013.

responsibilities, developing workflows, and identifying steps toward service integration. As sites established stronger programmatic infrastructure, the focus for year two and three shifted to program improvement and creating more sustainable systems and relationships.

In 2023, sites continued to face multiple implementation challenges. All Nurture Oregon teams reported that they often experienced burnout, particularly when short-staffed or stretched by the level of effort required to maintain contact with participants. Nurture sites and their participants also faced stigma. For example, the Umatilla County site building landlord removed sharps containers from the bathrooms and required that all doors be locked after a certain hour, creating a barrier for participants. In Jackson County, the hospital required that all Nurture Oregon participant guests check their backpacks at the nursing station, creating an air of mistrust. Staff turnover at partner organizations, such as high turnover at Child Protective Services (CPS) in Deschutes County, hindered relationship building. Nurture sites create Plans of Care with participants but lack a shared platform to house the plans across organizations with different EHRs. Competing priorities and limited leadership engagement at Malheur and Umatilla sites hindered implementation. The Malheur County site experienced infrastructure, staffing, and partnership issues, leading to the non-renewal of their Nurture contract in June 2023.

Amidst these challenges, there were notable successes as sites continued to build relationships within their community and expand service offerings. Umatilla, Deschutes and Lincoln County sites maintained strong hospital ties, while still actively attempting to engage and build relationships with other community providers through lunch and learns and direct outreach. Jackson and Lincoln County sites began providing free or low-cost childcare services for Nurture participants. Oasis, in Jackson County, partnered with a local organization to open a pre-school program. Two Nurture sites focused on housing initiatives in response to community needs. The Deschutes County site was able to acquire a four-plex to house Nurture participants, and the Jackson County site welcomed the first Nurture occupants into three newly acquired apartments designated for participants needing shelter while waiting for residential treatment. Oasis worked with local CCOs to enable billing for peer services and implement a value-based payment model. Both CCOs are now allowing Oasis to use community health worker billing codes for peer services. Nurture sites also engaged in dissemination of their experiences and findings from the program to broader audiences. For instance, in May 2023, Deschutes, Jackson, and Lincoln sites presented on a joint panel highlighting their Nurture programs to a statewide audience at the Oregon Conference on Opioids + Other Drugs, Pain + Addiction Treatment (OPAT).

Site level implementation data are reported in the pages that follow. Descriptive findings of site successes, challenges, and goals were captured through site visits, monthly huddles, TA provider communication, and cross-site meetings. **Quantitative data were summarized from monthly site data submissions and are cumulative.** Note: Site data are reported from August 2021 through December 2023. Site data from Malheur are reported through June 2023, which was the end of their funding period.

DESCHUTES

Population (2022): 206,549

Size of county: 3,018 square miles

Background: 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. Both partners are located in the same building in Redmond. The Program Supervisor/team lead for Best Care attends weekly provider meetings at the St. Charles clinic to discuss shared Nurture participants. Best Care is working to strengthen a relationship with East Cascades Women's Group, the largest obstetrics care provider in Central Oregon.

Strengths & Successes:

- Acquired a four-plex and now offers housing to participants
- Services and close coordination with prenatal care providers at St. Charles
- Experienced Best Care team
- History of effective peer outreach and engagement
- Strong Nurture group program with consistent attendance

Challenges & Barriers:

- Staff turnover with team experiencing burnout at times
- Difficulty building a relationship with one medical group despite repeated attempts
- Closure of a major housing resource in the community
- Challenges with hospital relationship and access to connect with potential participants before CPS visits following birth
- High turnover at Deschutes County CPS, preventing a strong relationship

Goals Achieved from Last Year:

The Best Care group expanded services to include a new housing offering in Redmond. A CADC/Peer leads NO support groups, using contingency management to increase group attendance. The group continued efforts to establish inroads with the East Cascades Women's Group.

SITE STATS

117 Referrals

Top Referral Sources:

- Medical/Physical Health Providers
- Self-referral or word-of-mouth

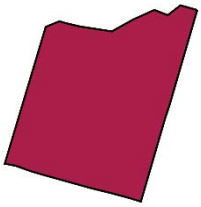
75 Participants

AVG SERVICE DOSAGE

24.4	SUD Tx Visits
10.5	MOUD (MAT) Visits
7.8	Mental Health Visits
12.1	Nurture OR Support Groups
25.4	Hours of Peer Support
5.9	Prenatal Care Visits

56 Births

JACKSON



Population (2022): 221,644

Size of county: 2,783 square miles

Background:
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 disorders. 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 physical space for all Nurture Oregon services. Historically, most patients have been involved with DHS Child Welfare or criminal justice systems. Nurture Oregon peer outreach provided an opportunity to reach more non-mandated patients. Last year, the Oasis team expanded housing support and services for Nurture participants.

Strengths & Successes:

- Worked with local CCOs to enable billing for peer services and implement a value-based payment model. Both CCOs are allowing Oasis to use community health worker billing codes for peer services.
- Oasis Behavioral has regular care coordination meetings with the local delivery hospital social workers
- Opened a pre-school to support Nurture families
- Expanded prenatal provider staffing
- Collaborated with a local organization to open a preschool program that supports Nurture families
- All services are provided at one location

Challenges & Barriers:

- Local hospitals don't use a harm reduction lens when serving pregnant people who use substances
- No electronic platform to share Plans of Care with the hospital, so participants must bring paper copy

Goals Achieved from Last Year:
The team developed financial sustainability around peer services billing and behavioral health and implemented value-based payment through their work with the local CCOs.

SITE STATS

156 Referrals

Top Referral Sources:

- Medical/Physical Health Providers
- Behavioral Health Providers

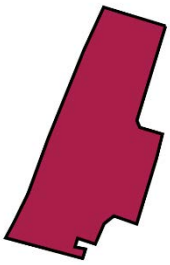
147 Participants

AVG SERVICE DOSAGE

5.8	SUD Tx Visits
4.9	MOUD (MAT) Visits
2.4	Mental Health Visits
4.8	Nurture OR Support Groups
4.3	Hours of Peer Support
2.3	Prenatal Care Visits

100 Births

LINCOLN



Population (2022): 50,813

Size of county: 981 square miles

Background:
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 participants 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), the Community Doula Program, Samaritan Health Services, and ODHS Child Welfare. ReConnections coordinates with prenatal and pediatric care providers at Samaritan Hospital's women's clinic. Nurture Oregon medical care is provided in separate locations from the other services, though space is now available to host all services at ReConnections.

Strengths & Successes:

- Expanded services to include childcare
- Physical space to host all services at ReConnections
- History of effective peer outreach and engagement
- Multidisciplinary team consistently engaging in meetings
- Strong development and use of Plans of Care
- Expanded to a new location in Benton County

Challenges & Barriers:

- Difficulty building relationships with hospital staff in labor and delivery and establishing referral pathways from the hospital; hospital staff turnover a factor
- No electronic platform to share Plans of Care
- Difficulty integrating w/ OB staff in Samaritan Hospital system
- Dropoff in service utilization by participants following birth

SITE STATS

65 Referrals

Top Referral Sources:

- Medical/Physical Health Providers
- ODHS Child Welfare

44 Participants

AVG SERVICE DOSAGE

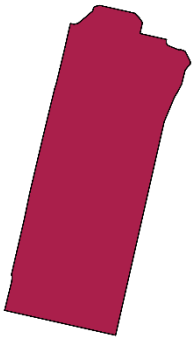
55.0	SUD Tx Visits
4.0	MOUD (MAT) Visits
2.1	Mental Health Visits
7.6	Nurture OR Support Groups
4.6	Prenatal Care Visits

Peer support hours are excluded due to data quality issues

25 Births

Goals Achieved from Last Year:
The ReConnections team has the potential to integrate medical services in their new Benton County location. The team made efforts to reach the Spanish-speaking population in their community by hiring a bilingual peer/doula, reaching out to known contacts for Spanish speakers and medical translations, and translation of Nurture materials into Spanish.

MALHEUR



Population (2022): 31,879

Size of county: 9,888 square miles

Background:
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, Malheur County was slow to develop Nurture Oregon programmatic structure. OHA ended the Nurture Contract in July of 2023.

Strengths & Successes:

- Valley Family team brings experience providing prenatal care, medications for opioid use disorder, mental health services, and care coordination
- Hired new peer at the start of 2023

Challenges & Barriers:

- Services are primarily offered in three distinct physical locations
- Difficulty getting people engaged in groups due to expansive geography & poor broadband internet connection not allowing for hybrid virtual groups
- High staff turnover at Health Department and Valley Family led to workforce burnout and retention challenges

Goals Achieved from Last Year:
The Nurture Oregon peer and SUD counselor began working one day per week on site at Valley Family.

SITE STATS

33 Referrals

Top Referral Sources:

- Medical/Physical Health Providers
- ODHS Child Welfare

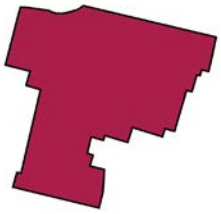
24 Participants

AVG SERVICE DOSAGE

6.1	SUD Tx Visits
2.0	MOUD (MAT) Visits
3.7	Mental Health Visits
4.8	Nurture OR Support Groups
9.4	Hours of Peer Support
4.0	Prenatal Care Visits

18 Births

UMATILLA



Population (2021): 80,215

Size of county: 3,215 square miles

Background:
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 program. The OWhN team experienced turnover in the executive director position and a new peer joined the team. They are now fully staffed.

Strengths & Successes:

- Success developing collaboration with St. Anthony's birthing center; Nurture staff have unrestricted access and positive relationships with OB-GYNs
- Physical space available to house all services
- Connecting with other medical providers in the community through networking and Lunch and Learn opportunities

Challenges & Barriers:

- High staff turnover in key positions
- Lack of referrals from DHS Child Welfare in Pendleton
- Geographic challenges contribute to low attendance at support groups
- High levels of community stigma (from landlord, police, etc.)
- Turnover in obstetrics providers

Goals Achieved from Last Year:
Despite the challenges in holding groups due to geography and participation, the OWhN team continues to lead groups and encourage participation through contingency management and other activities. The OWhN team is now fully staffed, with a new CADC and a Project Manager on the project.

SITE STATS

103 Referrals

Top Referral Sources:

- Medical/Physical Health Providers
- ODHS Child Welfare

51 Participants

AVG SERVICE DOSAGE

12.5	SUD Tx Visits
2.8	MOUD (MAT) Visits
5.8	Mental Health Visits
5.2	Nurture OR Support Groups
14.1	Hours of Peer Support
4.3	Prenatal Care Visits

26 Births

NURTURE PARTICIPANTS

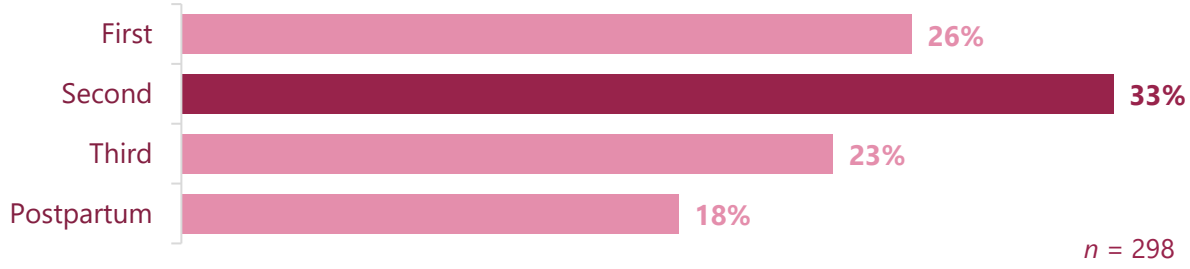
Oregon Health and Science University is conducting a formal evaluation of Nurture Oregon. Comagine Health and Oregon Health Authority collaboratively developed indicators for program monitoring, which are reported here.

One site (Jackson County) had the programmatic infrastructure to begin serving participants soon after receiving funding on September 1, 2020. Other sites worked on partnerships, hiring, and executing subcontracts, and began serving participants after the cross-site kickoff in March 2021. Services reported occurred from September 1, 2020 – December 31, 2023, and data are cumulative. Malheur provided data through June 30, 2023, the end of their funding period.

PARTICIPANTS REACHED

Of the 474 individuals who were referred to Nurture Oregon, 341 participants received services and comprised the final cohort for this period. Nurture aims to identify and engage individuals prenatally to have the greatest impact. Data show that 82% of participants engaged prenatally.

Exhibit 1: Participants' Trimester at Engagement
For all participants who engaged from 2020-2023, slightly more participants engaged during the second trimester (33%) than the other two trimesters[2].



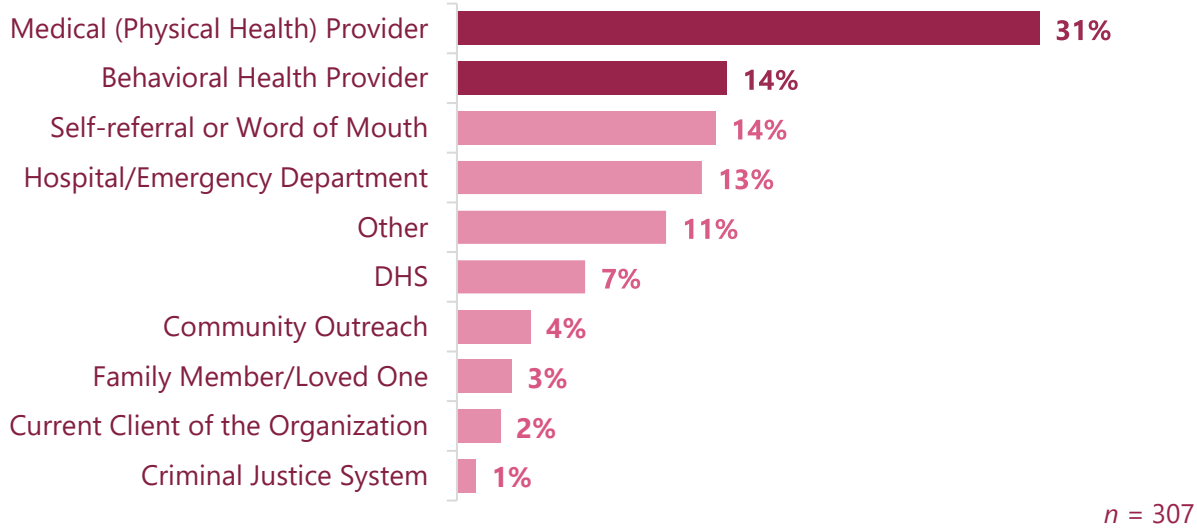
[2] The pregnancy due date was missing for 43 (12.6%) participants.

REFERRAL SOURCES & ENGAGEMENT PATHWAYS

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

> *45% of participants were referred by a physical or behavioral health provider in the community, and 13% were referred by hospitals or emergency departments.*
>
> *Informal engagement pathways were important: many participants were self-referred; referred by family members, loved ones, or other clients/patients of the organization; or engaged through direct community outreach (street outreach) by peers.*
>
> *Other referral pathways included community organizations, Department of Human Services (DHS) and the criminal justice system.*

Exhibit 2: Referral Sources and Engagement Pathways
Most participants were referred to Nurture Oregon by a medical or behavioral health provider, or through self-referral. [3]



n = 307

[3] The referral source was missing for 34 (10%) participants.

PARTICIPANT DEMOGRAPHICS

Age, Race, Ethnicity, Housing status

> *Most participants were between the ages of 20 and 34, with an average age of 29.*
>
> *81% were White, 2% were Black/African American, 7% were American Indian/Native American*
>
> *17% were Hispanic/Latinx*
>
> *58% were unstably housed or experienced homelessness*

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

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

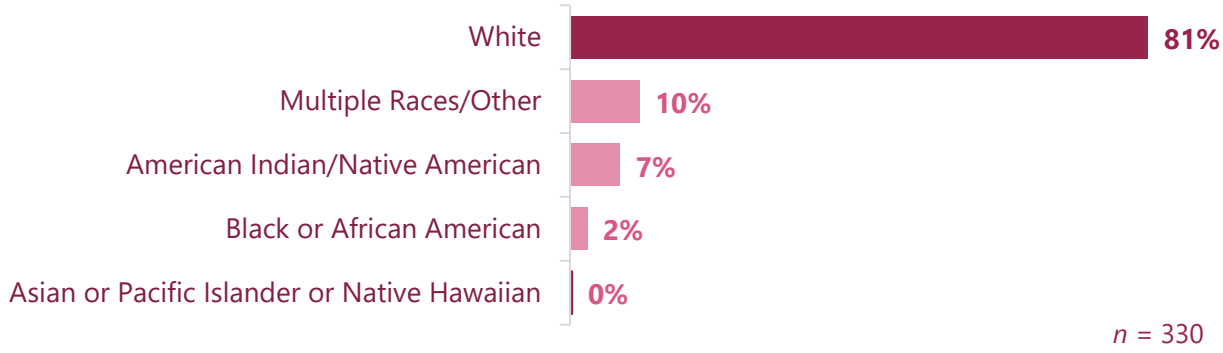
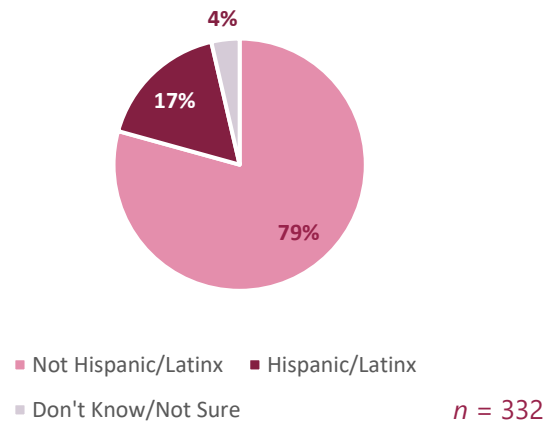


Exhibit 5: Participant Ethnicity
Seventeen percent of participants were Hispanic/Latinx.



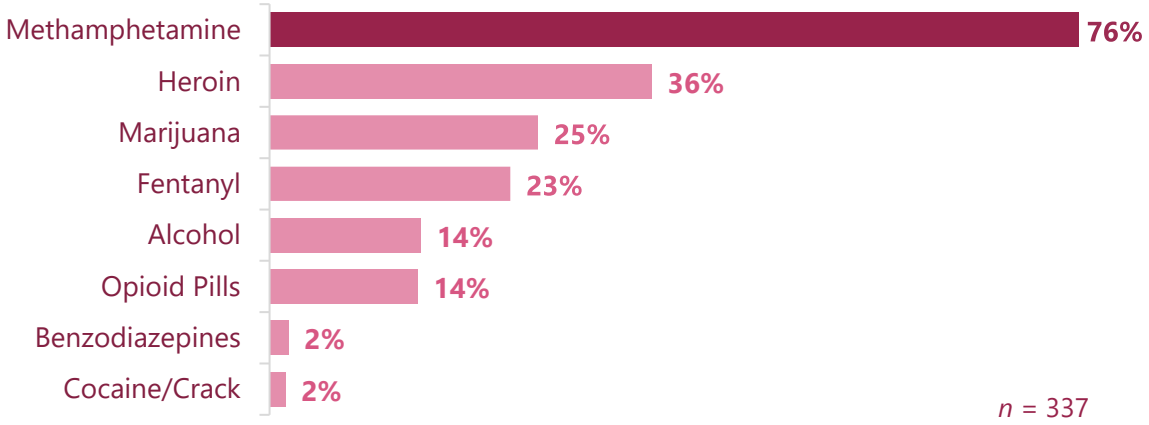
Housing Status

Exhibit 6: Housing Status at Engagement
A total of 58% of participants were either unstably housed or experiencing homelessness.

SUBSTANCE USE AT TIME OF ENGAGEMENT

For participants with available data (n = 337), **63% of participants used multiple substances**. Methamphetamine was the most common substance used (76%). Thirty-six percent of participants used heroin and 25% used marijuana.

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



SERVICES PROVIDED

90% of participants engaged in peer services

55% engaged in SUD treatment; 56% received medications for SUD

65% received prenatal care

70% of participants who used opioids received MOUD (MAT)

Behavioral Health and Prenatal Care

Nurture Oregon is a voluntary program in which participants are encouraged and supported to participate in all program services but may choose not to engage in all services. Most participants (90%) engaged in peer support services. Fifty-five percent of all participants engaged in any type of non-medication substance use disorder (SUD) treatment and 56% received a medication for opioid use disorder (e.g., buprenorphine, methadone). Just over a quarter of participants (30%) received mental health services. Thirty-eight percent of participants engaged in Nurture Oregon support groups. Sixty-five percent of participants who engaged in Nurture Oregon received prenatal care. Among participants who reported using opioids at engagement (N=196), 70% received medication for opioid use disorder treatment.

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

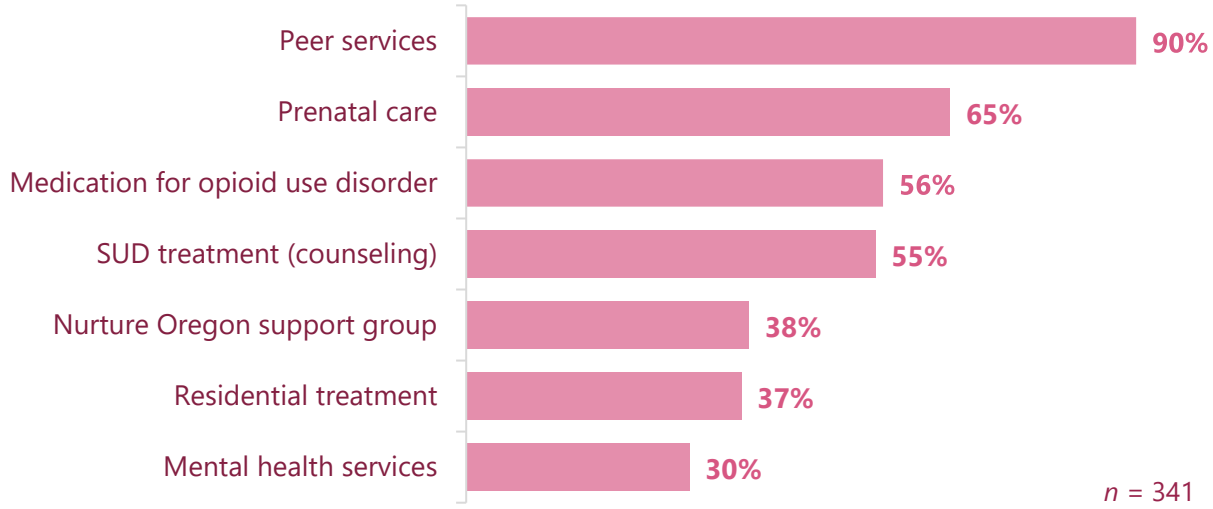
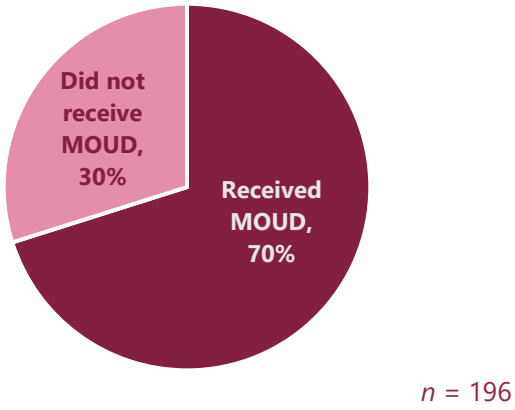


Exhibit 9: Medications for Opioid Use Disorder Among Participants Who Use Opioids
Most participants who reported opioids as a primary substance used at engagement received MOUD (MAT).

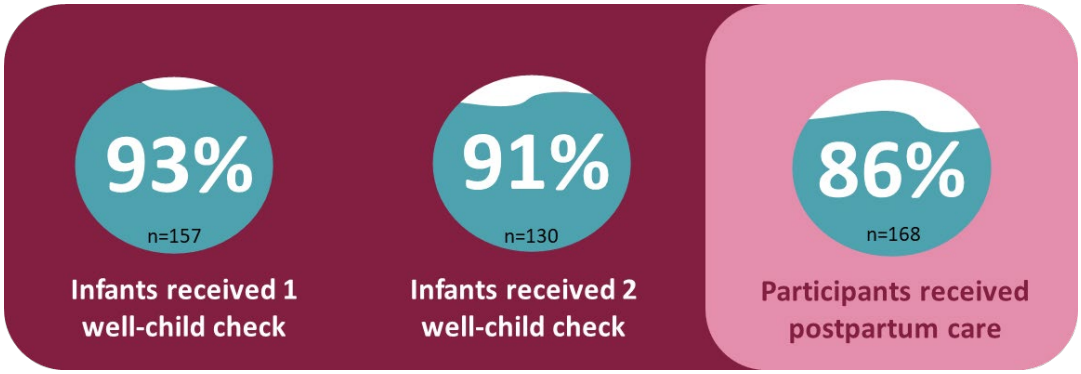


Postpartum and Postnatal Care

> *86% of participants received postpartum care*
>
> *93% of infants born to participants had at least 1 well-child check*
>
> *91% had at least 2 well-child checks in their first year of life*

To date, 224 participants have given birth; seven of these participants were missing data on the number of babies that were delivered. There were 225 babies delivered among the 217 participants with available data (nine participants gave birth to twins). One participant lost their baby prior to birth. Among participants with data available for postpartum care (N=168), 86% reported receiving postpartum care. Most infants (93%) received at least one well-child visit, with 91% receiving two well-child checks in their first year. Data were missing for many participants and infants. Sites are working to build relationships with pediatricians to ensure completeness of data and consistent support for infants during the first year after birth.

Exhibit 9: Postpartum and Postnatal Care[4]
Nearly all Nurture Oregon infants for whom data were available received 2 well-child checks within 12 months of birth.



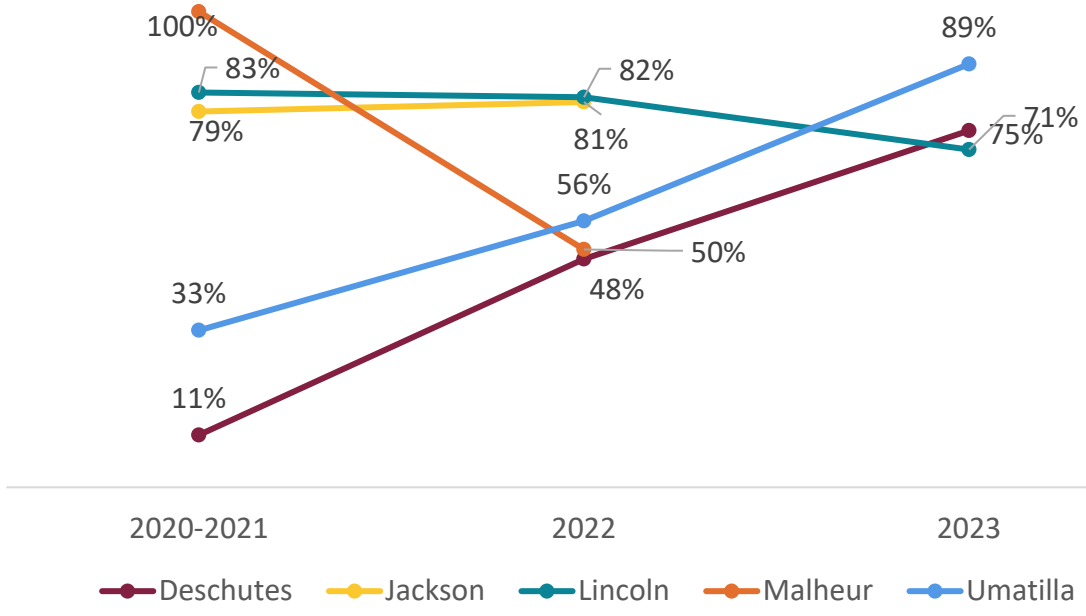
[4] There were 67 participants missing 1 well-child check data, 94 missing 2 well-child check data, and 56 participants missing any postpartum/postnatal care data.

CARA PLANS OF CARE

> *Among participants who gave birth (N=225), 60% had a Plan of Care developed, and 63% had their Plan of Care developed prenatally.*
>
> *Most sites increased development of Plans of Care over time or remained high.*
>
> *Development of Plans of Care were often led by participants (37%), followed by SUD providers, prenatal clinicians, and peer specialists. ART/FIT providers and hospital social workers also contributed to their development.*

Among participants who had given birth at the time of this report (N = 225), **60% had a Plan of Care developed.** Among all participants (N = 341), 42% had a Plan of Care developed. Plan of Care development numbers include participants served before all sites began Plan of Care development, and new Nurture participants.

Exhibit 11: Plan of Care Development Trends Among Participants Who Gave Birth
Two sites experienced an increase over time in the number of birthing participants who had a Plan of Care developed; two sites started and remained high in Plan of Care development.



Note: Jackson County was excluded from 2023 due to staffing changes causing a pause in tracking Plan of Care data. Malheur County was excluded from 2023 because their data collection ended in June 2023.

Exhibit 12: Plan of Care Development Timeframe Among Participants Who Gave Birth
Among participants who gave birth and had data available on Plan of Care timeframe, 63% had a Plan of Care developed prenatally.

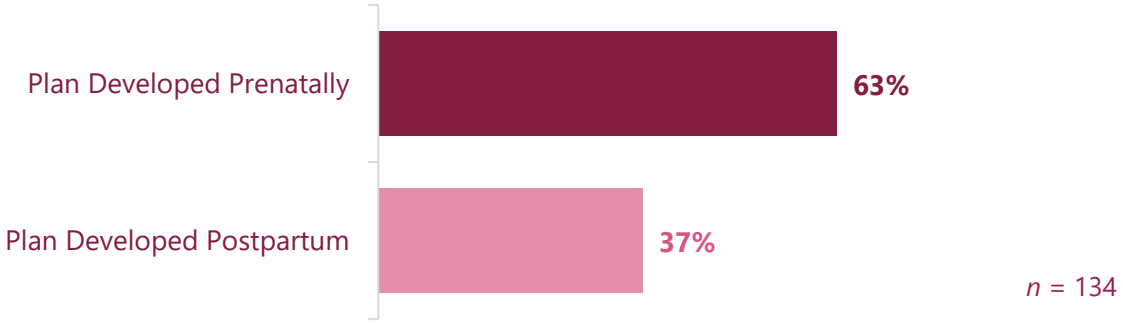


Exhibit 13: Plan of Care Development Leadership Among Participants Who Gave Birth
Participants mainly led the development of Plans of Care, followed by SUD providers and prenatal clinicians. The 'Other' category included doulas or other professionals.

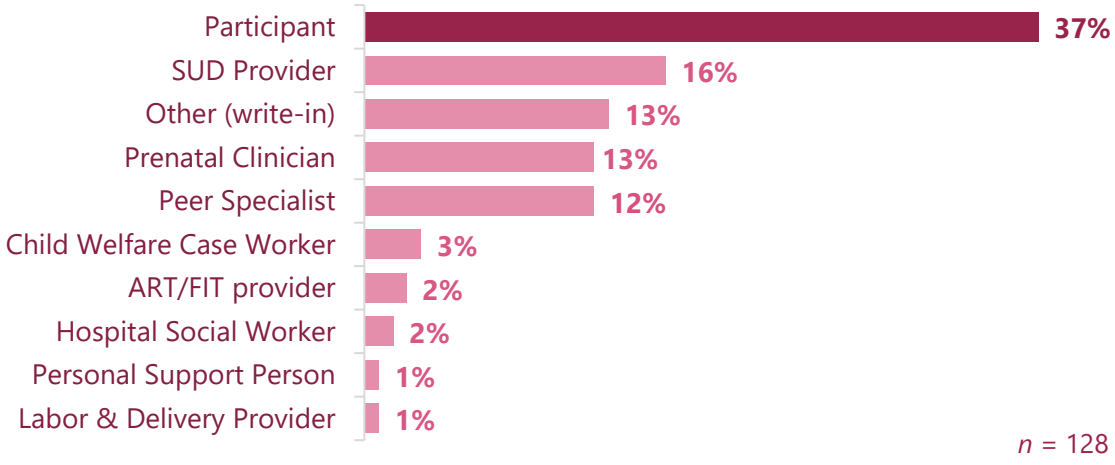
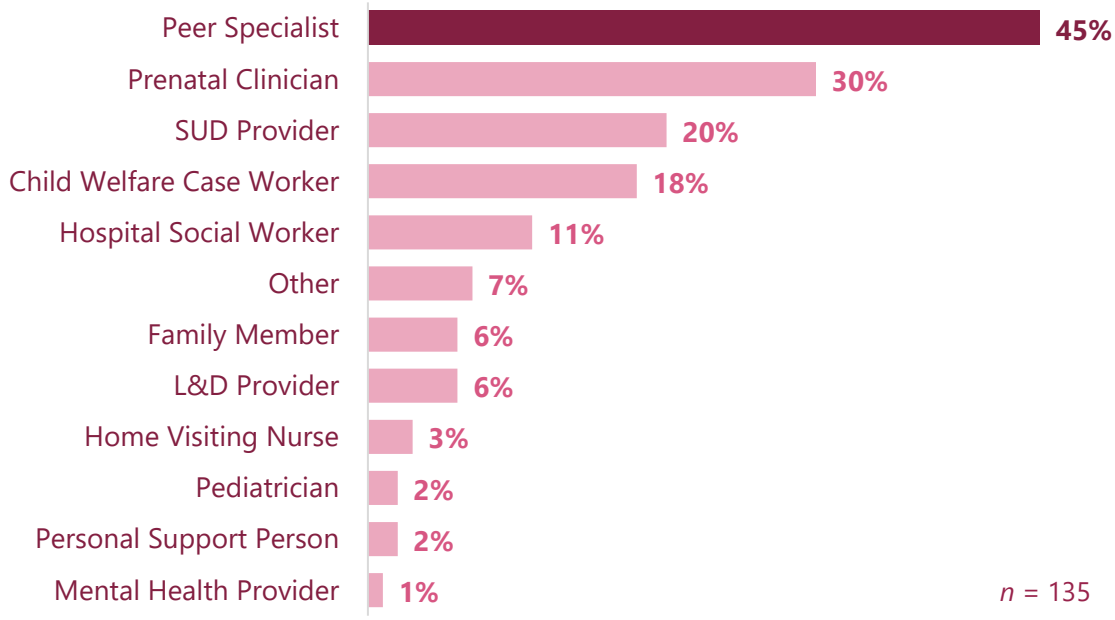


Exhibit 14: Other Plan of Care Contributors Among Participants Who Gave Birth
Besides the participant, peer specialists, prenatal clinicians, and SUD providers were the top contributors to the Plans of Care.



ODHS also provided Safe Sleep materials to Nurture Oregon sites to distribute to participants. Of the 166 participants for whom data was available, 63% were given Safe Sleep materials.

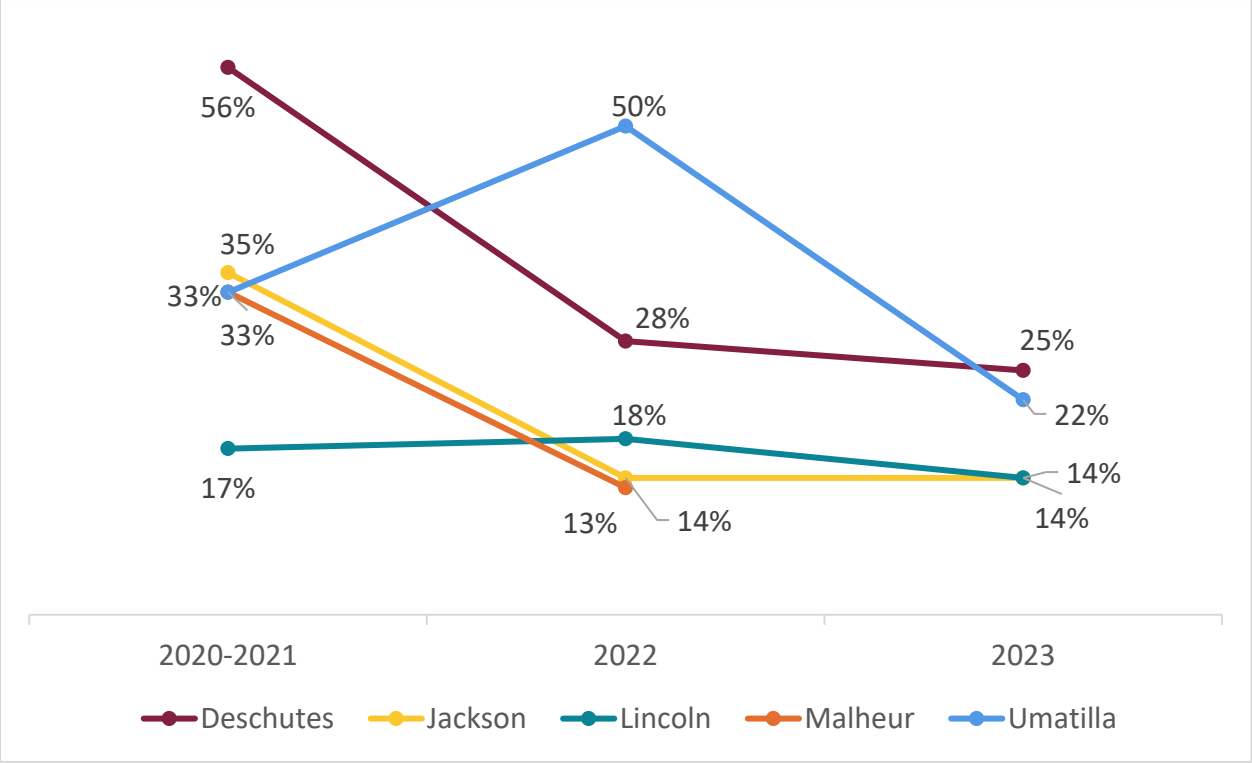
CHILD WELFARE INVOLVEMENT

> *32% of participants had prior involvement with Child Welfare for a different child at engagement.*
>
> *66% of participants went home from the hospital with their baby.*
>
> *Most sites experienced a decline over time in court interventions to remove Nurture Oregon infants from the participant in the first year after birth.*

Among participants who gave birth by the end of the reporting period, 221 had data available on prior Child Welfare involvement, and 223 had data available for Nurture child removals at birth and court removals. Among participants who gave birth, **66% went home from the hospital with their Nurture Oregon child** and did not experience a removal at birth.

Exhibit 14: Court Interventions to Remove Nurture Oregon Child from Participant During First Year After Birth

Most sites experienced a decline over time in the number of birthing participants who had their child removed through court intervention; one site started and remained low.



Note: Malheur County was excluded from 2023 because their data collection ended June 2023.

STATE-LEVEL INFRASTRUCTURE

CONVENINGS

Nurture Oregon convenings support site progress and cross-site learning. 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.

Meeting	Attendees	Frequency	Details
Site Case Coordination Huddles	Site team staff	Weekly	Discuss general coordination and participant-specific needs
Site Implementation Reflection Huddles	Comagine & TA providers, OHA, site teams	Monthly	Reflect on implementation progress and needs; includes staffing and partnership updates, integration, and next steps
Cross-Site Meetings and Learning Collaborative	Comagine & TA providers, OHA, site teams	Monthly	Convene to brainstorm strategies to overcome barriers; Expert speakers and cross-site sharing on relevant topics
Database Meetings	Comagine, site data leads	Monthly	Review data report, discuss data quality and results

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 in response to team experiences or requests for training, featuring subject matter expert speakers. The Nurture Oregon leadership team organized 12 Learning Collaborative/Cross-site meeting sessions in calendar year 2023. Nurture Oregon peers were also invited to attend PRIME+ Peer Learning Collaborative sessions.

12 Nurture Learning Collaborative Sessions

Topic	Presenter
Review of Nurture Data	Nurture Teams
Housing Solutions for Rural Communities	Lola Jones

Overcoming Alienation in the Peer Role	Kasey Edwards Snider
Soup to Nuts: Pregnancy Basics	Julia Vance
Nurture Oregon Re-Orientation	Nurture Teams
Small Group Discussion: Peer Supervision, NO Medical Questions, CCOs, and NO Data	Nurture Teams
Telemedicine Buprenorphine	Sara Sanderson, Amy Potter
Small Group Discussion: Peer Supervision, Housing for Nurture Participants	Kasey Edwards Snider, Lola Jones
Site Share-Outs and NO Jeopardy Trivia	Nurture Teams
Small Group Discussion: Peer Supervision, NO Medical Questions, ODHS Child Welfare Questions	Kasey Edwards Snider, Julia Vance, Alicia Kleen, Carmen Mims
Nurture Oregon Groups that Support Women in Treatment and While Parenting	Laura Elder
Celebrations for Nurture Oregon Participants	Nurture Teams

9 PRIME+ Learning Collaborative Sessions

Topic	Presenter
QPR Suicide Prevention	Debra Buffalo Boy
Crisis Prevention & De-escalation	Elaine Walters
Overamping Prevention Planning	Alexis Cooke, Gillian Leichtling
Justice-Involved Individuals	Noel Vest
Wound Care & Outreach Kits	Elona Dellabough-Gormley
Buprenorphine Induction in the Age of Fentanyl	Joshua Reagan, Kasey Edwards Snider
Ethical Mandate of Self-Care and Burn-out Prevention (Parts I & II)	Jon Gieber
Overdose Prevention Planning	Gillian Leichtling
Cultural Responsiveness (Parts I & II)	Debra Buffalo Boy

RESOURCES

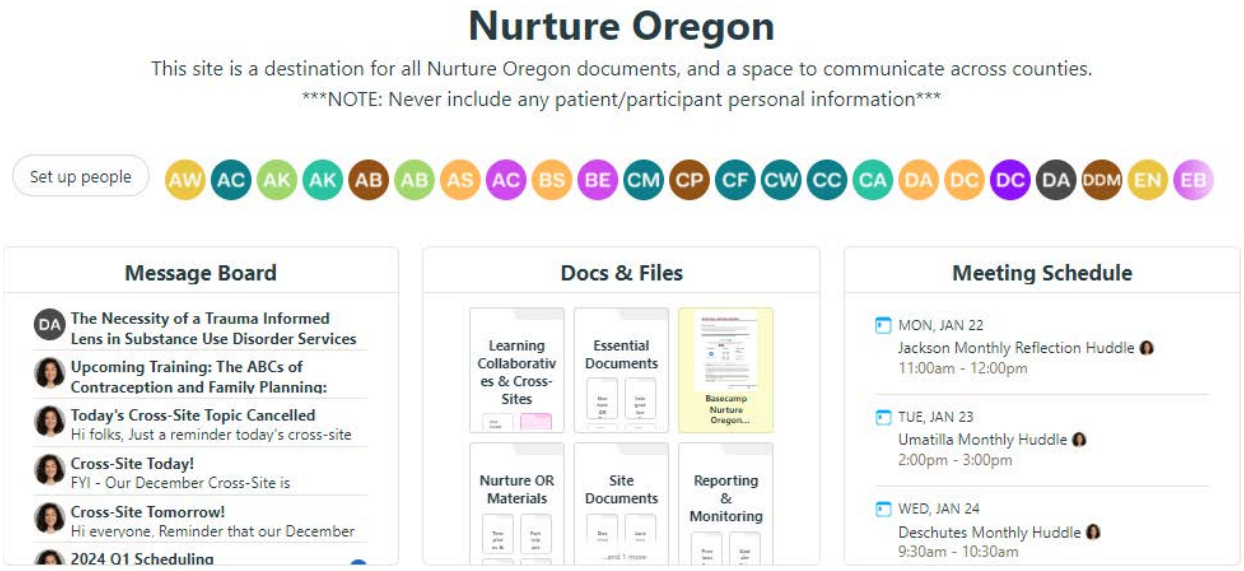
Documents

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
- **Biannual briefs:** highlights of 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.



Data Summaries

The Comagine team provides an auto-calculated report within the Nurture data reporting tool that gives sites real-time access to site-level information on the number of new people reached each month, cumulative numbers and percentages for all data points, and comparison of participant demographics to county Census statistics. The team also provides a monthly site

matrix comparing key data points across sites. The implementation team discusses the data reports with sites monthly.

Participant Feedback

The Nurture implementation team created a participant feedback survey for sites focused on four programmatic components: intake and assessment, service delivery, participant perceptions of team integration, and plan of care development. The survey is administered anonymously at three timepoints during a Nurture participant's engagement. **See Appendix 3 for survey items**.

Participant Feedback Survey Results

To date, the survey has been completed by 59 participants. Site staff receive summaries of participant feedback surveys once the survey has been completed by at least five participants, and any month in which there are at least three new responses (**see Appendix 4 for summary template**).

Timepoint 1 – currently pregnant – completed by **20** participants.

Timepoint 2 – gave birth in the last 3 months – completed by **23** participants.

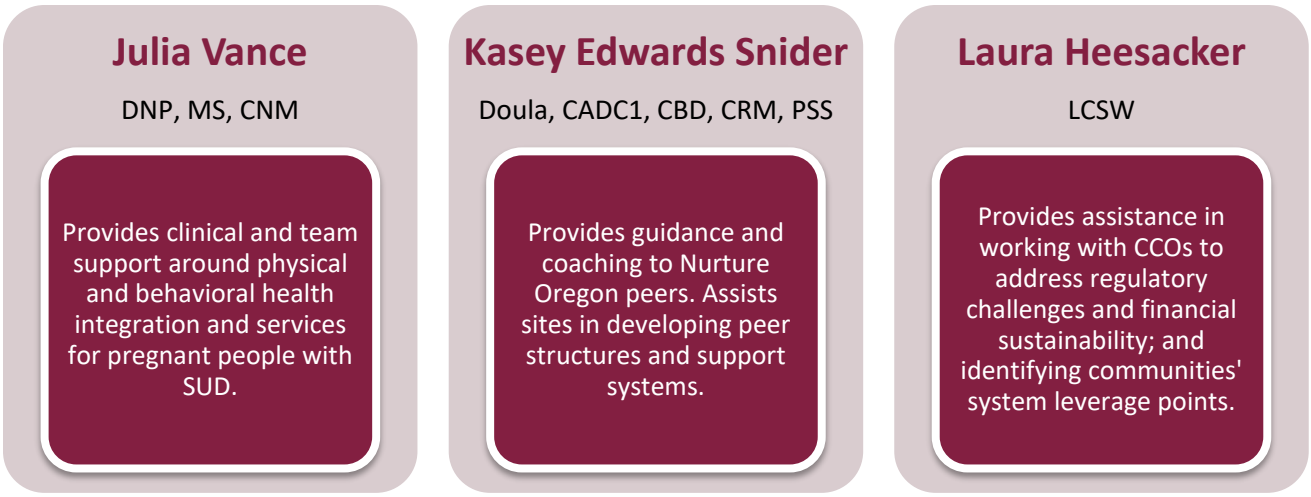
Timepoint 3 – gave birth over 9 months ago – completed by **16** participants.

TECHNICAL ASSISTANCE

Nurture Oregon sites receive technical assistance (TA) through monthly site huddles, cross-site meetings, and individual and team coaching from TA providers. After year one, OHA provided resources to expand specialized support for Nurture Oregon sites.

Nurture Oregon Technical Assistance Team

Three subcontracted TA specialists provide support to Nurture Oregon sites in various areas of need, including: 1) Clinician and team structure support, 2) Peer supervision and support, 3) CCO connection and support. The TA providers attend and offer guidance at Nurture site meetings and yearly in-person site visits and communicate directly with sites to support implementation progress.



Clinical and Team Structure Support

Dr. Julia Vance is a Certified Nurse Midwife who served as the lead clinician and program developer for one of the original Project Nurture sites. She has advised Nurture Oregon sites since June 2021, providing support and expertise in Nurture integrated services, pregnancy and caring for newborns exposed to substances, and development and use of Plans of Care. Julia has:

- presented or co-presented Learning Collaborative sessions on topics such as neonatal withdrawal and caring for infants exposed to substances, developing plans of care, pregnancy basics, and buprenorphine prescribing for Nurture Oregon participants.
- attended Nurture participant support groups and presented on topics such as contraception education.
- conducted trainings on advocating for peer specialists within organizations and assisted sites in defining peer roles (prior to the peer TA provider joining in June 2022).
- conducted education on pregnancy and breastfeeding for a SUD lens.
- advised on best practices on addiction care related to DHS allegations/investigations and provided court room testimony for a Nurture participant in 2023.

Peer Supervision and Support

Kasey Edwards Snider is a doula and peer specialist who serves as peer team lead for one of the original Project Nurture sites. Beginning in June 2022, she has provided education, coaching, and support to peers, doulas, supervisors, and medical providers. Kasey has:

- conducted more than 200 one-on-one peer mentorship/support meetings to Nurture team members in 2023.
- provided direct support regarding systems integration, perinatal education, maternal harm reduction, peer boundaries, Nurture team structure, how to influence a culture shift in healthcare, and person-first medical navigation.
- given on-call support to doula/peers for complicated situations.

- began offering a specialized peer doula support work group in 2023, offering a safe space for doulas to discuss complicated births and the unique challenges of being a peer and doula.
- provided routine check-ins and supervision to peers when staff turnover at sites resulted in the absence of peer supervisors. This has been imperative towards continuing positive program outcomes and maintaining the safety of Nurture Oregon peers.
- began developing a workbook of living documents to provide guidance on topics including how to conduct oneself as a peer/first impressions, working with ODHS, relapse prevention, examples of pre-filled safety plans, and more.
- led or co-presented topics at cross-sites including personal recovery, selfcare, boundaries, work/life balance, advocacy for self and participant, and supportive resources. She co-presented on MOUD for pregnant people to medical providers and has facilitated discussions at Nurture cross-site meetings.

CCO Connection and Support

Laura Heesacker is a Licensed Clinical Social Worker who provides technical assistance and mentoring to organizations in the development of integrated behavioral health programs that include state of the art treatment for pain and substance use disorders. Beginning in July 2022, Laura has:

- assisted sites in working with CCOs to address regulatory challenges and financial sustainability, and in identifying communities' system-level leverage points.
- met with CCO clinical directors at the Quality and Health Outcomes Committee to support financing and value-based payment options for Nurture sites across Oregon.
- conducted exploratory conversations and sharing of best practices with local hospital nursing directors on hospital policies related to breastfeeding, toxicology screening, NO participants "rooming in" with infants, use of Medication Supported Recovery medications, and visitor policies.
- initiated, coordinated, convened, and co-created a statewide OPAT conference presentation with representation from Deschutes, Jackson, and Lincoln NO sites.
- assisted the Jackson site work with Jackson Care Connect/Care Oregon CCO to develop and implement a prenatal package value-based payment model for Nurture Oregon services.
- assisted the Jackson site work with Jackson Care Connect/Care Oregon to pilot billing for peers as community health workers using a fee-for-service reimbursement rate.
- conducted discussions with Deschutes and Lincoln sites to explore connecting with CCOs to develop a pilot program around billing for pre-engagement activities.
- facilitated discussions at cross-site meetings and huddles with sites.

Site Visits

Comagine and the TA team conducted site visits to Lincoln and Deschutes in 2023. The site visits were used to discuss challenges and brainstorm potential solutions; and better understand team functioning and service approaches to inform the TA provided **(see Appendix 5 for sample site visit agenda)**. The TA providers also made individual site visits to provide targeted coaching.

Other Support

Alicia Kleen is a Comprehensive Addiction and Recovery Act (CARA) Coordinator in the ODHS Child Fatality Prevention and Review Program and Carmen Mims is a CARA/Safe Sleep Coordinator. Together, they guided sites on plans of care, linked sites to local DHS staff, co-presented at cross-site meetings, and provided case consultations and assistance as needed.

CROSS-SITE SUPPORT

Nurture Oregon Shared Learning

Sites use the Basecamp message board to communicate with each other when they need assistance. Sites also reach out to each other directly for assistance. For example, the Lincoln site shared housing documents with the Jackson site that led Oasis to develop their own in-house inventory of housing programming. Monthly cross-site meetings create opportunities for idea exchange, with topics such as housing solutions for rural communities, CCOs and value-based payments, pregnancy basics, and overcoming alienation and stigma.

APPENDIX 1. SITE MATRIX TEMPLATE

County	Total Referred	Number of people with SUD who gave birth in FFY 2021*	Total Participants	Number/percent participating in Nurture Oregon services																	
				SUD tx				MOUD/MAT*				Mental Health Services				Nurture OR support groups				Peer support			
				#	%	Total Visits	Avg visits per person	#	%	Total Visits	Avg visits per person	#	%	Total Visits	Avg visits per person	#	%	Total Visits	Avg groups per person	#	%	Total Visits	Avg hours per person
Deschutes		75			######		#DIV/0!		######		#DIV/0!		######		#DIV/0!		######		#DIV/0!		######		#DIV/0!
Jackson		159			######		#DIV/0!		######		#DIV/0!		######		#DIV/0!		######		#DIV/0!		######		#DIV/0!
Lincoln		43			######		#DIV/0!		######		#DIV/0!		######		#DIV/0!		######		#DIV/0!		######		#DIV/0!
Malheur		25			######		#DIV/0!		######		#DIV/0!		######		#DIV/0!		######		#DIV/0!		######		#DIV/0!
Umatilla		33			######		#DIV/0!		######		#DIV/0!		######		#DIV/0!		######		#DIV/0!		######		#DIV/0!
				Percents based on numbers among ***total engaged participants***																			

KEY:	
#	Total number of people who have received services since the start of Nurture
%	Percent of people who have received services since the start of Nurture *(total number of people who have recieved services/total number of engaged participants)*
Avg	Average dosage of each sector *(total hours/total monthly engaged participants)*
Average Dosage	Cumulative total average dosage of engaged participants from the start of Nurture services *(total hours/number of participants who received that particular service)*
***Notes**	We will calculate a percentage of people who use opiods in the future for MOUD/MAT

Prenatal care				# % participants who have developed a plan of care		# % participants who have given birth		# % participants received postpartum care		# % infants received at least *one* well-child check		# % participants who went home with child from hospital		# % court intervention child removal		Number of children placed in foster care Jan. – Dec. 2021 with removal reason "parent drug abuse"
#	%	Total Visits	Avg visits per person	#	%	#	%	#	%	#	%	#	%	#	%	
	######		#DIV/0!		######		#####		#####		#####		#####	54	#####	63
	######		#DIV/0!		######		#####		#####		#####		#####		#####	120
	######		#DIV/0!		######		#####		#####		#####		#####		#####	24
	######		#DIV/0!		######		#####		#####		#####		#####		#####	42
	######		#DIV/0!		######		#####		#####		#####		#####		#####	54
								Percents based on numbers among participants ***who have given birth***								

APPENDIX 2. QUALITY CONTROL REPORT TEMPLATE

NURTURE OREGON

Quality Control Report - Nurture Database

Comagine Health

January 2023

Date of Last Use Missing

Participant	Notes
	Add date of last use. If participant was using at the time of engagement, just enter the engagement date. If participant is never accessed Nurture services, you can remove the date engaged in Nurture, so these won't appear as missing.

Participant doesn't have at least one primary substance

Participant	Notes

Participant gave birth >14 days after due date

Participant	Notes

Gender is missing

Participant	Notes

Race is missing

Participant	Notes

Ethnicity is missing

Participant	Notes

Housing status is missing

Participant	Notes

APPENDIX 3. PARTICIPANT FEEDBACK SURVEY

Intake & Assessment Procedures			
	Timepoint 1	Timepoint 2	Timepoint 3
I have a clear understanding of the Nurture Oregon program and all the services that are available to me.			
I feel supported by my Nurture Oregon providers.			
I feel comfortable asking my Nurture Oregon providers questions.			
My Nurture Oregon providers know my values and beliefs that are important to the care I receive.			
Service Delivery			
My Nurture Oregon medical providers are knowledgeable about pregnancy and substance use.			
If I try to contact my Nurture Oregon medical providers, I usually get a response in a timely manner.			
My Nurture Oregon mental health, substance use and peer providers are knowledgeable about pregnancy and substance use.			
If I try to contact my Nurture Oregon mental health, substance use and peer providers, I usually get a response in a timely manner.			
If I miss an appointment, my Nurture Oregon team usually follows up with me to reschedule			
Team Integration			
I know who is in charge of my care for each of my healthcare needs (for example, prenatal care, substance use treatment, mental health) related to Nurture Oregon.			

Providers on my Nurture Oregon care team are familiar with my most recent medical history			
My providers are aware of changes in my treatment that other providers recommended.			
I know who to ask when I have questions about pregnancy, substance use, or mental health.			
I always know what the next step in my care is.			
Plan of Care & Safe Sleep			
A written plan was developed with me and my support system to address my treatment needs, health needs, and needs of my infant and family.			
The services and supports provided in the plan meet my needs.			
How often does your baby sleep alone and laid down on their back on a firm flat sleep surface?			
Who and/or what helped you decide how to lay your baby to sleep? (Check all that apply)			

APPENDIX 4. PARTICIPANT DATA SUMMARY TEMPLATE

INTAKE & ASSESSMENT PROCEDURES	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I have a clear understanding of the Nurture Oregon program and all the services that are available to me.						
I feel supported by my Nurture Oregon providers.						
I feel comfortable asking my Nurture Oregon providers questions.						
My Nurture Oregon providers know my values and beliefs that are important to the care I receive.						

SERVICE DELIVERY	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
My Nurture Oregon medical providers are knowledgeable about pregnancy and substance use.						
If I try to contact my Nurture Oregon medical providers, I usually get a response in a timely manner.						
My Nurture Oregon mental health, substance use and peer providers are knowledgeable about pregnancy and substance use.						
If I try to contact my Nurture Oregon mental health, substance use and peer providers, I usually get a response in a timely manner.						
If I miss an appointment, my Nurture Oregon team usually follows up with me to reschedule						

TEAM INTEGRATION	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
I know who is in charge of my care for each of my healthcare needs (for example, prenatal care, substance use treatment, mental health) related to Nurture Oregon.						
Providers on my Nurture Oregon care team are familiar with my most recent medical history						
My providers are aware of changes in my treatment that other providers recommended.						
I know who to ask when I have questions about pregnancy, substance use, or mental health.						
I always know what the next step in my care is.						

PLAN OF CARE	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
A written plan was developed with me and my support system to address my treatment needs, health needs, and needs of my infant and family.						
The services and supports provided in the plan meet my needs.						

SAFE SLEEP	Never	Almost Never	Sometimes	Almost Always	Always
How often does your baby sleep alone and laid down on their back on a firm flat sleep surface?					

Who and/or what helped you decide how to lay your baby to sleep? (Check all that apply)	Counts	Write In Responses
A family member helped me decide how to lay my baby to sleep		
The hospital helped me decide how to lay my baby to sleep		
A Nurture Oregon provider helped me decide how to lay my baby to sleep		
A CPS worker helped me decide how to lay my baby to sleep		
It's what I have done with my other children helped me decide how to lay my baby to sleep		
I was given a firm, flat, sleep surface helped me decide how to lay my baby to sleep		

Total New Survey Responses:	

TIMEPOINT BREAKDOWN	
I am currently pregnant	
I gave birth in the last 3 months	
I gave birth over 9 months ago	

APPENDIX 5. SITE VISIT AGENDA TEMPLATE

NURTURE OREGON
Site Visit Agenda

Comagine Health

February 16, 2023

Attendance Requirement: All Nurture Oregon team members and partners are expected to block time for this meeting. This includes: NO site lead, peers, CADC providers, prenatal clinic managers and providers, MAT prescribers, mental health providers.

Goals for site visit:

- Tour of program
- Reflection huddle/ Goal setting
- Integration Troubleshooting & Forward Movement
- Where is additional help needed?

Time	Time Allocated	Agenda Thursday, February 16, 2023
9:30-10am	30 min	**Arrival & site tour** • Meet with team to make introductions • Tour of facilities where services are currently taking place (behavioral health and physical health)
10am-11am	1hr	**Sit in/observe MOM's Group**
11am – 12:30pm	1.5hrs	**Monthly Huddle/Goal setting** • Discuss current challenges/successes • Determine technical assistance needs and next steps • Goal setting for the year
12:30pm – 1:30pm	1hr	**Lunch**
1:30 -2:30pm	1hr	**Monthly Huddle/Goal setting (cont'd)**
2:30-4:00pm	1.5 hr	**Supportive housing tour** • Tour of housing facility • A "journey" story from two MOMs program participants

This report was prepared by Comagine Health (Kacey Little, Diane Addison) 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 & Science University.

The Nurture Oregon leadership team consists of Gregory Bledsoe of OHA; TA providers Julia Vance, Kasey Edwards Snider, and Laura Heesacker; the authors and Gillian Leichtling of Comagine Health.

Oregon Health Authority

Gregory.B.Bledsoe@dhsoha.state.or.us

Comagine Health

https://comagine.org/

@ComagineHealth

Prevention Collaboration

OHA, Public Health
Population served: Children, young adults, adults

Shared primary, secondary and tertiary prevention:

Comprehensive Addiction and Recovery Act
Safe sleep
State Child Fatality Review Team
Suicide prevention
Family Connects
Home visiting nurses
Substance use
Title V
Gun safety
Near fatalities
Project Nurture
FASD
NAS
Death review
Injury prevention
Mental health
EHDI

ODHS, Child Welfare
Population served: Children, young adults, families

Equity, protective factors, social determinants of health, safety culture, ACEs, trauma informed, anti-racist strategies, data

Safe Systems Mapping 2023: Father Engagement: Addendum to ODHS-CW Recommendations

A Call for Intentional, Coordinated, Systemic Response

The Safe Systems Mapping process was initiated with the intent and focus of improving practice within the Oregon Child Welfare system. The above recommendations were developed collaboratively with the mapping team and aimed towards the initial purpose of improving Child Welfare practice.

This process honored and highlighted the experiences of those who have been affected by these systems, and passionate advocates for fathers and families came to discuss the full scope of the systemic barriers. **Any of the recommendations outlined above should be developed in consultation and input from individuals who have been impacted by the child welfare system.** The mapping team emphatically highlighted the societal bias towards fathers reaches far beyond Child Welfare. These enduring barriers have unquantifiable impact on the wellbeing of families interfacing at every level of the child and family serving system. While the problem is centered around fathers, the team highlighted that children are the most impacted by these systemic failures. No organization or system was singled out, as there are room for growth and strengths to build on throughout the broader system.

Some of the ideas recommended by the mapping team which fall outside of child welfare practice include:

- Development of additional treatment options where fathers can have their children and receive residential SUD treatment. Improved spaces where fathers can visit their children in a comfortable setting.
- Increased availability of father-specific, and other culturally specific resources
- Expanded parenting classes and support specific to fathers.
- Increased efforts to include and meaningfully engage fathers in prenatal, perinatal, and early childhood periods by hospitals, public health programs, home-visiting early childhood education, and early intervention programs.
- Expansion of the Family Dependency Treatment Court model, which has been linked to improved child welfare outcomes and full family engagement.
- Voicing the need to address the bias of fathers as secondary caregivers when interfacing with the legal system, in appropriate venues for judges, attorneys, CASA, etc.
- Addressing systemic processes such as establishing paternity and child support which impact father involvement early in a child's life.
- Efforts to address the significant barriers for incarcerated fathers to be involved in their children's lives.

- Greater integration and networking between child and family serving agencies to support increased father engagement and improved outcomes for children.
- Collaborative involvement with individuals who have lived expertise to guide systemic improvement.
- Advocacy for legislative support.

Given the outstanding need to address broad-system improvement opportunities, the Child Fatality Prevention and Review Program stands with the mapping team and other advocates in the call for an expansive response to these systemic barriers, to enhance the wellbeing of children and families.

The mapping team recommends the development of an interagency collaborative specific to father engagement, which spans the child and family serving system.

This recommendation stems from extensive collaboration with the mapping team, Father's Advisory Board, fathers with lived experience, Tribal representatives, the Office of Tribal Affairs, and the Washington Fatherhood Interagency Council.

The range of participants in systems mapping process proved there are invested partners motivated to create change. An interagency collaborative *may* include:

- Quarterly meetings to prioritize initiatives, changes, and strategies to address improved father engagement across systems.
- Subdivision into smaller workgroups between multiple agencies to address specific barriers.
- Virtual and in-person support groups to fathers
- Periodic trainings or topics for providers/agencies, summits, and networking to share resources.
- Pursuit of grants, legislation for increased programming and other culturally specific services.

Vision for Transformation: Guiding Principles
Child Fatality Prevention & Review Program

The Child Fatality Prevention and Review Program's mission is to improve child safety by identifying determinants of child maltreatment fatalities and collaborating with child and family serving systems to employ equitable, innovative and data informed strategies for systemic change.

Supporting families and promoting prevention

- Trauma-informed approach
- Seek diverse perspectives and prioritize cultural responsiveness
- Promote a culture of safety
- Strength-based system improvement recommendations focused on better outcomes for children and families
- Engagement with community to listen and focus on being more responsive to the needs of families
- Honor children who lost their lives, value the voices of families through the staff who serve them
- Multi-generational approach to address factors that contribute to safety concerns and the cycles of child maltreatment
- Outreach and engagement with community to find resources where families naturally go when needing assistance
- Collaborating with early support services with small interventions: *engaging ODHS contracted nurses, ART/FIT, funding for safe sleep options; providing education; father's groups*
- Addressing the individual needs of each family, providing appropriate services through a Plan of Care

Enhancing our staff and infrastructure

- Committed to equity, inclusion, accessibility, transparency and diversity in recruitment and building of the CFPRP program
- Committed to a strong anti-racism approach, including utilization of an anti-racism tool
- Recognize the importance and the struggle in dismantling systemic racism
- Unlearn behavior that has oppressed people of color in a white supremacist culture
- Create a culture of psychological safety that values and enhances individual, team and system well-being
- High, clear expectations and accountability for our work
- Regularly practice the 6 habits of a healthy team:
  1. Spend time identifying what could go wrong
  2. Talk about mistakes and ways to learn from them
  3. Test change in everyday work activities
  4. Develop an understanding of who knows what and communicate clearly
  5. Appreciate colleagues and their unique skills
  6. Make candor and respect a precondition to teamwork
- Respect and empower staff as the experts in child safety and support their expertise
- Develop culture carriers to expand on creating a safety culture within child welfare

Enhancing the structure of our system by using data with continuous quality improvement

- Identify opportunities for education, procedural guidance, policies, and prevention strategies through intentional data gathered from fatalities, near fatalities, and serious physical injuries
- Complete human factor debriefs which help identify system improvement opportunities
- Use of accurate and relevant data to support system improvement strategies
- Use of the Safe Systems Improvement Tool (SSIT) to gather aggregate data, develop reports and holistically understand the child welfare system to help steer larger system improvement recommendations
- Utilize existing data in comparison with statewide and localized case practice trends to focus on information that supports key goals. Existing data reports reviewed on a regular basis include: r*ecurrence of maltreatment, foster care re-entry, CFSR, CPS & Permanency Fidelity Reviews*
- Enhancement of CIRT process by using post CIRT surveys to evaluate and improve our process

Leveraging Relationships

The Child Fatality Prevention and Review Program has focused on building and strengthening relationships with community partners and ODHS partners. The relationships have focused on equity, transparency, collaboration, and supporting families without the involvement of the child welfare system. Some of the partnerships include:

- Domestic Violence & Sexual Assault Coordinators and Domestic Violence and Sexual Assault Coalition
- Oregon Parenting Education Collaborative
- Oregon Health Authority
- County child fatality review teams and the State medical examiner's office
- Self-Sufficiency
- Project Nurture
- Tribal Affairs and Tribal Nations
- Local office staff and leadership re: CIRTs and Safety Culture
- OHSU
- ORCAH

Safe Sleep for Oregon's Infants

All the moments in an infant's day matter

A self-study training opportunity for family serving professionals

Oregon Department of Human Services
CHILD WELFARE DIVISION

Oregon Health Authority

Acknowledgment: Thank you to Oregon's Early Learning Division (ELD) and specifically Roni Pham and Sydney Traen for your work on the ELD version of the self-study training. Thank you to Anna Stiefvater with Oregon Health Authority (OHA), Public Health, Maternal and Child Health, Chelsea Whitney with Lane County Health and Human Services and Sara Stankey with ODHS Child Welfare in Lane County, for rolling out a safe sleep training in Lane County and sharing your resources. Also, a thank you to the Office of Child Welfare Programs, ODHS Child Welfare professionals, the ODHS Office of Equity and Multicultural Services, Oregon's Nine Confederated Tribes and the ODHS Tribal Affairs unit with special thanks to Ashley Harding, Joan Bacchus, Native American Rehabilitation Association of the Northwest, the Oregon Foster Parent Association, the Oregon Coalition Against Domestic and Sexual Violence, Oregon domestic violence programs, Oregon substance use disorder treatment programs and those served by these programs, OHA Public Health, ODHS Self Sufficiency professionals, Oregon Parenting Education Collaborative (OPEC) Coordinators, OPEC Parenting Educators and Shauna Tominey Ph.D. with Oregon State University and OPEC.

Primary Audience: Professionals engaging families in the community or the home environment.

Length: Approximately one hour to one and a half hours.

You can get this document in other languages, large print, braille or a format you prefer. Contact Child Welfare's Child Fatality Prevention and Review Program at CW.Prevention@dhsoha.state.or.us.

DHS 2416d (9/21)

Contents

Dear Oregon professionals,

Thank you for your commitment to the safety of Oregon's children. It is important for us all to continue to learn and refresh our knowledge to provide quality services and support to Oregon's families.

Safe sleep practices are critical in preventing child fatalities. This training is an opportunity for professionals working with parents and caregivers to learn about safe sleep practices, how to reduce risk and your role in supporting families to reduce risk to infants in their care.

These organizations and individuals are excited to support infant safe sleep and this effort to achieve consistent messaging across all of Oregon's family serving professionals:

Oregon Association of Hospitals and Health Systems

Oregon Coalition Against Domestic Violence and Sexual Assault

Oregon Department of Education, Early Learning Division

Oregon Department of Human Services, Child Welfare

Oregon Department of Human Services, Self Sufficiency Programs

Oregon Health Authority, Public Health Division

Oregon Medical Board

Oregon Parenting Collaborative

Oregon State Board of Nursing

Ben Hoffman MD, Medical Director, Tom Sargent Children's Safety Center, OHSU Doernbecher Children's Hospital

Joan Bacchus, Native American Rehabilitation Association of the Northwest

Karen L Ayers, Program and Partnership Manager, Safe Kids Oregon/Oregon Child Development Coalition

Safe Sleep for Oregon's Infants

A Self-Study Training Opportunity

How to complete the "Safe Sleep for Oregon's Infants" self-study:

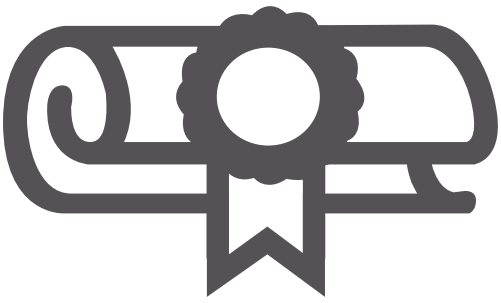
1. Watch the lived experience video at https://youtu.be/Xx0Yfv42rOg

   This video is on YouTube. The title is "Sudden Infant Death Syndrome (SIDS)" and it is provided by St. Elizabeth Healthcare. The five-minute video is an opportunity to hear from parents who have experienced the sleep-related death of an infant. These individuals present the importance of safe sleep practices. While this video is powerful and moving and can be used as a tool with parents and caregivers, please prioritize your self-care when deciding whether to watch.

2. Read the self-study information and complete all the activities. (Your responses are private.) This document contains the self-study information and related activities.
3. Complete the knowledge check. The knowledge check includes 10 questions and the answer key is in this document.
4. Complete the survey. Once you complete the self-study, there is a link within this document to an online survey and opportunity to provide feedback related to the self-study materials.

Consider printing or saving these materials for future reference. Also consider discussing what you learned with your peers and practicing having conversations about safe sleep.

If you have questions or need assistance with the self-study, please email: CW.Prevention@dhsoha.state.or.us



What to expect:

Each professional who takes this training has a vital role in child safety. Whether a parenting educator, treatment provider, health care professional or other professional engaging families with infants, it is critical for you to know how to keep infants safe and be able to share that knowledge with parents and caregivers.

"Infant" refers to a child between birth and age one. This training will give you valuable information about safe sleep practices for infants in a way that honors families' unique values and needs.

Many of us come to this topic with our own beliefs and experiences. Be aware the content of the training may evoke different emotions and may be difficult depending on individual's personal or professional experience. Reflect on your own feelings and those families may have when discussing this topic. Please complete the training at your own pace and engage in needed self-care.

Objectives:

1. Explore how your own experiences and preferences with sleep connect with the recommendations for infant safe sleep practices.
2. Understand your responsibilities around safe sleep as a professional who serves families.
3. Understand sleep-related risks.
4. Understand what actions increase and decrease sleep-related risks.
5. Understand how to talk about safe sleep practices with parents and caregivers.

The sections of this self-study training cover:

Part 1: Understanding sleep-related sudden unexpected infant death (SUID) and how to reduce risk
Part 2: Safe sleep practices and substance use
Part 3: Communicating with parents and caregivers
Part 4: Wrap up: Professional action plan, knowledge check and survey

By the end of this training, you will be able to:

- Articulate your responsibilities regarding safe sleep
- Define sleep-related SUID

- Identify actions that increase and decrease risk factors for SIDS and sleep-related infant deaths
- Recognize safe and high risk sleep environments, and
- Communicate safe sleep practices to parents and caregivers with a strength-based, trauma aware approach that honors their values and needs.

Part 1: Understanding sleep-related SUID, risk factors and what risks a parent or caregiver can change

Examine your current knowledge and/or practices

Imagine that you are sitting in a rocking chair holding a baby. The baby hungrily sucks from a breast or bottle while you both enjoy exploring each other's face and eyes. After several burps over your shoulder, you hold them in the crook of your arms again. The baby starts to fall asleep but wakes slightly to make sure you're still there keeping them safe. Finally, the baby falls asleep and you hear their breathing as their chest rises and falls. You get up to lay the baby down to sleep. You are confident that you have made the sleeping area safe and free from all risks.

What do you already know about safe sleep for infants?

Use the space below to write what you did in the story above to make the sleeping space safe and free from all risks.

What does sleeping comfortably look like for you as an adult?

Imagine that it is the end of a long day. All you want is to get comfortable and have a good sleep. Use the space below to write what you have done to make this happen for you. What comforts have you prepared to help you get the sleep you so need and want? What makes it so comfortable? For example, think about your sleep position, bedding, pillows and clothes. What gets you ready for sleep?

In this training you will learn that adult sleeping behaviors and comfort needs are different from infant sleeping needs. Some adult sleep comforts can be risky to an infant's safety. This doesn't mean infants will be uncomfortable; it means they will sleep safely

How did you develop your current knowledge or practices around laying an infant down to sleep?

As a professional who serves families, it is important to know research-supported best practices to safely lay an infant down to sleep, whether for a nap or for the night. People often rely on experiences, knowledge, culture, friends and family to know how to care for an infant. Use the space below to write how you developed your current knowledge or practices around laying an infant down to sleep.

Your role in safe sleep

Professionals who serve families may interact with the families they serve in their home environments, virtually, on the phone or in the community. Their responsibilities often include sharing information about parenting practices that support children's safety, health and well-being. You are in a unique position to talk to parents and caregivers about safe sleep

As part of an intake, evaluation or during ongoing work with a family, consider:

1. Observing the infant sleep environment when possible or asking for a description
2. Asking about sleep practices the family uses anytime the infant is laid down to sleep
3. Providing education on safe sleep recommendations (consider providing both written information and a verbal explanation), and
4. Helping the family problem solve to reduce risk.

Many people have strongly held beliefs about sleep practices, but you are still encouraged to make sure parents and caregivers are aware of safe sleep practices. For many families, discussions about how to reduce risk for their infants will be more effective in changing their practices than simply giving them written material.

Professionals who serve families must be equipped to share the most up-to-date, research-supported practices with families caring for an infant. This training uses current information and research from multiples sources. Please carefully read the information and complete the activities to test your knowledge along the way.

Why safe sleep practices are important

You touch the lives of children and their families in many important ways. Safe sleep practices are critical to reducing the risk of sleep-related infant death. Not following these practices could have a devastating outcome. Helping parents and caregivers understand the importance of safe sleep practices and supporting these practices as part of a family's routine may save lives.

The connection between SUID and safe sleep

Once a child reaches one month of age, the most common cause of death is Sudden Unexplained Infant Death (SUID).

The three commonly reported types of SUID are:

- Sudden Infant Death Syndrome (SIDS)
- Accidental suffocation and strangulation in bed (ASSB), and
- Other ill-defined or unspecified causes

Here are the definitions of SUID and SIDS:

Sudden Unexplained Infant Death (SUID)	Sudden Infant Death Syndrome (SIDS) (a type of SUID)
SUID is the sudden and unexpected death of a seemingly healthy infant under 12 months of age in which cause of death is not immediately obvious.	SIDS is a SUID death that is still unexplained after a death scene investigation, autopsy and review of the infant's medical history.[1]

The goal of safe sleep practices is to reduce sleep-related SIDS deaths and ASSB deaths. Infant deaths in a sleep environment that are not considered SIDS may be caused by suffocation or strangulation and fall under the category ASSB, so it is important to understand both.

Mechanisms that lead to accidental suffocation include the following:

- **Suffocation by soft bedding**
  For example, when a pillow or waterbed mattress covers an infant's nose and mouth.
- **Overlay**
  For example, when another person rolls on top of or against the infant while sleeping.

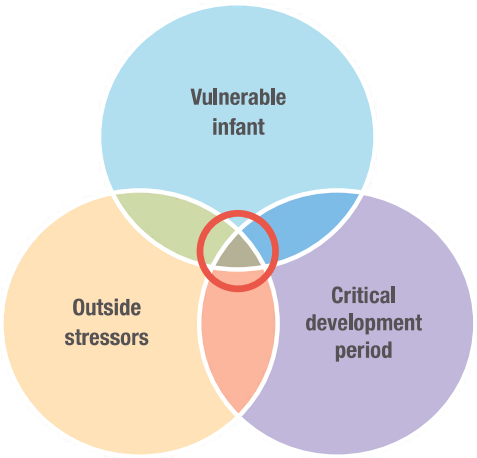
- **Wedging or entrapment**
  For example, when an infant is wedged between two objects, such as a mattress and wall, bed frame or furniture.
- **Strangulation**
  For example, when an infant's head and neck become caught between crib railings.

Now for the good news…

The good news is, a parent or caregiver can take actions to lower the risk of SIDS and in most cases prevent ASSB. Most of these actions relate to the infant's sleep environment. Understanding how safe sleep reduces risks for Sudden Infant Death Syndrome (SIDS) and other sleep-related deaths is key to engaging parents and caregivers in conversations and planning that may save a child's life.

Before going over ways to reduce risk, first let's learn more about SIDS and the risk factors a parent or caregiver can and can't change..

Multiple risk factors for SIDS[2]



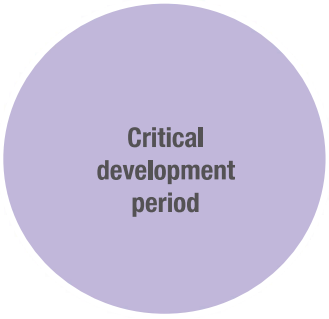
There is no one definitive cause of SIDS. This diagram shows how three common risk factors interact. When an infant is experiencing risk factors from all the three circles, as shown in the center area of the diagram, they are at a much higher risk for SIDS. Although these factors contribute to higher risk, all infants are at risk.

Let's look at each of the risk categories in the diagram individually.

Vulnerable infant

All infants are vulnerable to SIDS. Some factors can make an infant more vulnerable. These can be unknown to parents, caregivers and heath care providers. Risk factors include:

- Genetic conditions passed down from biological parents
- Unknown physical developmental issues, and
- Issues with brain development.



Critical development period

Infants' brains grow and develop a lot in the first six months of life. They are at highest risk for SIDS during this time because the part of the brain that allows them to wake up when their oxygen level is too low or their carbon dioxide level is too high is still developing. The muscles in the neck and core are also not fully developed at this time. This means the infant can't roll over or pick up their head if their airway is blocked.

Outside stressors

The only risk factors that a parent or caregiver has an ability to change are in the "**outside stressors**" category. These are called "outside stressors" because they occur outside the infant's body. Some examples of outside stressors include:

- Bumper pads
- Too much clothing
- Loose bedding
- Being placed on their stomach, and
- Exposure to cigarette smoke.

Professionals who serve families have a role in helping parents and caregivers reduce these risks. Reducing **outside stressors** is best for an infant's health and safety.

Reducing outside stressors

Knowing the outside stressors and how to reduce the number of outside stressors is critical to having informed, constructive conversations with reporters about safe sleep practices.

The outside stressors focused on in this training are the 5 safe sleep categories Child Welfare professionals must evaluate and discuss.

1. Sleep position
2. Sleep surface and area
3. Sleep location
4. Smoke free environment
5. Sleep temperature

1: Sleep position:

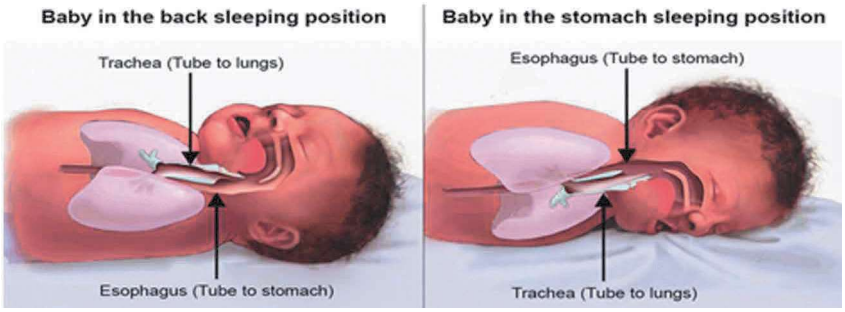
Decreased risk	Increased risk
The infant is placed on their back to sleep.	The infant is placed on their stomach or side to sleep.

More information about sleep position:

- Placing an infant on their back is the most effective way parents and caregivers can reduce the risk of SIDS.

  If an infant is a stomach or side sleeper at home, the risk for SIDS is much higher. The side position is just as dangerous as placing the infant on their stomach because the infant can accidentally roll to their stomach. If an infant is put to sleep on their back and rolls on their own to their stomach, in this instance, it is not necessary to change their position. If a swaddled infant is able to roll, it is important to stop swaddling altogether.
- Infants love consistency. In fact, infants who usually sleep on their backs but are then placed to sleep on their stomachs, like for a nap, are at very high risk for SIDS.[3]
- **Tummy time** (placing your awake infant on their stomach) is important. Infants need tummy time to develop different muscles and to get a good view of their world. However, tummy time should only take place when the infant is awake and supervised.[4] If an infant falls asleep during tummy time, they should be placed on a safe sleep surface on their back.
- Swaddled infants may roll more easily from back to stomach and can't use their arms for support. Swaddled infants have an increased risk of death if they are placed or roll onto their stomach. If swaddling is used, infants should always be placed on their back. When an infant exhibits signs of attempting to roll, swaddling should no longer be used. To be safe, stopping swaddling by two months of age is recommended.[5]
- Infants are less likely to choke on their backs.

  It used to be a common belief that back sleeping increases the chance of choking if an infant vomits while they are sleeping. This is not true. Infants can clear fluids better when they are on their backs. When an infant is sleeping on their back, the trachea (airway that goes to the lungs) lies on top of the esophagus (tube that goes to the stomach). When an infant spits up, gravity will keep the spit-up in the esophagus and it will either come out of the mouth or the infant will swallow it. Either way, the trachea is protected when the infant is on their back. When an infant is sleeping on their stomach, any spit-up will pool at the opening of the trachea. This makes it easier for the infant to choke from breathing fluid into their lungs.



Because of misinformation about back sleeping, you may encounter new parents who have heard from grandparents and others that their infant slept on their stomach. Many infants who sleep on their stomach never experience SIDS. However, the risk of SIDS is far greater for those infants. This is part of the conversation you will have with parents and caregivers about how, over time, research has informed new best practices. Seat belts are a good example to use; they were uncommon in cars until 1958 and then their use was inconsistent. Many children were not harmed by riding in cars with no seat belt, but some experienced devastating consequences. So, while many of us survived never wearing a seat belt, we wear them now. We now know that if we were in a car crash, our chances of surviving are much greater if we are wearing a seat belt.

Since the Back to Sleep campaign started in 1992, there has been a 50 % reduction in infant deaths.

2: Sleep surface and area

Decreased risk	Increased risk
The infant sleeps on a firm, flat surface (for example, a safety-approved bassinet, crib or Pack N' Play). The firm surface, even a Pack 'N Play, has a fitted sheet and no other soft bedding or loose materials.	The infant sleeps on soft surface or surface that is not flat (for example, a couch, armchair, adult mattress such as memory foam, mattress topper, waterbed or car seat). There is soft bedding or loose materials in the sleep area (for example pillows, toys, stuffed animals, blankets or bumper pads).

Sleep surfaces can vary depending on cultural tradition, space and mobility. The most important thing is to put an infant to sleep on a firm, flat surface. The most common firm, flat surfaces are bassinets, cribs or Pack N' Plays.

Below are examples of firm, flat sleep surfaces other than bassinets, cribs or Pack N' Plays that may be used:

Basket

Box or carton

Drawer

Washtub

Below are examples of traditional tribal sleep surfaces:

Umatilla Tribe style cradleboard[7]

Navajo Tribe style cradleboard[8]

First Nations and Woodlands Tribes moss bag[9]

Many traditional sleep surfaces have been around for a long time. Some of the safest traditional sleep surfaces come from American Indian/Alaska Native (AI/AN) or First Nations (FN) traditions. If you are caring for an AI/AN or FN child, some traditional sleep surfaces may be available. These include:

- Cradleboards or baskets, which are common across many AI/AN tribes, and
- Moss bags, which are common among Canadian First Nations and Woodlands AI/AN Tribes.

American Indian and Alaska Native communities may have originated the concept of "Back to Sleep" with the use of traditional infant sleep devices. Although the specific design of the sleep devices differ between Tribes, the infant is placed on their back and swaddled into place in a safe and secure environment. Rates of infant death and SIDS are high in many American Indian or Alaska Native communities, and using these traditional methods is a good way to keep infants safe. If you are unaware of specific Tribal safe sleep practices, contact the infant's Tribe to learn more. Understanding how to use traditional Tribal sleep devices is critical to keeping the infant safe.

No matter what container or device is used, the surface should be firm and flat. If the sleep surface can't accommodate a snug fitting mattress, it is safer to place the infant on the firm, uncovered surface than it is to use a pillow or other soft or loose surface.

Infants who sleep on soft surfaces or are placed with soft, squishy objects are at risk for SIDS or suffocation. Examples of soft surfaces or objects include:

- Soft mattresses
- Pillows
- Blankets, comforters and quilts
- Other loose bedding (such as non-fitted sheets)
- Sheepskins
- Bumper pads
- Stuffed toys, and
- Infant positioners (products designed to keep an infant in a certain position, such as wedges, padded tubes or mats with side bolsters).

More information about sleep surface and area:

- Sitting or reclining devices, such as car seats, strollers, swings, infant carriers and infant slings, are not recommended for routine or unsupervised infant sleep. Infants in these sitting devices may be able to move into a slouched forward position that can cut off their airway. Even using the straps included in the device does not prevent this.
- Soft objects and loose bedding can obstruct an infant's nose and mouth.
- It is **not** recommended to put an infant to sleep with a bottle propped in their mouth.
    - It is a choking hazard and can lead to bottle rot as teeth come in.[10]
    - The items typically used to prop a bottle (such as blankets or stuffed animals) pose a suffocation risk.[11]
- Infant sleep clothing, such as a wearable blanket or sleep sack, is an alternative to blankets.
- Swaddling can be an effective technique to help calm infants, but if the infant breaks free of the swaddle, the blanket can then be available to cover their face and block their airway. However, it is also important to make sure the blanket is not too tight. The infant's hips and legs should be able to move freely, and two or three fingers should fit between the infant's chest and the swaddling blanket. Also, swaddling may decrease an infant's arousal, so that it's harder for them to wake up. According to HealthyChildren.org, "We know that decreased arousal can be a problem and may be one of the main reasons that babies (infants) die of SIDS."5
- Bumper pads are not necessary to prevent head entrapment because of new safety standards for crib slats.
- Remove teething necklaces or jewelry when laying an infant down to sleep.
- Although the reason is unclear, studies have reported pacifiers may reduce the risk of SIDS. Offering a pacifier to infants is recommended. Pacifiers help infants wake from sleep more easily, which is important if their breathing becomes blocked. A pacifier falling out of the infant's mouth and on to the sleep surface is ok.
- If a pacifier is used when placing the infant for sleep, it does not need to be reinserted once the infant falls asleep. If the infant refuses the pacifier, they should not be forced to take it.
- It is recommended that the crib, bassinet or portable crib follow the safety standards of the Consumer Product Safety Commission (CPSC). See the "Resources" section in Part 4 of this training and click on the CPSC link for more information on safety standards.

3: Sleep location

Decreased risk	Increased risk
Room sharing The crib or bassinet is close to parent or caregiver	The infant shares a sleep surface with caregiver, non-primary caregiver, siblings, other person or pets The crib or sleep surface is located in a separate room

Room sharing versus bed sharing

Before discussing room sharing and bed sharing, here are the definitions of each of these terms:

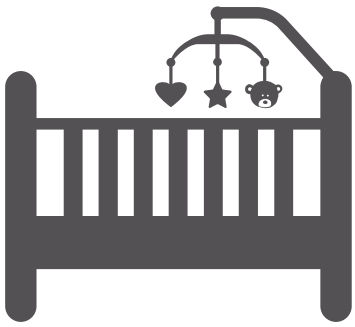
Room sharing refers to an infant sleeping in the same room as a caregiver or other household members but not sharing the same surface such as a bed, couch, chair or futon.

Bed sharing refers to an infant and one or more adults or children sleeping together on any surface, not necessarily a bed; they could be sharing another surface, such as a couch, chair or futon.

It is recommended that infants sleep in the parents' or caregivers' room, close to the parents' or caregivers' bed but on a separate surface designed for infants. The American Academy of Pediatrics (AAP) guidelines are designed to promote breast feeding, bonding and safety. Keeping the infant close to the parent or caregiver supports these goals.

The AAP recommendations acknowledge that parents frequently fall asleep while feeding an infant. Evidence suggests it is less hazardous to fall asleep with the infant in the adult bed than on a sofa or armchair. However, adult beds are associated with a lot of risk factors, such as soft, pillow-top mattresses, blankets and pillows. Infants are not coordinated enough to move a blanket or pillow off their face.

Bed sharing is not recommended. Bed sharing increases the risk of suffocation, entrapment and other sleep-related causes of infant death. An adult bed is not designed for infants, and there are no safety standards for adult beds.



Although bed sharing is **not** recommended by the AAP, there are many rational reasons why a parent chooses to bed share:

- It encourages breastfeeding by making nighttime breastfeeding more convenient.
- It makes it easier for a nursing mother to get her sleep cycle in sync with her infant's.
- It helps infants fall asleep more easily, especially during their first few months and when they wake up in the middle of the night.
- It helps infants get more nighttime sleep (because they awaken more with a shorter feeding time, which can add up to a greater amount of sleep throughout the night).
- It helps parents regain closeness with their infant after being separated from their infant during the workday.
- It is a common practice within the family's culture.
- The parent or caregiver had a positive experience with bed sharing with other children.
- If a parent or caregiver has experienced domestic violence, bed sharing may occur:
    - Because the abusive partner requires the infant to be in the bed
    - To protect an infant from an abusive partner
    - To be prepared to leave quickly, or
    - As a coping mechanism after fleeing an unsafe situation.

Oregon Health Authority and AAP recommend precautions to consider if, contrary to recommendations, a parent or caregiver chooses to have their infant sleep in their adult bed:

- ❑ Wait until the infant is older than four months old.
- ❑ Remove pillows, quilts or comforters.
- ❑ Do not have pets or other children in the bed at the same time as the infant.
- ❑ Avoid sleeping on soft surfaces such as a waterbed, mattress topper, sofa, couch or armchair.
- ❑ Avoid bed sharing if the adult is actively smoking.
- ❑ Avoid bed sharing if the adult has consumed alcohol, used substances that may impair them, taken sleep aids or if they are overly exhausted and there is a chance that they will not awake in an emergency. This will be addressed with more detail in the next section

More information about sleep location:

- Exhaustion is an inevitable part of parenting an infant. Support the parent or caregiver by developing a plan to lay the infant down to sleep safely when managing exhaustion. A plan may involve other adults in the home. When planning, always listen to what the

caregiver says is doable. Especially when there are no other adults in the home, consider a plan involving a babysitter, respite provider or other alternative caregiver providing scheduled or as-needed respite to allow the parent or caregiver to get uninterrupted sleep.

- Room sharing is safer than bed sharing or solitary sleeping in a separate room.
- Placing the crib or bassinet next to the caregiver's bed can make nighttime feedings easier.

4: Smoke-free environment

Decreased risk	Increased risk
The infant is in a smoke-free environment.	The infant is exposed to secondhand or thirdhand smoke.

Secondhand smoke effect

Secondhand smoke is smoke inhaled from tobacco being smoked by others. This happens when you are in an enclosed space or sitting near someone who is smoking. Exposure to secondhand smoke significantly increases an infant's chances of dying from SIDS.[13] Children exposed to secondhand smoke are also at higher risk of other diseases, such as asthma, the common cold and other viruses.

Thirdhand smoke effect

Thirdhand smoke is tobacco smoke toxins that remain after the cigarette is put out. Thirdhand smoke toxins can build up on the smoker's hair, clothing and other surfaces. The toxins in smoke can cause harm to an infant's developing brain.

To reduce infants' risk of exposure to thirdhand smoke, parents and caregivers can cover their clothing with a jacket or sweater, pull back long hair or wear a hat to cover their hair while smoking. After smoking, it is important to wash their hands and face and change any clothing that will come into direct contact with the infant. This will protect the infant's vulnerable developing body systems.

5: Sleeping temperature

Decreased risk	Increased risk
The room temperature is comfortable for a lightly clothed adult. The infant is in a maximum of one layer more than would typically be comfortable for an adult to wear.	The room temperature is too warm or uncomfortable for an adult. The infant is overdressed or underdressed for the temperature of the room.

Overheating increases sleep-related SUID risk. Overheated infants are more likely to go into a deep sleep that might be more difficult for them to wake up from. Signs that an infant is too hot include sweating, damp hair, flushed cheeks, heat rash and rapid breathing.

Many parents and caregivers are concerned that an infant will get cold without a blanket. Blankets can increase the risk of SIDS and accidental suffocation. Instead of a blanket, use the general guideline of dressing an infant in clothes, sleepers or a nonrestrictive sleep sack that provide one layer more than would typically be comfortable for an adult. Healthy infants do a good job regulating their own body temperature. Extreme temperatures, such as sleeping outdoors in winter, may require additional layers. If adding layers, pay special attention to the signs the infant is too hot.

Overheating may also occur if an infant is swaddled. If caregivers swaddle, including swaddling for a cradleboard or other traditional Tribal safe sleep practice, it is important to consider what else the infant is wearing and the temperature where the infant is sleeping.

Share the message

The parents and caregivers of infants look to you for parenting guidance and support. There are many opportunities when working with families to share information about safe sleep practices. It is important to make sure the information is shared with all the individuals in a family who have a role in laying the infant down to sleep. Encourage parents and caregivers to share this information with family members, friends and others who also provide care for their infant, including babysitters and childcare providers.

For American Indian/Alaska Native families, provide information in a way that does not confront or question the family's knowledge about Tribal traditions. Consider engaging elders from Tribal communities and do so in a manner that does not question their authority as important community members with knowledge and expertise that could benefit families. Learn about traditions that are important to families. Ask for guidance about how to support families within Tribal communities to make decisions that both honor their values and traditions and follow research-supported practices.

What did you learn about increasing and decreasing the risk of sleep-related deaths?

Activity 1: Identify which actions in the list increase risk of SIDS:

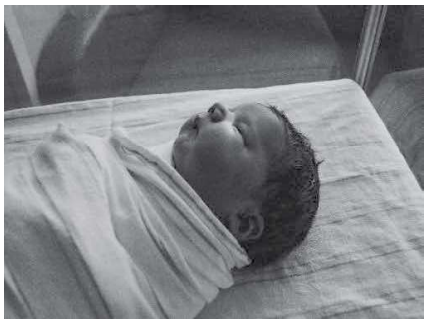
1. Placing the infant on their side to sleep
2. Placing only one stuffed animal in the crib
3. Wearing a hat to cover your hair when smoking
4. Swaddling when the infant can roll
5. Placing no blankets at all in the crib

Answers: 1, 2 and 4 increase risk

Activity 2: If you were with a family and saw the sleep practices in the photos below, would you recognize the outside stressors and know what to recommend the family do to reduce risk?

View the photos below and write your answers and observations in the space provided for each photo.

Does the above picture show any safe sleep practices? ☐ Yes ☐ No	How would you reduce risk?
List any risks or protective factors you see:	



Does the above picture show any safe sleep practices? ☐ Yes ☐ No	How would you reduce risk?
List any risks or protective factors you see:	

Does the above picture show any safe sleep practices? ☐ Yes ☐ No	How would you reduce risk?
List any risks or protective factors you see:	

Does the above picture show any safe sleep practices? ☐ Yes ☐ No	How would you reduce risk?
List any risks or protective factors you see:	

Part 2: Bed sharing and substance use

Substance use prior to bed sharing

As you learned in Part 1, bed sharing increases the risk of sleep-related infant death. While the AAP recommends avoiding bed sharing, some parents and caregivers will choose to continue to share a sleep surface with their infant for a variety of reasons. In this case, engage in conversations as much as possible and partner with the parent or caregiver to develop a plan to reduce risks. A parent may continue to bed share, but they may agree to remove the comforter from the bed and have the other adults or children sleep elsewhere. Harm reduction is an important approach when talking to families about infant safe sleep.

"Substance use" includes many legal or illegal drugs with potential for misuse, including controlled substances, prescription medications, over-the counter medications and alcohol. However, right now let's look at marijuana specifically.

What are your attitudes and beliefs about marijuana use?

Marijuana use is common and legal in Oregon. As a professional who serves families, it is important to examine your own beliefs about marijuana use and parenting to make sure personal bias does not interfere with how you provide parental support and education. In the space below, write your understanding of how marijuana use while parenting may put an infant at risk.

Bed sharing, substance use and infant death

Marijuana, alcohol and prescribed substances are legal in Oregon. The form, method or legality of a substance does not make its effects on parental impairment and child safety less dangerous. Whether a substance is legal or illegal, prescribed or not prescribed, is not the issue. The focus is on the affect the substance has on the parent or caregiver.

When a parent uses sedating substances such as marijuana, it increases the probability that they the will go to sleep faster and sleep harder and deeper than usual. Being sedated or impaired can make a parent or caregiver unresponsive to an infant. The parent may not be aware they have rolled onto the infant and may not feel the infant or hear the infant's distress sounds. According to BASIS (Baby Sleep Info Source):

> The most recent studies have shown that most bed sharing deaths happen when an adult sleeping with a baby (infant) has been smoking, drinking alcohol, or taking drugs (illegal or over the counter meds) that make them sleep deeply.[14]

For this reason, it is even more crucial to have conversations, provide information and make plans for infant safe sleep practices with families where parents or caregivers use substances. There is a clear standard here. It is unsafe for a parent or caregiver to bring an infant into their bed if they have used any substance that could interfere with their normal sleep patterns. If the parent or caregiver is impaired and plans to share a sleep surface with their infant, support the family in making an alternative plan. This support may include reaching out to other individuals in the family or community. If all attempts are unsuccessful, consider whether it is a mandatory report of child abuse.

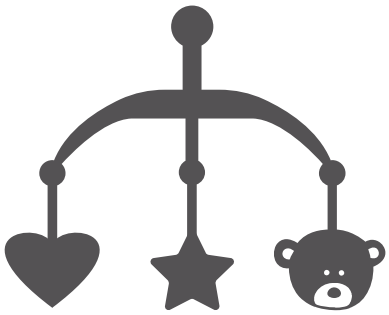
Collaborative approach

Be clear about risks with parents. If a parent or caregiver is using a substance that can impair them, then support them in developing a plan to ensure that a safe, unimpaired individual is caring for the infant.

Consider including other community partners in these conversations with the family, such as experts on substance use disorders, safe sleep or infant health, or culturally specific providers or supports. Collaborating with a Self Sufficiency Program family coach, a nurse or a Tribal member will allow for a different voice and another perspective. Also, consider connecting the family with providers they trust and who would have credibility on the topic, such as their pediatrician. Studies have repeatedly shown that hearing messages from multiple sources, multiple times increases likely acceptance and implementation of safe sleep behaviors.[15]

Part 3: Safe sleep conversations with families

Conversations with families



When talking with families about safe sleep, they may express concerns or share misconceptions about safe sleep practices. They may also share ideas or opinions on topic that you haven't thought of before. Parents or caregivers may resist engaging in some safe sleep practices because they are committed to a sleep practice that is not recommended.

It is the role of professionals who serve families to not only educate families, but also to engage in authentic conversations with families about safe sleep. These conversations must respect and engage with their lived experiences and opinions. They must also acknowledge and elevate them as experts in and advocates for their children's health.

Think about safe sleep improvements in terms of building parents' and caregivers' sense of competency and control in a purposeful, positive way. That means partnering with families to build their capacity. This can be done by avoiding situations that make parents feel judged, talked down to or overwhelmed. Instead, focus on opportunities to help them feel like they are in control of their infant's health. Take time to celebrate the ways families are already creating comfortable and safe sleep environments for their infants as you also share information about reducing the risks of sleep-related infant death. Engage parents and caregivers as partners in the conversation. Ask if there are ways they think they could enhance their infant's safety based on the information you share.

When the parent or caregiver resists making the recommended change, try to reduce risks as much as possible. The following information, as well as the information covered in Parts 1 and 2, will prepare you to engage families in conversations about safe sleep.

Reducing risk

"If I talk with families about doing anything except what is recommended, then I am condoning unsafe or unhealthy behaviors. They need a firm message about what to do and what not to do or else they may not follow the recommendations."

This concern is common and understandable. Since families will decide what they want to do, it is most productive to focus on giving information about how they can carry out their decisions. If they decide not to use all the recommendations, provide information about what factors create risk so they can address those factors. Help them reduce as much risk as possible. This approach is now included in the new American Academy of Pediatrics (AAP) safe sleep guidelines, which urges open and honest conversations with families.

Not talking about accommodating families' decisions may put infants at risk.[14]

If you suspect power dynamics are creating resistance to changing sleep practices, and if it is safe and within your role to do so, engage both the abusive partner and survivor in the conversation and focus on the safety risks to the infant. Focusing on the effects on children has been shown to be a successful way to engage abusive partners in behavior change. Whenever possible, the best and safest practice is to connect with the survivor first to better understand the abusive partner's pattern of coercive control and any personal safety risks that engaging in these conversations may create for the survivor, the infant and the family.

How the conversation starts

Consider starting the safe sleep conversation with an open-ended question such as one of the following. Several may sound familiar; you were asked some of these questions at the beginning of the training. You may wish to refer to your responses and the related guidance.

- "What do you know about how you were put to sleep as an infant?"
- "What do you already know about safe sleep practices?"
- "What does sleeping comfortably look like for you as an adult?"
- "Would you show me where you put your infant to sleep?" or "Can you describe your infant's sleep environment?"
- "What are all the ways you help make sure your infant has a good sleep?"
- "Tell me how you and your spouse or partner made the decisions about the sleep practices you use?"

Approach to resistance

How do you approach resistance from a parent or caregiver?

- Use a strength-based approach and build on their protective factors (Protective factors are conditions or attributes of individuals, families, communities, or the larger society that reduce risk and promote healthy development and well-being of children and families).
- Praise families for what they are already doing to set up a healthy and supportive sleep environment.
- Explain the risks associated with sleep-related infant death, but don't use shame or fear.
- Explain the worst-case scenario with empathy and in a constructive, personal and caring manner.
- Explain risk reduction measures and encourage their use.
- Encourage follow-up with their medical provider about safe sleep.
- Collaborate with other community professionals and Tribes to share the message in a way that honors family and cultural traditions and values.

It is important to **listen** and understand why families may not utilize the AAP recommendations.

Reasons for resistance may include:

- Comfort of the infant or themselves
- Exhaustion
- Prior experience with other children or their own childhood
- Advice from family members or friends
- Lack of space for a crib
- Lack of a crib (money or access)
- Disbelief in the science because it changes all the time
- Receiving mixed messages from health care providers
- Receiving information that is outside of their cultural framework
- Belief that SIDS is "fate" or "God's will"
- An incorrect perception of what a "good sleeper" is (Contrary to what many believe, a "good sleeper" is not an infant who sleeps 10 hours a night without waking up. A good sleeper is an infant who wakes up periodically and can go back to sleep on his or her own.)
- Feeling that the conversation about safe sleep implies that they are not a "good parent."

Ask the parents and caregivers why they feel the way they do. Their words will guide how you respond and with what information. Approach the conversation with questions and **affirm you are hearing and understanding the family's feelings and reasoning**.

To provide information in a constructive way to the parent or caregiver consider the following:

- Avoid using "should," which may seem like a directive.
- Use interactive educational materials.
- The Jackson County Nurse-Family Partnership Program created safe sleep educational tools that use photos showing various infant sleeping arrangements to spark discussion with prenatal and new mothers about safer sleep practices. They asked parents and caregivers to explain what they see in the pictures and give feedback about the educational tool and how to improve it. This helped the home visitors understand what parents and caregivers learned and how to improve the tool itself. Making the clients the "experts" on how they felt about the tool elevated their participation and engagement as well as knowledge.
- Repeat, reinforce and layer additional information to encourage changing behavior.
- Parents or caregivers are not always ready to receive information or may not have the energy to learn a lot of new information at once. Provide aspects of safe sleep information that are relevant for them when they need it and build on that information over time.
- Combine safe sleep education with providing or referring to community resources for infant sleep sacks or sleep spaces. This increases knowledge and helps reduce economic barriers at the same time.
- Engage in conversations about values and beliefs with a non-judgmental attitude. This may increase trust and honesty about safe sleep practices.

Engagement, trust and ongoing efforts, often from multiple people, are necessary to effect change and reduce risk.

Scenarios

Below are six scenarios showing some statements and questions you may encounter when having conversations about infant safe sleep. Each statement or question is followed by an example response you may find helpful. Consider how you might adapt these potential responses to fit your voice and help in your work.

Scenario 1

When I was an infant, I was put on my stomach to sleep. Was that wrong?

No. Parents and caregivers were following advice based on the evidence they had at that time. Since then, research has shown that sleeping on the stomach increases the risk for SIDS. This research also shows that sleeping on the back carries the lowest risk of SIDS. That's why the recommendation is "back is best."

Scenario 2

"I put my infant to sleep on their stomach because they can roll over if needed."

When infants can easily turn over from back to stomach and from stomach to back, they should still be placed to sleep on their back. After they are asleep, if they roll over, you do not need to put them on their backs again. However, make sure there are no blankets, pillows, bumper pads or other items in the crib that the infant can roll against and suffocate.

Scenario 3

"My infant sleeps on their side because they are most comfortable that way."

If an infant is a stomach or side sleeper, the risk for SIDS is much higher. The side position is just as dangerous as placing the infant on the stomach because they can accidentally roll to the stomach. If an infant is used to sleeping on their stomach or side, changing to sleeping on their back **does not** increase the risk of SIDS. However, infants who are used to sleeping on their backs and are then placed to sleep on their stomachs are more likely to die from SIDS. That's why it's important to tell this to anyone caring for your infant, such as a grandparent who may not have the most current information.

Scenario 4

"When my infant is put to sleep on their back, they wake up scared, so I put them to sleep on their stomach."

The startle response is a sudden movement that is sometimes seen as scary for the infant. Sometimes the infant gasps. This protects the infant, letting them get a breath of air or wake up slightly from too deep a sleep. Try using soothing techniques such as singing, patting or using a pacifier.

Scenario #5

"My parent said I had a bald spot from sleeping on my back and I don't want that to happen to my infant."

Infants who sleep on their backs can develop temporary bald spots on the back of the head. As the infant grows, moves and begins to sit up more often, the hair on the back of the infant's head will grow back. A bald spot on the back of an infant's head can be a sign of a healthy infant, one whose risk for sleep-related SUID or SIDS is lower because they are a back sleeper.

While the infant is awake, aware and supervised, tummy time is recommended and will help decrease the friction on the back of the head that leads to temporary bald spots.

Scenario #6

"I refuse to let my infant sleep on their back because I have heard that they will get a flat head."

Back sleeping can contribute to flattening of the back of the head, but head flattening is usually temporary. As infants grow and become more active, their skulls will round out. You can reduce head flattening by doing the following:

- Providing tummy time during waking hours
- Switching which end of the crib you place the infant's feet and, when changing infant's diaper, alternating where the infant's head is on the changing table
- Changing positions often when the infant is awake, and
- Limiting time spent in freestanding swings, bouncy chairs, car seats and other surfaces that, with a lot of use, can lead to head flattening or temporary bald spots.

Scenario #7

"My infant sleeps in our bed because my partner gets very upset if I get in and out of bed during the night. He has to get a good night sleep to be able to work the next day."

I hear your concern. Are you open to considering other options, such as sleeping in another room or a different bed? If bedsharing is a practice you will continue, let's talk about other ways you can reduce risk for your infant. Are there safe ways to talk about infant sleep with you and your partner at the same time? Also, would you like to talk to someone about when your partner gets upset?

Activity: Practice communicating about safe sleep practices

This is your opportunity to practice responding to a parent's statements or questions. In the space below each of the four statements, fill in how you would respond to the parent or caregiver. Remember, as with all communication with families, building and keeping trust is key!

1. **I know putting my infant to sleep in a crib is safest, but they cry when they are laid down.**

2. **I put this blanket on my infant when they go to sleep so they won't get cold.**

3. **I smoke marijuana in the evening, outside of the home and after the children are asleep to help my anxiety, but I do not smoke around my infant and even shower and change my clothes after coming back into the house.**

4. **I don't drink around the children. Instead, I go out on weekends to drink while a babysitter watches the children (however, the parent comes home intoxicated and relieves the babysitter of duties).**

When an infant's medical needs change sleep recommendations

Some infants may have special prescribed medical equipment, such as a G-tube. In these situations, a medical professional may alter sleeping arrangements. What might you do in these situations?

- If the parent needs clarification about the prescribed sleeping arrangement, consider offering to have a joint conversation with the medical provider and the parent. This may help the parent better understand the infant's current medical needs.
- Make sure the parent understands the recommendations and how they may differ for another infant in the home without the same medical needs.

Part 4: Wrap up

You have almost made it — great work! This is the final part to the safe sleep self-study. In this section you will:

- Complete the professional action plan
- Complete the knowledge check
- Complete the survey, and
- Review the resources.

Professional action plan

Fill out your action plan here.

As a result of this self-study training, what are three things you will do to make sure you share the information with families who have infants?	

Knowledge check

Answer key provided

Question	Answer options	Write the letter(s) that match your answer
1. What is the age range for an infant?	A. Under 2 years B. 0-12 months C. 0-6 months D. 2-12 months	
2. Side sleeping is an acceptable and safe sleep position for an infant.	A. True B. False	

Question	Answer options	Write the letter(s) that match your answer
3. Sleep-related SUID only occurs in the infant's crib.	A. True B. False	
4. What is a good time in an infant's development to stop swaddling?	A. Two weeks B. One month C. 2 months D. 6 months	
5. What should you do if an infant falls asleep in a baby swing?	A. Be very quiet B. Move the infant to a flat, firm sleep space. C. Stop the swinging.	
6. It is unsafe for a parent or caregiver to bring an infant into their bed if they are under the influence of any substances that interfere with normal sleep patterns.	A. True B. False	
7. Community partners play an important role in engaging parents in safe sleep conversations.	A. True B. False	
8. Examples of outside stressors include the following:	A. Placed to sleep on stomach B. Cigarette smoke C. Too much clothing D. All of the above	
9. Placing an infant on their back is the most effective action caregivers can take to reduce SIDS.	A. True B. False	
10. It is recommended that infants sleep in the same room as their caregiver or parent but on a separate sleep surface.	A. True B. False	

1.B **2.**B **3.**B **4.**C **5.**B **6.**A **7.**A **8.**D **9.**A **10.**A

Online survey

Please complete the online survey and opportunity to provide feedback on this self-study by clicking on this link or pasting the link into your web browser: https://forms.office.com/g/KV94eBzAis

You can also access the survey with the camera on your mobile device using the QR code. Point your camera at the QR code so it appears on your screen. Click the banner and it takes you directly to the survey!

Questions and support

Family serving professionals in Oregon may email questions and requests for support related to this safe sleep self-study to CW.Prevention@dhsoha.state.or.us

Resources

The Safe to Sleep® campaign offers a variety of materials to help share safe infant sleep messages with diverse family audiences (African American, American Indian/Alaska Native and Spanish-speaking) https://www1.nichd.nih.gov/sts/materials/Pages/default.aspx

Videos for parents or guardians
https://www1.nichd.nih.gov/sts/news/videos/Pages/default.aspx

Oregon Public Health safe sleep webpage
https://www.oregon.gov/oha/ph/HealthyPeopleFamilies/Babies/Pages/sids.aspx

Safe Sleep for Babies brochure
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8213.pdf

Spanish Safe Sleep for Babies brochure (Sueño seguro para bebés)
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/ls8213.pdf

NICHQ webinar: "Improving Infant Safe Sleep Conversations"
https://www.nichq.org/improving-infant-safe-sleep-conversations

Oregon Prenatal and Newborn Resource Guide (English and Spanish)
http://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WOMEN/PREGNANCY/PRENATALNEWBORNRESOURCEGUIDE/Pages/index.aspx

Cribs for Kids
https://www.cribsforkids.org

AAP 2016 SIDS Task Force Recommendations
https://pediatrics.aappublications.org/content/138/5/e20162938

How to Keep Your Sleeping Baby Safe: AAP Policy Explained
https://healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

Consumer Product Safety Commission (CPSC)
For information on crib safety, contact the CPSC at 1-800-638-2772 or https://www.cpsc.gov/

Promising Futures: Best Practices for Serving Children, Youth and Parent's Experiencing Domestic Violence
https://promising.futureswithoutviolence.org/

Thank you for doing your part in keeping Oregon's infants safe

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