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Practice Summary & Implementation Guidance

Project Nurture

The Project Nurture model provides person-centered, team-based maternity care and substance use disorder treatment during pregnancy and the first year postpartum.

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Location	Topic Area	Setting
Oregon	Care Coordination, Perinatal Substance Use, Primary & Preventative Care	Clinical; Community

Population Focus	Date Added
Families & Caregivers; Infant; Women & Maternal	Spring 2026

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Section 1: Practice Summary

PRACTICE DESCRIPTION

Project Nurture is a Center of Excellence model that concentrates providers with expertise in maternity care and treatment of substance use disorders in one location. Development of the Project Nurture model was led and funded by Health Share of Oregon, the state's largest Medicaid Coordinated Care Organization, with more than 450,000 Medicaid members in the Portland tri-county region. In 2013, Health Share and local healthcare leaders convened dozens of representatives from local healthcare systems, state and local agencies, and community-based organizations to address a gap in the systems that provided pregnancy-related healthcare and substance use disorder (SUD) treatment and recovery services. The workgroup developed Project Nurture, a new model of integrated maternity and substance use care with social services and care coordination, centered around peer and group supports. The first Project Nurture site started in September 2014, and as of 2026, there are eight sites across Portland.

People who are pregnant and newly parenting and facing concurrent substance use challenges are a vulnerable population with unique needs. Project Nurture was created to meet those needs, with the goals of increasing access to high-quality evidence-based maternity and addiction care, improving maternal and child outcomes, and reducing child welfare involvement and adverse childhood experiences (ACEs). Project Nurture's essential components are centered around a community created by and for people with lived experience. Services are provided during pregnancy and through one year postpartum, and all the elements are delivered using a trauma-informed approach and harm reduction lens. Project Nurture believes:

- Pregnant and parenting people need and deserve support in their efforts at recovery and safe and healthy parenting.
- Stigma in healthcare contributes to the challenges and poor outcomes experienced by pregnant and parenting people with substance use disorder and their infants.
- Healthcare providers and staff must actively work to end bias and stigma in the healthcare system.
- Transparency and partnership with the Department of Human Services (DHS)/Child Welfare is essential and possible while working toward a common goal: a unified family that is healthy and thriving.

CORE COMPONENTS & PRACTICE ACTIVITES

This integrated maternity and addiction healthcare model includes comprehensive pregnancy care and integrated behavioral healthcare including SUD assessment and treatment (including medications), and care management and care coordination, centered around a community of people with lived experience. All services are offered in a single location, during weekly, drop-in group sessions, maintaining a low-barrier, one-door approach. The weekly groups follow an established curriculum and are facilitated by certified Peers and Doulas with lived experience and other SUD professionals. Integrated medical care is structured using flexible, open scheduling templates so it can be offered to participants as needed during weekly group sessions. Nurse or Social Work-trained case managers meet one-to-one with participants during group sessions and provide them and their families with support and advocacy to meet health-related social needs and navigate interactions with

child welfare and court systems. The integrated teams support participants during pregnancy, intrapartum, and through one year postpartum.

Core Components & Practice Activities		
Core Component	**Activities**	**Operational Details**
Community	- Peer Support Specialists - Harm Reduction Doulas - Weekly participant groups	The core of the model is a community built by and for people with lived experience; certified and specialized peer support specialists and harm reduction doulas with lived experience of SUD and pregnancy or parenting are integrated members of the care team; weekly groups facilitate engagement and building relationships with the program peers and doulas and other participants
Physical Healthcare	- Pregnancy care - Labor & Delivery care - Primary Care - Doula support	Comprehensive prenatal, labor & delivery, and postpartum care including family planning provided by licensed independent providers (Obstetric or Primary Care, MD or CNM/NP); Primary Care offered on-site or via collaborative referral; full-spectrum perinatal doula care; care provided throughout pregnancy until one-year post-delivery
Behavioral Healthcare	- SUD treatment, including medications - Mental health treatment - Peer Support	SUD assessments offered, including "level of care" or treatment setting recommendation; SUD counseling and treatment for any SUD; medication prescribing for any SUD, including opioid or alcohol use disorders; hospital based withdrawal management; mental health treatment for co-occurring disorders; collaborative referrals offered if any specialized services aren't offered within the program; Peer support from people with lived experience of SUD and pregnancy and parenting
Care Management	- Care coordination - Transitional care & discharge planning - Connecting to health-related social needs resources - Advocacy when engaging with other systems (Child Welfare, courts, etc.)	Care managers have social work or nursing training/license Activities include: - Navigation and connection to clinical and treatment services and other resources, including safe housing, secure food sources, transportation, and other social supports - Support and advocacy when engaging with other systems in which participants might

		interface (e.g. DHS/Child Welfare, criminal justice, etc.) - Support transitions between levels of care while in Project Nurture or when exiting out of the program - Provide connections and warm handoffs to healthcare, community-based resources, or other organizations based on patient needs and preferences
Group-based care model	- Weekly, drop-in groups - SUD treatment group model - Follows adapted curriculum such as "Seeking Safety" or "Centering Pregnancy" - Concurrent flexible clinic template	Weekly, drop-in (no appointment needed) treatment/recovery groups for prenatal and postpartum participants; Groups facilitated or co-facilitated by SUD professional (e.g. certified alcohol & drug counselors) and Peers & Doulas; Group topics may also include pregnancy and parenting-related issues & education; Physical and behavioral healthcare and care management services are offered during drop-in group sessions using a flexible clinic scheduling template

COMMUNITY WELLNESS

Prior to the implementation of Project Nurture in 2014, the systems providing perinatal care and substance use disorder treatment in the Portland Metro area were disconnected and siloed. Concentrating professionals with expertise in maternity care and treating concurrent SUD in one location removes many barriers to care for families. Maternal and infant outcomes improved for Project Nurture participants in the initial pilot, who were more likely to receive adequate prenatal care and experienced fewer preterm births and c-sections compared to non-participants. Project Nurture infants required less high-needs care, and 93% of participants retained custody of their children one year after delivery. Improved child welfare outcomes were reflected at the community level by a study of county-based comparisons of child welfare reports, which showed reduced foster care placements and substantiated child harm during the first year of life following the implementation of Project Nurture.

One decade after implementation and the programs have seen many participants complete the program and return during subsequent pregnancies, highlighting the value of the program's enhanced support and perinatal SUD care for people in recovery. Another trend has been observed, where former Project Nurture participants are entering the SUD treatment and recovery workforce. Several Peers who were past-Project Nurture participants work in integrated SUD treatment programs around the Portland Metro region, including Project Nurture. The Project Nurture programs contribute to community wellbeing by providing downstream treatment and recovery services for people who are pregnant and using substances, promoting primary prevention for children by disrupting generational cycles of trauma and reducing Adverse Childhood Experiences, and enhancing local workforce development by growing a thriving community of people with lived experience supporting one another.

EVIDENCE OF EFFECTIVENESS

There have been two major evaluations of the Project Nurture model.

The first evaluation was conducted in 2016-2018 by the Providence Center for Outcomes Research and Education (CORE). This study used an observational, mixed methods approach that included multiple key data sources: Medicaid claims, program data, surveys, and interviews. To study the potential impact of Project Nurture on clinical outcomes from 2016-2017, CORE used a combination of diagnoses, provider, and facility codes to designate someone as a likely Project Nurture participant and a likely non-participant who also suffered from substance use. Further description of methods is included here: https://digitalcommons.providence.org/providence_core/7/

The second major Project Nurture evaluation was conducted by the Center of Health Systems Effectiveness (CHSE) at Oregon Health Science University (OHSU). This evaluation used a difference-in-differences methodology to compare outcomes in 2012-2014 to outcomes in 2016-2017, after Project Nurture's implementation. The team, led by John McConnell, obtained linked Medicaid claims from the Oregon Health Authority and birth certificates from its vital records, as well as child welfare records from the Oregon Department of Human Services (DHS). Further description of the methods is included here: https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01574

Providence CORE found several key clinical outcomes among those that engaged in substance use:

- Project Nurture participants had a 70% reduction in the odds of having a pre-term birth compared to non-participants.
- Cesarean section was significantly decreased for Project Nurture participants compared to non-participants (28.5% vs. 36.5%, respectively).
- Significantly more Project Nurture participants had 7 or more prenatal care visits compared to non-participants.
- Use of Medication for Opioid Use Disorder was significantly increased for Project Nurture participants compared to non-participants.
- Fewer infants of Project Nurture participants required additional care at birth compared to infants of non-participants.
- 93% of Project Nurture participants had custody of their infants at program exit.

CORE conducted qualitative interviews with Project Nurture providers and participants. Providers shared that before the program they did not feel equipped to treat pregnant individuals with substance use disorder, and that the program integrated care in a way that removed barriers and reduced stigma.

CORE heard from Project Nurture participants that the program helped create a community of people with similar lived experience that helped participants to feel welcome and involved; that Project Nurture supported stability in recovery and navigation of systems; and that Project Nurture fostered self-determination in individuals and their recovery process.

The CHSE study found that among opioid-dependent women enrolled in Medicaid, Project Nurture was associated with improved outcomes, including reductions in infant foster care placements and child maltreatment, and increases in prenatal visits and maternal lengths-of-stay in the hospital, compared to women who were opioid-dependent and enrolled in Medicaid in Oregon counties not served by the programs.
Child welfare-related outcomes:

- "The implementation of Project Nurture in Multnomah County was associated with reductions in the placement of children in foster care within the first twelve months of life. Among Medicaid-enrolled women with OUD who gave birth in Multnomah County, the placement rate dropped from 19.7 percent

in 2012–14 to 16.6 percent in 2016–17, while the rate increased in the comparison group from 14.2 percent to 19.4 percent (exhibit 3). In our adjusted difference-in-differences model, this translated into a decrease of 8.3 percent associated with the implementation of Project Nurture."

- "The rate of substantiated reports of child maltreatment displayed a similar pattern, decreasing from 29.9 percent to 26.3 percent in Multnomah County and increasing from 24.5 percent to 28.1 percent in comparison counties. In the adjusted difference-in-differences model, this translated into a decrease of 7.2 percentage points associated with the implementation of Project Nurture."

Clinical outcomes:

- "Project Nurture was associated with an increase of 1.13 prenatal visits and an increase of 0.46 days in maternal lengths-of-stay."

Section 2: Implementation Guidance

COLLABORATORS AND PARTNERS

Two primary forums for practice collaboration have been convening since 2014, hosted by Health Share: monthly steering committee meetings and quarterly learning collaboratives.

The Steering Committee assures continuity and quality of the integrated model and addresses emerging issues, business, growth, and sustainability. Each Project Nurture team identifies a Program Lead and a Clinical Lead to be assigned to the Steering Committee. Members are subject matter experts on substance use in pregnancy and may be available for consultation beyond the Steering Committee meetings on a case-by-case basis to support education and quality improvement in their larger organizations or the community.

Quarterly learning collaborative meetings are open to the full Project Nurture teams and other community stakeholders. Meetings typically include presentations by subject matter experts or community agencies, site-specific updates, and opportunities to engage and network with other teams. Broad participation is highly encouraged. Partners from DHS/Child Welfare often attend, as do teams who are exploring new Project Nurture sites and other local agencies and community organizations who routinely interact with this population.

Practice Collaborators and Partners

Partner/ Collaborator	How are they involved in decision-making throughout practice processes?	How are you partnering with this group?	Does this collaborator have lived experience of come from a community impacted by the practice?
Traditional Health Workers (specialized Peers & Doulas)	THWs participate in program team huddles and system-wide monthly steering committee and quarterly learning collaborative meetings. They are also involved in program evaluation and improvement.	Health Share hired a THW Lead consultant, who represents all the THWs in system-wide work, leads a THW community of practice, and is leading work to develop "Project Nurture THW practice standards"	Yes, personal experience of SUD and pregnancy or parenting is a requirement for the Project Nurture THWs; the THW Lead consultant also has personal experience
Program Leaders	Each team identifies a Program Lead and a Clinical Lead, to lead their local sites, facilitate team huddles, and participate in monthly	Collaboration happens primarily through the steering committee, which assures continuity of the model and addresses pressing topics such as emerging clinical	Lived experience in this group is not required or tracked

	system-wide steering committee meetings.	issues and program growth and sustainability	
Medical providers	Each program is embedded in a larger clinic that provides primary care or maternity services; Project Nurture medical providers are actively involved in their program's team huddles, the steering committee meetings, and participate in program evaluation and improvement	Collaboration happens primarily through the steering committee, and each team has one medical provider assigned as the Clinical Lead who participates in the steering committee; providers also attend learning collaboratives and many present topics of interest	Lived experience in this group is not required or tracked
SUD treatment professionals	Project Nurture SUD treatment professionals are actively involved in their program's team huddles and meetings, and participate in program evaluation and improvement	Some of the SUD treatment professionals participate in the steering committee and most attend the learning collaboratives	Yes, some do, but lived experience in this group is not required or tracked
Care managers	Care managers are actively involved in their program's team huddles, most participate in the steering committee meetings, and they all participate in program evaluation and improvement	Most of the care managers participate in the steering committee and attend the learning collaboratives	Lived experience in this group is not required or tracked
Clinic & Organizational leaders	Clinic and organizational leaders participate in program evaluation and improvement	Clinic and organizational leaders are involved in program evaluation and improvement, and some attend the learning collaboratives	Lived experience in this group is not required or tracked
Payers	Health Share funded the initial model, convenes the steering committee and learning collaboratives, and provides centralized supports including the THW	Project Nurture was adopted as a network standard, part of Health Share's clinical practice guidelines; Project Nurture sites and Health	The involved payer exclusively serves Medicaid populations

	lead, Program & Policy Advisor, and ongoing data collection and analysis	Share engage regularly around steering committee-identified issues and alignment with standards	

REPLICATION

Since the initial pilot, two more Project Nurture teams have started in Portland. As of 2026, five teams currently facilitate Project Nurture groups in eight locations in the region. Every team is fully engaged in steering committee work and participated in the initial Project Nurture Continuous Quality Improvement evaluation in 2025. Health Share supports systemwide data collection with investments in analysis and sustainability initiatives. The continuation and expansion of the Project Nurture sites, over a decade later, is strong evidence of the critical nature and benefit of this model.

In 2019, the Oregon state legislature approved funding for a statewide expansion pilot of the Project Nurture model. “Nurture Oregon” started in 2020 in five rural counties across Oregon. The Nurture Oregon programs have expanded and evolved beyond the initial 3-year pilot and continue to provide comprehensive SUD treatment services and peer-doula support with integrated or collaborative maternity care throughout Oregon.

INTERNAL CAPACITY

The Project Nurture model uses a non-hierarchical, team approach to address the needs of people who are pregnant and parenting with substance use disorders. All phases of program development and implementation should be collaborative and include the Program Leads and team members who will be providing program components, supported by clinic leadership. Team members with lived experience must be closely involved in the earliest phases of program development. Implementation strategies focused on team-based collaboration will help identify potential barriers and increase buy-in to ensure successful program implementation and sustainability.

The Project Nurture Program Lead, Clinical Lead, and other key team members need to be identified early to facilitate program development. Examples of early development activities include creating program roles and responsibilities, writing policies and procedures, defining clinic and program workflows, and developing documentation and communication tools. At minimum, a Project Nurture team will include:

- Peers with lived experience of SUD and pregnancy/parenting
    - Average caseload of about 15 participants for 1.0 FTE
- Doulas with perinatal SUD training
    - Average caseload of about 4 births/month, per doula; capacity may vary depending on participant acuity and doula availability
        - **NOTE:** some programs integrate peer-doulas who have dual training and certification, which is an effective model for providing both services
- Medical providers with training in maternity care and addiction medicine
    - Clinical provider for one group/week is 0.1 clinical FTE; plan for backup provider(s) for cross-coverage or to increase # of weekly groups

- Addiction counselors
    - Maximum caseload of about 40-50 participants for 1.0 FTE
- Care managers with social work or registered nurse licensing
    - Maximum caseload of about 40-50 participants for 1.0 FTE
- Project Nurture Leads
    - Program Lead and Clinical Lead, each about 0.2 FTE

Initial and ongoing education and cross-training will be needed to ensure that every Project Nurture team member is comfortable with the model components and their role and responsibilities to provide care to people who are both pregnant and have SUD. Additional training and education for all program and clinic staff will be needed to ensure the clinic environment remains stigma-free, trauma-informed, and nurturing. Project Nurture teams should also anticipate partnering with inpatient clinical teams to ensure participants receive inpatient maternal and newborn care that is supportive, evidence-based, and trauma-informed.

PRACTICE TIMELINE

Examples of anticipated implementation activities are described in the table below. However, actual timelines will vary between organizations, depending on existing resources, workflows, organizational culture, and leadership support. In nearly all cases, organizational leadership should anticipate needing 12-18 months to adequately plan, implement, and grow a Project Nurture caseload. Doing so will ensure adequate time to gain organizational commitment, establish norms, define roles and hire staff, develop workflows and protocols, and establish partnerships among maternity care, substance use disorder, and inpatient providers.

Phase: Planning/Pre-Implementation (example)		
Activity Description	**Time Needed**	**Responsible Party**
Write/Revise job descriptions; Identify (or hire) Program Lead & Clinical Lead; Hire new positions	6 months, ongoing	Clinic Manager, Medical Director, Clinical Lead, Program Lead
Develop program policies, procedures, treatment guidelines, & group curriculum (adopt existing models)	4-6 months	Project Nurture Team & Clinic Leadership
Develop care pathways & clinic workflows; Build schedule template	2-3 months	Project Nurture Team & Clinic Leadership
Team & clinic staff training:	3-4 months (varies, up to 2 months for training + 1-2 months for scheduling)	Project Nurture Team, Clinic Staff

• ASAM – Treatment of OUD in Pregnant Patients (meets DEA requirement) • Training for clinical teams integrating peers • Trauma-Informed Care & Harm Reduction training • Other role-specific training		
Communication & Documentation Tools: Obtain and/or establish communication tools: Email distribution list; shared document drive; confidential chat/messaging; staff cell phones Documentation: EHR configurations for patient lists, data reports; draft shared note templates, dot phrases	1-2 months (could take much longer if EHR build is needed)	Clinic Manager, Project Nurture Leads, IT/EHR team support

Phase: Implementation (example)

Activity Description	Time Needed	Responsible Party
Team Huddle – "run the list"; care planning and clinical priorities for participants	Weekly	Project Nurture team
Facilitate groups	Weekly	Addiction counselor, Peer, Doula
Program operational meetings – Discuss workflows, program issues and needs	Weekly, initially, then move to bi-weekly or monthly as practice stabilizes	Project Nurture team, Clinic Manager, Medical Director, Clinic Staff as needed
Participant tracking & data collection	Ongoing	Program Lead

Peer Supervision – professional and relational support provided to Peers by a Peer leader	Ongoing	Peer supervisor – Peer leader with professional and lived experience of SUD and pregnancy or parenting; internal or by contract with an external organization

Phase: Sustainability (example)		
Activity Description	**Time Needed**	**Responsible Party**
Quality Improvement assessments	Annually	CQI Process led by Program & Clinical Leads, with participation from Project Nurture team and Clinic leadership
Continue all activities described in "Implementation Phase"	See "Implementation Phase"	See "Implementation Phase"

PRACTICE COST

Start-up costs and annual budget will vary depending on organization and context. Start-up costs are estimated at approximately $200,000-250,000, and include expenses such as onboarding new staff, administrative time for pre-implementation activities, EMR enhancements, communication tools, and other resources, and training expenses.

The annual budget will also vary greatly depending on the organization and context. An estimated initial annual budget is approximately $350,000-400,000. This amount includes the salaries of the core Project Nurture team (as described in the section, "Internal Capacity") and other resources to support a program with one weekly group and up to 25-30 participants. As capacity increases, additional FTE would be needed to facilitate additional groups and support more participants.

For additional information, please Dr. Cat Livingston at livingstonc@healthshareoregon.org.

LESSONS LEARNED

Lesson: Healthcare integration requires a lot of upfront effort, but it is well worth it. During the CORE evaluation, program staff described needing additional training in addiction treatment and trauma-informed care, planning innovative clinic processes and workflows to support flexible scheduling, documentation, and billing, and

establishing best practices as a few critical implementation efforts. Some had to create new positions in their organizations or contractual agreements to provide peer-delivered services or peer supervision.

Lesson: Medical provider champions for integrated maternity SUD care are key to successful implementation. Programs that didn't have medical provider champions from the beginning experienced more barriers along the continuum of care, especially during labor and delivery and newborn care in the hospitals. These barriers included stigma, restrictive and harmful policies, and less supportive and compassionate care. Programs with strong medical champions who participated in implementation, experienced greater organizational culture change and support for the programs and their participants.

Lesson: Careful attention must be paid to how peers are integrated into physical healthcare settings. In clinical settings, peer roles and functions are often not well understood. There is a tendency for peers integrated into medical teams to experience "scope drift" and the role to become over-clinicalized. Additionally, perinatal SUD peer work is challenging and intensive and not comparable to traditional peer work. Perinatal peers need effective and appropriate support to sustain this vital component of the model.

Lesson: There's no one right way to implement the model. Programs may look a little different, and that's okay. However, when all the core Project Nurture components are implemented, the outcomes are consistent regardless of those differences.

NEXT STEPS

Health Share's existing Project Nurture sites will continue with the goal of expanding and adding additional sites in the future to serve rural and culturally specific populations in the region. There is ongoing work to develop a more sustainable financial model from the payer and clinical side.

RESOURCES PROVIDED

For more information about practice startup resources and program documents, please contact Cat Livingston directly at LivingstonC@healthshareoregon.org

APPENDIX

References:

1. Center for Outcomes Research and Education, Providence Health and Services. Project Nurture Final Report.; 2018. https://providence.elsevierpure.com/ws/portalfiles/portal/33448642/Project%20Nurture%20Final%20Report%20Health%20Share%20of%20Oregon.pdf

2. McConnell KJ, Kaufman MR, Grunditz JI, Bellanca H, Risser A, Rodriguez MI et al. Project nurture integrates care and services to improve outcomes for opioid-dependent mothers and their children. Health Aff (Millwood). 2020 Apr;39(4):595-602.

Project Nurture website: https://partners.healthshareoregon.org/project-nurture

YouTube video links about Project Nurture:

3. https://youtu.be/GeOmKACjnpY?si=4GaSQAGRNnuToY__
4. https://youtu.be/QLA9kxsY7f0?si=DSDeTExWjaDbrdWQ