

Program Element # 63 Maternal and Child Health LPHA Family Connects Oregon Community Lead

OHA Program Responsible for Program Element: Public Health Division/Center for Prevention and Health Promotion, Maternal and Child Health/Family Connects Oregon

- 1. Description.** Funds provided under this Agreement for the Community Lead may only be used in accordance with, and subject to, the requirements and limitations set forth below to plan, implement and sustain community alignment activities central to the Family Connects model that was selected for universally offered newborn nurse home visiting.

The Family Connects model was developed within the context of the Durham Family Initiative, funded by the Duke Endowment in 2002, with the primary goal of reducing community rates of child maltreatment. The program centers on a theory-driven and evidence-based assessment of child and family strengths and needs, provided in an informal and family-friendly manner. As a community-based program, Family Connects supports new parents in caring for their newborn(s), offers physical assessments of the caregiver and the newborn, answers questions about caring for the newborn(s), and connects families with community resources based on their interest. In addition, through this connection to resources, Family Connects helps to identify gaps in critical community-wide resources with the goal of working toward increasing needed services locally.

Family Connects is a systems level transformation that uses an evidence-based, newborn nurse home visiting program to provide services to families and children, assist in aligning resources that support families with newborns, and maximize population reach through its universal implementation within a community. The goals of Family Connects are:

1. To connect with a caregiver to enhance caregiver skills and self-efficacy
2. To assess each family’s unique strengths and interest in additional supports
3. To connect the family with community services (i.e. health care, childcare, financial or social support) to promote family functioning and child well-being

Funds provided through this Program Element support LPHA’s efforts toward ensuring community-wide participation in the delivery of, and assurance of access to, culturally responsive, high-quality, and evidence-based voluntary newborn nurse home visiting services.

All changes to this Program Element are effective the first day of the month noted in Issue Date of Exhibit C Financial Assistance Award unless otherwise noted in Exhibit C of the Financial Assistance Award.

2. Definitions Specific to MCH LPHA

Community Lead: A LPHA that is designated by the Oregon Health Authority to serve as the coordinating entity for the newborn nurse home visiting program in a specified community.

- 3. Alignment with Modernization Foundational Programs and Foundational Capabilities.** The activities and services that the LPHA has agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities and the public health accountability metrics (if applicable), as follows (see [Oregon’s Public Health Modernization Manual](http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf), (http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf):

- a. Foundational Programs and Capabilities** (As specified in Public Health Modernization Manual)

Program Components	Foundational Program	Foundational Capabilities
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	CD Control	Prevention and health promotion	Environmental health	Population Health Direct services	Access to clinical preventive services	Leadership and organizational competencies	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
<i>Asterisk (*) = Primary foundational program that aligns with each component</i>						<i>X = Foundational capabilities that align with each component</i>						
<i>X = Other applicable foundational programs</i>												
Develop strategic partnerships with shared accountability driving collective impact to support public health goals related to all families with newborns		*		*		X	X	X		X	X	
Identify barriers to access and gaps in services to all families with newborns		X		*			X	X	X	X	X	
Develop and implement strategic plans to address these gaps and barriers to access to all families with newborns		X		*			X	X	X	X	X	
Ensure community access to home visiting services for all families with newborns		X		*		X	X	X		X	X	

b. The work in this Program Element helps Oregon’s governmental public health system achieve the following Public Health Accountability Metric, Health Outcome Measure:

Not applicable

c. The work in this Program Element helps Oregon’s governmental public health system achieve the following Public Health Accountability Metric, Local Public Health Process Measure:

Not applicable

4. Procedural and Operational Requirements. By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, LPHA agrees to conduct activities in accordance with the following community alignment requirements:

a. Community Lead must:

(1) Oversee the development and implementation of plans required for model implementation for their community.

- (2)** Coordinate with all certified providers in its identified community so that all families with newborns are contacted no later than two weeks after birth of the newborn to engage families and offer services.
- (3)** Develop and implement strategies in collaboration with OHA to supplement funding to support the Family Connects Oregon program in their community.
- (4)** Collaborate with all home visiting providers to integrate newborn nurse home visiting services within the existing services for families in the identified community so that a coordinated system of support is in place.
- (5)** Maintain a written plan describing how the Community Lead will comply with i-iv above.
- (6)** Maintain and consider input from an advisory board that:
 - (a)** Includes stakeholders from the identified community with representation from the following where applicable: parents, medical providers, hospitals, social service providers serving families, WIC, child protective services, Early Learning Hubs, tribal leadership, LPHA, Coordinated Care Organizations, insurers that offer health benefit plans, newborn nurse home visiting services providers and other home visiting providers.
 - (b)** Meets at least quarterly and distributes meeting minutes to board members and certified providers in the identified community.
- (7)** Assure local community resources are compiled in a web-based format or printed directory and updated at least quarterly for use by certified providers.
- (8)** Engage in quality assurance activities that include:
 - (a)** A monthly review of data including key performance indicators such as scheduling rate, comprehensive newborn nurse home visit completion rate, follow-up rate, demographic profile of families receiving services, community connections and referrals in the identified community.
 - (b)** A monthly review of feedback from service recipients using standardized methodology.
 - (c)** Monitoring program reach in the identified community measured by the ratio of number of completed comprehensive newborn nurse home visits to total births in the identified community taking into consideration the number of births served by other home visiting providers.
- (9)** Provide OHA access to data for program monitoring and evaluation in a manner and format designated by OHA.
- (10)** Work with OHA to engage continuous quality improvement.
- (11)** Submit the following de-identified data electronically to OHA in a manner and formation designated by OHA on a quarterly basis:
 - (a)** The number of infants born during the previous quarter who reside in the identified community
 - (b)** For each certified provider in the identified community:
 - (i)** The scheduling rate
 - (ii)** Comprehensive newborn nurse home visit completion rate
 - (iii)** Follow-up rate

- (iv) Demographic profile of families receiving newborn nurse home visiting services
- (v) Community connections and referrals
- (vi) Feedback from families and referral partner feedback;
- (vii) Other data identified by OHA.

(12) Collaborate and coordinate with Tribes designated as Community Leads operating in the same geographic area.

b. Community Lead Training Requirements: Community Leads must

(1) Ensure Community Lead staff members working with the newborn nurse home visiting program receive an orientation within six weeks of beginning work in the program that includes but is not limited to:

- (a) Overview of the home visiting model implemented by the Community Lead.
- (b) Training in early childhood systems coordination that includes stakeholder engagement, working with community advisory boards, identification of community resources, and using data.
- (c) Training in adverse childhood experiences and resilience.

(2) Ensure staff working with the program receive within six weeks of beginning work in the program and annually, training in the following:

- (a) Cultural and linguistic responsiveness
- (b) Implicit bias; and
- (c) Other training specified by OHA.

c. Community Leads must submit plans required for model implementation and an annual local program budget to OHA for approval.

d. Community Leads must use funds for this Program Element in accordance with its local program budget, which has been approved by OHA. Modification to the local program budget may only be made with OHA approval.

5. General Revenue and Expense Reporting. Community Leads must complete an “Oregon Health Authority Public Health Division Expenditure and Revenue Report” located in Exhibit C of this Agreement. These reports must be submitted to OHA each quarter on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 20

6. Reporting Requirements.

Community Leads must provide quarterly progress reports in a format designated by the Authority. Quarterly reports include updates on scaling, staffing, and community alignment activities.

7. Performance Measures.

Community Leads must operate the **Family Connects Oregon Community Lead work** in a manner designed to make progress toward achieving the following Public Health Accountability Metric, Local

Public Health Process Measure: Not applicable

Attachment 1: Local Program Budget Template

Local Program Budget Template

OREGON HEALTH AUTHORITY

Family Connects Oregon

EMAIL TO: Oregon.UOHV@dhsaha.state.or.us

Sub-Recipient Organization Name: _____

Budget Period From: _____ To: _____

BUDGET			
Categories	OHA/PHD	Non-OHA/PHD	Total Budget
Salaries			\$ -
Benefits			\$ -
Personal Services (Salaries and Benefits)	\$ -	\$ -	\$ -
Professional Services/Contracts			\$ -
Travel & Training			\$ -
General Supplies			\$ -
Interpretation			\$ -
Translation			\$ -
Outreach/advertising materials			\$ -
Child care			\$ -
Catering/food			\$ -
Incentives			\$ -
Other			\$ -
Services and Supplies (Total)	\$ -	\$ -	\$ -
Capital Outlay			\$ -
Indirect Rate (_____ %)			\$ -
TOTAL BUDGET	\$ -	\$ -	\$ -
_____ PREPARED BY (print name)			
_____ Email		_____ PHONE	