Program Element #182 Rural Health Transformation Program

OHA Program Responsible for Program Element:

Public Health Division/Office of the State Public Health Director

1. **Description.** Funds provided under this Agreement for this Program Element may only be used in accordance with, and subject to, the requirements and limitations set forth below and by the Rural Health Transformation Program (RHTP) Centers for Medicare & Medicaid Services (CMS) standard grant and cooperative agreement terms and conditions (located at: https://www.cms.gov/files/document/standard-terms-conditions-fy26-12-14-2025.pdf), to deliver Rural Health Transformation Program: Healthy Communities & Prevention Initiative.

   The Healthy Communities & Prevention Initiative focuses on bolstering Rural health systems by expanding access to integrated primary care and social health services that promote prevention, healthy nutrition, care coordination, and care management, especially for individuals with complex health statuses. Investments made under this initiative promote whole person health across all facets of life, from prenatal and infancy to end-of-life care. This initiative has three aims:

   a. **Demonstrate strategies to ensure Rural Oregonians can easily and affordably access necessary services, including for behavioral health, maternal and child health, oral health, long-term care, and emergency services, in their community across a variety of settings by leveraging local partnerships and technology-driven solutions.**

      This may include:

      - Expanding home visiting programs to Rural communities,
      - Establishing or expanding projects that close service gaps for people living with mental health conditions,
      - Expanding access to services and supports for people living with or at risk for cognitive impairment,
      - Conducting activities that increase access to comprehensive oral health services for patients across Oregon through innovative solutions including mobile dental clinics and tele-dentistry, and
      - Expanding and ensuring access to critical access pharmacies via expanded services such as pharmacy lockers, telepharmacy, including pharmacy preparedness for emergencies and other technologies.

   b. **Implement strategies to increase social health services, navigation and outreach capabilities, non-traditional care teams, and population health infrastructure.**

      This may include investments in locally developed networks to:

- Identify and connect individuals needing social supports (including but not limited to food, housing, and transportation) to resources to maintain their overall health,
- Increase access to health services in school settings,
- Expand community-based prevention and health promotion initiatives, including those addressing physical activity, nutrition, the built environment, sleep, stress, and social connectedness, and
- Launch new or expand mobile care offerings (including but not limited to oral, perinatal, behavioral health, and/or optometry services.).

c. **Implement strategies to advance innovative, community-driven solutions that provide choice and tools to support personal health care management.**

This may include expansion of telehealth and digital health tools, including Remote patient monitoring (RPM), expanding resources and supports for caregivers, and expanding self-management education programs to help Rural patients with chronic conditions. These programs include but are not limited to:

- Heart Healthy Ambassador Program (https://pmc.ncbi.nlm.nih.gov/articles/PMC11414079/),
- Chronic Disease Self-Management Program (https://www.ruralhealthinfo.org/toolkits/chronic-disease/2/self-management), and
- Walk With Ease (https://www.arthritis.org/health-wellness/healthy-living/physical-activity/walking/walk-with-ease/wwe-about-the-program).

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

2. **Definitions Specific to this Program Element.**

a. **"Community Lead"** means an organization designated by the Authority to provide community coordination and quality assurance services in accordance with OAR 333-006-0050 for the newborn nurse home visiting program in a specified community.

b. **"Frontier"** means any county with six or fewer people per square mile.

c. **"Newborn Nurse Home Visiting Provider" (NNHVP) or "Certified Provider"** means an organization certified by the Authority to provide newborn nurse home visits in accordance with OAR 333-006-0070 and OAR 333-006-0120.

d. **"Rural"** means any geographic areas in Oregon ten or more miles from the center of a population center of 40,000 people or more.

3. **Alignment with Modernization Foundational Programs and Foundational Capabilities.** The activities and services that the Grantee 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 Public Health Modernization Manual at: https://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						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services: Population Health	Access to clinical preventive services: Direct services	Leadership and organizational	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
Ensure community access to home visiting services for all families with newborns, pregnant people and young children needing additional supports, and children with complex health needs.		X		*	X	X	X	X		X	X	
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 Metrics, Health Outcome Indicators:**

Not applicable

c. **The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Accountability Metrics, Grantee Process Measures:**

Not applicable

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

Grantee must:

a. Direct funding and activities to Rural and Frontier areas. Any activities and spending in urban areas must clearly demonstrate benefit to Rural populations in the jurisdiction.

b. Submit local program plan and local program budget to OHA for approval on templates and timeline as prescribed by OHA and that meets federal Centers for Medicaid and Medicare Services requirements. Once approved the local program plan and local program budget are incorporated herein by this reference.

c. Engage in activities as described in its local program plan and budget.

d. Use funds for this Program Element in accordance with its local program budget. Modification to the local program budget may only be made with OHA approval. RHTP staff must review and approve any adjustments according to CMS terms and conditions.

e. Use funds for this Program Element activities that are not currently reimbursable by Medicaid or any other payor.

f. **General Requirements for Community Lead and Newborn Nurse Home Visiting Grantees**

Grantee must:

(1) Use funds for this Program Element in accordance with its local program

budget. Modifications to the local program budget may only be made with OHA written approval.

(2) Attend a monthly planning and coordination meeting with OHA's Family and Child Health staff.

(3) Funding Limitations: Funds awarded under this Program Element and listed in the Exhibit C, Financial Assistance Award are limited to expenditures for Family Connects Oregon Community Lead activities and Newborn Nurse Home Visiting Provider activities.

g. Designated Community Lead, or authorized by OHA to perform Community Lead Activities

Grantee must:

(1) Maintain staffing required by the program which includes the Family Connects Oregon Community Alignment Specialist and Program Administrator roles.

(2) Ensure a subcontract and/or Memorandum of Understanding is in place if Family Connects Program is implemented through a cross-county collaboration with shared staff across jurisdictions, defining the staffing and supervision agreements.

(3) Deliver services in accordance with OARs 333-006-0000 through 333-006-0190 and Family Connects Oregon Program Guidance provided by the Family and Child Health Section.

(4) Take all appropriate steps to maintain client confidentiality and obtain any necessary written permissions or agreements for data analysis or disclosure of protected health information, in accordance with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations.

h. Designated Newborn Nurse Home Visiting Provider Activities

Grantee must:

(1) Maintain staffing required by the program which includes but is not limited to Family Connects Oregon Nursing Supervisor or Family Connects Nursing Lead, Nurse Home Visitor(s), and Program Support Specialist roles.

(2) Ensure a subcontract and/or Memorandum of Understanding (MOU) is in place if Family Connects Program is implemented through a cross-county collaboration with shared staff across jurisdictions, defining the staffing and supervision agreements.

(3) Deliver services in accordance with OARs 333-006-0000 through 333-006-0190 and Family Connects Oregon Program Guidance provided by the Family and Child Health Section.

(4) Take all appropriate steps to maintain client confidentiality and obtain any

necessary written permissions or agreements for data analysis or disclosure of protected health information, in accordance with HIPAA (Health Insurance Portability and Accountability Act of 1996) regulations.

(5) All nurses working in the Family Connects Oregon program must adhere to nursing practice standards as defined by the Oregon State Board of Nursing.

i. **Designated Newborn Nurse Home Visiting Provider Billing Activities**

Grantee must:

(1) As a provider of Medicaid services, the Newborn Nurse Home Visiting Provider must comply with Medical and Targeted Case Management billing policy and codes in OAR 410-130-0605.

5. **General Expense Reporting.** Grantee must submit quarterly and annual expense reports on reporting template and timeline prescribed by OHA that meets federal Centers for Medicaid and Medicare Services requirements. A separate report must be filed for each applicable Program Element and any sub-element.

6. **Program Reporting Requirements.**

a. Submit local program plan progress reports using the timeline and format prescribed by OHA that meets federal Centers for Medicaid and Medicare Services requirements.

b. Reports must include number of people served and achievements on stated outcomes, metrics, and milestones.

Reporting Timelines		
Report Type	CMS Reporting Period	Report Due Date
Budget Period 1 Reporting Schedule *Spending period: 12/31/25 - 9/30/2027*		
Annual Report	12/31/2025 - 7/31/2026 (May be updated depending on date of agreement execution)	7/31/2026 (May be updated depending on date of agreement execution)
Budget Period 2 Reporting Schedule *Spending period: 10/31/26 - 9/30/2028*		
Quarterly Report	8/1/2026 - 10/29/2026	10/29/2026
Quarterly Report	10/30/2026 - 2/1/2027	2/1/2027
Quarterly Report	2/2/2027 - 4/30/2027	4/30/2027
Annual Report	8/1/2026 - 7/31/2027	7/31/2027

c. Requirements for Grantees implementing Family Connects Oregon:

Grantee must provide progress reports to OHA in a format designated by OHA that include the following:

(1) **Community Lead Report:** If the Grantee is the Community Lead, submit reports using the Community Lead Report on a schedule determined by OHA. The report includes information on the Family Connects program population reach, staffing, and community alignment activities. OHA will provide the Grantee the report template.

(2) **Program Sustainability Report (PSR):** If the Grantee is the Community Lead or the Newborn Nurse Home Visiting Provider, submit a PSR in a format and on a schedule determined by OHA. The purpose of the PSR is to support Family Connects program sustainability. The report includes information on a site's projected and actual program funding and expenditures including for this Program Element, as well as program revenue. If the Community Lead and Newborn Nurse Home Visiting Provider are different Grantee organizations, the two will receive one PSR from OHA and are required to coordinate and submit one PSR only.

(3) **Data Collection and Reporting:** Grantee must ensure that data on individuals who receive Family Connects Oregon services are collected and entered into the state-designated data system in a timely manner that is aligned with expectations defined by the program and within no more than 30 business days of visiting the client and 45 days of case closure (information shall be obtained from Community Leads and NNHVP).

7. Performance Measures.

a. Grantee must operate the Rural Health Transformation Program: Healthy Communities & Prevention Initiative in a manner designed to make progress toward achieving the following Rural Health Transformation Program Outcome

(1) Outcome 1: Universal access to home visiting services