Program Element #082 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 groups or efforts 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" or "Remote"** 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. **"Remote Patient Monitoring"** means a type of telehealth in which healthcare providers monitor patients outside the traditional care setting using digital

medical devices, such as weight scales, blood pressure monitors, pulse oximeters, and blood glucose meters. The data collected from these devices are then electronically transferred to providers for care management. Automated feedback and workflows can be built into data collection, and out-of-range values or concerning readings can be flagged.

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

f. **"Telepharmacy"** means a form of pharmaceutical care in which pharmacists and patients are not in the same place and can interact using information and communication technology (ICT) facilities. Telepharmacy has been adopted to provide pharmaceutical services to underserved areas and to address the problem of pharmacist shortage.

g. **"Self-Management and Education (SME) Programs"** means programs that help people who have ongoing health conditions learn how to live life to the fullest. For many people, this means lives with less stress, more energy, and a greater ability to do the things they want to do. SME Programs are clinically proven to reduce symptoms and improve quality of life.

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 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		Leadership and organizational	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
				Population Health	Direct services							
Asterisk (*) = Primary foundational program that aligns with each component						*X = Foundational capabilities that align with each component*						

X = Other applicable foundational programs												
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	
Convene local and statewide partners and organizations to cultivate leadership and vision for prevention and health promotion policies, programs and strategies in rural areas of the jurisdiction		X		X			X	*		X	X	
In collaboration with community partners, identify barriers to health care access and gaps in services and implement strategics to address these gaps and barriers to care				*			X		X	X	X	
Coordinate and/or implement multifaceted prevention and health promotion policies, programs and strategies across the lifespan to mitigate or enhance the health impact of social determinants, improve health equity (3) and address specific health topics that contribute to chronic diseases.		*		X	X		X			X		
Implement community health worker models to		*		X	X		X	X				

support navigation to community health and social resources.												
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	
Identify barriers to access and gaps in services to 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, LPHA 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, LPHA agrees to conduct activities in accordance with the following requirements:

LPHA 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. Implement projects within the following funding categories.

(1) Perinatal Care Coordination

(2) Nurse home visiting programs

(3) Mobile health programs

(4) Chronic disease self-management programs

(5) School-based prevention programs

(6) Treatment and recovery programs

(7) Nutrition programs

(8) Lead testing programs

(9) Developing or expanding behavioral health clinic partnerships and coordination

(10) If needed to be responsive to a specific previously identified local community need, LPHAs may propose a project or activity not listed above. LPHA must demonstrate alignment with a current community health improvement plan priority and with Healthy Communities and Prevention Outcome 4 (new health care and social health services).

e. Implement strategies and activities in accordance with this Program Element. Strategies and activities in the local program plan must support one of the three aims outlined in Section 1 and must align with at least one of the following:

(1) 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.

(2) Convene local and statewide partners and organizations to cultivate leadership and vision for prevention and health promotion policies, programs and strategies in rural areas of the jurisdiction.

(3) In collaboration with community partners, identify barriers to health care access and gaps in services and implement innovative strategics to address these gaps and barriers to care.

(4) Coordinate and/or implement multifaceted prevention and health promotion policies, programs and strategies across the lifespan to mitigate or enhance the health impact of social determinants, improve health equity,

and address specific health topics that contribute to chronic diseases.

(5) Implement community health worker models to support navigation to community health and social resources.

f. Implement activities designed to support progress for Outcome 4 in Section 7 of this Program Element. In addition, LPHA may choose to implement activities that also support progress for one other outcome measure in Section 7.

g. Support new access points and expansion of services to Rural communities and not use funding to replace or duplicate existing funding sources. Funds may only be applied to the costs associated with new populations, new activities, new program milestones, etc. when used to expand an existing pilot program or initiative, or to develop new programs with existing partners.

h. Use funds for activities that are not currently reimbursable by Medicaid or other payor.

i. **Requirements for sites selected to implement Family Connects Oregon (FCO) program:**

General Requirements for Community Lead and Newborn Nurse Home Visiting Grantees

LPHA 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.

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

LPHA 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.

k. Designated Newborn Nurse Home Visiting Provider Activities

LPHA 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.

l. Designated Newborn Nurse Home Visiting Provider Billing Activities

LPHA 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. LPHA 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. <u>Note, reporting requirements may change to meet OHA oversight and CMS reporting requirements.</u>

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. Tentative reporting timelines are listed below. A final schedule will be posted online here: https://www.oregon.gov/oha/ph/providerpartnerresources/localhealthdepartmentresources/pages/index.aspx and sent out to LPHAs when revised.

Tentative 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 LPHAs implementing Family Connects Oregon:**

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

(1) **Community Lead Report:** If the LPHA 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 LPHA the report template.

(2) **Program Sustainability Report (PSR):** If the LPHA 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 LPHA organizations, the two will receive one PSR from OHA and are required to coordinate and submit one PSR only.

(3) **Data Collection and Reporting:** LPHA 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. LPHA must operate the Rural Health Transformation Program: Healthy Communities & Prevention Initiative in a manner designed to make progress toward achieving Outcome 4 of the Rural Health Transformation Program Outcomes based on the strategies and activities LPHA is implementing from section 4d. In addition, LPHA may select one additional outcome from the list below when implementing strategies and actions from section 4d. LPHAs selected to implement strategies and actions in section 4h must also operate in a manner that supports progress toward Outcome 1.

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

(2) Outcome 2: Increase availability of mental health and substance use disorder treatment

(3) Outcome 3: Increase patient engagement with new preventive health and/or self-management programs

(4) Outcome 4: Increase rural populations served by new health care and social health services (i.e., health services)

(5) Outcome 5: Expanded access to health care services, including chronic disease management, through increased availability of telehealth