Family Connects Oregon

Guidance for Coordinated Care Organizations

Under the CY 2023 contract, Coordinated Care Organizations (CCOs) are responsible for providing Care Coordination for their Members[1] who receive services through the Family Connects Oregon (FCO) program. Specific CCO requirements relating to FCO are described in Exh. B, Pt. 2, Secs. 9 and 12 of the contract.

FCO is on an eight-year timeline for statewide rollout. This means FCO is not yet available to all CCO Members. The program is currently offered in four communities. Community alignment and planning activities are expected to begin in at least two additional communities in 2023. Details are provided on the FCO website.

The purpose of this document is to provide CCOs with background information about FCO and guidance relating to Care Coordination and reporting requirements described in the contract.

I. Background

The vision for Oregon's universally offered home visiting (UoHV) program is to offer a home visit to every family with a newborn child, including foster and adoptive families. This program is designed to be a brief touch point with families as they begin to integrate the newborn into their lives. Another intended benefit of the UoHV program is to remove stigma and promote health equity, because unaddressed disparities during the earliest years can lead to intensified health problems and widening social, educational, and economic gaps.

In 2019, the Legislature passed Senate Bill 526 requiring the Oregon Health Authority (OHA) to develop, implement and maintain a UoHV program in Oregon. The legislation also required health benefit plans to offer this benefit to their members so the program could be offered universally. The recommended UoHV intervention, now known as Family Connects Oregon, includes a rollout of UoHV over an eight-year timeline in accordance with the following plan:

- **Establish the state-level infrastructure** necessary to support the development and implementation of universally offered home visiting in the 2019-2021 biennium.
- **Implement a phased-in approach**, beginning with communities most ready.
- Continue the rollout by **adding more service delivery sites** in the subsequent biennia, reaching statewide coverage by 2028.

[1] For CCO Members up to six months of age whose physical health benefits are covered by the CCO.

- **Engage commercial insurance plans** to support these services for their members.
- **Evaluate the effectiveness** of the intervention.

II. Family Connects Model

Family Connects Oregon (FCO) is an evidence-based universally offered nurse home visiting intervention available to all families with newborns residing within a defined community. It consists of one to three nurse home visits, typically when the infant is two to twelve weeks old, and follow-up contacts with families and community agencies to confirm successful linkages with community resources. During the initial home visit, a nurse conducts a physical health assessment of the caregiver and newborn, screens families for potential risk factors associated with caregiver's and infant's health and well-being, and may offer direct assistance (i.e., guidance on infant feeding and sleeping). The nurse and family then work together to identify and connect with community resources for the family.

Additionally, studies have shown a positive return on investment in the Family Connects model, based on savings primarily associated with reduced use of the emergency room and hospital care for infants.

Family Connects Model Components

The program components of the Family Connects model are community alignment, home visiting, and data & monitoring (see Figure 1). It is the interplay of these three components that is associated with improved health outcomes. Implementation of all three components are required to demonstrate fidelity to the empirically supported evidence-based model.

Figure 1. Program components of the Family Connects model

Community Alignment is the process to create and/or strengthen and maintain the community system of care. This is critical as families are referred into this system and the services available in the community are identified to meet their needs. The model implementation begins with a robust assessment of services and collaboration with community partners prior to starting home visiting services. As home visiting services begin, maintenance and quality improvement of the system continues based on identified needs.

Home Visiting services are delivered by a nurse in the home typically three weeks after the birth. That visit is comprehensive and includes assessments, screenings, education, and referrals into desired services. Some families participate in an additional one to two visits to ensure their needs are met. Four weeks after the last visit, the family receives a post-visit connection call to see if they connected with the referrals they received and to assess their satisfaction with the services received.

Data & Monitoring includes the collection of the data from the nurse visits, referral information, and the metrics used to determine model fidelity. It also contributes to the continuous quality improvement efforts of the services in a community—identifying gaps and improvements to better serve families.

III. Contract Requirements

A. Provide Care Coordination (Exh. B, Pt. 2, Secs. 9 and 12)

These activities promote communication, data sharing, and collaboration between the CCO's Care Coordination programs (including Intensive Care Coordination) and FCO Providers in order to jointly support families. Table 1 lists examples of Care Coordination activities.

Table 1 - Care Coordination Activities

Care Coordination	Activities
1. Notify Members receiving CCO Care Coordination about FCO	• For newborn members enrolled in CCO Care Coordination or Intensive Care Coordination activities, notify families about FCO services if available in the Member's county. Work with Community Lead to clarify program eligibility.
2. Identify Members receiving both CCO Care Coordination and FCO	• Work with FCO Community Lead to explore a process for identifying families who are receiving CCO Care Coordination/Intensive Care Coordination activities and FCO services.
3. Establish communication methods	• Work with FCO Community Lead to explore a communication process between FCO nurse home visitors and CCO Care Coordinators.

B. Participate in Community Alignment and Planning (Exh. B, Pt. 2, Sec. 12)

Community alignment is a core element of the Family Connects model. FCO program staff will facilitate initial contact between CCOs and FCO Community Leads to participate in community alignment activities. Suggested community alignment activities are listed in Table 1 below. CCOs are required to submit bi-annual reports on their engagement in FCO community alignment and planning activities.

A current list of FCO Community Leads is found on the "Meet the Teams" section of the Family Connects Oregon website at https://www.familyconnectsoregon.org/

IV. Reporting

A. Care Coordination (Exh. B, Pt. 2, Sec. 12 e. (1))

By 1/15/2023, each CCO will email OHA the name and contact information for its designee for activities related to perinatal care coordination and the FCO program. The CCO will send this information to the CCO deliverables mailbox at CCO.MCODeliverableReports@dhsoha.state.or.us.

If the FCO program is not yet offered in any part of the CCO's Service Area, then this information will be used to notify the CCO when community alignment and planning activities are expected to begin.

B. Engagement in Community Alignment and Planning Activities (Exh. B, Pt. 2, Sec. 12 e. (2))

Each CCO must submit a bi-annual report about its engagement in FCO community alignment and planning activities. Examples of activities CCOs should include in this report are provided in Table 2 below.

The CCO should report on any activities related to FCO community alignment and planning, not limited to the examples in Table 2. The CCO will be required to report on how each activity was completed, any barriers to completion, and any changes since the previous report.

The report will provide an option for the CCO to indicate there is no information to submit because the FCO program is not offered or there are no community alignment and planning activities underway. No further information is necessary for the report in these cases.

The CCO will submit this report online via SmartSheet. The URL for the online form is: https://app.smartsheet.com/b/form/1e89dd0c49624a1fa48b9e15be740945.

The CCO must submit each report within 45 days after the reporting period. The reporting schedule is provided in Table 3 below.

Table 2 – Examples of Community Alignment and Planning Activities

Category	Possible Activities
1. Meeting participation	• Engage in local FCO Community Advisory Board (CAB) and/or planning meetings.
2. CCO Community Advisory Council (CAC) collaboration	• Share relevant reports and learnings from CAC with FCO Community Leads. • Facilitate FCO presentations to the CAC. • Utilize the CAC as a potential resource for feedback on the FCO program.
3. Provider engagement	• In collaboration with FCO Community Lead, increase healthcare provider awareness of FCO through: ○ newsletter articles ○ presentations

Category	Possible Activities
	○ or other established communication channels.
4. Referral systems	• Collaborate with FCO Community Lead to develop FCO referral systems for families with eligible newborns.
5. Hospital engagement	• Facilitate collaboration between FCO Community Lead and key hospital partners to improve FCO outreach in the hospital setting, establish data sharing, facilitate home visit scheduling, and/or establish discharge plans which include referral to FCO.
6. Information and referral systems	• Engage FCO Community Lead in community-level planning related to implementation of information and referral systems (e.g., Unite Us).
7. Clinical Champion support	*Clinical Champions are local medical providers who assist FCO through participation in case conferences, FCO promotion, and other activities.* • Assist FCO Community Lead to identify a healthcare provider to serve as a Clinical Champion. • Support FCO Community Lead in securing funding for a Clinical Champion.
8. Member advocacy	• Support effective processes for FCO home visiting nurses to advocate on behalf of Members in order to resolve Grievances including but not limited to the CCO's contracted Primary Care Providers or Member access to FCO services. Processes to resolve Grievances must be in compliance with the Grievance and Appeal System requirements described in Exh. I and applicable OARs.
9. FCO program marketing	• Collaborate with OHA and FCO Community Lead to develop FCO marketing strategies.
10. Other	• Any other activities: (please specify)

Table 3 – 2023 Reporting Schedule

Reporting period	Report due date	OHA review and feedback to CCO
January 1- June 30, 2023	August 14, 2023	September 13, 2023
July 1- December 31, 2023	February 14, 2024	March 16, 2024

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