

Family Connects Oregon

Guidance for Coordinated Care Organizations

Under the CY 2024 contract, Coordinated Care Organizations (CCOs) are responsible for providing Care Coordination for their Members¹ 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 a scaled timeline for statewide rollout. This means FCO is not yet available to all CCO Members. The program is currently offered in select communities across the state. 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 (FCO), includes a scaled rollout of Family Connects Oregon 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, eventually reaching statewide coverage.
- **Engage commercial insurance plans** to support these services for their members.
- **Evaluate the effectiveness** of the intervention.

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

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 four 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 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	<ul style="list-style-type: none"> For newborn members enrolled in CCO Care Coordination 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	<ul style="list-style-type: none"> Work with FCO Community Lead to explore a process for identifying families who are receiving CCO Care Coordination and FCO services.
3. Establish communication methods	<ul style="list-style-type: none"> 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. Community Alignment activities are listed in Table 2 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 [Find Family Connects Near You](#) 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 January 15 of each contract year, 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.MCOCDeliverableReports@dhsosha.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. This guidance document clarifies the requirements for the bi-annual report. Activities CCOs should include in this report are provided in Table 2 below, and in the FCO Community Alignment Report Evaluation Criteria document.

The CCO should report on any activities related to FCO community alignment and planning. The CCO will be required to describe their current progress towards FCO implementation in their service area and any barriers to completion.

The report will provide an option for the CCO to indicate there is no information available for the deliverable submission because the FCO program is not currently planned or offered in a CCO’s service area. No further information is necessary for the report in these cases.

The CCO will submit this report online via CCO Deliverables Portal. The CCO Portal can be accessed at <https://oha-cco.powerappsportals.us/>.

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

Table 2 –Community Alignment and Planning Activities

Elements	Activities
1. Meeting participation	<ul style="list-style-type: none"> • Engage in local FCO Community Advisory Board (CAB) and/or planning meetings.
2. CCO Community Advisory Council (CAC) collaboration	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • In collaboration with FCO Community Lead, increase healthcare provider awareness of FCO through: <ul style="list-style-type: none"> ○ newsletter articles ○ presentations ○ or other established communication channels (e.g. Provider Manual/Handbook) • Support FCO Community Lead in connecting with providers and/or clinics.

Elements	Activities
4. Referral systems	<ul style="list-style-type: none"> Collaborate with FCO Community Lead to develop FCO referral systems for families with eligible newborns.
5. Hospital engagement	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Engage FCO Community Lead in community-level planning related to implementation of information and referral systems (e.g., Unite Us).
7. Member advocacy	<ul style="list-style-type: none"> 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.
8. FCO program marketing	<ul style="list-style-type: none"> Collaborate with FCO Community Lead to inform members about FCO and increase awareness and participation in FCO.
9. Other (Optional)	<ul style="list-style-type: none"> Any other activities, including but not limited to providing FCO Community Lead Funding for FCO implementation or addressing resource or service gaps for families with newborns.

Table 3 – 2024 Reporting Schedule

Reporting period	Report due date	OHA review and feedback to CCO
January 1- June 30, 2024	August 14, 2024	September 13, 2024
July 1- December 31, 2024	February 14, 2025	March 16, 2025

FCO program contact: LaShanda Hill, MPH, Health Systems Integration Specialist
 OHA Public Health Division - Maternal and Child Health
 503-979-5345 (mobile)
LASHANDA.N.Hill@oha.oregon.gov