

Agreement Amendment	
University	Collaborator
Institution/Organization ("UNIVERSITY") Oregon Health & Science University 3181 SW Sam Jackson Park Road Mail Code: L106RGC Portland, OR 97239	Institution/Organization ("COLLABORATOR") Yamhill County Public Health Division 412 NE Ford Street McMinnville, OR 97128
Prime Award Number: HRSA B04MC25366 via OHA Subaward 143021	Subaward Number: 1004395_Yamhill_CaCoon
University PI: Marilyn Hartzell	Collaborator PI: Lindsey Manfrin
Period of Performance: 10/01/14-09/30/16	Amount Funded this Action: \$ 24,000
Budget Period: 10/01/15-09/30/16	Amendment Number: 1
Project Title: Title V MCAH Block Grant Program	

Amendment(s) to Original Terms and Conditions

Article 2. SCOPE OF WORK

For the current budget period from 10/01/2015 through 09/30/2016, COLLABORATOR shall utilize the funds to complete the PROJECT Goals as identified in **Attachment A.1, Scope of Work and Attachment B.1, Promotora Services Scope of Work, Attachment E, Babies First and CaCoon Risk Factors (A Codes and B Codes)** in accordance with **Attachment C, Use of Allotment Funds**. COLLABORATOR shall meet the standards of performance as identified in **Attachment D, Minimum Standards of Program Performance**. The conditions of Eligibility Criteria in **Attachment A.1** shall also be met by COLLABORATOR when admitting clients into the PROJECT.

Article 3. PERIOD OF PERFORMANCE

The period of performance of this AGREEMENT is hereby extended through 09/30/2016.

Article 4. ESTIMATED COST AND EXPENDITURE LIMITATION

The maximum award available for the new budget period from 10/01/2015-09/30/2016 is \$24,000 per Attachment F.1, Categorical Funding Structure.

Article 6. PROJECT PERSONNEL

The Principal Investigator for COLLABORATOR is hereby changed from Patricia Seemueller to Lindsey Manfrin.

Article 7. TERMS OF PAYMENT & INVOICING

COLLABORATOR shall submit invoices to UNIVERSITY per the quarterly payment schedule, below, for reimbursement of all allowable direct and indirect costs, as per the applicable cost principles and as described in **Attachment C**, to spasub@ohsu.edu.

PAYMENT SCHEDULE for the new budget period from 10/01/2015-09/30/2016:

- (1) Initial Payment of \$8,000.00, payable upon execution of this Agreement and receipt of invoice on or after 10/1/2015.
- (2) Second Payment of \$8,000.00, payable upon invoice on or after 3/1/2016.

(3) Final Payment of \$8,000.00, payable upon invoice and acceptance by UNIVERSITY of COLLABORATOR's Financial Report on or after 09/30/2016.

Article 8. NOTICES

All notices required to be given under this AGREEMENT shall be in writing and sent to the party as indicated below:

TO UNIVERSITY

Jen Michaud,
Subaward Grants & Contracts Administrator
Oregon Health & Science University
3181 SW Sam Jackson Park Road
L106OPAM
Portland, OR 97239-3098
Phone: 503.494.2379
Email: michauj@ohsu.edu

ALL ATTACHMENTS REFERENCED ARE HEREBY MADE A PART OF THIS AGREEMENT. ALL OTHER TERMS AND CONDITIONS OF THIS SUBAWARD AGREEMENT REMAIN IN FULL FORCE AND EFFECT.

Approved and Agreed:
**Yamhill County Public Health
Division**

By: 

Oregon Health & Science University



Digitally signed by Jen Michaud, Subaward Grants & Contracts Administrator
DN: cn=Jen Michaud, Subaward Grants & Contracts Administrator, o=Oregon Health & Science University, ou=Office of Proposal & Award Management, email=michauj@ohsu.edu, c=US
Date: 2015.12.11 11:13:32 -08'00'

Jen Michaud
Subaward Grants & Contracts Administrator

12/8/15

Accepted by Yamhill County
Board of Commissioners on
12-10-15 by Board Order
15-495

(3) Final Payment of \$8,000.00, payable upon invoice and acceptance by UNIVERSITY of COLLABORATOR's Financial Report on or after 09/30/2016.

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Division**

Oregon Health & Science University

By: 

Jen Michaud
Subaward Grants & Contracts Administrator

12/8/15

Accepted by Yamhill County
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12-10-15 by Board Order
15-495

ATTACHMENT A.1 – SCOPE OF WORK
BUDGET PERIOD FROM 10/01/2015–09/30/2016

**Oregon Center for Children and Youth with Special Health Needs –
Title V CYSHCN (Part I) and CaCoon Program (Part II)**

Mission: The Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) improves the health, development and well-being of all of Oregon’s children and youth with special health care needs.

Vision: All of Oregon’s children and youth with special health care needs are supported by a system of care that is family centered, community-based, coordinated, accessible, comprehensive, continuous and culturally competent.

Population of Focus – Children and youth with special health care needs (CYSHCN): Children and youth, through 20 years of age, who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition AND who also require health and related services of a type or amount beyond that required by children generally.

Contract Goal: OCCYSHN seeks to improve state and community-based systems of care for CYSHCN throughout Oregon. The goal of this contract is to achieve, in partnership with the Local Health Department (LHD)/Subawardee, systems improvement at the community level through LHD/Subawardee:

- Leadership or participation in health care system development and/or quality improvement to achieve optimal health outcomes for CYSHCN.
- Assurance of the capacity of the workforce to support OCCYSHN’s mission and vision.
- Promotion of effective and efficient use of the healthcare system.

Part I. Children and Youth with Special Health Care Needs – Scope of Work

This section specifies the responsibilities of the LHD/Subaward in accepting a contract with OCCYSHN, on behalf of Oregon’s Title V children and youth with special health care needs program, to assure the needs of CYSHCN are met at the community level.

Responsibilities of the LHD/Subawardee in assuring integrated, coordinated community-based systems of care for CYSHCN.

1. Title V CYSHCN/CaCoon:
 - a. Participate in OCCYSHN special initiatives, program planning and coordination of LHD/Subawardee services for CYSHCN residing in their county.
 - b. Receive and disseminate all communication from OCCYSHN.
 - c. Attend OCCYSHN sponsored in-service training, including the annual OCCYSHN/CaCoon Regional Meetings.
 - d. Share and disseminate OCCYSHN resources.
2. Local Health Department/Other contracting entities’ staff:
 - a. Be available as a resource to other health, education and community service providers regarding children and youth with special health needs.
 - b. Share OCCYSHN resources, tools and special training.
3. Local community (service area):
 - a. Assure the needs of the population are represented in community planning as available.

- b. Be a resource regarding children with special health care needs.
- c. Assure CYSHCN are represented on the Local Interagency Coordinating Council (LICC), Early Childhood Team (ECT), or combined LICC/ECT within Local County for the purposes of representing the needs of children with special health needs and their families.
- d. Assist in community process to identify needs and resources for CYSHCN.
- e. Participate in multidiscipline team processes for CYSHCN as either a member or a resource to a child's Community Health Team. (E.g. Community Connections, other service coordination teams for CYSHN or PHN clients).

Title V CYSHCN Contract Standards

All contracting LHDs/Subawardees will:

1. Conduct public awareness activities in order to assure that families and community organizations are aware of local services and system-improvement efforts pertaining to CYSHCN.
2. Represent the interests of CYSHCN at relevant local agencies and discussions.
3. Demonstrate evidence of continuous quality improvement efforts in service of CYSHCN (for example, increasing the number of CYSHCN who receive care at a Patient Centered Primary Care Home (PCPCH), increasing the number of CYSHCN who successfully transition from pediatric to effective adult health care models, or increasing effective linkages across systems of care).
4. Engage in educational opportunities that support workforce development and systems improvement, including participation in the annual OCCYSHN Regional Meetings.
5. Designate an individual with the authority to assure accountability to the contract standards/scope of work, above, and to submit a short annual report describing how the LHD/Subawardee is meeting each of the standards above, due July 1, 2016. A report template will be provided by OCCYSHN.

Part II. Oregon Care Coordination Program: CaCoon – SCOPE OF WORK

This scope of work is designed for local health departments with the capacity to implement a public health nurse home visiting program.

A. Specifications of the Program

This section provides specifics of the CaCoon Program that define its population, eligibility, program purpose and activities.

CaCoon is a statewide public health program that focuses on community based Care COordination for CYSHCN through nurse home visiting for families with children, birth to 21 years, with special health care needs

1. The **definition of the program population** to be served is:
“Children with special health needs are those who have or are at risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. (McPherson, et al., 1998, p. 138).”
2. **CaCoon Program Eligibility**
 - a. **Age Eligibility:** The CaCoon program serves children birth through 20 years of age.

- b. Diagnostic/Condition eligibility is outlined in the “B” column of the A and B Code Eligibility List (**See Attachment F**). Public health nurses may use their professional judgement if a child has a chronic health condition or disability that is not specifically identified in the list by assigning risk code “B90-other chronic conditions.”
- 3. Financial Eligibility**
- a. The CaCoon program is open to all children regardless of child or family insurance status or income.

CaCoon Program Purpose

The CaCoon Program provides LHDs/Subawardees an opportunity to contract with OCCYSHN to:

- a. Provide CaCoon services with practice and evidence-based program standards;
- b. Receive technical and professional supports to achieve CaCoon contract standards;
- c. Implement a State Plan Amendment supported program which allows an additional LHD funding stream through TCM reimbursement

CaCoon Program Goals

- a. Promote the development of effective care teams which center on the child/family.
- b. Increase family knowledge, skills, and confidence in caring for their children and youth with special health care needs (CYSHCN).
- c. Promote effective and efficient use of the healthcare system.

Responsibilities of all PHNs providing CaCoon services:

- a. Implement and assure fidelity to CaCoon Program Standards.
- b. Participate in CaCoon Program orientation and other educational opportunities related to CaCoon practice.
- c. Lead or participate in efforts to identify children and youth who are in need of home visiting with community-based care coordination.
- d. Identify and act upon learning goals to continuously improve practice
- e. Conduct accurate assessments of child/family strengths and needs.
- f. Work with healthcare team members, including families, to develop actionable, effective plans of care.
- g. Report data per the CaCoon program guidelines for entry into the ORCHIDS or other state data system.
- h. Learn about and access local resources.
- i. Coordinate and/or monitor delivery of health care and other services as needed.
- j. Adhere to Oregon State Board of Nursing requirements in working with Unlicensed Assistive Personal (Promotora, Community Health Workers).

Responsibilities of Local Health Department and other entities implementing CaCoon

- a. Assure fidelity to CaCoon Standards by nurses and others working with CaCoon clients.
- b. Provide supports for work space and access to community.
- c. Enter CaCoon encounter data into the ORCHIDS Database. Assure CaCoon service through participation in State and local efforts to leverage funds and provide service to this population (e.g. Targeted Case Management and Medicaid

- Administrative Match and service agreement with CCOs to provide CaCoon services.
- d. Provide adequate supervisor support related to scheduling and staff reflection for attaining program goals and personal growth for CaCoon staff.
 - e. Implement a Triage system

B. Promotora Program

Under the direction of the CaCoon Nurse, the Health Promotora promotes health behaviors and helps families access and coordinate health and related services (See Attachment B).

Oregon Care Coordination Program: CaCoon Minimum Standards of Program Performance CaCoon Standards

CaCoon Program

CaCoon is a statewide public health program that focuses on community based Care COordination for CYSHCN through nurse home visiting.

CaCoon Goals

- Promote the development of effective care teams which center on the child/family.
- Increase family knowledge, skills, and confidence in caring for their children and youth with special health care needs (CYSHCN).
- Promote effective and efficient use of the healthcare system.

CaCoon Standards

1. The Subawardee establishes and maintains a triage system for home visiting that prioritizes the most vulnerable children with special health care needs for CaCoon services. Priority will be given to:
 - a. Families with a newly diagnosed infant/child with a chronic condition and/or disability.
 - b. Families who report difficulty accessing or coordinating their child's care and services.
2. When the Subawardee is unable to provide home visiting services for a child who has been referred, the Subawardee will, at a minimum:
 - a. Refer the child/family to primary care, specifically a patient centered primary care home when available, as well as appropriate educational services.
 - b. Notify the referring entity that Subawardee is unable to provide services and provide rationale.
3. The Subawardee assures timely contact with CaCoon home visiting referrals. At a minimum, initial outreach is implemented within 10 business days of receiving referral into the CH referral system. Initial outreach may be by telephone or other means.
4. All nurses serving CaCoon clients collaborate with the healthcare team to assure that the following assessments are completed for each child/family on the CaCoon caseload:
 - Assessment of child/family's strengths, needs, and goals.
 - Assessment of child/family's health-related learning needs.
 - Assessment of child's functional status and limitations, including ability to attend school and school activities.

- Early and continuous screening for special health care needs including physical, developmental, mental health, and oral health assessments as recommended by the American Academy of Pediatrics. ¹
 - Assessment of access to health care team members as well as social supports. ²
 - Assessment of access to supportive medical and/or adaptive equipment and supplies, e.g. suction machine, wheelchair, medications, formula, feeding tube.
 - Assessment of family financial burden related to care of child with special health needs.
 - Assessment of housing and environmental safety.
 - Assessment of emergency preparedness.
 - Assessment of preparedness for youth transition to adult health care, work, and independence, if appropriate to age.
 - Assessment of child/family satisfaction with services they receive.
5. In partnership with the child/family and the broader health care team, nurses serving CaCoon clients develop the nursing care plan which:
Is based in, and responsive to accurate and appropriate assessments (see #4 above).
- Includes goals, progress notes, and a plan for discharge from CaCoon services.
 - Demonstrates evidence of nursing support to increase patient/family engagement with primary care; specifically a patient centered primary care home when available.
 - Demonstrates evidence of effective coordination with the primary care physician and specialty providers as well as the broader health care team. ¹
Coordination includes:
 - Timely and appropriate referral to needed services.
 - Identification and problem-solving around barriers to referral follow-up.
 - Identification and elimination of redundancy of services.
 - Promotion of a shared and actionable plan of care that speaks to the continuum of child/family experience with healthcare and related systems.
 - Timely, informative, and concise updates that are shared with appropriate members of the health care team, including the primary care provider and the family.
 - Demonstrates evidence of patient/family centeredness, including:
 - Strategies to increase the child/family's capacity to obtain, process, and understand health information to make informed decisions about health care
 - Evidence of child/family partnership in developing the plan of care
 - Evidence of interventions that increase the patient/family's capacity to implement the plan of care, e.g. caregiver support, teaching, and provision of anticipatory guidance.
 - Cultural and linguistic responsiveness
 - Provides for nurse visits that are sufficient in frequency and length to achieve the goals outlined in the care plan.
 - Anticipates and supports youth transition to adult health care, work, and independence.

- Is re-evaluated as required with changing circumstances but no less frequently than every six months.
6. The Subawardee works with partners, at both the state and local level, to collect data to inform system-level quality improvement efforts and achieve optimal health outcomes for CYSHCN.
 7. Each CaCoon nurse³ and supervisor actively participates in educational opportunities that support continuous improvement of his/her CaCoon practice. At a minimum:
 - a. When beginning his/her CaCoon practice, each CaCoon nurse completes the "Introduction to CaCoon" posted on the OCCYSHN website.
 - b. The majority of nurses working with the CaCoon program in a given county participate in the annual CaCoon Regional Meetings.
 8. Encounter data for every CaCoon visit will be entered into the ORCHIDS database, or Oregon Home Visiting Data System when brought online, according to OHA standards.
 9. The Subawardee designates an individual who has the authority to assure accountability to contract standards. This individual will submit a short (2-4 pages) annual report describing how the Subawardee is meeting each of the standards. The report is due to OCCYSHN by July 1, 2016. OCCYSHN will provide a report guidance and template.

Note: Only one report is due from the LHD in relation to this contract.

¹ American Academy of Pediatrics "Bright Futures" - Recommendations for Preventive Pediatric Health Care - Periodicity Schedule. <https://www.aap.org/en-us/professional-resources/practicesupport/Pages/PeriodicitySchedule.aspx>

² In addition to the primary care provider and the family, the broader health care team for CYSHCN might include:

- ✓ Child care and/or respite care
- ✓ Community Connections Network (CCN)
- ✓ Dentist/Orthodontist
- ✓ Department of Human Services – Child welfare
- ✓ Developmental Disabilities (DD) Services
- ✓ Durable medical equipment agency
- ✓ Early Intervention/ Early Childhood Special Education (EI/ECSE)
- ✓ Emergency medical services
- ✓ Exceptional Needs Care Coordinator (ENCC) at the Coordinated Care Organization (CCO)
- ✓ Family to Family (F2F) or other family support organization
- ✓ Housing supports
- ✓ Medical specialists
- ✓ Mental health services
- ✓ Occupational therapy
- ✓ Pharmacy
- ✓ Physical therapy
- ✓ School systems, including special education
- ✓ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- ✓ Speech therapy
- ✓ Supplemental Security Income (SSI)
- ✓ Transportation supports

³ A CaCoon nurse is defined as a registered nurse who is employed by the CH and who either spends the majority of his/her FTE in support of CaCoon clients OR who supports the majority of CaCoon clients in a given county.

ATTACHMENT B.1 – Promotora Services Scope of Work
BUDGET PERIOD FROM 10/01/2015–09/30/2016

Oregon CaCoon (Care Coordination) Program: Promotora Services

Responsibilities of the public health nurse in counties where Promotora services are funded: Marion, Jackson, Hood River and Malheur counties

The CaCoon Program sponsors a **Health Promotora** in selected counties to address health care disparities, as well as provide more culturally appropriate care coordination for the Latino population with children and youth with special health needs

Responsibilities of the public health nurse working with the Health Promotora:

In compliance with Oregon State Board of Nursing regulations, the CaCoon Nurse will provide direction and oversight to the **Health Promotora** when carrying out the plan of care for a child/family.

At a minimum, the nurse is responsible for:

- Orienting the Health Promotora to the CaCoon Program and to state and community services for children with special health needs;
- Conducting all child and family health assessments;
- Implementing the home visit protocol;
- Assuring CaCoon program standards are met. (See Protocol for the CaCoon Nurse and Health Promotora).

The CaCoon Nurse directs the work of the Promotora and initiates weekly meetings to monitor the plan of care.

The CaCoon Nurse will meet face-to-face with the family no less than every three months and document her assessments/evaluation of the progress or redevelopment of the plan to meet the client's needs. Home visits by the CaCoon Nurse and the Promotora must be sufficient in frequency and length to achieve the goals outlined in the care plan.

Responsibilities of the Health Promotora:

The CaCoon Health Promotora works under the direction of the CaCoon Nurse to provide services to the target population (Attachment D). The Health Promotora promotes health behaviors and helps families access and coordinate health and related services.

Health Promotora interventions include (but may not be limited to):

- Participates as a member of the health team;
- Conducts outreach activities to identify families needing services;
- Visits families in their homes;
- Assists the CaCoon Nurse to identify individual and family needs;

- Links families with appropriate services;
- Assists families to arrange for supports to access health and related services, e.g.,
- transportation and interpretation services;
- Advocates for the child's and family's needs;
- Acts as a liaison and source of information between the family and service providers by translating and interpreting if necessary;
- Collaborates with other community agencies and service providers;
- Participates in CaCoon orientation and continuing education opportunities;
- Assists in the development of educational materials;
- Participates on community coalitions, committees and other appropriate groups;
- Collects data and reports activity.

Protocol for the CaCoon Nurse and Health Promotora

1. The CaCoon Nurse makes the initial and subsequent home visits on all new referrals to complete child health and family assessment, OR this/these visits may occur jointly with the CaCoon Nurse and the Health Promotora.
2. In partnership with the child/family and the broader health care team, nurses serving CaCoon clients develop the nursing care plan which:
 - a. addresses the CaCoon Standards
 - b. defines the role of the Promotora.
 - c. describes the process for supervision of the Promotora.
3. The Health Promotora carries out the activities of the care plan that are not within the exclusive domain of nursing practice as indicated by Oregon Nurse Practice Law. The CaCoon Nurse and Health Promotora review cases on a weekly basis to:
 - a. Conduct chart reviews and review the plan of care.
 - b. Review interventions performed by the Health Promotora.
 - c. Identify additional training needs for the Promotora and develop a plan for meeting them.

When delegating to an unlicensed person, the Registered Nurse is authorizing that person to perform a task of nursing care normally within the Registered Nurse's scope of practice. Prior to agreeing to delegate tasks of nursing care, the Registered Nurse has the responsibility to understand the rules for delegating tasks of nursing care and achieve the competence to delegate and supervise as described in the Oregon State Board of Nursing "Standards for Community-Based Registered Nurse Delegation" (Division 47).

http://arcweb.sos.state.or.us/pages/rules/oars_800/oar_851/851_047.html

4. The CaCoon Nurse must be available by phone for consultation with the Promotora. If the child's health or family circumstances change, the Promotora consults with the PHN who will decide if additional assessment is necessary.
5. A joint home visit with the CaCoon Nurse and Health Promotora is completed at least quarterly for evaluation and reassessment of the plan.

ATTACHMENT F.1 – Funding Structure Breakdown
BUDGET PERIOD FROM 10/01/2015–09/30/2016

To: OHSU
Child Development and Rehabilitation Center
PO Box 574
Portland, OR 97207

Re: Subaward 1004396_Yamhill_CaCoon, Amendment 1 under HRSA Award Number
4B04MC06604-01-004 via OHA Subaward Number 14302

Budget Period: 10/01/2015-09/30/2016

Award Amount: \$24,000

Funding Category	Approved Budget for Funding Category
CaCoon Coordinator	\$21,600.00
Promotora	\$0
Administrative Support	\$2,400.00
TOTAL	\$24,000.00