Research Subaward Agreement
Amendment Number 1

Pass-through Entity (PTE)	Subrecipient
Institution/Organization ("PTE") Entity Name: Oregon Health & Science University Email Address: spasub@ohsu.edu Principal Investigator: Benjamin Hoffman	Institution/Organization ("Subrecipient") Entity Name: Yamhill County Email Address: malayt@co.yamhill.or.us Principal Investigator: Amber G. Miller

Project Title: Title V: Maternal & Child Services			
PTE Federal Award No. B04MC31511	Federal Awarding Agency: HRSA		
Subaward Period of Performance: Start Date: 10/01/2018 End Date: 09/30/2020	Amount Funded This Action: $28,454	Subaward No: 1015198_YAMHILL	
Effective Date of Amendment: 10/01/2019	Total Amount of Federal Funds Obligated to Date: $55,814	Subject to FFATA: ☒ Yes ☐ No	Automatic Carryover: ☐ Yes ☒ No

Amendment(s) to Original Terms and Conditions

This Amendment revised the above-referenced Research Subaward Agreement as follows:

The Period of Performance is hereby extended through 09/30/2020.

The Current Budget Period is from 10/01/2019 through 09/30/2020.

Funds for the Current Budget Period are hereby awarded in the amount of $28,454 per Attachment 5.1, Payment Schedule (1 page).

The Statement of Work for the Current Budget Period is hereby included as Attachment 5.1, Statement of Work (18 pages).

All other terms and conditions of this Subaward Agreement remain in full force and effect.

By an Authorized Official of PTE	By an Authorized Official of Subrecipient
Digitally signed by Jen Michaud, Subout Grants & Contracts Administrator Date: 2019.12.06 08:54:47 -08'00' Date:	Date: 12/2/19
Jen Michaud Subout Grants & Contracts Administrator	Name: Title: HHS DIRECTOR

Accepted by Yamhill County Board of Commissioners on 12/5/19 by Board Order # 19-486

PAYMENT SCHEDULE:

PTE shall pay Subrecipient according to the following schedule upon receipt of invoice from Subrecipient. Invoices are to be submitted via email to spasub@ohsu.edu. If email of invoices is not possible, they may be mailed to the Financial Contact listed in Attachment 3A.

Payment 1) Upon full execution of this Agreement and receipt of invoice, PTE will issue an advance payment of $17,072.40.

Payment 2) Upon satisfactory completion of the Statement of Work on or after 9/30/2020, receipt of invoice and Certification of Completion per Attachment 4, PTE will issue a payment of $11,381.60.

The final invoice must be recieved no later than 45 days after the end of the budget period and must be clearly marked "FINAL."

Oregon Center for Children and Youth with Special Health Needs
Title V CYSHCN
Attachment A – Scope of Work

Part I - Introduction

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.

2015-2020 Oregon Title V CYSHCN - National and State Priorities:

- Medical Home
- Health Care Transition (Transition to Adult Health Care)
- Culturally and Linguistically Appropriate Services (CLAS)

Population of Focus – children and youth with special health care needs (CYSHCN):

"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)."

Contract Goals:

- Increase capacity of the workforce to support OCCYSHN's mission and vision.
- Contribute to Oregon meeting the Title V CYSHCN national and state priority measures.

Sub-contractor Responsibilities General:

- Sub-contractor will ensure that all deliverables outlined within the subsequent scope of work documents are completed by the end of the contract period and that ALL participation requirements have been met.
- In order to receive payment sub-contractor will submit invoices to OHSU as outlined in Attachment D.
- Final Invoices must include "Certificate of Completion" language.
    - Final Invoice template will be provided by OCCYSHN*.
- Sub-contractor will submit an expenditure report at the end of the contracting period.
    - Financial reporting template will be provided by OCCYSHN*.
- Sub-contractor will submit a Final Invention Statement at the end of the contracting period.
    - Invention Statement form will be provided by OCCYSHN*.

**A year end packet with templates/forms will go out separately from the contract documents.*

Part II - CaCoon – Scope of Work

Up to 30 percent of county's contracted funds must be directed toward the CaCoon program. Please see Attachment D for breakdown of activities and payments for your local health department (LHD).

Contract Goals:

- Increase families' knowledge, skills, and confidence in caring for children and youth with special health care needs (CYSHCN) through CaCoon home visiting.

- CaCoon focuses on community-based care coordination. Services are provided by LHD-employed registered nurses, and delivered primarily through home visiting.

CaCoon Program Eligibility

- **Age Eligibility**: CaCoon serves children and youth ages birth to 21st birthday.

- **Diagnostic eligibility**: The "B Codes" of the Oregon Child Health Information Data System (ORCHIDS) outline diagnostic eligibility or Targeted Case Management (TCM) diagnostic/condition eligibility as outlined in OAR 410-138-004.

- **Financial Eligibility**: CaCoon is open to all children regardless of insurance status or family income.

Subcontractor Responsibilities (CaCoon Standards):

1. The Subcontractor establishes and maintains a triage system for home visiting that prioritizes the most vulnerable children and youth with special health care needs for CaCoon services.

2. When the subcontractor is unable to provide home visiting services for a child who has been referred, the Subcontractor will, at a minimum…
    i. Notify the referring entity that Subcontractor is unable to provide services and provide rationale AND
    ii. Refer the child/family to…
        - primary care (specifically a Patient-Centered Primary Care Home, when available).
        - appropriate educational services
        - a family-support program (such as the Oregon Family to Family Health Information Center).

3. The Subcontractor assures timely contact with CaCoon home-visiting referrals. At a minimum, initial outreach is implemented within ten (10) business days of receiving referral. Initial outreach may be by telephone or other means.

4. All nurses serving CaCoon clients collaborate with the child's health care 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 child's 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 care 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 regarding 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 number 4 above).
   - Includes goals, progress notes, and a plan for discharge from CaCoon services.
   - Demonstrates evidence of nursing support to increase child/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. 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 health care 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 child/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 child/family's capacity to implement the plan of care, *e.g.* caregiver support, teaching, and provision of anticipatory guidance.
- Cultural and linguistic appropriateness.

- 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 (6) months.

6. Encounter data for every CaCoon visit is entered into the Oregon Health Authority's information management system (either the ORCHIDS database or "Tracking Home-visiting Effectiveness in Oregon" - THEO when it is brought online).

7. Each CaCoon nurse and supervisor actively participates in educational opportunities that support continuous improvement of his/her CaCoon practice. At a minimum, when beginning his/her CaCoon practice, each CaCoon nurse completes the "Introduction to CaCoon" posted on the OCCYSHN website.

8. The subcontractor's Principal Investigator (PI) is responsible for compliance with the subcontract. PI may designate a different person to serve as CaCoon Lead as key point of contact with the OCCYSHN staff. The CaCoon Lead will submit the Annual CaCoon Accountability Report which is due to OCCYSHN by September 1, 2018.

[1]American Academy of Pediatrics "Bright Futures" - Recommendations for Preventive Pediatric Health Care - Periodicity Schedule. https://www.aap.org/en-us/professional-resources/practice-support/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
- ✓ Children's Intensive In-home Services
- ✓ Community-based family support organizations
- ✓ Community Developmental Disabilities (DD) Programs (CDDP)
- ✓ Dentist/Orthodontist
- ✓ Department of Human Services – Child welfare
- ✓ 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)
- ✓ Oregon Family to Family Health Information Center (OR F2F HIC)
- ✓ 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

Part III - Shared Plans of Care (SPOC) – Scope of Work

At least 70 percent of county's contracted funds must be directed toward the development and implementation of Shared Plans of Care (SPOC). Please see Attachment D for breakdown of activities and payments for your LHD.

Contract Goals:

- Increase effective and efficient use of the health care system, with focus on the National and State Priority Measures, through development and implementation of Shared Plans of Care (SPOC) for selected CYSHCN.

- Enhance communication and accountability between families of referred children and youth with special health care needs (CYSHCN) and their key providers and service system representatives.

Subcontractor Responsibilities:

1. The Subcontractor's Principal Investigator (PI) is responsible for compliance with the subcontract. PI may designate a different person to serve as SPOC Lead as key point of contact with the OCCYSHN staff.

2. Convene SPOC meetings and communicate with SPOC team members as needed to ensure effective meetings and ongoing care coordination.

3. Engage partner agencies, at the system level, as needed to support the work.

4. The content described in the OCCYSHN-provided SPOC Template, as supported by the SPOC Handbook, is required. (Note that fidelity to formatting of the SPOC Template is not a requirement). (http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/SPoC.cfm)

5. The SPOC Team will jointly develop SPOCs in real time. Virtual attendance at meetings may be allowable if all legal and access conditions are met.

6. Include, at a minimum, representatives from the following sectors:
    i. family member or youth,
    ii. Medical Home primary care provider or designee,
    iii. appropriate education system representative,
    iv. mental/behavioral health provider (if applicable),
    v. public health professional, and
    vi. payor.

7. Ensure fidelity to the SPOC process as described in the SPOC Handbook (http://www.ohsu.edu/xd/outreach/occyshn/programs-projects/SPoC.cfm)

8. Conduct the total number of required SPOC (numbers vary per LHD). Please see Attachment D for a breakdown of your LHD's activities and payments.

    - 60% of required SPOC are 6-month re-evaluations. Re-evaluations should follow the SPOC process.

    - 40% of required SPOC must be for newly-identified CYSHCN (i.e. initiation of a SPOC for a client who does not have one).

    - Approximately 20% of total SPOC must address **transition** to adult health care for a child 12 years up to their 21st birthday. Please see Attachment D for breakdown of activities.

    - At least 40% of total SPOC must address the needs of a child with a **complex** condition. Please see Attachment D for breakdown of activities and Attachment E for Memorandum with Definition of Complex for SPOC.

    - The transition-focused and complex requirements are not mutually exclusive. That is, a SPOC may serve a CYSHCN who is both transition-focused AND complex. In this case, the SPOC would count toward both the transition requirements AND the complex requirements.

9. Ensure:

    - all appropriate releases of information are signed;
    - participation in monthly OCCYSHN-facilitated technical assistance webinars; and
    - participation in annual SPOC Regional Meetings facilitated by OCCYSHN.

10. Participate in evaluation activities required by OCCYSHN:

    - submit SPOC Information Forms for each SPOC initiated or re-evaluated;
    - offer Study Interest Form to every family and return all completed forms to OCCYSHN;
    - complete a Year-end Report via REDCap or email.

Attachment B

Use of Allotment Funds [Section 504]

The SUBAWARDEE may use funds paid to it for the provision of health services and related activities (including planning, administration, education, and evaluation) consistent with its application. It may also purchase technical assistance if the assistance is required in implementing programs funded by Title V.

Funds may be used to purchase technical assistance from public or private entities if required to develop, implement, or administer the MCH Block Grant.

Funds may be used for salaries and other related expenses of National Health Services Corps personnel assigned to the State.

Funds may not be used for cash payments to intended recipients of health services or for purchase of land, buildings, or major medical equipment.
Other restrictions apply.

Funds may not be used to make cash payments to intended recipients of services.

Funds may not be provided for research or training to any entity other than a public or non-profit private entity.

Funds may not be used for inpatient services, other than for children with special health care needs or high-risk pregnant women and infants or other inpatient services approved by the Associate Administrator for Maternal and Child Health. Infants are defined as persons less than one year of age.

Funds may not be used to make payments for any item or service) other than an emergency item or service) furnished by an individual or entity excluded under Titles V, XVIII (Medicare), XIX (Medicaid), or XX (Social Services Block Grant) of the Social Security Act.

MCH Block Grant funds may not be transferred to other block grant programs.

Babies First and CaCoon Risk Factors
(A Codes and B Codes)

Babies First! (Birth through 4 years of age)	CaCoon (Birth through 20 years of age)
Medical Risk Factors	**Diagnoses**
A1. Drug exposed infant (See A29)	B1. Heart disease
A2. Infant HIV positive	B2. Chronic orthopedic disorders
A3. Maternal PKU or HIV positive	B3. Neuromotor disorders including cerebral palsy & brachial nerve palsy
A4. Intracranial hemorrhage (excludes Very High Risk Factor B16)	B4. Cleft lip and palate & other congenital defects of the head and face
A5 Seizures (excludes VHR Factor B18) or maternal history of seizures	B5. Genetic disorders (i.e., cystic fibrosis)
A6. Perinatal asphyxia	B6. Multiple minor physical anomalies
A7. Small for gestational age	B7. Metabolic disorders
A8. Very low birth weight (1500 grams or less)	B8. Spina bifida
A9. Mechanical ventilation for 72 hours or more prior to discharge	B9. Hydrocephalus or persistent ventriculomegaly
A10. Neonatal hyperbilirubinemia	B10. Microcephaly & other congenital or acquired defects of the CNS including craniosynostosis
A11. Congenital infection (TORCH)	B12. Organic speech disorders (dysarthria/dyspraxia)
A12. Central nervous system infection (e.g., meningitis)	B13. Hearing loss
A13. Head trauma or near drowning: monitoring change	B23. Traumatic brain injury
A14. Failure to grow	B24. Fetal Alcohol Spectrum Disorder
A16. Suspect vision impairment: monitoring change	B25. Autism, Autism Spectrum Disorder
A18. Family history of childhood onset hearing loss	B26. Behavioral or mental health disorder with developmental delay
A24. Prematurity	B28. Chromosome disorders (e.g., Down syndrome)
A25. Lead exposure	B29. Positive newborn blood screen
A26. Suspect hearing impairment: newborn hearing screen REFER	B30. HIV, seropositive conversion
A29. Alcohol exposed infant	B31. Visual impairment
Social Risk Factors	**Very High Risk Medical Factors**
A19. Maternal age 16 years or less	B16. Intraventricular hemorrhage (grade III, IV) or cystic periventricular leukomalacia (PVL) or chronic subdurals
A21. Parental alcohol or substance abuse	B17. Perinatal asphyxia accompanied by seizures
A22. At-risk caregiver	B18. Seizure disorder
A23. Concern of parent/provider	B19. Oral-motor dysfunction requiring specialized feeding program (gastrostomies and/or failure to grow, both organic and non-organic)
A28. Parent with history of mental illness	B20. Chronic lung disease (e.g., on oxygen, infants with tracheostomies)
A30. Parent with developmental disability	B21. Suspect neuromuscular disorder including abnormal neuromotor exam at NICU discharge
A31. Parent with Child Welfare history	**Developmental Risk Factors**
A32. Parent with domestic violence history	B22. Developmental delay
A33. Parent with limited financial resources	**Other**
A34. Parent with sensory impairment or physical disability	B90. Other chronic conditions not listed
A35. Parent with inadequate knowledge and supports	
A36. Other evidence-based social risk factor	
Other	
X99. Child is not being enrolled in High Risk Infant Tracking protocol	
X00. Change in X99 status to enrollment in High Risk Infant Screening Protocol	

Babies First Risk Factor Definitions

Babies First! Medical Risk Factors		
A1.	Drug exposed infant (See A29)	Documented history of maternal drug use or infant with positive drug screen at birth
A2.	Infant HIV Positive	Infant tested positive at birth or after 1 year of age
A3.	Maternal PKU or HIV Positive	Maternal history of PKU or mother tested positive HIV virus
A4.	Intracranial hemorrhage (excludes Very High Risk Factor B16)	Subdural, subarachnoid, intracerebral, or intraventricular hemorrhage, Grade I or II. Excludes Grade III or IV hemorrhage, or other factors listed in B16.
A5.	Seizures (excludes Very High Risk Factor B18) or maternal history of seizures	History of seizure disorder in mother. Seizures not requiring medical intervention (i.e., febrile seizures). Excludes factors in B18.
A6.	Perinatal asphyxia	Perinatal asphyxia (includes one or more of the following: 5 minute Apgar score of 4 or less, no spontaneous respiration until 10 minutes of age, hypotonia persisting to 2 hours of age, or renal failure & other medical complications of asphyxia).
A7.	Small for gestational age	Birth weight below 10th percentile for gestational age
A8.	Very low birth weight	Birth weight 1500 grams or less
A9.	Mechanical ventilation	For 72 hours prior to hospital discharge
A10.	Neonatal hyperbilirubinemia	Requiring treatment with exchange transfusion
A11.	Congenital infection (TORCH)	Toxoplasmosis/Toxoplasma gondii, other infections (hepatitis B, syphilis, varicella-zoster virus, HIV, and parvovirus), rubella, cytomegalovirus, herpes simplex virus
A12.	Central nervous system (CNS) infection	Includes bacterial meningitis, herpes, or viral encephalitis/meningitis with no sequel.
A13.	Head trauma or near drowning: monitoring for change	Head trauma with loss of consciousness, needs monitoring
A14.	Failure to grow	Failure to grow. Unknown etiology needs persistent referral for medical work-up and ongoing monitoring for change.
A16.	Suspect vision impairment: monitoring for change	Inability to visually fix or track per vision screen

Babies First! Medical Risk Factors		
A18.	Family history of childhood hearing loss	Family member is a blood relative and loss is not associated with injury, accident or other non-genetic problem.
A24.	Prematurity	Infant born before completion of 37 weeks gestation, regardless of birth weight. For Babies First program, also includes low birth weight infants, birth weight less than 2500 grams.
A25.	Lead exposure	Blood lead levels >10µg/dL
A26.	Suspect hearing impairment: newborn hearing screen REFER	Newborn hearing screening status REFER, needs further assessment and monitoring.
A29.	Alcohol exposed infant	Heavy and/or Binge Drinking at any time during pregnancy. Heavy Drinking is more than one alcoholic drink per day on average. Binge Drinking is 4 alcoholic drinks or more in one sitting. Often Heavy Drinking also includes Binge Drinking. However, both do not have to have occurred during the pregnancy to use this risk code.

Babies First! Social Risk Factors		
A19.	Maternal age 16 years or less	Mother was 16 years or less at time of delivery.
A21.	Parental alcohol or substance abuse	Known or suspected abuse of substances
A22.	At-risk caregiver	Suspect caregiver/child interaction, incarcerated parent, no prenatal care
A23.	Concern of parent or provider	Any other concern related to infant growth, physical or emotional health, or development.
A28.	Parent with history of mental illness	Parent reports or has current symptoms of mental health problems.
A30.	Parent with developmental disability (DD)	Parent has a disability that is likely to continue, and significantly impact adaptive behavior. DD includes mental retardation, autism, cerebral palsy, epilepsy, or other neurological disabling conditions that require training or support similar to that required by individuals with intellectual disabilities.
A31.	Parent with Child Welfare history	Parent has a history of being abused and/or neglected as a child, or a history of abusing or neglecting a child.

Babies First! Social Risk Factors		
A32.	Parent with domestic violence history	Parent is impacted by current or past history of domestic violence: a pattern of assaultive and/or coercive behaviors including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their domestic or intimate partners.
A33.	Parent with limited financial resources	Inadequate financial resources. Struggles to provide basic needs: food, clothing, shelter, utilities.
A34.	Parent with sensory impairment or physical disability	Sensory impairment or incapacitating physical disability.
A35.	Parent with inadequate knowledge and supports	Parent has inadequate knowledge and abilities related to basic infant care, and has inadequate social support and limited coping abilities.
A36.	Other evidence-based social risk factor	Other social risk factor, established through research, is associated with poor child health outcomes.

Babies First! Other Risk Factors		
X99.	Child is not being enrolled in High Risk Infant Tracking protocol	The client is not being enrolled in the HRI (High Risk Infant) tracking protocol. The nurse does not intend to follow or monitor the client for growth and development, according to the protocol listed in the Babies First! Manual. This could be a client who is seen once or twice for breastfeeding support, or for an initial assessment that indicated the client did not need HRI follow-up. Client must be enrolled in Babies First, NFP, or CaCoon if TCM billing occurs.
X00.	Change in X99 status to enrollment in High Risk Infant Screening Protocol	If a child was originally determined to fit into the X99 category and then the nurse later determines she will enroll the child in the HRI protocol, then the code X00 is added to the eligibility criteria.

CaCoon Risk Factor Definitions

CaCoon Diagnoses		
B1.	Heart disease	Congenital or acquired heart disease or arrhythmias
B2.	Chronic orthopedic disorders	Congenital or acquired, chronic or recurrent orthopedic problems, e.g., club feet, congenital hip dislocation, juvenile rheumatoid arthritis and growth disorders
B3.	Neuromotor disorders including cerebral palsy & brachial nerve palsy	Static neuromotor disorder, including cerebral palsy and brachial nerve palsy (congenital or acquired); primary muscle disease; and movement disorders
B4.	Cleft lip and palate & other congenital defects of the head & face	Cleft lip and/or palate, submucousal cleft palate or congenital/acquired velopharyngeal incompetence. Anomalies of the face or cranium that are sufficient to interfere with function or to significantly alter appearance. Examples of syndromes which typically fit these criteria: Crouzon; Apert's; Goldenhaar's, Microtia/atresia.
B5.	Genetic disorders (i.e., cystic fibrosis)	Any condition that can be inherited including single gene disorders and chromosome abnormalities
B6.	Multiple minor physical anomalies	Multiple minor anomalies, one or more major anomalies, or a combination of minor and major anomalies.
B7.	Metabolic disorders	Inborn errors of metabolism including amino acid disorders (e.g. PKU), fatty acid oxidation disorders, organic acid disorders, storage disorders, galactosemia, vitamin D deficient rickets.
B8.	Spina bifida	Neural tube defects including myelomeningocele, spinal cord and peripheral nerve injury
B9.	Hydrocephalus or persistent ventriculomegaly	Congenital or acquired dilatation of the cerebral ventricles
B10.	Microcephaly & other congenital or acquired defects of the CNS including craniosynostosis	Congenital small head size; brain injury acquired by postnatal neurological insult (i.e., vascular accident, shaken baby syndrome, CNS tumor or toxin, or head trauma)
B12.	Organic speech and language disorders (dysarthria/dyspraxia, only oral motor dysfunction, dysphasia)	Disorders resulting from congenital or acquired deficits involving neuromotor, structural, oral systems

CaCoon Diagnoses		
B13.	Hearing loss	As confirmed by diagnostic evaluation
B23.	Traumatic brain injury	An injury to the brain by an external physical force or event, resulting in the impairment of one or more of the following areas: speech, memory, attention, reasoning, judgment, problem solving, motor abilities, and psychosocial behavior
B24.	Fetal Alcohol Spectrum Disorder	A pattern of physical features and developmental delay that occurs in children whose mother consumed alcohol during pregnancy
B25.	Autism, Autism Spectrum Disorder	Confirmed diagnosis of developmental disorder affecting communication, understanding language, play, and interaction with others, often with stereotypical behaviors. E.g., Autism with Mental Retardation, High Functioning Autism, Pervasive Developmental Disability, Asperger's Syndrome.
B26.	Behavioral or mental health disorder with developmental delay	Confirmed diagnosis of extreme or unacceptable chronic behavior problems or maladaptive behavior; or medical diagnosis of mental health disorder. Either condition must also have developmental delay. Not for children with ONLY mental health disorders. Examples of individuals who qualify: a three year old who can no longer attend day care because of aggressive behavior and whose language is delayed but without signs of autism; a child diagnosed with OCD and cognitive impairment; a child whose parents are considering out of home placement who also qualifies for special education.
B28.	Chromosome disorders, e.g., Down syndrome	Any chromosome disorder, including trisomies, monosomies, deletions, duplications or rearrangements.
B29.	Positive newborn blood screen	Positive newborn screening blood test or confirmed condition detected by newborn screening.
B30.	HIV, seropositive conversion	Infant/child without maternal antibodies, producing own HIV antibodies.
B31.	Visual impairment	Inability to visually track or fix, medical diagnosis of visual impairment requiring educational accommodation.

CaCoon Very High Risk Medical Factors		
B16.	Intraventricular hemorrhage (Grade III, IV) or cystic periventricular leukomalacia (PVL) or chronic subdurals	Intracranial hemorrhage usually occurring due to anoxia, birth trauma, or disturbances in neonatal circulation
B17.	Perinatal asphyxia accompanied by seizures	Perinatal asphyxia accompanied by seizures resulting from the anoxic event (asphyxia includes one or more of the following: 5 minute Apgar score of 4 or less, no spontaneous respiration until 10 minutes of age, hypotonia persisting to 2 hours of age, or renal failure & other medical complications of asphyxia)
B18.	Seizure disorder	Seizures requiring medical intervention and where family needs assistance accessing medical and/or other services
B19.	Oral-motor dysfunction requiring specialized feeding program (gastrostomies) and/or failure to grow, both organic and non-organic	Difficulty coordinating suck/swallow/breathing; reflux; inadequate suck, lip closure (around bottle, cup, or spoon), poor tongue motion, no tongue laterization, no munching or chewing in older children, organic and non-organic Failure To Thrive
B20.	Chronic lung disease (e.g., on oxygen, infants with tracheostomies)	Respiratory distress syndrome, transient tachypnea of the newborn, meconium aspiration syndrome, bronchiopulmonary dysplasia, trachent malacia, hypoplastic lung disease, cystic hygroma, near drowning
B21.	Suspect neuromuscular disorder	Abnormal motor screen or abnormal exam at NICU discharge, or test results that are suggestive of cerebral palsy or other neuromotor disorders

CaCoon Developmental Risk Factors		
B22.	Developmental Delay	Below average performance, including delays in cognitive, motor, communication and/or social skills; abnormal developmental screening results on a standardized developmental test, including children with behavioral concerns related to their delays.

CaCoon Other		
B90.	Other chronic conditions not listed	Other chronic health conditions, especially where family needs significant assistance accessing medical or other needed services.

Attachment D

Yamhill County Public Health Division
FY20 Activity Breakdown and Payment Schedule

Yamhill County Public Health Division shall complete the following:

CaCoon Activities At most 30%	SPOC Activities At most 70%	Total Subcontract 100%
$7,488.00	$20,966.00	$28,454.00

With your SPOC activities, you agree to complete the following number of SPOC in the following categories (see Attachment A Part III (SPOC scope of work) and Attachment E for definitions of complex and further details)

4	Re-evaluation
2	New
6	Total SPOC

Each SPoC developed will serve a unique child or youth and their family.

Of the total SPOC to be completed:

a minimum of	2	must be Complex SPOCs; and
a minimum of	2	must be Transition-Focused SPOCs

Note: The transition-focused and complex requirements are not mutually exclusive. That is, a SPOC may serve a CYSHCN who is both transition-focused AND complex. In this case, the SPOC would count toward both your transition-focused requirements AND your complex requirements.

This subcontract will be paid in two installments on the following schedule:

	Direct Costs	Indirect Costs	Total Costs
LHD to invoice OHSU an initial 60% as soon as subcontract is fully executed	$15,520.36	$1,552.04	$17,072.40
LHD to invoice OHSU the FINAL 40% after LHD has submitted all required deliverables	$10,346.91	$1,034.69	$11,381.60
Total Funding	$25,867.27	$2,586.73	$28,454.00

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January 19, 2017

ATTACHMENT E

MEMORANDUM

TO: OCCYSHN Local Public Health Partners

FROM: OCCYSHN SPOC Implementation Team

RE: Definition of Complex for SPOC

Children and youth with special health care needs (CYSHCN) are "those 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" (McPherson et al., 1998).

For the purposes of county SPOC implementation, CYSHCN may be identified as complex if they have (a) medically complex conditions or (b) have both a health condition(s) and social complexity(ies).

- CYSHCN with *medical complexity* "have multiple significant chronic health problems that affect multiple organ systems and result in functional limitations, high health care need or utilization, and often the need for or use of medical technology" (Kuo & Houtrow, 2016, p. e1).
  - i. Examples
    - A child with a genetic syndrome with an associated congenital heart defect, difficulty with swallowing, cerebral palsy, and a urologic condition. The child requires the care of a primary care physician, pediatric subspecialists, home nurses, rehabilitative and habilitative therapists, community-based services, pharmaceutical therapies, special nutritional attention, and durable medical equipment.
    - A child with a chronic neurodevelopmental disability in need of assistance with medical equipment, such as a tracheostomy and gastrostomy tubes.
  - ii. Functional limitations are restrictions in the child's ability to do the things typically developing children of the same age can do in their daily lives. The limitations may be permanent or temporary. Examples include inability to perform tasks like dressing or walking or unable to participate in life events like attending school. More information is available on functional limitations in the World Health Organization's *International Classification of Functioning, Disability, and Health (ICF).*

- CYSHCN with *social complexity* have a physical, developmental, behavioral, or emotional condition and they, or their families, have experienced or currently are experiencing one or more of the following:

1. Adolescent exposure to intimate partner violence
2. Child abuse/neglect – child welfare system involvement
3. Child criminal justice involvement
4. Child mental illness
5. Child substance abuse
6. Discontinuous insurance coverage
7. Foreign born parent
8. Foster care
9. Homelessness
10. Low English proficiency
11. Low parent educational attainment
12. Parent criminal justice involvement
13. Parent death
14. Parent domestic violence
15. Parent mental illness
16. Parent physical disability
17. Parent substance abuse
18. Severe poverty (TANF eligible)

Source: Center of Excellence on Quality of Care Measures for Children with Complex Needs, University of Washington & Seattle Children's Research Institute, 2016