Sustainable Relationships for Community Health (SRCH)

The Oregon Public Health Division has awarded grants to consortia representing local public health authorities, Medicaid Coordinated Care Organizations, clinics, and community-based organizations to design innovative referral and payment/reimbursement processes that can be adapted to a variety of populations, conditions, and settings.

The Sustainable Relationships for Community Health (SRCH) initiative engages cross-sector leaders involved in health system transformation to advance health system interventions and promote community-clinical linkages toward reducing the burden of tobacco use, diabetes, hypertension, and colorectal cancer in Oregon's communities.

Between May 2016 and June 2017, grantees convened for facilitated discussions via three SRCH institutes and received technical assistance to delineate roles and responsibilities; identify staffing and training needs; outline data sharing and payment agreements; plan and pilot mechanisms to facilitate better health and better care at lower cost; and share out results.

2016 Grantees

Grantees	Project Focus
Clackamas County Public Health Division FamilyCare, Inc.	Tobacco cessation Diabetes prevention
The Public Health Foundation of Columbia County Columbia Pacific CCO	Tobacco cessation Diabetes and hypertension self-management
InterCommunity Health Network CCO (focusing on Lincoln County)	Tobacco cessation Colorectal cancer screening
Klamath County Public Health Cascade Health Alliance	Tobacco cessation Diabetes and hypertension self-management
Lane County Department of Health & Human Services Trillium Community Health Plan	Tobacco cessation Diabetes prevention

The SRCH initiative is designed to address CCO performance metrics for quality of care related to tobacco use, diabetes and hypertension management, and colorectal cancer screening. To improve these metrics, SRCH participants identified Medicaid beneficiaries in need of services, referred and enrolled people to services, provided feedback to the referring entity, and used data to track progress and patient outcomes.

Project outputs included referral protocols, payment methodologies, and formal commitments such as memoranda of understanding and data sharing agreements to reinforce collaboration and a long-term commitment to improving community health.