Process Evaluation Report:

SRCH: Sustainable Relationships for Community Health (2015)

April 29, 2016

Oregon Health Authority
PUBLIC HEALTH DIVISION
Health Promotion and Chronic Disease Prevention

Contents

Executive Summary

SRCH Overview

Sustainable Relationships for Community Health (SRCH) was a grant and technical assistance initiative designed to develop sustainable community-based models that address hypertension, pre-diabetes and diabetes prevention, early detection and self-management. SRCH was co-designed by the Oregon Health Authority's (OHA) Public Health Division, Health Promotion and Chronic Disease Prevention section and the Coraggio Group, an Oregon-based strategy and organizational consulting firm. SRCH was funded by the Centers for Disease Control and Prevention (CDC) and the Administration for Community Living (ACL).

Five community-based consortium each consisting of a county public health authority, Medicaid Coordinated Care Organization (CCO), a self-management program delivery organization, and a community healthcare clinic[1] were selected to receive SRCH funding and technical assistance. Consortium teams focused on developing "closed-loop referrals" - a referral tracking, communication, and follow-up system - and financing mechanisms for the Stanford Chronic Disease Self-Management Program (CDSMP) and the National Diabetes Prevention Program (DPP). The five consortium grantees were provided with techniques and tools to improve their communication, collaboration and coordination across partnering organizations. Each SRCH consortium (1) delineated roles and responsibilities; (2) identified staffing and training needs; (3) outlined data sharing and payment agreements; and (4) created mechanisms to facilitate an effective, efficient and sustainable approach to provide a CDSMP and / or the DPP.

SRCH included three, two-day "Learning and Doing Institutes" that provided intensive, customized facilitation to meet the varying needs of SRCH grantees. SRCH also offered ongoing technical assistance to help leverage and align existing community-wide health improvement initiatives and resources.

[1] Not all consortium teams included a representative from a community healthcare clinic.

The initial funding period for SRCH was February through August 2015, with an extension period from August 2015 to June 2016. This evaluation report focuses on the ***initial*** funding period.

SRCH Evaluation Result Highlights

1. The dedicated time and space to co-create approaches to address chronic conditions was the most valuable part of the SRCH process.
2. The project management and improvement tools helped the five consortium teams set goals, organize tasks and stay focused; however, some tools were confusing and duplicative.
3. A thorough orientation with grantees is needed prior to the institutes to ensure roles, goals and expectations are clear and that the right decision makers are involved in SRCH.
4. OHA program staff were critical to progressing the grantees' CDSMP and DPP work.
5. External technical expertise helps teams to ideate, formulate and implement their plans.
6. Five months was insufficient to conduct the SRCH work. Several grantees communicated that they had just begun their work after the conclusion of the third and final SRCH institute. Each consortium indicated that it had more work to do before its new system was sustainable.

Recommendations

1. Continue to provide dedicated time and space for teams to work collaboratively away from daily distractions.
2. Tailor process and quality improvement tools to be more user-friendly to people with public health and health care backgrounds, who may be less familiar with business terminology and strategies, and improvement science.
3. Meet at least once with each grantee consortium prior to the first face-to-face institute to ensure each team is starting with an appropriate level of understanding regarding goals and expectations.
4. Continue to have OHA program staff assigned to each grantee to help with maintaining direction and momentum between institutes.

5. Bring in more external technical experts with applicable experiences to help teams ideate, formulate and implement their plans.
6. Extend the SRCH timeframe to allow grantees to co-create and pilot sustainable referral and financing systems.

SRCH Overview

Sustainable Relationships for Community Health (SRCH) was a grant and technical assistance initiative designed to develop sustainable community-based models that address hypertension, pre-diabetes and diabetes prevention, early detection and self-management. SRCH was co-designed by the Oregon Health Authority's (OHA) Public Health Division, Health Promotion and Chronic Disease Prevention section and the Coraggio Group, an Oregon-based strategy and organizational consulting firm. SRCH was funded by the Centers for Disease Control and Prevention (CDC) and the Administration for Community Living (ACL).

SRCH engaged leaders from diverse sectors involved in local health system transformation efforts to learn with and from one another. Five community-based consortium each consisting of a county public health authority, Medicaid Coordinated Care Organization (CCO), a self-management program delivery organization, and a community healthcare clinic[2] were selected to receive SRCH funding and technical assistance (see Appendix A). Local consortium teams focused on developing referral tracking systems and financing mechanisms for the Stanford Chronic Disease Self-Management Program (CDSMP) and the National Diabetes Prevention Program (DPP).

Through greater communication, collaboration, and coordination, the grantees developed and tested action plans to build sustainable prevention, early detection, and self-management health improvement initiatives. Using quality and process improvement science, SRCH teams co-designed local initiatives to improve cross-sector partnerships and developed tools and techniques that enhance and sustain community health partnerships. More specifically, SRCH teams:

[2] Not all consortium teams included a representative from a community healthcare clinic.

1. Aligned their vision for their work together;
2. Agreed on a new way of working;
3. Identified promising practices and how to operationalize their approach;
4. Created a multi-phased implementation plan to support their vision;
5. Established closed loop referral and payments / reimbursements processes; and
6. Developed a robust process improvement approach.

The five consortium grantees were provided with techniques and tools to improve their communication, collaboration and coordination across partnering organizations. Throughout SRCH, grantees were coached to use process and quality improvement methods to co-create local initiatives to make system changes, and improve health outcomes and equity. SRCH grantees focused on the use of quality measures, electronic health records / health information technology, and traditional health workers. Each SRCH consortium delineated roles and responsibilities; identified staffing and training needs; outlined data sharing and payment agreements; and created mechanisms to facilitate an effective, efficient and sustainable approach to provide CDSMP and / or DPP.

SRCH included three, two-day "Learning and Doing Institutes" that provided intensive, customized facilitation to meet the varying needs of SRCH grantees. SRCH also offered monthly calls with OHA program staff and other content experts to help maintain momentum, and leverage and align existing community health improvement resources and initiatives (see Appendix B).

Although the activities funded by the SRCH grant focused on CDSMP and DPP and specific health conditions, the processes and agreements that each community consortium developed are applicable to other conditions and risk factors.

The initial grant funding for SRCH was February through August 2015, with an extension period from August 2015 to June 2016. ***This evaluation report focuses on the initial funding period.***

SRCH Evaluation

This evaluation offers information and insights to the CDC, ACL, OHA and others about SRCH, and can inform future grant and technical assistance initiatives similar to SRCH. ***This evaluation focused on the SRCH process and approach, rather than specific health outcomes,*** and was designed to determine SRCH's effectiveness in addressing its three goals:

- Serve as a learning and doing cooperative for local consortium members;
- Co-design local initiatives to improve cross-sector partnerships; and
- Develop tools and techniques that enhance and sustain community health partnerships.

This report offers information and insights to understand the impact of SRCH on grantees and their approaches on system and policy change.

Evaluation Framework

SRCH evaluation methods were modeled after the CDC's framework for program evaluation.[3] The goal of using this framework was to provide a clear systematic way to improve and account for SRCH activities. The framework involves the following steps:

- Engage stakeholders (identify those involved, those affected and primary intended users);
- Describe the program (the need, expected effects, activities, resources, stage, context and logic model);
- Focus on the evaluation design (purpose, users, uses, questions, methods, agreements);
- Gather credible evidence (indicators, sources, quality, quantity, logistics);

[3] http://www.cdc.gov/eval/framework/index.htm

- Justify conclusions (standards, analysis, interpretations, judgment, recommendations); and
- Ensure use and share lessons learned (design, preparation, feedback, follow-up, dissemination.)

Engage Stakeholders

In keeping with the CDC's framework for program evaluation, stakeholders were engaged and served as the SRCH evaluation advisory group. There were 12 members in the evaluation advisory group (as footnoted in Appendix A and B). Advisory group members included those involved in the design and implementation of SRCH, OHA leaders and evaluation experts, and SRCH grantees. Each of the five grantees nominated several members of their consortium to participate in the evaluation advisory group. OHA staff chose an average of two participants from each consortium and ensured there was representation across the sectors involved in SRCH: community clinics, public health, Medicaid Coordinated Care Organizations, and self-management program delivery organizations.

Through an interactive webinar process, the evaluation advisory group (1) co-created a SRCH logic model (see Appendix C), (2) guided the evaluation design, including the evaluation questions, and (3) assisted with interpreting the findings.

The evaluation advisory group activities are outlined in Table 1.

Table 1: Schedule of Stakeholder Activities

Timing	Meeting type	Purpose
Early August 2015	SRCH Institute #3 (in person)	Orientation to the evaluation project
Late August & early September 2015	Webinar	Described SRCH; developed Logic model
Late September 2015	HPCDP Grantees & Contractors Meeting	Finalized logic model, developed evaluation questions, and designed evaluation
October 2015 – November 2015	Webinar	Reviewed initial results of SRCH evaluation, interpreted findings, and provided feedback
December 2015 – January 2016	Webinar and in person meetings	Disseminated results of evaluation to advisory group and other key stakeholders

Evaluation Design

The SRCH evaluation advisory group was committed to identifying evaluation procedures that were practical, viable and cost-effective. Further, the advisory group wanted to learn about:

- What did the SRCH teams accomplish during SRCH?
- What barriers were identified by the grantees, and how did SRCH help overcome them?
- How did SRCH help build sustainable relationships for community health?

Table 2 describes the evaluation questions, data collection methods, and data sources designed by the SRCH evaluation advisory group and used to evaluate the effectiveness of SRCH.

Table 2: Evaluation Questions, Data Collection Methods and Data Sources

Evaluation Questions	Data Collection Methods	Data Sources
1. What did the SRCH teams accomplish during SRCH?	Review key documents and place into accomplishments table. Send to SRCH team members to validate and edits accomplishments table. Develop a crosswalk of the logic model activities and outputs with formative evaluation phases to ensure completeness of logic model.	*Quantitative data inputs*: • SRCH grant proposals • Needs assessments • Multi-phased plans • 30/60/90 day reports • Formative evaluation *Qualitative data inputs*: • SRCH team member's validation • SRCH team members interview
2. What barriers did you identify and how did SRCH help you overcome them? • How significant an impact did these barriers have on your SRCH experience? • How helpful was SRCH in helping you overcome these barriers?	Deploy survey questions using a 4-point scale to identify the magnitude of the barrier for the theme.	*Quantitative data inputs:* • *Results of Question #1* *Qualitative data inputs:* • *SRCH team members survey* • *SWOT interviews*
3. How did this project help you build sustainable relationships for community health?	Develop and facilitate a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis of SRCH.	*Qualitative data inputs:* • *SRCH team members interview*

Evaluation Questions	Data Collection Methods	Data Sources
4. How did these various elements help you build sustainable relationships? What specifically worked well? What specifically could have gone better? • The Institutes • Webinars • TA structure • Tools • Basic logistics • Learning modalities	• Review existing SRCH post institute survey results to determine gaps in information. • Develop and deploy a survey question using a 4-point scale to identify the strengths and opportunities for each element. Include open comment field for additional elaboration.	*Quantitative data inputs:* • *SRCH Post Institute Surveys* • *TA call notes* *Qualitative data inputs:* • *SRCH team members survey participation* • *SRCH team members interview*
5. How can teams be best prepared for SRCH?	Develop discussion guide and interview SRCH consortium teams.	*Qualitative data inputs:* • *SRCH team members interview*
6. During SRCH, how did you establish a shared understanding of the roles of each of the consortium members?	Develop discussion guide and interview SRCH consortium teams.	*Qualitative data inputs*: SRCH team members interview
7. How do you anticipate applying the SRCH approach in the future?	Develop discussion guide and interview SRCH consortium teams.	*Qualitative data inputs*: SRCH team members interview

Gathering Credible Evidence

The SRCH evaluation advisory group determined that both qualitative and quantitative data sources were needed to learn about the effectiveness of meeting the needs of the grantees and the three goals of SRCH:

- Serve as a learning and doing cooperative for local consortium members;
- Co-design local initiatives to improve cross-sector partnerships; and
- Develop tools and techniques that enhance and sustain community health partnerships.

Further, it was determined that ***existing*** data could and should be used, and that ***new data*** was needed to adequately understand the effectiveness of SRCH. Data used for this evaluation was collected in four primary ways:

- **Review of existing documents** developed by the grantee teams during SRCH including grant applications, self-evaluations, SRCH institute evaluations, project management tools, and meeting notes;
- **Group interviews** with each of the five consortium teams;
- **One-on-one interviews** with each of the five OHA program leads and the two primary SRCH facilitators from Coraggio Group; and
- A web-based **survey** of scaled multiple-choice and open-ended questions completed by 20 participants of SRCH (see Appendix D).

Justifying Conclusions

Once the information was gathered, it was analyzed, and preliminary insights and recommendations were developed. To ensure the evaluation insights and recommendations were justified, the SRCH evaluation advisory group and other key stakeholders reviewed the following:

- A preliminary report detailing SRCH background, evaluation purpose, insights and recommendations;
- A table that aggregated each consortium's accomplishment in order to gain a comprehensive picture of all five grantees (see Table 6);
- A Strengths, Weakness, Threats and Opportunities (SWOT) analysis (see Appendix E) that detailed the status of their work together;
- A table that aggregated each grantees SWOT analysis to gain a holistic picture of all five of the grantees (see Table 4); and
- A crosswalk (see Appendix F) table based on the logic model activities (see Appendix C) and outputs and the formative evaluation tool (see Appendix G) to ensure completeness of the logic model.

NOTE: Due to time constraints of SRCH, the evaluation design, including the logic model, was developed after the completion of the third SRCH institute.

Findings: Lessons Learned

Members felt that SRCH helped them. Engaging consortium teams allowed each grantee and the entire consortia to further develop relationships and discuss and work through challenges associated with sustaining CDSMP and DPP. Furthermore, each consortium team expressed that the relationships they developed, as a part of SRCH, would be valuable in addressing health issues in their communities regardless of continued SRCH funding.

Most grantees expressed that they were eager to continue the work they had begun and planned to continue working together as a team to implement the work they started during SRCH. Some teams had hopes to use this model to address other health issues in their community. In one instance, a team was not confident they would be able to continue this work or apply this approach in the future, because of the demand on their time and internal resources.

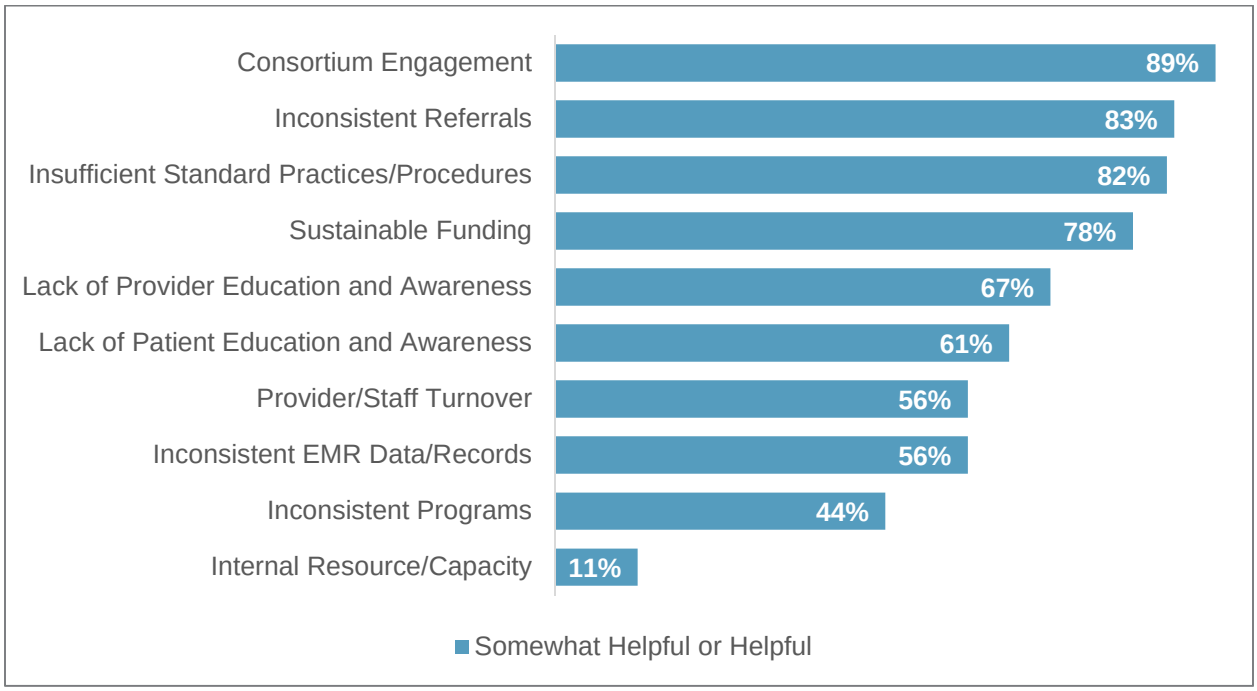
The four primary data sources and the corresponding crosswalk to confirm the evaluation findings, provided the following lessons learned:

1. The dedicated time and space to co-create approaches to address chronic conditions was the most valuable part of the SRCH process.
2. The project management and improvement tools helped the five consortium teams set goals, organize tasks and stay focused; however, some tools were confusing and duplicative.
3. A thorough orientation with grantees is needed prior to the institutes to ensure roles, goals and expectations are clear and that the right decision makers are involved in SRCH.
4. OHA program staff were critical to progressing the grantees' CDSMP and DPP work.
5. External technical experts with applicable experiences help teams ideate, formulate and implement their plans.
6. Five months was insufficient to conduct the SRCH work. Several grantees communicated that they had just begun their work after the conclusion of the third and final SRCH institute. Each consortium indicated that it had more work to do before its new system was sustainable.

Learning #1: The dedicated time and space to co-create approaches to address chronic conditions was the most valuable part of the SRCH process.

As indicated in Table 3, the greatest benefit identified by the SRCH grantees was engaging multiple local health organizations to develop relationships. These relationships afforded participants the ability to gain a larger, more comprehensive understanding of the roles, responsibilities and complexities of implementing sustainable community health improvement programs across multiple organizations. Further, grantees appreciated that SRCH provided the consortium teams with the dedicated time, space, and resources to discuss and work through challenges in order to develop CDSMP and DPP referral systems and payment mechanisms.

Table 3: How helpful was SRCH in helping consortia overcome identified barriers?



Learning #2: The project management and improvement tools helped the five consortium teams set goals, organize tasks and stay focused; however, some tools were confusing and duplicative.

The introduction of project management and improvement tools helped the consortia organize roles, tasks and objectives as they moved through the identification of system change complexities and the approaches necessary to address them. The consortia elaborated in interviews that while the project management tools seemed difficult at times, the overarching theme of monitoring and tracking project objectives and action items was important in making progress. As indicated in the strengths, weaknesses and opportunities quadrants within Table 4, the consortia indicated that tools could be consolidated, simplified and tailored to help give participants a clearer understanding of their purpose and make them more user-friendly.

Table 4: SRCH Strengths, Weaknesses, Opportunities and Threats

Strengths	Weaknesses
• Having the dedicated time and space to bring the right partners to the table • Tools helped consortium set goals, organize tasks and stay focused • Developing relationships and finding common goals and solutions across consortium and communities • OHA program staff working with grantees • Technical experts / specialists / consultants • Project management / improvement tools	• Tools were sometimes confusing and duplicative • Unclear roles, goals and expectations • Not having the right key decision makers involved • Short timeline for the complexity of the work
Opportunities	**Threats**
• A pre-SRCH meeting to afford consortia the ability to begin relationship building and outline clear roles and expectations • Longer project time frame • More consolidated and simplified forms, tailored to help participants understand intent and purpose • Involve clinical expertise from the beginning	• The lack of funding and time necessary to ensure long-term program sustainability given its complexity • Insufficient data and payment models • Lack of engagement and motivation • Failing to identify a champion to ensure the adoption of this approach • Inconsistent or lack of referrals

SRCH used quality and process improvement science tools such as 30/60/90-day action plans (see Appendix H), current and future state process analysis (see Appendix I), multi-phase planning (see Appendix J), and Plan-Do-Study-Act (PDSA) cycles to assist teams with understanding current issues, organizing tasks, and driving results. As noted in Table 5, most of the grantees felt that the 30-60-90 day plan was the tool that they were most likely to continue using in their work.

Table 5: For each of the following aspects of SRCH, please describe what worked well in helping you achieve your goals.

TOOLS	
“Helpful to keep us moving ahead and stay on task”	“30-60-90 It was nice to make a plan and get everyone to commit to some sort of timeline”
“30-60-90 worked for planning”	“I personally liked the 30-60-90 day tool for trying to keep on track”
“These forced measurement and deadlines. I liked this.”	“Current and future state mapping we did with our own tool helped me grasp the work of the project. And 30-60-90 day planning tool helped keep on task”
”30/60/90 plan idea helps”	“The plan templates helped guide our work, assign timeframes and responsible organization. This is great for tracking and accountability.”
“Having tools that we could adapt so we were not starting from scratch”	“Flexibility in adapting other tools, sources”

Learning #3: A thorough orientation with each grantee is needed prior to the institutes to ensure roles, goals and expectations are clear and that the right decision makers are involved in SRCH.

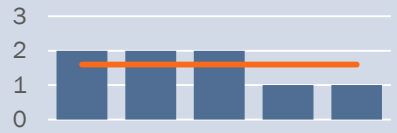
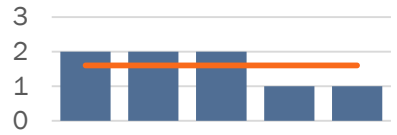
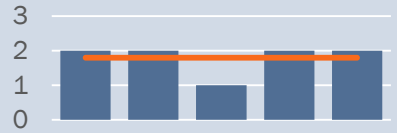
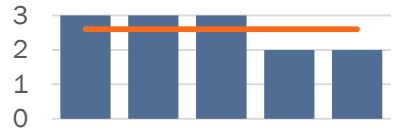
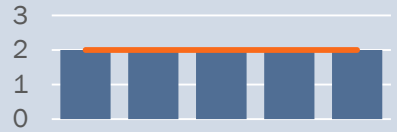
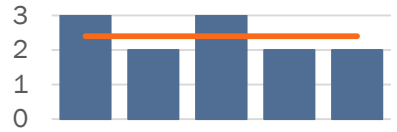
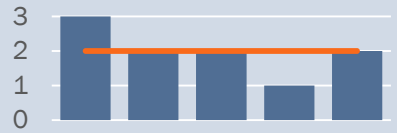
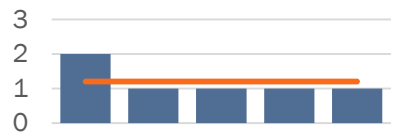
It was a common perception among the grantees that a pre-institute meeting with consortium teams would have been helpful. This would have enabled grantees to better understand the goals of SRCH, further build relationships with members of their consortium, clarify and ensure that the consortium team would have decision making authority, outline clear roles, and establish team expectations. The absence of such a meeting appeared to have led to some

teams feeling constrained and at times left behind in the process, as identified in the weaknesses and opportunities quadrants within Table 4.

Learning #4: OHA program staff were critical to progressing the grantees' CDSMP and DPP work.

As indicated in the strengths quadrant within Table 4, many of the grantees identified that it was helpful to have OHA program staff assigned to each consortium team. OHA program staff helped the grantees maintain momentum and accomplish work between institutes. The consortia reported that these accomplishments assisted in their progress toward addressing the complexities of closed-loop referrals and payments and reimbursements for diabetes prevention and chronic disease self-management programs. As indicated in Table 6, all of the grantees made progress within the five-month initial SRCH grant period.

Table 6: Combined Accomplishments Table

Activity Level					
Logic Model Activity	**Avg**	**Min**	**Max**	**Level Description**	**Teams, AllCare, Clackamas, Deschutes, IHN, Lane**
Develop, implement, and monitor sustainability plans, agreements, and partnerships between organizations at institutes	1.6	1	2	Plans implemented and agreements in place	
Identify performance measures and monitor progress	1.6	1	2	Performance Measures developed but not used to monitor progress	
Identify and share progress, lessons learned, and outcomes of SRCH	1.8	1	2	Progress, Outcomes, and Lessons Learned identified with limited sharing	
Participate in TA and monitor planning tools	2.6	2	3	All organizations actively participate	
Develop, manage, and implement plans, processes, and best practices for self-management models	2.0	2	2	Plans, processes, or best practices developed, partial implementation but not actively managed	
Get buy-in and participation from all representative organizations	2.4	2	3	Some participation with limited buy-in from representative organizations	
Perform gaps analysis/ current state documentation	2.0	1	3	Current and Future State documented	
Perform data collection, entry, and monitoring	1.2	1	2	Initial Data Collected	

Learning #5: External technical experts with applicable experiences help teams ideate, formulate and implement their plans.

Members of the consortia elaborated on the positive impact of including and learning from an industry expert with practical relevant insights on alternative payment methodology and sustainability, as indicated in the strengths quadrant within Table 4. Healthcare and public health consultants with practical, real world experiences specializing in closed-loop referral, alternative payment methodologies, sustainability, and community collaboration would help grantees make improvements to their own systems.

Learning #6: Five months was insufficient to conduct the SRCH work. Several grantees communicated that they had just begun their work after the conclusion of the third and final SRCH institute. Each consortium indicated that it had more work to do before its new system was sustainable.

As indicated in the weaknesses and opportunities quadrants within Table 4, overall, grantees felt time constrained given their objectives; most teams felt like having more time for the entire process would have allowed more progress in their work. Given the complexity and scope of work involved, many participants indicated that there could have been more preparation time prior to the first SRCH session for teams to identify roles, set goals/expectations and become more familiar with each other. Further, grantees indicated that constraints on internal resources and capacities directly affected the team's ability to come to agreements and make progress during the SRCH institutes. Additionally, a longer SRCH time frame would have increased each consortium's ability to identify and engage key decision-makers, create a quality referral process, and develop a payment and financing mechanism.

Recommendations

Recommendation #1: Continue to provide dedicated time and spaces for teams to work collaboratively away from daily distractions.

As indicated in learning #1, dedicated times and spaces allowed grantees the ability to focus on a single objective at a time, have access to key stakeholders, and begin to implement plans across organizations. The value of this face-to-face time was indispensable to the success of SRCH, its grantees, and the CDSMP and DPP work. Therefore, future iterations of SRCH should continue to make time and space available to all consortium teams as a means of ensuring progress and sustainability.

Recommendation #2: Tailor process and quality improvement tools to be more user-friendly to people with public health and health care backgrounds, who may be less familiar with business terminology and strategies, and improvement science.

As indicated in learning #2, grantees found the planning and quality improvement tools to be useful in helping them ground their objectives and tasks. However, it was commonly mentioned that these tools were onerous given their unfamiliarity of their application. Going forward, such tools should be better tailored to their audiences. Templates and tools with simplified non-business nomenclature would improve their utility and promote their continued use by SRCH members.

Recommendation #3: Meet at least once with each grantee consortium prior to the first face-to-face institute to ensure each team is starting with an appropriate level of understanding regarding goals and expectations.

As indicated in learning #3, future iterations of SRCH would benefit from incorporating a pre-SRCH meeting into the logic model. This meeting would provide grantees the opportunity to meet prior to the start of the first institute. Such a meeting would help teams initiate

relationships, identify key decision makers and ensure an appropriate level of understanding about roles, goals and expectations of SRCH.

Recommendation #4: Continue to have OHA program staff assigned to each grantee to provide technical assistance, and help with maintaining the grantee's direction and momentum between institutes.

As indicated in learning #4, given the complexity of creating sustainable community health initiatives, it is recommended that SRCH and similar initiatives, continue to assign a dedicated OHA program staff to each consortium team as a means of maintaining direction and momentum between institutes. Many members of the consortia indicated that the largest threat to the sustainability of SRCH projects and initiatives was dwindling momentum and direction. OHA program staff were integral in ensuring that successes remained intact and that the momentum continued between institutes. It is important that OHA program staff remain with their respective consortium team throughout SRCH to help ensure the grantees meet their goals and those of SRCH.

Recommendation #5: Bring in more external technical experts with applicable experiences to help teams ideate, formulate and implement their plans.

As indicated in learning #5, the inclusion of an external consultant at the third institute was seen as a success amongst SRCH grantees. The grantees indicated that learning about practical, real world experiences specific to alternative payment methodologies and sustainability helped make improvements to their own systems. Many grantees indicated that learning about relevant and directly relatable insights from outside experts would be beneficial to future SRCH participants. Going forward, OHA should consider expanding the inclusion of more subject matter experts to advance transformation, innovation and equity.

Recommendation #6: Extend the SRCH timeframe to allow grantees to co-create and pilot sustainable referral and financing systems.

As indicated in learning #6, grantees often spoke of the time constraints they felt SRCH placed on them given their objectives and the required complex system change. Some teams felt they were required to move on to new tasks before they had adequately addressed others. Given the complexity of creating sustainable systems across organizational boundaries, it is recommended that future SRCH timeframes be expanded to ensure that any and all objectives are sufficiently addressed. Having this additional time and resources will enhance grantees' overall chances of successfully developing sustainable systems that promote better care, better health, lower costs, and equity.

Appendix

Appendix A: SRCH Teams & Participants[4]

ALLCARE CCO

Name	Organization
Cynthia Ackerman	AllCare CCO
Liz Bardon	Rogue Valley Council of Governments
Kimberly Caffrey	AllCare Health Plan, Inc.
Lauren Champagne	Rogue Valley Council
Kenneth Dukek	Curry Community Health
*Heather Hartman	AllCare CCO
*Diane Hoover	Josephine County Public Health Department
Richard Lewis	AllCare
Kathy Mahannah	Mid Rogue Health Plan
Claudia Pohling	Mid Rogue Health Plan
Hollie Strahm	Curry Community Health
Paige Sutherland	Curry Community Health
Kari Swoboda	AllCare Health Plan
Dave Toler	Rogue Valley Council of Governments

IHN CCO

Name	Organization
*Sarah Ballini-Ross	Oregon Cascades West Council of Governments
Jenna Bates	InterCommunity Health Network CCO
Barbara Croney	Samaritan Health Services
Pat Crozier	Linn County
Mitchell Heath	Samaritan Health Services
Kaity Lundgren	Oregon Cascades West Council of Governments
Kerri Lux	Signs of Victory
Megan Mackey	IHN CCO
Emily McNulty	Samaritan Health Services
Sandy Minta	IHN-CCO
Randi Moore	Oregon Cascades West
Patricia Parsons	Benton County Health Department
Erin Sedlacek	Linn County
Kelly Volkmann	Benton County Health Department

[4] An asterisk (*) is designated for those who participated on the SRCH Evaluation User Group

Clackamas County

Name	Organization
*Julie Aalbers	Clackamas County Public Health
Michael Anderson-Nathe	Health Share of Oregon
*Sandra Clark	Health Share of Oregon
Brenda Durbin	Clackamas County
Apryl Herron	Clackamas County Public Health
Kirsten Ingersoll	Clackamas County Public Health Division
Jennifer Jungenberg	Clackamas County Social Services
*Janelle McLeo	Clackamas County CHC
Lois Orner	Clackamas County Social Services
Cathy Perry	Clackamas County Community Health

Deschutes County

Name	Organization
Rebeckah Berry	Central Oregon Health Council
Lindsey Hopper	Central Oregon Health Council
Brenda Johnson	Deschutes County Health Dept.
*Tom Kuhn	Deschutes County Health Services
Therese Madrigal	PacificSource Health Plans - Central Oregon
Philip Mason	Clackamas County Public Health Division
Penny Pritchard	Deschutes County Health Services
Jane Smilie	Deschutes County Health Services
Kate Wells	PacificSource CCO Central OR/Columbia Gorge
Sarah Worthington	Deschutes County Health Services

Lane County

Name	Organization
Leslie Gilbert	LCOG Senior and Disabled Services
Kristal Green	Trillium
Lori McKay	Community Health Centers of Lane County
Renee Mulligan	Lane County Public Health
*Theresa Rice-Alft	Community Health Centers of Lane County
Kate Scott	Lane Council of Governments
*Jocelyn Warren	Lane County Public Health
Nina Watkins	Trillium
Jennifer Webster	Lane County Public Health

Appendix B: OHA Staff Support[5]

Oregon Health Authority

Name	Organization
Kirsten Aird	OHA-Public Health Division
*Laura Chisholm	OHA - Health Promotion and Chronic Disease Prevention
Andrew Epstein	OHA - Health Promotion and Chronic Disease Prevention
Jennifer Mead	Oregon DHS
Scott Montegna	OHA - Health Promotion and Chronic Disease Prevention
Rebecca Pawlak	OHA - Health Promotion and Chronic Disease Prevention
*Shira Pope	OHA - Health Promotion and Chronic Disease Prevention
Patricia Schoonmaker	OHA - Health Promotion and Chronic Disease Prevention

Oregon Transformation Center

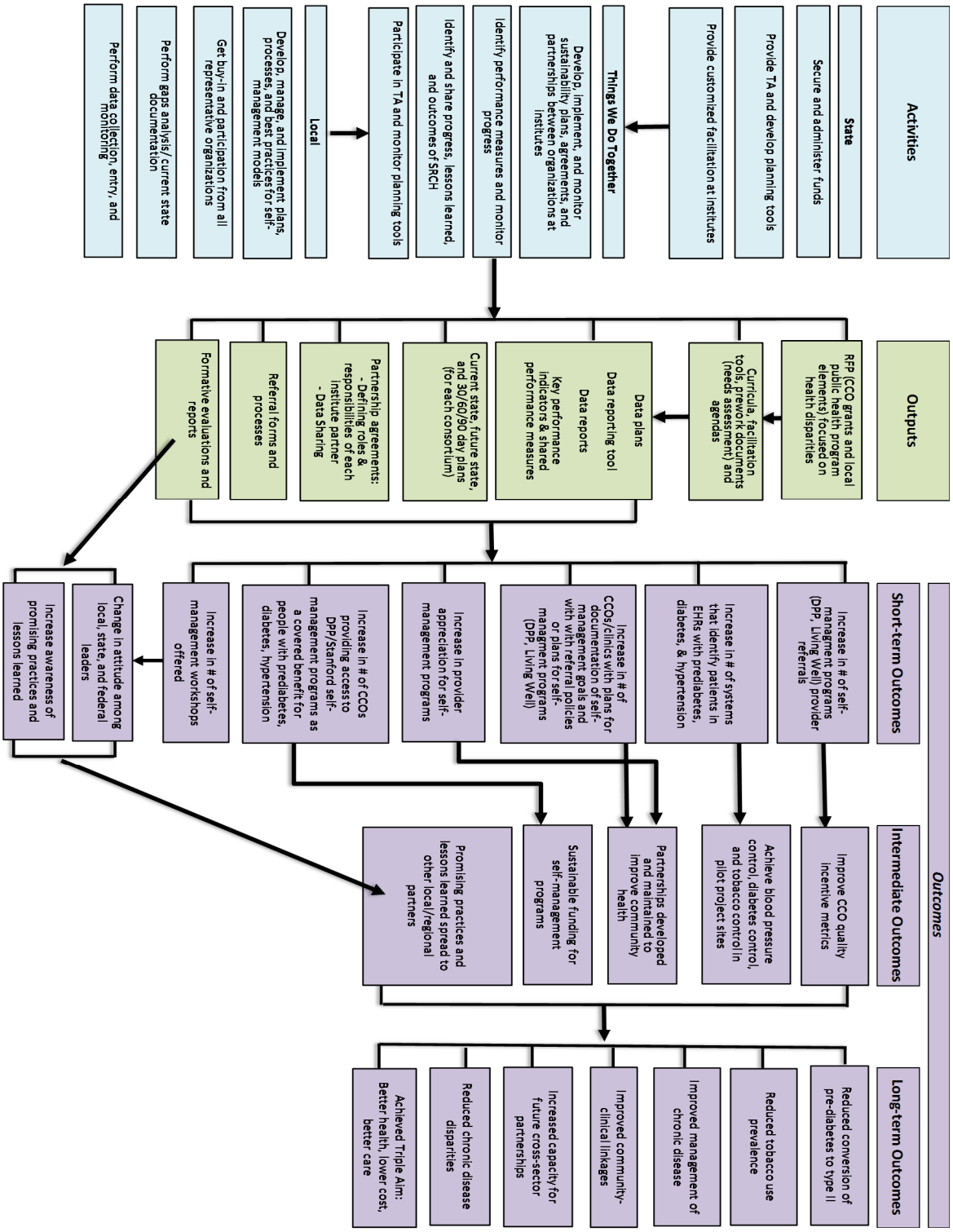
Name	Organization
Summer Boslaugh	OHA/Transformation Center
Bill Bouska	Oregon Health Authority
Bevin Hansell	Oregon Health Authority
Angela Kimball	Oregon Health Authority
Priscilla Lewis	Oregon Health Authority
Dustin Zimmerman	Oregon Healthy Authority

Other Supporting Organizations

Name	Organization
*Laura Brennan	Coraggio Group
Tracy Carver	Acumentra Health
*Susan Kerosky	Coraggio Group
Tim McNeil	HealthCare Consultant
Nancy Siegel	Acumentra Health

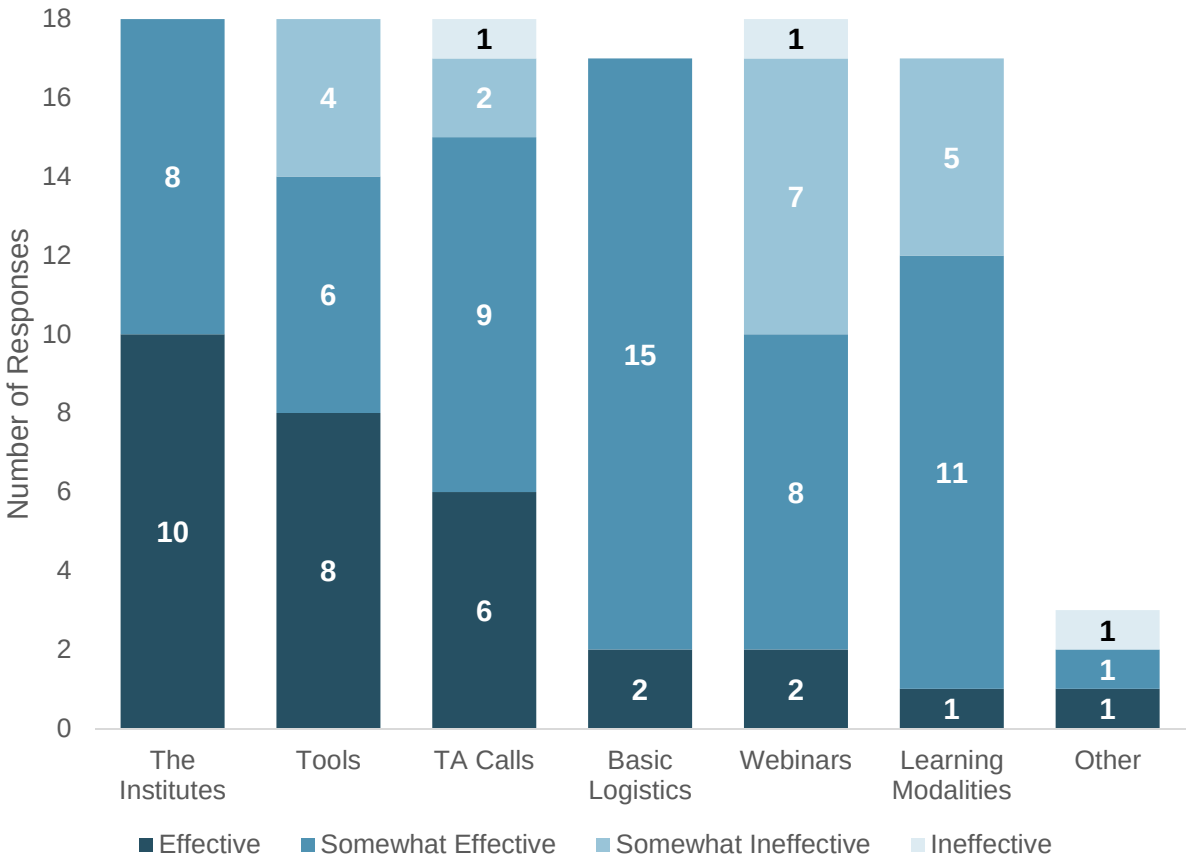
[5] An asterisk (*) is designated for those who participated on the SRCH Evaluation User Group

Appendix C: SRCH Logic Model



Appendix D: Survey Data

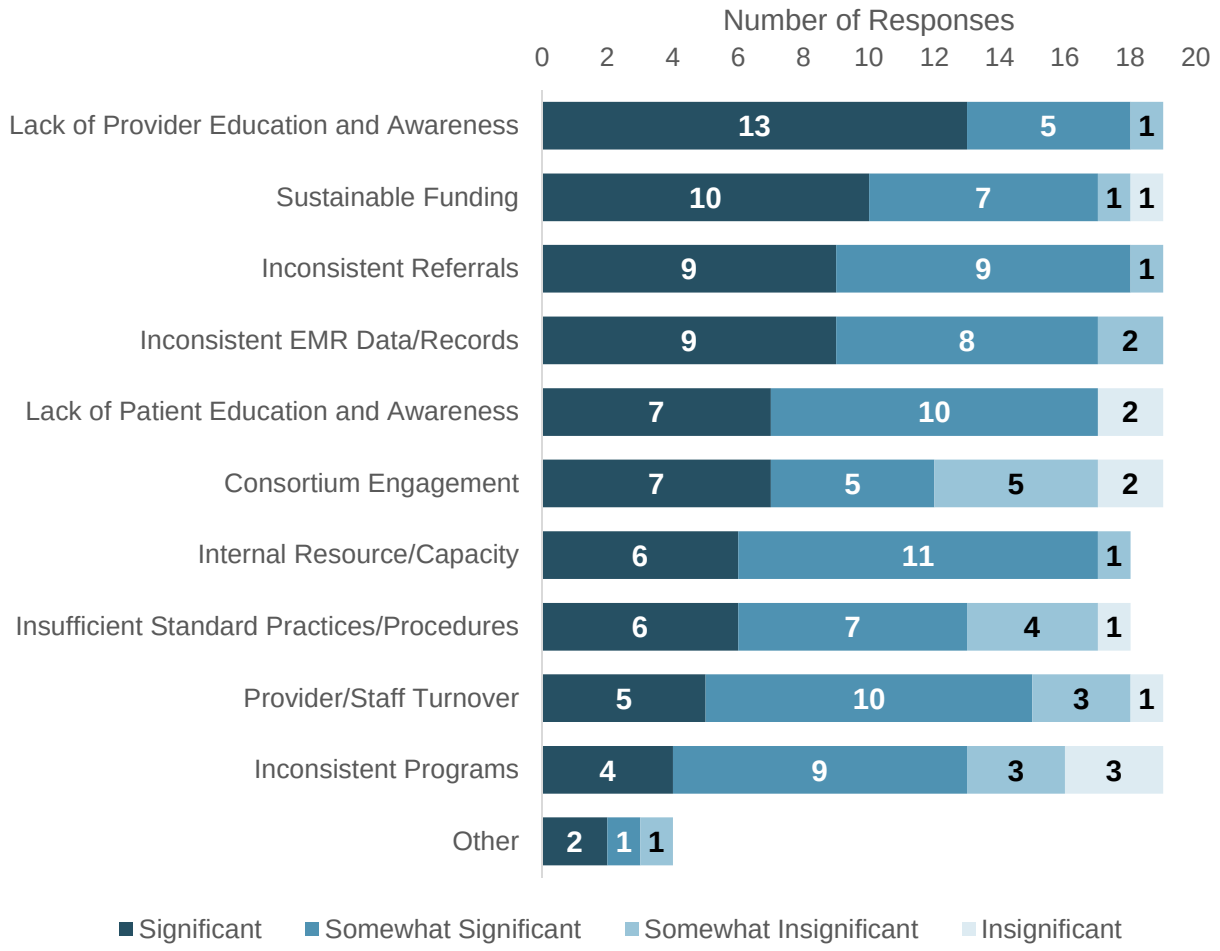
Appendix D1) How effective were the following aspects of SRCH in helping you build sustainable relationships for community health?



Other Responses

- While some relationships were strengthened others were damaged.
- Unable to answer the question as a "whole".
- We had strong relationships going into this process and we will continue this work regardless of the SRCH grant.

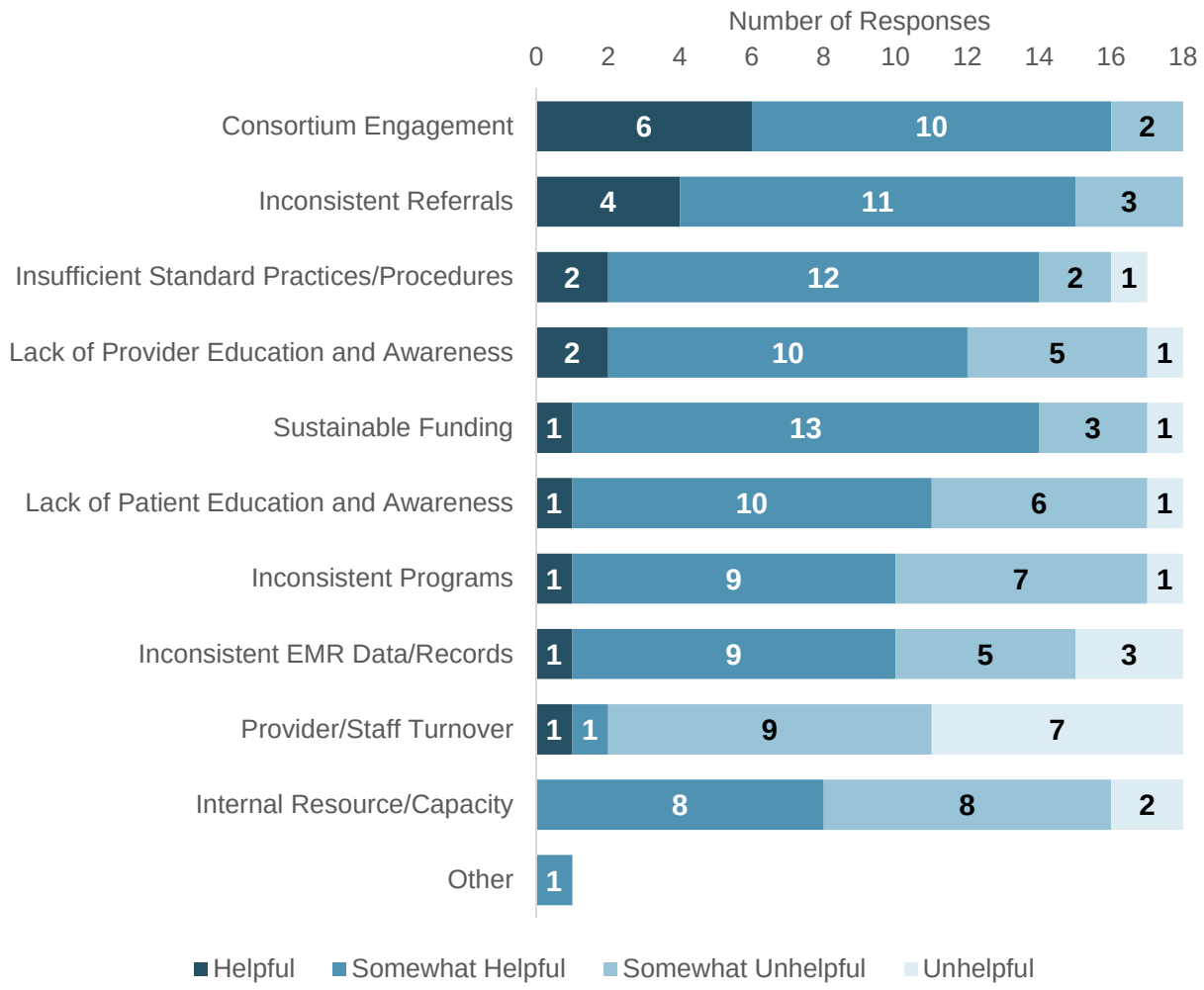
***Appendix* D2)** How significant of an impact did these barriers have on your SRCH experience? If something comes to mind that is not on the list, please rate "OTHER" and elaborate in the space provided.



Other Responses

- Significant - Communication, transparency, commitment and roles and responsibilities.

Appendix D3) How helpful was SRCH in helping you overcome these barriers?



Other Responses

- Somewhat helpful - Very challenging to complete a survey, as there were + and - that resulted from this process. A neutral score leaning towards the negative is probably where I would land on the overall project.

Appendix E: SWOT Summaries by Consortium

All CARE

Strengths: Were most helpful/impactful?

- The Structure of the institutes
- Planning time with enough structure and flexibility
- Forced action to work through plans goals and strategies
- Created accountability
- Ability to come together with like professionals and build relationships
- TA calls helped focus people
- Current state mapping helped build accurate realities and help identify focal points

Weaknesses: Were least helpful/impactful?

- Speakers sometimes took away from time that could have been used to make more progress within the group
- Understanding the complexity of the work

Opportunities: Could be added / improved upon?

- Timeframe: Short time frames are good for momentum but longer periods are necessary to get everything done
- Complexity of project didn't sync with the allocated time frame
- Webinar or meet and greet before first session to clarify work, goals, and expectations

Threats: Could fail or negatively impact other community health initiatives?

- Not having the necessary funding to sustain programs
- Not having a lead person in place. Could jeopardize programs in the long run
- Not scaling fast enough to bring in funds or additional support
- Lack of commitment and coverage
- Lack of referrals for covered members

Clackamas County

Strengths: Were most helpful / impactful?

- The infrastructure allowed for constructive conversations
- 30-60-90s helped put realistic expectations on goals
- Sharing out with other groups
- Support structure, getting the right people to the table

Weaknesses: Were least helpful/impactful?

- 30-60-90s were duplicative. Similar tasks across goals
- Relationship building activities: some people were on different levels of relationships
- Misalignment on the need and identification of key decision makers to make things move
- Short timeline for deliverables: always playing catch up

Opportunities: Could be added / improved upon?

- A Meet & Greet before first institute
- The identification of project leads, members, roles, goals & responsibilities
- Build and share tools early: OHA had tools that would have helped earlier (reimbursement mechanisms)
- More information on reimbursements as this is a key part of sustainability
- More frequent shorter meetings

Threats: Could fail or negatively impact other community health initiatives?

- Time pressure
- Clarity on project expectations, participants etc.
- Clarity issues could cause fall off
- Lack of concrete, motivational relationships that are important to long term sustainability
- Lack of resources- classes & systems & tools

Deschutes County

Strengths: Were most helpful/impactful?

- Finding common goals between consortia and communities
- Bring the right people to the same table at the same time
- Helped people think about health as a community effort, exposing the potential of community centered health initiatives
- Learning opportunities from specialized speakers

Weaknesses: Were least helpful/impactful?

- Not understanding the overarching theme before the start
- Unclear roles and expectations
- Various levels of group maturity in relationship and process. Felt they were held back or some topics were redundant (already had some processes in place)
- Two day institutes were lengthy
- Process, Tools, Reviews didn't't help a lot. Sometimes they confused people. Business based logic and too many forms.
- Wanted more practical topics not conceptual

Opportunities: Could be added / improved upon?

- Have clearer upfront goals, expectations and purpose. Felt the 1st institute could have been better if we did. This would also help to understand who the right people are to have involved earlier in the process
- Build further the educational opportunities and potential within community based health programs
- Consolidated and simplified forms
- Having more specialist facilitate group discussions, particularly on practical aspects instead on conceptual

Threats: Could fail or negatively impact other community health initiatives?

- Not having the necessary funding to sustain programs
- Retention: people involved with this program leaving before it can become standard practice…. the loss of a champion
- Not getting payment models intact so that we can sustain these programs
- Lack of clinical involvement.

IHN CCO

Strengths: Were most helpful/impactful?

- The ability to bring different partners to the table
- Developing relationships across stakeholders
- Educational to learn about what other communities are doing

Weaknesses: Were least helpful/impactful?

- Unclear expectations
- Deliverable scope didn't't match with the deliverable time line we were given
- Logistics: Budget constraints alienated certain groups which affected working relationships within the consortium

Opportunities: Could be added / improved upon?

- A Meet & Great: allows consortia to get to know each other before being asked to jump right into problem solving
- The identification of members, roles, goals & responsibilities
- Bring Clinical to the table

Threats: Could fail or negatively impact other community health initiatives?

- Work load on clinics could be too much to handle
- Inefficiencies in data systems
- Lack of data integration

Lane County

Strengths: Were most helpful/impactful?

- The institutes: having the dedicated time and space to get everyone together
- Having access to leaders and experts
- Forced to sit down and get through tasks and goals
- 30.60.90's were helpful in organizing work and staying on task

Weaknesses: Were least helpful/impactful?

- Constraints discussions: Limiting to current and future state and not allowing flexibility between the two.
- Duplicative templates and tasks
- Templates for templates
- Verbiage at time was confusing. Used words that were not common in the health world

Opportunities: Could be added / improved upon?

- Flexibility on long-term time frames. Some things take longer than 90 days
- Living documents. Have one document that constantly changes with updates
- Forum/Comment board to share out and ask questions across consortia
- Meet & Greet to set roles and begin building relationships prior to the first SRCH session.
- Tailor templates to fit the project and environment

Threats: Could fail or negatively impact other community health initiatives?

- Tasks not capable of being completed in 90 days feels like a failure and could discourage future involvement
- Time constraints place pressure on the process and can be discouraging
- Keeping people engaged. This is a labor-intensive project based on temporary grant dollars in a capacity constrained environment.
- Losing a lead person. Who picks up and how up to speed are they?
- Cumbersome model: in a capacity constrained field, more work and frameworks can be discouraging.

Appendix F: Logic Model and Formative Evaluation Cross Walk

Activity	Logic Model	Formative Evaluation
Secure and administer funds	X	X
Provide TA and develop planning tools	X	
Provide customized facilitation at institutes	X	
Develop, implement, and monitor sustainability plans, agreements, and partnerships between organizations at institutes	X	X
Identify performance measures and monitor progress	X	X
Identify and share progress, lessons learned, and outcomes of SRCH	X	
Participate in TA and monitor planning tools	X	
Develop, manage, and implement plans, processes, and best practices for self-management models	X	X
Get buy-in and participation from all representative organizations	X	
Perform gaps analysis/ current state documentation	X	
Perform data collection, entry, and monitoring	X	
Develop and Implement Governance Structure		X
Develop Common Goals		X
Identify Internal Champions		X
Met Outcome Goal(s)		X

Formative Self-Evaluation

Team Name: _____

Completed by: _____
(Name & Organization)
_____
_____

Date Completed: _____

Please choose the level (red, yellow, orange, green, blue, purple, pink, brown, grey or black) that best represents your assessment of your Team's progress developing innovative sustainable hypertension, pre-diabetes and diabetes prevention, early detection and self-management models through greater communication, collaboration, and coordination. Please add comments to support your selection. (Please use the Team Needs Analysis you completed as well as your SRCH grant proposal to guide you).

After <u>each</u> SRCH Institute, please complete this self-evaluation as a team, and include at least one representative from each member of your Team.

Results from this formative evaluation tool will help further develop the SRCH technical assistance offered to the Consortia. Further, the formative evaluation is a tool to guide you in your planning and implementation of sustainable hypertension, pre-diabetes and diabetes prevention, early detection and self-management work.

Please note: Below, when using the word "team" we mean the individuals who are directly part of SRCH and represent their organization within the SRCH Consortium. When we use the word "consortium" we are referring more broadly to the organizations within the SRCH consortium e.g., all CCO / public health department / AAA staff, managers, directors, administrators…

Also, please note: Each subsequent level assumes that the elements of prior levels are in place.

Level	Self-Assessment Characteristics of Each Level
1	☐ The Team has engaged various partners to improve chronic disease prevention, early detection and self-management, and is developing a governance[6] structure for the work. ☐ Team members are beginning to understand the existing work and assets within the Team that might be pulled into a prevention, early detection and self-management initiative(s). However, currently there is not a common set of goals for the Team's prevention, early detection and self-management collaborative work. ☐ The Team has identified an overall population, identified the most important priorities for improving prevention, early detection and self-management, and is starting to think about how to serve the needs of targeted segment of the population. However, the Team has not yet selected specific prevention, early detection and self-management initiative(s) (as they have not yet weighed the benefits of the various strategies).
2	☐ The Team has confirmed a governance* structure for the work, and identified senior level leaders with time and attention committed to the work. ☐ Team members understand and can articulate the existing assets that can be pulled into the prevention, early detection and self-management collaborative work. ☐ The Team has established consensus around which needs are the most important to address at this time. ☐ The Team has developed a common set of goals for chronic disease prevention, early detection and self-management, including explicit health equity goals. ☐ The Team has drafted a portfolio of prevention, early detection and self-management initiative(s) drawing upon existing work and assets.
3	☐ The Consortium's governance* structure is in place, and members are learning to make effective decisions and resolve conflicts. ☐ The Team leaders are committed to being a local champion of this work (or have designated an influential champion). ☐ Every leader of the Team is very clear on the goals of its chronic disease prevention, early detection and self-management collaborative work. The benefits of this work are clearly articulated and shared with all members of the Consortium. ☐ The Team has agreed to the prevention, early detection and self-management initiative(s) that address a subpopulation and created an implementation plan to pilot the work. However, the specific resources required to implement the initiative(s) are not yet in place. ☐ The Team has established measures for the initiative(s), including explicit equity measures, and is currently developing an overall set of metrics for prevention, early detection and self-management initiative(s).

[6] The processes of interaction and decision-making among the actors involved in a collective problem that lead to the creation, reinforcement, or reproduction of social norms and institutions. See http://en.wikipedia.org/wiki/Governance

Level	Self-Assessment Characteristics of Each Level
4	☐ The Consortium's governance* structure is in place, and members can move swiftly to make progress and resolve conflict effectively. ☐ Consortium members have widespread awareness of and consensus on the purpose of the prevention, early detection and self-management initiative(s). ☐ Consortium members have a clear understanding of how the initiative(s) will affect the established goals and measures. ☐ The Team has confirmed its prevention, early detection and self-management initiative(s), created an implementation plan and there is strong momentum to implement. ☐ A set of metrics for prevention, early detection and self-management initiative(s), including explicit equity metrics, has been established but there is not yet a process for tracking them regularly for decision-making / process improvement.
5	☐ The prevention, early detection and self-management initiative(s) is being implemented at a pilot level (e.g., one sub-population, one zip code, one neighborhood) with a fully resourced team. ☐ A set of metrics, including explicit equity metrics, is established and there is a process for tracking and reporting them regularly for decision-making. ☐ Metrics are being used to make mid-course changes, improve the implementation process, and sustain engagement. ☐ The Team has begun concerted conversations on addressing sustainable funding source (s) for prevention, early detection and self-management initiative(s).
6	☐ There has been measurable progress on meeting at least one outcome goal at the pilot level. This work is regularly reported to all Consortium partners. ☐ The Team has begun to think about how to spread and adapt the initiative(s) beyond the pilot level. ☐ The Team understands the cost drivers within their system and has a plan for new financing mechanisms.
7	☐ The Consortium has met at least one outcome goal for prevention, early detection and self-management initiative(s). ☐ The Team is creating an implementation plan to spread and adapt initiative(s) beyond the pilot level. ☐ The Consortium has made progress toward establishing a sustainable funding source(s) for the long term, though these mechanisms are not yet in place.
8	☐ The Consortium is implementing the plan to spread and adapt prevention, early detection and self-management initiative(s) beyond the pilot level. ☐ The Consortium has a *confirmed* sustainable funding source (s).
9	☐ The Consortium has met more than one outcome-level goal for the overall targeted population. ☐ The Consortium has the infrastructure / mechanisms in place to administer claims and process payments for prevention, early detection and self-management work.
10	☐ The Consortium has met the outcome goals for the prevention, early detection and self-management initiative(s) at full scale. ☐ The Consortium has implemented a financing mechanism(s) to sustain prevention, early detection and self-management initiative(s), and the dollars are flowing.

Appendix H: 30-60-90 Day Plan Template

Activity	Timing	Owner

Appendix I: Current and Future State Process Analysis Template

Process Step	Step Owner	System	Metric	Output

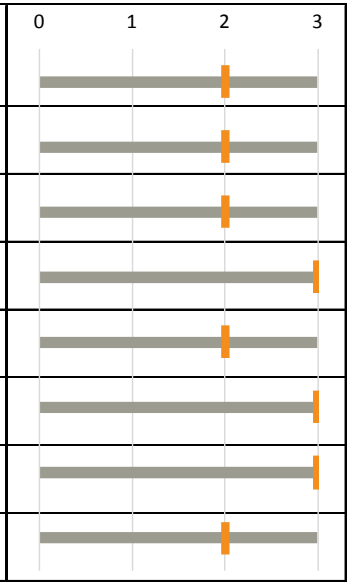
Appendix J: Multiphase Planning Template

	Phase 1 TIMING	Phase 2 TIMING	Phase 3 TIMING
End State Vision			
People / Process / Tools			
Metrics			

CRITERIA

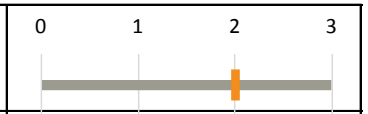
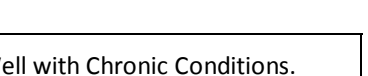
Logic Model Activity	0	1	2	3
Develop, implement, and monitor sustainability plans, agreements, and partnerships between organizations at institutes	No Activity	Plans developed, but not agreed to or implemented	Plans implemented and agreements in place	Partnerships in place and actively monitored
Identify performance measures and monitor progress	No Activity	Some activity in developing Performance Measures, but not finalized or utilized	Performance Measures developed but not used to monitor progress	Performance Measures in place and actively monitored
Identify and share progress, lessons learned, and outcomes of SRCH	No Activity	Progress and Outcomes Identified but not shared	Progress, Outcomes, and Lessons Learned identified with limited sharing	Outcomes and lessons learned actively shared
Participate in TA and monitor planning tools	No Activity	Lead organization participates in TA activities	Occasional participation from member organizations	All organizations actively participate
Develop, manage, and implement plans, processes, and best practices for self-management models	No Activity	Plans, processes, or best practices developed but not in use	Plans, processes, or best practices developed, partial implementation but not actively managed	All Plans, processes, or best practices implemented and actively managed
Get buy-in and participation from all representative organizations	No Activity	Limited participation from representative organizations	Some participation with limited buy-in from representative organizations	Active participation and buy-in from representative organizations
Perform gaps analysis/ current state documentation	No Activity	Current State documented	Current and Future State documented	Current and Future State analysis with improvement opportunities clearly identified
Perform data collection, entry, and monitoring	No Activity	Data Collected	Data entered into usable format	Data being used to inform decisions

ALLCARE CCO

Logic Model Activity	Level	Level Description	
Develop, implement, and monitor sustainability plans, agreements, and partnerships between organizations at institutes	2	Plans implemented and agreements in place	
Identify performance measures and monitor progress	2	Performance Measures developed but not used to monitor progress	
Identify and share progress, lessons learned, and outcomes of SRCH	2	Progress, Outcomes, and Lessons Learned identified with limited sharing	
Participate in TA and monitor planning tools	3	All organizations actively participate	
Develop, manage, and implement plans, processes, and best practices for self-management models	2	Plans, processes, or best practices developed, partial implementation but not actively managed	
Get buy-in and participation from all representative organizations	3	Active participation and buy-in from representative organizations	
Perform gaps analysis/ current state documentation	3	Current and Future State analysis with improvement opportunities clearly identified	
Perform data collection, entry, and monitoring	2	Data entered into usable format	

What was the strategy/plan?	Sustaining Chronic Disease Self-Management Programs (Living Well Programs to start), strengthening the collaboration with local Public Health departments, and increasing access in Josephine and Curry Counties.
Why was the strategy chosen?	Low number of primary care referrals, decrease in number of lay leaders providing the course, workshops being supported by some grant funding and Medicaid as the only payers, no workshops
What was the focus area or population?	AllCare Medicaid members and Medicare dual eligible who: have Pre-diabetes/Diabetes or Hypertension, and live in Josephine and Curry Counties
What was accomplished?	Created workgroup to ensure provider outreach is completed, established stronger working relationships, increase in number of referrals to Living Well Program, training for new leaders, identification of Curry Community Health as lead agency in Curry County, development of improved referral processes

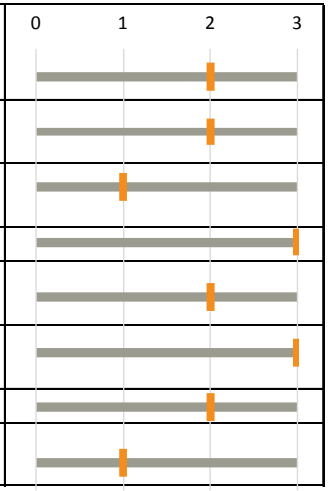
CLACKAMAS

Logic Model Activity	Level	Level Description	
Develop, implement, and monitor sustainability plans, agreements, and partnerships between organizations at institutes	2	Plans implemented and agreements in place	
Identify performance measures and monitor progress	2	Performance Measures developed but not used to monitor progress	
Identify and share progress, lessons learned, and outcomes of SRCH	2	Progress, Outcomes, and Lessons Learned identified with limited sharing	
Participate in TA and monitor planning tools	3	All organizations actively participate	
Develop, manage, and implement plans, processes, and best practices for self-management models	2	Plans, processes, or best practices developed, partial implementation but not actively managed	
Get buy-in and participation from all representative organizations	2	Some participation with limited buy-in from representative organizations	
Perform gaps analysis/ current state documentation	2	Current and Future State documented	
Perform data collection, entry, and monitoring	1	Data Collected	

What was the strategy/plan?	Pilot, test and refine the closed loop referral process for Living Well with Chronic Conditions. Looking to expand this model to other programs such as DPP. Strengthen the referral process between social services, public health and the Clackamas County FQHC for those identified with prediabetes, diabetes or hypertension. Also, seeking reimbursement for self-management programs through HealthShare/Care Oregon CCO.
Why was the strategy chosen?	Living Well with Chronic Conditions is a program that was already in place before SRCH started, and those participating in SRCH were directly involved with this program, as well as the referral process to this program. The strategy was chosen to focus on improving referral processes and reimbursement models for self-management programs. Currently, there is no DPP program in Clackamas County so this pilot will influence the referral process for those with pre-diabetes to DPP once a program is up and running.
What was the focus area or population?	People diagnosed with prediabetes, diabetes, or hypertension
What was accomplished?	Improved referral process, created an infrastructure to use this model for other chronic conditions, strengthened partnership with all participating organizations, established trust in each other as a team, and defined roles among SRCH organizations.

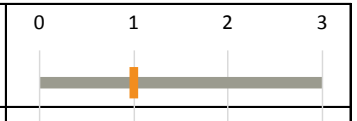
DESCHUTES

Logic Model Activity	Level	Level Description
Develop, implement, and monitor sustainability plans, agreements, and partnerships between organizations at institutes	2	Plans implemented and agreements in place
Identify performance measures and monitor progress	2	Performance Measures developed but not used to monitor progress
Identify and share progress, lessons learned, and outcomes of SRCH	1	Progress and Outcomes identified but not shared
Participate in TA and monitor planning tools	3	All organizations actively participate
Develop, manage, and implement plans, processes, and best practices for self-management models	2	Plans, processes, or best practices developed, partial implementation but not actively managed
Get buy-in and participation from all representative organizations	3	Active participation and buy-in from representative organizations
Perform gaps analysis/ current state documentation	2	Current and Future State documented
Perform data collection, entry, and monitoring	1	Data Collected



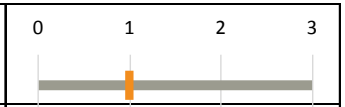
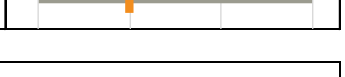
What was the strategy/plan?	Increase referrals to Living Well and Tomando Control. Implement a Diabetes Prevention Program. Increase electronic referrals to the Oregon Tobacco Quit Line.
Why was the strategy chosen?	With DPP and QL referral systems: strong public health leadership for these initiatives (from Jane Smilie), SRCH was an opportunity to move them forward. These were originally in the grant proposal from the beginning. Living Well: Confluence with existing goals. Everyone on SRCH group is involved in creation of regional health improvement plan; opportunity to plug these into plan for 2016. Aligned with strategic vision for Central Oregon.
What was the focus area or population?	Living Well: tri-county region focus; attempting to increase OHP regional referrals from Mosaic as well as other primary care providers and COCOA. DPP: OHP population served by Mosaic Redmond clinic was original focus, meet diagnostic criteria, high readiness to commit. (took advantage of an established partnership). As of 11/2015 broadened to St. Charles Family Practice clinic patients (possibly with comorbid depression). QL: any providers using OCHIN Epic EMR; focus on Mosaic includes OHP and non-OHP clients.
What was accomplished?	DPP is the pilot of the first cohort. Working with Federally Qualified Health Center to increase closed loop referrals through improved messaging and communication to providers. Planned strategy for approaching funder to support DPP and LW/TC. Consulted with Texas and Wisconsin, and later worked with OHA and OCHIN, to learn, communicate, and replicate best practices for electronic Quit Line referrals.

IHN CCO

Logic Model Activity	Level	Level Description	
Develop, implement, and monitor sustainability plans, agreements, and partnerships between organizations at institutes	1	Plans developed, but not agreed to or implemented	
Identify performance measures and monitor progress	1	Some activity in developing Performance Measures, but not finalized or utilized	
Identify and share progress, lessons learned, and outcomes of SRCH	2	Progress, Outcomes, and Lessons Learned identified with limited sharing	
Participate in TA and monitor planning tools	2	Occasional participation from member organizations	
Develop, manage, and implement plans, processes, and best practices for self-management models	2	Plans, processes, or best practices developed, partial implementation but not actively managed	
Get buy-in and participation from all representative organizations	2	Some participation with limited buy-in from representative organizations	
Perform gaps analysis/ current state documentation	1	Current State documented	
Perform data collection, entry, and monitoring	1	Data Collected	

What was the strategy/plan?	Develop and pilot tobacco / Chronic Disease Self-Management Program referral and closed loop process.
Why was the strategy chosen?	The priority strategy was closed loop referrals; there are already systems in place with Samaritan and the Oregon Cascades West Council of Governments. The team explored the use of a centralized email approach, as fax referrals were not effective in the clinic setting. One member organization has experience with closed loop referrals. The team explored reimbursement, through flexible spending accounts, as shared by another SRCH team.
What was the focus area or population?	The audience was broadly defined as people who have chronic diseases. The question about insurance status and equal access to the Living Well program remained a concern for the team.
What was accomplished?	1. A health system partner provided education about the Living Well program to clinic staff who were not active referral sources. 2. Team members reviewed regional Living Well data for patient demographics and referral sources, which had not been done previously. The team identified the Compass Portal as a centralized referral and scheduling resource and increased referrals from local public health into the existing Living Well program network in the region as future opportunities for the team.

LANE COUNTY

Logic Model Activity	Level	Level Description	
Develop, implement, and monitor sustainability plans, agreements, and partnerships between organizations at institutes	1	Plans developed, but not agreed to or implemented	
Identify performance measures and monitor progress	1	Some activity in developing Performance Measures, but not finalized or utilized	
Identify and share progress, lessons learned, and outcomes of SRCH	2	Progress, Outcomes, and Lessons Learned identified with limited sharing	
Participate in TA and monitor planning tools	2	Occasional participation from member organizations	
Develop, manage, and implement plans, processes, and best practices for self-management models	2	Plans, processes, or best practices developed, partial implementation but not actively managed	
Get buy-in and participation from all representative organizations	2	Some participation with limited buy-in from representative organizations	
Perform gaps analysis/ current state documentation	2	Current and Future State documented	
Perform data collection, entry, and monitoring	1	Data Collected	

What was the strategy/plan?	Develop a closed loop referral system for Living Well with Chronic Conditions
Why was the strategy chosen?	Build on existing relationships. Aligned with health priorities identified in Community Health Improvement Plan
What was the focus area or population?	Trillium and Federally Qualified Health Center patients with chronic diseases
What was accomplished?	Established referral system form for Living Well with Chronic Conditions. Identified most effective communication channels. More effective working relationships/committed partnership. Increased referrals to Living Well due to this process. Expanded types of programs offered to include Stanford Diabetes Self-Management Program and Chronic Pain.

Appendix L: Glossary of Terms

Closed-Loop Referral Pathways are referral processes that, in addition to identifying and linking the referred individual to a given self-management intervention or screening service, also provide the referring entity with timely follow-up information pertinent to the individual's continuing care. Examples of information to close the referral loop include updates on whether the referred individual received the intervention, outcomes related to receipt of the intervention (e.g., achievement of identified self-management goals, tobacco use status or reduction in chronic condition severity) and any barriers precluding receipt of the intervention.

Community Clinical Linkages are connections between community and clinical sectors to improve the health of a population, including interventions such as clinical referral, community delivery, and payment for effective programs.

Consortium means a group of entities served by a Lead Fiscal Agent that, at a minimum, includes at least one local public health authority (LPHA) and one Coordinated Care Organization (CCO) that serve a shared geographic population and includes clinic-level partner(s) and organization(s) that deliver the SMPs identified by the Proposer.

Coordinated Care Organization (CCO) means a corporation, governmental agency, public corporation or other legal entity that is certified as meeting the criteria adopted by the Oregon Health Authority under ORS 414.625 to be accountable for care management and to provide integrated and coordinated health care for each of the organization's members.

Health Promotion and Chronic Disease Prevention Program (HPCDP) refers to the program within the Oregon Health Authority, Public Health Division responsible for administering this funding opportunity.

"**Local Public Health Authority (LPHA)** means a county government, or a health district created under ORS 431.414 (District board of health) or a person or agency a county or health district has contracted with to act as the local public health authority."

Self-Management Programs (SMPs): according to the Institute of Medicine, self-management programs are "the systematic provision of education and supportive interventions…to increase patients' skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support." SMPs include tobacco cessation and other self-management programs that are provided in settings that are accessible and culturally sensitive to participants, e.g., community centers, places of worship, community-based organization offices, or by telephone or online. SMPs focus on patient-perceived problems and needs, and emphasize skills, such as problem solving and decision-making. They prepare people with chronic conditions to build the skills and confidence to manage their disease(s) on a daily basis and to manage its impact on activities and emotions. Self-management programs also support those changing their behavior to reduce risk factors, including quitting tobacco use, improving their nutrition, being physically active

and losing weight. SMPs improve quality of life and support the Triple Aim of health systems transformation by reducing costly health crises and improving health outcomes for patients with chronic conditions, such as tobacco use, cancer, asthma, hypertension, depression, prediabetes, diabetes, and arthritis. SMPs are delivered by people who are known, trusted, culturally sensitive, and fluent in the language of the target community. SMP facilitators need not be health professionals, but they are trained and prepared for their role. For the purposes of this document, SMPs are limited to those identified and supported by the Oregon Health Authority's Public Health Division. These currently include Stanford Chronic Disease Self-Management Programs (e.g., Living Well, Tomando Control de su Salud, the Diabetes Self-Management Program, the Positive Self-Management Program, the Chronic Pain Self-Management Program, and the online Better Choices, Better Health program), the National Diabetes Prevention Program (in-person or on-line), and Walk With Ease. For more information about the evidence-based CSMPs currently supported by OHA/PHD, see http://www.healthoregon.org/takecontrol.

SRCH Initiative means an OHA initiative to support building sustainable relationships for community health (SRCH). The SRCH Initiative will engage cross-sector leaders involved in health system transformation to advance health system interventions and promote community-clinical linkages in order to reduce the burden of tobacco use and chronic conditions in Oregon's communities.

SRCH Institute means as a learning session convened by OHA during the period of July 2016 through June 2017 through which Consortium members will participate in a series of facilitated discussions and receive technical assistance for developing and implementing sustainable systems changes. See Section 3.1 below for more information.