Program Element #271: Sustainable Relationships for Community Health (SRCH) – Urban Indian Program

OHA Program Responsible for Program Element:

Public Health Division/Center for Health Prevention & Health Promotion/ Health Promotion and Chronic Disease Prevention Section

1. Description.

Funds provided under the Financial Assistance Agreement for this Program Element may only be used, in accordance with and subject to the requirements and limitations set forth below to deliver Sustainable Relationships for Community Health (SRCH) services. Through the SRCH initiative, the Grantee may work with clinics and/or CBOs (community-based organizations) , and other entities involved with health system transformation to deliver Culturally-Validated Practice-Based Evidence or Evidence-Based Interventions and Services to prevent and improve chronic conditions and improve Community-Clinical Linkages. More specifically, these leaders from multiple sectors will use data to identify at-risk populations, refer and connect at-risk populations to Culturally-Validated Practice-Based Evidence or Evidence-Based Interventions and Services, share and use data to improve referral systems and health outcomes, and reduce disparities / inequities. SRCH will provide Grantee the opportunity to develop and strengthen relationships, co-design Closed-Loop Referral strategies, develop sustainable payments and/or reimbursement methodologies, implement quality improvement processes, and collect, analyze and share data in order to reduce some of the leading causes of death and disability in Oregon and in Tribal communities. Developing and improving these sustainable systems may require steps such as creating new payment or reimbursement strategies, increasing the capacity of Tribes and tribal serving organizations, improving and coordinating referral systems, and documenting referral outcomes.

Grantee may specifically address issues related to areas of quality improvement, including use of quality measures, electronic health records (EHR) and health information technology (HIT), and/or traditional health workers in team-based care. Grantee may also increase the use of Evidence-based Community Self- Management Programs (CSMP) through Closed-Loop Referral health systems and reimbursement.

This Program Element, and all changes to this Program Element are effective the first day of the month noted in Issue Date section of Exhibit C of the Financial Assistance Award unless otherwise noted in Comments and Footnotes of Exhibit C of the Financial Assistance Award.

2. Definitions Specific to Sustainable Relationships for Community Health (SRCH).

a. Closed-Loop Referrals: Referrals that, in addition to linking the referred individual to self-management intervention, 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., identified self-management goals, improved disease status, reduction of risk factors such as tobacco use) and any barriers precluding receipt of the intervention.

b. Community-Clinical Linkages: Refers to forming partnerships and relationships among clinical, community, and public health organizations to coordinate health care delivery, and public health and community-based activities to promote healthy behaviors and improve the health of a population.

c. Culturally-Validated Practice-Based Evidence or Evidence-Based Interventions and Services: Refers to practices set forth in public health or health care that have been shown through research and evaluation to improve health outcomes, and have been recommended through national guidance from expert organizations such as the Centers for Disease Control

and Prevention's Community Guide to Preventive Services or the United States Preventive Services Task Force. This may include (but is not limited to) chronic disease self-management programs, asthma self-management, the national Diabetes Prevention Program, tobacco cessation services or colorectal cancer screening. This also includes practices and programs that have been culturally adapted and validated for implementation in Tribal communities.

d. **Health Information Technology (HIT):** Encompasses a wide range of products and services including software, hardware and infrastructure designed to collect, store and exchange patient data throughout the clinical practice of medicine.

3. Alignment with Modernization Foundational Programs and Foundational Capabilities.

The activities and services that the Grantee has agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities as follows (see Oregon's Public Health Modernization Manual, (http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf):

a. **Foundational Programs and Capabilities** (As specified in Public Health Modernization Manual)

Program Components	**Foundational Program**					**Foundational Capabilities**						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services: Population Health	Access to clinical preventive services: Direct services	Leadership and organizational competencies	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
Participate in activities to create Sustainable Relationships for Community Health (SRCH) Institutes		*	X	X	X	X	X	X		X	X	
Advance Health System Interventions		X	X	*	X	X	X	X	X	X	X	
Promote Community-Clinical Linkages to Support Patient Self-Management		X	X	*	X	X	X	X	X	X	X	

Development and Implementation of a Plan to Sustain Relationships for Community Health		*	X	X	X	X	X	X	X	X	X	

b. The work in this Program Element helps Tribal-serving health systems achieve Public Health Accountability Metrics:

Not applicable

c. The work in this Program Element helps Tribal-serving health systems achieve the following Public Health Modernization Process Measure:

Not applicable

4. Procedural and Operational Requirements:

By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, Grantee agrees to conduct activities in accordance with the following requirements:

a. General Requirements.

Grantee must:

(1) Submit a Program Plan and program budget for approval by OHA within a timeframe designated by OHA. Grantee must engage in activities as described in its Program Plan, which has been approved by OHA.

(2) Use funds for this Program Element in accordance with its program budget, which has been approved by OHA. Modification to the program budget may only be made with OHA approval.

(3) Assure that it is staffed at the appropriate level to conduct the activities described in Subsections b.(1) through b.(3) of this Section 4 of this Program Element. Grantee must designate a point of contact between Grantee and OHA. Funds for this Program Element are to be directed to personnel, travel and other expenses in support of Subsections b.(1) through b.(3).

(4) Attend all Institute Meetings with partnering CBOs (if applicable).

(5) Attend all meetings reasonably required by OHA's Health Promotion and Chronic Disease Program.

(6) Comply with OHA's Health Promotion and Chronic Disease Prevention Program Guidelines and Policies, located at: https://apps.state.or.us/Forms/Served/me010-019.pdf

In the event of any omission from, or conflict or inconsistency between, the provisions of the approved program budget and the provisions of the Agreement and this Program Element, the provisions of the Agreement and this Program Element shall control.

b. Activities. Grantee must focus efforts on some or all of the activities described in Subsections (1) through (3) below. Together, these collaborative activities will support participating partners in the development of plans to improve inter-organizational partnerships and the creation of joint agreements with Grantee and partners to address chronic disease prevention, early detection and self-management.

(1) **Advance Health System Interventions:** Work with partners, including OHA (if appropriate) to co- design and advance health system interventions addressing prevention, early detection, and self-management of chronic disease that:

(a) Support culturally appropriate program adaptation.

(b) Increase implementation of quality improvement processes in health systems.

(c) Increase EHR utilization and the use of HIT to improve quality of care.

(d) Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider and systems level.

(e) Increase use of team-based care in health system, clinical, and community settings.

(f) Increase engagement of non-physician team members (e.g., care coordinators, pharmacists, community health workers, patient navigators, peer support specialists, peer wellness specialists) in hypertension, pre-diabetes and diabetes management in health care systems and community settings.

(2) **Promote Community-Clinical Linkages to Support Patient Self-Management:** Work with partners to develop and reinforce long-term commitments to Community-Clinical Linkages, quality improvement, data-sharing, collaboration and partnerships between Grantee, CBOs, and others, including co-designing self-management support strategies for those enrolled in the Oregon Health Plan and/or Tribal Health Program that:

(a) Increase access to Culturally-Validated Practice-Based Evidence Interventions and Services and Evidence-Based Interventions and Services, especially those delivered in community settings.

(b) Increase Closed-Loop Referrals and reimbursement for Culturally-Validated Practice-Based Evidence Interventions and Services and Evidence-Based Interventions and Services, especially those delivered in community settings.

(c) Increase use of traditional health workers in Tribal community and health care settings in support of self-management.

(3) **Development and Implementation of a Plan to Sustain Relationships for Community Health:**

(a) By the conclusion of the SRCH funding period, Grantee and partners will have co-created a plan and agreements that enhance collaboration, promote Community-Clinical Linkages and advance health system interventions.

(b) The plan and agreements must delineate roles and responsibilities; identify staffing and training needs; and ultimately create mechanisms to facilitate better care, better health, and lower cost. The plan and agreements must include specific strategies, actions, organizational/individual responsibilities and a timeline to:

i. Improve the use of quality measures, EHR/HIT, and traditional health workers in team-based care, and;

ii. Increase the use of Culturally-Validated Practice-Based Evidence Interventions and Services and Evidence-Based Interventions and Services through development or improvement of systems enabling Closed-Loop Referrals of appropriate patients and payments or reimbursement to organizations providing such Interventions and Services.

5. General Revenue and Expense Reporting.

Grantee must complete an "Oregon Health Authority Public Health Division Expenditure and Revenue Report" located in Exhibit C of this Agreement. These reports must be submitted to OHA each quarter

on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 20

6. Reporting Requirements.

Grantee must submit to OHA's Health Promotion and Chronic Disease Prevention Section (HPCDP) copies of products developed through the SRCH Institute including: 1) official agreements such as Memorandum of Understanding, data sharing agreements, and other legal agreements; 2) protocols for referrals, payment and data sharing; and 3) other documentation demonstrating successful implementation which may include position descriptions, staffing plans, business plans, technology plans, etc. Grantee will also work with OHA to share experiences and promising practices with others.

7. Performance Measures.

If Grantee completes fewer than 75% of the planned activities in its OHA-approved SRCH Program Plan during a six-month period, the Grantee will be required to submit a revised plan that ensures the Grantee will meet program requirements. The revised Program Plan will be subject to OHA's approval.

8. Program Evaluation.

Grantee must assist OHA with program evaluation throughout the duration of this Agreement, as well as with final project evaluation. Such activities may include, but are not limited to, meeting with a state level evaluator soon after execution of this Agreement to help develop an evaluation plan specific to the project, collecting data and maintaining documentation throughout this Agreement, responding to the evaluator's requests for information and collaborating with the evaluator to develop final reports to highlight the outcomes of the work. One representative from each team will be required to participate on a project evaluation advisory group.