

Program Element #04: Sustainable Relationships for Community Health (SRCH)

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 Relationship for Community Health (SRCH). The Local Public Health Authority (LPHA) must partner with their regional Coordinated Care Organizations (CCO) and local community-based organizations (CBOs) will align and delineate organizational roles and responsibilities to improve health outcomes, while leveraging existing community-wide health improvement initiatives.

Through the SRCH initiative, the LPHA must work with CCOs, clinics, and/or CBOs delivering Evidence-Based Interventions and Services, and others involved with health system transformation 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 Evidence-Based Interventions and Services, and share and use data to improve referral systems and health outcomes, and reduce disparities / inequities. SRCH will provide teams 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. Developing and improving these sustainable systems may require steps such as creating new payment or reimbursement strategies, increasing the capacity of CBOs, improving and coordinating referral systems, and documenting referral outcomes.

LPHA must specifically address issues related to areas of quality improvement, including use of quality measures, electronic health records and HIT, and traditional health workers in team-based care. LPHA must also increase the use of evidence-based Community Self-Management Programs (CSMP) through Closed-Loop Referral health system 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 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 a given self-management intervention as described below, 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. **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.

- 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 LPHA has agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities and the public health accountability metrics (if applicable), as follows (see [Oregon’s Public Health Modernization Manual](http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf), (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	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 = Foundational capabilities that align with each component							
X = Other applicable foundational programs												
Participate in activities to create Sustainable Relationships for Community Health (SRCH) Institutes	*	X	X	X	X	X	X	X		X	X	
Advance Health System Interventions	X	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	X	
Development and Implementation of a Plan to Sustain Relationships for Community Health	*	X	X	X	X	X	X	X	X	X	X	

- b. **The work in this Program Element helps Oregon’s governmental public health system achieve the following Public Health Accountability Metric:**

Adults who smoke cigarettes

- c. **The work in this Program Element helps Oregon’s governmental public health system 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, LPHA agrees to conduct activities in accordance with the following requirements:

- a. **General Requirements.** LPHA must:

- (1) Submit a local program plan and local budget for approval by OHA within a timeframe designated by OHA. LPHA must engage in activities as described in its local program plan, which has been approved by OHA.
- (2) Use funds for this Program Element in accordance with its local program budget, which has been approved by OHA. Modification to the local program budget may only be made with OHA approval.
- (3) Assure that it is staffed at the appropriate level to address Subsections b.(1) through b.(4) of this Section 4 of this Program Element. LPHA must designate a point of contact between LPHA 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.(4).
- (4) Attend all Institute Meetings with partnering CCO and CBOs.
- (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 local program budget and the provisions of the Agreement and this Program Element, the provisions of the Agreement and this Program Element shall control.

- b. **Local Activities.** LPHA must focus efforts in cooperation with CCOs, and CBOs on the activities described in Subsections (1) through (4) 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 LPHA, regional CCOs and CBOs to address chronic disease prevention, early detection and self-management.

- (1) **Participate in Institute Activities to create Sustainable Relationships for Community Health (SRCH) Institutes:** LPHA, including Key Person(s) from each team, will actively participate in Institutes to develop Sustainable Relationships for Community Health Institutes (SRCH Institutes). OHA will convene the SRCH Institutes as a “learning collaborative,” where local team members must participate in a series of facilitated discussions and receive technical assistance. Discussions and technical assistance will engage local leadership involved in health system transformation and development of Community-Clinical Linkages to align and delineate organizational roles and responsibilities to improve health outcomes, while leveraging existing community-wide health improvement initiatives.
 - (a) The SRCH Institutes will assist team members to co-design (1) local initiatives to improve cross-sector partnerships and (2) joint agreements with team member organizations to address the local burden related to prevention, early detection, and self-management.

- (b) The SRCH Institutes will include up to four in-person two-day meetings during the funding period. Additionally, LPHAs must:
 - i. Conduct pre-work on the team’s needs, strengths, and goals for participation in the SRCH Institutes;
 - ii. Engage in activities between Institute in-person meetings, including facilitated technical assistance calls/webinars, and individual coaching;
 - (c) The SRCH Institutes will support LPHAs, CCOs and CBOs in developing formal commitments, such as memoranda of understanding and data-sharing agreements, to reinforce collaboration and a long-term commitment to health system improvement and Community-Clinical Linkages. Team members will share outcomes and assist OHA with the dissemination of findings.
- (2) **Advance Health System Interventions:** During the SRCH Institutes, team members must participate in structured, facilitated discussions and activities to co- design and advance health system interventions addressing prevention, early detection, and self-management of chronic disease that:
- (a) Increase implementation of quality improvement processes in health systems.
 - (b) Increase electronic health records (EHR) utilization and the use of HIT to improve quality of care.
 - (c) Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider and systems level.
 - (d) Increase use of team-based care in health system, clinical, and community settings.
 - (e) 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.
- (3) **Promote Community-Clinical Linkages to Support Patient Self-Management:** During the SRCH Institutes, team members must participate in structured facilitated discussions and activities that develop and reinforce long-term commitments to Community-Clinical Linkages, quality improvement, data-sharing, collaboration and partnerships between LPHAs, CCOs, CBOs and others. Team members will co-design self-management support strategies for those enrolled in the Oregon Health Plan that:
- (a) Increase access to Evidence-Based Interventions and Services, especially those delivered in community settings
 - (b) Increase Closed-Loop Referrals and reimbursement for Evidence-Based Interventions and Services, especially those delivered in community settings.
 - (c) Increase use of traditional health workers in community and health care settings in support of self-management.
- (4) **Development and Implementation of a Plan to Sustain Relationships for Community Health:**
- (a) By the conclusion of the facilitated discussions and technical assistance offered during the SRCH Institutes, local team members must 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. Each team’s 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 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 Evidence-Based Interventions and Services.

5. **General Revenue and Expense Reporting.** LPHA 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.** LPHA must submit to HPCDP copies of products developed through the SRCH Institutes 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. Successful Proposers will also work with OHA to share experiences and promising practices with others.

7. **Performance Measures.**

LPHAs that complete fewer than 75% of the planned activities in its Local Program Plan, for two consecutive calendar quarters in one state fiscal year will not be eligible to receive funding under this Program Element in the next state fiscal year.

8. **Program Evaluation.** LPHA 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 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.