

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

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, for a Local Public Health Authority (LPHA) to partner with their regional Coordinated Care Organizations (CCO) and local Community Self-Management Program (CSMP) organizations to align and delineate organizational roles and responsibilities to improve health outcomes, while leveraging existing community-wide health improvement initiatives. LPHA will specifically address issues related to areas of quality improvement, including use of quality measures, electronic health records and health information technology, and traditional health workers in team-based care. LPHA will also increase the use of evidence-based Community Self-Management Programs (CSMP) through closed-loop health system referral and reimbursement.
2. **Definitions Specific to this Program Element.**
 - a. **Community Self-Management Program (CSMP):** 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.” Community Self-Management Programs (CSMPs) are provided in community settings that are accessible and culturally sensitive to participants, e.g. community centers, places of worship, community-based organization offices. CSMPs focus on patient-perceived problems and needs, and emphasize skills such as problem solving and decision-making. They prepare people with chronic conditions to have 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 improve quality of life and support the Triple Aim of health systems transformation by reducing costly health crises and improving health outcomes for chronically ill patients with conditions such as asthma, cardiovascular disease, depression, diabetes, and arthritis. CSMPs are delivered by people who are known, trusted, culturally sensitive and fluent in the language of the target community. CSMP facilitators need not be health professionals, but they are trained and prepared for their role. For the purposes of this document, CSMPs 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., CDSMP/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, and Walk With Ease. For more information about the evidence-based CSMPs currently supported by OHA/PHD, see <http://www.healthoregon.org/takecontrol>.
 - b. **Closed-Loop Referrals:** are 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.

- c. **Evidence-Based Practice**: refers to practices set forth in disease management criteria established by national guideline from expert organizations such as the Centers for Disease Control and Prevention, Administration for Community Living, National Institutes of Health, the Community Guide to Preventive Services, the National Council on Aging, the American Diabetes Association and the American Heart Association.
- 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. **Local Activities.** LPHAs, will focus efforts in cooperation with CCOs, and CSMP organizations (consortium partners) on the activities described in subsections 3.a. through 3.d. 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 LPHAs, regional CCO and local community-based organization to address chronic disease prevention, early detection and self-management.

a. **Participate in Institute Activities to create Sustainable Relationships for Community Health (SRCH) Institutes.** LPHAs, including Key Person(s) from each consortium partner, 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 consortium members will participate in a series of facilitated discussions and receive technical assistance. Discussions and technical assistance will engage local leaders 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.

- (1) The SRCH Institutes will assist consortium members to co-design (1) local initiatives to improve cross-sector partnerships and (2) joint agreements with consortium partners to address the local burden related to prevention, early detection and self-management.
- (2) The SRCH Institutes will include three in-person two-day meetings during the period April through September, 2015. Additionally, LPHAs will:
 - (a) Conduct pre-work on the consortium’s needs, strengths, and goals for participation in the SRCH Institutes;
 - (b) Engage in activities between Institute in-person meetings, including facilitated Technical Assistance calls/webinars, and individual coaching;
- (3) The SRCH Institutes will support LPHAs, CCOs and CSMP Providers 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. Consortium members will share outcomes and assist OHA with the dissemination of findings.

b. Advance Health System Interventions. During the SRCH Institutes, consortium members will 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:

- (1) Increase implementation of quality improvement processes in health systems.
- (2) Increase electronic health records (EHR) utilization and the use of health information technology (HIT) to improve quality of care.
- (3) Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider and systems level.
- (4) Increase use of team-based care in clinical and community health systems settings.
- (5) 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.

c. Promote Community-Clinical Linkages to Support Patient Self-Management. During the SRCH Institutes, consortium members will 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 LPHA(s), CCO(s), CSMP Providers and others. Consortium members will co-design self-management support strategies for those enrolled in the Oregon Health Plan that:

- (1) Increase access to evidence-based chronic disease self-management programs (CSMPs), especially those delivered in community settings
- (2) Increase closed-loop referrals and reimbursement for evidence-based chronic disease self-management programs (CSMPs), especially those delivered in community settings.
- (3) Increase use of non-physician health workers in community and health care settings in support of self-management.

d. Development and Implementation of a Plan to Sustain Relationships for Community Health.

- (1) By the conclusion of the facilitated discussions and technical assistance offered during the SRCH Institutes, local consortium members will have co-created a plan and agreements that enhance collaboration, promote community-clinical linkages and advance health system interventions.
- (2) The plan and agreements will delineate roles and responsibilities; identify staffing and training needs; and ultimately create mechanisms to facilitate better care, better health, and lower cost. Each consortium's plan and agreements shall include specific strategies, actions, organizational/individual responsibilities and a timeline to:
 - (a) Improve the use of quality measures; EHR/HIT, and traditional health workers in team-based care, and;
 - (b) Increase the use of CSMPs through development or improvement of systems enabling Closed Loop Referrals of appropriate patients and payments or reimbursement to organizations providing CSMPs.

4. Procedural and Operational Requirements.

- a.** By accepting and using the financial assistance funding provided by Department under the Financial Assistance Agreement and this Program Element, LPHA agrees to conduct activities in accordance with the following requirements:
- (1) LPHA shall implement its activities in accordance with this Program Element.
 - (2) LPHA must assure that it is staffed at the appropriate level to address subsections 3.a. through 3.d. of this Program Element. LPHA will designate a point of contact between the Recipient and OHA. Funds for this program element are to be directed to personnel, travel and other expenses in support of subsections 3.a. through 3.d.
 - (3) LPHA must use the funds awarded under this Agreement for this Program Element in accordance with its budget as approved by the Department. Modifications to the budget may only be made with Department approval.
 - (4) LPHA must attend all Institute Meetings with partnering CCO and community-based organizations.
 - (5) LPHA must attend all meetings reasonably required by HPCDP.
 - (6) LPHA must comply with Department's Health Promotion and Chronic Disease Prevention Program Guidelines and Policies.

- b. In the event of any omission from, or conflict or inconsistency between, the provisions of the Budget and the provisions of the Agreement and this Program Element, the provisions of the Agreement and this Program Element shall control.
- 5. **Reporting Requirements.** Successful Proposers shall 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.
- 6. **Program Evaluation.** LPHAs will assist OHA with program evaluation throughout the duration of the Agreement period(s), 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 the Agreement period, 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 consortium will be required to participate on a project evaluation advisory group.
- 7. **Performance Measures.** LPHA's that complete fewer than 75% of the planned activities in its Local Program Budget, set forth as Attachment 1 to this Program Element and incorporated herein the Agreement by reference, 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.

Attachment 1 to Program Element #04 Sustainable Relationships for Community Health (SRCH)

Local Program Budget