North Central Public Health District

"Caring For Our Communities"

North Central Public Health District Board of Health Meeting

February 10, 2015
3:00 PM
Meeting Room @ NCPHD

AGENDA -

1. **Minutes**
   a. Approve from January 13, 2015 Meeting
   b. Set Next Meeting Date
2. **Additions to the Agenda**
3. **Unfinished Business**
   a. HWR Program Transition – Consideration of potential resolution for transfer of program if received by counsel.
   b. Wasco County's BOCC vote to withdraw from NCPHD – Update
   c. Triennial Review Update
4. **New Business**
   a. Regional Health Equity Coalition (RHEC)
   b. 2nd Quarter 14/15 Fiscal Report
   c. Budget (FY 2015-16)
      - ✓ Process
      - ✓ Budget Calendar
      - ✓ Budget Committee
   d. Contracts Review
      - ✓ Jefferson Health Information Exchange Agreement
      - ✓ OHSU CCN Agreement (Harpole)
      - ✓ Providence Health Plan Provider Agreement
   e. Director's Report

Note: This agenda is subject to last minute changes.

Meetings are ADA accessible. If special accommodations are needed please contact NCPHD in advance at (541) 506-2626. TDD 1-800-735-2900. NCPHD does not discriminate against individuals with disabilities.

If necessary, an Executive Session may be held in accordance with: ORS 192.660 (2) (d) Labor Negotiations; ORS 192.660 (2) (h) Legal Rights; ORS 192.660 (2) (e) Property; ORS 192.660 (2) (i) Personnel

North Central Public Health District
Board of Health
Meeting Minutes
January 13, 2015 (3:00 pm)

In Attendance: Teri Thalhofer, Director NCPHD; Commissioner Mike Smith – Sherman County; Roger Whitely – Sherman County; Bill Hamilton – Sherman County; Commissioner Steve Kramer – Wasco County; Judge Steve Schafer – Gilliam County; and Michael Takagi – Gilliam County.

Guests: Fred Schubert, Kathi Hall - Business Manager NCPHD; John Zalaznik NCPHD EH Supervisor; Tyler Stone – Wasco County.

Minutes taken by Gloria Perry

Meeting called to order on January 13, 2015 at 3:03pm by Chair Commissioner Mike Smith.

<u>Summary of Actions Taken</u>

Motion by Judge Shaffer, second by Bill Hamilton, to approve the minutes from the December 9, 2014 Board meeting as presented.

Vote:	6-0
Yes:	Commissioner Smith, Roger Whitely, Bill Hamilton, Judge Shaffer, Commissioner Kramer and Michael Takagi.
No:	0
Abstain:	0

Motion carried.

Welcome and Introductions

Judge Shaffer welcomed and introduced Michael Takagi as the new Gilliam County representative. He is a physician assistant at the South Gilliam County Medical Center.

1. **MINUTES**
   a. Approval of past meeting minutes.
   b. Set next meeting date:
      - The next regular meeting was scheduled for Tuesday, February 10, 2015 at 3 pm. Meeting location will be at the North Central Public Health District, Meeting Room. (419 E. 7th St., The Dalles).

2. **ADDITIONS TO THE AGENDA**

3. **UNFINISHED BUSINESS**
   a. Accreditation Update
      - We received notice from the Public Health Accreditation Board that they would like us to submit an action plan to meet some standards they didn't feel that our documentation met in the initial review and site visit. Jane Palmer (Accreditation

Coordinator) and Teri are working on this. We have until the middle of March to submit the action plan. Once the action plan is accepted, we have one year to complete the activities in the action plan.

b. Fiscal Audit Update
   - Auditors are scheduled to report on the audit at the February 10, 2015 board of health meeting.
   - The auditing firm will be providing an electronic copy of the completed audit but would like to know if paper copies are required as well.
     - As long as the auditors can provide an electronic copy in advance of the February board meeting, the board prefers receiving an electronic copy with the exception of Roger Whitley who requested a paper copy.
     - Kathi will request two (2) paper copies (one for our records and one for Roger).

c. Consideration of Operational Agreements with Wasco County – Update
   - No update provided.

d. HWR Program Transition – Wasco County Update
   - It's very clear that this transfer cannot be done by motion but rather by a resolution. To that end, Wasco County's attorney Dan Olsen is drafting a resolution and will send it to NCPHD's attorney Tom Sponsler for review.
   - Mike Smith is hoping that the resolution will be completed by the February board of health meeting.
   - Mike Smith asked since Wasco County has new legal representation if Wasco County's legal representation regarding this issue will remain with Dan Olsen. Steve Kramer stated yes.
   - Once the resolution is completed and approved, the process and timeline of how to transfer this program to Wasco County will need to be discussed.

4. **NEW BUSINESS**

a. Wasco County's BOCC vote to withdraw from NCPHD
   - Steve Kramer gave a brief recap that at the 12/17/14 Wasco County BOCC meeting they heard a presentation from NCPHD. He stated that NCPHD staff left the meeting after their presentation and shortly thereafter following a lengthy discussion the BOCC opted to explore other options and bring it back in-house and take care of it.
   - Mike Smith stated because he had heard several different things and he wants to make sure every understands it. Wasco County had talked about the possibility of withdrawing at the end of the fiscal year or the beginning of the next calendar year.
   - Steve Kramer said they stated in their motion for 12-months so we would have January to January.
   - Tyler Stone stated, "The idea is because of the challenges in reorganizing everything yet again, and the time it takes to do that we've given notice of our 180-days but we expect that that process is going to take longer than a 180 days. Essentially we've targeted that as a 12-month time period to be able to get everything transitioned from start to finish. While I anticipate that it's going to take longer than 180 days. Once we get past that 180 days I'm hopeful that we are in the process of starting that transfer."

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- Mike Smith stated, "Another thing I read in the papers is that Wasco is talking about having someone do an assessment of the value of public health or is it simply a transition thing."
- Steve Kramer stated, "A little of both. I have personally asked Kathy Schwartz to come forward to help with this project as a private individual and a past director of public health and she has graciously agreed to help us. The next step in that piece, she's going to contact a fellow by the name of Jan Kaplan with Oregon Health Authority and then also send Ms. Thalhofer an email this afternoon and basically layout her next steps and she is going to advise us as we move forward."
- Steve Shaffer stated, "If Kathy Schwartz and Oregon Health Authority comes in and says you've got a great operation here and it makes all the sense in the world for you to go ahead and stay, is there going to be any thought about trying to create solutions to solve whatever problems it is that we have? My understanding up to this point is that we're talking some financial issues. I really haven't felt that it's been pinpointed to myself, maybe some of the other board members, of what the overall concerns are or have them specified to see if we can create solutions. Maybe people have some input on it."
- Steve Kramer stated, "We as a board decided that we would leave all options open. We would listen to dialogue; we would explore all our options. That's where the three of us voted on the 17th to go with. Yes, if Kathy comes back and says she finds something other than our direction at this point, then we'd have to take a look at that. We haven't had an opportunity to visit with this Mr. Kaplan yet."
- Teri stated, "You actually have. Mr. Kaplan has presented at this meeting to you."
- Tyler Stone stated, "I think there is more than the financial; there are a number of other things. If everyone is in the dark then I would be surprised about that going forward. Our ability to control finances is an issue. The governance is an issue. All of those things that we've talked about for really the last five years they have been challenging. I don't think anyone is saying anything about the quality or quantity of services that NCPHD has provided. I think their service has been excellent, but the way that this entity is structured is not working for us."
- Judge Shafer stated, "That would be both the financial and governance structure? There was this discussion about looking at the IGA in a different structure, is that something that we can talk about maybe having some input within this 180-day period or 12-months. It might create some solutions to this."
- Tyler Stone stated "I think everybody is willing to listen to it but I don't know that people have been listening for the past however long, which unfortunately has gotten us to this point. I'm hopeful that we can work through this but there have been some challenges in the past and if everybody's going to sit here and say well we don't recognize that there has been challenges then we're not being honest with ourselves. There have been challenges. That would have to be done, I think, regardless of what happens even if we continue to move forward with Kathy because one of the charges is going to be to really look at the entity and see how we're providing public health services and if we can do it better, faster, cheaper, add more services and if we've got the right mix. All of those kinds of things as part of that analysis. I don't know how the rest of this board feels but we embrace that process because that can make this a better

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entity regardless of who is running it. I would assume that we would still move forward with that process."

- Bill Hamilton stated, "I'm a little confused about the time line. If I understood what you said, you've given a 180-day notice, which is what's required. Have you set a firm time beyond that? Is it December 1, 2015?"
- Tyler Stone replied, "The target date for us would be January 1, 2016 which is 12-months. For me that is the drop-dead date that we need to have all our ducks in row to make any kind of transition. Might some of that happen prior to January 1 – potentially; HHW is a prime example. We would expect that that would be taken care of and done expeditiously. We've been working on that for over a year now and it's still not done."
- Bill Hamilton stated, "Part of the reason I asked this question is, for this board, and the public health entity it's important from a planning point of view to know when that is - to have a definitive "this is the end of it". I don't think it would work very well to say well we think it will be December 31st and then September 1st you say well we've given you the 180-day notice and we've got things worked out now so this is it. From a planning point of view we need something more definitive. I don't know the requirement, but have you officially notified us in writing?"
- Tyler Stone responded, "Yes."
- Mike Smith stated, "I have a question on that too because it didn't exactly follow the IGA agreement 9.1 as you needed to wait until the term expires and it hadn't when you voted to do this and send the notifications out. I got one just recently, I don't know if it was lost in the mail, but I got it after our last court or I would have brought it up so we could discuss it. We'll certainly discuss it at our next board. But I'm not sure what to do with that because you read the IGA instructions it says you need to wait for the term to expire the five years and once it does give a 180-day notice. You can count the days and you would have needed to do a special meeting January 1st or 2nd so I don't know what to do with that."
- Tyler Stone stated, "So we gave you a few extra weeks of notice. Is this board going to make that an issue?"
- Mike Smith stated, "I'm just saying the IGA stated a certain thing."
- Teri Thalhofer stated, "That's not the piece, it's not the notice piece that's the violation of the IGA. The piece that's the violation of what the IGA step sets out is the step that the parties to the IGA have to wait until the initial five-year term ends before they provide notice and Wasco County didn't do that."
- Steve Kramer stated, "Didn't it also state that it automatically rolls over if we don't take action."
- Teri Thalhofer stated, "Absolutely, but it says that you can't take action until it expires."
- Mike Smith stated, "I don't know what to do with that. I'm just pointing out that that was actually probably a mistake. I'm pointing it out because NCPHD's lawyer pointed it out to us and said that's actually not correct but I don't know what you do with that. I'm just stating that didn't exactly follow the IGA."
- Judge Shaffer stated, "In way they sort of are kind of following it based on what I'm hearing today because the five years is June 30th."
- Teri Thalhofer and Mike Smith both stated that no the five years was December 31st.

- Teri Thalhofer stated, “Tom Sponler’s words were the Wasco County action has no legal consequence because it does not follow the terms of the Intergovernmental agreement.”
- Tyler Stone stated, “Once again I’ll ask are you going to enforce that as a board the fact that we did this two weeks early. That’s kind of like saying that we’re going to force an unwilling partner to be a partner.”
- Fred Schubert stated, “It seems to me that an easy solution is send a formal notice now. It’s simply writing another letter or a first letter, which ever the case may be, to fall within the parameters of the IGA. I don’t think anyone here is saying we refuse to take action based on two weeks but if the lawyer points out a legal issue, I think it’s easy enough to address.”
- Tyler Stone stated, “The reason that I ask is because we’ve got some feedback from our attorney today that made it sound like North Central Public Health is going to pursue that issue and also illegal meetings issue and if that’s the case that would be nice to understand.”
- Teri Thalhofer stated, “We haven’t had any meeting taking any action. There hasn’t been a discussion at a public meeting of taking any action.”
- Tyler Stone stated, “But that came from your attorney.”
- Teri Thalhofer stated, “Possibly, but we haven’t spoken to the attorney today.”
- Mike Smith stated, “I’m not trying to hold you into it, I’m just pointing out this mistake. The other issue is that how do you think we serve you if you do withdraw July 1st, how do we continue to be giving you services for that 6-month period or whatever that is – how do we do that as it’s only 6 months away. So when you actually withdraw, legally from there, we have to have a legal way of providing services if you leave the district. If you’re exiting on that date we have to figure out a way to provide services to your public for the rest of that period. Not sure what we do. Perhaps it’s a question for Olsen as well.”
- Tyler Stone stated, “I think that the approach there is we would turn back around and contract for the remaining 180 days for service.”
- Mike Smith stated, “We have to have something in place obviously because we can’t do it with a wink and a nod. Are there any further questions from the board?”
- John Zalaznik stated, “The uncertainty is really disturbing for the employees and I think a lot of employees are going to be leaving. It would be nice to have some guide as to what is going to happen and the sooner the better otherwise I think there will be some fallout.”
- Teri Thalhofer stated, “The reality is, Wasco County leaving does not destroy North Central Public Health District. So that’s a discussion for Sherman and Gilliam County to have about how they intend to move forward for public health services. And this is not a matter of if North Central Public Health District continues to exist everything doesn’t then roll back to Wasco County. It’s not the same process that moved the Wasco County Wasco-Sherman Health Department into North Central Public Health District. It’s not the same process because if North Central Public Health District continues to operate and remain as an entity, everything doesn’t necessarily roll back into Wasco County i.e. policies and procedures, documents, equipment, all of that. And, the IGA doesn’t allow for that.”

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- Steve Kramer stated, "I agree with you 100% on that Teri."
- Tyler Stone stated, "Just to address the employee component. It's one of the reasons we're working with Kathy Schwartz is to work on what a plan would look like, a transition plan, and what this new model would entail, what the services would be, all those kinds of things. So it's not something that I have that I can hand you today but it's something that through the analysis and the evaluation will be developed."
- Mike Smith stated, "Alright, well I guess we do need to move forward. Does this give us some certainty – some idea of timing."
- Teri Thalhofer stated, "No. According to Mr. Sponsler, the IGA does not allow one of the parties to leave at the calendar year, that you are only allowed to leave at the fiscal year."
- Tyler Stone stated, "I hope, again we're able to extend this time line so that we can answer these kinds of issues and work on a smooth transition. If the 180 days is the drop dead deadline then things are going to be significantly different in how we approach the transition between now and 6-months."
- Mike Smith stated, "Yes, I don't know how you can do it that quickly. That would be brutal. Is your counsel Dan Olsen your counsel for all NCPHD issues or simply the HHW transfer issues?"
- Tyler Stone stated, "He's been acting as both because of the transition we're making him legal counsel; whether he'll continue on the public health side or not, that has yet to be determined. He's probably most certainly on the HHW side because he's been so involved with that process."
- Mike Smith stated, "The reason I ask that is because obviously we only meet once a month and it would be great if counsel could ask how do you contract, what does that mean, how would that work, how does that work within the IGA to someone who is already experienced in working in this. Or if not, then to talk to the right person so that they understand how that would work and what you do to make that work. Because the work has to be done right now, we can't wait month after month and then figure out what to do at the very last moment."
- Mike Smith asked if there are any further questions or comments.
- Roger Whitely asked if we are going to get a letter.
- Teri Thalhofer stated, "The board isn't a party to the IGA. Notification would go to the county courts."
- Teri asked the board for direction about working with Kathy Schwartz and Jan Kaplan.
- Mike Smith asked, "So this is in place now? She's going to be reviewing this or auditing - how do we work with her?"
- Steve Kramer stated, "She's going to contact Teri and have a chat with her as we look at and assess as we move forward."
- Mike Smith stated, "Do you know how much time, any idea of how much time she may have dedicated to that being that there is still public health work to do and there is only so much time in the day. So do you know how much time she is going to need, any clue or any idea?"
- Tyler Stone stated, "I think she is really going to need to sit down and have that discussion with North Central Public Health to be able to evaluate what it's going to take to start that process because it's an interviewing process between the two."

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- Teri Thalhofer stated, “So who are you referring to? You’re not referring to this board as North Central Public Health, you’re referring to me.”
- Tyler Stone stated, “Yah, it’s going to be you and Kathy.”
- Teri Thalhofer stated, “So how much time am I supposed to dedicate to this, is my question. We’re trying to get accreditation on board, we’ve got budget coming besides the work of public health, we’ve got targeted case management transition, we’ve got the CCO work.”
- Mike Smith stated, “That’s what I’m trying to point out, there is only a certain amount of time.”
- Steve Kramer stated, “Maybe after you read her email, then maybe you’ll know. I don’t know. She was going to contact Teri. She told me that today.”
- Mike Smith stated, “Okay, hopefully she can shed some light. Hopefully she can respect that there is a limited amount of time. Certainly be available and answer whatever questions you can but there is a certain amount of time in the day to do that and the work at hand as well. I don’t know if you can pull her out 2 or 3 days a week to try to do this kind of work.”
- Tyler Stone stated, “I don’t think that’s our intention to try and do that. There’s obviously some discovery that has to happen as part of that process, but after that discovery is done, we’re really, at that point, relying on Kathy to take that piece and move forward.”
- Teri Thalhofer stated, “Is there a contract in place with Kathy Schwartz so that you have a dedicated amount of time that she’s contracted to work on this process?”
- Tyler Stone stated, “No, she’s volunteering.”
- Steve Kramer stated, “She’s volunteering her services.”
- Fred Schubert stated, “Are you holding any public hearings or surveying community partners of public health, etc.?”
- Steve Kramer stated, “As we move forward.”
- Fred Schubert stated, “So not yet.”
- Mike Smith asked if there are any further questions. No further questions at this time.

b. Pioneer Potlatch
- John wanted the board to be aware of this concern of Pioneer Potlatch.
- He reviewed with the board the complaint received regarding the inspection fee now being charged for inspections of benevolent organizations and what his response was to that complaint.

c. Contracts Review
- Teri gave a brief explanation of the following contracts:
    - Direct-Compliant Certification
    - MCOC MOU (March of Dimes Grant)
    - MOU 2014 (March of Dimes Grant)
    - OCDC 02-031-2
    - PCS
    - Pauly Rogers & Co (Website Agreement)

d. Director’s Report
- No report.

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Motion to adjourn was made and the meeting was adjourned at 3:50p.m.

{Copy of 12/9/14 board of health meeting minutes, Letter from Pioneer Potlatch, Letter to Pioneer Potlatch, Direct-Compliant Certification contract, MCOC MOU, One Community Health MOU, OCDC contract, PSC contract, and Pauly, Rogers and Co Website Agreement attached and made part of this record.}

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Mid-Columbia Fire and Rescue

Form: Fire & Life Safety (Group B)

Occupancy: **North Central Public Health**
Address: **419 E 7th ST Apt/Suite #100**
The Dalles OR 97058

Inspection Type: **2nd Re-Inspection**
Inspection Date: **1/2/2015** By: HAMMEL, Daniel R (3)
Time In: **00:00** Time Out: **00:00**
Authorized Date: **Not Author** By:
Next Inspection Date: **No Inspection Scheduled**

Inspection Topics:

MEANS OF EGRESS

Minimum Number of Exits

Two exits or exit access doorways from any space shall be provided when the occupant load is 50 or more than the values listed in the code.

Status: PASS

Notes: Annex C:
-Two means of egress are required from the building. Exception allowing a single exit on a second floor, requires that the calculated occupant load to be 29 or less occupants and a maximum travel distance of 75 feet.
The use of the front exit to accommodate a second exit will require that all doorways have a single motion lock and that the exit path have illumination as required by code.

08/26/2014: In Process/Crash Bar on Door to Front Entrance to be Installed

Exit Signs/Illumination

Exit signs shall be illuminated at all times.

Status: PASS

Notes: Required exit signs shall be illuminated at all times. Self illuminated signs which are designed to provide a minimum of 30 minutes illumination shall be used when substituted for illuminated signs. Self illuminated signs shall be replaced per manufacturers recommendations (10 years). Glow in the dark plastic signs do not meet the intent of the code.

08/26/2014: In Process

FIRE PROTECTION SYSTEMS

Fire Extinguishing Systems/Inspection, Testing & Maintenance

Fire extinguishing systems shall be inspected, tested and maintained in accordance with applicable NFPA Standard.

Status: PASS

Notes: Fire Extinguishers shall be inspected monthly and documented on back of attached tag. Monthly inspections consist of ensuring that the pressure is correct, safety pin is in place and that the extinguisher appears to be visibly ready for use.

HOUSEKEEPING

Combustible Materials Storage/Ceiling Clearance

Storage shall be maintained a minimum of 2 feet below the ceiling.

Status: PASS

Notes: Annex C:(Storage Room)
-Maintain 24" clearance between combustible storage and ceiling on center shelving unit.

FIRE PROTECTION

Fire Resistance Rated Construction/Maintenance

Fire resistance rated construction shall be maintained.

Status: PASS

Notes: Annex C: (Storage Room)
-Ceiling tiles missing
-Wall penetration in closet

Additional Time Spent on Inspection:

Category	Start Date / Time	End Date / Time

Notes: No Additional time recorded

Total Additional Time: 0 minutes

Inspection Time: 0 minutes

Total Time: 0 minutes

Summary:

Overall Result: Resonable Degree of Fire Safety Exists

Inspector Notes:

2 Hazards Abated
All Previously Noted Hazards Abated

Inspector:

Name: HAMMEL, Daniel R
Rank: Division Chief/EMT-B
Work Phone(s): None on file
Email(s): dhammel@mcfr.org

PUBLIC HEALTH DIVISION
Office of the State Public Health Director, Community Liaison
John A. Kitzhaber, MD, Governor

Oregon Health Authority
800 NE Oregon Street, Suite 930
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January 9, 2015

The Honorable Michael Smith
Sherman County Commissioner
Chair, North Central Public Health District Board
PO Box 365
Moro, OR 97039

Dear Commissioner Smith:

The triennial onsite agency review of North Central Public Health District (NCPHD) was conducted between March 5 and April 11, 2014. The compliance findings in the review are based on federal or state statutes or rules, contract requirements, or specific minimum standards agreed to by the local health departments in Oregon.

A letter listing items that needed correction was sent to you after the review (copy enclosed). Teri Thalhofer, Public Health Director, was provided a document listing the specific items and the time frame for correction.

I am very please to write you this letter thanking you and your staff for resolving all of the compliance findings.

Sincerely,

Jan Kaplan, MSW, Manager
Office of Community Liaison

cc: David Anderson, NCPHD Board
William Hamilton, NCPHD Board
Dave Jones, NCPHD Board
Steve Kramer, Wasco County Commissioner
Fred Schubert, NCPH Board
Steve Shaffer, Gilliam County Judge
Carrie Ramsey-Smith, NCPHD Board
Teri Thalhofer, Public Health Director
Roger Whitley, NCPHD Board

Regional Health Equity Coalitions

Project Profile: This project was funded by the Oregon Health Authority's Office of Equity and Inclusion.From 2006-2012, the Northwest Health Foundation funded NCS to support Latinos in finding their voices and be heard as advocates for improved health at a policy level. The project was first called La Voz Latina/The Latino Voice, and later changed to Nuestra Voz, Nuestra Salud/Our Voice, Our Health.

A Latino needs assessment completed in 2007 identified obesity/diabetes as the most pressing health issue and Latino community members decided to advocate for culturally appropriate physical activity and healthy eating policies. That's how Mid-Columbia Health Equity Advocates (MCHEA) was created. MCHEA was started from scratch and created to learn about challenges and issues related to health equity, how to advocate, and how a bill becomes a law. Community members became advocates and got very involved in making long lasting changes, on related health issues. Additionally state and private funding provided opportunities to capture MC Latinos' input on cultural competency issues through listening sessions and to build the capacity of MCHEA's grass root members. MCHEA volunteers have advocated for legislative bills that impacted the health of MC Latinos such as cultural competency in health care, expansion of Oregon's Citizen Alien Waived Emergency Medical (CAWEM), undocumented residents' drivers licensing and tuition equity for undocumented students.

As the staffing agency of MCHEA, NCS has collaborated with numerous community partners to positively impact thousands of MC Latinos. With the many changes healthcare systems are confronted with, it is of the utmost importance to address the health disparities that are faced by some of our most vulnerable residents: low income individuals, Latinos and migrant/seasonal farmworkers. The need to build capacity among decision makers, agency representatives and individuals to address health disparities is at a critical stage. By establishing policies and protocols from the onset that include addressing social determinants as well as ensuring that services are provided in a culturally competent manner, all residents will have access to quality healthcare.

Purpose of RHEC: The role of our regional coalition is to work together towards achieving health equity, and engaging community, stakeholders and all people to participate in eliminating health disparities and promoting health. RHEC's willunderstand policy influence and also help in spreading awareness and raising consciousness about health equity issues surrounding our communities.

NCS' proposed Mid Columbia Health Equity Advocates (MCHEA) Regional Health Equity Coalition will:

1) Expand MCHEA's membership and gather and convene most CHWs that are, or provide services to, Latinos, low income individuals and/or migrant/seasonal farmworkers – from the major providers of services, information and resources related to social determinants of health in the PacificSourceCCO Columbia Gorge Region (Wasco & Hood River Counties);
2) Compile community assessment data as related to health disparities and health promotion,
3) Assess MCHEA RHEC participants' knowledge of health equity and social determinants of health and other health promotion policies, as well as analyze current health promotion systems to learn how to enact population level change;
4) Build capacity in MCHEA RHEC participants, based on assessment results, to advocate for issues related to reducing health disparities and take action on social determinants of health to facilitate health equity for low income individuals, Latinos and/or migrant/seasonal farmworkers;
5) Gather and report MCHEA RHEC participants' input on how to change systems;
6) Build trust, provide input and serve in an advisory capacity in regard to health equity related issues with the OHA Transformation Center, CCO's Board (Columbia Gorge Health Council), CCO-CAC, CCO-CAP and other decision makers;
7) Select and prioritize strategies to enact population level changes, and make necessary changes to enforce policies that already address health disparities, by developing a regional strategic health equity plan;
8) Monitor progress of plan goals, objectives and activities, as well as the progress of advocacy work done at micro and macro levels within county, CCO and OHA;
9) Change systems through policies – joining others throughout Oregon with shared advocacy initiatives to promote health equity.

Coalition member responsibilities: commitment will be around 4-6 meetings a year to share and be the oversight body to carry out the tasks Nuestra Comunidad Sana is responsible for. Compensation will be gas money, and dinner for every meeting.

Taskforce member responsibilities: commitment will be around 10-12 meetings a year to sharetheir experiences and stories related to health equity and health disparities. Compensation will be gas money, and dinner for every meeting.

Why Regional Health Equity Coalitions?

One in five Oregonians is a person of color and within the Oregon Health Plan, people of color comprise 40 percent of the client base. These growing populations, however, continue to experience gross health disparities that are costing our system in lives and dollars. In order to improve health for all of Oregon's communities, we must support local, culturally-specific activities. As members of the diverse communities in which they reside, Regional Health Equity Coalitions are uniquely positioned to engage communities in understanding and advancing their health priorities and ultimately, eliminating health disparities.

What are the anticipated outcomes?

During their first year of funding, each RHEC utilized community outreach, education and engagement; equity and cultural competency training; collaboration and coordination; earned media to advance policies that reduce health disparities and promote health equity. They culminated year one of the grant with the development of a five-year plan for achieving equity and eliminating disparities through the development of culturally specific programs and policies.

As Regional Health Equity Coalitions continue to engage their communities, they will seek to achieve the following outcomes:

- Increased awareness of the significance of health disparities, their impact on the state, and the actions necessary to improve health outcomes for racial and ethnically diverse and underserved populations
- Increased capacity and leadership for addressing health disparities at all levels
- Improved data availability, and coordination, utilization, and diffusion of research and evaluation outcomes
- Increased coordination across health and other social support entities to collaborate on cross-cutting community wide issues.
- Implementation of policies at local, regional and state level that reduce health disparities and promote health equity.

What are opportunities to partner with the RHECs?

Through their five-year plans, each RHEC has identified community priorities for improving health outcomes. OHA programs and other entities can partner with RHECs and support them in implementing aspects of their plans. Working together, government programs and local community leaders can eliminate disparities in Oregon.

NORTH CENTRAL PUBLIC HEALTH DISTRICT

7/1/2014 through 12/31/2014

Account Number			Adjusted Estimate	Year to Date	REV - EXP	Balance	Prct Rcvd	Comments
201.00.1201	PUBLIC HEALTH RESOURCES			512			**0.21**	
201.23.7141	PUBLIC HEALTH	**REV**	664,019	389,412		274,607	**58.64**	
		EXP	559,340	268,434	120,978	290,906	**47.99**	
201.23.7142	WIC	**REV**	173,808	83,948		89,860	**48.30**	*OHA Dec rcvd in Jan
		EXP	166,910	92,028	-8,080	73,764	**55.81**	
201.23.7143	MCH - CAH	**REV**	83,516	30,313		53,203	**36.30** *	
		EXP	123,805	54,711	-24,398	69,094	**44.19**	Bal. is within bugdeted amount
201.23.7144	REPRODUCTIVE HEALTH	**REV**	301,125	128,135		172,990	**42.55** *	
		EXP	364,028	191,161	-63,027	172,867	**52.51**	Not within budget due to $30k red. In CCARE Jul-Dec 2014 compared to Jul-Dec 2013.
201.23.7145	STATE SUPPORT	**REV**	47,708	23,352		24,356	**48.95** *	
		EXP	47,170	22,650	702	24,520	**48.02**	
201.23.7146	ENVIRONMENTAL HEALTH	**REV**	94,300	62,421		31,879	**66.19**	
		EXP	68,314	30,524	31,897	37,790	**44.68**	
201.23.7148	PERINATAL HEALTH	**REV**	94,682	69,648		25,034	**73.56**	Medicaid Match amt.$28,882 for 3 Qtr.
		EXP	80,245	32,057	37,591	48,187	**39.95**	
201.23.7149	PHEP	**REV**	159,974	60,600		99,374	**37.88**	
		EXP	167,928	75,423	-14,823	92,505	**44.91**	
201.23.7152	HEALTH PROMOTION	**REV**	44,486	24,065		20,421	**54.09**	CCO & MOD grants
		EXP	44,399	15,583	8,482	28,816	**35.10**	
201.23.7153	IMMUNIZATION SPECIAL PAYMENTS	**REV**	18,418	8,970		9,448	**48.70** *	
		EXP	15,701	8,193	777	7,508	**52.18**	
201.23.7154	CACOON & CCN	**REV**	23,800	21,528		2,272	**90.45**	Amt. Incl AR invoices for 2014
		EXP	32,042	13,687	7,841	18,355	**42.72**	
201.23.7155	TOBACCO PREV & ED (OHA $93,666	**REV**	132,266	36,830		95,436	**27.85** *	
	(Tob Grant PHN II $35,849)	**EXP**	145,374	33,609	3,221	111,765	**23.12**	Bud amt incl. Tob. Grant

NORTH CENTRAL PUBLIC HEALTH DISTRICT

Account Number		Adjusted Estimate	Year to Date	REV - EXP	Balance	Prct Rcvd	Comments
201.23.7156 WATER	REV	42,184	21,078		21,106	**49.97** *	
	EXP	44,254	24,103	-3,025	20,150	**54.47**	
201.23.7158 BABIES FIRST	REV	85,825	100,841		-15,016	**117.50**	Rev. incl. Jan - June 2014 TCM
	EXP	142,997	88,622	12,219	54,374	**61.98**	
201.23.7159 OREGON MOTHERS CARE	REV	8,701	4,068		4,633	**46.75** *	
	EXP	12,552	6,614	-2,546	5,938	**52.69**	
201.23.7500 PASS THROUGH	REV	3,900	5,800		-1,900	**148.72**	
	EXP	3,900	4,900	900	-1,000	**125.64**	
201.23.7999 NON-DEPARTMENTAL		0	0			**0.00**	
		204,238			204,238	**0.00**	
TOTAL FUND 201	REV	2,223,195	1,071,521		907,703	**54.13**	
	EXP	2,223,195	962,300	109,220			
207.23.7207 HAZARDOUS WASTE & RECYCLING							
	REV	479,739	23,320		287,880	**7.49**	
	EXP	479,739	118,557	-95,237	361,182	**24.71**	
	2014 unadited Ending Balance			84,679			
				-10,558			Recvd $33k Wasco Transfer in Feb.

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into 21st day of November, 2014 ("Effective Date") by and between Jefferson Health Information Exchange (the "Business Associate") and North Central Public Health District, ("Covered Entity") (each a "Party" and collectively the "Parties").

RECITALS

WHEREAS, the Parties have entered or may enter into one or more agreement(s) ("Services Agreement") pursuant to which Business Associate provides Health Information Exchange services ("Services") to the Covered Entity that require the creation, disclosure and use of Protected Health Information;

WHEREAS, both Parties are committed to complying with requirements of the HIPAA privacy standards set forth in Section 45 CFR, Section 164.504 ("Privacy Rule"), and the HIPAA Security Standards for Business Associate Contracts set forth in Section 45 CFR 164.314 ("Security Standards"), and the requirements and guidance issued by United States Department of Health and Human Services ("HHS") pursuant to the Health Information Technology Act of 2009, as codified at 42 U.S.C.A. prec. § 17901 (the "HITECH" Act);

WHERAS, this Agreement sets forth the terms and conditions pursuant to which Protected Health Information that is provided by, or created or received by, the Business Associate from or on behalf of the Covered Entity ("Protected Health Information"), will be handled between the Business Associate and the Covered Entity and with third parties during the term of each Services Agreement and after its termination;

WHEREAS, Covered Entity wishes to ensure that Business Associate will appropriately safeguard Individually Identifiable Health Information;

NOW THEREFORE, in consideration of the mutual covenants, promises and agreements contained herein, the Parties hereby agree as follows:

1. **DEFINITIONS**: terms used but not otherwise defined in this Agreement shall have the same meaning as the meaning ascribed to those terms in the Health Information Portability and Accountability Act of 1996, codified as 42 U.S.C. §1320d ("HIPAA"), the Health Information Technology Act of 2009, as codified at 42 U.S.C.A. prec. § 17901 (the "HITECH" Act), and any current and future regulations promulgated under HIPAA or HITECH.

   1.1. **"Breach"** shall mean the acquisition, access, use or disclosure of Protected Health Information in a manner not permitted under 45 C.F.R. Part 164, Subpart E (the "HIPAA Privacy Regulations") which compromises the security or privacy of the Protected Health Information. "Breach" shall not include:

      1.1.1. Any unintentional acquisition, access, or use of Protected Health Information by a workforce member or person acting under the authority of Covered Entity or Business Associate, if such acquisition, access or use was made in good faith and within the scope

of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy Regulations; or

1.1.2. Any inadvertent disclosure by a person who is authorized to access Protected Health Information at Covered Entity or Business Associate to another person authorized to access Protected Health Information at Covered Entity or Business Associate, respectively, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Regulations; or

1.1.3. A disclosure of Protected Health Information where Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

1.2. **"Designated Record Set"** shall have the same meaning as the term "designated record set" in 45 C.F.R. § 164.501, as such provision is currently drafted and as it is subsequently updated, amended or revised. This means a group of records maintained by or for a Covered Entity that is;

1.2.1. The medical and billing records about Individuals maintained by or for a covered health care provider;

1.2.2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

1.2.3. Information used in whole or in part by or for the Covered Entity to make decisions about Individuals.

1.3. **"Electronic Protected Health Information"** or "Electronic PHI" means Protected Health Information that is transmitted by or maintained in electronic media as defined by the HIPAA Security Regulations.

1.4. **"Health Care Operations"** shall have the same meaning as the term "health care operations" in 45 C.F.R. § 164.501, as such provision is currently drafted and as it is subsequently updated, amended or revised.

1.5. **"HIPAA Privacy Regulations"** shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E.

1.6. **"HIPAA Security Regulations"** shall mean the Standards for Security of Individually Identifiable Health Information at 45 C.F.R. part 160 and subparts A and C of part 164.

1.7. **"HITECH Standards"** means the privacy, security and security Breach notification provisions applicable to a Business Associate under Subtitle D of the HITECH Act and any regulations promulgated thereafter.

1.8. **"Individual"** shall have the same meaning as the term "individual" in 45 C.F.R. §164.501 as such provision is currently drafted and as it is subsequently updated, amended or revised, and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. §164.502(g).

1.9. **"Privacy Officer"** shall have the same meaning as the term "privacy officer" in 45 C.F.R. §

164.530(a)(1), as such provision is currently drafted and as it is subsequently updated, amended or revised.

1.10. **"Protected Health Information" or "PHI"** shall have the same meaning as the term "protected health information" in 45 C.F.R. §160.103 (as amended by the HITECH Act), limited to the information created or received by Business Associate from or on behalf of Covered Entity including, but not limited to Electronic PHI, which means identifiable health information that is transmitted by or maintained in electronic media.

1.11. **"Required by Law"** shall have the same meaning as the term "required by law" in 45 C.F.R. § 164.501, as such provision is currently drafted and as it is subsequently updated, amended or revised.

1.12. **"Secretary"** shall mean the Secretary of the Department of Health and Human Services or his/her designee.

1.13. **"Unsecured Protected Health Information"** shall mean Electronic PHI that is not secured through the use of technology or methodology specified by the Secretary in regulations or as otherwise defined in section 13402(h) of the HITECH Act.

1.14. **"Unsuccessful Security Incidents"** include activity such as pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of Electronic PHI.

1.15. **"Timely Notice"** shall mean within 24 hours.

2. OBLIGATIONS OF BUSINESS ASSOCIATE:

2.1. Limited Use or Disclosure of PHI. Business Associate, its directors, officers, subcontractors, employees, affiliates, agents, and representatives agrees not to use or further disclose PHI other than as permitted or required by the Agreement or as required by law; and shall not use or disclose PHI in any manner that violates applicable federal and state laws or would violate such laws if used or disclosed in such manner by Covered Entity. Business Associate may:

2.1.1. Use or disclose PHI only in connection with fulfilling its duties and obligations under this Agreement and the Service Agreement and disclose PHI to perform the services agreed to by the Parties;

2.1.2. Use or disclose PHI for the proper management and administration of Business Associate or in accordance with its legal responsibilities pursuant to the Service Agreement;

2.1.3. Use PHI to provide data aggregation services relating to health care operations of Covered Entity;

2.1.3.1. Business Associate may aggregate the PHI in its possession with the PHI of other covered entities that the Business Associate has in its possession through its capacity as a Business Associate to said other covered entities provided that the

purpose of such aggregation is to provide the Covered Entity with data analyses relating to the Health Care Operations of the Covered Entity. Under no circumstances may the Business Associate disclose PHI of one Covered Entity to another Covered Entity absent the explicit authorization of the Covered Entity or for the purpose of health information exchange as specified in the terms and conditions of the Memorandum of Understanding and by law.

2.1.4. Use or disclose PHI to report violations of the law to law enforcement; or,

2.1.5. Use PHI to create de-identified information provided that the de-identification conforms to the requirements of 45 C.F.R. § 164.514(b), and further provided that the Covered Entity maintains the documentation required by 45 C.F.R. § 164.514(b) which may be in the form of a written assurance from the Business Associate. Pursuant to 45 C.F.R. § 164.502(d)(2), de-identified information does not constitute PHI and is not subject to the terms of this Agreement.

2.2. Disclosure to Subcontractors and Third Parties. Business Associate agrees to require any subcontractor or third party to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity, to agree to the same restrictions, terms and conditions that apply to Business Associate pursuant to this Agreement with respect to such PHI. Business Associate shall incorporate this requirement in writing into any agreement between Business Associate and any of its subcontractors. Covered Entity reserves the right to review documentation and other evidence of compliance with this requirement.

2.3. Safeguards. Business Associate agrees to comply with all applicable federal and state laws and regulations relating to maintaining and safeguarding the confidentiality of PHI and implement administrative, physical and technical safeguards, consistent with the size and complexity of Business Associate's operations that reasonably and appropriately protect the confidentiality, integrity and availability of the PHI that it creates, receives, maintains or transmits on behalf of Covered Entity.

2.3.1. Business Associate shall comply with Safeguards, including Administrative (as defined in 45 C.F.R. 164.308), Physical (as defined in 45 C.F.R. 164.310), Technical (as defined is 45 C.F.R. 164.312, and Procedure and Documentation Requirements (as defined in C.F.R. 45/164.316) as of the applicable dates pursuant to HIPAA and HITECH and their respective implementing regulations. Such safeguards shall include, without limitation, implementing written policies and procedures in compliance with HIPAA and HITECH, and conducting a security risk assessment.

2.3.2. Business Associate shall provide adequate and training to Business Associate employees and subcontractors who will have access to PHI with respect to the policies and procedures required by HIPAA and HITECH to ensure compliance with this section.

2.4. Mitigation. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Association in violation of this Agreement.

2.5. Notice of Use or Disclosure, Security Incident or Breach. Business Associate agrees to provide timely notice to the designated Privacy Officer of the Covered Entity of any use or disclosure of PHI by Business Associate not permitted by this Agreement, any Security Incident (as defined in

45 C.F.R. §164.304) involving Electronic PHI, and any Breach of Unsecured PHI without unreasonable delay, but in no case more than five (5) days following discovery of breach and/or receipt of such information from a subcontractor.

2.5.1. Business Associate shall provide the following information in such notice to Covered Entity:

2.5.1.1. The identification of each Individual whose PHI has been or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such Breach;

2.5.1.2. A description of the nature of the Breach including the types of unsecured PHI that were involved, the date of the Breach and the date of discovery;

2.5.1.3. A description of the type of unsecured PHI acquired, accessed, used or disclosed in the Breach (e.g., full name, social security number, date of birth, etc.);

2.5.1.4. The identity of the person who made and who received (if known) the unauthorized acquisition, access, use or disclosure;

2.5.1.5. A description of what the Business Associate is doing to mitigate the damages and protect against future breaches; and

2.5.1.6. Any other details necessary for Covered Entity to assess risk of harm to Individual(s), including identification of each Individual whose unsecured PHI has been breached and steps such Individuals should take to protect themselves.

2.5.2. Business Associate agrees that notice to Covered Entity shall not be delayed due to lack of all the elements listed above.

2.5.3. In the event of a Breach, Business Associate shall, in consultation with Covered Entity, mitigate, to the extent practical, any harmful effect of such Breach that is known to Business Associate.

2.5.4. Business Associate agrees to establish procedures to investigate the Breach, mitigate losses, and protect against any future Breaches, and to provide a description of these procedures and the specific findings of the investigation to Covered Entity in the time and manner reasonably requested by Covered Entity.

2.6. The Parties agree that this section satisfies any notice requirements of Business Associate to Covered Entity of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined above) for which no additional notice to Covered Entity shall be required.

2.7. Access of Individuals to PHI. In the event that Business Associate maintains PHI in a Designated Record Set, Business Associate shall within five (5) days of a request by Covered Entity for access to PHI about an individual, make available to Covered Entity such PHI for so long as such information is maintained. In the event any individual or their authorized representative/designee requests access to PHI directly from Business Associate, Business Associate shall within two (2) days forward such requests to Covered Entity. Any denial of access to the PHI requested shall be the responsibility of Covered Entity. Business Associate may charge Covered Entity or Individual for the actual labor cost involved in providing such

access. Business Associate and Covered Entity agree to work cooperatively to meet applicable requirements under 45 CFR Section 164.524.

2.8. Ownership. Business Associate acknowledges that, as between Business Associate and Covered Entity, all PHI shall be and remain the sole property of Covered Entity, including any and all forms thereof developed by Business Associate in the course of its fulfillment of its obligations pursuant to the Agreement and Service Agreement.

2.9. Amendments. Business Associate agrees to provide the necessary tools such that Covered Entity may make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees, upon request by an Individual, pursuant to 45 C.F.R. § 164.526. Provided, however, that at the Covered Entity makes the determination that the amendment(s) are necessary because the PHI that is the subject of the amendment(s) has been, or could foreseeably be, relied upon by the Business Associate's users or others to the detriment of the Individual who is the subject of the PHI to be amended.

2.10. Disclosure of Practices, Books and Records. Business Associate agrees to make internal practices, books and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity, available within 14 days to Covered Entity or the Secretary and other regulatory and accreditation authorities in a time and manner designated by the Covered Entity or Secretary, for the purposes of the Secretary in determining the Parties' compliance with HIPAA, the HITECH Act and corresponding regulations, , subject to attorney-client and other applicable legal privileges.

2.10.1. Notwithstanding this provision, no attorney-client, accountant-client or other legal privilege will be deemed waived by Business Associate or Covered Entity as a result of this subsection.

2.10.2. Business Associate shall provide Covered Entity with a copy of its written information security policy/procedure upon request.

2.11. Accounting of Disclosures. Business Associate agrees to provide to Covered Entity an accounting of each PHI disclosure made by Business Associate or its users, employees, agents, representatives, or subcontractors, including disclosures made for treatment, payment and health care operations. The accounting shall be made within a reasonable amount of time upon receipt of a request from Covered Entity.

2.11.1. Business Associate shall implement a process that allows for an accounting to be collected and maintained for any disclosure of PHI for which Covered Entity is required to maintain. Business Associate shall include in the accounting: (a) the date of the disclosure; (b) the name, and address if known, of the entity or person who received the PHI; (c) a brief description of the PHI disclosed; and (d) a brief statement of the purpose of the disclosure. For each disclosure that requires an accounting under this section, Business Associate shall document the information specified in (a) through (d), above, and shall securely retain this documentation for six (6) years from the date of the disclosure.

2.12. Security of Electronic Protected Health Information.

2.12.1. Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of Electronic PHI that it creates, receives, maintains or transmits on behalf of Covered Entity;

2.12.2. Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and,

2.12.3. Report to the Covered Entity any security incidents of which it becomes aware.

2.12.4. Business Associate shall also comply with any additional security requirements contained in HITECH or subsequent rules promulgated by HHS that are applicable to Business Associates.

2.13. Minimum Necessary. Business Associate agrees to limit its uses and disclosures of and requests for PHI:

2.13.1. When practical, to the information making up a Limited Data Set; and,

2.13.2. In all other cases subject to the requirements of 45 C.F.R. §164.502(b), to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

2.14. Permitted Uses and Disclosures. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity provided that such use or disclosure would not violate HIPAA or the HITECH Act if done by the Covered Entity. Uses or disclosure for research are not permitted without prior approval by the Covered Entity.

3. **OBLIGATIONS OF COVERED ENTITY:**

3.1. Use and Disclosures. Covered Entity warrants that its directors, officers, subcontractors, employees, affiliates, agents, and representatives: (I) shall comply with the Privacy Standards in its use or disclosure of PHI; (2) shall not use or disclose PHI in any manner that violates applicable federal and state laws; and (3) may request Business Associate to disclose PHI directly to another Party only for the purposes allowed by the Privacy Rule. The provisions of this subsection shall survive the termination of this Agreement.

3.2. Notice of Privacy Practices of Covered Entity. Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 C.F.R. §164.520, as well as any changes to such notice and any limitation(s) that may affect Business Associate's use or disclosure of PHI .

3.3. Changes in the Use of PHI. Covered Entity agrees to notify Business Associate of any changes in, or revocation of permission or consent authorization by an Individual to use or disclose PHI, pursuant to 45 C.F.R. § 164.506 or § 164.508, to the extent such changes or revocation affects Business Associate's use or disclosure of PHI.

3.4. Appropriate Requests. Except as otherwise provided in this Agreement, Covered Entity will not ask Business Associate to use or disclose PHI in any manner that would violate the HIPAA

Privacy Regulations or the HITECH Act of done by Covered Entity.

3.5. Breach Notification. Covered Entity will be responsible for providing notification to Individuals whose unsecured PHI has been disclosed, as well as the Secretary and the media in certain cases, as required by HIPAA and the HITECH Act.

3.6. Amendment. Covered Entity will notify the Business Associate, in writing, of any amendment(s) to the PHI in the possession of the Business Associate that the Business Associate shall make and inform the Business Associate of the time, form and manner in which such amendment(s) shall be made.

3.7. Access of Individuals to PHI. Covered Entity agrees to notify the Business Associate, in writing, of any PHI that Covered Entity seeks to make available to an Individual or their authorized representative/designee pursuant to 45 C.F.R. § 164.524 and the time, manner and form in which the Business Associate shall provide such access.

4. **REPRESENTATIONS AND WARRANTIES:** Each Party represents and warrants to the other Party:

4.1. That it is duly organized, validly existing, and in good standing under the laws of the jurisdiction in which it is organized or licensed, it has the full power to enter into this Agreement and to perform its obligations here under, and that the performance by it of its obligations under this Agreement have been duly authorized by all necessary corporate or other actions and will not violate any provision of any license, corporate charter or bylaws.

4.2. That neither the execution of this Agreement, nor its performance hereunder, will directly or indirectly violate or interfere with the terms of another agreement to which it is a party, or give any governmental entity the right to suspend, terminate, or modify any of its governmental authorizations or assets required for its performance hereunder. Each Party represents and warrants to the other Party that it will not enter into any agreement the execution and/or performance of which would violate or interfere with this Agreement.

4.3. That it is not currently the subject of a voluntary or involuntary petition in bankruptcy, does not currently contemplate filing any such voluntary petition, and is not aware of any claim for the filing of an involuntary petition.

4.4. That all of its employees, agents, representatives and members of its workforce, whose services may be used to fulfill obligations under this Agreement are or shall be appropriately informed of the terms of this Agreement and are under legal obligation to each Party, respectively, by contract or otherwise, sufficient to enable each Party to fully comply with all provisions of this Agreement including, without limitation, the requirement that modifications or limitations that the Covered Entity has agreed to adhere to with regards to the use and disclosure of PHI of any individual that materially affects and/or limits the uses and disclosures that are otherwise permitted under the Privacy Rule will be communicated to the Business Associate, in writing, and in a timely fashion.

4.5. That it will reasonably cooperate with the other Party in the performance of the mutual obligations under this Agreement.

4.6. Business Associate will verify through the U.S. Department of Health and Human Services Office

of Inspector General's List of Excluded Individuals/Entities that none of its current or future members, shareholders, directors, officers, agents, employees or workforce members have been excluded from participation in Medicare, Medicaid, or other Federal healthcare programs. Business Associate further agrees to notify the Covered Entity immediately after the Business Associate becomes aware that any of the foregoing representations and warranties may be inaccurate or may become incorrect.

5. <u>TERMS AND TERMINATION</u>

5.1. <u>Term</u>. The Term of this Agreement shall be effective as of the date set forth above. It shall remain in effect until such time either party terminates the Agreement and when all PHI provided by Covered Entity to Business Associate or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy PHI, protections are extended to such information, in accordance with the terms of this Agreement.

5.2. <u>Termination for Cause</u>. As provided for under 45 C.F.R. § 164.504(e)(2)(iii), upon either Party's determination that the other Party has committed a violation or material breach of this Agreement, the non-breaching Party may take one of the following steps:

5.2.1. Provide an opportunity for the breaching Party to cure the breach or end the violation upon mutually agreeable terms, and if the breaching Party does not cure the breach or end the violation to the satisfaction of the non-breaching Party within twenty (20) days time, terminate this Agreement. Failure to cure in the manner set forth in this paragraph is grounds for the immediate termination of this Agreement and any Services Agreement;

5.2.2. Immediately terminate this Agreement if the other Party has committed a material breach of this Agreement or cure of the material breach is not possible; or

5.2.3. If neither cure nor termination is feasible, elect to continue this Agreement and the non-breaching Party shall report the violation or material breach to the Secretary in accordance with the requirements set forth under 45 C.F.R. § 164.504(e)(I)(ii).

5.3. <u>Effect of Termination</u>.

5.3.1. Upon termination of this Agreement for any reason, Business Associate agrees to return or destroy all PHI received from Covered Entity that it maintains in any form within 180 days of termination, pursuant to 45 C.F.R. § 164.504(e) (2)(ii)(I). This provision shall also apply to PHI that is in the possession of subcontractors or agents of Business Associate.

5.3.2. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification in writing of the conditions that make return or destruction infeasible. Said notification shall include: (i) a statement that the Business Associate has determined that it is infeasible to return or destroy the PHI in its possession, and (ii) the specific reasons for such determination, which reasons the Parties agree may include, but are not limited to, (none).

5.3.3. Upon mutual agreement of the Parties that return or destruction of PHI is infeasible, Business Associate shall extend the protections limitations and restrictions contained in this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

5.3.4. This section (5.3) shall survive the termination of this Agreement.

6. INSURANCE AND INDEMNIFICATION

6.1. Insurance. Business Associate has and will maintain policies of insurance for commercial general liability and commercial technical, privacy and cyber-liability with coverage limits commensurate with associated risks.

6.2. Indemnification. The Parties agree to indemnify, defend and hold harmless each other and each other's respective affiliates, employees, directors, officers, subcontractors, agents or other members of its workforce, each of the foregoing hereinafter referred to as "indemnified party," from and against all actual and direct losses suffered by the indemnified party and all liability to third parties arising from or in connection with any breach of this Agreement or of any warranty hereunder or from any negligence or wrongful acts or omissions, including failure to perform its obligations under the Privacy Rule, by the indemnifying party or its affiliates, employees, directors, officers, subcontractors, agents or other members of its workforce. Accordingly, on demand, the indemnifying party shall reimburse any indemnified party for any and all actual and direct losses, liabilities, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any indemnified party by reason of any suit, claim, action, proceeding or demand by any third party which results from the indemnifying party's breach hereunder. The Parties' obligation to indemnify any indemnified party shall survive the expiration or termination of this Agreement for any reason.

6.3. LIMITATION OF LIABILITY. NEITHER PARTY SHALL BE LIABLE TO THE OTHER PARTY FOR ANY INCIDENTAL, CONSEQUENTIAL, SPECIAL, OR PUNITIVE DAMAGES OF ANY KIND OR NATURE, WHETHER SUCH LIABILITY IS ASSERTED ON THE BASIS OF CONTRACT, TORT (INCLUDING NEGLIGENCE OR STRICT LIABILITY), OR OTHERWISE, EVEN IF THE OTHER PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH LOSS OR DAMAGES.

7. MISCELLANEOUS

7.1. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA or the HITECH Act and any applicable amendments, interpretations, or regulations in regard to such laws. The Parties may, with thirty (30) business days written notice duly signed by authorized representatives of the Parties, amend this Agreement to the extent necessary to comply with such amendments or interpretations. This Agreement modifies and supplements the terms and conditions of the Service Agreement, and the provisions set forth herein shall be deemed a part of the Service Agreement.

7.2. Survival. The respective rights and obligations of Business Associate and Covered Entity under the provisions of Sections 2, 3, 5, and 6 shall survive termination of this Agreement indefinitely.

7.3. Prior Agreement. This Agreement shall replace and supersede any prior Business Associate Agreement between the Parties.

7.4. Ambiguity. Any ambiguity of this Agreement shall be resolved to permit the Parties to comply with the HITECH Act, HIPAA, and the Privacy and Security Rules and other implementing regulations and guidance.

7.5. Conflicting Terms. In the event any terms of this Agreement conflict with any terms of the Service Agreement, the terms of this Agreement shall govern and control.

7.6. Disputes. If any controversy, dispute or claim arises between the Parties with respect to this Agreement, the Parties shall make good faith efforts to resolve such matters informally.

7.7. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon.

7.8. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended to convey, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

7.9. Notices. Any notices to be given hereunder to a Party shall be made via U.S. Mail or express courier to such Party's address given below, and/or (other than for the delivery of fees) via facsimile to the facsimile telephone numbers listed below.

If to Business Associate, to:
Jefferson Health Information Exchange
520 Medical Center Drive, Suite 120
Medford, Oregon 97504

If to Covered Entity, to:
North Central Public Health District
419 E 7th St #100
The Dalles, OR 97058

Each Party named above may change its address and that of its representative for notice by the giving of notice thereof in the manner hereinabove provided.

IN WITNESS WHEREOF, each of the undersigned has duly executed this Agreement on behalf of the Party and as of the Effective Date.

Jefferson Health Information Exchange
(Business Associate)

Richard Bolager

Name

[signature]

Signature

1/5/15

Date

North Central Public Health District
(Covered Entity)

Teri L. Thalhofer, RN, BSN

Name

[signature]

Signature

12/22/2014

Date

This AGREEMENT is by and between the Oregon Health & Science University located at 3181 SW Sam Jackson Park Road Portland, Oregon, 97239 (hereinafter referred to as the UNIVERSITY) and North Central Public Health District located at 419 E 7th Street, Room 100, The Dalles, OR 97058 (hereinafter referred to as COLLABORATOR).

Witnesseth:
Whereas, DHHS Health Resources and Services Administration, (hereinafter referred to as HRSA), has awarded the Oregon Health Authority (hereinafter referred to as OHA) Grant Number B04MC06604; and

OHA has awarded UNIVERSITY Subaward number 143021 for support for the **Title V MCAH Block Grant Program** (hereinafter referred to as the PROGRAM);

Whereas, UNIVERSITY is committed to using its own funds outside of the awarded amount to fulfill commitment to HRSA of matching funds under the OHA Contract 143021, and the funds for this AGREEMENT are from UNIVERSITY funds and not from direct federal funds;

Whereas, UNIVERSITY and COLLABORATOR wish to cooperate in the completion of work on the project titled "Community Connections Network" (hereinafter referred to as PROJECT);

Whereas, COLLABORATOR and UNIVERSITY desire this AGREEMENT and the work to be performed under it to fully comply with:

- All applicable administrative requirements, cost principles and other pertinent Federal laws, rules and regulations; including but not limited to the following (as applicable per COLLABORATOR type):
  - A-87 – Cost Principles for State, Local, and Indian Tribal Governments
  - A-21 – Cost Principles for Educational Institutions
  - A-122 – Cost Principles for Non-Profit Organizations
  - A-110 – Uniform Administrative Requirements for Grants and Agreement with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations.

Now therefore, the parties agree to the following conditions:

Article 1. AGREEMENT TYPE
This AGREEMENT is cost-reimbursable with payments based on a quarterly payment schedule

Article 2. SCOPE OF WORK
COLLABORATOR shall utilize the funds to complete the PROJECT Goals as identified in **Attachment A, Vision and Purpose, Attachment B, Scope of Work,Attachment C, Use of Allotment Funds, Attachment D, Training and Continuing Education for Community Connections Network Teams**. COLLABORATOR shall meet the standards of performance as identified in **Attachment E, Minimum Standards of Program Performance.**

Article 3. PERIOD OF PERFORMANCE
The period of performance of this AGREEMENT shall be **10/01/14-03/30/15.** The

Period of Performance may be modified upon mutual agreement by UNIVERSITY and COLLABORATOR.

Article 4, ESTIMATED COST AND EXPENDITURE LIMITATION
The maximum award available for the period 10/01/14-03/30/15 is $3,460.80.

Estimated Cost and Expenditure Limitation may be increased or decreased at the discretion of the UNIVERSITY dependent on levels of funding provided by OHA under Subaward 143021. Such adjustment will be implemented by way of an amendment executed by both parties.

Article 5, BUDGET & ALLOWABLE EXPENDITURE
Funds awarded under this AGREEMENT are required to be compliant with **Attachment C**, and are to be utilized to accomplish the objectives and produce the deliverables related to this PROJECT. All costs incurred shall support the objectives of the PROJECT described herein.

Article 6. PROJECT PERSONNEL
The Principal Investigator for UNIVERSITY is **Marilyn Sue Hartzell,** who is responsible for coordinating the research efforts under this PROJECT. The Principal Investigator for COLLABORATOR is **Vern Harpole,** who is responsible for coordinating the research efforts under this project. Neither UNIVERSITY's nor the COLLABORATOR's Principal Investigator is authorized to amend or alter this AGREEMENT. Any amendments or alterations must be approved by the written mutual agreement of the parties hereto.

Article 7. TERMS OF PAYMENT & INVOICING
COLLABORATOR shall submit invoices to UNIVERSITY per the quarterly payment schedule, below, for reimbursement of all allowable direct and indirect costs, as per the applicable cost principles and as described in **Attachment C**, to spasub@ohsu.edu.

PAYMENT SCHEDULE:
(1) Initial Payment of $1,730.40, payable upon execution of this Agreement and receipt of invoice on or after 10/1/2014.
(2) Final Payment of $1,730.40, payable upon invoice and acceptance by UNIVERSITY of COLLABORATOR's Financial Report on or after 03/30/2015.

Invoices shall be submitted in accordance with the instructions provided. Invoices that do not include the details requested below may be returned for correction and re-submission.

The COLLABORATOR IS REQUIRED to include the following minimum information on invoices:

(A) COLLABORATOR's name and invoice date;
(B) AGREEMENT Number – 1004395_Wasco_CCN_Harpole;
(C) Description and price of services actually rendered;
(E) Name, title, phone number, and mailing address of responsible official to whom payment is to be sent; and
(G) The Internal Revenue Service Taxpayer Identification Number.

days after the end date of the AGREEMENT, and must include a Financial Report a format sufficient to document allowable expenses.

Failure to comply with these requirements, including the inclusion of the Financial Report, may result in nonpayment of the final invoice.

Article 8. NOTICES

All notices required to be given under this AGREEMENT shall be in writing and sent to the party as indicated below:

TO UNIVERSITY	Jen Raupp, Subaward Grants & Contracts Administrator Oregon Health & Science University 3181 SW Sam Jackson Park Road, L106OPAM Portland, OR 97239-3098 Phone: 503.494.2379 Email: rauppj@ohsu.edu
TO COLLABORATOR	North Central Public Health District Teri Thalhofer, RN, BSN, Director 419 East Seventh Street The Dalles, OR 97058 Phone: 541-506-2600 Email: terit@co.wasco.or.us

Article 19. TERMINATION

This AGREEMENT may be terminated by mutual consent of both parties or by either party upon thirty (30) days notice. This termination must be in writing and delivered by certified mail or in person.

Any such termination of this AGREEMENT shall be without prejudice to any obligations or liabilities of either party already accrued prior to such termination.

Article 10. INSPECTION

COLLABORATOR agrees to maintain financial records, in accordance with generally accepted accounting practices and applicable OMB policies and regulations, which clearly identify and describe the nature and type of all costs on the project and e3stablish the COLLABORATOR's right to reimbursement. All costs will be subject to audit by the UNIVERSITY's Financial Officer. From time-to-time, UNIVESRITY will conduct desk audits.

COLLABORATOR agrees to comply with requests for information in a timely manner when selected for audit.

Article 11. INDEPENDENT CONTRACTOR

The COLLABORATOR is an independent contractor. No provision of this AGREEMENT shall be deemed to constitute the COLLABORATOR or any agent or employee of the COLLABORATOR as an agent or employee of the UNIVERSITY. The COLLABORATOR agrees that it has entered into this AGREEMENT and will discharge its obligations, duties, and undertakings and the work pursuant thereto whether requiring professional judgment or otherwise as an independent COLLABORATOR and without liability on the part of the UNIVERSITY.

whether requiring professional judgment or otherwise as an independent COLLABORATOR and without liability on the part of the UNIVERSITY.

Article 12. INDEMNIFICATION

To the extent permitted by state law, the COLLABORATOR agrees to defend, indemnify, and hold the UNIVERSITY and its officers, employees, and agents, harmless from and against any and all liability, loss expense (including reasonable attorney's fees), or claim for injury or damages arising out of the performance of this AGREEMENT, but only in proportion to and to the extent that such liability, loss, expense, attorney's fees, or claim for injury or damages are caused by or result from the negligent or intentional acts of the COLLABORATOR.

The UNIVERSITY agrees to defend, indemnify, and hold the COLLABORATOR and its officers, employees, and agents, harmless from and against any and all liability, loss expense (including reasonable attorney's fees), or claim for injury or damages arising out of the performance of this AGREEMENT, but only in proportion to and to the extent that such liability, loss, expense, attorney's fees, or claim for injury or damages are caused by or result from the negligent or intentional acts of the UNIVERSITY.

Article 13. ATTRIBUTION

Neither party may produce any book, article or paper based upon or arising from the activities conducted under this AGREEMENT without (1) providing a copy of the book, article or paper to the other party and (2) attributing, in the book, article or paper, the contributions of the other party to the activities conducted under this Agreement or obtaining written permission from the other party to forego such attribution.

Article 14. OWNERSHIP OF DELIVERABLES

COLLABORATOR and UNIVERSITY shall jointly own all materials produced or required to be delivered under this AGREEMENT. UNIVERSITY and ACOLLABORATOR herby grant to HRSA, an irrevocable, non-exclusive, perpetual, royalty-free license to use, reproduce, prepare derivative works based upon, distribute copies of, perform, and display the materials produced, and to authorize others to do the same.

Article 15. USE OF NAME

Neither party shall use the name of the other party or that party's employees, agents or assigns in any form of advertisement or publicity, or Internet sites, without first obtaining the other party's written approval for such use.

Article 16. MODIFICATIONS

The parties agree that the terms and provisions of this AGREEMENT shall be modified in writing and executed by the parties hereto, to reflect any additional requirements or changes mandated by HHS as a condition of receiving the grant, or as a result of changes to the guidelines promulgated by the HHS for the participants of consortium grants.

Article 17. SECOND TIER AGREEMENTS

COLLABORATOR shall not enter into any Second Tier Agreements to allocate any portion of the funds or Scope of Work described in this AGREEMENT.

Article 18. CERTIFICATIONS

Unless exempt under 45CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, COLLABORATOR shall

comply and, as indicated, cause all sub-contractors to comply with the following federal requirements to the extent that they are applicable to this AGREEMENT, to COLLABORATOR, to the PROGRAM or to the PROJECT, or to any combination of the foregoing. For purposes of this AGREEMENT, all references to federal and state laws are references to federal and state laws as they may be amended from time to time.

1. **Miscellaneous Federal Provisions.** Agency shall comply and require all subcontractors to comply with all federal laws, regulations, and executive orders applicable to the Agreement or to the delivery of Work. Without limiting the generality of the foregoing, Agency expressly agrees to comply and require all subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to the Agreement: (a) Title VI and VII of the Civil Rights Act of 1964, as amended, (b) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, (c) the Americans with Disabilities Act of 1990, as amended, (d) Executive Order 11246, as amended, (e) the Health Insurance Portability and Accountability Act of 1996, as amended, (f) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (g) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (h) all regulations and administrative rules established pursuant to the foregoing laws, (i) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, (j) all federal law governing operation of Community Mental Health Programs, including without limitation, all federal laws requiring reporting of client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the Agreement and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 USC 14402.
2. **Equal Employment Opportunity.** If this Agreement, including amendments, is for more than $10,000, then Agency shall comply and require all subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60).
3. **Clean Air, Clean Water, EPA Regulations.** If this Agreement, including amendments, exceeds $100,000 then Agency shall comply and require all subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 1857(h)), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 U.S.C. 1251 to 1387), specifically including, but not limited to Section 508 (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under non-exempt Federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported to OHA, HHS and the appropriate Regional

Office of the Environmental Protection Agency. Agency shall include and require all subcontractors to include in all contracts with subcontractors receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this section.

4. **Energy Efficiency.** Agency shall comply and require all subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94163).
5. **Truth in Lobbying.** The Agency certifies, to the best of the Agency's knowledge and belief that:

   a. No federal appropriated funds have been paid or will be paid, by or on behalf of Agency, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

   b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Agency shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

   c. The Agency shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients and subcontractors shall certify and disclose accordingly.

   d. This certification is a material representation of fact upon which reliance was placed when this Agreement was made or entered into. Submission of this certification is a prerequisite for making or entering into this Agreement imposed by section 1352, Title 31 of the U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

6. **HIPAA Compliance.** OHA is a Covered Entity for purposes of the Health Insurance Portability and Accountability Act and the federal regulations implementing the Act (collectively referred to as HIPAA), and in accordance with OAR 125-055-0100 through OAR 125-055-0130. OHA

must comply with HIPAA to the extent that any Work or obligations of OHA arising under this Agreement are covered by HIPAA. Agency shall determine if Agency will have access to, or create any protected health information in the performance of any Work or other obligations under this Agreement. To the extent that Agency will have access to, or create any protected health information to perform functions, activities, or services for, or on behalf of, OHA as specified in the Agreement, Agency shall comply and cause all subcontractors to comply with OAR 125-055-0100 through OAR 125-055-0130 and the following:

a. Privacy and Security of Individually Identifiable Health Information. Individually Identifiable Health Information about specific individuals is confidential. Individually Identifiable Health Information relating to specific individuals may be exchanged between Agency and OHA for purposes directly related to the provision of services to Clients which are funded in whole or in part under this Agreement. Agency shall not use or disclose any Individually Identifiable Health Information about specific individuals in a manner that would violate OHA Privacy Rules, OAR 943-014-0000 *et. seq.*, or OHA Notice of Privacy Practices, if done by OHA. A copy of the most recent OHA Notice of Privacy Practices is posted on the OHA web site at https://apps.state.or.us/Forms/Served/DE2090.pdf or may be obtained from OHA.

b. Data Transactions Systems. If Agency intends to exchange electronic data transactions with OHA in connection with claims or encounter data, eligibility or enrollment information, authorizations or other electronic transaction, Agency shall execute an EDI Trading Partner Agreement with OHA and shall comply with OHA EDI Rules.

c. Consultation and Testing. If Agency reasonably believes that the Agency's or OHA's data transactions system or other application of HIPAA privacy or security compliance policy may result in a violation of HIPAA requirements, Agency shall promptly consult the OHA Information Security Office. Agency or OHA may initiate a request for testing of HIPAA transaction requirements, subject to available resources and the OHA testing schedule.

7. **Resource Conservation and Recovery.** Agency shall comply and require all subcontractors to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 USC 6901 et. seq.). Section 6002 of that Act (codified at 42 USC 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Part 247.

8. **Audits.**

a. Agency shall comply and, if applicable, require a subcontractor to comply, with the applicable audit requirements and responsibilities set forth in the Office of Management and Budget Circular A-133 entitled "Audits of States, Local Governments and Non-Profit Organizations."
b. Sub-recipients shall also comply with applicable Code of Federal Regulations (CFR) sections and OMB Circulars governing expenditure of federal funds. State, local and Indian Tribal Governments and governmental hospitals must follow OMB A-102. Non-profits, hospitals, colleges and universities must follow 2 CFR Part 215. Sub-recipients shall monitor any organization to which funds are passed for compliance with CFR and OMB requirements.

9. **Debarment and Suspension.** Agency shall not permit any person or entity to be a subcontractor if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12549 and No. 12689, "Debarment and Suspension". (See 2 CFR Part 180.) This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors declared ineligible under statutory authority other than Executive Order No. 12549. Subcontractors with awards that exceed the simplified acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.
10. **Drug-Free Workplace.** Agency shall comply and cause all subcontractors to comply with the following provisions to maintain a drug-free workplace: (i) Agency certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in Agency's workplace or while providing services to OHA clients. Agency's notice shall specify the actions that will be taken by Agency against its employees for violation of such prohibitions; (ii) Establish a drug-free awareness program to inform its employees about: The dangers of drug abuse in the workplace, Agency's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations; (iii) Provide each employee to be engaged in the performance of services under this Agreement a copy of the statement mentioned in paragraph (i) above; (iv) Notify each employee in the statement required by paragraph (i) above that, as a condition of employment to provide services under this Agreement, the employee will: abide by the terms of the statement, and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such

conviction; (v) Notify OHA within ten (10) days after receiving notice under subparagraph (iv) above from an employee or otherwise receiving actual notice of such conviction; (vi) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988; (vii) Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs (i) through (vi) above; (viii) Require any subcontractor to comply with subparagraphs (i) through (vii) above; (ix) Neither Agency, or any of Agency's employees, officers, agents or subcontractors may provide any service required under this Agreement while under the influence of drugs. For purposes of this provision, "under the influence" means: observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Agency or Agency's employee, officer, agent or subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Agency or Agency's employee, officer, agent or subcontractor's performance of essential job function or creates a direct threat to OHA clients or others. Examples of abnormal behavior include, but are not limited to: hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to: slurred speech, difficulty walking or performing job activities; and (x) Violation of any provision of this subsection may result in termination of the Agreement.

11. **Pro-Children Act.** Agency shall comply and require all subcontractors to comply with the Pro-Children Act of 1994 (codified at 20 USC section 6081 et. seq.).
12. **Medicaid Services.** Agency shall comply with all applicable federal and state laws and regulation pertaining to the provision of Medicaid Services under the Medicaid Act, Title XIX, 42 USC Section 1396 et. seq., including without limitation:
    a. Keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving Medicaid assistance and shall furnish such information to any state or federal agency responsible for administering the Medicaid program regarding any payments claimed by such person or institution for providing Medicaid Services as the state or federal agency may from time to time request. 42 USC Section 1396a (a)(27); 42 CFR 431.107(b)(1) & (2).
    b. Comply with all disclosure requirements of 42 CFR 1002.3(a) and 42 CFR 455 Subpart (B).
    c. Maintain written notices and procedures respecting advance directives in compliance with 42 USC Section 1396(a)(57) and (w), 42 CFR 431.107(b)(4), and 42 CFR 489 subpart I.d.
    d. Certify when submitting any claim for the provision of Medicaid Services that the information submitted is true, accurate and

complete. Agency shall acknowledge Agency's understanding that payment of the claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

e. Entities receiving $5 million or more annually (under this Agreement and any other Medicaid contract) for furnishing Medicaid health care items or services shall, as a condition of receiving such payments, adopt written fraud, waste and abuse policies and procedures and inform employees, contractors and agents about the policies and procedures in compliance with Section 6032 of the Deficit Reduction Act of 2005, 42 USC § 1396a(a)(68).

13. **Agency-based Voter Registration.** If applicable Agency shall comply with the Agency-based Voter Registration sections of the National Voter Registration Act of 1993 that require voter registration opportunities be offered where an individual may apply for or receive an application for public assistance.

14. **Disclosure.**

a. 42 CFR 455.104 requires the State Medicaid agency to obtain the following information from any provider of Medicaid or CHIP services, including fiscal agents of providers and managed care entities: (A) the name and address (including the primary business address, every business location and P.O. Box address) of any person (individual or corporation) with an ownership or control interest in the provider, fiscal agent or managed care entity; (2) in the case of an individual, the date of birth and Social Security Number, or, in the case of a corporation, the tax identification number of the entity, with an ownership interest in the provider, fiscal agent or managed care entity or off any subcontractor I which the provider, fiscal agent or managed care entity has a 5% or more interest; (3) whether the person (individual or corporation) with an ownership or control interest in the provider, fiscal agent or managed care entity is related to another person with ownership or control interest in the provider, fiscal agent or managed care entity as a spouse, parent, child or sibling, or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the provider, fiscal agent or managed care entity has a 5% or more interest is related to another person with ownership or control interest in the provider, fiscal agent or managed care entity as a spouse, parent, child or sibling; ((4) the name of any other provider, fiscal agent or managed care entity in which an owners of the provider, fiscal agent or managed care entity has an ownership or control interest; and, (5) the name, address, date of birth and Social Security Number of any managing employee of the provider, fiscal agent or managed care entity.

b. 42 CFR 455.434 requires as a condition of enrollment as a

Medicaid or CHIP provider, to consent to criminal background checks, including fingerprinting when required to do so under state law, or by the category of the provider based on risk of fraud, waste and abuse under federal law.

c. As such, a provider must disclose any person with a 5% or greater direct or indirect ownership interest in the provider whom has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years.

d. COLLABORATOR shall make the disclosures required by this Section 14, to UNIVESRITY. UNIVESRITY reserves the right to take such action required by law, or where UNIVESRITY has discretion, it deems appropriate, based on the information received (or the failure to receive information) form the provider, fiscal agent or managed care entity.

15. **Federal Intellectual Property Rights Notice.** The federal funding agency, as the awarding agency of the funds used, at least in part, for the PROGRAM under this AGREEMENT, may have certain rights as set forth in the federal requirements pertinent to these funds. For purposes of this subsection, the terms "grant" and" award" refer to funding issued by the federal funding agency to OHA. The COLLABORATOR agrees that it has been provided the following notice:

a. The federal funding agency reserves a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the SCOPE OF WORK, and to authorize others to do so, for Federal Government purposes with respect to:

   i. The copyright in any work developed under a grant, subgrant or agreement under a grant or subgrant; and

   ii. Any rights of copyright to which a grantee, subgrantee or a county purchases ownership with grant support.

b. The parties are subject to applicable federal regulations governing patents and inventions, including government-wide regulations issued by the Department of Commerce at 37 CFR part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements".

c. The parties are subject to applicable requirements and regulations of the federal funding agency regarding rights in date first produced under a grant, subgrant or agreement under a grant or subgrant.

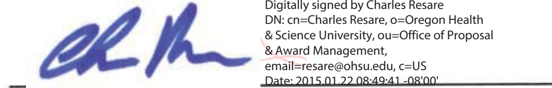
ALL ATTACHMENTS REFERENCED ARE HEREBY MADE A PART OF THIS AGREEMENT. THIS AGREEMENT CONSTITUTES THE ENTIRE AGREEMENT BETWEEN UNIVERSITY AND COLLABORATOR. NO WAIVER, CONSENT, MODIFICATION OR CHANGE OF TERMS OF THIS AGREEMENT SHALL BIND EITHER PARTY UNLESS IN WRITING AND SIGNED BY A DULY AUTHORIZED REPRESENTATIVE OF BOTH ORGANIZATIONS.

Approved and Agreed:
North Central Public Health District

By:

Date: 1/16/2015

Oregon Health & Science University



Charles Resare
Policy & Financial Compliance Manager

Date: ______________________

ATTACHMENT A – VISION AN PURPOSE

Community Connections Network
Vision and Purpose

Oregon Center for Children and Youth with Special Health Care Needs (OCCYSHN) promotes optimal health and development for Oregon's children and youth with special health care needs by assuring a family-centered, community based, comprehensive, coordinated and culturally appropriate system of care. OCCYSHN achieves this goal by working in partnership with families, service providers, public health and communities.

Community Connections Network (CCN) is OCCYSHN's partnership with community teams to serve families of children with unmet complex health needs effecting social, educational and community success. Local multidisciplinary teams commit to collaborating in ways which promote optimal health and development in individual children and youth with special health needs while expanding community capacity, confidence and coordination of local services for CYSHN. Oregon Center for Children and Youth with Special Health Needs supports the development and growth of local CCNs through education, consultation, technical assistance and direct financial support.

Community Connection Teams and Oregon Center for Children and Youth share commitment to the following guiding principles:

Community Connection Network Guiding Principles

Services for Children with Special Health Needs are best when driven by confident, knowledgeable families and delivered as close to home as possible, in a coordinated fashion by a team of skilled professionals.

Professional and community knowledge, skill and motivation to serve CYSHN are best supported by family partnership, collaboration across agencies and specialized training and experiences related to working with children and youth with special needs.

Community Connections Network Teams are dedicated to the promotion of health enhancing activities for children and youth with special health needs which become self-sustaining and community owned and in partnership with families.

ATTACHMENT B - SCOPE of WORK

Community Connections Network
Scope of Work

Purpose:
The North Central Public Health District will partner with the Oregon Center for Children and Youth with Special Health Needs (OCCYSHN) Community Connections Network (CCN) program.

OCCYSHN supports several positions necessary for a successful CCN and the multidisciplinary team process including:

1. A CCN Local Coordinator* to schedule CCN meetings, obtain releases and records, and to coordinate communication between the CCN team, and between CCN and OCCYSHN.
2. A physician or nurse practitioner to review records, conduct evaluations as needed, provide a medical perspective and health information, and help with the planning process.
3. A professional adjunct* to work in partnership with the CCN Local Coordinator to conduct community outreach on behalf of CCN services, and network with other entities including family organizations serving CYSHN.
4. A family liaison to support families of children seen during CCN team meetings.
5. CaCoon nurse participation is encouraged.

**Roles to be performed by County Chosen Individuals*

Local determination of how CCN team roles & responsibilities are assigned and provided at team meetings is encouraged. OCCYSHN supports CCN team service provision within the context of a community system of care. Services may vary depending on local need and may include evaluation of the child or youth's strengths, identification of care and service needs, establishing a plan of care, coordinating services between agencies, and identifying the primary case management provider, all in partnership with the family.

Roles and Responsibilities Contract Year 2015:

The following are lists of functions by role on the CCN Team:

ALL TEAM MEMBERS

- Participate in referral, planning and CCN regularly scheduled team meetings to provide local, family-centered, coordinated care for Children and Youth with Special Health Needs (CYSHN).
- Participate in identifying local, unmet needs of CYSHN and their families, and in identifying and accessing resources.
- Participate in networking/training opportunities such as: webcasts, regional conferences, and conference calls.
- Participate in team evaluation activities including completion of team meeting day checklist, parent surveys and end of year team evaluation.
- Network with other CCN teams as needed.

- Communicate with OCCYSHN as needed.
- Commit to the CCN vision and purpose as described in Attachment A.

LOCAL CCN COORDINATOR – ROLE TO BE PERFORMED BY COUNTY CHOSEN COORDINATOR

Local Coordinator General Duties

- Work with team to develop and distribute annual CCN team meeting schedule (dates and times).
- Facilitate data collection onto Child Visit Data Form and Team Activity Data Forms.
- Facilitate completion of Year End Evaluation (required), Parent Evaluation of Team Meeting (optional), and share findings of evaluations with the team and OCCYSHN.
- Develop and distribute list of CCN team members and contact information to team members and community-based services consultant.
- Customize forms, letters, consents etc. with the local community's name, and the coordinator's name, telephone number and address.
- With CCN team members, contact and provide information to appropriate entities to increase awareness of the CCN team services. Groups may include the Local Interagency Coordinating Council (LICC), school districts/special education departments, parent groups, medical community, and the community at large.
- Obtain confidentiality signatures of all CCN team members participating in the team meeting on the Annual Confidentiality Statement (yearly) and have providers sign the Confidentiality Agreement and Attendance Roster (each meeting day).
- With the help of the team, identify your local agency's HIPAA-compliant Release of Information and Notice of Privacy Practice forms to be signed by each family attending the team meeting. OHSU forms should no longer be used.
- Create and maintain locally medical files for children seen in the CCN. OCCYSHN no longer retains a copy of the child's CCN medical record.

Pre-Meeting

- With the help of the team identify if a referred child/youth should be seen by the CCN team or referred elsewhere. If additional testing or information is needed, identify which disciplines need to see the child (triage).
- Contact family to provide information about CCN and determine interest in participation. Secure a signed copy of your agency's Release of Information and Notice of Privacy Practices acknowledgement form in order to gather health, school, social service and other related information.
- Create an organized file for each child and make it available to team medical provider in a timely manner.
- If additional assessments are needed on the day of the team meeting, contact the responsible provider at least 2 weeks prior to the team meeting date to schedule a time for the assessment.
- Contact parents, health, school personnel, social services and other critical providers involved in the care of the child to schedule a meeting time and to tell them what information they need to bring for the team meeting.
- Send a reminder note to appropriate people one week prior to established team meeting day giving the time for planning and referral meeting. If any changes must be made, the coordinator will contact anyone not present as soon as possible to cancel and reset new meeting time.
- Contact designated local family liaisons at least two weeks prior to meeting regarding information on meeting dates and family contact information.

Team Meeting Day

- Facilitate meeting, or assign facilitator, to lead the team and family in sharing information and developing recommendations allowing each participant time to share concerns while staying within time scheduled. Assignment of a facilitator for each team meeting is encouraged.
- Complete or assign someone to complete the Assessment Summary (or summary and recommendations) for plan of care that was agreed on by the team and family.
- Distribute the Assessment Summary (or summary and recommendations) to professionals upon completion of the meeting, or if preferred, soon after the meeting.
- Distribute the Assessment Summary (or summary and recommendations) to the child's family to be included in their child's Care Notebook.
- Maintain a list of all CCN team meeting participants for local team and OCCYSHN outreach purposes.
- If time allows review referrals for upcoming team meetings and schedule children.
- Encourage and reinforce family involvement in team meetings; promote family participation in decision-making.
- Give the family a Parent Evaluation of Team Meeting (optional) to complete and return.

Post Meeting

- Complete Child Visit Data Form and Team Activity Data Form and FAX it to the Oregon Center for Children and Youth with Special Health Needs at (503) 494-2755. Physician payment is triggered upon receipt of the checklist.
- Ensure reports are completed and distributed in a timely fashion to the appropriate professionals involved with the child and family.
- Ensure reports are completed and distributed to the family for inclusion in their child's Care Notebook.
- As appropriate, in 3-4 months, contact the family and/or referral source regarding implementation and success of the recommendations, report to the team, and determine the need for subsequent visit.

End of Year

Distribute the necessary evaluation materials to determine strengths and needs of the CCN team process:

1. Year End Evaluation (required). Please return to your OCCYSHN Community Consultant.
2. Parent Evaluation of Team Meeting (optional). Share with team and OCCYSHN consultant.
3. Referral Source Evaluation (optional).

LOCAL CCN PHYSICIAN/NURSE PRACTITIONERS

- Participate as a team member in scheduled CCN meeting.
- Assist in the selection of children for evaluation or provide feedback on children selected, participate in triage of children.
- Evaluate children and develop recommendations for care to be shared with the team and family with a focus on family-centered care and coordinated care.
- Write reports in a timely fashion. Follow up with child's PCP.
- Assist in the planning and evaluation of the CCN team process.
- Enlist support from, and assist in the education of local physicians as to the services available through CCN.

- Participate in trainings to increase knowledge base and skills to care for CYSHN.
- Invite local providers to CCN training events.

PROFESSIONAL ADJUNCT TO THE LOCAL CCN COORDINATOR – ROLE TO BE PERFORMED BY COUNTY CHOSEN ADJUNCT

In many CCN sites the CCN Local Coordinator role of the program is provided by administrative or support staff personnel. The professional adjunct role is intended to assist in those aspects of coordination that benefit from professional input and from infrastructure building activities including:

- Engaging other community professionals in CCN meetings.
- Facilitation of CCN data collection onto the Child Visit Data Form and the Team Activity Data Form, sharing of parent survey findings and Year End Evaluation.
- Follow-up with the family, family liaison, and/or referral source regarding plan implementation and success of team recommendations as appropriate.
- Contact and provide information to appropriate entities to increase awareness of the CCN team services. Groups may include the Local Interagency Coordinating Council (LICC), school districts/special education departments, parent groups, medical community, and the community at large.

Professional adjunct assistance to the local coordinator may also include the following duties:

- Assist coordinator in gathering signatures on HIPAA documents (Release of Information Notice of Privacy Practices).
- Assist coordinator with contacting parents and providers to notify them of team meeting schedule and what information they need to bring for the staffing meeting.
- Assist physician or other team member in facilitating team meetings for each child to allow each professional to have time to share their test results and recommendations and staying within time scheduled.
- Write or review the Assessment Summary (or summary and recommendations) of the team.

FAMILY LIAISON

The role of the Family Liaison is to support the family being seen by the team before the team meets, during the team meeting, and after the team meeting with a follow-up phone call. The Family Liaison will:

- Call or meet with the family before the team meeting to explain the team process and assist the family with their questions and goals for the team.
- Support the family during the team meeting. Support may include asking questions of the team that the family is uncomfortable asking (with the family's permission), taking notes for the family, refocusing discussion on family questions and goals, being aware of the needs of the family and asking for a break if needed, etc.
- Represent a family perspective during the team meetings when the family being seen is not present.
- Follow up with the family to see if their questions were answered and if plan met family's needs. Provide further follow-up or assistance if needed.
- Refer unanswered questions to appropriate team member(s).
- Assist team in identifying local resources for families.
- Participate in planning and evaluation of meetings and team process.

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ATTACHMENT C – USE OF ALLOTMENT FUNDS [Section 504]

The SUBAWARDEE may use funds paid to it for the provision of health services and related activities (including planning, administration, education, and evaluation) consistent with its application. It may also purchase technical assistance if the assistance is required in implementing programs funded by Title V.

Funds may be used to purchase technical assistance from public or private entities if required to develop, implement, or administer the MCH Block Grant.

Funds may be used for salaries and other related expenses of National Health Services Corps personnel assigned to the State.

Funds may not be used for cash payments to intended recipients of health services or for purchase of land, buildings, or major medical equipment.
Other restrictions apply.

Funds may not be used to make cash payments to intended recipients of services.

Funds may not be provided for research or training to any entity other than a public or non-profit private entity.

Funds may not be used for inpatient services, other than for children with special health care needs or high-risk pregnant women and infants or other inpatient services approved by the Associate Administrator for Maternal and Child Health. Infants are defined as persons less than one year of age.

Funds may not be used to make payments for any item or service (other than an emergency item or service) furnished by an individual or entity excluded under Titles V, XVIII (Medicare), XIX (Medicaid), or XX (Social Services Block Grant) f the Social Security Act.

Matching funds under MCH Block Grant funds may not be transferred to other block grant programs or used as matching commitment under other federal awards.

ATTACHMENT D – TRAINING AND CONTINUING EDUCATION FOR COMMUNITY CONNECTIONS NETWORK (CCN) TEAMS

Community Connections Network
Role of Oregon Center for Children and Youth with Special Health Needs (OCCYSHN)

TRAINING AND CONTINUING EDUCATION
FOR COMMUNITIY CONNECTIONS NETWORK (CCN) TEAMS

Training and continuing education is an important part of the support OCCYSHN provides to CCN communities. Within budgetary constraints, this role takes a few forms:

Annual Training
An annual training in a central location accessible to all teams may be offered. The training agenda is developed through feedback from community team members on topics of special interest. The training is multidisciplinary in presentation and breadth. All team members from all communities are invited to participate and a limited number may be funded to attend.

Other Continuing Education
Networking with other CCN teams and additional education may be available through OCCYSHN using methods such as Webcasting, regional conferences and conference calls. Team members are encouraged to seek other experiences which increase knowledge, skills and motivation to serve CYSHN.

CONSULTATION TO LOCAL CCN TEAMS

Community Consultant
OCCYSHN provides each CCN site an assigned Community Consultant who will make periodic site visits and stay in regular contact with the communities. The Community Consultant will also provide training to CCN Local and Adjunct Coordinators and facilitate problem-solving and team member replacement as necessary.

Mentoring
Mentoring of CCN members is available to all community teams, especially in communities with new members. In addition to the local consultant, mentoring relationships with discipline specific professionals can be arranged. We offer nutrition, special education, nursing and other specialties as requested.

Physician or nurse practitioner mentoring is available through CDRC at Oregon Health and Sciences University (OHSU) which maintains the Developmental Pediatrician Consult line for physicians. If CCN doctors or nurse practitioners have questions about the development or behavior of a child in practice or through CCN, they may call the OHSU consult service and ask for the developmental pediatrician on call. One of the OHSU Developmental Pediatricians will be available Monday - Friday, 7:00 am to 6:00 pm. The toll free number of the consult service is 1-800-245-6478; and if you are local, the number is, 503-494-4567. The goal of the consult service is to return a call within 2 hours if someone is not readily available.

Family Consultant

Family consultants are available to all CCN teams to provide input on Family Professional Partnerships and Family Centered Care. Family Consultants provide support and training for Family Liaisons that participate on the CCN teams.

Financial Supports

Yearly contracts are sent to CCN communities specifying dollar supports and terms of service to local communities and families. OCCYSHN distributes federal Title V dollars to support activities which improve the health and outcomes for children and youth with special health needs. Teams receiving dollars for Community Connections Network activities abide by the contract terms. Team and OCCYSHN evaluations seek to assure CCN activities are effective for local communities and OCCYSHN.

ATTACHMENT E – MINIMUM STANDARDS FOR PROGRAM PERFORMANCE

Community Connections Network
Minimum Standards for Network Physician

Vern Harpole will participate on the NNC Evaluation Team.

PROVIDENCE HEALTH PLAN
PROVIDER AGREEMENT

THIS AGREEMENT ("Agreement") between **Providence Health Plan** (PHP), an Oregon non-profit corporation, operating in Oregon and Southwest Washington, **Providence Health Assurance** (PHA), an Oregon non-profit corporation, operating in Oregon (hereinafter referred to as "Health Plan") and **North Central Public Health District** (hereinafter referred to as "Provider") and any attachment(s), describes the terms and conditions under which Provider shall participate in PHP and/or PHA Provider Network(s).

RECITALS

WHEREAS, Health Plan operates as a health care service contractor under the laws of Oregon and Washington; and

WHEREAS, Health Plan offers or administers one or more health benefit plans and desires to enter into a written agreement to arrange for the provision of certain Covered Services to Members of such products or plans; and

WHEREAS, Provider is lawfully qualified to provide health care services and is willing to provide such services to Members of Health Plan; and

WHEREAS, Health Plan and Provider mutually desire to preserve and enhance patient dignity; and

WHEREAS, Health Plan and Provider desire to create a culture of health care safety; and

WHEREAS, Health Plan desires to advance the healing ministry of Jesus in the communities it serves;

NOW, THEREFORE, in consideration of the promises and mutual covenants herein stated, it is agreed by and between the parties as follows:

ARTICLE I.
DEFINITIONS

As used in this Agreement and its Attachments, each of the following terms (and the plural thereof, when appropriate) shall have the meaning set forth herein, except where the context makes it clear that such meaning is not intended.

Attachment(s) shall mean the documents that accompany this Agreement that may contain proprietary information and procedures produced by Health Plan. Each Attachment is incorporated herein by this reference. Such Attachment(s) may contain compensation and reimbursement information, fee schedules, medical management and quality of care guidelines and procedures, and such other matters that may be unique to the features of Health Plan.

Care Management shall mean a program of care coordination and case management developed to manage high cost and at-risk members with complex medical needs.

Chief Medical Officer (CMO) shall mean the physician so designated by Health Plan to supervise utilization and quality management activities and to be responsible for such other programs and activities as may be designated by Health Plan. Medical Directors may be utilized by the CMO to assist in these functions.

Clean Claim shall mean a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

Clinical Quality Improvement Studies are studies regarding the measurable outcome or end result of care.

CMS is the Centers for Medicare and Medicaid Services, the federal government agency that regulates the Medicare program.

Coinsurance is the percentage or portion of the cost of care that a Member may be obligated to pay for a Covered Service.

Copayment or Copay is the fixed dollar amount that a Member may be obligated to pay for a Covered Service at the time the care is provided.

Covered Services are Medically Indicated health care services and supplies rendered or furnished to Member by Provider for which benefits are available under a Member's health care contract or plan.

Credentialing is the initial process by which Health Plan, or its designee, verifies practitioner or facility qualifications for panel membership in accordance with criteria adopted by Health Plan.

Deductible is the amount of out-of-pocket expense that Member is responsible to pay for Covered Services prior to being eligible to receive Health Plan benefits.

Emergency shall mean the sudden and unexpected onset of a condition requiring medical or surgical care for which Member secures care immediately after the onset of the condition, or as soon thereafter as care can be available, but in any case no later than twenty-four (24) hours after the onset. An Emergency situation shall include, but not be limited to, suspected heart attack or stroke, poisoning, loss of consciousness, severe respiratory distress, hemorrhaging or convulsion. The State of Oregon defines an "Emergency medical condition" as a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy. Health Plan may determine that other similarly acute conditions are Emergencies. The final determination of whether a condition is an Emergency rests with Health Plan and may be subject to the procedures for post treatment utilization review.

HIPAA is the Health Insurance Portability and Accountability Act of 1996 that contains federal regulations addressing standards for electronic transactions and other administrative issues for the health care and health insurance industries.

Individual Service Agreement or **Group Service Agreement** shall mean the agreement between Health Plan and Member, or between Health Plan and Member's employer group, which defines terms and conditions of Health Plan's obligation to provide, arrange for, and/or reimburse for medical care provided to Member.

Medical Directors shall mean physicians who are designated by the CMO and are responsible for quality management and utilization management review, including concurrent hospital review.

Medically Indicated shall mean a service or supply provided or ordered by a practitioner that is necessary in order to prevent, treat or care for symptoms of an illness or injury, or to diagnose an illness or condition that is harmful to life or health, and which is commonly and customarily recognized throughout the practitioner's profession as appropriate in the treatment. The decision whether a service or supply ordered by the practitioner was Medically Indicated for the purposes of qualifying for payment by Health Plan rests with Health Plan, subject to the procedures for reconsideration.

Member shall mean any person entitled to receive benefits for Covered Services underwritten or administered by Health Plan and with respect to whom the Member or another person has paid premium entitling such person to have claims paid by Health Plan, as evidenced by Health Plan's logo on a membership card presented to Provider. Members include all persons covered by plans underwritten by Health Plan, including entities for which Health Plan provides administrative or claims services only.

Participating Practitioner shall mean a physician or other health care professional who is contracted to provide Covered Services to Members of Health Plan under this Agreement or otherwise. Any Participating Practitioner who serves Health Plan Members under this Agreement will be bound by its terms. Participating status shall be contingent upon Health Plan's designation as such.

Participating Facility shall mean a hospital or other health care facility that is contracted to provide Covered Services to Members of Health Plan. Participating status shall be contingent upon Health Plan's designation as such.

Physician Advisor shall mean a physician who has entered into a separate agreement to advise Health Plan with respect to medical appropriateness.

Preventive and Clinical Practice Guidelines shall mean the statements systematically developed from time to time by Health Plan, which assist Participating Practitioners and their Member patients in deciding upon appropriate health care for specific clinical circumstances.

Recredentialing is the process by which continued eligibility to participate in Health Plan contracts is determined. Health Plan, or its designee, verifies practitioner or facility qualifications in accordance with criteria adopted by Health Plan. This process is completed at least every three years.

Rules and Regulations of Health Plan shall mean the criteria and procedures pertaining to credentialing and recredentialing, participation, compensation, payment rules, processing guidelines, medical policy, utilization management, quality improvement, Health Plan standards, and such other matters determined from time to time by Health Plan. The Rules and Regulations of Health Plan may be viewed on Health Plan's website.

Scope of Service shall mean those services which fall within the geographic and CPT code limits established in the Attachments. If no geographic or CPT code limits are established in the Attachments, Scope of Service shall refer to those services which Provider is professionally qualified to render.

Standards of Care and Service shall mean standards which have been developed by Health Plan incorporating concepts from OMAP, from CMS, from medical group practice accreditation programs, and from community standards. These standards include, but are not limited to, access, accommodations, panel size and medical record documentation, and are contained in the Rules and Regulations of Health Plan.

Urgent shall mean services that are needed right away but are not life threatening. These include, but are not limited to, high fevers, minor sprains, cuts and burns, and ear, nose and throat infections. Routine care that can be delayed until Member can be seen by Member's physician is not Urgent care. The final determination of whether a condition is Urgent rests with Health Plan and may be subject to the procedures for post-treatment utilization review.

ARTICLE II.
OBLIGATIONS OF HEALTH PLAN

Services. Health Plan agrees to provide the following services necessary to fulfill the terms of this Agreement including, but not limited to:

Claims processing services
Member services
Medical and quality management services
Credentialing services
Claims review process linked to peer review
Marketing, sales and public relations

Support. Health Plan may provide statistical support and assistance to Provider for quality assurance, peer review, and medical management review functions, through the development and operation of a medical management information system.

Orientation and Training. Health Plan agrees to provide orientation and training for Provider in the use of the administrative services described herein, and the Rules and Regulations of Health Plan.

Eligibility Verification. Health Plan agrees to provide eligibility verification and benefit information through its customer service department.

Documents Provided. Copies of any Health Plan documents referenced in this Agreement will be provided to, or made available for examination by, Provider.

ARTICLE III.
OBLIGATIONS OF PROVIDER

Provider Scope of Service. Health Plan retains Provider to render Covered Services to Health Plan Members within Provider's Scope of Service. All services shall be rendered subject to the terms and conditions of this Agreement and in accordance with the Rules and Regulations of Health Plan.

Provider/Patient Relationship. Provider may not terminate a relationship with a Member solely for inconvenience reasons. However, a Participating Practitioner may withdraw from the care of a Member when, in the professional judgment of the Participating Practitioner, it is in the best interest of the Member to do so. In terminating any patient relationship, the Participating Practitioner should give due regard to ethical considerations. This action may only occur after following the procedural steps identified in the Rules and Regulations of Health Plan.

Authorization. Provider agrees not to admit any Member to a hospital or other inpatient facility in a non-Emergency or elective situation without first receiving the necessary authorizations pursuant to the Rules and Regulations of Health Plan and Health Plan's Prior Authorization Program.

Prompt Service. Services rendered will be instituted as promptly as practicable, consistent with sound medical practice and in accordance with accepted community professional standards.

Sufficient Practitioners. Provider agrees at all times to maintain a sufficient number of Participating Practitioners to guarantee prompt and adequate access to Health Plan Members.

Utilization Management. Provider understands that the purpose of the utilization management program is to determine which services are Medically Indicated. Cooperation shall extend to provision of or access to medical records, on-site review and telephone review, at no additional cost to Health Plan. Health Plan will make every reasonable effort to meet Provider's needs when scheduling an on-site review.

Non-Discrimination. Provider agrees that in accordance with the provisions, spirit and intent of this Agreement, and within the limits of Provider's specialty, (A) not to discriminate in the provision of medical services to Members on the basis of membership in Health Plan, source of payment, race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status or handicap, or any other category protected under State or Federal law, and (B) to render medical services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to other patients.

Services To Practitioner's Family. Provider agrees not to seek compensation for Covered Services rendered by a Participating Practitioner to that Participating Practitioner's immediate family member, i.e., spouse, daughter, son, stepdaughter, stepson, grandchild.

Call/Non-Par Coverage. Provider agrees to make prior arrangements to provide coverage for Members on a 24-hour a day, 7-day a week basis with a Participating Practitioner of same or similar specialty. When Provider is unable to make prior arrangements to provide coverage with a Participating Practitioner of same or similar specialty due to the unavailability of Participating Practitioners in the Provider's geographic area, Provider agrees to provide such coverage through non-participating practitioners; such arrangements shall be determined by Provider, with notice to Health Plan, which has the right to disapprove. Notification of any permanent on-call changes are to be in writing thirty (30) days prior to the scheduled change. The same terms and conditions as agreed to by Provider shall be in effect and primary coverage may not be through a hospital emergency room or urgent care center.

Non-Par Coverage Compliance. Provider agrees that if arrangements are made with a non-participating provider to treat Members in the absence of Participating Practitioners, Provider agrees to ensure that such non-participating provider will comply with the obligations of this Agreement, including but not limited to (A) acceptance of the fee established by Health Plan as full payment for Covered Services rendered to Member; (B) acceptance of the peer and medical management procedures of Health Plan; (C) agreement not to bill Members directly under any circumstances except for Copayments, Coinsurance, Deductibles and non-Covered Services as defined in Individual and Group Service Agreements; (D) obtaining required authorization from Health Plan prior to hospitalizations; and (E) agreement to undergo credentialing by Health Plan.

Refer To In-Plan Providers. Provider agrees to, whenever possible, provide or arrange for care of Members with Participating Practitioners and/or Participating Facilities.

Prior Authorization. Except in cases requiring Emergency treatment, Provider will not be compensated for Covered Services rendered to Members which were not provided in compliance with the Rules and Regulations of Health Plan and/or which were not authorized by Health Plan, nor will such services be billable to Member. Provider will follow the Prior Authorization Requirements as described in the Attachments.

Change In Status. Provider agrees to provide Health Plan with an updated schedule of Participating Practitioners categorized by name, board status, facility status, hospital affiliation, and relationship to Provider, at Health Plan's request or when there is a change in Participating Practitioner status. Provider agrees that Health Plan may use Participating Practitioners' name, office address, office telephone number, type of practice and an indication of willingness to accept new patients, in Health Plan directories.

Appeals and Grievances. Provider agrees to cooperate with Health Plan in resolving any Member appeals or grievances related to the provision of Covered Services.

Subcontracting. Prior to services being provided, Health Plan must authorize the use of a subcontractor to perform services covered under the Agreement.

ARTICLE IV.
PROVIDER WARRANTIES / COMPLIANCE WITH RULES AND REGULATIONS

Initial and Periodic Appraisal. Provider agrees to cooperate with such programs of initial and periodic appraisal as may be established by Health Plan. Provider agrees to require its Participating Practitioners to permit Health Plan to obtain any utilization, peer review or other information regarding Participating Practitioner practice of medicine from any participating institution at which Participating Practitioner has practiced, provided that Provider is not prohibited from disclosing such information under state or federal law. Provider releases Health Plan and its employees or agents or any person furnishing information to Health Plan from liability for acts made in good faith and without malice in connection with this provision.

Conditional Credentialing. Initial and periodic appraisal may result in conditional credentialing. Whether to grant conditional credentialing is determined solely by Health Plan.

Rules and Regulations of Health Plan. Provider agrees to be bound by the Rules and Regulations of Health Plan as they may be amended from time to time. If Provider violates any of the provisions of the Rules and Regulations of Health Plan, or any of the principles of professional conduct adopted by Health Plan, or acts contrary to or in violation of any Health Plan agreements, all contractual rights under this Agreement which pertain to Provider may be terminated in accordance with the Term and Termination section of this Agreement. The Rules and Regulations of Health Plan are available for examination by Provider on Health Plan's website.

Physician Practitioner Requirements. Participating Practitioners covered by this Agreement agrees that he or she is now, and will remain as long as this Agreement remains in effect, (A) the holder of (i) a currently valid license to practice

medicine or osteopathy in the state of Oregon and/or Washington within his or her scope of practice, and (ii) a valid DEA or CDS certificate, as applicable, a copy of which shall be submitted to Health Plan, (B) certified as recognized by the Board of Medical Specialists or the American Osteopathic Association (unless Participating Practitioner graduated prior to 1980), and (C) a medical staff member, as appropriate, in good standing on the medical staff of a participating institution.

Participating Practitioner agrees to notify Health Plan immediately of any change in licensure or hospital privileges status (whether or not such hospital is a participating institution).

Non-Physician Practitioner Requirements. Provider states as a material term of this Agreement that Provider and all professional employees of Provider are now and will remain, as long as this Agreement remains in effect, the holders of all currently required licenses, certificates and/or registrations by appropriate federal, state and local governmental agencies to provide health care services that Provider and professional employees of Provider undertake to provide to Health Plan Members under this Agreement.

Provider agrees to notify Health Plan immediately upon a change in status of such licensure, certification, or registration.

Specialty Education. Provider agrees to require all Participating Practitioners covered by this Agreement to have education and/or training and experience in the field in which they practice and to be Board Certified, or have completed an approved specialty education and/or training program.

Patient Advocate. Provider may act as a patient advocate regarding a decision, policy, or practice without being subject to termination or penalty for the sole reason of such advocacy. Provider can freely communicate with patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Fraud and Abuse. Provider agrees to comply with Health Plan's Fraud and Abuse program and questionable billing practices policies and procedures.

Facility Certification. Provider warrants that its facilities are currently certified under Title XVIII (Medicare) of the Social Security Act, when applicable, and have appropriate state licensure. Provider warrants that should it provide services in exempt units (skilled nursing, psychiatric, swing, rehabilitation, etc.), the units will be certified under Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act and have appropriate state licensure. Provider further warrants that it is currently accredited by a recognized accrediting organization, such as JCAHO, AAAHC or CARF, as applicable. State and/or CMS site surveys may satisfy Health Plan criteria, provided information is current. Provider agrees to maintain such licensure and certification during the term of this Agreement.

Liability Insurance. Provider agrees to ensure that its Participating Practitioners, Participating Facilities, and all persons and entities performing services under this Agreement, maintain such policies of general liability and professional liability insurance or such other program of liability coverage as may be customary and acceptable to Health Plan to insure Provider, its Participating Practitioners, its Participating Facilities, its employees, and agents against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of, or failure to perform, any health care service provided under this Agreement, the use of any property and facilities provided by Provider, and activities performed by Provider in connection with this Agreement. Such coverage may be provided via a self-insured program. The amounts and extent of such insurance coverage shall be subject to the approval of Health Plan, which approval shall not be unreasonably withheld. Certificates of Insurance for the above insurance policies shall be provided to Health Plan upon request and shall provide that Health Plan be given at least thirty (30) days prior written notice of reduction or cancellation of such coverage. Any declaration sheets, exclusions, endorsements, or information on any incident which might reasonably result or has resulted in a lawsuit or legal action may be requested by Health Plan as deemed necessary.

Liability Oregon Public Hospitals. Health Plan recognizes that if a Provider is a public entity its liability is limited pursuant to ORS 30.260 through 30.300, and the Oregon Constitution, Article XI, Section 7. In such event, Provider's obligations with respect to liability insurance are limited by those provisions.

Program Cooperation and Participation. Provider agrees to cooperate and participate in the following, as designated from time to time by Health Plan and/or as required by state or federal regulations:

A. Internal medical and quality management, quality improvement, and customer service activities;
B. Disease management programs;
C. External audit systems;
D. Rules and Regulations of Health Plan;
E. Development of evaluation criteria for new medical technologies or new applications of established technologies (including medical procedures, drugs and devices);
F. Such other systems, activities and procedures relating to Health Plan accreditation by external accrediting bodies as may be determined from time to time by Health Plan;

G. Clinical Quality Improvement and Outcome studies; and
H. Standards of Care and Service, all of which are set forth in Rules and Regulations of Health Plan and/or other Health Plan documents and communications.

Provider shall further agree to comply with any final determinations made pursuant to any of the review processes noted above, as such determination(s) relates to Provider's rights and responsibilities under this Agreement. Failure to comply with such final determinations may constitute grounds for termination in accordance with the Term and Termination section of the Agreement.

Facility Inpatient Admission. If Provider is a hospital Participating Facility it agrees to notify Health Plan within twenty four (24) hours after any Emergency-related inpatient hospital admission of a Member, or by the end of the next working day if the admission occurs on a weekend or holiday, and will permit review of the admission by a Health Plan physician reviewer or designated representative. The purpose of the review is to provide certification of the medical indications for the admission under Health Plan's utilization management program, which certification shall, for approved admissions, in no event be for a period shorter than the period between date of admission and receipt by Provider of notice of certification. Failure by such Provider to notify Health Plan of Member's admission and to substantiate the medical indication for the admission within the time period set forth above may result in forfeiture of Provider's right to compensation from either Health Plan or Member for services rendered to such Member during his or her stay.

ARTICLE V.
BILLING AND COMPENSATION

Payment for Covered Services. Health Plan agrees to pay Provider for Covered Services rendered by Provider to Members, within Provider's Scope of Service.

Compensation Terms. Provider will be compensated for Covered Services rendered in accord with the terms set forth in the Attachments.

Implementation of Member Benefits. Provider agrees to comply with all Health Plan Rules and Regulations relating to the delivery of Covered Services. Health Plan may consult with Provider regarding significant changes to existing Health Plan administrative policies and procedures prior to implementation. Provider agrees to cooperate with Health Plan in monitoring Member Coinsurance, Copayment and/or Deductible in order to ensure that payment limitations imposed by federal law are not exceeded.

Member Responsibility. Health Plan may require Members to pay a Coinsurance, Copayment, and/or Deductible for certain Covered Services as set forth in the Member's Individual or Group Service Agreement with Health Plan. Provider agrees to be responsible for the collection of such Coinsurance, Copayment, and/or Deductibles. Provider may not waive Member's responsibility as set forth in the Member's Individual or Group Service Agreement with Health Plan. Members will be responsible for the payment of such Coinsurance, Copayment, and/or Deductibles.

Coordination Of Benefits. Coordination of benefits (COB) refers to the rules for the order of benefit determination under which health benefit plans pay claims when a person is covered under more than one plan. Such coordination of benefits is intended to provide the covered person with the most allowable benefits available under the plans and to preclude the Provider from receiving an aggregate of more than one hundred percent (100%) of covered charges from all coverage. When the primary and secondary plan benefits are coordinated, determination of liability will be in accordance with the administrative rules adopted by Oregon Department of Consumer and Business Services and applicable state and federal regulation. For Providers residing outside the State of Oregon, applicable state laws will apply.

Contract Allowable. Health Plan will have no obligation to pay any amount that, together with all other Health Plan payments to and contractual adjustments made by the Provider, exceeds the amount allowable by Health Plan for the service as set forth in the Attachments.

Additional Fees Prohibited. Provider understands and agrees that any additional fees or surcharges for Covered Services charged to Members are prohibited. An additional fee shall mean any charge that is not previously approved by Health Plan. A surcharge is an additional fee which is charged to a Member for Covered Services but which is not provided for under the applicable enrollment agreement or disclosed in the evidence of the Member's coverage.

Claim Submission. Provider agrees to submit claims whether primary, secondary or other payor to Health Plan on industry accepted claim forms for all Covered Services rendered to Members. Such claim form shall include statistical and descriptive medical and patient data in a form specified by Health Plan. Diagnosis codes listed will note the highest level of specificity. Billings will be consistent with ethical and community standard billing practices, and shall include such "CMS compliant" encounter data or other information as may be required of Health Plan by CMS or by state agencies. Under usual circumstances, such claim form shall be submitted to Health Plan within sixty (60) days of the date of service, and in no case later than twelve (12) months from the date of service. Neither Member nor Health Plan shall be responsible for the payment

of bills submitted after the twelve (12) month period, except in cases where Provider submits the claim no later than 12 months after a different insurer (a) denied the claim in whole or in part; or (b) requested a refund of an erroneous payment made on the claim.

Accepting Partial Member Payment. Provider may accept a partial or estimated payment on coinsurance and/or deductible obligations before Health Plan has adjudicated the amount of such obligations, but only if the following conditions have been met: (1) Provider has verified Member's eligibility and benefits, and (2) Provider has a reliable process in place for timely reconciliation and timely repayment to Member of any overpayments by Member.

Provider is expected to make extended payment options available to the patient when necessary. Provider may not redirect Member to another provider solely for the purpose of shifting financial risk to the other provider.

Third Party. In the event of a Member's illness or injury for which a third party other than Health Plan has accepted financial responsibility or has been judged to be liable by an entity empowered to assess liability (such as a court or similar adjudicative body), Provider will bill the third party for payment prior to billing Health Plan. Any remaining unpaid balance due after forty five (45) days from billing may be billed to Health Plan for payment consideration. The amount available for collection by Provider from the third party shall be applied to charges for medical care of a Member at Health Plan's contracted rates prior to accessing the resources of Health Plan. If such third party liability eliminates any financial obligation of Health Plan on a Member's behalf, Health Plan will have no liability under this Agreement with respect to such illness or injury. In the event the third party is not liable for the illness or injury of a Member or if recovery from the third party is less than Health Plan's obligation to Member in the absence of payment by a third party, Provider must comply with Health Plan's rules governing the provision of Covered Services and the terms of this Agreement in order for Health Plan to be financially responsible.

Electronic Claims. The parties agree to cooperate in electronic submission of claims whenever possible.

Pay Clean Claim. Health Plan agrees to pay a Clean Claim within the time period mandated by applicable state and federal law.

Refund Request by Health Plan. Except in cases of coordination of benefits, fraud or abuse of billing, Health Plan may not request refunds from Provider unless it is within 18 months of initial payment. The request must be in writing and must specify why the refund is being requested. Health Plan may not request that a contested refund be paid earlier than six months after the Provider receives the request. In the case of coordination of benefits, Health Plan may not request a refund unless it is within 30 months after the date of payment. The request must be in writing and must specify why the refund is being requested and include the name of the primary payor or entity. If Provider fails to contest the refund request within 30 days, the request is deemed accepted and Provider must pay within 30 days (60 days total). If Provider does not pay, Health Plan can recover through offset of a future claim. Health Plan may at any time request a refund if the third party or government entity is found responsible by law, or if the Health Plan is unable to recover directly from the third party because the third party already paid or will pay the Provider for the health care services covered by the claim.

Additional Payment Request by Provider. Except in cases of coordination of benefits, fraud or abuse of billing, Provider may not request additional payment unless the request is in writing and within 18 months of the date of a denial or partial payment. The request must be in writing and must specify why the additional payment is being requested. The Provider may not request that an additional payment be paid earlier than six months after Health Plan receives the request. In the case of coordination of benefits, Provider may not request additional payment unless it is within 30 months after the date the claim was denied or payment intended to satisfy the claim was made. The request must be in writing and must specify the reason for the request and must include the name and address of the primary payor or entity.

Once Per Case. A request for re-review will be performed by Health Plan only once per case.

Never Events. Neither Participating Practitioners nor Participating Facilities shall seek payment from Health Plan or from Member for costs associated with "never events". Health Plan will not provide payment for identified "never events". Health Plan will be guided by the recommendations of the National Quality Forum, the American Hospital Association, CMS, and other relevant sources.

ARTICLE VI.
RECORDS AND CONFIDENTIALITY

Record Sharing. Provider agrees to participate in any system established by Health Plan that will facilitate, to the extent feasible, the maximum sharing of records, subject to compliance by Health Plan with state and/or federal law regarding confidentiality. Provider agrees to retain records in accordance with other minimum requirements of state law. Such obligations continue despite the termination of this Agreement. Health Plan shall have access at reasonable times upon

demand to the records of Provider. Provider and Health Plan agree to treat all medical records of Members as confidential so as to comply with all federal and/or state laws and regulations regarding the confidentiality of patient records. Provider agrees to cooperate with Health Plan in maintaining and providing financial records, and medical histories, administrative and other records of Members as shall be requested. Requests for copies shall be reasonable in nature.

Record Copying. Provider agrees, upon reasonable request by Health Plan, to provide access to and/or copies of all records necessary (A) for purposes of assessing quality of care, medical indications and/or appropriateness of care, (B) for claims adjudication, and (C) to comply with the provisions of the Rules and Regulations of Health Plan and/or the utilization and quality management program, the re-appraisal process, and records requests from state and federal regulatory agencies and review organizations. Health Plan will allow Provider a reasonable length of time within which to provide the requested documents. The parties agree that such records shall maintain the same confidential nature they had while in the possession of Provider. Provider is responsible for costs associated with record copying.

Record Retention. All clinical records shall be retained for seven (7) years after the date of service for which claims are made. If an audit, litigation, or research and evaluation, or other action involving the records is started before the end of the seven (7) year period, the records must be retained until all issues are resolved.

Audit of Records. Provider agrees, at all reasonable times, to provide Health Plan and any state or federal regulatory agency, and their duly authorized representatives, access to its facilities and to its medical records for the purpose of making audit or examination; upon request, Provider agrees to provide a suitable work area and copying capabilities to facilitate such a review or audit. This right to inspect, evaluate, and audit extends through seven (7) years from expiration or termination of this Agreement or completion of audit, whichever is later, unless the regulator extends this period or asserts a right to inspect, evaluate, or audit at any other time on account of a special need to retain particular records or a dispute or possibility of dispute related to such records, in which case the regulator's determination shall govern. This provision shall continue in effect notwithstanding the termination of this Agreement.

Proprietary Information. Provider agrees to maintain the confidentiality of documents, terms, and conditions relating to reimbursement rates and methods and other proprietary information of Health Plan. Upon request, Provider agrees to return all copies of documents containing any of Health Plan's proprietary information upon termination of this Agreement.

Medical Record Availability. Subject to applicable confidentiality requirements, Provider agrees to provide for a system, to the extent feasible, which permits sharing of records by Participating Providers and other health care professionals providing service to Members. Medical records shall be made available to each Participating Provider and other health care professional treating Member. In addition, medical records shall be made available upon request by any proper committee of Provider or Health Plan to determine that content and quality are acceptable, as well as for peer review or grievance review.

ARTICLE VII.
AMENDMENTS

Amendment. Health Plan may amend this Agreement by providing 30 days' written notice to Provider. If no written objection is received within thirty (30) days, Provider shall be deemed to approve such amendment.

Regulatory Amendment. If state or federal law, government agency regulations or accrediting agency requirements change and affect any provisions of this Agreement, then this Agreement will be deemed amended to conform with such changes effective the date such changes become effective. Health Plan will give Provider written notice of such changes.

ARTICLE VIII.
TERM AND TERMINATION

Effective Date. Provider will be notified by Health Plan of the effective date of this Agreement. Signed Agreements received by Health Plan by the 18th day of the month will generally be effective the 1st day of the following month, subject to credentialing approval as noted below. (Example: Signed Agreement received by 1/18, effective date will be 2/1. Signed Agreement received 1/19 to 2/18, effective date will be 3/1.) This Agreement shall remain in effect until December 31st of the year of execution and thereafter to December 31st of each subsequent year, unless terminated pursuant to the terms of this Agreement.

Credentialing Required. Participating status for individual practitioners or facilities covered under this Agreement is contingent upon credentialing approval in advance by Health Plan. Provider will be notified by Health Plan of the effective date for each Participating Practitioner or Participating Facility.

Termination Without Cause. This Agreement may be terminated without cause by Provider or Health Plan upon sixty (60) days prior written notice. Upon such termination, the rights of Provider shall terminate, provided, however, that such action shall not release Provider from obligations to persons then receiving treatment. Provider agrees to be paid in accordance with this Agreement for Covered Services provided prior to termination of this Agreement.

Termination Automatic With Cause.

The following provision applies to Participating Facilities:

This Agreement will automatically terminate upon the revocation, non-renewal, limitation or suspension of a Provider's license for any or part of its facilities or services.

The following provisions apply to Participating Practitioners:

This Agreement will automatically terminate upon the occurrence of any of the following events: if Participating Practitioner (i) dies, (ii) retires, (iii) is adjudicated incompetent, (iv) has his or her professional license revoked, restricted, suspended, or not renewed, (v) loses his or her hospital privileges, or (vi) voluntarily leaves active practice in Health Plan service area for a period of six (6) months or more.

Termination With Cause.

The following provisions apply to Participating Facilities and to Participating Practitioners:

This Agreement may be terminated with cause by either party by giving written notice to the other party at least thirty (30) days in advance of the effective date of termination in the event that the other party (i) fails to pay valid, past due debts, (ii) lacks the financial resources to pay its financial obligations, (iii) fails to maintain required professional liability insurance coverage, (iv) makes any intentional misrepresentation to Member regarding the provision of medical services or the payment thereof, (v) fails to accept the results of and comply with the requirements of the utilization and quality management committees of Health Plan, (vi) fails to participate in and accept the Rules and Regulations of Health Plan, (vii) is determined by Health Plan to no longer meet Health Plan's standards for credentialing, (viii) suffers limitation of a required license, or (ix) is in breach of any material provision of this Agreement. Such notice shall set forth the facts underlying the alleged breach. Remedy of such breach within twenty (20) days of the receipt of such notice shall revive the Agreement in effect for its remaining term, subject to any other provision of this Agreement.

The following provision also applies to Participating Practitioners:

At Health Plan's discretion, with thirty (30) days prior written notice, this Agreement may be terminated with cause if any Participating Practitioner suffers limitation of hospital medical staff privileges. If Provider is terminated under this provision, payment for Covered Services provided prior to termination shall be made in accordance with this Agreement and the notice of termination shall set forth the facts underlying the alleged breach.

Termination With Cause of Less Than Entire Agreement. Health Plan may, at its sole discretion, choose to terminate an individual practitioner or individual facility providing Covered Services under this Agreement whose conduct would otherwise give Health Plan cause to terminate this Agreement in its entirety. Upon such individual termination, the Agreement shall remain in effect as to all other practitioners or facilities covered by it.

Immediate Termination. Nothing herein shall be construed as limiting the right of Health Plan to terminate this Agreement, or an individual practitioner or facility providing Covered Services under this Agreement, immediately where Health Plan determines that the health, safety or welfare of any Member is jeopardized by failing to do so. If Provider is terminated under this provision, payment for Covered Services provided prior to termination shall be made in accordance with this Agreement.

Transitional Plan For Member. The parties recognize and agree that Member must not suffer or be exposed to avoidable risks to life and welfare due to circumstances related to termination of this Agreement. Therefore, upon receipt of termination notice by either party and under the supervision of the Chief Medical Officer, the parties agree to establish a written plan for transitional services for any affected Member. Such plan shall be completed within seven (7) working days of issuance of a termination notice. If Provider is a hospital, reimbursement for Covered Services provided after termination for any Member who is an inpatient of hospital as of the effective date of termination will continue to be governed by this Agreement until discharged from inpatient stay.

Coordination Of Member Communication. Health Plan and Provider agree to coordinate any communications to be made by Health Plan or Provider to other parties of the reasons for and circumstances surrounding any termination of this Agreement.

Obligations After Termination. The following obligations of the parties shall continue after any termination of this Agreement:

A. To indemnify and hold each other harmless as otherwise described in this Agreement;
B. To cooperate with each other in the event any action or other proceeding based on or related to the facts having to do with this Agreement is brought by any third party against either of them;
C. To maintain medical records and allow access to information as provided in this Agreement.
D. To maintain the confidentiality of records.

E. To resolve disputes under this Agreement in accord with its terms.
F. To hold members harmless with respect to billings for Covered Services provided during the term of this Agreement.
G. To accept payment under this Agreement for members hospitalized at the time of termination.
H. To coordinate member communications.

Participating Practitioner Rights Upon Termination or Other Disciplinary Action. The Rules and Regulations of Health Plan (Credentialing Policies and Procedures) are incorporated by reference into this Agreement, including but not limited to those related to:

1. The process by which improvements and corrections may be required with respect to a Participating Practitioner's or Participating Provider's performance.
2. The processes for identifying any need to take action with regard to limiting or terminating a Participating Practitioner or Participating Provider's credentialing occurs.
3. The Participating Practitioner or Participating Provider's rights to notice and opportunity to be heard when the Health Plan acts to remove or to limit participation in the Health Plan.

ARTICLE IX.
DISPUTE RESOLUTION AND ARBITRATION

Disputes/Arbitration. In the event of any dispute arising out of or relating to this Agreement, the parties shall first attempt in good faith mutually to resolve the dispute. If the parties are unable to resolve the dispute, then all matters in controversy shall be submitted to binding arbitration before a single arbitrator under the auspices, rules, and regulations of the United States Arbitration & Mediation Service in Portland, Oregon. The parties agree to be bound by the decision of the arbitrator, which shall be a final determination of the matter in dispute. The parties further agree to divide the cost of arbitration equally, including filing, administration, and arbitrator's fees, but to be responsible each for its own attorneys' fees.

Legal Fees in Matters Other than in Arbitration. In the event suit or legal action is instituted by any party seeking interpretation of the terms hereof seeking redress for a breach of this Agreement, or seeking to enforce or to invalidate an arbitration award, the prevailing party shall be entitled to all costs and attorneys' fees incurred at trial or on any appeal.

ARTICLE X.
HOLD HARMLESS

Hold Harmless. Provider may bill Member for non-Covered Services that Provider provides. Provider agrees that in no event, including but not limited to nonpayment by Health Plan, insolvency of Health Plan, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a subscriber, an enrollee or persons (other than Health Plan) acting on a Member's behalf for Covered Services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting Copayments, Coinsurance, Deductibles or fees for non-Covered Services delivered to Health Plan Members (subscribers/enrollees).

Provider agrees that this provision shall survive the termination of this Agreement, for Covered Services rendered prior to the termination of this Agreement, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This provision is not intended to apply to services provided after this Agreement has been terminated.

Provider agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and Member, or persons acting on their behalf insofar as such contrary agreement relates to liability for payment for services provided under the terms and conditions of this Agreement.

Any modification, addition, or deletion to this provision shall become effective on a date no earlier than fifteen (15) days after the appropriate regulating entity has received written notification of proposed changes.

ARTICLE XI.
GOVERNING LAW & REGULATORY REQUIREMENT

Regulatory Amendment. If state or federal law changes, including government agency regulations and accrediting agency requirements, affect any provisions of this Agreement, then this Agreement will be deemed amended to conform with such changes effective the date such changes become effective. Health Plan will give Provider written notice of such changes.

Agree to Comply. The Parties agree to comply with all applicable state and/or federal laws and regulations, including HIPAA.

ARTICLE XII.
TRANSPARENCY

Data Sharing. Health Plan intends to collect objective measurements relating to Provider's practice and to make such measurements available to other Providers, to patients, and/or to the public, in detail or in summary format, subject only to protecting patients' state and/or federal confidentiality rights. Provider will have the opportunity to meet with Health Plan to discuss the methodology of data collection and will have the opportunity to review and correct Health Plan's source data prior to publishing. Provider hereby waives any claim that such measurements are privileged or confidential, under ORS 41.675 or otherwise, and consents to Health Plan's use and disclosure of such practice measurements.

ARTICLE XIII.
GENERAL PROVISIONS

Assignment. Provider may not assign rights, duties or obligations under this Agreement without the prior written consent of Health Plan. This Agreement shall survive the sale, merger or asset transfer of Health Plan, and bind any successor of Health Plan to its terms and conditions.

Behavioral Health Services. Covered mental health and chemical dependency benefits administered by United Behavioral Health, Inc. are not covered under this contract. Covered mental health and chemical dependency benefits administered by Health Plan are covered under this contract.

Entire Agreement. This Agreement, including its Attachments, Addendums or Exhibits, contains all of the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement and the Attachments, Addendums or Exhibits hereto, are null and void and of no further force or effect.

Headings. The headings of the various sections of this Agreement are inserted merely for the purpose of convenience and do not expressly or by implication limit or define or extend the specific terms of the section so designated.

Indemnification. Within the limits of its insurance policies and to the extent not otherwise inconsistent with the laws of the State of Oregon and/or Washington, the parties mutually agree to indemnify and to hold each other (including their officers, agents and employees) harmless against any and all claims, demands, damages, liabilities and costs incurred by the other party, including reasonable attorney fees, arising out of or in connection with, either directly or indirectly, the breach of this Agreement by or willful misconduct of the indemnifying party or its employees or agents. The fact that a physician or other provider is a Participating Practitioner does not make such person an agent of Health Plan unless the person's agreement with Health Plan explicitly so provides. The principles of comparative fault shall govern the interpretation and enforcement of this indemnity provision.

Independent Parties. None of the provisions of this Agreement is intended to create, nor shall any be deemed or construed to create, any relationship between the parties other than that of independent entities contracting with each other under this Agreement solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be deemed to be the agent, employer, partner, joint venture, or representative of the other, except as specifically provided herein.

Invalid Provisions. The invalidity or unenforceability of any terms or conditions hereof shall in no way affect the validity or enforceability of any other term or provision.

Liaison. The parties agree to maintain an effective liaison and close cooperation with each other to provide maximum benefits to each Member at the most reasonable cost consistent with quality standards of medical practice.

Notices. Notices required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent to Health Plan or Provider at their respective places of business.

Waiver. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach.

PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE PROVIDER AGREEMENT SIGNATURE PAGE

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed in their names by the undersigned officers, the same being duly authorized to do so.

NORTH CENTRAL PUBLIC HEALTH DISTRICT

Signature

Teri L. Thalhofer RN

Print Name

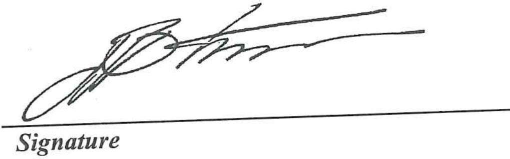
Director

Title

1-7-2015

Date

PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE



Signature

Jeff Butcher

Print Name

Chief Financial Officer

Title

December 30, 2014

Date

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PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE
COMMERCIAL (EPO) LINE OF BUSINESS
ATTACHMENT EPO
EXCLUSIVE PROVIDER ORGANIZATION

Exclusive Provider Organization (EPO) is a closed network of Providers contracted to provide services on a fee-for-service basis with no risk borne by Providers. The network is available to Health Plan Members enrolled in an EPO product. EPO products include Providence Administrative Services Only (ASO) products where Member's employer bears risk. Employers who select a Providence ASO product may at their discretion elect to exclude one or more Participating Practitioners or Participating Facilities from their designated network.

To the extent the Exclusive Provider Organization (EPO) provisions in this Attachment are in conflict with or not addressed in the Agreement, the EPO provisions in this Attachment supersede the provisions of the Agreement for EPO.

DEFINITIONS

Member shall mean any person who is enrolled in Health Plan's EPO and for whom required premium or other payments have been made to Health Plan by Member or by Member's employer.

Open Option Member shall mean a Member of Health Plan's EPO who, in addition to benefits for Covered Services provided by Participating Practitioners and Participating Facilities, also has benefits covering services by non-participating practitioners or facilities These benefits may require additional Member cost sharing.

Personal Option Member shall mean a Member of Health Plan's EPO who has benefits for Covered Services provided by Participating Practitioners and Participating Facilities and has no coverage for non emergent services provided by non-participating practitioners or facilities unless prior authorized by Health Plan.

Personal Physician shall mean a Participating Practitioner specializing in Internal Medicine, Family Practice, General Practice, Pediatrics or Obstetrics/Gynecology who has contracted with Health Plan and is (A) the case manager who acts as a Member's point of entry to the delivery system, and (B) manages/oversees all services for the Member including office care, preventive health Maintenance, and referral management. A Personal Physician may not be a Personal Physician for immediate family members under this Agreement.

OBLIGATIONS OF PROVIDER

Accepting Members. If Provider is a Personal Physician, Provider agrees to accept newly enrolled Members and Members who transfer from another Personal Physician. A Personal Physician shall provide Covered Services for a reasonable number of Members, as defined in the Rules and Regulations of Health Plan. Upon prior approval of Health Plan, Provider may limit his or her practice to existing patients who are or become Members. A Personal Physician with an open practice may not refuse to be a Personal Physician for a Member who chooses them.

PROVIDENCE CHOICE PLAN

Providence Choice Plan Member shall mean a Member of Health Plan's EPO who is enrolled in the Providence Choice Plan and for whom required premium payments have been made to Health Plan. Benefits are covered under Providence Health Plan's Medical Home Program.

Providence Choice Plan. Providence Choice Plan is a Providence Health Plan EPO point of service product with a primary medical home benefit design.

Referral Provider shall mean a Participating Practitioner or a Participating Facility who is contracted with Health Plan to provide Covered Services to Providence Choice Plan Members upon a referral from the Providence Choice Plan Member's designated medical home. A Referral Provider will provide coordinated Covered Services based upon Providence Choice Plan Member's proposed plan of treatment as directed by the designated medical home.

Providence Choice Plan Out of Plan Benefits. Participating Practitioners who see a Providence Choice Plan Member without a referral from the Providence Choice Plan Member's designated Medical Home will be reimbursed in accordance with the terms of this Agreement at the Providence Choice Plan Member's out-of-plan benefit.

Plan Of Treatment. Providence Choice Plan Member's designated medical home and Referral Provider shall agree on the proposed plan of treatment prior to implementation of such treatment by Referral Provider. Should the Referral Provider desire to refer Providence Choice Plan Member to another Referral Provider, such referral must be obtained from Member's designated medical home in advance. Referral Provider will send a copy of Member's record to Member's designated medical home after all approved visits or after any urgent or emergent care visits.

Referral Systems. Referral Providers shall participate in the referral system to facilitate appropriate referral services for Providence Choice Plan Members.

Hold Harmless. Except in cases where Providence Choice Plan utilizes their opt-out benefit, Provider hereby agrees that Provider will not be compensated by Health Plan or Providence Choice Plan Member for Covered Services rendered to Providence Choice Plan Member that have not been referred by Providence Choice Plan Member's designated medical home unless such Providence Choice Plan Member requires Emergency treatment.

PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE
ATTACHMENT A
COMPENSATION STRUCTURE

SCOPE OF SERVICES

Provider is engaged only to provide Covered Services from sites within the limits of the following counties: Gilliam, Hood River, Morrow, Sherman, Umatilla and Wasco Counties in OR, and Klickitat and Skamania Counties in WA

Provider is engaged only to provide Covered Services which Provider is professionally qualified to render.

The rates in Attachment A-1 are premised on services offered by Provider as of the inception of this Agreement. In the event Provider adds new services, Provider agrees to notify Health Plan within a reasonable time, 1) in order for Health Plan to determine if services will be incorporated into current Agreement, and 2) to negotiate in good faith to establish rates applicable to such new services should they be incorporated into current Agreement.

PAYMENT FOR MEDICAL SERVICES

Health Plan will pay Covered Services at 100% of the allowed compensation, less any applicable copayment, coinsurance and deductibles, in accordance with the fee schedule in the Attachments. Member coinsurance and deductibles are calculated using the allowed compensation, not billed charges. No withhold is applied.

PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE
COMMERCIAL (EPO) LINE OF BUSINESS
ATTACHMENT A-1
FEE SCHEDULE

RATE EFFECTIVE DATE: JANUARY 1, 2015

PHYSICIAN/PRACTITIONER
(MD, DO, DPM, NP, PA, CNMW, DDS, DMD)

Provider is only contracted to provide Immunizations to Health Plan Members

Service Type	Codes	Payment Source	Rate
RBRVS	90460, 90461, 90471-90474 (CPT)	2014 CMS RBRVS RVUs (available as of 12/31/2013)	$ 62.00
Immunizations	9XXXX (CPT)	Immunizations priced using Oregon Immunization Program (OIP), if no OIP priced at Wholesale Acquisition Cost (WAC), if no WAC priced at CMS Average Sales Price (ASP) or Average Wholesale Price (AWP)	100% OIP 110 % WAC, ASP, AWP

- Reimbursement will be at the allowed amount or billed charges, whichever is less.
- New codes not included in the existing fee schedules may be evaluated and priced by Health Plan applying the most current published fee schedule rates, weights or RVUs. Service codes not encompassed by fee schedules may be priced at Health Plan's discretion by applying a most comparable rate. The most current code sets will be recognized by Health Plan in accordance with HIPAA regulations
- Specific services within the code ranges listed above may be excluded from this Agreement. For example, Provider may not be contracted to provide the technical component for MRI, CT or other high tech services.
- If there is no separate Providence Connect Fee Schedule, Provider will be reimbursed in accordance with the terms of this Attachment A-1, Fee Schedule, at the Providence Connect Member's out-of-plan benefit.
- If there is no separate Providence Connected Care Fee Schedule, Provider will be reimbursed in accordance with the terms of this Attachment A-1, Fee Schedule and the Providence Connected Care Member's benefits.
- For any other commercial network, if there is no separate Fee Schedule, Provider will be reimbursed in accordance with the terms of this Attachment A-1, Fee Schedule and the Member's benefits.

PROVIDENCE HEALTH PLAN AND PROVIDENCE HEALTH ASSURANCE
ATTACHMENT C
QUALITY AND MEDICAL MANAGEMENT
QUALITY AND MEDICAL MANAGEMENT PROGRAM

Health Plan oversees the quality, cost and utilization of services rendered to Members through its Quality and Medical Management Program. The Quality and Medical Management Program adheres to state and regulatory rules and regulations, Health Plan policy and quality management measures. Provider, Participating Practitioners and Participating Facilities support the administration of the Quality and Medical Management Program.

PROGRAM SUMMARY

A description of the Quality and Medical Management Program may be viewed on Health Plan's website.

Key features:

Quality and Medical Management Program Committees that review and monitor medical management and quality management activities.

Continuous quality of care and service improvements.

Program oversight by Medical Directors and experienced Quality and Medical Management Program staff.

Medical Policy and Payment Rule development process.

Technology Assessment Program.

Formal appeal and complaint resolution process.

Ethics Committee participation.

Medical Management Activities:

Preauthorization of selected inpatient admissions, day surgery, selected outpatient services and drugs. A complete list of these procedures is available on Health Plan's website. This list is subject to periodic modification.

Second opinions.

Concurrent review of inpatient admissions, continued stays, and discharge planning.

Identification of patients needing individualized care management, case management, and exceptional needs care coordination (ENCC).

Review of urgent and emergent claims for appropriateness of level of care.

Specialized maternity management program, Providence Beginnings.

Mental Health/Chemical Dependency Program.

Organ Transplant Program.

Pharmacy Management Program.

PRIOR AUTHORIZATION

Prior Authorization. Prior authorization is required for certain health care services. A list of inpatient, outpatient and short-stay services that require prior authorization is available on Health Plan's website.

Periodic Modification. The list of services requiring prior authorization is subject to periodic modification by Health Plan.

Benefit Guarantee. Authorization does not guarantee benefits or payment. Benefits are based on eligibility at the time the service is rendered and are subject to any applicable contract terms.

Questions. Questions regarding materials posted on the Health Plan website should be directed to the appropriate Health Plan Provider Relations Representative.

Denied Services. Provider may request a re-review of a service denied for lack of medical indications within one hundred and eighty (180) days of the initial denial. The request must be in writing and must include additional information that was not available at the time of the original determination.

Review. Professional medical staff will review all of the available information submitted with the request for re-review. At the discretion of the Chief Medical Officer or designated medical Director, a review by a physician advisor or independent third party may be requested.

Time to Complete Review. Health Plan will complete the review within twenty (20) business days of receipt of all information necessary to process the request. If Health Plan cannot make a determination within twenty (20) business days, Member and/or Provider will be notified of the reason for the delay. Health Plan will make a decision and notify Member and/or Provider within ten (10) additional business days.

NCPHD Directors Report for February 10, 2015

Communicable Disease Work: All staff has been working recently to address a Strepto coccus outbreak in Condon. Local providers throughout the region were engaged in the efforts. Single cases of Strep are not reportable, but outbreaks of any communicable disease are reportable. Congratulations to Mike Tagaki, PA, for identifying and addressing. No 'smoking gun' was identified. All local providers were cooperative and contributed to the efforts.

EARLY LEARNING: 4 Rivers Early Learning HUB work continues. It is anticipated that the entity will be contracted with the Early Learning Division prior to July. This will make the region eligible for increased funding. Areas of highest need (most at risk children and not ready for Kindergarten) and strategies will be put in place to address the needs. If the BOH desires, a fuller presentation on the work can be done at the March meeting.

Healthy Communities: Oregon Solutions , on behalf of NCPHD, convened the second Wasco County meeting around the issue of childhood obesity on February 4, 2015. Much work had been done by the participants just in the month since the first meeting. Most substantial was City of The Dalles Councilor Dan Spatz's work to get wellness and the HEAL cities initiative into the City's 18 month work plan. Policy and environmental change have the largest impact on population obesity issues.

Shellie Campbell, NCPHD Tobacco and Education Prevention Coordinator, presented to the Chamber of Commerce Government Affairs Committee on February 5, 2015. The presentation was well received. Shellie is available to present to community groups and clubs throughout the region. Please contact her if you know of a group interested in improving community health!

Staff is participating in 'Go Red for Women's Heart Health' Friday, February 6, 2015. The event is co-sponsored with MCMC. Staff are involved in the planning group for the event, will be staffing booths at the event, and help staff the walk-run on Saturday. The event helps to raise awareness around the issue of women and heart disease.

Health Care Reform: I have attended the Community Advisory Committees for Columbia Gorge CCO, Gilliam County and Sherman County. Interesting discussions all around regarding community based interventions. Jane Palmer and I are participating in a maternal-child health work group to address the needs of that demographic specifically for Columbia Gorge CCO. I have met with case management staff from both Pacific Source and MODA to coordinate case management efforts. Work around targeted case management integration into the CCO global budgets continues. Maintainin current service levels, at least, and programmatic efforts has been the emphasis for this first year.

Working with Legislators: I met with John Huffman on January 27, prior to the beginning of this legislative session to discuss issues that are relevant to public health and early learning.

Submitted: February 6, 2015