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North Central Public Health District

"Caring For Our Communities"

North Central Public Health District Board of Health Meeting

February 9, 2016
3:00 PM
Meeting Room @ NCPHD

AGENDA -

1. **Minutes**
   a. Approve from January 12, 2016 meeting.
   b. Set Next Meeting Date (March 8, 2016)

2. **Additions to the Agenda**

3. **Public Comment**

4. **Unfinished Business**
   a. Updates from Wasco County
   b. Current Status of Services
   c. Columbia Gorge Health Council Funding

5. **New Business**
   a. Playspent.org
   b. Review of A/P checks issued (January 2016)
   c. Policy & Procedures:
      i. Return-to-Work Policy
   d. Contracts
      i. OHA 148025-2
      ii. OCDC 02-031-4
      iii. United Healthcare
   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

"Caring For Our Communities"

419 East Seventh Street
The Dalles, OR 97058-2676
541-506-2600
www.ncphd.org

North Central Public Health District
Board of Health
Meeting Minutes
January 12, 2016 (3:00pm)

In Attendance: Commissioner Mike Smith – Sherman County; Roger Whitely – Sherman County; Judge Steve Shaffer – Gilliam County; Michael Takagi – Gilliam County; Commissioner Scott Hege – Wasco County; William Hamilton – Wasco County; and Fred Schubert – Wasco County.

Staff Present: Teri Thalhofer, RN BSN – Director NCPHD; Kathi Hall – Finance Manager NCPHD; Lori Treichel – NCPHD PH Nurse; Allyson Smith – NCPHD PH Nurse; and Tanya Wray PHEP Coordinator NCPHD.

Guests Present: Neita Cecil – The Dalles Chronicle

Minutes taken by Gloria Perry

Meeting called to order on January 12, 2016 at 3:02pm by Commissioner Mike Smith.

SUMMARY OF ACTIONS TAKEN

Motion by Commissioner Scott Hege, second by Fred Schubert, to approve the minutes from the 12/8/15 board of health meeting with corrections discussed.

Vote:	7-0
Yes:	Commissioner Mike Smith, Roger Whitley, Judge Steve Shaffer, Michael Takagi, Commissioner Scott Hege, William Hamilton and Fred Schubert.
No:	0
Abstain:	
Motion carried.	

Motion by William Hamilton, second by Judge Steve Shaffer, to approve the All Hazards Base Response Plan with corrections discussed.

Vote:	7-0
Yes:	Commissioner Mike Smith, Roger Whitley, Judge Steve Shaffer, Michael Takagi, Commissioner Scott Hege, William Hamilton and Fred Schubert.
No:	0

Abstain:
Motion carried.

Motion by Judge Steve Shaffer, second by William Hamilton, to accept the new Vital Records Fee Schedule set forth by the State of Oregon.

Vote: 7-0
Yes: Commissioner Mike Smith, Roger Whitley, Judge Steve Shaffer, Michael Takagi, Commissioner Scott Hege, William Hamilton and Fred Schubert.
No: 0
Abstain:
Motion carried.

Motion by Judge Steve Shaffer, second by Commissioner Scott Hege, to appoint Kathi Hall as the Budget Officer for the 2016-17 fiscal year budget process.

Vote: 7-0
Yes: Commissioner Mike Smith, Roger Whitley, Judge Steve Shaffer, Michael Takagi, Commissioner Scott Hege, William Hamilton and Fred Schubert.
No: 0
Abstain:
Motion carried.

Motion by Fred Schubert, second by Roger Whitely, to approve the policies and procedures presented as is.

Vote: 7-0
Yes: Commissioner Mike Smith, Roger Whitley, Judge Steve Shaffer, Michael Takagi, Commissioner Scott Hege, William Hamilton and Fred Schubert.
No: 0
Abstain:
Motion carried.

Motion by Judge Steve Shaffer, second by Michael Takagi, to approve the A/P Checks Issued in December 2015 report as presented.

Vote: 7-0
Yes: Commissioner Mike Smith, Roger Whitley, Judge Steve Shaffer, Michael Takagi, Commissioner Scott Hege, William Hamilton and Fred Schubert.
No: 0
Abstain:
Motion carried.

WELCOME & INTRODUCTIONS

1. **MINUTES**
    a. Approval of past meeting minutes
        - Minutes were approved with the following corrections:
            - ✓ Page 1 > In Attendance section: Add Kathi Hall as being present at the 12/8/2015 board of health meeting.
            - ✓ Page 5 > 12th check mark: Correct comment to say, "Is there any sense of urgency on the Wasco County Commissions part about public health in the county?"
            - ✓ Page 10 > Last check mark: Add birth control in front of the word pills.
            - ✓ Page 11 > 14th check mark: Correct the spelling of Commissioner Hege's first name.

b. Set next meeting date

- The next regular meeting was scheduled for Tuesday, February 9, 2016 at 3:00 PM. Meeting location will be at the North Central Public District office located at 419 E. 7th Street, The Dalles, OR.

2. **ADDITIONS TO THE AGENDA**

3. **PUBLIC COMMENT**
   a. None

4. **UNFINISHED BUSINESS**
   a. Updates from Wasco County – Wasco County Project Plan
      - Commissioner Hege advised the board that he sent a rough draft proposal regarding changes to the By-Laws and IGA to Judge Shaffer and Commissioner Smith to review and provide feedback to him. He wanted to give Judge Shaffer & Commissioner Smith an opportunity to provide feedback on his proposal before it was brought to the full board.
      - Commissioner Hege mentioned he had heard that the CGCCO Clinical Advisory Panel had voted to allocate money to public health in the amount of $168,000.
      - Teri Thalhofer asked Commissioner Hege to comment on the process that Wasco County talked about a year ago when they rescinded their decision. We've seen nothing about this process and NCPHD staff has been asking about this and would like to know what is going to happen.
        - ✓ Commissioner Hege stated there is no process or plan. His goal, right now, is to work with the District to move forward and deal with the first item that he thinks would be helpful which is the issue of governance.
        - ✓ Wasco County had envisioned this idea of convening partners in the world of public health to talk about public health and he has heard that Duane Francis of MCMC is talking about convening a public health summit. He believes this is something underway and it takes it out of Wasco County's hands and into the world of partners in health. Right now, he is focused on moving forward with NCPHD and trying to work on issues that Wasco County has concerns with and the first on those is governance.
        - ✓ Teri said she's heard that it is being called a health services summit and public health really isn't about health services so it's going to be interesting. Dr. McDonell is on the planning panel for that summit.

   b. Current Status of Services
      - Lori Treichel one of our home visiting nurses addressed the board regarding the effects the reductions have had on the clients she serves. She also described what she does and talked about the clients she sees and the many struggles those clients have. Some of the things that Lori does include such things as:
        - ✓ Working two (2) afternoons a month in the walk-in clinic.
        - ✓ Coordinating and overseeing the WIC program which includes overseeing training for the WIC staff and reporting to the state time studies, accounting, nutrition/education planning and seeing high risk kids in the WIC office.
        - ✓ Home visits:
          - ➢ To work with pregnant women who have high risk pregnancies.
          - ➢ Sees babies that are drug exposed, don't pass their hearing screen, failure to thrive, low birth rates, and intrauterine growth reduction.
          - ➢ She also sees kids with diagnosed conditions such as cerebral palsy, autism, congenital heart defects, pervasive developmental disorders, Down syndrome.
          - ➢ Sees families with an incarcerated parent, a parent with a mental illness, low income families, families involved with child welfare.
          - ➢ She follows up on things such as growth development and access to resources.
        - ✓ CaCoon nurse on the Community Connections team with is a multi-disciplinary team that meets once a month around families that have children that have behavioral, educational, health & social needs to assist families that have difficulty accessing services.

- ✓ Coordinates the Home Visiting Connections group.
- ✓ Coordinates the Breastfeeding Coalition group.

- Allyson Smith our communicable disease nurse addressed the board regarding the effects the budget cuts have had on our ability to respond to outbreaks. Since July, Allyson has also had to take on staffing the walk-in clinic because of our decreased capacity which has greatly affected the time needed to respond to and investigate outbreaks.
  - ✓ Allyson provided a detailed handout to the board that talked about the impacts of reduced nursing staff due to the decreased funding and consequences to the community this has had. (see attached).
- School Exclusion Day
  - ✓ Teri advised the board that an upcoming challenge will be School Exclusion Day which is February 18th. State law requires that all children in public and private schools, preschools, Head Start and certified child care facilities have up-to-date documentation on their immunizations, or have an exemption.
  - ✓ If school and child care vaccination records are not up-to-date, the child will be sent home from school.
  - ✓ In early Fall, Teri started sending notifications to the clinicians in Wasco County to let them know that our walk-in hours had been reduced and NCPHD would not be able to provide walk-in clinic for this. Once letters go out to parents, our office is typically packed up until the day after Exclusion. Parents will come to our office because they don't have to make an appointment.
  - ✓ Teri has not heard from any of the clinics that they are going to open an after-hours or expand clinic hours for immunizations.
  - ✓ With our reduced walk-in clinic hours, Teri anticipates kids will miss school.
  - ✓ NCPHD does not have the money or the capacity to provide additional immunization hours.

- Access Issues
  - ✓ Judge Shaffer said that the State of Oregon thought the CCO's would cover this. He asked Teri for an update on where are we at with this as far as the CCO's stepping up and recognizing some of these things or issues.
  - ✓ Teri stated that we get funding from the CCO. We are a billable provider. We can bill them but nobody has enough access. There are not enough primary care providers. There is not enough space in the community for people to be seen.
  - ✓ Dr. Hamilton said, with the influx of people who have been put on the Oregon Health Plan, it was considerably more than we expected and it exceeds the capacity of our providers. MCMC & One Community Health who are the two main providers in the county are working really hard to provide access.
  - ✓ Teri said that the mechanism for the safety net has always been public health. With the reduced funding from Wasco County, a hole was ripped in the safety net without there being any mechanism to fill that. The health system can't be transformed as fast as the Governor thought we could do it. Those most vulnerable are the ones that are least able to get services.
  - ✓ Roger Whitely asked Commissioner Hege if Wasco County had anything coming up on if Wasco is going to participate more with the health district and if they are still thinking of separating.
    - ➢ Commissioner Hege stated that was not what he said. He explained that the CCO came to Wasco County Commission and there was a discussion about this issue gap and trying to get the clinic back open more hours. He believes our CCO is going to fund some more money and that's the discussion Wasco County had with them.
    - ➢ Teri explained that what came out of the CAP meeting was not that the CCO was necessarily going to fund us to bring NCPHD back to the capacity that Wasco County pulled out of. Her understanding from staff that attended the meeting was there was a recommendation from the CAP that money go to public health; however Commissioner Joplin who is the chair of the health council was not thrilled with the idea of this being replacement money for county dollars. This is also not sustainable money.

5. **NEW BUSINESS**

a. Fiscal Audit Results (Audit review presented by Hans Graichen of Pauly Rogers & Co.)

- Audit opinion letter – an unmodified opinion on the basic financial statements has been issued. This means the auditors have given a "clean" opinion with no reservations.
- State minimum standards – Auditors found no exceptions or issues requiring comment.
- Management letter – A management letter dated November 4, 2015, detailing a significant deficiency in internal control was reviewed:
  - ✓ Auditors noted there was no evidence of review of bank reconciliations by someone independent of preparation. They recommend that someone independent of the bank reconciliation preparation process review the monthly bank reconciliations in a timely manner to ensure that there are no discrepancies or unusual reconciling items and that they document that review with a signature and date to enhance internal controls.
- Other Matters – Best Practices:
  - ✓ In reviewing fidelity insurance (employee honesty) coverage, the auditors noticed that the District carries cash and investment balances in excess of the insurance coverage amount. They recommend that the Board examine this exposure risk and make a determination as to the amount of insurance coverage they feel is prudent in regard to their oversight.
  - ✓ This is the same issue brought to the board's attention in last year's audit. Commissioner Smith asked Teri to look into this and update the board at the next board meeting.

b. All Hazards Base Response Plan

- The All Hazards Base Response Plan was provided to the board for review. The Board asked that last names be added to staff listed in the phone tree in the command and control section of the plan.
- A motion was made and the All Hazards Base Response plan was approved with corrections discussed.
- Chair Commissioner Smith signed the plan approval after corrections were made.

c. 2nd Quarter Fiscal Report

- Kathi Hall gave a brief recap of 2nd quarter discussing the comparison of the current fiscal year to previous fiscal years. She also explained that she is tracking the fund balances from previous years to the current year. With revenue down from family planning she is keeping a close watch on our fund balance.
- A discussion was held regarding the reduced revenue. Commissioner Smith said that if we keep losing money like this at some point the board is going to have to take some sort of action on this. We have to make sure we don't end the year with a negative balance.

d. Vital Records Fee Increase

- Oregon Health Authority's Center for Health Statistics announced that fees for Oregon vital records, including birth, death and marriage certificates will increase by $5.00 effective January 1, 2016. This increase is to cover increasing administrative costs. The basic fee for a certificate will be $25.00.
- All county vital records offices must charge the same fees as the state vital records office.
- A motion was made to accept the new vital records fee schedule as set forth by the State of Oregon.

e. Appointment of Budget Officer

- A motion was made and approved to appoint Kathi Hall as the Budget Officer for the 2016-17 fiscal year budget.

f. Policies & Procedures

- The following policies & procedures were approved as presented: Alcohol/Drug Use, Abuse and Testing; Bad Weather/Emergency Closing; Benefits; Budgetary Control Procedures; Cell Phone/Smart Phone Usage; Compliance with the ADA/Civil Rights Act; Corrective Action/Discipline Policy; Criminal Arrests and Convictions; Driving While on Business; Employee Personal Data Changes; Employee-Incurred Expenses and Reimbursements; Employment Classification/Work Hours/Work Week; Ethics; Family and Medical Leave; Introductory Period of Employment; NCPHD Email and Electronic Equipment, Facilities & Services; No-Harassment Policy; Non-Discrimination; Open-Door Policy; Outside Employment; Performance Reviews; Political Activity; Rest Breaks; Retirement or Resignation from NCPHD; Smoke-Free Workplace; Time Keeping; Wage and Salary; Workplace Privacy and Confidentiality; Workplace Rules and Prohibited Conduct; and Workplace Violence.
- A motion was made to accept and approve the policies and procedures presented as is.

g. Review of A/P Checks Issued in December 2015.

- Report reviewed and approved as presented.

h. Contracts for Review
- Teri reviewed the following contracts with the board:
  - ✓ DEQ Agreement 023-16
  - ✓ Homeland Security Grant No 15-244
  - ✓ MESD Contract #C02349
  - ✓ OHA Agreement 48025-1
  - ✓ OHSU Agreement AFF-2016-0486

i. Director's Report
- Report presented.
  - ✓ 'Fit in Beverage' update: Commissioner Smith received a verbal confirmation from Kevin Campbell from EOCCO of funding for the fee reduction the 'Fit n Beverage' policy may create. Dr. Harpole will create a written proposal and submit it to Mr. Campbell.
  - ✓ Oregon Reproductive Health Program – Agency Data Review.
    - ➢ In calendar year 2014 NCPHD averted 173 unintended pregnancies (37 teen pregnancies under age 20 and 136 adult pregnancies 20+). In 2014, the average cost of an OHP delivery and the first year of infant healthcare costs was $22,157. Nationally, approximately 42% of unintended pregnancies result in a live birth. This means that 75 unintended births were averted among our clients, resulting in a taxpayer savings of $1,617.461.00. This will not be the same for the 2015 calendar year.

Meeting adjourned at 4:26pm

_____ _____

Commissioner Michael Smith, Chair Date

{Copy of 12/8/2015 board of health meeting minutes, Handout Impacts of Lost Nursing Staff (Allyson Smith), Handout Nurse Staffing Perspective (Allyson Smith), Manager Letter, Communication to the Governing Body Letter, Financial Report 6-30-15, All Hazards Base Response Plan, 2nd Quarter Fiscal Report, Vital Records Fee Increase Handout, Policies & Procedures, A/P Checks Report, Director's Report, and Oregon Reproductive Health Program – Agency Data Review handout, attached and made part of this record.}

FOR IMMEDIATE RELEASE
February 4, 2016

Contact:
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541.308.5526, karen.joplin@co.hood-river.or.us
Kristen Dillon, MD, Columbia Gorge CCO Director,
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COLUMBIA GORGE HEALTH COUNCIL COMMITS MORE THAN $1 MILLION IN HEALTH-FOCUSED INVESTMENTS

Funds Build Health in the Columbia Gorge

The Columbia Gorge Health Council will be making more than $1 Million in one-time investments in health promotion and local healthcare services in Hood River and Wasco Counties in the first half of 2016. These payments will promote high quality healthcare that allows patients to have a more convenient, better coordinated, and more cost-effective experience.

Together, PacificSource and Columbia Gorge Health Council lead the PacificSource Columbia Gorge Coordinated Care Organization (CCO), which includes nearly every healthcare provider in Hood River and Wasco Counties and serves 12,800 members of the Oregon Health Plan (OHP), Oregon's Medicaid program. Medicaid, which is government-funded health insurance for low income individuals and families, currently covers 1 in 4 residents in the two counties.

The Columbia Gorge CCO successfully earned 100% return on the Oregon Health Authority's 2013 and 2014 Performance Metrics, which led to over $1M in quality-related payments to the health council for the benefit of local healthcare providers and patients. Quality measures are used by the Oregon Health Authority to determine how

successful CCOs have been at improving care, making quality care accessible, eliminating health disparities and curbing the rising cost of healthcare for the populations they serve. "The fact that the Columbia Gorge Health Council has these funds to invest back into the healthcare ecosystem is a direct result of the performance of the clinicians in the region and those that support the CCO model of care," said Hood River County Commissioner Karen Joplin, chair of the Columbia Gorge Health Council.

Approximately sixty percent (60%) of the $1M investment is directed towards mental health providers who serve the region's OHP members and primary care clinics to advance Oregon's Patient-Centered Primary Care Home (PCPCH) strategy. Payments to primary care clinics will be used to augment the clinics' care teams with professionals such as pharmacists, mental health counselors, health coaches, nurse care coordinators, and community health workers. More than 90 percent of Hood River and Wasco County OHP members today receive care through a primary care clinic that has achieved high-level certification through Oregon's PCPCH program. By investing in PCPCH, PacificSource and the Health Council expect to see immediate benefits to local OHP members, as well as the community at large. Each primary care setting will choose which services to incorporate to meet the healthcare needs of their patients. Primary care and mental health clinics will receive grants of $8,000-$160,000 depending on clinic size and scope of services.

Based on the endorsement from the provider community, the health departments serving Hood River and Wasco Counties will each receive a $90,000 one-time payment. In making this payment, the Health Council's Clinical Advisory Panel (CAP) seeks to recognize and support the important role of health departments in safety-net services such as immunizations, support for pregnant and parenting families, family planning, and treatment and prevention of contagious illnesses. "These programs are a vital part of the healthcare system and have profound impacts on the overall health of our community," said Dr. Kim Humann, one of the co-chairs of the CAP. Oregon is currently conducting a state-level assessment of public health service models, and the expansion of health insurance under the Affordable Care Act has affected the demand for services

historically provided to patients by county public health programs. In response to this uncertainty, the CAP provided these funds as a temporary bridge.

In addition, the Clinical Advisory Panel designated funds to invest in management of chronic pain and opiate prescribing and an integrated approach to tobacco use prevention and cessation for all ages. "Management of chronic pain and opiate addiction have been repeatedly identified as areas of concern for local healthcare providers and for Oregonians in general," said Dr. Kristen Dillon, Director of the Columbia Gorge CCO. "Compared to other states, Oregon has high rates of prescribing for pain medications as well as a high rate of accidental overdose from this family of drugs. Having money available to pay for training, expert consultation, and regional meetings will support our efforts to develop a comprehensive, community-wide approach to this challenge."

About the Columbia Gorge Health Council:

The Columbia Gorge Health Council consists of healthcare, county, and other community leaders in Hood River and Wasco Counties who work together to recommend and guide solutions and improvements to the region's healthcare system. They work in partnership with PacificSource Community Solutions to guide the area's Coordinated Care Organization as well as develop strategies and policies to address the needs of the poor and vulnerable in the region.

About PacificSource Community Solutions:

PacificSource Community Solutions serves Medicaid members through its coordinated care organizations in Central Oregon and the Columbia Gorge. It is part of the PacificSource family of companies, which has a 77-year history and reputation for taking great care of people. PacificSource employs 700 people, and serves more than 300,000 members with individual, employer, Medicare, and Medicaid plans throughout the Northwest.

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NCPHD
Accounts Payable Checks
Issued - January 2016

Check Date	Check Number	Vendor Name	Amount	
Reserved in Que	223			Payroll A/P (EFT)
Reserved in Que	224			
Reserved in Que	225			
Reserved in Que	226			
1/8/2016	227	IRS	$8,804.59	
1/8/2016	228	ASIFLEX	$240.00	
1/8/2016	229	P E R S	$7,463.08	
1/8/2016	230	OREGON STATE, DEPT OF REVENUE	$2,183.88	
Reserved in Que	231			
1/25/2016	232	IRS	$8,443.45	
1/25/2016	233	ASIFLEX	$330.00	
Reserved in Que	234			
1/25/2016	235	OREGON STATE, DEPT OF REVENUE	$1,989.29	
1/4/2016	11155	CIS TRUST	$21,575.18	
1/7/2016	11156	OREGON STATE, DEPT OF HUMAN SERVICES	$40.00	
1/7/2016	11157	QWIK CHANGE LUBE CENTER INC.	$42.50	
1/7/2016	11158	RICOH USA INC.	$145.35	
1/7/2016	11159	SATCOM GLOBAL INC.	$52.06	
1/7/2016	11160	SEACOAST MEDICAL, LLC, DBA SEACOAST MEDICAL	$600.00	
1/7/2016	11161	STAEHNKE, DAVID	$100.08	
1/7/2016	11162	WASCO COUNTY	$339.83	
1/11/2016	11163	NATIONWIDE RETIREMENT SOLUTION	$275.00	Payroll A/P Checks
1/11/2016	11164	CA STATE DISPURSEMENT UNIT	$231.50	
1/11/2016	11165	NATIONWIDE RETIREMENT SOLUTION	$865.00	
1/13/2016	11166	AHLERS & ASSOCIATES	$980.00	
1/13/2016	11167	DEVIN OIL CO INC.	$67.66	
1/13/2016	11168	H2OREGON BOTTLED WATER INC.	$50.50	
1/13/2016	11169	MID-COLUMBIA MEDICAL CENTER	$337.50	
1/13/2016	11170	OREGON BOARD OF PHARMACY	$150.00	
1/13/2016	11171	OREGON STATE, DEPT OF ENVIRONMENTAL QUA	$800.00	
1/13/2016	11172	QWIK CHANGE LUBE CENTER INC.	$80.45	
1/13/2016	11173	SAIF CORPORATION	$743.00	
1/13/2016	11174	UPS	$92.80	
1/13/2016	11175	US BANK	$1,068.13	
1/22/2016	11176	BEERY ELSNER & HAMMOND LLP	$225.00	
1/22/2016	11177	COLUMBIA RIVER WOMENS CLINIC	$6,049.03	
1/22/2016	11178	OFFICE MAX INCORPORATED	$807.32	
1/22/2016	11179	OPTIMIST PRINTERS	$1,075.98	
1/22/2016	11180	TYLER TECHNOLOGIES, INC.	$4,609.83	

1/22/2016	11181	U.S. CELLULAR	$342.51
1/25/2016	11182	CA STATE DISPURSEMENT UNIT	$231.50
1/25/2016	11183	NATIONWIDE RETIREMENT SOLUTION	$865.00
		TOTAL:	**$72,297.00**

Payroll A/P Checks

NCPHD Board of Health authorizes check numbers 11155 - 11183 and payroll EFT numbers 227 - 230, 232 - 233, & 235 totalling $72,297.00.

Signed:_____ Date: _____

Commissioner Michael Smith, Chair

TOPIC: Return-to-Work Policy **Effective Date:** 1/22/2016 **Revised:** **Reviewed:**	**Regulation/ Reference:** ORS 656; ORS 659.415 - .420
AREA OF SERVICE: AD	**Program Responsible:** Administration
Approved By: NCPHD Board of Health **Title:** Michael Smith, Chair	**Approval Level Required**: __X___Board _____ Director _____Legal Counsel _____ Health Officer _____ Supervisor _____Department

AD_Return-to-Work-Policy_01222016

POLICY
NCPHD is committed to providing employees with a safe work environment and encouraging safe work habits. It is the objective of NCPHD to return injured workers to employment at the earliest date possible after an injury.

PURPOSE
The purpose is to provide clarity of the responsibilities an employee and employer has if an on-the-job injury occurs. This policy applies to all workers and will be followed whenever appropriate.

NCPHD defines “transitional” work as temporary modified work assignments within the worker’s physical abilities, knowledge, and skills.

Where feasible, transitional positions will be made available to injured employees in order to minimize or eliminate time loss.

For any business reason, at any time, we may elect to change the working shift of any employee based on the business needs of this company.

The physical requirements of transitional/temporary work will be provided to the attending physician. Transitional/temporary positions are then developed with consideration of the worker’s physical abilities, the business needs of NCPHD, and the availability of transitional work.

PROCEDURE

In case of an on-the-job accident
If you have a work-related injury and are missing time from work, contact our Human Resource Department (Executive Assistant) or SAIF Corporation for details regarding time loss.

Transitional temporary work assignment
NCPHD will determine appropriate work hours, shifts, duration, and locations of all work assignments. NCPHD reserves the right to determine the availability, appropriateness, and continuation of all transitional assignments and job offers.

Communication
It is the responsibility of the worker and/or supervisor to immediately notify Human Resources (Executive Assistant) of any changes concerning a transitional/temporary work assignment. Human Resources (Executive Assistant) will then communicate with the insurance carrier and attending physician as applicable.

EMPLOYEE RESPONSIBILITIES

Accident reporting
- An accident is any unplanned event that disrupts normal work activities and may or may not result in injury or property damage. All work-related accidents, injuries, and near misses must be reported immediately to your supervisor and/or Human Resources (Executive Assistant).
- If an accident occurs, but **does not** require professional medical treatment, the supervisor should immediately be informed so that an accident analysis can be completed. If first-aid treatment is needed, it should be sought on-site.
- If an accident occurs which **requires professional medical treatment**, the worker should follow the emergency response plan. The worker must fill out a workers' compensation **801** form as soon as possible.

Worker's physical condition
- If professional medical treatment is sought, the worker should inform the attending physician that NCPHD has a return-to-work program with light duty/modified assignments available.
- The worker should obtain a **Release to Return-to-Work** form and completed **Job Description** form (if available) from Human Resources. This should be provided to the treating physician and should be returned to Human Resources (Executive Assistant) following the initial medical treatment.

Worker able to return to work
- If the attending physician releases the worker to return to work, as evidenced by completed of a **Release to Return-to-Work** form and **Job Description Form**, the form(s) must be returned to Human Resources (Executive Assistant) within 24 hours for assignment of light duty/modified work. The worker must report for work at the designated time.
- The **worker cannot return to work with a release** from the attending physician.

- If the worker returns to a transitional/temporary job, the worker must make sure that he or she does not go beyond either the duties of the job or the physician's restrictions. If the worker's restrictions change at any time, he or she must notify his or her supervisor at once and give the supervisor a copy of the new medical release.

Worker unable to return to work

- If the worker is unable to report for any kind of work, the worker must call in at least weekly to report medical status.
- While off work, it is the responsibility of the worker to supply Human Resources with a current telephone number (listed or unlisted) and an address where the worker can be reached.
- The worker will notify Human Resources (Executive Assistant) within 24 hours of all changes in medical condition.

EMPLOYER RESPONSIBILITIES

Accident reporting

- The safety committee will conduct an accident analysis on all accidents, regardless of whether an injury occurs.
- When an accident occurs which results in injury requiring **professional medical treatment**, Human Resources (Executive Assistant) will forward a completed workers' compensation **801** form to the insurance carried within five (5) calendar days of knowledge of the injury or illness.
- Other information will be forwarded as soon as developed, including:
    - Name of worker's attending physician
    - Completed **Release to Return-to-Work Form** from attending physician and medical documentation, if applicable.
    - Completed transitional/modified or regular **Job Description**
    - **Job Offer** letter and responses
- Human Resources (Executive Assistant) will notify the insurance carrier of any changes in the worker's medical or work status as soon as possible.

Medical treatment and temporary/transitional duty physical condition

- A **Release to Return-to-Work** form and a completed **Job Description** form (if available) will be provided to the worker to take to the attending physician for completed and/or approval.
- At the time of first medical treatment the **Release to Return-to-Work** form must be completed and returned to Human Resources (Executive Assistant). If one is not, Human Resources (Executive Assistant) will request one from the attending physician.
- The completed **Release to Return-to-Work** form will be reviewed by Human Resources (Executive Assistant). A temporary/transitional **Job Description** form will be prepared from information obtained from the attending physician for review and approval.

Job Offer Letter

- Upon receipt of a signed temporary/transitional **Job Description** form from the attending physician, a written **Job Offer** letter will be prepared by the employer. It will be mailed by both regular and certified mail to the worker's last known address or presented to the worker.
- The letter will note the doctor's approval and will explain the job duties, report date, wage, hours, report time duration of transitional work assignment, phone number, and location of the transitional assignment.
- The worker will be asked to sign the bottom of the **Job Offer** letter indicating acceptance or refusal of the offered work assignment.
- Copies of the **Job Description, Work Releases,** and **Job Offer** letters will be forwarded to the insurance carrier.

Supervisor

- The supervisor will monitor the worker's performance to ensure the worker does not exceed the worker's physician release.
- The supervisor will monitor the worker's recovery progress through regular contact to assess when and how often duties may be changed. The supervisor will assess the company's ability to adjust work assignments upon receipt of changes in physical capacities.

Note: *This document is not designed as a substitute for reasonable accommodation under any applicable federal or state laws, such as Americans with Disabilities Act, The Rehabilitation Act of 1973, Family Medical Leave Act, or other applicable laws.*

To preserve the ability to meet company needs under changing conditions, this company reserves the right to revoke, change, or supplement guideliens at any time with written notice. The policies and procedures in this return-to-work program are not intended to be contractual commitments and they shall not be construed as such by our employees. This policy is not intended as a guarantee of continuity of benefits or rights. No permanent employment for any term is intended or can be implied by this policy.

Worker acknowledgement

- The return-to-work policy and procedures have been explained to me.
- I have read and fully understand all procedures and responsibilities.
- I agree to observe and follow these procedures.
- I have received a copy of this policy and procedure.
- I understand failure to follow these procedures, may affect my re-employment, reinstatement, and vocational assistance rights.

_____ _____

Worker Signature Date

_____
Worker's Printed Name

REVIEWED BY: **DATE:**

_____ _____

Agreement #148025

SECOND AMENDMENT TO OREGON HEALTH AUTHORITY 2015-2017 INTERGOVERNMENTAL AGREEMENT FOR THE FINANCING OF PUBLIC HEALTH SERVICES

In compliance with the Americans with Disabilities Act, this document is available in alternate formats such as Braille, large print, audio recordings, Web-based communications and other electronic formats. To request an alternate format, please send an e-mail to *dhs-oha.publicationrequest@state.or.us* or call 503-378-3486 (voice) or 503-378-3523 (TTY) to arrange for the alternative format.

This Second Amendment to Oregon Health Authority 2015-2017 Intergovernmental Agreement for the Financing of Public Health Services, effective July 1, 2015 (as amended the "Agreement"), is between the State of Oregon acting by and through its Oregon Health Authority ("OHA") and Gilliam, Wasco, and Sherman Counties, acting by and through the North Central Public Health District ("LPHA"), the entity designated, pursuant to ORS 431.375(2), as the Local Public Health Authority for Gilliam, Wasco, and Sherman Counties.

RECITALS

WHEREAS, OHA and LPHA wish to modify the set of Program Element Descriptions set forth in Exhibit B of the Agreement.

NOW, THEREFORE, in consideration of the premises, covenants and agreements contained herein and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows

AGREEMENT

1. Exhibit B "Program Element Descriptions", Program Element #12 "Public Health Emergency Preparedness (PHEP)" only is hereby superseded and replaced in its entirety by Attachment 1 "Program Element #12 Public Health Emergency Preparedness (PHEP)" attached hereto and hereby incorporated into the Agreement by this reference.

2. LPHA represents and warrants to OHA that the representations and warranties of LPHA set forth in Section 2 of Exhibit E of the Agreement are true and correct on the date hereof with the same effect as if made on the date hereof.

3. Capitalized words and phrases used but not defined herein shall have the meanings ascribed thereto in the Agreement.

4. Except as amended hereby, all terms and conditions of the Agreement remain in full force and effect.

5. This Amendment may be executed in any number of counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Amendment so executed shall constitute an original.

6. This Amendment becomes effective on the date of the last signature below.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the dates set forth below their respective signatures.

7. **Signatures.**

STATE OF OREGON ACTING BY AND THROUGH ITS OREGON HEALTH AUTHORITY (OHA)

By: _____
Name: Priscilla M. Lewis
Title: Deputy Public Health Director

Date: 12/21/15

GILLIAM, WASCO, AND SHERMAN COUNTIES ACTING BY AND THROUGH THE NORTH CENTRAL PUBLIC HEALTH DISTRICT (LPHA)

By: _____

Name: Teri L. Thalhofer

Title: Director

Date: 12/15/2015

DEPARTMENT OF JUSTICE – APPROVED FOR LEGAL SUFFICIENCY
Amendment form group-approved by D. Kevin Carlson, Senior Assistant Attorney General, by email on October 2, 2015. A copy of the emailed approval is on file at OCP.

OHA PUBLIC HEALTH ADMINISTRATION

Reviewed by: _____
Name: Carole Yann *(or designee)*
Title: Program Support Manager

Date: 12/21/15

OFFICE OF CONTRACTS & PROCUREMENT

By: _____
Name: Phillip G. McCoy, OPBC, OCAC
Title: Contract Specialist

Date: 12/30/15

Attachment 1 to Amendment 2 to Agreement #148025

Program Element #12: Public Health Emergency Preparedness Program (PHEP)

1. Description. Funds provided under this Agreement to Local Public Health Authorities (LPHA) for a Public Health Emergency Preparedness Program (PHEP) may only be used in accordance with, and subject to, the requirements and limitations set forth below. The PHEP shall address mitigation, preparedness, response and recovery phases for public health emergencies through plan development and revision, exercise and response activities based on the 15 CDC identified Public Health Preparedness Capabilities.

2. Definitions Relevant to PHEP Programs.

a. Budget Period: Budget period is defined as the intervals of time (usually 12 months) into which a multi-year project period is divided for budgetary/ funding use. For purposes of this Program Element, budget period is July 1 through June 30.

b. CDC: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

c. CDC Public Health Preparedness Capabilities:
http://www.cdc.gov/phpr/capabilities/

d. Community Hazard Risk Assessment: A community hazard risk assessment is a process leading to a written document that presents findings used to assess and identify community-specific public health hazards and vulnerabilities so that plans may be developed to reduce or eliminate these threats.

e. Deadlines: If a due date falls on a weekend or holiday, the due date will be the next business day following.

f. Health Alert Network (HAN): A web-based, secure, redundant, electronic communication and collaboration system operated by OHA, available to all Oregon public health officials, hospitals, labs and service providers. The data it contains is maintained jointly by OHA and all LPHAs. This system provides continuous, high-speed electronic access for Oregon public health officials and service providers to public health information including the capacity for broadcasting information to Oregon public health officials and service providers in an emergency 24 hours per day, 7 days per week, 365 days per year. The secure HAN has a call down engine that can be activated by state or local Preparedness Health Alert Network administrators.

g. Health Security Preparedness and Response (HSPR): A state level program that is a joint effort with the Conference of Local Health Officials (CLHO) and Native American Tribes (Tribes) to develop plans and procedures to prepare Oregon to respond, mitigate, and recover from public health emergencies.

h. Hospital Preparedness Program (HPP): provides leadership and funding through grants and cooperative agreements to States, territories, and eligible municipalities to

improve surge capacity and enhance community and hospital preparedness for public health emergencies. To date, states, territories, and large metropolitan areas have received HPP grants totaling over $4 billion to help Healthcare Coalitions, hospitals and other healthcare organizations strengthen medical surge and other Healthcare Preparedness Capabilities across the nation.

i. **National Incident Management System (NIMS):** The U.S. Department of Homeland Security system for integrating effective practices in emergency preparedness and response into a comprehensive national framework for incident management. The NIMS enables emergency responders at all levels and in different disciplines to effectively manage incidents no matter what the cause, size or complexity. More information can be viewed at: *https://www.fema.gov/national-incident-management-system.*

j. **Public Information Officers (PIOs)**: The communications coordinators (officers) or spokespersons for governmental organizations.

k. **Public Health Accreditation Board (PHAB):** A non-profit organization dedicated to improving and protecting the health of the public by advancing the quality and performance of Tribal, state, local and territorial public health departments. *http://www.phaboard.org/*. Accreditation standards and measurements are outlined on *http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf*

l. **Public Health Emergency Preparedness (PHEP):** local public health programs designed to better prepare Oregon to respond to, mitigate, and recover from public health emergencies.

m. **Public Health Preparedness Capability Surveys:** A series of surveys on the state of Oregon Capability Assessment Tool website for capturing information from LPHAs in order for HSPR to report to CDC.

n. **Volunteer Management:** The ability to coordinate the identification, recruitment, registration, credential verification, training, and engagement of volunteers to support the jurisdictional public health agency's response to incidents of public health significance.

3. **General Requirements.** All LPHAs' PHEP services and activities supported in whole or in part with funds provided under this Agreement and particularly as described in this Program Element Description shall be delivered or conducted in accordance with the following requirements and to the satisfaction of OHA:

a. **Non-Supplantation.** Funds provided under this Agreement for this Program Element shall not be used to supplant state, local, other non-federal, or other federal funds.

b. **Work Plan.** LPHA shall implement its PHEP activities in accordance with its HSPR approved work plan using the example set forth in Attachment 2 to this Program Element. Dependent upon extenuating circumstances, modifications to this work plan may only be made with HSPR agreement and approval. Proposed work plan will be due

on or before August 1. Final approved work plan will be due on or before September 1.

c. **Public Health Preparedness Staffing.** LPHA shall identify a Public Health Emergency Preparedness Coordinator. The Public Health Emergency Preparedness Coordinator will be the OHA's chief point of contact related to program issues. LPHA must implement its PHEP activities in accordance with its approved work plan. The Public Health Emergency Preparedness Coordinator will ensure that all scheduled preparedness program conference calls and statewide preparedness program meetings are attended by the Coordinator or an LPHA representative.

d. **Use of Funds.** Funds awarded to the LPHA under this Agreement for this Program Element may only be used for activities related to the CDC Public Health Preparedness Capabilities in accordance with an approved Budget using the template set forth as Attachment 1 to this Program Element. Modifications to the budget totaling $5,000 or more require submission of a revised budget to the liaison and final receipt of approval from the HSPR fiscal officer.

e. **Conflict between Documents.** In the event of any conflict or inconsistency between the provisions of the PHEP work plan or budget (as set forth in Attachments 1 and 2) and the provisions of this Agreement, this Agreement shall control.

f. **PHEP Program Reviews.**

i. This Agreement will be integrated into the Triennial Review Process. This review will be completed in conjunction with the statewide Triennial Review schedule as determined by the Office of Community Liaison.

ii. The LPHA will complete work plan updates in coordination with their HSPR liaison on at least a minimum of a semi-annual basis and by August 15 and February 15.

g. **Budget and Expense Reporting:** Using the budget template Excel file set forth in Attachment 1 and available through the liaison and incorporated herein and by this reference, LPHA shall provide to OHA by August 1, of each year, a budget using actual award amounts, through June 30 of each year. LPHA shall submit to OHA by February 15 of each year, the actual expense-to-budget report for the period of July 1, through December 31. The LPHA shall provide to the OHA by September 15 of each year, the actual expense-to-budget report for the prior fiscal period of July 1, through June 30. The budget and expense-to-budget set forth in Attachment 1 shall be the only form used to satisfy this requirement. All capital equipment purchases of $5,000 or more that use PHEP funds will be identified in this budget report form under the Capital Equipment tab.

4. Procedural and Operational Requirements.

a. **Statewide and Regional Coordination:** LPHA must attend HSPR meetings and participate as follows:

i. Attendance to the annual HSPR-hosted health preparedness conference.

ii. Participation in emergency preparedness subcommittees, work groups and projects for the sustainment of public health emergency preparedness as appropriate.

iii. Participation in a minimum of 75% of the regional or local HPP Coalition meetings.

iv. Participation in Participation in a minimum of 75% of statewide HSPR-hosted PHEP monthly conference calls for LPHAs and Tribes.

v. Participation in activities associated with statewide emerging threats or incidents as identified by HSPR.

b. **Public Health Preparedness Capability Survey:** LPHA shall complete all applicable Public Health Preparedness Capability Surveys on the State of Oregon Capability Assessment Tool website by August 15 each year.

c. **Community Hazard Risk Assessment:** The LPHA will provide public health perspective and data for their local, county and/ or hospital vulnerability assessment (HVA) in conjunction with the national format and timelines.

d. **Work Plan:** PHEP work plans must be written with clear and measurable objectives with timelines and include:

i. At least three broad program goals that address gaps and guide work plan activities.
ii. Development, review and local public health leadership approval of plans and procedures in support of any of the 15 CDC PHP Capabilities.
iii. Planning activities in support of any of the 15 CDC PHP Capabilities.
iv. Training and Education in support of any of the 15 CDC PHP Capabilities.
v. Exercises in support of any of the 15 CDC PHP Capabilities.
vi. Community Education and Outreach and Partner Collaboration in support of any of the 15 CDC PHP Capabilities.
vii. Administrative and Fiscal activities in support of any of the 15 CDC PHP Capabilities.

e. **Emergency Preparedness Program Work Plan Performance**: LPHA shall complete activities in their HSPR approved PHEP work plans by June 30 each year. If LPHA completes fewer than 75% of the non-fiscal and non-administrative planned activities in its local PHEP work plan for two consecutive years, not due to unforeseen public health events, it may not be eligible to receive funding under this Program Element in the next fiscal year. Work completed in response to a novel or uncommon disease outbreak or other event of significance, may be documented to replace work plan activities interrupted or delayed.

f. **24/7/365 Emergency Contact Capability.**

i. LPHA shall establish and maintain a single telephone number whereby, physicians, hospitals, other health care providers, OHA and the public can report public health emergencies within the LPHA service area.

ii. The contact number will be easy to find through sources in which the LPHA typically makes information available including local telephone directories, traditional websites and social media pages. It is acceptable for the publicly listed phone number to provide after-hours contact information by means of a recorded message.

iii. The telephone number shall be operational 24 hours a day, 7 days a week, 365 days a year and be an eleven digit telephone number available to callers from outside the local emergency dispatch. LPHA may use an answering service or their 911 system in this process, but the eleven digit telephone number of the local 911 operators shall be available for callers from outside the locality.

iv. The LPHA telephone number described above shall be answered by a knowledgeable person or by a recording that clearly states the above mentioned 24/7/365 telephone number. LPHA shall list and maintain both the switchboard number and the 24/7/365 numbers on the HAN.

v. Quarterly test calls to the 24/7/365 telephone line will be completed by HSPR program staff and LPHA will be required to respond within 60 minutes.

g. HAN

i. A local HAN Administrator will be appointed for each LPHA and this person's name and contact information will be provided to the HSPR liaison and the State HAN Coordinator.

ii. The local HAN Administrator shall:

(a) Agree to and sign the HAN Security Agreement
(b) Ensure local HAN user and county role directory is maintained (add, modify and delete users; make sure users have the correct license).
(c) Act as a single point of contact for all LPHA HAN issues, user groups, and training.
(d) Serve as the LPHA authority on all HAN related access (excluding hospitals and Tribes).
(e) Coordinate with the State HAN Coordinator to ensure roles are correctly distributed within each county.
(f) Ensure participation in Emergency Support Function 8 (Health and Medical) tactical communications exercises. Deliverable associated with this exercise will be the test of the LPHA's HAN system roles via alert confirmation for: Health Officer, CD Coordinator(s), Preparedness Coordinator, PIO and LPHA County HAN Administrator within one hour.
(g) Perform general administration for all local implementation of the HAN system in their respective organizations.
(h) Review LPHA HAN users two times annually to ensure users are updated, assigned their appropriate roles and that appropriate users are deactivated.
(i) Facilitate in the development of the HAN accounts for new LPHA users.

h. **Training and Exercise Plan (TEP):** LPHA shall annually submit to HSPR on or before October 31, an updated TEP. The TEP shall meet the following conditions:

i. The plan shall demonstrate continuous improvement and progress toward increased capability to perform critical tasks.

ii. The plan shall include priorities that address lessons learned from previous exercises as described in the LPHA's existing AAR/ IP.

iii. LPHA shall make an effort to work with Emergency Management and community partners to integrate exercises.

iv. At a minimum, the plan shall identify at least two exercises per year and shall identify a cycle of exercises that increase in complexity from year one to year three, progressing from discussion-based exercises (e.g. seminars, workshops, tabletop exercises, games) to operation-based exercises (e.g. drills, functional exercises and full scale exercises); exercises of similar complexity are permissible within any given year of the plan. Disease outbreaks or other public health emergencies requiring an LPHA response may, upon HSPR approval, be used to satisfy exercise requirements. For an exercise or incident to qualify under this requirement the exercise or incident must:

(a) Have public health objectives that are described in the Exercise Plan or the Incident Action Plan.
(b) Involve public health staff in the planning process
(c) Involve more than one county public health staff and/ or related partners as active participants
(d) Result in an AAR/IP

v. LPHA shall submit to HSPR for approval, an exercise scope including goals, objectives, activities, a list of invited participants and a list of exercise team members, for each of the exercises in advance of each exercise.

vi. LPHA shall provide HSPR an AAR/IP documenting each exercise within 60 days of conducting the exercise.

vii. Staff responsible for emergency planning and response roles shall be trained for their respective roles consistent with their local emergency plans and according to the Public Health Accreditation Board, the National Incident Management System and the Conference of Local Health Officials Minimum Standards. The training portion of the plan must:

(a) Include training on how to discharge LPHA statutory responsibility to take measures to control communicable disease in accordance with applicable law.

(b) Identifying and training appropriate LPHA staff to prepare for public health emergency response roles and general emergency response based on the local identified hazards.

i. **Training Records:** LPHA shall maintain training records for all local public health staff with emergency response roles.

j. **Planning:** The LPHA shall maintain and execute emergency preparedness procedures/ plans as a component of its jurisdictional Emergency Operations Plan (see attachment 3 for a recommended list). All LPHA emergency procedures shall comply with the NIMS. The emergency preparedness procedures shall address the 15 CDC PHP capabilities and/or hazards described in their Community Hazard Risk Assessment., Revisions shall be done according to the schedule included in each LPHA plan, or according to the local emergency management agency schedule, but not less than once every five years after completion as required in OAR 104-010-005. The governing body of the LPHA shall maintain and update the other components and shall be adopted as local jurisdiction rules apply.

k. **Contingent Emergency Response Funding:** Such funding is subject to restrictions imposed by CDC at the time of the emergency and would provide funding under circumstances when a delay in award would result in serious injury or other adverse impact to the public.

Since the funding is contingent upon Congressional appropriations, whether contingent emergency response funding awards can be made will depend upon the facts and circumstances that exist at the time of the emergency; the particular appropriation from which the awards would be made, including whether it contains limitations on its use; authorities for implementation; or other relevant factors. No activities are specified for this authorization at this time.

ATTACHMENT 1
TO PROGRAM ELEMENT #12
BUDGET TEMPLATE

Preparedness Program Annual Budget				
_____ County				
July 1, 201_ - June 30, 201_				
				Total
PERSONNEL			Subtotal	**$0**
	List as an Annual Salary	% FTE based on 12 months	0	
(Position Title and Name)			0	
Brief description of activities, for example, This position has primary responsibility for _____ County PHEP activities.				
			0	
			0	
			0	
Fringe Benefits @ (__)% of describe rate or method			0	
TRAVEL				**$0**
Total In-State Travel: (describe travel to include meals, registration, lodging and mileage)	$0			
Out-of-State Travel: (describe travel to include location, mode of transportation with cost, meals, registration, lodging and incidentals along with number of travelers)	$0			
CAPITAL EQUIPMENT (individual items that cost $5,000 or more)	$0			**$0**
SUPPLIES, MATERIALS and SERVICES (office, printing, phones, IT support, etc.)	$0			**$0**
CONTRACTUAL (list each Contract separately and provide a brief description)	$0			**$0**
Contract with (____) Company for $_____, for (_____) services.				
Contract with (____) Company for $_____, for (_____) services.				
Contract with (____) Company for $_____, for (_____) services.				

OTHER	$0			**$0**
TOTAL DIRECT CHARGES				**$0**
TOTAL INDIRECT CHARGES @ ___% of Direct Expenses or describe method				**$0**
TOTAL BUDGET:				**$0**
Date, Name and Phone Number of person who prepared budget.				
NOTES:				

Salaries should be listed as a full time equivalent (FTE) of 2,080 hours per year - for example an employee working .80 with a salary of $50,000 would be listed as $62,500

% of FTE should be based on a full year FTE percentage of 2080 hours per year - for example an employee listed as 50 hours per month would be 50*12/2080 = .29 FTE

Preparedness Program Expense to Budget			
_____ County			
Period of the Report (July 1, 201_-December 31, 201_)			
	Budget	**Expense to date**	**Variance**
PERSONNEL	**$0**	**$0**	**$0**
Salary	$0		
Fringe Benefits	$0		
TRAVEL	**$0**		**$0**
In-State Travel:	$0		
Out-of-State Travel:	$0		
CAPITAL EQUIPMENT	**$0**		**$0**
-			
SUPPLIES	**$0**		**$0**
CONTRACTUAL	**$0**		**$0**
OTHER	**$0**		**$0**
TOTAL DIRECT	**$0**	**$0**	**$0**
TOTAL INDIRECT	**$0**	**$0**	**$0**
TOTAL:	**$0**	**$0**	**$0**
Date, Name and Phone Number of person who prepared budget.			
Notes:			
The budget total should reflect the total amount in the most recent Notice of Grant Award.			
The budget in each category should reflect the total amount in that category for that line item in your submitted budget.			

Preparedness Program Expense to Budget			
_____ County			
Period of the Report (July 1, 201_ - June 30, 201_)			
	Original Budget	**Expense to date**	**Variance**
PERSONNEL	**$0**	**$0**	**$0**
Salary			
Fringe Benefits			
TRAVEL	**$0**	**$0**	**$0**
In-State Travel:			
Out-of-State Travel:			
EQUIPMENT	**$0**		**$0**
-			
SUPPLIES: communications, professional services, office supplies	**$0**		**$0**
CONTRACTUAL	**$0**		**$0**
OTHER: facilities, continued education	**$0**		**$0**
TOTAL DIRECT	**$0**	**$0**	**$0**
TOTAL INDIRECT @ XX% of Direct Expenses (or describe method):	**$0**		**$0**
TOTAL:	**$0**	**$0**	**$0**
DATE.			
Date, name and phone number of person who prepared expense to budget report			
Notes:			
The budget total should reflect the total amount in the most recent Notice of Grant Award.			
The budget in each category should reflect the total amount in that category for that line item in your submitted budget.			

Public Health Emergency Preparedness
Equipment Inventory List

To be completed for all major equipment or property acquired or furnished with Public Health Emergency Preparedness fu year with a unit acquisition cost of $5,000 or more.

Equipment Location:
Completed by:
Phone Number:

Item Description	Serial # or Identification Number	Acquisition Date	Purchase Price	% Purchased by Federal Funds

* in accordance with 45 CFR 74.37 or 45 CFR 92.5

Please return the completed form to your Regional Liaison by August 31 of each year.
Questions on this form can be directed to Jill Snyder at 971-673-0714 or your Region Liaison.

ATTACHMENT 2
TO PROGRAM ELEMENT #12

Work Plan Instructions
Oregon HSPR Public Health Emergency Preparedness Program

FOR GRANT CYCLE: JULY 1, 2015 – JUNE 30, 2016

DUE DATE
Proposed work plan will be due on or before August 1. Final approved work plan will be due on or before September 1.

REVIEW PROCESS
Your approved work plan will be reviewed with your PHEP liaison by February 15 and August 15.

WORKPLAN CATEGORIES
GOALS: At least three broad program goals that address gaps and guide work plan activities will be developed.

TRAINING AND EDUCATION: List all preparedness trainings, workshops conducted or attended by preparedness staff.

DRILLS and EXERCISES: List all drills you plan to conduct and identify at least at least two exercises annually in accordance with your three-year training and exercise plan. For an exercise to qualify under this requirement the exercise must a.) Be part of a progressive strategy, b.) Involve public health staff in the planning process, and c.) Involve more than one county public health staff and/or related partners as active participants. A real incident involving a coordinated public health response may qualify as an exercise.

PLANNING: List all plans, procedures, updates, and revisions that need to be conducted this year in accordance with your planning cycle. You should also review all after action reports completed during the previous grant year to identify planning activities that should be conducted this year.

OUTREACH AND PARTNER COLLABORATION: In addition to prefilled requirements, list all meetings regularly attended and/or led by public health preparedness program staff.

COMMUNITY EDUCATION: List any community outreach activities you plan conduct that that enhance community preparedness or resiliency.
Column Descriptions

PRE-FILLED ACTIVITIES
Activities required under the 2015-16 PE-12 are prefilled in the work plan template. Although you may not eliminate any specific requirements, you may adjust the language as necessary to fit your specific planning efforts within the scope of the PE-12.

COLUMN DESCRIPTIONS

CDC Cap. #s	DRILLS and EXERCISES Objective	Planned Activity	Date Completed	Actual Outcome	Notes
1	By December 31, 2015, 90% of all health department staff will respond to drill within 60 minutes.	Conduct local call down drill to all staff.	09/15/14	80% of health department staff responded within designated time. Contact information was updated and processes reviewed to improve future compliance.	Did not reach goal, but demonstrated improvement as only 70% of staff responded at last drill.

CDC CAPABILITY: Indicate the target capability number(s) addressed by this activity.

OBJECTIVE: Use clear and measurable objectives with identified time frames to describe what the LPHA will complete during the grant year.

PLANNED ACTIVITY: Describe the planned activity. Where activity is pre-filled you may customize, the language to describe your planned activity more clearly.

DATE COMPLETED: When updating the work plan, record date of the completed activities and/or objective.

ACTUAL OUTCOMES: To be filled in after activity is conducted. Describe what is actually achieved and/or the products created from this activity.

NOTES: For additional explanation.

INCIDENTS AND RESPONSE ACTIVITIES: Explain what incidents and response activities that occurred during the 2015-16 grant cycle. If an OERS Number was assigned, please include the number. Identify the outcomes from the incident and response activities, include date(s) of the incident and action taken.

UNPLANNED ACTIVITY: Explain what activities or events occurred that was not described when work plan was first approved. Please identify outcomes for the unplanned activity, include date(s) of occurrence and actions taken.

____Public Health Preparedness Program

Goal 1: Current HHS staff will receive ICS training appropriate for identified response role and responsibilities
Goal 2:
Goal 3:

Ongoing and Goal Related PHEP Program Work

Training and Education

CDC Cap. #s	Objectives	Planned Activities	Date Completed	Actual Outcome	Notes
3	***This is an example*** *By June 30, 2016, 75% of the identified HHS staff will complete the basic ICS training including NIMS 700 and IS-100.* *Goal 1.*	*September Staff meeting, all preparedness related training requirements/expectations reviewed. Explain the identified trainings--NIMS 700, NRF 800, IS-100 and IS-200 and who is to take these courses by the established time frames.*	*9/15/2015*	*20 of 30 HHS staff identified as needing 700, 800, and 100 completed the trainings by the end of December 2015.*	*Identified staff completed 700 and 800 series training online prior to December class.*
		December 15, 2015, first classroom training.	*12/15/2015*		
		March 18, 2016, second classroom training.	*3/18/0216*	*Five management staff completed IS-200 on March 18, 2016.*	
		May 12, 2016, third classroom training.	*5/12/2016*	*Remaining 10 staff completed 700, 800, and 100 trainings on May 12, 2016.*	
		PHEP coordinator will update all training records by 6-30-2016.	*6/15/2016*	*Trainings records updated on June 15, 2016*	
3, 4, 6, 7, 8, 9, 11, 12	*This is an example* *By June 30, 2016, 75% of the HHS staff will identify three individual expectations and three organizational expectations*	*PHEP coordinator will work with management staff to determine staff training expectations by job classification.*	*9/1/2015*	*Met with management staff on September 1, 2015.*	

and 13	*required during an emergency response. Goal 1.*	*By October 31, 2015, PHEP coordinator will develop comprehensive emergency preparedness training and exercise plan (TEP) for the organization, both minimum and developmental training.*	*10/29/2015*	*Met with Emergency Management and other partners to develop TEP on 9/17/15. Sent TEP to Liaison on 10/29/15.*	
		PHEP Coordinator will develop a presentation for staff for orienting them to the organization's expectations, individual expectations and emergency response plans and procedures.	*9/15/2015*	*Presentation developed and gave to staff on 9/15/15*	
		PHEP Coordinator will present organization's expectations, individual expectations, and emergency response plans and procedures overview at All Staff meeting.	*9/15/2015*		
		Give a quiz to all staff by February 17, 2016 on the presentation provided in September on expectations and response plan.	*2/17/2016*	*82% of the staff responded to quiz. 73% did demonstrated retained knowledge on the expectations for the organization and the individual.*	

Drills and Exercises

CDC Cap. #s	Objectives	Planned Activities	Date Completed	Actual Outcomes	Notes

Planning					
CDC Cap. #s	**Objectives**	**Planned Activities**	**Date Completed**	**Actual Outcomes**	**Notes**

Outreach and Partner Collaboration					
CDC Cap. #s	**Objectives**	**Planned Activities**	**Date Completed**	**Actual Outcome**	**Notes**

Community Education					
CDC Cap. #s	**Objectives**	**Planned Activities**	**Date Completed**	**Actual Outcome**	**Notes**

INCIDENT AND RESPONSE ACTIVITIES				
CDC Cap. #s	**Incident Name/OERS #**	**Date(s)**	**Outcomes**	**Notes**

UNPLANNED ACTIVITY				
CDC Cap. #s	Activity	Date(s)	Outcomes	Notes

CDC Cap. #s	FISCAL/ADMINISTRATIVE	Due Dates	Notes
n/a	Participate in Triennial program review process with OHA staff. *PE-12.3.f.i.*		Dates TBD by OHA
n/a	Develop annual work plan. *PE-12.3.b, PE-12.4.d.i-vii.*	09/01/15	Proposed draft work plan due to Liaison by 8/1/15. Final work plan due 9/1/15.
n/a	Participate in mid-year work plan review with liaison. *PE-12.3.f.*	02/15/16	
n/a	Participate in year-end work plan review with liaison. *PE-12.3.f.*	08/15/16	
n/a	Submit annual proposed budget to liaison for period July 1 to June 30. *PE-12.3.g.*	08/01/15	
n/a	Submit actual expense-to-budget report to liaison for the period of July 1 through Dec. 31. *PE-12.3.g.*	02/15/16	
n/a	Submit annual actual expense-to-budget report to liaison for the period of July 1 through June 30. *PE-12.3.g.*	09/15/16	
CDC Cap. #s	**TRAINING and EDUCATION**	**Due Date**	**Notes**
1 3	Update three-year training and exercise plan (TEP). *PE-12.4.h.i-vi.*	10/31/15	Draft due date may be established by liaison.
1 3	Ensure staff and supervisors responsible for public health emergency planning and response roles are trained for respective roles. *PE-12.4.h and CLHO Minimum Standards* **[Relevant details from your three-year training plan should be described on lines below.]**		

1 3 6	Ensure that local HAN users complete training necessary for user level. *PE-12.4.g.ii.*	06/30/16	
CDC Cap. #s	**DRILLS AND EXERCISES**	**Due Date**	**Notes**
3 4 6	Participate in statewide ESF-8 tactical communications exercises. *PE-12.4.f.*		
	EXERCISE 1: **[define]** *PE-12.4.h.iv.(a)-(d).*		
n/a	Submit exercise scope to liaison for approval in advance of exercise. *PE-12.4.h.v.*		
3	Submit AAR/IP to liaison within 60 days of exercise completion. *PE-12.4.g.iii., PE-12.4.h.vi.*		
	EXERCISE 2: **[define]** *PE-12.4.h.iv.(a)-(d).*		
n/a	Submit exercise scope to liaison for approval in advance of exercise. *PE-12.4.h.v.*		
3	Submit AAR/IP to liaison within 60 days of exercise completion. *PE-12.4.g.iii., PE-12.4.h.v.*		
CDC Cap. #s	**PLANNING**	**Due Date**	**Notes**
1	Complete annual public health preparedness capabilities survey. *PE-12.4.b.*	08/15/15	
1-15	Review and update public health plans and MOUs every 5 years. *PE-12.4.j, OAR104-01000-005(3)*		

1 3	Maintain knowledge of and participate in development or revisions of county emergency operations plan. **[describe specific activities on additional lines below, if applicable.]** *CLHO Minimum Standard 2.1*		
1	Maintain or develop written policies and procedures that describe the role and responsibilities of LPHA staff when responding to a public health emergency including disease outbreaks and environmental emergencies. **[describe specific activities on additional lines below.]** *CLHO Minimum Standard 2.1*		
1 6	Maintain policies and procedures for reporting emergencies. *CLHO Minimum Standard 2.1*	ongoing	
CDC Cap. #s	**OUTREACH AND PARTNER COLLABORATION**	**Due Date**	**Notes**
6	Participate in monthly preparedness calls for LPHA/Tribes. *PE-12.4.a.iv*	ongoing	First Tuesday of every month, 1 to 2 p.m.
1 6	Attend annual HSPR preparedness conference. *PE-12.4.a.i.*	10/7- 9/15	
1 6	Participate in regional healthcare preparedness coalition meetings. *PE-12.4.a.iii.*	ongoing	Dates established by HPP Liaison.
	HAN: Identify a HAN Administrator to facilitate all local HAN access, issues, user groups, and trainings - excluding hospitals and tribes. *PE-12.4.g.*		
1 3	HAN: (1 of 2) Review local HAN users twice annually to ensure local directory is maintained with appropriate users and roles. *PE-12.4.g.*		

1 3	HAN: (2 of 2) Review local HAN users twice annually to ensure local directory is maintained with appropriate users and roles. *PE-12.4.g.*		
3 4 13	Maintain 24/7 health department telephone contact capability. *PE-12.4.f.*	ongoing	
1 3 6	Maintain partnerships with local emergency management, medical examiner, and public safety agencies. **[detail activities on additional lines]** *CLHO Minimum Standard 2.1*		
CDC Cap. #s	**COMMUNITY EDUCATION**	**Due Date**	**Notes**
3 4	Maintain ability to inform citizens of actual and potential health threats. **[detail activities on additional lines]** CLHO Minimum Standard 2.1		

ATTACHMENT 3
TO PROGRAM ELEMENT #12

Recommended Plans for Public Health

- ❑ Emergency Support Function (ESF) #8 – Public Health and Medical Services
  - Includes but not limited to:
    - Public Health actions during response and recovery phases
    - Medical Services/EMS actions during response and recovery phases
    - Behavioral/Mental Health actions during response and recovery phases
  - Is an appendix to the County Emergency Operations Plan (EOP)
  - Coordinated in conjunction with Emergency Management and partners
  - Is not an exclusively a public health responsibility. Public health should be deeply involved in most if not all of the issues included therein, however, and will likely act as the coordinating entity for ESF-8. This is something that must be worked out locally in coordination with local emergency management and with EMS, mental health services, health care providers and chief elected officials.
- ❑ All-Hazards Base Plan
  - Functional Annexes, including Hazard Specific Annexes, includes but not limited to:
    - Medical Countermeasure Dispensing and Distribution Plan
    - Emerging Infectious Diseases
    - Chemical Incidents
    - Influenza Pandemic
    - Climate Change
    - Weather / natural disasters- floods, earthquake, wildfire
  - Support Annexes, includes but not limited to:
    - Inventory Management Operations Guide
    - Continuity of Operations Plan (COOP)
    - Information and Communication Plan
    - Volunteer Management
  - Appendices, includes but not limited to:
    - Public Health and Partner Contact Information
    - Public Health Incident Command Structure
    - Legal Authority
    - Job Action Sheets

Sustaining Public Health Emergency Preparedness Program

- ❑ Maintain Multi-year Training and Exercise Plan (MYTEP)
- ❑ Public Health agency participates or performs in two exercises per year
- ❑ Complete After Action Report/Improvement Plans (AAR/IP) sixty days after each exercise
- ❑ Apply identified improvement plan items to future exercises and work plans
- ❑ Coordinate with partners including Emergency Management, Tribal and Healthcare partners
- ❑ Attend Healthcare Preparedness Program (HPP)/Healthcare Coalition meetings
- ❑ Conduct 24/7/365 testing with Public Health personnel
- ❑ Test HAN on a regular basis
- ❑ Document meetings with partners including minutes and agendas
- ❑ Schedule a five year plan to update plans and Memorandums Of Understanding (MOUs)
- ❑ Participate in the County Threat and Hazard Identification Risk Assessment (THIRA) process
- ❑ Ensure current Access and Functional Needs populations data is current in plans

Resources

State:

- ❑ Oregon Conference of Local Health Officials Minimum Standards http://www.oregonclho.org/uploads/8/6/1/7/8617117/draft_minimum_standards_for_local_public_health_departments.pdf
- ❑ Public Health Emergency Preparedness Triennial Review http://public.health.oregon.gov/ProviderPartnerResources/LocalHealthDepartmentResources/Pages/lhd-trt.aspx
- ❑ Health Security, Preparedness and Response http://public.health.oregon.gov/Preparedness/Pages/index.aspx
- ❑ Oregon ESSENCE http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/PreparednessSurveillanceEpidemiology/essence/Pages/index.aspx
- ❑ Oregon Web Links https://public.health.oregon.gov/Preparedness/Partners/HealthAlertNetwork/Pages/weblinks.aspx
- ❑ Secure HAN Login https://oregonhealthnetwork.org
- ❑ State Emergency Registry of Volunteers in Oregon (SERV-OR) https://serv-or.org
- ❑ Public Health Preparedness Capability Surveys https://orassessment.ene.com/Login.aspx?ReturnUrl=%2fdefault.aspx
- ❑ Oregon Emergency Management (OEM) http://www.oregon.gov/omd/oem/Pages/index.aspx
- ❑ OEM OpsCenter https://oregonem.com/opscenter/Login.aspx?ReturnUrl=%2fopscenter
- ❑ OEM Emergency Support Functions http://www.oregon.gov/OMD/OEM/docs/ESF%20Realignment%20Issue%20Paper.pdf

Federal:

- ❑ CDC Public Health Preparedness Capabilities: National Standards for State and Local Planning http://www.cdc.gov/phpr/capabilities/
- ❑ CDC Division of Strategic National Stockpile (DSNS) http://www.cdc.gov/phpr/stockpile/stockpile.htm
- ❑ CDC Office of Public Health Preparedness and Response http://www.cdc.gov/about/organization/ophpr.htm
- ❑ CDC Public Health Preparedness http://emergency.cdc.gov/
- ❑ FEMA National Preparedness Resource Library, including Emergency Support Functions http://www.fema.gov/national-preparedness-resource-library
- ❑ FEMA Core Capabilities https://www.fema.gov/core-capabilities
- ❑ FEMA Comprehensive Preparedness Guides https://www.fema.gov/plan

Other:

- ❑ Association of State and Territorial Health Officials http://www.astho.org/Programs/Preparedness/
- ❑ Public Health Accreditation Board (PHAB) http://www.phaboard.org/
- ❑ National Association of City and County Health Officials (NACCHO) http://www.naccho.org/topics/emergency/
- ❑ Public Health Incident Command Structure http://www.ualbanycphp.org/pinata/phics/
- ❑ Public Health Preparedness http://www.phe.gov/preparedness/Pages/default.aspx
- ❑ Medical Reserve Corps (MRC) https://www.medicalreservecorps.gov/HomePage

OREGON CHILD DEVELOPMENT COALITION
Post Office Box 2780
9140 S.W. Pioneer Court, Suite "E"
Wilsonville, Oregon 97070

Contract Number: **02-031**

AMENDMENT 4

Date: October 28, 2015

1. This amendment (the Amendment) is made by **OREGON CHILD DEVELOPMENT COALITION** and **NORTH CENTRAL PUBLIC HEALTH DISTRICT** parties to Contract No. 02-031 dated December 19, 2011 (the "Contract").

2. The Contract is amended as follows:

   a. Add funding for Fiscal Year 2016, starting January 1, 2016 through December 31, 2016.

   b. Breakout of funding:

	Est # Hrs or # Children	Rate	Extended
Staff Training:	10	$ 41.47	$ 414.70
Parent Training:	4	$ 41.47	$ 165.88
Immunizations:	0	$ 21.96	$ -
Site Visits/Consulting:	144	$ 18.77	$ 2,702.88
		Amendment 4 Total:	$ 3,283.46

Except as set forth in this Amendment, the Contract is unaffected and shall continue in full force and effect in accordance with its Terms and Conditions. If there is a conflict between this Amendment and the Contract or any earlier amendments, the Terms of this Amendment will prevail

IN WITNESS WHEREOF, the PARTIES do mutually agree to the changes described herein and have caused this instrument to be executed. By my signature below, I certify that I have the authority to execute this instrument within the scope of my corporate powers.

OREGON CHILD DEVELOPMENT COALITION, INC.

Donald L Horseman 12/30/15
Donald L. Horseman, Date
Director of Financial Services

NORTH CENTRAL PUBLIC HEALTH DISTRICT

Teri Thalhofer, Bos 12/2/2015
Teri Thalhofer, Date
Director

Donalda Dodson 1/5/16
Donalda Dodson, RN, MPH, Date
Executive Director

INTRODUCTION

Our agreement consists of this contract, the appendices, and the additional materials we reference in the attached Appendix 1.

Guiding principles

We strive to operate in accordance with the following principles:

- *We want to work together with America's best physicians to improve the health care experience of our customers.*
- *We respect and support the physician/patient relationship while adhering fairly to the contract for benefits we provide our customers.*
- *Whether a particular treatment is covered under a benefit contract should not determine if the treatment is provided. Physicians and health care professionals should provide the care they believe is necessary regardless of coverage.*
- *You should discuss treatment options with patients regardless of coverage. We encourage that communication.*
- *Physicians should describe any factors that could affect their ability to render appropriate care. Matters such as professional training, financial incentives, availability constraints, religious or philosophical beliefs, and similar matters are all things that a physician should consider discussing with a patient. We encourage these communications. We urge full disclosure.*
- *Fairness and efficiency will govern the ways in which we administer our products. We will make our determinations promptly. Our commitments to our customers will be clear. We will honor our agreements. When it comes to coverage determinations, the language of the benefit contract will take precedence.*

Next steps

Please read this agreement. If you have questions, write to or call:

UnitedHealthcare
Network Contract Support
780 Shiloh Road, MS-1.700
Plano, TX 75074
(866) 574-6088

You can visit our website at www.unitedhealthcareonline.com (UnitedHealthcare Online®) for additional details on items described in the agreement. If the agreement is acceptable to you, please sign both of the enclosed copies of the contract, and send both copies to the address above.

MEDICAL GROUP CONTRACT

UnitedHealthcare Insurance Company is entering into this agreement with you. It is doing so on behalf of itself, UnitedHealthcare of Oregon, Inc. and its other affiliates for certain products and services we offer our customers, all of which we describe in the attached Appendix 2.

This agreement applies to you and to your professional staff (the physicians and other professionals who are your employees, or your independent contractors providing services to your patients, and who are subject to credentialing by us) and the services you provide at the locations in the attached Appendix 4. When this agreement refers to "you", it also refers to your professional staff. Your professional staff is bound to the same requirements of this agreement as you are. You represent to us that you have the authority to bind your professional staff to this agreement.

What you will do

You need to be credentialed in accordance with our Credentialing Plan, as referenced in Appendix 1, for the duration of this agreement.

You must notify us in a timely manner about certain services you provide in accordance with our Administrative Guide so that we can provide our customers with the services we have committed to provide. If you do not so notify us about these services, you will not be reimbursed for the services, and you may not charge our customer.

Within one year of the effective date of this agreement, you must conduct business with us entirely on an electronic basis to the extent that we are able to conduct business electronically (described in the Administrative Guide), including but not limited to determining whether your patient is currently a customer, verifying the customer's benefit, and submitting your claim. We will communicate enhancements in UnitedHealthcare Online® functionality as they become available and will make information available to you as to which products are supported by UnitedHealthcare Online.

You must submit your claims within 90 days of the date of service. After we receive your claim, if we request additional information in order to process your claim, you must submit this additional information within 90 days of our request. If your claim or the additional information is not submitted within these timeframes, you will not be reimbursed for the services, and you may not charge our customer.

You will submit claims only for services performed by you or your staff. Pass through billing is not payable under this agreement and may not be billed to our customer. For laboratory services, you will only be reimbursed for the services that you are certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform, and you must not bill our customers for laboratory services for which you are not certified.

You will submit claims that supply all applicable information. These claims are complete claims. Further information about complete claims is provided in our Administrative Guide.

If you disagree with our payment determination on a claim, you may submit an appeal as described in our Administrative Guide.

You will not charge our customers anything for the services you provide, if those services are covered services under their benefit contract, but the applicable co-pay, coinsurance or deductible amount. If the

services you provide are denied or otherwise not paid due to your failure to notify us, to file a timely claim, to submit a complete claim, to respond to our request for information, or based on our reimbursement policies and methodologies, you may not charge our customer. If the services you provide are denied for reason of not being medically necessary, you may not charge our customer unless our customer has, with knowledge of our determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges. If the services you provide are not covered under our customer's benefit contract, you may, of course, bill our customer directly. You will not require a customer to pay a "membership fee" or other fee in order to access you for covered services (except for co-payments, coinsurance and/or deductibles provided for under the customer's benefit contract) and will not discriminate against any customer based on the failure to pay such a fee.

You will cooperate with our reasonable requests to provide information that we need. We may need this information to perform our obligations under this agreement, under our programs and agreements with our customers, or as required by regulatory or accreditation agencies.

You will refer customers only to other network physicians and providers, except as permitted under our customer's benefit contract, or as otherwise authorized by us or the participating entity.

What we will do

We or the other applicable participating entity will promptly adjudicate and pay your complete claim for services covered by our customer's benefit contract. If you submit claims that are not complete,

- You may be asked for additional information so that your claim may be adjudicated; or
- Your claim may be denied and you will be notified of the denial and the reason for it; or
- We may in our discretion attempt to complete the claim and have it paid by us or the other applicable participating entity based on the information that you gave in addition to the information we have.

If governing law requires us to pay interest or another penalty for a failure to pay your complete claim for covered services within a certain time frame, we will follow those requirements. The interest or other penalty required by law will be the only additional obligation for not satisfying in a timely manner a payment obligation to you. In addition, if we completed a claim of yours that was not complete, there shall be no interest or other late payment obligation to you even if we subsequently adjust the payment amount based on additional information that you provide.

The applicable participating entity will reimburse you for the services you deliver that our customer's benefit contract covers. The amount you receive will be based on the lesser of your billed charges or our fee schedule, which is described at Appendix 1 and is subject to the reimbursement (coding) policies and methodologies of us and the participating entities. Our reimbursement policies and methodologies are updated periodically and will be made available to you online or upon request. To request a copy of our reimbursement policies and methodologies, write to UnitedHealthcare, Network Contract Support, 780 Shiloh Road, MS-1.700, Plano, TX 75074. Your reimbursement is also subject to our rules concerning retroactive eligibility, subrogation and coordination of benefits (as described in the Administrative Guide). We recognize CPT reporting guidelines as developed by the American Medical Association, as well as ICD diagnostic codes and hospital-based revenue codes. Following these guidelines does not imply a right to reimbursement for all services as coded or reported.

Ordinarily, fee amounts listed in the Payment Appendix(ices) are based upon primary fee sources. We reserve the right to use gap-fill fee sources where primary fee sources are not available.

We routinely update our fee schedule in response to additions, deletions and changes to CPT codes by the

American Medical Association, price changes for immunizations and injectable medications, and in response to similar changes (additions and revisions) to other service coding and reporting conventions that are widely used in the health care industry, such as those maintained by the Centers for Medicare and Medicaid Services (for example, HCPCS). Ordinarily, our fee schedule is updated using similar methodologies for similar services. We will not generally attempt to communicate routine maintenance of this nature and will generally implement updates within 90 days from the date of publication.

We will give you 90 days written or electronic notice of non-routine fee schedule changes which will substantially alter the overall methodology or reimbursement level of the fee schedule. In the event such changes will reduce your overall reimbursement under this agreement, you may terminate this agreement by giving 60 days written notice to us, provided that the notice is given by you within 30 days after the notice of the fee schedule change.

If either of us believes that a claim has not been paid correctly, either of us may seek correction of the payment within a 12-month period following the date the claim was paid, except that overpayments as a result of abusive or fraudulent billing practices may be pursued by us beyond the 12-month time frame mentioned above. In the event of an overpayment, we will correct these errors by adjusting future claim payment and/or by billing you for the amount of the overpayment.

Your professional staff and Practice Locations

You represent to us that all of the members of your professional staff, as of the date you executed this agreement, are listed in Appendix 3. All of the members of your professional staff will participate in our network through this agreement, except in cases in which one of your professional staff is not accepted for participation or is removed from participation under our credentialing program, or removed from participation by us immediately due to that professional being sanctioned by any governmental agency or authority (including Medicare or Medicaid), or having lost a license to provide all or some of the professional services under this agreement, or no longer having hospital admitting privileges in any participating hospital. Your professional staff will cooperate with our credentialing program.

If a new professional joins your professional staff, you will give us 60 days notice and provide the information included in Appendix 3. You will assure that the new professional will promptly submit a credentialing application to us (unless the new professional is already credentialed with us) and cooperate with our credentialing program.

You will assure that a member of your professional staff who has not been approved or is not in good standing under our credentialing program will not provide covered services to our customers. In the event that professional does provide covered services, you will not bill us, our customer, or anyone acting on our customer's behalf for the service, and you will assure that the professional also does not bill for the service.

If a professional leaves your professional staff, you will notify us within ten business days after you become aware that the professional will leave. The notice will include the date that the professional will depart from your professional staff. If you know the future contact information for the professional and whether the professional will continue to practice after leaving your professional staff, you will make reasonable commercial efforts to include that information in the notice and will provide that information to us if we request it.

This agreement applies to your practice locations identified in Appendix 4. If you begin providing services at other locations (either by opening such locations yourself, or by acquiring, merging or coming

under common ownership and control with an existing provider of services that was not already under contract with us or one of our affiliates to participate in a network of health care providers), those additional locations will become subject to this agreement 30 days after we receive notice from you.

If you acquire or are acquired by, merged with, or otherwise become affiliated with another provider of health care services that is already under contract with us or one of our affiliates to participate in a network of health care providers, this agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to those agreements.

If you decide to transfer some or all of your assets to another entity, and the result of the transfer would be that all or some of the services subject to this agreement would be rendered by the other entity rather than by you, you must first request that we approve an assignment of this agreement as it relates to those services and the other entity must agree to assume this agreement.

How long our agreement lasts; how it gets amended; and how it can end

Assuming you are credentialed by us, and we execute this agreement, you will receive a copy from us with the effective date noted below the signature block. It continues until one of us terminates it.

We can amend this agreement or any of the appendices on 90 days written or electronic notice by sending you a copy of the amendment. Your signature is not required to make the amendment effective. However, if you do not wish to continue your participation with our network as changed by an amendment that is not required by law or regulation but that includes a material adverse change to this agreement, then you may terminate this agreement on 60 days written notice to us so long as you send this termination notice within 30 days of your receipt of the amendment.

In addition, this agreement has an initial term of three years, and it will automatically renew after the initial term, for renewal terms of one year each. Either you or we can terminate this agreement, effective at the end of the initial term or effective at the end of any renewal term, by providing at least 90 days prior written notice. Either you or we can terminate this agreement at any time if the other party has materially breached this agreement, by providing 60 days written notice, except that if the breach is cured before our agreement ends, the agreement will continue.

Either of us can immediately terminate this agreement if the other becomes insolvent or has bankruptcy proceedings initiated.

Finally, we can immediately terminate this agreement if any governmental agency or authority (including Medicare or Medicaid) sanctions you.

We both agree that termination notices under this agreement must be sent by certified mail, return receipt requested, to UnitedHealthcare, Network Contract Support, 780 Shiloh Road, MS-1.700, Plano, TX 75074, or to the post office address you provided us. We both will treat termination notices as "received" on the third business day after they are sent.

About data and confidentiality

We agree that your medical records do not belong to us. You agree the information contained in the claims you submit is ours. We both will protect the confidentiality of our customers' information in accordance with applicable state and federal laws, rules, and regulations.

We are both prohibited from disclosing to third parties any fee schedule or rate information. There are three exceptions:

- You can disclose to our customer information relating to our payment methodology for a service the customer is considering (e.g., global fee, fee for service), but not specific rates (unless for purposes of benefit administration).

- We and the participating entities may use this information to administer our customers' benefit contracts and to pay your claims. We also may permit access to information by auditors and other consultants who need the information to perform their duties, subject to a confidentiality agreement.

- We both may produce this information in response to a court order, subpoena or regulatory requirement to do so, provided that we use reasonable efforts to seek to maintain confidential treatment for the information, or to a third party for an appropriate business purpose, provided that the disclosure is pursuant to a confidentiality agreement and the recipient of the disclosure is not a competitor of either of us.

What if we do not agree

We will resolve all disputes between us by following the dispute procedures set out in our Administrative Guide. If either of us wishes to pursue the dispute beyond those procedures, they will submit the dispute to binding arbitration in accordance with the Commercial Dispute Procedures of the American Arbitration Association (see http://www.adr.org) within one year.

We both expressly intend that any dispute between us be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with our dispute. We both agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to our intent and would require immediate judicial review of such ruling. The arbitrator will not vary the terms of this agreement and will be bound by governing law. We both acknowledge that this agreement involves interstate commerce, and is governed by the Federal Arbitration Act, 9 U.S.C. § 1 et seq. The arbitrator will not have the authority to award punitive or exemplary damages against either of us, except in connection with a statutory claim that explicitly provides for such relief. Arbitration will be conducted in Multnomah County, OR.

If a court allows any litigation of a dispute to go forward, we both waive rights to a trial by jury with respect to that litigation, and the judge will be the finder of fact. Any provision of this agreement that is invalid or unenforceable shall not affect the validity or enforceability of the remaining provisions of this agreement or the validity or enforceability of the offending provision in any other situation or in any other jurisdiction. This section of the agreement shall survive and govern any termination of this agreement.

What is our relationship to one another

You are an independent contractor. This means we do not have an employer-employee, principal-agent, partnership, joint venture, or similar arrangement. It also means that you make independent health care treatment decisions. We do not. We do not reserve any right to control those treatment decisions. It further means that each of us is responsible for the costs, damages, claims, and liabilities that result from our own acts.

You will look to the applicable participating entity for reimbursement for the products and services under our agreement. This means that we are not financially responsible for claims payment for groups that are self-funded or that are not affiliated with us.

We may assign this agreement to any entity that is an affiliate of UnitedHealthcare Insurance Company at the time of the assignment.

This is it

This contract, the appendices and the items referenced in the attached Appendix 1, constitute our entire understanding. It replaces any other agreements or understandings with regard to the same subject matter - - oral or written - - that you have with us or any of our affiliates.

Federal law and the applicable law of the jurisdiction where you provide health care services govern our agreement. Such laws and the rules and regulations promulgated under them, when they are applicable, control and supersede our agreement. The Regulatory Appendix referenced in Appendix 1, and any attachment to it, is expressly incorporated to govern our agreement and is binding on both of us. In the event of any inconsistent or contrary language between the Regulatory Appendix (when it applies) and any other part of our agreement, including but not limited to appendices, amendments and exhibits, the Regulatory Appendix will control.

Conclusion

If you agree with these terms, please execute both copies of the agreement below and return them to us. With your signature, you confirm you understand the contract, including the dispute resolution procedures described in the section of this agreement entitled "What if we do not agree", the appendices and the items referenced in the attached Appendix 1.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

AGREED BY:

Medical Group :NORTH CENTRAL PUBLIC HEALTH DISTRICT	Address to be used for giving notice under the agreement:
DBA (if applicable):NORTH CENTRAL PUBLIC HEALTH DISTRICT	Street: 419 E 7TH ST
Signature: Teri L Thalhofer, BSN	City: THE DALLES
Print Name: Teri L Thalhofer, RN BSN	State: OR
Title: Director	Zip Code: 97058-2676
Date: January 20, 2016	TIN: 461790232
E-Mail: terit@co.wasco.or.us	National Provider Identification (NPI) Number: 1073620068

UnitedHealthcare Insurance Company, on behalf of itself, UnitedHealthcare of Oregon, Inc. and its other affiliates, as signed by its authorized representative:
Signature:
Print Name: Dustin Taylor, VP Network
Date: 01/21/2016
For office use only: GD-3497599 1037521 Month, day and year in which agreement is first effective 03/01/2016

Appendix 1

We include as part of our agreement the following additional materials that bind you and us:

Appendix 2	**Definitions, Products and Services** This appendix sets forth definitions for our "customer" and "participating entities" as well as lists the type of benefit contracts offered to our customers
Payment Appendices	**Fee Information Document includes**: Fee Specifications Document, Fee Schedule Sample, and Additional Information About Your Fee Schedule. Further information about the fee schedule (such as additional fee samples) can be requested by writing to UnitedHealthcare, Network Contract Support, 780 Shiloh Road, MS-1.700, Plano, TX 75074 or through our website at www.unitedhealthcareonline.com.
Appendix 3	This document provides information about the members of your professional staff.
Appendix 4	This document provides information about your practice locations.
State Regulatory Requirements Appendix	In some instances, states add requirements to our agreement that are set forth in this appendix.
Medicare Regulatory Requirements Appendix	(This appendix applies only if you are in our Medicare network.) Your participation in our network for customers with Medicare benefit contracts is subject to additional Medicare requirements set forth in this appendix.
Medicaid and/or CHIP Regulatory Requirements Appendix(ices)	(These appendix(ices) apply only if you are in our Medicaid and/or CHIP network.) Your participation in our network for customers with Medicaid or CHIP benefit contracts is subject to additional requirements set forth in these appendix(ices).
Administrative Guide	Our Administrative Guide governs the mechanics of our relationship. Our Administrative Guide may be viewed by going to www.unitedhealthcareonline.com, and it will also be made available to you upon request. We may make changes to the Administrative Guide or other administrative protocols upon 30 days electronic or written notice to you. Additionally, for some of the benefit contracts for which you may provide covered services under this agreement, you are subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this agreement refers to protocols or reimbursement policies it is also referring to the Additional Manuals. An Additional Manual may be a separate document or it may be a supplement to the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide ("UnitedHealthcare Administrative Guide").

For benefit contracts subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this agreement or of the UnitedHealthcare Administrative Guide; or (2) a United protocol or reimbursement policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

The Additional Manuals will be made available to you on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the benefit contracts to which they apply, are listed in Table 1 below. We may change the location of a website or the customer identification card identifier used to identify customers subject to a given Additional Manual; if we do so, we will inform you.

We may make changes to the Additional Manuals subject to this provision in accordance with the provisions of this agreement relating to protocol and reimbursement policy changes.

Table 1.

Benefit Contract	Description of Applicable Additional Manual	Website
Benefit contracts issued or administered by UnitedHealthcare of Oregon, Inc. "WEST" is referenced on the identification card for customers eligible for and enrolled in those benefit contracts.	UnitedHealthcare West Non-Capitated Supplement to the UnitedHealthcare Administrative Guide	www.unitedhealthcareonline.com

Credentialing Plan	To review our credentialing plan, visit www.unitedhealthcareonline.com. This plan requires your professional staff to be covered by malpractice insurance in amounts with carriers and on terms and conditions that are customary for professionals like them in your community. To request access to, or a copy of, our credentialing plan, write to UnitedHealthcare, Network Contract Support, 780 Shiloh Road, MS-1.700, Plano, TX 75074.

Appendix 2
Definitions, Products and Services

Section 1. Customer. Individuals who are enrolled in benefit contracts insured or administered by us or any participating entity are included in our use of the phrase "customer" in this agreement.

Section 2. Participating entities. The following entities have access to our agreement:

- UnitedHealthcare Insurance Company and its affiliates.

- Groups receiving administrative services from UnitedHealthcare Insurance Company or its affiliates or that have arranged for network access through an entity that has contracted with UnitedHealthcare Insurance Company or one of its affiliates.

Section 3. Products and services.

a. We may allow participating entities to access your services under this agreement for the benefit contract types described in each line item below, unless otherwise specified in section 3b of this Appendix 2:

- Benefit contracts where customers are offered a network of participating providers and must select a primary physician, who in some cases must approve any care provided by other health care providers. Such benefit contracts may or may not include an out-of-network benefit.

- Benefit contracts where customers are offered a network of participating providers but are not required to select a primary physician. Such benefit contracts may or may not include an out-of-network benefit.

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b. Notwithstanding the above section 3a of this Appendix 2, this agreement will not apply to the benefit contract types described in the following line items:

- Benefit contracts where customers are not offered a network of participating providers from which they may receive covered services.

- Medicare Advantage Benefit Contracts.

- Medicare and Medicaid Enrollees (MME) Benefit Contracts.

- Medicaid Benefit Contracts.

- CHIP Benefit Contracts.

- Benefit contracts for Medicare Select.

- Benefit Plans for workers' compensation benefit programs.

- Medicare Advantage Private Fee-For-Service benefit contracts and Medicare Advantage Medical Savings Account benefit contracts.

- Other Governmental Benefit Contracts.

- TRICARE benefit contracts.

- Capitation Arrangements.

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Note: Excluding certain benefit contracts or programs from this agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for your participation in a network for such benefit contracts or programs.

Section 4. Definitions:

Note: We may adopt a different name for a particular benefit contract, and/or may modify information referenced in the definitions below regarding customer identification cards. If that happens, section 3a or section 3b of this Appendix will continue to apply to those benefit contracts as it did previously, and we will provide you with the updated information. Additionally, we may revise the definitions in this section 4 to reflect changes in the names or roles of our business units, provided that doing so does not change your participation status in benefit contracts impacted by that change, and further provided that we provide you with the updated information.

MEDICARE:

- **Medicare Advantage Benefit Contracts** means benefit contracts sponsored, issued or administered by a Medicare Advantage organization as part of:
  i) the Medicare Advantage program under Title XVIII, Part C of the Social Security Act, or
  ii) the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act,
  as those program names may change from time to time.

- **Medicare and Medicaid Enrollees (MME) Benefit Contract** means the CMS sponsored Financial Alignment Demonstration Plan providing integrated care benefits for individuals eligible for both the state Medicaid program and the Medicare program (Parts A, B, C and D). At such time as this benefit contract is no longer a demonstration project and is fully implemented in the state, this definition will be interpreted to refer to the fully implemented plan.

MEDICAID:

- **Medicaid Benefit Contracts** means benefit contracts that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

- **Children's Health Insurance Program ("CHIP") Benefit Contracts** are benefit contracts under the program authorized by Title XXI of the federal Social Security Act that are jointly financed by the federal and state governments and administered by the state.

- **Other Governmental Benefit Contracts** means benefit contracts that are funded wholly or substantially by a state or district government or a subdivision of a state (such as a city or county), but do not include benefit contracts for:
  i) employees of a state government or a subdivision of a state and their dependents;
  ii) students at a public university, college or school;
  iii) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage;
  iv) Medicaid beneficiaries;
  v) Children's Health Insurance Program (CHIP) beneficiaries; and
  vi) Medicare and Medicaid Enrollees (MME).

OTHER:

- **Capitation Arrangements** are when all of the following apply:
  i) You (directly or through an IPA or other provider organization in which you participate) are part of a network for one of our affiliates; and
  ii) As part of that network, you arrange directly with our affiliate, or an IPA, or another medical group or other provider organization, for certain designated services to be provided to members who are assigned to you or to the IPA or the other medical group or other provider organization (as the case may be) and who are covered under benefit contracts; and under which either:
     a) Your IPA, medical group or other provider organization is capitated or otherwise has financial responsibility; or
     b) You or your IPA, medical group or other provider organization are paid on a fee for service basis directly by the IPA, medical group or other provider organization that has financial responsibility for the service, at a rate you have agreed upon with the IPA, medical group or other provider organization that has financial responsibility; and
  iii) You provide those designated services to one of those assigned members.

  In such cases, the obligation for payment will be solely that of the IPA, medical group or other provider organization that has financial responsibility for the service, and not ours or our affiliate's.

Payment Appendix - All Payer

All Payer Fee Information Document: REGN 27992/27993

Unless another Payment Appendix to this agreement applies specifically to a particular benefit contract as it covers a particular customer, the provisions of this Payment Appendix apply to covered services rendered by you to customers covered by benefit contracts sponsored, issued or administered by all participating entities.

Appendix 3
Professional Roster

IMPORTANT NOTE: You acknowledge your obligation under the agreement to notify us of any change in your professionals. Failure to do so may result in denial of claims or incorrect payment.

You represent that you have provided us with a Professional Roster that includes all of the following data elements for the physicians and other professionals on your staff:

- Name of Professional (first name, middle initial, last name)
- Degree (MD, DO, NP, PA, other)
- Gender (M/F)
- Provider Specialty(ies) (primary, secondary, additional specialties)
- Willing to be listed/assigned as a Primary Care Professional "PCP" (Y/N)
- State License Number
- Medicaid ID Number
- NPI Number
- Foreign Language(s)
- Admitting Hospital(s)

If any data element is not applicable to a specific professional, you will indicate "not applicable" in the appropriate field. Acceptable formats include in writing, electronically in Excel, ANSI, or text (comma delineated) formats.

Appendix 4
Your Practice Locations

Medical Group attests that this Appendix identifies all services and locations covered under this agreement.

BILLING ADDRESS

All sites of service billing under all TINs listed in Appendix 4 must be included as par providers.

Identify only if a common name and address appears on all medical group practice location bills that utilize the medical group's Tax ID under the Agreement.

Practice Name NORTH CENTRAL PUBLIC HEALTH DISTRICT

Street Address 419 E 7TH ST

City THE DALLES
State OR Zip 97058-2676
Tax ID Number (TIN) 461790232

National Provider ID (NPI) 1073620068

PRACTICE LOCATIONS (complete one for each service location)		
Clinic Name	**Clinic Name**	**Clinic Name**
same as above		
Street Address	**Street Address**	**Street Address**
same as above		
City	**City**	**City**
same as above		
State and Zip Code	**State and Zip Code**	**State and Zip Code**
same as above		
Phone Number	**Phone Number**	**Phone Number**
same as above		
TIN (*If different from above*)	**TIN (*If different from above*)**	**TIN (*If different from above*)**
National Provider ID (NPI)	**National Provider ID (NPI)**	**National Provider ID (NPI)**

PRACTICE LOCATIONS (complete one for each service location)		
Clinic Name	**Clinic Name**	**Clinic Name**
Street Address	**Street Address**	**Street Address**
City	**City**	**City**
State and Zip Code	**State and Zip Code**	**State and Zip Code**

Practitioner Roster
(complete and return with signed contract)

1. **Roster of Practitioners Using Group Tax ID# and Group Practice, Billing, and Administrative Addresses:**

Practitioner:	**Medical Title:** (e.g., MD, DO, ARNP, PA-C)	**Specialty:**
Miriam McDonell	MD	OB/Gyn

2. **Roster of Practitioners Using Tax ID # *Different* from the Group and/or Practice Address, Billing Address, or Administrative Address *Different* from the Group:**

Please Attach Separate Sheet Including Practitioner Name, Medical Title, Specialty, and Tax ID and Address Information that Differs from the Group. Attach a completed W-9 for all practitioners with a Tax ID differing from the Group Tax ID.

NORTH CENTRAL PUBLIC HEALTH DISTRICT

"Caring For Our Communities"

Directors Report for the Board of Health: February 8, 2016

Strategic Planning: Due to staffing capacity issues, we were not able to complete the strategic planning document this month. I am hoping to have it completed for adoption in March.

Staffing:
As previously announced, Shellie Campbell accepted the Clinical Program Supervisor position. That left an opening in for the TPEP Coordinator. That position has been advertised and the first round of interviews was held. Second interviews are scheduled for this week we hope to offer the position by the end of the week. The Nurse Practitioner position was opened, expanding the application to include Physician Assistants. We received one PA applicant. With further consideration of their needs, HRHD has decided to end our shared staffing agreement. We are currently evaluating our options, but have a potential to fill the position.

Community Engagement:
Work continues with the two CCO's that serve our region. NCPHD has applied, in coordination with Gilliam, Sherman, Hood River and Wasco County prevention departments for a grant to increase youth advocacy to decrease tobacco use in the 4 County region. As announced earlier, Governor Brown has named me to the newly formed Public Health Advisory Board. My position represents the smallest of Oregon Counties. This new PHAB will be responsible for guiding the governmental public health system through the Modernization of Public Health.

Columbia Gorge Health Council Funding:
Included in your Board packet is a press release from Columbia Gorge Health Council announcing their plan to distribute $90,000 to each public health entity in the region. I currently have an email in to Coco Yackley, Operations Consultant for CGHC; and Molly Rogers, Wasco County representative to the CGHC. I have asked if any more detail is available on the distribution, and I have invited Molly to the BOH meeting if possible.