



Public Health
Prevent. Promote. Protect.

North Central Public Health District
"Caring For Our Communities"

North Central Public Health District Board of Health Meeting

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

AGENDA -

1. **Community Meeting**
2. **Minutes**
 - a. Approve from October 13, 2015 meeting.
 - b. Set Next Meeting Date (December 8, 2015)
3. **Additions to the Agenda**
4. **Public Comment**
5. **Unfinished Business**
 - a. Updates from Wasco County – Wasco County Project Plan
6. **New Business**
 - a. Status of Services
 - b. Review of A/P checks issued (October 2015)
 - c. Contracts Review
 - i. MCCC MOU 2015-16
 - ii. MODA Commercial Agreement
 - iii. Sherman Co Medical Clinic
 - d. 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



Public Health
Prevent. Promote. Protect.

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
October 13, 2015 (3:00pm)**

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

Staff Present: Kathi Hall – Finance Manager and John Zalaznik – EH Supervisor

Minutes taken by Gloria Perry

Meeting called to order on October 13, 2015 at 3:02pm by Commissioner Mike Smith.

SUMMARY OF ACTIONS TAKEN

Motion by Fred Schubert, second by Bill Hamilton, to approve the minutes from the 9/8/15 board meeting with the correction of removing Commissioner Kramer’s name from the list of those who voted.

Vote: 8-0
Yes: Commissioner Mike Smith, Roger Whitley, Linda Thompson, Judge Steve Shaffer, Michael Takagi, Commissioner Scott Hege, Fred Schubert and William Hamilton.
No: 0
Abstain:
Motion carried.

Motion by Judge Steve Shaffer second by Scott Hege to approve the A/P Checks Issued in September 2015 as presented with clarification on check #11021.

Vote: 8-0
Yes: Commissioner Mike Smith, Roger Whitley, Linda Thompson, Judge Steve Shaffer, Michael Takagi, Commissioner Scott Hege, Fred Schubert and William Hamilton.
No: 0
Abstain:
Motion carried.

Motion by William Hamilton second by Michael Takagi to approve the Board of Health Communication Policy & Procedure with the amendment to add “or advisory” actions.

Vote: 8-0
Yes: Commissioner Mike Smith, Roger Whitley, Linda Thompson, Judge Steve Shaffer, Michael Takagi, Commissioner Scott Hege, Fred Schubert and William Hamilton.
No: 0
Abstain:
Motion carried.

WELCOME & INTRODUCTIONS

1. MINUTES

- a. Approval of past meeting minutes
 - Minutes from the 9-8-2015 board of health meetings approved with the following correction:
 - i. Remove Commissioner Kramer’s name from the list of voters.
- b. Set next meeting date
 - The next regular meeting was scheduled for Tuesday, November 10, 2015 at 3:00pm. Meeting location will be at the North Central Public Health District office located at 419 E. 7th Street, The Dalles, OR.

2. ADDITIONS TO THE AGENDA

- a. None

3. PUBLIC COMMENT

- a. No comments

4. UNFINISHED BUSINESS

- a. Updates from Wasco County – Wasco County Project Plan
 - No update provided.
- b. Funding Reduction Implementation
 - During the month of September 2015:
 - ✓ 79 clients were seen during the 9, 4-hour walk-in clinic slots.
 - ✓ During that same time period, 72 clients were not able to be seen. 25 of those who were not seen arrived during walk-in hours but we did not have capacity to see them in the allotted time.
 - ✓ All but one of these clients resided in Wasco County.

5. NEW BUSINESS

- a. 2015 Fiscal Report
 - Kathi Hall presented a 2015 fiscal report with unaudited numbers. Handout was provided.
 - We anticipate the auditors will present the 2014-15 fiscal audit results at either the November or December board of health meeting.
- b. Review of A/P Checks Issued (September 2015)
 - Report reviewed.
 - Fred Schubert questioned why check number 11021 was not listed on the report. Gloria will research this and report back to the board at the November meeting.
 - Report was approved as presented with the notation that check number 11021 was not listed.

c. Board Notification Policy (draft)

- Draft board notification policy was reviewed. After discussion it was the consensus of the board to change the 3rd sentence in the Policy Section to read: In addition, the Board of Health members who are County Commissioners or Judges, representing Wasco, Sherman or Gilliam Counties will receive notification of regulatory **or advisory** actions pending or occurring in their respective jurisdiction.
- A motion was made to approve and accept this policy with the noted change in section POLICY.
- John Zalaznik notified the board of a possible “boil water” notice being issued for the City of Maupin. John is working with state officials and the City of Maupin on this issue. If a boil water notice is issued, John will notify the entire board via email.

d. Contracts Review

- The following contracts were reviewed:
 - ✓ OHSU CaCoon Subaward 1004396

e. Directors Report

- Written report provided. No questions were asked.

Meeting adjourned at 3:42pm

Commissioner Michael Smith, Chair

Date

{Copy of 9/8/2015 board of health meeting minutes, Fiscal Report Handout, Sanctuary Handout, A/P Checks Report for September 2015, Memo regarding proposed policy on communication with board of health members, P&P – board of Health Communication, Memo regarding contracts, OHSU Cacoon Subaward agreement, and Director’s Report attached and made part of this record.}

First Qtr Revenue Analysis and Beginning Balance

NCPHD Recap Report	FY 2014	FY 2015	FY 2016	Annual		
	July-Sept	July-Sept	July-Sept	FY 2014	FY 2015	FY 2016
	2013	2014	2015			
201 PUBLIC HEALTH FUND						
Grand Total REVENUE	412,156	441,152	367,812	1,231,900	2,102,785	
Grand Total EXP	448,752	496,516	466,005	1,009,314	1,982,607	
	-36,596	-55,364	-98,193	222,586	120,178	
Beg Balance				0	222,586	342,764

Fee Analysis		FY 2014	FY 2015	FY 2016	FY 2014	FY 2015	FY 2016
Clinic Fees & OHP	Immunizations	7,704	4,296	1,271	33,728	22,767	
	Family Planning	11,012	10,379	10,461	70,045	103,337	
	CD & STD	3,278	2,680	1,140	9,588	7,764	
		21,994	17,355	12,873	113,361	133,868	
		-4,639	-4,482		20,508	due to more OHP elig	
CCARE Fees		38,288	20,770	11,113	133,782	101,023	
			-17,517	-9,657		-32,759	

Beg Balance Budegted to spend:

2016	Budgeted	Actual	
Beg Bal	257,948	342,764	84,816 higher
less Contingency & unapprop.	220,921		
Budgeted to spend			
Beg Bal	37,027		
per qtr	9256.75		

Staff Adjustments:

Proposed 15-16 FTE	15-16 FTE Adjusted		annual	qtr avg.
23.8	20.8			
July - 1 FTE PHN		-6150	-73,800	
July - 1 FTE Bill Clrk		-3542	-42,504	
Aug - 1 FTE Off Spec		-4030	-40,300	
Sep - .40 PHN		-2641	-26,410	
Aug + .40 Acct. Spec.		3264	35,904	
		-3.00	-147,110	-36,778

**NCPHD
Accounts Payable Checks
Issued - October 2015**

Check Date	Check Number	Vendor Name	Amount
10/9/2015	198	IRS	\$10,083.06
10/9/2015	199	ASIFLEX	\$270.00
10/9/2015	200	P E R S	\$8,762.27
10/9/2015	201	OREGON STATE, DEPT OF REVENUE	\$2,387.92
Reserved in Que	202	OREGON STATE, DEPT OF REVENUE	
10/23/2015	203	IRS	\$10,571.03
10/23/2015	204	ASIFLEX	\$270.00
Reserved in Que	205	P E R S	
10/23/2015	206	OREGON STATE, DEPT OF REVENUE	\$2,534.09
7/1/2015	11021	SAIF CORPORATION	\$742.99
10/5/2015	11030	CIS TRUST	\$23,218.18
10/7/2015	11031	MCDONELL, MIRIAM	\$105.00
10/7/2015	11032	OFFICE MAX INCORPORATED	\$37.49
10/7/2015	11033	OPTIMIST PRINTERS	\$269.73
10/7/2015	11034	OREGON STATE, DEPT OF ENVIRONMENTAL QUA	\$900.00
10/7/2015	11035	OREGON STATE, DEPT OF HUMAN SERVICES	\$10,000.00
10/7/2015	11036	RICOH USA INC.	\$144.57
10/7/2015	11037	SATCOM GLOBAL INC.	\$51.39
10/7/2015	11038	SPARKLE CAR WASH, LLC	\$62.50
10/7/2015	11039	STAEHNKE, DAVID	\$106.33
10/7/2015	11040	UPS	\$78.36
10/7/2015	11041	WASCO COUNTY	\$571.97
10/12/2015	11042	CA STATE DISPURSEMENT UNIT	\$231.50
10/12/2015	11043	NATIONWIDE RETIREMENT SOLUTION	\$1,704.56
10/12/2015	11044	AHLERS & ASSOCIATES	\$980.00
10/12/2015	11045	CURASCRIPT SPECIALTY, DISTRIBUTION	\$5,350.80
10/12/2015	11046	CYTOCHECK LABORATORY LLC	\$105.00
10/12/2015	11047	DEVIN OIL CO INC.	\$120.29
10/12/2015	11048	H2OREGON BOTTLED WATER INC.	\$45.00
10/12/2015	11049	MID-COLUMBIA MEDICAL CENTER	\$337.50
10/12/2015	11050	MULTNOMAH EDUC. SERVICE DIST	\$255.00
10/12/2015	11051	OR STATE PUBLIC, HEALTH LABORATORY	\$291.90
10/12/2015	11052	OREGON STATE, DEPT HUMAN SERVICES- OFS	\$260.00
10/12/2015	11053	OREGON STATE, DEPT OF HUMAN SERVICES	\$22.00
10/12/2015	11054	PARAGARD DIRECT	\$700.02
10/12/2015	11055	PETTY CASH	\$41.31
10/12/2015	11056	SAIF CORPORATION	\$743.00
10/12/2015	11057	SMITH MEDICAL PARTNERS LLC	\$5,457.76
10/12/2015	11058	STERICYCLE INC.	\$460.41
10/12/2015	11059	THE DALLES AREA CHAMBER OF, COMMERCE	\$216.00
10/12/2015	11060	THE DALLES TIRE FACTORY	\$199.76
10/12/2015	11061	U.S. CELLULAR	\$116.75
10/12/2015	11062	US BANK	\$1,664.37
10/12/2015	11063	WASCO COUNTY	\$72.39
10/21/2015	11064	GOVERNMENT ETHICS COMMISSION	\$396.10
10/21/2015	11065	NACCHO	\$205.00
10/21/2015	11066	QWIK CHANGE LUBE CENTER INC.	\$55.93

**Payroll A/P (EFT)
Electronic Fund Transfers**

Payroll A/P Checks

10/21/2015	11067	WRAY, TANYA	\$34.00
10/26/2015	11068	CA STATE DISPURSEMENT UNIT	\$231.50
10/26/2015	11069	NATIONWIDE RETIREMENT SOLUTION	\$1,040.00
10/28/2015	11070	MCDONELL, MIRIAM	\$708.83
10/28/2015	11071	OFFICE MAX INCORPORATED	\$466.46
10/28/2015	11072	QWIK CHANGE LUBE CENTER INC.	\$87.95
10/28/2015	11073	RICOH USA INC.	\$150.84
10/28/2015	11074	STAEHNKE, DAVID	\$82.87
		TOTAL:	\$94,001.68

Payroll A/P Checks

NCPHD Board of Health authorizes check numbers 11021, 11030 - 11074 and payroll EFT numbers 198 - 201, 203 - 204, & 206 totalling \$94,001.68.

Signed: _____ Date: _____
 Commissioner Michael Smith, Chair



1100 E. MARINA WAY SUITE 215 HOOD RIVER, OR 97031 (541) 386-2010 (541) 386-4597 MCCC@MCCCHEADSTART.ORG



HS
HEAD START

Country Club
Dallesport
Goldendale
Klickitat
Madras
Pine Grove
Stevenson
The Dalles
Tygh Valley
White Salmon

**Nutritional Services/Maternity Support Agreement
MEMORANDUM OF UNDERSTANDING
2015-2016**

The purpose of this memo of understanding is to set forth the responsibilities of North Central Public Health District and Mid-Columbia Children's Council in the provision of collaborative services to enrolled participants.

RESPONSIBILITIES OF EACH AGENCY:



EHS
EARLY HEAD START

Country Club
Goldendale
Hood River
Madras
Stevenson
The Dalles
Wahlooka
White Salmon
Wishram

1. Exchange and share information on mutual clients for which a release of information is obtained.
 - a. Topics assessed in maternity support programs will include: baby's feeding, sleeping, and growing; the parent's physical health and emotional adjustment; and family's needs and resources.
2. Arrange maternity support or home visit with expectant women enrolled in the Early Head Start Program within 2 weeks after infant's birth to ensure the well-being of the family.
3. Exchange and share information on training opportunities for staff and clients.
4. Recognize and accept nutritional educational training provided by either agency as meeting required agency performance standards.
5. Participate in mutual advisory groups.
6. Share information about nutrition and health initiatives and find ways to promote consistent nutrition and health messages.
7. Provide outreach and referrals.
8. Offer combined services for shared families when financially and logistically feasible, including group socializations.
9. Maintain confidentiality of records at each agency.

OPK
OREGON
PRE-KINDERGARTEN
PROGRAM
Country Club
Pine Grove
The Dalles

ECEAP

WASHINGTON
EARLY CHILDHOOD
EDUCATION
ASSISTANCE
PROGRAM
GOLDFENDALE

RESPONSIBILITIES OF MID-COLUMBIA CHILDREN'S COUNCIL:

1. Cooperate with WIC Interagency Nutrition Education Agreement.
 - a. Develop parent education that meet the need of WIC's second nutrition education opportunity.

EFFECTIVE

**FOR MODA HEALTH USE ONLY
CONTRACT EFFECTIVE DATE:**

JUN 15 2015

**MODA HEALTH PLAN, INC.
PARTICIPATING PROVIDER AGREEMENT**

This Participating Provider Agreement ("Agreement") is entered into between Moda Health Plan, Inc. (hereinafter referred to as "Moda Health") and North Central Public Health District [on behalf of Gilliam, Sherman & Wasco County Health Departments] (hereinafter referred to as "Provider"). This Agreement shall be effective as of the date it is countersigned by Moda Health ("Effective Date"). Notwithstanding the Effective Date, Provider shall not provide services to Members under this Agreement unless and until all licensure verification and credentialing processes (if applicable) have been completed and approved by Moda Health.

RECITALS

A. Moda Health is an Oregon corporation engaged in the business of providing health insurance and administering or providing Health Benefit Plans.

B. Moda Health and Provider desire to enter into this Participating Provider Agreement under which Provider will provide medical services within the scope of its licensure or accreditation with respect to the Health Benefit Plans offered by Moda Health.

C. Moda Health and Provider recognize that while the Health Benefit Plans under which a Member may seek medical services may or may not cover and/or pay for the medical services requested, the final decision to provide or receive medical services is to be made by the Member and Provider. Provider will consider the Member's input into the proposed treatment plan, including the opportunity for the Member to refuse treatment and express preferences for future treatment and decisions.

NOW, THEREFORE, the parties agree as follows:

I. DEFINITIONS

- 1.1 "Administrative Services Only" or "ASO" means an arrangement whereby an employer or other entity has retained Moda Health to perform certain administrative tasks, such as claims handling and claims payment, for its employees. In an ASO arrangement, the employer acts in a self-insured role which means that they are financially responsible for any claim payments on behalf of their employees and Moda Health fulfills the role of a third party administrator.
- 1.2 "Billed Charge" is the fee for health care services typically charged by Provider for a particular service.
- 1.3 "Clean Claim" means a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment in accordance with this Agreement.
- 1.4 "Continuity of Care" means the feature of a health benefit plan under which a Member who is receiving care from an individual provider is entitled to continue with the individual provider for a limited period of time after the medical services contract terminates.

- 1.5 **"Covered Services"** means those medically necessary health care services covered under a Health Benefits Plan, as determined under the terms and conditions of the applicable Health Benefits Plan.
- 1.6 **"Emergency Medical Condition"** means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.
- 1.7 **"Fully Insured Plan"** means an employer group health plan under which the employer pays a monthly premium to Moda Health for health coverage for the employer's employees and dependents of such employees and under which Moda Health administers the plan and assumes the risk. Fully Insured Plan also includes an individual plan for which the individual pays a premium to Moda Health for health coverage for the individual and/or the individual's dependents under which Moda Health administers the plan and assumes the risk.
- 1.8 **"Health Benefits Plan"** means a group health benefits plan, including individual or group health insurance policies, offering the services of approved health care providers participating in the Moda Health Benefit Plans funded, underwritten or administered by Moda Health and which describes the Covered Services, applicable co-payments, co-insurance and deductibles (if any), and other information pertinent to the provision of services.
- 1.9 **"Hospital"** means a fully licensed medical hospital.
- 1.10 **"Medical Case Management"** means the evaluation of a medical condition, developing and implementing a plan of care, coordinating medical resources, communicating health care needs to the Member and the Member's health care provider, and monitoring the Member's progress to facilitate quality care.
- 1.11 **"Medically Necessary"** means a service or supply that is required for the diagnosis or treatment of an illness or injury and which, in the opinion of Moda Health, is (1) appropriate to the treatment setting and level of care in terms of the amount, duration, and frequency and consistent with the symptoms, diagnosis, and treatment of the Member's condition; (2) received in the least costly medically appropriate treatment setting; (3) appropriate with regard to the accepted standards of medical practice as determined by Moda Health; (4) and not primarily for the convenience of the Member, the Provider, or the Member's treating health care provider.
- 1.12 **"Member"** means an individual who has enrolled in a Health Benefits Plan offered or administered by Moda Health.
- 1.13 **"Never Events"** means errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care provider. Examples of include surgery on the wrong body part; foreign body left in a patient after surgery; mismatched blood transfusion; major medication error; severe "pressure ulcer" acquired at Provider's facility; and preventable post-operative deaths.
- 1.14 **"Participating Provider Manual"** means the manual available on the Moda Health website which contains information and instructions for facilities and physicians, and which is prepared and provided by Moda Health, as revised by Moda Health from time-to-time.

- 1.15 **"Participating Provider"** means any individual health care professional, clinic or facility who: (a) is fully licensed or certified within their scope of practice to provide medical services to Members including but not limited to individuals who practice medicine or osteopathy who may be a sole practitioner or is an owner, member, shareholder, partner, or employee of a partnership or professional corporation; and (b) has entered into an agreement with Moda Health to render health care services to Members.
- 1.16 **"Payer"** means an insurance company, employer health plan, Taft-Hartley Fund, or other self-funded entities for which Moda Health administers a plan or contract that is responsible to pay or arrange to pay for the provision of health care services to Members.
- 1.17 **"Primary Care Provider or PCP"** means a health care professional who is a family physician, pediatrician, nurse practitioner or internist, and whose billings for primary care services are at least fifty percent (50%) of the physician's total billings. With respect to women patients, "Primary Care Provider" may include a women's health care provider, defined as an obstetrician, gynecologist, or physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health or certified nurse midwife practicing within the applicable lawful scope of practice, under applicable state law.
- 1.18 **"Prior Authorization" or "Service Authorization"** means a determination by Moda Health, prior to the provision of services, that the Member is eligible for coverage and/or determinations by Moda Health relating to benefit coverage and medical necessity.
- 1.19 **"Referral Physician"** means a Participating Provider (including specialist and Primary Care Provider) who provides medical services to members upon referral from a Primary Care Provider.

II. TERM AND TERMINATION

- 2.1 **Effective Date; Term.** This Agreement will become effective on the Effective Date and will continue in effect for a period of twelve (12) months. Unless otherwise terminated as provided in this Agreement, on each anniversary of the Effective Date this Agreement will automatically extend and continue in effect for successive renewal terms of twelve (12) months each on the same terms and conditions then in effect.
- 2.2 **Discretionary Termination.** Either party may terminate this Agreement at any time by giving at least one hundred twenty (120) calendar days' prior written notice to the other party specifying that termination is being made under the provisions of this clause and specifying the effective date of termination.
- 2.3 **Termination for Cause.** Either party may terminate this Agreement at any time for cause by providing thirty (30) calendar days' prior written notice to the other party. Cause shall mean any material violation of this Agreement. The notice must specify the basis for the termination and provide the other party thirty (30) calendar days to cure the breach to avoid termination under this section.
- 2.4 **Immediate Termination.** This Agreement shall terminate immediately upon written notice upon: (i) the institution by or against either party of insolvency, receivership, or bankruptcy proceedings or any other proceedings for the settlement of either party's debts; (ii) either party making an assignment for the benefit of creditors; or (iii) either party's dissolution or ceasing to operate in the ordinary course of business.

2.5 Effect of Termination. If this Agreement is terminated for any reason other than for quality of care concerns or Provider's failure to maintain licenses or certifications as described herein, the terms of this Agreement shall continue to be in effect as follows:

(a) Until the day following the date on which an active course of treatment entitling the Member to Continuity of Care is completed or the 120th day after date of notification by Moda Health to the Member of the termination of the contractual relationship with Provider, whichever is first; or

(b) For those Members undergoing care by Provider for pregnancy and who become entitled to Continuity of Care after commencement of the second trimester of the pregnancy, such Members shall receive the care until the later of the following dates:

(i) The 45th day after the birth; or

(ii) As long as the Member continues under an active course of treatment, but not later than the 120th day after the date of notification by Moda Health to the Member of the termination of the contractual relationship with Provider.

During this continuation period, Provider shall be paid at the rates and terms in effect as of the date of termination. Moda Health will make a good faith effort to direct Members to other participating providers.

2.6 Survival of Rights Upon Termination. The parties' confidentiality and indemnification obligations under this Agreement shall continue after termination.

2.7 NPDB Reporting Obligation. In the event that any Provider is given notice that their participation in this Agreement is being terminated for any cause relating to credentialing, re-credentialing, and quality of care or for any reason reportable to the National Practitioner Data Bank ("NPDB"), Provider shall have the appeal rights as specified in the Participating Provider Manual.

III. GENERAL REQUIREMENTS OF MODA HEALTH

3.1 Enrollment of Members. Moda Health shall use best efforts to contract with individuals or employers to provide Health Benefit Plans and to enroll Members in the Health Benefit Plans.

3.2 Changes to Member Contracts. Moda Health may change, revise, modify or alter the form and/or content of Health Benefit Plans without prior approval of or notice to Provider.

3.3 Notification to Provider. Moda Health shall notify Provider in writing of any material changes to policies, procedures, rules, the Participating Provider Manual, regulations, and schedules that Moda Health considers material to the performance of this Agreement, as well as any amendments thereto. Moda Health shall provide Provider sixty (60) days prior notice of any such changes. Such notification may be accomplished via written notification or electronic mail or through a conspicuous posting on Moda Health's website.

3.4 Member Identification and Eligibility. Each Member shall be provided with an identification card which is to be presented by Member upon visits to Provider.

3.5 Publication. Moda Health will promote use of Participating Providers by including their names and telephone numbers in its Participating Provider directory, and by so designing its Health

Benefit Plans as to offer financial incentives to Members to use Participating Providers' services and facilities. Any incorrect or incomplete information involving Provider published by Moda Health shall be corrected and disseminated by Moda Health in a timely manner.

- 3.6 Agreements with Payers. During the term of this Agreement, Moda Health will make reasonable efforts to maintain its existing agreements with its ASO groups and other Payers. Moda Health shall also evaluate the ability of ASO groups and Payers to meet claims payments obligations and to terminate or bring into compliance an ASO group or Payer that has defaulted.

IV. GENERAL REQUIREMENTS OF PROVIDER

- 4.1 Provider shall possess and will maintain in good standing, all licenses, registrations, certifications, and accreditations required by law to render health care in the State in which Provider is located, and will comply with any applicable local, state and/or federal laws or regulations related to the delivery of health care services.
- 4.2 Provider shall promptly notify Moda Health in writing, but within not more than thirty (30) days, of any formal action against any licenses or, if applicable, against any certifications by any certifying boards or organizations, as well as any changes in Provider's practice ownership or business address, along with any other problem or situation that may or will impair the ability of Provider to carry out the duties and obligations of this Agreement.
- 4.3 Provider staff shall not have confessed to, been convicted or found guilty of any offense or act that is a violation of any applicable regulations or statutes governing professional conduct of health care professionals. A conviction shall include a plea or verdict of guilty or a conviction following a plea of *nolo contendere*.
- 4.4 Provider shall participate in, accept and abide by the results of, and comply with the requirements and result of the Credentialing, Peer Review, Utilization Review and Quality Assurance Programs as set forth in the Participating Provider Manual, which is incorporated herein by this reference. These shall include, but are not limited to, medical records review, investigation of complaints, outcomes studies and data collection from monitoring and evaluation of health care service and delivery for Members. Provider shall share outcomes studies and data with Moda Health to the same extent it shares such information with any other health plan or Payer.
- 4.5 Any individual employed by Provider and providing health care services hereunder shall be competent and have the training necessary to perform the services as set forth in this Agreement.
- 4.6 Provider will cooperate with Moda Health so that Moda Health may meet any requirements imposed on Moda Health, or imposed on the Health Benefit Plans subject to this Agreement, by state and federal law, as amended, and all regulations issued pursuant thereto. To the extent that the terms of this Agreement conflict with applicable state and federal law, this Agreement will be deemed amended to comply with the applicable state and federal law and all regulations issued pursuant thereto.
- 4.7 Moda Health and Provider recognize that federal and state law may impose certain reporting requirements on Moda Health. By way of example, but not limitation, such reporting requirements may involve reports concerning utilization review and quality assurance or quality assessment, including preventative health care. Provider agrees to cooperate with Moda Health to provide data within Provider's control in order to assist Moda Health to respond to such reporting requirements imposed upon Moda Health.

- 4.8 Provider shall comply with the Participating Provider Manual, as may be modified by Moda Health from time to time. Moda Health shall provide Provider sixty (60) days prior notice of any such material changes. Changes to this manual may be communicated to Provider via written notification, electronic mail, or through a conspicuous posting on Moda Health's website.
- 4.9 Provider shall permit Moda Health to use Provider's name, address, telephone number, applicable specialty designation, and other information concerning Provider in directories provided to Members and other participants in Health Benefit Plans. Any incorrect or incomplete information involving Provider published by Moda Health shall be corrected and disseminated by Moda Health in a timely manner.
- 4.10 Provider shall ensure that each of its employed or contracted physicians is a Participating Provider with Moda Health.
- 4.11 Moda Health and Provider recognize that while the Health Benefit Plans under which a Member may seek medical services may or may not cover and/or pay for the medical services requested, the final decision to provide or receive medical services is to be made by the Member and Provider.
- 4.12 Provider may collect any applicable co-payments at the time of service. Provider shall not require advance payment of deductible and co-insurance amounts.

V. PROVISION OF SERVICES

- 5.1 Availability of Services. Provider agrees to provide medical services to Members in accordance with this Agreement and shall make best efforts to render services in a manner that assures availability, adequacy, and Continuity of Care to Members.
- 5.2 Services to Members. Services to Members shall be in accordance with appropriate professional standards of care. The quality and availability of Covered Services provided to Members shall be no less than the quality and availability provided to other patients. This Agreement shall not be construed so as to alter Provider's relationship with Provider's patients or to interfere with Provider's ability to provide services acceptable under current medical standards.
- The final decision to provide or receive services is to be made by the Member and Provider, regardless of whether Moda Health or its designated agent has determined such services are medically necessary or Covered Services. Provider will consider the Member's input into the proposed treatment plan, including the opportunity for the Member to refuse treatment and express preferences for future treatment and decisions.
- 5.3 Coverage During Absence. Provider agrees to maintain appropriate coverage arrangements among health care professionals so that Covered Services remain available and accessible to Members, including access to Provider's emergency medical services on a 24-hour, 7-day-a-week basis. The parties acknowledge that with respect to certain Participating Providers, an after-hours telephone service may satisfy this coverage requirement, provided Members are directed to an on-call physician or area facility offering urgent and emergent care.
- 5.4 Referrals. Provider agrees, in the treatment and care of Members, to the extent feasible, to use only Participating Providers and facilities. Provider agrees to make best efforts to obtain prior approval of Moda Health pursuant to procedures set forth in the Participating Provider Manual before obtaining the services of a non-Participating Provider or agency, in the event Provider believes that such health care professional or agency possesses unique skills or services necessary

to give adequate care to any Member; provided, however, that consistent with Section 5.2 of this Agreement, this limitation on referrals is not intended to cause Provider to deny referral of a Member to a non-Participating Provider for the provision of such care, if the Member is informed that the Member will be responsible for the payment of such non-covered, experimental or referral care and the Member nonetheless desires to obtain such care or referral.

- 5.5 Prior Authorizations. Provider understands that prior authorization by Moda Health is necessary with respect to certain services to be provided by Provider to a Member and, in such cases, Provider shall make best efforts to obtain prior authorization of Moda Health pursuant to procedures set forth in the Participating Provider Manual before authorizing or providing such services. If Provider fails to obtain a prior authorization where one is required, Moda Health may deny the services and Provider may not balance bill the Member.
- 5.6 Emergency Admission. In the event of a medical emergency admission in circumstances where prior consent is not possible, not feasible, or might involve delays jeopardizing the Member's care, Provider shall proceed with its best medical judgment and shall make best efforts to notify Moda Health within two (2) business days of patient admission.
- In such event, Moda Health shall pay for all Covered Services (pursuant to coverage limitations and payment provisions in the applicable Health Benefits Plan) rendered up to the time of such notification and the Moda Health approval or disapproval of the continuation of any such service. In the event that the notice required by this section is not given as required, Moda Health reserves the right to suspend, refuse, or terminate payment for Covered Services rendered between the time such notice should have been given to Moda Health and the time notice was actually given to Moda Health.
- 5.7 Withdrawal. Subject to Provider's professional responsibilities, Provider may withdraw from the care of a Member when, in the professional judgment of Provider, it is in the best interest of the Member to do so.
- 5.8 Advocacy. Provider may advocate a decision, policy or practice to Moda Health on behalf of a Member that is a patient of Provider without being subject to termination or penalty for the sole reason of such advocacy.
- 5.9 Member Identification and Eligibility. Provider shall use best efforts to verify an Moda Health Member's eligibility for service before treatment commences or as soon thereafter as reasonably possible.
- 5.10 Laboratory Certification. Provider shall take all reasonable measures to ensure that all laboratory testing sites providing services under this Agreement have either a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA Identification number. Those laboratories with certificates of waiver will provide only the eight types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.
- 5.11 Moral or Religious Objections of Provider. The parties acknowledge that Provider shall not be obligated to provide health care services that are judged morally wrong by any religious teachings or authority under which Provider operates, except to the extent that such services are required by applicable state or federal law.

VI. RELATIONSHIP OF PARTIES

- 6.1 Provider - Moda Health. It is expressly understood that Provider renders services to Members as an independent medical service. Neither party acts as the agent, principal, joint venturer or partner of the other. It is the sole responsibility of Provider to care for Members and to determine with the Member what services are medically appropriate for any Member.
- 6.2 Liability for Obligations. Notwithstanding any other section or provision of this Agreement, nothing contained herein shall cause either party to be liable or responsible for any debt, liability or obligation of the other party, any third party or Payer, unless such liability or responsibility is expressly assumed by the party sought to be charged therewith. With the exception of those items subject to Section 6.3 of this Agreement, each party shall be solely responsible for the payment of debts and obligations which may be sought by a third party that may be due as a result of that party's actions and exercise of its obligations hereunder.
- 6.3 Indemnification and Contribution.

These provisions relate to third party claims made by persons or entities, including Members, other than Provider and Moda Health.

- 6.3.1 Medical Treatment. In the event of alleged improper medical treatment of a Member by Provider, Provider agrees to indemnify and hold Moda Health harmless from and against any and all liabilities, costs, damages and expenses, including attorney's fees, resulting from or attributable to the negligence or intentional acts of Provider or Provider's employees.
- 6.3.2 Mutual Indemnification. With respect to claims other than those described in Section 6.3.1, as between Provider and Moda Health and within the limits of their respective policies of professional and general liability insurance, and to the extent to not be otherwise inconsistent with the laws of the applicable jurisdiction, each party shall indemnify and hold harmless the other, its appointed board members, officers, employees, agents and subagents, individually and collectively, from all fines, claims, demands, suits or actions of any kind or nature arising by reason of the indemnifying party's intentional or negligent acts or omissions in the course of its performance of its obligations under this Agreement. Nothing in this Agreement or in its performance will be construed to result in any person being deemed the officer, servant, agent or employee of the other party when such person, absent this Agreement and its performance, would not in law have held such status.

VII. PAYMENT AND BILLING

- 7.1 Billings. Provider shall make best efforts to submit written claims and detailed billings to Moda Health within ninety (90) days of the date services were provided, and in any event, shall submit claims no later than fifteen (15) months from the date that the Member received the services. Except for claims for which Moda Health is the secondary insurer, claims not submitted within fifteen (15) months of the date of services shall be disallowed and Provider shall not bill the Member nor Moda Health for services or supplies associated with such claims. Notwithstanding the foregoing, for ASO groups, claims shall be submitted no later than twelve (12) months from the date that the Member received services, and such claims not submitted within twelve (12) months of the date of services shall be disallowed and Provider shall not bill the Member, the group or Moda Health for services or supplies associated with such claims. No claims may be submitted before the date of service. Provider shall not bill Moda Health for amounts in excess of Provider's Billed Charge for such services.

- 7.2 Never Events. Provider agrees that should a Never Event occur that Provider waives the right to bill and collect any reimbursement from either Moda Health or the Member for any and all services (medical or otherwise) that are related to the Never Event and for any medical services provided thereafter as a result of the Never Event occurring.

In the event that Moda Health has made any payment(s) for services that are defined after payment as Never Events, Provider agrees to promptly refund all monies paid related to the Never Event services, including any amounts paid to Provider by Member as co-payments, deductibles, and co-insurance. Provider will refund such monies promptly upon its own discovery of the occurrence of a Never Event or upon learning of a Never Event from Moda Health, the Member or any other third party.

- 7.3 Moda Health as the Secondary Insurer. Provider shall make best efforts to submit claims for which Moda Health is the secondary insurer within thirty (30) days of the primary carrier's payment or denial but in no case more than three-hundred sixty five (365) days from the date of the primary carrier's payment or denial. Should a Member fail to provide Provider with information regarding Member's coverage through Moda Health prior to expiration of the twelve (12) month claim limitation period, Member shall be responsible for payment.

- 7.4 Claim Forms and Content. Provider is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines). Claims will be submitted on the CMS UB 04 and/or CMS 1500 or other recognized forms (including any future editions), for health care services to Members. Such billings shall include a full itemization for charges, use of modifiers or extenders (if any), and summary information on diagnosis, scope of treatment and patient identity. Moda Health shall make payment to Provider within the time frames required by applicable state and federal law. Such payment shall be based on maximum fees payable by Moda Health as described in Exhibit B.

- 7.5 Claim Payment. For Covered Services provided to Members, Moda Health shall pay a Clean Claim or deny the claim not later than thirty (30) days after the date on which Moda Health receives the claim. If Moda Health requires additional information before payment of a claim, not later than thirty (30) days after the date on which Moda Health receives the claim, Moda Health shall notify the Member and Provider in writing of the delay and provide an explanation of the additional information needed to process the claim. Moda Health shall pay a Clean Claim or deny the claim not later than thirty (30) days after the date on which Moda Health receives the additional information. If Moda Health fails to pay a Clean Claim within the time frames specified herein, Provider shall be entitled to interest payments as provided in ORS 743.913. The parties acknowledge that, consistent with applicable law, the thirty (30) day payment provision and the corresponding interest payment requirements specified herein do not apply to Members who obtain coverage through a plan offered on a health care exchange, including but not limited to plans offered through Cover Oregon.

- 7.6 Limitation of Member Liability. Provider shall not bill or collect payment from the Member, or seek to impose a lien, for the difference between the amount billed under this Agreement and Provider's Billed Charges or for any amount denied or otherwise not paid under this Agreement for any reason including, but not limited to, the following:

- (a) Provider's failure to timely file claims;
- (b) Lack of medical necessity as determined by Payer or failure to obtain prior authorization;

- (c) Inaccurate or incorrect claim processing;
- (d) Insolvency or other failure by Payer to fund claim payments if Payer is an entity required by law to ensure that its Members not be billed in such circumstances.

Nothing in this provision is intended to prevent Provider and Member from contracting for the payment by a Member for services that are not Covered Services under the Member's applicable Health Benefits Plan. In addition, Member and Provider may enter into a payment agreement regarding the provision of Covered Services where the Member requests to obtain such services outside the scope of the Health Benefits Plan. In such instance, Moda Health shall not be billed for such Covered Services and Provider may collect payment for such services directly from the Member.

- 7.7 Overpayment/Underpayment/Erroneous Payment. As required under applicable state law, Moda Health shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previously submitted claim. Any request for a corrective adjustment must specify the reason as to why the requesting entity believes it is entitled to an adjustment. Moda Health shall have no obligation to pay additional amounts and Provider shall have no obligation to refund any amounts unless the request for corrective adjustment is made within eighteen (18) months from the date the claim was originally paid or denied. In addition, for claims involving coordination of benefits, the request for corrective action must be made within thirty (30) months from the date that the claim was originally paid or denied, and any such request must specify the reason the party believes it is owed the refund or additional payment and include the name and mailing address of the entity that has primary responsibility for payment of the claim or who has disclaimed responsibility for payment of the claim. Moda Health shall have the right to request a refund at any time on claims involving fraud or instances where a third party is found responsible for satisfaction of the claim as a consequence of liability imposed by law and where Moda Health is unable to recover directly from the third party because the third party has either already paid or will pay Provider for the health services covered by the claim.

If Provider fails to contest a refund request in writing to Moda Health within thirty (30) days of its receipt, the request is deemed accepted and the refund must be paid. If Provider contests the refund request, the dispute will be processed in accordance with the appeal procedure set forth in Section 9.1. If Moda Health does not receive payment or a request for appeal within thirty (30) days of Provider's receipt of the written request, then the amount owed may be deducted from the amounts due Provider on the next claim(s) processed for Provider until the debt is settled. Neither party may request that a corrective adjustment be made any sooner than six (6) months after receipt of the request. Nothing in this section prohibits Provider from choosing at any time to refund to Moda Health any payment previously made to satisfy a claim.

- 7.8 Coordination of Benefits. Coordination of Benefits ("COB") refers to the determination of which of two or more health benefit plans, including Medicare or Medicaid, will pay, as either primary or secondary payer, for medical services provided to a Member. The determination of liability for payment of medical services, subject to COB, will be in accordance with applicable state and federal laws and regulations and applicable language in the Health Benefit Plans issued or administered by Moda Health. Provider agrees to cooperate with Moda Health in presenting claims for payment to other payers, or pursuing claims against other payers, for appropriate application of COB as set forth in this section. To the extent permitted by applicable state law, a secondary payer may adjust COB payments within two (2) years from the date of the initial estimated payment, should the primary carrier provide actual benefit information.
- 7.9 Services Not Medically Necessary and Services Considered Experimental/Investigational. If Moda Health determines that a service or supply rendered to a Member was not Medically Necessary or was experimental or investigational, Provider will not charge either Payer or

Member for such service or supply, unless Provider can demonstrate that the Member was notified prior to receiving such service or supply that Payer considered the service or supply experimental, investigational or not Medically Necessary and that the Member had agreed in writing, in advance, to pay for such service or supply.

- 7.10 Audits of Provider by Moda Health. Moda Health or its designee may conduct audits of Provider's facility and Members' records at Provider's office during Provider's regular business hours. Moda Health shall provide Provider not less than thirty (30) calendar days advance notice of such audit, except when Moda Health, in its discretion, determines there is a significant quality of care issue or risk that Provider's documents may be altered, created or destroyed. In such case, Provider shall provide Moda Health access to facility or records upon twenty-four (24) hours' notice. For Member record audits, Moda Health's notice shall apprise Provider of the period of the audit. Provider agrees to have all Member records for that period available at the time of the audit. Such records shall include dates of service, name of Member, diagnosis, description of services provided, any supporting documentation, medical and billing records and identity of practitioner providing the services. Records not produced at the time of the audit will be deemed non-existent. Moda Health shall be responsible for the cost of copying any records photocopied during an on-site audit. Audits shall be conducted in a manner that, to the greatest extent possible, avoids disruption of Provider's business affairs and minimizes the burden on Provider. Audits will comply with all laws, statutes and regulations pertaining to the confidentiality of Member records. Failure by Provider to cooperate with the audit will be a breach of this Agreement. These rights shall survive termination of this Agreement.

Moda Health's remedies for Provider's failure to cooperate with the auditors, for overutilization or lack of documentation, or for Provider's inappropriate billing, whether fraudulent, undocumented, or for medically unnecessary services, shall include, but not be limited to: application of payment of current claims to reduce the amount that Moda Health determines Provider owes for past inappropriate billing; one-hundred percent (100%) review of Provider's current and future claims and their supporting documentation; recovery of payments made to Provider for past inappropriately billed claims; denial of future inappropriately billed claims and immediate termination of Provider's agreements with Moda Health. If Moda Health denies claims for inappropriate billing, Provider shall not bill the Member.

- 7.11 Special Investigations Unit. The Moda Health Special Investigations Unit (SIU) may conduct audits of Provider during Provider's regular business hours. The SIU shall provide Provider ten (10) business days (or lesser notice if mutually agreed upon) advance notice of such audit. However, if Moda Health reasonably determines there is a significant quality of care issue or risk that Provider's documents may be altered, created or destroyed, Provider shall provide Moda Health access to facility or records upon twenty-four (24) hours' notice, except as shall not be allowed by applicable law. Except as otherwise restricted by applicable law, all medical records provided to Moda Health shall include dates of service, name of Member, diagnosis, description of services provided, any supporting documentation, medical and billing records and identity of practitioner providing the services.

Unless otherwise specified, Moda Health follows Centers for Medicare and Medicaid Services Guidelines and MCG Care Guidelines (formerly Milliman) (collectively, the "Guidelines") for the purposes of determining the appropriateness of the services and/or accuracy of the claim. Records not produced at the time of the audit will be deemed non-existent if not produced by Provider to Moda Health within thirty (30) days after the submission of the final audit report by Moda Health fully describing the audit findings. Provider shall be responsible for the cost of copying any records photocopied during an on-site audit. Audits shall be conducted in a manner that, to the greatest extent possible, avoids disruption of Provider's business affairs and minimizes the burden on Provider. Audits (including access to Provider's records) will be limited to and comply with all laws, statutes and regulations pertaining to the confidentiality of Member

records. Failure by Provider to cooperate with the audit will be a breach of this Agreement. Moda Health's rights to audit shall survive termination of this Agreement.

Provider may appeal audit findings in accordance with the SIU appeal rights set forth in the Participating Provider Manual.

- 7.12 Audits of Moda Health by Provider. Provider shall have the right to audit Moda Health's records related to adjudication of Provider's claims. The audit may be performed either by Provider or by an independent auditor selected by Provider. Such audits shall be conducted during Moda Health's regular business hours at Moda Health's office and shall be limited to records necessary to perform the audit. Provider shall give Moda Health no less than thirty (30) calendar days advance notice of such claims audit and shall inform Moda Health of the claim records to be audited. Moda Health shall have the records for that time period available for the auditors at the time of the audit. Such audits shall be conducted in a manner that, to the greatest extent possible, avoids disruption of Moda Health's business affairs and minimizes the burden on Moda Health. Audits will comply with all laws, statutes and regulations pertaining to the confidentiality of Member records. Failure by Moda Health to cooperate with the audit will be a breach of this Agreement. These rights shall survive termination of this Agreement.

VIII. COST EFFECTIVENESS

Provider agrees to practice in a cost-effective manner while ensuring quality patient care for Members and to the extent feasible, Provider agrees that it shall make best efforts to:

- (a) Avoid referring Members to an emergency room when other treatment would be equally medically appropriate and more cost-effective.
- (b) Utilize outpatient services whenever medically feasible in lieu of in-patient services.
- (c) Cooperate fully with the Moda Health pre-authorization program and particularly to obtain prior approval for all but emergency hospital admissions.
- (d) Participate in Moda Health utilization review planning for appropriate discharge of hospitalized patients.
- (e) In the event of a medical emergency which requires emergency admission to a hospital, to comply with the provisions of Section 5.6 of this Agreement.

IX. APPEALS AND DISPUTE RESOLUTION

- 9.1 Appeal Procedure. Provider shall have the right to appeal compensation disputes to Moda Health including disputes regarding adjustments pursuant to Section 7.7. Such appeal shall result in review by the Moda Health Director with oversight of Claims and the Moda Health Medical Director or their designees. If such appeal remains unresolved to the satisfaction of Provider, a final appeal may be made, in writing, to an appeals committee comprised of the Moda Health Chief Medical Officer, and the Moda Health Vice Presidents with responsibility for Claims and Provider Contracting respectively, and a hearing will be held, unless waived by the parties.
- 9.2 On behalf of a Member and with the Member's consent, Provider may appeal a denied claim to Moda Health pursuant to the appeal grievance procedures set forth in the Health Benefits Plan providing coverage to the Member. If a Member consents to a Provider's appeal of a denied claim, as provided herein, such consent must be in writing and provide that the Member agrees to

be bound by the decisions rendered in the appeal process to the same extent as if the Member were prosecuting the appeal.

- 9.3 Dispute Resolution. Any claims, disputes, or controversies between the parties arising out of or relating to this Agreement that cannot be resolved informally shall be submitted to binding arbitration in the City of Portland, Oregon and in accordance with the Commercial Arbitration Rules of the American Arbitration Association. One arbitrator will be named by each party involved in the dispute and a third neutral arbitrator will be named by the arbitrators chosen. Judgment, vacation, modification, or correction upon the award rendered by the arbitrators may be entered by either party in any court having jurisdiction thereof. The costs of arbitration will be shared equally by Provider and Moda Health, except that each party will be responsible for its own attorney's fees.

X. MISCELLANEOUS

- 10.1 Professional Liability Insurance. During the term of this Agreement, Provider shall maintain professional liability insurance in an amount not less than \$1,000,000 per claim/\$3,000,000 aggregate. This coverage is to be primary, and insure against claims for damages arising by reason of personal injury, including bodily injury or death, directly or indirectly, in connection with the acts or omissions of Provider and/or its agents or employees, with the exception of general liability. Such coverage may be provided via a self-insured program. Provider will not make material changes to its coverage without giving thirty (30) days prior written notice to Moda Health. Upon request by Moda Health, Provider will produce evidence of such insurance.

- 10.2 General Liability Insurance. As applicable, during the term of this Agreement, Provider shall maintain general liability insurance in an amount not less than \$1,000,000 per claim/\$3,000,000 aggregate. Notwithstanding the foregoing, if Provider is an ambulatory surgery center, Provider shall maintain general liability insurance in an amount not less than \$2,000,000 per claim/\$5,000,000 aggregate. This coverage is to be primary, and insure against claims for damages arising by reason of personal injury, including bodily injury or death, directly or indirectly, in connection with the acts or omissions of Provider and/or its agents or employees, with the exception of professional liability. Such coverage may be provided via a self-insured program. Provider will not make material changes to its coverage without giving thirty (30) days prior written notice to Moda Health. Upon request by Moda Health, Provider will produce evidence of such insurance.

10.3 Records.

- 10.3.1 Records. As applicable, Provider and Moda Health shall maintain reasonable and necessary financial, medical, and other records pertinent to this Agreement. All financial records pertinent to this Agreement shall be maintained pursuant to generally accepted accounting principles, and other records shall be maintained to the extent necessary to clearly reflect actions taken. All medical records shall conform to professional standards, permit encounter claim review and allow for an adequate system for follow-up treatment. All records shall be retained by the parties for at least seven (7) years or such other longer period required by applicable law.

- 10.3.2 Confidentiality of Personal Health Information. Provider and Moda Health recognize each Member's right to confidentiality of personal health information. Moda Health and Provider agree to abide by applicable state and federal laws and regulations concerning confidentiality of patient medical records and personal health information, including financial information. The parties will cooperate in the exchange of information

sufficient to permit Moda Health and Provider to perform its functions under this Agreement and its Health Benefit Plans. Moda Health agrees not to disclose any personal health information or privileged information to third parties, except, to the extent permitted by law, in its performance of Peer Review, Utilization Review and Quality Assurance Review programs, or in compliance with applicable state or federal law.

- 10.3.3 Request for Records. Subject to any legal restrictions and upon request by Moda Health, Provider will promptly provide copies of the medical and billing records to Moda Health, at no charge, for those purposes which Moda Health deems reasonably necessary, including without limitation, claims adjudication, quality assurance, medical audit, credentialing or re-credentialing.
- 10.4 Notice. Except as otherwise specified herein, any notices required or permitted to be given hereunder shall be given in writing by personal delivery or by overnight mail delivery via a nationally recognized carrier. Notices shall be addressed to the parties at the following addresses:
- | | |
|---|--|
| To Moda Health: | To Provider: |
| Moda Health Plan, Inc.
601 SW Second Avenue
Portland, OR 97204-3156
Attn: Provider Contracting Dept. | North Central Public Health District
419 E. 7th Street, Room 100
The Dalles, OR 97058 |
- Either party may change such party's address for notice by written notice given in accordance with this paragraph. Notice sent to the last known address of a party shall be deemed sufficient notice. Notices will be deemed given as of the date of actual receipt.
- 10.5 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon.
- 10.6 Medical Decisions. A licensed doctor of medicine or osteopathy shall be retained by Moda Health and shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to this Agreement.
- 10.7 Force Majeure. Neither party shall be liable in damages or have the right to terminate this Agreement for any delay or default in performing hereunder if such delay or default is caused by conditions beyond its reasonable control and occurring without its fault or negligence including, but not limited to, acts of nature, government restrictions, wars, strikes, and insurrections. As a condition to the claim of non-liability, the party experiencing the delay shall give the other party prompt written notice of the reason for its non-performance and the date by which it believes performance can be resumed.
- 10.8 Entire Agreement. This Agreement supersedes any and all agreements, either written or oral, between the parties hereto with respect to the subject matter contained herein. In the event of a conflict or inconsistency between this Agreement and any exhibit, attachment, plan program, policy, manual or any other document affecting this Agreement, the provisions of this Agreement shall control.
- 10.9 Authority. Provider has the unqualified authority to and hereby binds itself and any health care professionals employed or contracted by Provider to provide services covered by this Agreement, to the terms and conditions of this Agreement, including any addenda, appendices, attachments and exhibits, extensions and renewals, as applicable. In the event Provider does not possess the right to legally bind

any of its employed or contracted physicians to this Agreement, Provider shall ensure that each such physician executes a statement in substantially the form provided by Moda Health in which each such physician agrees to be bound by the terms and conditions of this Agreement, including any addenda, appendices, attachments and exhibits, extensions and renewals, as applicable.

- 10.10 Severability and Right to Terminate. If any provision of this Agreement is held by a court of competent jurisdiction or applicable state or federal law to be invalid, void or unenforceable, the remaining provisions will nevertheless continue in full force and effect; provided, however, that in such event, either party shall have the right to terminate this Agreement upon ninety (90) calendar days written notice to the other that this Agreement is being terminated pursuant to this section.
- 10.11 Amendment. This Agreement may not be modified or amended except by mutual consent in writing signed by the duly authorized representatives of Provider and Moda Health; provided however, that Provider and Moda Health will comply with any and all amendments and exhibits contained in this Agreement.
- 10.12 Assignment. Neither party may assign this Agreement without the written consent of the other party.
- 10.13 Waiver. Any waiver of compliance with any provision or waiver of the breach of any provision of this Agreement must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future breach of such provision or of any other provision.
- 10.14 Confidentiality. The terms of this Agreement are confidential and proprietary information. Each of the parties agrees to use its best efforts to maintain the confidentiality of such information and to safeguard such information against loss, theft, or other inadvertent disclosure. To the extent consistent with applicable state law, neither party will disclose this or any other proprietary information or trade secret without the express written approval of the other party.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

Moda Health Plan, Inc.
601 SW Second Avenue
Portland, OR 97204-3156

North Central Public Health District
419 E. 7th Street, Room 100
The Dalles, OR 97058

(Signature)

DR WILLIAM JOHNSON
William E. Johnson, MD, MBA, FACS
(Print Name)

President
(Title)

(Date)

6/15/2015

(Signature)

Teri L. Thalhoffer, RN, BSN
(Print Name)

(Title)

(Date)

Director
3/27/2015
46-1790232
(Tax ID Number)

**EXHIBIT A
PRACTICE INFORMATION**

Tax ID #: 46-1790232
NPI: 1548376445

Claims Remittance / Billing Location

Remittance/Billing Address*:

419 East Seventh Street
The Dalles, OR 97058

Telephone Number:

541-506-2600

Fax Number:

541-506-2601

Office Contact:

Kathi Hall

Email address (if applicable):

Kathih@co.wasco.or.us

Payments will be made to Group/Clinic unless otherwise requested

**Remittance address listed must match information provided in Box 33 on CMS 1500 or equivalent form, or Box 2 on a UB-04 or equivalent form.*

Practice Location(s)

Physical Address (Primary):

419 East Seventh Street
The Dalles, OR 97058

Telephone Number:

541-506-2600

Fax Number:

541-506-2601

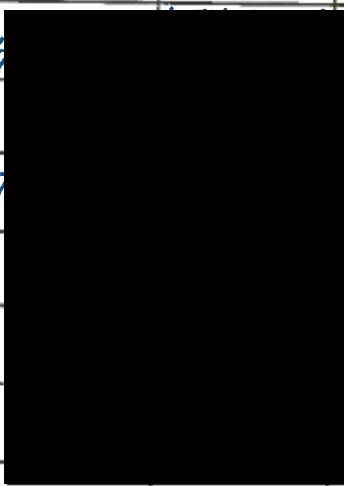
Physical Address 2 (if applicable):

Telephone Number:

Fax Number:

Please attach a separate locations listing, as necessary.

**EXHIBIT A
PROVIDER ROSTER**
(Complete or attach your own)

Provider Name: Include License Type (e.g., MD, DO, NP, etc.)	TIN:	NPI:	Specialty:	Provider Effective Date:	Accepting New patients: Yes/No
NCPHD - Immunizations			45 Immun, STD		Y
NCPHD - Family Planning			FP		Y
NCPHD - Babies First			Home Visiting		Y
MiMi McDanel, MD			Family Practice	3/20/2013	Y
Lisa Newara, NP		Family Nurse Practitioner	1/2/2013	Y	

**EXHIBIT B
PARTICIPATING PROVIDER AGREEMENT
REIMBURSEMENT – PROFESSIONAL SERVICES**

1. Moda Health shall not, without written consent of Provider, reduce the maximum allowable fee for any Covered Service or procedure nor cancel or eliminate payment for any code in its entirety during the term of this Agreement. Nothing herein shall be construed as preventing Moda Health from denying and/or reducing payment for claims that are coded in a manner that is contrary to nationally-accepted coding guidelines
2. Contracted reimbursement will be accepted by Provider for services rendered to members. Members will be held harmless for amounts billed over contracted reimbursement levels.
3. Except for any applicable co-payments, co-insurance and deductibles or as otherwise expressly permitted herein, Provider agrees to look solely to Moda Health for compensation for Covered Services provided to Members and to accept such compensation as payment in full, as further described in this Agreement.
4. Nothing in this contract shall prohibit Provider and a Member from entering into an agreement for payment by a Member for medical services that are not covered by the applicable Health Benefits Plan. In addition, a Member and Provider may enter into a payment agreement regarding the provision of Covered Services where the Member requests to obtain such services outside the scope of the Health Benefits Plan. In such instance, Moda Health shall not be billed for such Covered Services and Provider may collect payment for such services directly from the Member.
5. **Maximum Fees**
Moda Health shall compensate Provider for all Covered Services rendered by Provider to Members. Provider understands and agrees that the maximum plan allowable shall be the lesser of Provider's Billed Charges or the fee schedule maximum approved by Moda Health.
6. **Fee Schedule**
For services billed on a CMS 1500 or successor form, the Fee Schedule will be set at the rates set forth below using the Medicare rates in place on January 1 of the current year. The RVUs will be based on place of service and will not be geographically adjusted. Moda Health will not implement CMS updates throughout the year.

Medicine	150% of Medicare Fee Schedule
Surgery	150% of Medicare Fee Schedule
Lab/Pathology	150% of Medicare Fee Schedule

Laboratory services without an RBRVS weight will be allowed at **100%** of the **Medicare Clinical Diagnostic Lab Fee Schedule** available as of January 1 of the current year.

Radiology	150% of Medicare Fee Schedule
Anesthesia	150% of Medicare Fee Schedule

Anesthesia will be reimbursed on Anesthesia Relative Value Units. Most current ASA methodology for standard AMA defined codes in the range 00100 through 01999. ASA time units will be based on 15 minute time intervals.

**EXHIBIT B
PARTICIPATING PROVIDER AGREEMENT
REIMBURSEMENT – PROFESSIONAL SERVICES (Continued)**

7. Carve-Outs

The following codes will be carved out and reimbursed at the rates set forth below.

HCPCS	Description	U/M Quantity	Allowable
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid).	Per procedure	100% of billed charges
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure).	Per procedure	100% of billed charges
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid).	Per procedure	100% of billed charges

8. Carve-Out Charge Master - Effective January 1, 2015

Solely pertaining to the carve-out codes outlined in Exhibit B, Section 7, Provider's Charge Master Increase to Moda Health over any consecutive twelve-month time period will be capped at five percent (5%). Should Provider increase its Charge Master more than five percent (5%) in any consecutive twelve month period, Moda Health requires Provider to provide at least sixty (60) days advance written notice. Payment rates for all services will be adjusted to ensure budget neutrality as intended for the contract period. Moda Health will work with Provider to adjust rates to accommodate unusual and non-routine adjustments to its Charge Master.

9. Hearing Aids

Reimbursement of Hearing Aids will be paid at one hundred percent (100%) of billed charges, not to exceed acquisition cost, plus five percent (5%). Audits will be done to establish conformity and substantiate billed charges for these items. For audits, as well as on request, Provider is required to provide the manufacturer's original invoice. Invoices must be dated within six (6) months of the date of service and be for the specific Hearing Aid in each case. Refunds may be requested for amounts paid that are not consistent with this pricing methodology.

10. Hearing Aid Services

Fitting, Orientation and Checking of Hearing Aids is considered a miscellaneous charge. These services are reimbursed using the Medicine Conversion Factor (see Fee Schedule under this Exhibit) and are subject to any Hearing Aid benefit limitation.

11. Unlisted Procedures and/or Supplies (not including Hearing Aids or Medicare Part B Drugs)

Unlisted procedures will be allowed at sixty percent (60%) of billed charges for medically necessary supplies or unlisted procedures (a procedure without a Relative Value Unit).

EXHIBIT B
PARTICIPATING PROVIDER AGREEMENT
REIMBURSEMENT – PROFESSIONAL SERVICES (Continued)

12. Medicare Part B Drugs (including Injectables and Cancer Drugs)

Moda Health shall compensate Provider at one hundred percent (100%) of billed charge, not to exceed acquisition cost. Audits will be done to establish conformity and substantiate billed charges for these items. For audits, as well as on request, Provider is required to provide the manufacturer's invoice. Invoices must be dated within six (6) months of the date of service and be for the specific Part B Drug. Refunds may be requested for amounts paid that are not consistent with this pricing methodology.

13. Durable Medical Equipment (DME) (not including Hearing Aids)

In accordance with CMS guidelines and Moda Health Medical Necessity Criteria guidelines, DME will be reimbursed at ninety-five percent (95%) of the then-current Medicare DMEPOS schedule, available as of January 1. Moda Health will not implement Medicare quarterly updates.

For rental DME, Moda Health requires that the purchase price be supplied at the time of initial rental. Moda Health will pay the lesser of the amount required to purchase the DME or rental charges for DME, up to the maximum rental period for DME as defined by CMS.

14. Second and Subsequent Surgeries

For outpatient services, subsequent (secondary or tertiary) procedures performed on the same day as primary procedures will be reimbursed at fifty percent (50%) of the allowed amount for the procedure.

15. Reimbursement Below Cost

If reimbursement is below acquisition cost, Provider can submit an appeal and the claim will be paid at cost when an invoice is included with the claim.

**EXHIBIT B-1
PARTICIPATING PROVIDER AGREEMENT
REIMBURSEMENT – VACCINES**

[See separately attached Exhibit B-1 Vaccine Pricing Table]

EXHIBIT B-1
Reimbursement - Vaccines
Oregon Immunization Program, Vaccine Costs by Dose for Billable Clients
(County Health Clinics Must Not Charge Higher Than Published Prices)

VACCINE	CPT	CVX	MFG	Brand	Allowable
DTaP	90700	20	GSK	Inflarix	100% of billed charges
		106	SANOFI-PASTUER	Tripedia *	100% of billed charges
	90700	106	SANOFI-PASTUER	Daptacel	100% of billed charges
DTaP/HepB/HPV	90723	110	GSK	Pediarix	100% of billed charges
DTaP/HPV	90696	130	GSK	Kinrix	100% of billed charges
DTaP/HPV/Hib	90698	120	SANOFI-PASTUER	Pentacel	100% of billed charges
DT	90702	28	SANOFI-PASTUER	Pediatric DT	100% of billed charges
Eipv	90713	10	SANOFI-PASTUER	IPOL	100% of billed charges
IG	90281	86	GRIFOLS	GamaSTAN S/D	100% of billed charges
HBIG	90371	30	GRIFOLS	HyperHep B S/D	100% of billed charges
Hep A	90633	83	GSK	Havrix	100% of billed charges
		83	MSD	Vaqla	100% of billed charges
	90632	52	GSK	Havrix (Adult)	100% of billed charges
		52	MSD	Vaqla (Adult)	100% of billed charges
	90730	85	Not Specified - Pediatric		100% of billed charges
		85	Not Specified - Adult		100% of billed charges
Hep B	90744	8	GSK	Engerix-B	100% of billed charges
		8	MSD	Recombivax HB	100% of billed charges
	90746	43	GSK	Engerix-B (Adult)	100% of billed charges
		43	MSD	Recombivax HB (Adult)	100% of billed charges
	90731	45	Not Specified - Pediatric		100% of billed charges
		45	Not Specified - Adult		100% of billed charges
Hep A/B	90636	104	GSK	Twinrix	100% of billed charges
HepB-Hib	90748	51	MSD	Comvax	100% of billed charges
Hib	90648	48	SANOFI-PASTUER	ActiHIB	100% of billed charges
		48	GSK	Hiberix	100% of billed charges
	90647	49	MSD	PedVaxHIB	100% of billed charges
	90737	17	Not Specified		100% of billed charges
Men/Hib	90644	148	GSK	MenHibrix	100% of billed charges
HPV	90649	62	MSD	Gardasil	100% of billed charges
Meningococcal	90734	114	SANOFI-PASTUER	Menactra	100% of billed charges
	90734	136	NOVARTIS	Menveo	100% of billed charges
	90733	32	SANOFI-PASTUER	Menomune	100% of billed charges
MMR	90707	3	MSD	MMR II	100% of billed charges
MMR-V	90710	94	MSD	ProQuad	100% of billed charges
Pneumo 23	90732	33	MSD	PneumoVax 23	100% of billed charges
Pcv 13	90670	133	LED	Prenar 13	100% of billed charges
Rotavirus	90681	119	GSK	Rotarix	100% of billed charges
	90680	116	MSD	RotaTeq	100% of billed charges
Td	90714	113	SANOFI-PASTUER	Decavac*	100% of billed charges
		113	SANOFI-PASTUER	Tenivac	100% of billed charges
Tdap	90715	115	GSK	Boostrix	100% of billed charges
		115	SANOFI-PASTUER	Adacel	100% of billed charges
	90715	115	Not Specified		100% of billed charges
Varicella	90716	21	MSD	Varivax	100% of billed charges
Influenza	90654	144	Fluzone ID		100% of billed charges
	90656	140	Fluzone, Fluvirin, FLUARIX, Afluria		
	90657	141	Fluzone		
	90658	141	Fluzone, Fluvirin, FluLaval, Afluria		
	90661	153	Flucevax		
	90662	135	Fluzone High Dose		
	90672	149	FluMist Quadrivalent		
	90673	155	Flublok		
	90685	161	Fluzone Quadrivalent		
	90686	150	Fluzone, Fluarix Quadrivalent		
	90687	158	Fluzone Quadrivalent		
90688	158	Fluzone, FluLaval Quadrivalent			

* This vaccine is no longer available. Price (reflector) is the most recent price per dose prior to leaving the market.

SPECIAL TERMS & CONDITIONS: Provider's billed charges to Moda Health for the above-listed vaccines may not exceed Provider's actual acquisition cost regardless of supplier source. For State-supplied vaccines, billed charges may not exceed the "Price Per Dose" for the applicable period as established by the Oregon Immunization Program on January 1 & July 1 of each year. For non-State supplied vaccines, billed charges may not exceed Provider's acquisition cost from the pharmaceutical supplier. Moda Health understands and agrees that such pricing is subject to change during the term of this Agreement. Audits will be done from time to time to establish conformity and to substantiate billed charges for these vaccines. For audits as well as upon request, where non-State supplied vaccines are concerned, Provider is required to provide the supplier's invoice. Invoices must be dated within six (6) months of the date of service and be for the specific vaccine. Refunds may be requested for amounts paid that are not consistent with this pricing methodology. The parties agree to review the content herein as needed. Moda Health reserves the right to accept or deny any new vaccine addition and/or other material change to the terms and conditions of this Exhibit B-1.

Exhibit B-1
 County Name: Clatsop / Sherman / Wasco
 Approved by County: [Signature] (initial here) | Date Approved: 3/27/2015



**Local Public Health Authority–Delegate Agency-
Oregon Immunization Program
Addendum Agreement 2015**

Name of Delegate Agency: Sherman County Medical Clinic

Vaccines for Children (VFC) PIN#: P000463

The Delegate Addendum is an agreement between local public health authority (LPHA) and a clinic to increase access to immunizations in areas of need. Below are the requirements that must be met to create/maintain the relationship. LPHA will ensure the requirements are met by visiting each site biennially. Please use the check boxes below to ensure those items are met.

1. Delegate must maintain enrollment as a Vaccines for Children Provider, including meeting all requirements laid out in the VFC Public Provider Agreement.
2. Oregon Vaccine Stewardship Statute. Delegates will comply with all sections of the Oregon Vaccine Stewardship Statute.
3. Delegate agency reviews and oversight. Local Public Health Authority is encouraged to attend the compliance visit conducted at least biennially by the Oregon Immunization Program (OIP).
4. Delegate will track, store and manage the supply and distribution of vaccine according to OHA and CDC guidelines as documented in the current edition of OHA's Vaccine Management Guide.
5. Required vaccine administration & management documentation and reporting by the delegate agency:
 - a. All Delegate Agencies will use current, signed, OIP Model Standing Orders.
 - b. Delegate agencies will complete and save a physical vaccine inventory and reconcile the ALERT inventory monthly. Inventories shall be made available when requested by the LPHA or the OHA.
 - c. Provide to the patient, parent or legal representative, documentation of vaccines received at the visit with either a new immunization record or update the patient's existing record.
 - d. Document administration of the immunization in a permanent record according to federal requirements. Screen for contraindications and precautions prior to administering vaccine and document that screening has occurred.
6. Delegate will comply with state and federal statutory and regulatory retention schedules, available for review at OHA's office located at 800 NE Oregon St, Suite 370, Portland, OR 97232

7. Vaccine Billing for Insured Clients.
Delegate agencies will be billed quarterly by OIP for state-supplied vaccine provided to insured clients. Payment is due 30 days after the invoice date. If timely payment is not received, OIP will not fill future vaccine orders until payment is received.
8. Vaccine charges for Billable doses must not exceed the Oregon Health Authority published price list.
9. Tracking and Recall.
 - a. Delegates will forecast shots due using ALERT IIS or an approved forecasting system for all patients requiring immunization services.
 - b. Delegates must cooperate with OHA to recall a client if a dose administered to client is found to have been mishandled and/or administered incorrectly, thus rendering such dose subpotent or invalid.
10. Vaccine Information Statements.
 - a. Delegates will confirm that a recipient, parent, or legal representative has read, or has had read to them, the VIS and has had their questions answered prior to the administration of the vaccine.
 - b. Delegates will make the VIS available in other languages or formats when needed (e.g, when English is not a patient's primary language or for those needing the VIS in braille.)
 - c. Delegates documenting vaccine administration electronically must demonstrate the ability to override a VIS date in their EHR system.
 - d. Delegates are encouraged to attend state-sponsored immunization conferences and trainings as well as CDC-sponsored educational webinars and teleconferences.
11. Adverse Events Following Immunization. Delegates must complete a VAERS form when:
 - a. An adverse event occurs, as listed in "Reportable Events Following Immunization", <http://vaers.hhs.gov/professionals/index#Guidance1> or any event that may be related to the receipt of a vaccine. Form may be completed online by going to <https://vaers.hhs.gov/esub/step1>. Save the report number for records and send the number to the OIP Vaccine Safety Coordinator.
12. Delegate agencies will comply with any VAERS follow-up requested by CDC, VAERS, or OHA.
 - a. Termination of the delegate relationship may be done at any time. Either party may terminate the certification upon 30 days written notice. This certification shall be terminated on day of receipt of notice if any of the conditions are not adhered to by the delegate agency or its staff.

Total number of clinic sites: _____ 1 _____

Delegate Agency Administrator or Director ~ Please print & include title

Caitlin Blagg, District Administrator

Signature of Delegate Agency Administrator or Director

Caitlin M. Blagg

Date

9/21/2015

Name of Delegate Agency Immunization Contact Person ~ Please print & include title

Jerrilea Mayfield – Medical Assistant and Referral Coordinator

Name of Local Health Department

North Central Health District

Signature of Local Health Department Administrator

Paul Malhotra, BSW

Date

10/9/2015

Signature of OIP Health Educator

Date



Public Health
Prevent. Promote. Protect.

NORTH CENTRAL PUBLIC HEALTH DISTRICT

“Caring For Our Communities”

Directors Report for the Board of Health: November 6, 2015

Oregon Public Health Association (OPHA): 3 staff, including myself, attended the annual OPHA conference on the OSU campus in Corvallis. The conference offered two days of learning on a wide variety of public health topics. Key note speakers included Oregon Senator Elizabeth Steiner-Hayward presenting on legislation around vaccine exemptions and US Senator Jeff Merkley presenting on the success and continuing challenges of health care reform. In addition to many other interesting topics, I attended a session that included a presentation by our community partner agency, HAVEN. HAVEN staff presented on the integration of Intimate Partner Violence screening and intervention in a reproductive health clinic. NCPHD has been proud to partner with HAVEN on this effort for the last few years. The success of this project has been recognized by Futures Against Violence at both the state and national conferences.

Strategic Planning: Leadership team has been working to update our strategic plan to a meaningful, useful, guiding document. It has been especially important at this time to consider the changing landscape of the health system and governmental public health in Oregon. Leadership team chose the following four priority areas for planning:

- Priority #1: Support wellness at every age, size and ability.
- Priority #2: Align with and actively participate in systems transformation.
- Priority #3: Focus on strategies having the greatest impact to improve health.
- Priority #4: Enhance our strengths

After creating the Priority Areas, Performance Management Teams were created to craft goals, objectives and strategies for improvement. The Performance Management Teams are:

- Community Disease Prevention and Protection
- Public Health Emergency Preparedness and Response
- Chronic Disease Prevention
- Promoting Healthy Families
- Administrative Functions

These teams are currently creating goals and objectives that are informed by a state or national standard, fit into one of the four Priority areas, and are measurable. When that process is complete, the full strategic plan will be presented to the Board of Health for review. Staff will be gathering data and reporting to leadership team, all staff, and the board of health periodically.

Community Engagement:

A snapshot of meetings staff have attended with community partners in the last month include the community advisory councils for EOCCO and CGCCO; the Wasco County Early Childhood Committee; the AOC District 3 meeting; a meeting in Gilliam County to discuss Healthy Families services in the Frontier Counties. In addition, NCPHD staff convened the Wasco County Solid Waste Advisory Committee and subsequently reported the results and recommendations to the Wasco County Board of Commissioners. NCPHD staff attended a safety committee training presented by CIS. I have attended the Systems Integration Team meetings of the CGCCO and today will attend a community partner meeting to begin the next round of the CGCCO Community Health Assessment.

Respectfully Submitted,

Teri L. Thalhofer, RN, BSN
Director