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Agreement #169528

NINTH AMENDMENT TO OREGON HEALTH AUTHORITY 2021-2023 INTERGOVERNMENTAL AGREEMENT FOR THE FINANCING OF PUBLIC HEALTH SERVICES

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This Ninth Amendment to Oregon Health Authority 2021-2023 Intergovernmental Agreement for the Financing of Public Health Services, effective July 1, 2021, (as amended and restated the "Agreement"), is between the State of Oregon acting by and through its Oregon Health Authority ("OHA") and Tillamook County, ("LPHA"), the entity designated, pursuant to ORS 431.003, as the Local Public Health Authority for Tillamook County.

RECITALS

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

WHEREAS, OHA and LPHA wish to modify the Fiscal Year 2023 (FY23) Financial Assistance Award set forth in Exhibit C of the Agreement.

WHEREAS, OHA and LPHA wish to modify the Exhibit J information required by 2 CFR Subtitle B with guidance at 2 CFR Part 200;

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. This Amendment is effective on August 1, 2022, regardless of the date this amendment has been fully executed with signatures by every Party and when required, approved by the Department of Justice. However, payments may not be disbursed until the Amendment is fully executed.

2. The Agreement is hereby amended as follows:

a. Exhibit A "Definitions", Section 18 "Program Element" is amended to modify the certain line items titles and funding source identifiers as follows, deleted language is ~~struck through~~ and new language is **bold and underlined**:

PE NUMBER AND TITLE • SUB-ELEMENT(S)	FUND TYPE	FEDERAL AGENCY/ GRANT TITLE	CFDA#	HIPAA RELATED (Y/N)	SUB-RECIPIENT (Y/N)
PE 04 – Sustainable Relationships for Community Health (SRCH)					
PE 04-02 Community Chronic Disease Prevention	**FF**	**NACDD/Building Capacity for Public and Private Payer Coverage of the National DDP Lifestyle Change Program**	**93.421**	**N**	**Y**
	FF	**CDC/Improving the Health of Americans through Prevention and Management of Diabetes and Heart Disease and Stroke**	**93.426**	**N**	**Y**
PE 43 – Immunization Services					
PE 43-01 Immunization Services	**FF**	**CDC/Immunization Cooperative Agreements**	**93.268**	**N**	**Y**
PE 43-02 Wallowa County and School Law	**GF**	**N/A**	**N/A**	**N**	**N**
PE 43-06 CARES Flu	**FF**	**CDC/Immunization and Vaccines for Children**	**93.268**	**N**	**Y**
PE 43-07 School Law	**GF**	**N/A**	**N/A**	**N**	**N**
PE 46 – Reproductive Health					
PE 46-05 RH Community Access	~~GF~~**FF**	**DHHS/Family Planning Services**~~N/A~~	~~N/A~~ **93.217**	N	~~N~~ **Y**

b. Exhibit B Program Element Descriptions are either added or modified as stated by Attachment A attached hereto and incorporated herein by this reference:

c. Section 1 of Exhibit C of the Agreement, entitled "Financial Assistance Award" for FY23 is hereby superseded and replaced in its entirety by Attachment B, entitled "Financial Assistance Award (FY23)", attached hereto and incorporated herein by this reference. Attachment B must be read in conjunction with Section 3 of Exhibit C.

d. Exhibit J of the Agreement entitled "Information required by 2 CFR Subtitle B with guidance at 2 CFR Part 200" is amended to add to the federal award information datasheet as set forth in Attachment C, attached hereto and incorporated herein by this reference.

3. LPHA represents and warrants to OHA that the representations and warranties of LPHA set forth in Section 4 of Exhibit F of the Agreement are true and correct on the date hereof with the same effect as if made on the date hereof.

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

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

6. 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.

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

Signature: _____

Name: /for/ Nadia A. Davidson

Title: Director of Finance

Date: _____

TILLAMOOK COUNTY LOCAL PUBLIC HEALTH AUTHORITY

By: _____

Name: _____

Title: _____

Date: _____

DEPARTMENT OF JUSTICE – APPROVED FOR LEGAL SUFFICIENCY

Agreement form group-approved by Wendy Johnson, Senior Assistant Attorney General, Tax and Finance Section, General Counsel Division, Oregon Department of Justice by email on September 19, 2022, copy of email approval in Agreement file.

REVIEWED BY:

OHA PUBLIC HEALTH ADMINISTRATION

By: _____

Name: Derrick Clark *(or designee)*

Title: Program Support Manager

Date: _____

Attachment A
Program Element Description(s)

This Program Element #01 is hereby superseded and replace as follows:

Program Element #01: State Support for Public Health (SSPH)

OHA Program Responsible for Program Element:

Public Health Division/Office of the State Public Health Director

1. **Description.** Funds provided under this Agreement for this Program Element may only be used in accordance with, and subject to, the requirements and limitations set forth below, to operate a Communicable Disease control program in LPHA's service area that includes the following components: (a) epidemiological investigations that report, monitor and control Communicable Disease, (b) diagnostic and consultative Communicable Disease services, (c) early detection, education, and prevention activities to reduce the morbidity and mortality of reportable Communicable Diseases, (d) appropriate immunizations for human and animal target populations to control and reduce the incidence of Communicable Diseases, and (e) collection and analysis of Communicable Disease and other health hazard data for program planning and management.

   Communicable Diseases affect the health of individuals and communities throughout Oregon. Inequities exist for populations that are at greatest risk, while emerging Communicable Diseases pose new threats to everyone. The vision of the foundational Communicable Disease Control program is to ensure that everyone in Oregon is protected from Communicable Disease threats through Communicable Disease and Outbreak reporting, investigation, and application of public health control measures such as isolation, post-exposure prophylaxis, education, or other measures as warranted by investigative findings. The work in this Program Element is also in furtherance of the Oregon Health Authority's strategic goal of eliminating health inequities by 2030.

   This Program Element, and all changes to this Program Element are effective the first day of the month noted in Issue Date section of Exhibit C Financial Assistance Award unless otherwise noted in Comments and Footnotes of Exhibit C of the Financial Assistance Award.

2. **Definitions Specific to State Support for Public Health**

   a. **Case:** A person who has been diagnosed by a health care provider, as defined in OAR 333-017-0000, as having a particular disease, infection, or condition as described in OAR 333-018-0015 and 333-018-0900, or whose illness meets defining criteria published in the OHA's Investigative Guidelines.

   b. **Communicable Disease:** A disease or condition, the infectious agent of which may be transmitted to and cause illness in a human being.

   c. **Outbreak:** A significant or notable increase in the number of Cases of a disease or other condition of public health importance (ORS 431A.005).

   d. **Reportable Disease:** Any of the diseases or conditions specified in OAR 333-018-0015 and OAR 333-018-0900.

3. **Alignment with Modernization Foundational Programs and Foundational Capabilities.** The activities and services that the LPHA has agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities and the public health accountability metrics (if applicable), as follows (see Public Health Modernization Manual at https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf:

a. Foundational Programs and Capabilities (As specified in Public Health Modernization Manual)

Program Components	**Foundational Program**					**Foundational Capabilities**						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services: Population Health	Access to clinical preventive services: Direct services	Leadership and organizational competencies	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
Epidemiological investigations that report, monitor and control Communicable Disease (CD).	*						**X**		**X**			**X**
Diagnostic and consultative CD services.	*								**X**			
Early detection, education, and prevention activities.	*						**X**	**X**	**X**		**X**	
Appropriate immunizations for human and animal target populations to reduce the incidence of CD.	*			**X**			**X**					
Collection and analysis of CD and other health hazard data for program planning and management.	*						**X**		**X**	**X**		**X**

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

Gonorrhea rates

c. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Modernization Process Measure:

(1) Percent of gonorrhea Cases that had at least one contact that received treatment; and

(2) Percent of gonorrhea Case reports with complete "priority" fields.

4. Procedural and Operational Requirements. By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, LPHA agrees to conduct the following activities in accordance with the indicated procedural and operational requirements:

a. LPHA must operate its Communicable Disease program in accordance with the Requirements and Standards for the Control of Communicable Disease set forth in ORS Chapters 431, 432, 433 and 437 and OAR Chapter 333, Divisions 12, 17, 18, 19 and 24, as such statutes and rules may be amended from time to time.

b. LPHA must use all reasonable means to investigate in a timely manner all reports of Reportable Diseases, infections, or conditions. To identify possible sources of infection and to carry out appropriate control measures, the LPHA Administrator shall investigate each report following procedures outlined in OHA's Guidelines or other procedures approved by OHA. OHA may provide assistance in these investigations, in accordance with OAR 333-019-0000. Investigative guidelines are available at:

https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/ReportingCommunicableDisease/ReportingGuidelines/Pages/index.aspx

c. As part of its Communicable Disease control program, LPHA must, within its service area, investigate the Outbreaks of Communicable Diseases, institute appropriate Communicable Disease control measures, and submit required information in a timely manner regarding the Outbreak to OHA in Orpheus (or Opera for COVID-19 Cases) as prescribed in OHA CD Investigative Guidelines available at:

https://www.oregon.gov/oha/PH/DiseasesConditions/CommunicableDisease/ReportingCommunicableDisease/ReportingGuidelines/Pages/index.aspx

d. LPHA must establish and maintain a single telephone number whereby physicians, hospitals, other health care providers, OHA and the public can report Communicable Diseases and Outbreaks to LPHA 24 hours a day, 365 days a year. LPHA may employ an answering service or 911 system, but the ten-digit number must be available to callers from outside the local emergency dispatch area, and LPHA must respond to and investigate reported Communicable Diseases and Outbreaks.

e. LPHA must attend Communicable Disease 101 and Communicable Disease 303 training.

f. LPHA must attend monthly Orpheus user group meetings or monthly Orpheus training webinars.

g. COVID-19 Specific Work

In cooperation with OHA, the LPHA must collaborate with local and regional partners, including CBOs and tribal partners where available in the jurisdiction, to assure adequate culturally and linguistically responsive COVID-19 -related services are available to the extent resources are available. In addition, to the extent resources are available, the LPHA must assure individuals requiring isolation have basic resources to support a successful isolation period. OHA has entered into grant agreements with community-based organizations (CBOs) to provide a range of culturally and linguistically responsive services, including community engagement and education, social services and wraparound supports. Services provided by CBOs will complement the work of the LPHA. LPHA must conduct the following activities in accordance with the guidance to be provided by OHA:

(1) Cultural and linguistic competency and responsiveness.

LPHA must:

(a) Partner with CBOs, including culturally-specific organizations where available in the jurisdiction. OHA will share with LPHA the grant agreement and deliverables between OHA and OHA-funded CBOs and the contact information for all the CBOs. LPHA must communicate with OHA-funded CBOs about any changes that will affect coordination for wraparound services.

(b) Work with local CBOs including culturally-specific organizations to develop and implement culturally and linguistically responsive approaches to COVID-19 prevention and mitigation of COVID-19 health inequities among populations most impacted by COVID-19, including but not limited to communities of color, tribal communities and people with physical, intellectual and developmental disabilities.

(c) Work with disproportionately affected communities to ensure COVID-19 related services, including case investigation, social services and wraparound supports are available to eligible individuals, and provided in a culturally and linguistically responsive manner with an emphasis on serving disproportionately impacted communities.

(d) Ensure the cultural and linguistic needs and accessibility needs for people with disabilities or people facing other institutionalized barriers are addressed in the LPHA's delivery of social services and wraparound supports.

(e) Have and follow policies and procedures for meeting community members' language needs relating to both written translation and spoken or American Sign Language (ASL) interpretation.

(f) Employ or contract with individuals who can provide in-person, phone, and electronic community member access to services in languages and cultures of the primary populations being served based on identified language (including ASL) needs in the County demographic data.

(g) Ensure language access through telephonic interpretation service for community members whose primary language is other than English, but not a language broadly available, including ASL.

(h) Provide written information provided by OHA that is culturally and linguistically appropriate for identified consumer populations. All information shall read at the sixth-grade reading level.

(i) Provide public health communications (e.g. advertising, social media) that are culturally and linguistically appropriate for identified consumer populations. All information shall read at the sixth-grade reading level.

(j) Provide opportunities to participate in OHA trainings to LPHA staff and LPHA contractors that provide social services and wraparound supports; trainings should be focused on long-standing trauma in Tribes, racism and oppression.

(2) Testing

LPHA must:

(a) Work with OHA regional field operations coordinator, local and regional partners including health care, communities disproportionately affected by COVID-19 and other partners to assure COVID-19 testing is available to individuals within the LPHA's jurisdiction.

(b) Work with health care and other partners to ensure testing is provided in a culturally and linguistically responsive manner with an emphasis on making testing available to disproportionately impacted communities

(3) Case Investigation

LPHA must:

(a) Conduct high-risk Case investigations and monitor Outbreaks in accordance with Investigative Guidelines and any OHA-issued surge guidance.

(b) Enter all high-risk COVID-19 case investigation and outbreaks in Opera and Opera Outbreaks, as directed by OHA.

(c) Collect and enter all components of Race, Ethnicity, Language, and Disability (REALD) data for high-risk cases being interviewed if data are not already entered in OPERA.

(d) Ensure all LPHA staff designated to utilize Opera are trained in this system. Include in the data whether new high-risk positive Cases are tied to a known existing positive Case or to community spread.

(4) Isolation.

LPHA must facilitate efforts, including by partnering with OHA-funded CBOs and other community resources to link individuals needing isolation supports such as housing and food. The LPHA will utilize existing resources when possible such as covered Case management benefits, WIC benefits, etc.

(5) Social services and wraparound supports.

LPHA must ensure social services referral and tracking processes are developed and maintained and, to the extent the LPHA has sufficient resources, make available direct services as needed. LPHA must cooperate with CBOs and other community resources to provide referral and follow-up for social services and wraparound supports for affected individuals and communities.

(6) Tribal Nation support.

LPHA must ensure alignment of supports for patients and families by coordinating with Federally-recognized tribes if a patient identifies as American Indian/Alaska Native and/or a member of an Oregon Tribe, if the patient gives permission to notify the Tribe.

(7) Support infection prevention and control for high-risk populations.

LPHA must:

(a) Migrant and seasonal farmworker support. Partner with farmers, agriculture sector and farmworker service organizations to develop and execute plans for COVID-19 testing, isolation, and social service needs for migrant and seasonal farmworkers.

(b) Congregate care facilities. In collaboration with State licensing agency, support infection prevention assessments, COVID-19 testing, infection control, and transmission-based precautions in congregate care facilities.

(c) Vulnerable populations. Support COVID-19 testing, infection control, isolation, and social services and wraparound supports for houseless individuals, individuals residing in houseless camps, individuals involved in the carceral system and other vulnerable populations at high risk for COVID-19.

(8) COVID-19 Vaccine Planning and Distribution.

As CARES/COVID supplemental funding resources are available, LPHA must:

(a) Convene and collaborate with local and regional health care partners, CBOs, communities disproportionately affected by COVID-19 and other partners to assure culturally and linguistically appropriate access to COVID-19 vaccines in their communities.

(b) Convene and collaborate with local and regional health care partners, CBOs, communities disproportionately affected by COVID-19 and other partners to identify, assess and address gaps in the vaccine delivery system using local data and in collaboration with local advisory boards if present in the jurisdiction. Operate in accordance with federal and OHA guidance, including expanding access through expanded operations and accessibility of operations (e.g., providing vaccinations during evenings, overnight, and on weekends) when needed to ensure access to COVID-19 vaccines.

(c) Prioritize vaccine distribution and administration in accordance with federal and OHA guidance.

(d) LPHAs that provide COVID-19 vaccine administration must submit vaccine orders, vaccine administration data and VAERS (Vaccine Adverse Event Reporting System) information in accordance with federal and OHA guidance.

(e) Plan and implement vaccination activities with organizations as needed to ensure equitable access to COVID-19 vaccines in the jurisdiction. Example organizations include but are not limited to:

- Colleges and Universities
- Occupational health settings for large employers
- Faith-based or religious institutions
- Federally Qualified Health Centers (FQHCs), including Community Health Centers (CHCs)
- Pharmacies
- Long-term care facilities (LTCFs), including independent living facilities, assisted living centers, and nursing homes

- Organizations and businesses that employ critical workforce
- First responder organizations
- Non-traditional providers and locations that serve high-risk populations
- Other partners that serve underserved populations

(f) Promote COVID-19 and other vaccinations to increase vaccine confidence by culturally specific groups, communities of color, and others and to also increase accessibility for people with disabilities

(9) Community education. LPHA must work with CBOs and other partners to provide culturally and linguistically responsive community outreach and education related to COVID-19.

5. General Revenue and Expense Reporting. LPHA must complete an "Oregon Health Authority Public Health Division Expenditure and Revenue Report" located in Exhibit C of the Agreement.

a. These reports must be submitted to OHA each quarter on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 20

b. All funds received under a PE or PE- supplement must be included in the quarterly Revenue and Expense reports.

6. Reporting Requirements. Provide quarterly reporting to OHA on COVID-19 vaccine activities.

7. Performance Measures. LPHA must operate its Communicable Disease control program in a manner designed to make progress toward achieving the following Public Health Modernization Process Measures:

a. Percent of gonorrhea Cases that had at least one contact that received treatment and

b. Percent of gonorrhea Case reports with complete "priority" fields.

This Program Element #10 is hereby added as follows:

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

OHA Program Responsible for Program Element:

Public Health Division/Center for Health Prevention & Health Promotion/ Health Promotion and Chronic Disease Prevention Section

1. Description. Funds provided under the Financial Assistance Agreement for this Program Element may only be used, in accordance with and subject to the requirements and limitations set forth below to deliver Sustainable Relationship for Community Health (SRCH) services. The Local Public Health Authority (LPHA) must partner with their regional Coordinated Care Organizations (CCO) and local community-based organizations (CBOs) to align and delineate organizational roles and responsibilities to improve health outcomes, while leveraging existing community-wide health improvement initiatives.

Through the SRCH initiative, the LPHA must work with CCOs, clinics, CBOs and others others involved with health system transformation and delivering Evidence-Based Interventions and Services, and to prevent and improve chronic conditions and improve Community-Clinical Linkages. More specifically, these leaders from multiple sectors will use data to identify at-risk populations, refer and connect at-risk populations to Evidence-Based Interventions and Services, and share and use data to improve referral systems and health outcomes, and reduce disparities / inequities. SRCH will provide teams the opportunity to develop and strengthen relationships, co-design Closed-Loop Referral strategies, develop sustainable payments and/or reimbursement methodologies, implement quality improvement processes, and collect, analyze and share data in order to reduce some of the leading causes of death and disability in Oregon. Developing and improving these sustainable systems may require steps such as creating new payment or reimbursement strategies, increasing the capacity of CBOs, improving and coordinating referral systems, and documenting referral outcomes.

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

This Program Element, and all changes to this Program Element are effective the first day of the month noted in Issue Date section of Exhibit C Financial Assistance Award unless otherwise noted in Comments and Footnotes of Exhibit C of the Financial Assistance Award.

2. Definitions Specific to Sustainable Relationships for Community Health (SRCH).

a. Closed-Loop Referrals: Referrals that, in addition to linking the referred individual to self-management intervention, also provide the referring entity with timely follow-up information pertinent to the individual's continuing care. Examples of information to close the referral loop include updates on whether the referred individual received the intervention, outcomes related to receipt of the intervention (e.g., identified self-management goals, improved disease status, reduction of risk factors such as tobacco use) and any barriers precluding receipt of the intervention.

b. Community-Clinical Linkages: Refers to forming partnerships and relationships among clinical, community, and public health organizations to coordinate health care delivery, and public health and community-based activities to promote healthy behaviors and improve the health of a population.

c. Evidence-Based Interventions and Services: Refers to practices set forth in public health or health care that have been shown through research and evaluation to improve health outcomes, and have been recommended through national guidance from expert organizations such as the Centers for Disease Control and Prevention's Community Guide to Preventive Services or the

United States Preventive Services Task Force. This may include (but is not limited to) chronic disease self-management programs, asthma self-management, the national Diabetes Prevention Program, tobacco cessation services or colorectal cancer screening.

d. **Health Information Technology (HIT):** Encompasses a wide range of products and services including software, hardware and infrastructure designed to collect, store and exchange patient data throughout the clinical practice of medicine.

3. **Alignment with Modernization Foundational Programs and Foundational Capabilities.** The activities and services that the LPHA has agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities and the public health accountability metrics (if applicable), as follows (see Oregon's Public Health Modernization Manual, (http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf):

a. **Foundational Programs and Capabilities** (As specified in Public Health Modernization Manual)

Program Components	**Foundational Program**					**Foundational Capabilities**						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services: Population Health	Access to clinical preventive services: Direct services	Leadership and organizational competencies	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
Participate in activities to create Sustainable Relationships for Community Health (SRCH) Institutes		*	X	X	X	X	X	X		X	X	
Advance Health System Interventions		X	X	*	X	X	X	X	X	X	X	
Promote Community-Clinical Linkages to Support Patient Self-Management		X	X	*	X	X	X	X	X	X	X	
Development and Implementation of a Plan to Sustain Relationships for Community Health		*	X	X	X	X	X	X	X	X	X	

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

Adults who smoke cigarettes

c. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Modernization Process Measure:

Not applicable

4. Procedural and Operational Requirements: By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, LPHA agrees to conduct activities in accordance with the following requirements:

a. General Requirements. LPHA must:

(1) Submit a local program plan and local budget for approval by OHA within a timeframe designated by OHA. LPHA must engage in activities as described in its local program plan, which has been approved by OHA.

(2) Use funds for this Program Element in accordance with its local program budget, which has been approved by OHA. Modification to the local program budget may only be made with OHA approval.

(3) Assure that it is staffed at the appropriate level to address Subsections b.(1) through b.(4) of this Section 4 of this Program Element. LPHA must designate a point of contact between LPHA and OHA. Funds for this Program Element are to be directed to personnel, travel and other expenses in support of Subsections b.(1) through b.(4).

(4) Attend all Institute Meetings with partnering CCO and CBOs.

(5) Attend all meetings reasonably required by OHA's Health Promotion and Chronic Disease Program.

(6) Comply with OHA's Health Promotion and Chronic Disease Prevention Program Guidelines and Policies, located at: https://apps.state.or.us/Forms/Served/me010-019.pdf

In the event of any omission from, or conflict or inconsistency between, the provisions of the local program budget and the provisions of the Agreement and this Program Element, the provisions of the Agreement and this Program Element shall control.

b. Local Activities. LPHA must focus efforts in cooperation with CCOs and CBOs on the activities described in Subsections (1) through (4) below. Together, these collaborative activities will support participating partners in the development of plans to improve inter-organizational partnerships and the creation of joint agreements with LPHA, regional CCOs and CBOs to address chronic disease prevention, early detection and self-management.

(1) **Participate in Institute Activities to create Sustainable Relationships for Community Health (SRCH) Institutes:** LPHA, including key person(s) from each team, will actively participate in Institutes to develop Sustainable Relationships for Community Health Institutes (SRCH Institutes). OHA will convene the SRCH Institutes as a "learning collaborative," where local team members must participate in a series of facilitated discussions and receive technical assistance. Discussions and technical assistance will engage local leadership involved in health system transformation and development of Community-Clinical Linkages to align and delineate organizational roles and responsibilities to improve health outcomes, while leveraging existing community-wide health improvement initiatives.

(a) The SRCH Institutes will assist team members to co-design (1) local initiatives to improve cross-sector partnerships and (2) joint agreements with team member organizations to address the local burden related to prevention, early detection, and self-management.

(b) The SRCH Institutes will include up to four in-person two-day meetings during the funding period. Additionally, LPHAs must:

i. Conduct pre-work on the team's needs, strengths, and goals for participation in the SRCH Institutes; and

ii. Engage in activities between Institute in-person meetings, including facilitated technical assistance calls/webinars, and individual coaching.

(c) The SRCH Institutes will support LPHAs, CCOs and CBOs in developing formal commitments, such as memoranda of understanding and data-sharing agreements, to reinforce collaboration and a long-term commitment to health system improvement and Community-Clinical Linkages. Team members will share outcomes and assist OHA with the dissemination of findings.

(2) **Advance Health System Interventions:** During the SRCH Institutes, team members must participate in structured, facilitated discussions and activities to co- design and advance health system interventions addressing prevention, early detection, and self-management of chronic disease that:

(a) Increase implementation of quality improvement processes in health systems.

(b) Increase electronic health records (EHR) utilization and the use of HIT to improve quality of care.

(c) Increase the institutionalization and monitoring of aggregated/standardized quality measures at the provider and systems level.

(d) Increase use of team-based care in health system, clinical, and community settings.

(e) Increase engagement of non-physician team members (e.g., care coordinators, pharmacists, community health workers, patient navigators, peer support specialists, peer wellness specialists) in hypertension, pre-diabetes and diabetes management in health care systems and community settings.

(3) **Promote Community-Clinical Linkages to Support Patient Self-Management:** During the SRCH Institutes, team members must participate in structured facilitated discussions and activities that develop and reinforce long-term commitments to Community-Clinical Linkages, quality improvement, data-sharing, collaboration and partnerships between LPHAs, CCOs, CBOs and others. Team members will co-design self-management support strategies for those enrolled in the Oregon Health Plan that:

(a) Increase access to Evidence-Based Interventions and Services, especially those delivered in community settings.

(b) Increase Closed-Loop Referrals and reimbursement for Evidence-Based Interventions and Services, especially those delivered in community settings.

(c) Increase use of traditional health workers in community and health care settings in support of self-management.

(4) Development and Implementation of a Plan to Sustain Relationships for Community Health:

(a) By the conclusion of the facilitated discussions and technical assistance offered during the SRCH Institutes, local team members must have co-created a plan and agreements that enhance collaboration, promote Community-Clinical Linkages and advance health system interventions.

(b) The plan and agreements must delineate roles and responsibilities; identify staffing and training needs; and ultimately create mechanisms to facilitate better care, better health, and lower cost. Each team's plan and agreements must include specific strategies, actions, organizational/individual responsibilities and a timeline to:

i. Improve the use of quality measures, EHR/HIT, and traditional health workers in team-based care, and;

ii. Increase the use of Evidence-Based Interventions and Services through development or improvement of systems enabling Closed-Loop Referrals of appropriate patients and payments or reimbursement to organizations providing Evidence-Based Interventions and Services.

5. General Revenue and Expense Reporting. LPHA must complete an "Oregon Health Authority Public Health Division Expenditure and Revenue Report" located in Exhibit C of this Agreement. These reports must be submitted to OHA each quarter on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 20

6. Reporting Requirements. LPHA must submit to HPCDP copies of products developed through the SRCH Institutes including: 1) official agreements such as Memorandum of Understanding, data sharing agreements, and other legal agreements; 2) protocols for referrals, payment and data sharing; and 3) other documentation demonstrating successful implementation which may include position descriptions, staffing plans, business plans, technology plans, etc. LPHA will also report and share experiences and promising practices with OHA and others.

7. Performance Measures.

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

8. Program Evaluation. LPHA must assist OHA with program evaluation throughout the duration of this Agreement, as well as with final project evaluation. Such activities may include, but are not limited to, meeting with a state level evaluator soon after execution of this Agreement to help develop an evaluation plan specific to the project, collecting data and maintaining documentation throughout this Agreement, and responding to evaluator's requests for information and collaborating with the evaluator to develop final reports to highlight the outcomes of the work. One representative from each team will be required to participate on a project evaluation advisory group.

This Program Element #13 is hereby superseded and replace as follows:

Program Element #13: Tobacco Prevention Education Program (TPEP)

OHA Program Responsible for Program Element:

Public Health Division/Center for Health Prevention & Health Promotion/ Health Promotion and Chronic Disease Prevention Section

1. Description. Funds provided under this Agreement for this Program Element may only be used in accordance with, and subject to, the requirements and limitations set forth below, to deliver the Tobacco Prevention Education Program (TPEP). As described in the local program plan, permitted activities are in the following areas:

a. Facilitation of Community and Statewide Partnerships: Accomplish movement toward tobacco-free communities through a coalition or other group dedicated to the pursuit of agreed upon local and statewide tobacco control objectives. Community partnerships should include local public health leadership, health system partners, non-governmental entities as well as community leaders.

(1) TPEP program should demonstrate ability to mobilize timely community support for local tobacco prevention objectives.

(2) TPEP program should be available and ready to respond to statewide policy opportunities and threats.

b. Creating Tobacco-Free Environments: Promote the adoption of tobacco-free policies, including policies in schools, workplaces and public places. Demonstrate community progress towards establishing jurisdiction-wide tobacco-free policies (e.g. local ordinances) for workplaces that still allow indoor smoking or expose employees to secondhand smoke. Establish tobacco-free policies for all county and city properties and government campuses.

c. Countering Pro-Tobacco Influences: Reduce the promotion of tobacco in retail environments by educating and aligning decision-makers about policy options for addressing the time, place and manner tobacco products are sold. Counter tobacco industry advertising and promotion. Reduce youth access to tobacco products, including advancing tobacco retail licensure and other evidence-based point of sale strategies.

d. Promoting Quitting Among Adults and Youth: Promote evidence-based practices for tobacco cessation with health system partners and implementation of Health Evidence Review Commission initiatives, including cross-sector interventions. Integrate the promotion of the Oregon Tobacco Quit Line into other tobacco control activities.

e. Enforcement: Assist OHA with the enforcement of statewide tobacco control laws, including the Oregon Indoor Clean Air Act, minors' access to tobacco and restrictions on smoking through formal agreements with OHA, Public Health Division.

f. Reducing the Burden of Tobacco-Related Chronic Disease: Address tobacco use reduction strategies in the broader context of chronic diseases and other risk factors for tobacco-related chronic diseases including cancer, asthma, cardiovascular disease, diabetes, arthritis, and stroke. Ensure Local Public Health Authority (LPHA) decision-making processes are based on data highlighting local, statewide and national tobacco-related disparities. Ensure processes engage a wide variety of perspectives from those most burdened by tobacco including representatives of racial/ethnic minorities, Medicaid users, LGBTQ community members, and people living with disabilities, including mental health and substance use challenges.

The statewide Tobacco Prevention and Education Program (TPEP) is grounded in evidence-based best practices for tobacco control. The coordinated movement involves state and local programs working together to achieve sustainable policy, systems and environmental change in local communities that mobilize statewide. Tobacco use remains the number one cause of preventable death in Oregon and nationally. It is a major risk factor in developing asthma, arthritis, diabetes, stroke, tuberculosis and ectopic pregnancy – as well as liver, colorectal and other forms of cancer. It also worsens symptoms for people already living with chronic diseases.

Funds provided under this Agreement are to be used to reduce exposure to secondhand smoke, prevent youth from using tobacco, promote evidence-based practices for tobacco cessation, educate decision-makers about the harms of tobacco, and limit the tobacco industry's influence in the retail environment. Funds allocated to Local Public Health Authorities are to complement the statewide movement towards population-level outcomes including reduced tobacco disparities.

This Program Element, and all changes to this Program Element are effective the first day of the month noted in Issue Date section of Exhibit C of the Financial Assistance Award unless otherwise noted in Comments and Footnotes of Exhibit C of the Financial Assistance Award.

2. Definitions Specific to Tobacco Prevention Education Program (TPEP).

Oregon Indoor Clean Air Act (ICAA) (also known as the Smokefree Workplace Law) protects workers and the public from secondhand smoke exposure in public, in the workplace, and within 10 feet of all entrances, exits, accessibility ramps that lead to and from an entrance or exit, windows that open and air-intake vents. The ICAA includes the use of "inhalant delivery systems." Inhalant delivery systems are devices that can be used to deliver nicotine, cannabinoids and other substances, in the form of a vapor or aerosol. These include e-cigarettes, vape pens, e-hookah and other devices. Under the law, people may not use e-cigarettes and other inhalant delivery systems in workplaces, restaurants, bars and other indoor public places in Oregon.

3. Alignment with Modernization Foundational Programs and Foundational Capabilities. The activities and services that the LPHA has agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities and the public health accountability metrics (if applicable), as follows (see Oregon's Public Health Modernization Manual, (http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf):

a. Foundational Programs and Capabilities (As specified in Public Health Modernization Manual)

Program Components	Foundational Program					Foundational Capabilities						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services	Population Health / Direct services	Leadership and organizational competencies	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response

Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
Facilitation of Community Partnerships		*		X		X	X	X	X	X	X	
Creating Tobacco-free Environments		*		X		X	X	X	X	X	X	
Countering Pro-Tobacco Influences		*				X	X	X	X	X	X	
Promoting Quitting Among Adults and Youth		X		*		X	X	X	X	X	X	
Enforcement		*	X			X	X	X	X	X	X	
Reducing the Burden of Tobacco-Related Chronic Disease		*		X		X	X	X	X	X	X	

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

Adults who smoke cigarettes

c. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Modernization Process Measure:

Percent of community members reached by local tobacco-free policies

4. Procedural and Operational Requirements. By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, LPHA agrees to conduct activities in accordance with the following requirements:

a. Engage in activities as described in its local program plan and local program budget, which has been approved by OHA and on file based on a schedule to be determined by OHA. OHA will supply the required format and current service data for use in completing the plans. LPHA must implement its TPEP activities in accordance with its approved local program plan and local program budget. Modifications to the plans may only be made with OHA approval.

b. Ensure that LPHA leadership is appropriately involved and its local tobacco program is staffed at the appropriate level, depending on its level of funding, as specified in the award of funds for this Program Element.

c. Use the funds awarded under this Agreement for this Program Element in accordance with its local program budget as approved by OHA and incorporated herein by this reference. Modifications to the local program budget may only be made with OHA approval. Funds awarded for this Program Element may be used for direct, evidence-based or culturally appropriate cessation delivery including the provision of Nicotine Replacement Therapy (NRT), but may not be used for other treatment services, other disease control programs, or other efforts not devoted to tobacco prevention and education.

d. Attend all TPEP meetings reasonably required by OHA.

e. Comply with OHA's TPEP Guidelines and Policies.

f. Coordinate its TPEP activities and collaborate with other entities receiving TPEP funds or providing TPEP services.

g. In the event of any omission from, or conflict or inconsistency between, the provisions of the local program plan and local program budget on file at OHA, and the provisions of the Agreement and this Program Element, the provisions of this Agreement and this Program Element shall control.

5. General Revenue and Expense Reporting. LPHA must complete an "Oregon Health Authority Public Health Division Expenditure and Revenue Report" located in Exhibit C of this Agreement. These reports must be submitted to OHA each quarter on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 20

6. Reporting Requirements. LPHA must submit local program plan reports on a semi-annual schedule to be reviewed by OHA. The reports must include, at a minimum, LPHA's progress during the reporting period towards completing activities described in its local program plan. Upon request by OHA, LPHA must also submit reports that detail quantifiable outcomes of activities and data accumulated from community-based assessments of tobacco use. LPHA leadership and program staff must participate in reporting interviews on a schedule to be determined by OHA and LPHA.

7. Performance Measures.

a. LPHA must operate the Tobacco Prevention Education Program (TPEP**)** described in its local program plan and in a manner designed to make progress toward achieving the following Public Health Modernization Process Measure:

Percent of community members reached by local tobacco-free policies

b. If LPHA completes fewer than 75% of the planned activities in its local program plan for two consecutive reporting periods in one state fiscal year, LPHA will not be eligible to receive funding under this Program Element during the next state fiscal year.

This Program Element #43 is hereby added as follows:

Program Element #43: Immunization Services

OHA Program Responsible for Program Element:

Public Health Division/Center for Public Health Practice, Immunization Section

1. Description. Funds provided under this Agreement for this Program Element may only be used in accordance with, and subject to, the requirements and limitations set forth below, to deliver Immunization Services.

Immunization Services are provided in the community to prevent and mitigate vaccine-preventable diseases for all people by reaching and maintaining high lifetime immunization rates. Services include population-based services including public education to increase vaccine confidence, enforcement of school immunization requirements, and technical assistance for healthcare providers that provide vaccines to their client populations, as well as vaccine administration to vulnerable populations with an emphasis on ensuring access and equity for all persons in the jurisdiction.

This Program Element, and all changes to this Program Element are effective the first day of the month noted in the Issue Date section of Exhibit C of the Financial Assistance Award unless otherwise noted in Comments and Footnotes of Exhibit C of the Financial Assistance Award.

2. Definitions Specific to Immunization Services.

a. ALERT IIS: OHA's statewide immunization information system.

b. Billable Doses: Vaccine doses given to individuals who opt to pay out of pocket or are insured for vaccines, including adults on Medicare and/or the Oregon Health Plan

c. Case Management: An individualized plan for securing, coordinating, and monitoring disease-appropriate treatment interventions.

d. Centers for Disease Control and Prevention or CDC: Federal Centers for Disease Control and Prevention.

e. Clinical Immunization Staff: LPHA staff that administer immunizations or who have authority to order immunizations for patients.

f. Delegate Addendum: A document serving as a contract between LPHAs and an outside agency agreeing to provide Immunization Services under the umbrella of the LPHA. The Addendum is signed in addition to a Public Provider Agreement and Profile.

g. Delegate Agency: An immunization clinic that is subcontracted with the LPHA for the purpose of providing Immunization Services to targeted populations.

h. Deputization: The process that allows Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) to authorize local health departments (LHDs) to vaccinate underinsured VFC-eligible children.

i. Electronic Health Record (EHR) or Electronic Medical Record (EMR): A digital version of a patient's paper medical chart.

j. Emergency Use Authorization or EUA: Federally required patient handouts produced by the FDA with information about the risks and benefits of vaccines authorized for emergency use.

k. Exclusion Orders: Legal notification to a parent or guardian of their child's noncompliance with the School/Facility Immunization Law.

l. Forecasting: Determining vaccines due for an individual, based on immunization history and age.

m. **HBsAg Screening**: Testing to determine presence of Hepatitis B surface antigen, indicating the individual carries the disease.

n. **Immunization Quality Improvement for Providers (IQIP)**: A continuous quality improvement process developed by CDC to improve clinic immunization rates and practices. Previously called AFIX.

o. **Oregon Vaccine Stewardship Statute:** State law requiring all Vaccine Access Program enrolled providers to:

(1) Submit all vaccine administration data, including dose level eligibility codes, to ALERT IIS;

(2) Use ALERT IIS ordering and inventory modules; and

(3) Verify that at least two employees have current training and certification in vaccine storage, handling and administration, unless exempt under statute.

p. **Orpheus:** An electronic communicable disease database and surveillance system intended for local and state public health epidemiologists and disease investigators to manage communicable disease reporting.

q. **Public Provider Agreement and Profile:** Signed agreement between OHA and LPHA that receives vaccines through VAP or VFC. Agreement includes clinic demographic details, program requirements and the number of patients vaccinated.

r. **Service Area:** Geographic areas in Oregon served by immunization providers.

s. **Surveillance:** The routine collection, analysis and dissemination of data that describe the occurrence and distribution of disease, events or conditions.

t. **Vaccine Access Program (VAP)**: Vaccine or Immune Globulin procured by the OHA with state and federal funds used to assure vaccine availability to specified groups.

u. **Vaccine Adverse Events Reporting System (VAERS):** Federal system for reporting adverse events following vaccine administration.

v. **Vaccine Eligibility:** An individual's eligibility for VAP based on insurance coverage for immunization.

w. **Vaccines for Children (VFC) Program:** A Federal entitlement program providing no-cost vaccines to children 0 through 18 years who are:

(1) American Indian/Alaskan Native; or,

(2) Uninsured; or,

(3) Medicaid-enrolled; or,

(4) Underinsured and are served in Federally Qualified Health Centers (FQHC) or Rural Health Centers (RHC); or,

(5) Underinsured and served by LPHAs that have Deputization agreements with FQHCs/RHCs.

x. **Vaccines for Children Site Visit:** An on-site visit conducted at least every two years to ensure compliance with state and federal VFC requirements.

y. **Vaccine Information Statement (VIS):** Federally required patient handouts produced by the CDC with information about the risks and benefits of each vaccine.

3. Alignment with Modernization Foundational Programs and Foundational Capabilities. The activities and services that the LPHA has agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities and the public health accountability metrics (if applicable), as follows (see Oregon's Public Health Modernization Manual, (http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf):

a. Foundational Programs and Capabilities (As specified in Public Health Modernization Manual)

Program Components	**Foundational Program**					**Foundational Capabilities**						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services: Population Health	Access to clinical preventive services: Direct services	Leadership and organizational competencies	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
Vaccines for Children Program Enrollment					*		X					X
Oregon Vaccine Stewardship Statute					*	X						
Vaccine Management					*							X
Billable Doses/IG					*		X					
Delegate Agencies					*			X				
Vaccine Administration					*							X
Immunization Rates, Outreach and Education				*								
Tracking and Recall				*					X			
Surveillance of Vaccine-Preventable Diseases	*								X			
Adverse Events Following Immunizations					*							
Perinatal Hepatitis B Prevention, Screening and Documentation	*								X			
School/Facility Immunization Law				*					X			

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

Two-year-old vaccination rates.

c. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Modernization Process Measure:

IQIP program.

4. Procedural and Operational Requirements. By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, LPHA agrees to conduct activities in accordance with the following requirements**:**

a. Vaccine Access Program OR Vaccines for Children Program Enrollment. LPHA must maintain enrollment as an active VAP provider or VFC Provider. In addition, if LPHA contracts out for clinical services, LPHA must ensure that Subcontractor maintains enrollment as an active VAP or VFC Provider.

b. Oregon Vaccine Stewardship Statute. LPHA must comply with all sections of the Oregon Vaccine Stewardship Statute.

c. Vaccine Management.

(1) LPHA must conduct a monthly, physical inventory of all vaccine storage units and must reconcile their inventory in ALERT IIS. Inventories must be kept for a minimum of three years.

(2) LPHA must submit vaccine orders according to the tier assigned by the OHA's Immunization Program.

d. Billable Doses/Immune Globulin.

(1) OHA will bill LPHA quarterly for Billable Doses of vaccine.

(2) OHA will bill the published price in effect at the time the vaccine dose is administered.

(3) LPHA may not charge or bill a patient more for the vaccine than the published price.

(4) Payment is due 30 days after the invoice date.

e. Delegate Agencies.

If LPHA has a Subcontract for Immunization Services, LPHA must complete a Delegate Addendum. A new Delegate Addendum must be signed when either of the authorized signers changes or upon request.

f. Vaccine Administration.

(1) Vaccines must be administered as directed in the most current, signed version of OHA's Model Standing Orders for Immunizations.

(2) LPHA must ensure that Clinical Immunization Staff annually view a minimum of one hour of immunization-specific continuing education like the Epidemiology and Prevention of Vaccine-Preventable Diseases program **or** the annual Immunization Update. Other immunization continuing education from sources like the CDC, Children's Hospital of Philadelphia, American Academy of Pediatrics, etc. are also acceptable.

(3) In connection with the administration of a vaccine, LPHA must:

(a) Confirm that a recipient, parent, or legal representative has read, or has had read to them, the EUA or VIS and has had their questions answered prior to the administration of the vaccine.

(b) Make the EUA or 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 EUA VIS in braille).

(c) Provide to the recipient, parent or legal representative, documentation of vaccines received at visit. LPHA may provide a new immunization record or update the recipient's existing handheld record.

(d) Screen for contraindications and precautions prior to administering vaccine and document that screening has occurred.

(e) Document administration of an immunization using a vaccine administration record or electronic equivalent, including all federally-required charting elements, in a permanent medical record. (Note- ALERT IIS does not record all federally-required elements and cannot be used as a replacement for this requirement.)

(f) If LPHA documents vaccine administration electronically, LPHA must demonstrate the ability to override a VIS date in their EHR system.

(g) Comply with state and federal statutory and regulatory retention schedules, available for review at http://arcweb.sos.state.or.us/doc/recmgmt/sched/special/state/sched/20120011ohaphdrrs.pdf, or OHA's office located at 800 NE Oregon St, Suite 370, Portland, OR 97232.

(h) Comply with Vaccine Billing Standards as provided in Attachment 1 to this PE, incorporated by reference.

g. Immunization Rates, Outreach and Education.

(1) OHA will provide annually to LPHA their IQIP rates and other population-based county rates.

(2) LPHA must, during the state fiscal year, design and implement two educational or outreach activities in their Service Area (either singly or in collaboration with other community and service provider organizations) designed to raise immunization rates. Activities may include:

- Activities intended to reduce barriers to immunization, or special immunization clinics that provide vaccine for flu prevention or school children.
- One of these activities must be related to promoting IQIP participation with local VFC-enrolled clinics. This activity may also be outreach to a local coordinated-care organization to promote IQIP activities.

h. Tracking and Recall.

(1) LPHA must provide Forecasting for clients requiring Immunization Services using the ALERT IIS electronic Forecasting system.

(2) LPHA must review their patients on the statewide recall list(s) in the first two weeks of the month and make any necessary demographic or immunization updates.

(3) LPHA must cooperate with OHA to recall a client if a dose administered by LPHA to such client is found by LPHA or OHA to have been mishandled and/or administered incorrectly, thus rendering such dose invalid.

i. **Surveillance of Vaccine-Preventable Diseases.** LPHA must conduct Surveillance within its Service Area in accordance with the Communicable Disease Administrative Rules, the Investigation Guidelines for Notifiable Diseases, the Public Health Laboratory User's Manual, and the Model Standing Orders for Vaccine, available for review at:

http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease
http://public.health.oregon.gov/LaboratoryServiceshttp://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/Pages/provresources.aspx

j. **Adverse Events Following Immunizations.**

LPHA must complete and electronically file a VAERS form if:

(1) An adverse event following immunization administration occurs, as listed in "Reportable Events Following Immunization", available for review at http://vaers.hhs.gov/professionals/index#Guidance1;

(2) An event occurs that the package insert lists as a contraindication to additional vaccine doses;

(3) OHA requests a 60-day and/or one year follow-up report to an earlier reported adverse event; or

(4) Any other event LPHA believes to be related directly or indirectly to the receipt of any vaccine administered by LPHA or others occurs within 30 days of vaccine administration, and results in either the death of the person or the need for the person to visit a licensed health care provider or hospital.

k. **Perinatal Hepatitis B Prevention, Screening and Documentation**

(1) LPHA must provide Case Management services to all confirmed or suspect HBsAg-positive mother-infant pairs identified by LPHA or OHA in LPHA's Service Area.

(2) Case Management will be performed in accordance with the Perinatal Hepatitis B Prevention Program Guidelines posted on the OHA website at *https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/ReportingCommunicableDisease/ReportingGuidelines/Documents/hepbperi.pdf* and must include, at a minimum:

(a) Screen for HBsAg status or refer to a health care provider for screening of HBsAg status, all pregnant women receiving prenatal care from public prenatal programs.

(b) Work with birthing hospitals within LPHA's Service Area when maternal screening and documentation of hepatitis B serostatus in the Electronic Birth Registration System drops below 95%.

(c) Work with birthing hospitals within LPHA's Service Area when administration of the birth dose of hepatitis B vaccine drops below 80% as reported in the Electronic Birth Registration System.

(d) Ensure that laboratories and health care providers promptly report HBsAg-positive pregnant women to LPHA.

(e) Provide Case Management services to HBsAg-positive mother-infant pairs to track administration of hepatitis B immune globulin, hepatitis B vaccine doses and post-vaccination serology.

(f) Provide HBsAg-positive mothers with initial education and referral of all susceptible contacts for hepatitis B vaccination.

l. School/Facility Immunization Law

(1) LPHA must comply with the Oregon School Immunization Law, Oregon Revised Statutes 433.235 - 433.284, available for review at https://www.oregonlegislature.gov/bills_laws/ors/ors433.html.

(2) LPHA must take orders for and deliver Certificate of Immunization Status (CIS) forms to schools and children's facilities located in their jurisdiction. Bulk orders of CIS forms will be provided to the LPHA by the state.

(3) LPHA must cover the cost of mailing/shipping to parents and to schools all Exclusion Orders, school-facility packets which are materials for completing the annual school/facility exclusion process as required by the Oregon School Immunization Law, Oregon Revised Statutes 433.235 - 433.284 and the administrative rules promulgated pursuant thereto, which can be found at https://secure.sos.state.or.us/oard/displayDivisionRules.action%3bJSESSIONID_OARD=2rAGjMwAFKyKGiwIdp_03oUv7xaI6kjlhXdVWS78XLgPdYNa0jj7%21479495115?selectedDivision=1265. LPHA may use electronic mail as an alternative or an addition to mailing/shipping if the LPHA has complete electronic contact information for all schools and children's facilities, and can confirm receipt of materials.

(4) LPHA must complete an annual Immunization Status Report that contains the immunization levels for attendees of: certified childcare facilities; preschools; Head Start facilities; and all schools within LPHA's Service Area. LPHA must submit this report to OHA no later than 23 days after the third Wednesday of February of each year in which LPHA receives funding for Immunization Services under this Agreement.

m. Supplemental Funding Opportunities

(1) LPHA may apply for additional supplemental funding grants by submitting an application outlining activities and timelines. The application is subject to approval by the OHA Immunization Program.

(2) At the discretion of the OHA Immunization Program, a supplemental funding opportunity may not require application, but will be distributed through a formula approved by the Conference of Local Health Officials.

(3) LPHA may receive mini-grant funds from the Immunize Oregon Coalition. If LPHA is awarded such funds, it will fulfill all activities required to meet the mini-grant's objectives, submit reports as prescribed by Immunize Oregon, and utilize the funds in keeping with mini-grant guidance.

5. General Revenue and Expense Reporting. LPHA must complete an "Oregon Health Authority Public Health Division Expenditure and Revenue Report" located in Exhibit C of the Agreement. These reports must be submitted to OHA each quarter on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 20

6. Reporting Requirements.

a. LPHA must submit vaccine orders according to the ordering tier assigned by OHA.

b. If LPHA is submitting vaccine administration data electronically to ALERT IIS, LPHA must electronically flag clients who are deceased or have moved out of the Service Area or the LPHA jurisdiction.

c. LPHA must complete and return a VAERS form to OHA if any of the conditions precedent set forth at Section 4.j. of this Program Element occur.

d. LPHA must complete and submit an Immunization Status Report as required in Section 4.l.(4) of this Program Element.

e. LPHA must submit a written corrective action plan to address any compliance issues identified at the triennial review site visit.

f. LPHA must submit any status reports required by supplemental grants accepted by the LPHA.

7. Performance Measures.

a. LPHA must operate Immunization Services in a manner designed to achieve the following public health accountability process measure: Percent of Vaccines for Children clinics that participate in the IQIP program.

b. If LPHA provides Case Management to 5 births or more to HBsAg-positive mothers annually LPHA must ensure that 90% of babies receive post-vaccination serology by 15 months of age. If LPHA's post-vaccination serology rate is lower than 90%, LPHA must increase the percentage of babies receiving post-vaccination serology by at least one percentage point.

c. LPHA must achieve VFC vaccine accounting excellence in all LPHA-operated clinics in the most recent quarter. Clinics achieve vaccine accounting excellence by:

(1) Accounting for 95% of all vaccine inventory in ALERT IIS.

(2) Reporting fewer than 5% of accounted for doses as expired, spoiled or wasted during the quarter.

(3) Recording the receipt of vaccine inventory in ALERT IIS.

d. LPHA must receive 95% of Primary Review Summary follow-up reports (Sections E-H) from schools and children's facilities within 21 days of the annual exclusion day. LPHA must follow the steps outlined in OAR 333-050-0095 with any school or facility that does not submit a follow-up report in a timely manner.

Attachment 1

OREGON'S IMMUNIZATION BILLING STANDARDS

Standards for providing and billing for immunization services in Oregon's Local Public Health Authorities (LPHAs)

Purpose: To standardize and assist in improving immunization billing practice

Guiding Principles

A modern LPHA understands their actual costs of doing business and dedicates resources to assuring continued financially viable operations. As such:

1. LPHAs should continually assess immunization coverage in their respective communities, assure that vaccine is accessible to all across the lifespan, and bill appropriately for services provided by the LPHA.
2. LPHAs who serve insured individuals should work to develop and continuously improve immunization billing capacity that covers the cost of providing services to those clients (e.g., develop agreements or contracts with health plans, set up procedures to screen clients appropriately, and bill vaccine administration fees that reflect the actual cost of services).
3. Public and private health plans should reimburse LPHAs for the covered services of their members, with vaccine serum and administration fees reimbursed at 100% of actual costs.
4. Each LPHA is uniquely positioned to assess the appropriate implementation of these standards. For example, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are obligated to follow a certain set of rules that may differ from these standards.
5. LPHAs that contract out some or all clinical immunization services should consider including these standards in their contracts as expectations of the contracted service provider.

Standards require that an LPHA that provides immunization services:

☐ Identify staff responsible for billing and contracting activities, dedicating at least a portion of one or more full-time equivalent (FTEs) positions to meet agency billing needs

☐ Determine vaccine administration fees based on the actual cost of service and document how fees were determined

☐ Charge the actual costs for vaccine administration fees for all clients and discount the fee(s) as needed by contract, rule, or internal policy approved by OIP

☐ Develop immunization billing policies and procedures that address:

- Strategies to manage clients who require vaccines by state law, are not eligible for VFC or 317 and are unable to meet the cost of immunizations provided (out of network or unaffordable cost sharing)
- The purchasing of privately owned vaccine and how fees are set for vaccine charges to the client
- The appropriate charge for vaccine purchased from OIP, by including a statement that says, “We will not charge more than the OIP-published price for billable vaccine.”
- Billing processes based on payor type (Medicaid/CCOs, private insurance, etc.), patient age, and vaccine eligibility

☐ With certain limited exceptions as published in vaccine eligibility charts, use no federally funded vaccine on insured clients, including adult Medicaid and all Medicare clients

☐ Identify and develop contracts or other appropriate agreements with relevant payors – including Coordinated Care Organizations (CCOs) to assure access to immunization services for insured members of the community

☐ Bill private and public health plans directly for immunization services, when feasible, rather than collecting fees from the client and having them submit for reimbursement

☐ Conduct regular quality assurance measures to ensure costs related to LPHA’s immunization services are being covered

☐ Work to assure access to immunizations for Medicare-eligible members of the community and, if access is poor, provide Medicare Part B and/or Part D vaccines, as needed, and bill appropriately to cover the cost

This Program Element #46 is hereby added as follows:

Program Element # 46: Reproductive Health

OHA Program Responsible for Program Element:

Public Health Division/Center for Prevention & Health Promotion/Adolescent, Genetic & Reproductive Health Section

1. **Description.** Funds provided under this Agreement for this Program Element may only be used in accordance with, and subject to, the requirements and limitations set forth below, to ensure access to reproductive health services.

   Funds provided through this Program Element support LPHAs efforts toward ensuring community-wide partnerships and assurance of access to, culturally responsive, high-quality, and evidence-based reproductive health services.

   This Program Element uses a systems approach to ensure that LPHAs lead efforts to develop a community-based approach to ensuring that equitable access to reproductive health services is available – leveraging partnerships with community organizations and other service providers to assist in meeting the need.

   Health disparity data highlight pre-existing, deeply entrenched societal inequities that may inhibit individuals' ability to access services and achieve reproductive autonomy. Therefore, it is critical that interventions aimed at access to services be wide-reaching and sensitive to the unique circumstances and challenges of different communities.

   This Program Element, and all changes to this Program Element are effective the first day of the month noted in Issue Date section of Exhibit C Financial Assistance Award unless otherwise noted in Comments and Footnotes of Exhibit C of the Financial Assistance Award.

2. **Definitions Specific to Reproductive Health.** Not applicable.

3. **Program with Modernization Foundational Programs and Foundational Capabilities.** The activities and services that the LPHA has agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities and the public health accountability metrics (if applicable), as follows (see Oregon's Public Health Modernization Manual, (http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf):

   a. **Foundational Programs and Capabilities** (As specified in Public Health Modernization Manual)

Program Components	**Foundational Program**					**Foundational Capabilities**						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services		Leadership and organizational competencies	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
				Population Health	Direct services							

Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
Develop and maintain strategic partnerships with shared accountability driving collective impact to support public health goals related to reproductive health				*			**X**	**X**	**X**	**X**		
In collaboration with community partners, identify barriers to access and gaps in reproductive health services		**X**		*			**X**	**X**	**X**			
In collaboration with community partners, develop and implement strategic plans to address these gaps and barriers to access to reproductive health services		**X**		*			**X**	**X**		**X**	**X**	
In collaboration with community partners, evaluate the impact of the strategic plan (developed in Program Component 3).		**X**		*			**X**	**X**	**X**	**X**		

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

Effective Contraceptive Use

c. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Modernization Process Measure:

Effective Contraceptive Use

4. Procedural and Operational Requirements. By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, LPHA agrees to conduct activities in accordance with the following requirements:

a. LPHA must deliver all PE 46 activities supported in whole or in part with funds provided under this Agreement in compliance with the requirements of the Federal Title X Program as detailed in statutes and regulations, including but not limited to 42 USC 300 et.seq., 42 CFR Part 50, subsection 301 et seq., and 42 CFR Part 59 et seq., the Title X Program Requirements, and OPA Program Policy Notices (PPN).

b. LPHA must develop and engage in activities as described in its Local Program Plan as follows:

(1) The Local Program Plan must be developed using the guidance provided in Attachment 1, "Reproductive Health Program – FY 22 Local Program Plan Guidance", incorporated herein with this reference.

(2) The Local Program Plan must address the Program Components as defined in Section 3.a., above, that meet the needs of their specific community.

(3) The Local Program Plan must include activities that address community needs and readiness and are reasonable based upon funds approved in the OHA approved local program budget.

(4) The Local Program Plan must outline how LPHA intends to ensure access to comprehensive, culturally responsive and high-quality, evidence-based reproductive health services with a focus on serving those with limited resources and experiencing health disparities.

(5) The Local Program Plan must be submitted to OHA by June 15th of each year for OHA approval.

(6) OHA will review and approve all Local Program Plans to ensure that they meet statutory and funding requirements relating to assurance of access to Reproductive Health services.

c. LPHA must use funds for this Program Element in accordance with its local program budget, which has been approved by OHA. LPHA must complete and submit its local program budget for PE 46 funds, by June 15th of each year for OHA approval, using the Local Program Budget Template and as set forth in Attachment 2, incorporated herein with this reference. Modification to the approved local program budget may only be made with OHA approval.

5. General Revenue and Expense Reporting. LPHA must complete an "Oregon Health Authority Public Health Division Expenditure and Revenue Report" located in Exhibit C of the Agreement. These reports must be submitted to OHA each quarter on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 20

6. Reporting Requirements.

LPHA must provide progress reports as included in the OHA approved Local Program Plan.

7. Performance Measures.

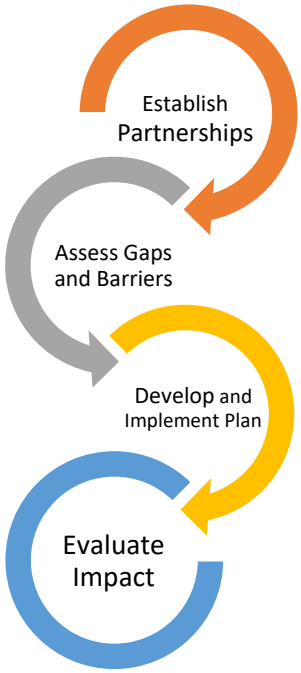
LPHA must operate the PE 46 program in a manner designed to make progress toward achieving the following Public Health Modernization Process Measure:

Effective Contraceptive Use.

Attachment 1
Reproductive Health Program – FY 22 Local Program Plan Guidance
Community Partnerships and Assurance of Access to Reproductive Health Services

Overarching Goal: Ensure regional access to comprehensive, culturally responsive and high-quality, evidence-based reproductive health services with a focus on serving individuals with limited resources and experiencing health disparities.

Instructions
LPHA should determine where their agency best fits on the continuum of program components identified to meet the overarching goal. LPHA should identify at least one objective and associated activities to support work at that stage, with the goal of eventually moving to the next component on the continuum. LPHAs should collaborate with community partners, and consider including community members experiencing health disparities, within each program component.



Partnerships with other health care providers and/or RHCare agencies is highly encouraged. In addition, LPHA should consider developing partnerships outside the health care sector. This may include local governmental, private, or non-profit agencies focused on culture, education, criminal justice, housing, social justice, sexual/domestic violence, workforce development, and/or parenting, to name a few. LPHA should consider other local task forces or advisory groups focused on improving quality of life/health disparaties/inequities for the populations the LPHA is trying to serve. LPHAS are also encouraged to think about inviting and engaging community members from the populations the LPHA is trying to serve, to be partners.

It is understood that the work may not necessarily be linear but may identify the need to circle back to an earlier step, such as the need to bring in additional partners.

Program Component 1: Develop and maintain strategic partnerships with shared accountability to drive a collective impact to support public health goals related to Reproductive Health (RH) services.
Objective 1A: Convene on-going partnership meetings focused on assuring access to RH services, minimizing gaps and barriers, and/or improving the quality of reproductive health services within the community.
Objective 1B: Create objective related to developing strategic partnerships, with shared accountability, to drive a collective impact in support of public health goals related to RH.

Suggested Activities: Create partnership agreements with community providers/organizations identifying roles and areas of collaboration; host or co-host community forums/outreach events; establish coalition with regular meetings; or create charter and/or workplan.

Program Component 2: In collaboration with community partners, identify barriers to access and gaps in RH services
Objective 2A: Conduct local assessment(s) of access to culturally responsive, high-quality, evidence-based RH services to identify barriers to access and gaps in services.
Objective 2B: Evaluate the impact of local policies, interventions, and programs on access to culturally responsive, high-quality, evidenced-based RH services and associated barriers and gaps.
Objective 2C: Following assessment and/or evaluation, share data, summaries and reports, following assessment and/or evaluation, with community members, partners, policy makers, and others.
Objective 2D: Create own objective to identify barriers to access and gaps in RH services.
Suggested Activities: Conduct survey or focus groups; interview key stakeholders and/or consumers; present findings and other data to community partners, members, and decision-makers; review regional policies and evaluate effectiveness in addressing gaps or barriers in access; or share data/results through community meetings, written reports, and/or online resources.

Program Component 3: In collaboration with community partners, develop and implement strategic plans to address gaps and barriers to accessing RH services
Objective 3A: Develop a plan for improving access to RH services, addressing how to reduce or eliminate health disparities.
Objective 3B: Specifically engage communities experiencing health disparities so they can actively participate in planning to address their needs.
Objective 3C: Implement plan for improved access to RH services.
Objective 3D: Assure that community members are aware of RH providers within the community through multiple communication channels.
Objective 3E: Create own objective to develop and implement strategic plans to address gaps and barriers to accessing RH services.
Suggested Activities: Host community listening and planning sessions to create a strategic plan; collaboratively develop and implement strategic outreach/marketing plan; develop online or print materials with information about RH providers within the community; develop evaluation plan or process; utilize evaluation findings to make system improvements; hold a forum; or create a website.

Program Component 4: In collaboration with community partners, evaluate the impact of the strategic plan (developed in Program Component 3)
Objective 4A: With community partners, evaluate previously implemented plan to improve access to RH services.
Objective 4B: Consult with the RH Program to determine evaluation process.
Objective 4C: Determine own evaluation process.
Suggested Activities: Evaluate impact of community coalitions; evaluate existing resources/ tools.

Attachment 2

Local Program Budget Template

OREGON HEALTH AUTHORITY	**Fiscal Year:**		
Program Element #46			
Reproductive Health Program			
EMAIL TO: RH.program@state.or.us			
Sub Recipient Organization Name:			
Budget period From:		**To:**	

Budget

Categories	OHA/PHD	Non-OHA/PHD	Total Budget
Salaries			$ -
Benefits			$ -
Personal Services (Salaries and Benefits)	$ -	$ -	$ -
Professional Services/Contracts			$ -
Travel			$ -
Supplies			$ -
Facilities			$ -
Telecommunications			$ -
Catering/Food			$ -
Other			$ -
Total Services and Supplies	$ -	$ -	$ -
Capital Outlay			$ -
Indirect: Rate (%):_____			$ -
TOTAL Budget	$ -	$ -	$ -

Prepared by (print name)

Email | Telephone

This Program Element #50 is hereby superseded and replace as follows:

Program Element #50: Safe Drinking Water Program

OHA Program Responsible for Program Element:

Public Health Division/Center for Health Protection/Drinking Water Services Section

1. Description.

Funds provided under this Agreement for this Program Element may only be used in accordance with, and subject to, the requirements and limitations set forth below, to ensure safe drinking water.

The purpose of the Safe Drinking Water Program is to provide services to public water systems that result in reduced health risk and increased compliance with drinking water monitoring and Maximum Contaminant Level (MCL) requirements. The Safe Drinking Water Program reduces the incidence and risk of waterborne disease and exposure of the public to hazardous substances potentially present in drinking water supplies. Services provided through the Safe Drinking Water Program include investigation of occurrences of waterborne illness, drinking water contamination events, response to emergencies, Water Quality Alerts, technical and regulatory assistance, inspection of water system facilities, and follow up of identified deficiencies. Safe Drinking Water Program requirements also include reporting of data to OHA, Public Health Division, Drinking Water Services (DWS) necessary for program management and to meet federal Environmental Protection Agency (EPA) Safe Drinking Water Act program requirements.

a. Funds provided under this Program Element are intended to enable LPHAs and the Department of Agriculture (hereafter referred to as "Partners") to assume primary responsibility for the regulatory oversight of designated public water systems located within the Partners' jurisdiction.

b. The work described herein is designed to meet the following EPA National Drinking Water Objective as follows:

> "91% of the population served by Community Water Systems will receive water that meets all applicable health-based drinking water standards during the year; and 90% of the Community Water Systems will provide water that meets all applicable health-based drinking water standards during the year."

c. Public drinking water systems addressed in this Program Element include Community Water Systems, Non-Transient Non-Community Water System (NTNC), and Transient Non-Community Water Systems Water Systems (TNC), serving 3,300 or fewer people and using Groundwater sources only, or purchased surface water, and those activities specifically listed for OVS Systems using Groundwater sources only.

d. Partners are responsible for public water systems that purchase their water from other public water suppliers when the purchasing systems serve 3,300 or fewer people.

This Program Element, and all changes to this Program Element are effective the first day of the month noted in Issue Date section of Exhibit C Financial Assistance Award unless otherwise noted in Comments and Footnotes of Exhibit C of the Financial Assistance Award.

2. Definitions Specific to Safe Drinking Water Program

a. **COMMUNITY WATER SYSTEM:** A public water system that has 15 or more service connections used by year-round residents, or that regularly serves 25 or more year-round residents.

b. **CONTACT REPORT:** A form provided by DWS to Partners to document contact with water systems.

c. **COLIFORM INVESTIGATION:** An evaluation to identify the possible presence of sanitary defects, defects in distribution system coliform monitoring practices, and the likely reason that the Coliform Investigation was triggered at the public water system.

d. **DRINKING WATER SERVICES (DWS)**: DWS is a program within OHA that administers and enforces state and federal safe drinking water quality standards for 3,600 public water systems in the state of Oregon. DWS prevents contamination of public drinking water systems by protecting drinking water sources; assuring that public water systems meet standards for design, construction, and operation; inspecting public water systems and assuring that identified deficiencies are corrected; providing technical assistance to public water suppliers; providing financial assistance to construct safe drinking water infrastructure; and certifying and training water system operators.

e. **GROUNDWATER:** Any water, except capillary moisture, beneath the land surface or beneath the bed of any stream, lake, reservoir or other body of surface water within the boundaries of this state, whatever may be the geologic formation or structure in which such water stands, flows, percolates, or otherwise moves.

f. **LEVEL 1 COLIFORM INVESTIGATION:** An investigation conducted by the water system or a representative thereof. Minimum elements of the investigation include review and identification of atypical events that could affect distributed water quality or indicate that distributed water quality was impaired; changes in distribution system maintenance and operation that could affect distributed water quality (including water storage); source and treatment considerations that bear on distributed water quality, where appropriate (for example, whether a Groundwater system is disinfected); existing water quality monitoring data; and inadequacies in sample sites, sampling protocol, and sample processing. Partners review sanitary defects identified and approves corrective action schedules.

g. **LEVEL 2 COLIFORM INVESTIGATION:** An investigation conducted by Partners and is a more detailed and comprehensive examination of a water system (including the system's monitoring and operational practices) than a Level 1 Coliform Investigation. Minimum elements include those that are part of a Level 1 investigation and additional review of available information, internal and external resources, and other relevant practices. Sanitary defects are identified and a schedule for correction is established.

h. **MAXIMUM CONTAMINANT LEVEL (MCL) VIOLATION:** MCL violations occur when a public water system's water quality test results demonstrate a level of a contaminant that is greater than the established Maximum Contaminant Level.

i. **MONITORING OR REPORTING (M/R) VIOLATION:** Monitoring or Reporting violations occur when a public water system fails to take any routine samples for a particular contaminant or report any treatment performance data during a compliance period, or fails to take any repeat samples following a coliform positive routine or where the public water system has failed to report the results of analyses to DWS for a compliance period.

j. **NON-TRANSIENT NON-COMMUNITY WATER SYSTEM (NTNC):** A public water system that is not a Community Water System and that regularly serves at least 25 of the same persons over 6 months per year.

k. **OHA:** Oregon Health Authority

l. **OREGON VERY SMALL (OVS): SYSTEM** A public water system serving 4-14 connections or 10-24 people during at least 60 days per year.

m. **PARTNERS:** A Local Public Health Authority (LPHA) and the Oregon Department of Agriculture who are under contract to provide regulatory oversight of designated water systems on behalf of Oregon Health Authority Drinking Water Services.

n. **PRIORITY DEFICIENCIES:** Deficiencies identified during Water System Survey that have a direct threat pathway to contamination or inability to verify adequate treatment include the following:

Well: Sanitary seal or casing not watertight

Well: No screen on existing well vent

Spring: No screen on overflow

Spring: Spring box not impervious durable material

Spring: Access hatch / entry not watertight

Storage: No screened vent

Storage: Roof and access hatch not watertight

Storage: No flap valve, screen, or equivalent on overflow

Treatment (UV): No intensity sensor with alarm or shut-off

o. **PRIORITY NON-COMPLIER (PNC):** Water systems with System Scores of 11 points or more.

p. **PROFESSIONAL ENGINEER (PE):** A person currently registered as a Professional Engineer by the Oregon State Board of Examiners for Engineering and Land Surveying.

q. **REGISTERED ENVIRONMENTAL HEALTH SPECIALIST (REHS):** A person currently registered as an Environmental Health Specialist by the Oregon Environmental Health Registration Board.

r. **REGULATED CONTAMINANTS:** Drinking water contaminants for which Maximum Contaminant Levels, Action Levels, or Water Treatment Performance standards have been established under Oregon Administrative Rule (OAR) Chapter 333, Division 061.

s. **SAFE DRINKING WATER INFORMATION SYSTEM (SDWIS):** USEPA's computerized safe drinking water information system database used by DWS.

t. **SYSTEM SCORE:** A point-based value developed by USEPA, based on unaddressed violations for monitoring periods ending within the last five years, for assessing a water system's level of compliance.

u. **TRANSIENT NON-COMMUNITY WATER SYSTEMS (TNC):** A public water system that serves a transient population of 25 or more persons.

v. **USEPA or EPA:** United States Environmental Protection Agency.

w. **WATER QUALITY ALERT:** A report generated by the SDWIS data system containing one or more water quality sample results from a public water system that exceed the MCL for inorganic, disinfection byproducts, or radiological contaminants, detection of any volatile or synthetic organic chemicals, exceeds one-half of the MCL for nitrate, any excursion minimum water quality parameters for corrosion control treatment, any positive detection of a microbiological contaminant, or any exceedance of lead or copper action levels.

x. **WATER SYSTEM SURVEY:** An on-site review of the water source(s), facilities, equipment, operation, maintenance and monitoring compliance of a public water system to evaluate the adequacy of the water system, its sources and operations in the distribution of safe drinking water. Significant deficiencies are identified and a schedule for correction is established.

3. **Alignment with Modernization Foundational Programs and Foundational.** The activities and services that the Partners have agreed to deliver under this Program Element align with Foundational Programs and Foundational Capabilities and the public health accountability metrics (if applicable), as follows (see Oregon's Public Health Modernization Manual, (http://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/public_health_modernization_manual.pdf):

a. **Foundational Programs and Capabilities** (As specified in Public Health Modernization Manual)

Program Components	**Foundational Program**					**Foundational Capabilities**						
	CD Control	Prevention and health promotion	Environmental health	Access to clinical preventive services: Population Health	Access to clinical preventive services: Direct services	Leadership and organizational competencies	Health equity and cultural responsiveness	Community Partnership Development	Assessment and Epidemiology	Policy & Planning	Communications	Emergency Preparedness and Response
Asterisk (*) = Primary foundational program that aligns with each component *X = Other applicable foundational programs*						*X = Foundational capabilities that align with each component*						
Emergency Response	**X**		*					**X**			**X**	**X**
Investigation of Water Quality Alerts	**X**		*						**X**			
Independent Enforcement Actions	**X**		*			**X**						
Technical Regulatory Assistance	**X**		*				**X**					**X**
Water System Surveys	**X**		*			**X**						
Resolution of Priority Non-compliers (PNC)	**X**		*			**X**						
Water System Survey Significant Deficiency Follow-ups	**X**		*			**X**						
Enforcement Action Tracking and Follow-up	**X**		*			**X**						

Program Components	Foundational Program					Foundational Capabilities						
Resolution of Monitoring and Reporting Violations	X		*			X						
Inventory and Documentation of New Water Systems	X		*			X						

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

Percent of Community Water Systems that meet health-based standards

c. The work in this Program Element helps Oregon's governmental public health system achieve the following Public Health Modernization Process Measures:

(1) Water System Surveys completed. Calculation: number of surveys completed divided by the number of surveys required.

(2) Water Quality Alert responses. Calculation: number of alerts responded to divided by the number of alerts generated.

(3) Resolution of PNCs. Calculation: number of PNCs resolved divided by the total number of PNCs.

4. Procedural and Operational Requirements. By accepting and using the Financial Assistance awarded under this Agreement and for this Program Element, Partner agrees to conduct activities in accordance with the following requirements:

a. General Requirements. Partners must prioritize all work according to the relative health risk involved and according to system classification with Community Water Systems receiving the highest priority. All services supported in whole or in part with funds provided to Partners under this Program Element must be delivered in accordance with the following procedural and operational requirements:

b. Required Services:

(1) Emergency Response: Partners must develop, maintain, and carry out a response plan for public water system emergencies, including disease outbreaks, spills, operational failures, and water system contamination. Partners must notify DWS in a timely manner of emergencies that may affect drinking water supplies.

(2) Independent Enforcement Actions: Partners must take independent enforcement actions against licensed facilities that are also public water systems as covered under the following OAR Chapters and Divisions: 333-029, 333-030, 333-031, 333-039, 333-060, 333-062, 333-150, 333-162, and 333-170. Partners must report independent enforcement actions taken and water system status to DWS using the documentation and reporting requirements specified in this Program Element Description.

(3) Computerized Drinking Water System Data Base: Partners must maintain access via computer to DWS's Data On-line website. Access via computer to DWS's Data On-line is considered essential to carry out the program effectively. Partners must make timely changes to DWS's SDWIS computer database inventory records of public water systems to keep DWS's records current.

(4) Technical and Regulatory Assistance: Partners must provide technical and regulatory assistance in response to requests from water system operators for information on and interpretation of regulatory requirements. Partners must respond to water system complaints received as appropriate or as requested by DWS.

(5) Investigation of Water Quality Alerts: Partners must investigate all Water Auality Alerts for detections of Regulated Contaminants at community, NTNC, TNC, and OVS Systems.

(a) Immediately following acute MCL alerts (E.coli, Nitrate, and Arsenic), Partners must consult with and provide advice to the water system operator on appropriate actions to ensure that follow-up sampling is completed, applicable public notices are distributed, and that appropriate corrective actions are initiated. Partners must submit a Contact Report to DWS within 2 business day of the alert date.

(b) For all other alerts, Partners must promptly consult with and provide advice to the subject water system operator on appropriate actions to ensure that follow-up sampling is completed, applicable public notices are distributed, and that appropriate corrective actions are initiated. Partners must submit a Contact Report to DWS within 6 business days of the alert date.

5. Conduct Level 2 Coliform Investigations: After a Level 2 investigation is triggered by DWS, Partners must conduct a water system site visit (or equivalent), complete the Level 2 Coliform Investigation form and must submit to DWS within 30 days of triggered investigation date.

6. Water System Surveys: Partners must conduct a survey of each CWS within Partners' jurisdiction every three years, or as otherwise scheduled by DWS; and each NTNC and TNC water system within Partners' jurisdiction every five years or as otherwise scheduled by DWS. Surveys must be completed on forms provided by DWS using the guidance in the Water System Survey Reference Manual and using the cover letter template provided by DWS. Cover letter and survey forms must be submitted to DWS and water systems within 45 days from site visit completion.

7. Resolution of Priority Non-compliers (PNC): Partners must review PNC status of all water systems at least monthly and must contact and provide assistance to community, NTNC, and TNC water systems that are Priority Non-compliers (PNCs) as follows:

a. Partners must review all PNCs at three months after being designated as a PNC to determine if the water system can be returned to compliance within three more months.

b. If the water system can be returned to compliance within three more months, Partners must send a notice letter to the owner/operator (copy to DWS) with a compliance schedule listing corrective actions required and a deadline for each action. Partners must follow up to ensure corrective actions are implemented.

c. If it is determined the water system cannot be returned to compliance within six months or has failed to complete corrective actions in (b) above, Partners must prepare and submit to DWS a written request for a formal enforcement action, including Partners' evaluation of the reasons for noncompliance by the water supplier. The request must include the current owner's name and address, a compliance schedule listing corrective actions required, and a deadline for each action. Partners must distribute a copy of the enforcement request to the person(s) responsible for the subject water system's operation.

8. Level 1 Coliform Investigation Review: After a Level 1 Coliform Investigation is triggered by DWS, Partners must contact the water system and inform them of the requirements to conduct the investigation. Upon completion of the investigation by the water system, Partners must review it for completeness, concur with proposed schedule, and submit the completed form to DWS within 30 days of triggered investigation date.

9. Water System Survey Significant Deficiency Follow-ups: Partners must follow-up on significant deficiencies and rule violations in surveys on community, NTNC, and TNC water systems. Deficiencies include those currently defined in the DWS-Drinking Water Program publication titled Water System Survey Reference Manual (March 2016).

- **a.** After deficiencies are corrected, Partners must prepare a list of the deficiencies and the dates of correction and submit to DWS within 30 days of correction.
- **b.** If any deficiencies are not corrected by the specified timeline, Partners must follow up with a failure to take corrective action letter.
- **c.** For Priority Deficiencies, Partners must ensure that the deficiencies are corrected by the specified timeline or are on approved corrective action plan. Partners must submit the approved corrective action plan to DWS within 30 days of approval. After the deficiencies are corrected Partners must prepare a list of the deficiencies and the dates of correction and submit to DWS within 30 days of correction. If Priority Deficiencies are not corrected by specified timeline, Partners must ensure the water system carries out public notice, and refer to DWS for formal enforcement.

10. Enforcement Action Tracking and Follow-up: For both EPA and OVS Systems, after DWS issues an enforcement action, Partners must monitor the corrective action schedule, and verify completion of each corrective action by the water supplier. Partners must document all contacts and verifications and submit documentation to the DWS. Partners must document any failure by the water supplier to meet any correction date and notify the DWS within 30 days. Partners must notify DWS when all corrections are complete and submit the notice within 30 days.

11. Resolution of Monitoring and Reporting Violations:

- **a.** Partners must contact and provide assistance at community, NTNC, and TNC water systems to resolve (return to compliance) non auto-RTC violations for bacteriological, chemical, and radiological monitoring. Violation responses must be prioritized according to water system's classification, System Score, and violation severity.
- **b.** Contact the water supplier, determine the reasons for the noncompliance, consult with and provide advice to the subject water system operator on appropriate actions to ensure that violations are corrected in a timely manner.
- **c.** Submit Contact Reports to DWS regarding follow-up actions to assist system in resolving (returning to compliance) the violations.

12. Inventory and Documentation of New Water Systems: Partners must inventory existing water systems that are not in the DWS inventory as they are discovered, including OVS Systems, using the forms designated by DWS. Partners must provide the documentation to DWS within 60 days of identification of a new or un-inventoried water system. Alternatively, Partners may perform a Water System Survey to collect the required inventory information, rather than submitting the forms designated by DWS.

13. Summary of Required Services Based on Water System Type

	CWS	NTNC	TNC	OVS
Independent Enforcement Actions	X	X	X	
Computerized Drinking Water System Data Base	X	X	X	X
Technical and Regulatory Assistance	X	X	X	X
Investigation of Water Quality Alerts	X	X	X	X
Conduct Level 2 Coliform Investigations	X	X	X	
Water System Surveys	X	X	X	
Resolution of Priority Non-compliers (PNC)	X	X	X	
Level 1 Coliform Investigation Review	X	X	X	
Water System Survey Significant Deficiency Follow-ups	X	X	X	
Enforcement Action Tracking and Follow-up	X	X	X	X
Resolution of Monitoring and Reporting Violations	X	X	X	X
Inventory and Documentation of New Water Systems	X	X	X	X

14. Staffing Requirements and Qualifications.

a. Partners must develop and maintain staff expertise necessary to carry out the services described herein.

b. Partners' staff must maintain and assimilate program and technical information provided by DWS, attend drinking water training events provided by DWS, and maintain access to information sources as necessary to maintain and improve staff expertise.

c. Partners must hire or contract with personnel registered as Environmental Health Specialists or Professional Engineers with experience in environmental health to carry out the services described herein.

15. General Revenue and Expense Reporting. Partners must complete an "Oregon Health Authority Public Health Division Expenditure and Revenue Report" located in Exhibit C of this Agreement. These reports must be submitted to OHA each quarter on the following schedule:

Fiscal Quarter	Due Date
First: July 1 – September 30	October 30
Second: October 1 – December 31	January 30
Third: January 1 – March 31	April 30
Fourth: April 1 – June 30	August 20

16. Reporting Requirements.

a. Documentation of Field Activities and Water System Contacts. Partners must prepare and maintain adequate documentation written to meet a professional standard of field activities and water system contacts as required to:

(1) Maintain accurate and current public water system inventory information.

(2) Support formal enforcement actions.

(3) Describe current regulatory status of water systems.

(4) Guide and plan program activities.

b. Minimum Standard for Documentation. Partners must, at a minimum, prepare and maintain the following required documentation on forms supplied by DWS:

(1) Water System Surveys, cover letters, and significant deficiencies: must be submitted on DWS forms to DWS and water system within 45 days of site visit completion.

(2) Level 1 and Level 2 Coliform Investigation forms: must submit on DWS forms to DWS within 30 days of investigation trigger.

(3) Water system Inventory, entry structure diagram, and source information updates: must submit on DWS forms to DWS within 6 business days of completion.

(4) Field and office contacts in response to complaints, PNCs, violations, enforcement actions, regulatory assistance, requests for regulatory information: must submit Contact Reports to DWS within 2 business day of alert generation for MCL alerts, and 6 business days for all other alerts and contact made with water systems.

(5) Field and office contacts in response to water quality alerts: 1) for acute MCL alerts (E.coli, Nitrate, and Arsenic): must submit Contact Reports to DWS within 2 business days of alert; 2) for all other alerts, must submit to DWS within 6 business days of alert.

(6) Waterborne illness reports and investigations: must submit Contact Report to DWS within 2 business day of conclusion of investigation.

(7) All correspondence with public water systems under Partners' jurisdiction and DWS: submit Contact Reports within 6 business days of correspondence to DWS.

(8) Documentation regarding reports and investigations of spills and other emergencies affecting or potentially affecting water systems: must submit Contact Reports to DWS within 2 business days.

(9) Copies of public notices received from water systems: must submit to DWS within 6 business days of receipt.

17. DWS Audits. Partners must give DWS free access to all Partner records and documentation pertinent to this Agreement for the purpose of DWS audits.

18. Performance Measures. Partners must operate the Safe Drinking Water Program in a manner designed to make progress toward achieving the following Public Health Modernization Process Measure: Percent of Community Water Systems that meet health-based standards. DWS will use three performance measures to evaluate Partners' performance as follows:

a. Water System Surveys completed. Calculation: number of surveys completed divided by the number of surveys required per year.

b. Water Quality Alert responses. Calculation: number of alerts responded to divided by the number of alerts generated.

c. **Resolution of PNCs.** Calculation: number of PNCs resolved divided by the total number of PNCs.

19. **Responsibilities of DWS.** The intent of this Program Element description and associated funding award is to enable Partners to independently conduct an effective local drinking water program. DWS recognizes its role to provide assistance and program support to Partners to foster uniformity of statewide services. DWS agrees to provide the following services to Partners. In support of local program services, DWS will:

a. Distribute drinking water program and technical information on a monthly basis to Partners.

b. Sponsor at least one annual 8-hour workshop for Partners' drinking water program staff at a central location and date to be determined by DWS. DWS will provide workshop registration, on-site lodging, meals, and arrange for continuing education unit (CEU) credits. Partners are responsible for travel expenses for Partner staff to attend. Alternatively, at the discretion of the DWS, the workshop may be web-based.

c. Sponsor at least one regional 4-hour workshop to supplement the annual workshop. DWS will provide training materials and meeting rooms. Partners are responsible for travel expenses for its staff to attend. Alternatively, at the discretion of the DWS, the workshop may be web-based.

d. Provide Partners with the following information by the listed method:

(1) Immediate Email Notification: Water Quality Alert data, plan review correspondence

(2) Monthly Email Notification: Violations, System Scores, PNCs Continuously: Via Data On-line listings of PNCs, individual water system inventory and water quality data, compliance schedules, and individual responses for request of technical assistance from Partners.

(3) Immediate Phone Communication: In circumstances when the DWS technical contact assigned to a Partner cannot be reached, DWS will provide immediate technical assistance via the Portland phone duty line at 971-673-0405.

e. Support electronic communications and data transfer between DWS and Partners to reduce time delays, mailing costs, and generation of hard copy reports.

f. Maintain sufficient technical staff capacity to assist Partners' staff with unusual drinking water problems that require either more staff than is available to Partners for a short time period, such as a major emergency, or problems whose technical nature or complexity exceed the capability of Partners' staff.

g. Refer to Partners all routine inquiries or requests for assistance received from public water system operators for which Partners are responsible.

h. Prepare formal enforcement actions against public water systems in the subject County, except for licensed facilities, according to the priorities contained in the current State/EPA agreement.

i. Prepare other actions against water systems as requested by Partners in accordance with the Oregon Administrative Rules Oregon Health Authority, Public Health Division Chapter 333, Division 61.

Attachment B
Financial Assistance Award (FY23)

State of Oregon
Oregon Health Authority
Public Health Division

1) Grantee	2) Issue Date	This Action
Name: Tillamook County	Monday, August 1, 2022	Amendment
Street: PO Box 489		FY 2023
City: Tillamook	3) Award Period	
State: OR Zip: 97141-0489	From July 1, 2022 through June 30, 2023	

4) OHA Public Health Funds Approved

Number	Program	Previous Award Balance	Increase / Decrease	Current Award Balance
PE01-01	State Support for Public Health	$31,495.00	$0.00	$31,495.00
PE04-02	Community Chronic Disease Prevention	$0.00	$22,000.00	$22,000.00
PE10-02	Sexually Transmitted Disease (STD)	$123,892.00	$0.00	$123,892.00
PE12-01	Public Health Emergency Preparedness and Response (PHEP)	$70,728.00	$0.00	$70,728.00
PE13-01	Tobacco Prevention and Education Program (TPEP)	$94,511.00	($1,498.00)	$93,013.00
PE40-01	WIC NSA: July - September	$35,268.00	$0.00	$35,268.00
PE40-02	WIC NSA: October - June	$105,804.00	$0.00	$105,804.00
PE40-05	Farmer's Market	$1,780.00	$0.00	$1,780.00
PE42-03	MCAH Perinatal General Funds & Title XIX	$2,119.00	$0.00	$2,119.00
PE42-04	MCAH Babies First! General Funds	$6,775.00	$0.00	$6,775.00
PE42-06	MCAH General Funds & Title XIX	$3,977.00	$0.00	$3,977.00
PE42-11	MCAH Title V	$20,846.00	$0.00	$20,846.00
PE43-01	Public Health Practice (PHP) - Immunization Services	$0.00	$10,000.00	$10,000.00
PE46-05	RH Community Participation & Assurance of Access	$0.00	$16,494.53	$16,494.53

4) OHA Public Health Funds Approved

Number	Program	Previous Award Balance	Increase / Decrease	Current Award Balance
PE50	Safe Drinking Water (SDW) Program (Vendors)	$44,326.00	$0.00	$44,326.00
PE51-01	LPHA Leadership, Governance and Program Implementation	$183,994.00	$0.00	$183,994.00
PE51-03	ARPA WF Funding	$57,994.00	$0.00	$57,994.00
		$783,509.00	$46,996.53	$830,505.53

5) Foot Notes:

PE40-01	5/2022: Underspent SFY2023 Q1 funding award needs to be spent by 9/30/2022. No unspent funds carryover to Q2-4 period.
PE40-05	5/2022: Submit final quarterly Revenue and Expense Report to State LPHA by 1/31/2023.
PE42-11	5/2022: Indirect rate maximum is 10%

6) Comments:

PE40-01	5/2022: SFY23 award; require spend $7054 on Nutrition Ed, $873 on BF Promotion
PE40-02	5/2022: SFY23 Q2-4 award: spend $21161 on Nutrition Ed, $2619 on BF Promotion
PE40-05	5/2022:SFY2023 WIC FDNP mini grant, to be paid in equal installment on 7/1 and 10/1 of 2022.
PE42-04	5/2022: SFY23 award is for the period of 7/1/2022 to 6/30/2023.
PE46-05	07/2022: SFY23 Title X Initial Award

7) Capital outlay Requested in this action:

Prior approval is required for Capital Outlay. Capital Outlay is defined as an expenditure for equipment with a purchase price in excess of $5,000 and a life expectancy greater than one year.

Program	Item Description	Cost	PROG APPROV	

Attachment C
Information required by CFR Subtitle B with guidance at 2 CFR Part 200

PE04-02 Community Chronic Disease Prevention		
Federal Award Identification Number:	5-NU38OT000286-05	NU58DP006542
Federal Award Date:	08/01/22	06/19/22
Budget Performance Period:	08/01/2022-07/31/2023	06/30/2022-06/29/2023
Awarding Agency:	NACDD	CDC
CFDA Number:	93.421	93.426
CFDA Name:	Building Capacity for Public and Private Payer Coverage of the National DDP Lifestyle Change Program	Improving the Health of Americans through Prevention and Management of Diabetes and Heart Disease and Stroke
Total Federal Award:	250,000	2,071,748
Project Description:	Building Capacity for Public and Private Payer Coverage of the National DDP Lifestyle Change Program	Oregon's Application for Diabetes and Heart Disease and Stroke Prevention Programs - Improving the Health of Americans through Prevention and Management
Awarding Official:	Jennifer Barnhart	Paris Brookins
Indirect Cost Rate:	17.64%	17.64%
Research and Development (T/F):	FALSE	FALSE
HIPPA	No	No
PCA:	52749	52079
Index:	50341	50341

Agency	UEI	Amount	Amount	Grand Total:
Tillamook	000060584554	$11,000.00	$11,000.00	$22,000.00

PE43-01 Public Health Practice (PHP) - Immunization Services	
Federal Award Identification Number:	NH23IP922626
Federal Award Date:	07/01/22
Budget Performance Period:	07/01/2019-06/30/2024
Awarding Agency:	HHS/CDC
CFDA Number:	93.268
CFDA Name:	Immunization Cooperative Agreements
Total Federal Award:	109,473,648
Project Description:	Immunization and Vaccines for Children
Awarding Official:	Divya Cassity
Indirect Cost Rate:	17.64%
Research and Development (T/F):	FALSE
HIPPA	No
PCA:	53534
Index:	50404

Agency	UEI	Amount	Grand Total:
Tillamook	000060584554	$10,000.00	$10,000.00

PE46-05 RH Community Participation & Assurance of Access		
Federal Award Identification Number:	FPHPA006556	FPHPA006556
Federal Award Date:	03/24/22	03/24/22
Budget Performance Period:	04/01/2022-03/31/2023	04/01/2022-03/31/2023
Awarding Agency:	DHHS	DHHS
CFDA Number:	93.217	93.217
CFDA Name:	Family Planning Services	Family Planning Services
Total Federal Award:	13,168,883	13,168,883
Project Description:	Oregon Reproductive Health Program	Oregon Reproductive Health Program
Awarding Official:	Dr. Helene Rimberg	Dr. Helene Rimberg
Indirect Cost Rate:	17.64%	17.64%
Research and Development (T/F):	FALSE	FALSE
HIPPA	No	No
PCA:	52797	TBD
Index:	50333	50333

Agency	UEI	Amount	Amount	Grand Total:
Tillamook	000060584554	$12,370.90	$4,123.63	$16,494.53