Diabetes Toolkit

The Diabetes Toolkit is a compilation of the dental resources, diabetes prevention and self-management programs, nutrition and food support, health-related services, and pharmacy resources that are available to UHA diabetic members. You can use this toolkit as a reference guide to connect your patients to resources they need to manage their chronic condition(s).

Questions? Contact UHQualityImprovement@umpquahealth.com.

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UMPQUA HEALTH ALLIANCE

Dental Resources

UMPQUA HEALTH
ALLIANCE

ORAL HEALTH TIPS FOR MANAGING YOUR DIABETES

Diabetes can affect any part of your body. You can do something about it.

If you have diabetes, make sure you take care of your whole body, including your mouth. Diabetes is diagnosed when your blood sugar is too high. Blood flows through every part of your body, so your whole body needs your care. Even if you feel fine, the high blood sugar can harm your eyes, mouth, kidneys, nerves and more. It can also lead to heart disease or a stroke. The good news is you can prevent most of these problems by keeping your blood sugar under control, eating healthy, getting exercise and working with your doctors.

You are doing a great job by seeing your dentist!

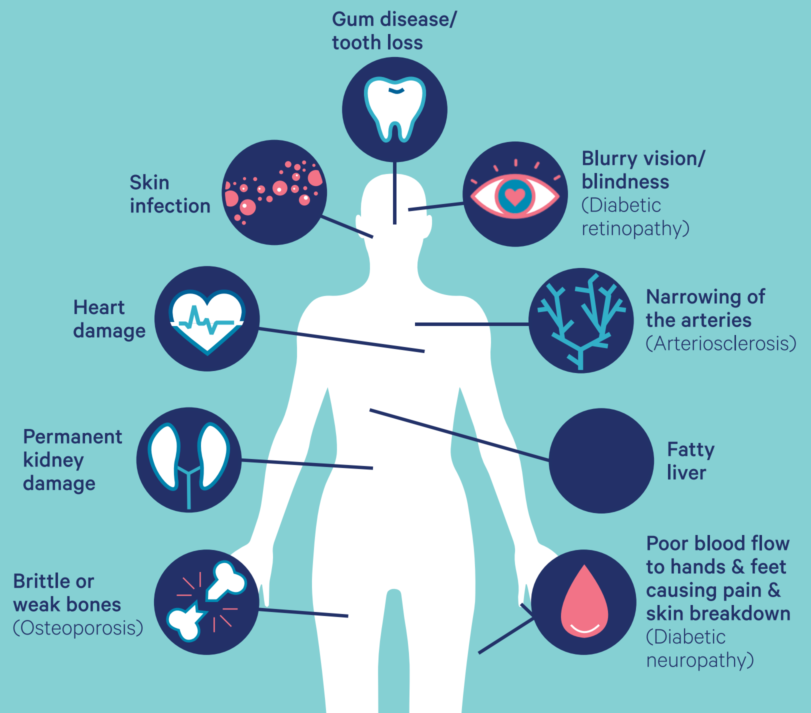
If you have diabetes, make sure to keep taking good care of your mouth. People with diabetes are at risk for mouth problems, especially gum disease. Gum disease can damage the gum and bone that hold your teeth in place and may lead to painful chewing problems and even tooth loss. Gum disease also makes it hard to control your blood sugar. Blood sugar is in your saliva – the fluid in your mouth that makes it wet. When diabetes is not controlled, you will have extra blood sugar in your saliva. The extra blood sugar helps bacteria (germs) grow. This can lead to tooth decay and cavities.

DIABETES CAN AFFECT ANY PART OF YOUR BODY.

You can do something about it.

STEPS FOR SUCCESS

- Keep your blood sugar, blood pressure, and cholesterol numbers as close to your goal as possible.
- Take your diabetes medication as directed by your doctor.
- Eat healthy meals and exercise.
- Take care of your feet.
- Brush and floss your teeth every day.
- Visit your dentist and doctor regularly.
- Quit smoking. Smoking makes gum disease worse. Your doctor or dentist can help you quit.



Dental Care Organizations
Advantage Dental Services, toll-free (866) 268-9631

Information created and provided by Advantage Dental from DentaQuest

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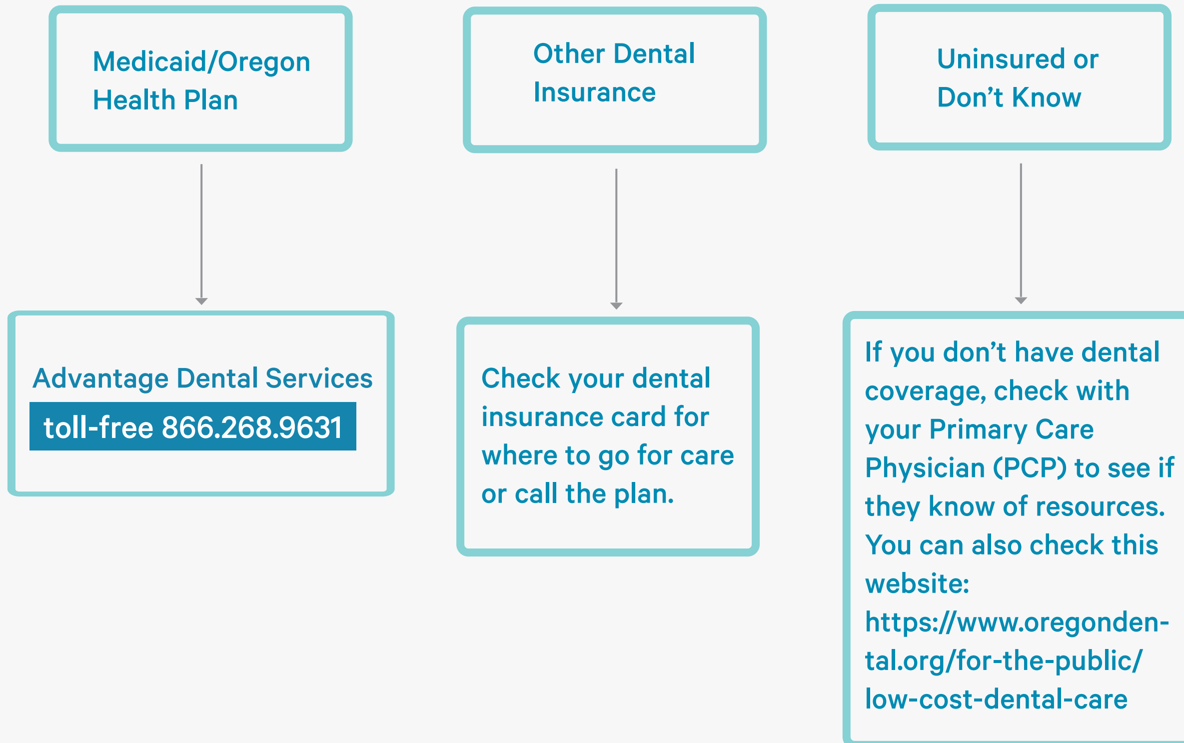
DO YOU HAVE DIABETES?

Make sure you go to the dentist!

What dental coverage do you have?



Why is oral health care important if I have diabetes?

If you have diabetes, make sure to keep taking good care of your mouth. People with diabetes are at risk for mouth problems, especially gum disease. Gum disease can damage the gum and bone that hold your teeth in place and may lead to painful chewing problems and even tooth loss. Gum disease also makes it hard to control your blood sugar. Blood sugar is in your saliva – the fluid in your mouth that makes it wet. When diabetes is not controlled, you will have extra blood sugar in your saliva. The extra blood sugar helps bacteria (germs) grow. This can lead to tooth decay and cavities.

Your community dental providers are here to help! Dentists are prepared and equipped to help you with your dental needs, including emergency care and preventive dental services too!

Advantage Dental
From DentaQuest

Advantage Dental Services
toll-free 866.268.9631

561SPP_08222021

UMPQUA HEALTH ALLIANCE

Diabetes Prevention & Self-Management Programs

Cow Creek Health and Wellness Center

(541) 672-8533, press #3 for Roseburg or #4 for Canyonville

2589 NW Edenbower Blvd, Roseburg OR   480 Wartahoo Lane, Canyonville OR

Diabetes Prevention Program

You have the power to prevent Type 2 Diabetes

Program Topics:

- Healthy eating
- Ways to get active
- Stress management
- Much more

Program Highlights:

- One-year course developed by the Centers for Disease Control
- Group classes led by a Certified Lifestyle Coach
- Helpful incentives and a supportive community
- Private weekly weigh-ins
- Covered by most insurance

One in Three Americans has prediabetes and only 11% know they have it.

Get checked by your provider for prediabetes regularly.

For more information and eligibility requirements, please contact our Lifestyle Coach at:

(541) 492-5267

Oregon Wellness Network:
Diabetes Prevention Program

Your Prediabetes: A Hidden Risk for Your Patients

Prediabetes occurs when a person’s blood glucose levels are higher than normal but not high enough to be diagnosed as type 2 diabetes. Any of the following positive lab test result within the previous 12 months indicates prediabetes:

- HbA1C 5.7–6.4% **or**
- FPG 100–125 mg/dL** **or**
- OGTT 140–199 mg/dL

**Note that Medicare uses f FPG of 110-125 mg/dL

Prediabetes has no clear symptoms—9 out of 10 people with prediabetes don’t even know they have it.

Patients with a history of gestational diabetes, a BMI $\geq$ 25 (23 for patients of Asian descent) or patients with a family history of diabetes are at increased risk.

What Prediabetes Means for Patients

- Approximately one in three of your patients may have prediabetes. Without intervention, prediabetes can progress to type 2 diabetes within five years. [About Prediabetes & Type 2 Diabetes (2019, April 4). Centers for Disease Control & Prevention]
- According to the American Medical Association, $8,000 is the average medical expense a person may face over the first three years after transitioning from prediabetes to a diagnosis of type 2 diabetes. [Prevent Diabetes STAT (2019). American Medical Association]
- **The good news: Prediabetes can usually be reversed. Initiatives like the National Diabetes Prevention Program lifestyle change program help significantly lower the risk of developing type 2 diabetes.**

About the National Diabetes Prevention Program

The National Diabetes Prevention Program lifestyle change program (National DPP) is a year-long program developed by the Centers for Disease Control and Prevention (CDC) that helps participants lose weight, adopt healthy habits and reduce their risk for type 2 diabetes. Participants learn strategies to eat more healthfully, increase their physical activity and manage stress. Some National DPP lifestyle change program courses meet in person with a coach and small group while others take place entirely online.

How the National DPP Can Help Your Patients and Practice

A person with type 2 diabetes is significantly more likely to develop hypertension or have a heart attack or stroke. **Research has showed that people who have participated in the National DPP and lose 5 percent of their body weight are significantly (58%) less likely to develop diabetes. The reduction in risk is even greater (71%) for those over 60 years old.** [Knowler, W., et al. (2002, Feb. 7) US National Library of Medicine National Institutes of Health]

The United States Preventive Services Task Force recommends screening at-risk adults for abnormal blood glucose and intensive lifestyle interventions for persons found to have abnormal blood glucose. [Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening. (2015, Oct.) U.S. Preventive Services Task Force]

Diagnostic Criteria and Who Should Be Screened

Screening and diagnosis for prediabetes are key to identifying patients at risk of prediabetes.

Screening criteria for abnormal glucose:

- Adults 18+ with a BMI of ≥25 (≥23 for adults of Asian descent)
- Women who have had gestational diabetes
- Adults 18+ with a family history of diabetes
- Adults 18+ with high blood pressure

Diagnostic criteria for prediabetes:

- HbA1C 5.7–6.4% **or**
- FPG 100–125 mg/dL **or**
- OGTT 140–199 mg/dL
- ICD-10 Diagnostic Code: R73.03

Program eligibility under Medicare and Oregon Health Plan have specific requirements:

- Oregon Health Plan requires a patient to have a prediabetes diagnosis (R73.03) or a personal history of gestational diabetes (Z86.32).
- Medicare requires a blood-based diagnosis of HbA1C 5.7–6.4% or FPG 110–125 mg/dL.

Incorporating Screening for Abnormal Blood Glucose into Existing Encounters

- All adult wellness visits (women's health, men's health)
- Medicare Annual Wellness Visit (AWV)
- Medicare Initial Preventive Physical Exam (IPPE)
- Hypertension care visits
- Six-week post-partum checkup and annual exam for women who had Gestational Diabetes

Other Opportunities to Screen

- Include risk test in check-in procedure for all adult visit types; identify who on the care team can connect patient to local program resources while they are at the clinic
- Query EHR to identify patients with BMI ≥25 (≥23 if Asian*) and blood glucose level in the prediabetes range; hypertension patients; patients with a known family history of diabetes
- Assign staff person to call at-risk patients on behalf of provider to connect them with a program

Who Is Covered for the National DPP Lifestyle Change Program?

Oregon Health Plan members, Medicare beneficiaries, state public employees (OEBB/PEBB members) and some privately insured patients are covered for the National DPP. Other organizations offer the program for a nominal cost or free of charge to eligible patients who do not have insurance coverage.

Where to Refer: Oregon Wellness Network (OWN) at 1-833-673-9355 or 1-833-ORE-WELL

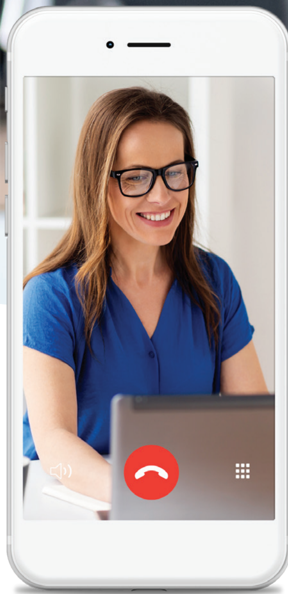
OR FAX referral forms to 1-503-304-3465

OR Email to: Health.promotion@nwsds.org

UMPQUA HEALTH ALLIANCE

Nutrition & Food Supports

foodsmart™ TELENUTRITION



From weight loss to higher energy, **Foodsmart Telenutrition** can help you reach your health goals!

Improve your health with

One-on-One Virtual Visits

Online Grocery Ordering

Personalized Care

Custom Meal Planning

Umpqua Health Alliance members are eligible for **$0 COST telenutrition virtual visits** with our network of Registered Dietitians!

Download the Foodsmart app and **select "Foodsmart for Umpqua"** to sign up today!

OHP-UHA-22-008

foodsmart™

Foodsmart Fits Your Lifestyle

Each feature of the Foodsmart program is completely accessible through the Foodsmart App. This means you can make healthier changes to your diet from the comfort of your home.

My life is already busy, what happens if one day I don't have time to cook a recipe from my meal plan?

Don't worry! Your custom meal plan is built around your personal lifestyle.

If you are only able to cook 2-3 times a week, Foodsmart can suggest healthy meals from local restaurants that can be delivered to you through services like GrubHub. You can even choose meals from prepared meal services like Sun Basket or Plantable.

Get up to $50 in Grocery Gift Cards

Get a $25 grocery gift card each for completing a NutriQuiz and having a TeleNutrition Visit with a Registered Dietician. Gift Cards will be sent to you by email from Foodsmart.

Get Started Today

Call Foodsmart Customer Care at:
888-837-5325

Visit the website at:
https://www.foodsmart.com/umpqua

Download the Foodsmart app:
on the Apple or Android app store

Get this information in any language or format for free. All interpretation services are free. Call 541-229-4842 (TTY 711).

Obtenga esta información de forma gratuita en cualquier idioma o formato. Todos los servicios de interpretación son gratuitos. Llame al 541-229-4842 (TTY 711).

UMPQUA HEALTH

How to Find Affordable Healthy Food

Powered by foodsmart

#OHP-UHA-22-005

About Foodsmart

As an Umpqua Health Alliance (UHA) member, you have access to Foodsmart at no cost to you. Foodsmart gives you an easy-to-use platform that helps you manage every part of your diet.

Access to Advice from Registered Dieticians

When you join Foodsmart, you'll be able to set up a meeting with a Registered Dietician. You can meet with the dietician over the phone or through video chat. Foodsmart's dietitians are licensed to help with all types of conditions, like:

- CKD
- Heart disease
- Autoimmune conditions
- Pre-Diabetes
- Diabetes
- Hypertension
- and much more!

How It Works

Your Grocery Trip — Planned for You!

Foodsmart automatically adds the items you need from your custom meal plan recipes into a single grocery list. This way, when you go shopping you have everything you need to know right in front of you.

Did you know that Foodsmart can do the shopping for you?

You can select which grocery store you want to shop at and order your groceries from your phone! You have the option to have them delivered or pick them up. Foodsmart will even compare prices for your grocery list at different stores in your community based on your budget.

Custom Meal Plans at Your Fingertips

You will get custom meal plans from your Registered Dietician directly to your Foodsmart App. This custom meal plan is based on:

- Health goals you talked about with the Registered Dietician
- Your personal taste preferences

You can even select meals from that custom meal plan to add them to your grocery list.

Now Accepting SNAP/EBT

Foodsmart also accepts SNAP/EBT benefits through services like Walmart or Instacart. If you are unsure if you qualify for SNAP/EBT benefits, you can ask your Registered Dietician for help applying.

Get to Know Foodsmart™

Foodsmart is a digital nutrition platform with a variety of tools that make it **easy to eat well!**

Telenutrition

Our national network of Registered Dietitians are experienced in helping you to overcome your specific challenges to eating well.

Recipes

Our vast database of recipes has plenty for everyone's preferences, time, and budget.

Grocery List

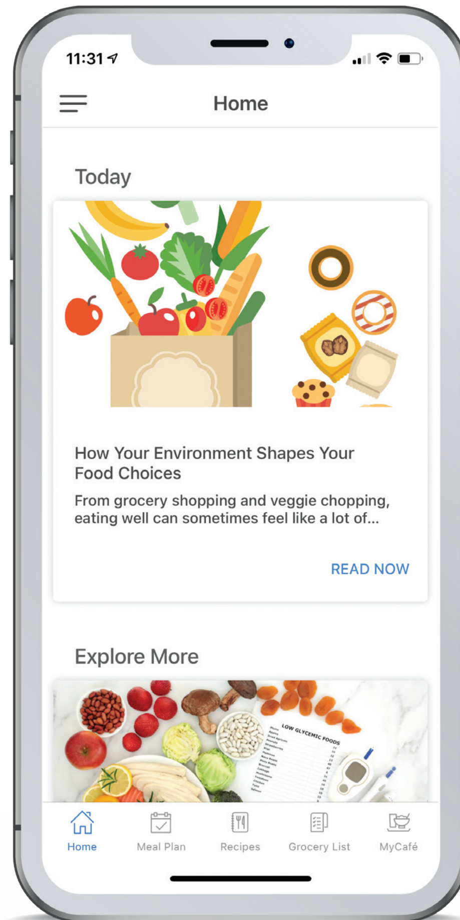
A digital grocery list is automatically created for your selected recipes.

Online Grocery Ordering

Convert your digital grocery list to an online order, delivered to your door.

Cook It Now

Recipe recommendations using foods you already have in your kitchen.



Meal Plan

Get a week of tasty meal plans automatically generated to match your preferences.

Restaurant Guidance

Find healthy meal options at all of your favorite restaurants.

Deals

Grocery deals for healthy food from your favorite local stores, directly in the product.

Marketplace

Pre-portioned meal kits and delicious heat-and-eat meals delivered to your door.

Favorites

Add your favorite recipes so you can easily find them whenever you want.

NutriQuiz

See how your eating habits stack up and instantly get personalized tips and recipes.

Access all of these great features **on the Foodsmart app!**

OHP-UHA-22-009

foodsmart™

Get $80 per month to spend on fresh fruits & vegetables!

HOW DOES IT WORK?

1. Eligible patients can enroll in this free, 6-month, VeggieRx program to receive a prescription for fresh fruits and vegetables. The program runs from May-October 15.
2. Redeem prescriptions on your Fresh Connect debit card at redemption sites around Douglas County for fresh produce!

HOW DO I SIGN UP?

Contact your health care provider at the following clinics to learn more about Spring enrollment:

OUR PARTNERS

Reciba $80 por mes para gastar en frutas frescas y vegetales.

¿COMO FUNCIONA?

1. Los pacientes elegibles pueden inscribirse al programa gratuito Veggie Rx por 6 meses para recibir una receta para frutas y vegetales frescos. El programa perdurara de Mayo-15 de Octubre.

2. ¡Canjee recetas en su tarjeta de débito Fresh Connect en sitios de canje en el condado de Douglas por productos frescos!

¿COMO ME INSCRIBO?

Comuníquese con sus proveedores de atención medica en una de las siguientes clínicas para obtener más información sobre la inscripción de primavera.

NUESTROS COLABORADORES

UMPQUA HEALTH ALLIANCE

Douglas County Food Support

Farmers Market

Canyonville Farmers Market
146 Chief Miwaleta Ln, Canyonville, OR 97417
(541) 375-0725
Wednesday 9:30am - 1:30pm (May - October)
http://www.canyonvillefarmersmarket.org/

Umpqua Valley Farmers Market
1771 W Harvard Ave, Roseburg, OR 97471
(541) 530-6200
Saturday 9am - 1pm
https://www.uvfarmersmarket.com/

Kitchens

Friendly Kitchen - Meals on Wheels
1771 W Harvard Blvd Roseburg, OR 97471
(541) 673-5929
Monday - Friday 11am - 12pm

Living Hope Outreach Kitchen
337 C Ave Drain, OR 97435
(541) 836-7051
Wednesday 12pm - 1pm

St. Francis Community Kitchen
323 N Comstock Sutherlin, OR 97479
(541) 459-8807
Monday & Wednesday 3pm - 4pm

St. Joseph's Community Kitchen
630 W. Stanton Roseburg, OR 97471
(541) 673-5157
Tuesday & Thursday 4pm - 5:30pm

Programs

Feeding Umpqua/UCAN
(541) 492-2126
https://www.ucancap.org/eating-healthier/

Foodsmart
(888) 837-5325
https://www.foodsmart.com/umpqua

OSU Extension Services
1134 SE Douglas Ave Roseburg, OR 97470
(541) 672-4461
https://extension.oregonstate.edu/county/douglas/events

Supplemental Nutrition Assistance Program (SNAP)
https://www.oregon.gov/odhs/food/Pages/snap.aspx

Roseburg Rescue Mission
752 SE Pine St lot a, Roseburg, OR 97470
(541) 673-3004
Monday-Saturday 12pm-6pm
https://www.roseburgrescuemission.org/how-we-change-lives/new-life-program/

Thrive Umpqua
556 SE Jackson St, Roseburg, OR 97470
(541) 203-0325
Monday-Friday 10am-5pm
https://thriveumpqua.com/wellbeingchallenge/

UC VEG
556 SE Jackson St, Roseburg, OR 97470
(541) 378-6359
https://ucveg.org/

Food Banks

Care & Share Pantry
1008 Hayhurst Rd Yoncalla, OR 97499
(541) 849-2800
Last Tuesday of the month 9am-12pm

Community Care Food Pantry
518 Pacific Ave Glendale, OR 97442
(541) 761-4967
Thursday 1pm - 3pm

Dillard Winston Food Pantry
243 SE Thompson Ave. Winston, OR 97496
(541) 679-8281
Monday & Wednesday 9:30am - 11:30am
1st & 3rd Wednesday of the month 4:30pm - 5:30pm

FISH of Drain Food Pantry
128 W. C St Drain, OR 97435
Tuesday 9 am - 1 pm

FISH of Roseburg
405 Jerry's Drive Roseburg, OR 97470
(541) 672-5242
Monday & Wednesday 1:30pm - 3:30pm
Thursday & Friday 9:30am - 11:30 am

Living Hope Outreach Pantry
337 C Ave Drain, OR 97435
(541) 836-7051
Wednesday 12pm - 2:30pm

Outpost Mobile Food Center
(541) 492-3522
Elkton: Tuesday 1pm - 3 pm
Days Creek: Wednesday 1pm - 3pm
Camas Valley: Thursday 1pm - 3pm
Diamond Lake: Friday 1pm - 3pm

Project Blessing Pantry
150 S 20th St Reedsport, OR 97467
Tuesday & Wednesday 1pm - 3pm
Friday 11am - 1pm

Roseburg Dream Center Pantry
2555 Diamond Lake Blvd Roseburg, OR 97470
(541) 673-5918
Monday & Wednesday 10am - 1:45pm

Salvation Army
3130 NE Stephens Roseburg, OR 97470
(541) 672-6581
Tuesday - Friday 1pm - 4pm

SDA Glide Food Pantry (Helping Hands)
174 Abbott St Glide, OR 97443
(541) 496-3956
Wednesday 10am - 2pm

SDA Roseburg Food Pantry
1109 NW Garden Valley Roseburg, OR 97471
(541) 672-1542
Tuesday 10am - 12pm, 12:30pm - 2:30 pm

South Douglas Food Bank
420 E St Riddle, OR 97469
(541) 391-2796
Thursday 9am - 12pm
3rd, 4th, and 5th Saturday 10am - 12pm

St Vincent DePaul Pantry
116 N Main St Myrtle Creek, OR 97457
(541) 863-3310
Monday & Wednesday 9am to 1pm

Sutherlin Oakland Emergency Pantry
183 E 1st St Sutherlin, OR 97479
(541) 459-4082
Monday & Wednesday 9am - 11pm

Helpful Links

Food Hero

https://foodhero.org/

211

https://www.211info.org/get-help/food/

UMPQUA HEALTH
ALLIANCE

Health-Related Services

Health Related Services

Overview

Health-related services (flex funds) are non-covered services that are offered as a supplement to covered benefits to improve care delivery and overall member and community health and well-being.

All flex requests must meet one of the following criteria:

- Improve health outcomes compared to a baseline and reduce health disparities among specified populations.
- Prevent avoidable hospital readmissions through a comprehensive program for hospital discharge.
- Improve patient safety, reduce medical errors, and lower infection and mortality rates.
- Implement, promote, and increase wellness and health activities.
- Support expenditures related to health information technology and meaningful use requirements necessary to accomplish the activities above that are set for the in 45 CFR 158.151 that promote clinic, community linkage and referral processes or support other activities as defined in 45 CFR 158.150.
- Social Determinates of Health and Equity (SDOH-E).

They must also meet all of the following:

- Likely improve health outcomes.
- Lack billing and encounter codes.
- Be health related.
- Be consistent with a care/treatment plan.
- Likely to be a cost-effective alternative.
- Have no other community resources available.

Examples for flex funds include (but are not limited to):

- Gym membership
- AC/heating units
- Short-term, temporary housing
- Rental assistance, appliances, high dollar repairs

Visit the UHA website (https://www.umpquahealth.com/hrsflex/#1684265606901-9184c770-bf15) for more information on flex funds.

UMPQUA HEALTH
ALLIANCE

Submission Instructions

Unite Us

These requests can be sent to UHA using Connect Oregon's referral platform Unite Us. Connect Oregon is a coordinated care network of health and social service organizations. If you would like access to the Unite Us platform, please check out our Connect Oregon Flyer and/or visit https://uniteus.com/networks/oregon/.

Referral Form

For users that do not yet have access to Unite Us, please fill out the Health-Related Services – Flexible Spending form (https://www.umpquahealth.com/?wpdmdl=13104%27%3EHealth%20Related%20Services-%20Flexible%20Spending%20Request%20Form%3C/a%3E).

This form can be submitted via:

- Fax to 541-677-5881
- Email to flexspending@umpquahealth.com
- Mail or hand delivery to 3031 SE Stephens St. Roseburg, OR 97470
    - ATTN: Utilization Management – Flexible Spending

All requests will be processed in 5-10 business days. For urgent requests (requests in which the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function will be completed and notice will be provided as expeditiously as the member's health condition requires and no later than 72 hours). These requests will require intake from our Care Coordination team at 541-229-4842.

If the request is for services being provided by independent vendor/provider, they must include a W9 to make the payment (if one is not already on file).

Both clinical (providers, primary care teams, specialists, and other health care providers) and non-clinical (i.e. care coordinators, patient navigators, community health workers, community partners, members or representatives) may initiate a flexible services request for a member at any time. Documentation and/or supporting notes (chart notes, treatment plans, etc.) may be required to determine appropriateness of need depending on the service/item being requested. If this is not submitted with the original request, UHA may work with the member and/or care team to obtain the needed information to make the request valid.

For questions, please reach out to flexspending@umpquahealth.com.

Health-Related Services

Flexible Spending Request Form

- Health-related services are defined by Oregon Administrative Rules (OAR 410-141-3500 and 410-141-3845), the 1115 waiver special terms and conditions, and Code of Federal Regulations (CFRs) 45 CFR 158.150 and 45 CFR 158.151
- These are non-covered services that are offered as a supplement to covered benefits under Oregon's Medicaid State Plan to improve care delivery and overall member and community health and well-being.
- **Flexible services,** which are cost-effective services offered to an individual member to supplement covered benefits, must meet requirements for:
  - Activities that improve health care quality (45 CFR 158.150); or
  - Expenditures related to health information technology and meaningful use requirements to improve health care quality (45 CFR 158.151).

Instructions:

- Please complete this form as well as the Health Risk Assessment for this request to be reviewed. These can be faxed to 541-677-5881, emailed to flexspending@umpquahealth.com or dropped off or mailed to 3031 SE Stephens St. Roseburg, OR 97470, ATTN: Utilization Management – Flexible Spending.
- Please note that all resources must be exhausted prior to the approval of a flexible spending request. This must be supported in form.
- All requests will be processed in 5-10 business days. For urgent requests (requests in which the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function will be completed and notice will be provided as expeditiously as the member's health condition requires and no later than 72 hours). These requests will require a call to our Care Coordination team at 541-229-4842.
- If the request is for services being provided by independent vendor/provider, they must include a W9 to make the payment.
- Both clinical (providers, primary care teams, specialists, and other health care providers) and non-clinical (i.e. care coordinators, patient navigators, community health workers, community partners, members or representatives) may initiate a flexible services request for a member at any time. Documentation and/or supporting notes (chart notes, treatment plans, etc.) may be required to determine appropriateness of need depending on the service/item being requested. If this is not submitted with the original request, UHA may work with the member and/or care team to obtain the needing information to make the request valid.

UMPQUA HEALTH ALLIANCE

Member Information			
Member Name:		Member ID:	
Date of Birth:		Member Address:	
Member Phone:		Member Email:	

Submitter Information			
All requests must be completed by a provider/community partner/care coordinator (with exception of ongoing requests for continuation of services, and AC/heating units).			
Submitter Name:		Submitter Credentials:	
Submitter Office:		Submitter Email:	
Submitter Phone:		Submitter Fax:	

Request Details			
Primary Diagnosis:			
Requested Item/Service:		Expected Total Cost:	
Vendor Information: (Address and phone number or link)			
Duration of payment: One-time One Month Two Months	Three Months Other:	Frequency of Payment: Daily Weekly Monthly	Quarterly Annually
Describe how the requested service treats/prevents physical, oral or behavioral health conditions, improves health outcomes, or prevents/delays health deterioration:			
Describe how this can efficiently and effectively reduce medical costs and improve care (Example: prevent avoidable hospital admission):			

Describe how this is consistent with the member's treatment plan. (If you are a treating provider, treatment plan must be included in the documentation or as an attachment):
Describe other community resources that have been pursued and the reason they cannot be accessed. Indicate the attempts and results. (All community options must be exhausted, and documentation of denial attached).

Specific Requests	
Gym Membership Requests Only	
• Initial requests must have medical notes to support the request and submitted by a provider/community partner/care coordinator • Initial requests will only be approved in 3 month increments to ensure member is utilizing services • For members to be approved for ongoing membership, they must utilize services at least 8 times/month	
If the request is for a facility other than the YMCA, please provide rationale explaining the need for the alternative facility.	
AC/Heating Units Requests Only	
Are you 55 or older, or age 4 or younger? Yes No	
Are you living alone or socially isolated? Yes No	
Do you have a history of heat-related illness requiring treatment or hospitalization that home cooling/heating could have prevented? Yes No	
Do you have one of the following conditions that increases risk of a heat related illness?	

Age 65 or older Morbid obesity Heart disease Diabetes Alcohol use disorder	History of certain brain injuries/tumors or spinal cord injuries Hyperthyroidism Asthma or COPD	Parkinson's disease Use of a medication that cause temperature regulation interruption Multiple sclerosis

Short Term, Temporary Rental/Housing Assistance Only

- Submission must include a signed Temporary Housing Member Agreement by the member (see last page).
- Rental assistance submissions must also include W9 from the landlord.
- The member must be engaged with Care Coordination services with UHA before a request will be considered.
- Initial requests must be submitted by a provider/community partner/care coordinator.
- Stays will be approved for the shortest time necessary and will not exceed 3 months.

Please select the type of housing:	Apartment/Unit House	Hotel/Motel Transitional Housing
What is the expected length of stay?		
Please provide reasons why housing is being requested:		

Please list current monthly expenses (attach proof of expenses):

Housing	$	Food	$
Utilities	$	Transportation	$

Are you employed?	
What is your monthly income?	
Are you looking for employment?	

Please list business/jobs you have applied for:

Please provide plan to secure long term housing in the future.

What is your landlord/management address and contact information?

Is your rent past due?	Yes	No
Are medically fragile (e.g., newborn, ongoing chemotherapy or dialysis, oxygen dependent, etc.) and at risk of homelessness?	Yes	No
Are you currently homeless or living in substandard housing or experiencing a disruption in your housing?	Yes	No
Do you have a short-term housing needed for recovery after hospital discharge or a medical procedure?	Yes	No
Enrolled in the New Day or New Beginning programs?	Yes	No
Have you already received your Direct Acting Antiviral (DAA) medication for the treatment of Hepatitis C?	Yes	No
Do you have a valid ID (hotel only requirement)?	Yes	No
Have you previously broken the rules outlined in the Temporary Housing Member Agreement (last page)?	Yes	No

Temporary (Short Term) Housing Member Agreement

Umpqua Health Alliance (UHA) offers Flexible Services to its members. These are to help you by paying for services that are not covered under your health benefits (covered services). They are to help you with your overall health and wellbeing. You must agree to the rules below to get short term housing in a hotel or motel. You must also complete any other necessary paperwork and meet criteria to receive this help.

Member Name	
Name of Hotel/Motel	
Approval Date	
Check-In Date	

I will follow all hotel or motel rules. I understand that UHA staff or other provider staff may check on me during my stay. I understand that I will be asked to leave the hotel or motel if I do not follow their rules. I will also be asked to leave if I do not follow this agreement. If I am asked to leave, I know that I will no longer receive this help. I understand that I will be asked to leave if I:

- Cause or threaten to cause injury to any staff or guests.
- Engage in unsafe actions that could affect the safety or health of staff or guests.
- Have or use any illegal drugs, alcohol, or paraphernalia (items or supplies used to take drugs) while at the hotel or motel.
- Smoke inside or within ten feet of the hotel or motel.

- Have any guests over. All visitors or anyone that will be in room must be listed on the request form and approved by UHA (children or family member).
- Harass, cause or threaten to cause harm to staff or guests by what I say, write, or do.
- Cause or threaten to cause damage to hotel or motel property.
- Use or threaten to use any weapon on hotel or motel property.
- Bring a weapon to the hotel or motel.

I understand that I am responsible for my actions. This includes damage to the hotel room. It also includes breaking any hotel rule. I understand that I must treat hotel staff and guests with respect. I understand that an eviction within 24 hours may be given if UHA, the hotel/motel staff, or my provider suspects violation of any rules or regulations.

Member Signature: ____ **Date:** __________________
Provider Signature: ____ **Date:** __________________

Health Risk Assessment Screening

Member Information		
First and Last Name	**Member ID**	**DOB** ☐
Mailing Address	**Phone Number**	**Email Address**

Personal Characteristics

1. **Would you like to receive email or text communication from us?** ☐ Yes ☐ No ☐ Don't know
2. **How tall are you?**
3. **How much do you weigh?**
4. **Do you need an interpreter to communicate with us do you need notices in another format?**
   ☐ Yes ☐ No ☐ Don't know
5. **Do you need a sign language interpreter to communicate with us?**
   ☐ Yes (type needed) ______________________________ ☐ No ☐ Don't know
6. **What is your preferred spoken language?** ☐ English ☐ Spanish ☐ Other: _______________
7. **What is your preferred written language?** ☐ English ☐ Spanish ☐ Other: ________________
8. **What is your gender? (check all that apply)** ☐ Woman/Girl ☐ Man/Boy ☐ Non-binary
   ☐ Agender/No Gender ☐ Transgender ☐ Questioning ☐ Don't Know
   ☐ Not Listed. Please specify: ____
   ☐ I don't know what this question is asking ☐ I don't want to answer
9. **How do you describe your sexual orientation or sexual identity? (check all that apply)**
   ☐ Same-gender loving ☐ Same-sex loving ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Pansexual
   ☐ Asexual ☐ Queer ☐ Straight (attracted mainly to or only to other gender(s) or sex(es)
   ☐ Questioning ☐ Don't know
   ☐ Not listed. Please specify: ____
   ☐ I don't know what this question is asking ☐ I don't want to answer
10. **What is your relationship status?** ☐ Single ☐ Significant Other/Domestic Partner ☐ Married
    ☐ Widowed ☐Separated ☐ Divorced ☐ Other: _______________________________________
11. **Which of the following describes your ethnic identity?**
    ☐ Hispanic ☐ Not Hispanic ☐ Don't know ☐ Decline to answer
12. **Which of the following describes your racial identity? (see next page)**

☐ **American Indian or Alaska Native**	☐**Asian**	☐ **Native Hawaiian or Pacific Islander**	☐ **Hispanic or Latino/a**
☐ American Indian	☐ Asian Indian	☐ Guamanian or Chamorro	☐ Hispanic or Latino/a Central American
☐ Alaska Native	☐ Chinese	☐ Micronesian	☐ Hispanic or Latino/a Mexican
☐ Canadian Inuit, Metis, or First Nation	☐ Filipino/a	☐ Native Hawaiian	☐ Hispanic or Latino/a South American
☐ Mexican Native or Indio	☐ Laotian	☐ Samoan	
☐ Central American, or South American	☐ Hmong	☐ Tongan	
	☐ Japanese	☐ Other Pacific Islander	
	☐ Korean		
	☐ South Asian		
	☐ Vietnamese		
	☐ Other Asian		

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			☐ Other Hispanic or Latino/a
☐ **Black or African American** ☐ African American ☐ African (Black) ☐ Caribbean (Black) ☐ Other Black	☐ **Middle Eastern/ North African** ☐ North African ☐ Middle Eastern	☐ **White** ☐ Eastern European ☐ Slavic ☐ Western European ☐ Other	**Other Categories** ☐ Other (please list) ____________ ☐ Don't know ☐ Decline to answer

Family and Home

13. **Are you currently pregnant?** ☐ Yes ☐ No **If yes, when are you due?** Due Date: ______________
14. **Have you been told your pregnancy is "high risk?"** ☐ Yes ☐ No
15. **Have you been discharged from the armed forces of the United States?** ☐ Yes ☐ No ☐ Don't know ☐Decline to answer
16. **Are you or is your close family a veteran?** ☐ Yes ☐ No ☐ Don't know ☐ Decline to answer
17. **Are you a refugee?** ☐ Yes ☐ No ☐ Don't know ☐Decline to answer
18. **In the past year, have you or any family members you live with been <u>unable</u> to get any of the following when it was <u>really needed</u>? Check all that apply.**
    ☐ Food ☐ Clothing ☐ Utilities ☐ Phone ☐ Medicine ☐Child Care
    ☐ Vision ☐ Housing ☐ Medical care ☐ Dental care ☐ Mental Health care
    ☐ Other: ________________________
19. **Do you need help with any of these daily activities?**
    ☐ Eating ☐ Getting dressed ☐ Grooming ☐ Bathing ☐ Using the toilet
    ☐ Taking or organizing medications ☐ Preparing food ☐ Walking ☐ Falling often
20. **Do you live in one of the following locations?**
    ☐ Nursing home ☐ Assisted living home ☐ Behavioral health home ☐ None of these
21. **What is your housing situation?**
    ☐ I have housing
    ☐ I do not have housing (staying with others, hotel, shelter, living outside, in a car, or in a park)
22. **Are you worried about losing your housing?** ☐ Yes ☐ No
23. **How many family members, including yourself, do you currently live with?** (write number):____
24. **YOUTH ONLY: Has DHS Child Welfare been involved with your family?** ☐ Yes ☐ No
    Please explain : ____
25. **YOUTH ONLY: What is your child's current living arrangement?** ☐ Parent(s)/guardian ☐ DHS ☐ Foster home ☐ Other (please explain): ______________________
26. **YOUTH ONLY: Was your child exposed to drug or alcohol during pregnancy?**
    ☐ Yes ☐ No ☐Decline to answer
27. **YOUTH ONLY: Does your child show signs of social, emotional, or behavioral problems?**
    ☐ Yes ☐ No ☐Decline to answer
28. **YOUTH ONLY: Has your child been diagnosed with any of the following: anxiety disorders, conduct disorders, obsessive-compulsive disorder, psychotic disorder; bipolar disorder?**
    ☐ Yes ☐ No ☐Decline to answer

29. **YOUTH ONLY: Is your child currently attending school?**
☐ Yes ☐ No ☐Decline to answer

Money and Resources

30. **Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.**
☐ Yes, it has kept me from medical appointments or from getting my medications
☐ Yes, it has kept me from non-medical needs, work, or appointments
☐ No

31. **What is the highest level of school that you have finished?**
☐ Less than high school ☐ High school diploma/GED ☐ More than high school

32. **What is your current work situation?**
☐ Part-time or temporary work ☐ Full-time work ☐ Unemployed
☐ Unemployed but not seeking work (student, retired, disabled, unpaid care giver)
☐ Other (please explain):

33. **At any point in the past 2 years, has seasonal or migrant farm work been your or your family's main source of income?** ☐ Yes ☐ No ☐Decline to answer

34. **During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.**
(write amount): ____________________________

35. **What is your main health insurance?**
☐ None/Uninsured ☐ Medicaid (UHA/OHP) ☐ VA ☐ Other Public Insurance (CHIP)
☐ Private Insurance ☐ Medicare ☐Medicare Advantage ☐ Other Public Insurance (not CHIP)

36. **In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correction facility?** ☐ Yes ☐ No ☐Decline to answer

Social and Emotional Health

37. **Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?**
☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

38. **How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)**
☐ Less than once a week 1 or 2 times a week ☐ 3 to 5 times a week ☐ 5+ times a week

39. **Do you feel physically and emotionally safe where you currently live?** ☐ Yes ☐ No
☐ Don't know

40. **In the past year, have you been afraid of your partner or ex-partner?** ☐ Yes ☐ No
☐ Don't know

41. **Are there any cultural, religious, or spiritual beliefs or practices that may influence your care? If yes, please explain:**
____

Medical and Dental

42. **Who is your Primary care provider?** **Date of last visit?**

43. **Who is your Oral health provider/Dentist?** **Date of last visit?**

44. **Do you have one of these disabilities?** ☐ Hard of hearing ☐ Deaf ☐ Blind
☐ Other: ____

45. **Do you see your dental provider every 6 months for routine care?** ☐ Yes ☐ No

46. **Do you have high health needs or medical issues?**
☐ No ☐ Yes (please explain):______________________________

47. **Do you use tobacco products (cigarettes, chew, snuff, pipes, cigars, vapor cigarettes)?**
☐ Yes ☐ No

48. **Do you have any health concerns you need help with?**
☐ No ☐ Yes (please explain):______________________________

49. **Do you have any of the following?**
☐ Congestive Heart Failure (CHF) ☐ Hepatitis C ☐ Heart Disease ☐ Diabetes
☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Tuberculosis HIV/AIDs
☐ Other (please explain): ______________________________

Medications

50. **Do you have trouble taking your daily medications?** ☐ Yes ☐ No

51. **If yes, is it due to side effects, the cost, trouble understanding the directions or when to take them?** ☐ Yes ☐ No

52. **Would you like help with your medication concerns?** ☐ Yes ☐ No

Behavioral Health

53. **Do you have a substance use disorder?** ☐ Yes ☐ No ☐ Decline to answer

54. **If yes, what do you use?** ☐ Alcohol ☐ Methamphetamines ☐ Cocaine ☐ Heroin
☐ Fentanyl Other: ______________________________
How do you use it? ☐ Ingest (swallow) ☐Smoke ☐Snort ☐Inject

55. **Are you on any medication assisted treatment (Methadone, Buprenorphine) for Opiate Use Disorder?** ☐ Yes ☐ No ☐Decline to answer

56. **Do you want help with drug use?** ☐ Yes ☐ No **If yes, would you like help with medication assisted therapy for opiate use?** ☐ Yes ☐ No

57. **Do you have a mental illness?** ☐ Yes ☐ No ☐Decline to answer

58. **Do you have a family history of mood disorders, psychotic disorders, or schizophrenia?**
☐ Yes ☐ No ☐Decline to answer

59. **Do you ever experience any of the following: Hearing, seeing, tasting, or believing things that others don't, persistent unusual thoughts or beliefs that can't be set aside regardless of what others believe, strong and inappropriate emotions or no emotions at all?**
☐ Yes ☐ No ☐Decline to answer

60. **Do you have a developmental disability, or have you ever been diagnosed with the following: autism, brain injury, cerebral palsy, Down syndrome, fetal alcohol syndrome, spina bifida, or intellectual disability?**
☐ Yes ☐ No ☐Decline to answer

61. **Do you want help managing your mental health needs?** ☐ Yes ☐ No

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Pharmacy Resources

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Pharmacy Services

Medication Management Program

The Umpqua Health Alliance (UHA) Medication Management program includes a range of services offered by the UHA Clinical Pharmacy team that help our members achieve maximum benefit from their medications. The goals of pharmacist directed medication management include identifying, preventing, and resolving medication-related problems. Medication management services are offered via phone or mail to all referred members. Providers, case managers or other members of the care team can refer members as needed.

Medication Management Referral Reasons (examples):

- A high risk of developing medication-related problems
- An identified medication-related problem
- Medication adherence issues
- Polypharmacy related to the member having two or more chronic conditions and eight or more maintenance medications

Provider Referral Process:
To refer a member to UHA Medication Management, complete the Medication Management Referral Form (https://www.umpquahealth.com/wp-content/uploads/2022/09/mm-referral-fillable-form-2022.pdf) and submit the form via fax to (541) 677-5881 or email to UHPharmacyServices@UmpquaHealth.com.

Diabetic Therapy Guidance

The UHA Clinical Pharmacy team developed a provider diabetes treatment document as a quick reference guide. You can find the treatment guide on the UHA website (https://www.umpquahealth.com/?wpdmdl=13530%27%3EDiabetes%20-Provider%20Guidance%20Treatment%3C/a%3E).

Additional Pharmacy Services

UHA is committed to providing appropriate, high-quality, and cost-effective medication therapy to our members. For a list of the medications we cover, refer to the Drug List and Prior Authorization on the UHA website (https://www.umpquahealth.com/pharmacy-services/#1684263139773-59e04baf-100a). For all pharmacy and medication questions, please contact us at UHPharmacyServices@UmpquaHealth.com.

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Medication Management Program Referral Form

Fax this completed form to (541) 677-5881 Or email UHPharmacyServices@UmpquaHealth.com

**** Required Field***

*Referred by (name): ___________________________________ Date of Referral: _____/_____/________

*Relationship to member: ☐Self (member) ☐Provider ☐Other: ______________________

MEMBER INFORMATION	
*Member Name:	*Member Date of Birth:
*Member ID #:	*Member Phone Number:

PROVIDER INFORMATION		
*Provider Name: MD ☐ DO ☐ FNP ☐ NP ☐ PA ☐		*NPI #:
*Office Contact Person:	*Office Fax:	*Office Phone:
*Address:		

REASONS FOR REFERRAL (Check all that apply)

- ☐ **Medication synchronization:** Coordinating medication refills to reduce trips to the pharmacy to pick up medications.
- ☐ **Medication reconciliation:** Identify and verify the list of current medications being taken is accurate and understood to avoid confusion about which drugs are the correct ones to be taken.
- ☐ **Dose orchestration:** Aligning doses and timing of doses for compatibility and optimum therapy to focus on taking medicines at the right time of day and as few times as possible.
- ☐ **Medication education:** Explaining names and purposes for medications that are being taken, and what side effects or precautions to watch for to ensure understanding of drugs and their effects.
- ☐ **Economic/formulary review of medications:** Evaluating current medications to identify appropriate but less expensive or preferred alternative treatments for relevant condition(s) and recommending changes to the physician/prescriber.
- ☐ **Therapeutic review of medications:** Evaluating current medications to identify alternative treatments with therapeutic advantages for relevant condition(s) and recommending changes to the physician/prescriber.
- ☐ **Adherence assistance:** Evaluating challenges and factors that affect members taking their medications as prescribed and working with members to develop strategies for improvement.
- ☐ **Other:** ____

BRIEF DESCRIPTION OF CONCERNS

REFERENCED MATERIALS (attach additional chart notes)

Questions? Call UHA Clinical Pharmacy Services at (541) 229-7007 or email us at UHPharmacyServices@UmpquaHealth.com.

Pharmacologic Treatment of Hyperglycemia in Adults with Type 2 Diabetes

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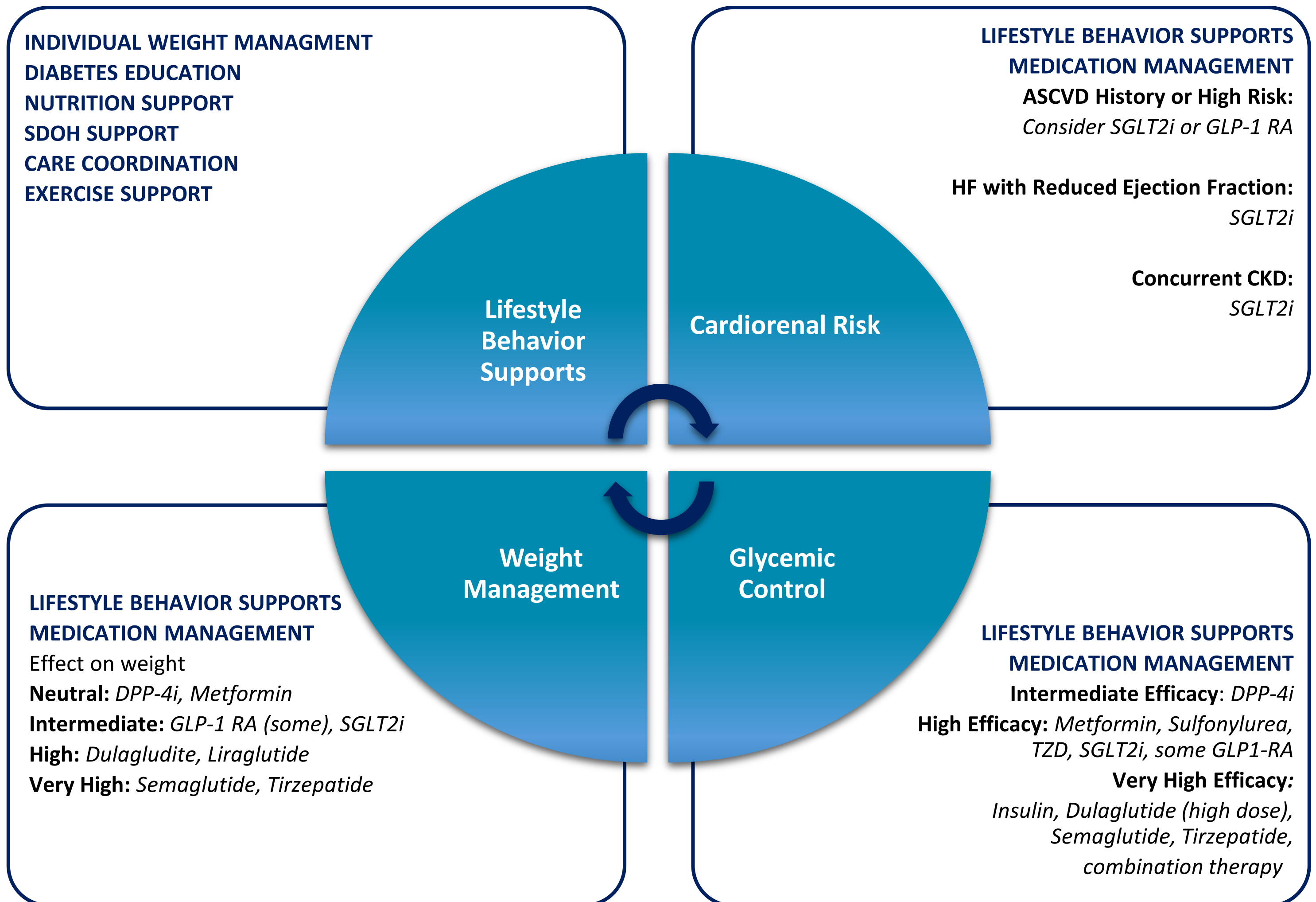
TYPE 2 DIABETES MANAGEMENT KEY POINTS

- 1st line therapy still includes metformin for most patients.
- Insulin is recommended for most patients with an A1C >10%.
- Review treatment barriers such as behavioral health, medication adherence, and social factors before escalating therapy.
- Encourage patient engagement with behavioral health coordinators and/or clinical pharmacists.
- Escalate therapy after three months, if member is not at A1c goal.
- Consider patient-specific factors when selecting pharmacologic treatment.



LIFESTYLE SUPPORT RESOURCES

- FOODSMART (www.foodsmart.com, UHA Foodsmart Benefit Brochure [Spanish])
- VEGGIE RX (UCVEG Umpqua Community Veg Education Group)
- EXERCISE SUPPORTS (YMCA of Douglas County)
- DIABETES PREVENTION PROGRAM (DPP Program)
- DIABETES SELF MANAGEMENT PROGRAMS

Umpqua Health Alliance CCO Pharmacy Services
Updated 3-29-2023

Pharmacologic Treatment of Hyperglycemia in Adults with Type 2 Diabetes

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UHA FORMULARY AND CLINICAL CRITERIA SUMMARY

- The most current formulary and PA guidelines are available online: https://www.umpquahealth.com/pharmacy-services/
- Non-preferred agents require prior authorization (PA) with documentation of trial and failure or contraindication to preferred agents.
- Preferred products do not require PA unless indicated.

MEDICATION CLASS	FORMULARY STATUS	MEDICATION NAMES
Biguanides	Preferred – No PA Required	Metformin IR and ER
Sulfonylureas and TZDs	Preferred – No PA Required	TZDs: Pioglitazone Sulfonylureas: Glipizide IR and ER, Glimepiride, Glyburide
DPP-4 Inhibitor	Preferred – No PA Required	Alogliptin
Insulin	Preferred – No PA Required	Insulin Glargine 100/ML Pens and Vials Insulin Glargine-YGFN 100/ML Pens and Vials Insulin Lispro Kwikpen and Vials Insulin Aspart Flexpen, Cartridge, and Vials Humulin and Novolin 70-30 Admelog Vials Humalog Mix 50-50 and 75-25 Vials Humulin and Novolin R Vials Insulin Aspart-Protamine Vials Humulin and Novolin N Vials
	Non-preferred – PA Required	Admelog Solostar Basaglar Humalog Kwikpen and Cartridge Levemir Vials and Pens Toujeo 300 units/mL Pen Novolin and Humulin 70-30 Pens Novolin R Pen Lantus Vials and Pens Humulin R U-500 Pens and Vials Insulin Lispro-Protamine Pen Insulin Aspart-Protamine Pen Humulin N Kwikpen Novolin N Flexpen
SGLT-2 Inhibitors	Preferred – No PA Required	Steglatro (ertugliflozin)
	Non-preferred – PA Required	Farxiga (dapagliflozin) Invokana (canagliflozin) Jardiance (empagliflozin)
GLP-1 Agonists	Preferred – PA Required	Byetta (exenatide, daily) Bydureon (exenatide, weekly) Rybelsus (semaglutide, oral) Trulicity (dulaglutide)
	Non-preferred – PA Required	Ozempic (semaglutide, SQ) Victoza (liraglutide)

Keep Track of Your Medications

This chart can help you keep track of the different medicines, vitamins and over-the-counter drugs you take. Because your medications may change over time, make a copy of the blank form so you will always have a clean copy to use. Try to bring a completed and updated copy of this form to every doctor appointment.

Date:_______________________

Name of Drug	What It's For	Date Started	Doctor	Color/ Shape	Dose (How Much/ How Often)	Instructions

Name of Drug	What It's For	Date Started	Doctor	Color/ Shape	Dose (How Much/ How Often)	Instructions

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Additional Diabetes Resources

Diabetes Zones

Green Zone

ALL CLEAR – This Zone is Your Goal.

You have no symptoms of high or low blood sugar and you have:

- A fasting blood sugar of 90–130 (before food or drink in the morning).
- A blood sugar 1 to 2 hours aftermeals that is less than 180.
- A1c (your average blood sugar over several months) under 7%.

Yellow Zone

CAUTION – This is a Warning Zone LOW blood sugar:

▲ Shakiness, dizziness, extreme hunger, headache, pale skin, sweating
▲ Sudden mood or behavior changes (crying without reason)

What to Do:

1. Check your blood sugar (if possible) and write it down.
2. Eat or drink 15 to 20 grams of sugar or starches (such as 1/2 cup of fruit juice, or regular soda; or 4 or 5 saltine crackers; or 4 teaspoons of sugar; or 1 tablespoon of honey or corn syrup).
3. Wait 15 to 20 minutes and check your blood sugar again—if it is still below 60, eat 15 to 20 grams of sugar/starch again.

If your symptoms do not go away:

1. Call your Primary Care Provider's office NOW (day or night).
2. Tell them: "I have diabetes and my blood sugar is too low. I need to talk to my doctor or the Medical Assistant."

_______________________________ _______________________

Your Primary Care Provider Phone number

CAUTION – These are warnings of HIGH blood sugar:

▲ Blood sugar of 240 (or higher if you are used to higher levels)
▲ Extreme thirst, *or*
▲ Nausea and vomiting, *or*
▲ Belly (stomach) pain, *or*
▲ Increase in urinating/passing water, *or*
▲ Fruity smelling breath, *or*
▲ Deep/rapid breathing, *or*

What to Do:

1. Call your Primary Care Provider's office NOW (day or night).
2. Tell them: "I have diabetes and my blood sugar is too high. I need to talk to my doctor or the Medical Assistant."

_______________________________ _______________________

Your Primary Care Provider Phone number

Red Zone

EMERGENCY—Call 911 or go to the Emergency Room if you have ANY of the following symptoms:

- Lack of coordination and confusion
- Double vision
- Fainting or passing out
- Convulsions or a seizure

500 SE Cass St. Suite 101
Roseburg, OR 97471
Tel (541) 229-4842
UmpquaHealth.com