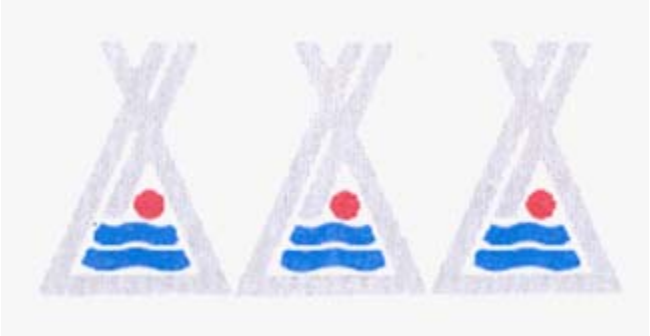
The Confederated Tribes of the Warm Springs Reservation of Oregon

and

The Indian Health Service



Annual Health System Report

for the

Warm Springs Indian Reservation

October 28, 2010

2010 Edition
Reporting Information through 2009

2010 Annual Health System Report

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EXECUTIVE SUMMARY

This Annual Health System Report includes information about the community members served by the health system at Warm Springs, the services provided and resources utilized during 2009 and prior years. It is published in response to requirements set forth within the Joint Comprehensive Plan for the Delivery of Health Services to the Warm Springs Indian Reservation. In adopting the plan, and the requirements for this report, the Tribal Council recognized that good and reliable information is needed as a foundation for developing sound policy and for setting priorities and designing effective programs to serve the Warm Springs community. The report is also considered an important tool to communicate information, to the community, about its health status, and the services and resources available to provide health services. It is designed to respond to questions put forth by the health plan.

- How do we best know and focus on our customers?
- How do we design and deliver high quality responsive health services?
- How do we deploy and maximize resources toward a healthier community?
- How do we maintain and forge strategic alliances and relationships that augment and support the overall effort?
- How do we assemble and report information to support informed decision making?
- How do we evaluate our progress and our effectiveness?

The health plan sets forth requirements for this report and assigns responsibility to the Warm Springs Joint Health Commission to direct its publishing and improvement. The Commission took formal action adopting the format and content of this report, and recommending information collection efforts to improve it in the future.

The report indicates that the community faces significant health challenges. Overall, members suffer at great deal from chronic disease, with a high number having or being at high risk for diabetes. It also reveals that longevity at Warm Springs falls well behind that of the general public, as well as the American Indian population in the United

States. A substantial number of community members rely on Indian Health Service and Contract Health Services to obtain medical care, having no other insurance or alternate resource. Many identify factors that place them at higher risk of illness and injury. Personal choices underlie the cause of many illnesses and injuries.

Reports on the various services indicate a gradually growing demand. They also indicate that a significant portion of emergency services are related to substance abuse or other preventable conditions. Access to services has been a long-time issue for the community. Extended hours were developed to address after hours access, however, the report indicates very low utilization, and high cost per visit for this additional access. Information suggests that this service should be better supported and promoted to justify the resources utilized. Missed appointments stands out as a factor that affects the use of resources and access to care. Measuring and reporting this issue, along with efforts to reduce the impact of this expensive waste of resources. Information is being collected and presented on the physician hospital practice to determine its impact on access and resources. Information and reporting by community health services and counseling programs require improvement as these programs are assigned significant responsibility for prevention efforts.

Resources available through federal appropriations to the Indian Health Service have trended upward, but do not keep pace with inflation. An increase in 2009 helped somewhat, and another expected in 2010 will help. However, the national deficit is expected to limit increases beyond the current year. Hospitalization and emergency room visits utilize the majority of Contract Health Service resources, which limits the amount of resources available for non-emergent care needed by the community. Collections, which provide an important resource to finance health services have trended down recently. Budget constraints may further limit collections in the future as Oregon, like most states, faces pressure on health programs. Some savings are available which may be re-directed to higher priorities, however, resource limitations will always require careful priority-setting.

The Indian Health Service has adopted Government Performance and Results Act (GPRA) measures to provide for evaluation of services. Accreditation reviews by outside bodies that are skilled and evaluation the quality of operations are also conducted. These reports point to high quality in services provided and highlight a high degree of patient satisfaction with services received.

The report presents cost vs value of services for earlier years. Information on most recent years was not readily available for this publication, but is being gathered as is expected for subsequent year reports. To respond to the health plan goal of maximizing resources, it is important to measure efficiency in utilizing resources.

Overall, the report reflects a significant amount of information that is not currently being maintained or reported. Efforts are underway to assure that programs maintain and report the information in the future. Interested readers of this report should expect to find future reports improved and more complete.

SECTION 1

Overview of Health Delivery System

The Warm Springs health delivery system is comprised of ambulatory care, community health services, community counseling services and emergency medical transport (ambulance). Contract Health Service resources (Managed Care) are utilized to purchase outside services for eligible Indians. The majority of outside services involve hospital and specialty care not offered by the health delivery system in Warm Springs.

The health delivery system is operated in part by the Confederated Tribes, and in part by the Indian Health Service. Programs being operated by the system are discussed and depicted in this section, and reflect the connections between Tribal and Indian Health Service operations and purchased care.

In 2009 the Confederated Tribes and the Indian Health Service entered into a Memorandum of Understanding, creating the Warm Springs Joint Health Commission to oversee the ongoing development of the health care system and the implementation of the Joint Comprehensive Plan for the Delivery of Health Services to the Warm Springs Indian Reservation.

The Tribal Health and Welfare Committee retains its role as liaison addressing community member access and concerns to the health system and Tribal Council. It also maintains a role in addressing regional and national health care issues and developments.

The health care system is confronted with all of the complexities of the national health care system, including inability of federal and state governments, industry and individuals to keep up with the rising cost of health care. The demographics of the nation reflect an aging population, demonstrating longer life expectancy. This creates increasing demand on the system as the older population uses a proportionally higher

share of the overall health care systems. This national demographic is also present in the Warm Springs community, in that the local population also reflects increasing portions of the total population in the older age groups.

Advances in technology and new therapies create additional demand, and while more effective against disease, bring a much higher price tag. The U.S. system continues to be based on curative care, with only a modest proportion devoted to prevention.

At Warm Springs, there has been recognition of the need to improve health status and wellness. Resources have been channeled to health promotion and disease prevention. There has long been recognition that the community can't "cure" its way to good health. One major advantage to the partnership forged with the Indian Health Service, over that of other communities, is the ability to coordinate all health system efforts to better serve and educate the community.

Although the Tribe' plan calls for a shift from curative to a more preventive orientation, the payoff is a long term proposition. Therefore the design of programs and the allocation of resources must be carefully examined to ascertain the most effective approaches. This report has been mandated to ensure evaluation and measurement of progress.

Rural health care is challenged around the nation with distance to hospitals and other providers, and difficulty in recruiting the health professions needed in a community. Warm Springs is similarly challenged and recruitment and retention is a major focus. Attracting and maintaining highly qualified and committed health professionals is essential.

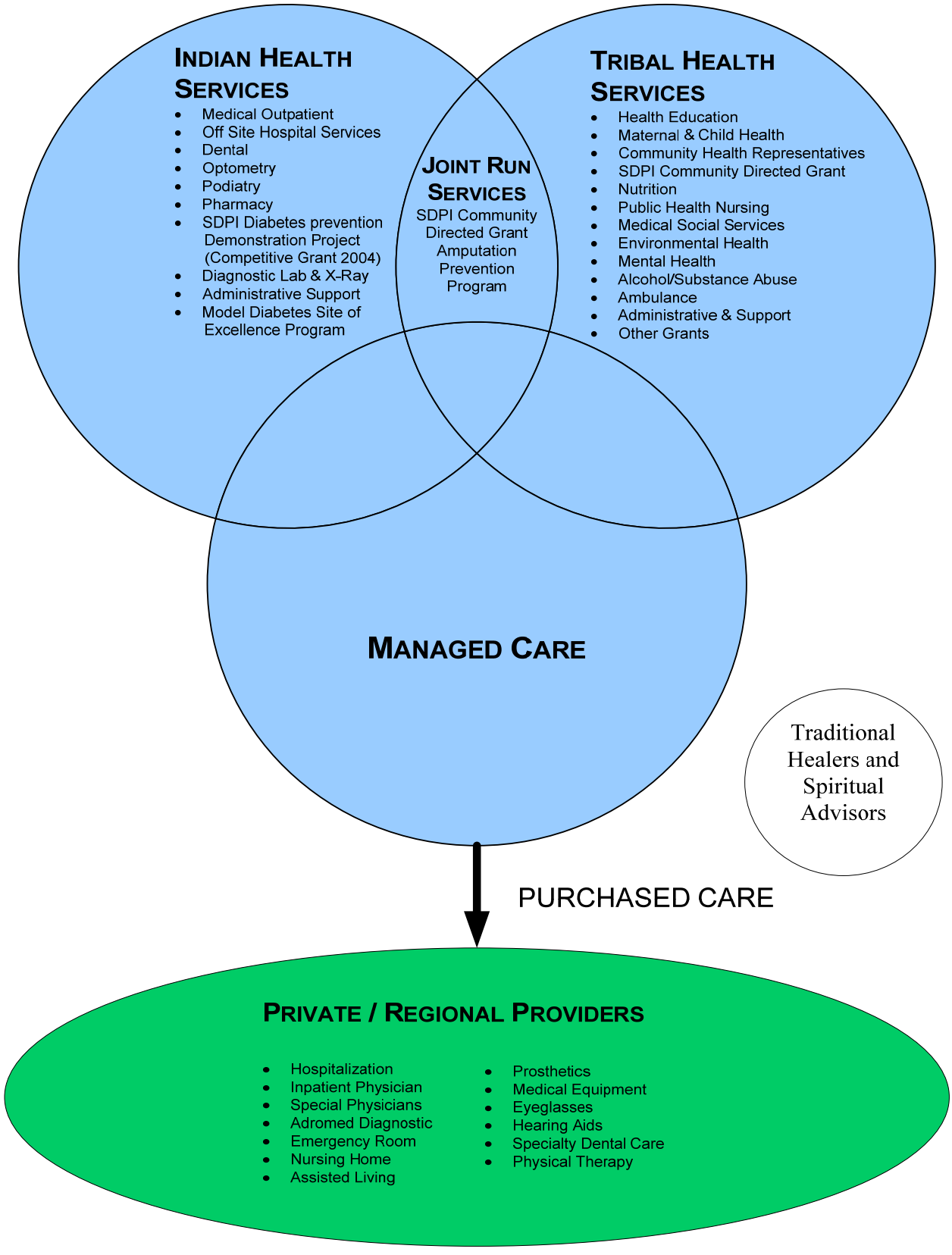
Throughout the years, the Tribe has contracted various portions of the Indian Health Service financed community health programs, mental health and alcohol and substance abuse programs, completing that transition in 2008. The Tribe has also appropriated tribal resources and sought and received grants to enhance the health system, in addition to providing health insurance for Tribal employees.

The financial vitality of the delivery system has been primarily dependent upon federal appropriations and, to a lesser extent, collections. In and environment that suggests very limited increases in federal resources in the coming years, the system will increase its level of dependence on collections and efficiency of operations.

It is anticipated that there will be grants available from federal, state and foundation sources, for which there will be heavy competition. The health system will need to be able to clearly articulate its needs and proposed solutions, all of which will rely on good record keeping and reporting.

The outline on the following page reflects the major health programs and functions as they are currently operated.

Warm Springs Health Delivery System



SECTION 2

Customers

How do we best know and focus on our customers?

This section describes our customer base in terms of demographics (age profile, tribal affiliation, community of residence, alternative resource eligibility, etc.) It also provides a historical picture of picture of the Tribe's vital statistics (births, deaths, age of death and cause). The major diseases in the community and major health risks are also identified and quantified. This information helps to determine not only the present conditions, but also the trends that affect the delivery of health services.

Customers That Use the Services

Purpose: To identify the number of new registered patients, the active clinic patients, the official IHS user population, and the corresponding trends for each category.

Relevance: New registered patients are those who have not previously accessed services, including newborns, new eligible residents, and eligible visitors who presented themselves for service. This is one factor in growth of the service population. Active clinic patients are those who have actually utilized the service within a three year period. This is another indication of the growth of the service population. The IHS official user population excludes users residing in other services areas, and is used for resource allocation purposes.

Warm Springs Health and Wellness Center

Year	New Registrations	Active Clinic Patients	User Population
2001	417	6,048	5,057
2002	471	6,302	5,375
2003	449	6,478	5,402
2004	409	6,558	5,471
2005	346	6,612	5,564
2006	368	6,685	5,634
2007	328	6,612	5,229
2008	370	6,703	5,298
2009	320	6,665	5,454

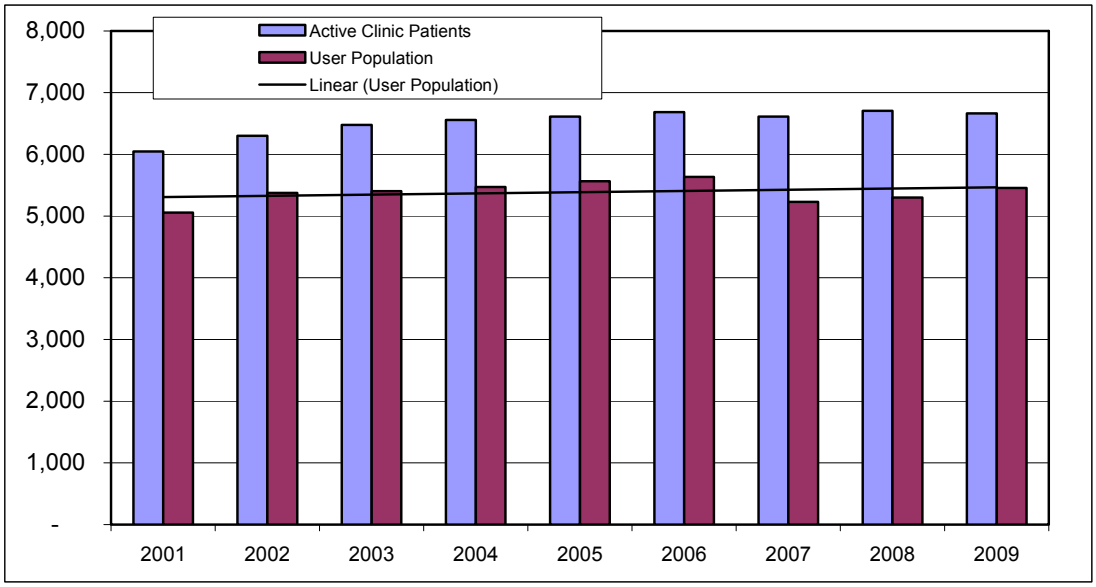


Figure 2-1

Interpretation: Between 1996 and 2009, new patient registrations have decreased by approximately 17.3%. During that timeframe, new patient registrations peaked in 2003 at 449; an increase of about 16% since 1996. Since then, new patient registrations decreased to their lowest point in 2009 at 320 registrations. In that thirteen year time span, the user population has increased from 4,301 to 4,454 (26.8%) and the population of active clinic patients has increased by 20.5%. The user population and active clinic population have followed the same trends over time with only two population change percentage differences greater than 5%; one in 1998 and the other in 2007 with a difference of -5.3% and 6.6% respectively.

Customers Served by Year

Purpose: To identify our patients by community of residence, tribal affiliation and the associated trends.

Relevance: While services are generally planned and financed for those who reside on or near the reservation (service area), a significant number reside outside the service area. Changes in the make-up of visits can impact access and resources.

Patients Served by Fiscal Year

By Commuinity of Residence	2000	2007	2008*	2009	Chg(07- 09)
Warm Springs Indian Reservation	3,724	3,503	3,559	3,686	183
Madras/Redmond/Bend	1,319	1,057	1,104	1,035	(22)
Maupin/The Dalles/Hood River	114	77	91	85	8
Portland/Salem	152	68	90	90	22
Other Oregon	237	483	470	461	(22)
Outside Oregon	416	319	237	137	(182)
TOTAL	**5,962**	**5,507**	**5,551**	**5,494**	(13)

By Tribal Affiliation	2000	2007	2008	2009	
Warm Springs Member	3,738	3,703	3,773	3,812	109
Other Oregon Tribes	325	261	244	241	(20)
All Other Tribes	1,732	1,442	1,432	1,350	(92)
Non-Indians	167	101	102	91	(10)
TOTAL	**5,962**	**5,507**	**5,551**	**5,494**	(13)

Figure 2-2

***** 2008 Data: May be some small discrepancies for the Community of Residence.

RPVC Registered Patients and Visits by Community

RPVT Registered Patients and Visits by Tribe

Interpretation: Trends have remained stable from 2000 to 2009 with approximately two-thirds of our patients being Warm Springs Tribal Members and approximately two-thirds of our patients residing on the Warm Springs Indian Reservation:

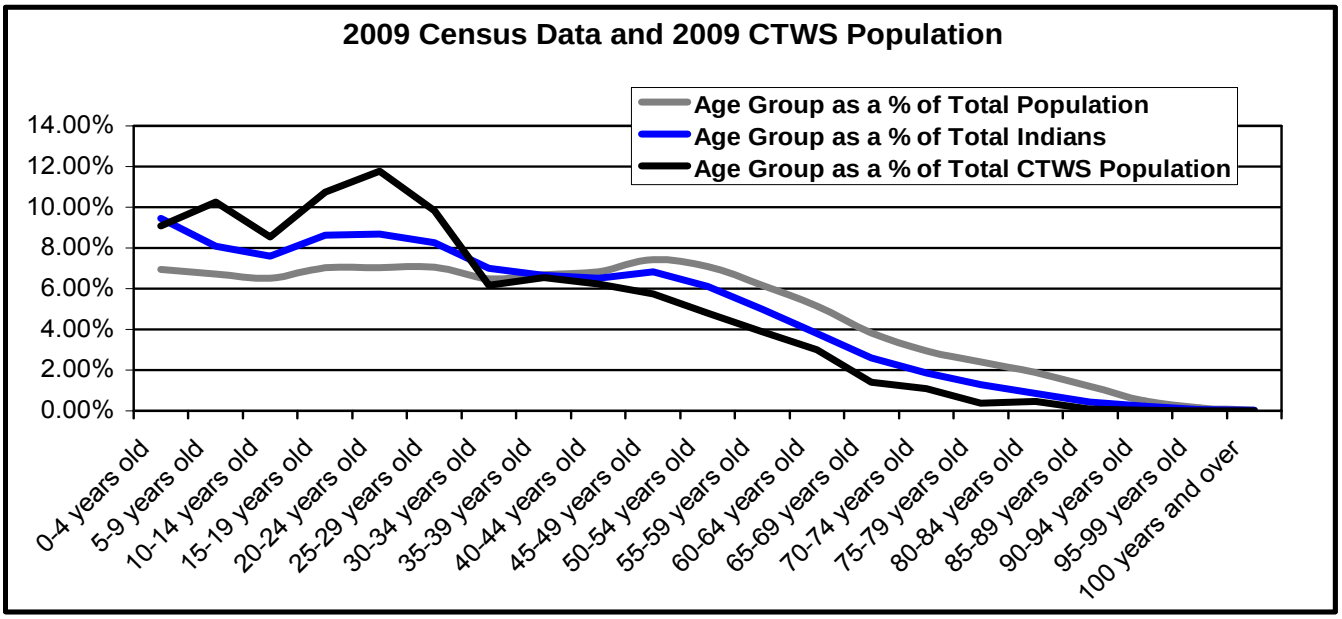
- 2000 - 62.7% Warm Springs Tribal Members; 62.5% residing on the reservation
- 2007- 67.2% Warm Springs Tribal Members; 63.6% residing on the reservation
- 2009- 69.4% Warm Springs Tribal Members; 67.1% residing on the reservation

From 2000 to 2009 there has been a small increase in patients who are Warm Springs Tribal Members and a slight decrease in patients who are members of other tribes or who have no tribal affiliation. Between 2000 and 2009, we saw an increase of approximately 4.5% of patients who reside on the Warm Springs Indian Reservation. As of 2009, over 85% of our patients resided either on the reservation or in the Madras/Redmond/Bend area.

Age of Enrolled Members of the Confederated Tribes of Warm Springs (CTWS)

Purpose: The relationship exists between the IHS and the CTWS, under the Treaty of 1855 and federal law, in whose absence there would be no service area. Tribal age profile is displayed to support planning.

Relevance: Resource deployment is guided by differences in demands placed on the system for services by differing age groups.



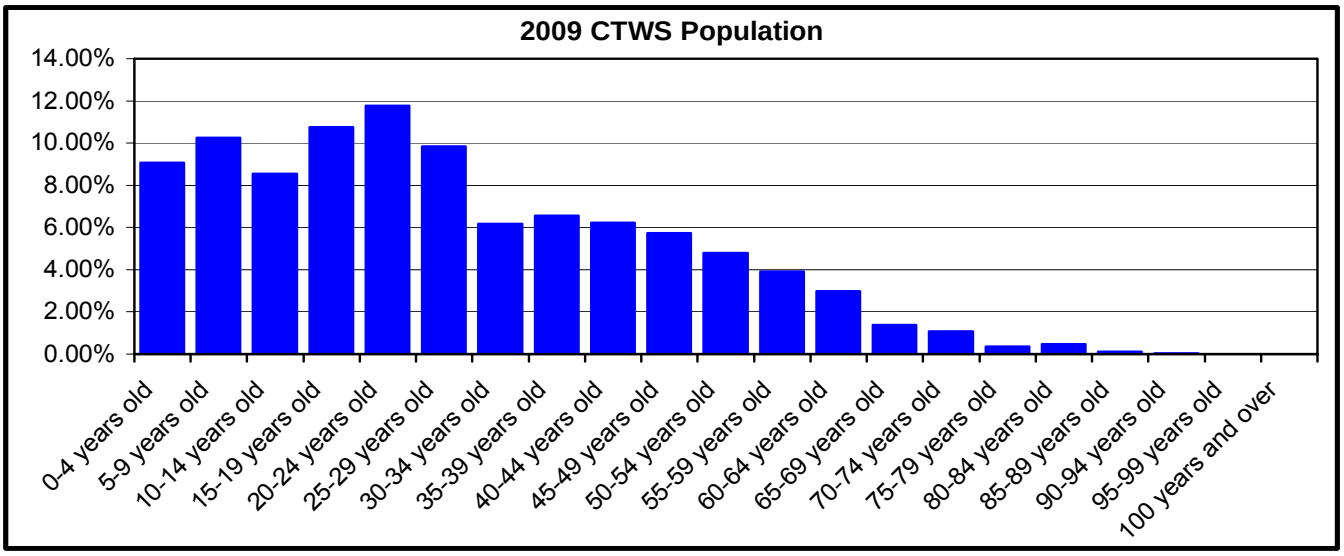


Figure 2-3

Interpretation: The CTWS population has a higher percentage of its population in younger age groups and fewer persons in older age groups than the U.S. general and Native American populations.

Age of Patients

Purpose: To display the age profile of patients who utilize the services over several different periods.

Relevance: Different age groups place different types of demands on the health system for services, and require different strategies. Trends advise planning for such strategies as well as resource allocation.

Patients by Age Group

Age Group	FY 1993 Patients	FY 2000 Patients	FY 2009 Patients
0-4	615	543	573
5-9	691	460	556
10-19	1,098	1,367	1,023
20-29	954	971	989
30-39	843	912	643
40-49	571	738	674
50-59	269	440	565
60-69	137	204	330
70-79	67	98	150
80+	28	40	57
TOTAL, Patients	**5,273**	**5,773**	**5,560**

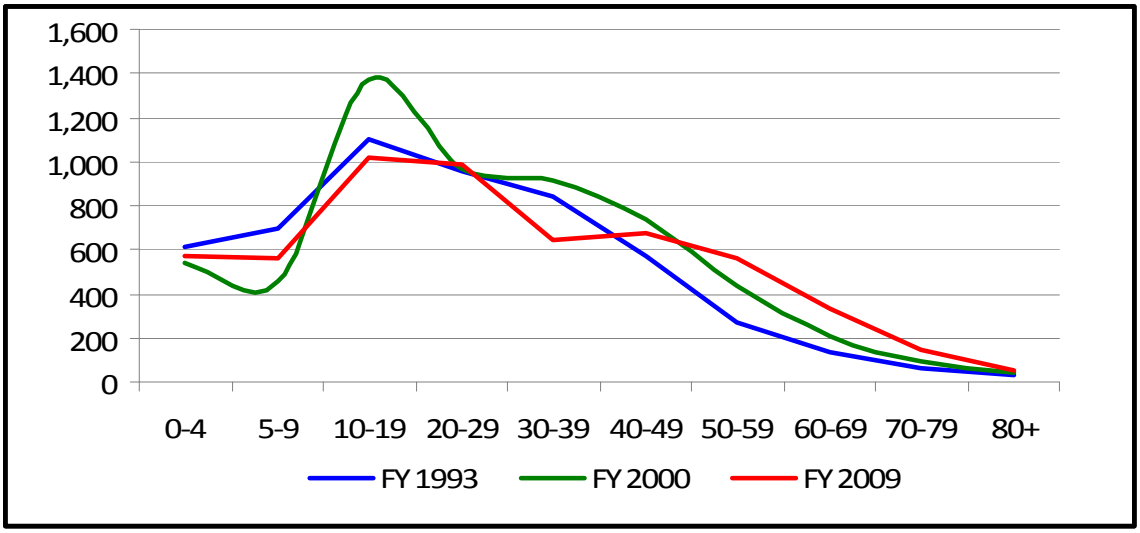


Figure 2-4

Interpretation: The graph reflects that the number of individuals in the over 40 age group has grown in proportion to the younger age groups over the past several years. Note: The major upwards adjustment in total patients bears further study and analysis.

Alternate Resource Eligibility

Purpose: To identify the availability of alternate resources for active patients and the corresponding trends. Active patients are displayed by billable and non-billable categories.

Relevance: The composition of our patient population with respect to alternate resources measured for two reasons; 1) Managed Care, as payer of last resort, is directly impacted by alternate resource availability, and 2) the ability to collect for services directly impacts total collections, which in turn are a significant financing source for the health delivery system.

Active Patients by Eligibility

Unduplicated Patient Counts

Billable	**FY 2007**	**FY 2008**	**FY 2009**
Medicaid Only:	1,118	1,241	1,340
Private Insurance Only:	1,383	1,398	1,436
Medicare A Only:	21	20	16
Medicare B Only:	-	-	-
Medicare Part A & B Only:	124	123	121
Medicare Part D:	184	188	176
Medicaid & Medicare:	22	18	32
Medicaid & Private Ins.:	138	145	181
Medicare & Private Ins.:	117	117	114
Medicaid, Medicare, & PI:	1	1	5
Total	3,108	3,251	3,421
Non-Billable*			
Tribal Employee Self-Insurance**	391	311	286
No Alternate Resource	2,932	2,983	2,737
Total	3,323	3,294	3,023
Total Patients	**6,431**	**6,545**	**6,444**

Figure 2-5

Interpretation: Over the past three years the number of patients with billable alternate resources has been slowly risings. Those with Tribal insurance (non-billable) also trended upwards. Those with no alternate resources seem to have dropped dramatically from 2008.

Tribal Member Births by Age of Mother

Purpose: To identify the changing trend in the age of mothers at the time of childbirth.

Relevance: Tracking total births is important for planning services and education efforts. Age of mother also identifies high risk patients that may require additional or special services.

Warm Springs Births by Age of Mother

Calendar Year	Age 14 & under	Age 15-19	Age 20-24	Age 25-29	Age 30-34	Age 35-44	Total Births
1996		22	20	17	7	7	73
1997		20	27	16	9	5	77
1998		14	23	14	12	7	70
1999		22	19	18	14	2	75
2000		16	20	17	9	6	68
2001							0
2002							0
2003							0
2004							0
2005							0
2006							0
2007							0
2008	0	30	39	21	10	7	108
2009	0	16	28	18	13	7	81
Total	**0**	**94**	**109**	**82**	**51**	**27**	**363**
% of Total	**0.0%**	**25.9%**	**30.0%**	**22.6%**	**14.0%**	**7.4%**	**100.0%**

Figure 2-6

Interpretation: Information reported through 2000 reflected a large portion of births to very young mothers. The information has not been updated or reported in a number of years. Efforts are underway to collect and update the recent information.

Birth Rate Comparison

Purpose: To compare the Warm Springs birth rate to that of the State of Oregon

Relevance: This information tracks the trend of birth rates.

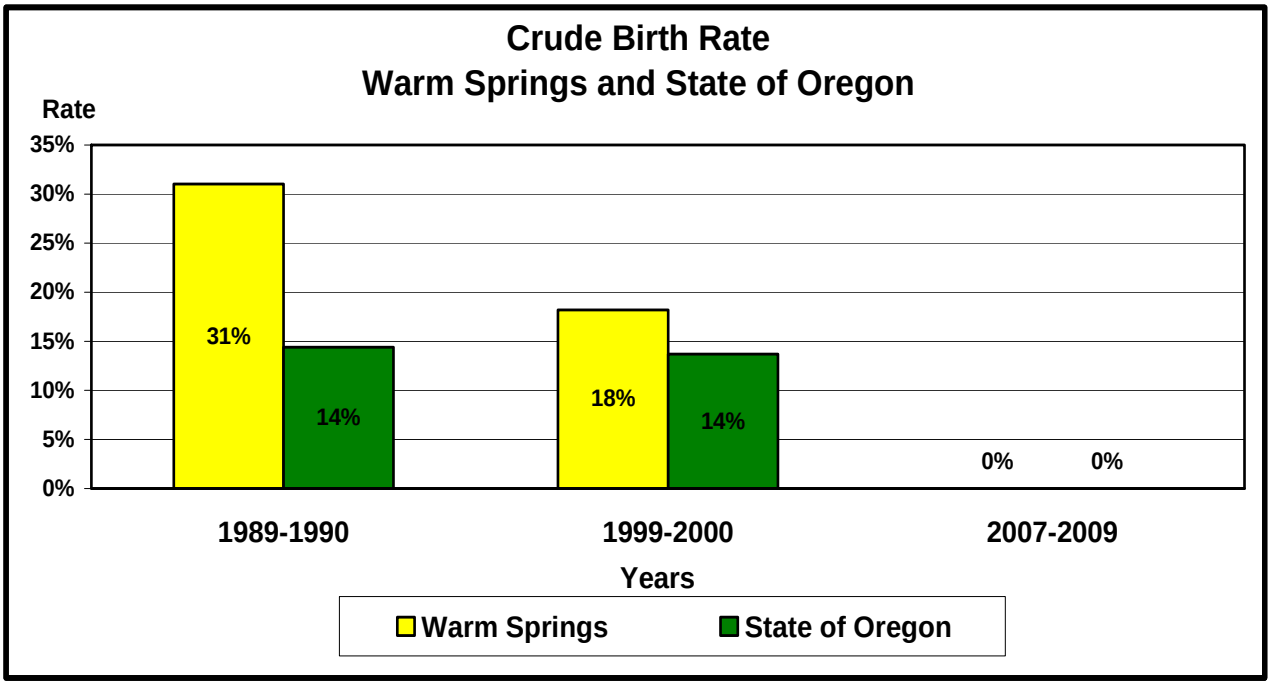


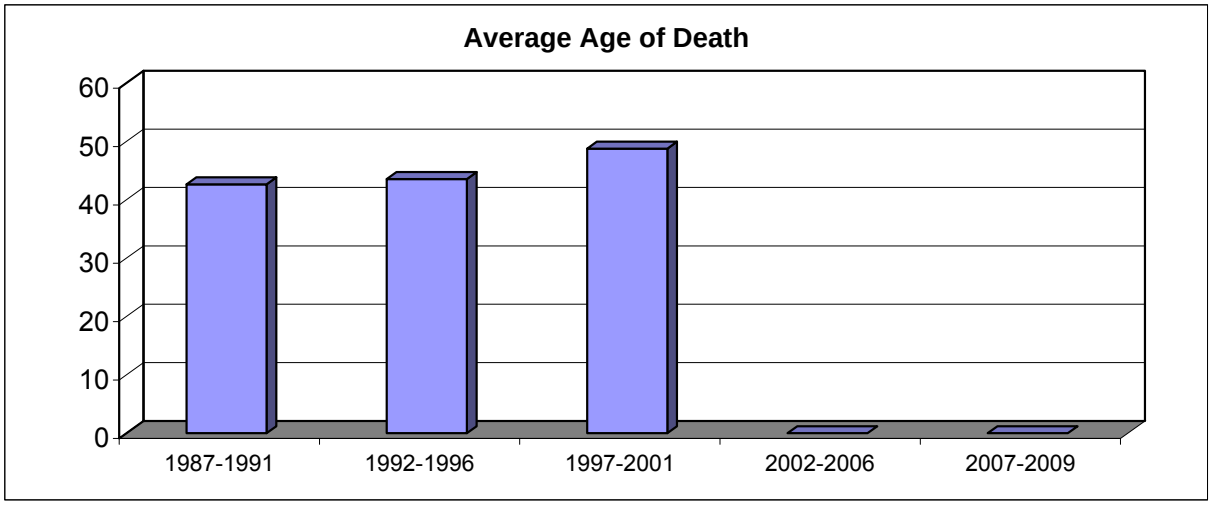
Figure 2-7

Interpretation: Past reports reflected a substantially higher birth rate at Warms Springs that the general Oregon population. The difference had reduced in the 2000 report. Recent data has not been reported but is expected to be available for subsequent reports.

Average Age of Death, Crude Death Rate and Years of Productive Life Lost

Purpose: To record and display the number of deaths each year and to relate this to the Tribal population to produce a rate. Years of productive life lost is a measure of premature death. Average age of death advises life expectancy of the population.

Relevance: Understanding the trends along with causation is important to understand how programs can impact on the outcomes, as well as forecasting changing needs as the population ages.



Crude Death Rates, Years of Productive Life Lost

	1989-1991	1992-1994	1995-1997	1998-2000	2001-2003	2004-2007	2008-2009
Number of Deaths	81	73	88	85			
Tribal Population	9,747	10,381	11,058	11,674			
Crude Death Rate	831	703	796	728			
Years of Productive Life Lost	**2,106**	**1,614**	**1,917**	**1,805**			

Figure 2-8

Interpretation: This report reflects a significant loss of life at earlier ages than is reflected in the general U.S. population. Research has not been updated recently, but is expected to be available for the 2010 report.

Child Mortality Rates

Purpose: To identify the trends in infant and child mortality.

Relevance: Infant and child mortality is a major factor in determining the health of a community and is helpful in designing intervention strategies to reduce incidence. Native populations have historically been concerned with high incidence of child mortality. Emphasis has been placed on this issue and resources increased to address it.

Child Mortality

	Infant: Less than 1 year	3 year Avg Rate per 1,000	Child: Ages 1-12	3 year Avg Rate per 1,000	Teen: Ages 13-17	3 year Avg Rate per 1,000
1990-1992	10	46.9	5	1.52	3	3.4
1993-1995	3	22.7	5	1.45	1	1
1996-1998	1	7.4	5	1.52	3	2.2
1999-2001	1	5.9	0	0	2	1.3
2002-2004						
2005-2007						

Leading Causes of Death from 1990 to 2007

Cause 1		#	%
Cause 2		#	%
Cause 3		#	%
All Other Causes		#	%
Total			

Figure 2-9

Interpretation: This report reflected significant improvement on infant mortality in the 1990 - 2000 year timeframe. However, reports were not prepared for more recent years. Information is expected to be available for future reports.

Cause of Death

Purpose: To identify trends in the leading causes of death over time.

Relevance: The Health System needs to be constantly aware of the leading causes of death, and in particular premature death, in order to design and implement effective health promotion and prevention efforts.

Number of Deaths by Cause Per Three-Year Period

		1989-1991	1992-1994	1995-1997	1998-2000	2001-2003	2004-2006	2009-2010
1	Heart/Stroke	15	16	31	16			11
2	Injuries							
	MVA	15	8	10	15			8
	Other	2	13	11	2			2
3	Suicide/Homicide	7	7	7	6			7
4	Cancer	3	3	3	6			4
5	Alcoholism	13	8	7	8			11
6	SIDS/Neonatal	11	1	1	3			1
7	Diabetes	5	6	5	2			2
8	Other	14	12	11	27			48
	Total	**85**	**74**	**86**	**85**	**0**	**0**	**94**

Figure 2-10

Interpretation: Information for years prior to 2000 reflected high loss of life to accidents and preventable causes. Analysis is currently being requested to provide information for the years 2001 through 2008. 2009 and 2010 current year information was provided for this report.

Prevalence of Major Chronic Diseases

Purpose: To highlight the prevalence of chronic disease by major condition.

Relevance: This information is vital to understanding the extent of each condition and the development of effective responses. Chronic diseases account for 70% of all deaths in the United States. The medical care costs of people with chronic diseases account for more than 75% of the nation's medical care costs. Chronic diseases account for one-third of the years of potential life lost before age 65.

Patients Identified with Chronic Disease in 2007 - 2009

Condition	FY 2000	FY 2007	FY 2008	FY 2009
Diabetes	365	538	551	568
Ischemic Heart Disease (IHD)	61	122	119	121
Hypertension 18-85 w/HTN DX	302	489	496	486
Asthma	149	243	209	225
Prediabetes/Metabolic Syndrome	89	792	847	883
Neoplasms		Not available at this time		
Rheumatoid Arthritis		Not available at this time		

Figure 2-11

Interpretation: In each of the disease categories reviewed, the numbers of patients with these chronic conditions has increased compared to a decade ago. The dramatic increases in pre-diabetes/metabolic syndrome likely reflect some degree of increased recognition as the Diabetes Program has been actively involved in the SDPI program for identifying and treating pre-diabetes over the past several years. Continued efforts at providing resources to more effectively address these chronic conditions will be critical in helping to effectively address these conditions and their impacts on our community.

Customer Diabetes Profile

Purpose: To identify the number of patients with the diagnosis by year, along with the number with an acceptable control of their blood sugar.

Relevance: Diabetes identification and control of blood sugar are essential to managing the progression of the disease and delaying or preventing the resulting damage to the health of the individual. Monitoring this group of patients, counseling and educational efforts can have a great impact on the health status of the patient and future health care costs to the program.

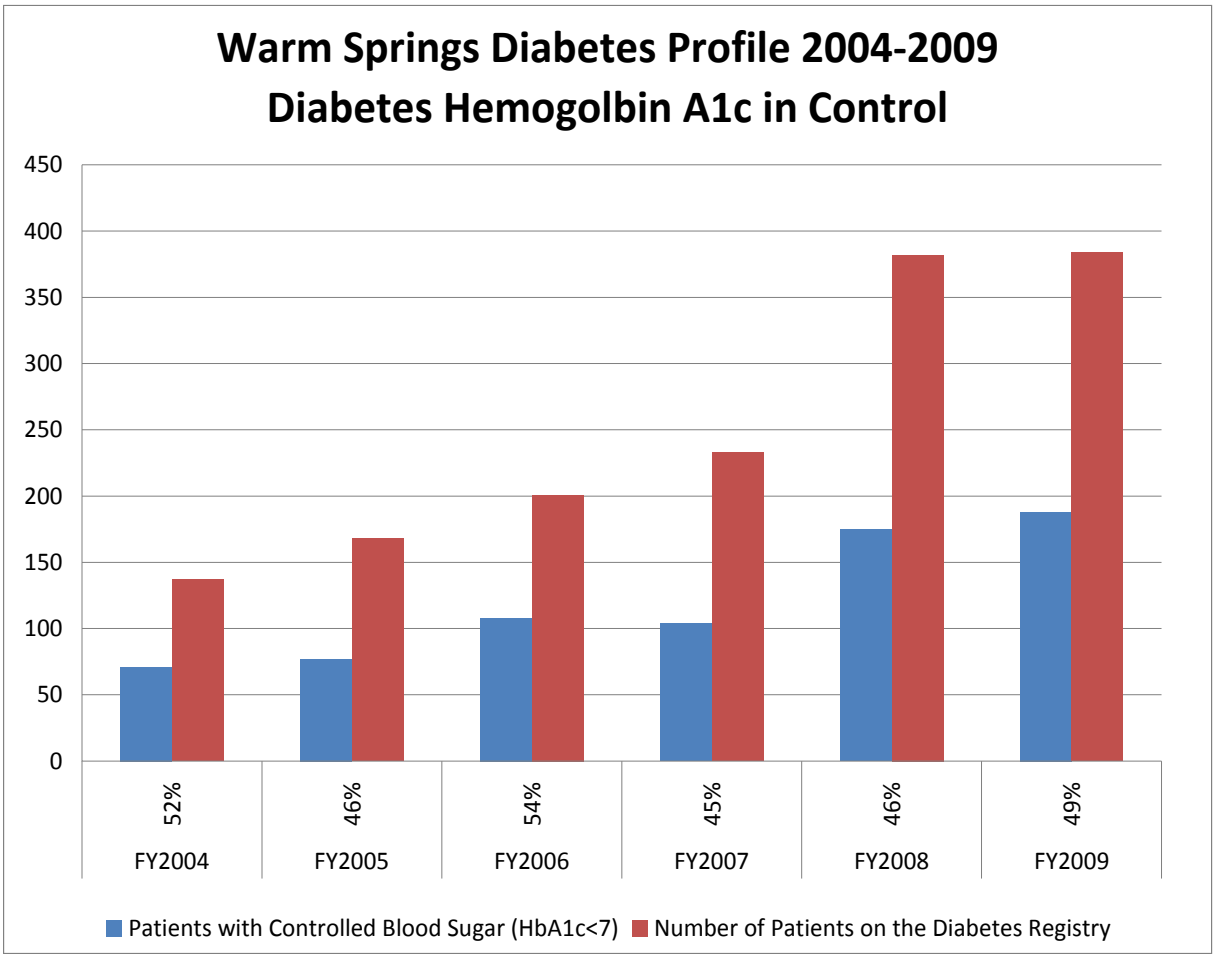


Figure 2-12

Interpretation: Approximately half of the patients listed in the DM Registry from 2004 to 2009 achieved the ideal A1c target level of less than 7 as reflected in the above chart in blue. The chart also reflects a significant increase in the number of patients that have been diagnosed with diabetes over the past two years, some of which is due to better surveillance of the population.

Hospitalization of Customers

Purpose: To ensure that the Health System is aware of hospitalization rates and causes and the associated trends.

Relevance: Hospitalization is a measure of morbidity pointing to serious breakdowns in individual health status, and is a major consumer of health resources. The Health System needs to respond to the causes of hospitalization and its financial impact.

Managed Care Financed Hospitalization
2008 - 2009

Inpatient Indicators	2008	2009
Total Admissions	200	204
Average Length of Stay	4.29	4.42
Total Hospital Days	858	901
Average Daily Patient Load	2.35	2.47
W.S. Hospitalization Rate per 1000		
U.S. Hospitalization Rate per 1000		
Emergency Room Visits	1,197	1,325
Emergency Room Admitted	N/A	N/A

Managed Care Hospitalizations and Those Paid by Other Resources
Warm Springs Patients by Primary Diagnosis
2009

Condition	Number of Admissions	% of Admissions	Number of Hospital Days	% of Hospital Days
Obstetrics	137	28.1%	262	17.1%
Motor Vehicle Accidents	11	2.3%	41	2.7%
Other Accidents/Injuries	23	4.7%	94	6.2%
Cancer	3	0.6%	12	0.8%
Heart and Circulatory	59	12.1%	253	16.6%
Respiratory	70	14.4%	202	13.2%
Renal	15	3.1%	55	3.6%
Digestive	81	16.6%	235	15.4%
Infectious Disease	2	0.4%	4	0.3%
Diabetes	9	1.8%	26	1.7%
Substance Abuse	24	4.9%	65	4.3%
Mental Health	7	1.4%	16	1.0%
All Other	46	9.4%	263	17.2%
TOTALS	**487**		**1528**	

Figure 2-13

Interpretation: The Figures in the top table of Figure 2-13 tie directly to the "Number of Warm Springs Patients hospitalized and the Total Hospital Days" for which Managed Care provided payment.

This data is important because it reflects the patients that the Managed Care Program paid for and is used to determine total inpatient costs and average costs per unit which can be found in another section of this report.

The information indicates a fairly consistent pattern for the years 2008 and 2009. There was on a 2% increase in admissions and a 5% increase in hospital days which was due to the slight increase in hospital days which was due to the slight increase in Average Length of Stay.

The second table (2009 only) includes patients that Managed Care provided payment as well as cases that were fully paid by another alternate resource. This suggests a significant dependence on the alternate resources (Oregon Health Plan/Medicaid, Medicare and Private Insurance). The Managed Care Program covered only 42% of the admissions and 59% of the hospital days for Warm Springs patients. If further restrictions in eligibility were imposed by the State, the Managed Care Program would experience am enormous financial problem. If individuals dropped health insurance a similar impact would be felt. It is critical that everyone in the Community understands the importance of fully utilizing these alternate resources for which they are eligible.

The total admissions and days by category and the percentages of each help us understand the extent of the problems. Reporting this information over time will further that understanding and enable the health care team to measure progress and redeploy resources to reduce the level of hospitalization.

Hospitals Utilized and Expenditures

Purpose: To determine the extent of hospitalization at the various facilities within the areas. This data includes only cases that Managed Care has spent resources.

Relevance: While this represents an incomplete picture of total hospitalization, highlights where Managed Care resources are being expended.

Hospitals Utilized
2009

Hospital	Admissions	Hospital Days	Total Cost $
Mountain View	148	590	$1,191,007
Redmond	5	16	$32,042
St. Charles	44	258	$697,001
OHSU	1	5	$10,193
All Other	6	32	$80,662
Totals	**204**	**901**	**$2,010,905**

Figure 2-14

Interpretation: This table reflects the total cost of hospitalization MCP paid for in 2009, and the number of admissions and hospital days that comprised this cost at four major hospitals utilized. Mountain View Hospital accounts for 60% of the total hospital costs, with St. Charles accounting for 35%.

Emergency Room Utilization

Purpose: Patient utilization of Emergency Room represents a high cost element of Managed Care. It is important to monitor utilization to determine how best to reduce the budget impact.

Relevance: Understanding the volume, cause and timing of Emergency Room Visits will provide insight as to what strategies might be employed to reduce usage.

EMERGENCY ROOM VISITS

	2009	2008	2007	2006	2005	2004
ALLERGIC REACT	6	2	5	12	10	13
CARDIOVASCULAR	59	52	28	54	34	32
CELLULITIS/INFECTIONS (impetigo)	48	36	33	63	29	21
CHRONIC CONDIT.	36	43	23	21	38	18
COMMUNICABLE DISEASE	2	4	0	2	0	0
DENTAL	14	10	22	26	23	27
DERMATOLOGY (includes spider bites)	21	18	28	24	36	33
DRUG/ALCOHOL	103	70	69	103	84	60
ENT (ear, nose, throat)	108	92	80	134	109	168
EYES	10	14	10	14	18	7
GI	113	133	82	127	137	144
GU	66	86	49	82	35	38
HEADACHES	43	44	43	47	49	69
MEDS ONLY / DRESSING CHGS	2	4	2	2	5	17
MISCELLANEOUS	73	53	45	46	54	36
NEUROLOGY	31	34	32	37	30	28
OB-GYN	12	13	10	6	41	6
ORTHOPEDIC (musculoskeletal)	178	177	158	188	225	209
PULMONARY	122	89	76	70	88	64
PSYCHIATRIC (MENTAL HEALTH)	22	13	15	24	6	18
SNAKE BITE	1	0	0	0	0	4
TRAUMA						
ASSAULT	17	19	38	21	22	46
GUNSHOTS	1	1	2	2	2	0
LACERATIONS/BURNS/CONTUSIONS/	185	143	162	183	153	87
MVA	12	17	5	7	15	20
POISONS (ingested/breathed)	2	6	9	4	2	0
DROWNING	0	0	0	1	0	0
POSSIBLE CHILD ABUSE	0	0	0	1	0	0
TRIAGE ONLY	4	0	0	0	0	0
VIRAL SYNDROME	39	17	7	7	30	16
VASCULAR (blood) - anemia/hem	7	7	1	7	3	0
TOTALS	**1,325**	**1,197**	**1,034**	**1,315**	**1,278**	**1,181**

NOTE: IN 2009 MVA'S ARE NOT COUNTED IN THE TOTAL, BUT THE PRINCIPAL DIAGNOSIS IS COUNTED.
AS AN EXAMPLE, BECAUSE THIS IS A DX CHART, PT MAY HAVE BEEN IN AN MVA AND
MAY HAVE A BROKEN LEG, AND WOULD THUS BEING COUNTED IN THE ORTHOPEDIC CATEGORY.

Figure 2-15

Interpretation: A closer look at purposes of ER visits indicates fairly stable patterns of use in 2009 compared to previous years. There has been a downward trend in visits related to assaults and MVA's There was an increase in visits for viral syndromes and pulmonary issues, possibly reflective of the impact of the 2009 H1N1 pandemic.

Emergency Room Utilization, Continued

EMERGENCY ROOM VISITS - TIMES / DAYS

	2009	2008	2007	2006	2005	2004
0800-2000,weekdays (8:00am-8:00pm)	413	290	289	359	339	271
2000-2400, weekdays (8:00pm-midnight)	193	268	161	212	201	196
2400-0800, weekdays (midnight-8:00am)	140	115	97	95	140	108
0800-1600, sat, sun (8:00am-4:00pm)	196	185	148	205	193	191
1600-2400, fri, sat, sun (4:00pm-midnight)	289	263	258	313	300	293
2400-0800, sat, sun, mon (midn-8:00am)	94	76	81	131	105	122
TOTALS	**1,325**	**1,197**	**1,034**	**1,315**	**1,278**	**1,181**

Figure 2-16

Interpretation: Emergency care is a critical component of the overall healthcare system. However, there has been a national trend towards increased utilization of emergency room services provided for what would be more appropriately cared for in ambulatory care settings. Historically, the Warm Springs Health & Wellness Center had previously provided a significant amount of emergency care during hours when the Clinic was open, filling a previous need when the Mountain View Hospital ER was covered by private physicians during the daytime hours. Now that this ER has permanent ER physician coverage, there has been a shift in having ambulances transport patients with medical emergencies directly to the MVH-ER, as the next appropriate level of care for those patients. These statistics support that trend in the past year, with increased ER visits on weekdays between 0800-2000 hrs. Overall, ER utilization has been stable and averaged 1,200 visits per year.

Major Community Health Risk Factors

Purpose: To highlight community health risk factor surveys most recently identified through behavioral risk factor surveys conducted in 2006.

Relevance: Behavioral risk factor survey is a scientific method of quantifying risks. The prevention orientation of the program requires on-going examination and program and strategy adjustments which relate to changes identified.

Health Risks Most Recently Identified:	Estimated % of Population Affected*
• Motor Vehicle Accidents	45.0%
• Tobacco Use	44.0%
• Alcohol and other Drug Use	45.0%
• Overweight/Obesity	75.0%
• Hypertension	24.5%
• Diabetes	18.6%
• High Cholesterol	21.7%
• Arthritis	26.4%
• Mental Health / Suicidal thought	14.0%
• Abuse (various)	30.0%
• Unintentional Injury	71.1%
Perceived Health Status: Poor	4.4%
Perceived Health Status: Fair	29.1%

Figure 2-17

***** 2006 – Behavioral Risk Factor Survey

Interpretation: All of the most prevalent risks identified can be reduced through lifestyle changes and other personal choices. Improvement in health status can be expected through reducing these risk factors.

SECTION 3

Services

How do we design and deliver high quality responsive health services?

The comprehensive health plan anticipates an ongoing review of services being provided and other information that will aid in understanding the deployment of resources to provide them. Workload measures aid in understanding how patients are accessing the health system.

This section describes the workload associated with each of the health care components. The workload is a function of patient demand and available staff. The information is useful to determine staffing priorities and what adjustments need to be made to better provide more access to services. The efficiency of various services can also be evaluated. For example, how well does the workload conform to the priorities identified by the Health Commission? How effective and efficient has been the extension of clinic hours? What is the impact of the clinic physicians continuing hospital practice? Missed appointments are also an important factor that must be monitored as they seriously impact the efficiency of operations.

A significant portion of program information has not been maintained for items to be reported. New reporting mandates are being implemented to assure that the needed information will be available to future reports.

This section indicates a continual upward trend in the number of most services, despite fairly constant staffing levels to provide the services. Review of workload measures and targets will be ongoing.

Medical Services

Purpose: To identify the Medical Program workload directly associated with patient contacts by provider category for each year and the associated trends.

Relevance: Workload measures are useful to describe overall program growth, plan resources – particularly personnel requirements. Two issues that must be decided relate to future hospital inpatient care and extended hours of operation.

Medical Department

	FY2005	FY2006	FY2007	FY2008	FY2009
Medical Visits by Provider					
Physicians	9,828	11,147	10,788	8,511	11,412
Mid Level Practitioners	4,452	1,875	1,569	5,166	3,772
Nursing Staff	6,570	6,990	5,759	5,013	4,604
Total Medical Visits	**20,850**	**20,012**	**18,116**	**18,690**	**19,788**
Workload Factors					
Clinic Days	250	250	250	250	250
Average Visits Per Clinic Day	83	80	72	75	79
Total FTE's In Medical Department	21	21	21	21	21
Physician FTE's	5	5	4.75	4.25	5.5
Mid-Level Practitioner FTE's	2	1	1	2	2
Avg Annual Visits Per FTE	993	953	863	890	942
Avg Annual Visits Per Physician FTE	1,966	2,229	2,271	2,003	2,075
Avg Annual Visits Per Mid-Level FTE	2,226	1,875	1,569	2,583	1,886
Extended Hours of Service					
Days of Late Clinic	209	199	167	118	175
Hours of Service (M-Th, 7pm)	418	398	334	236	350
Visits	1,054	811	582	458	692
Visits Per Hour of Service	2.5	2.0	1.7	1.9	2.0
Hospital Patient Count	519	514	461	455	478
Hospital Visit Count	1,866	1,955	1,780	1,869	1,988
Average Hospital visits per patient	3.6	3.8	3.9	4.1	4.2
Average Hospital patients per day	1.4	1.4	1.3	1.2	1.3
Average Hospital visits per day	5.1	5.4	4.9	5.1	5.4

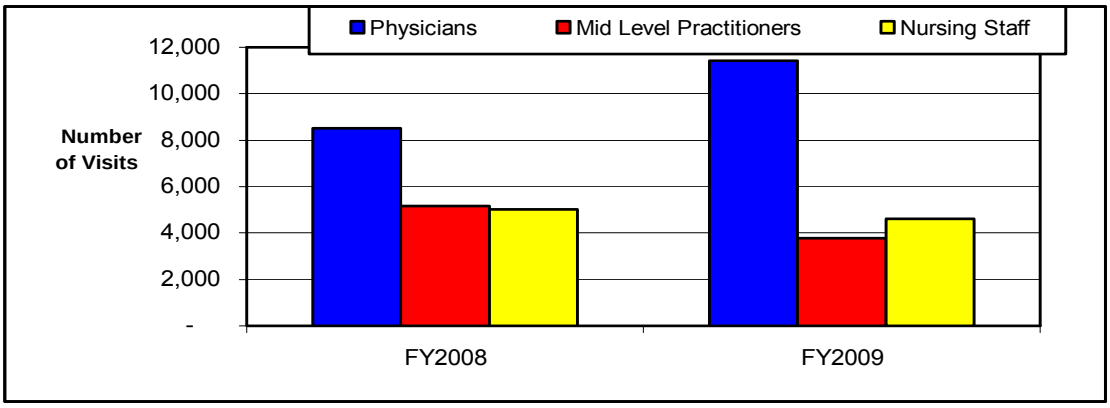


Figure 3-1

Continued on next page

Medical Services, Continued…

Interpretation: From 2005 to 2009, the medical department averaged 19,491 medical visits per year. Of those visits; 10,337 of those were physician visits, 3,367 were seen by mid-level providers, and 5,787 were nursing visits. The average number of visits per day was 78 over a 250 day time-span. There is an average of 21 FTE's in the medical department including five physicians and two mid-level providers. Each FTE physician had an average of 2,109 visits per year and each FTE mid-level provider had an average of 2,028 visits per year. FTE physicians had approximately 3.8% more visits per year than mid-level providers.

There was an average of 174 days when the clinic was open late for extended hours and during those times, the late clinic averaged two medical visits per hour. The average number of medical visits during late clinic has been less than three per hour from 2005 to 2009 with the highest amount, 2.5 visits per hour, in 2005 and the lowest, 1.7 visits per hour, in 2007. Notably, 2007 was the year when there was the least amount of providers in the clinic.

Additionally, there were about 485 patients per year that visited the hospital an average of 3.9 times each for a total of 1,892 hospital visits per year between 2005 and 2009. Average hospital visits per day have remained at approximately 5 visits per day during this five year timeframe.

Dental Services

Purpose: To identify the Dental Program workload by provider category. For each year, to determine the impact of broken appointments, to identify the categories of care provided.

Relevance: Workload measures are useful to describe overall program growth and plan resources – particularly personnel requirements. Broken appointments represent a loss of resource capability and waste of health resources. The categories of care describe the patient service needs.

Dental Department

	2005	2006	2007	2008	2009
Dental Visits by Provider					
Dentist Visits	6,949	5,854	5,350	5,402	Not able to obtain See Note below
Hygienist Visits	1,217	970	867	1,075	
Total Dental Visits	**8,166**	**6,824**	**6,217**	6477	
Missed Appointments					
No Shows (Broken Appointments)	409	2,036	1,421	No reliable data	
Broken Appointments vs Total Visits	5	30	23	No reliable data	
Treatment Plans Completed					
Patients Completing Treatment	578	239	147	141	
Completed Treatment/1st Visits	21.5%	9.5%	5.8%	5.70%	
Workload Factors					
Clinic Days	250	250	250	250	
Average Visits Per Clinic Day	33	27	25	26	
Total FTE's	14	13	13	13	
Average Annual Visits Per FTE	587	529	497	491	
Extended Hours of Service					
Hours of Service	2,000	2,000	2,000	2,000	
Visits	8,166	6,824	6,217	6,477	
Visits Per Hour of Service	4.08	3.41	3.11	3.23	
Categories of Care					
Preventive	7,287	6,195	5,988	7,719	
Restorative including Crowns	4,145	2,820	2,407	3,039	
Dentures including Bridges	296	144	87	123	
Surgical	1,358	1,290	1,104	1,213	
Orthodontic	41	41	38	37	
Endodontic	260	145	71	92	
Other	6,460	5,268	4,551	unknown	
Total Identified Problems Treated	19,847	15,903	14,246		

Figure 3-2

Interpretation: Unable to get the 2009 data as the IHS moved to a Dental E.H.R. System.

Pharmacy Services

Purpose: To identify the Pharmacy Program workload.

Relevance: Workload measures are useful to describe overall program growth and plan resources - both personnel and drug costs. If possible determination of the number of prescriptions provided to patients residing outside the service area may be important.

Pharmacy

Prescriptions Filled	2005	2006	2007	2008	2009
New Prescriptions	47,788	48,499	46,359	47,689	48,297
Refills	17,472	17,948	20,062	21,891	24,659
Total Prescriptions	**65,260**	**66,447**	**66,421**	**69,580**	**72,956**
Workload Factors					
Clinic Days	255	249	261	250	249
Avg Prescriptions per Clinic Day	256	267	254	278	293
Visits to the Pharmacy	28,847	28,219	28,356	29,769	30,245
Prescriptions per Pharmacy Visit	2.26	2.35	2.34	2.34	2.41
Total FTE's	7	7	7	7	6
Avg Annual Prescriptions Per FTE	9,323	9,492	9,626	9,940	12,159
Pharmaceuticals					
Total Expenses				$ 741,282	$ 772,273
Avg Cost Per Perscription	0.00	0.00	0.00	$ 10.65	$ 10.59
Rx for Patients outside Service Area				Unavailable	Unavailable

Figure 3-3

Interpretation:

Workload in FY2009 as compared to FY2008 is up 4.9% in the number of prescriptions filled. The number of prescriptions per day has increased by 5.3%. As we did not have a resident in FY 2009 and FY 2010 (the resident helps staff the pharmacy half of each workday and does the residency rotation the other half of the day), the average number of prescriptions per FTE increased 22.3%. There was also a 3% increase in the number of prescriptions per patient. This increase is likely due to 2 causes:

1) The FDA restricted use of over-the-counter (OTC) products in children under 4 years of age. This required the pharmacy staff to ask parents of these younger children who were seeking cough and cold products other than acetaminophen or saline drops to consult a provider.

2) In January of 2009, the P&T committee limited the products that were available at the clinic as OTC. Several products that are available OTC in the stores, now require a prescription at our clinic.

Drug costs as compared to FY2008 have remained stable. The pharmacy staff is vigilant in looking for the best contract price available for each drug product.

Workload as compared to 5 years ago has increased by 11.8% in the number of prescriptions filled. The number of prescriptions filled per day is up 14.4%. Not only has the number of prescriptions increased significantly, but the pharmacy has added additional value-added services over the 5-year period that includes a pharmacy-run hypertension clinic, a pharmacy-run alcohol abstinence clinic and an adult immunization service. These additional services have been added with no additional increase in staff and no additional automation. No further increase in pharmacy-run clinics is expected in the near future as we feel the current staffing package is at the safest maximum capacity that we can handle at this time.

Diagnostic Services

Purpose: To identify the workload associated with the diagnostic services (X-Ray and Medical Laboratory).

Relevance: Workload measures are useful to describe the overall program growth and plan resources for personnel and supplies necessary.

Diagnostic Services - X-Ray

	2005	2006	2007	2008	2009
Imaging Exams					
X-Ray Exams	2,012	1,923	1,825	1,641	1,796
Ultrasound Exams	140	132	-	-	-
Total Exams	2,152	2,055	1,825	1,641	1,796
Workload Factors					
Clinic Days	250	250	250	250	250
Average Exams per Clinic Day	9	8	7	7	7
Average Exams per Year	2,152	2,055	1,825	1,641	1,796
Total Patients	2,216	2,081	1,668	1,531	1,693
Average Exam per Patient	1.0	1.0	1.1	1.1	1.1
Total PCPV's	11,873	15,454	13,038	14,387	12,747
Average Exams per PCPV	0.18	0.13	0.14	0.11	0.14
Total FTE's	1.0	1.0	1.0	1.2	1.25
Exams per FTE	2,152	2,055	1,825	1,368	1,437

Figure 3-4

Diagnostic Services, Continued…

Diagnostic Services - Medical Laboratory

	2005	2006	2007	2008	2009
Medical Lab Tests					
Tests collected in the Lab	83,580	87,301	88,555	n/a	89,820
Tests collected outside the Lab	4,800	5,100	5,435	n/a	3,617
Tests performed off-site	1,620	2,549	2,925	n/a	5,778
Total Lab Tests Ordered	**90,000**	**94,950**	**96,915**	**n/a**	**99,215**
Workload Factors					
Clinic Days	250	250	250	250	250
Tests Ordered per Clinic Day	360	380	388	n/a	397
Total Medical Visits	20,850	20,012	18,116	18,690	19,788
Average Tests per Visit	4.3	4.7	5.3	n/a	5.0
Total FTE's	5	5	5	4	4
Tests per FTE	18,000	18,990	19,383	n/a	24,804
Category of Tests Ordered					
Hematology	23,376	21,045	16,476	n/a	30,221
Chemistry	54,212	64,709	68,874	n/a	63,164
Bacteriology	6,808	3,508	2,892	n/a	1,404
Urinalysis	5,604	5,688	5,748	n/a	4,426
Total Lab Tests Ordered	**90,000**	**94,950**	**96,915**	**n/a**	**99,215**

Figure 3-5

Source:
RPMS Data: Count Accessioned Tests
Quest Laboratories

Interpretation: The Diagnostic Services – Medical Laboratory table asks for information that is contained in the RPMS server. We generate these statistics from the workload lists. Unfortunately, RPMS does not go back far enough to cover 2008. The information is contained, of course, in the medical record but not in a way that is amenable to mining laboratory statistics.

The overall numbers that are listed show an approximate increase in the test counts of 4%/year. This increase has occurred in spite of the fact that staff shortages have occurred in the medical and laboratory departments. A quick perusal of the 2010 statistics indicates that this trend will continue.

Optometry Services

Purpose: To identify the Optometry Program workload for each year. To determine the impact of broken appointments. To identify the categories of care provided.

Relevance: Workload measures are useful to describe the overall program growth and plan resources accordingly. Broken appointments represent a loss of resource capability and a waste of health resources.

Optometry Department

	FY2005	FY2006	FY2007	FY2008	FY2009
Optometry Visits					
Clinic Visits	1,643	1,612	1,733	1,595	1,796
Missed Appointment Rate	37%	33%	32%	28%	23%
Workload Factors					
Clinic Days	220	220	220	220	220
Average Visits per Clinic Day	7	7	8	7	8
Total FTE's**	2	2	2	2	2
Nature of Visits					
Refractions	701	825	944	762	835
Diabetic Eye Exam (Patients)*	221	229	201	233	188
Contact Lens Visit	51	86	145	107	111
Early Childhood Education Visits	38	35	47	27	32
Glasses Repair/Adjustment	253	139	245	354	383

* includes JVN

** 1 -Optometrist, 1 -Assistant

Figure 3-6

Interpretation: The optometry department continues to see slight an increase in the number of patient visits from year to year even without the services of a fourth year Optometry student.

The rate of patients who do not keep appointment s has decreased by 14% since 2005.

The number of diabetic patients seen in the clinic is down from prior years even despite enhanced attempts to get them in.

All other categories of Optometric services have increased over the years except for the number of staff providing these services.

Managed Care Program

Purpose: To identify workload of the Managed Care Program.

Relevance: To assure effective processing and management of resources.

	2006	2007	2008	2009
Staffing & Other Workload				
FTEs	7	7	7	7
Number of Obligations	6,120	5,022	7,162	9,089
Funds Obligated	$5,049,015	$3,447,984	$3,875,173	$4,917,407
Number of Provider Contracts	0	0	0	0
Amount of Obligations Under Provider Contract	0	0	0	0

Figure 3-7

Interpretation: Once the Managed Care Program was able to obtain Medicare Rates it lessened the need for Hospital Contracts. Those Medicare rates reduced the cost per day considerably once it was implemented. The Managed Care Program has information as to the savings that resulted.

Community Health Nursing Services

Purpose: To identify the workload associated with the Community Health Nursing Program.

Relevance: Workload measures are needed to assess program growth, personnel requirements and efficiency.

Community Health Nursing Services

	2005	2006	2007	2008	2009
Public Health Nurse Visits					
Total Contacts	3,359	1,844	3,208	1,072	1,097
Workload Factors					
Clinic Days	250	250	250	250	250
Average Visits per Clinic Day	13.4	7.4	12.8	4.3	4.4
Total FTE's	4	5	3	5	2
Average Visits Per FTE per Year	840	369	1,069	214	549

Figure 3-8

Interpretation:

Maternal and Child Health (MCH) Program

Purpose: To identify the number of births and those to tribal members. To determine the number of high risk pregnancies and high risk infants. To identify the workload of the program.

Relevance: The MCH Program workload is directly related to number of pregnancies and births and especially those identified as high risk.

Maternal and Child Health (MCH)

	2008	2009
Total number of births	107	83
Total number of births (Tribal members)		
Number of high risk pregnancies	31	20
Number of high risk infants identified*	29	33
Post-Partum Home Visits	98	78
Other Home Visits		
Number of hospital visits		
Number of birthing classes and number of participants		
Number of well-child clinics and number of visits		
Immunization levels		

Figure 3-9

* Born pre-mature, low birth weight, congenital defects, multiple births, transferred infant to high-level care facility, exposure en uteri to toxins such as drugs, alcohol, tobacco and infants born in facilities other than Mt. View Hospital.born in facilities other than Mt. View Hospital.

Interpretation:

Community Health Representative

Purpose: To identify the caseload and workload by category for the CHR program.

Relevance: The CHR Program is an important liaison between the health delivery system and the community. As priorities shift within the health system the CHR program priorities should shift as well.

Community Health Representative

	2008	2009
Caseload by category:		
- Transports	63	95
- Patient Care	100	432
- Case Findings/Screening	112	471
- Monitoring Patient	43	339
- Case Management	51	188
- Health Education	7	36
- Other	23	110
Total Client Encounters	**399**	**1,671**

Figure 3-10

Interpretation:

Health Education

Purpose: To provide an overall assessment of the progress on health goals and objectives. To identify major health promotion activities and number of participants.

Relevance:

Health Education

	2009	2010
Report of progress on health goals and priorities		
Activities and number of participants		
Positions have been vacant; Need to identify workload factors		
-		
-		
-		
-		

Figure 3-11

Interpretation: Position recently filled – Critical workload factors will be identified soon and reported in the future.

Diabetes Program Services

Purpose: To identify the workload by category associated with the diabetes program.

Relevance: The extent of the diabetes problem requires special attention and the workload demand assessed to determine if appropriate level of resources are devoted to this problem.

Diabetes Program

	2007	2008	2009
Diabetes Program Visits			
Clinical Visits (FNP & RN-all visits)	1,679	1,792	1,501
Community Encounters	1,922	1,882	2,433
Total Visits	**3,601**	**3,674**	**3,934**
Workload Factors			
Clinic Days	250	250	250
Average Visits per Clinic Day	14.4	14.7	15.7
Total FTE's	4.0	4.0	5.0
Average Visits Per FTE	900	919	787
Categories of Service			
General Diabetes Clinic Contacts			
Special Diabetes Clinic Contacts			
Education Contacts	899	769	753
Community Contacts	1,922	1,822	2,433
Patients in Dialysis			
Number of Patients	8	10	11

Figure 3-12

Interpretation:

1. 2009 clinical visit data reflects decrease in staff 8/2009 – 5/2010 (FTE's for 2009 reflects Jan-July + administrative secretary).
2. 2009 data shows community contacts remain high regardless of decrease in Diabetes Program staff.
3. Categories of service unclear – visits are coded with the general clinic code 01, 06 code is not currently used.
4. 2009 Education contacts decreased with loss of Diabetes Nurse Educator and position being vacant.
5. Dialysis statistics below projections
   - Number remains stable regardless of increase in patients in I.H.S. Diabetes Register and number of patients with CKD.

Women and Infant Children (WIC) (# of Clients)

Purpose: To identify the caseload for the WIC program.

Relevance: The growth of the WIC program reflects on many other health services and there is a need for coordination.

Women and Infant Children (WIC)

	2008	2009
Infants and children under 5 years of age	537	538
Pregnant, breastfeeding and postpartum women	214	198
Total number of Women, Infants and Children served	**751**	**736**

Figure 3-13

Interpretation:

Prevention Health Education Team Alcohol Program

Purpose: To identify the activities and the associated number of participants involved.

Relevance: There is a need to measure the workload and level of community participation for all prevention activities.

Prevention Activities:	Number of Participants 2008	2009
Program		
Cancer		
Women's Health		
Women's Health Retreat		100
(Candle Light Service, Women's		65
Women's Health Fair		100
Women of Wellness (Education)		540
Fetal Alcohol Spectrum Disorder		
FASD Training - Diane Malbin		80
FASD Training Part 2		80
Health and Wellness		
Honoring the Gift of Heart/Health		30
H1N1 Outreach		1,000
Pi-umh-sha Health Fair		800
Men's Health Fair		5
Cultural Prevention		
Drum Making for Men and Boys		20
Jingle Dress Making		60
HIV/ Aides		
World Aids Day		25
Oregon Indian Education meeting		30
Alcohol and Drug Prevention		
Back to School BBQ		500
Back to Boards		20
METH Conference		90
Gang Prevention Conference		120
Girl's Club		25
Lil Miss Warm Springs Pageant		40
Smoking cessation class		25
Tobacco		
Seeds of Discovery		375
Great American Smoke-Out		100

Figure 3-14

Continued on next page

Prevention Health Education Team Alcohol Program, Continued…

Interpretation: Data not available for 2008; program change and updated categories for 2009. The Community Health Education Team (CHET) has had many supervisors over the last three years which has made it difficult to find data reports prior to 2009. However, many of the larger events such as the health fairs and the Back to School Barbeque have been going on for many years and CHET has always participated. It can be assumed that the numbers attending were similar within one or two hundred. The Women of Wellness Program which has met every month for the last ten years had similar numbers.

In fiscal year 2009-10 CHET (now being renamed to PHET (Prevention Health Education Team) has been entering demographic data from all team activities into the State of Oregon's Management Data system. This will allow us to compare and contrast number of people served, age and sex, and type of prevention activity. The system also can create charts and graphs from the data.

Mental Health

Purpose: To identify the caseload and number of visits by category and by age of patient and alternate resources. To identify collections billed and received. To determine the value and cost of those services.

Relevance: Understanding patient demand and workload is necessary to determine staffing and resource allocation. Every program must capture the full potential of its collection capability.

Mental Health

	2007	2008	2009
Mental Health Visits			
Number of Patients Seen			
Total Number of Adult Visits		1,003	1,602
Total Number of Child / Adolescent Visits		1,254	1,076
Psychiatric Evaluations & Medical Mgmt.		291	358
Number of Clinic Days			
Average Visits per Clinic Day			
Categories of Service			
Alcohol / Drug			
Depression			
Suicide			
Abuse Issues			
Adolescent Resource Care		19	9
Parenting Classes		239	200

Figure 3-15

* In 2009, Child/Adolescent visits due to 6 months down one therapist.
* In 2009, Psychiatrist visits up due to new doctor also sees children and adolescents.

Interpretation:

Alcohol & Substance Abuse

Purpose: To identify the extent of the substance abuse problem and the workload response by activity age group of patient. To determine collection effectiveness (visits billed and collected by alternate resource.

Relevance: Substance abuse represents a significant health risk to the Warm Springs community. Resources are small in proportion to the size of the problem and therefore efficiency of effort is critical. The collection potential must be fully developed to sustain and enhance the operation of the program.

Alcohol and Substance Abuse

	2007	2008	2009
Adult Encounters		2,049	2,409
Number of Visits*			
Number of Clinic Days			
Average Visits per Clinic Day			
Categories of Service			
Alcohol Abuse			
Drug Abuse			
Residential Care		25	37
Follow Up Rehabilitation Cases			
Family Counseling			
Sobriety Success			
List Others			

Figure 3-16

*	A&D Prevention B-Ball (Adults & Kids)	300+	*400+*
*	Jail Groups (estimate)	216	Unknown
*	Relapse Anger Resolution gap (Estimate) Quarterly	75	*75*
*	Healing from Grief & Trauma - 1 day conf.		*25*
*	Recovery Month Dinner		100+
*	Community Grief/Trauma Gathering		90+

Interpretation:

Adolescent Aftercare

Purpose:

Relevance:

Adolescent Aftercare

	2007	2008	2009
Outpatient Visits		231	465
Number of Clients In			
Residential Care		19	11
Suicide Prevention Camp		20	50
Healing Wounded Spirits Camp		103	-
Movie Nights (started Dec 2009, families)		-	2 nights/47
Wii Bowling Tournaments (Dec 2009)		-	4
Hoop Camp (Dec 2009)		-	52

Figure 3-17

Interpretation:

Ambulance Services

Purpose: To identify the workload by category of incident. To identify the effectiveness of the collection effort (patients with alternate resources, total billed, total collected).

Relevance: Ambulance services are expensive but necessary in the Warm Springs community. Understanding the causes of these transports can signal needed health promotion campaigns (i.e. seat belt use). Patients serviced by alternate resource measurers collection potential of this enterprise.

Ambulance Activity Summary

SUMMARY OF ACTIVITY

Reason for Call	Calls		Patients Transported		Calls w/Substance Factor	
	2008	2009	2008	2009	2008	2009
Motor Vehicle Accident	78	128	24	81	57	13
Other Accident	416	558	115	178	101	145
Assault and Battery	92	161	142	45	56	72
Suicides/Attempts	27	24	2	17	4	9
Corrections	222	246	54	45	16	92
Pediatric	117	124	31	25		
Cardiac	86	91	26	53		10
Respiratory	101	121	24	41	69	4
Other Illness	684	773	155	87		
Substance	247					
Total	**2,070**	**2,226**	**573**	**572**	**303**	**345**

TRIBAL AFFILIATION RELATED TO CALLS

Reason for Call	Calls Dispatched		Patients Transported		Calls w/Substance Factor	
	2008	2009	2008	2009	2008	2009
Members and Dependents	1,284	1,147	429	435	303	343
Other Eligible Indian			23	26		
Non Tribal	190	130	121	111		2
Total	**1,474**	**1,277**	**573**	**572**	**303**	**345**

Figure 3-18

Interpretation: Transports may at times be transferred to other ambulance provider between Warm Springs and destination hospital. Calls with substance factor include only those for which substance factor is verified, and does not include those where substance factors are suspected but cannot be verified.

Summary of Grants (Their Purpose etc.)

Purpose:

Relevance:

Diabetes Grant (Tribe)

State Women, Infants and Children (WIC)

Woman's Wellness Conference

CHET Dental Project

Senior Fitness Enhancement

Tobacco Pilot Site

State Tobacco Prevention

USDA Commodity Warehouse

State Alcohol & Drug

State Alcohol Prevention

State Mental Health

State Youth Suicide Prevention

Vocational Rehabilitation

Social Services Disability

Meth Prevention Project

Interpretation: Data to be available for subsequent reports.

SECTION 4

Resource Availability and Use

How do we deploy and maximize resources toward a healthier community?

This section provides an overview of all the resources that have been devoted to the provision of health care including Indian Health Service, State of Oregon, awarded grants and those resources allocated by the Warm Springs Tribe. The resources are compared to the national medical inflation factors to determine our status. The information also identifies expenditures by program. Detailed history of collected revenue is captured by year and by program. Since almost one quarter of all health care resources are absorbed by Managed Care, it is important that the system continue to monitor total costs and unit costs of all those services that are purchased. The staffing levels of each program are identified and further reviewed to determine the extent of tribal member employees. An accounting of carryover funds and reserves is also maintained.

The vast majority of the resources that are provided annually are associated with ongoing programs and services, leaving only limited resources to add new services or address special needs. Implementing the comprehensive health plan anticipates a careful examination of resources and careful priority setting for available resources. This section highlights the available resources for the past several years, as well as the spending patterns.

Resources that are not expended in a given year are, for the most part, available to the subsequent year. Some, but not all, may be available to re-allocate to other purposes.

This section also indicates that federal funding has lagged medical inflation for many years. Purchasing power is diminished when this happens. An increase in 2009 and another anticipated in 2010 have helped to close this gap. However, the federal budget deficit will place pressure on federal budgets for many years to come.

Health System Funding by Major Source

Purpose: To provide a complete picture of all funding available to the overall health system to serve the community.

Relevance: The Health Programs rely on funding from several sources, many of which the health system has little control. While the historical viewpoint is important, the current funding is most useful for addressing planning and priorities.

Health System Funding by Major Source

	2006	2007	2008	2009
Indian Health Service				
Recurring Funding	12,454,591	12,883,003	13,340,464	13,995,065
Non-Recurring Funding	368,971	1,339,696	982,431	1,350,517
Collections IHS				
Medicare	141,850	230,133	227,606	231,819
Medicaid	2,544,845	1,967,963	2,196,249	1,809,197
Private Insurance	664,213	563,197	520,907	443,555
Collections Tribe				
Ambulance	*	*	120,878	199,242
Community Counseling	262,143	313,129	308,736	201,524
Grant Awards	1,188,305	1,528,653	659,064	1,303,029
Tribal Employee Group Insurance (Est)	614,877	733,071	1,233,674	1,260,238
Tribal Appropriations	1,165,104	1,023,197	933,387	1,160,988
Total	$19,404,900	$20,582,041	$20,523,396	$21,955,174

* Information not available

Figure 4-1

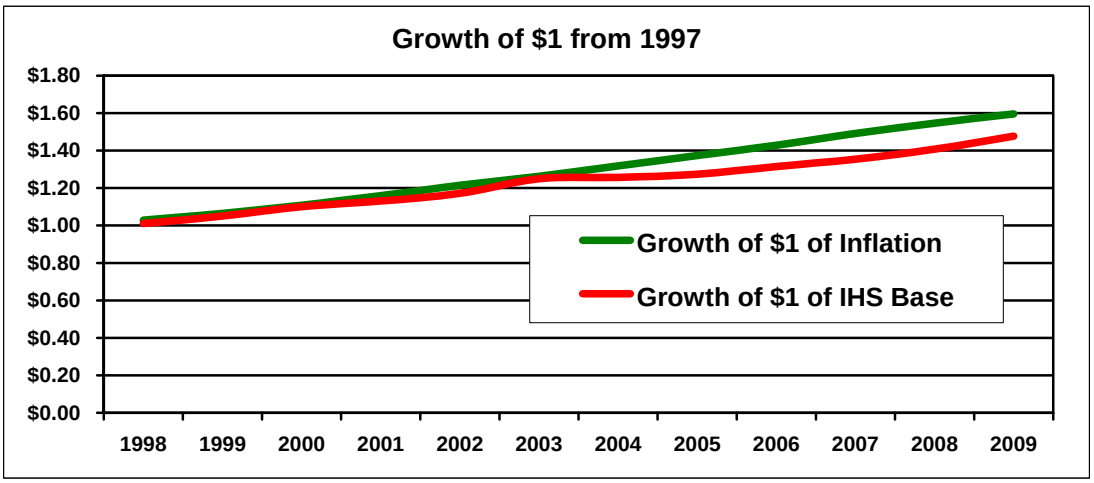
Interpretation: Funding tends to be stable supported by recurring appropriations, but increased population and medical inflation are ongoing concerns. Another key issue to watch will be the impact of Oregon State budget deficit issues on Medicaid collections in coming years. The Indian Health Service budget received healthy increases in FY 2009 and 2010, but it is expected that future years will be constrained by deficit reduction efforts in the U.S. Congress.

Base Health System Funding Versus Inflation

Purpose: To identify the historical Indian Health Service recurring funding base and to compare it with medical inflation.

Relevance: Measuring the purchasing power of ongoing resources is vital to addressing resource allocation and priorities. While there are numerous other resources the Indian Health Service recurring funding base represents the only source derived directly from the federal obligation that is adjusted for inflation.

	Annual IHS Base Funding	Base Increase	Medical Inflation
1998	9,570,435	1.0%	2.9%
1999	9,955,164	4.0%	3.5%
2000	10,428,865	4.8%	4.1%
2001	10,716,132	2.8%	4.6%
2002	11,102,601	3.6%	4.7%
2003	11,836,295	6.6%	4.0%
2004	11,914,200	0.7%	4.4%
2005	12,072,614	1.3%	4.2%
2006	12,454,591	3.2%	4.0%
2007	12,833,003	3.0%	4.4%
2008	13,340,464	4.0%	3.7%
2009	13,995,065	4.9%	3.2%



Note: Medical inflation is the U.S. Department of Labor, Bureau of Labor Statistics Composite index for all medical categories

Figure 4-2

Interpretation: The erosion of purchasing power is evident in the disparity between the health system funding base and inflation, a loss of purchasing power of 12% over the period. This does not take population growth into account, with over 20% increase over the same period. A continuation of this pattern requires ongoing evaluation of program effectiveness and productivity.

Health System Spending by Program

Purpose: To report actual outlays by each program as well as overall carryover and savings.

Relevance: Important to understand, plan and adjust resource allocation to meet the changing health system priorities.

	2008	2009
Clinical Services		
Medical	1,929,661	3,094,316
Dental	998,027	1,281,141
Optometry	238,015	196,034
Pharmacy	1,902,709	1,623,812
Podiatry	186,125	160,460
Medical Lab/X-Ray	341,988	570,217
Diabetes - Clinic	117,326	513,641
Community Health		
Community Health Dept.	337,561	332,515
Health Education	122,503	60,687
WIC Program	59,671	69,447
Diabetes Grant (Tribal)	172,101	344,986
Environmental Health	119,690	90,919
Public Health Nursing	628,273	595,325
Community Center	229,039	237,450
Community Counseling		
Community Counseling	815,913	801,698
Mental Health	330,801	315,369
Adolescent Aftercare	89,789	145,569
Vocational Rehabilitation	464,171	302,172
Prevention Projects	196,898	149,769
Administrative Support		
Facilities	829,658	888,266
Security	22,671	28,860
Health Administration	799,352	860,193
Business Office	230,308	298,583
Quality Assurance	162,643	174,627
Data Systems	367,642	369,952
Indirect Costs	531,257	575,006
Other		
Managed Care	4,073,862	5,498,295
Ambulance	897,125	897,006
Quarters	149	10,578
Clinic Equipment	187,945	334,497
Total	**17,382,873**	**20,821,390**

Figure 4-3

Interpretation:

Clinic Billing

Purpose: To identify visits billed, collected revenue and source by year.

Relevance: To identify trends and determine action of program considerations to improve billed revenues.

	2005	2006	2007	2008	2009
Visits Billed					
Medical	12,687	16,970	12,860	11,874	11,336
Dental	3,288	3,432	2,216	2,469	1,911
Pharmacy	16,435	15,422	15,050	19,720	19,830
Optometry	220	218	219	410	431
All Other	2,608	2,220	1,487	1,448	1,478
Total Visits Billed	**35,238**	**38,262**	**31,832**	**35,921**	**34,986**

	2005	2006	2007	2008	2009
Collections					
Medical	$1,814,179	$2,039,412	$1,730,783	$1,878,176	$1,770,324
Dental	538,819	513,318	324,767	436,894	244,363
Pharmacy	470,833	441,566	457,968	577,689	581,929
Optometry	6,094	7,170	14,406	66,642	65,006
All Other	67,576	48,776	47,044	24,134	11,846
Total Collected	**$2,897,501**	**$3,050,242**	**$2,574,968**	**$2,983,536**	**$2,673,468**

	2005	2006	2007	2008	2009
Source by Year of Receipt					
Medicaid	2,543,108	2,579,324	1,974,105	2,242,011	2,050,000
Medicare	123,648	151,038	278,307	241,542	200,000
Private Insurance	456,785	645,384	555,644	522,950	450,000

Figure 4-4

Interpretations: Total Medical billed visits trended downward in 2007 through 2009. Just under 60% of medical visits were billed in 2009, and collections generally average about 50% of amounts billed.

Tribal Billing

Purpose: To identify visits billed, collected revenue and source by year.

Relevance: To identify trends and determine action of program considerations to improve billed revenues.

	2005	2006	2007	2008	2009
Incidents/Visits Billed					
Ambulance	(not available)			615	692
* Alcohol & Substance and Mental Health	1,582	1,532	1,294	1,206	797
Other					
Total Incidents/Visits B	**1,582**	**1,532**	**1,294**	**1,821**	**1,489**

	2005	2006	2007	2008	2009
Collections					
Ambulance	(not available)			$ 120,878	$ 199,242
Alcohol & Substance and Mental Health	341,700	262,143	313,129	308,736	201,524
Other					
Total Collected	**$ 341,700**	**$ 262,143**	**$ 313,129**	**$ 429,614**	**$ 400,766**

	2005	2006	2007	2008	2009
Source	not available				
Medicaid					241,180
Medicare					45,957
Private Insurance					108,986
Other					4,643

* Billed one year in arrears

Figure 4-5

Interpretation: Ambulance collections are depicted in more detail in figure 4-6. It is believed that substantial potential collections are not being realized. The Tribe added billing staff in 2010 in an effort to improve collections.

Ambulance Financial Summary

Purpose: To identify cost and sources of revenue for ambulance operations and to identify trends in collections.

Relevance: Provides information needed for decisions regarding financing of ambulance operations.

SUMMARY OF TRANSPORT CHARGES AND COLLECTIONS

Payer Source	# Transports Billed		Amount Billed		Amount Collected	
	2008	2009	2008	2009	2008 (1)	2009
Workers Compensation	2	6	1,999			4,568
Medicaid	110	148	116,845	161,600		39,656
Medicare	78	102	88,656	114,845		45,957
Private Insurance	114	117	130,224	128,320		108,986
Private Pay	67	49	76,199	61,338		75
Managed Care	229	249	245,117	277,326	0	0
No Source	15	21		2,404	0	0
Total	**615**	**692**	**$ 659,040**	**$ 745,832**	**$ 120,878**	**$ 199,242**
Average Per Transport			**$ 1,072**	**$ 1,078**	**$ 197**	**$ 288**

(1) Collection source breakout not reported

OUTLAYS AND FUNDING	2008	2009
Outlays		
Allocated Salaries and Benefits	640,395	603,601
Medical Supplies	19,718	32,292
Other Supplies & Expenses	32,638	34,980
Vehicle Expenses	51,115	54,407
Equipment	45,259	23,725
Vehicle & Equip. Depreciation	108,000	108,000
Total	**$ 897,125**	**$ 857,005**
Average Direct Cost Per Transport	**$ 1,459**	**$ 1,238**
Funding Source		
Indian Health Service (PL 93-638)	$ 105,032	$ 97,946
Collections	$ 120,878	$ 199,242
Warm Springs Tribe - Direct Appropriation	$ 671,215	$ 559,817

Figure 4-6

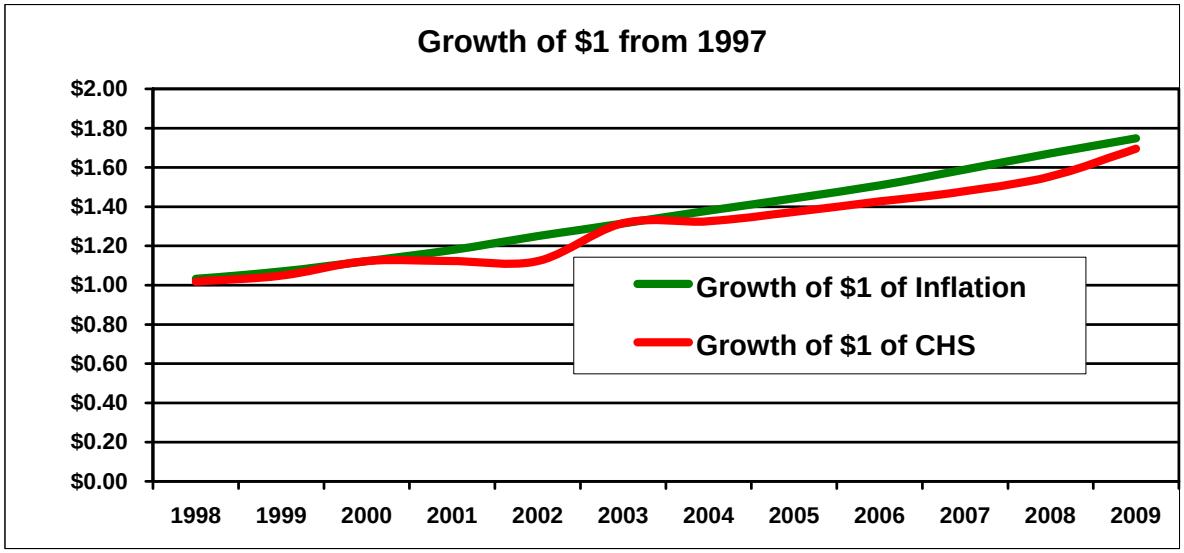
Interpretations: The service utilized an average market total billing rate of $1,164 for 2008 and 2009. No charges are billed for dispatched calls where no transport occurs. Salaries and Benefits include personnel during dispatch, transport, training, and other time related to ambulance services. Allocations represent 71% of total fire and safety payroll based on a five year study. Depreciation represents five year life on five ambulances.

Contract Health Services – Funding

Purpose: To compare annual CHS base funding to medical inflation and to report on all CHS Funding.

Relevance: Identifies gap between medical inflation and funding.

	CHS Annual Funding Base	N/R & Deferred Services	CHEF	Total	Base Increase	Medical Inflation
1998	2,716,800	78,547	193,567	2,988,914	1.8%	3.2%
1999	2,798,596		23,857	2,822,453	3.0%	3.7%
2000	2,997,244		259,696	3,256,940	7.1%	4.9%
2001	2,997,244	431,485	115,450	3,544,179	0.0%	5.2%
2002	2,997,244	436,886	71,117	3,505,247	0.0%	6.0%
2003	3,511,606	32,831	166,859	3,711,296	17.2%	5.2%
2004	3,538,505	180,023	479,118	4,197,646	0.8%	5.0%
2005	3,665,746	90,206	155,406	3,911,358	3.6%	4.6%
2006	3,807,490	97,119	239,859	4,144,468	3.9%	4.6%
2007	3,947,624	79,971	397,960	4,425,555	3.7%	5.4%
2008	4,148,016		470,258	4,618,274	5.1%	5.2%
2009	4,522,779		422,971	4,945,750	9.0%	4.6%



Note: Medical Inflation is the average of U.S. Department of Labor, Bureau of Labor Statistics Medical Services (50% Professional Services and 50% Hospital Services).

Figure 4-7

Interpretations: CHS Base increases have lagged significantly behind medical inflation for most of the period, losing 13% of the purchasing power of the base funding over the period. Tribal enrollment was up by more than 20% over the same period – reflecting even greater disparity in meeting the service demand.

Contract Health Services - Spending

Purpose: To provide a report of major categories of spending for the program.

Relevance: Purchased care represents a significant portion of the health care resource. Understanding the nature of costs is important to policy and priority decisions.

	In-Patient	Out-Patient	Emergency	Dental	Vision	Pharmacy	Supplies	Total	
2001	784,579	1,018,889	399,575	298,965	4,476	35,171	57,216	2,598,871	
2002	1,004,325	1,296,560	170,067	280,945	5,135	48,467	62,071	2,867,570	
2003	1,493,029	1,893,488	49,565	270,138	3,038	58,417	78,388	3,846,063	
2004	1,662,882	1,927,564	88,150	358,298	4,416	81,942	92,879	4,216,131	
2005	1,787,196	2,260,454	467,070	169,229	3,640	137,381	80,571	4,905,541	
2006	2,575,549	1,684,794	553,401	65,901	-	110,504	58,866	5,049,015	
2007	1,835,234	1,083,811	441,008	38,592	2,307	5,915	41,117	3,447,984	
2008	1,728,937	1,476,173	507,835	52,544	3,424	17,373	88,052	3,874,338	*
2009	2,007,677	1,884,641	780,950	90,704	5,611	18,620	107,812	4,896,015	*

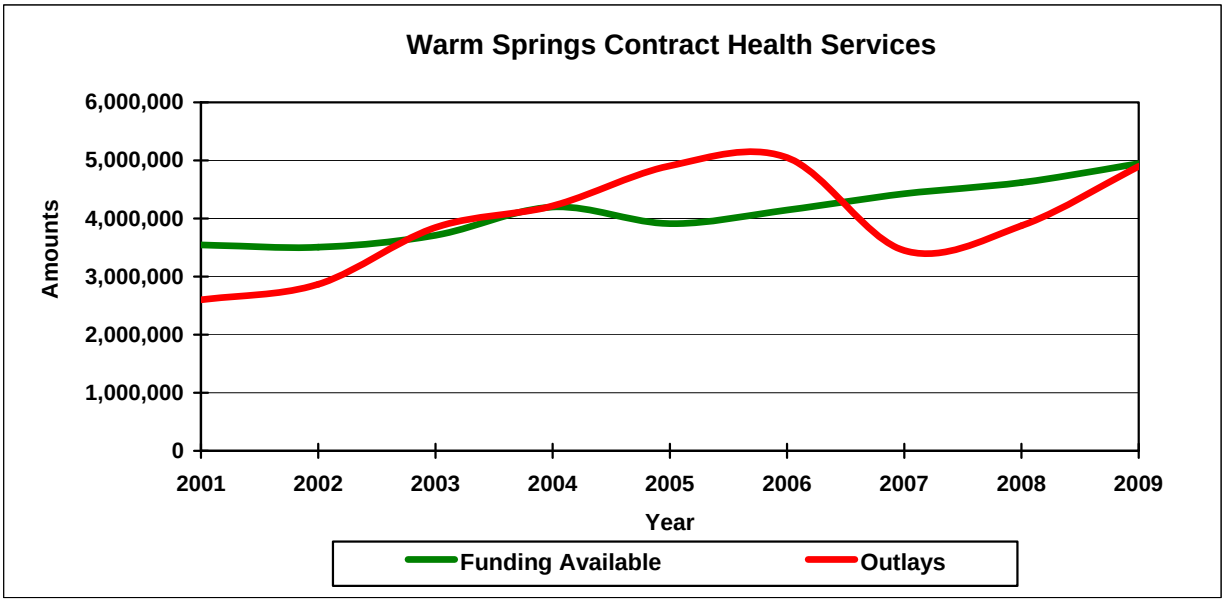


Figure 4-8

* Includes am additional $63,114 Obligated, but not yet paid for 2008.
* Includes an additional $209,412 Obligated, but not yet paid for 2009.

Interpretation: Hospitalization consumes substantial resources and accounts for years when outlays outstrip resources. Illustrates fluctuations in MCP total costs, as well as seven components of that total cost, over nine years. Even with the implementation of priorities in July 2005, costs peaked in 2006. The implementation of Medicare-Like Rates in July 2007 had a huge positive impact as costs fell by roughly $500-$700K for both In-Patient and Out-Patient. The rise in Out-Patient in 2008 ad 2009 is the result of both the $550K T.C. Resolution (2008) and $500K “carve-out” (2009). Priority I’s were relaxed in April, 2010, and most Priority II,III and IV have been authorized since then.

Contract Health Services – Utilization and Unit Cost

Purpose: To identify the cost and source of funding for hospitalizations, and the unity costs of services purchased through the Managed Care program.

Relevance: CHS funds are limited and managed on a priority basis. Patterns of utilization and costs must be monitored to support resource decisions and program priorities.

	2008			2009		
	Units	**Total Cost**	**Cost per Unit**	**Units**	**Total Cost**	**Cost per Unit**
Hospital Days	858	$1,728,937	$ 2,015	901	$ 2,010,905	$ 2,232
Inpatient Physician Visits	N/A	N/A	N/A	N/A	N/A	N/A
Outpatient Physician Visits	N/A	$1,483,196	N/A	N/A	$ 1,907,159	N/A
Pharmacy Prescriptions	51	$ 17,373	$ 341	74	$ 18,620	$ 252
Dental Visits	213	$ 52,544	$ 247	178	$ 90,704	$ 510
Emergency Room Visits	1,197	$ 507,835	$ 424	1,325	$ 782,900	$ 591

Figure 4-9

Interpretation: This table reflects the units and total cost for several categories of services paid for by MCP. While the cost and units are accurate, “cost per unit” may be misleading in certain instances.

Deferred Services

Purpose: To identify the number of cases and estimated costs for recommended care that could not be purchased under current circumstances.

Relevance: It is important that the program maintain a record of these cases and track progress.

2009

Priorities*	Cases Deferred	Estimated Cost
Priority 1	0	-
Priority 2	286	60,000.00
Priority 3	906	420,000.00
Priority 4	116	20,000.00
	1,308	**$ 500,000.00**

***** Definitions of Priorities is contained within Tribal/IHS Policy

Figure 4-10

Interpretation: Throughout 2009 MCP was technically still on "Priority I's" implemented in July 2005. Thus, although all "Priority I's"were paid with current year's budget, Priority II's,III's, and IV's were listed as deferred. However, due to implementation of Medicare-Like Rates in July 2007, and $500K T.C. Resolution implemented late 2007, MCP started 2009 with sufficient reserves to "carve-out" $500K to pay for "non-Priority I" referrals. Thus, the above cases listed as "deferred" were actually paid for with Tribal funds. The number of "Cases Deferred" above are extracted from reports submitted to PAO, while the "Estimated Cost" reflects the $500K MCP reserves used to pay the non-Priority I referrals.

CHS – Catastrophic Health Emergency Fund

Purpose: To identify the numbers of cases qualifying for CHEF reimbursement, the funding request, the received and the shortfall for each year.

Relevance: Catastrophic cases have a huge impact on the Managed Care budget. All must be aware of these high cost cases as they develop since they affect overall service priorities and impact reserves of the program.

					RECEIVED			
YEAR	Total CHEF Obligation	Total CHEF Cases	CHEF Threshold	Total CHEF Funds Due MCP	Current Year	Following Year	Total	Shortfall
2003	645,794	11	22,700	396,094	166,859	2,006	168,865	227,229
2004	1,150,945	14	23,800	817,745	472,981	-	472,981	344,764
2005	680,159	13	24,700	359,059	116,860	-	116,860	242,199
2006	1,388,591	24	25,000	788,591	336,978	240,802	577,780	210,811
2007	521,458	7	25,000	346,458	157,158	138,617	295,775	50,683
2008	1,008,323	15	25,000	633,323	331,651	187,833	519,484	113,839
* **2009**	996,036	19	25,000	521,036	235,139	346,681	581,820	(60,784)
Totals	**$ 6,391,306**	**103**		**$ 3,862,306**	**$ 1,817,626**	**$ 915,939**	**$ 2,733,565**	**$ 1,128,741**

Figure 4-11

Interpretations: From 2003-2007, there was a total of 69 cases qualifying for reimbursements of $ 2,707,947. A total reimbursement of $ 1,534,990 was received from IHS, leaving a shortfall of over $1.1 million to be absorbed by the Managed Care program.

The CTWS MCP operates on a calendar year fiscal year. However, the IHS operates on an Oct-Sept fiscal year. Historically, the IHS CHEF is exhausted about May or June, and is then replenished in October. Thus, a prime reason for a shortfall in reimbursement is that a CHEF case occurred after the funds were exhausted for that year. Then, when the new CHEF year starts in October, reimbursement for a CHEF case falling in the last three months of the year usually will not take place until the following year. Using 2008 as an example, 15 CHEF cases resulted in $633,323 due CTWS MCP; $331,651 was reimbursed in 2008, and $187,833 was reimbursed in 2009.

Timely application for CHEF is very important, and the MCP Case Manager places highest priority on this process. Receipt of CHEF can have a significant impact in helping to offset expenditures for high cost cases. Application for CHEF is competitive across IHS.

Medicare-Like Rates Legislation effective July 2007 has resulted in CHEF lasting longer into the fiscal year the last couple of years.

In 2009, $91,274 was received on a very high cost CHEF case. Several months later, upon appeal, the OHP retroactively covered the patient for DOS including CHEF costs. Thus, this money may have to be paid back to IHS. Thus, the reason for the apparent negative shortfall in 2009 above**.**

Grants Received

Purpose: To monitor the availability and funding levels of grants received to support the health care system.

Relevance: Grants represent an important part of the health care system's financing, and are frequently targeted at key risk factors and national priorities. Numerous grants finance ongoing staff and programs at Warm Springs.

Grant Names		2008		2009
Grant Amount				
Diabetes Grant (Tribe)	$	193,268	$	193,268
State Women, Infants, and Children (WIC)		71,200		72,046
Woman's Wellness Conference		4,437		-
CHET Dental Project		4,253		-
Senior Fitness Enhancement		22,078		-
Tobacco Pilot Site		-		-
State Tobacco Prevention		44,614		-
USDA Commodity Warehouse		86,214		-
State Alcohol & Drug				297,752
State Alcohol Prevention				100,000
State Mental Health				294,444
State Youth Suicide Prevention		30,000		-
Influenza Pandemic		41,444		
Vocational Rehabilitation		103,000		345,519
Meth Prevention Project		100,000		-
Total	**$**	**700,508**	**$**	**1,303,029**
Grant Expenditures				
Diabetes Grant (Tribe)	$	172,101	$	344,986
State Women, Infants, and Children (WIC)		59,671		69,447
Woman's Wellness Conference Grant		4,436		-
CHET Dental Project Grant		23,037		32,051
Senior Fitness Enhancement Grant		28,224		10,970
Tobacco Pilot Site Grant		-		-
State Tobacco Prevention Grant		24,959		63,345
USDA Commodity Warehouse Grant		65,110		-
State Alcohol & Drug Grant		124,401		163,378
State Alcohol Prevention Grant		51,225		39,273
State Mental Health Grant		137,837		138,534
State Youth Suicide Prevention Grant		35,137		(1,964)
Influenza Pandemic		3,321		16,105
Vocational Rehabilitation Grant		464,171		302,172
Meth Prevention Project Grant		110,536		112,460
Total	**$**	**1,304,166**	**$**	**1,290,757**

Note: Grant Awards are on a variety of fiscal years and may be multiple years.
Awards are reported in year received.
Grant expenditures are refected by calendar year of expenditure.

Figure 4-12

Interpretation:

Staffing

Purpose: To provide an overall summary of personnel devoted to healthcare, and the number of Warm Springs tribal members employed in the system.

Relevance: Staffing represents the single largest use of health resources. Tracking the number of enrolled members reports against a key objective of the health plan.

	2000 FTE			2009 FTE			2009 Enrolled TM	
	Tribal	IHS	Total	Tribal	IHS	Total	Enrolled WS Members	Total
Clinical Services								
Medical		26.0	**26.0**		26.0	**26.0**	6.0	**6.0**
Dental		15.0	**15.0**		13.6	**13.6**	5.0	**5.0**
Optometry		2.0	**2.0**		2.0	**2.0**	1.0	**1.0**
Pharmacy		6.0	**6.0**		6.0	**6.0**	0.0	**0.0**
Medical Records		9.0	**9.0**		5.0	**5.0**	2.0	**2.0**
Medical Lab		4.0	**4.0**		4.0	**4.0**	0.0	**0.0**
X-Ray		3.0	**3.0**		2.3	**2.3**	1.0	**1.0**
Diabetes - Clinic		4.0	**4.0**		9.3	**9.3**	3.0	**3.0**
Community Health								
Community Health Dept.	2.0		**2.0**	To still		**0.0**		**0.0**
Health Education	1.0		**1.0**	obtain Tribal		**0.0**		**0.0**
CHET	4.0		**4.0**	Data for 2009		**0.0**		**0.0**
Maternal Child Health	2.0		**2.0**			**0.0**		**0.0**
Community Health Rep.						**0.0**		**0.0**
WIC Program	1.0		**1.0**			**0.0**		**0.0**
Wellness Coordinator	3.0		**3.0**			**0.0**		**0.0**
Diabetes Grant (Tribal)						**0.0**		**0.0**
Environmental Health	2.0		**2.0**			**0.0**		**0.0**
Public Health Nursing		6.0	**6.0**	1.0		**1.0**	1.0	**1.0**
Nutrition		3.0	**3.0**			**0.0**		**0.0**
Medical Social Work	3.5	1.0	**4.5**			**0.0**		**0.0**
Physical Therapy	1.0		**1.0**			**0.0**		**0.0**
Community Wellness Center						**0.0**		**0.0**
Community Counseling								
Community Counseling	5.0		**5.0**			**0.0**		**0.0**
Mental Health	6.0		**6.0**			**0.0**		**0.0**
Alcohol & Substance Abuse	12.0		**12.0**			**0.0**		**0.0**
Administrative Support								
Facilities	11.0	2.0	**13.0**			**0.0**		**0.0**
Security	2.0		**2.0**			**0.0**		**0.0**
Health Administration		14.0	**14.0**		12.0	**12.0**	4.0	**4.0**
Personnel		2.0	**2.0**			**0.0**	0.0	**0.0**
Procurement		1.0	**1.0**		2.0	**2.0**	1.0	**1.0**
Business Office		6.0	**6.0**		8.0	**8.0**	5.0	**5.0**
Data Systems					3.0	**3.0**	0.0	**0.0**
Transportation				1.0		**1.0**	1.0	**1.0**
Quality Assurance					1.0	**1.0**	0.0	**0.0**
Registration						**0.0**	0.0	**0.0**
Other								
Managed Care	8.5		**8.5**			**0.0**		**0.0**
Ambulance						**0.0**		**0.0**
Total	**64.0**	**104.0**	**168.0**	**2.0**	**94.1**	**96.1**	**30.0**	**30.0**

Figure 4-13

Interpretation:

Facilities

Purpose: To provide an overview of the major facility deficiencies and estimated costs for correction (Threshold estimate $20,000).

Relevance: The Tribes' facilities must be well maintained to protect its assets.

Facility Deficiency	Facility*	Estimated Cost	Date Identified as Priority	Date of Approval
4-New Heatpumps	Health & Wellness Center	20,000	2010	Nov.-2010
6-more before the end of the year	Health & Wellness Center	30,000	2010	Completed
Exterior Painting	Health & Wellness Center	20,000	2010	July-10
Bids for Infectious Waste Building	Health & Wellness Center	8,000	2010	Dec.-2010
Small Ambulatory Grant	Health & Wellness Center and Family Resource Center	1,320,000	2009	Ongoing
		$ 1,398,000.00		

***** Health & Wellness Center
Family Resource Center
Community Counseling Center
108 Quarters
Mobile Clinic

Figure 4-14

Interpretation: Treatment for aging medical building is to replace, repair and maintain all parts of the structure.

Small Ambulatory Grant (SAP) is modernization of Warm Springs Health facilities: Community Counseling and the Health & Wellness Center.

Capital Equipment

Purpose: To identify equipment requests and approvals for capital equipment.

Relevance: Equipment requests should include justification, materials, program impact and cost.

Description	Cost $	Program	Date of Request	Date of Approval
2-Patient Monitors for treatment rooms	9,000	Medical	Apr-10	4/29/2010
Weight Bearing Stand Radiography	8,000	Medical	Apr-10	4/27/2010
Foot Exam Cair	6,258	Medical	Apr-10	4/19/2010
EKG Machine	5,300	Medical	Apr-10	FY 09
Warming Cabinet	5,725	Medical	Apr-10	4/5/2010
6-Power Exam Tables	22,233	Medical	Apr-10	4/19/2010
Fetal Monitor	5,149	Medical	Apr-10	4/19/2010

***** In Excess of $5,000

Figure 4-15

Interpretation:

Capital expenditures for the replacement of equipment are an expected expense. The majority of the above expenditures were necessary to replace equipment that was worn or broken after years of use. Such expenditures are reviewed and approved by the Equipment Committee at the Warm Springs Health and Wellness Center in order to assess justifications and make priorities within the budget for these expenditures.

Savings and Reserves

Purpose: To report all funds carried from year to year and their status

Relevance: This information is important to overall planning, including potential reallocation of funds to priority efforts or projects.

	2007	2008	2009
Tribe - Self Determination Contract			
Program Savings and Carryover			
Community Health	85,751	300,784	1,247,935
Community Counseling	855,589	1,001,783	1,154,130
Managed Care	1,895,433	2,768,366	2,575,459
Ambulance	13,805	35,008	12,062
Facilities Operations	275,095	386,904	458,203
Environmental Health	92,077	75,998	40,974
Indirect Contract Support Costs	1,225,349	1,384,142	1,514,614
Reserves			
M & I Reserve Wellness Center	936,824	842,074	810,142
M & I Reserve Community Counseling	221,259	263,354	304,145
Equipment Replacement	86,431	93,165	99,481
Projects			
Joint Venture - Clinic Remodel	839,157	460,225	460,225
Other JV Projects	135,774	282,547	106,866
Total	**6,662,544**	**7,894,350**	**8,784,236**
Indian Health Service			
Medicare/Medicaid	940,701	1,079,000	1,258,967
Private Insurance	374,467	86,000	235,522
Other Funds			
Total	**1,315,168**	**1,165,000**	**1,494,489**
Grants			
Diabetes-competitive grant	397,100	562,100	482,100
Suicide Prevention		2,289	2,289
Meth/Suicide			247,374
Diabetes-Noncompetitive grant	88,145	88145	88,145
Domestic Violence	30,000		80,000
Total	**485,245**	**652,534**	**899,908**

Figure 4-16

Interpretations: For the ongoing programs financed by the Self-Determination Agreement, savings other than Managed Care may be reprogrammed to higher priority health programs or projects authorized by the agreement. This report reflects significant savings that may help to address key strategies and efforts.

SECTION 5

Evaluation

How do we evaluate our progress and our effectiveness?

This section presents information available to assist in evaluation of operations. For Indian Health Service operated services, GPRA (Government Performance and Results Act) mandate performance based measures to compare the clinical operations with national efforts. The Warm Springs clinical operations maintain high scores in these measurements.

Some reports are provided at other times during the year and are presented here for the reader's information.

Patient Satisfaction Survey

Purpose: To determine by random sample the patient perceptions with regard to courtesy and professionalism of staff, cleanliness of clinic, adequacy of the care provided, accessibility and waiting times.

Relevance: AAAHC requires that quarterly patient satisfaction surveys be conducted, information be evaluated. Improvements needed are identified and staff is informed of any necessary changes in operations.

> These quarterly assessments should be provided to the Health Commission at their regularly scheduled meetings as well as a yearly summary.

Interpretation: The Warm Springs Health and Wellness Center has consistently received high marks from the patients surveyed over the years. Attention to the comments of patients is what good service is all about.

GPRA Performance Measurements Summary

Purpose: The Indian Health Service requires the reporting of a number of clinical activities. The results are compared to an IHS goal, national IHS performance and site behavior.

Relevance: These performance based measures are an important benchmark and an indicator of how effective the clinic is in comparison to national efforts. There are also a number of non-GPRA measures of clinical performance that are equally important. Many of these efforts are patient screening and assessments that relate directly to health promotion and disease prevention.

> The GPRA annual summary should be presented to the Health Commissioner in the regular meeting following its completion.

Interpretation: The Warm Springs Health and Wellness Center has consistently exceeded all national rates in every category and has made great progress when compared to the baseline.

Accreditation Information

Purpose: To access the operation and performance of the WSHWC every three years and report and deficiencies and recommendations discovered by this outside review. The overall review is conducted to certify accreditation of the program.

Relevance: Accreditation is requested to enable the program to bill Medicare and Medicaid. This outside review ensures that policies, facilities, medical records and clinical operations meet all the standards requested for accreditation.

> The report of findings should be presented to the Health Commissioner in the meeting following its receipt. Deficiencies and recommendations should be reviewed to determine what changes in operations might be considered.
>
> Information presented in the annual report should summarize most recent findings and deficiencies, as well as corrective actions and other activities to support ongoing improvement.

Interpretation: The Warm Springs Health and Wellness Center has been accredited for many years. The program has consistently done well in the surveys. All deficiencies and recommendations are reviewed with each survey to determine how best to improve.

Cost versus Value of Service

Purpose: To compare the cost of services provided with their market value using average insurance billing rate as an indication of value.

Relevance: Provides a measure of efficiency against which to consider program direction and staffing levels.

	1998-2000			2008-2009		
	Unit Cost w/o Load	**Unit Cost w/ Load**	**Unit Value**	**Unit Cost w/o Load**	**Unit Cost w/ Load**	**Unit Value**
Medical	97	156	110			
Dental	80	125	127			
Optometry	66	116	134			
Pharmacy	24	29	32.21			
Lab	19	27	unknown			
X-Ray	66	128	104			
Diabetes	91	129	110			

Figure 5-1

Interpretation: This evaluation provides a measure of value vs cost of services provided. It represents one measure, a financial measure. While there are numerous "values" to be considered in evaluating services, market value is an important indicator of maximizing resources. Information is being gathered for the years 2008-2010 and will be reported in the next publication of this report.