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

DRAFT

June 16, 2011

2011 Edition
Reporting Information through 2010

2011 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 2010 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 saw improvement in this latest report. Continued improvement in information and reporting is expected.

Resources available through federal appropriations to the Indian Health Service have trended upward, but do not keep pace with inflation. Increases in 2009 and 2010 helped. 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 improved for 2010. Increases in patient eligibility for alternate resources has been helpful to the program. 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. Information on most recent years was gathered for this report, as is expected for subsequent year reports. Such information is not easily obtained from existing Indian Health Service financial systems. Further effort will be needed to improve the timeliness and consistency of such information. 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 effort to improve information that is being maintained and 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 to continue improvement.

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, when Public Health Nursing and Nutrition programs were contracted. 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. Due to an environment that suggests very limited increases in federal resources in the coming years, the system will need to 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.

During 2010, having become familiar with the overall health system and its duties, the Joint Health Commission considered available information and trends in considering guidance for setting strategies and priorities within the system. The following guidance was adopted for the health system.

Priorities and Strategies

Today the community has a number of health problems and, more importantly, health risks in the community do not point to a bright future for many community members. Research indicates that an individual's health is 90% determined by his/her environment and personal choices, and only 10% related to delivery of health care. It is therefore essential that all involved in the health care system focus beyond actual delivery of health services and work cooperatively to address those external factors and individual choices that impact the health of the community.

Bringing about a state of excellent health and brighter prospects for the future is something we all need to strive for. It begins with the individual and family, requires a supportive community, a safe and secure environment, an effective education system, an active government, a responsive health care system as well as economic opportunity.

Our priorities and strategies must be about engaging all parties and focusing the resources of the system to do the things today that bring about change and a brighter future tomorrow.

In developing effective teamwork, we believe that the family (not government) should be the dominant force in people's lives, and that the path to a healthy lifestyle is a personal commitment driven by values and virtues. Our spirituality is a source of inspiration and hope for many of us. The focus of any plan should consider support for strong families and the community.

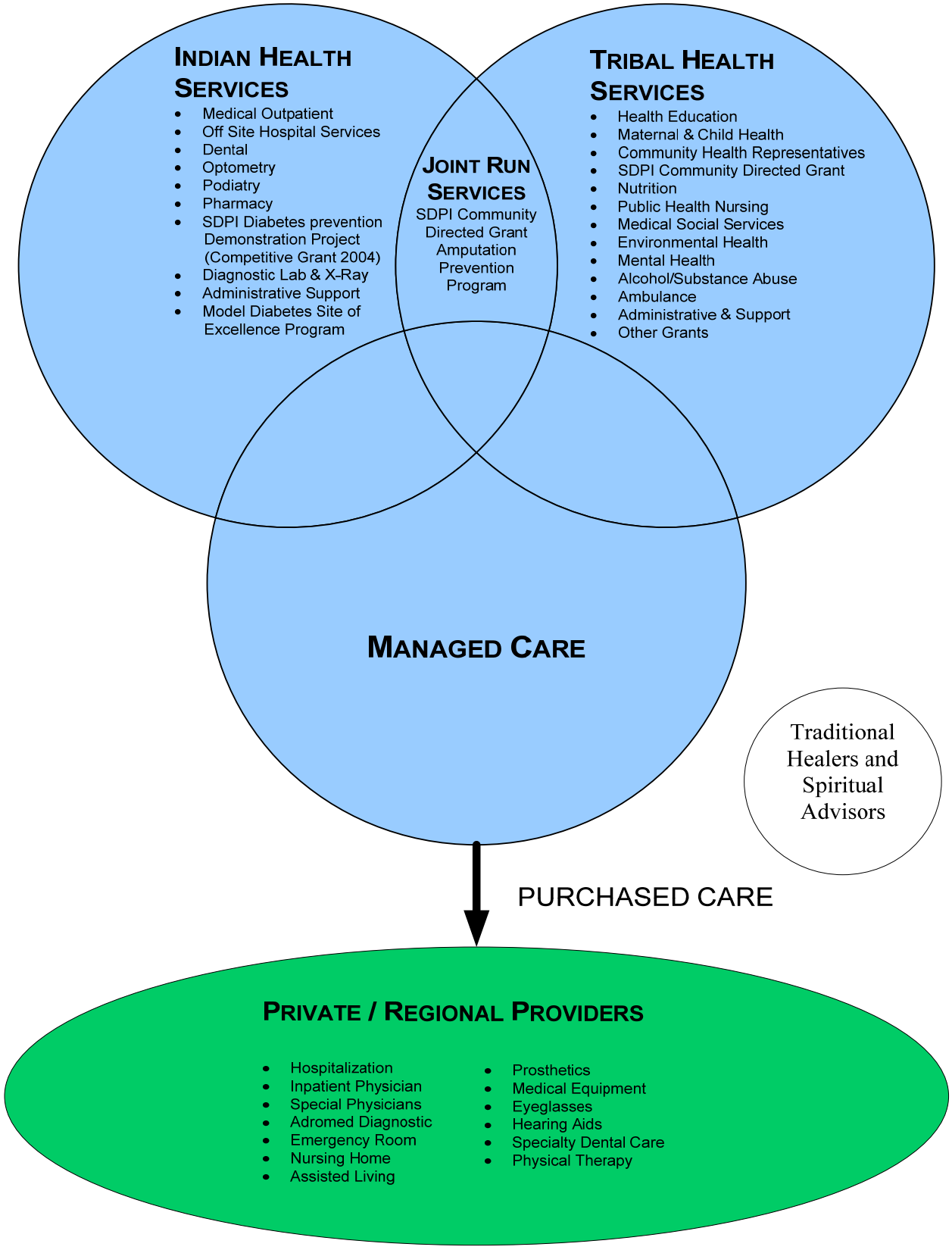
We know that a substantial portion of the suffering in the population and the utilization of health resources today result from lifestyle choices, conditions and environmental issues that can be prevented. Therefore, our emphasis is on a "Strategic Wellness and Prevention Approach". This approach should ensure that;

1. *Each child has had the advantage of knowledgeable care, concern and safety during its mother's pregnancy to ensure that child is born with maximum health and brain development.*
2. *Each child, during its critical first years of life, has optimal experience with primary caregivers who are educated and motivated to ensure a healthy happy start to life.*
3. *Each child's experience in early childhood education includes all appropriate tools upon which to build a healthy happy life.*

4. *Each school age child is engaged in a system of age specific learning and incentives for healthy lifestyle and strong interpersonal skills as a platform for a bright future.*
5. *Each child having formative and environment related issues has access to a support and treatment system to ensure that he/she can maximize life experience and potential.*
6. *Each young adult at reproduction age already has substantial knowledge of choices and recognizes his/her obligation to future generations. (Understand vital information about brain and character development)*
7. *Each minor that chooses poorly finds peers, family, local government, health system and community that is willing to provide positive pressure toward healthy behavior, including the productive use of leisure.*
8. *Young adults find a community, government and health system to support healthy lifestyles, education about child development, etc. They also find plentiful support and opportunities for education and employment.*
9. *The community, government and health system coordinate with other institutions to ensure availability of healthy events, including cultural and recreational events that promote community, pride and belonging. Incentives are available for individual and family improvement.*
10. *The community is provided high quality information about health status, health care available, health risks and opportunities for health improvement.*
11. *The community, government and health system have created dis-incentives for minors and adults who engage in continued destructive lifestyles, while at the same time providing the broadest possible support for those who wish to change. (explore opportunities for community based detox, aftercare housing, and other needed support)*
12. *The Tribe as an employer and government provides incentives and support for healthy lifestyles. (Health Education, environmental considerations, wellness activities – on job recreation/exercise opportunities, etc.)*
13. *Focused attention and resources toward elders to ensure that the system supports best possible health status and life experience. Promotion of opportunities for younger generations to learn from and engage elders.*
14. *Community members experience a health system that has its customers as its primary focus in providing access to needed services.*
15. *Members of the Tribe occupy a large number of the professional provider positions within the health care delivery system.*

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
2010	333	6,692	5,628

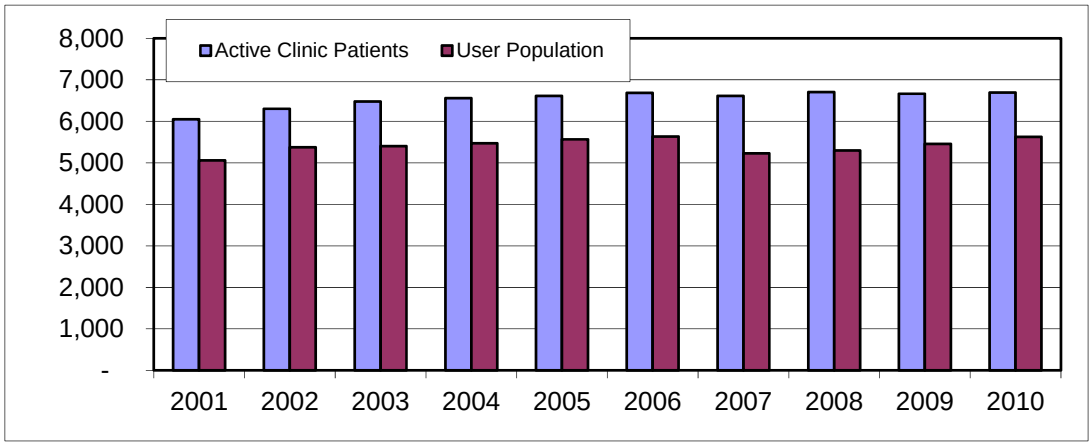


Figure 2-1

Interpretation: Between 2001 and 2010, new patient registrations have decreased by approximately 20%. During that timeframe, new patient registrations peaked in 2002 at 471; an increase of about 13% from 2001. Since then, new patient registrations decreased to their lowest point in 2009 at 320 registrations. In the ten year time span from 2001 - 2010, the user population has increased from 5,057 to 5,628 (11.3%) and the population of active clinic patients has increased by 10.6%. 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 2002 and the other in 2007 with a difference of 6.3% and -7.2% 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 Community of Residence	2000	2007	2008	2009	2010	Chg(09-10)
Warm Springs Indian Reservation	3,724	3,503	3,559	3,686	3,665	(21)
Madras/Redmond/Bend	1,319	1,057	1,104	1,035	1,119	84
Maupin/The Dalles/Hood River	114	77	91	85	90	5
Portland/Salem	152	68	90	90	91	1
Other Oregon	237	483	470	461	460	(1)
Outside Oregon	416	319	237	137	213	76
TOTAL	**5,962**	**5,507**	**5,551**	**5,494**	**5,638**	144

By Tribal Affiliation	2000	2007	2008	2009	2010	Chg(09-10)
Warm Springs Member	3,738	3,703	3,773	3,812	3,893	81
Other Oregon Tribes	325	261	244	241	240	(1)
All Other Tribes	1,732	1,442	1,432	1,350	1,402	52
Non-Indians	167	101	102	91	103	12
TOTAL	**5,962**	**5,507**	**5,551**	**5,494**	**5,638**	144

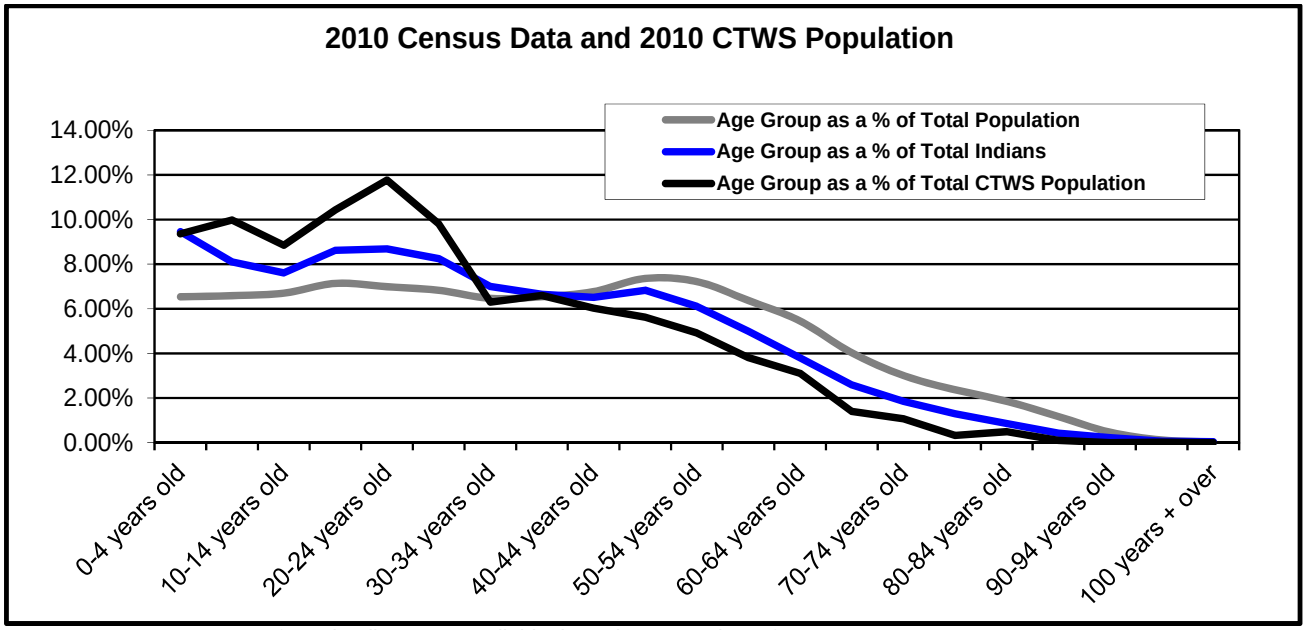
Figure 2-2

Interpretation: Trends have remained stable from 2000 to 2010 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.

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.



Note: Age Group as a % of Total Indians was available through 2009 at time of Report.

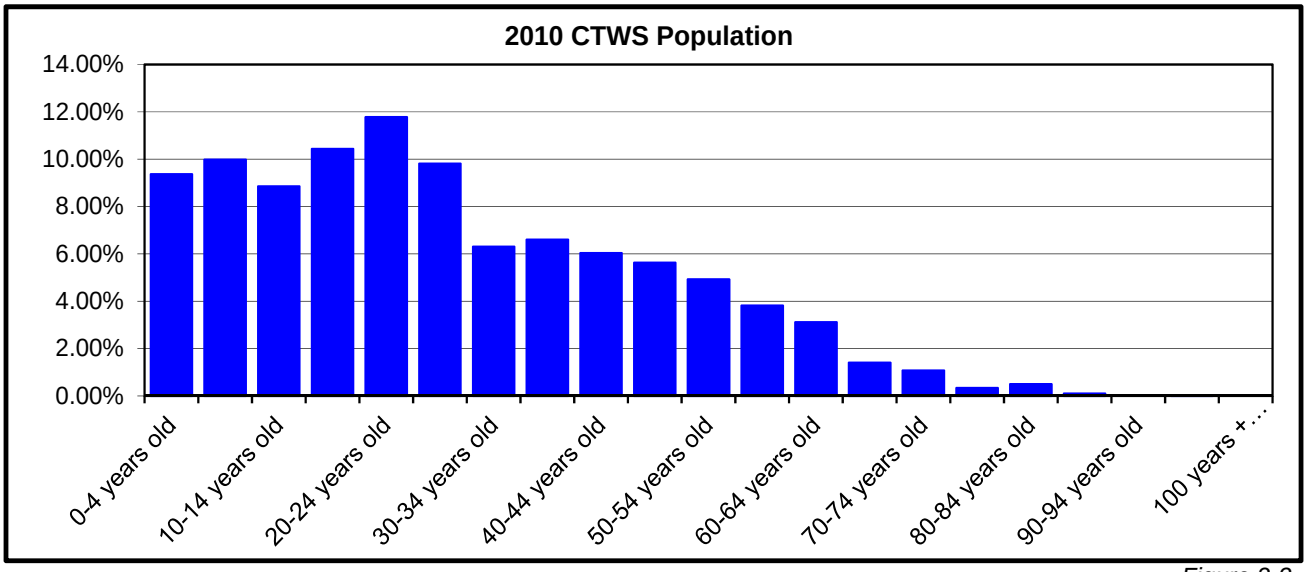


Figure 2-3

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 2010 Patients
0-4	615	543	675
5-9	691	460	603
10-19	1,098	1,367	1,082
20-29	954	971	1,056
30-39	843	912	690
40-49	571	738	694
50-59	269	440	604
60-69	137	204	368
70-79	67	98	169
80+	28	40	56
TOTAL, Patients	**5,273**	**5,773**	**5,997**

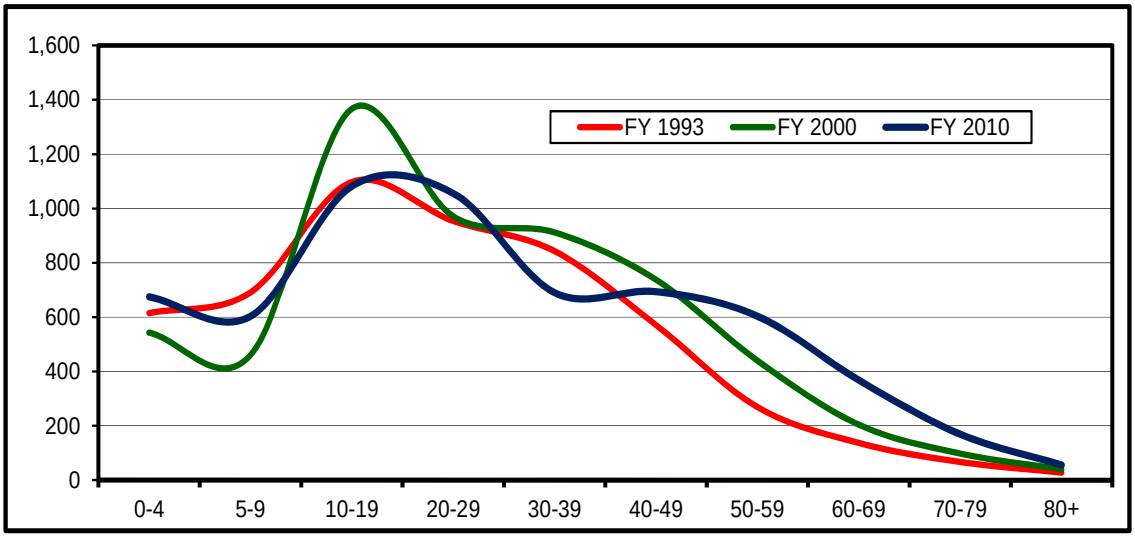


Figure 2-4

Interpretation: During the period from 1993 to 2000 there increase in patients was 9.5%. The number of patients utilizing services has increased by 7.8% over the period of 2000 to 2010. These numbers reflect a very moderate growth rate consistent with normal population growth.

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

Billable	FY 2007	FY 2008	FY 2009	FY 2010
Medicare Only	1,118	1,241	1,340	1,206
Private Insurance Only	1,383	1,398	1,436	1,351
Medicare A Only	21	20	16	25
Medicare B Only				0
Medicare Part A & B Only	124	123	121	141
Medicare Part D	184	188	176	179
Medicaid & Medicare	22	18	32	41
Medicaid & Private Ins.	138	145	181	606
Medicare & Private Ins.	117	117	114	143
Medicaid, Medicare, & PI	1	1	5	11
Total	3,108	3,251	3,421	3,703
Non-Billable				
Tribal Employee Self-Insurance	391	311	286	269
No Alternate Resource	2,932	2,983	2,737	2,673
Total	3,323	3,294	3,023	2,942
Total Patients	**6,431**	**6,545**	**6,444**	**6,645**

Figure 2-5

Interpretation: Over the past four years the number of patients with billable alternate resources has been steadily rising. From 2007 to 2010 the alternate resource potential has increased 19%. Over that same period non-billable patients have declined 11.5%. Both trends have had a positive influence on collections.

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
2010	0	21	27	22	11	5	86
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: The total number of births and pregnancies has been increasing with the biggest increase seen in very young mothers. After previewing data for the upcoming year of 2011, it is expected that the increases will be seen again and will show the biggest gains in the number of very young mothers.

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.

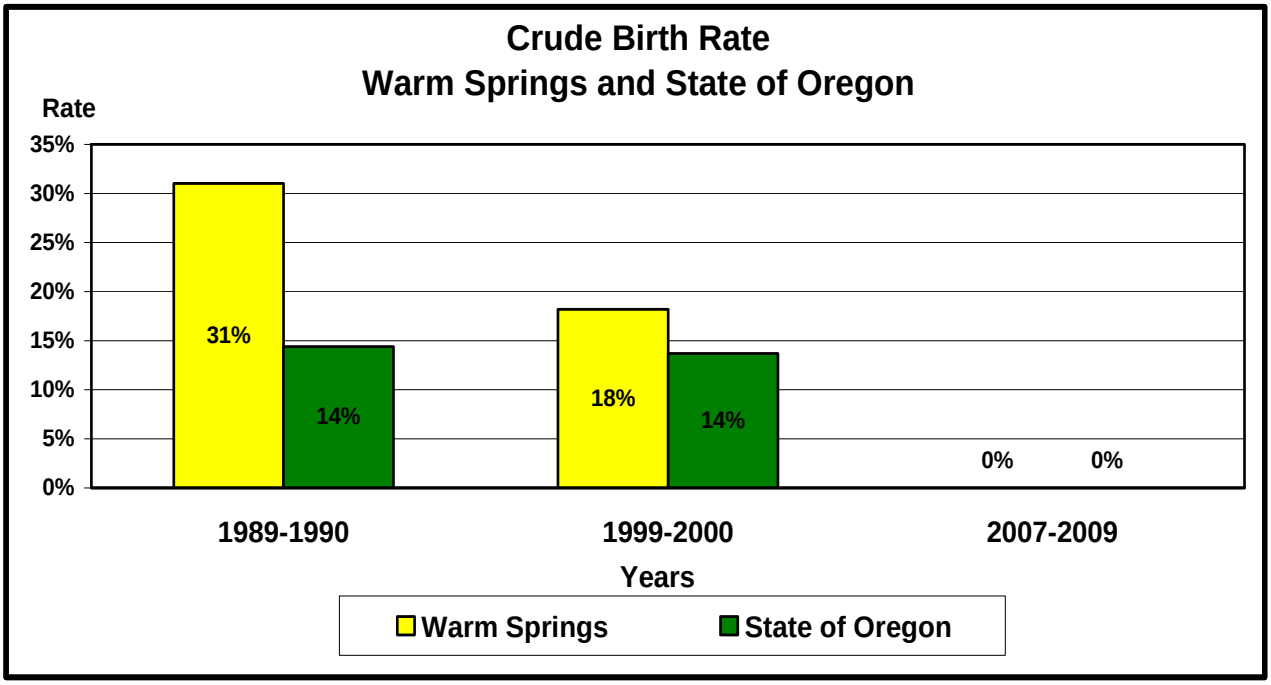


Figure 2-7

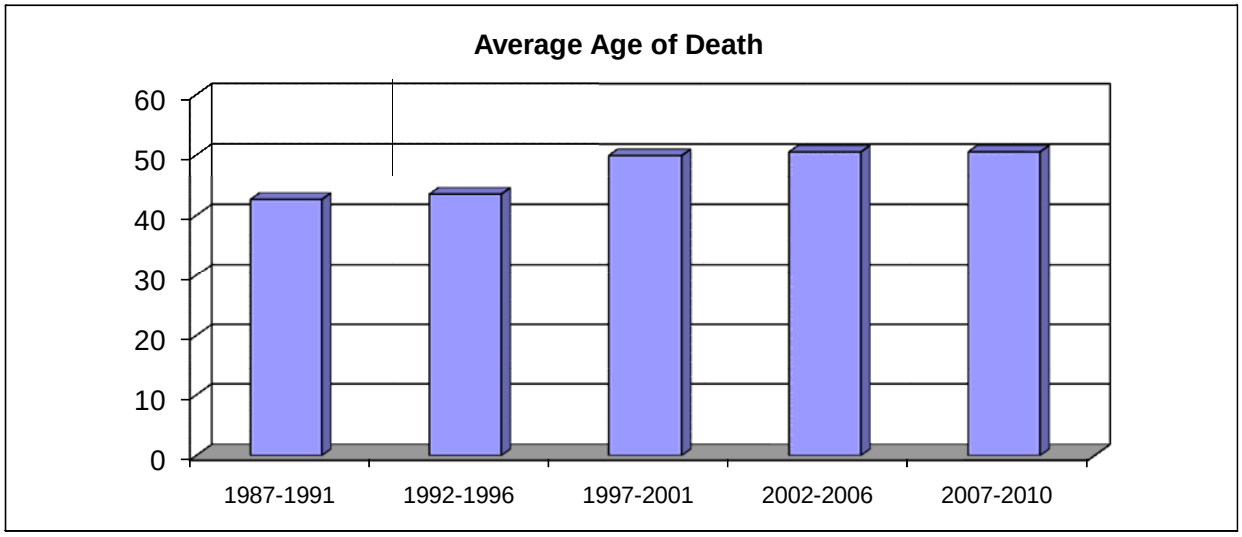
Interpretation: Past reports reflected a substantially higher birth rate at Warms Springs that the general Oregon population. The difference had reduced in the 2000 report.

Research has not been completed in time for this report. All Vital Statistics will be published in a separate report and the information will be included in next year's annual report.

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	2008-2010
Number of Deaths	81	73	88	85	95	123	139
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 completed in time for this report. All Vital Statistics will be published in a separate report and the information will be included in next year's annual 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	1		3		2	
2005-2007	1		0		4	
2008-2010	9		3		0	

Leading Causes of Death from 2002 to 2010

Cause 1: Asphyxiation: House Fire/Homicide/Position/?	4
Cause 1: Drownings/Globoid Cell Leukodystrophy	4
Cause 2: MVAs	3
All Other Causes	12
Total	23

Figure 2-9

Interpretation: This report reflected significant improvement on infant mortality in the 1990 - 2000 year timeframe.

Research has not been completed in time for this report. All Vital Statistics will be published in a separate report and the information will be included in next year's annual report.

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. 2009 and 2010 current year information was provided for this report.

Research has not been completed in time for this report. All Vital Statistics will be published in a separate report and the information will be included in next year's annual 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 - 2010

Condition	FY 2007	FY 2008	FY 2009	FY 2010
Diabetes	538	551	568	574
Ischemic Heart Disease (IHD)	122	119	121	125
Hypertension 18-85 w/HTN DX	489	496	486	470
Asthma	243	209	225	248
Prediabetes/Metabolic Syndrome	792	847	883	906
Rheumatoid Arthritis			119	119

Figure 2-11

Interpretation: With the exception of Rheumatoid Arthritis, 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 last 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.

Data for previous years of Rheumatoid Patients is not easily obtained because it lists patients that are no longer living also. This list shows the current Active Workload of Rheumatoid Arthritis Patients.

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.

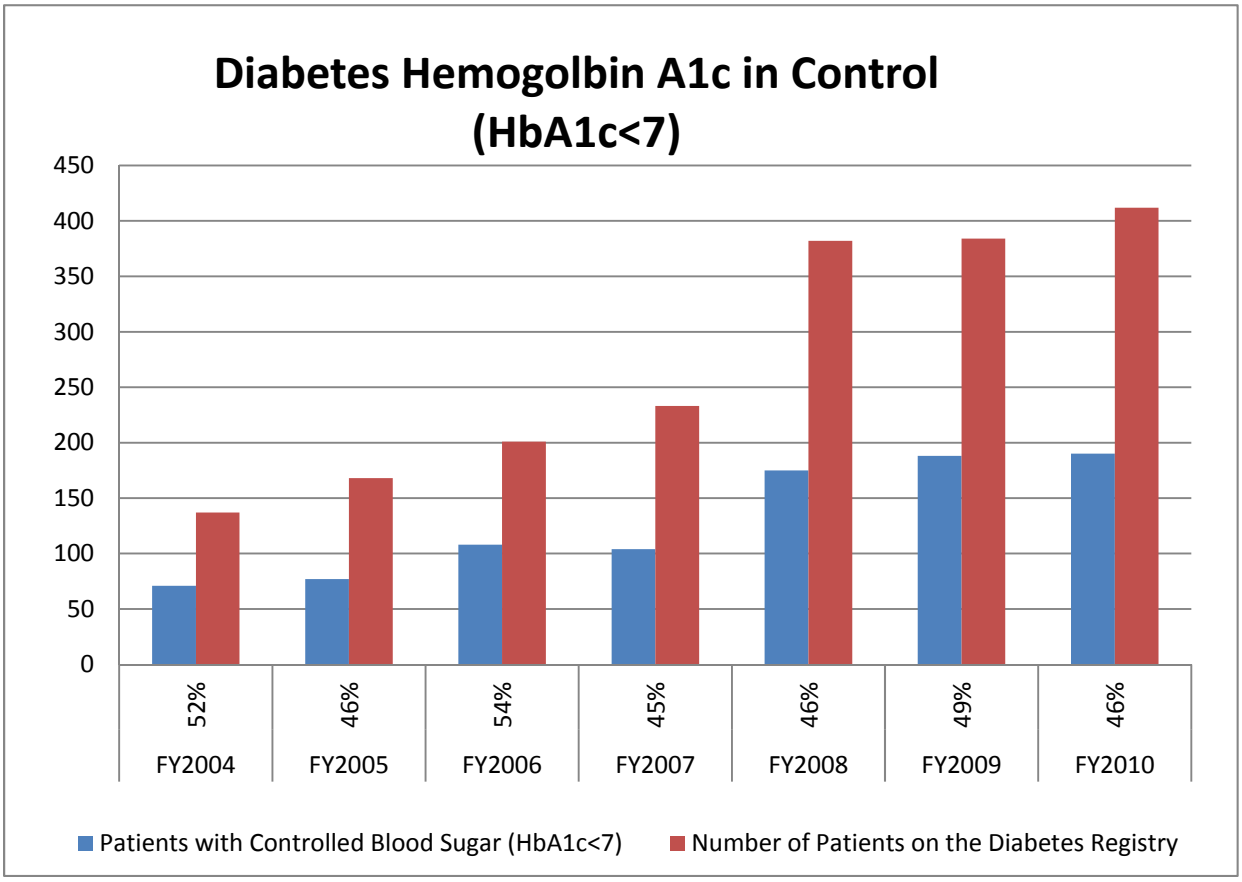


Figure 2-12

Interpretation: Approximately half of the patients listed in the Diabetes Management Registry from 2004 to 2010 achieved the ideal A1c target level of less than 7 as reflected in the 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
2009 - 2010

Inpatient Indicators	2009	2010
Total Admissions	313	305
Average Length of Stay	3.56	4.05
Total Hospital Days	1113	1236
Average Daily Patient Load	3.05	3.39
Emergency Room Visits	1,440	1,466

Managed Care Hospitalizations and Those Paid by Other Resources
Warm Springs Patients by Primary Diagnosis
2010

Condition	Number of Admissions	% of Admissions	Number of Hospital Days	% of Hosptial Days
Obstetrics	122	25.4%	264	15.3%
Motor Vehicle Accidents	10	2.1%	49	2.8%
Other Accidents/Injuries	18	3.7%	97	5.6%
Cancer	8	1.7%	54	3.1%
Heart and Circulatory	55	11.4%	234	13.6%
Respiratory	67	13.9%	233	13.5%
Renal	23	4.8%	89	5.2%
Digestive	58	12.1%	227	13.2%
Infectious Disease	25	5.2%	149	8.7%
Diabetes	13	2.7%	39	2.3%
Substance Abuse	45	9.4%	146	8.5%
Mental Health	15	3.1%	37	2.2%
All Other	22	4.6%	102	5.9%
TOTALS	**481**	**100.00%**	**1,720**	**100.00%**

Figure 2-13

Interpretation: The Figures in the preceding table of Figure 2-13 tie directly to the "Hospitals Utilized" Report (Figure 2-14) which shows total admits and 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 (Figure 4-9).

The Average Length of Stay as well as Average Daily Patient Load increased from 2009 to 2010.

The second table includes patients that Managed Care provided payment for as well as cases that were fully paid by another alternate resource for calendar year 2010 admits. This suggests a significant dependence on alternate resources (Oregon Health Plan/Medicaid, Medicare and Private Insurance). The Managed Care Program covered 63% of the admissions and 72% of the hospital days for Warm Springs' patients. If further restrictions in eligibility were imposed by the State, the Managed Care Program would experience a significant financial problem. If individuals dropped health insurance a similar impact would be felt. It is important that everyone in the Community fully utilize those 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
2010

Hospital	Admissions	Hospital Days	Total Cost $	Cost per Day
Mountain View	217	812	$1,230,384	$1,515.25
Redmond	5	19	$37,241	$1,960.05
St. Charles	67	313	$739,577	$2,362.87
OHSU	4	53	$200,958	$3,791.67
All Other	12	39	$34,966	$896.57
Totals	**305**	**1,236**	**$2,243,127**	
			Total Cost per Day	**$1,814.83**

Figure 2-14

Interpretation: This table reflects the total cost of hospitalization MCP paid for in 2010, and the number of admissions and hospital days that comprised this cost at the four major hospitals utilized. Mountain View Hospital accounts for 55% of the total hospital costs, with St. Charles Medical Center accounting for 35%, and OHSU in Portland 9% of the total hospital costs.

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

	2005	2006	2007	2008	2009	2010
ALLERGIC REACT	10	12	5	2	7	3
CARDIOVASCULAR	34	54	28	52	67	72
CELLULITIS/INFECTIONS (impetigo)	29	63	33	36	49	67
CHRONIC CONDIT.	38	21	23	43	37	24
COMMUNICABLE DISEASE	0	2	0	4	2	3
DENTAL	23	26	22	10	15	29
DERMATOLOGY (includes spider bites)	36	24	28	18	21	13
DRUG/ALCOHOL	84	103	69	70	111	140
ENT (ear, nose, throat)	109	134	80	92	116	100
EYES	18	14	10	14	11	23
GI	137	127	82	133	121	124
GU	35	82	49	86	75	95
HEADACHES	49	47	43	44	44	50
MEDS ONLY / DRESSING CHGS	5	2	2	4	2	5
MISCELLANEOUS	54	46	45	53	78	61
NEUROLOGY	30	37	32	34	34	39
OB-GYN	41	6	10	13	14	17
ORTHOPEDIC (musculoskeletal)	225	188	158	177	199	208
PULMONARY	88	70	76	89	136	106
PSYCHIATRIC (MENTAL HEALTH)	6	24	15	13	23	22
SNAKE BITE	0	0	0	0	1	0
TRAUMA						
ASSAULT	22	21	38	19	17	38
GUNSHOTS	2	2	2	1	1	1
LACERATIONS/BURNS/CONTUSIONS/	153	183	162	143	201	215
MVA	15	7	5	17	15	11
POISONS (ingested/breathed)	2	4	9	6	2	10
SEXUAL ASSAULT	0	0	0	0	0	2
DROWNING	0	1	0	0	0	0
POSSIBLE CHILD ABUSE	0	1	0	0	0	0
TRIAGE ONLY	0	0	0	0	5	9
VIRAL SYNDROME	30	7	7	17	43	10
VASCULAR (blood) - anemia/hem	3	7	1	7	8	18
TOTALS	**1,278**	**1,315**	**1,034**	**1,197**	**1,440**	**1,466**
COST (As Of 4/28/11)	$467,070	$553,401	$441,008	$507,635	$784,841	$789,377
COST PER VISIT	$365	$421	$427	$424	$545	$538

Note: The above data is for MVH; ER care at other hospitals is an extremely small portion of the whole. In 2009 & 2010 MVA's are not counted in the total, and in 2010 assaults are not counted in the total; however, the principal diagnosis is counted. As an example, because this is a Diagnosis chart, pt may have been in an MVA and may have a broken leg, and would thus be counted in the orthopedic category.

Figure 2-15

Interpretation: 2009 and 2010 have seen a noticeable increase in ER visits, and a corresponding significant increase in costs. While the cost is slightly higher in 2010 than 2009, the 2010 cost will continue to increase as ER claims are received for 2010. This trend is especially noteworthy in that the average Medicare-Like Rates discount in 2010 (45%) was essentially the same as in 2008 (46%). However, it is important to note the above totals for ER visits are inclusive and thus include those for which MCP is not responsible (i.e. OHP), while the “COST” is the total amount paid by MCP for ER claims. However, the trend from the prior four years to 2009 & 2010 is disturbing.

Emergency Room Utilization, Continued

EMERGENCY ROOM VISITS - TIMES / DAYS

	2005	2006	2007	2008	2009	2010
0800-2000,weekdays (8:00am-8:00pm)	339	359	289	290	444	462
2000-2400, weekdays (8:00pm-midnight)	201	212	161	268	210	235
2400-0800, weekdays (midnight-8:00am)	140	95	97	115	151	168
0800-1600, sat, sun (8:00am-4:00pm)	193	205	148	185	221	180
1600-2400, fri, sat, sun (4:00pm-midnight)	300	313	258	263	311	325
2400-0800, sat, sun, mon (midn-8:00am)	105	131	81	76	103	96
TOTALS	**1,278**	**1,315**	**1,034**	**1,197**	**1,440**	**1,466**

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. Locally, that trend exhibits itself in increased utilization of MVH ER when the IHS Clinic would be much more appropriate. These statistics support that trend in the past two years, with significant ER visits on weekdays between 0800-2000 hours. Overall, ER utilization has increased significantly the last two years as well.

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

	FY2006	FY2007	FY2008	FY2009	FY2010
Medical Visits by Provider					
Physicians	11,147	10,788	8,511	11,412	11,407
Mid Level Practitioners	1,875	1,569	5,166	3,772	4,492
Nursing Staff	6,990	5,759	5,013	4,604	4,596
Total Medical Visits	**20,012**	**18,116**	**18,690**	**19,788**	**20,495**
Workload Factors					
Clinic Days	250	250	250	250	250
Average Visits Per Clinic Day	80	72	75	79	82
Total FTE's In Medical Department	21	21	21	21	21
Physician FTE's	5	4.75	4.25	5.5	5.5
Mid-Level Practitioner FTE's	1	1	2	2	2
Avg Annual Visits Per FTE	953	863	890	942	976
Avg Annual Visits Per Physician FTE	2,229	2,271	2,003	2,075	2,074
Avg Annual Visits Per Mid-Level FTE	1,875	1,569	2,583	1,886	2,246
Extended Hours of Service					
Days of Late Clinic	199	167	118	175	202
Hours of Service (M-Th, 7pm)	398	334	236	350	404
Visits	811	582	458	692	802
Visits Per Hour of Service	2.0	1.7	1.9	2.0	2.0
Hospital Patient Count	514	461	455	478	424
Hospital Visit Count	1,955	1,780	1,869	1,988	1,809
Average Hospital visits per patient	3.8	3.9	4.1	4.2	4.3
Average Hospital patients per day	1.4	1.3	1.2	1.3	1.2
Average Hospital visits per day	5.4	4.9	5.1	5.4	5.0

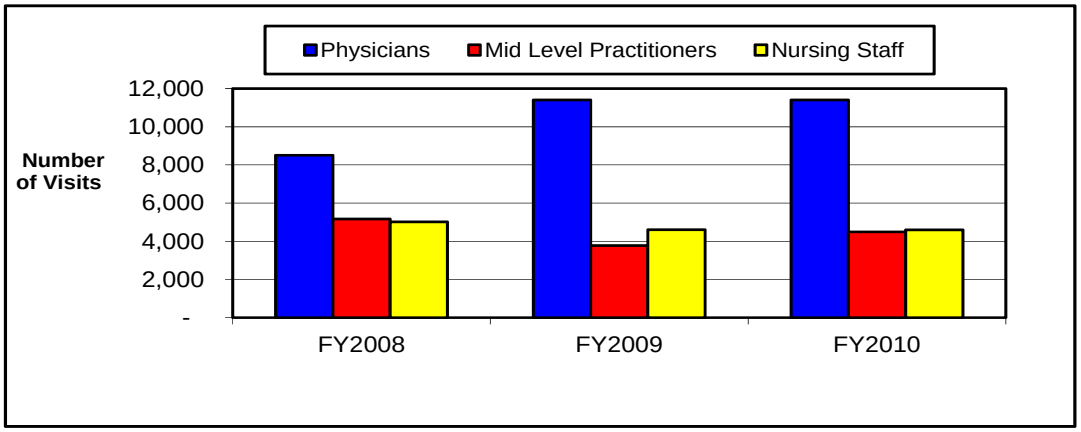


Figure 3-1

Medical Services Continued…

Interpretation: From 2008 to 2010, the medical department averaged 19,658 medical visits per year. Of those visits; 10,443 of those were physician visits, 4,477 were seen by mid-level providers, and 4,738 were nursing visits. The average number of visits per day was 79 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 2,050 visits per year and each FTE mid-level provider had an average of 2,238 visits per year. FTE physicians had approximately 7.6% less visits per year than mid-level providers due to physicians taking hospital call.

There was an average of 165 days when the clinic was open late for extended hours from 2007 - 2010 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 452 patients per year that visited the hospital an average of 4.2 times each for a total of 1,889 hospital visits per year between 2007 and 2010. Average hospital visits per day have remained at approximately 5 visits per day during this three 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	2010
Dental Visits by Provider						
Dentist Visits	6,949	5,854	5,350	5,402	Not able	4,541
Hygienist Visits	1,217	970	867	1,075	to obtain	1,158
Total Dental Visits	**8,166**	**6,824**	**6,217**	**6,477**	See Note below	**5,699**
Missed Appointments						
No Shows (Broken Appointments)	409	2,036	1,421	No Reliable		371
Broken Appointments vs Total Visits	5	30	23	Data		7%
Treatment Plans Completed						
Patients Completing Treatment	578	239	147	141		No longer
Completed Treatment/1st Visits	21.5%	9.5%	5.8%	5.70%		tracked
Workload Factors						
Clinic Days	250	250	250	250		250
Average Visits Per Clinic Day	33	27	25	26		23
Total FTE's	14	13	13	13		11.5
Average Annual Visits Per FTE	587	529	497	491		496
Extended Hours of Service						
Hours of Service	2,000	2,000	2,000	2,000		
Visits	8,166	6,824	6,217	6,477		No longer
Visits Per Hour of Service	4	3	3	3.23		provided
Categories of Care						
Preventive	7,287	6,195	5,988	7,719		6,861
Restorative including Crowns	4,145	2,820	2,407	3,039		2,698
Dentures including Bridges	296	144	87	123		106
Surgical	1,358	1,290	1,104	1,213		1,031
Orthodontic	41	41	38	37		12
Endodontic	260	145	71	92		163
Other	6,460	5,268	4,551	unknown		10,030
Total Identified Problems Treated	**19,847**	**15,903**	**14,246**	**12,223**		**20,901**

Figure 3-2

Interpretation: With 11.5 FTE's rather than 13 FTE'S Dental provided more prevention in 2010 than 2007 and 2006 and 88% of 2008. No-shows were decreased to 7% and annual visits per FTE increased slightly in 2010 compared to 2008. Total Dental Visits in 2010 were 87% of 2008 numbers while dental visits in 2010 were 91% and 83% of 2007 and 2006 respectively. Total numbers of dental problems treated in 2010 were more than any other recorded year. *Note for 2009: 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**	**2010**
New Prescriptions	47,788	48,499	46,359	47,689	48,297	54,243
Refills	17,472	17,948	20,062	21,891	24,659	26,359
Total Prescriptions	**65,260**	**66,447**	**66,421**	**69,580**	**72,956**	**80,602**
Workload Factors						
Clinic Days	255	249	261	250	249	250
Avg Prescriptions per Clinic Day	256	267	254	278	293	323
Visits to the Pharmacy	28,847	28,219	28,356	29,769	30,245	33,052
Prescriptions per Pharmacy Visit	2.26	2.35	2.34	2.34	2.41	2.44
Total FTE's	7	7	7	7	6	6.25
Avg Annual Prescriptions Per FTE	9,323	9,492	9,626	9,940	12,159	12,896
Pharmaceuticals						
Total Expenses				$ 741,282	$ 772,273	$882,251
Avg Cost Per Perscription	0.00	0.00	0.00	$ 10.65	$ 10.59	$10.95
Rx for Patients outside Service Area				Unavailable	Unavailable	

Figure 3-3

Interpretation: Workload in FY2010 as compared to FY2009 is up 10.5% in the number of prescriptions filled. The number of prescriptions per day has increased by 10.2%. There was an increase in the average number of prescription per FTE of 6%. This number is affected by the lack of a pharmacy resident in FY2009 and most of FY2010 (the resident helps staff the pharmacy half of each workday and does the residency rotation the other half of the day). The new resident began in July 2010. There was also a 1.2% increase in the number of prescriptions per patient.

Drug costs as compared to FY2009 have increased by 14% overall (due to the increased number of prescriptions), but just 3.4% per prescription. The pharmacy staff is vigilant in looking for the best contract price available for each drug product.

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

	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
Imaging Exams						
X-Ray Exams	2,012	1,923	1,825	1,641	1,796	1,886
Ultrasound Exams	140	132	0	0	0	0
Total Exams	2,152	2,055	1,825	1,641	1,796	1,886
Workload Factors						
Clinic Days	250	250	250	250	250	250
Average Exams per Clinic Day	8.6	8.2	7.3	6.6	7.2	7.5
Average Exams per Year	2,152	2,055	1,825	1,641	1,796	1,886
Total Patients	2,216	2,081	1,668	1,531	1,693	1,772
Average Exam per Patient	1.0	1.0	1.1	1.1	1.1	1.1
Total PCPV's	11,873	15,454	13,038	14,387	12,747	15,783
Average Exams per PCPV	0.18	0.13	0.14	0.11	0.14	0.12
Total FTE's	1	1	1	1.2	1.25	1
Exams per FTE	2,152.0	2,055.0	1,825.0	1,367.5	1,436.8	1,886.0

Figure 3-4

Interpretation: The total exam count went down beginning in 2006 reaching its lowest point in 2008. The increase since that time has been 7% per year and will be at the 2006 level this fiscal year.

Diagnostic Services Continued…

Diagnostic Services - Medical Laboratory

	2005	2006	2007	2008	2009	2010
Medical Lab Tests						
Tests collected in the Lab	83,580	87,301	88,555	n/a	89,820	90,914
Tests collected outside the Lab	4,800	5,100	5,435	n/a	3,617	3,203
Tests performed off-site	1,620	2,549	2,925	n/a	5,778	6,309
Total Lab Tests Ordered	**90,000**	**94,950**	**96,915**	**n/a**	**99,215**	**100,426**
Workload Factors						
Clinic Days	250	250	250	250	250	250
Tests Ordered per Clinic Day	360	380	388	n/a	397	402
Total Medical Visits	20,850	20,012	18,116	18,690	19,788	19,788
Average Tests per Visit	4.3	4.7	5.3	n/a	5.0	5.1
Total FTE's	5	5	5	4	4	4
Tests per FTE	18,000	18,990	19,383	n/a	24,804	25,107
Category of Tests Ordered						
Hematology	23,376	21,045	16,476	n/a	30,221	30,173
Chemistry	54,212	64,709	68,874	n/a	63,164	64,625
Bacteriology	6,808	3,508	2,892	n/a	1,404	778
Urinalysis	5,604	5,688	5,748	n/a	4,426	4,850
Total Lab Tests Ordered	**90,000**	**94,950**	**96,915**	**n/a**	**99,215**	**100,426**

Figure 3-5

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

	2005	2006	2007	2008	2009	2010
Optometry Visits						
Clinic Visits	1,643	1,612	1,733	1,595	1,796	1,846
Missed Appointment Rate	37%	33%	32%	28%	23%	22%
Workload Factors						
Clinic Days	220	220	220	220	220	220
Average Visits per Clinic Day	7	7	8	7	8	8
Total FTE's	2	2	2	2	2	2
Nature of Visits						
Refractions	701	825	944	762	835	673
Diabetic Eye Exam (Patients)*	221	229	201	233	188	199
Contact Lens Visit	51	86	145	107	111	58
Medical Visit	38	35	47	27	32	
Early Childhood Education Visits	253	139	245	354	383	35
Glasses Repair/Adjustment	253	139	245	354	383	394
Other						487

Figure 3-6

Interpretation: The optometry department continues to see a slight 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 1% over the past year.

The number of diabetic patients seen in the clinic is up from last year.

The number of patients seen in most all categories has increased over the years except for stall levels which remain at 2.

Podiatry Program

Purpose: The practice of podiatry is to preserve human movement and thereby improve human life. The program's aim is to teach and enable all who are served to "Walk Well" at the highest level of ambulatory ability; given each person's physical potential.

Relevance: The adage "if your feet hurt" everything hurts and perhaps even suffers is likely true to one degree or another; therefore it is relevant to provide excellent and up-to-date podiatric medicine, foot and ankle surgery and wound care, age appropriate extremity education.

Podiatry Department

	2008	2009	2010
Podiatry Visits			
Clinic Visits	1,808	1,669	1,643
Missed Appointment Rate	16%	19%	21%
Workload Factors			
Clinic Days	161	165	149
Average Visits per Clinic Day	11	10	11
Average Visits per Year			
Nature of Visits			
PT with Diabetes	664	551	570
PT with Open Wound	346	297	278
Comprehensive or Annual DM Ft Exam	42	39	91
Office Procedure Performed	531	354	326
OR Case	29	35	32
Hospital Patient	142	136	132
Other Visit Reasons	225	428	378
Total Podiatry Visits	**1,979**	**1,840**	**1,807**

Figure 3-7

Interpretation: Education and patient training takes time so pure numbers don't tell the complete story. More people are getting better about Diabetes Management foot care prevention resulting in less relative numbers of foot wounds.

The podiatrist has had a personal healthcare issue in 2010-11, leading to a decrease in clinic days and patient numbers.

Managed Care Program

Purpose: To identify workload of the Managed Care Program.

Relevance: To assure effective processing and management of resources.

	2005	2006	2007	2008	2009	2010
Staffing & Other Workload						
FTEs	7	7	7	7	7	7
Number of Obligations	8,190	6,120	5,022	7,162	9,136	9,757
Funds Obligated	$4,905,541	$5,049,015	$3,447,984	$3,875,173	$4,932,401	$5,706,031

Figure 3-8

Interpretation: The Number of Obligations/Funds Obligated reflects the implementation of Priority 1's in 2005 and the elimination of specialty clinics in 2006; thus, the decrease seen from 2005 through 2007. The Tribal Council passed a Resolution funding some non-Priority 1 healthcare implemented late in 2007 and 2008 and 2009 reflected increased healthcare coverage funded via "carve-outs" from MCP reserves accumulated through Medicare-Like Rate saving; thus the increase seen from 2007 through 2010. 2010 marked the expansion of Priority 1's back to full coverage of Priority 1-4's. Significant personnel time was involved in the implementation of Medicare-Like Rates reimbursement, but was time well spent as exhibited by the documented savings found elsewhere in the Report.

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

Services Provided by Category	2008	2009	2010
Prenatal Visits			5
Post Partum Visits			
Well Child Visits			
Immunization Visits			381
Diabetes Visits			
Cardiovascular Visits			
Mental Health Visits			
STD Visits			25
Family Planning			42
Other Visits			27
Total Community Health Nurse Visits - (In Office Only)	-	-	480
Visits by Location			
Out of Clinic Visits			594
Clinic Visits			603
Total Community Health Nurse Visits	-	1,097	1,197
Total Days of Service		250	250
Average Visits Per Day		4.4	4.8
Total FTE's	5	2	2.5
Average Visits per FTE per year	-	549	479

Figure 3-9

Interpretation: Services provided by Category are In-Clinic visits only. Out of Clinic Visits may include visits to patients in corrections, at-home settings, in work and school settings, etc.

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	2010
Total number of births	107	83	118
Total number of births (Tribal members)			
Number of high risk pregnancies	31	20	32
Number of high risk infants identified*	29	33	36
Prenatal Home Visits			
Post-Partum Home Visits	98		
Other Home Visits		78	454
Number of hospital visits			109
Number of birthing classes and number of participants			47 classes/ 240 Participants
Infant Immunization level**	89.4%	88.6%	87.3%

Figure 3-10

* 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.

** Infant Immunization Level figures - Source: GPRA Report Figures on Children 19-35 months of age.

Interpretation: As the number of births and the MCH caseload grows, it is to be expected that the number of complicated pregnancies and high risk newborns will also increase. Immunization rates in newborns is mostly affected by the administration of vaccine at the hospital before newborns are discharged and then is affected by parents' compliance with care by attending well-child clinics and immunization visits starting from about the age of 3 months.

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	2010
Caseload by Category:			
- Transports	63	95	157
- Patient Care	100	432	649
- Case Findings/Screening	112	471	784
- Monitoring Patient	43	339	438
- Case Management	51	188	171
- Health Education	7	36	27
- Other	23	110	350
Total Client Encounters	**399**	**1,671**	**2,576**
Total Days of Service		**250**	**250**
Average Number of Encounters per Day	250	7	10
Total FTE's	3	3	3
Average Number of Encounters per FTE per Year	133	557	859
Total Mileage Reimbursed			

Figure 3-11

Interpretation: More elders have been identified each year as more people have been living longer. In addition, with the rising cost of transportation, more patients state they need assistance with getting to medical appointments that are off the reservation. Increasing better communication and decreasing the amount of time spent by CHRs doing duplicate documentation has increased their effectiveness to meet some of the demand.

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 is devoted to this problem.

Diabetes Program

	2007	2008	2009	2010
Diabetes Program Visits				
Clinical Visits (FNP & RN-all visits)	1,679	1,792	1,501	1,457
Community Encounters	1,922	1,882	2,433	2,010
Total Visits	**3,601**	**3,674**	**3,934**	**3,467**
Workload Factors				
Clinic Days	250	250	250	250
Average Visits per Clinic Day	14.4	14.7	15.7	13.9
Total FTE's	4.0	4.0	5.0	5.0
Average Visits Per FTE	900	919	787	693
Categories of Service				
General Diabetes Clinic Contacts				
Special Diabetes Clinic Contacts				
Education Contacts	899	769	753	787
Community Contacts	1,922	1,882	2,433	2,010
Patients in Dialysis				
Number of Patients	8	10	11	13

Figure 3-12

Interpretation:

1. 2010 statistics continue to reflect professional staff positions being vacant.
2. 2010 education visits increased which is directly related to the Diabetes Program RN achieving a certificate as a Certified Diabetes Educator and becoming the Nurse Educator for the Program.
3. Dialysis – 2 of the 13 patients do not have type 2 Diabetes. 1 of the 13 patients receives dialysis care elsewhere. Dialysis statistics are below projections regardless of patients in the I.H.S. Diabetes Register and increase in patients with chronic kidney disease.
4. Community contacts remain higher than 2007 and 2008 even with decreased staff.

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	2010
Infants and children under 5 years of age	537	538	543
Pregnant, breastfeeding and postpartum women	214	198	219
Total number of Women, Infants and Children served	751	736	762

Figure 3-13

Interpretation: The total number of families served by out Tribal WIC Program is 351, which is an increase from 2009 when we served 333 families.

Also an increase in 2010 was the percentage of moms who started out breastfeeding. In 2009 that was 89.2% and in 2010 it increased to 91.5% which has shown to have health advantages for both mothers and infants.

The increase in families served can be correlated with the increased number of women delivering babies, but also to additional nutrition education and healthy food choices available to them and their families.

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	2010
Program Prevention Health Education Team			
Note: Services not delivered in 2010 will be marked by an N.			
Cancer			
Women's Health			
Women's Health Retreat		100 N	
(Candle Light Service, Women's		65 N	
Women's Health Fair		100	125
Women of Wellness (Education))		540	720
My Future My Choice curriculum			20
Fetal Alcohol Spectrum Disorder			
FASD Training - Diane Malbin		80 N	
FASD Training - Part 2		80 N	
Health and Wellness			
Honoring the Gift of Heart/Health		30 N	
H1N1 Outreach		1000 N	
Pi-Ume-Sha Health Fair		800	700
Men's Health Fair		5	20
Museum Health Fair			61
P.H.E.T. Health Fair			210
Cultural Prevention			
Drum Making for Men and Boys		20 N	
Jingle Dress Making		60	6
HIV/Aides			
World Aids Day		25	40
Oregon Indian Education Meeting		30	20
Alcohol and Drug Prevention			
Back to School BBQ		500	700
Back to Boards 8 - 5 session classes		20	40
METH Conference		90 N	
Gang Prevention Conference		120	380
Girl's Club		25 N	
Lil Miss Warm Springs Pageant		40 N	
Smoking Cessation Class		25 N	
All Night Alcohol/Drug free parties 2 total			268
Community Garden training			17
3 on 3 basketball			94
Agency presentations			28
Tobacco			
Seeds of Discovery		375	350
Great American Smoke-Out		100	40

Figure 3-14

Prevention Health Education Team Alcohol Program, Continued…

Interpretation: In the fiscal year 2009-2010 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 for the analyzing of number of people served, age and sex, and type of prevention activity. The system also can create charts and graphs from the data.

PHET's goal is to provide a balance among the Six Prevention Strategies as outlined by the Center for Substance Abuse Prevention (CSAP). These are Information Dissemination, Prevention Education, Alternative Activities, Community-based Processes, Environmental Strategies, and Early Identification and Referral. Additionally, PHET is being influenced by the State of Oregon's efforts in identifying "Tribal Best Practices" in prevention. In 2010, the data shows PHET was most heavily weighted in providing "Information" through educational presentations, Health Fairs, and "Alternative Activities" for youth. PHET will use this information for planning in 2011 to provide better balanced-more productive programs and services to the community.

A "policy" area that has been identified to work on will involve discussions with law enforcement, adult/juvenile probation and the court system. PHET would like to propose that every adult and juvenile that comes in contact with the court system because of an alcohol and/or drug related offense at a minimum be required to complete an educational program. PHET along with the Community Counseling Program would be able to deliver these classes. This policy would be of great benefit to the Tribes in providing education and encouragement to many Tribal Members who are currently not receiving any services.

Mental Health

Purpose: Provide individual, group, family counseling, evaluations, and assessments to mental health clients. Develop treatment plans for clients. Refer clients to outside resources. Document all treatment activities and maintains files in accordance with established guidelines and requirements. Provide and participate in consultation and prevention services with other agencies and the community. Provide and participate in follow-up and after-care services. Coordinate residential treatment referrals. Participate in continuing education and staff development activities. Maintain various paperwork and records. Develop a therapeutic and supportive relationship with clients. Carry out practical and short- and long-range plans. Participate in crisis/emergency mental health services. Maintain sensitivity and confidentiality. Participate on the Center's emergency service system. Participate in the Center emergency call system.

Relevance: To provide mental health service to the Warm Springs Community in a profession manor this includes presenting therapeutic interventions which are culturally relevant. This also includes access to psychiatric facilities for one's own safety and treatment of those who meet the criteria for severe and persistently mentally ill.

Mental Health

	2008	2009	2010
Visits & Clients Served			
Number of Adult Visits	858	905	1,021
Number of Children Visits	1,288	1,810	2,042
Total Visits	2,146	2,715	3,063
Categoryes of Service			
Depression Visits	we are unable to break down this information at this time		
Post Traumatic Stress Visits			
Crisis Management Visits	201	236	275
Other			
Service Hours			
Client Contact Hours			
Total FTE Hours			
% hours of Client Service			

Figure 3-15

Mental Health, Continued…

Interpretation: All local and State data was not available at time of report. The Community Counseling Center has been selected as one of the five pilot programs for the State of Oregon's new OWIT electronic health record system. It will be implemented in the summer of 2011.

The Counseling Center has seen a steady increase in the delivery of services. This demonstrates the increase in participation by the community and commitment by the Community Counseling staff. The implementation of the OWIT data system will make variables in the delivery of services easier to categorize and analyze.

Alcohol and 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

	2008	2009	2010
Adult Encounters			
Number of Visits*	2,146	2,866	2,570
Number of Clinic Days	239	239	239
Average Visits per Clinic Day	9	12	11
Categories of Service			
Alcohol Abuse	1,913	2,549	2,287
Drug Abuse	233	317	283
Residential Care	25	37	35
Follow-Up Rehabilitation Cases			

Figure 3-16

* A&D Prevention B-Ball (Adults & Kids)	300+		400+
* Jail Groups (estimate)	216	256	246
* Relapse Anger Resolution gap (Estimate) Quarterly	75	75	*75*
* Healing from Grief & Trauma - 1 day conf.			*25*
* Recovery Month Dinner			100+
* Community Grief/Trauma Gathering			90+

Interpretation: Due to staff shortages, there has been a decrease in services between 2009 and 2010. This reduction in services is short term.

Adolescent Aftercare

Purpose: Initiate, conduct and coordinate children's aftercare program which includes substance abuse, suicide, and mental health prevention activities, with an emphasis on adolescent suicide prevention with other Tribal, State and Federal agencies.

Relevance: An integrated children's aftercare treatment program which includes suicide, substance abuse, and mental health prevention programs in coordination with other Tribal work groups and committees. Initiate and conduct aftercare prevention activities, document and report prevention activities to Program director. Develop and conduct aftercare program in coordination with prevention programs, with an emphasis on adolescent prevention within the Warm Springs community.

Adolescent Aftercare

	2008	2009	2010
Outpatient Visits	231	465	347
Number of Clients In			
Residential Care	19	11	15
Suicide Prevention Camp	20	50	32
Healing Wounded Spirits Camp	103	0	0
Winter Youth Conference	107	0	0
Movie Nights (started Dec 2009, families)	0	47	297
Wii Bowling (Dec 2009)	0	4	49
Hoop Camp (Dec 2009)	0	52	62
Madras Bowling			84
Wellness Walk			18

Figure 3-17

Interpretation: The aftercare program has taken a new approach to providing services which include health alternatives to social activities in a group setting. In addition one on one services are provided to clients who are having difficulties returning from a treatment setting. Through this program additional support is provided to youths who are in danger of relapsing without the positive interactions provided through the aftercare program.

Social Services

Purpose: To identify the case load and resources by associated with programs administered by Social Services (Housing & Energy Assistance, Medical Travel, Disability Assistance and Commodities).

Relevance: The Social Services Program serves some of the community's most vulnerable members. Monitoring these services and their impact is very important.

Social Services

	2008	2009	2010
Housing & Energy Assistance			
Number of Clients Served			
Total Vouchers Processed			
Total $ Value of Vouchers			
Medical Travel			
Number of Clients Served			
Total Vouchers Processed			
Total $ Value of Vouchers			
Disability			
Number of Disabled Adults			
Number of Survivor Clients			
Total Clients Served			
Total Visits			
Number of Successful Applicants			
Number of Appeals			
Number of Court Hearings			
Number of Applicants Pending			
Commodities			
Number of Families Served			
Number of Individuals Served			
Number of Warm Springs Tribal Members			

Figure 3-18

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 measures collection potential of this enterprise.

SUMMARY OF AMBULANCE ACTIVITY

Reason for Call	Calls		Patients Transported		Calls w/Substance Factor	
	2009	2010	2009	2010	2009	2010
Motor Vehicle Accident	128	175	81	59	13	35
Other Accident	558	590	178	86	145	48
Assault and Battery	161	69	45	43	72	28
Suicides/Attempts	24	21	17	13	9	13
Corrections	246	383	45	40	92	30
Pediatric	124	99	25	34		0
Cardiac	91	79	53	46	10	12
Respiratory	121	73	41	52	4	8
Other Illness	773	301	87	281		143
Total	**2,226**	**1,790**	**572**	**654**	**345**	**317**

TRIBAL AFFILIATION RELATED TO CALLS

Reason for Call	Calls Dispatched		Patients Transported		Calls w/Substance Factor	
	2009	2010	2009	2010	2009	2010
Members and Dependents	1,147	1,527	435	537	343	440
Other Eligible Indian		36	26	36		18
Non Tribal	130	227	111	81	2	21
Total	**1,277**	**1,790**	**572**	**654**	**345**	**479**

Figure 3-19

IMPORTANT NOTE: the top call block with the Substance factor ONLY includes Transports invloving Alochol/ Drug the bottom call block with Substance factor includes TOTAL amount for the year

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: Education and assistance for Native Americans.

Relevance: Grants enable programs to offer a multitude of services including: health education, presentations, cooking classes and community interaction to the Warm Springs Community.

Diabetes Grant (Tribe): The Tribal SDPI Program offers group activities and renal clinics for the education, prevention and treatment of Diabetes in the Community of Warm Springs.

State Women, Infants and Children (WIC): WIC provides nutrition education, one on one nutritional consultants and assistance to purchase nutritious foods and formula for pregnant/nursing mothers and children up to age 5.

Woman's Wellness Conference:

Senior Fitness Enhancement:

State Tobacco Prevention: On-going project that concentrates on promoting policy such as having smoke free buildings, events and worksites.

USDA Commodity Warehouse: Provide food to low income/disabled households on the Reservation.

State Alcohol & Drug:

State Alcohol Prevention:

State Mental Health:

State Youth Suicide Prevention: Youth encouragement of self-worth and family values. Hosts community events that provide family activities.

Vocational Rehabilitation: Program helps Native Americans with disabilities find, obtain, maintain or become promoted in employment.

Social Services Disability: Assists clients in establishing SSI/SSDI claims supporting clients throughout the process.

Meth Prevention Project: Provides education and resistance education through Health Fairs, Prevention Conference and various community events.

Interpretation:

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 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	2010
Indian Health Service					
Recurring Funding	12,454,591	12,883,003	13,340,464	13,995,065	16,174,897
Non-Recurring Funding	368,971	1,339,696	982,431	1,350,517	1,670,645
Collections IHS					
Medicare	141,850	230,133	227,606	231,819	81,657
Medicaid	2,544,845	1,967,963	2,196,249	1,809,197	2,283,902
Private Insurance	664,213	563,197	520,907	443,555	478,426
Collections Tribe					
Ambulance			120,878	199,242	207,994
Community Counseling	262,143	313,129	308,736	201,524	269,916
Community Health					33,928
Grant Awards	1,188,305	1,528,653	659,064	1,303,029	859,469
Tribal Employee Group Insurance (Spent)	614,877	733,071	1,233,674	1,260,238	1,269,463
Tribal Appropriations	1,165,104	1,023,197	933,387	1,160,988	1,790,924
Total	$19,404,899	$20,582,042	$20,523,396	$21,955,174	$25,121,221

Figure 4-1

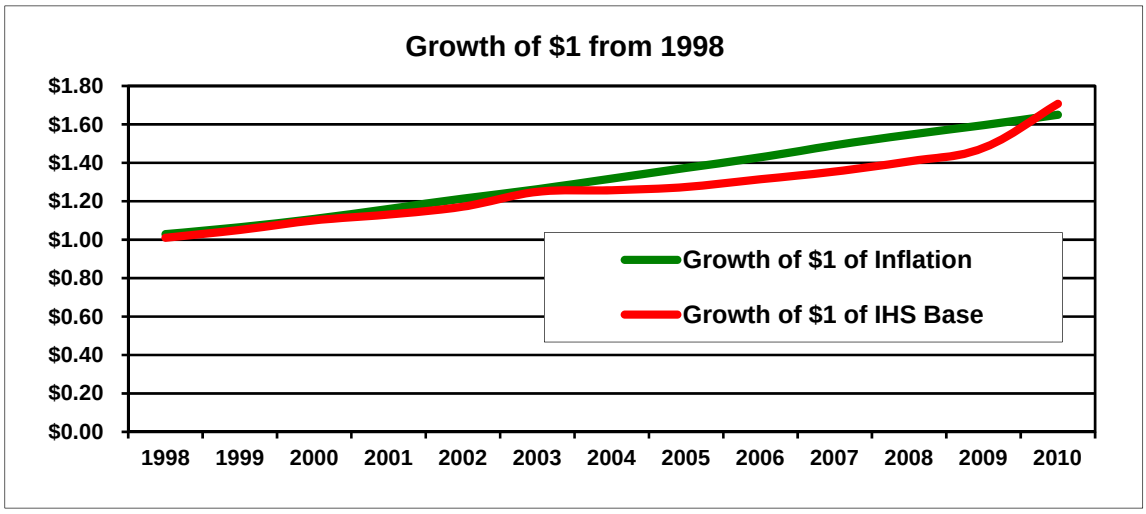
Interpretation: Funding tends to be stable supported by recurring appropriations, but increased population and medical inflation are ongoing concerns. Another key issue to watch will be the impact of Oregon State budget deficit issues on Medicaid collections in coming years. The Indian Health Service 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%
2010	16,174,897	15.6%	3.4%



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	2010
Clinical Services			
Medical	1,929,661	2,752,506	3,562,634
Dental	998,027	1,081,141	1,111,249
Optometry	238,015	196,619	254,790
Pharmacy	1,902,709	1,375,587	1,459,292
Podiatry	186,125	160,939	181,846
Medical Lab/X-Ray	341,988	587,557	912,072
Diabetes - Clinic	117,326	515,174	370,600
Community Health			
Community Health Dept.	337,561	332,515	194,176
Health Education	122,503	60,687	140,073
WIC Program	59,671	69,447	25,051
Diabetes Grant (Tribal)	172,101	344,986	35,024
Environmental Health	119,690	90,919	83,678
Public Health Nursing	628,273	395,325	487,956
Community Center	229,039	237,450	58,245
Community Counseling			
Community Counseling	815,913	801,698	748,449
Mental Health	330,801	265,369	215,132
Adolescent Aftercare	89,789	145,569	125,644
Vocational Rehabilitation	464,171	302,172	306,586
Prevention Projects	196,898	149,769	26,563
Administrative Support			
Facilities	829,658	888,266	958,080
Security	22,671	28,860	21,408
Health Administration	799,352	812,088	657,133
Business Office	230,308	299,474	282,104
Quality Assurance	162,643	175,148	174,143
Data Systems	367,642	371,056	393,030
Indirect Costs	531,257	575,006	587,803
Other			
Managed Care	4,073,862	5,498,295	5,935,441
Ambulance	897,125	858,007	939,514
Quarters	149	10,578	-
Clinic Equipment	187,945	334,497	105,518
Total	**17,382,873**	**19,716,704**	**20,353,234**

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	2010
Visits Billed						
Medical	12,687	16,970	12,860	11,874	11,336	10,411
Dental	3,288	3,432	2,216	2,469	1,911	2,168
Pharmacy	16,435	15,422	15,050	19,720	19,830	23,645
Optometry	220	218	219	410	431	440
All Other	2,608	2,220	1,487	1,448	1,478	1,882
Total Visits Billed	**35,238**	**38,262**	**31,832**	**35,921**	**34,986**	**38,546**

	2005	2006	2007	2008	2009	2010
Collections						
Medical	$ 1,814,179	$ 2,039,412	$ 1,730,783	$ 1,878,176	$ 1,770,324	$ 2,023,029
Dental	538,819	513,318	324,767	436,894	244,363	373,161
Pharmacy	470,833	441,566	457,968	577,689	581,929	635,645
Optometry	6,094	7,170	14,406	66,642	65,006	72,419
All Other	67,576	48,776	47,044	24,134	11,846	43,133
Total Collected	**$ 2,897,501**	**$ 3,050,242**	**$ 2,574,968**	**$ 2,983,536**	**$ 2,673,468**	**$ 3,147,386**

	2005	2006	2007	2008	2009	2010
Source						
Medicaid	2,543,108	2,579,324	1,974,105	2,242,011	2,050,000	2,283,902
Medicare	123,648	151,038	278,307	241,542	200,000	81,657
Private Insurance	456,785	645,384	555,644	522,950	450,000	478,426

Figure 4-4

Interpretations: Total Medical visits billed trended downward in 2007 through 2010 (-18%). Conversely, pharmacy visits billed trended upward at an increase of 44% from 2005-2010. Total visits billed have increased an average of 10% in 2009-2010. Overall, total visits billed averaged around 10%with increases and decreases throughout the time span. In 2010, Medical billed out for 10,411 visits and received $2,023,029 (an average of $195/visit). Medicaid accounted for approximately 80% of collections, Medicare around 17% and Private Insurance makes up 3%.

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	2010
Incidents/Visits Billed						
Ambulance				615	692	681
Alcohol & Substance/ Mental Health	1,582	1,532	1,294	1,206	797	1,015
Community Health						236
Other						
Total Incidents/Visits Billed	**1,582**	**1,532**	**1,294**	**1,821**	**1,489**	**1,932**

	2005	2006	2007	2008	2009	2010
Collections						
Ambulance				$ 120,878	$ 199,242	$ 215,961
Alcohol & Substance/ Mental Health	341,700	262,143	313,129	308,736	201,524	272,060
Community Health						33,928
Other						
Total Collected	**$ 341,700**	**$ 262,143**	**$ 313,129**	**$ 429,614**	**$ 400,766**	**$ 521,949**

	2005	2006	2007	2008	2009	2010
Source						
Medicaid					241,180	358,593
Medicare					45,957	
Private Insurance					108,986	
Other					4,643	

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	
	2009	2010	2009	2010	2009 (1)	2010
Medicaid	148	159	161,600	169,610	39,656	52,605
Medicare	102	84	114,845	97,930	46,956	40,297
Private Insurance	123	110	135,152	278,352	111,554	121,971
Private Pay	49	65	61,338	74,875	75	1,088
Managed Care	249	246	277,326	275,742	0	0
No Source	21	17	2,404	0	0	0
Total	**692**	**681**	**$ 752,665**	**$ 896,509**	**$ 198,241**	**$ 215,961**
Average Per Transport			**$ 1,088**	**$ 1,316**	**$ 286**	**$ 317**

(1) Collection source breakout not reported

OUTLAYS AND FUNDING	2009	2010
Outlays		
Allocated Salaries and Benefits	603,601	642,341
Medical Supplies	32,292	47,737
Other Supplies & Expenses	34,980	34,891
Vehicle Expenses	54,407	55,118
Equipment	23,725	24,455
Vehicle & Equip. Depreciation	108,000	108,000
Total	**$ 857,005**	**$ 912,542**
Average Direct Cost Per Transport	**$ 1,238**	**$ 1,340**
Funding Source		
Indian Health Service (PL 93-638)	$ 97,946	$ 97,946
Collections	$ 198,241	$ 215,961
Warm Springs Tribe - Direct Appropriation	$ 560,818	$ 598,635

Figure 4-6

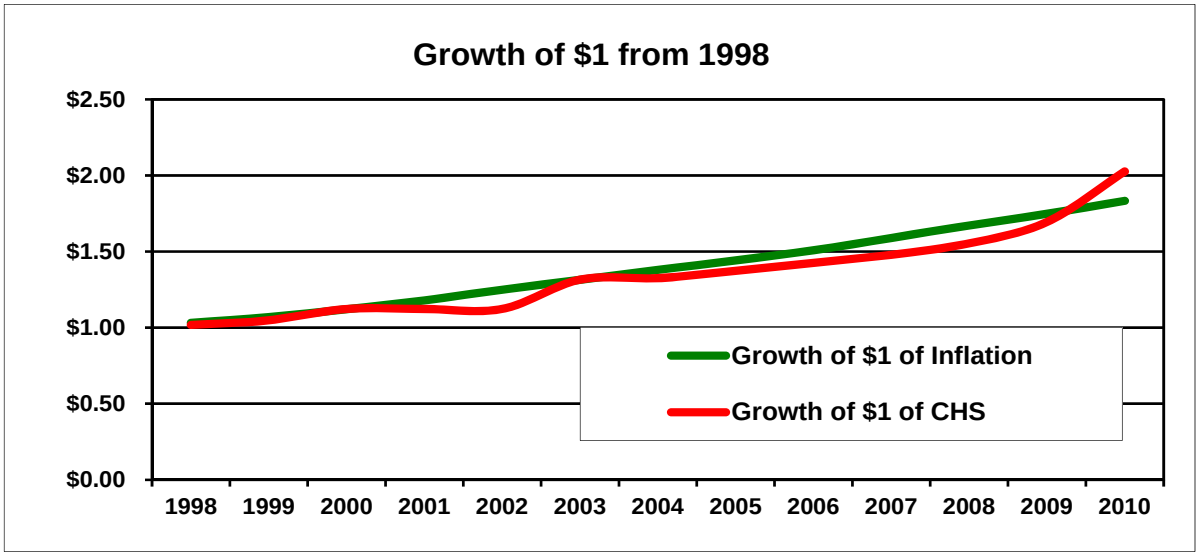
Interpretations: The service utilized an average market total billing rate of $1,164 for 2009 and 2010. No charges are billed for dispatched calls where no transport occurs. Salaries and Benefits include personnel during dispatch, transport, training, and other time related to ambulance services. Allocations 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%
2010	5,409,429	243,152	867,507	6,520,088	19.6%	4.9%



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	1,830,812	1,116,134	441,008	38,592	2,483	5,915	10,094	3,445,038	
2008	1,729,093	1,486,931	507,635	52,544	3,424	17,373	82,811	3,879,811	
2009	2,015,882	1,914,685	784,841	90,704	5,611	18,620	103,108	4,933,451	*
2010	2,243,127	2,016,563	789,377	72,489	7,154	25,384	110,510	5,264,604	*

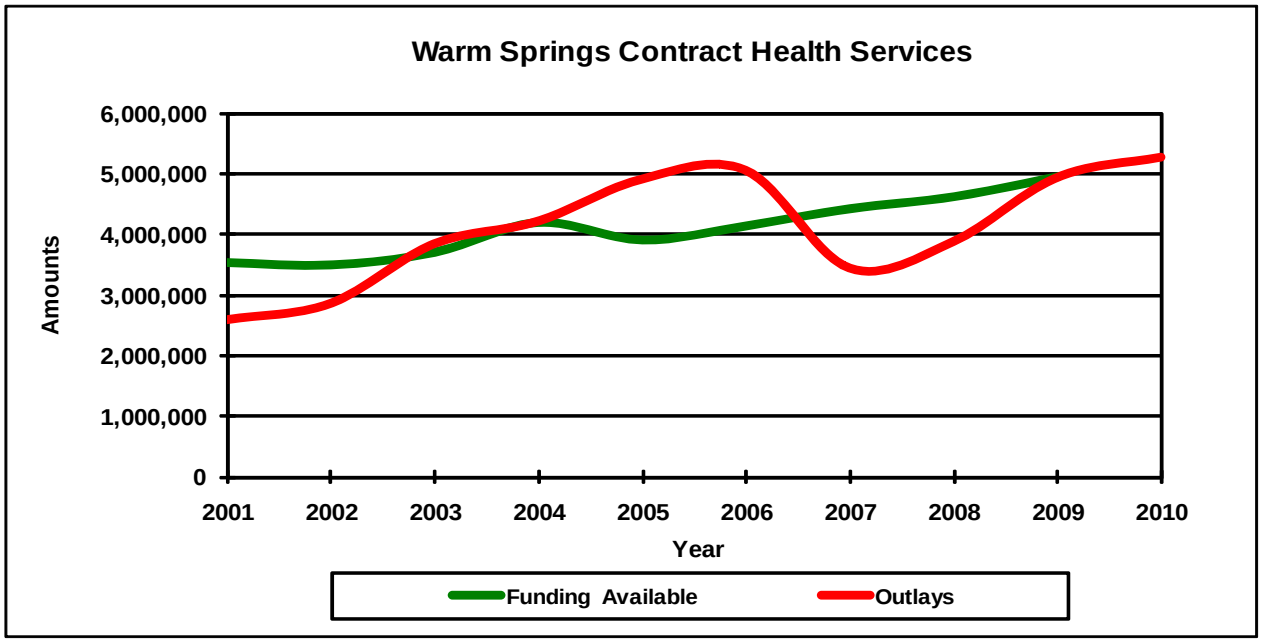


Figure 4-8

Interpretation: Illustrates fluctuations in MCP total costs, as well as seven components of that total cost, over ten years. Even with the implementation of Priority I's 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 $600-700k for both In-Patient and Out-Patient in 2008, 2009 and 2010 is the result of the $500k of the Tribal Council Resolution (2008), $500k carryover "carve-out" from reserves (2009), $250k carryover "carve-out" from reserves (2010), and relaxation of the Priority I's in April 2010. Most Priority II, III, and IV have been authorized since then, with the resulting yearly peak cost of $5,264,604 in 2010.

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.

	2009			2010		
	Units	Total Cost	Cost per Unit	Units	Total Cost	Cost per Unit
Hospital Days	1,113	$ 2,015,882	$ 1,811	1,236	$ 2,243,127	$ 1,815
Emergency Room Visits	1,440	$ 784,841	$ 545	1,466	$ 789,377	$ 538

Figure 4-9

Interpretation: This table reflects the units, total cost and cost per unit for both Hospital Days and Emergency Room Visits that MCP paid for. There was a slight increase in Hospital Cost per Unit from 2009 to 2010, but a slight decrease in Emergency Room Cost per Unit for the same time period.

While the data in the table indicates the Cost per Unit for Hospital Days in 2010 was $1,815, more detailed information is found in Figure 2-14 for each of the four major hospitals that serve the community.

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.

2010		
Priorities*	**Cases Deferred**	**Estimated Cost**
Priority 1	0	-
Priority 2	135	5,834.00
Priority 3	625	233,420.00
Priority 4	68	10,746.00
	828	**$ 250,000.00**

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

Figure 4-10

Interpretation: At the beginning of 2010 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 the Medicare-Like Rates in July 2007, MCP started 2010 with sufficient reserves (i.e. "carryover") to "carve-out" $250k to pay for "non-Priority I" referrals. Thus, the cases in the table above 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 $250k MCP reserves used to pay the non-Priority I referrals. MCP relaxed Priority I status in April and, when $250k was exhausted, expanded coverage to Priority II-IV with current year's budget.

Priority I: Emergent/Acutely Urgent Care Services; i.e. immediate threat to life or limb.
Priority II: Preventive Care Services; i.e. Screening Mammograms
Priority III: Primary & Secondary Care Services; i.e. Specialty Consultations
Priority IV: Chronic Tertiary & Extended Care Service; i.e. Physical Therapy

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.

YEAR	Total CHEF Obligation	Total CHEF Cases	CHEF Threshold	Total CHEF Funds Due MCP	RECEIVED Current Year	RECEIVED Following Year	RECEIVED 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	0	472,981	344,764
2005	680,159	13	24,700	359,059	116,860	0	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	374,375	609,514	(88,478)
2010	1,840,220	34	25,000	990,220	493,132	201,226	694,358	295,862
Totals	**$ 8,231,526**	**137**		**$ 4,852,526**	**$ 2,310,758**	**$ 1,144,859**	**$ 3,455,617**	**$ 1,396,909**

Figure 4-11

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. This money may have to be paid back to HIS. Thus, the apparent negative shortfall in 2009.

Interpretations: The IHS Catastrophic Health Emergency Fund (CHEF) exists to reimburse for high cost cases that exceeds a given threshold, thus limiting financial risk to that threshold until the CHEF is exhausted for a given year. $25k has been the threshold for the last 5 years.

The CTWS MCP operates on a calendar year. However, the IHS operates on an Oct-Sept fiscal year. Historically, the IHS CHEF is exhausted by 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 to 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.

From 2003-2010, there was a total of 137 cases qualifying for CHEF reimbursements of $4,852,526. Total reimbursement of $3,455,617 was received from IHS, leaving a shortfall of $1.4 million to be absorbed by the Managed Care Program in addition to the $3,379,000 initially paid out to meet the threshold.

Medicare-Like Rate (MLR) Savings

Purpose: Illustrate the significance of the savings resulting from implementation of the Medicare-Like Rates Legislation effective mid-2007.

Relevance: Savings resulting from implementation of Medicare-Like Rates are the prime reason MCP has been able to relax Priority I's and expand coverage to paying for many Priority II-IV referrals.

	2008	2009	2010
Mountain View Hospital (MVH)			
Inpatient	800,501	1,154,243	1,215,681
Outpatient	634,365	777,509	873,079
Mixed	139,824	84,704	83,972
Total	**$1,574,690**	**$2,016,456**	**$2,172,732**
Other Critical Access Hospitals			
Inpatient	706	4,089	13,647
Outpatient	0	285	2,672
Mixed	0	0	849
Total	**$706**	**$4,374**	**$17,168**
Hospitals that Bill on DRG Rates			
Inpatient	741,502	1,700,090	1,877,149
Outpatient	435,972	441,297	404,065
Mixed	82,843	$25,604	32,458
Total	**$1,260,317**	**$2,166,991**	**$2,313,672**
TOTAL MLR SAVINGS	**$2,835,713**	**$4,187,821**	**$4,503,572**

Figure 4-12

Interpretation: After exhausting $1M in reserves three years in a row (2004-2006), and beginning in 2007 with only $500k in reserves, the huge positive effect of Medicare-Like Rates (MLR) cannot be overemphasized.

The Federal Medicare-Like Rates legislation basically states that any Indian Health Services Contract Health Service (CHS) or Tribally contracted plan which operates CHS locally (i.e. Warm Springs Managed Care Program) may reimburse a Medicare contracted hospital no more than the total reimbursement the hospital would have received from Medicare.

Medicare-Like Rate (MLR) Savings, Continued..

MLR became effective 7/5/07 which resulted in significant savings for MCP. Savings resulting from MLR implementation 3 ½ years ago not only was responsible for halting the erosion of MCP reserves, but allowed MCP to add non-Priority I services through specified "carve-out" of $500k under strict criteria in 2009. After a $250k "carve-out" to begin 2010, the decision was made effective April 1, 2010 to cover Priority II, III & IV under Committee Review and methodical implementation. I.H.S. physicians and Health & Welfare Committee were consulted and they gave input on services to add back. As seen in the table above, MLR savings have resulted in $11.5 million to MCP and thus potential healthcare referrals over the last three years.

MCP monitors closely expenditures and is ready to make adjustments if needed. The goal is to carefully implement authorization and payment for additional services (II, III, IV) without trying to implement "too much" and having to the "restrict again".

This is all made possible through MCP taking advantage of the MLR legislation which has resulted in the significant savings realized from MLR documented 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	2006	2007	2008	2009	2010
Grant Amount					
Diabetes Grant (Tribe)	$ 194,212	$ 193,268	$ 193,268	$ 193,268	$ 193,268
State Women, Infants, and Children (WIC)	59,375	54,538	71,200	72,046	80,586
Woman's Wellness Conference	4,437	-	4,437		
CHET Dental Project	1,500	-	4,253		
Senior Fitness Enhancement	19,000	19,000	22,078		
Tobacco Pilot Site	-	4,000			
State Tobacco Prevention	30,420	23,954	44,614	57,557	90,057
USDA Commodity Warehouse	55,500	64,758	86,214	100,481	58,358
State Alcohol & Drug	-	135,787		297,752	
State Alcohol Prevention	50,000	55,000		100,000	
State Mental Health	-	135,006		294,444	
State Youth Suicide Prevention	30,000	27,500	30,000		26,000
Influenza Pandemic			41,444		
Vocational Rehablilitation	400,000	712,000	103,000	345,519	411,200
Meth Prevention Project	100,000	100,000	100,000	-	-
Total	**$ 944,444**	**$ 1,524,811**	**$ 700,508**	**$ 1,461,067**	**$ 859,469**
Grant Expenditures					
Diabetes Grant (Tribe)	$ 121,797	$ 121,797	$ 172,101	$ 344,986	$ 35,024
State Women, Infants, and Children (WIC)	59,375	32,868	59,671	69,447	25,051
Woman's Wellness Conference Grant	4,421	-	4,436		
CHET Dental Project Grant	1,500	-	23,037	32,051	
Senior Fitness Enhancement Grant	19,000	4,278	28,224	10,970	
Tobacco Pilot Site Grant	-	4,000		26,383	26,197
State Tobacco Prevention Grant	1,994	3,968	24,959	63,345	
USDA Commodity Warehouse Grant	8,669	11,134	65,110	67,437	21,087
State Alcohol & Drug Grant	97,148	52,445	124,401	163,378	130,864
State Alcohol Prevention Grant	21,356	21,776	51,225	39,273	37,797
State Mental Health Grant	95,740	56,267	137,837	138,534	100,446
State Youth Suicide Prevention Grant	16,523	2,709	35,137	(1,964)	11,310
Influenza Pandemic			3,321	16,105	11,509
Vocational Rehabilitation Grant	59,158	64,708	464,171	302,172	306,586
Meth Prevention Project Grant	402	48,384	110,536	112,460	15,253
Total	**$ 507,083**	**$ 424,334**	**$ 1,304,166**	**$ 1,384,577**	**$ 721,124**

Note: Grant Awards are on a variety of fiscal years and reflect the award for their particular year.
Grant expenditures are by calendar year.

Figure 4-13

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			2010 FTE			2010 Enrolled TM		
	Tribal	**IHS**	**Total**	**Tribal**	**IHS**	**Total**	**Tribal**	**IHS**	**Total**
Clinical Services									
Medical		26.0	**26.0**		33.5	**33.5**		6.0	**6.0**
Dental		15.0	**15.0**		11.5	**11.5**		4.0	**4.0**
Optometry		2.0	**2.0**		2.0	**2.0**		1.0	**1.0**
Pharmacy		6.0	**6.0**		5.0	**5.0**		1.0	**1.0**
Medical Records		9.0	**9.0**		6.0	**6.0**		5.0	**5.0**
Medical Lab		4.0	**4.0**		4.0	**4.0**		0.0	**0.0**
X-Ray		3.0	**3.0**		1.0	**1.0**		0.0	**0.0**
Diabetes - Clinic		4.0	**4.0**		9.5	**9.5**		2.0	**2.0**
Community Health									**0.0**
Community Health Dept.	2.0		**2.0**	**2.0**		**2.0**	**2.0**		**2.0**
Health Education	1.0		**1.0**	**0.0**	**0.0**	**1.0**	**0.0**		**0.0**
CHET	4.0		**4.0**	**4.0**	**0.0**	**3.0**	**3.0**		**3.0**
Maternal Child Health	2.0		**2.0**	**1.0**		**1.0**	**0.0**		**0.0**
Community Health Rep.				**3.0**		**3.0**	**2.0**		**2.0**
WIC Program	1.0		**1.0**	**1.0**		**1.0**	**1.0**		**1.0**
Wellness Coordinator	3.0		**3.0**			**0.0**			**0.0**
Diabetes Grant (Tribal)						**0.0**			**0.0**
Environmental Health	2.0		**2.0**	**3.0**		**3.0**	**2.0**		**2.0**
Public Health Nursing		6.0	**6.0**	**4.0**		**4.0**	**2.0**		**2.0**
Nutrition		3.0	**3.0**	**2.0**		**2.0**			**0.0**
Medical Social Work	3.5	1.0	**4.5**	**1.0**		**1.0**	**1.0**		**1.0**
Physical Therapy	1.0		**1.0**			**0.0**			**0.0**
Community Wellness Center				**4.0**		**4.0**	**4.0**		**4.0**
Community Counseling									**0.0**
Community Counseling	5.0		**5.0**	**10.0**		**10.0**	**7.0**		**7.0**
Mental Health	6.0		**6.0**	**6.0**		**6.0**	**4.0**		**4.0**
Alcohol & Substance Abuse	12.0		**9.0**	**9.0**		**9.0**	**8.0**		**8.0**
Administrative Support									**0.0**
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**	1.0	6.0	**7.0**	0.0	5.0	**5.0**
Personnel		2.0	**2.0**			**0.0**			**0.0**
Procurement		1.0	**1.0**		1.0	**1.0**		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**
Transportation				1.0		**1.0**	1.0		**1.0**
Quality Assurance					1.0	**1.0**			**0.0**
Registration					2.0	**2.0**		1.0	**1.0**
Other									**0.0**
Managed Care	8.5		**8.5**			**0.0**			**0.0**
Ambulance						**0.0**			**0.0**
									0.0
Total	**64.0**	**104.0**	**168.0**	**52.0**	**93.5**	**145.5**	**37.0**	**31.0**	**68.0**

Figure 4-14

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 & 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 4-15

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		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 4-16

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	2010
Tribe - Self Determination Contract				
Program Savings and Carryover				
Community Health	85,751	300,784	1,247,935	1,047,895
Community Counseling	855,589	1,001,783	1,154,130	1,395,902
Managed Care	1,895,433	2,768,366	2,575,459	3,575,143
Ambulance	13,805	35,008	12,062	12,131
Facilities Operations	275,095	386,904	458,203	516,868
Environmental Health	92,077	75,998	40,974	120,212
Indirect Contract Support Costs	1,225,349	1,384,142	1,514,614	2,411,497
Reserves				
M & I Reserve Wellness Center	936,824	842,074	810,142	724,951
M & I Reserve Community Counseling	221,259	263,354	304,145	341,859
Equipment Replacement	86,431	93,165	99,481	104,089
Projects				
Joint Venture - Clinic Remodel	839,157	460,225	460,225	338,225
Other JV Projects	135,774	282,547	106,866	91,555
Total	**6,662,544**	**7,894,350**	**8,784,236**	**10,680,326**
Indian Health Service				
Medicare/Medicaid	940,701	1,079,000	1,258,967	1,993,250
Private Insurance	374,467	86,000	235,522	357,053
FSA				214,432
Equipment				38,849
Total	**1,315,168**	**1,165,000**	**1,494,489**	**2,603,584**
Grants				
Diabetes-competitive grant	397,100	562,100	482,100	397,100
Diabetes-competitive grant - prior years				397,100
Diabetes Grant - Clinical (IHS operation)				956,806
Suicide Prevention		2,289	2,289	-
Meth/Suicide			247,374	126,571
Diabetes-Noncompetitive grant	88,145	88145	88,145	-
Domestic Violence	30,000		80,000	-
Total	**485,245**	**652,534**	**899,908**	**1,877,577**

Figure 4-17

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 - 2010			
	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	110.00	153	227	123.38	*
Dental	80	125	127.00	171	252	219.26	*
Optometry	66	116	134.00	122	181	100.00	**
Pharmacy	24	29	32.21	20	25	53.51	***
Lab	19	27		4	5		
X-Ray	66	128	104.00	110	175		
Podiatrist				96	134	154.59	*

Figure 5-1

* The Value was derived by adding the Paid Amount plus the Unpaid Amount for each bill divided by the number of units billed.

** Estimate of Optometry Visit Value is based on National Information.

*** Data from Kaiser Family Foundation (State Health Facts):
-Total Retail Value of prescriptions filled in Oregon divided by the total prescriptions filled in Oregon ($53.51).

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.