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

June 30, 2012

2012 Edition
Reporting Information through 2011

2012 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 2011 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. There are many identified factors that place the Community 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 reveal 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, continue to improve in 2011. 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 retain 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 Tribes' plan calls for a shift from curative to a more preventive orientation, the payoff is a long term proposition. Therefore the design of programs and the allocation of resources must be carefully examined to ascertain the most effective approaches. This report has been mandated to ensure evaluation and measurement of progress.

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

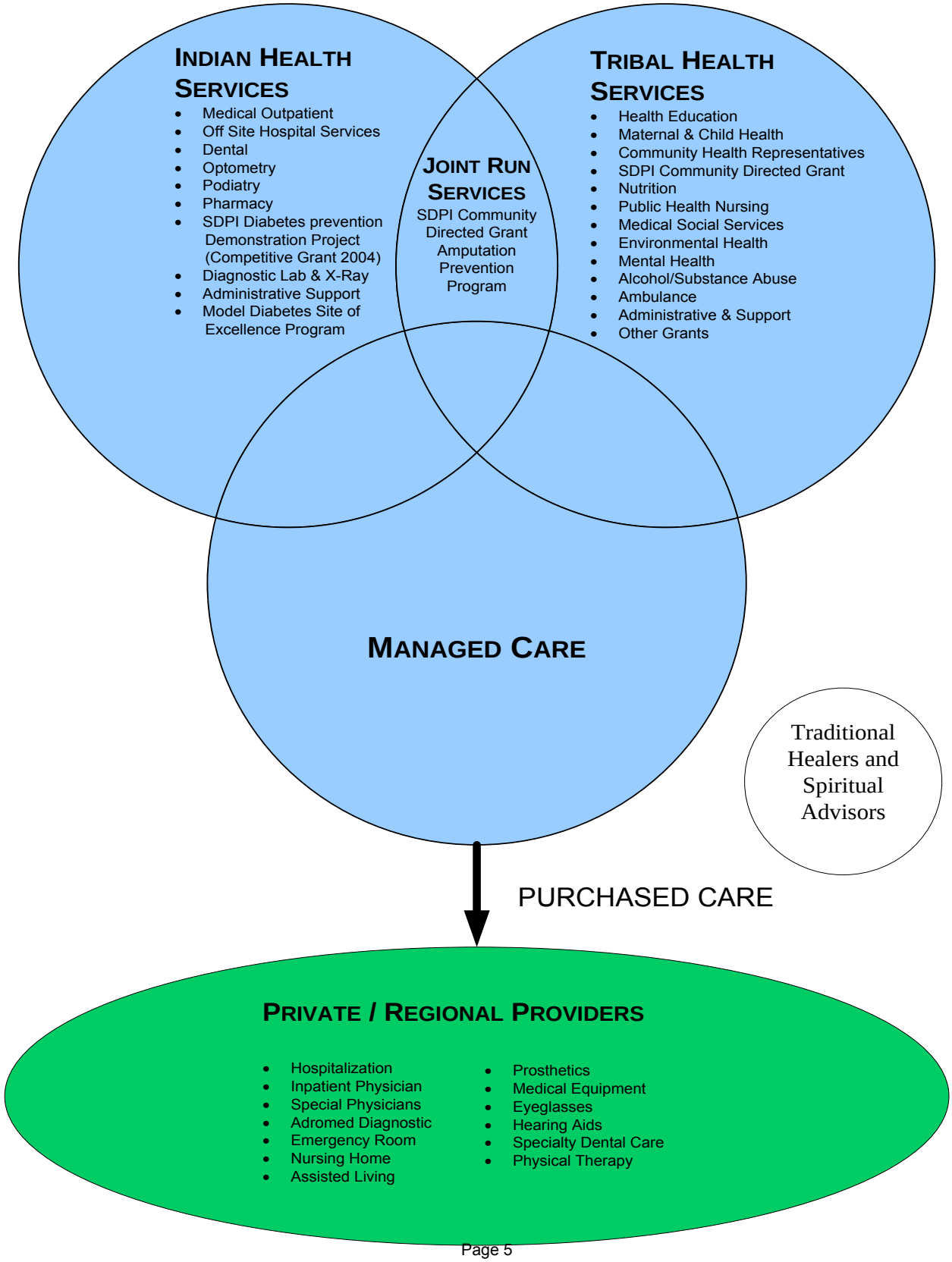
Throughout the years, the Tribe has contracted various portions of the Indian Health Service financed community health programs, mental health and alcohol and substance abuse programs, completing that transition in 2008. The Tribe has also appropriated tribal resources and sought and received grants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

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

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

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

Warm Springs Health Delivery System



SECTION 2

Customers

How do we best know and focus on our customers?

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

Customers That Use the Services

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

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

Warm Springs Health and Wellness Center

Year	New Registrations	Active Clinic Patients	User Population
2001	417	6,048	5,057
2002	471	6,302	5,375
2003	449	6,478	5,402
2004	409	6,558	5,471
2005	346	6,612	5,564
2006	368	6,685	5,634
2007	328	6,612	5,229
2008	370	6,703	5,298
2009	320	6,665	5,454
2010	333	6,692	5,628
2011	338	6,672	5,669

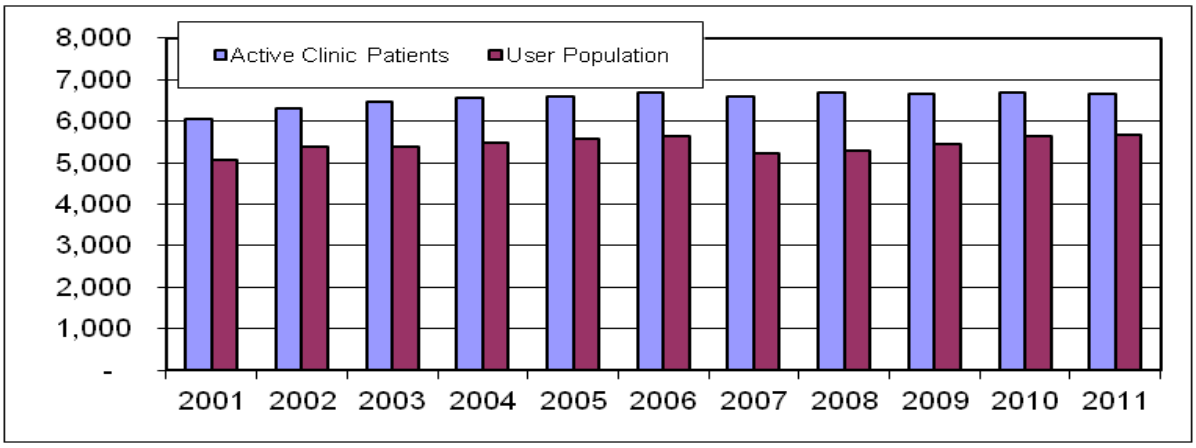


Figure 2-1

Customers That Use the Services Continued…

Interpretation: Between 2001 and 2011, new patient registrations have decreased by approximately 19%. During that timeframe, new patient registrations peaked in 2002 at 471; an increase of about 13% from the prior year. Since then, new patient registrations decreased to their lowest point in 2009 at 230 registrations. In that eleven year time span, the user population has increased from 5,057 to 5,669 (12%) and the population of active clinic patients has increased by 10.3%. 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 in user population.

The number of new registered patients has been remarkably consistent over this 10 year span (averaging 338 over the past five years or a little less than one/new patient per calendar day). The number of Active Clinic Patients has shown little variance over the past five years. A consistent population trend is an advantage in planning services and deploying resources.

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	2008	2009	2010	2011	Chg(10-11)
Warm Springs Indian Reservation	3,559	3,686	3,665	3,690	25
Madras/Redmond/Bend	1,104	1,035	1,119	1,190	71
Maupin/The Dalles/Hood River	91	85	90	85	(5)
Portland/Salem	90	90	91	94	3
Other Oregon	470	461	460	440	(20)
Outside Oregon	237	137	213	181	(32)
TOTAL	**5,551**	**5,494**	**5,638**	**5,680**	42

By Tribal Affiliation	2008	2009	2010	2011	Chg(10-11)
Warm Springs Member	3,773	3,812	3,893	3,990	97
Other Oregon Tribes	244	241	240	219	(21)
All Other Tribes	1,432	1,350	1,402	1,377	(25)
Non-Indians	102	91	103	94	(9)
TOTAL	**5,551**	**5,494**	**5,638**	**5,680**	42

Figure 2-2

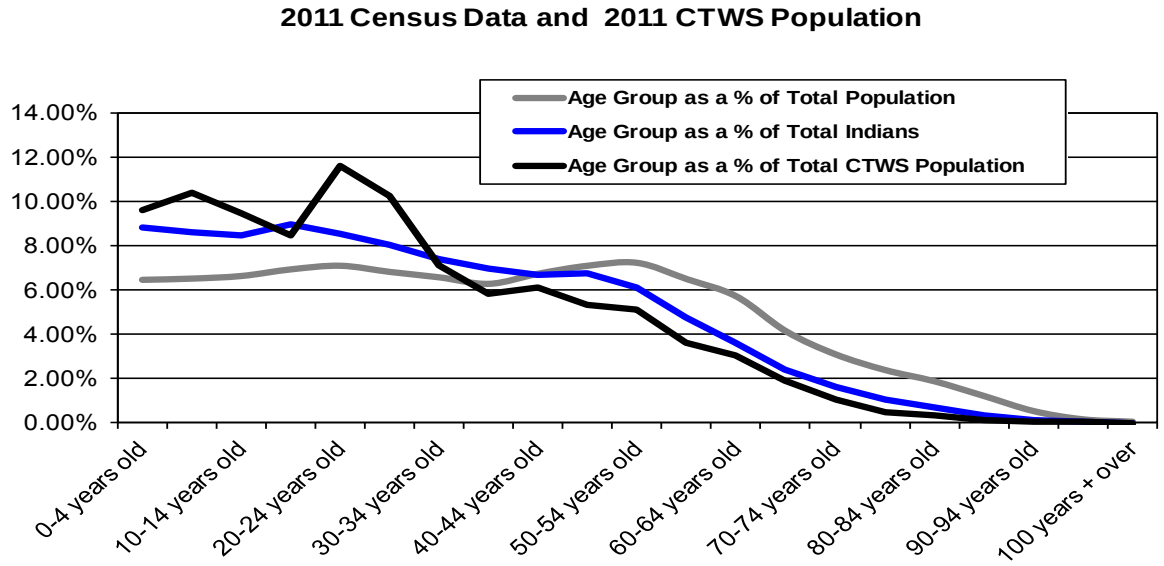
Interpretation: Trends have remained stable from 2008 to 2011 with approximately two-thirds of patients being Warm Springs Tribal Members and approximately two-thirds of patients residing on the Warm Springs Indian Reservation.

From 2008 to 2011 there has been a small increase in patients who are Warm Springs Tribal Members and a slight decrease in patients who are members of other Tribes or who have no tribal affiliation. Between 2008 and 2011, we saw an increase in approximately 3.7% of patients who reside on the Warm Springs Indian Reservation. As of 2011, over 85% of patients resided either on the reservation or in the Madras/Redmond/Bend area.

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

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

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



Note: Age Group as a % of Total Indians was an estimate from Census for 2010 at time of Report.

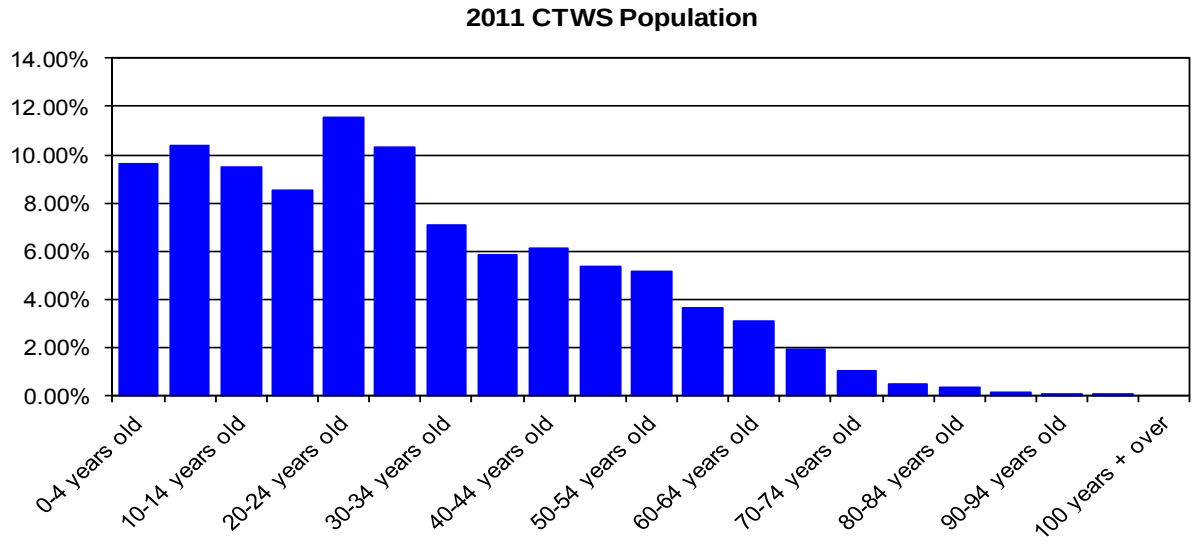


Figure 2-3

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	2011 Patients
0-4	615	543	677
5-9	691	460	551
10-19	1,098	1,367	1,094
20-29	954	971	1,077
30-39	843	912	719
40-49	571	738	693
50-59	269	440	615
60-69	137	204	397
70-79	67	98	168
80+	28	40	62
TOTAL, Patients	**5,273**	**5,773**	**6,053**

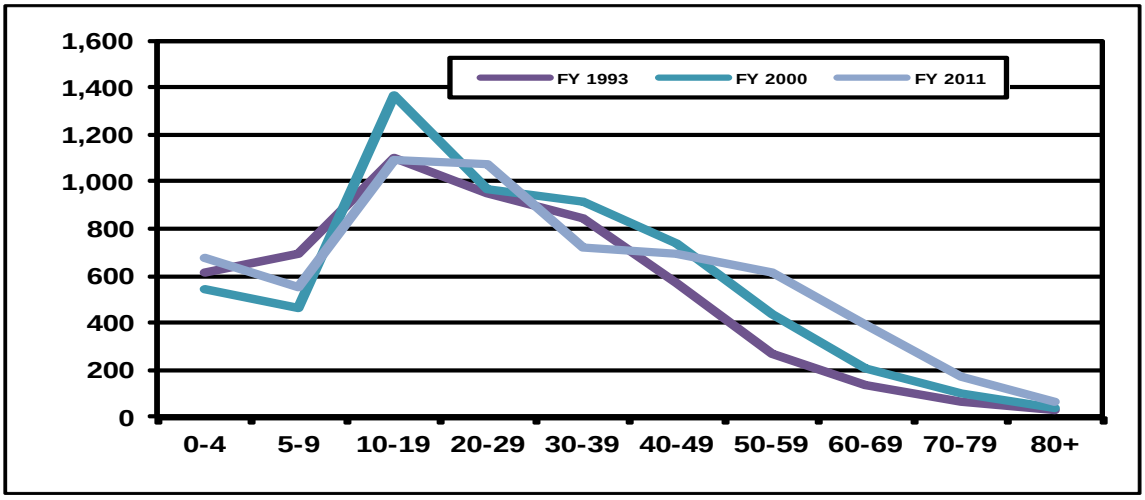


Figure 2-4

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

Alternate Resource Eligibility

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

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

Active Patients by Eligibility

Billable	FY 2008	FY 2009	FY 2010	FY 2011
Medicare Only	1,241	1,340	1,206	1,181
Private Insurance Only	1,398	1,436	1,351	1,269
Medicare A Only	20	16	25	28
Medicare B Only			-	-
Medicare Part A & B Only	123	121	141	139
Medicare Part D	188	176	179	189
Medicaid & Medicare	18	32	41	30
Medicaid & Private Ins.	145	181	606	842
Medicare & Private Ins.	117	114	143	141
Medicaid, Medicare, & PI	1	5	11	10
Total	3,251	3,421	3,703	3,829
Non-Billable				
Tribal Employee Self-Insurance	311	286	269	278
No Alternate Resource	2,983	2,737	2,673	2,492
Total	3,294	3,023	2,942	2,770
Total Patients	**6,545**	**6,444**	**6,645**	**6,599**

Figure 2-5

Interpretation: Over the past four years the number of patients with billable alternate resources has been slowly rising. Those with Tribal Insurance (non-billable) have declined by 11% between 2008 and 2011. Those with no alternate resources seem to have dropped dramatically from 2008.

Tribal Member Births by Age of Mother

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

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

Warm Springs Births by Age of Mother

Calendar Year	Age 14 & under	Age 15-19	Age 20-24	Age 25-29	Age 30-34	Age 35-44	Total Births
2008	0	30	39	21	10	7	108
2009	0	16	28	18	13	7	81
2010	0	21	27	22	11	5	86
2011	0	17	41	31	16	6	111
Total	**0**	**84**	**135**	**92**	**50**	**25**	**386**
% of Total	**0.0%**	**21.8%**	**35.0%**	**23.8%**	**13.0%**	**6.5%**	**100.0%**

Figure 2-6

Interpretation: Information reported reflects a large portion of births to very young mothers. The information has not been updated or reported in a number of years. Efforts are underway to update the information. The early age pregnancies are often classified as high-risk and do require extra monitoring and services.

Birth Rate Comparison

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

Relevance: This information tracks the trend of birth rates.

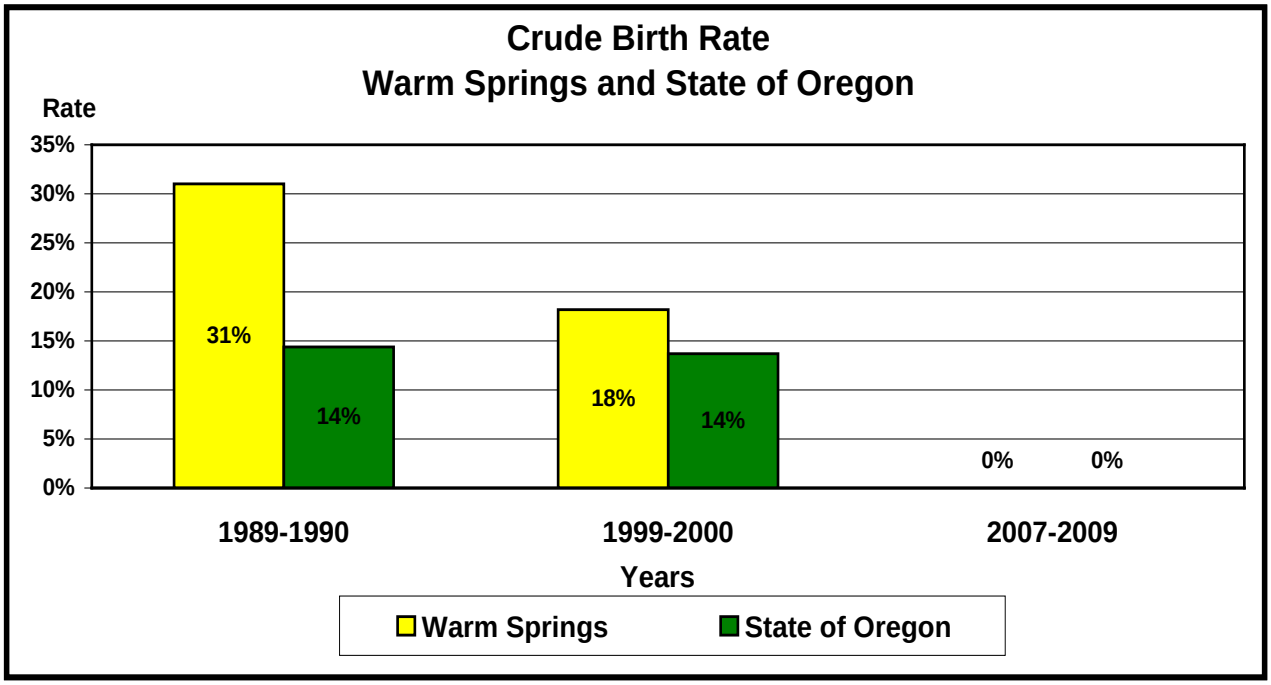


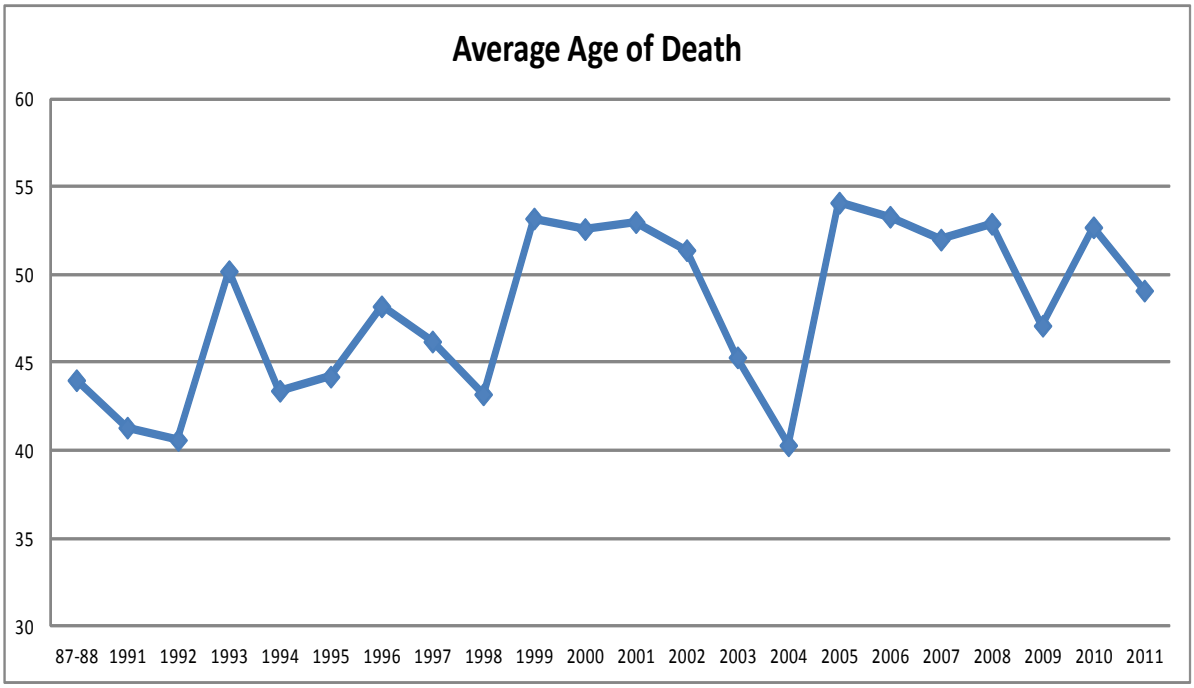
Figure 2-7

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

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

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

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



Crude Death Rates, Years of Productive Life Lost

	1991-1993	1994-1996	1997-1999	2000-2002	2003-2005	2006-2008	2009-2011
Number of Deaths	79	83	84	111	103	121	155
Crude Death Rate	478	502	482	608	524	605	774
Years of Productive Life Lost	1,785	1,889	1,877	1,794	2,141	1,906	2,898

Figure 2-8

Interpretation: This report reflects a significant loss of life at earlier ages than is reflected in the general U. S. population, where the average life expectancy was 78.7 in 2010. Crude death rates were historically lower than in the US, but are now almost equal (US rate = 798.7 in 2010). Deaths early in life continue to have a disproportionately high impact on the local population. The years of productive life loss and crude death rate reached its highest level in the 2008-2011 time period.

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 Infant Death Rate*	Child: Ages 1-12	3 year Avg Death Rate+	Teen: Ages 13-17	3 year Avg Death Rate+
1991-1993	3		4	24.2	2	12.1
1994-1996	2		8	48.4	1	6
1997-1999	1		6	34.4	3	17.2
2000-2002	4		2	10.9	2	10.9
2003-2005	5		3	15.3	4	20.4
2006-2008	5		3	15	3	15
2009-2011	8	26.9	6	29.9	0	0

* Deaths per 1,000 live births + Deaths per 100,000 population

Leading Causes of Death 2002-2011

Infant

Cause 1	Accidents (Unintentional Injuries)
Cause 2	Congenital malformations, deformations and chromosomal abnormalities
Cause 3	Sudden infant death syndrome (SIDS)
	Disorders related to length of gestation and fetal malnutrition

Child

Cause 1	Accidents

Teen

Cause 1	Accidents

Figure 2-9

Child Mortality Rates Continued…

Interpretation: This report reflects the changing nature of infant mortality in the past decade. In 1987-88, there were four deaths due to sudden infant death syndrome (SIDS).

In the last decade, there have only been 2 deaths due to SIDS. Despite the decline in SIDS, infant deaths have been increasing, primarily due to accidental death and birth defects.

The vast majority of childhood and teen deaths in the past decade are due to accidental death. The majority of accidental deaths were due to motor vehicle accidents, though firearm deaths and toxicity from alcohol and inhalants also contributed in teens.

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.

The Five Principal Causes of Death
(Warm Springs 2009-2011, IHS 2002-2003, US 2010)

	Warm Springs	Indian Health Service	U.S.
Cause 1	Chronic liver disease and cirrhosis	Diseases of the heart	Diseases of the heart
Cause 2	Accidents	Malignant neoplasms	Malignant neoplasms
Cause 3	Diabetes mellitus	Accidents	Chronic lower respiratory diseases
Cause 4	Malignant neoplasms	Diabetes mellitus	Cerbrovascular diseases
Cause 5	Cerebrovascular diseases	Chronic liver diseas and cirrhosis	Accidents

Trends in the Leading Causes of Death (3-yr average), Warm Springs, 1991-2011

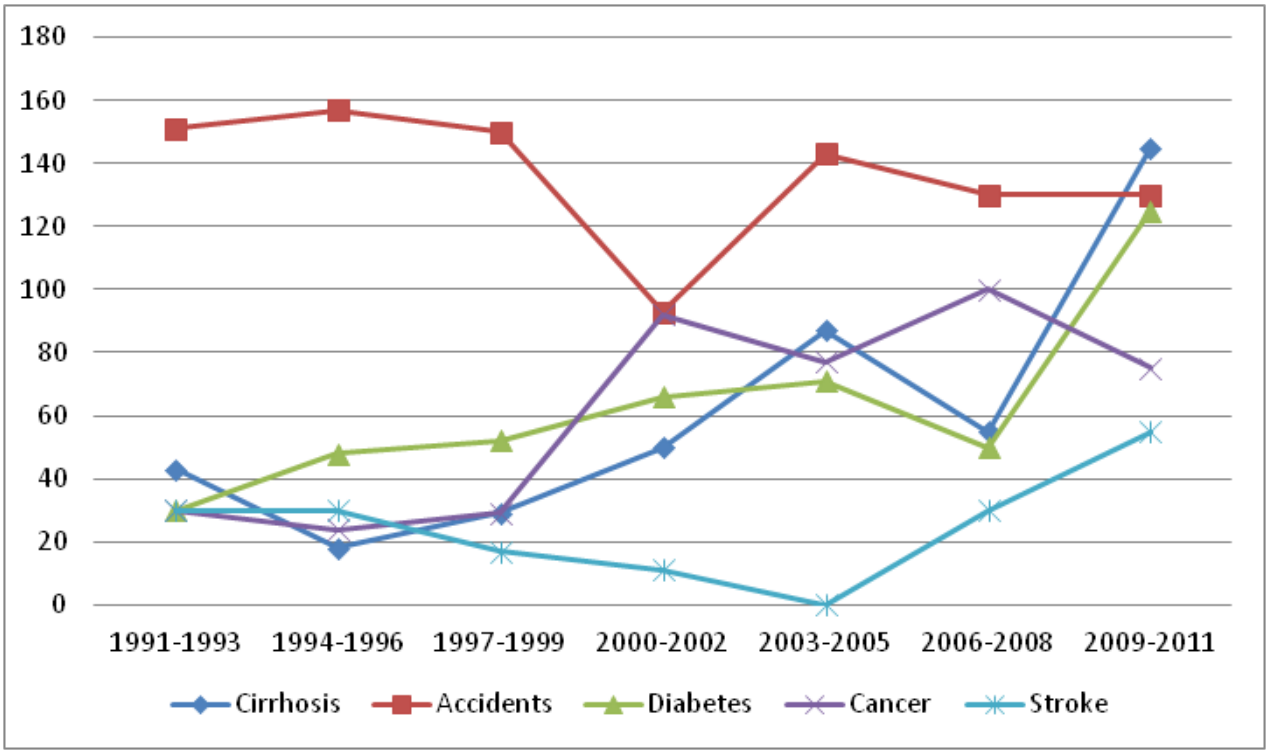


Figure 2-10

Cause of Death Continued…

Interpretation: Accidental deaths had been the leading cause of death since the 1950's. Rates of accidental death are gradually declining. Since 2001, the rate of motor vehicle accidents has decreased significantly, likely due to the passage of the Tribal Seat-Belt Law.

Rates of death related to cirrhosis, diabetes, cancer and stroke are climbing. Most significant is that cirrhosis is now the leading cause of death. Death from cirrhosis is 15 times more common among the Warm Springs people than for other Americans. Cirrhosis is also a major contributor to early death. The average age of those dying with cirrhosis in 2011 was only 40 years old. Alcohol abuse and Hepatitis C infection are the major contributors to this disease.

Diabetes is a growing concern. The majority of patients with diabetes died from related heart disease or kidney failure. This remains an area that needs emphasis for our local population. We can combat this through healthier diets and increased physical activity, reducing the number of overweight and obese people in our community.

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 2008 - 2011

Condition	FY 2008	FY 2009	FY 2010	FY 2011
Diabetes	551	568	574	600
Ischemic Heart Disease (IHD)	76	82	83	88
Hypertension 18-85 w/HTN DX	496	486	470	500
Asthma	209	225	248	256
Prediabetes/Metabolic Syndrome	847	883	906	970
Rheumatoid Arthritis		90	75	79

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 past several years. Continues 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 long 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.

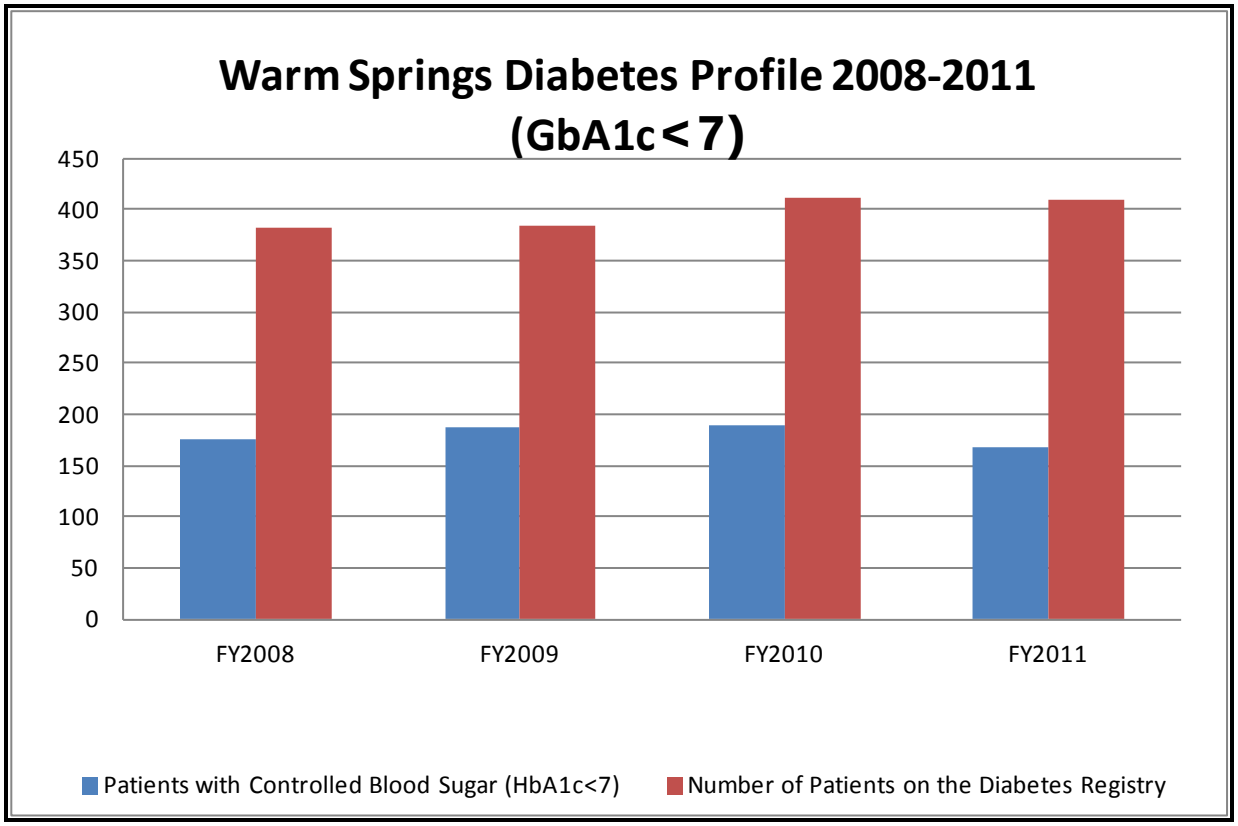


Figure 2-12

Interpretation: Approximately half of the patients listed on the DM Registry from 2008 to 2011 achieved the ideal A1C target level of less than 7 as reflected in the above chart in blue. That number has dropped 5% from 2008 to 2011. The chart also reflects an increase in the number of patients that have been diagnosed with diabetes over the past four years, some of which is due to improved surveillance of the population. Nevertheless, diabetes represents a significant problem in the Community that requires special attention.

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 - 2011

Inpatient Indicators	2009	2010	2011
Total Admissions	313	305	258
Average Length of Stay	3.56	4.05	3.85
Total Hospital Days	1113	1236	994
Average Daily Patient Load	3.05	3.39	2.75
Emergency Room Visits	1,440	1,466	1,294

Managed Care Hospitalizations and Those Paid by Other Resources
Warm Springs Patients by Primary Diagnosis 2011

Condition	Number of Admissions	% of Admissions	Number of Hospital Days	% of Hosptial Days
Obstetrics	178	35.9%	380	22.4%
Motor Vehicle Accidents	3	0.6%	9	0.5%
Other Accidents/Injuries	29	5.8%	134	7.9%
Cancer	10	2.0%	68	4.0%
Heart and Circulatory	25	5.0%	138	8.1%
Respiratory	58	11.7%	192	11.3%
Renal	24	4.8%	81	4.8%
Digestive	60	12.1%	196	11.6%
Infectious Disease	36	7.3%	186	11.0%
Diabetes	13	2.6%	65	3.8%
Substance Abuse	27	5.4%	77	4.5%
Mental Health	9	1.8%	51	3.0%
All Other	24	4.8%	118	7.0%
TOTALS	**496**		**1695**	

Figure 2-13

Hospitalization of Customers Continued…

Interpretation: The two tables (Figure 2-13) on the previous page describe our hospitalization experience in two different ways. The first table describes the cases for which the Managed Care Program provided payment. The second table is all inclusive covering cases that were paid by the Managed Care Program plus all other cases that were financed by other alternate resources. Each presentation compares the experience of the last two years.

The Managed Care Caseload (first table)

- The number of hospital admissions declined by 47 (15.4%) from the experience of the prior year.
- The Average Length of Stay declined by 0.2 (5 %) from the prior year.
- The Total number of hospital days declined by 242 (20%) from the previous year.
- The total number of Emergency Room Visits declined by 172 (12%) from the previous year.

This suggests that the Managed Care Program was quite successful in reducing our overall hospitalization costs for 2011. Better use of alternate resources has had an important role in this development. Nearly half of our total admissions were financed by another resource.

Total Hospitalization Caseload regardless of payment source (second table)

The actual number of admissions for patients in 2011 regardless of payment source increased slightly from the prior year (496 vs 481). Overall hospital days decreased modestly from 1720 to 1695. This further underscores our major dependence on alternate resources (Oregon Health Plan/Medicaid, Medicare and Private Insurance). In 2011 the Managed Care Program covered 52% of hospital admissions and 59% of hospital days. This was a significant improvement over 2010 when the Managed Care Program covered 63% of hospital admissions and 71% of hospital days.

If restrictions in eligibility were imposed by the State or if individuals dropped their health insurance, the Managed Care Program would experience a significant financial problem.

The total admissions and days by category help us understand which conditions are the source of our hospitalizations. The most significant change in 2011 was increase in the number of obstetrical cases.

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
2011

Hospital	Admissions	Hospital Days	Total Cost $	Cost per Day
Mountain View	185	657	$1,075,784	$1,637.42
Redmond	2	6	$21,706	$3,617.67
St. Charles	59	276	$648,039	$2,347.97
OHSU	2	5	$34,555	$6,911.00
All Other	10	50	$69,562	$1,394.24
Totals	**258**	**994**	**$1,849,646**	
			Total Cost per Day	**$1,860.81**

Figure 2-14

Interpretation: This table reflects the total cost of hospitalization MCP paid for in 2011, and the number of admissions and hospital days that comprised this cost at the four major hospitals utilized. Mountain View Hospital accounts for 58% of the total hospital costs, with St. Charles Medical Center accounting for 36% and OHSU in Portland 2% of the total hospital costs.

When comparing 2011 to the prior year (2010) a significant decrease (47) in the number of hospital admissions financed by the Managed Care Program was noted. There was also a corresponding decrease in the number of hospital days (242) covered by in the Managed Care Program. This resulted in a significant reduction of overall hospital expenditures for the Managed Care Program in 2011. There was $394,000 less spent by Managed Care in 2011 for hospitalizations. Again the effective use of alternate resources contributed to this outcome.

Hospitals Utilized and Expenditures Continued…

The average cost per day for our primary hospital (Mountain View) increased by $122/day (8%) over the previous year. The costs per day for St. Charles actually declined slightly from our experience the previous year. Our costs per day at other lesser used hospitals all increased significantly but the number of cases were too small to draw any conclusions. The rate of medical inflation is something we must continually watch as federal appropriations have not kept pace with medical inflation and it appears that appropriations will lag even further in the years ahead.

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

	2008	2009	2010	2011
ALLERGIC REACT	2	7	3	9
CARDIOVASCULAR	52	67	72	53
CELLULITIS/INFECTIONS (impetigo)	36	49	67	76
CHRONIC CONDIT.	43	37	24	42
COMMUNICABLE DISEASE	4	2	3	13
DENTAL	10	15	29	19
DERMATOLOGY (includes spider bit	18	21	13	45
DRUG/ALCOHOL	70	111	140	69
ENT (ear, nose, throat)	92	116	100	120
EYES	14	11	23	15
GI	133	121	124	129
GU	86	75	95	77
HEADACHES	44	44	50	48
MEDS ONLY / DRESSING CHGS	4	2	5	7
MISCELLANEOUS	53	78	61	32
NEUROLOGY	34	34	39	41
OB-GYN	13	14	17	17
ORTHOPEDIC (musculoskeletal)	177	199	208	169
PULMONARY	89	136	106	104
PSYCHIATRIC (MENTAL HEALTH)	13	23	22	30
SNAKE BITE	0	1	0	0
TRAUMA				
ASSAULT	19	17	38	20
GUNSHOTS	1	1	1	1
LACERATIONS/BURNS/CONT	143	201	215	105
MVA	17	15	11	19
POISONS (ingested/breathed)	6	2	10	4
SEXUAL ASSAULT	0	0	2	0
DROWNING	0	0	0	0
POSSIBLE CHILD ABUSE	0	0	0	0
OTHER				42
TRIAGE ONLY	0	5	9	2
VIRAL SYNDROME	17	43	10	18
VASCULAR (blood) - anemia/hem	7	8	18	7
TOTALS	**1,197**	**1,440**	**1,466**	**1,294**
COST (As Of 4/30/12)	$507,635	$784,841	$789,377	$795,965
COST PER VISIT	$424	$545	$538	$615

Note: The above data is for MVH; ER care at other hospitals is an extremely small portion of the whole.
In 2009, 2010 & 2011MVA's are not counted in the total, and in 2010 & 2011 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: There was a noticeable increase in ER visits but a decrease in 2011 from 2010. There has been a corresponding significant increase in costs each of the last three years. It is important to note the above totals for ER visits are inclusive and thus include those which MCP is not responsible (i.e. OHP), while the "COST" is the total amount paid by MCP for ER claims. The trend in "COST PER VISIT" is disturbing, with a 45% increase experienced in the three years from 2008-2011.

Emergency Room Utilization Continued…

EMERGENCY ROOM VISITS - TIMES / DAYS

	2008	2009	2010	2011
0800-2000,weekdays (8:00am-8:00pm)	290	444	462	472
2000-2400, weekdays (8:00pm-midnight)	268	210	235	232
2400-0800, weekdays (midnight-8:00am)	115	151	168	112
0800-1600, sat, sun (8:00am-4:00pm)	185	221	180	225
1600-2400, fri, sat, sun (4:00pm-midnight)	263	311	325	185
2400-0800, sat, sun, mon (midn-8:00am)	76	103	96	68
TOTALS	**1,197**	**1,440**	**1,466**	**1,294**

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 appropriately cared for in ambulatory care settings. Locally, that trend exhibits itself by increased utilization of MVH ER when the IHS Clinic would be more appropriate. These statistics support that trend in the past three years, with increased ER visits on weekdays between 0800-2000 hrs. It's interesting there has been a distinct decrease in ER visits between 1600-2400 hrs on weekends. After significant increases in overall ER utilization in 2009 and 2010, overall ER utilization dropped in 2011, although it remains above the 2008 level.

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%

***** 2006 – Behavioral Risk Factor Survey

Figure 2-17

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.

Improving the health status of the Warm Springs Community and containing costs associated with our health services is dependent upon reducing the health risks described above. Repeating this survey should be considered so that we may measure progress in reducing risk factors. Also it would be helpful to know how the Warm Springs Community compared to other Northwest Tribes who have also been surveyed.

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

	FY2008	FY2009	FY2010	FY2011
Medical Visits by Provider				
Physicians	8,511	11,412	11,407	11,579
Mid Level Practitioners	5,166	3,772	4,492	4,591
Nursing Staff	5,013	4,604	4,596	4,785
Total Medical Visits	**18,690**	**19,788**	**20,495**	**20,955**
Workload Factors				
Clinic Days	250	250	250	250
Average Visits Per Clinic Day	75	79	82	84
Total FTE's In Medical Department	21	21	21	21
Physician FTE's	4.25	5.5	5.5	5.5
Mid-Level Practitioner FTE's	2	2	2	2
Avg Annual Visits Per FTE	890	942	976	998
Avg Annual Visits Per Physician FTE	2,003	2,075	2,074	2,105
Avg Annual Visits Per Mid-Level FTE	2,583	1,886	2,246	2,296
Extended Hours of Service				
Days of Late Clinic	118	175	202	245
Hours of Service (M-Th, 7pm)	236	350	404	490
Visits	458	692	802	869
Visits Per Hour of Service	1.9	2.0	2.0	1.8
Hospital Patient Count	455	478	424	476
Hospital Visit Count	1,869	1,988	1,809	2,107
Average Hospital visits per patient	4.1	4.2	4.3	4.4
Average Hospital patients per day	1.2	1.3	1.2	1.3
Average Hospital visits per day	5.1	5.4	5.0	5.8

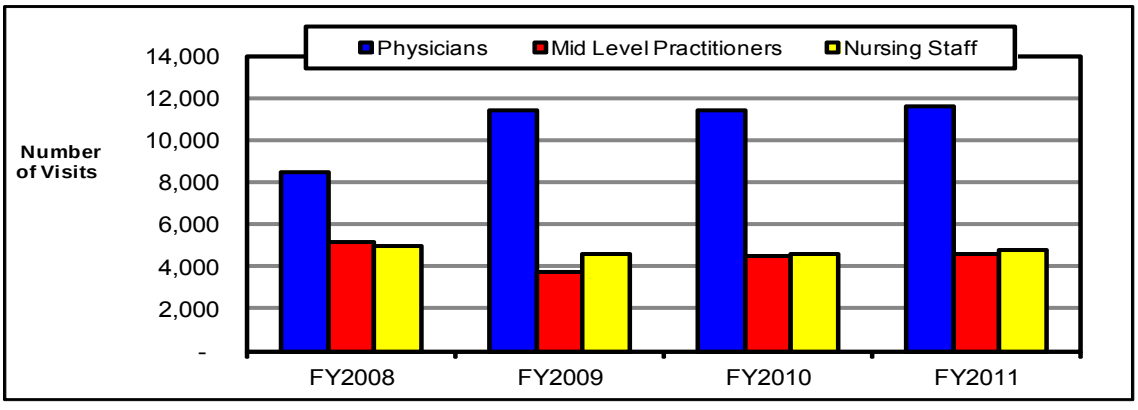


Figure 3-1

Medical Services Continued…

Interpretation: From 2008 to 2011, the medical department averaged 19,982 medical visits per year. Of those visits: 10,727 of those were physician visits, 4,505 were seen by mid-level providers and 4,750 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 2,145 visits per year and each FTE mid-level provider had an average of 2,252 visits per year.

There was an average of 185 days when the clinic was open late for extended hours from 2008–2011 and during those times; the late clinic averaged 1.9 medical visits per hour. The average number of medical visits during late clinic has been 2 or less per hour from 2008 to 2011 with 2009 & 2010 having the highest visits per hour; 2.0. 2008 was the year when there was the least amount of providers in the clinic.

Additionally, there were about 458 patients per year that visited the hospital an average of 4.3 times each for an average of 1,943 hospital visits per year between 2008 and 2011. Average hospital visits per day have remained at approximately 5 visits per day during this four year timeframe.

Podiatry Program

Purpose: We are in the practice of podiatry to preserve human movement and thereby improve human life. We aim to teach and enable all who are served by us 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 for our service to provide excellent and up-to-date podiatric medicine, foot and ankle surgery and wound care, age appropriate extremity education in such a manner that lower extremity health and wellness become a proactive and preventative art practiced by patients even before they come into the clinic.

Podiatry Department

	FY2008	FY2009	FY2010	FY2011
Podiatry Visits				
Clinic Visits	1,808	1,669	1,643	1,753
Missed Appointment Rate	16%	19%	21%	18%
Workload Factors				
Clinic Days	161	165	149	170
Average Visits per Clinic Day	11	10	11	10
Average Visits per Year				
Nature of Visits				
PT visit with Diabetes	664	551	570	813
PT visit with Open Wound	346	297	278	313
Comprehensive or Annual DM Ft Exam	42	39	91	97
Office Procedure Performed	531	354	326	489
OR Case	29	35	32	10
Hospital Patient	142	136	132	64
Other Visit Reasons	225	428	378	473
Total Podiatry Visits (Some patient visits include multiple problems)	**1,808**	**1,669**	**1,643**	**1,753**

Figure 3-2

Interpretation: Education and patient training takes time, so pure numbers don't tell the complete story. More people are getting better about Diabetes Mellitus (DM) foot care prevention resulting in less relative numbers of foot wounds and serious foot infections. There has been a significant drop in hospitalizations regarding DM foot infections in 2011. The podiatrist has a personal healthcare issue continuing to impact some small decrease in clinic days and patient numbers.

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

	FY2008	FY2010	FY2011
Dental Visits by Provider			
Dentist Visits	5,402	4,541	4,342
Hygienist Visits	1,075	1,158	758
Total Dental Visits	6,477	5,699	5,100
Missed Appointments			
No Shows (Broken Appointments)	No reliable data	371	408
Broken Appointments vs Total Visits	No reliable data	0	0
Treatment Plans Completed			
Patients Completing Treatment	141	No longer	No longer
Completed Treatment/1st Visits	0	tracked	tracked
Workload Factors			
Clinic Days	250	250	250
Average Visits Per Clinic Day	26	23	20
Total FTE's	13	12	12
Average Annual Visits Per FTE	491	496	443
Categories of Care			
Preventive	7,719	6,861	6,524
Restorative including Crowns	3,039	2,698	2,558
Dentures including Bridges	123	106	134
Surgical	1,213	1,031	1,067
Orthodontic	37	12	6
Endodontic	92	163	304
Other	unknown	10,030	8,920
Total Identified Problems Treated		20,901	19,513

Figure 3-3

Interpretation: Unable to get the 2009 data as the IHS moved to a Dental E.H.R. System. The Identified problems treated have increased.

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	FY2008	FY2009	FY2010	FY2011
New Prescriptions	47,689	48,297	54,243	54,672
Refills	21,891	24,659	26,359	28,360
Total Prescriptions	**69,580**	**72,956**	**80,602**	**83,032**
Workload Factors				
Clinic Days	250	249	250	251
Avg Prescriptions per Clinic Day	278	293	323	331
Visits to the Pharmacy	29,769	30,245	33,052	34,567
Prescriptions per Pharmacy Visit	2.34	2.41	2.44	2.40
Total FTE's	7	6	6.25	6.8
Avg Annual Prescriptions Per FTE	9,940	12,159	12,896	12,211
Pharmaceuticals				
Total Expenses	$ 741,282	$ 772,273	$ 882,251	$ 796,241
Avg Cost Per Perscription	$ 10.65	$ 10.59	$ 10.95	$ 9.59
Rx for Patients outside Service Area	Unavailable	Unavailable	Unavailable	Unavailable

Figure 3-4

Interpretation: Workload in FY 2011 as compared to FY 2010 is up 3% in the number of prescriptions filled. The number of prescriptions per day has increased by 2.4%.

The number of prescriptions filled per FTE decreased by 5.3% in FY 2011. This is related to changes in the residency program. In FY2009 the residency program was temporarily discontinued, placing a greater burden on the remaining staff (the resident helps staff the pharmacy half of each workday and does the residency rotation the other half of the day), and thus causing a large increase in average prescriptions per FTE. In the 3rd quarter of FY 2010 the residency program was reinstated. Even with this change in staffing, this number remains significantly higher (22.8%) than it was 3 years prior in FY 2008.

Pharmacy Services, Continued

There was a slight decrease (1.6%) in the number of prescriptions per pharmacy visit in FY 2011 compared to FY 2010.

Drug costs compared to FY 2010 have decreased. Several formulary changes have been made to items of equivalent effectiveness but lower cost which has impacted these numbers. Average cost per prescription decreased by 12.4%. Drug costs will continue to fluctuate as existing formulary drugs are becoming available generically at lower costs, as well as newer, more expensive agents being added to the formulary.

Workload as compared to 5 years ago has increased by 25% in the number of prescriptions filled. The number of prescriptions filled per day is up 30%. Furthermore, we have continued to manage patients in four pharmacy based clinics and increased our medication therapy management services over this time period, as well as provide adult immunizations, with no additional increase in staff or automation.

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

	FY2008	FY2009	FY2010	FY2011
Imaging Exams				
Total X-Ray Exams	1,641	1,796	1,886	1,645
Workload Factors				
Clinic Days	250	250	251	250
Average Exams per Clinic Day	6.56	7.18	7.51	6.58
Total Patients	1,531	1,693	1,772	1,556
Average Exam per Patient	1.07	1.06	1.06	1.06
Total PCPV's	14,387	12,747	15,783	15,839
Average Exams per PCPV	0.11	0.14	0.12	0.10
Total FTE's	1	1	1	1
Exams per FTE	1,368	1,437	1,572	1,645

Figure 3-5

Interpretation: Between 2008 and 2011 there was an average of 1,742 X-Ray exams per year. Average X-Ray exams per patient remained consistent across time at 1.1 X-Ray exams per patient.

Diagnostic Services Continued…

Diagnostic Services - Medical Laboratory

	FY2009	FY2010	FY2011
Medical Lab Tests			
Tests collected in the Lab	89,820	90,914	85,069
Tests collected outside the Lab	3,617	3,203	3,407
Tests performed off-site	5,778	6,309	6,561
Total Lab Tests Ordered	**99,215**	**100,426**	**95,037**
Workload Factors			
Clinic Days	250	250	250
Tests Ordered per Clinic Day	397	402	380
Total Primary Care Provider Visits	15,184	15,899	16,170
Average Tests per Visit	6.5	6.3	5.9
Total FTE's	4.0	4.0	5.0
Tests per FTE	24,804	25,107	19,007
Category of Tests Ordered			
Hematology	30,221	30,173	25,707
Chemistry	63,164	64,625	63,347
Bacteriology	1,404	778	831
Urinalysis	4,426	4,850	5,152
Total Lab Tests Ordered	**99,215**	**100,426**	**95,037**

Figure 3-6

Interpretation: Total lab tests ordered increased from 2008 through 2010, then dropped off in 2011. The decrease between 2010 and 2011 was 5.4%.

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

	FY2008	FY2009	FY2010	FY2011
Optometry Visits				
Clinic Visits	1,595	1,796	1,846	1,973
Missed Appointment Rate	28%	23%	22%	22%
Workload Factors				
Clinic Days	220	220	220	220
Average Visits per Clinic Day	7	8	8	9
Total FTE's	2.0	2.0	2.0	2.0
Nature of Visits				
Refractions	762	835	673	795
Diabetic Eye Exam (Patients)	233	188	199	264
Contact Lens Visit	107	111	58	45
Medical Visit	27	32	-	-
Early Childhood Education Visits	354	383	35	31
Glasses Repair/Adjustment	354	383	394	350
Other	-	-	487	488

Figure 3-7

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 appointments 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 staff levels which remain at 2.

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	2011
Staffing & Other Workload							
FTEs	7.0	7.0	7.0	7.0	7.0	7.0	7.0
Number of Obligations	8,190	6,120	5,022	7,162	9,136	9,757	9,099
Funds Obligated	$4,905,541	$5,049,015	$3,447,984	$3,875,173	$4,932,401	$5,706,031	$5,334,444

Figure 3-8

Interpretation: The Number of Obligations/Funds Obligated reflects the implementation of Priority I'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 I healthcare implemented last 2007, and 2008 & 2009 reflected increased healthcare coverage funded via "carve-outs" from MCP reserves accumulated through Medicare-Like Rate savings; thus the increase seen from 2007 through 2010. 2010 marked the expansion of Priority I's back to full coverage of Priority I-IV'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	2011
Prenatal Visits			5	29
Post Partum Visits				
Well Child Visits				
Immunization Visits			381	1,034
Diabetes Visits				
Cardiovascular Visits				
Mental Health Visits				
STD Visits			25	42
Family Planning			42	95
Phone Contact/Follow-ups				545
Other Visits			27	594
Total Community Health Nurse Visits - (In Office Only)	-	-	480	2,339
Visits by Location				
Out of Clinic Visits			594	1,046
Clinic Visits			603	748
Total Community Health Nurse Visits	-	1,097	1,197	1,794
Total Days of Service		250	250	250
Average Visits Per Day		4.4	4.8	7.2
Total FTE's	5	2	1.8	2.0
Average Visits per FTE per year	-	549	665	897

Figure 3-9

Interpretation: Personnel changes occurred throughout the year with a part time CHN leaving the department and a full time CHN being replaced so FTE's are averaged at 2. Visits listed as "other" include anything from education, screening and collecting samples, treatments as ordered by physicians and follow-up care. The number of CHN visits has increased as we grow in proficiency and the needs of the community grow.

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	2011
Total number of births	107	83	103	111
Total number of births (Tribal members)				
Number of high risk pregnancies	31	20	32	44
Number of high risk infants identified*	29	33	36	32
Prenatal Home Visits				116
Post-Partum Home Visits	98			196
Other Home Visits		78	454	
Number of Hospital Visits			109	87
Number of Birthing Classes			47	
Total Number of Participants			240	
Infant Immunization level**	89.4%	88.6%	87.3%	90.9%

Figure 3-10

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. Total number of births reflects all births that are eligible for care under IHS standards. Tribal Member births may vary from the number on page 14. MCH counts all Tribal Member births that were seen by their program.

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

	2009	2010	2011
Caseload by category:			
- Transports	111	172	164
- Patient Care	431	738	592
- Case Findings/Screening	559	932	532
- Monitoring Patient	339	502	425
- Case Management	385	393	312
- Health Education	60	34	42
- Other	168	739	500
Total Client Encounters	**2,053**	**3,510**	**2,567**
Total Days of Service	**250**	**250**	**250**
Average Number of Encounters per Day	**8.2**	**14.0**	**10.3**
Total FTE's	**3.0**	**3.0**	**3.0**
Average Number of Encounters per FTE per Year	**684**	**1,170**	**856**
Total Mileage Reimbursed			

Figure 3-11

Interpretation: The data from 2010 was reported as the top 10 reasons for visits and does not correlate as the reasons for visits in 2011 so the category of “other” is actually home and hospital visits by CHRs. Visits are down due to CHRs providing long range medical transportation. When providing medical transportation from outlying areas, Simnasho/Sidwalter to Portland/Bend, CHRs are unable to provide home visits.

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

	FY2008	FY2009	FY2010	FY2011
Diabetes Program Visits				
Clinical Visits (FNP & RN-all visits)	1,792	1,501	1,457	1,931
Community Encounters	1,882	2,433	2,010	2,032
Total Visits	**3,674**	**3,934**	**3,467**	**3,963**
Workload Factors				
Clinic Days	250	250	250	250
Average Visits per Clinic Day	14.7	15.7	13.9	15.8
Total FTE's	4.0	5.0	5.0	5.0
Average Visits Per FTE	919	787	693	793
Categories of Service				
General Diabetes Clinic Contacts				
Special Diabetes Clinic Contacts				
Education Contacts	769	753	787	985
Community Contacts	1,882	2,433	2,010	2,032
Patients in Dialysis				
Number of Patients	10	11	13	12

Figure 3-12

Interpretation: There was an increase in education visits which is directly related to adding a Diabetes Awareness Day and increasing Diabetes Education classes to 2 times per month. In regards to our Dialysis patients: 2 of the 12 patients do not have Type 2 Diabetes, 1 of the 12 receives dialysis care elsewhere. One patient on dialysis died this year, one moved away and one was added. Dialysis statistics are below projections regardless of an increase of patients in the IHS Diabetes Register and an increase of patients with chronic kidney disease.

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	2011
Infants and children under 5 years of age	537	538	543	550
Pregnant, breastfeeding and postpartum women	214	198	219	232
Total number of Women, Infants and Children served	751	736	762	782

Figure 3-13

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

Additional emphasis has been placed on increasing breastfeeding rates and supporting families who chose to breastfeed their babies for longer periods as opposed to giving formula.

Community 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 2011
Program	
Cancer	
Women's Health	
Women of Wellness - 12 Classes	504
Girlz Club (5th,-12th Grades)	100
Alcohol Program	
VOC men's support group 2 Classes	9
CPS parent support group 3 Classes	21
VOC women's group 3 classes	16
Red Ribbon Week - Presentation & Displays	35
Pi-Ume-Sha Health Fair Booth	300
FASD coalition meetings 10 meetings	120
Youth Camp presentation	40
4-H camp presentation	32
Cultural Prevention	
Craft Classes: shell dress, wing dress, moccasins, vests, chaps, ribbon shirts, quilts, beaded necklaces, and jewelry - 13 classes	236
HIV/AIDS	
World AIDS Day	70
Pi-Ume-Sha Health Fair Booth	200
HIV/AIDS Training at KNT	25
FASD training	20
HIV PSAs 3	
Alcohol and Drug Prevention	
All night party - 2 events	250
JCMS 8th Grade Presentation	180
CAT Open House Display	50
Pi-Ume-Sha Health Fair Booth	300
Produced Underage Drinking Video	
Summer Elder Video Project (employed 6 youth)	700
Back to School Barbeque (back packs & supplies)	
Basketball Camp for Youth	50
Tobacco	
Display at CAT Open House	40
Display at men's Wellness Conference	30
Presentation to Youth on Probation	20
Pi-Ume-Sha Health Fair Booth	300
Youth Camp Presentation	40
4-H Camp presentation	40
Presentation at Fun Run	35
Presentation at CPS	5

Figure 3-14

Community Health Education Team Alcohol Program, Continued…

Interpretation: In 2011 CHET participated in or initiated a total of 61 events. This was an increase of 67% over the previous year. There was an increased emphasis in providing traditional cultural crafts experiences for adults and youth. This follows in line an increasing body of research recommending cultural teachings and crafts as a component of Native American prevention programming.

December of 2011 saw the end of a chapter in the long history of the CHET program. The Tribe's Prevention Coordinator and the Tobacco Prevention Coordinator positions were taken out of CHET and into a newly formed Prevention Team under the Community Counseling Program. It is uncertain what the new structure and mission of CHET will be from this point forward with only two full-time health educators. It is possible that the CHET Manager's position will be shifted into the Health Department and the CHET program would be administered through that department.

Mental Health

Purpose: To provide cultural relevant Mental Health Services for all by providing a full continuum of services covering prevention, treatment and aftercare.

Relevance: Understanding patient demand and workload is necessary to determine appropriate resources and staffing.

Mental Health

	2008	2009	2010	2011
Visits & Clients Served				
Number of Adult Visits	858	905	1,021	1,268
Number of Children Visits	1,288	1,810	2,042	1,515
Total Visits	2,146	2,715	3,063	2,783
Categories of Service				
*Depression Visits				
*Post Traumatic Stress Visits				
Crisis Management Visits	201	236	275	275
Other				
Prevention Services				
Positive Indian Parenting (5)				299
Elvis Birthday Bash				97
MSPI Madras High School Presentations				103
QPR Trainings (5)				115
Sock-Hop Event				62
All Night Lock-In				105
He-He Butte Prevention Camp				43
"Spring Into Action" Event				100
Oregon Native Youth Survey				24
Halloween Party				500
Prevention Basics Power Point				5
W. S. Christmas Fun Party				1,400
Spring Into Action (Prev. Coalition)				200
Total Prevention Services Attendance				3,053
Service Hours				
Client Contact Hours				2,275
Total FTE Hours				
% hours of Client Service				

Figure 3-15

Interpretation: Mental Health cases dropped by 527 for children for unknown reasons. Have not been able to determine why numbers dropped. It is hoped by providing all year round prevention – family activities, that this trend will continue.

Alcohol & Substance Abuse

Purpose: Substance abuse is the center of behavioral, mental, physical and spiritual problems in our community. The purpose of this program is to provide cultural relevant services for all by providing a full continuum of services covering prevention, treatment and aftercare.

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	2011
Encounters -- Outpatient Treatment				
Number of Visits	2,146	2,866	2,570	2,570
Number of Clinic Days	239	239	239	239
Average Visits per Clinic Day	9	12	11	11
Relaps Anger Resolution Grp (Quarterly)	75	75	75	33
Jail Groups (estimate)	216	256	246	250
Aftercare				
Healing from Grief & Trauma - 1 day conf.			25	57
Recovery Month Dinner			100+	n/a
A&D Prev. B-Ball "And 1" (Street Ball Tour) all ages	300+		400+	250
Community Grief/Trauma Gathering (2 workshops)			90+	80
Healing Family Circle Conference				40
Native Pride Men's Conference				35
Native Family Wellness Conference				35
Categories of Service				
Alcohol Abuse	1,913	2,549	2,287	2,899
Drug Abuse	233	317	283	
Residential Care - Adult	25	37	35	47
Residential Care - Adolescent	19	11	15	13

Figure 3-16

Interpretation: Number of visits has increased, we do not know if this can be correlated with the decrease in Mental Health visits and better assessment. We will be switching over to a State data system which will provide more accurate data in the future.

Adolescent Aftercare

Purpose: Initiate, conduct and coordinate children/adolescent outreach to prevent behavioral problems such as: substance abuse, delinquency, school drop-out, teenage pregnancy and violence. The outreach program collaborates with other Tribal prevention programs.

Relevance: To provide children/adolescent services to those who are at risk of needing treatment if intervention programs are not provided.

Adolescent Aftercare

	2008	2009	2010	2011
Outpatient Visits	231	465	347	unk
Number of Clients In:				
Suicide Prevention Camp	20	50	32	50
Healing Wounded Spirits Camp	103	0	0	n/a
Winter Youth Conference	107	0	0	n/a
Movie Nights	0	47	297	319
Wii Bowling	0	4	49	n/a
Hoop Camp (2)	0	52	62	144
Madras Bowling			84	83
Wellnss walk			18	81
All Night Sobriety Party				160
Kids Bingo				76
Red Road to Recovery				93
Tribal Youth Leadership				24
Total	**230**	**153**	**542**	**1,030**

Figure 3-17

Interpretation: As the outreach program stabilizes and community awareness increases, it is anticipated that more children/adolescents are going to continue to access this program.

Community Health & Prevention Resource Center

Purpose: To determine the number of people utilizing Community Health & Prevention Resource Center (CHPRC) resources. To identify the number and kind of resources they use.

Relevance: CHPRC provides centralized service to all ages in the community's, including free access to health resources and other information.

Community Health & Prevention Resource Center
2011

	Totals
Library Usage	
Patrons that checked out materials	248
Materials checked out	733
Health/prevention materials checked out	46
Native American materials checked out	139
Circulations**	1,424
Visitors	3,833
Library cards issued	477
Graphic Design Requests	
Posters/Banners printed	199

**A circulation occurs whenever material is checked out and renewed, i.e. the number of times materials are loaned out.

Figure 3-18

Interpretation: Library usage statistics cover only 6 months (July – December) because the Library did not open until July 2011. These numbers reflect the total number of people that utilized CHPRC resources, how many times they checked out material, how many materials were checked out and what kind of material it was. From this we can determine that 52% of card holders checked out material, 6.2% of which was health related while 20% was Native American related.

Graphic design requests reflect the number of posters and banners printed for Tribal Entities and Programs for the whole year.

Social Services

Purpose: To identify the case load and resources associated with programs administered by Social Services (Housing & Energy Assistance, Medical Travel, Disability Assistance & 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	2011
Housing & Energy Assistance				
Number of Clients Served				
Total Vouchers Processed				
Total $ Value of Vouchers	63,442	117,751	144,294	84,443
Medical Travel				
Number of Clients Served	691	691	923	789
Total Vouchers Processed	691	691	923	789
Total $ Value of Vouchers	28,519	28,519	27,108	20,211
Disability				
New Clients pursuing claims for SSI/SSDI			23	92
Number of clients currently checking on Survivorship/widow benefits			16	28
Number of Clients inquiring about Retirement Benefits			8	21
Number of Clients that have been denied			31	77
Number of Clients that have filed their 1st Appeal			21	49
Number of Clients in middle of Appeal			25	54
Number of Clients in Court Hearings			7	16
Commodities				
Number of Families Served				82
Number of Individuals Served				134
Number of Warm Springs Tribal Members				

Figure 3-19

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 ACTIVITY

Reason for Call	Calls		Patients Transported		Calls w/Substance Factor	
	2010	2011	2010	2011	2010	2011
Motor Vehicle Accident	175	116	59	36	35	26
Other Accident	590	218	86	180	48	135
Assault and Battery	69	90	43	34	28	48
Suicides/Attempts	21	13	13	11	13	13
Corrections	383	139	40	35	30	100
Pediatric	99	152	34	43	0	0
Cardiac	79	67	46	39	12	7
Respiratory	73	67	52	45	8	11
Other Illness	301	207	281	191	143	100
Substance						
Total	**1,790**	**1,069**	**654**	**614**	**317**	**440**

TRIBAL AFFILIATION RELATED TO CALLS

Reason for Call	Calls Dispatched		Patients Transported		Calls w/Substance Factor	
	2010	2011	2010	2011	2010	2011
Members and Dependents	1,527	870	537	519	440	348
Other Eligible Indian	36	8	36	3	18	5
Non Tribal	227	191	81	64	21	87
Total	**1,790**	**1,069**	**654**	**586**	**479**	**440**

Figure 3-20

Interpretation: Transports may at times be transferred to other ambulance providers 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): Offers group activities and renal clinics for the education, prevention and treatment of Diabetes.

State Women, Infants and Children (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.

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

Vocational Rehabilitation: 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 is 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. Increases in 2009 and 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

	2008	2009	2010	2011
Indian Health Service				
Recurring Funding	13,340,464	13,995,065	16,174,897	16,284,305
Non-Recurring Funding	982,431	850,831	1,670,645	1,538,649
Collections IHS				
Medicare	241,542	231,819	81,657	201,700
Medicaid	2,242,011	1,809,197	2,283,902	2,400,000
Private Insurance	522,950	443,555	478,426	428,600
Collections Tribe				
Ambulance	120,878	199,242	207,994	171,068
Community Counseling	308,736	201,524	269,916	537,996
Community Health			33,928	266,563
Grant Awards	659,064	1,303,029	859,469	1,373,068
Tribal Employee Group Insurance (Est)	1,233,674	1,260,238	1,269,463	
Tribal Appropriations	933,387	1,160,988	1,790,924	
Total	$20,585,137	$21,455,488	$25,121,221	$23,201,949

Figure 4-1

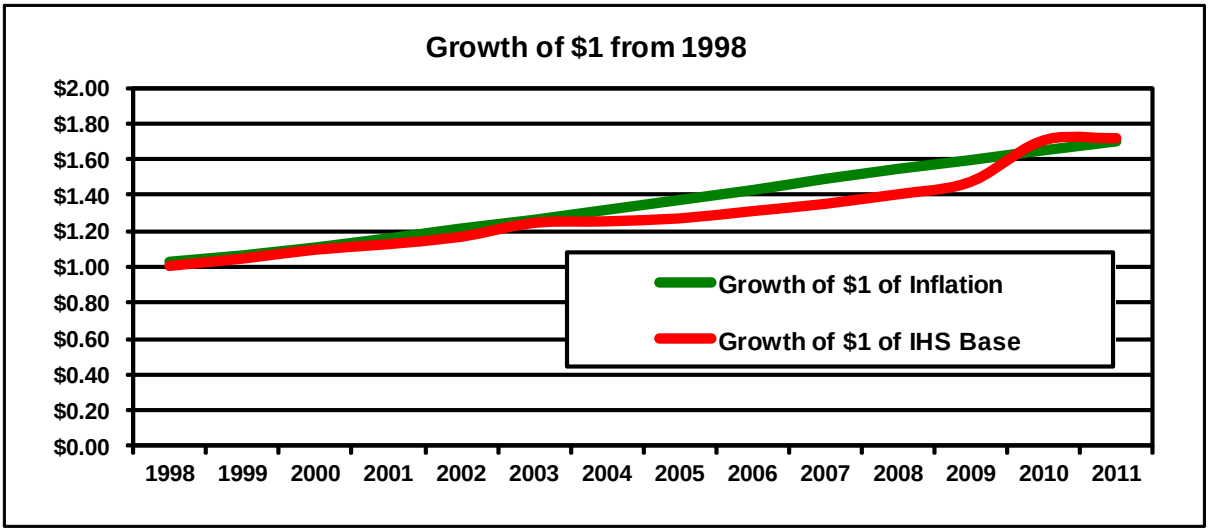
Interpretation: Funding tends to be stable supported by recurring appropriations, but increased population and medical inflation are ongoing concerns. Another key issue to watch will be the impact of Oregon State budget deficit issues on Medicaid collections in coming years. The Indian Health Service 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%
2011	16,284,305	0.7%	3.0%



. Department of Labor, Bureau of Labor Statistics
e index for all medical categories

Figure 4-2

Base Health System Funding Versus Inflation, Continued

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.

	2009	2010	2011
Clinical Services			
Medical	2,752,506	3,562,634	3,586,014
Dental	1,081,141	1,111,249	1,038,130
Optometry	196,619	254,790	202,119
Pharmacy	1,375,587	1,459,292	1,286,068
Podiatry	160,939	181,846	190,773
Medical Lab/X-Ray	587,557	912,072	549,939
Diabetes - Clinic	515,174	370,600	1,679,713
Community Health			
Community Health Dept.	332,515	228,104	377,052
Health Education	60,687	140,073	177,030
WIC Program	69,447	25,051	70,962
Diabetes Grant (Tribal)	344,986	35,024	96,192
Environmental Health	90,919	83,678	46,939
Public Health Nursing	395,325	487,956	705,379
Community Center	237,450	216,412	70,124
Community Counseling			
Community Counseling	801,698	1,028,767	1,383,062
Mental Health	265,369	215,132	369,093
Adolescent Aftercare	145,569	125,644	105,297
Vocational Rehabilitation	302,172	306,586	380,723
Prevention Projects	149,769	26,563	189,942
Administrative Support			
Facilities	888,266	958,080	1,138,310
Security	28,860	21,408	21,872
Health Administration	812,088	657,133	559,991
Business Office	299,474	282,104	83,851
Quality Assurance	175,148	174,143	165,751
Data Systems	371,056	393,030	561,032
Indirect Costs	575,006	587,803	825,743
Other			
Managed Care	5,498,295	5,935,441	5,306,338
Ambulance	858,007	939,514	248,714
Quarters	10,578	-	-
Clinic Equipment	334,497	105,518	326,118
Total	**19,716,704**	**20,825,647**	**21,742,271**

Figure 4-3

Health System Spending by Program, Continued

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.

	2008	2009	2010	2011
Visits Billed				
Medical	11,874	11,336	10,411	10,101
Dental	2,469	1,911	2,168	2,001
Pharmacy	19,720	19,830	23,645	23,578
Optometry	410	431	440	356
All Other	1,448	1,478	1,882	2,657
Total Visits Billed	**35,921**	**34,986**	**38,546**	**38,693**

	2008	2009	2010	2011
Collections				
Medical	$ 1,878,176	$ 1,770,324	$ 2,023,029	$ 2,122,715
Dental	436,894	244,363	373,161	402,762
Pharmacy	577,689	581,929	635,645	683,018
Optometry	66,642	65,006	72,419	65,328
All Other	24,134	11,846	43,133	242,347
Total Collected	**$ 2,983,536**	**$ 2,673,468**	**$ 3,147,386**	**$ 3,516,170**

	2008	2009	2010	2011
Source				
Medicaid	2,242,011	2,050,000	2,283,902	2,675,989
Medicare	241,542	200,000	81,657	103,461
Private Insurance	522,950	450,000	478,426	556,209

Figure 4-4

Interpretations: Total Medical visits billed have fluctuated between 2008 & 2011. Total visits billed increased by about 0.04% from 2010 to 2011. Overall, total visits billed averaged around 10% with increases and decreases throughout the time span. In 2011, Medical billed out for 10,101 visits and received $2,122,715 (an average of $210/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.

	2008	2009	2010	2011
Incidents/Visits Billed				
Ambulance	615	692	681	614
Alcohol & Substance/ Mental Health	1,206	797	1,015	
Community Health			236	1,459
Other				
Total Incidents/Visits Billed	**1,821**	**1,489**	**1,932**	**2,073**

	2008	2009	2010	2011
Collections				
Ambulance	120,878	199,242	215,961	172,032
Alcohol & Substance/ Mental Health	308,736	201,524	272,060	400,000
Community Health			33,928	266,563
Other				
Total Collected	**$ 429,614**	**$ 400,766**	**$ 521,949**	**$ 838,595**

	2008	2009	2010	2011
Source				
Medicaid		241,180	358,593	698,517
Medicare		45,957	40,297	36,171
Private Insurance		108,986	121,971	1,893
Other		4,643	1,088	4,048

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	
	2010	2011	2010	2011	2010	2011
Workers Compensation	2	9	2,610	12,562	1,991	4,048
Medicaid	159	128	169,611	145,435	52,605	31,954
Medicare	55	88	97,930	100,988	40,297	36,171
Private Insurance	71	145	121,285	161,746	119,980	97,965
Private Pay	47	36	74,875	40,233	1,088	1,893
Managed Care	178	186	276,882	207,403	-	-
No Source	12	22	-	4,550	-	-
Total	**524**	**614**	**$ 743,193**	**$ 672,917**	**$ 215,961**	**$ 172,032**
Average Per Transport			**$ 1,418**	**$ 1,096**	**$ 412**	**$ 280**

(1) Collection source breakout not reported

OUTLAYS AND FUNDING	2010	2011
Outlays		
Allocated Salaries and Benefits	642,341	612,211
Medical Supplies	47,737	14,073
Other Supplies & Expenses	34,891	2,876
Vehicle Expenses	55,118	53,160
Equipment	24,455	
Vehicle & Equip. Depreciation	108,000	44,000
Total	**$ 912,542**	**$ 726,320**
Average Direct Cost Per Transport	**$ 1,741**	**$ 1,183**
Funding Source		
Indian Health Service (PL 93-638)	$ 77,646	
Collections	$ 172,032	
Warm Springs Tribe - Direct Appropriation	$ 476,642	

Figure 4-6

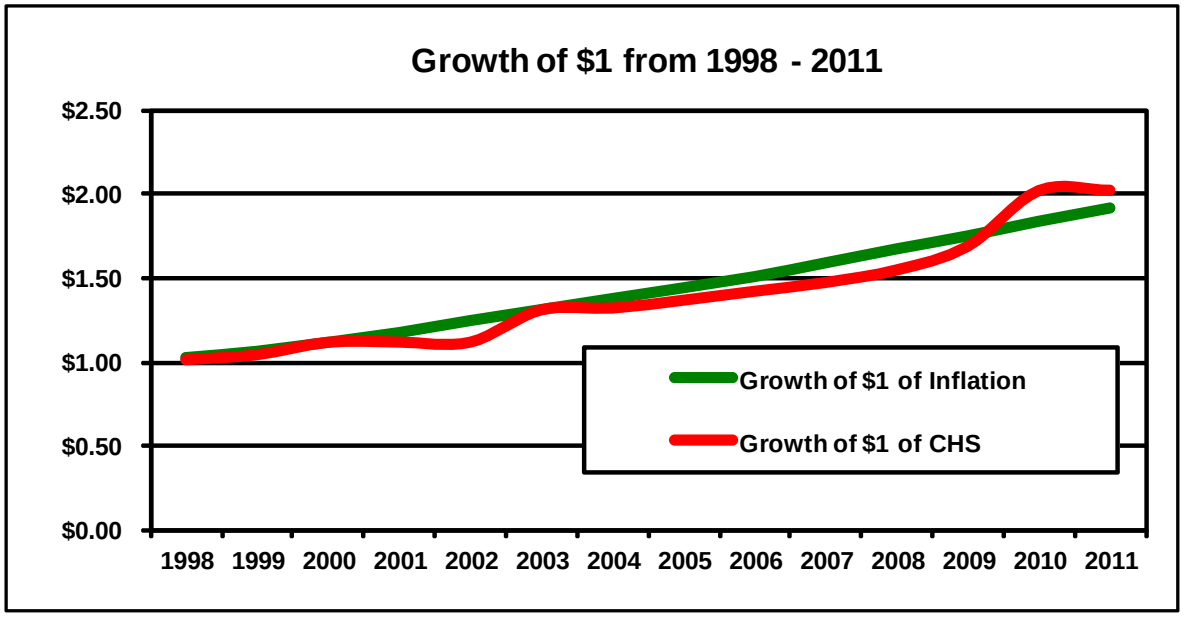
Interpretations: The service utilized an average market total billing rate of $1,244 for 2010 and 2011. No charges are billed for dispatched calls where no transport occurs. Salaries and Benefits include personnel during dispatch, transport, training, and other time related to ambulance services. Allocations 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%
2011	5,414,309	206,376	675,421	6,296,106	0.1%	4.3%



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

Contract Health Services – Funding, Continued

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	1,781,146	2,261,024	467,070	169,229	3,640	137,381	80,571	4,900,061	
2006	2,575,549	1,684,794	553,401	65,901	-	110,504	58,866	5,049,015	
2007	1,830,704	1,116,191	441,008	38,592	2,483	5,915	10,094	3,444,987	
2008	1,729,093	1,489,246	507,499	52,544	3,424	17,373	82,811	3,881,990	
2009	2,021,967	1,915,068	786,645	90,704	5,611	18,620	101,888	4,940,503	
2010	2,236,131	1,983,161	779,294	72,569	7,154	25,384	118,325	5,222,018	*
2011	1,849,646	2,000,961	795,965	170,096	12,466	34,497	132,942	4,996,573	*

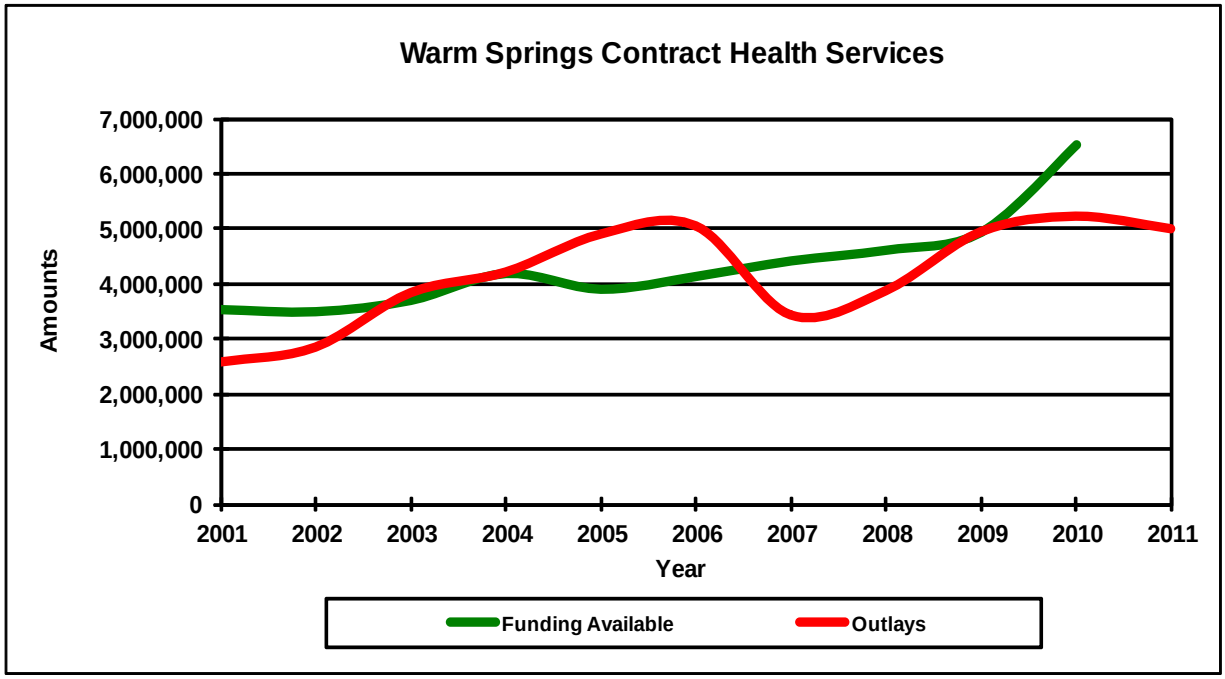


Figure 4-8

* There are Obligations for Services that have not been finalized. Final payment amounts will vary.
* There is an additional $107,220 Obligated, but not yet paid for 2010.
* There is an additional $337,871 Obligated, but not yet paid for 2011.

NOTES:
2002 Total does not include an additional $602,123 that was transferred from MCP to C&B for 2002 medical costs on MCP-eligible patients paid by C&B.

Contract Health Services – Spending, Continued

Interpretation: Illustrates fluctuations in MCP total costs, as well as seven components of that total cost, over eleven 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. The rise in Out-Patient in 2008-2010 is the result of the $500k from Tribal Council Resolution (2008), $500k carryover "carve-out" from reserves (2009), $250k carryover "carve-out" from reserves (2010), and relaxation of Priority I's in April 2010. Most Priority II, III, and IV have been authorized since then, with the resulting yearly peak costs of $5,222,018 in 2010. However, with $337,871 Obligated but not yet Paid for in 2011, the final costs may exceed those for 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.

	2010			2011		
	Units	Total Cost	Cost per Unit	Units	Total Cost	Cost per Unit
Hospital Days	1,236	$2,243,127	$ 1,815	994	$1,849,646	$ 1,861
Emergency Room Visits	1,466	$ 789,377	$ 538	1,294	$ 795,965	$ 615

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. Although there was a 19.6% decrease in Hospital Days from 2010 to 2011, there was a 2.5% increase in Hospital Cost per Unit for this same period of time.

This same trend continued for Emergency Room Visits with an 11.7% decrease in Emergency Room Visits from 2010 to 2011, but a 14.3% increase in Emergency Room Cost per Unit.

While the data in the table indicates the Cost per Unit for Hospital Days in 2011 was $1,861, 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.

2011

Priorities*	Cases Deferred	Estimated Cost
Priority 1	0	-
Priority 2	0	-
Priority 3	1,452	175,000.00
Priority 4	0	-
	1,452	**175,000.00**

*Definitions of Priorities is contained within Tribal/IHS Polic *Figure 4-10*

Interpretation: MCP was fortunate from 1995 through June 2005 to cover Priorities I-IV with its current year's budget supplemented by carryover dollars when necessary, and thus fortunately did not have a Deferred Services list. From the implementation of the Priority I coverage only in July 2005, MCP kept a Deferred Services list defined as those services in Priorities II-IV.

IN April 2010, MCP was able to expand coverage beyond Priority I's to Priority II-IV coverage once again. Thus, 2011's report included $250k in "Estimated Cost" for 828 "Cases Deferred" from January until expansion of Priority coverage, but paid for with Tribal "carve-out" dollars.

MCP was able to cover Priority I-IV throughout 2011, and had minimal "Deferred Services" as defined as those which MCP had covered pre-2005. The MCP Case Manager in conjunction with the PAO CHS Manager compiled the numbers in the table above for a report requested by PAO.

For Dental, MCP covers only emergent conditions such as abscesses and Priority I situations, in addition to dentures and partials. Other cases are determined on a case by case basis. The approximate cost for dental services is about $100k. There were approximately 252 dental cases deferred.

Deferred Services, Continued

For Pharmacy, MCP covers only emergent conditions, in addition to anti-rejection drugs, chemotherapy, anti-coagulant after heart surgery, or knee and hip replacement surgery. The approximate cost for pharmacy was $75k. There were an estimated 1,200 scripts at $100 per month.

Both Dental and Pharmacy were determined by estimating from years past when MCP did cover both.

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 II: Primary & Secondary Care Services: i.e. Specialty Consultations
Priority IV: Chronic Tertiary & Extended Care Services: i.e. Hip/Knee Replacement

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	1,900,122	34	25,000	1,050,122	493,132	301,223	794,355	255,767
2011	1,622,370	36	25,000	722,370	374,198	124,070	498,268	224,102
Totals	**$9,913,798**	**173**		**$5,634,798**	**$2,684,956**	**$1,368,926**	**$4,053,882**	**$1,356,814**

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 IHS. Thus, the apparent negative shortfall in 2009.

Figure 4-11

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

CHS – Catastrophic Health Emergency Fund, Continued

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	2011
Mountain View Hospital (MVH)				
Inpatient	800,501	1,154,243	1,215,681	1,060,954
Outpatient	634,365	777,509	873,079	1,163,798
Mixed	139,824	84,704	83,972	145,678
Total	**$1,574,690**	**$2,016,456**	**$2,172,732**	**$2,370,430**
Other Critical Access Hospitals				
Inpatient	706	4,089	13,647	10,511
Outpatient	0	285	2,672	5,299
Mixed	0	0	849	0
Total	**$706**	**$4,374**	**$17,168**	**$15,810**
Hospitals that Bill on DRG Rates				
Inpatient	741,502	1,700,090	1,877,149	1,898,748
Outpatient	435,972	441,297	404,065	395,179
Mixed	82,843	$25,604	32,458	29,551
Total	**$1,260,317**	**$2,166,991**	**$2,313,672**	**$2,323,478**
TOTAL MLR SAVINGS	**$2,835,713**	**$4,187,821**	**$4,503,572**	**$4,709,718**

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 that the total reimbursement the hospital would have received from Medicare.

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

Medicare-Like Rate (MLR) Savings, Continued

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 on the previous page, 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	2008	2009	2010	2011
Grant Amount				
Diabetes Grant (Tribe)	$ 193,268	$ 193,268	$ 193,268	$ 193,268
State Women, Infants, and Children (WIC)	71,200	72,046	80,586	84,578
Woman's Wellness Conference	4,437			
CHET Dental Project	4,253			
Senior Fitness Enhancement	22,078			
Tobacco Pilot Site				
State Tobacco Prevention	44,614	57,557	90,057	74,262
USDA Commodity Warehouse	86,214	100,481	58,358	79,136
State Alcohol & Drug		297,752		230,000
State Alcohol Prevention		100,000		105,000
State Mental Health		294,444		278,366
State Youth Suicide Prevention	30,000		26,000	
Influenza Pandemic	41,444			
Vocational Rehablilitation	103,000	345,519	411,200	328,458
Meth Prevention Project	100,000			
Total	**$ 700,508**	**$ 1,461,067**	**$ 859,469**	**$ 1,373,068**
Grant Expenditures				
Diabetes Grant (Tribe)	$ 172,101	$ 344,986	$ 35,024	$ 96,192
State Women, Infants, and Children (WIC)	59,671	69,447	25,051	70,962
Woman's Wellness Conference Grant	4,436			
CHET Dental Project Grant	23,037	32,051		
Senior Fitness Enhancement Grant	28,224	10,970		3,278
Tobacco Pilot Site Grant		26,383	26,197	
State Tobacco Prevention Grant	24,959	63,345		78,464
USDA Commodity Warehouse Grant	65,110	67,437	21,087	82,019
State Alcohol & Drug Grant	124,401	163,378	130,864	188,479
State Alcohol Prevention Grant	51,225	39,273	37,797	111,478
State Mental Health Grant	137,837	138,534	100,446	234,837
State Youth Suicide Prevention Grant	35,137	(1,964)	11,310	
Influenza Pandemic	3,321	16,105	11,509	12,548
Vocational Rehabilitation Grant	464,171	302,172	306,586	380,723
Meth Prevention Project Grant	110,536	112,460	15,253	
Total	**$ 1,304,166**	**$ 1,384,577**	**$ 721,124**	**$ 1,258,980**

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

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			2011 FTE			2011 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									
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									
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									
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**		6.0	**6.0**
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									
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**	**32.0**	**69.0**

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	Date of Approval
Inergen fire suppression system	Health & Wellness Center	$ 40,129	2011	2011
10 heat pumps & split system	Health & Wellness Center	$ 53,147	2011	2011
Vinyl project	Health & Wellness Center	$ 69,553	2011	2011
Retro lighting project	Health & Wellness Center	$ 48,180	2011	2011
Permanent sink	Health & Wellness Center	$ 2,089	2011	2011
Infectious waste buildings	Health & Wellness Center	$ 4,420	2011	2011
Warehouse/boiler room wall & floor project	Health & Wellness Center	$ 9,654	2011	2011
Front fence replacement	Health & Wellness Center	$ 9,300	2011	2011
Front entry gate	Health & Wellness Center	$ 2,861	2011	2011
		$ 239,333		

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	Cost	Program	Date of Request	Date of Approval
MTI Podiatry Table	6,258	Podiatry	Jun-11	6/1/2011
Dell Power Vault	8,465	Computer Support	Oct. 2011	10/1/2011
Spectralis PCTPlus	69,000	Optometry	Sept. 2011	9/1/2011
Reliance Examination Chair	5,021	Optometry	Jul-11	7/1/2011
Fuji X-Ray 3-step wt bearing	5,120	Radiology	Dec. 2011	12/1/2011
87" Smart Board	4,386	Computer Support	Sept. 2011	9/1/2011
Kubota Tractor w attachments	21,928	Facilities	Oct. 2011	10/1/2011

***** 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.

	2008	2009	2010	2011
Tribe - Self Determination Contract				
Program Savings and Carryover				
Community Health	300,784	1,247,935	1,047,895	1,095,354
Community Counseling	1,001,783	1,154,130	1,395,902	1,306,703
Managed Care	2,768,366	2,575,459	3,575,143	4,976,885
Ambulance	35,008	12,062	12,131	9,486
Facilities Operations	386,904	458,203	516,868	309,752
Environmental Health	75,998	40,974	120,212	199,057
Indirect Contract Support Costs	1,384,142	1,514,614	2,411,497	3,096,251
Reserves				
M & I Reserve Wellness Center	842,074	810,142	724,951	900,391
M & I Reserve Community Counseling	263,354	304,145	341,859	344,883
Equipment Replacement	93,165	99,481	104,089	108,029
Projects				
Joint Venture - Clinic Remodel	460,225	460,225	338,225	226,578
Other JV Projects	282,547	106,866	91,555	282,491
Total	**7,894,350**	**8,784,236**	**10,680,326**	**12,855,860**
Indian Health Service				
Medicare/Medicaid	1,079,000	1,258,967	1,993,250	2,940,379
Private Insurance	86,000	235,522	357,053	331,789
FSA & M&I			214,432	254,037
Equipment			38,849	97,712
Total	**1,165,000**	**1,494,489**	**2,603,584**	**3,623,917**
Grants				
Diabetes-competitive grant	562,100	482,100	397,100	
Diabetes-competitive grant - prior years			397,100	
Diabetes Grant - Clinical (IHS operation)			162,606	165,390
Suicide Prevention	2,289	2,289	-	
Meth/Suicide		247,374	126,571	
Diabetes-Noncompetitive grant	88145	88,145	-	
Domestic Violence		80,000	-	
Total	**652,534**	**899,908**	**1,083,377**	**165,390**

Figure 4-17

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

SECTION 5

Evaluation

How do we evaluate our progress and our effectiveness?

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

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

Patient Satisfaction Survey

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

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

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

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

GPRA Performance Measurements Summary

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

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

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

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

Accreditation Information

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

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

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

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

Cost versus Value of Service

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

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

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

Figure 5-1

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