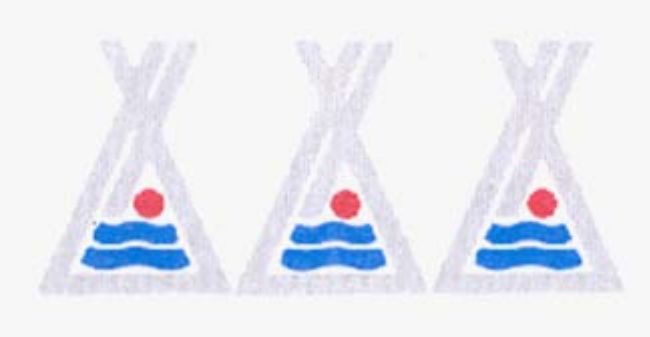
The Confederated Tribes of the Warm Springs Reservation of Oregon

and

The Indian Health Service



Annual Health System Report

for the

Warm Springs Indian Reservation

September 4, 2013

2013 Edition
Reporting Information through 2012

2013 Annual Health System Report

Table of Contents

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 2012 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 afterhours 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 2012. An increase 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.

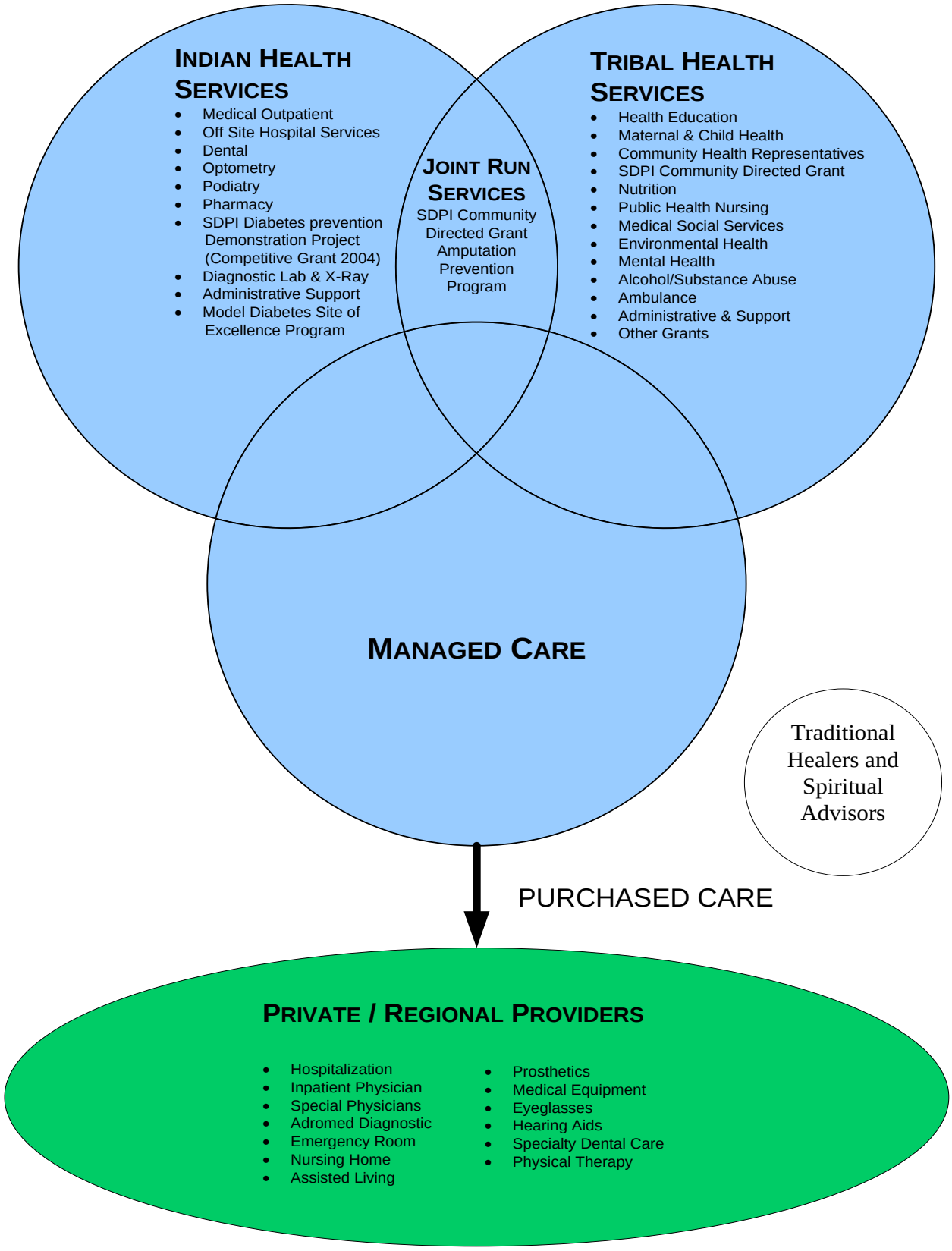
Throughout the years, the Tribe has contracted various portions of the Indian Health Service financed community health programs, mental health and alcohol and substance abuse programs, completing that transition in 2008. The Tribe has also appropriated tribal resources and sought and received grants 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	6048	5057
2002	471	6302	5375
2003	449	6478	5402
2004	409	6558	5471
2005	346	6612	5564
2006	368	6685	5634
2007	328	6612	5229
2008	370	6703	5298
2009	320	6665	5454
2010	333	6692	5628
2011	338	6672	5669
2012	304	6680	5649

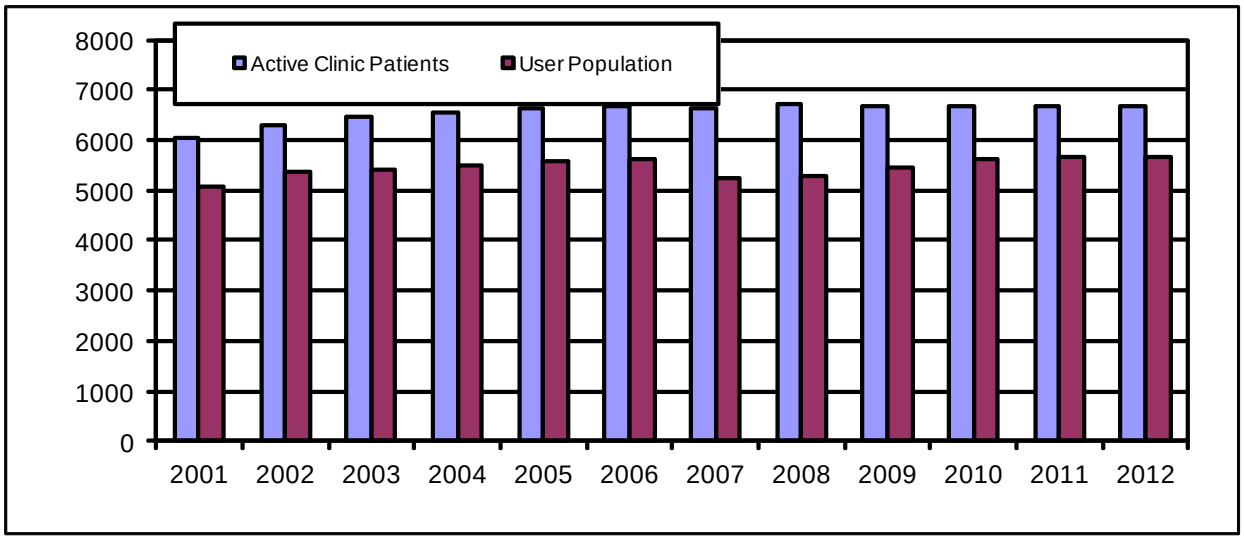


Figure 2-1

Customers That Use the Services Continued…

Interpretation: Between 2001 and 2012, new patient registrations have decreased by approximately 27%. During that timeframe, new patient registrations peaked in 2002 at 471; an increase of 54 patients from the previous year. Since then, new patient registrations decreased to their lowest point in 2012 at 304 registrations. In that twelve year time span, the user population has increased from 5,057 to 5,649 (11.7%) and the population of active clinic patients has increased by 10.5%. The user population and active clinic population have followed the same trends over time averaging a change within 1% in either direction. 2007 had the most significant value change; a decrease of 7.2% for the active user population.

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	2012	Chg(11-12)
Warm Springs Indian Reservation	3,559	3,686	3,665	3,690	3,536	(154)
Madras/Redmond/Bend	1,104	1,035	1,119	1,190	1,266	76
Maupin/The Dalles/Hood River	91	85	90	85	93	8
Portland/Salem	90	90	91	94	104	10
Other Oregon	470	461	460	440	427	(13)
Outside Oregon	237	137	213	181	200	19
TOTAL	**5,551**	**5,494**	**5,638**	**5,680**	**5,626**	(54)

By Tribal Affiliation	2008	2009	2010	2011	2012	Chg(11-12)
Warm Springs Member	3,773	3,812	3,893	3,990	3,955	(35)
Other Oregon Tribes	244	241	240	219	218	(1)
All Other Tribes	1,432	1,350	1,402	1,377	1,364	(13)
Non-Indians	102	91	103	94	89	(5)
TOTAL	**5,551**	**5,494**	**5,638**	**5,680**	**5,626**	(54)

Figure 2-2

Interpretation: Trends have remained stable from 2008 to 2012 with approximately two-thirds of our patients being Warm Springs Tribal Members and approximately two-thirds of our patients residing on the Warm Springs Indian Reservation:

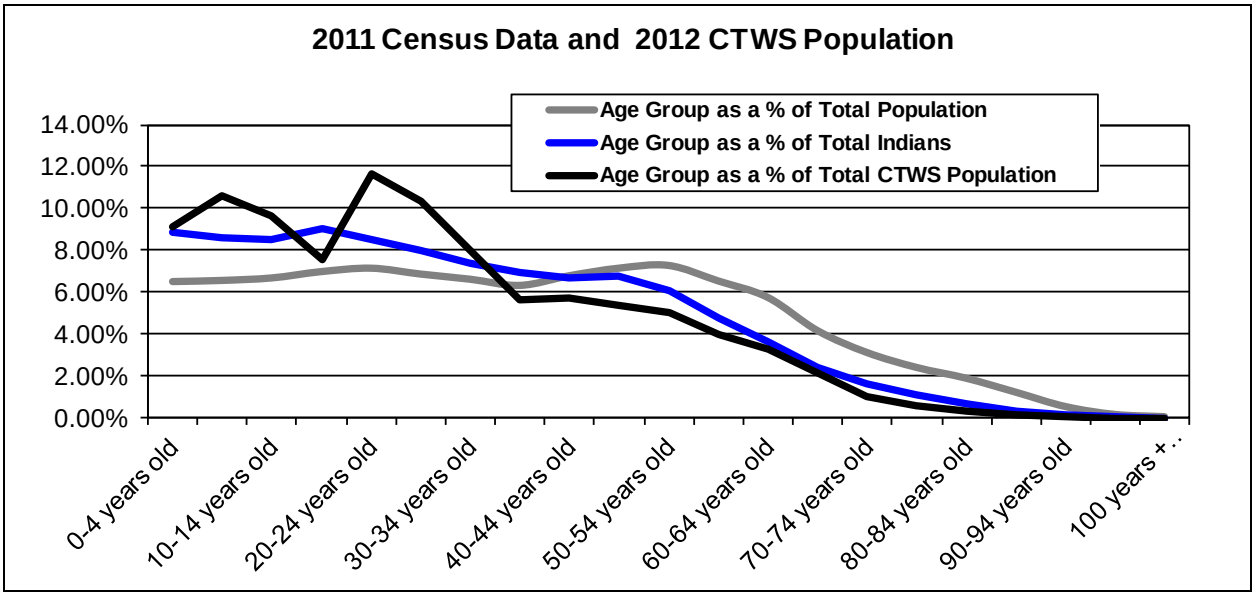
- 2008 – 68.0% Warm Springs Tribal Members; 64.1% residing on Reservation
- 2010—69.1% Warm Springs Tribal Members; 65.0% residing on Reservation
- 2012—70.3% Warm Springs Tribal Members; 62.7% residing o Reservation.

From 2008 to 2011 there was a small increase in patients who are Warm Springs Tribal Members and a small decrease in 2012. There was a slight decrease in patients who are members of other Tribes or who have no tribal affiliation. Between 2008 and 2012, we saw a decrease of approximately 1.4% of patients who reside on the Warm Springs Indian Reservation. As of 2012, over 85% of our patients resided either on the Reservation or in the Madras/Redmond/Bend area.

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

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

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



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

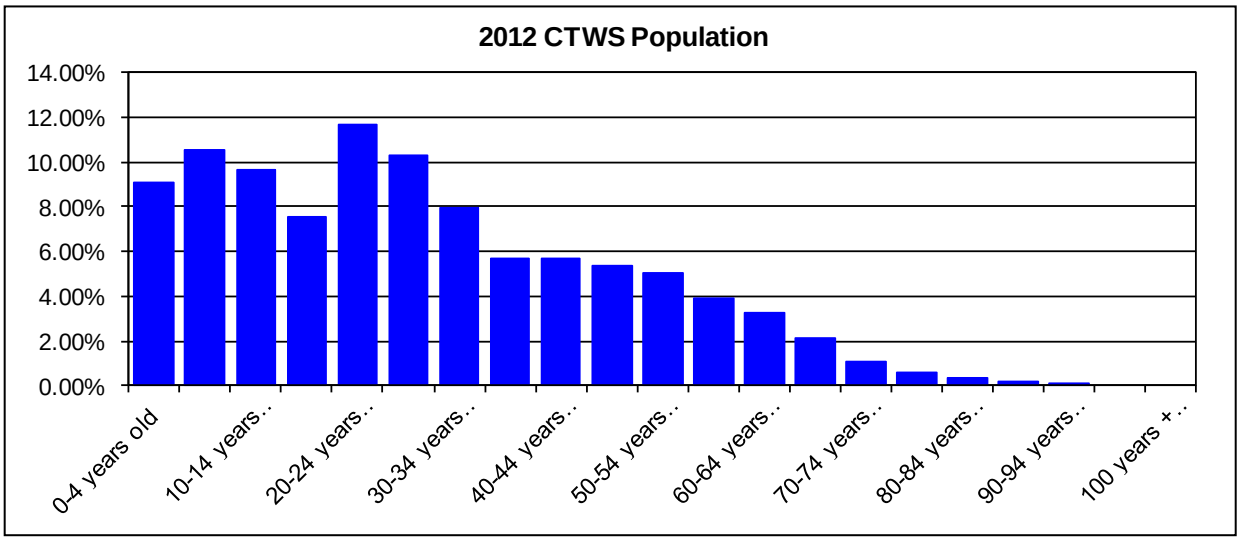


Figure 2-3

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 2000 Patients	2009 Patients	2010 Patients	2011 Patients	2012 Patients
0-4	543	573	675	677	699
5-9	460	556	603	551	545
10-19	1,367	1,023	1,082	1,094	968
20-29	971	989	1,056	1,077	1,082
30-39	912	643	690	719	725
40-49	738	674	694	693	699
50-59	440	565	604	615	633
60-69	204	330	368	397	449
70-79	98	150	169	168	180
80+	40	57	56	62	62
TOTAL, Patients	**5,773**	**5,560**	**5,997**	**6,053**	**6,042**

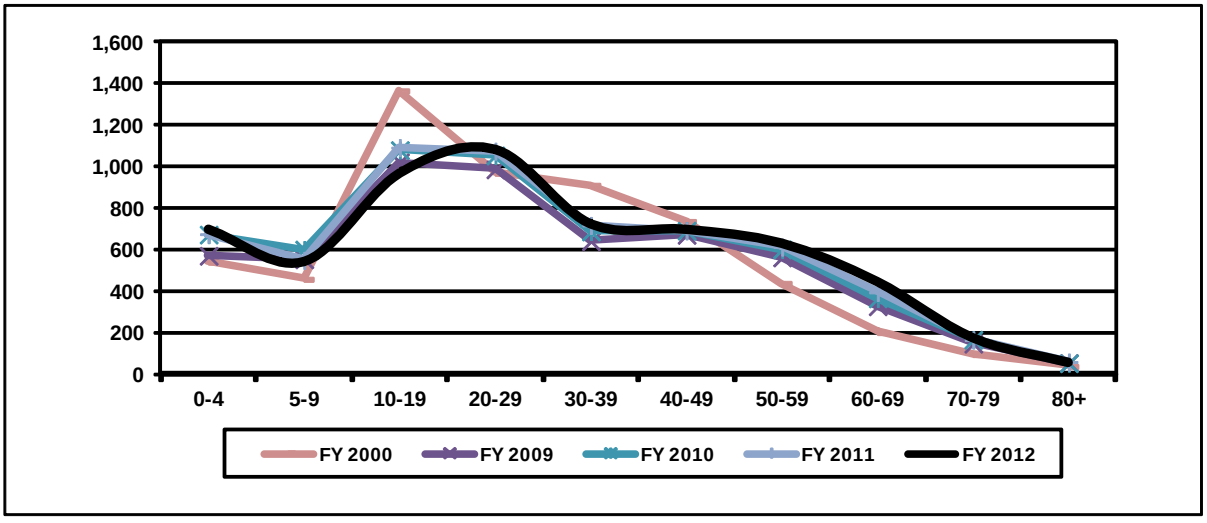


Figure 2-4

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	FY 2012
Medicaid Only	1,241	1,340	1,206	1,181	1,455
Private Insurance Only	1,087	1,150	1,082	1,269	1,263
Medicare A Only	20	16	25	28	33
Medicare B Only			-	-	-
Medicare Part A & B Only	123	121	141	139	138
Medicare Part D	188	176	179	189	200
Medicaid & Medicare	18	32	41	30	35
Medicaid & Private Ins.	145	181	606	842	736
Medicare & Private Ins.	117	114	143	141	142
Medicaid, Medicare, & PI	1	5	11	10	6
Total	2,940	3,135	3,434	3,829	4,008
Non-Billable					
Tribal Employee Self-Insurance	311	286	269	278	224
No Alternate Resource	2,983	2,737	2,673	2,492	2,276
Total	3,294	3,023	2,942	2,770	2,500
Total Patients	**6,234**	**6,158**	**6,376**	**6,599**	**6,508**

Figure 2-5

Interpretation: Over the past four years the number of patients with billable alternate resources has increased by almost 40%. Those with Tribal Insurance (non-billable) also trended upwards. Those with no alternate resources have dropped dramatically from 2008 as a result. The increase in patients with alternate resources is due in part to an aging population becoming eligible for Medicare as well as Medicaid expansion. Staff works aggressively to ensure that all patients get enrolled in any outside benefits that they may be eligible for.

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

	Age 14 & under	Age 15-19	Age 20-24	Age 25-29	Age 30-34	Age 35-44	Total 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
2012	0	7	33	24	14	8	86
	0	**91**	**168**	**116**	**64**	**33**	**472**
		19.3%	**35.6%**	**24.6%**	**13.6%**	**7.0%**	**100.0%**

Figure 2-6

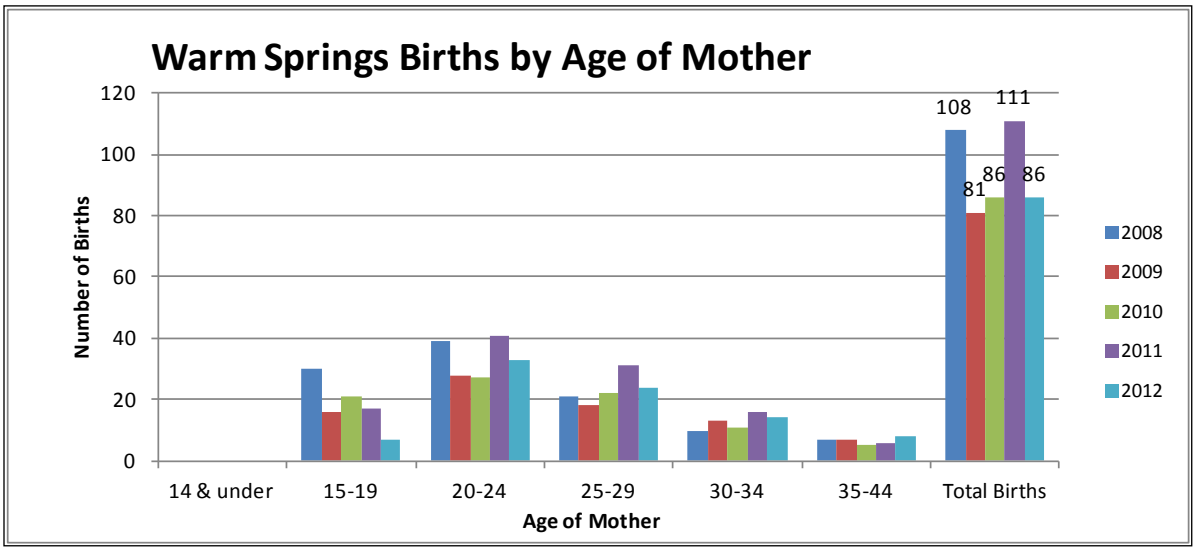


Figure 2-7

Interpretation: Information reported through 2000 reflected a large portion of births to very young mothers. From 2008 to present, total births to the 15-19 year old age range has trended downward for the past 3 years with the lowest percentage recorded in 2012.

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.

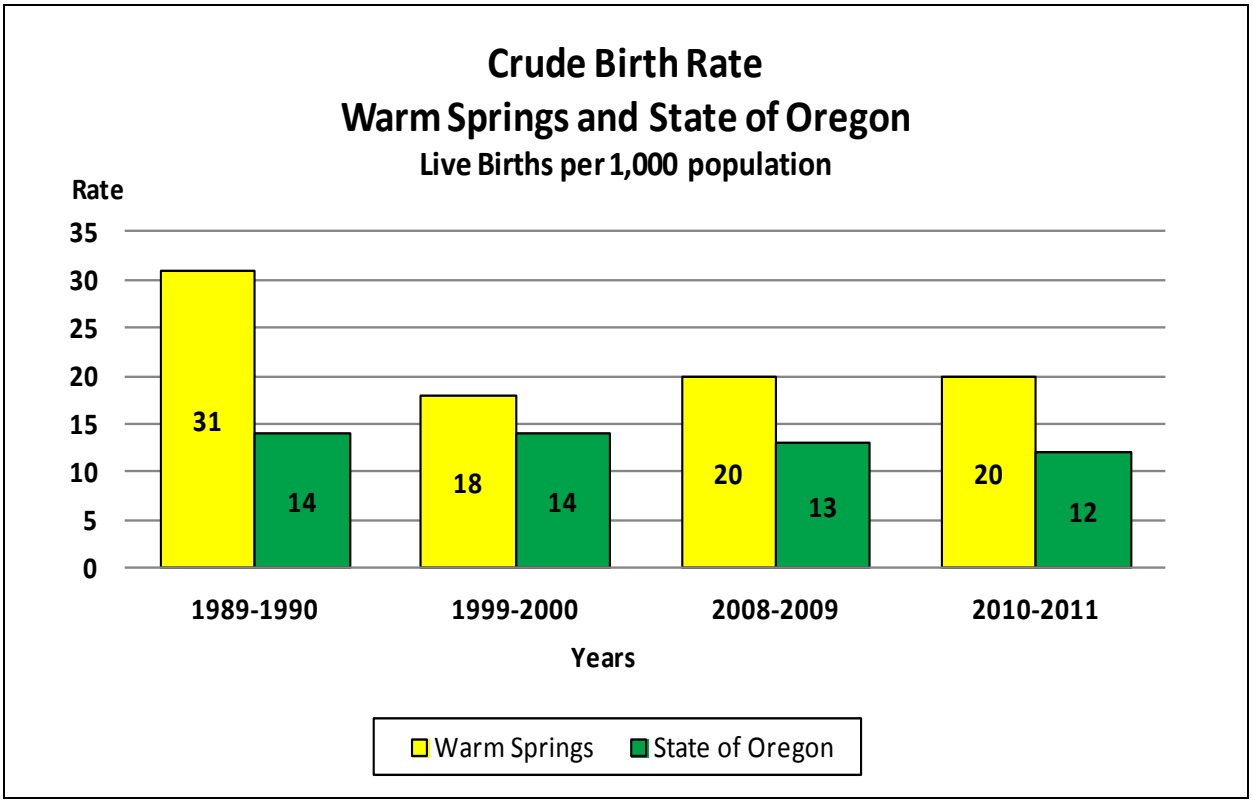


Figure 2-8

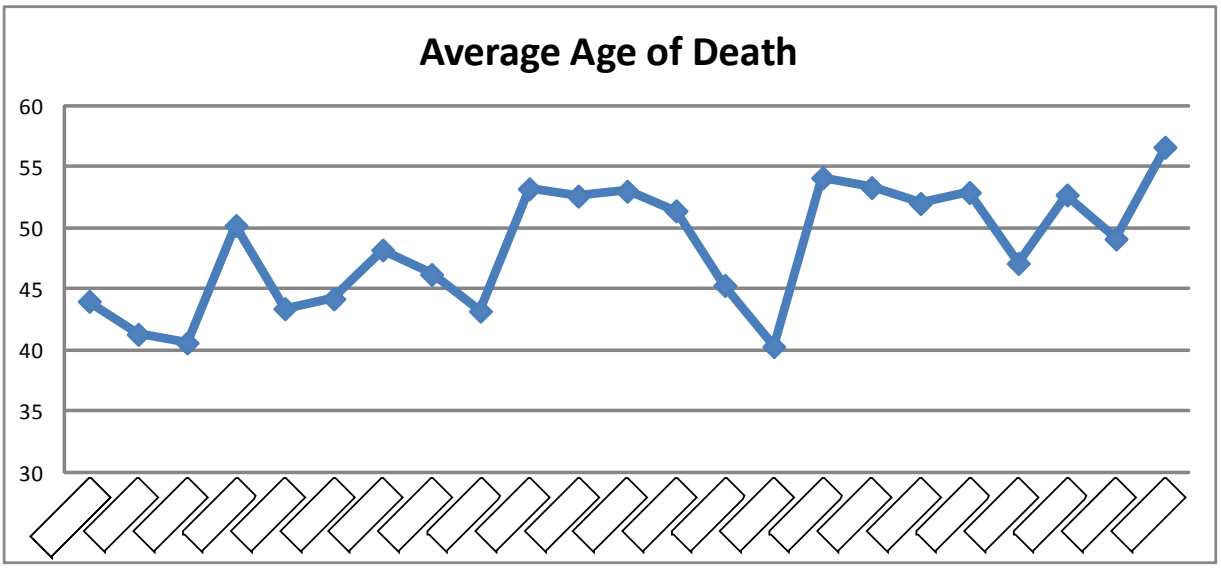
Interpretation: Past reports reflected a substantially higher birth rate at Warm Springs then the general Oregon population. The difference reduced in the 2000 report but has remained consistent since then.

The statistics for the 2012 birth rate comparison will be finalized through the State of Oregon Vital Statistics Department in August 2013 and reflected in the next annual report.

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

Purpose: To record and display the number of deaths each year and to relate this to the Tribal population to produce a rate. A year 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

	1994-1996	1997-1999	2000-2002	2003-2005	2006-2008	2009-2011	2012
Number of Deaths	83	84	111	103	121	155	39
Crude Death Rate	502	482	608	524	605	774	584
Years of Productive Life Lost	1,889	1,877	1,794	2,141	1,906	2,898	558*

* single year's data

Figure 2-9

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 is 78.7 in 2011. In 2012, crude death rates were lower than in the U.S., and the average age at death was the highest in over two decades. Deaths early in life continue to have a disproportionately high impact on the local population, but the impact is decreasing.

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+
1995-1997	1		8	47.7	2	11.9
1998-2000	3		4	22.7	3	17
2001-2003	3		3	15.9	3	15.9
2004-2006	4		2	10.1	3	15.1
2007-2009	8	36.8	4	17.4	1	4.4
2010-2012	5	16.6	2	8.6	3	12.9

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

Leading Cause of Death 2003-2012

Infant:
Cause 1: Accidents
Cause 2: Congenital Malformations, Deformations and Chromosomal Abnormalities
Cause 3: Sudden Infant Death Syndrome
Disorders related to length of gestation and fetal malnutrition.

Child:
Cause 1: Accidents

Teen:
Cause 1: Accidents

Figure 2-9

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 death had been increasing, primarily due to accidental death and birth defects. However, in the past 3 years, we are seeing this trend reverse.

Child Mortality Rates Continued…

The vast majority of childhood and teen deaths in the past two decades are due to accidental death. The majority of accidental deaths were due to motor vehicle accidents, though accidental firearm deaths and toxicity from alcohol and inhalants also contributed in teens. There has been a steady decline in childhood deaths since 1995.

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 2010-2012, IHS 2002-2003, US 2011)

	Warm Springs	Indian Health Service	U.S.
Cause 1	Accidents	Diseases of the heart	Diseases of the heart
Cause 2	Chronic liver disease and cirrhosis*	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

*-Tied

Trends in the Leading Causes of Death (3-yr average), Warm Springs, 1994-2012

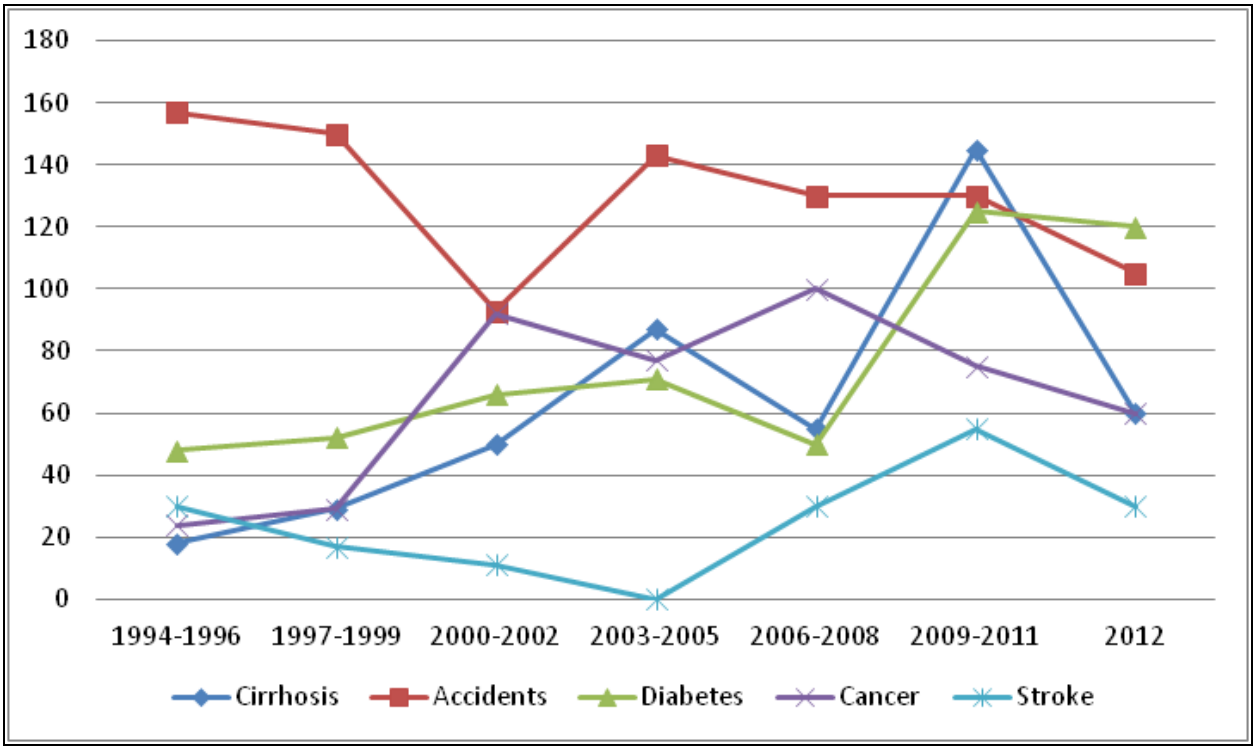


Figure 2-11

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 rates of motor vehicle accidents have decreased significantly, likely due to the passage of the Tribal Seat-Belt Law.

Rates of death related to cirrhosis, cancer and stroke are climbing. Cirrhosis had been the leading cause of death in 2011, but in 2012 showed a decline. Death from cirrhosis remains more common among the Warm Springs people than for other Americans. Cirrhosis is also a major contributor to early death. 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 - 2012

Condition	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Diabetes	551	568	574	600	605
Ischemic Heart Disease (IHD)	76	82	83	88	100
Hypertension 18-85 w/HTN DX	496	486	470	500	503
Asthma	209	225	248	256	286
Prediabetes/Metabolic Syndrome	847	883	906	970	904
Rheumatoid Arthritis		90	75	79	81

Figure 2-12

Interpretation: With the exception of Rheumatoid Arthritis, in each of the disease categories reviewed, the numbers of patients with these chronic conditions has increased over the years. Although there was a decrease in 2012, the dramatic increases in pre-diabetes/metabolic syndrome from 2008-2012 likely reflect some degree of increased recognition as the Diabetes Program has been actively involved in the SDPI program for identifying and treating pre-diabetes over the past several years. Continued efforts at providing resources to more effectively address these chronic conditions will be critical in helping to effectively address these conditions and their impacts on our community.

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

Customer Diabetes Profile

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

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

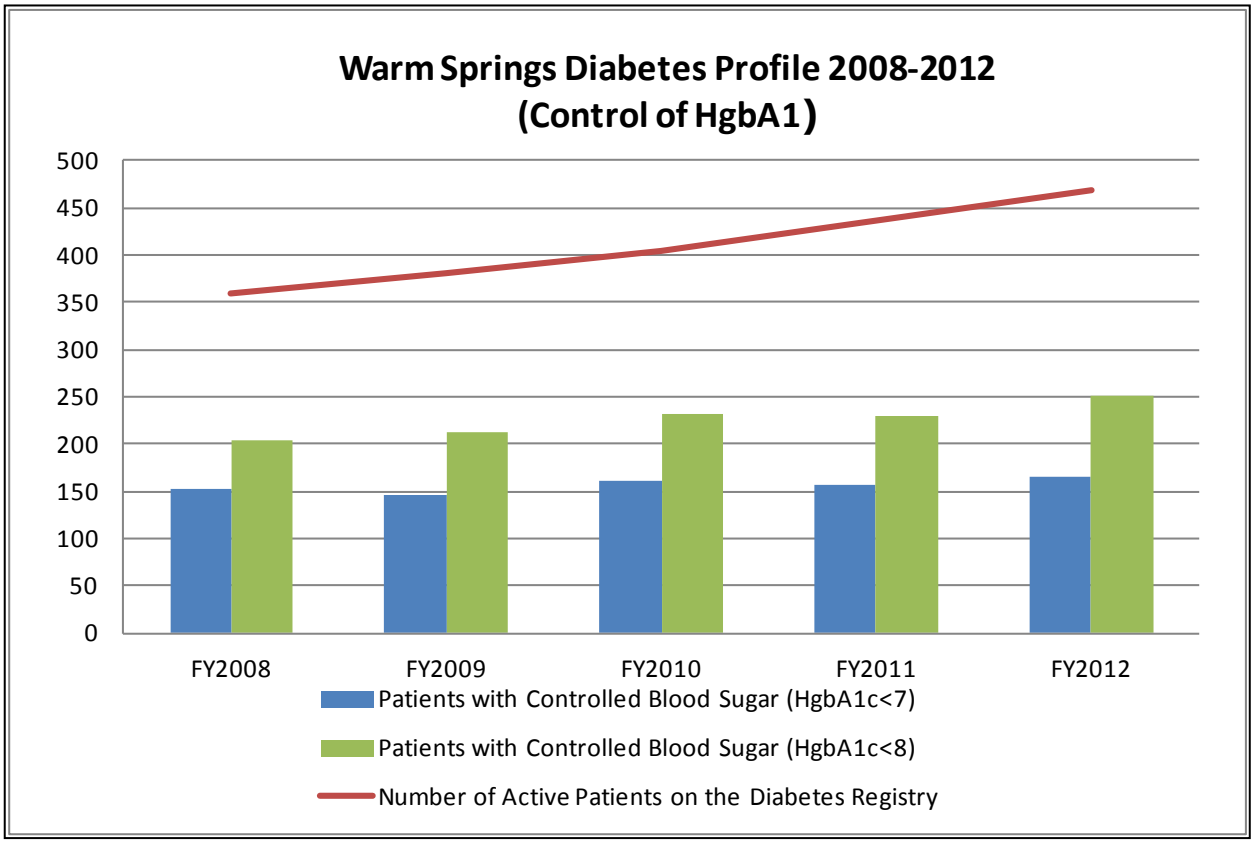


Figure 2-13

Customer Diabetes Profile, continued…..

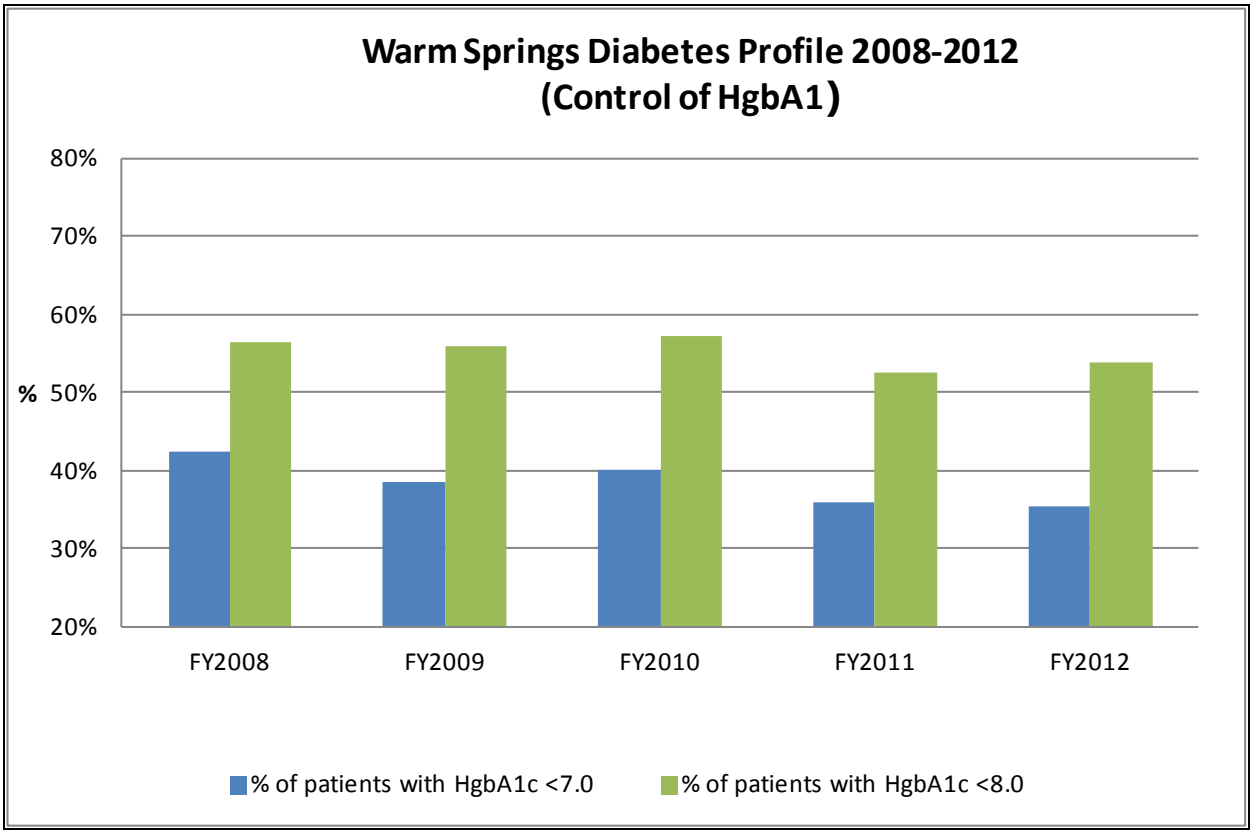


Figure 2-14

Interpretation: The number of patients diagnosed with diabetes mellitus increased slightly from FY 2011 to FY 2012. Figures for FY 2008 through FY 2011 were revised to reflect comparison of the same panel of patients through the time period. Ideal control of HgbA1c decreased slightly from 35.8% to 35.3% between FY 2011 and FY 2012. IHS has recently changed the goal of good HgbA1c control from <7% to <8% based on national changes in standards of care. Based upon the new standard, HgbA1c control <8% improved from 52.5% to 53.8% from FY 2011 to FY 2012. One clinical position was vacant during the 2nd through 4th quarters of FY 2012 which negatively impacted HgbA1c control.

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
2010 - 2012

Inpatient Indicators	2010	2011	2012
Total Admissions	305	258	220
Average Length of Stay	4.05	3.85	3.88
Total Hospital Days	1236	994	854
Average Daily Patient Load	3.39	2.72	2.34
Emergency Room Visits	1,485	1,297	1,097

Managed Care Hospitalizations and Those Paid by Other Resources
Warm Springs Patients by Primary Diagnosis
2012

Condition	Number of Admissions	% of Admissions	Number of Hospital Days	% of Hosptial Days
Obstetrics	112	27.9%	237	17.7%
Motor Vehicle Accidents	4	1.0%	42	3.1%
Other Accidents/Injuries	31	7.7%	108	8.1%
Cancer	1	0.2%	4	0.3%
Heart and Circulatory	42	10.5%	196	14.6%
Respiratory	49	12.2%	140	10.4%
Renal	20	5.0%	73	5.4%
Digestive	56	14.0%	193	14.4%
Infectious Disease	22	5.5%	71	5.3%
Diabetes	19	4.7%	98	7.3%
Substance Abuse	21	5.2%	101	7.5%
Mental Health	5	1.2%	8	0.6%
All Other	19	4.7%	70	5.2%
TOTALS	**401**	**100%**	**1,341**	**100%**

Figure 2-15

Hospitalization of Customers Continued…

Interpretation: The two tables (Figure 2-15) 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.

The Managed Care Caseload (first table)

- The number of hospital admissions declined by 38 (14.7%) from the experience of the prior year.
- The Average Length of Stay declined by 0.03 (<1 %) from the prior year.
- The Total number of hospital days declined by 140 (14%) from the previous year.
- The total number of Emergency Room Visits declined by 200 (15%) from the previous year.

This suggests that the Managed Care Program was quite successful in reducing our overall hospitalization utilization for 2012. Use of alternate resources has played an important role. 45% of our total admissions were financed by another resource, primarily the Oregon Health Plan (Medicaid).

Total Hospitalization Caseload regardless of payment source (second table)

The actual number of admissions for patients in 2012 regardless of payment source decreased from the prior year (401 vs 496; 19.1%). Overall hospital days decreased from 1695 to 1341 (20.1%). In 2012 the Managed Care Program covered 55% of hospital admissions and 63% of hospital days. This was a slight reversal of the significant improvement made in 2011 when the Managed Care Program covered 52% of hospital admissions and 59% of hospital days.

The total admissions and days by category help us understand which conditions are the sources of our hospitalizations. As of 2011, the number of obstetrical cases led in both total admissions and days.

The Managed Care Program depends heavily on alternate resources (Oregon Health Plan/Medicaid, Medicare and Private Insurance). 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.

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
2012

Hospital	Admissions	Hospital Days	Total Cost $	Cost per Day
Mountain View	139	548	$1,125,046	$2,053.00
St. Charles-Redmond	7	20	$73,003	$3,650.15
St. Charles-Bend	61	252	$682,243	$2,707.31
OHSU	2	4	$32,603	$8,150.75
All Other	11	30	$87,714	$2,923.80
Totals	**220**	**854**	**$2,000,609**	
			Total Cost per Day	**$2,342.63**

Figure 2-16

Interpretation: This table reflects the total cost of hospitalization MCP paid for in 2012, and the number of admissions and hospital days that comprised this cost at the four major hospitals utilized. Mountain View Hospital accounts for 56% of the total hospital costs, with St. Charles Medical Center-Bend accounting for 34%.

When comparing 2012 to 2011, a decrease 38 in the number of hospital admissions financed by the Managed Care Program was noted. There was also a corresponding decrease of 140 in the number of hospital days covered by the Managed Care Program. However, there was an increase of $150,963 (8%) in overall hospital expenditures for the Managed Care Program in 2012. A significant 26% increase of $482 in Total Cost per Day from 2011 ($1,861) to 2012 ($2,343) contributed to the total increase. A substantial increase in Medicare-Like Rate Reimbursement to Mountain View ("Critical Access Hospital") as well as a smaller overall increase in reimbursement methodology to "Diagnostic Related Group" hospitals (SCMS-Bend & Redmond, OHSU) was responsible for the Total Cost per Day increase.

Hospitals Utilized and Expenditures Continued…

The Average Cost per Day for Mountain View increased by $416 (25%) over 2011, while the Average Cost per Day for St. Charles Medical Center – Bend increased by $359 (15%). 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.

The effective use of alternate resources could mitigate this outcome. For example, increasing the 45% of total admissions financed by primarily the Oregon Health Plan would be financially beneficial. Medicaid Expansion in 2015 should have a significant positive effect on elevating this %.

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

	2007	2008	2009	2010	2011	2012
Allergic Reaction	5	2	7	3	11	14
Cardiovascular	28	52	67	73	53	46
Cellulitis/Infections (impetigo)	33	36	49	67	76	77
Chronic Condition	23	43	37	26	42	31
Communicable Disease	0	4	2	5	13	12
Dental	22	10	15	29	19	30
Dermatology (includes spider bites)	28	18	22	16	45	19
Drug/Alcohol	69	70	111	140	69	57
ENT (ear, nose, throat)	80	92	116	102	120	85
Eyes	10	14	11	23	15	7
GI	82	133	121	125	129	106
GU	49	86	75	96	77	80
Headaches	43	44	44	50	48	35
Meds Only/Dressing Changes	2	4	2	5	7	4
Miscellaneous	45	53	78	61	32	28
Neurology	32	34	34	39	41	11
OB-GYN	10	13	14	17	17	9
Orthopedic (musculosketetal)	158	177	199	209	169	187
Pulmonary	76	89	136	106	104	69
Psychiatric (Mental Health)	15	13	23	24	30	20
Snake Bite	0	0	1	0	0	0
Trauma						
Assault	38	19	17	36	20	21
Gunshots	2	1	1	1	1	1
Lacerations/Burns/Contusions	162	143	201	217	106	129
MVA	5	17	15	12	19	21
Poisons (ingested/breathed)	9	6	2	10	4	9
Sexual Assault	0	0	0	2	0	0
Drowning	0	0	0	0	0	0
Other				2	42	18
Triage Only	0	0	5	9	2	0
Viral Syndrome	7	17	43	10	18	13
Vascular (blood) - anemia/hem	1	7	8	18	7	0
TOTALS	**1,034**	**1,197**	**1,441**	**1,485**	**1,297**	**1,097**
COST (As Of 4/26/13)	$440,908	$507,499	$789,554	$778,472	$784,868	$738,466
COST PER VISIT	$426	$424	$548	$524	$605	$673

Note: The above data is for MVH; ER care at other hospitals is an extremely small portion of the whole. In 2009, 2010, 2011 & 2012 MVA's are not counted in the total, and in 2010, 2011, & 2012 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 2-17

Emergency Room Utilization Continued…

Interpretation: After three consecutive years of increases (2007-2010) in ER visits, the last two years (2011 & 2012) have seen a decrease of approximately 200 visits each year. However, ER cost per visit has increased the last two years from $525 in 2010, to $605 (15%) in 2011, to $673 (11%) in 2012.

It is important to note the above totals for ER visits are inclusive and thus include those visits for 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 59% increase experienced in the four years from 2008-2012.

EMERGENCY ROOM VISITS - TIMES / DAYS

	2007	2008	2009	2010	2011	2012
0800-2000,weekdays (8:00am-8:00pm)	289	290	445	471	474	481
2000-2400, weekdays (8:00pm-midnight)	161	268	210	237	233	225
2400-0800, weekdays (midnight-8:00am)	97	115	151	169	112	60
0800-1600, sat, sun (8:00am-4:00pm)	148	185	221	182	225	134
1600-2400, fri, sat, sun (4:00pm-midnight)	258	263	311	330	185	85
2400-0800, sat, sun, mon (midn-8:00am)	81	76	103	96	68	112
TOTALS	**1,034**	**1,197**	**1,441**	**1,485**	**1,297**	**1,097**

Figure 2-18

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 four years, with ER visits on weekdays between 0800-2000 hrs increasing each year. It's interesting there has been a distinct decrease in ER visits between 1600-2400 hrs on weekends each of the last two years. After increases in overall ER utilization each year in 2008, 2009 and 2010, overall ER utilization dropped in 2011 and 2012, although it remains above the 2007 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%

Figure 2-19

***** 2006 – Behavioral Risk Factor Survey

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

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? Effective August 15, 2013, 24/7 services of the Warm Springs Health & Wellness Center (WSH&WC) Doctors will no longer be provided at St. Charles Hospital – Madras.

It has been a long standing goal of the Confederated Tribes of Warm Springs (CTWS) Tribal Council that the Warm Springs Community be a healthy community. The WSH&WC fully supports the Tribes' goal and we believe we can best help meet this goal by focusing on the care provided at the WSH&WC and more importantly to work in partnership with each patient to improve their health.

Areas of Focus that Supports Improved Patient Care:

- Beginning in the Summer of 2013, the WSH&WC will work with the Community Health Nurses to provide health care throughout the community in the Mobile Health Clinic.
- Along with our community partners, we will review the professional staff needs and make necessary changes. For example: Hire a Pediatrician.
- With focus on care provided at the WSH&WC, we anticipate increased access to provider appointments each day.
- The service unit will continue to work closely with the St. Charles Hospital – Madras to ensure that our community patient needs are met.

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

	FY2009	FY2010	FY2011	FY2012
Medical Visits by Provider				
Physicians	11,412	11,407	11,579	11,459
Mid Level Practitioners	3,772	4,492	4,591	3,920
Nursing Staff	4,604	4,596	4,785	3,961
Total Medical Visits	**19,788**	**20,495**	**20,955**	**19,340**
Workload Factors				
Clinic Days	250	250	250	250
Average Visits Per Clinic Day	79	82	84	77
Total FTE's In Medical Department	21	21	21	22
Physician FTE's	5.5	5.5	5.5	5.0
Mid-Level Practitioner FTE's	2	2	2	2
Avg Annual Visits Per FTE	942	976	998	879
Avg Annual Visits Per Physician FTE	2,075	2,074	2,105	2,292
Avg Annual Visits Per Mid-Level FTE	1,886	2,246	2,296	1,960
Extended Hours of Service				
Days of Late Clinic	175	202	202	202
Hours of Service (M-Th, 7pm)	350	404	404	404
Visits	692	802	869	902
Visits Per Hour of Service	2.0	2.0	2.2	2.2
Hospital Patient Count	478	424	476	381
Hospital Visit Count	1,988	1,809	2,107	1,654
Average Hospital visits per patient	4.2	4.3	4.4	4.3
Average Hospital patients per day	1.3	1.2	1.3	1.0
Average Hospital visits per day	5.4	5.0	5.8	4.5

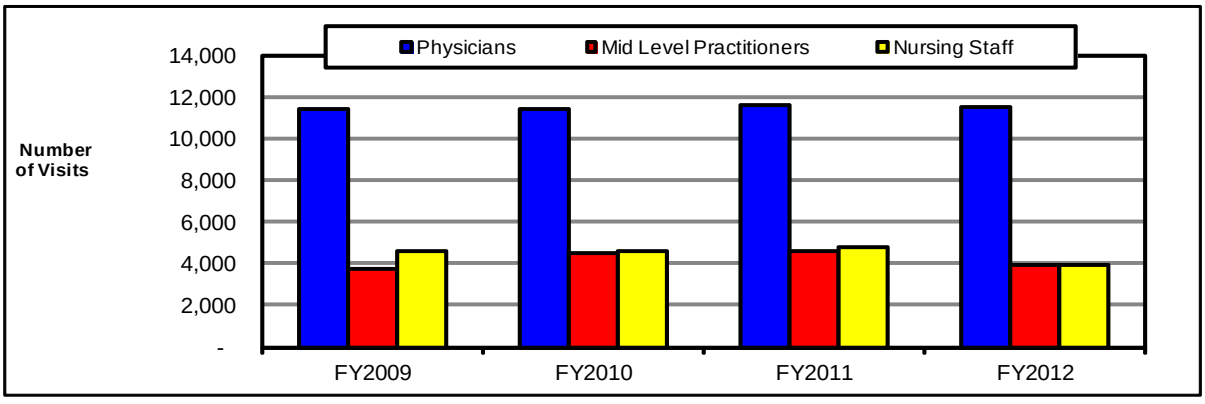


Figure 3-1

Medical Services Continued…

Interpretation: From 2009 to 2012, the medical department averaged 20,145 medical visits per year. Of those visits; 11,464 were physician visits, 4,194 were seen by mid-level providers and 4,487 were nursing visits. The average number of visits per day was 81 over a 250 day time-span. There was as average of 21 FTEs in the medical department including five physicians and tow mid-level providers. Each FTE physician had an average of 2,136 visits per year and each FTE mid-level provider had an average of 2,097 visits per year. FTE physicians had approximately 1.7% more visits per year than mid-level providers.

There was an average of 195 days when the clinic was open late for extended hours from 2009-2012 and during those times; the late clinic averaged 2.1 medical visits per hour. The average number of medical visits during late clinic has been 2 or more per hour from 2009 to 2012 with 2011 & 2012 having the highest visits per hour; 2.2, and an average of 2.2 visits per hour during 2009 and 2010.

Additionally, there were about 440 patients per year that visited the hospital an average of 4.3 times each for an average of 1,890 hospital visits per year between 2009 and 2012. 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

	FY2009	FY2010	FY2011	FY2012
Podiatry Visits				
Clinic Visits	1,669	1,643	1,753	1,608
Missed Appointment Rate	19%	21%	18%	21%
Workload Factors				
Clinic Days	165	149	170	143
Average Visits per Clinic Day	10	11	10	11
Average Visits per Year				
Nature of Visits				
PT visit with Diabetes	551	570	813	615
PT visit with Open Wound	297	278	313	223
Comprehensive or Annual DM Ft Exam	39	91	97	105
Office Procedure Performed	354	326	489	376
OR Case	35	32	10	4
Hospital Patient	136	132	64	19
Other Visit Reasons	428	378	473	503
Total Podiatry Visits (Some patient visits include multiple problems)	**1,669**	**1,643**	**1,753**	**1,685**

Figure 3-2

Interpretation: Education and patient training takes time so pure numbers of patients seen doesn't tell the complete story. More people are getting better about DM foot care prevention resulting in less relative numbers of foot wounds. The podiatrist had to deal with a personal healthcare issue in 2012 and was out on FMLA for 10+ weeks in 2012 leading to a 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	FY2012
Dental Visits by Provider				
Dentist Visits	5,402	4,541	4,342	4,657
Hygienist Visits	1,075	1,158	758	713
Total Dental Visits	6,477	5,699	5,100	5,370
Missed Appointments				
No Shows (Broken Appointments)	No data	371	408	265
Broken Appointments vs Total Visits	No data	7%	8%	5%
Workload Factors				
Clinic Days	250	250	250	250
Average Visits Per Clinic Day	26	23	20	21
Total FTE's	13	12	12	13
Average Annual Visits Per FTE	491	496	443	413
Categories of Care				
Preventive	7,719	6,861	6,524	6,950
Restorative including Crowns	3,039	2,698	2,558	2,856
Dentures including Bridges	123	106	134	115
Surgical	1,213	1,031	1,067	985
Orthodontic	37	12	6	8
Endodontic	92	163	304	324
Diagnostic	unknown	10,030	8,920	6,749
Total Identified Problems Treated		20,901	19,513	17,987

Figure 3-3

Interpretation: Dental visits in FY 2012 have held relatively steady even with the fluctuations in dental staff. Broken appointments have decreased since we have been trying to keep patients with the same dentist.

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

Pharmacy Services

Purpose: To identify the Pharmacy Program workload.

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

	Pharmacy			
Prescriptions Filled	**FY2009**	**FY2010**	**FY2011**	**FY2012**
New Prescriptions	48,297	54,243	54,672	53980
Refills	24,659	26,359	28,360	27211
Total Prescriptions	**72,956**	**80,602**	**83,032**	**81,191**
Workload Factors				
Clinic Days	249	250	251	250
Avg Prescriptions per Clinic Day	293	323	331	325
Visits to the Pharmacy	30,245	33,052	34,567	33,688
Prescriptions per Pharmacy Visit	2.41	2.44	2.40	2.41
Total FTE's	6	6.25	6.8	6.0
Avg Annual Prescriptions Per FTE	12,159	12,896	12,211	13,532
Pharmaceuticals				
Total Expenses	$ 772,273	$ 882,251	$ 796,241	$ 784,700
Avg Cost Per Perscription	$ 10.59	$ 10.95	$ 9.59	$ 9.66
Rx for Patients outside Service Area	Unavailable	Unavailable		Unavailable

Figure 3-4

Interpretation: Workload in FY 2012 as compared to FY 2011 is down 2.2% in the number of prescriptions filled. However, the number of prescriptions per FTE has increased.

The number of prescriptions per FTE increased by 9.8% in FY 2012. This is related to vacancies within the pharmacy staffing throughout the year. The total number of prescriptions has increased by 16.7% compared to 5 years ago.

The number of prescriptions per pharmacy visit has remained stable in FY 2012 compared to FY 2011.

Pharmacy Services Continued…

Drug costs as compared to FY 2011 have decreased slightly (1.4%). This change is in part due to tighter control of inventory as requested by Portland Area Office (PAO). Several formulary changes were made to items of equivalent effectiveness but lower cost which has impacted these numbers. Average cost per prescription has remained the same. 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.

The average number of prescriptions filled per day as compared to 5 years ago has increased by 16.9%. 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

	FY2009	FY2010	FY2011	FY2012
Imaging Exams				
Total X-Ray Exams	1,796	1,886	1,645	1,649
Workload Factors				
Clinic Days	250	251	250	250
Average Exams per Clinic Day	7.18	7.51	6.58	6.60
Total Patients	1,693	1,772	1,556	1,468
Average Exam per Patient	1.06	1.06	1.06	1.12
Total PCPV's	12,747	15,783	15,839	14,980
Average Exams per PCPV	0.14	0.12	0.10	0.11
Total FTE's	1	1	1	1
Exams per FTE	1,437	1,572	1,645	1,649

Figure 3-5

Interpretation: Between 2008 and 2012, there was an average of 1,744 X-ray images completed each year. Throughout that time span, there was an average of 7 X-ray images per day completed. An average of 1,622 patients received approximately 1.08 visits each between 2009 and 2012.

Diagnostic Services Continued…

Diagnostic Services - Medical Laboratory

	FY2009	FY2010	FY2011	FY2012
Medical Lab Tests				
Tests collected in the Lab	89,820	90,914	85,069	77,797
Tests collected outside the Lab	3,617	3,203	3,407	3,407
Tests performed off-site	5,778	6,309	6,561	6,422
Total Lab Tests Ordered	**99,215**	**100,426**	**95,037**	**87,626**
Workload Factors				
Clinic Days	250	250	250	250
Tests Ordered per Clinic Day	397	402	380	351
Total Primary Care Provider Visits	15,184	15,899	16,170	15,379
Average Tests per Visit	6.5	6.3	5.9	5.7
Total FTE's	4.0	4.0	5.0	5.0
Tests per FTE	24,804	25,107	19,007	17,525
Category of Tests Ordered				
Hematology	30,221	30,173	25,707	25,707
Chemistry	63,164	64,625	63,347	55,936
Bacteriology	1,404	778	831	831
Urinalysis	4,426	4,850	5,152	5,152
Total Lab Tests Ordered	**99,215**	**100,426**	**95,037**	**87,626**

Figure 3-6

Interpretation: Between 2009 and 2012, there were an average 95,576 of lab tests ordered per year. Lab tests ordered increased from 2009 to 2010 to approximately 12.2% then decreased by 12.7% between 2010 and 2012. In 2012, 55,936 chemistry tests were ordered; 64% of tests ordered overall. Since 2010, amount of test ordered by provider has decreased significantly; by an average of 7,581 per provider per year.

Optometry Services

Purpose: To identify the Optometry Program workload for each year. To determine the impact of broken appointments per year. 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			
	FY2009	**FY2010**	**FY2011**	**FY2012**
Optometry Visits				
Clinic Visits	1,796	1,846	1,973	1,663
Missed Appointment Rate	23%	22%	22%	16%
Workload Factors				
Clinic Days	220	220	220	220
Average Visits per Clinic Day	8	8	9	8
Total FTE's	2.0	2.0	2.0	2.0
Nature of Visits				
Refractions	835	673	795	821
Diabetic Eye Exam (Patients)	188	199	264	308
Contact Lens Visit	111	58	45	56
Medical Visit	32	-	-	-
Early Childhood Education Visits	383	35	31	53
Glasses Repair/Adjustment	383	394	350	372
Other	-	487	488	53

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. We are scheduled to have a fourth year student full time for the upcoming academic year beginning in June.

The rate of patients who do not keep appointments is unchanged 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.

	2006	2007	2008	2009	2010	2011	2012
Staffing & Other Workload							
FTEs	7	7	7	7	7	7	8
Number of Obligations	6,120	5,022	7,162	9,136	9,757	9,099	8,667
Funds Obligated	$5,049,015	$3,447,919	$3,881,990	$4,953,270	$5,185,344	$4,999,277	$5,521,545

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 late 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 in Figure 4-12

This era of healthcare transformation, with implementation of CCO's this year, and preparing for implementation of the Oregon Health Insurance Exchange (Cover Oregon) for October enrollment and January 2014 coverage has greatly increased the complexity of MCP processes.

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	2009	2010	2011	2012
Prenatal Visits		5	29	
Post Partum Visits				
Well Child Visits				34
Immunization Visits		381	1,034	1,274
Diabetes Visits				
Cardiovascular Visits				
Mental Health Visits				
STD Visits		25	42	66
Family Planning		42	95	135
Phone Contact/Follow-ups			545	213
Other Activity		27	594	614
Total Community Health Nurse Visits - (In Office Only)	-	480	2,339	2,336
Visits by Location				
Out of Clinic Visits		594	1,046	742
Clinic Visits		603	748	666
Total Community Health Nurse Visits	1,097	1,197	1,794	1,408
Total Days of Service	250	250	250	250
Average Visits Per Day	4.4	4.8	7.2	5.6
Total FTE's	2	1.8	2.0	1.8
Average Visits per FTE per year	549	665	897	782

Figure 3-9

Interpretation: The Community Health Nursing Program continued to experience staffing challenges in 2012 as reflected by the 1.8 FTE count. The program stabilized in late fall after a new manager was hired and the senior Community Health Nurse returned from Maternity Leave. As of the end of the year, there was still one vacant Community Health Nurse Position. Other activity includes case review/coordination, education provided, screening and physician ordered treatments.

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)

	2009	2010	2011	2012
Total number of births	83	103	111	86
Total number of births (Tribal members)				
Number of high risk pregnancies	20	32	44	43
Number of high risk infants identified*	33	36	32	43
Prenatal Home Visits			116	56
Post-Partum Home Visits			196	143
Other Home/Office Visits	78	454		565
Number of Hospital Visits		109	87	115
Number of Birthing Classes		47		45
Total Number of Participants		240		157
Infant Immunization level**	88.6%	87.3%	90.9%	84.4%

Figure 3-10

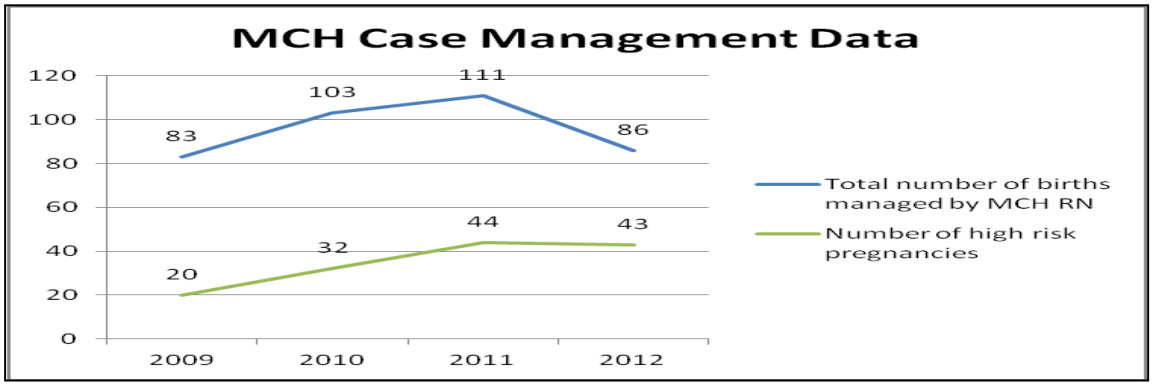


Figure 3-11

Maternal and Child Health (MCH) Continued…

Interpretation: In 2012, the MCH Program saw a decrease in the number of births managed by the program although the risk level of the pregnancies remained high. 50% of pregnancies were categorized as high risk which is a higher percentage of the births over last years. High risk status includes: Medical risk factors, tobacco, illicit drug or alcohol use, poor social situation and/or domestic violence, late or no prenatal care, and maternal age (<18 or >35). The drop in the birth rate in Warm Springs is not unlike what has been occurring regionally and across the state.

Total number of births reflects all births that were case managed by the MCH Nurse and are eligible for care under I.H.S. standards.

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	2012
Caseload by category:				
- Transports	111	172	164	274
- Patient Care	431	738	592	412
- Case Findings/Screening	559	932	532	428
- Monitoring Patient	339	502	425	284
- Case Management	385	393	312	109
- Health Education	60	34	42	32
- Other	168	739	500	445
Total Client Encounters	**2,053**	**3,510**	**2,567**	**1,984**
Total Days of Service	250	250	250	250
Average Number of Encounters per Day	8.2	14.0	10.3	7.9
Total FTE's	3.0	3.0	3.0	3.0
Average Number of Encounters per FTE per Year	684	1,170	856	661
Total Mileage Reimbursed				

Figure 3-12

Interpretation: The CHR Program saw an increase in the amount of transport requests by 110 transports over the previous year. This increase provided the justification for adding another position to the CHR staff as well as a GSA vehicle upgrade to accommodate the increasing numbers of dialysis clients. Dialysis client transportation statistics are not included in Figure 3-11 but average 5-6 clients per day, transported to Redmond 3 days per week.

Diabetes Program Services

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

Relevance: Diabetes Mellitus remains a continuing challenge to the health of the Warm Springs population. Continued monitoring of the clinical resources dedicated to improving the health of patients with diabetes is necessary to determine if community needs are being adequately addressed.

Diabetes Program

	FY2009	FY2010	FY2011	FY2012
Diabetes Program Visits				
Clinician Clinical Visits	1,501	1,457	1,931	4,156
Community Encounters	2,433	2,010	2,032	1,531
Total Visits	**3,934**	**3,467**	**3,963**	**5,687**
Workload Factors				
Clinic Days	250	250	250	250
Average Clinical Visits per Clinic Day	15.7	13.9	15.8	16.6
Total Clinical FTE's	5.0	5.0	5.0	4.0
Average Clinical Visits Per FTE	787	693	793	1,039
Categories of Service				
Diabetes Clinical Encounters				1,922
Diabetes Case Management Encounters				2,334
Diabetes Community Education Contacts	753	787	985	559
Diabetes Screening Community Contacts	2,433	2,010	2,032	972
Patients in Dialysis				
Number of Patients	11	13	12	13

Figure 3-13

Interpretation: The diabetes Coordinator position was vacant from 1/1/12 until 5/1/12. The Nurse Practitioner position was vacant from 4/1/12 until 9/30/12. A Provider from Medical worked in the Diabetes Program 9/11/12-9/30/12 for 2 days/week in place of a Nurse Practitioner.

Diabetes Staff participated in major educational events this year including Diabetes Awareness Day Conference, Heart Smart Dinner, Honor Seniors Day, Pi-Ume-Sha Health Fair, Senior Center Diabetes Support Group Dinners and Culture Camp.

H.O.P.E (Healthy Outcomes Promoted by Education) Program received a 4-year accreditation by the American Association of Diabetic Educators.

Diabetes Program Services Continued…

Community screening for diabetes and diabetes prevention education is being transitioned Diabetes Prevention Program Staff to increase the number of clinical appointments for the Diabetes Program.

One full-time administrative staff member is excluded from clinical statistics. In prior years this person was included in clinical statistics.

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)

	2009	2010	2011	2012
Infants and children under 5 years of age	538	543	550	550
Pregnant, breastfeeding and postpartum women	198	219	232	211
Total number of Women, Infants and Children served	736	762	782	761

Figure 3-14

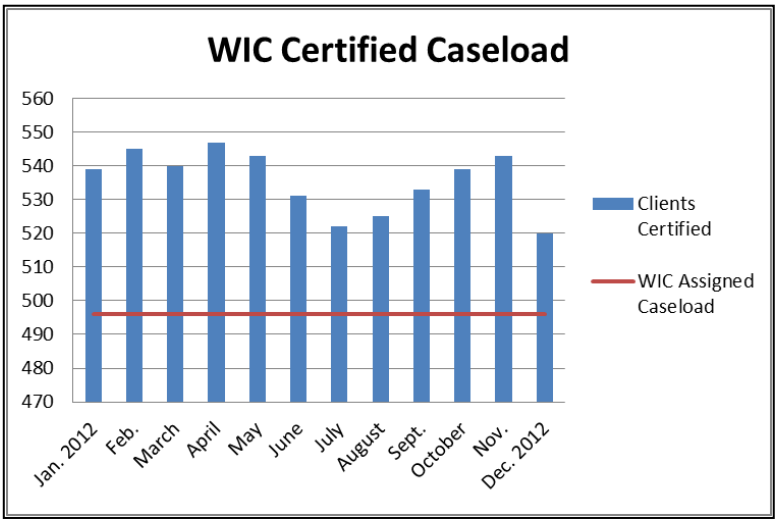


Figure 3-15

Interpretation: The number of Women, Infants and Children served by our program has remained relatively stable for the past 5 years. On a monthly basis, the Warm Springs WIC Program continually exceeds the certified caseload assigned by the State by more than 25 clients per month which indicates that we serve more clients than expected for our community size.

Other interesting facts for 2012, 91% of our new mothers start out breastfeeding and 41% of the families we serve are working families.

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** 2012
Program Prevention Health Education Team	
Cancer	
Women's Health	
Women of Wellness; 10/12 Classes	472
Pi-Ume-Sha Health Fair	992
4-H Culture Camp (Women's Health ed. Provided)	
Youth	61
Adults/Parents/Speakers/Counselors	33
College Fair with WFD	20
Heart Smart Dinner	249
Christmas Tree Lighting (Women's Health ed. provided)	475
Cultural Prevention	
Craft Classes	
Working with Pendleton; 10 Classes	112
Necklace Bead Making; 3 Classes	32
Cultural Fair at Mt. Hood	No data
Pi-Ume-Sha Health Fair	992
4-H Culture Camp	
Youth	61
Adults/Parents/Speakers/Counselors	33
HIV/AIDS	
World Aids Day	25
Suicide Prevention Camp	68
Pi-Ume-Sha Health Fair	992
4-H Culture Camp (HIV/AIDS ed. provided)	
Youth	61
Adults/Parents/Speakers/Counselors	33
College Fair with WFD	No data
Heart Smart Dinner (HIV/AIDS ed. provided)	249
Christmas Tree Lighting	475
Alcohol and Drug Prevention	
3D Project	30

Figure 3-16

Community Health Education Team Alcohol Program Continued…

Interpretation: In 2012, CHET participated in or initiated more than 30 events for the year which is a decrease from the 61 reported in 2011. Many of the activities were duplicates although multiple education topics were presented at each event. Much of the emphasis for CHET activities continued to promote traditional cultural craft experiences for adults and youth as it is an important component of Native American prevention programming.

Mental Health

Purpose: The purpose of this report is to examine the mental health services being provided in the Community Counseling Center. Looking at this data enables us to look at positive and negative trends in the community, examine services of interest and look at areas of need.

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

Mental Health

	2009	2010	2011	2012
Visits & Clients Served				
Number of Adult Visits	905	1,021	1,268	*
Number of Children Visits	1,810	2,042	1,515	*
Total Visits	2,715	3,063	2,783	3,012
Categories of Service				
*Depression Visits				
*Post Traumatic Stress Visits				
Crisis Management Visits	236	275	224	204
Other				
Prevention Services				
Positive Indian Parenting (5)			299	48
Elvis Birthday Bash			97	70
MSPI Madras High School Presentations			103	0
QPR Trainings (5)			115	3
Sock-Hop Event			62	30
All Night Lock-In			105	0
He-He Butte Prevention Camp			43	61
"Springs into Action" Event			100	NA
Oregon Native Youth Survey			24	24
Halloween Party			500	500
Prevention Basics Power Point			5	60
W.S. Christmas Fun Party			1,400	500
Spring Into Action (Prev. Coalition)			200	49
Penny Carnival				80
Rez Olympics				50
Street Dance				60
GONA Training				100
Total Prevention Services Attendance			3,053	1,635
Service Hours				
Client Contact Hours			2,275	*
*Total FTE Hours				3,216
*% hours of Client Service				

Figure 3-17

* We are unable to break down this information at this time.

Mental Health Continued…

Interpretation: It would be difficult to try to interpret this data. However; it is clear that there is a consistent need for Mental Health services in the community.

The Mental Health services have increased gradually over the past several years. In 2012, a new Mental Health Therapist with specialized training in group counseling, work with Veteran populations and the skill level to work with an increased number of challenging case presentations. Group work has been well received by our community and will be an area that will be looked at over the next few years as a way to reach more people in the community. Crisis management visits were down slightly which could be because more consistent care is being delivered.

Alcohol & Substance Abuse

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

Relevance: Substance abuse issues are prevalent in our community. Evaluation of A&D treatment is essential to see what is working and not working in our treatment program.

Alcohol and Substance Abuse

	2008	2009	2010	2011	2012
Encounters - Outpatient Treatment					
Number of Visits	2,146	2,866	2,570	2,899	2,501
Number of Clinic Days	239	239	239	239	254
Average Visits per Clinic Day	9	12	11	12	9
Relapse Anger Resolution Grp (Quarterly)	75	75	75	33	28
Jail Groups (estimate)	216	256	246	250	334
Aftercare					
Healing from Grief & Trauma - 1 day conf.			25	57	40
Recovery Month Dinner			100+	n/a	100
A&D Prev B-Ball "And 1" (Street Ball tour) all ages	300+		400+	250	NA
Community Grief/Trauma Gathering (2 workshops)			90+	80	NA
Healing Family Circle Conference				40	NA
Native Pride Men's Conference				35	NA
Native Family Wellness Conference				35	NA
Categories of Service					
Alcohol Abuse	1,913	2,549	2,287	2,899	2,501
Drug Abuse	233	317	283		
Residential Care - Adult	25	37	35	47	
Residential Care - Adolescent	19	11	15	13	

Figure 3-16

Interpretation: It is difficult to interpret due to lacking data. However, grief work is needed in our community and we will expand those services. In 2012, we hired two additional A&D staff to increase services to the jail and to adolescents in our program. Expansion will continue in 2013.

Adolescent Outreach

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

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

Adolescent Aftercare

	2009	2010	2011	2012
Outpatient Visits	465	347	unk	
Number of Clients In				
Residential Care	11	15		
Suicide Prevention Camp	50	32	50	68
Healing Wounded Spirits Camp	0	0	n/a	46
Winter Youth Conference	0	0	n/a	n/a
Movie Nights	47	297	319	416
Wii Bowling	4	49	n/a	112
Hoop Camp	52	62	144	73
Madras Bowling		84	83	88
Wellness walk		18	81	84
All Night Sobriety Party			160	n/a
Kids Bingo			76	26
Red Road to Recovery			93	0
Tribal Youth Leadership			24	274
Total			1,030	1,187

Figure 3-19

Interpretation: The outreach program includes services such as after school counseling, cultural activities, movie night, bowling and after school social activities. Services are provided to clients who are having difficulties returning from a treatment setting. Through this program additional support is provided to at risk youth who are in danger of relapsing without the positive interactions provided through the aftercare 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 including free access to health resources and other information.

Community Health & Prevention Resource Center
2012

	2011	2012
Resource Center Usage		
Patrons that checked out materials	248	486
Materials checked out	733	1,373
Health related materials checked out	46	80
Native American materials checked out	139	215
Circulations**	1,424	3,049
Number of visits	3,833	9,351
Patron cards issued	477	378
Graphic Design Requests		
Posters/Banners printed	199	197

**A circulation occurs whenever an item is loaned out (checked out or renewed).
When the number of circulations exceeds the number of items checked out, that means some items were checked out and/or renewed more than once.

Figure 3-20

Interpretation: CHPRC's resource center usage statistics for 2012 are nearly double those of 2011. This is because CHPRC was open twice as long in 2012 (12 months) versus 2011 (6 months). CHPRC's overall usage for 2012 was, therefore, very similar to 2011. CHPRC's 2012 graphic design usage was also nearly identical to 2011 (graphic design was available all 12 months of 2012 and 2011).

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

	2009	2010	2011	2012
Housing & Energy Assistance				
Number of Clients Served				
Total Vouchers Processed				
Total $ Value of Vouchers	117,751	144,294	84,443	86,131
Medical Travel				
Number of Clients Served	691	923	789	458
Total Vouchers Processed	691	923	789	458
Total $ Value of Vouchers	28,519	27,108	20,211	12,200
Disability				
New Clients pursuing claims for SSI/SSDI		23	92	78
Number of clients currently checking on Survivorship/widow benefits		16	28	16
Number of Clients inquiring about Retirement Benefits		8	21	24
Number of Clients that have been denied		31	77	36
Number of Clients that just filed their 1st Appeal		21	49	20
Number of Clients that are in the middle of Appeal		25	54	33
Number of Clients in Court Hearings		7	16	8
Commodities				
Number of Families Served				259
Number of Individuals Served	401	312	301	494
Number of Warm Springs Tribal Members	728	593	516	

Figure 3-21

Interpretation:

Ambulance Services

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

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

SUMMARY OF AMBULANCE ACTIVITY

	Calls		Patients Transported		Calls w/Substance Factor	
Reason for Call	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
Motor Vehicle Accident	116	97	36	38	26	13
Other Accident	218	137	180	154	135	128
Assault and Battery	90	88	34	11	48	50
Suicides/Attempts	13	12	11	7	13	7
Corrections	139	206	35	38	100	107
Pediatric	152	148	43	31	0	0
Cardiac	67	100	39	57	7	4
Respiratory	67	107	45	46	11	8
Other Illness	207	518	191	299	100	66
Total	**1,069**	**1,413**	**614**	**681**	**440**	**383**

TRIBAL AFFILIATION RELATED TO CALLS

	Calls Dispatched		Patients Transported		Calls w/Substance Factor	
Reason for Call	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
Members and Dependents	870	1,267	519	508	348	228
Other Eligible Indian	8	1	3	0	5	0
Non Tribal	191	148	64	61	87	13
Total	**1,069**	**1,416**	**586**	**569**	**440**	**241**

Figure 3-19

Interpretation: The number of calls received in 2012 increased by 32% over the previous year. The number of patients transported increased by 11% over that same period. The calls where substance abuse was a factor declined from 440 to 383.

Nearly 90% of the calls were for Tribal Members and Dependents in 2012. Nearly 90% of patients transported were also Tribal Members and Dependents.

Ambulance Services, Continued

More than 28% of our transports were for accidents (motor vehicle and other accidents). Assault and Battery, Suicides/Attempts and Corrections were the reasons for 8% of transports. Pediatric transports were nearly 5%.

Most of the transports were for Cardiac, Respiratory and Other Illnesses (59%).

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 Alcohol & Drug:

State Alcohol Prevention Grant:

State Mental Health:

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

Influenza Pandemic:

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

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.

Implementation of the ICD-10 will accommodate new procedures and diagnoses unaccounted for in the ICD-9 code set and allow for greater specificity of diagnosis-related groups and preventive services. This transition will lead to improved accuracy in reimbursement for medical services, fraud detection, historical claims and diagnoses analysis for the health care system.

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	2012
Indian Health Service					
Recurring Funding	13,340,464	13,995,065	16,174,897	16,284,305	17,348,813
Non-Recurring Funding	982,431	850,831	1,670,645	1,538,649	508,231
Total IHS Funding	**14,322,895**	**14,845,896**	**17,845,542**	**17,822,954**	**17,857,044**
Collections IHS					
Medicare	241,542	231,819	81,657	201,700	99,349
Medicaid	2,242,011	1,809,197	2,283,902	2,400,000	2,522,740
Private Insurance	522,950	443,555	478,426	428,600	503,833
Total IHS Collections	**3,006,503**	**2,484,571**	**2,843,985**	**3,030,300**	**3,125,922**
Collections Tribe					
Ambulance	120,878	199,242	207,994	171,068	146,086
Community Counseling	308,736	201,524	269,916	537,996	567,466
Community Health			33,928	266,563	398,428
Total Tribal Collections	**429,614**	**400,766**	**511,838**	**975,627**	**1,111,980**
Grant Awards	659,064	1,303,029	859,469	1,513,100	1,650,982
Tribal Employee Group Insurance (Est)	1,233,674	1,260,238	1,269,463	1,554,753	1,901,827
Tribal Appropriations	933,387	1,160,988	1,790,924	1,761,800	1,682,649
Total	$20,585,137	$21,455,488	$25,121,221	$26,658,534	$27,330,404

Figure 4-1

Interpretation: The funding trends have been positive over the past 5 years, although there will be some erosion of funding in 2013 as a result of the sequester.

The recurring FY 2012 IHS base funding increased by a little over $1 million (6.5%) from the previous year. The non-recurring funding for 2012 decreased by a little over $1 million. Therefore, overall IHS resources were essentially identical to those provided in FY 2011.

Health System Funding by Major Source, continued

Collections continued their upward trend for both IHS and Tribal Programs. IHS program collections increased by over $400,000 or 13.2% in 2012. Likewise Tribal program collections increased by $140,000 or 14.3% in 2012.

Most of the Tribal program increases were attributed to Community Health (+$132,000). Community Counseling increased by $30,000. Ambulance Service collections declined by $21,000 in 2012. It is essential that all programs continue to emphasize collections to maintain and enhance services.

Grant awards increased by nearly $100,000 from the previous year. Tribal appropriations declined by $80,000 over that same period. Tribal Employee Group Health expenditures were estimated at $1,901,827, which represents an increase of $347,074 or 22.3%.

The over total Health Program Funding for 2012 was $27,330,404 which represents an increase of 2.5% when compared to 2011.

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	16.4%	3.0%
2012	17,348,813	7.3%	3.4%

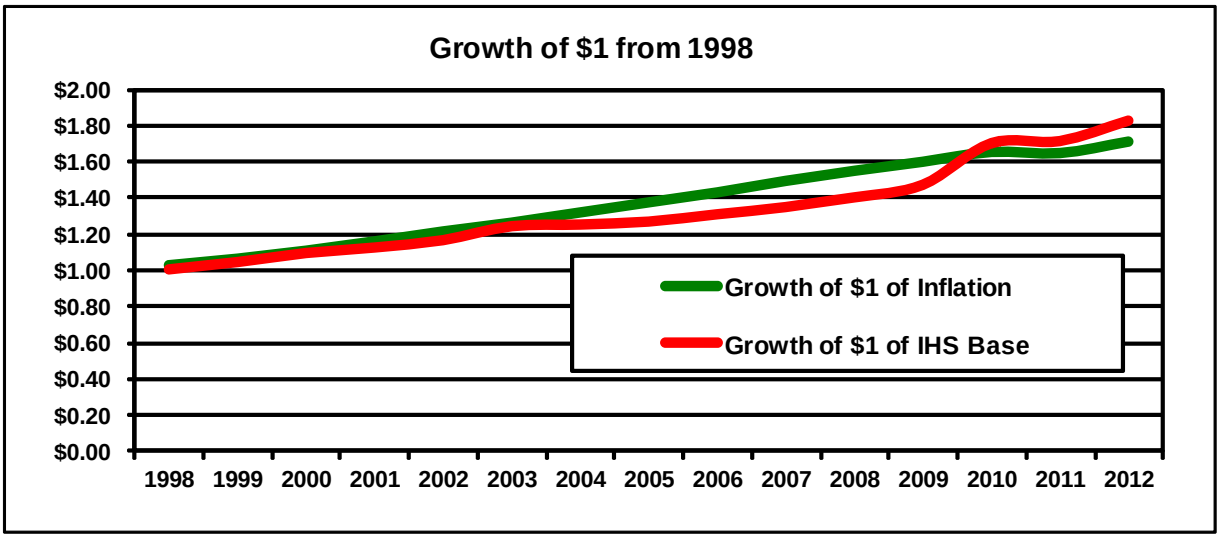


Figure 4-2

Base Health System Funding Versus Inflation, Continued

Interpretation: Over each of the 3 years (2010-2012), we experienced a growth in IHS base funding which exceeded the overall medical inflation rate. This trend was welcomed after a long period of time when budgets did not approach our inflationary experience. To sustain and grow a health program it is essential that the funding must meet or exceed both the medical inflation rate and population growth rate. The chart (Figure 4-2) clearly shows the relationship between our funding and inflation over the years.

Health System Spending by Program

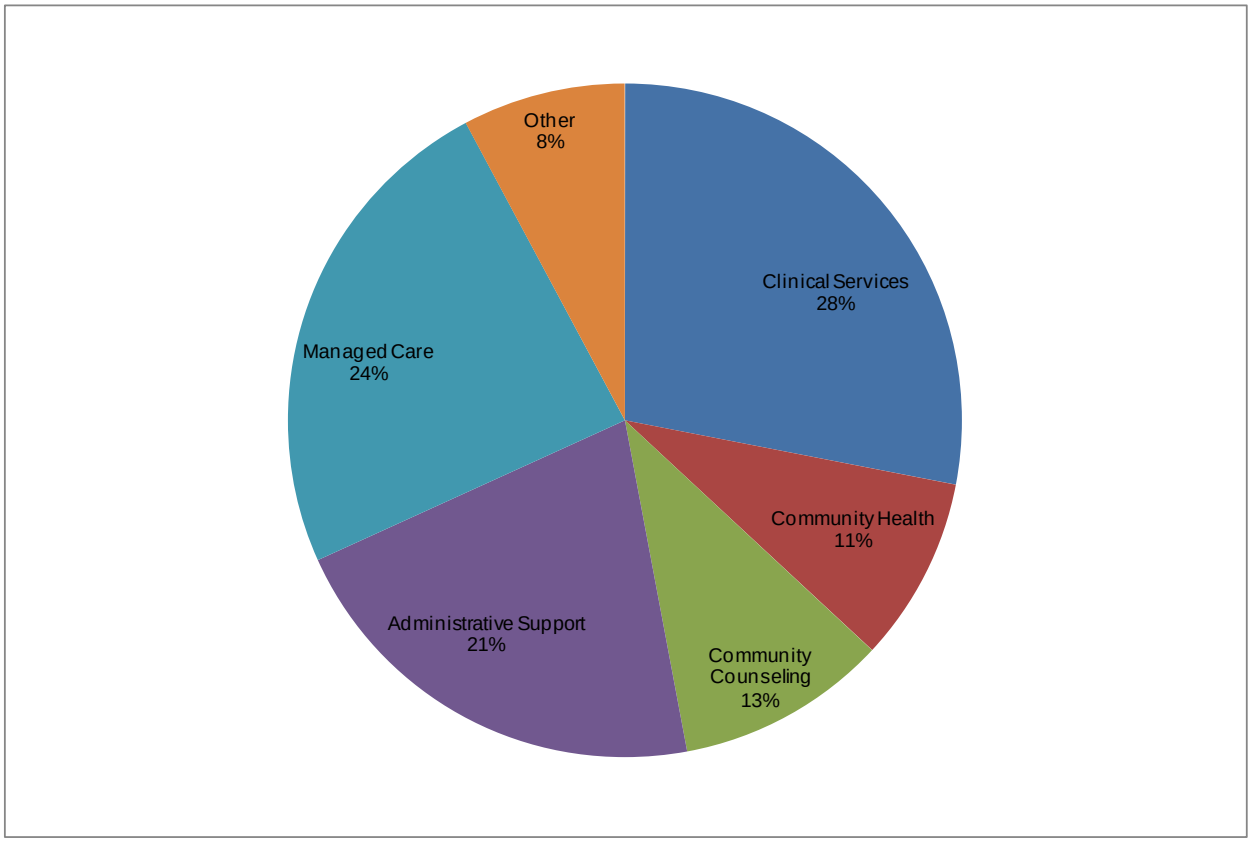
Purpose: To report actual outlays by each program as well as overall carryover and savings.

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

	2009	2010	2011	2012
Clinical Services				
Medical	2,752,506	3,562,634	3,586,014	2,229,705
Dental	1,081,141	1,111,249	1,038,130	1,217,056
Optometry	196,619	254,790	202,119	287,891
Pharmacy	1,375,587	1,459,292	1,286,068	1,122,677
Podiatry	160,939	181,846	190,773	107,033
Medical Lab/X-Ray	587,557	912,072	549,939	749,719
Diabetes - Clinic	515,174	370,600	1,679,713	797,546
Community Health				
Community Health Dept.	332,515	228,104	377,052	415,384
Health Education	60,687	140,073	177,030	221,757
WIC Program	69,447	25,051	70,962	64,620
Diabetes Grant (Tribal)	344,986	35,024	96,192	142,075
Environmental Health	90,919	83,678	46,939	56,113
Public Health Nursing	395,325	487,956	705,379	941,253
Community Center	237,450	216,412	149,287	214,402
Community Counseling				
Community Counseling	801,698	1,028,767	1,383,062	1,055,718
Mental Health	265,369	215,132	369,093	321,245
Adolescent Aftercare	145,569	125,644	105,297	79,931
Vocational Rehabilitation/Soc	302,172	306,586	380,723	552,314
Prevention Projects	149,769	26,563	189,942	337,782
Administrative Support				
Facilities	888,266	958,080	1,138,310	986,419
Security	28,860	21,408	21,872	22,891
Health Administration	812,088	657,133	559,991	1,264,624
Business Office	299,474	282,104	83,851	947,236
Quality Assurance	175,148	174,143	165,751	106,017
Data Systems	371,056	393,030	561,032	269,888
Indirect Costs	575,006	587,803	825,743	1,314,107
Other				
Managed Care	5,498,295	5,935,441	5,306,338	5,566,489
Ambulance	858,007	939,514	1,044,889	1,071,369
Quarters	10,578	-	-	-
Clinic Equipment	334,497	105,518	326,118	123,740
Childrens Protective Svs				617,463
Total	**19,716,704**	**20,825,647**	**22,617,609**	**23,204,464**

Figure 4-3

Health System Spending by Program, Continued



Interpretation: In the four year period (2009-2012) overall spending on total health services has increased by nearly $3 million (13.2%). That does not include the $617,463 for Child Protective Services, which was only recently added to the table in 2012.

Comparing the expenditures of 2009 with those of 2012 we find little difference in the Clinical Services and Managed Care Categories. Substantial increases occurred in Community Health (+60%) and Community Counseling (+75%). It suggests that the health delivery system is indeed responding to the priorities of the Health Plan with additional emphasis on prevention and expanding services in Alcohol and Substance Abuse. Administrative Services which includes Facilities increased 14% which is comparable to the overall increase in spending of 13.2%.

Clinic Billing

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

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

	2008	2009	2010	2011	2012
Visits Billed					
Medical	11,874	11,336	10,411	10,101	9,864
Dental	2,469	1,911	2,168	2,001	2,132
Pharmacy	19,720	19,830	23,645	23,578	21,845
Optometry	410	431	440	356	375
All Other	1,448	1,478	1,882	2,657	2,878
Total Visits Billed	**35,921**	**34,986**	**38,546**	**38,693**	**37,094**

	2008	2009	2010	2011	2012
Collections					
Medical	$ 1,878,176	$ 1,770,324	$ 2,023,029	$ 2,122,715	$ 2,181,021
Dental	436,894	244,363	373,161	402,762	380,597
Pharmacy	577,689	581,929	635,645	683,018	503,271
Optometry	66,642	65,006	72,419	65,328	76,897
All Other	24,134	11,846	43,133	242,347	260,246
Total Collected	**$ 2,983,536**	**$ 2,673,468**	**$ 3,147,386**	**$ 3,516,170**	**$ 3,402,032**

	2008	2009	2010	2011	2012
Source					
Medicaid	2,242,011	2,050,000	2,283,902	2,675,989	2,522,740
Medicare	241,542	200,000	81,657	103,461	99,349
Private Insurance	522,950	450,000	478,426	556,209	503,833

Figure 4-4

Interpretations: Total Medical visits billed have been trending downward since 2008 (-17%). Pharmacy visits billed trended upward through 2011 and then had a slight decrease in 2012. Total visits billed increased through 2011 and then had a decrease of 4.1% in 2012. Overall, total visits averaged 37,048 with increases and decreases throughout the time span. In 2012, Medical billed out for 9,864 visits and received $2,181,021 (an average of $221/visit). Medicaid accounted for approximately 81% of collections, Medicare around 16% 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	2012	
Incidents/Visits Billed						
Ambulance	615	692	681	614	594	
Alcohol & Substance/ Mental Health*	1,206	797	1,015		1,896	*
Community Health			236	1,459	2,075	
Other						
Total Incidents/Visits Billed	**1,821**	**1,489**	**1,932**	**2,073**	**4,565**	

	2008	2009	2010	2011	2012	
Collections						
Ambulance	120,878	199,242	215,961	172,032	146,086	
Alcohol & Substance/ Mental Health	308,736	201,524	272,060	400,000	567,466	**
Community Health			33,928	266,563	398,428	
Other						
Total Collected	**$ 429,614**	**$ 400,766**	**$ 521,949**	**$ 838,595**	**$1,111,980**	

	2008	2009	2010	2011	2012
Source					
Medicaid		241,180	358,593	698,517	1,000,140
Medicare		45,957	40,297	36,171	1,099
Private Insurance		108,986	121,971	1,893	98,325
Workers Comp					9,980
Other		4,643	1,088	4,048	2,437

* 2011 Visits billed in 2012: 824 Alcohol & Substance Abuse; 1072 Mental Health.
** 2012 Collections from 2011 billed visits.

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. Community Counseling Center bills one year behind.

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	
	2011	2012	2011	2012	2011	2012
Workers Compensation	9	9	$ 12,561.75	$ 10,400.25	$ 4,048.32	$ 9,979.50
Medicaid	128	98	$ 145,435.45	$ 110,517.00	$ 31,954.37	$ 34,245.59
Medicare	88	120	$ 100,988.25	$ 138,111.75	$ 36,170.95	$ 1,099.37
Private Insurance	145	145	$ 161,745.75	$ 157,574.00	$ 97,965.43	$ 98,324.62
Private Pay	36	43	$ 40,232.54	$ 47,411.25	$ 1,892.85	$ 2,436.93
Managed Care	186	167	$ 207,402.75	$ 183,977.50	$ -	$ -
No Source	22	12	$ 4,550.25	$ 264.00	$ -	$ -
Total	**614**	**594**	**$ 672,917**	**$ 648,256**	**$ 172,032**	**$ 146,086**
Average Per Transport			**$ 1,096**	**$ 1,091**	**$ 280**	**$ 246**

(1) Collection source breakout not reported

OUTLAYS AND FUNDING	2011	2012
Outlays		
Allocated Salaries and Benefits	612,211	760,740
Medical Supplies	14,073	27,896
Other Supplies & Expenses	2,876	4,209
Vehicle Expenses	53,160	34,012
Equipment		
Vehicle & Equip. Depreciation	44,000	5,782
Total	**$ 726,320**	**$ 832,639**
Average Direct Cost Per Transport	**$ 1,183**	**$ 1,402**

Funding Source
Indian Health Service (PL 93-638)
Collections
Warm Springs Tribe - Direct Appropriation

Figure 4-6

Ambulance Financial Summary, Continued

Interpretations: The collections for ambulance services declined by $26,000 or 15% in 2012. At the same time the expenses increased by $106,319 or nearly 15%. Most of this increase was attributable to Salaries and Benefits. The average cost per transfer increased by $219 or 18.5%.

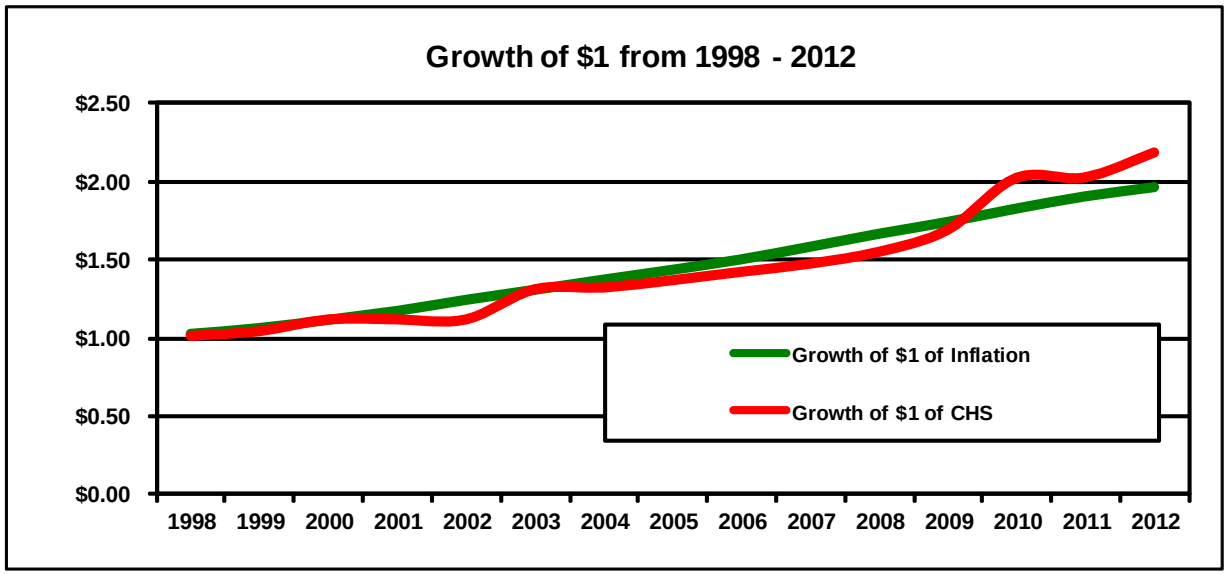
When costs increase and collections decrease, action is required. Overall the Department of Fire & Safety is presently seeking an Administrative Billing Specialist to capture past due payments and improve the Ambulance Collection process. In addition, there are plans to increase charges for services by 15%, effective June 2013.

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%
2012	5,838,361		255,088	6,093,449	7.8%	3.1%



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: The increases in funding for Managed Care have been at a higher level than cumulative inflation over the last 3 years. However, the funding has not reached the level of hospital and professional service inflation rates which are the categories we are most concerned with. It must also be noted that there has been no increase for population growth which is also a factor in Managed Care expenses. Therefore, despite the increases in funding Manage Care remains under financial pressure.

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	1,830,635	1,119,292	440,908	38,592	2,483	5,915	10,094	3,447,919	
2008	1,729,093	1,489,246	507,499	52,544	3,424	17,373	82,811	3,881,990	
2009	2,030,516	1,915,844	789,554	90,704	5,611	18,620	102,421	4,953,270	
2010	2,207,427	1,976,179	778,472	72,569	7,154	25,384	118,159	5,185,344	
2011	1,853,613	1,986,081	784,868	170,874	12,486	34,497	144,488	4,986,907	*
2012	2,000,609	2,010,272	738,466	178,257	11,060	21,908	163,984	5,124,556	*

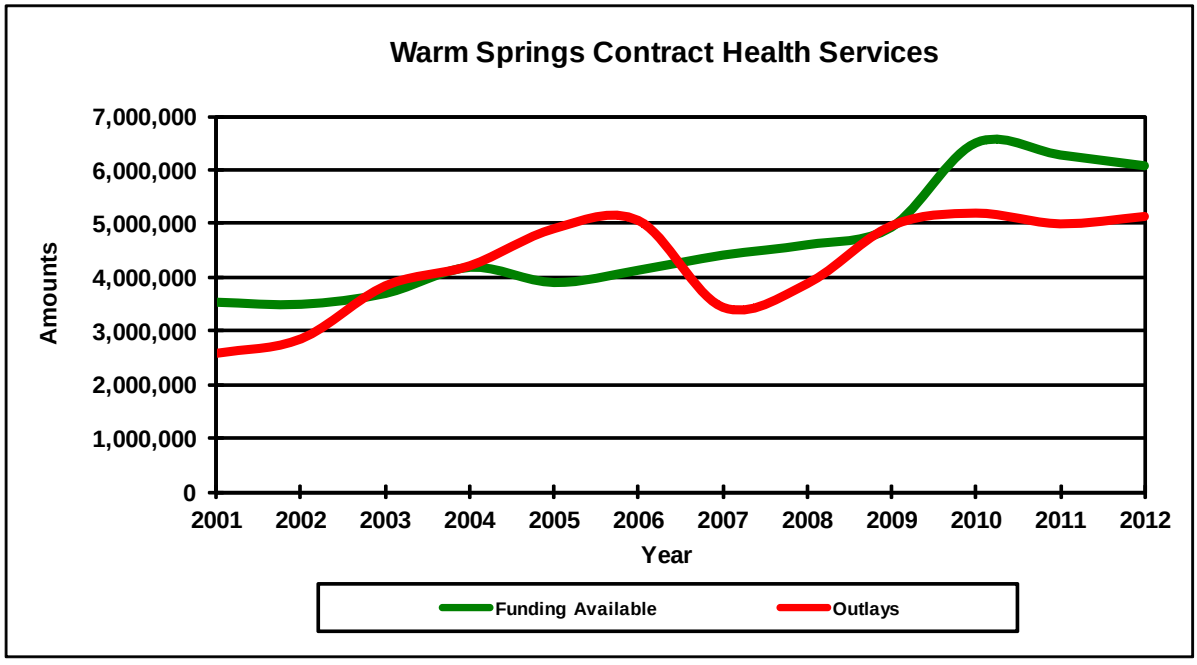


Figure 4-8

* There are Obligations for Services that have not been finalized. Final payment amounts will vary.
* There is an additional $12,370 Obligated, but not yet paid for 2011.
* There is an additional $396,989 Obligated, but not yet paid for 2012.

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 twelve 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, 2009 and 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. Priorities II, III, and IV have been authorized since then, with the resulting yearly peak costs of $5,185,344 in 2010. However, with $396,989 Obligated but not yet Paid for in 2012, the final costs may exceed those for 2010.

Contract Health Services – Utilization and Unit Cost

Purpose: To identify the total cost and unit cost for Hospitalization and Emergency Room 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.

	2011			2012		
	Units	**Total Cost**	**Cost per Unit**	**Units**	**Total Cost**	**Cost per Unit**
Hospital Days	994	$1,849,646	$ 1,861	854	$2,000,609	$ 2,343
Emergency Room Visits	1,297	$ 784,570	$ 605	1,097	$738,466	$ 673

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 14% decrease in Hospital Days from 2011 to 2012, there was a significant 26% increase in Hospital Cost per Unit for this same period of time.

This same trend continued for Emergency Room Visits with an 15% decrease in Emergency Room Visits from 2011 to 2012, but an 11% increase in Emergency Room Cost per Unit.

While the data in the table indicates the Cost per Unit for Hospital Days in 2012 was $2,343, more detailed information is found in Figure 2-16 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.

2012		
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 Policy *Figure 4-10*

Interpretation: MCP was fortunate from 1995 through 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 Priority I coverage only in July 2005, MCP kept a Deferred Services list defined as those services in Priorities II-IV that MCP had covered the preceding 10 years but no longer could cover due to Priority I coverage only.

In April 2010, MCP was able to expand coverage beyond Priority I's to Priority II-IV coverage once again. MCP was able to cover Priority I-IV throughout 2011 & 2012, and had minimal "Deferred Services" as defined as those which MCP had covered pre-2005. The data above was based on numbers compiled by the MCP Case Manager in conjunction with the PAO CHS Manager for a report requested by PAO last year.

For Dental, MCP covers 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. MCP is also covering more procedures this year based on dental recommendation and MCP review. Examples: a) teeth that are not able to be extracted by IHS dentist due to difficulty of extraction; b) a patient, elderly or fragile in health, may be referred to an Oral Surgeon for extractions; c) elderly patients may be sent to a dentist that specializes in mini posts to secure their dentures; d) "spacers" for children's teeth cared for by Dr. Mendoza. Working with IHS dental, MCP emphasis has been

Deferred Services, Continued

towards Elders and the children of the Reservation. Dr. Mendoza, pediatric dental surgeon, performs about two dental restorations a week at SCMS-Bend.

The approximate cost for dental services that are deferred is about $100,000. There were an estimated 252 dental cases deferred in the last year.

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. MCP also pays for high cost drugs for a one month period of time to allow a patient to get into a program sponsored by the pharmaceutical companies that will assume the cost after the initial month. In other words, MCP will do a “Bridge” to ease the high cost for the patient.

The approximate cost for pharmacy that is deferred is $75,000. There were an estimated 1200 scripts @ 100 per month average deferred.

Both Dental and Pharmacy were determined by estimating from pre-2005 when MCP was able to cover more Pharmacy and Dental.

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	1,650,223	35	25,000	775,223	374,198	154,381	528,579	246,644
2012	1,217,151	25	25,000	592,151	100,707	13,038	113,745	478,406
Totals	**$ 11,158,802**	**197**		**$ 6,279,802**	**$ 2,785,663**	**$ 1,412,275**	**$ 4,197,938**	**$2,081,864**

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 was paid back to IHS via future Budget Mod Amendment Adjustment.

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 7 years.

The CTWS MCP operates on a calendar fiscal year. However, the IHS operates on an Oct-Sept fiscal year. Historically, the IHS CHEF is exhausted by May or June, and was then replenished in October. Thus, a prime reason for a shortfall in reimbursement is that a CHEF case occurred after the funds were exhausted for that year. Then, when the new CHEF year starts in October, reimbursement for a CHEF case falling in the last three months of the year usually will not take place until the following year. Using 2011 as an example, 35 CHEF cases resulted in $775,223 due to CTWS MCP; $374,198 was reimbursed in 2011, and $154,381 was reimbursed in 2012.

CHS – Catastrophic Health Emergency Fund continued

Timely application for CHEF is very important, and the MCP Case Manager places highest priority on this process. Receipt of CHEF can have significant impact in helping to offset expenditures for high cost cases. Application for CHEF is competitive across IHS. Due to a larger budgeted CHEF allocation by IHS, combined with implementation of MLR nationwide, the CHEF has the potential to last longer than May/June. However, this is offset by healthcare inflation across the country. Utilization of MLR has significantly increased the CHEF workload for the Case Manager due to greatly increased documentation required.

In the ten years from 2003-2012, there was a total of 197 cases qualifying for CHEF reimbursements of $6,279,802. Total reimbursement of $4,197,938 was received from IHS, leaving a shortfall of $2 million to be absorbed by the Managed Care Program in addition to the $4,879,000 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.

	2009	2010	2011	2012
Mountain View Hospital (MVH)				
Inpatient	1,154,243	1,215,681	1,060,954	942,724
Outpatient	777,509	873,079	1,163,798	1,109,233
Mixed	84,704	83,972	145,678	57,508
Total	**$2,016,456**	**$2,172,732**	**$2,370,430**	**$2,109,465**
Other Critical Access Hospitals				
Inpatient	4,089	13,647	10,511	15,482
Outpatient	285	2,672	5,299	14,651
Mixed	0	849	0	0
Total	**$4,374**	**$17,168**	**$15,810**	**$30,133**
Hospitals that Bill on DRG Rates				
Inpatient	1,700,090	1,877,149	1,898,748	1,534,274
Outpatient	441,297	404,065	395,179	440,190
Mixed	$25,604	32,458	29,551	22,312
Total	**$2,166,991**	**$2,313,672**	**$2,323,478**	**$1,996,776**
TOTAL MLR SAVINGS	**$4,187,821**	**$4,503,572**	**$4,709,718**	**$4,136,374**

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.

Medicare-Like Rate (MLR) Savings, Continued

MLR became effective 7/5/07 which resulted in significant savings for MCP. Savings resulting from MLR implementation 5 ½ years ago not only was responsible for halting the erosion of MCP reserves, but allowed MCP to add non-Priority I services through specified "carve-out" of $500k under strict criteria in 2009. After a $250k "carve-out" to begin 2010, the decision was made effective April 1, 2010 to cover Priority II, III & IV under Committee Review and methodical implementation. I.H.S. physicians and Health & Welfare Committee were consulted and they gave input on services to add back. As seen in the table on the previous page, MLR savings have resulted in $16.2 million to MCP and thus potential healthcare referrals over the last four years.

MCP closely monitors expenditures and is ready to make adjustments if needed. The goal is to carefully implement authorization and payment for additional services (II, III, and IV) without trying to implement "too much" and having to then "restrict again". The MCP currently pays for most all specialty Priority I-IV referrals it did prior to implementation of Priority I coverage in 2005.

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.

However, it is noted the Total MLR Savings decreased significantly by $573,344 (12%) from $4,709,718 (2011) to $4,136,374 (2012). The MLR inpatient savings at Mountain View (Critical Access Hospital reimbursement) decreased by $118,230 (11%) from $1,060,954 in 2011 to $942,724 in 2012. The MLR inpatient savings at the hospitals that are reimbursed on Diagnostic Related Group Rates (St. Charles Bend/Redmond, OHSU) decreased by $364,474 (19%) from $1,898,748 in 2011 to $1,534,274 in 2012.

The $4,136,374 Total MLR Savings in 2012 is extremely positive for the reasons mentioned above. However, this one year drop bears watching to see whether a trend develops. Because the MLR Savings are dependent on the Medicare reimbursement determined by Centers for Medicare and Medicaid Services (CMS), MCP has to be prepared to react and adjust depending on future impact of CMS decisions.

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	2009	2010	2011	2012
Grant Amount				
Diabetes Grant (Tribe)	$ 193,268	$ 193,268	$ 193,268	$ 193,268
State Women, Infants, and Children (WIC)	72,046	80,586	84,578	78,355
Woman's Wellness Conference				
CHET Dental Project				
Senior Fitness Enhancement				
Tobacco Pilot Site				
State Tobacco Prevention	57,557	90,057	74,262	73,821
USDA Commodity Warehouse	100,481	58,358	79,136	39,918
State Alcohol & Drug	297,752		230,000	125,000
State Alcohol Prevention	100,000		105,000	
State Mental Health	294,444		278,366	381,733
State Youth Suicide Prevention		26,000		26,000
Influenza Pandemic				
Vocational Rehablilitation	345,519	411,200	328,458	232,742
Meth Prevention Project			140,032	
Total	**$ 1,461,067**	**$ 859,469**	**$ 1,513,100**	**$ 1,150,837**
Grant Expenditures				
Diabetes Grant (Tribe)	$ 344,986	$ 35,024	$ 96,192	$ 129,719
State Women, Infants, and Children (WIC)	69,447	25,051	70,962	84,061
Woman's Wellness Conference Grant				
CHET Dental Project Grant	32,051			
Senior Fitness Enhancement Grant	10,970		3,278	
Tobacco Pilot Site Grant	26,383	26,197		
State Tobacco Prevention Grant	63,345		78,464	54,516
USDA Commodity Warehouse Grant	67,437	21,087	82,019	71,905
State Alcohol & Drug Grant	163,378	130,864	188,479	172,187
State Alcohol Prevention Grant	39,273	37,797	111,478	79,897
State Mental Health Grant	138,534	100,446	234,837	144,006
State Youth Suicide Prevention Grant	(1,964)	11,310		25,094
Influenza Pandemic	16,105	11,509	12,548	3,219
Vocational Rehabilitation Grant	302,172	306,586	380,723	266,919
Meth Prevention Project Grant	112,460	15,253		13,813
Total	**$ 1,384,577**	**$ 721,124**	**$ 1,258,980**	**$ 1,045,336**

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

Grants Received, Continued

Interpretation: The above listing of active grants offers a historical glimpse of the awards received and their associated expenditures. Grants can be awarded at various times of the year and some cover periods of time which exceed a single year time frame. It is therefore difficult to draw conclusions without understanding the details of a specific grant. The list however presents an inventory of our grant activity which has totaled nearly $5 million over the past 4 years. This represents a significant enhancement of our available resources. Grants can fill important holes in our comprehensive health program especially when federal appropriations are limited.

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			2012 FTE			2012 Enrolled TM		
	Tribal	**IHS**	**Total**	**Tribal**	**IHS**	**Total**	**Tribal**	**IHS**	**Total**
Clinical Services									
Medical		26.0	**26.0**		29.0	**29.0**		6.0	**6.0**
Dental		15.0	**15.0**		10.0	**10.0**		4.0	**4.0**
Optometry		2.0	**2.0**		2.0	**2.0**		1	**1.0**
Pharmacy		6.0	**6.0**		7.0	**7.0**		0.0	**0.0**
Medical Records		9.0	**9.0**		6.0	**6.0**		2.0	**2.0**
Medical Lab		4.0	**4.0**		5.0	**5.0**			**0.0**
X-Ray		3.0	**3.0**		1.0	**1.0**		0.0	**0.0**
Diabetes - Clinic		4.0	**4.0**		5.0	**5.0**		1.0	**1.0**
Community Health									
Community Health Dept.	2.0		**2.0**	2.0		**2.0**	2.0		**2.0**
Health Education	1.0		**1.0**	2.0		**2.0**	1.0		**1.0**
CHET	4.0		**4.0**	3.0		**3.0**	3.0		**3.0**
Maternal Child Health	2.0		**2.0**	2.0		**2.0**	1.0		**1.0**
Community Health Rep.				3.0		**3.0**	2.0		**2.0**
WIC Program	1.0		**1.0**	2.0		**2.0**	1.0		**1.0**
Wellness Coordinator	3.0		**3.0**	2.0		**2.0**	0.0		**0.0**
Diabetes Grant (Tribal)						**0.0**			**0.0**
Environmental Health	2.0		**2.0**	2.0		**2.0**	1.0		**1.0**
Community Health Nursing		6.0	**6.0**	4.0		**4.0**	1.0		**1.0**
Nutrition		3.0	**3.0**	2.0		**2.0**	0.0		**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**			**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**	8.0		**8.0**
Mental Health	6.0		**6.0**	9.0		**9.0**	6.0		**6.0**
Alcohol & Substance Abuse	12.0		**9.0**	8.0		**8.0**	6.0		**6.0**
Prevention				6.0		**6.0**	6.0		**6.0**
Administrative Support									
Facilities	11.0	2.0	**13.0**						
Security	2.0		**2.0**	1.0	0.0	**1.0**	1.0	0.0	**1.0**
Health Administration		14.0	**14.0**		8.0	**8.0**		4.0	**4.0**
Personnel		2.0	**2.0**		1.0	**1.0**		1.0	**1.0**
Procurement		1.0	**1.0**		2.0	**2.0**		1.0	**1.0**
Business Office		6.0	**6.0**		9.0	**9.0**		9.0	**9.0**
Data Systems					3.0	**3.0**		1.0	**1.0**
Transportation									**0.0**
Quality Assurance					1.0	**1.0**			**0.0**
Registration					2.0	**2.0**		1.0	**1.0**
Other									
Managed Care	8.5		**8.5**	8.0		**8.0**	3.0		**3.0**
Ambulance				17.0		**17.0**	7.0		**7.0**
JV/JHC				4.0		**4.0**	3.0		**3.0**
Total	**64.0**	**104.0**	**168.0**	**92.0**	**91.0**	**183.0**	**57.0**	**31.0**	**88.0**

Figure 4-14

Staffing, Continued

Interpretation: This table reflects the staffing changes that have occurred over the twelve year period (2000-2012). Tribally operated programs have increased staffing by 44% (64 in 2000 vs 92 in 2012). Some of that increase was due to increased 638 contracting. IHS staffing consequently decreased over that period by 12.5%. Combining both health programs the overall increase in staff was a modest 15 positions over that twelve year period.

A major emphasis of both health care operations is to increase the number of tribal employees. The current staffing indicates there are 88 staff members who are enrolled out of the 183 total positions (48%). Both the Tribe and IHS continue to encourage tribal members to pursue health careers.

Facilities

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

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

Facility Deficiency	Facility	Estimated Cost	Date Identified as Priority	Date of Approval
11 New Heat Pump w/ 9 Flow Valves	HWC	$ 46,799	2011	6/14/2012
Cooling Tower System	HWC	$ 74,558	2011	6/11/2012
Walking Path	HWC	$ 58,380	2011	7/19/2012

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
Audio Care System	29,990	Medical	Feb-12	2/11/2012
Dental Sterilization system	9,667	Dental	Apr-12	4/6/2012
Dental Sensors	33,658	Dental	Oct. 2011	10/11/2011
Home Blood Pressure Monitoring (	8,302	Medical	Oct. 2011	10/18/2011
Medical Infusion Pump	5,346	Medical	Oct. 2011	10/18/2011
Visual Field Analyzer	20,844	Optometry	Oct. 2011	10/26/2011
Podiatry Chair	7,011	Podiatry	Apr-12	4/11/2012
Presto Scan Pressure	5,630	Podiatry	Oct. 2011	10/18/2011
Desktop computers/printers	49,682	Computer Support	Feb-12	2/22/2012
Conference room furnitures	7,916	Administration	Oct. 2011	10/18/2011

***** 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.

	2009	2010	2011	2012
Tribe - Self Determination Contract				
Program Savings and Carryover				
Community Health	1,247,935	1,047,895	1,095,354	1,414,810
Community Counseling	1,154,130	1,395,902	1,306,703	1,265,756
Managed Care	2,575,459	3,575,143	4,976,885	5,576,844
Ambulance	12,062	12,131	9,486	-
Facilities Operations	458,203	516,868	309,752	303,995
Environmental Health	40,974	120,212	199,057	269,833
Indirect Contract Support Costs	1,514,614	2,411,497	3,096,251	3,611,566
Reserves				
M & I Reserve Wellness Center	810,142	724,951	900,391	789,779
M & I Reserve Community Counseling	304,145	341,859	344,883	236,294
Equipment Replacement	99,481	104,089	108,029	6,189
				108,029
Projects				
Joint Venture - Clinic Remodel	460,225	338,225	226,578	-
Other JV Projects	106,866	91,555	282,491	66,424
Total - Tribal	**8,784,236**	**10,680,326**	**12,855,860**	**13,649,519**
Indian Health Service				
Medicare/Medicaid	1,258,967	1,993,250	2,940,379	1,964,000
Private Insurance	235,522	357,053	331,789	101,000
FSA & M&I		214,432	254,037	340,000
Equipment		38,849	97,712	30,000
Total - Indian Health Service	**1,494,489**	**2,603,584**	**3,623,917**	**2,435,000**
Grants				
Diabetes-competitive grant	482,100	397,100		485,145
Diabetes-competitive grant - prior years		397,100		114,000
Diabetes Grant - Clinical (IHS operation)		162,606	165,390	-
Suicide Prevention	2,289	-		293,811
Meth/Suicide	247,374	126,571		3
Diabetes-Noncompetitive grant	88,145	-		62,054
Domestic Violence	80,000	-		-
Red Talon HIV/AIDS				15,000
Total - Grant	**899,908**	**1,083,377**	**165,390**	**970,013**
Grand Total	**11,178,633**	**14,367,287**	**16,645,167**	**17,054,532**

Figure 4-17

Savings and Reserves, Continued

Interpretation: The cumulative savings for all accounts increased by $409,365 from 2011 to 2012. While savings in some categories can be reprogrammed to other priorities, other savings must be spent within the program that generated the savings. Examples include Managed Care, M&I and certain grants. Nevertheless there are opportunities to reprogram some resources.

The tribal directed accounts show increased savings of $793,659 over the totals of the previous year (2011). This includes program savings, carryover, reserves and projects. The most notable changes occurred in Community Health which increased by $319,000, Managed Care increased by $600,000 and Indirect Contract Support increased by $515,000.

The Indian Health Service accounts have limited carryover opportunities. Collections and Maintenance & Improvement are the only categories where savings can accrue. The ending balance of these savings shows a decrease of $1,188,917 from the ending balance of the prior year (2011). There is now just under $2.4 million in savings available at the end of 2012.

The total Grant savings has increased by $970,000. These funds generally must apply to the respective grant so they are not available for redistribution.

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.