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

November 19, 2014

2014 Edition
Reporting Information through 2013

2014 Annual Health System Report

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EXECUTIVE SUMMARY

This Annual Health System Report includes information about the community members served by the health system at Warm Springs, the services provided and resources utilized during 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 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.

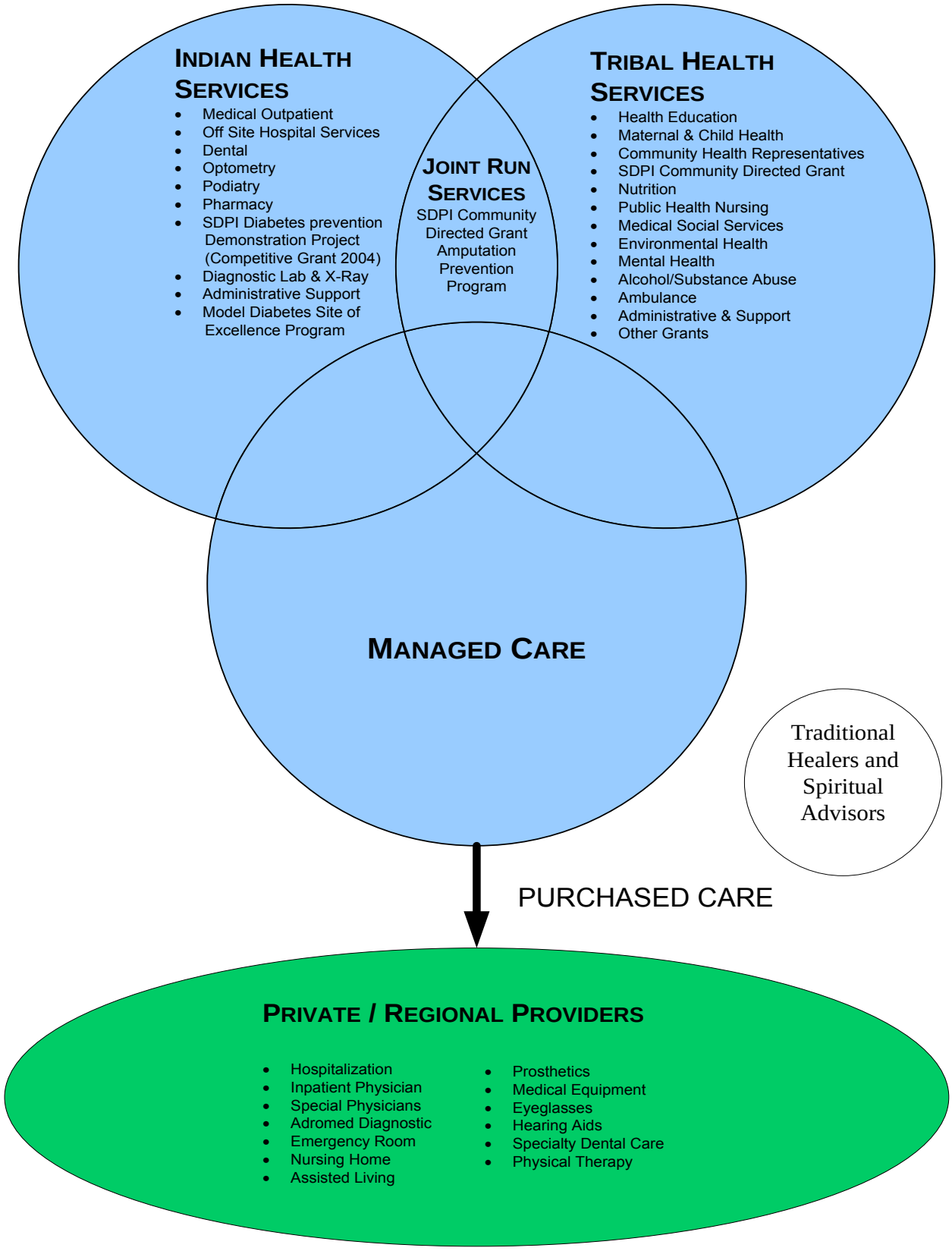
Throughout the years, the Tribe has contracted various portions of the Indian Health Service financed community health programs, mental health and alcohol and substance abuse programs, completing that transition in 2008. The Tribe has also appropriated tribal resources and sought and received grants 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
2013	323	6651	5772

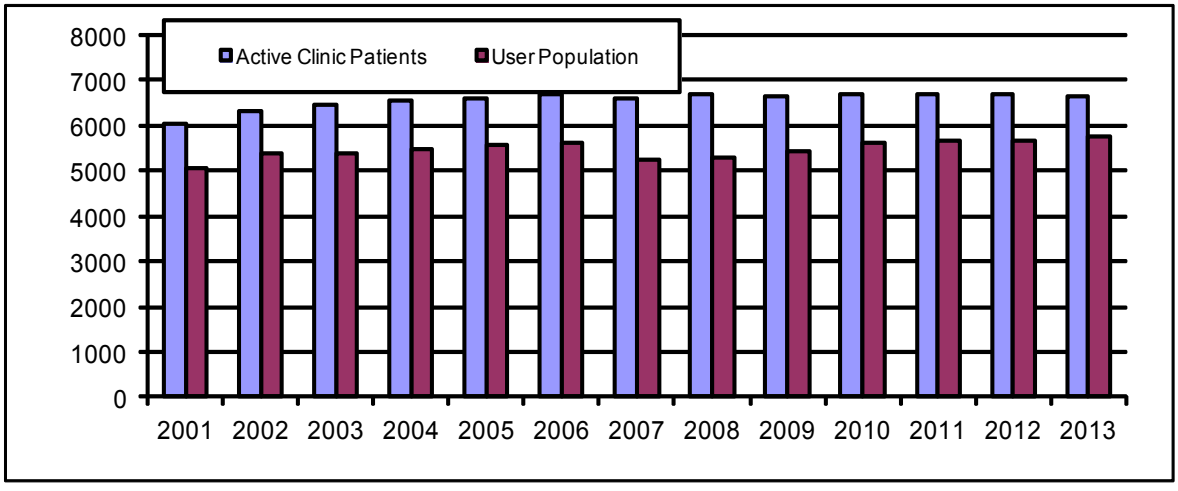


Figure 2-1

Customers That Use the Services Continued…

Interpretation: Between 2001 and 2013, new patient registrations have decreased by approximately 23%. 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 thirteen year time span, the user population has increased from 5,057 to 5,772 (14%) and the population of active clinic patients has increased by 10%. 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	2010	2011	2012	2013	Chg(12-13)
Warm Springs Indian Reservation	3,665	3,690	3,536	3,630	94
Madras/Redmond/Bend	1,119	1,190	1,266	1,263	(3)
Maupin/The Dalles/Hood River	90	85	93	85	(8)
Portland/Salem	91	94	104	110	6
Other Oregon	460	440	427	443	16
Outside Oregon	213	181	200	185	(15)
TOTAL	**5,638**	**5,680**	**5,626**	**5,716**	90

By Tribal Affiliation	2010	2011	2012	2013	Chg(12-13)
Warm Springs Member	3,893	3,990	3,955	4,048	93
Other Oregon Tribes	240	219	218	225	7
All Other Tribes	1,402	1,377	1,364	1,350	(14)
Non-Indians	103	94	89	93	4
TOTAL	**5,638**	**5,680**	**5,626**	**5,716**	90

Figure 2-2

Interpretation: Trends have remained stable from 2010 to 2013 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:

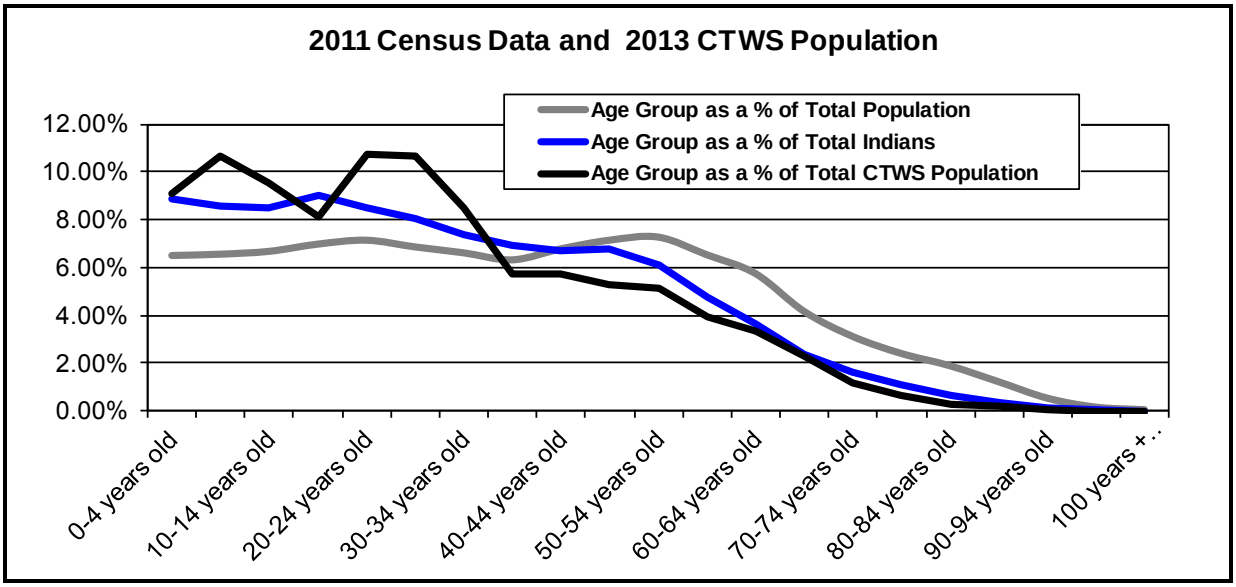
- 2010 -- 69.1% Warm Springs Tribal Members; 65.0% residing on Reservation.
- 2011 – 70.25% Warm Springs Tribal Members; 64.96% residing on Reservation.
- 2012 -- 70.3% Warm Springs Tribal Members; 62.7% residing on Reservation.
- 2013 -- 70.82% Warm Springs Tribal Members; 63.51% residing on Reservation.

In the years, 2010, 2011 & 2013 there was a small increase in patients who are Warm Springs Tribal Members and a small decrease in 2012. There was a slight increase in patients who are members of other Tribes or who have no tribal affiliation. Between 2010 and 2013, we saw a decrease of approximately 1% of patients who reside on the Warm Springs Indian Reservation. As of 2013, over 85.6% 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.

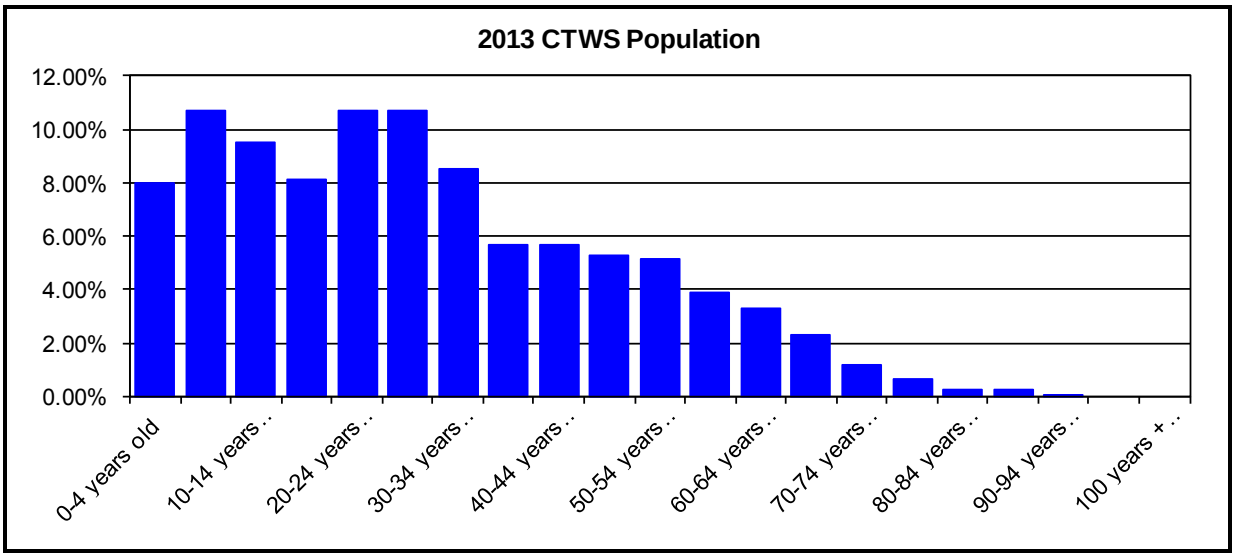


Figure 2-3

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

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	2010 Patients	2011 Patients	2012 Patients	2013 Patients
0-4	543	675	677	699	588
5-9	460	603	551	545	532
10-19	1,367	1,082	1,094	968	984
20-29	971	1,056	1,077	1,082	1,025
30-39	912	690	719	725	700
40-49	738	694	693	699	659
50-59	440	604	615	633	615
60-69	204	368	397	449	424
70-79	98	169	168	180	166
80+	40	56	62	62	63
TOTAL, Patients	**5,773**	**5,997**	**6,053**	**6,042**	**5,756**

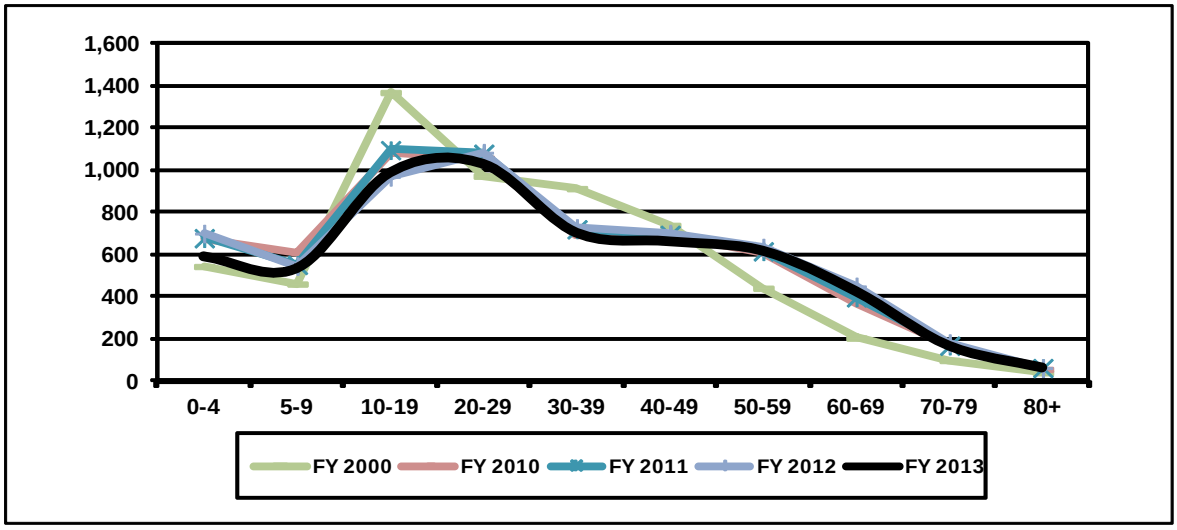


Figure 2-4

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 2010	FY 2011	FY 2012	FY 2013
Medicaid Only	1,206	1,181	1,455	1,637
Private Insurance Only	1,082	1,269	1,263	1,313
Medicare A Only	25	28	33	29
Medicare B Only	-	-	-	-
Medicare Part A & B Only	141	139	138	126
Medicare Part D	179	189	200	217
Medicaid & Medicare	41	30	35	28
Medicaid & Private Ins.	606	842	736	663
Medicare & Private Ins.	143	141	142	159
Medicaid, Medicare, & PI	11	10	6	7
Total	3,434	3,829	4,008	4,179
Non-Billable				
Tribal Employee Self-Insurance	269	278	224	52
No Alternate Resource	2,673	2,492	2,276	2,277
Total	2,942	2,770	2,500	2,329
Total Patients	**6,376**	**6,599**	**6,508**	**6,508**

Figure 2-5

Interpretation: Over the past four years the number of patients with billable alternate resources has increased by 36%. Those with Tribal Insurance (non-billable) also trended upwards. Those with no alternate resources have dropped about 15% 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

Calendar Year*	Age 14 & under	Age 15-19	Age 20-24	Age 25-29	Age 30-34	Age 35-44	Total Births
1996		22	20	17	7	7	73
1997		20	27	16	9	5	77
1998		14	23	14	12	7	70
1999		22	19	18	14	2	75
2000		16	20	17	9	6	68
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
2013	0	10	40	33	17	4	104
Total	**0**	**195**	**317**	**231**	**132**	**64**	**939**
% of Total	**0.0%**	**20.8%**	**33.8%**	**24.6%**	**14.1%**	**6.8%**	**100.0%**

Figure 2-6

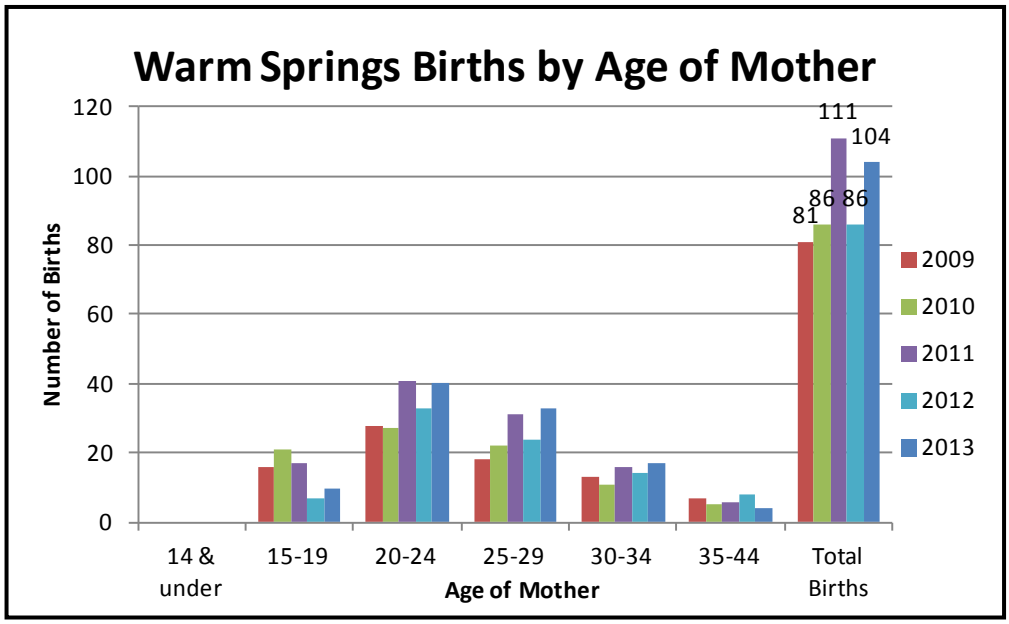


Figure 2-7

Tribal Member Births by Age of Mother, Continued

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 range has trended downward with a slight uptick in 2013 to 10 births for this age group.

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.

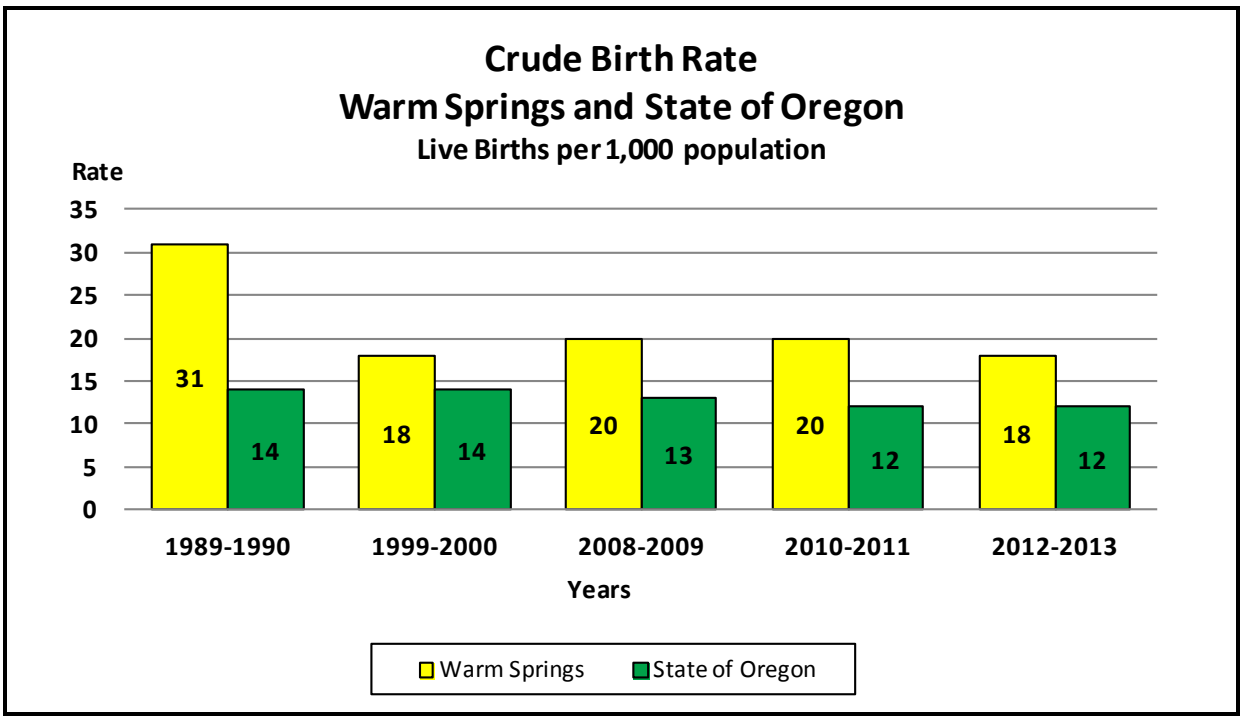


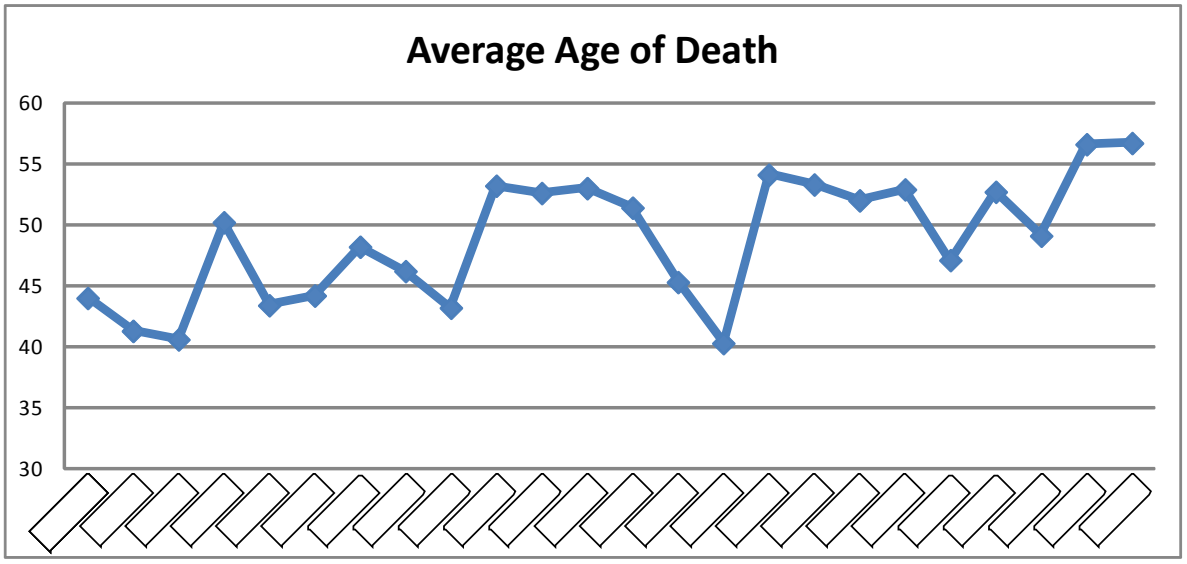
Figure 2-8

Interpretation: Past reports reflected a substantially higher birth rate in Warm Springs than the general Oregon population. The difference reduced by the 2000 report but has remained fairly consistent since then with a slight decrease noted in 2012-2013 to an average of 18 live births per 1,000 population.

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	2012-2013
Number of Deaths	83	84	111	103	121	155	72*
Crude Death Rate	502	482	608	524	605	774	540*
Years of Productive Life Lost	1,889	1,877	1,794	2,141	1,906	2,898	982*

*Two 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 2013, crude death rates remain lower than in the US, and the average age at death continues to increase and 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
2013	0		0		0	

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

Leading Cause of Death 2003-2013

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
Cause 2: Malignant neoplasms

Figure 2-10

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

Child Mortality Rates Continued…

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.

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.

There were no deaths age 0-17 in 2013.

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 2013 , IHS 2002-2004, US 2011)

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

Trends in the Leading Causes of Death (3-yr average), Warm Springs, 1994-2013

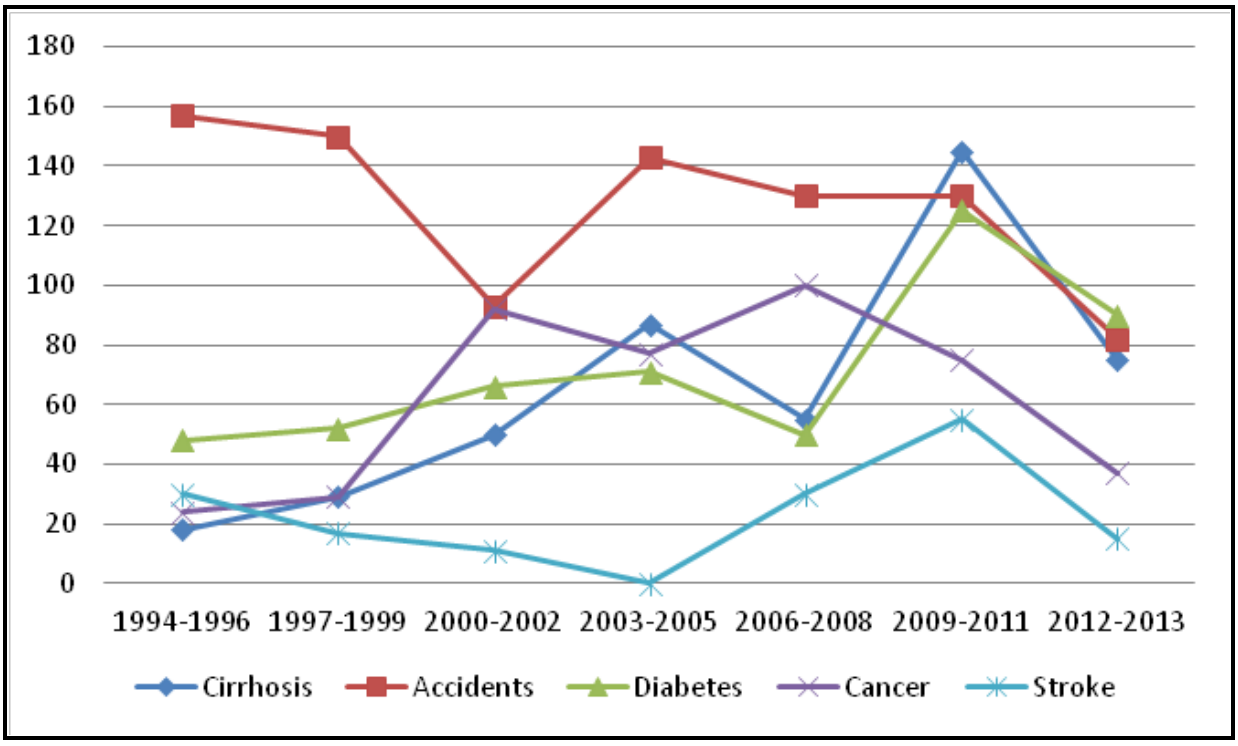


Figure 2-11

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 2010 - 2013

Condition	FY 2010	FY 2011	FY 2012	FY 2013
Diabetes	574	600	605	622
Ischemic Heart Disease (IHD)	83	88	100	104
Hypertension 18-85 w/HTN DX	470	500	503	510
Asthma	248	256	286	272
Prediabetes/Metabolic Syndrome	906	970	904	881
Rheumatoid Arthritis	75	79	81	76

Figure 2-12

Interpretation: Diabetes, Ischemic Heart Disease and Hypertension have shown a slight increase over the past year while Asthma, Rheumatoid Arthritis and Prediabetes have shown a downward trend over the past two years. The continued decreased prevalence of Prediabetes/metabolic syndrome likely reflects the efforts made by the SDPI Program to identify and engage people at risk for diabetes over the past several years. We have engaged in community education and events to promote personal health activities in order to prevent chronic diseases. It is important to continue providing resources to more effectively engage all people in identifying lifestyle factors that contribute to chronic disease and to provide support for self health management.

HEALTHY INDIVIDUALS CREATE A HEALTHY 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.

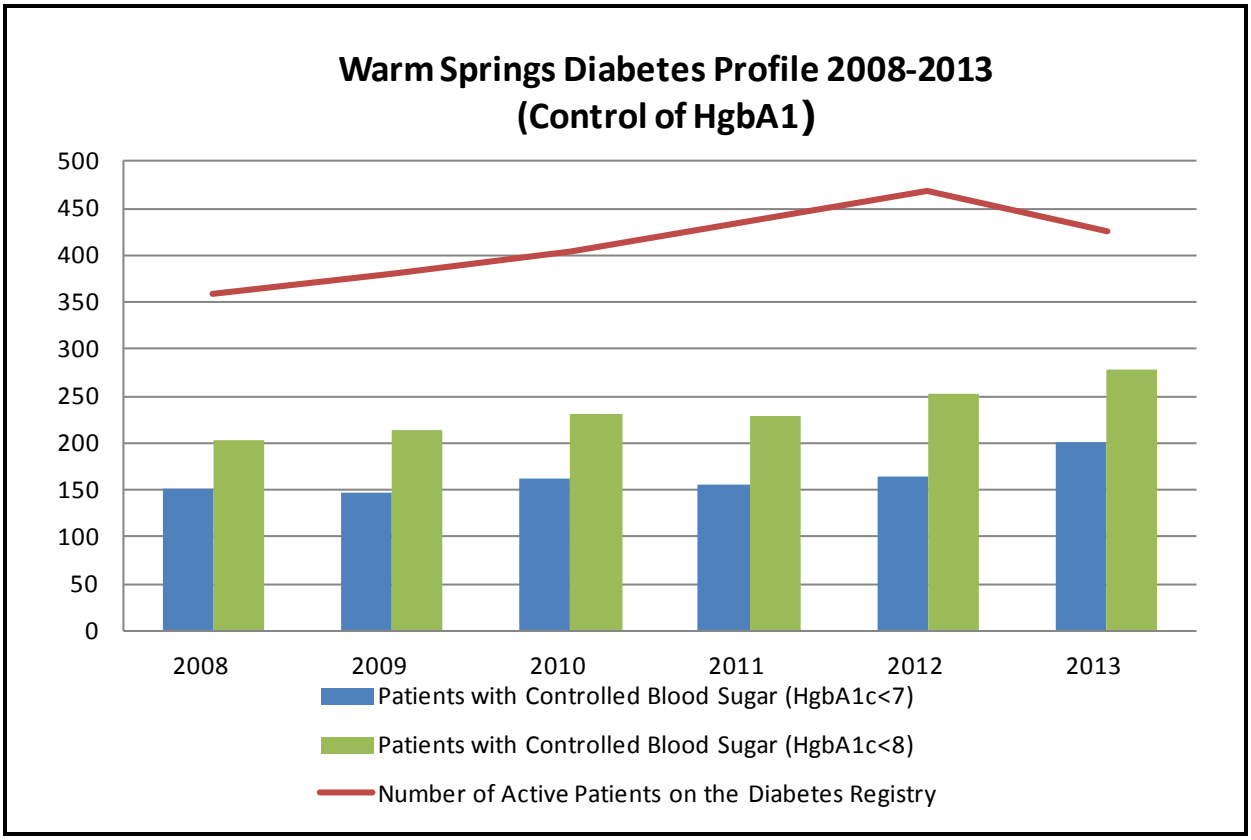


Figure 2-13

Customer Diabetes Profile, continued…..

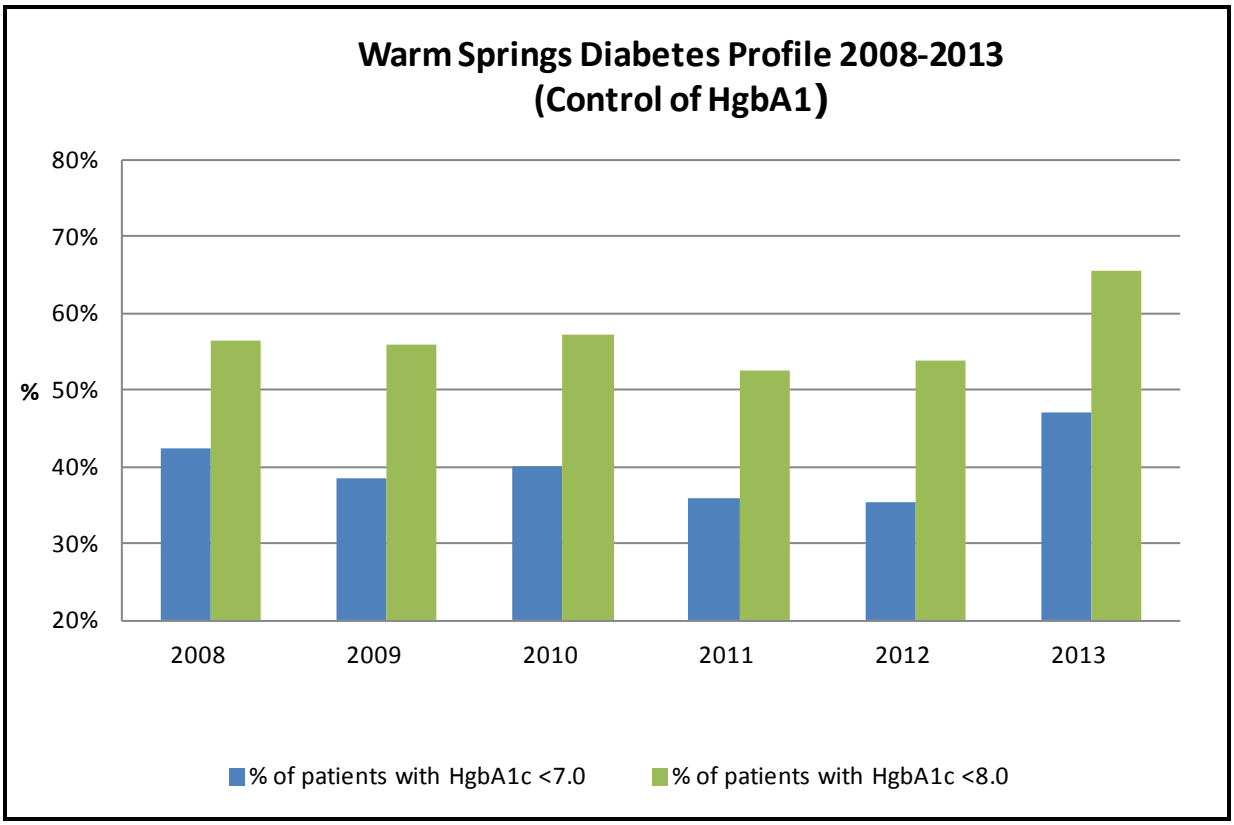


Figure 2-14

Interpretation: The number of active patients in the Diabetes Registry decreased slightly from 2012 to 2013. In order to be active in the Diabetes Registry, patients need to have made at least one visit for the purpose of improving their diabetes. Patients receiving their primary care with a provider out of the WSHWC (i.e. VA or private physician) are not included as active in the Diabetes Registry. Ideal control of HgbA1c (<7%) increased significantly from 35.3% to 47.0% between 2012 and 2013 for active registry patients. In 2012, IHS changed the goal of good HgbA1c control from <7% to <8% based on national changes in standards of care. Based on the new standard, good HgbA1c control (<8%) improved significantly from 53.8% to 65.6% from 2012 to 2013.

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
2011 - 2013

Inpatient Indicators	2011	2012	2013
Total Admissions	258	220	185
Average Length of Stay	3.85	3.88	3.61
Total Hospital Days	994	854	667
Average Daily Patient Load	2.72	2.34	1.83
Emergency Room Visits	1,297	1,097	1,146

Managed Care Hospitalizations and Those Paid by Other Resources
Warm Springs Patients by Primary Diagnosis
2013

Condition	Number of Admissions	% of Admissions	Number of Hospital Days	% of Hosptial Days
Obstetrics	107	30.7%	216	19.6%
Motor Vehicle Accidents	3	0.9%	7	0.6%
Other Accidents/Injuries	27	7.7%	120	10.9%
Cancer	3	0.9%	12	1.1%
Heart and Circulatory	28	8.0%	78	7.1%
Respiratory	44	12.6%	193	17.5%
Renal	18	5.2%	54	4.9%
Digestive	47	13.5%	133	12.1%
Infectious Disease	40	11.5%	205	18.6%
Diabetes	6	1.7%	17	1.5%
Substance Abuse	12	3.4%	30	2.7%
Mental Health	3	0.9%	7	0.6%
All Other	11	3.2%	29	2.6%
TOTALS	**349**	**100%**	**1,101**	**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 35 (16%) from the experience of the prior year.
- The Average Length of Stay declined by 0.27 (7 %) from the prior year.
- The Total number of hospital days declined by 187 (22%) from the previous year.
- The total number of Emergency Room Visits declined by 49 (4%) from the previous year.

This suggests that the Managed Care Program was quite successful in reducing our overall hospitalization utilization for 2013. Use of alternate resources has played an important role. 47% 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 2013 regardless of payment source decreased from the prior year (349 vs 401; 13%). Overall hospital days decreased from 1341 to 1101 (18%). In 2013 the Managed Care Program covered 53% of hospital admissions and 61% of hospital days. This was an improvement over 2012 when the Managed Care Program covered 55% of hospital admissions and 63% of hospital days.

The total admissions and days by category help us understand which conditions are the sources of our hospitalizations. As in 2012, 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). Next year a significant increase in OHP coverage is expected due to Medicaid Expansion effective 1/1/14, and is projected to further “shift” costs to alternate resources.

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
2013

Hospital	Admissions	Hospital Days	Total Cost $	Cost per Day
St. Charles-Madras	103	311	$992,340	$3,190.80
St. Charles-Redmond	10	25	$83,990	$3,359.60
St. Charles-Bend	60	249	$565,780	$2,272.21
VIBRA	1	34	$60,362	$1,775.35
All Other	11	48	$83,707	$1,743.90
Totals	**185**	**667**	**$1,786,179**	
			Total Cost per Day	**$2,677.93**

Figure 2-16

Interpretation: This table reflects the total cost of hospitalization MCP paid for in 2013, and the number of admissions and hospital days that comprised this cost at the three major hospitals utilized. St. Charles-Madras accounts for 56% of the total hospital costs, which was identical to last year, with St. Charles-Bend accounting for 32%.

When comparing 2013 to 2012, a decrease of 35 in the number of hospital admissions financed by the Managed Care Program was noted. There was also a corresponding decrease of 187 in the number of hospital days covered by the MCP. In addition, there was a decrease of $214,430 (11%) in overall hospital expenditures for the MCP in 2013. There was a significant 14% increase of $335 in Total Cost per Day from 2012 ($2,343) to 2013 ($2.678). A substantial increase in Medicare-Like Rate Reimbursement to St. Charles-Madras ("Critical Access Hospital") was largely responsible for the Total Cost per Day increase.

The Average Cost per Day for St. Charles-Madras increased by $1,138 (55%) over 2012, while the Average Cost per Day for St. Charles-Bend decreased by $435 (16%). The rate of medical inflation is something we must continually monitor when federal appropriations do not keep pace with medical inflation, and we must be vigilant that appropriations do not lag in the years ahead.

Hospitals Utilized and Expenditures Continued…

The effective use of alternate resources decreases Managed Care's expenditures on hospitalizations. For example, increasing the 47% of total admissions financed primarily by the Oregon Health Plan would be financially beneficial. Medicaid Expansion in 2014 is projected to have a significant positive effect on elevating this percentage.

Emergency Room Utilization

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

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

EMERGENCY ROOM VISITS

	2008	2009	2010	2011	2012	2013
ALLERGIC REACT	2	7	3	11	14	9
CARDIOVASCULAR	52	67	73	53	46	73
CELLULITIS/INFECTIONS (impetigo)	36	49	67	76	77	76
CHRONIC CONDIT.	43	37	26	42	31	30
COMMUNICABLE DISEASE	4	2	5	13	12	22
DENTAL	10	15	29	19	30	21
DERMATOLOGY (includes spider bites)	18	22	16	45	19	17
DRUG/ALCOHOL	70	111	140	69	57	68
ENT (ear, nose, throat)	92	116	102	120	85	74
EYES	14	11	23	15	7	10
GI	133	121	125	129	106	123
GU	86	75	96	77	80	69
HEADACHES	44	44	50	48	35	26
MEDS ONLY / DRESSING CHGS	4	2	5	7	4	2
MISCELLANEOUS	53	78	61	32	28	44
NEUROLOGY	34	34	39	41	11	12
OB-GYN	13	14	17	17	9	22
ORTHOPEDIC (musculoskeletal)	177	199	209	169	187	183
PULMONARY	89	136	106	104	69	69
PSYCHIATRIC (MENTAL HEALTH)	13	23	24	30	20	19
SNAKE BITE	0	1	0	0	0	1
TRAUMA						
ASSAULT	19	17	36	20	21	13
GUNSHOTS	1	1	1	1	1	1
LACERATIONS/BURNS/CONTUSIONS/	143	201	217	106	129	152
MVA	17	15	12	19	21	10
POISONS (ingested/breathed)	6	2	10	4	9	9
SEXUAL ASSAULT	0	0	2	0	0	1
DROWNING	0	0	0	0	0	0
OTHER			2	42	18	6
TRIAGE ONLY	0	5	9	2	0	0
VIRAL SYNDROME	17	43	10	18	13	6
VASCULAR (blood) - anemia/hem	7	8	18	7	0	1
TOTALS	**1,197**	**1,441**	**1,485**	**1,297**	**1,097**	**1,146**
COST (As Of 5/1/14)	$507,499	$789,554	$778,472	$784,868	$738,466	$817,277
COST PER VISIT	$424	$548	$524	$605	$673	$713

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 two consecutive years of decreases in ER visits (188 decrease from 2010-2011, and a 200 decrease from 2011-2012), there was a 4% increase from 2012-2013 of 49 ER visits. However, ER cost per visit has increased each of the last three years (albeit by a smaller % increase each year), from $524 in 2010, to $605 (15%) in 2011, to $673 (11%) in 2012, to $713 (6%) in 2013.

ETOH (alcohol) was a contributing factor in 169 of the 1,146 ER visits in 2013, or 15% of the total number of visits. These 169 ETOH-related visits were responsible for $268k of the $817k total cost, or 33% of the total cost to MCP.

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 68% increase experienced in the five years from 2008-2013.

EMERGENCY ROOM VISITS - TIMES / DAYS

	2008	2009	2010	2011	2012	2013
0800-2000,weekdays (8:00am-8:00pm)	290	445	471	474	481	459
2000-2400, weekdays (8:00pm-midnight)	268	210	237	233	225	245
2400-0800, weekdays (midnight-8:00am)	115	151	169	112	60	70
0800-1600, sat, sun (8:00am-4:00pm)	185	221	182	225	134	147
1600-2400, fri, sat, sun (4:00pm-midnight)	263	311	330	185	85	120
2400-0800, sat, sun, mon (midn-8:00am)	76	103	96	68	112	105
TOTALS	**1,197**	**1,441**	**1,485**	**1,297**	**1,097**	**1,146**

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 more appropriately cared for in ambulatory care settings. Locally, that trend exhibits itself by increased utilization of St. Charles-Madras ER when the IHS Clinic would be much more appropriate. These statistics support that trend in the past six years, with ER visits on weekdays between 0800-2000 hours ranging within a narrow margin from low of 445 in 2009 to a high of 481 in 2012, with this year's total of 459 below the five year average of 466.

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? How has the outpatient work load changed since August 15, 2013, when the doctors transitioned out of inpatient coverage 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:

- Since summer of 2013, the WSH&WC has been working with the Community Health Nurses to provide health care throughout the community in the Mobile Health Clinic. It is anticipated that this clinic will be fully functioning in Fall of 2014.
- Along with our community partners, we will review the professional staff needs and make necessary changes.
- 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

	FY2010	FY2011	FY2012	FY2013
Medical Visits by Provider				
Physicians	11,407	11,579	11,459	10,057
Mid Level Practitioners	4,492	4,591	3,920	5,297
Nursing Staff	4,596	4,785	3,961	4,249
Total Medical Visits	**20,495**	**20,955**	**19,340**	**19,603**
Workload Factors				
Clinic Days	250	250	250	250
Average Visits Per Clinic Day	82	84	77	78
Total FTE's In Medical Department	21	21	22	22
Physician FTE's	5.5	5.5	5.0	4.0
Mid-Level Practitioner FTE's	2	2	2	2.5
Avg Annual Visits Per FTE	976	998	879	891
Avg Annual Visits Per Physician FTE	2,074	2,105	2,292	2,514
Avg Annual Visits Per Mid-Level FTE	2,246	2,296	1,960	2,119
Extended Hours of Service				
Days of Late Clinic	202	202	202	114
Hours of Service (M-Th, 7pm)	404	404	404	228
Visits	802	869	902	741
Visits Per Hour of Service	2.0	2.2	2.2	3.3
Hospital Patient Count	424	476	381	325
Hospital Visit Count	1,809	2,107	1,654	1,378
Average Hospital visits per patient	4.3	4.4	4.3	4.2
Average Hospital patients per day	1.2	1.3	1.0	0.9
Average Hospital visits per day	5.0	5.8	4.5	3.8

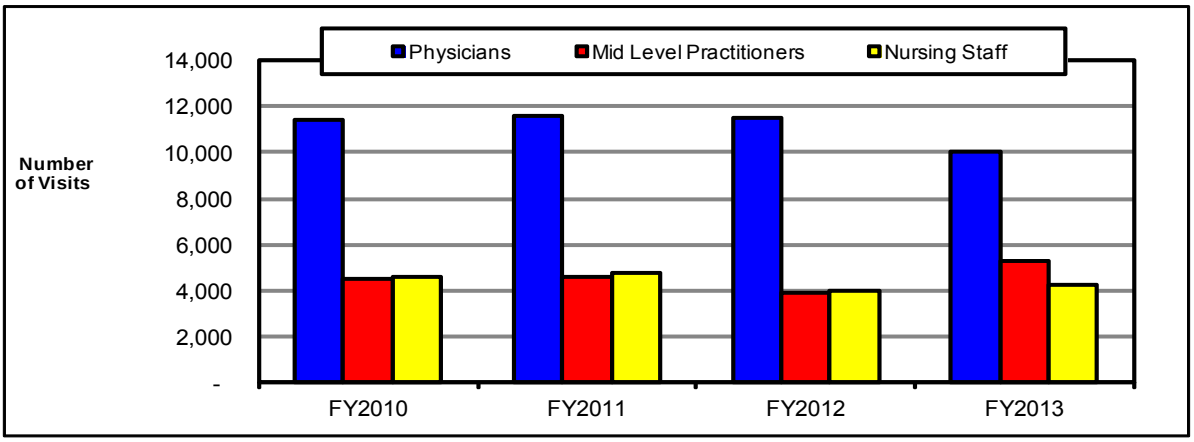


Figure 3-1

Medical Services Continued…

Interpretation: From 2010 to 2013, the medical department averaged 20,098 medical visits per year. Of those visits; 11,126 were physician visits, 4,575 were seen by mid-level providers and 4,398 were nursing visits. The average number of visits per day was 80 over a 250 day time-span. There was an average of 21.5 FTEs in the medical department including five physicians and tow mid-level providers. Each FTE physician had an average of 2,246 visits per year and each FTE mid-level provider had an average of 2,155 visits per year. FTE physicians had approximately 4% more visits per year than mid-level providers.

There was an average of 180 days when the clinic was open late for extended hours from 2010-2013 and during those times; the late clinic averaged 2.5 medical visits per hour. The average number of medical visits during late clinic increased in 2013 from 2 in previous years to 3.3 with increased staffing after the physicians transitioned out of hospital care.

The physicians transitioned out of hospital service August 15, 2013. The data presented represents only 10.5 months of the FY 2013.

Podiatry Program

Purpose: The practice of podiatry is to preserve human movement. We only get one pair of feet and we have to keep them healthy in order to carry us through our life's journey. In each of the program service areas of podiatry, we aim to teach each person to "Walk Well" at the highest level of ambulatory ability given each person's physical potential.

Relevance: The old saying "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, and especially age appropriate extremity education in such a manner that lower extremity health and wellness becomes a proactive and preventive priority practiced by patients even before they come into the clinic.

We want to do our best to educate all who we see on proper foot care so that all their travels can be as problem-free as possible.

Podiatry Department

	FY2010	FY2011	FY2012	FY2013
Podiatry Visits				
Clinic Visits	1,643	1,753	1,608	1,751
Missed Appointment Rate	21%	18%	21%	24%
Workload Factors				
Clinic Days	149	170	143	143
Average Visits per Clinic Day	11	10	11	12
Average Visits per Year				
Nature of Visits				
PT visit with Diabetes	570	813	615	808
PT visit with Open Wound	278	313	223	297
Comprehensive or Annual DM Ft Exam	91	97	105	108
Office Procedure Performed	326	489	376	464
OR Case	32	10	4	15
Hospital Patient	132	64	19	87
Other Visit Reasons	378	473	503	433
Total Podiatry Visits (Some patient visits include multiple problems)	**1,643**	**1,753**	**1,685**	**1,824**

Figure 3-2

Interpretation: Education and patient training take time so the pure numbers of patients seen in our service areas do not tell the complete story.

Podiatry Program Continued

More people are getting better about DM foot care prevention resulting in less relative numbers of serious foot infections and wounds. Increased numbers of patients are being treated, even with procedures, in the clinic rather than in the hospital setting.

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

	FY2010	FY2011	FY2012	FY2013
Dental Visits by Provider				
Dentist Visits	4,541	4,342	4,657	4,558
Hygienist Visits	1,158	758	713	818
Total Dental Visits	5,699	5,100	5,370	5,376
Missed Appointments				
No Shows (Broken Appointments)	371	408	265	664
Broken Appointments vs Total Visits	7%	8%	5%	8%
Workload Factors				
Clinic Days	250	250	250	249(snow day)
Average Visits Per Clinic Day	23	20	21	22
Total FTE's	12	12	13	12
Average Annual Visits Per FTE	496	443	413	448
Categories of Care				
Preventive	6,861	6,524	6,950	7,295
Restorative including Crowns	2,698	2,558	2,856	2,888
Dentures including Bridges	106	134	115	169
Surgical	1,031	1,067	985	1,106
Orthodontic	12	6	8	27
Endodontic	163	304	324	251
Diagnostic	10,030	8,920	6,749	6,700
Total Identified Problems Treated	20,901	19,513	17,987	19,193

Figure 3-3

Interpretation: Dental visits in FY 2013 were still holding relatively steady with loss and replacement of 1 Dentist and 2 Dental Assistants. The Broken Appointment rate is up, but is being coded more regularly by front desk staff. We also have a short notice list in place to try and fill broken appointments.

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	FY2010	FY2011	FY2012	FY2013
New Prescriptions	54,243	54,672	53980	53415
Refills	26,359	28,360	27211	26125
Total Prescriptions	**80,602**	**83,032**	**81,191**	**79,540**
Workload Factors				
Clinic Days	250	251	250	253
Avg Prescriptions per Clinic Day	323	331	325	314
Visits to the Pharmacy	33,052	34,567	33,688	33,622
Prescriptions per Pharmacy Visit	2.44	2.40	2.41	2.36
Total FTE's	6.25	6.8	6.0	6.8
Avg Annual Prescriptions Per FTE	12,896	12,211	13,532	11,697
Pharmaceuticals				
Total Expenses	$ 882,251	$ 796,241	$ 784,700	$ 791,276
Avg Cost Per Perscription	$ 10.95	$ 9.59	$ 9.66	$ 9.95
Rx for Patients outside Service Area	Unavailable		Unavailable	Unavailable

Figure 3-4

Interpretation: Workload in FY 2013 as compared to FY 2012 is down 2.0% in the number of prescriptions filled. The number of prescriptions per FTE also decreased by 13.6%. However, training of new staff (resident and technician) may have contributed to decreased prescriptions per FTE.

The decrease in the number of prescription per FTE is related to increased FTE (from 6.0 to 6.8) as well as the decrease in total prescription number. The total number of prescriptions has increased by 14.3% compared to 5 years ago.

The number of prescriptions per pharmacy visit has slightly decreased from FY 2012 to FY 2013.

Pharmacy Services Continued…

Drug costs as compared to FY 2012 have increased slightly (.08%). Average cost per prescription has also increased slightly (3.0%). These changes likely reflect fluctuations in drug costs as well as changes and additions to the formulary. Drug costs will continue to fluctuate as existing 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 13.9%. Furthermore, we have continued to manage patients in four pharmacy-based clinics as well as provide medication therapy management services and adult immunizations over this period of time, despite continued understaffing.

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

	FY2010	FY2011	FY2012	FY2013
Imaging Exams				
Total X-Ray Exams	1,886	1,645	1,649	1,711
Workload Factors				
Clinic Days	251	250	250	250
Average Exams per Clinic Day	7.51	6.58	6.60	6.84
Total Patients	1,772	1,556	1,468	1,493
Average Exam per Patient	1.06	1.06	1.12	1.15
Total PCPV's	15,783	15,839	14,980	16,568
Average Exams per PCPV	0.12	0.10	0.11	0.10
Total FTE's	1	1	1	1
Exams per FTE	1,572	1,645	1,649	1,711

Figure 3-5

Interpretation: Between 2010 and 2013, there was an average of 1,723 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 1,572 patients received approximately 1.10 visits each between 2010 and 2013.

Diagnostic Services Continued…

Diagnostic Services - Medical Laboratory

	FY2010	FY2011	FY2012	FY2013
Medical Lab Tests				
Tests collected in the Lab	90,914	85,069	77,797	76,743
Tests collected outside the Lab	3,203	3,407	3,407	3,173
Tests performed off-site	6,309	6,561	6,422	5,473
Total Lab Tests Ordered	**100,426**	**95,037**	**87,626**	**85,389**
Workload Factors				
Clinic Days	250	250	250	250
Tests Ordered per Clinic Day	402	380	351	342
Total Primary Care Provider Visits	15,899	16,170	15,379	16,568
Average Tests per Visit	6.3	5.9	5.7	5.2
Total FTE's	4.0	5.0	5.0	5.0
Tests per FTE	25,107	19,007	17,525	17,078
Category of Tests Ordered				
Hematology	30,173	25,707	25,707	19,491
Chemistry	64,625	63,347	55,936	60,491
Bacteriology	778	831	831	939
Urinalysis	4,850	5,152	5,152	4,468
Total Lab Tests Ordered	**100,426**	**95,037**	**87,626**	**85,389**

Figure 3-6

Interpretation: From 2010 to 2013, an average of 92,120 lab tests was ordered by the providers in which about 70% are chemistry tests. Comparing the numbers between fiscal years showed a substantial decline. From 2010 to 2011 showed a 5% drop, and again a 7% drop from 2011 to 2012 while FY 2012 to 2013 showed a 2.5% decline.

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

	FY2010	FY2011	FY2012	FY2013
Optometry Visits				
Clinic Visits	1,846	1,973	1,663	1,941
Missed Appointment Rate	22%	22%	16%	18%
Workload Factors				
Clinic Days	220	220	220	220
Average Visits per Clinic Day	8	9	8	9
Total FTE's	2.0	2.0	2.0	2.0
Nature of Visits				
Refractions	673	795	821	832
Diabetic Eye Exam	199	264	308	309
Contact Lens Visit	58	45	56	39
Medical Visit	-	-	-	-
Early Childhood Education Visits	35	31	53	60
Glasses Repair/Adjustment	394	350	372	338
Other	487	488	53	363

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 full time placement of a fourth year Optometry student. Dr. Corey retired in August of 2013. Dr. Dzuik started on August 8, 2013.

The rate of patients who do not keep appointments is up slightly over the last year.

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

The number of patients seen in most all categories has increased over the years except for the staff level, which remains at 2.

Managed Care Program

Purpose: To identify workload of the Managed Care Program.

Relevance: To assure effective processing and management of resources.

Managed Care Program

Staffing & Other Workload	FTEs	Number of Obligations	Funds Obligated
2005	7	8,190	$4,905,541
2006	7	6,120	$5,049,015
2007	7	5,022	$3,447,919
2008	7	7,162	$3,881,990
2009	7	9,136	$4,953,270
2010	7	9,757	$5,185,344
2011	7	9,099	$4,999,277
2012	8	8,667	$5,521,545
2013	8	8,861	$5,376,701

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 and 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 the 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, and more importantly, Medicaid Expansion, has greatly increase 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	2010	2011	2012	2013
Prenatal Visits	5	29		
Post Partum Visits				
Well Child Visits			34	42
Immunization Visits	381	1,034	1,274	1,380
Diabetes Visits				
Cardiovascular Visits				
Mental Health Visits				
STD Visits	25	42	66	145
Family Planning	42	95	135	213
Phone Contact/Follow-ups		545	213	219
Other Activity	27	594	614	898
Total Community Health Nurse Visits - (In Office Only)	480	2,339	2,336	2,897
Visits by Location				
Out of Clinic Visits	594	1,046	742	892
Clinic Visits	603	748	666	1,039
Total Community Health Nurse Visits	1,197	1,794	1,408	1,931
Total Days of Service	250	250	250	250
Average Visits Per Day	4.8	7.2	5.6	7.7
Total FTE's	1.8	2.0	1.8	2.0
Average Visits per FTE per year	665	897	782	966

Figure 3-9

Interpretation: The Community Health Nursing Program continued to work through staffing challenges in 2013 with one position being vacant the entire year. The productivity to the two nurses on staff was higher than it has been in previous years. The top diagnoses managed through the Community Health Nursing Program include: Vaccines/Immunizations, Family Planning, Communicable Disease/Sexually Transmitted Infections and Well Child Exams.

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)

	2010	2011	2012	2013
Total number of births	103	111	86	104
Total number of births (Tribal members)			72	82
Number of high risk pregnancies	32	44	43	33
Number of high risk infants identified*	36	32	43	39
Prenatal Home Visits		116	56	52
Post-Partum Home Visits		196	143	150
Other Home/Office Visits	454		565	399
Number of Hospital Visits	109	87	115	72
Number of Birthing Classes	47		45	43
Total Number of Participants	240		157	181
Infant Immunization level**	87.3%	90.9%	84.4%	83.5%

Figure 3-10

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

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

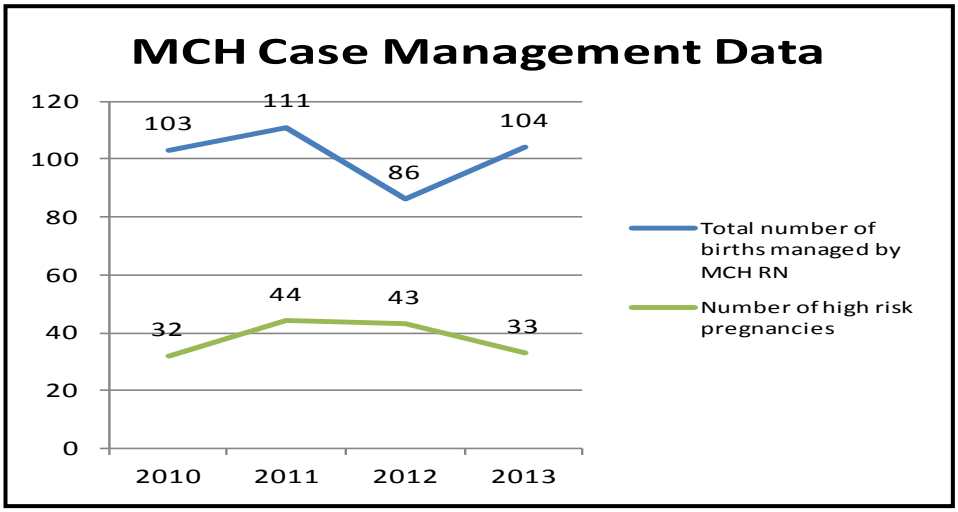


Figure 3-11

Maternal and Child Health (MCH) Continued…

Interpretation: In 2013, the MCH Program saw a slight increase in the number of births managed by the program. Although the risk level of the pregnancies appeared lower, 33 of pregnancies were categorized as high risk and 11 of the pregnancies were categorized as moderate-high risk which is still a very concerning issue for our community. 42% of our pregnancies required intensive services due to their risk status.

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).

Total number of births reflects all births that were case managed by the MCH nurse and are eligible for care under IHS 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

	2010	2011	2012	2013
Caseload by category:				
- Transports	172	164	274	467
- Patient Care	738	592	412	1395
- Case Findings/Screening	932	532	428	52
- Monitoring Patient	502	425	284	45
- Case Management	393	312	109	21
- Health Education	34	42	32	
- Other	739	500	445	119
Total Client Encounters	**3,510**	**2,567**	**1,984**	**2,099**
Total Days of Service	250	250	250	250
Average Number of Encounters per Day	14.0	10.3	7.9	8.4
Total FTE's	3.0	3.0	3.0	3.4
Average Number of Encounters per FTE per Year	1,170	856	661	617

Figure 3-12

Interpretation: The CHR program saw an increase in the amount of transport requests by 193 transports over the previous year. A new CHR was added to accommodate the increased transportation load as well as the increasing numbers of dialysis clients. During 2013, two additional dialysis transportation days were added to the schedule offering transportation service 5 days/week. Dialysis client transportation statistics are not included in Figure 3-11 but average 2-6 clients per day, 5 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

	FY2010	FY2011	FY2012	FY2013
Diabetes Program Visits				
Clinician Clinical Visits	1,457	1,931	4,156	4,729
Community Encounters	2,010	2,032	1,531	1,752
Total Visits	**3,467**	**3,963**	**5,687**	**6,481**
Workload Factors				
Clinic Days	250	250	250	250
Average Clinical Visits per Clinic Day	13.9	15.8	16.6	18.9
Total Clinical FTE's	5.0	5.0	4.0	4.0
Average Clinical Visits Per FTE	693	793	1,039	1,182
Categories of Service				
Diabetes Clinical Encounters			1,922	2,630
Diabetes Case Management Encounters			2,334	2,099
Diabetes Community Education Contacts	787	985	559	1,559
Diabetes Screening Community Contacts	2,010	2,032	972	193
Patients in Dialysis				
Number of Patients	13	12	13	17

Figure 3-13

Interpretation: Due to the Nurse Practitioner position being vacant, Dr. Terry worked in the Diabetes Program from 10/1/12-1/4/13 for 2 days/week.

Several major educational events were held including Diabetes Awareness Day Conference, Heart Smart Dinner, Honor Seniors Day, Pi-Ume-Sha Health Fair, Senior Center Diabetes Support Group Dinners, Youth Support Group, Food Demo & Support Group and Culture Camp.

H.O.P.E. (Healthy Outcomes Promoted by Education) diabetes education program is accredited by the American Association of Diabetic Educators through 2016.

Diabetes Program Services Continued…

Community screening for diabetes and diabetes prevention education has been transitioned to Diabetes Prevention Program Staff except for a few special events to increase the number of clinical appointments in Diabetes Program.

One full-time administrative staff member is excluded from clinical statistics. Prior to FY 2012 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)

	2010	2011	2012	2013
Infants and children under 5 years of age	543	550	550	534
Pregnant, breastfeeding and postpartum women	219	232	211	187
Total number of Women, Infants and Children served	762	782	761	721

Figure 3-14

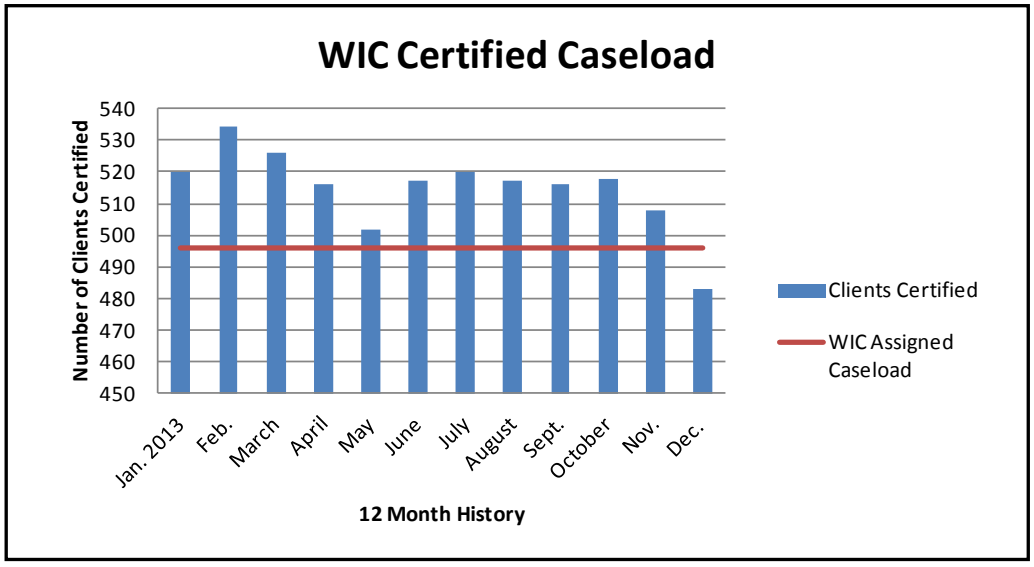


Figure 3-15

Interpretation: The number of Women, Infants and Children served by our program remained relatively stable for the past 5 years. Typically, the Warm Springs WIC program exceeds the certified caseload assigned by the State by more than 25 clients per month with the exception of December which fell below the benchmark. This decline was primarily attributed to children aging out of the program, clients not using their food vouchers and fewer clients coming in for certification due to the holidays.

Other interesting facts for 2013, 93% of our new mothers start out breastfeeding and 43% of the families we serve are working families. Both of these indicators are up 2% from 2012.

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 2013
Program Health Education Team	
General Health	
Honoring the Gift of Heart Health; 10 sessions	66
My Future My Choice; 5 Sessions (Sexuality Education)	42
Girlz Club (8-11 year olds); Hygiene	7
Senior Health Topic-December	200
Women's Health	
Women of Wellness; 10/12 Classes	282
Pi-Ume-Sha Health Fair	705
4-H Culture Camp (Women's Health ed. Provided)	
Youth	0
Adults/Parents/Speakers/Counselors	0
College Fair with WFD	0
Heart Smart Dinner	235
Christmas Tree Lighting (Women's Health ed. provided)	505
Cultural Prevention	
Craft Classes	
Sewing; 4 Classes	23
Gift Making; 6 Classes	71
Pi-Ume-Sha Health Fair	705
4-H Culture Camp	
Youth	0
Adults/Parents/Speakers/Counselors	0
HIV/AIDS	
World Aids Day	20
Suicide Prevention Camp	0
Pi-Ume-Sha Health Fair	705
4-H Culture Camp (HIV/AIDS ed. provided)	
Youth	0
Adults/Parents/Speakers/Counselors	0
Heart Smart Dinner (HIV/AIDS ed. provided)	235
Christmas Tree Lighting	505
Alcohol and Drug Prevention	
3D Project	50

Figure 3-16

Community Health Education Team Alcohol Program Continued…

Interpretation: In 2013, the Community Health Education Team participated in fewer events but initiated several new ones which included multiple sessions for sustained participant support and education. Many of the activities were duplicates although multiple education topics were presented at each event by different Health Educators. Much of the emphasis for CHET activities continued to promote traditional cultural craft experience for adults and youth as it is an important component on 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

	2010	2011	2012	2013
Visits & Clients Served				
Number of Adult Visits	1,021	1,268	*	
Number of Children Visits	2,042	1,515	*	
Total Visits	3,063	2,783	3,012	2,539
Categories of Service				
Crisis Management Visits	275	224	204	270
Prevention Services				
Soaring Butterflies/Warrior Spirit		NA	NA	300
Positive Indian Parenting (5)		299	48	48
Elvis Birthday Bash		97	70	NA
MSPI Madras High School Presentations		103	0	46
QPR Trainings (5)		115	3	3
Sock-Hop Event		62	30	83
All Night Lock-In		105	0	98
He-He Butte Prevention Camp		43	61	22
Oregon Native Youth Survey		24	24	NA
Halloween Party		500	500	100
Prevention Basics Power Point		5	60	NA
W.S. Christmas Fun Party		1,400	500	600
Spring Into Action (Prev. Coalition)		200	49	NA
Penny Carnival			80	178
Rez Olympics			50	48
Street Dance			60	75
GONA Training			100	NA
Total Prevention Services Attendance		2,953	1,635	1,601
Service Hours				
Client Contact Hours		2,275	*	3,703
*Total FTE Hours			3,216	

Figure 3-17

Mental Health Continued…

Interpretation: This year has been a time of transitions for the Mental Health Program. We had a number of staff vacancies and disruption of services. While crisis visits increased, total office visits are slightly down from previous years. That has steadily increased. We have changed the various community activities we offered so that is reflected in this report. Some of the prevention activities listed was not provided this year but new activities were. The prevention program is no longer a part of the Warm Springs Community Counseling Program.

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

	2010	2011	2012	2013
Encounters - Outpatient Treatment				
Number of Visits	2,570	2,899	2,501	1,793
Number of Clinic Days	239	239	254	251
Average Visits per Clinic Day	11	12	9	8
Relapse Anger Resolution Grp (Quarterly)	75	33	28	25
Jail Groups (estimate)	246	250	334	425
Aftercare				
Healing from Grief & Trauma - 1 day conf.	25	57	40	87
Recovery Month Dinner	100+	n/a	100	100
A&D Prev B-Ball "And 1" (Street Ball tour) all ages	400+	250	NA	36
Community Grief/Trauma Gathering (2 workshops)	90+	80	NA	50
Healing Family Circle Conference		40	NA	NA
Categories of Service				
Alcohol Abuse	2,287	2,899	2,501	1,793

Figure 3-18

Interpretation: We will continue to build on grief and trauma work as they are co morbid conditions with substance use.

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

	2010	2011	2012	2013
Outpatient Visits	347	NA		30
Prevention Youth Dance				72
Teen Craft Night				32
Rez Head Youth Conference				34
Baseball Camp				31
Suicide Prevention Camp	32	50	68	38
Healing Wounded Spirits Camp	0	n/a	46	NA
Winter Youth Conference	0	n/a	n/a	NA
Movie Nights	297	319	416	384
Wii Bowling	49	n/a	112	NA
Hoop Camp	62	144	73	36
Madras Bowling	84	83	88	79
Wellness walk	18	81	84	204
All Night Sobriety Party		160	n/a	n/a
Kids Bingo		76	26	196
Red Road to Recovery/Boys Circle		93	0	93
Tribal Youth Leadership		24	24	22
Total	542	1,030	1,187	1,251

Figure 3-19

Interpretation: The aftercare program provides services including healthy alternatives to social activities in a group setting. In addition one on one services to build coping

Adolescent Outreach Continued

skills and resilience. Services are provided also to clients returning from a treatment setting to help them readjust. Through this program additional support is provided to 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
2013

Resource Center Usage	2011	2012	2013
Patrons that checked out materials	248	486	339
Materials checked out	733	1,358	949
Health related materials checked out	46	80	81
Native American materials checked out	139	215	160
Circulations*	1,424	3,015	1,679
Number of visits	3,833	9,351	8,936
Patron cards issued	505	378	144
Graphic Design Requests			
Posters/Banners printed	199	197	99

*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 or renewed more than once.

Figure 3-20

Interpretation: 147 fewer people checked out items in 2013 than in 2012. This accounts for 2013's reduction in items checked out and reduction in circulations. Why did 147 fewer people check out materials in 2013? Of the 486 people who checked out material in 2012, 248 never returned their books: i.e., these 248 people never checked out material in 2013, and are the main reason why 2013 numbers were lower. Despite this, 339 people checked out material in 2013. That means at least 101 people checked out material in 2013 that had not checked out material in 2012. Even though fewer people checked out materials in 2013, the number of visits was very similar to 2012. The addition of public computers accounts for this. Lastly, fewer posters were printed in 2013 because the Casino started printing their own.

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

	2010	2011	2012	2013
Housing & Energy Assistance				
Number of Clients Served				248
Total Vouchers Processed				248
Total $ Value of Vouchers	144,294	84,443	86,131	87,346
Medical Travel				
Number of Clients Served	923	789	458	336
Total Vouchers Processed	923	789	458	336
Total $ Value of Vouchers	27,108	20,211	12,200	9,709
Disability				
New Clients pursuing claims for SSI/SSDI	23	92	78	67
Number of clients currently checking on Survivorship/widow benefits	16	28	16	10
Number of Clients inquiring about Retirement Benefits	8	21	24	20
Number of Clients that have been denied	31	77	36	23
Number of Clients that just filed their 1st Appeal	21	49	20	15
Number of Clients that are in the middle of Appeal	25	54	33	17
Number of Clients in Court Hearings	7	16	8	20
Commodities				
Number of Families Served			259	278
Number of Individuals Served	312	301	494	749
Number of Warm Springs Tribal Members*	593	516		

Figure 3-21

* For 2012 & 2013, Tribal Member data was not kept.
It will be included in the 2014 report.

Interpretation: The number of clients served has decrease from 458 to 336 (27%) from 2012 to 2013. The Number of Families Served showed an increase of 19 Families, 7 % change. A significant increase was also seen in the Number of Individuals served, 255 (52%),

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.

Ambulance Activity Summary

SUMMARY OF AMBULANCE ACTIVITY

Reason for Call	Calls		Patients Transported		Calls w/Substance Factor	
	2012	2013	2012	2013	2012	2013
Motor Vehicle Accident	97	47	38	27	13	3
Other Accident	137	-	154	-	128	0
Assault and Battery	88	43	11	14	50	12
Suicides/Attempts	12	2	7	0	7	2
Corrections	206	173	38	30	107	39
Pediatric	148	108	31	33	0	2
Cardiac	100	76	57	69	4	6
Respiratory	107	38	46	34	8	0
Other Illness	518	610	299	306	66	58
Total	**1,413**	**1,097**	**681**	**513**	**383**	**122**

TRIBAL AFFILIATION RELATED TO CALLS

Reason for Call	Calls Dispatched		Patients Transported		Calls w/Substance Factor	
	2012	2013	2012	2013	2012	2013
Members and Dependents	1,267	1,373	508	580	228	96
Other Eligible Indian	1	0	0	0	0	0
Non Tribal	148	104	61	46	13	45
Total	**1,416**	**1,477**	**569**	**626**	**241**	**141**

Figure 3-22

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.

Ambulance Services Continued

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

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.

Special Diabetes Prevention for Indians Grant (Tribe): Offers group activities and renal clinics for the education, prevention and treatment of Diabetes.

Maternal Child Health (MCH):

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.

Alcohol & Drug Prevention:

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

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

Influenza Pandemic:

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

Meth/Suicide Prevention (MSPI): 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

	2010	2011	2012	2013
Indian Health Service				
Recurring Funding	16,174,897	16,284,305	17,348,813	16,135,780
Non-Recurring Funding	1,670,645	1,538,649	510,231	603,603
Total IHS Funding	**17,845,542**	**17,822,954**	**17,859,044**	**16,739,383**
Collections IHS				
Medicaid	81,657	201,700	99,349	2,630,125
Medicare	2,283,902	2,400,000	2,522,740	265,122
Private Insurance	478,426	428,600	503,833	420,342
Total IHS Collections	**2,843,985**	**3,030,300**	**3,125,922**	**3,315,589**
Collections Tribe				
Ambulance	207,994	171,068	146,086	358,739
Community Counseling	269,916	537,996	567,466	944,058
Community Health	33,928	266,563	398,428	462,844
Total Tribal Collections	**511,838**	**975,627**	**1,111,980**	**1,765,641**
Grant Awards	859,469	1,513,100	1,650,982	2,133,838
Tribal Employee Group Insurance (Est)	1,269,463	1,554,753	1,901,827	2,231,557
Tribal Appropriations	1,790,924	1,761,800	1,682,649	396,905
Total	$25,121,221	$26,658,534	$27,332,404	$26,582,913

Figure 4-1

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

The recurring FY 2013 IHS base funding decreased by a little over $1.2 million (8%) from the previous year. The non-recurring funding for 2013 increased by a little over

Health System Funding by Major Source, continued

$95,000 (15%).

Collections continued their upward trend for both IHS and Tribal Programs. IHS program collections increased by over $189,000 or 6% in 2013. Likewise Tribal program collections increased by over $650,000 or 37% in 2013.

Most of the Tribal program increases were attributed to Community Counseling (+$376,000). Community Health increased by over $64,000. Ambulance Service collections increased by over $212,000 in 2013. It is essential that all programs continue to emphasize collections to maintain and enhance services.

Grant awards increased by $480,910 from the previous year. Tribal appropriations declined by $1.2 million over that same period. Tribal Employee Group Health expenditures were estimated at $2,231,557, which represents an increase of $329,730 or 15%.

The over total Health Program Funding for 2013 was $26,582,913 which represents an decrease of 3% when compared to 2012.

Base Health System Funding Versus Inflation

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

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

	Annual IHS Base Funding	Base Increase	Medical Inflation
1998	9,570,435	1.0%	2.9%
1999	9,955,164	4.0%	3.5%
2000	10,428,865	4.8%	4.1%
2001	10,716,132	2.8%	4.6%
2002	11,102,601	3.6%	4.7%
2003	11,836,295	6.6%	4.0%
2004	11,914,200	0.7%	4.4%
2005	12,072,614	1.3%	4.2%
2006	12,454,591	3.2%	4.0%
2007	12,833,003	3.0%	4.4%
2008	13,340,464	4.0%	3.7%
2009	13,995,065	4.9%	3.2%
2010	16,174,897	15.6%	3.4%
2011	16,284,305	0.7%	3.0%
2012	17,348,813	6.5%	3.7%
2013	16,135,780	-7.0%	2.5%

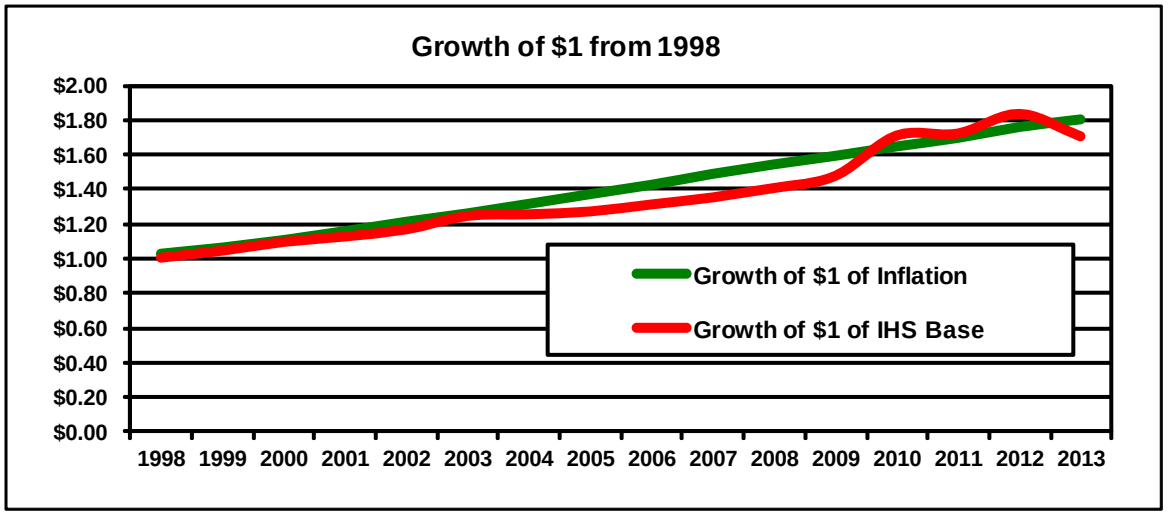


Figure 4-2

Base Health System Funding Versus Inflation, Continued

Interpretation: Due to the Sequester, 2013 was the first year in several that the IHS Base Funding has not exceeded the Medical Inflation rate. 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

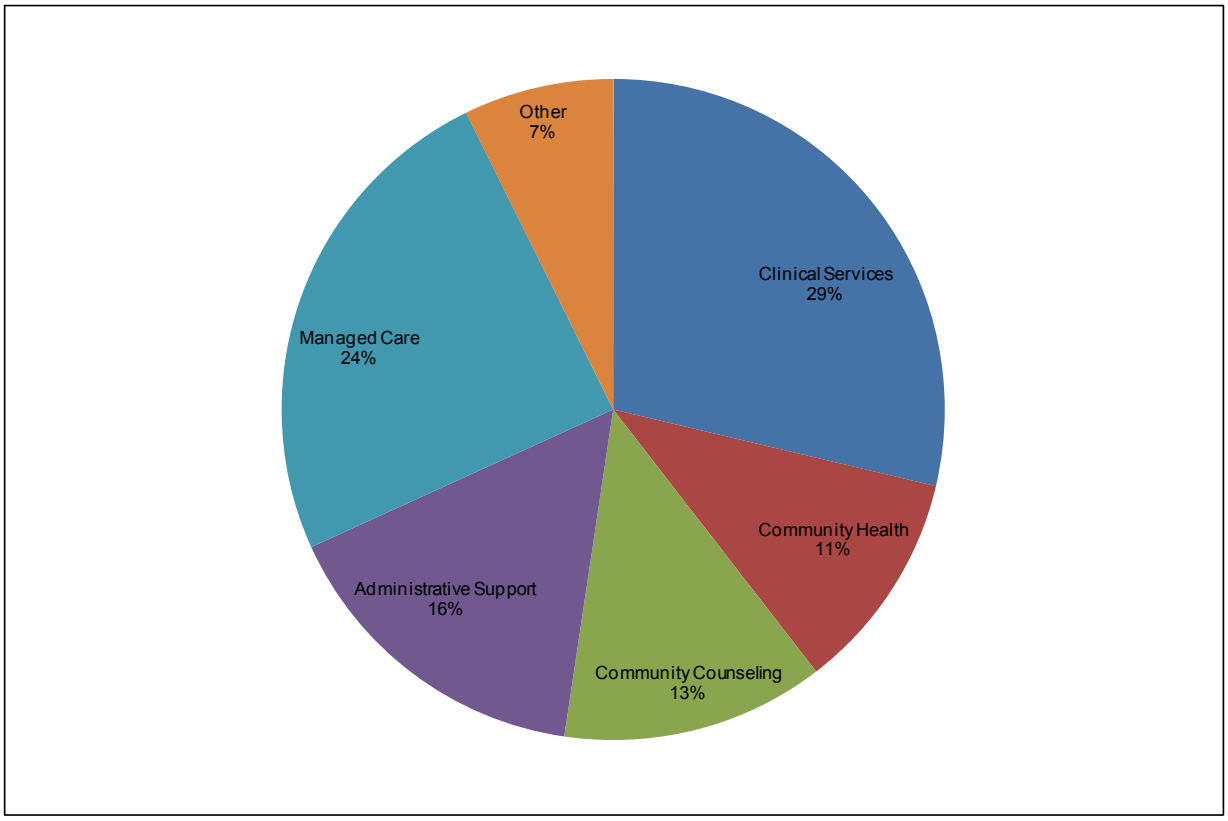
Purpose: To report actual outlays by each program as well as overall carryover and savings.

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

	2010	2011	2012	2013
Clinical Services				
Medical	3,562,634	3,586,014	2,229,705	2,875,284
Dental	1,111,249	1,038,130	1,217,056	1,217,823
Optometry	254,790	202,119	287,891	240,219
Pharmacy	1,459,292	1,286,068	1,122,677	1,492,054
Podiatry	181,846	190,773	107,033	101,993
Medical Lab/X-Ray	912,072	549,939	749,719	640,333
Diabetes - Clinic	370,600	1,679,713	797,546	680,280
Community Health				
Community Health Dept.	228,104	377,052	415,384	364,932
Health Education	140,073	177,030	221,757	299,954
WIC Program	25,051	70,962	64,620	63,190
Diabetes Grant (Tribal)	35,024	96,192	142,075	193,268
Environmental Health	83,678	46,939	56,113	46,624
Public Health Nursing	487,956	705,379	941,253	644,482
Community Center	216,412	149,287	214,402	293,289
Community Counseling				
Community Counseling	1,028,767	1,383,062	1,055,718	1,164,795
Mental Health	215,132	369,093	321,245	197,119
Adolescent Aftercare	125,644	105,297	79,931	85,647
Vocational Rehabilitation/Soc	306,586	380,723	552,314	411,200
Prevention Projects	26,563	189,942	337,782	423,370
Administrative Support				
Facilities	958,080	1,138,310	986,419	263,269
Security	21,408	21,872	22,891	-
Health Administration	657,133	559,991	1,264,624	1,007,004
Business Office	282,104	83,851	947,236	462,821
Quality Assurance	174,143	165,751	106,017	-
Data Systems	393,030	561,032	269,888	107,336
Indirect Costs	587,803	825,743	1,314,107	492,258
Other				
Managed Care	5,935,441	5,306,338	5,566,489	5,836,686
Ambulance	939,514	1,044,889	1,071,369	300,000
Quarters	-	-	-	-
Clinic Equipment	105,518	326,118	123,740	51,865
Total	**20,825,647**	**22,617,609**	**23,204,464**	**19,957,095**

Figure 4-3

Health System Spending by Program, Continued



Interpretation: From 2012 to 2013 the overall spending on total health services has decreased by over $3.2 million (16%).

Comparing the Clinical Services expenditures of 2010 with those of 2013, $604,497 less was spent in 2013. Managed Care expenditures for the same two years of comparison were very similar. Increases continue to occur in Community Health (+36%) and Community Counseling (+25%) spending. 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.

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.

	2009	2010	2011	2012	2013
Visits Billed					
Medical	11,336	10,411	10,101	9,864	9,902
Dental	1,911	2,168	2,001	2,132	2,296
Pharmacy	19,830	23,645	23,578	21,845	21,159
Optometry	431	440	356	375	467
All Other	1,478	1,882	2,657	2,878	2,232
Total Visits Billed	**34,986**	**38,546**	**38,693**	**37,094**	**36,056**

	2009	2010	2011	2012	2013
Collections					
Medical	$ 1,770,324	$ 2,023,029	$ 2,122,715	$ 2,181,021	$2,268,671
Dental	244,363	373,161	402,762	380,597	400,504
Pharmacy	581,929	635,645	683,018	503,271	493,904
Optometry	65,006	72,419	65,328	76,897	104,292
All Other	11,846	43,133	242,347	260,246	158,812
Total Collected	**$ 2,673,468**	**$ 3,147,386**	**$ 3,516,170**	**$ 3,402,032**	**$3,426,183**

	2009	2010	2011	2012	2013
Source					
Medicaid	2,050,000	2,283,902	2,675,989	2,522,740	2,687,154
Medicare	200,000	81,657	103,461	99,349	101,175
Private Insurance	450,000	478,426	556,209	503,833	438,490

Figure 4-4

Interpretations: Total Medical visits billed have decreased by 17% over the last 5 years and have leveled out in the last 3 years with an average of 9,956 visits. Pharmacy visits billed peaked in 2010 and have decreased by 11% over the last 3 years, with a 3% decrease in the last year. Total visits billed peaked in 2011 and decreased by 7% since then, with a 3% decrease in the last year. Total visits billed have averaged 37.075 for the last 5 years.

In 2013, Medical billed out for 9,902 visits and received $2,268,674 (an average of $229/visit an increase of $8 per visit over last year). Medicaid accounted for approximately 83% of collections, Medicare around 3% and Private Insurance makes up 14%.

Clinic Billing, continued

In regards to the decrease in clinic billing:

First, one must remember these figures reflect **billable** claims only. Indian Health Service provides primary care services, dental care, eye care, diabetes care, pharmacy, labs, radiology, and specialty care to all eligible AI/AN people whether they have 3rd party coverage or not; services to the uninsured are not reflected in these figures.

Second, the Confederated Tribes of Warm Springs assumed control and responsibility for PHN's, Nutrition, and transportation. As the Tribe progresses and these programs become fully functioning, they assume some of the services once provided by Indian Health Service. In particular, immunizations and some nursing visits, have become a significant part of CTWS billable claims with IHS actually delivering that much of that service population to them.

Third, professional (Medicare) visits represent the majority of the "All Other" category. A small percentage of Medicare eligible seniors in our community choose to have Medicare A (hospital) only as there is no premium. Even more are choosing not enroll in Medicare D (pharmacy). This decrease in patients enrolling in Medicare D or dropping Medicare B has affected the number of billable outpatient and pharmacy claims.

Finally, Oregon's Expanded Medicaid enrollment system continues to be complex. Even as Cover Oregon works connecting to the federal website by November, 2014, the current application process is not streamlined and requires much rework. Paper applications are still the norm and our Contact Representatives work daily to ensure everyone who has applied is being considered and applications or persons named on applications are not losing coverage. The confusion left by the Cover Oregon exchange failure has to be overcome and unfortunately, it happens one patient at a time. The number of new patients cover by Expanded Medicaid has increased by 600 but many children and others have been wrongly terminated from the program either because of an oversight or system error. We believe that using the federal technology to enroll our patients in November is the clearest and most cost effective path to new or continued enrollment in Oregon's Expanded Medicaid, increasing our number of billable visits.

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.

	2010	2011	2012	2013	
Incidents/Visits Billed					
Ambulance	681	614	594	636	
Alcohol & Substance/ Mental Health	1,015		1,896	2,938	*
Community Health	236	1,459	2,075	1,502	
Other					
Total Incidents/Visits Billed	**1,932**	**2,073**	**4,565**	**5,076**	

	2010	2011	2012	2013	
Collections					
Ambulance	215,961	172,032	146,086	358,739	
Alcohol & Substance/ Mental Health	272,060	400,000	567,466	944,058	**
Community Health	33,928	266,563	398,428	462,830	
Other					
Total Collected	**$ 521,949**	**$ 838,595**	**$ 1,111,980**	**$ 1,765,627**	

	2010	2011	2012	2013
Source				
Medicaid	358,593	698,517	1,000,140	1,519,144
Medicare	40,297	36,171	1,099	112,256
Private Insurance	121,971	1,893	98,325	115,964
Workers Comp			9,980	11,317
Other	1,088	4,048	2,437	6,946

*Includes 1,760 A&D/MH Visits from 2012 that were billed in 2013.
**Includes $555,740 that was collected for 2012 Visits.

Figure 4-5

Interpretation: Since 2010, there has been a 70% increase in Tribal Collections. 2013 collections saw an increase of 37% over 2012. Medicaid (OHP) accounted for approximately 86% of the total collected with Medicaid around 6%, Private Insurance at about 7%, Workers Comp and Other with less than 1% in collections each.

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

	# Transports Billed		Amount Billed		Amount Collected	
Payer Source	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**
Workers Compensation	9	6	$ 10,400	$ 13,965	$ 9,980	$ 11,317
Medicaid	98	135	$ 110,517	$ 151.397.45	$ 34,246	$ 112,256
Medicare	120	121	$ 138,112	$ 135,350	$ 1,099	$ 112,256
Private Insurance	145	134	$ 157,574	$ 147,730	$ 98,325	$ 115,964
Private Pay	43	28	$ 47,411	$ 27,374	$ 2,437	$ 6,946
Managed Care	167	212	$ 183,978	$ 236,255	$ -	
No Source	12		$ 264		$ -	
Total	**594**	**636**	**$ 648,256**	**$ 560,674**	**$ 146,086**	**$ 358,739**
Average Per Transport			**$ 1,091**	**$ 882**	**$ 246**	**$ 564**

(1) Collection source breakout not reported

OUTLAYS AND FUNDING	**2012**	**2013**
Outlays		
Allocated Salaries and Benefits	760,740	1,014,165
Medical Supplies	27,896	15,371
Other Supplies & Expenses	4,209	41,144
Vehicle Expenses	34,012	78,582
Equipment		
Vehicle & Equip. Depreciation	5,782	5,812
Total	**$ 832,639**	**$ 1,155,074**
Average Direct Cost Per Transport	**$ 1,402**	**$ 1,816**
Funding Source		
Indian Health Service (PL 93-638)		
Collections		
Warm Springs Tribe - Direct Appropriation		

Figure 4-6

Ambulance Financial Summary, Continued

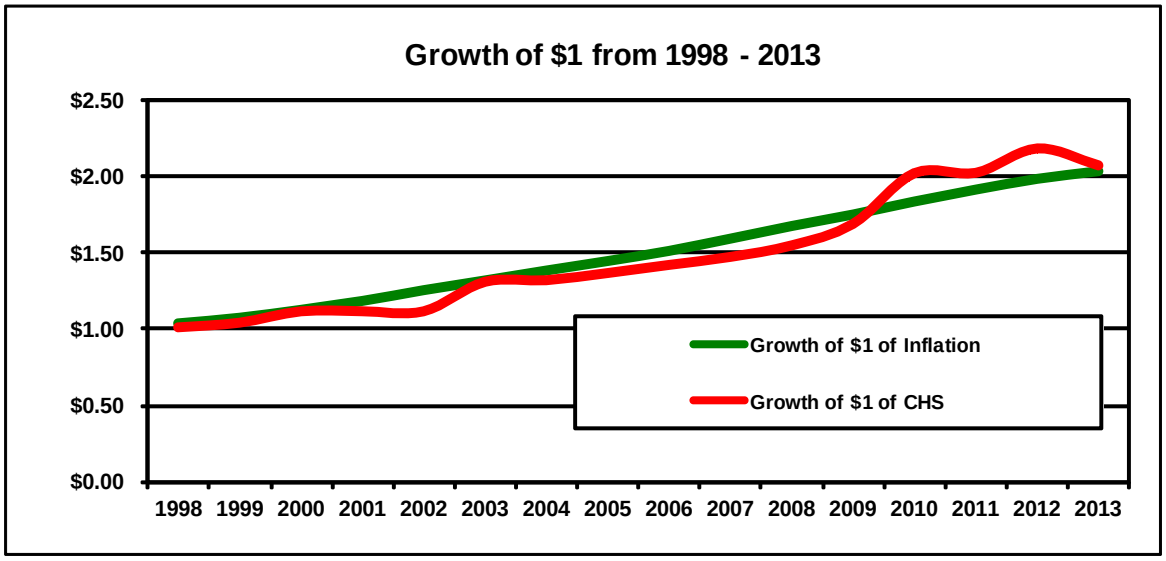
Interpretations: The collections for ambulance services increased by $212,653 or 59% in 2013. At the same time the expenses increased by $322,435 or 28%. Most of this increase was attributable to Salaries and Benefits. The average cost per transfer increased by $414 or 23%.

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	6,095,461	7.9%	3.7%
2013	5,545,485	156,873	315,168	6,019,539	2.4%	2.5%



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: Funding increases provided by the Congress in 2009, 10 and 12 addressed deficiencies in bringing the funding in line with inflation, but the sequester in 2013 stripped funding, thereby reducing the benefits realized from those increases. Funding has just kept pace with inflation but does not account for population growth over the past 15 years.

Purchased/Referred Care - 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	1,828,048	1,115,067	440,908	38,592	2,483	5,915	10,093	3,441,106	
2008	1,729,514	1,487,726	507,249	52,544	3,424	17,373	82,811	3,880,641	
2009	2,030,516	1,915,341	789,554	90,704	5,611	18,620	102,421	4,952,767	
2010	2,214,036	1,976,500	778,472	72,569	7,154	25,384	118,159	5,192,274	
2011	1,863,629	2,003,106	794,683	170,874	12,486	34,497	144,001	5,023,276	
2012	2,009,308	2,060,490	750,315	179,203	11,100	21,908	181,960	5,214,284	*
2013	1,786,179	1,909,078	817,277	158,596	14,592	32,833	109,366	4,827,921	*

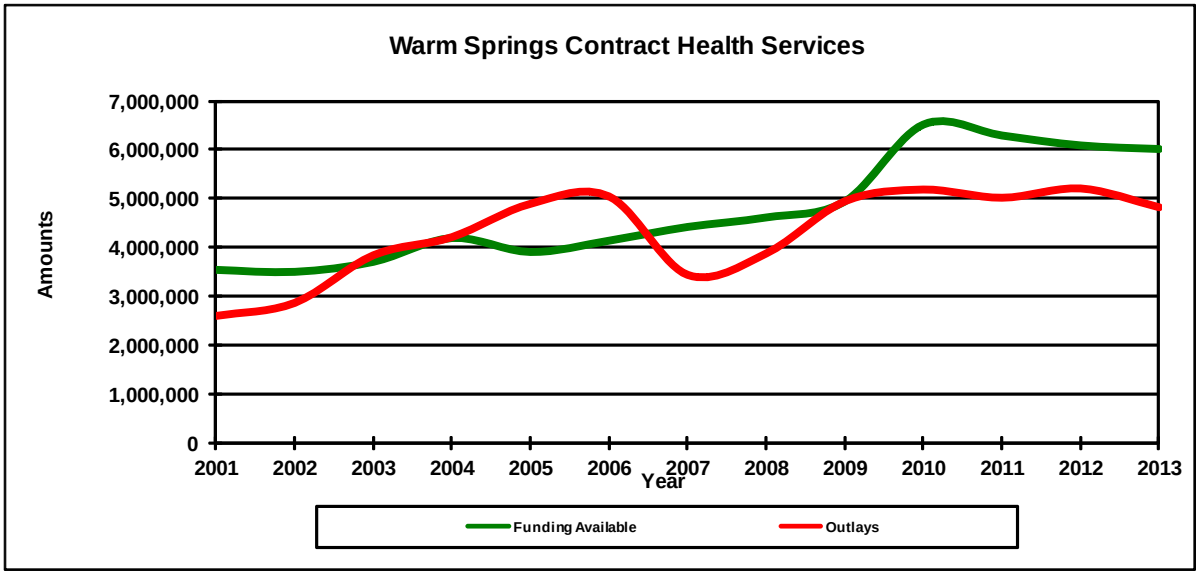


Figure 4-8

* There are Obligations for Services that have not been finalized. Final payment amounts will vary.
* There is an additional $107,396 Obligated, but not yet paid for 2012.
* There is an additional $548,780 Obligated, but not yet paid for 2013.

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 thirteen years. Even with the implementation of Priority I's in July 2005, costs appeared to peak in 2006. The implementation of the Medicare-Like Rates in July 2007 has 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 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 %5,214,284 in 2012. However, with $584,780 Obligated but not yet Paid for 2013, the final costs may exceed those of 2012.

Purchased/Referred Care – 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.

	2012			2013		
	Units	Total Cost	Cost per Unit	Units	Total Cost	Cost per Unit
Hospital Days	854	$2,000,609	$ 2,343	667	$1,786,179	$ 2,678
Emergency Room Visits	1,097	$738,466	$ 673	1,146	$817,277	$ 713

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 22% decrease in Hospital Days from 2012 to 2013, there was a 14% increase in Hospital Cost per Unit for this same period of time.

There was a 4% increase in Emergency Room Visits from 2012 to 2013, and a 6% increase in Emergency Room Cost per Unit.

While the data in the table indicates the Cost per Unit for Hospital Days in 2013 was $2,678, more detailed information is found in Figure 2-16 for each of the three 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.

Priorities*	Cases Deferred	Estimated Cost
Priority 1	0	-
Priority 2	0	-
Priority 3	1,800	250,000.00
Priority 4	0	-
	1,800	**$ 250,000.00**

***** Definitions of Priorities is below. *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 & 2013, 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 dentals and partials. MCP will cover dentures and partials automatically for an elder, but per approval through the MCP Review Team, MCP will cover a patient in any age group 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 dentist that specializes in mini posts to secure their dentures; d) "spacers" for children's teeth cared for by Dr. Mendoza; e) an anomaly that could possibly be a cancerous situation will be sent out to an Oral Surgeon for complete evaluation. 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 SCMC-Bend.

The approximate cost for dental services that are deferred is about $150,000. There were an estimated 300 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. This "bridge" will ease the high cost for the patient who may not be able to pay for that medication themselves, but are in critical need of that medication. Some of those medications have cost as much as $9,000 for one month.

The approximate cost for pharmacy that is deferred is $100,000. There were an estimated 1500 scripts @ 125 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, and both are higher than last year due to the increase in population and need, as well as a decrease in drugs in IHS formulary.

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
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	1,444,760	30	25,000	694,760	100,707	172,839	273,546	421,214
2013	971,425	25	25,000	346,425	149,087	0	149,087	197,338
Totals	**$ 11,712,042**	**216**		**$ 6,332,742**	**$ 2,767,891**	**$ 1,570,070**	**$ 4,337,961**	**$1,994,781**

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 8 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 2012 as an example, 30 CHEF cases resulted in $694,760 due to CTWS MCP; $100,707 was reimbursed in 2012, and $172,839 was reimbursed in 2013.

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 2004-2013, there was a total of 216 cases qualifying for CHEF reimbursements of $6,332,742. Total reimbursement of $4,337,961 was received from IHS, leaving a shortfall of $2 million to be absorbed by the Managed Care Program in addition to the $5,379,300 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.

	2010	2011	2012	2013
Mountain View Hospital (MVH)				
Inpatient	1,215,681	1,060,954	942,724	542,778
Outpatient	873,079	1,163,798	1,109,233	1,019,541
Mixed	83,972	145,678	57,508	35,705
Total	**$2,172,732**	**$2,370,430**	**$2,109,465**	**$1,598,024**
Other Critical Access Hospitals				
Inpatient	13,647	10,511	15,482	14,916
Outpatient	2,672	5,299	14,651	28,930
Mixed	849	0	0	0
Total	**$17,168**	**$15,810**	**$30,133**	**$43,846**
Hospitals that Bill on DRG Rates				
Inpatient	1,877,149	1,898,748	1,534,274	1,761,944
Outpatient	404,065	395,179	440,190	473,532
Mixed	32,458	29,551	22,312	13,108
Total	**$2,313,672**	**$2,323,478**	**$1,996,776**	**$2,248,584**
TOTAL MLR SAVINGS	**$4,503,572**	**$4,709,718**	**$4,136,374**	**$3,890,454**

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 6 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 $17.2 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 by $245,920 (6%) from $4,136,374 (2012) to $3,890,454 (2013). The MLR inpatient savings at St. Charles-Madras (Critical Access Hospital reimbursement) decreased by $399,946 (42%) from $942,724 in 2012 to $542,778 in 2013. The MLR inpatient savings at the hospitals that are reimbursed on Diagnostic Related Group Rates (St. Charles Bend/Redmond) increased by $227,670 (15%) from $1,534,274 in 2012 to $1,534,274 in 2013.

The $3,890,454 Total MLR Savings in 2013 is extremely positive for the reasons mentioned above. However, this one year drop from 2012-2013 of 6% ($245,920) follows the previous year's drop of 12% ($573,344), and 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	2010	2011	2012	2013
Grant Amount				
Diabetes Grant (Tribe)	$ 193,268	$ 193,268	$ 193,268	$ 510,846
State Women, Infants, and Children (WIC)	80,586	84,578	78,355	79,391
Woman's Wellness Conference				
CHET Dental Project				
Senior Fitness Enhancement				
Tobacco Pilot Site				
State Tobacco Prevention	90,057	74,262	73,821	73,821
USDA Commodity Warehouse	58,358	79,136	39,918	79,636
State Alcohol & Drug		230,000	125,000	
State Alcohol Prevention		105,000		62,500
State Mental Health		278,366	381,733	362,466
State Youth Suicide Prevention	26,000		26,000	
Influenza Pandemic				
Vocational Rehablilitation	411,200	328,458	232,742	
Meth Prevention Project		140,032		
Total	**$ 859,469**	**$ 1,513,100**	**$ 1,150,837**	**$ 1,168,660**
Grant Expenditures				
Diabetes Grant (Tribe)	$ 35,024	$ 96,192	$ 129,719	$ 83,549
State Women, Infants, and Children (WIC)	25,051	70,962	84,061	23,200
Woman's Wellness Conference Grant				
CHET Dental Project Grant				
Senior Fitness Enhancement Grant		3,278		
Tobacco Pilot Site Grant	26,197			
State Tobacco Prevention Grant		78,464	54,516	24,746
USDA Commodity Warehouse Grant	21,087	82,019	71,905	17,440
State Alcohol & Drug Grant	130,864	188,479	172,187	
State Alcohol Prevention Grant	37,797	111,478	79,897	-
State Mental Health Grant	100,446	234,837	144,006	80
State Youth Suicide Prevention Grant	11,310		25,094	
Influenza Pandemic	11,509	12,548	3,219	
Vocational Rehabilitation Grant	306,586	380,723	266,919	
Meth Prevention Project Grant	15,253		13,813	
Total	**$ 721,124**	**$ 1,258,980**	**$ 1,045,336**	**$ 149,015**

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			2013 FTE			2013 Enrolled TM		
	Tribal	**IHS**	**Total**	**Tribal**	**IHS**	**Total**	**Tribal**	**IHS**	**Total**
Clinical Services									
Medical		26.0	**26.0**		22.0	**22.0**		5.0	**5.0**
Dental		15.0	**15.0**		10.0	**10.0**		6.0	**6.0**
Optometry		2.0	**2.0**		2.0	**2.0**		1	**1.0**
Pharmacy		6.0	**6.0**		6.0	**6.0**		0.0	**0.0**
Medical Records		9.0	**9.0**		5.0	**5.0**		1.0	**1.0**
Medical Lab		4.0	**4.0**		4.0	**4.0**		0.0	**0.0**
X-Ray		3.0	**3.0**		1.0	**1.0**		0.0	**0.0**
Diabetes - Clinic		4.0	**4.0**		4.0	**4.0**		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		**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**		7.0	**7.0**		5.0	**5.0**
Personnel		2.0	**2.0**		0.0	**0.0**		0.0	**0.0**
Procurement		1.0	**1.0**		2.0	**2.0**		0.0	**0.0**
Business Office		6.0	**6.0**		7.0	**7.0**		7.0	**7.0**
Data Systems					3.0	**3.0**		1.0	**1.0**
Transportation				1.0			1.0		**1.0**
Quality Assurance					1.0	**1.0**		0.0	**0.0**
Registration					2.0	**2.0**		1.0	**1.0**
Other									
Managed Care	8.5		**8.5**	7.0		**7.0**	5.0		**5.0**
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**	**76.0**	**168.0**	**60.0**	**28.0**	**88.0**

Figure 4-14

Staffing, Continued

Interpretation: This table reflects the staffing changes that have occurred over the thirteen year period (2000-2013). Tribally operated programs have increased staffing by 30% (64 in 2000 vs 92 in 2013). Some of that increase was due to increased 638 contracting. IHS staffing decreased dramatically in 2013 when compared to 2010 by 37%. This was due to staffing shortages in Medical and Dental as well as the Tribe contracting three IHS Programs. Combining both health programs the overall staff count is the same over that thirteen 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 168 total positions (52%). 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
16 New Heat Pumps w/ 9 Flow Valves	HWC	$ 62,929	2013	2/22/2013
Mobile Medical Unit Shelter	HWC	$ 43,492	2013	4/4/2013
Vinyl Project	HWC	$ 62,864	2013	5/9/2013

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
Generator	8,537	Facilities	Mar-13	3/1/2013
Digital Camera	5,000	Medical	Feb-13	2/1/2013
Ultrasound Unit	24,389	Medical	Apr-13	4/1/2013
Tape Library 2	27,202	IT	Sep-13	9/1/2013
Array System	11,363	IT	Sep-13	9/1/2013
Servers Computer 2	11,336	IT	Sep-13	9/1/2013
Switch Network 2	74,376	IT	Sep-13	9/1/2013

* 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.

	2010	2011	2012	2013
Tribe - Self Determination Contract				
Program Savings and Carryover				
Community Health	1,047,895	1,095,354	1,414,810	610,642
Community Counseling	1,395,902	1,306,703	1,265,756	1,618,168
Managed Care	3,575,143	4,976,885	5,576,844	4,997,555
Ambulance	12,131	9,486	-	-
Facilities Operations	516,868	309,752	303,995	-
Environmental Health	120,212	199,057	269,833	300,492
Indirect Contract Support Costs	2,411,497	3,096,251	3,611,566	3,426,341
Reserves				
M & I Reserve Wellness Center	724,951	900,391	789,779	749,267
M & I Reserve Community Counseling	341,859	344,883	236,294	146,494
Equipment Replacement	104,089	108,029	6,189	2,090
Projects				
Joint Venture - Clinic Remodel	338,225	226,578	-	
Other JV Projects	91,555	282,491	66,424	
Total - Tribal	**10,680,326**	**12,855,860**	**13,541,490**	**11,851,049**
Indian Health Service				
Medicare/Medicaid	1,993,250	2,940,379	1,964,000	576,802
Private Insurance	357,053	331,789	101,000	182,884
FSA & M&I	214,432	254,037	340,000	272,723
Equipment	38,849	97,712	30,000	30,425
Total - Indian Health Service	**2,603,584**	**3,623,917**	**2,435,000**	**1,062,834**
Grants				
Diabetes-competitive grant	397,100		485,145	193,268
Diabetes-competitive grant - prior years	397,100		114,000	317,578
Diabetes Grant - Clinical (IHS operation)	162,606	165,390	-	455,596
Suicide Prevention	-		293,811	-
Meth/Suicide	126,571		3	126,571
Diabetes-Noncompetitive grant	-		62,054	-
Domestic Violence	-		-	38,697
Red Talon HIV/AIDS			15,000	
Total - Grant	**1,083,377**	**165,390**	**970,013**	**1,131,710**
Grand Total	**14,367,287**	**16,645,167**	**16,946,503**	**14,045,593**

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.