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

February 9, 2016

2015 Edition
Reporting Information through 2014

2015 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 2014 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 Commission is responsible under the plan…"to adopt coordinated health program priorities, strategies and action plans each year, and monitor their progress". Initial efforts have focused on addressing program deliverables, including reporting, as well as those reported herein. To guide priorities, the Commission has adopted a strategic wellness and prevention approach aimed at the following outcomes.

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

This report indicates that the community faces significant health challenges. Overall, members suffer at great deal from chronic disease and accidents, with a high number of deaths attributable to chronic liver disease and cirrhosis, diabetes and accidents. 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. While high relative to other populations, premature deaths, infant mortality and childhood deaths have decreased significantly. Diabetes which has been a long standing problem has shown some improvement in recent years with fewer individuals diagnosed and those afflicted have better blood sugar control. Recent studies put Warm Springs children at an unacceptable level of adverse risk factors. High levels of risk factors are observed throughout the community, but personal choices underlie the cause of many illnesses and injuries. Reducing risks and charting a path to better health must be a very high priority for the health system and the community (refer to Section 2 – Customers)

Efforts to address accessibility to the health system have been a major theme in recent years. Extended hours and community outreach through the community health programs have been in place for several years. In 2014 the system initiated a mobile clinic to serve outlying areas. Indications are that it has been well received. Clinic physicians no longer see patients at the hospital, which increases their availability at the health center. Efforts are underway to improve mental health and substance programs, as well as health education. These programs play a vital role in addressing identified health risks to the community. Efforts to improve the maternal and child health picture in the community have resulted in higher immunization rates, lower teen pregnancy rates and the development of “baby college”, an educational program to prepare young parents to provide a safe and healthy environment toward a solid start for our most vulnerable members of the community (refer to Section 3 – Services).

Resources available through federal appropriations to the Indian Health Service (IHS) have trended upward. The national deficit is expected to limit increases in the coming years and the system will rely more on alternate resources from Medicare, Medicaid and Insurance, as well as grants for maintenance and growth. Emphasis placed on billing is timely as access to alternate resources under the Affordable Care Act has improved dramatically. The Tribal programs are expected to consolidate all billing related functions to improve collection capabilities in 2015. The Purchased & Referred Care Program has been positively impacted by the additional alternate resource availability leading to savings that can improve care and reserve resources towards higher cost years in the future, while maintaining the current priority levels (refer to Section 4 – Resources).

The IHS 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 (refer to Section 5 – Evaluation).

The Commission anticipates the ability to report cost vs. value of services. Information on most recent years has not been made available. 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 increased information that is now being maintained and reported. Efforts are underway to continually improve the ability to collect, maintain and utilize information to guide management of the system and the future development of health priorities, strategies and action plans to address community needs.

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). Purchased/Referred Care 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 of Warm Springs, and in part by the Indian Health Service (IHS). 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 IHS 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 United States (US) 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 IHS, 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 subsequent 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.

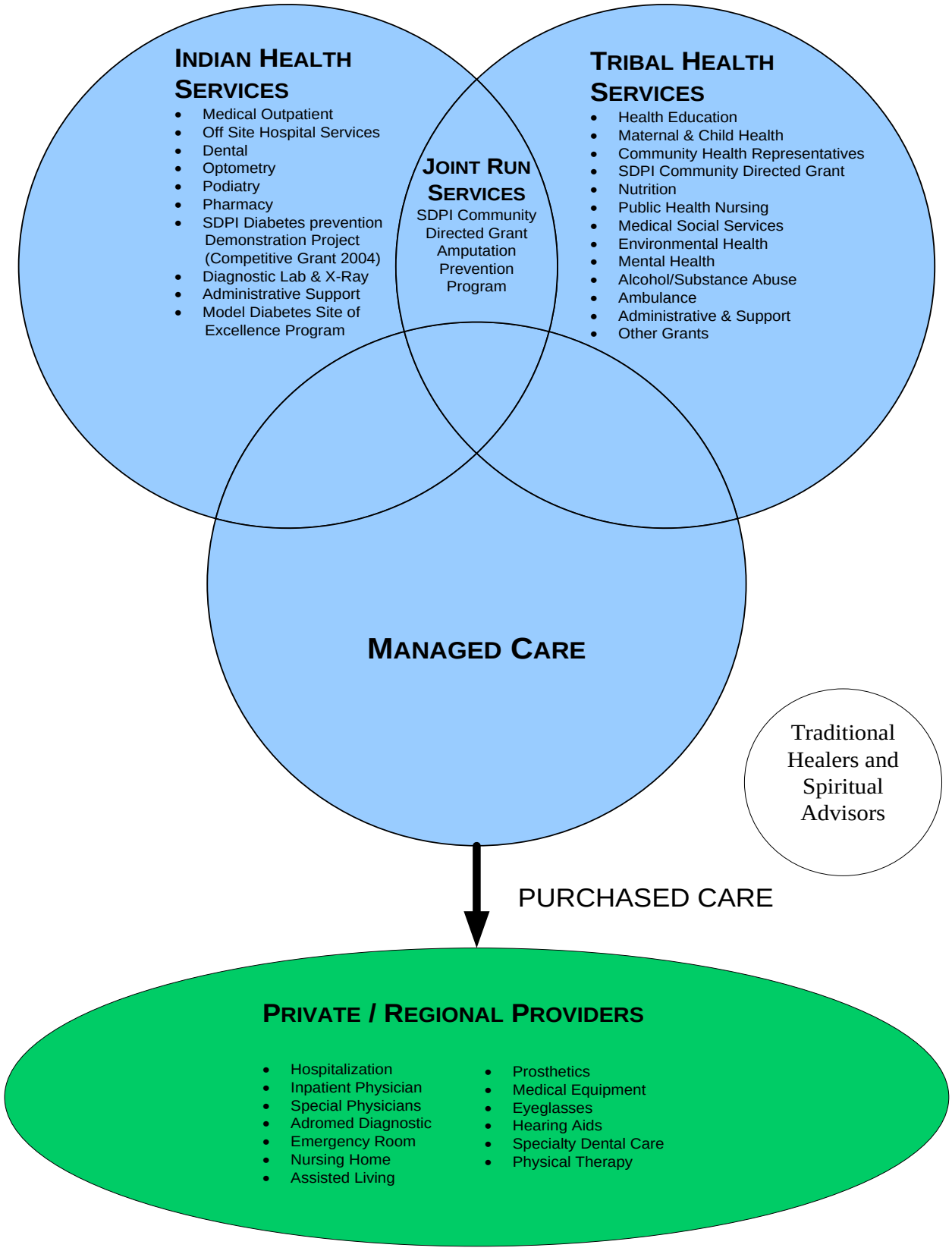
Throughout the years, the Tribe has contracted various portions of the IHS financed community health programs, mental health and alcohol and substance abuse programs, completing that transition in 2008. The Tribe has also appropriated tribal resources and sought and received grants to enhance the health 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, reporting and data.

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.

One of the most positive trends affecting the customers of service is the availability of Alternate Resources (Figure 2-5). From 2012-2014 the number of patients with Alternate Resources have increased by 27%. The increase in billable services had a major impact on reducing the expenditures of the Purchased/Referred Care Program which is operated by the Tribe through a Contract with IHS.

The Vital Statistics of the Tribal Members have improved dramatically over the last few years. Years of Productive Life Lost (YPLL, which is a measure of premature deaths) is the lowest ever recorded at Warm Springs. The number for the latest three year period (2012-2014) was nearly half of the experience recorded in the prior three year period (2009-2011) (Figure 2-9). Corresponding infant mortality and early childhood deaths have decreased significantly (Figure 2-10).

Leading causes of death in the three year period (Figure 2-11) were Cirrhosis, Accidents and Diabetes. These were the same leading causes in the previous three years. Each of these conditions is amenable to prevention efforts, but the individual is ultimately responsible for necessary behavior modification.

Teen pregnancies have averaged 20 per year from 1996-2011. Over the latest period (2012-2014) these high-risk pregnancies substantially declined to an average of 8 per year (Figure 2-6).

Recent student wellness surveys indicate that children of the Warm Springs community have lived with an unacceptable level of adverse risk factors. A community wide effort is needed to reverse this dangerous trend. Multidisciplinary teams, including the health system are working on this issue.

The number of patients listed on the Diabetes Register has declined from a high of 460 in 2012 to 402 in 2014. Also the patients with controlled blood sugar have improved to 70.9% from 54% in 2012. This is a very positive trend that has a major impact on the future health status of the population (Figure 2-4). The number of dialysis patients is still on the rise and has gone from 12 patients in 2011 to 19 patients in 2014.

Although our overall hospitalization admissions remained fairly stable (342 vs. 349) over the last two years, the number of hospital days decreased by 5%. Over 33% of our admissions and 22% of our hospital days were for Obstetrics (Figure 2-15). There were 87 births in 2014, 70 of which were Tribal Members.

There is no recent available data on the health risk factors of the community (Figure 2-19). Another Behavioral Risk Factor Survey is needed to make comparisons to the study done ten years ago. It is suspected that the community is making good progress with many high risk factors. A follow-up study would help determine the effectiveness of the health promotion effort and identify areas that need additional emphasis.

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
2014	278	6595	5737

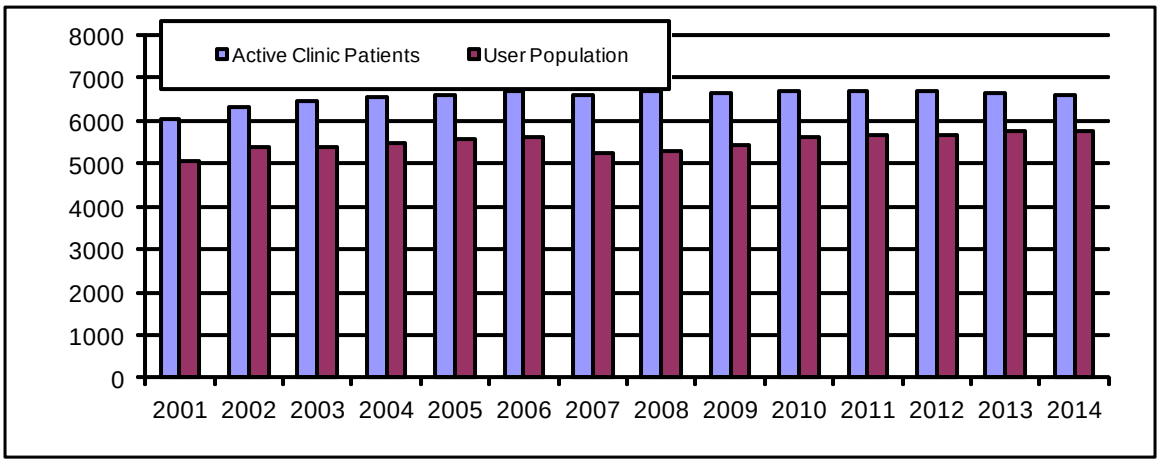


Figure 2-1

Customers That Use the Services, Continued

Interpretation: Between 2001 and 2014, new patient registrations have decreased by approximately 33%. During that timeframe, new patient registrations peaked in 2002 at 471, an increase of 54 patients from the previous year. In 2014, new patient registrations decreased to their lowest point 278 registrations. In that fourteen-year time span, the user population has increased from 5,057 to 5,737 (13%) and the population of active clinic patients has increased by 9%. The user population and active clinic population have followed the same trends over time averaging a change within 1% in either direction. New patient registrations in 2007 had the most significant value change with 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	2011	2012	2013	2014	Chg(13-14)
Warm Springs Indian Reservation	3,690	3,536	3,630	3,679	49
Madras/Redmond/Bend	1,190	1,266	1,263	1,234	(29)
Maupin/The Dalles/Hood River	85	93	85	77	(8)
Portland/Salem	94	104	110	84	(26)
Other Oregon	440	427	443	428	(15)
Outside Oregon	181	200	185	195	10
TOTAL	**5,680**	**5,626**	**5,716**	**5,697**	(19)

By Tribal Affiliation	2011	2012	2013	2014	Chg(13-14)
Warm Springs Member	3,990	3,955	4,048	4,038	(10)
Other Oregon Tribes	219	218	225	219	(6)
All Other Tribes	1,377	1,364	1,350	1,352	2
Non-Indians	94	89	93	88	(5)
TOTAL	**5,680**	**5,626**	**5,716**	**5,697**	(19)

Figure 2-2

Interpretation: Trends have remained stable from 2011 to 2014 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:

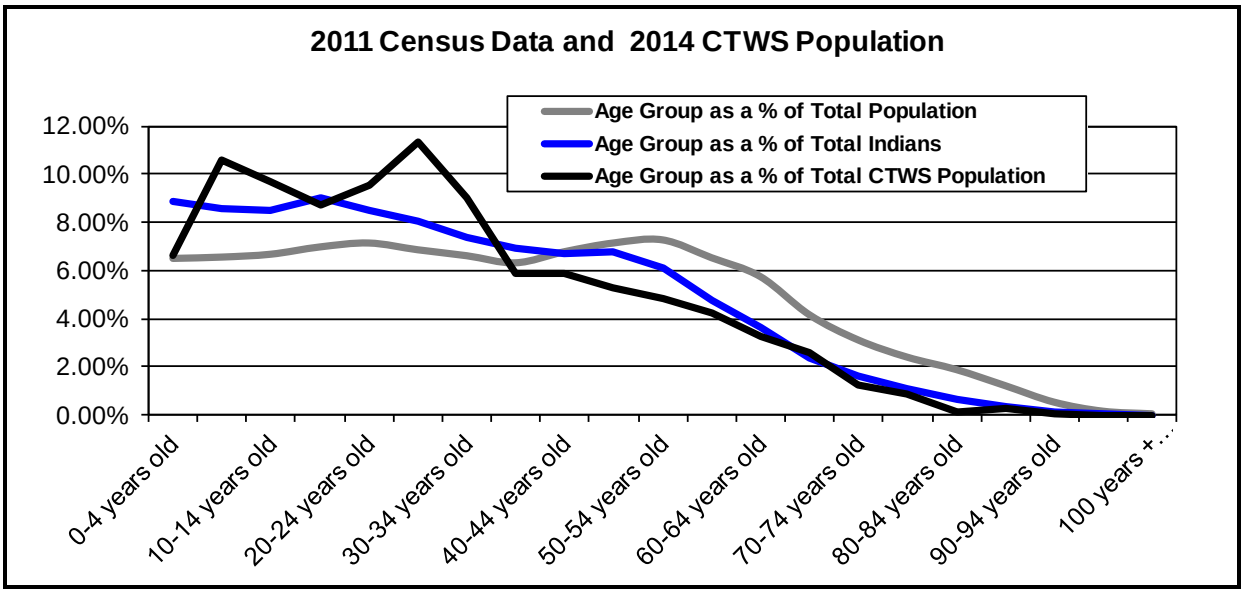
- 2011 – 70.25% Warm Springs Tribal Members; 64.96% residing on Reservation.
- 2012 – 70.3% Warm Springs Tribal Members; 62.7% residing on Reservation.
- 2013 – 70.82% Warm Springs Tribal Members; 63.51% residing on Reservation.
- 2014 – 70.88% Warm Springs Tribal Members; 64.58% residing on Reservation.

In the years, 2013 and 2014, there was a small increase in patients who are Warm Springs Tribal Members over the 2011 and 2012 patient counts. There was a slight decrease in patients who are members of Other Oregon Tribes or who have no tribal affiliation. Patients that are members of All Other Tribes seen an increase of 2. Between 2011 and 2014, there was a decrease of approximately 1% of patients who reside on the Warm Springs Indian Reservation. As of 2014, 86% 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

Purpose: The relationship exists between the IHS and the Confederated Tribes of Warm Springs (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.

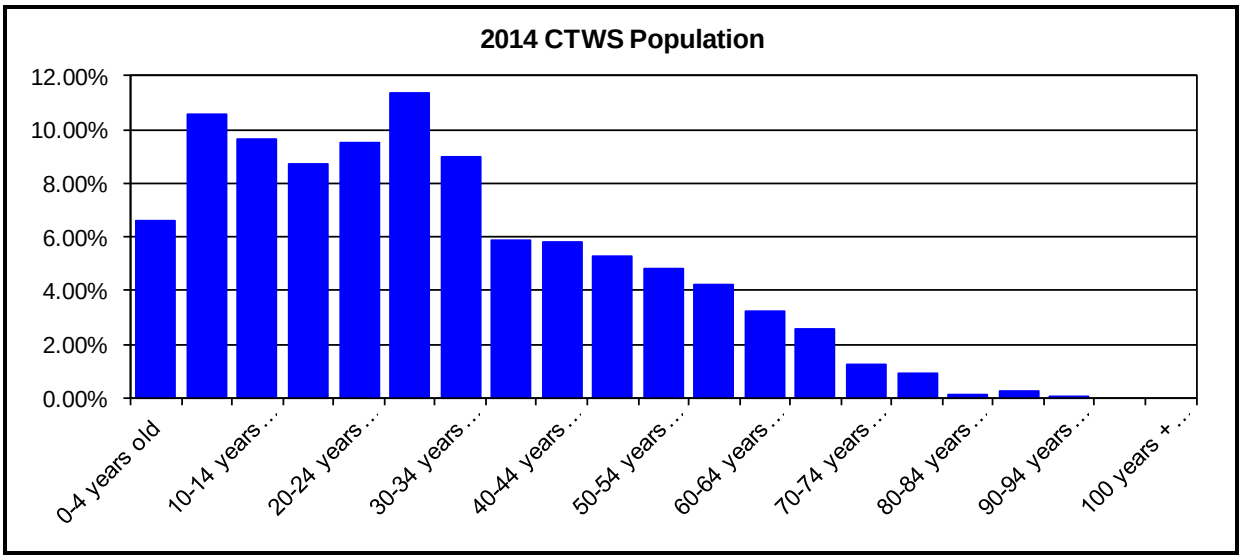


Figure 2-3

Age of Enrolled Members of the Confederated Tribes of Warm Springs, 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 US 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	2011 Patients	2012 Patients	2013 Patients	2014 Patients
0-4	543	677	699	588	618
5-9	460	551	545	532	562
10-19	1,367	1,094	968	984	981
20-29	971	1,077	1,082	1,025	963
30-39	912	719	725	700	714
40-49	738	693	699	659	643
50-59	440	615	633	615	579
60-69	204	397	449	424	441
70-79	98	168	180	166	180
80+	40	62	62	63	57
TOTAL, Patients	**5,773**	**6,053**	**6,042**	**5,756**	**5,738**

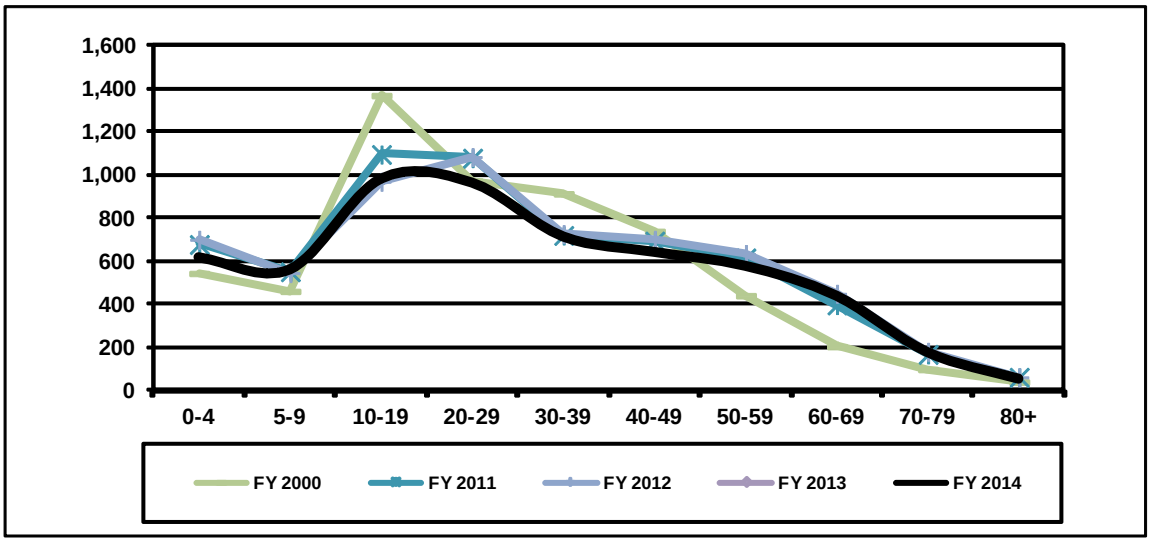


Figure 2-4

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 2011	FY 2012	FY 2013	FY 2014
Medicaid Only	1,181	1,455	1,637	2,264
Private Insurance Only	1,269	1,263	1,313	1,109
Medicare A Only	28	33	29	29
Medicare B Only	-	-	-	-
Medicare Part A & B Only	139	138	126	142
Medicare Part D	189	200	217	230
Medicaid & Medicare	30	35	28	35
Medicaid & Private Ins.	842	736	663	1,119
Medicare & Private Ins.	141	142	159	150
Medicaid, Medicare, & PI	10	6	7	7
Total	3,829	4,008	4,179	5,085
Non-Billable				
Tribal Employee Self-Insurance	278	224	52	67
No Alternate Resource	2,492	2,276	2,277	1,926
Total	2,770	2,500	2,329	1,993
Total Patients	**6,599**	**6,508**	**6,508**	**7,078**

Figure 2-5

Interpretation: Over the past four years the number of patients with billable alternate resources has increased by 33%. Those with Tribal insurance (non-billable) have seen a significant drop of 76% since 2011. Those with no alternate resources have decreased by 23%. 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
2014	0	8	29	30	14	6	87
Total	**0**	**203**	**346**	**261**	**146**	**70**	**1026**
% of Total	**0.0%**	**19.8%**	**33.7%**	**25.4%**	**14.2%**	**6.8%**	**100.0%**

Figure 2-6

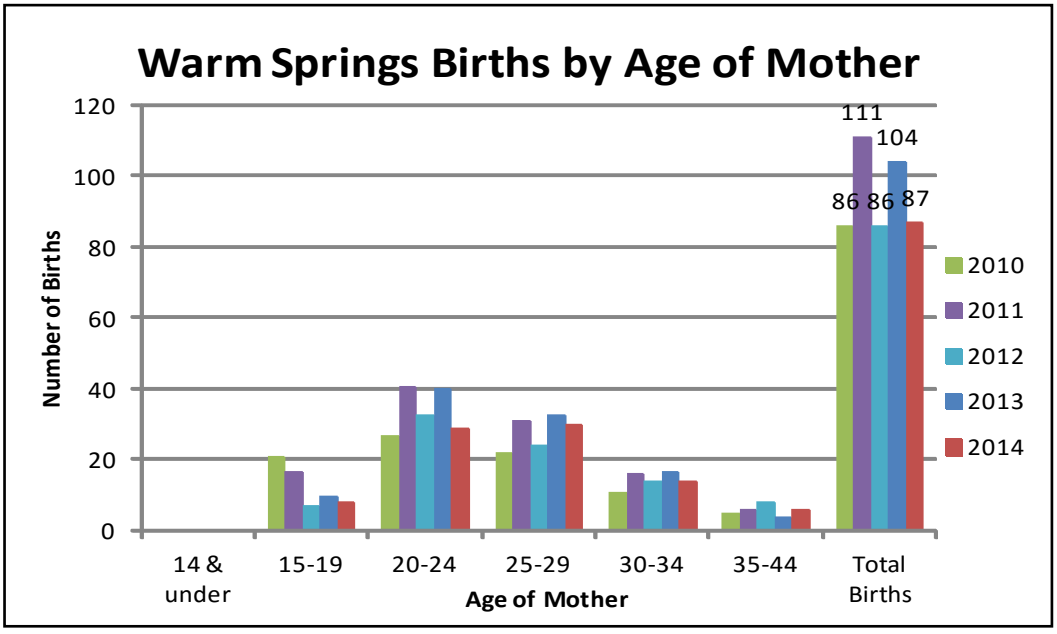


Figure 2-7

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 age range has continued to trend downward. There were 85 deliveries with two sets of twins for a total of 87 births.

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.

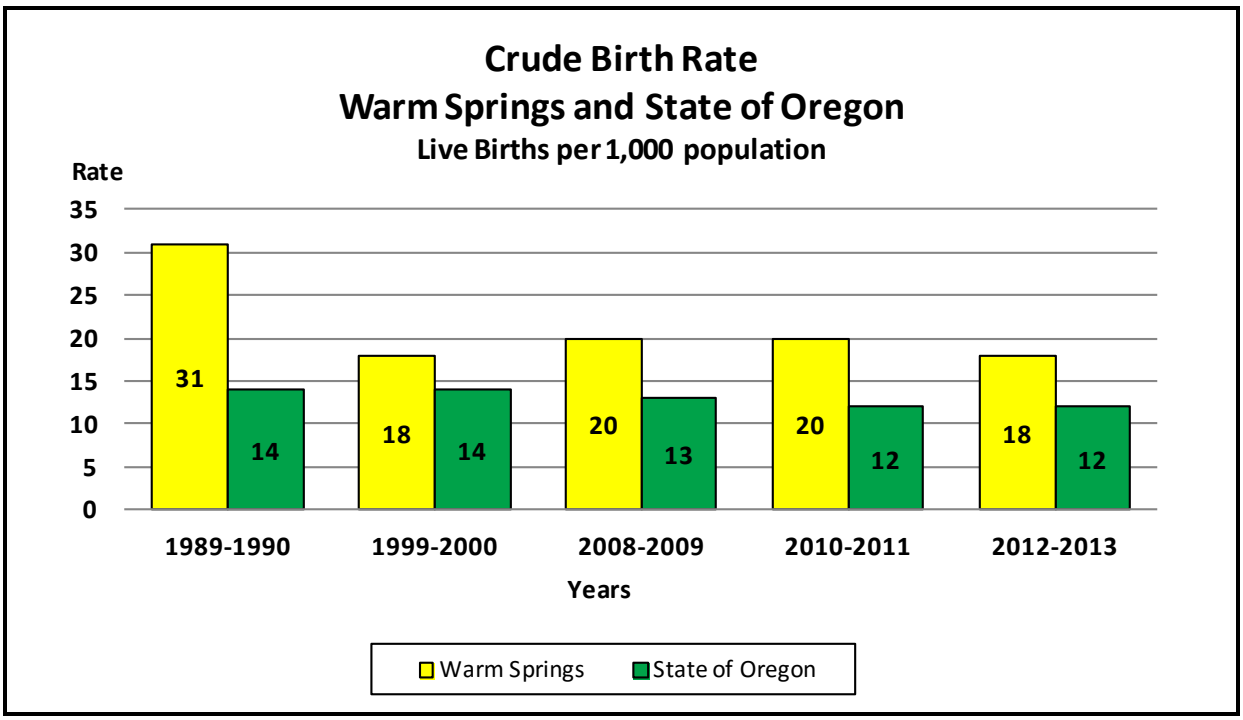


Figure 2-8

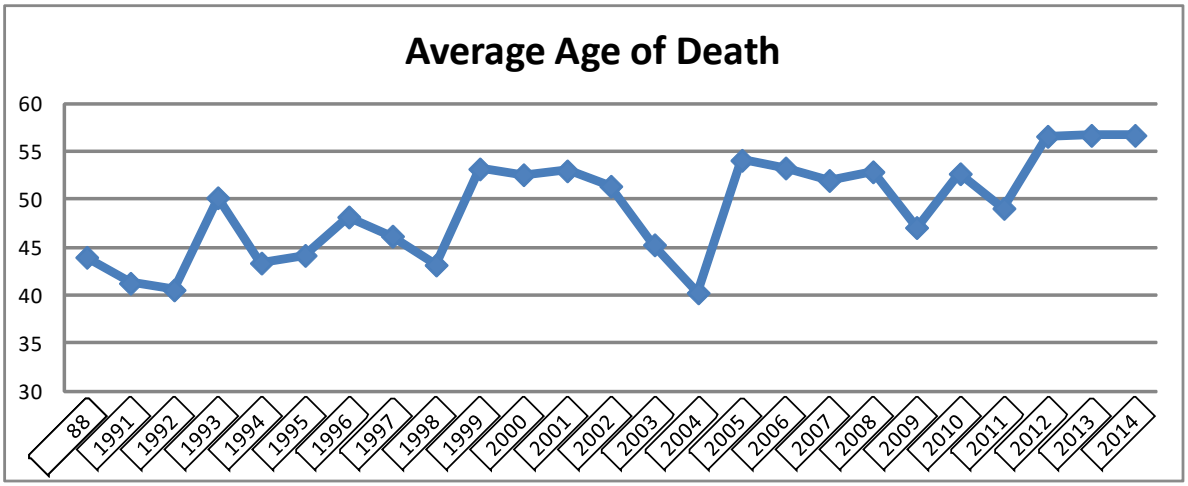
Interpretation: Past reports reflected a substantially higher birth rate in Warm Springs than the general Oregon population. The difference reduced by the 2000 report but has remained fairly consistent since then with a slight decrease noted in 2012.

The statistics for the 2014 Birth Rate Comparison will be finalized through the State of Oregon Vital Statistics Department in August 2015 and will be reflected in the next annual report.

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

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

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



Crude Death Rates, Years of Productive Life Lost

	1994-1996	1997-1999	2000-2002	2003-2005	2006-2008	2009-2011	2012-2014
Number of Deaths	83	84	111	103	121	155	117
Crude Death Rate	502	482	608	524	605	774	587
Years of Productive Life Lost	1,889	1,877	1,794	2,141	1,906	2,898	1,594

Figure 2-9

Interpretation: This report reflects a significant loss of life at earlier ages than is reflected in the general US population, where the average life expectancy was 78.7 in 2011. In 2013-2014, crude death rates remain lower than in the US, but 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
2013-2014	2	9.6	1	7.5	0	0

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

Leading Cause of Death 2003-2014

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

Child Mortality Rates, Continued

Interpretation: This report reflects the changing nature of infant mortality in the past decade. In the years 1987-88, there were 4 deaths due to sudden infant death syndrome (SIDS) and 6 deaths from SIDS from 1991-2007. Since 2007, there have been no SIDS deaths. Despite the decline in SIDS, infant deaths have occurred from accidental death and birth defects. From 2008 to 2011 there were 4 deaths from positional asphyxia due to incorrect cradle board use. With community education this trend is reversing with no deaths from this since 2011.

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

Cause of Death

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

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

The Five Principal Causes of Death
(Warm Springs 2014 , IHS 2012-2014, US 2013)

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

*Tied

Trends in the Leading Causes of Death (3-yr average), Warm Springs, 1994-2014

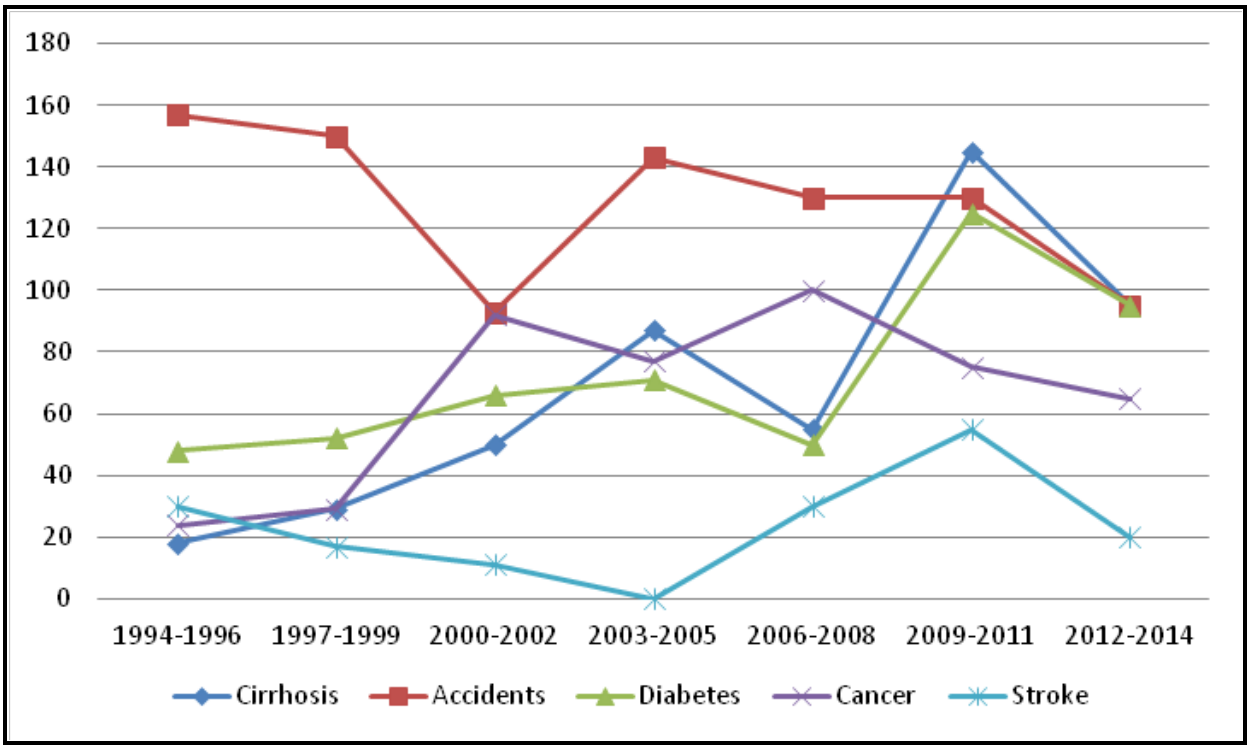


Figure 2-11

Cause of Death, Continued

Interpretation: Accidental deaths had been the leading cause of death since the 1950's but over the decades, 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 and can be combated through healthier diets, increased physical activity, and 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 US. 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 2011 - 2014

Condition	FY 2011	FY 2012	FY 2013	FY 2014
Diabetes	600	605	622	627
Ischemic Heart Disease (IHD)	88	100	104	108
Hypertension 18-85 w/HTN DX	500	503	510	512
Asthma	256	286	272	276
Prediabetes/Metabolic Syndrome	970	904	881	515**
Rheumatoid Arthritis	79	81	76	78

Figure 2-12

** Prediabetes not available in CRS v15.1 so used iCare which has a slightly different logic

Interpretation: Diabetes, Ischemic Heart Disease, Hypertension, Asthma and Rheumatoid Arthritis have shown a slight increase over the past year while Prediabetes continues to show 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. Community education and events have been used 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 active in the Diabetes Registry by year, along with the number of patients who maintained acceptable control of their blood glucose levels during the past year.

Relevance: Detection of diabetes and control of blood glucose levels 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 be a great impact on the health status of the patient and future health care costs of caring for patients with diabetes.

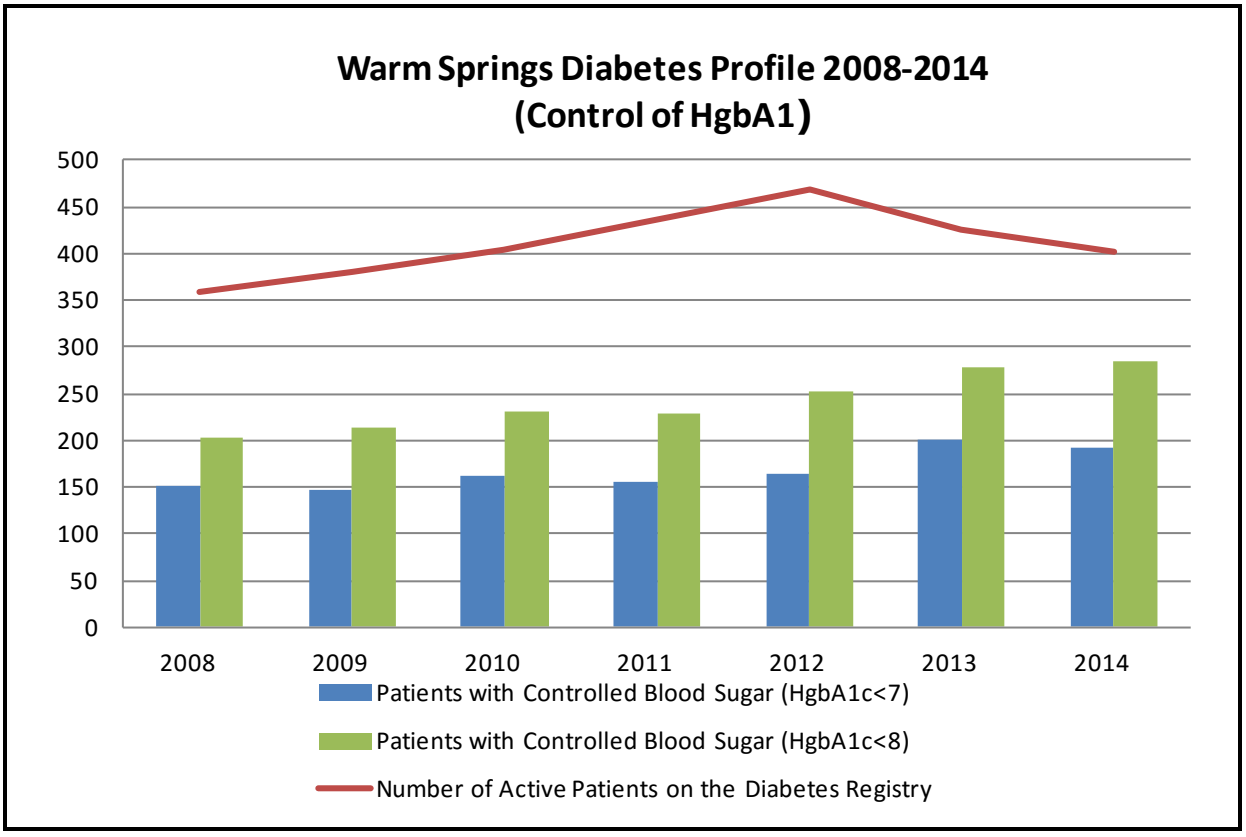


Figure 2-13

Customer Diabetes Profile, continued

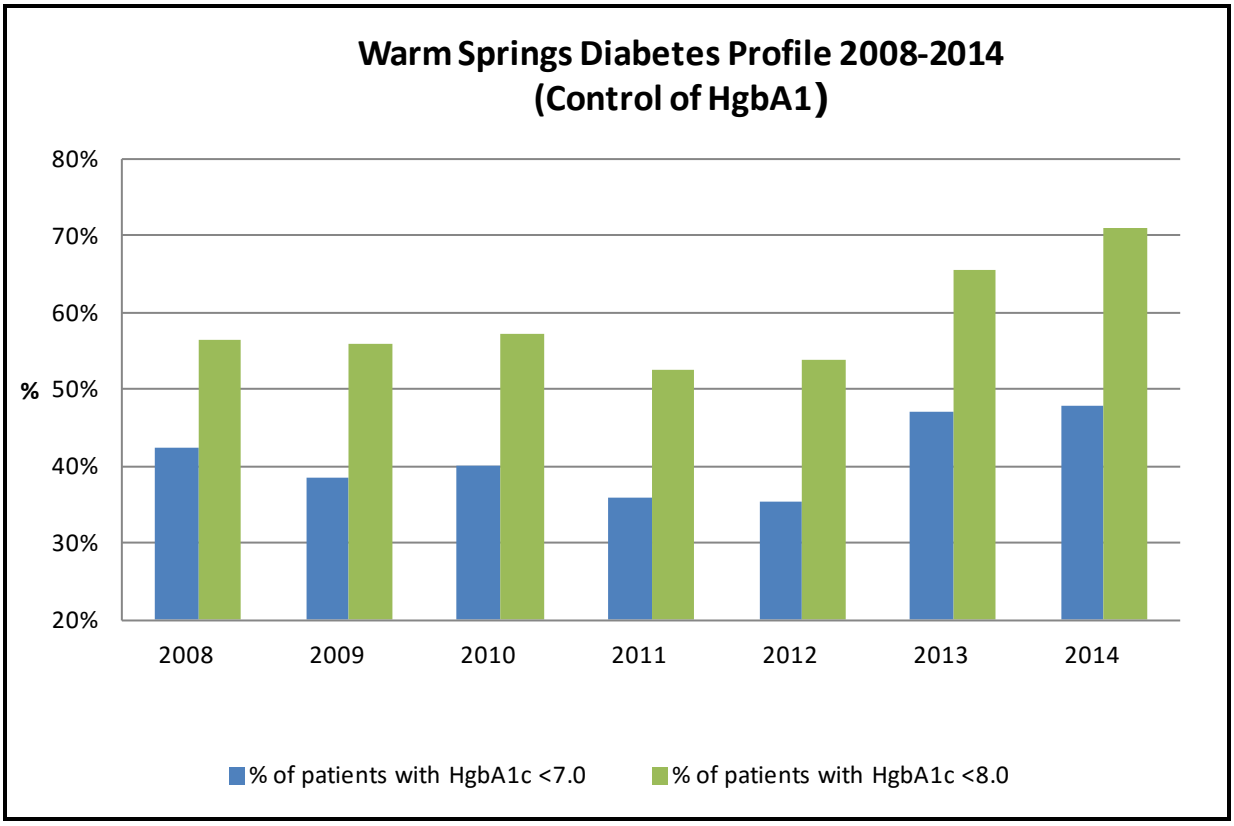


Figure 2-14

Interpretation: The number of patients in the diabetes registry decreased from 423 in 2013 to 402 in 2014. 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 outside of Warm Springs Health and Wellness Center (i.e. Veterans Affairs or private physician) are not included as active in the diabetes registry. Ideal control of HgbA1c (<7%) increased from 47.0% to 47.8% between 2013 and 2014 for active registry patients. In 2012, IHS changed the goal of good HgbA1c from <7% to <8% based on national changes in standards of care. Based upon the new standard, good HgbA1c control (<8%) improved significantly from 65.6% to 70.9% from 2013 to 2014.

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

2012 - 2014

Inpatient Indicators	2012	2013	2014
Total Admissions	220	185	118
Average Length of Stay	3.88	3.61	4.09
Total Hospital Days	854	667	483
Average Daily Patient Load	2.34	1.83	1.32
Emergency Room Visits	1,097	1,146	773

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

2014

Condition	Number of Admissions	% of Admissions	Number of Hospital Days	% of Hosptial Days
Obstetrics	115	33.6%	231	22.0%
Motor Vehicle Accidents	2	0.6%	2	0.2%
Other Accidents/Injuries	17	5.0%	97	9.2%
Cancer	7	2.0%	42	4.0%
Heart and Circulatory	24	7.0%	92	8.8%
Respiratory	40	11.7%	112	10.7%
Renal	16	4.7%	69	6.6%
Digestive	44	12.9%	115	10.9%
Infectious Disease	36	10.5%	143	13.6%
Diabetes	7	2.0%	41	3.9%
Substance Abuse	13	3.8%	40	3.8%
Mental Health	8	2.3%	14	1.3%
All Other	13	3.8%	53	5.0%
TOTALS	**342**	**100%**	**1,051**	**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 (MCP) provided payment. The second table is all inclusive covering cases that were paid by the MCP plus all other cases that were financed by other alternate resources.

The Managed Care Caseload (first table)

- The number of hospital admissions declined by 67 (36%) from the experience of the prior year.
- The Average Length of Stay declined by 0.48 (13 %) from the prior year.
- The Total number of Hospital Days declined by 184 (28%) from the previous year.
- The Total Number of Emergency Room Visits decreased by 373 (33%) from the previous year.

The above declines in hospital admissions, average length of stay and emergency room visits can all be directly attributed to the Medicaid Expansion which was effective January 1, 2014. In 2014, 66% of our total admissions were financed by the Oregon Health Plan (OHP) also known as Medicaid. This increased significantly from 47% in 2013.

Total Hospitalization Caseload regardless of payment source (second table)

The actual number of admissions for patients in 2014 regardless of payment source decreased from the prior year (342 vs. 349 or 2%). Overall hospital days decreased from 1101 to 1051 (5%). In 2014 the MCP covered 34% of hospital admissions and 46% of hospital days. This was an improvement over 2013 when the MCP covered 53% of hospital admissions and 61% of hospital days.

The total admissions and days by category help us understand which conditions are the sources of our hospitalizations. As in 2013, the number of obstetrical cases led in both total admissions (34% - 2014) and days (22% - 2014).

Hospitals Utilized and Expenditures

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

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

Hospitals Utilized
2014

Hospital	Admissions	Hospital Days	Total Cost $	Cost per Day
St. Charles-Madras	74	231	$190,112	$823.00
St. Charles-Redmond	3	10	$11,345	$1,134.50
St. Charles-Bend	33	199	$139,540	$701.21
Providence Portland	4	20	$346,313	$17,315.65
All Other	4	23	$5,860	$254.78
Totals	**118**	**483**	**$693,170**	
			Total Cost per Day	**$1,435.13**

Figure 2-16

Interpretation: This table reflects the total cost of hospitalization MCP paid for in 2014, and the number of admissions and hospital days that comprised this cost at the three major hospitals utilized. St. Charles-Madras accounts for 27% of the total hospital costs, compared to 56% last year, with St. Charles-Bend accounting for 20%, compared to 32% last year.

However, it is worth noting that costs were skewed this year by a very unique high cost oncology case treated at Providence Portland. If this outlier was subtracted, then St. Charles – Madras would have accounted for 55% (compared to 56% last year), and St. Charles – Bend would have accounted for 40% (32% last year). Both of these results are much closer to the historical average for each.

When comparing 2014 to 2013, a decrease of 67 in the number of hospital admissions financed by the MCP was noted. There was also a corresponding decrease of 184 in the number of hospital days covered by the MCP. In addition, there was a very significant decrease of $1,093,009 (61%) in overall hospital expenditures for the MCP in 2014. There was a significant 46% decrease of $1,242 in Total Cost per Day from 2013 ($2,678) to 2014 ($1,435). A substantial decrease in Medicare-Like Rate Reimbursement to St. Charles-Madras (“Critical Access Hospital”) was largely responsible for the Total Cost per Day decrease.

Hospitals Utilized and Expenditures, Continued

The Average Cost per Day for St. Charles-Madras decreased by $2,367 (74%) over 2013, while the Average Cost per Day for St. Charles-Bend decreased by $1,571 (69%).

The effective use of alternate resources decreases the MCP's expenditures on hospitalizations. For example, last year 47% of total admissions financed primarily by the OHP. Medicaid Expansion in 2014 increased this to 66%. Medicaid Expansion effective January 1, 2014, was largely responsible for the significant decreases in Costs seen above. Very significant cost savings attributable to Medicaid Expansion will be noted repeatedly in future figures in this Report.

Emergency Room Utilization

Purpose: Patient utilization of Emergency Room (ER) 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 ER Visits will provide insight as to what strategies might be employed to reduce usage.

EMERGENCY ROOM VISITS

	2009	2010	2011	2012	2013	2014
ALLERGIC REACT	7	3	11	14	10	10
CARDIOVASCULAR	67	73	53	49	80	45
CELLULITIS/INFECTIONS (impetigo)	49	67	76	78	83	47
CHRONIC CONDIT.	37	26	42	31	31	19
COMMUNICABLE DISEASE	2	5	13	12	22	4
DENTAL	15	29	19	30	23	25
DERMATOLOGY (includes spider bites)	22	16	45	19	18	10
DRUG/ALCOHOL	111	140	69	59	76	30
ENT (ear, nose, throat)	116	102	120	85	79	43
EYES	11	23	15	7	11	8
GI	121	125	129	106	134	82
GU	75	96	77	80	73	56
HEADACHES	44	50	48	35	29	14
MEDS ONLY / DRESSING CHGS	2	5	7	4	2	1
MISCELLANEOUS	78	61	32	28	46	29
NEUROLOGY	34	39	41	12	14	21
OB-GYN	14	17	17	9	22	15
ORTHOPEDIC (musculoskeletal)	199	209	169	187	201	99
PULMONARY	136	106	104	70	78	89
PSYCHIATRIC (MENTAL HEALTH)	23	24	30	20	19	10
SNAKE BITE	1	0	0	0	1	1
TRAUMA						
ASSAULT	17	36	20	22	13	3
GUNSHOTS	1	1	1	1	1	0
LACERATIONS/BURNS/CONTUSIONS/	201	217	106	131	159	90
MVA	15	12	19	22	11	4
POISONS (ingested/breathed)	2	10	4	10	10	0
SEXUAL ASSAULT	0	2	0	1	1	1
DROWNING	0	0	0	0	0	0
OTHER		2	42	18	6	1
TRIAGE ONLY	5	9	2	0	0	0
VIRAL SYNDROME	43	10	18	13	9	23
VASCULAR (blood) - anemia/hem	8	18	7	0	1	0
TOTALS	**1,441**	**1,485**	**1,297**	**1,109**	**1,239**	**773**
COST (As Of 4/2/15)	$790,176	$778,472	$794,683	$739,859	$880,062	$227,272
COST PER VISIT	$548	$524	$613	$667	$710	$294

Note: The above data is for St. Charles - Madras ER care at other hospitals is an extremely small portion of the whole. MVAs are not counted in the total, and since 2010 assaults have not been 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 12% increase from 2012-2013 of 130 ER visits. However, ER cost per visit has increased each of these three years (albeit by a smaller % increase each year), from $524 in 2010, to $613 (17%) in 2011, to $667 (9%) in 2012, to $710 (6%) in 2013.

The trend was reversed in 2014! Due primarily to Medicaid Expansion which started January 1, 2014, cost significantly decreased by $652,790 (74% decrease).

The MCP was unable to capture data for patients presenting to the ER as OHP patients. Thus, it is important to note the above totals for ER visits include some, but not all, visits for which MCP is not responsible (i.e. OHP), while the "COST" is the total amount paid by MCP for ER claims.

EMERGENCY ROOM VISITS - TIMES / DAYS

	2009	2010	2011	2012	2013	2014
0800-2000,weekdays (8:00am-8:00pm)	445	471	474	490	500	298
2000-2400, weekdays (8:00pm-midnight)	210	237	233	226	267	175
2400-0800, weekdays (midnight-8:00am)	151	169	112	60	74	31
0800-1600, sat, sun (8:00am-4:00pm)	221	182	225	136	154	82
1600-2400, fri, sat, sun (4:00pm-midnight)	311	330	185	84	130	90
2400-0800, sat, sun, mon (midn-8:00am)	103	96	68	113	114	97
TOTALS	**1,441**	**1,485**	**1,297**	**1,109**	**1,239**	**773**

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 ER services provided for what would be more appropriately cared for in an ambulatory care setting. 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 five years, with ER visits on weekdays between 0800-2000 hours ranging within a narrow margin from a low of 445 in 2009 to a high of 481 in 2012, with 2014'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 CTWS Tribal Council that the Warm Springs Community be a healthy community. The Warm Springs Health and Wellness Center (WSHWC) fully supports the Tribes' goal and we believe we can best help meet this goal by focusing on the care provided at the WSHWC 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 WSHWC has been working with the Community Health Nurses to provide health care throughout the community in the Mobile Health Clinic.
- Along with community partners, the WSHWC will review the professional staff needs and make necessary changes.
- With focus on care provided, anticipated increased access to provider appointments each day.
- The service unit will continue to work closely with the St. Charles Hospital – Madras to ensure that 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.

In an effort to improve accessibility to outpatient care, there have been a number of changes made. In October 2014 a new Mobile Clinic began service to the Community. There seems to be a good acceptance of this service but accurate utilization statistics will not be available until next year's report. Extended hours of clinic operations continue, but the associated workload has remained stubbornly low. Now that the clinic physicians no longer see patients in the hospital, it does increase their availability at the Health & Wellness Center during normal hours.

Because of a very stable population, a fairly stable workload is reported for most of the acute care services. The Medical, Dental, Pharmacy, Laboratory and X-Ray Departments have experienced very little change in workload over the past four years. On the other hand, the preventive clinical activities have grown considerably in concert with the priorities of increasing health promotion/prevention. Over the last two years Podiatry workload increased by 13%, Optometry by 50% and the Diabetes Program by 13%.

Infant immunization levels are now back over 90%. The Maternal Child and Health Program continues to follow all pregnancies, particularly the high-risk group. Of the 87 deliveries, 65% were considered moderate or high risk.

The health system initiated a new program referred to as "Baby College" which is an educational program to assist new mothers to support healthy child development.

Mental Health and Alcohol Services had disappointing results in 2014. There is obviously a mismatch between the extent of the problems and the level of service utilized. Is this a demand problem, an accessibility problem, a staffing problem or a data problem? There is an awareness the data must be improved to better understand the problem (Figure 3-17, Figure 3-18).

The Family Preservation Program, established in 2014 provided services to 146 children, 137 of which avoided protective care and were able to continue living in their home, with supportive measures.

Purchased/Referred Care had a fantastic year in 2014, attributable to an increase in availability of Alternate Resources. There was a significant decrease in expenditures and as a result an impressive increase in savings over that period of time. The Affordable Care Act together with the application of Medicare Like Rates and a very vigilant management have all contributed to this very positive development. Purchased/Referred Care financed hospital admissions declined by 36% from 2013-2014. The average length of stay was 13% less than the prior year. Hospital Days paid by Purchased/Referred Care declined by 28%. Emergency Room visits financed decreased by 33% from the previous year.

Ambulance calls dispatched increased from 1477 in 2013 to 1751 in 2014, an increase of 19%. Patients transported increased slightly from 626 to 671. The number of calls

with Substance Abuse as a factor increased from 96 to 227 which represent an alarming increase of 136% (Figure 3-22).

KWSO 91.9FM has become a great partner in the health education process. There were 13,850 health related public service announcements in 2014. Spilyay Tymoo has also been supportive with 241 articles and 408 announcements that were health related.

Included in the 2014 report are a number of services and programs not previously represented. The information will be further developed to see if it does represent the appropriate measures of utilization and services. It will be more meaningful when comparisons are made over time.

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

	FY2011	FY2012	FY2013	FY2014
Medical Visits by Provider				
Physicians	11,579	11,459	10,057	8,600
Mid Level Practitioners	4,591	3,920	5,297	5,933
Nursing Staff	4,785	3,961	4,249	4,357
Total Medical Visits	**20,955**	**19,340**	**19,603**	**18,890**
Workload Factors				
Clinic Days	250	250	250	250
Average Visits Per Clinic Day	84	77	78	76
Total FTE's In Medical Department	21	22	22	21
Physician FTE's	5.5	5.0	4.0	4.0
Mid-Level Practitioner FTE's	2	2	2.5	2.5
Avg Annual Visits Per FTE	998	879	891	900
Avg Annual Visits Per Physician FTE	2,105	2,292	2,514	2,150
Avg Annual Visits Per Mid-Level FTE	2,296	1,960	2,119	2,373
Extended Hours of Service				
Days of Late Clinic	202	202	114	201
Hours of Service (M-Th, 7pm)	404	404	228	402
Visits	869	902	741	851
Visits Per Hour of Service	2.2	2.2	3.3	2.1
Hospital Patient Count	476	381	325	2
Hospital Visit Count	2,107	1,654	1,378	2
Average Hospital visits per patient	4.4	4.3	4.2	N/A
Average Hospital patients per day	1.3	1.0	0.9	N/A
Average Hospital visits per day	5.8	4.5	3.8	N/A

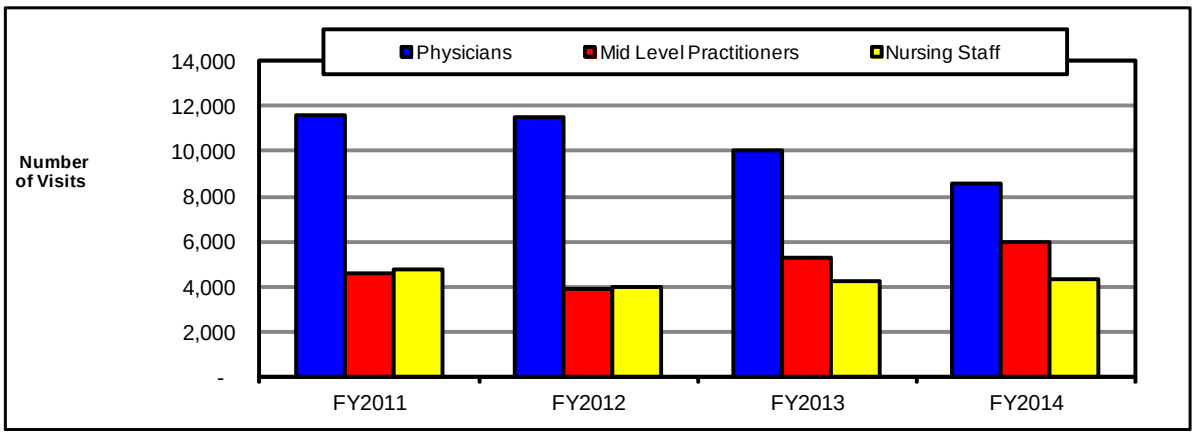


Figure 3-1

Medical Services, Continued

Interpretation: From 2011 to 2014, the medical department averaged 19,697 medical visits per year. Of those visits 10,424 were physician visits, 4,514 were seen by mid-level providers and 4,338 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 Full Time Employees (FTEs) in the medical department including five physicians and two mid-level providers. Each FTE physician had an average of 2,265 visits per year and each FTE mid-level provider had an average of 2,187 visits per year. FTE physicians had approximately 3.5% 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 2011-2014 and during those times the late clinic averaged 2.1 medical visits per hour.

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 podiatry program service areas, we aimed during 2014 to teach each person to "Walk Well" at the highest level of ambulatory ability; given each person's physical potential, whether impaired or not.

Relevance: There is an old saying "if your feet hurt, everything hurts" and perhaps even suffers is likely true to one degree or another; therefore it is relevant to provide excellent and up-to-date podiatric medicine, foot and ankle surgery, as well as wound care. The Podiatry Program provides age appropriate extremity education so that lower extremity health and wellness becomes a proactive and preventative art practiced by patients. Some patients already demonstrate these preventative measures and the program does their best to educate all clients on proper foot care so that their travels can be as problem-free as possible.

Podiatry Department

	FY2011	FY2012	FY2013	FY2014
Podiatry Visits				
Clinic Visits	1,753	1,608	1,751	1,976
Missed Appointment Rate	18%	21%	24%	23%
Workload Factors				
Clinic Days	170	143	143	155
Average Visits per Clinic Day	10	11	12	13
Average Visits per Year				
Nature of Visits				
PT visit with Diabetes	813	615	808	886
PT visit with Open Wound	313	223	297	359
Comprehensive or Annual DM Ft Exam	97	105	108	133
Office Procedure Performed	489	376	464	508
OR Case	10	4	15	9
Hospital Patient	64	19	87	2
Other Visit Reasons	473	503	433	469
Total Podiatry Visits (Some patient visits include multiple problems)	**1,753**	**1,685**	**1,824**	**1,987**

Figure 3-2

Interpretation: Education, patient training and patients' decisions to change take time so pure numbers of patients seen don't tell the complete story. Again this year (2014) more people were getting better about Diabetes Mellitus (DM) foot care prevention resulting in less numbers of serious foot infections and wounds. Increased numbers of patients were 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 and to identify the categories of care provided.

Relevance: Workload measures are useful to describe overall program growth and plan resources in particular 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

	FY2011	FY2012	FY2013	FY2014
Dental Visits by Provider				
Dentist Visits	4,342	4,657	4,558	4,203
Hygienist Visits	758	713	818	899
Total Dental Visits	5,100	5,370	5,376	5,102
Missed Appointments				
No Shows (Broken Appointments)	408	265	664	956
Broken Appointments vs Total Visits	8%	5%	8%	5%
Workload Factors				
Clinic Days	250	250	249(snow day)	250
Average Visits Per Clinic Day	20	21	22	20
Total FTE's	12	13	12	12
Average Annual Visits Per FTE	443	413	448	350
Categories of Care				
Preventive	6,524	6,950	7,295	8,030
Restorative including Crowns	2,558	2,856	2,888	2,556
Dentures including Bridges	134	115	169	85
Surgical	1,067	985	1,106	826
Orthodontic	6	8	27	7
Endodontic	304	324	251	270
Diagnostic	8,920	6,749	6,700	7,111
Total Identified Problems Treated	19,513	17,987	19,193	18,885

Figure 3-3

Interpretation: In 2014, Broken Appointments were still around 20%, which appears to be average. The Dental Services program maintains call lists and lists of employees that are in need of exams that can be pulled from, which has helped keep chairs full. Dr. Ashton's part time position was replaced with a full time Dentist. Two new Dental Assistants will be added soon.

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 cost.

Pharmacy

Prescriptions Filled	**FY2011**	**FY2012**	**FY2013**	**FY2014**
New Prescriptions	54,672	53980	53415	50464
Refills	28,360	27211	26125	26479
Total Prescriptions	**83,032**	**81,191**	**79,540**	**76,943**
Workload Factors				
Clinic Days	251	250	253	251
Avg Prescriptions per Clinic Day	331	325	314	306
Visits to the Pharmacy	34,567	33,688	33,622	33,975
Prescriptions per Pharmacy Visit	2.40	2.41	2.36	2.26
Total FTE's	6.8	6.0	6.8	6.8
Avg Annual Prescriptions Per FTE	12,211	13,532	11,697	11,315
Pharmaceuticals				
Total Expenses	$ 796,241	$ 784,700	$ 791,276	$ 753,909
Avg Cost Per Perscription	$ 9.59	$ 9.66	$ 9.95	$ 9.79
Rx for Patients outside Service Area		Unavailable	Unavailable	Unavailable

Figure 3-4

Interpretation: Workload in 2014 as compared to 2013 was down 4% in the number of prescriptions filled. The number of prescriptions per FTE also decreased by about 4%. However, for the first nine months of 2014, the pharmacy was understaffed by one full FTE pharmacist. Additionally, training of new staff (resident and technician) may have contributed to decreased prescriptions per FTE.

The decrease in the number of prescriptions 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 steadily decreased compared to four years ago.

Drug costs as compared to 2013 remain stable. Average cost per prescription has also remained stable. 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 formulary drugs are becoming available generically at lower costs, as well as newer, more expensive agents being added to the formulary.

Pharmacy Services, Continued

The average number of prescriptions filled per day remains consistent for the last four years. We continue 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 lack of staff. Pharmacy works closely with Tribal programs including Community Health Nursing, High Lookee Lodge and Warm Springs Corrections.

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

	FY2011	FY2012	FY2013	FY2014
Imaging Exams				
Total X-Ray Exams	1,645	1,649	1,711	1,713
Workload Factors				
Clinic Days	250	250	250	251
Average Exams per Clinic Day	6.58	6.60	6.84	6.82
Total Patients	1,556	1,468	1,493	1,606
Average Exam per Patient	1.06	1.12	1.15	1.07
Total PCPV's	15,839	14,980	16,568	15,757
Average Exams per PCPV	0.10	0.11	0.10	0.11
Total FTE's	1	1	1	1
Exams per FTE	1,645	1,649	1,711	1,713

Figure 3-5

Interpretation: Between 2011 and 2014, there was an average of 1,680 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 1,531 patients received approximately 1.10 visits each between 2011 and 2014.

Diagnostic Services, Continued

Diagnostic Services - Medical Laboratory

	FY2011	FY2012	FY2013	FY 2014
Medical Lab Tests				
Tests collected in the Lab	85,069	77,797	76,743	59,257
Tests collected outside the Lab	3,407	3,407	3,173	12,570
Tests performed off-site	6,561	6,422	5,473	19,332 *
Total Lab Tests Ordered	**95,037**	**87,626**	**85,389**	**71,827**
Workload Factors				
Clinic Days	250	250	250	250
Tests Ordered per Clinic Day	380	351	342	287
Total Primary Care Provider Visits	16,170	15,379	16,568	15,757
Average Tests per Visit	5.9	5.7	5.2	4.6
Total FTE's	5.0	5.0	5.0	5.0
Tests per FTE	19,007	17,525	17,078	14,365
Category of Tests Ordered				
Hematology	25,707	25,707	19,491	7,981
Chemistry	63,347	55,936	60,491	39,610
Bacteriology	831	831	939	1,752
Urinalysis	5,152	5,152	4,468	3,152
Referred Procedures (send Outs)				19,332
Total Lab Tests Ordered	**95,037**	**87,626**	**85,389**	**71,827**

* Tests performed Off-Site are not counted in the Medical Lab Tests Total

Figure 3-6

Interpretation: Due to spacing issues in EHR, data was purged from the Electronic Lab package. Data is not lost but stored in another electronic PCC file. Pulling data from this file is very tedious. When a new Lab Manager is hired, Management will discuss with the new Manager the best way to pull and maintain Lab workload data.

The 2013 and 2014 numbers vary due to the purging of data.

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

	FY2011	FY2012	FY2013	FY2014
Optometry Visits				
Clinic Visits	1,973	1,663	1,941	2,912
Missed Appointment Rate	22%	16%	18%	22%
Workload Factors				
Clinic Days	220	220	220	220
Average Visits per Clinic Day	9	8	9	13
Total FTE's	2.0	2.0	2.0	2.0
Nature of Visits				
Refractions	795	821	832	1,034
Diabetic Eye Exam	264	308	309	266
Contact Lens Visit	45	56	39	66
Medical Visit	-	-	-	-
Early Childhood Education Visits	31	53	60	-
Glasses Repair/Adjustment	350	372	338	732
Other	488	53	363	814

Figure 3-7

Interpretation: The Optometry department saw a significant increase in the number of patient visits this past year even without the services of a full time replacement of a fourth year Optometry student. Dr. Dziuk has increased the number of appointment slots available in a day.

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

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

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

Purchased and Referred Care

Purpose: To identify workload of the Managed Care Program (MCP).

Relevance: To assure effective processing and management of resources.

Purchased and Referred Care

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
2014	7	6,930	$2,726,209

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. During 2010 there was an 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. The implementation of Medicaid Expansion on January 1, 2014 had a significant impact, resulting in the 22% decrease in Number of Obligations from 2013.

This era of healthcare transformation, with the implementation of Coordinated Care Organizations (CCO's) in 2013, preparing for implementation of the Oregon health insurance exchange (Cover Oregon) for potential 2013 October enrollment, and, more importantly, January 2014 Medicaid Expansion, has greatly increased the complexity of MCP processes.

Community Health Nursing Services

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

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

Services Provided by Category	2011	2012	2013	2014
Prenatal	29	-	-	-
Post Partum	-	-	-	-
Well Child		34	42	58
Immunization	1,034	1,274	1,380	1,137
Diabetes				12
Cardiovascular				48
Mental Health				60
Sexually Transmitted Infections	42	66	145	202
Family Planning	95	135	213	201
Phone Contact/Follow-ups	545	213	219	261
Other Activity	594	614	898	1,537
Total Services Provided	2,339	2,336	2,897	3,516
Visits by Location				
Out of Clinic Visits	1,046	742	892	1,100
Clinic Visits	748	666	1,039	886
Total Community Health Nurse Visits	1,794	1,408	1,931	1,986
Total Days of Service	250	250	250	250
Average Visits Per Day	7.2	5.6	7.7	7.9
Total FTE's	2.0	1.8	2.0	3.0
Average Visits per FTE per year	897	782	966	662

Figure 3-9

Interpretation: The CHN Program was fully staffed for eight months of 2014 with three full-time nurses. The third nurse was hired to implement a new program to case manage patients being discharged from the regional hospitals who are not eligible for Home Health/Hospice Services. The goals for this new program are to reduce hospital readmissions and to provide a network of services to support our community members to return back to optimum health after a serious illness.

Community Health Nursing Services, Continued

The top 10 leading Purposes of Visit managed through the CHN Program include (highest to lowest):

- Vaccinations
- Corrections Care
- Health Counseling/Surveillance
- Sexually Transmitted Infections
- Contraception
- Routine Child Health
- Protective Care Visits
- Pregnancy Testing
- Diabetes Care/Follow up
- Laboratory testing/Blood Draws

Other activity includes case review/coordination, education provided, screening and physician ordered treatments.

Maternal and Child Health 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 Maternal and Children Health (MCH) Program workload is directly related to number of pregnancies and births managed each year as well as those identified as high risk. High-risk clients require more intensive services.

Maternal and Child Health (MCH)

	2011	2012	2013	2014
Total number of births	111	86	104	87
Total number of births (Tribal members)		72	82	70
Number of high risk pregnancies	44	43	33	37
Number of high risk infants identified*	32	43	39	36
Prenatal Home Visits	116	56	52	80
Post-Partum Home Visits	196	143	150	91
Other Home/Office Visits		565	399	327
Number of Hospital Visits	87	115	72	57
Number of Birthing Classes		45	43	43
Total Number of Participants		157	181	162
Infant Immunization level**	90.9%	84.4%	83.5%	90.7%

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.

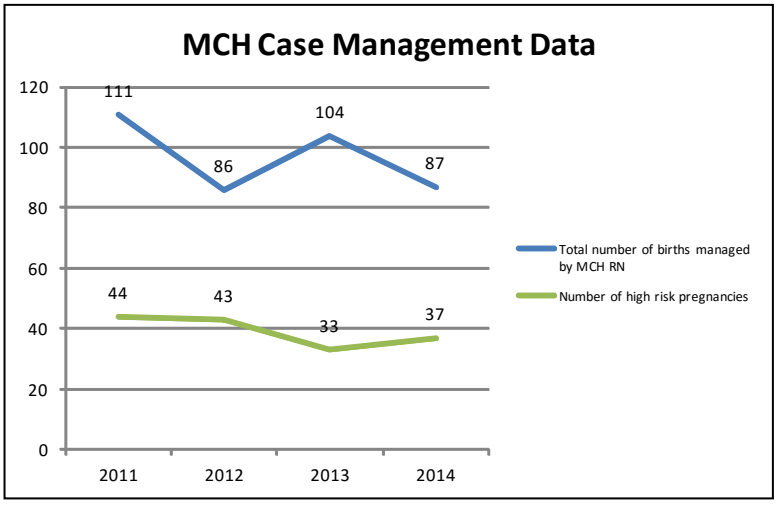


Figure 3-11

Maternal and Child Health Continued

Interpretation: In 2014, the birth rate for the MCH Program decreased to 87 deliveries case managed by the program, 70 of which were to Tribal Member mothers. Sixty-five percent of the deliveries were categorized as either moderate or high risk which is a very concerning issue for our community. Forty-three percent of the pregnancies required intensive services due to their high 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 eligible for care under IHS standards.

Community Health Representative

Purpose: To identify the caseload and workload by category for the Community Health Representative (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

	2011	2012	2013	2014
Caseload by category:				
- Transports	164	274	467	634
- Patient Care	592	412	1395	1364
- Case Findings/Screening	532	428	52	
- Monitoring Patient	425	284	45	
- Case Management	312	109	21	
- Health Education	42	32		
- Other	500	445	119	126
Total Client Encounters	**2,567**	**1,984**	**2,099**	**2,124**
Total Days of Service	250	250	250	250
Average Number of Encounters per Day	10.3	7.9	8.4	8.5
Total FTE's	3.0	3.0	3.4	4.0
Average Number of Encounters per FTE per Year	856	661	617	531

Figure 3-12

Interpretation: In 2014, the CHR Program once again had an increase in the amount of patient transport requests over the previous year. A new CHR was added in 2013 to accommodate the increased transportation load as well as the increasing numbers of dialysis clients. Currently the program provides dialysis transportation 5 days per week for 2-6 clients per trip. In 2015, dialysis services will be provided locally in the Madras area which will offer more convenient scheduling for our clients and more transportation options for families.

The average number of client encounters per CHR per day has remained fairly consistent for the past three years even with the addition of a new CHR in 2013. Unfortunately, in 2014, more of the CHR's times were spent providing transportation services and less on direct client care due to the increase in transportation requests.

Diabetes Program Services

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

Relevance: Diabetes Mellitus (DM) 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

	FY2011	FY2012	FY2013	FY2014
Diabetes Program Visits				
Clinician Clinical Visits	1,931	4,156	4,729	5,254
Community Encounters	2,032	1,531	1,752	2,083
Total Visits	**3,963**	**5,687**	**6,481**	**7,337**
Workload Factors				
Clinic Days	250	250	250	250
Average Clinical Visits per Clinic Day	15.8	16.6	18.9	21.0
Total Clinical FTE's	5.0	4.0	4.0	4.0
Average Clinical Visits Per FTE	793	1,039	1,182	1,314
Categories of Service				
Diabetes Clinical Encounters		1,922	2,630	2,868
Diabetes Case Management Encounters		2,334	2,099	2,386
Diabetes Community Education Contacts	985	559	1,559	2,083
Diabetes Screening Community Contacts	2,032	972	193	331
Patients in Dialysis				
Number of Patients	12	13	17	19

Figure 3-13

Interpretation: The Warm Springs Diabetes Program was fully staffed during 2014. Staff included the Program Coordinator, Nurse Practitioner, RN, Certified Diabetes Educator and Administrative Assistant.

Major educational events included 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.

The 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.

Monthly Diabetes Group Visits and Diabetes Mobile Clinic Visits are included in the clinician clinical visit statistics.

Women and Infant Children

Purpose: To identify the caseload for the Women and Infant Children (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)

	2011	2012	2013	2014
Infants and children under 5 years of age	550	550	534	482
Pregnant, breastfeeding and postpartum women	232	211	187	192
Total number of Women, Infants and Children served	782	761	721	674

Figure 3-14

Interpretation: The number of Women, Infants and Children served by our program remained relatively stable for the past four years with the exception of 2014 where Warm Springs noted a decline in women/children seeking WIC services. This site is not unique as WIC sites throughout the state are experiencing the same trend. State benchmarks for program participation have been adjusted lower for almost every WIC site for 2015.

Other interesting facts for 2014: 87% of our new mothers start out breastfeeding and 38% of the families we serve are working families. Both of these rates experienced a decline in 2014 over previous years.

Community Health Education Program

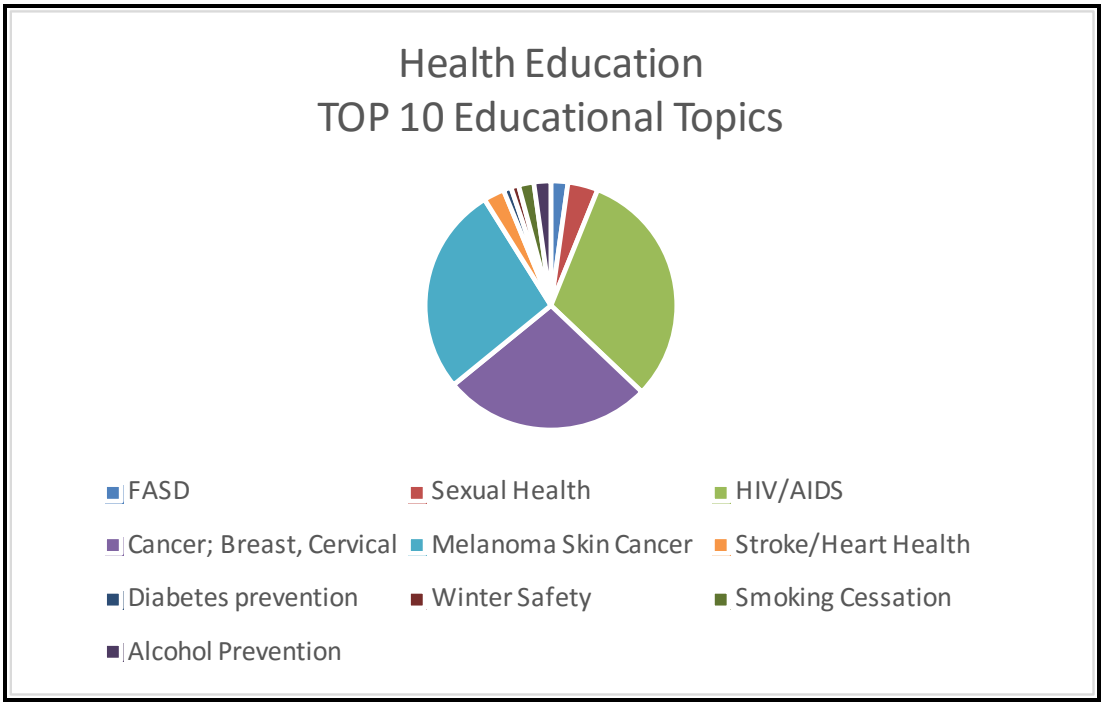
Purpose: To identify the activities and the associated number of participants involved.

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

	Number of Participants 2014
Program Health Education Team	
No. of Educational Encounters	71
Direct Time Spent Educating	129 hours
No. of Participants	2667
No. of PSA's generated	13
No. of Newspaper Articles	11
General Health	
My Future My Choice; 5 Sessions (Sexuality Education)	101
Girlz Club (8-11 year olds); Hygiene, Leadership, Wellness	32
Million Hearts Campaign	22
Great American Smokeout	50
Wellness of Warm Springs; 10/12 Classes	230
Pi-Ume-Sha Health Fair	723
Heart Smart Dinner	21
Alcohol and Drug Prevention	
FASD Awareness Day	61
3D Project	60
Cultural Prevention	
Craft Classes	5 classes
Jewlery Making	34
General Prevention	
Trunk or Treat	
HIV/AIDS	
World Aids Day	8

Figure 3-16

Community Health Education Program, Continued



Interpretation: In 2014, the reporting methods for the Community Health Education Program changed. We began tracking the number of educational encounters, the number of participants and amount of direct time spent educating. The number of educational encounters reflects classes that the Community Health Educators directly sponsored or provided health education at as well as participation in major events such as the Pi-Ume-Sha Health Fair. Also noted in the graphic are the Top 10 Educational Topics delivered to community members in 2014.

Mental Health

Purpose: To identify the caseload and number of visits by age and service category. To determine the efficiency of operations by comparing clinic contact hours to available FTE hours.

Relevance: Understanding patient demand and workload is necessary to determine appropriate resources and staffing. Mental health has potential to increase billing.

Mental Health

	2011	2012	2013	2014
Visits & Clients Served				
Number of Adult Visits	1,268	*		
Number of Children Visits	1,515	*		
Total Visits	2,783	3,012	2,539	1,494
Categories of Service				
Crisis Management Visits	224	204	270	219
Jail				94
Total	224	204	270	313
Prevention Services				
Soaring Butterflies/Warrior Spirit	NA	NA	300	53
Positive Indian Parenting (5)	299	48	48	0
Elvis Birthday Bash	97	70	NA	-
MSPI Madras High School Presentations	103	0	46	-
QPR Trainings (5)	115	3	3	100
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	300
Prevention Basics Power Point	5	60	NA	-
W.S. Christmas Fun Party	1,400	500	600	600
Spring Into Action (Prev. Coalition)	200	49	NA	-
Penny Carnival		80	178	200
Rez Olympics		50	48	-
Street Dance		60	75	65
GONA Training		100	NA	-
Total Prevention Services Attendance	2,953	1,635	1,601	1,318
Service Hours				
Client Contact Hours	2,275	*	3,703	
*Total FTE Hours		3,216		

Figure 3-17

Mental Health, Continued

Interpretation: Oregon Web Infrastructure for Treatment Services (OWITS) Electronic Health Records does not allow separation of age categories, but our Program is researching a different Electronic Health Record Program, that will be more category and user friendly for reporting.

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 Alcohol and Substance Abuse (A&D) treatment is essential to see what is working and not working in our treatment program.

Alcohol and Substance Abuse

	2011	2012	2013	2014
Encounters - Outpatient Treatment				
Number of Visits	2,899	2,501	1,793	1,567
Number of Clinic Days	239	254	251	252
Average Visits per Clinic Day	12	9	8	6
Relapse Anger Resolution Grp (Quarterly)	33	28	25	5
Jail Groups (estimate)	250	334	425	375
Aftercare				
Healing from Grief & Trauma - 1 day conf.	57	40	87	23
Recovery Month Dinner	n/a	100	100	100
A&D Prev B-Ball "And 1" (Street Ball tour) all ages	250	NA	36	-
Community Grief/Trauma Gathering (2 workshops)	80	NA	50	23
Healing Family Circle Conference	40	NA	NA	-
Categories of Service				
Alcohol Abuse	2,899	2,501	1,793	1,567

Figure 3-18

Interpretation: The program 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

	2011	2012	2013	2014
Outpatient Visits	NA		30	43
Prevention Youth Dance			72	236
Teen Craft Night			32	45
Rez Head Youth Conference			34	-
Baseball Camp			31	36
Suicide Prevention Camp	50	68	38	18
Healing Wounded Spirits Camp	n/a	46	NA	-
Winter Youth Conference	n/a	n/a	NA	-
Movie Nights	319	416	384	480
Wii Bowling	n/a	112	NA	-
Hoop Camp	144	73	36	89
Madras Bowling	83	88	79	96
Wellness walk	81	84	204	224
All Night Sobriety Party	160	n/a	n/a	-
Kids Bingo	76	26	196	159
Red Road to Recovery/Boys Circle	93	0	93	61
Tribal Youth Leadership	24	24	22	46
Total	1,030	1,187	1,251	1,533

Figure 3-19

Adolescent Outreach, Continued

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 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.

Services are also provided to clients returning from a Residential Treatment setting to help readjust with transition back into Family and Community. The Native American Rehabilitation Association (NARA) Youth Residential Treatment plans to provide an aftercare outreach program to Oregon Tribes to assist youth with transition back into their communities and home. The structure is still in Program Planning, in which NARA was chosen as lead treatment center to develop this youth treatment center.

Community Health & Prevention Resource Center

Purpose: Track the number of people using resources, and the number and type of resources used, to determine program usage and community need.

Relevance: These numbers help us determine the state of our program, how it's being used, where we can improve and where we need to focus.

Community Health & Prevention Resource Center
2014

Resource Center Usage	2011	2012	2013	2014
Patrons that checked out materials	248	486	339	300
Materials checked out	733	1,358	949	792
Health related materials checked out	46	80	81	30
Native American materials checked out	139	215	160	156
Circulations*	1,424	3,015	1,679	1,438
Number of visits	3,833	9,351	8,936	11,147
Patron cards issued	505	378	144	123
Graphic Design Requests				
Posters/Banners printed	199	197	99	66

*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: In 2014, there was a continued decrease in the number of people who checked out materials as well as a decrease of the number of materials they checked out. Three hundred people checked out an average of 2.6 books and renewed them at an average of 1.8 times in 2014. This is compared to 339 people who checked out an average of 2.8 books and renewing them 1.8 times in 2013. The main reason for the continual decline is that people aren't returning their overdue materials. This reduces the overall quality and selection available for other people to check out. While 123 new patrons were added in 2014, this did not offset the 500 plus people who had not returned their library materials by the end of 2014. One exception to the general decline was the notable 24.7% increase in the number of visits in 2014 over 2013. This increase is due to heavy public computer usage.

Social Services

Purpose: To appropriately identify the needs of the community and apply and direct the various resources associated with the programs administered by the Tribal Social Service Program which consists of the Energy Assistance Program, Medical Gas Voucher Program, Disabilities and Social Security Assistance and Commodity Food Program.

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

	2011	2012	2013	2014
Housing & Energy Assistance				
Number of Clients Served			248	292
Total Vouchers Processed			248	292
Total $ Value of Vouchers	84,443	86,131	87,346	94,843
Medical Travel				
Number of Clients Served	789	458	336	420
Total Vouchers Processed	789	458	336	420
Total $ Value of Vouchers	20,211	12,200	9,709	12,480
Disability				
New Clients pursuing claims for SSI/SSDI	92	78	67	105
Number of clients currently checking on Survivorship/widow benefits	28	16	10	12
Number of Clients inquiring about Retirement Benefits	21	24	20	32
Number of Clients that have been denied	77	36	23	28
Number of Clients that just filed their 1st Appeal	49	20	15	15
Number of Clients that are in the middle of Appeal	54	33	17	24
Number of Clients in Court Hearings	16	8	20	16
Commodities				
Number of Families Served		259	278	75
Number of Individuals Served	301	494	749	166
Number of Warm Springs Tribal Members*	516			137

Figure 3-21

*For 2012 & 2013, Tribal Member data was not kept. It will be in the 2014 report. The 2014 figures are a true reflection of the actual number of people served.

Interpretation: In 2014, the LIHEAP Energy Assistance Program served 44 more client households with assistance than 2013. This program also distributed 30 cooling fans, 20 heaters and 40 homes received weatherization kits.

Medical Travel funded 84 more clients this year with assistance to getting to Medical appointments. In 2014, the program started using the priority one system developed by IHS and mid-year lifted the priority one system due to receiving additional funding.

Social Services, Continued

Clients seeking services through the Disabilities Coordinator services have increased substantially with the Coordinator doing more home visits and outreach.

The Commodities Program has increased its participation level. The numbers have changed drastically due to staffing change and how numbers are calculated. A tracking system was set up to count the actual number of individual households served the entire year and actual number of individuals in each household for the entire year not counting the same households and participants every month.

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 (e.g. 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	
	2013	2014	2013	2014	2013	2014
Motor Vehicle Accident	47	88	27	30	3	4
Other Accident	-	-	-	-	0	-
Assault and Battery	43	66	14	21	12	21
Suicides/Attempts	2	22	0	13	2	8
Corrections	173	379	30	40	39	75
Pediatric	108	222	33	67	2	5
Cardiac	76	149	69	69	6	11
Respiratory	38	148	34	82	0	2
Other Illness	610	134	306	60	58	9
Total	**1,097**	**1,208**	**513**	**382**	**122**	**135**

TRIBAL AFFILIATION RELATED TO CALLS

Reason for Call	Calls Dispatched		Patients Transported		Calls w/Substance Factor	
	2013	2014	2013	2014	2013	2014
Members and Dependents	1,373	1,625	580	623	96	227
Other Eligible Indian	0	0	0	0	0	0
Non Tribal	104	126	46	48	45	2
Total	**1,477**	**1,751**	**626**	**671**	**141**	**229**

Figure 3-22

Interpretation: The number of calls received in 2014 increased by 10% over the previous year. The number of patients transported decreased by 26% over that same period. The calls where substance abuse was a factor increased from 122 to 135.

Ambulance Services, Continued

Nearly 93% of the calls were for Tribal Members and Dependents in 2014. Nearly 93% of patients transported were also Tribal Members and Dependents.

Almost 8% of our transports were for motor vehicle accidents. Assault and Battery, Suicides/Attempts and Corrections were the reasons for 19% of transports. Pediatric transports were nearly 18%.

Most of the transports were for Cardiac, Respiratory and Other Illnesses (55%).

Culture and Heritage Language Program

Purpose: Cultural and Heritage provides language and cultural education opportunities for Warm Springs Tribal and community members.

Relevance: Providing Cultural and Language Education opportunities gives Tribal members an understanding of the history, traditions, and sovereign rights reserved in the 1855 treaty with the US government. Tracking this data is important for planning and implementing outreach efforts and developing relevant materials.

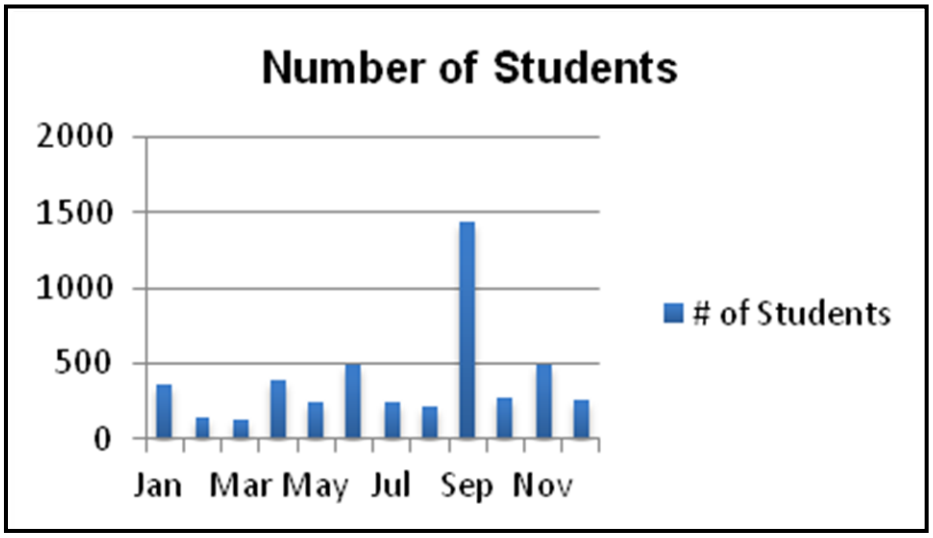


Figure 3-23

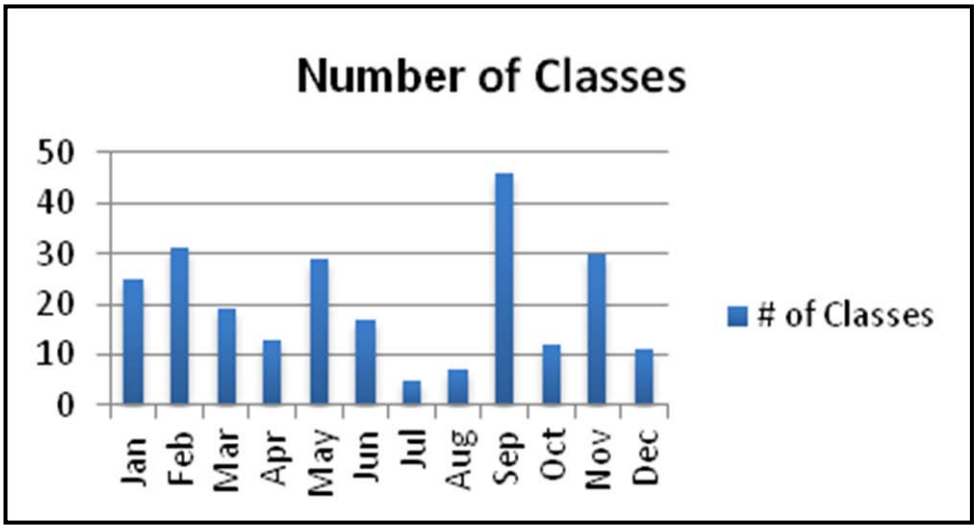


Figure 3-24

Culture and Heritage Language Program, Continued

Interpretation:

September is the busiest month for outreach with the attendance of staff to several community events. The largest draw is the invitation to the back-to-school barbeque. This opportunity allows Culture and Heritage to reach nearly all the Tribal members students enrolled in 509J school district and/or boarding schools to provide information on classes offered (community and out of school efforts). These opportunities also allow for information distribution via language materials for home to support our school age children effort.

The numbers of classes offered are steady throughout the year. September is when several classes were offered at the same time. This includes:

- Autni Ichishkin Sapsikwat (pre-school)
- Autni Ichishkin Sapsikwat (k-8)
- Out-of-school classes (morning and afternoon)
- Ittitamasha (math tutoring)
- College Success (middle school outreach)
- Leadership conferences (OIEA)
- Language Bowl Classes (prep for annual event)
- Rites of Passage

Over the course of the year, non-member communities request outreach presentations and services. These communities include:

- Local school districts
- Mt Hood Cultural Presentation
- Community colleges, universities and other higher education institutions
- Museums

KWSO 91.9 FM

Purpose: KWSO 91.9 FM is a non-commercial radio station with programming focused on meeting the needs of the Warm Springs Community. The radio station broadcasts Information and Education, Cultural and Language Education and music through on-air live calendar reads, pre-recorded PSAs, local news stories and locally produced news magazine segments. The station reaches 50,000 people in all of Jefferson County and into Wasco, Crook and Deschutes Counties with a primary focus on the residents of the Warm Springs Indian Reservation.

Relevance: Public Service Announcements (PSA's) are categorized for the purpose of identifying our broadcast efforts to the Guidance from Joint Health Commission strategies. KWSO 91.9 FM supports the work of the Health & Human Services Programs in Warm Springs by utilizing media to promote health related events and activities plus providing health education and information about services.

KWSO

PSAs by Category	2014
Health Educaiton	2,718
Community Event	1,988
Health Insurance	1,405
Mental Health Education	1,263
Health Related Event	1,261
Violence Prevention	825
FASD Awareness	822
Child Development/Parenting	732
Cultural Event	709
Child Mental Health	467
Youth Education	374
Child Abuse Prevention	319
Child Health	312
School Related Event	291
Elder Event	124
Mental Health Event	118
Youth Employment	82
Education	40
	13,850

Figure 3-25

KWSO, Continued

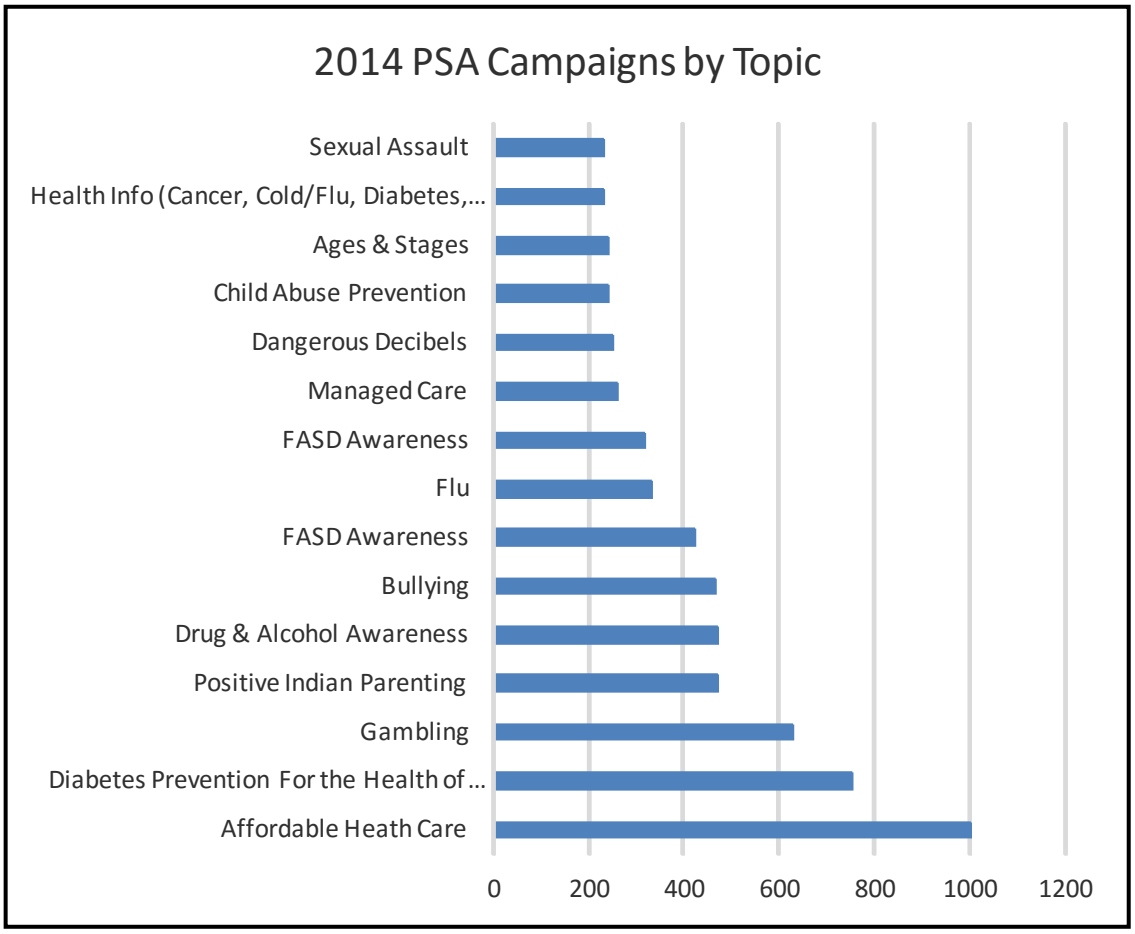


Figure 3-26

Interpretation: This data is focuses on the PSAs broadcasted that were categorized to tie in with the Guidance for Joint Health Commission strategies. This represents only a portion of all PSAs broadcast.

The top health related PSA campaigns focused on: Health Insurance; Diabetes Awareness; Gambling; Parenting/Child Development; Drug & Alcohol Awareness; Bullying' FASD Awareness (prenatal thru elders); Child Abuse Prevention; Sexual Assault Awareness; and Health Education.

Overall, "Events" were the topic most often broadcast in the PSAs. These included: Community Events; Health Related Events; Cultural Events; School Related Events; Elder Events; and Mental Health Events)

"Health Education" across a broad range of topics was the strategy second most often broadcast.

A total of 13,850 PSAs (60 seconds or less) were broadcast that were health related and relevant to the Joint Health Commission strategies representing a value of $277,000 ($20 per spot).

KWSO, Continued

In August of 2014, KWSO 91.9 FM re-launched their website (www.kwso.org) and saw significant growth in website visits and engagement. The first website report was compiled in September and during that month, the website had 663 users (user who has had at lease one session with the selected data range, includes both new and returning) who engaged in 942 sessions (period of time a user is engaged on the website). In October, users increased to 875 users engaging in 1,269 sessions and in November the website had 1,563 users engaging in 2,787 sessions. December had the largest engagement of the first 3 months of the website launch with 1,856 users engaging in 3,430 sessions.

Over the first three months of the website re-launch, traffic and engagement with the site have increased significantly and demonstrates that the public turns to KWSO 91.9 FM for Information and Education, Cultural and Language Education, music and timely information.

Spilyay Tymoo Newspaper

Purpose: To publish a comprehensive and informative newspaper devoted to the health and wellbeing of the Warm Springs Tribal Community.

Relevance: The Spilyay Tymoo strives to advance the health and wellness programs and opportunities available to Tribal Members. The publication is delivered every two weeks to 1200 Post Office boxes in the Warm Springs community and 1,200 are delivered to Tribal Members and other subscribers off the reservation. An additional 300 are left at the Tribal Administration Building.

Spilyay Tymoo

Article/Announcement Category	2014	
	Article	Announcements
Child Development/FASD	1	5
Early Childhood/Child Development	6	26
Youth Fitness	78	104
Youth Mental Health	13	26
Youth Health Education	20	26
Youth Support	13	13
Education & Job Opportunity Events	26	52
Health Services Information	26	52
Tribe's Health Education & Health Support	26	52
Elders	13	26
Health System	19	26
Total # of Health Related Articles/Announcements	241	408

Figure 3-27

Spilyay Tymoo Newspaper, Continued

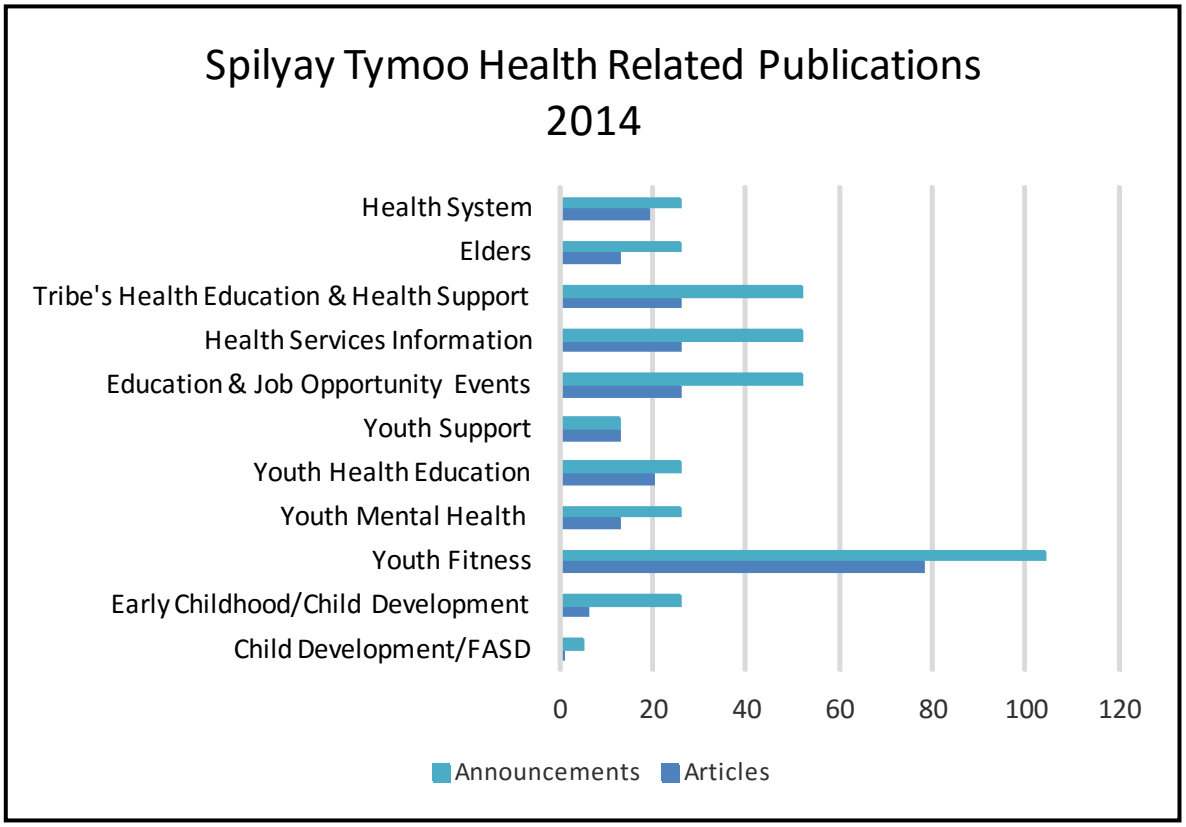


Figure 3-28

Interpretation: The semimonthly publication includes Health Education, Information about Available Health Services or details about local events. These all tie to the Guidance for Joint Health Commission strategies.

Vocational Rehabilitation

Purpose: To track the caseload of pending and eligible Vocational Rehabilitation (VR) consumers/clients.

Relevance: Tracking the case load helps the program to determine the success rates of consumers/clients from their initial contact until their cases are closed. This data is reported to the Joint Health Commission and funders to determine if the program is fulfilling the annual programmatic goals for number of consumers served under an Individual Plan of Employment (IPE) and the number of cases successfully rehabilitated. Reflective of VR program standards are "consumer informed choice" and service delivery effectiveness.

Vocational Rehabilitation

	FY2013	FY2014
Orientations	59	145
Intakes	26	61
Files Closed	34	13
New Cases Opened	19	44
Mo. Average Pending Eligibity	3	11

Figure 3-29

Interpretation: Consumer/Client attendance at VR Orientations more than doubled in 2014 from 59 in 2013 to 145. The total number served was 90 and the actual number served with an IPE was 109 well ahead of the program target. The 121% increase is a significant program improvement from 2013, where only 20% of the goal was met.

In 2014, 3 consumers enrolled in an educational training program. One attained a post secondary degree, 1 attained a post secondary certificate, 1 consumer is successfully moving into 2015 to complete their educational goal. This is compared to 2013, where 1 client was enrolled and 1 person completed a GED.

The data tells helps the program to determine if there are areas within the case management system that need to be addressed by the VR team. For example, the program can determine the effectiveness of outreach efforts by the attendance of

Vocational Rehabilitation, Continued

Orientations, tracking effectiveness of securing medical documentation as a measure of eligibility determination, and tracking the eligible consumer's files that are closed successfully rehabilitated, or closed "other" status. The program also has an electronic database that is used for all eligible clients that breaks data down further.

A majority of consumers have dual diagnosis, the most common being alcohol/drug dependency, with related psychological social diagnosis, such as depression, anxiety, PTSD, and medical diagnosis; such as diabetes, renal/kidney disease, obesity, arthritis, hypertension/high blood pressure, hearing and vision impairments. The rehabilitation process generally takes 12-18 months for most consumers.

The data is also a Community Collaboration indicator, of health, human and social service providers who serve common consumers/clients.

High Lookee Lodge Adult Living Facility

Purpose: High Lookee Lodge (HLL) Adult Living Facility (ALF) provides individualized services to elder and disabled adults who are in need of assistance with daily living, with an emphasis on a home like and cultural living environment. These services are provided within the ALF guidelines established by the State of Oregon licensing requirements. .

Relevance: High Lookee Lodge provides care to elder and disabled adults who are no longer capable of living on their own. Services provided include, but are not limited to, medication distribution, meals, assistance with dressing, laundry, setting up appointments and providing rides to appointments. Provide assistance to residents that helps maintain their independence with assistance in areas as needed.

High Lookee Lodge

	2012			2013			2014		
	Resident Count	Private Pay	Medicaid	Resident Count	Private Pay	Medicaid	Resident Count	Private Pay	Medicaid
January	18	4	14	21	7	14	21	5	16
February	19	4	15	21	6	15	20	5	15
March	19	5	14	22	6	16	21	5	16
April	19	5	14	22	7	15	21	5	16
May	19	5	14	24	6	18	20	5	15
June	18	5	13	25	6	19	20	5	15
July	20	5	15	24	7	17	20	5	15
August	19	5	14	24	7	17	19	5	14
September	21	6	15	22	7	15	19	6	13
October	20	6	14	22	7	15	17	5	12
November	20	6	14	20	6	14	17	4	13
December	20	6	14	20	5	15	18	4	14
Avg Number of Residents	**19**			**22**			**19**		

Figure 3-30

Interpretation: High Lookee Lodge currently provides service to 20 residents. The average for 2014 was 19. There is room for 36 total residents in the facility. We provide service to an average of 5 private pay residents and the remainder are Medicaid eligible.

Children's Protective Services

Purpose: Children's Protective Services (CPS) empowers parents, families and community members through support, accountability and cultural teachings to give all children an optimal start in life. CPS provides prevention and intervention services to families in need so that the family system has the opportunity to learn the skills needed to keep the family safe and together.

Relevance: Program statistics allow Children's Protective Services to evaluate the effectiveness of their response and resolution to Child Abuse and Neglect referrals as well as tailor their services to meet the unique needs of each child and family who enters the system.

Children's Protective Services

	FY2013	FY2014
Visits/Contact		
Total Number of Services Provided to Children		5,116
Total Number of At-Risk Children		325
Total Number of Child Abuse/Neglect	379	476
Children Placed in Emergency Shelter	129	97
Ave Length of Time in Emergency Shelter prior to being placed (days)		90
Ave time in Foster Care (days)		270

Figure 3-31

Interpretation: The statistical information provided represents the ongoing need for protective care services, intervention and prevention as the amount of children served in 2014 remains significant.

The average time in Foster Care days is an indicator of the amount of time children remain in protective care prior to reunification or alternative permanency is achieved. In 2014, the average time was 270 days which is much longer than our goal of 180 days. There are several contributing factors preventing CPS for achieving that goal for this reporting year including staff vacancies, foster care certification and records management. All of these issues have since been resolved.

Of significant note, the Family Preservation Program was established in 2014 and of the 146 children that received services from the that program, 137 avoided protective care and were able to continue living in the home with a parent or guardian while the safety issues were being addressed and resolved in a supportive manner.

Tribal Day Care Program

Purpose: The Tribal Day Care Program provides child care services to children ages 6 weeks to 12 years of age. The program provide a clean, healthy, safe-learning environment to children as well as utilize an age-appropriate curriculum to teach children in early learning and health-related curriculum. Attendees participate in healthy learning activities provided through community departments, social events, and healthy gross motor activities.

Relevance: The data being collected is used to track medical exclusions as well as child injuries and if they were a transport or a non-transport to IHS. Dental screenings are provided to those children whose parents give us authorization. These screenings help in the prevention or detection of cavities in young children. All enrolled children's immunizations are tracked via the Alert System in order to make sure all enrolled children are current on immunizations.

Tribal Day Care

	FY2014
Visits/Contact	
Dental Screenings	60
Medical Exclusions	80
Injuries/Accidents:	
Transport	6
Non-Transport	102
Head Lice Exclusions	56
Immunizations	1
Ages & Stages Questionnaire	60

Figure 3-32

Interpretation: This data reflects the number of dental screenings, Ages & Stages Questionnaires (ASQ's), medical & head lice exclusions, and injuries/accidents and whether they were a transport or non-transport to Indian Health Services (IHS). This data also reflects that we meet State requirements as far as all enrolled children having completed their immunizations before the exclusion day in March of every year.

Community Wellness Center

Purpose: To provide safe and properly supervised community/youth activities which enhance the physical, health, social, educational, cultural and leadership well-being of our community's youth and families.

Relevance: Work load measures are needed to assess program growth, community activities, community benefit and personnel requirements for the Community Wellness Center.

Community Wellness Center

	FY2014
Summary of Activity	
Youth and Community Activity	
Recreation Field Trips (incl. Chaperones)	437
Sports/Athletic Program Attendance (all)	49,872
Game Room Attendance	2,333
Snack Attack	4,071
After Shool Programs/Community Activities	9,426
Total Program Participation	66,139
Signed Weight Room Waivers	402

Figure 3-33

Interpretation: The Community Wellness Center continued to serve large numbers of community members through the programs in 2014, the majority of which were in the sports and athletics programs. After school programs and community events also had strong participation numbers as did the "snack attack" program which provided a healthy afterschool snack option for youth.

Summary/Purpose of Grants

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 IHS, 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 demostrates 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.

Summary and Highlights

Recurring Indian Health Service funding remains about the same as it was in 2011. An increase realized in 2012 was reversed with the national sequestration in 2013 and was not restored in 2014. A significant change in recurring appropriations to the Indian Health Service is not anticipated in the coming years. (Figure 4-1).

On a brighter note, collections by the Indian Health Service and the Tribal Programs have significantly increased in the past few years with more members eligible for alternate resources. Total IHS are up more than 50% from 2011, having topped $4.5 million. Tribal collections have nearly doubled over the same period, and efforts are underway to consolidate all billing activities to assure resources are captured. Collections are vital to providing support for the health system in the future.
(Figure 4-1).

Expenditures and workload are impacted by vacancies. Recruiting health professionals will always be challenging. Several programs saw significant turnover and vacancies, which affected workload and strategic priorities.

The Contract Health Service program has been significantly impacted by increases in appropriations to both the local program and the national catastrophic health emergency fund (CHEF). In addition, being able to pay hospitals at Medicare Like Rates and the improvements in alternate resources have saved the program significant resources. These factors have allowed the program to build savings and extend priorities, while be able to maintain healthy reserves against high cost years in the future.

The Purchased/Referred Care had its best year in 2014, primarily attributable to an increase in availability of Alternate Resources. Consequently, there was a significant decrease in expenditures and as a result an impressive increase in savings over that period of time. The Affordable Care Act together with the application of Medicare Like Rates and a very vigilant management have all contributed to this very positive development. Purchased/Referred Care financed hospital admissions declined by 36% from 2013-2014. The average length of stay was 13% less than the prior year. Hospital Days paid by Purchased/Referred Care declined by 28%. Emergency Room visits financed decreased by 33% from the previous year. If this trend continues, it would greatly impact the health program.

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

	2011	2012	2013	2014
Indian Health Service				
Recurring Funding	16,284,305	17,348,813	16,135,780	16,248,026
Non-Recurring Funding	1,538,649	510,231	603,603	1,236,741
Total IHS Funding	**17,822,954**	**17,859,044**	**16,739,383**	**17,484,767**
Collections IHS				
Medicaid	2,400,000	2,522,740	2,630,125	3,876,758
Medicare	201,700	99,349	265,122	285,257
Private Insurance	428,600	503,833	420,342	361,643
Total IHS Collections	**3,030,300**	**3,125,922**	**3,315,589**	**4,523,658**
Collections Tribe				
Ambulance	171,068	146,086	358,739	329,823
Community Counseling	537,996	567,466	944,058	1,196,976
Community Health	266,563	398,428	462,844	228,950
Total Tribal Collections	**975,627**	**1,111,980**	**1,765,641**	**1,755,749**
Grant Awards	1,513,100	1,650,982	2,133,838	1,114,664
Tribal Employee Group Insurance (Est)	1,554,753	1,901,827	2,231,557	3,091,229
Tribal Appropriations	1,761,800	1,682,649	396,905	477,754
Total	$26,658,534	$27,332,404	$26,582,913	$28,447,821

Figure 4-1

Interpretation: The funding trends have been positive over the past 4 years, although there was some erosion of funding in 2013 as a result of the sequester.

The recurring FY 2014 IHS base funding increased by a $112,245 (1%) from the previous year. The non-recurring funding for 2014 increased by a little over

Health System Funding by Major Source, Continued

$633,138 (51%).

IHS collections continued their upward trend while tribal collections saw a slight decrease. IHS program collections increased by $1,208,069 or 27% in 2014. Tribal program collections decreased by over $9,892 or -1% in 2014.

Most of the Tribal program's decrease was attributed to Community Health Program collections which saw a decrease of $233,894. Community Counseling continued to increase collections by over $252,918. Ambulance Service collections also saw a slight decrease of $28,916 in 2014. It is essential that all programs continue to emphasize collections to maintain and enhance services.

Grant awards decreased by $1,019,174 from the previous year. Tribal appropriations declined by $80,849 over the same period. Tribal Employee Group Health expenditures were estimated at $3,091,229, which represents an increase of $859,672 or 28%.

The over total Health Program Funding for 2014 was $28,447,821 which represents an increase of 7% when compared to 2013.

Base Health System Funding Versus Inflation

Purpose: To identify the historical IHS 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 IHS 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%
2014	16,248,026	0.7%	3.0%

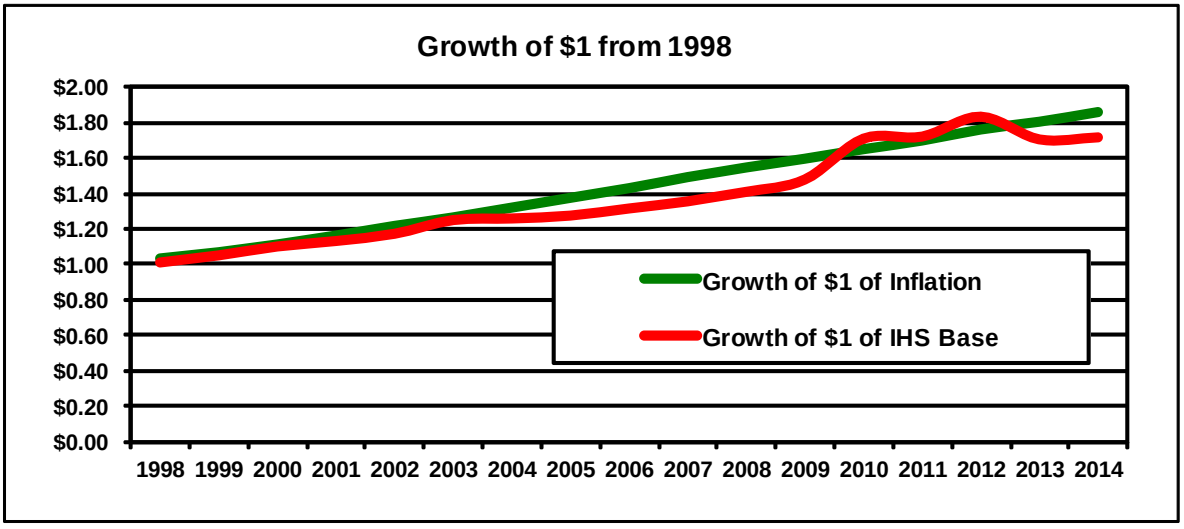


Figure 4-2

Base Health System Funding Versus Inflation, Continued

Interpretation: 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

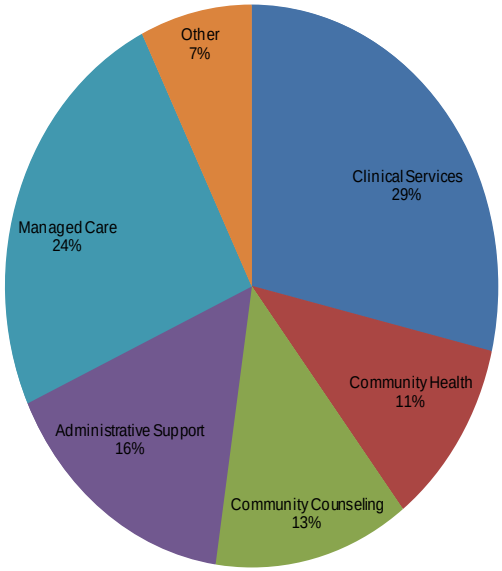
Purpose: To report actual outlays by each program as well as overall carryover and savings.

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

	2011	2012	2013	2014
Clinical Services				
Medical	3,586,014	2,229,705	2,875,284	2,653,814
Dental	1,038,130	1,217,056	1,217,823	1,314,421
Optometry	202,119	287,891	240,219	221,051
Pharmacy	1,286,068	1,122,677	1,492,054	1,631,774
Podiatry	190,773	107,033	101,993	344,842
Medical Lab	549,939	749,719	640,333	775,851
X-Ray				111,181
Diabetes - Clinic	1,679,713	797,546	680,280	483,737
Community Health				
Community Health Dept.	377,052	415,384	364,932	277,899
Health Education	177,030	221,757	299,954	816,638
WIC Program	70,962	64,620	63,190	40,020
Diabetes Grant (Tribal)	96,192	142,075	193,268	184,296
Environmental Health	46,939	56,113	46,624	94,400
Public Health Nursing	705,379	941,253	644,482	650,440
Community Center	149,287	214,402	293,289	174,291
Community Counseling				
Community Counseling	1,383,062	1,055,718	1,164,795	480,416
Mental Health	369,093	321,245	197,119	442,326
Adolescent Aftercare	105,297	79,931	85,647	130,052
Vocational Rehabilitation/Social S	380,723	552,314	411,200	66,509
Prevention Projects	189,942	337,782	423,370	419,615
Administrative Support				
Facilities	1,138,310	986,419	263,269	1,071,288
Security	21,872	22,891	-	
Medical Records				394,679
Health Administration	559,991	1,264,624	1,007,004	1,291,843
Business Office	83,851	947,236	462,821	646,238
Quality Assurance	165,751	106,017	-	110,678
Data Systems	561,032	269,888	107,336	482,681
Indirect Costs	825,743	1,314,107	492,258	1,335,157
Other				
Managed Care	5,306,338	5,566,489	5,836,686	3,048,409
Ambulance	1,044,889	1,071,369	300,000	325,021
Quarters	-	-	-	-
Clinic Equipment	326,118	123,740	51,865	176,684
Total	**22,617,609**	**23,204,464**	**19,957,095**	**20,196,251**

Figure 4-3

Health System Spending by Program, Continued



Interpretation: From 2013 to 2014 the overall spending on total health services increased by $288,685 (4%).

Comparing the Clinical Services expenditures of 2011 with those of 2014, $996,085 less was spent in 2014. Managed Care expenditures for the same two years of comparison also saw a reduction of $2,257,929 or 43%. Community Health also had an increase of $615,143 (38%) from the previous year. Community Counseling had a decrease of $889,199 (-37%) 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.

	2011	2012	2013	2014
Visits Billed				
Medical	10,101	9,864	9,902	12,395
Dental	2,001	2,132	2,296	3,228
Pharmacy	23,578	21,845	21,159	25,690
Optometry	356	375	467	674
All Other	2,657	2,878	2,232	2,854
Total Visits Billed	**38,693**	**37,094**	**36,056**	**44,841**

	2011	2012	2013	2014
Collections				
Medical	$ 2,122,715	$ 2,181,021	$ 2,268,671	$ 2,438,161
Dental	402,762	380,597	400,504	597,956
Pharmacy	683,018	503,271	493,904	642,661
Optometry	65,328	76,897	104,292	90,347
All Other	242,347	260,246	158,812	171,721
Total Collected	**$ 3,516,170**	**$ 3,402,032**	**$ 3,426,183**	**$ 3,940,846**

	2011	2012	2013	2014
Source				
Medicaid	2,675,989	2,522,740	2,687,154	2,944,046
Medicare	103,461	99,349	101,175	107,085
Private Insurance	556,209	503,833	438,490	400,532

Figure 4-4

Interpretations: Total Medical visits billed have increased by 16% over the last four years and an average of 10,566 visits. Pharmacy visits billed peaked in 2014 and have increased by 21% over 2013. Total visits billed peaked in 2014 with an increase of 24% over the previous year. Total visits billed have averaged 39,181 for the last four years.

In 2014, Medical billed out for 12,395 visits and received $2,438,161 (an average of $197/visit an increase of $32 per visit over last year). Medicaid accounted for approximately 75% of collections, Medicare around 3% and Private Insurance makes up 10%.

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.

	2011	2012	2013	2014
Incidents/Visits Billed				
Ambulance	614	594	636	690
Alcohol & Substance/ Mental Health		1,896	2,938 *	3,532 *
Community Health	1,459	2,075	1,502	839
Other				
Total Incidents/Visits Billed	**2,073**	**4,565**	**5,076**	**5,061**

	2011	2012	2013	2014
Collections				
Ambulance	172,032	146,086	358,739	329,823
Alcohol & Substance/ Mental Health	400,000	567,466	944,058 **	1,196,976 **
Community Health	266,563	398,428	462,830	228,950
Other				
Total Collected	**$ 838,595**	**$ 1,111,980**	**$ 1,765,627**	**$ 1,755,749**

	2011	2012	2013	2014
Source				
Medicaid	698,517	1,000,140	1,519,144	1,548,191
Medicare	36,171	1,099	112,256	77,849
Private Insurance	1,893	98,325	115,964	110,224
Workers Comp		9,980	11,317	15,013
Other	4,048	2,437	6,946	4,472

*Includes 983 A&D/MH Visits from 2013 that were billed in 2014.
**Includes $326,640 that was collected for 2013 Visits.

Figure 4-5

Interpretation: Since 2011, Tribal Collections have doubled. During 2014 collections had a slight decrease of $9,878 from the 2013 collections. Medicaid (OHP) accounted for approximately 88% of the total collected with Medicare 4%, Private Insurance at about 6%, Workers Comp and Other just over 1% in collections each.

Community Health visits was only billed through May. The June through December collections will be reflected in the 2015 Annual Report.

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	**2013**	**2014**	**2013**	**2014**	**2013**	**2014**
Workers Compensation	6	10	$ 13,964.67	$ 12,703.49	$ 11,317.00	$ 15,013.19
Medicaid	135	292	$ 189,664.09	$ 286,583.55	$ 112,256.22	$ 122,264.72
Medicare	121	88	$ 145,554.46	$ 99,769.16	$ 112,256.22	$ 77,848.88
Private Insurance	134	176	$ 159,983.88	$ 182,190.90	$ 115,963.57	$ 110,224.00
Private Pay	28	27	$ 30,977.93	$ 40,248.62	$ 6,945.90	$ 4,471.76
Managed Care	212	97	$ 237,638.30	$ 125,454.56	$ -	$ -
No Source						
Total	**636**	**690**	**$ 777,783**	**$ 746,950**	**$ 358,739**	**$ 329,823**
Average Per Transport			**$ 1,223**	**$ 1,083**	**$ 564**	**$ 478**

(1) Collection source breakout not reported

OUTLAYS AND FUNDING	**2013**	**2014**
Outlays		
Allocated Salaries and Benefits	760,740	957,301
Medical Supplies	27,896	16,786
Other Supplies & Expenses	4,209	13,210
Vehicle Expenses	34,012	38,583
Equipment		
Vehicle & Equip. Depreciation	5,782	5,795
Total	**$ 832,639**	**$ 1,031,675**
Average Direct Cost Per Transport	**$ 1,309**	**$ 1,495**
Funding Source		
Indian Health Service (PL 93-638)		
Collections		
Warm Springs Tribe - Direct Appropriation		

Figure 4-6

Ambulance Financial Summary, Continued

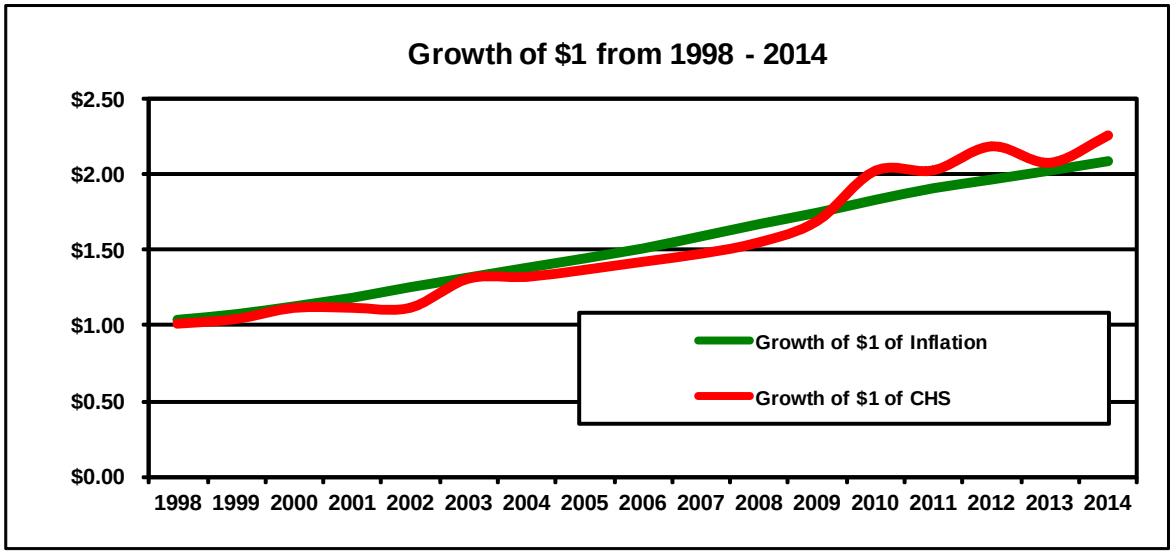
Interpretations: The collections for ambulance services decreased by $28,916 or 8% in 2014. At the same time the expenses increased by $199,036 or 24%. Most of this increase was attributable to Salaries and Benefits. The average cost per transfer increased by $186 or 12%.

Contract Health Services – Funding

Purpose: To compare annual Contract Health Services (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	7.8%	3.1%
2013	5,545,485	156,873	315,168	6,019,539	-5.0%	3.0%
2014	6,027,353		325,025	6,354,392	8.7%	3.1%



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

Figure 4-7

Contract Health Services – Funding, Continued

Interpretations: Funding increases provided by the Congress in 2009, 2010 and 2012 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 fifteen 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	
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	790,176	90,704	5,611	18,620	102,421	4,953,389	
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	1,956,174	2,091,392	739,859	179,203	11,100	21,908	179,056	5,178,692	
2013	2,109,483	1,989,259	880,062	161,423	14,592	32,833	114,555	5,302,207	*
2014	693,169	1,116,107	227,272	176,094	18,402	45,493	145,802	2,422,339	*

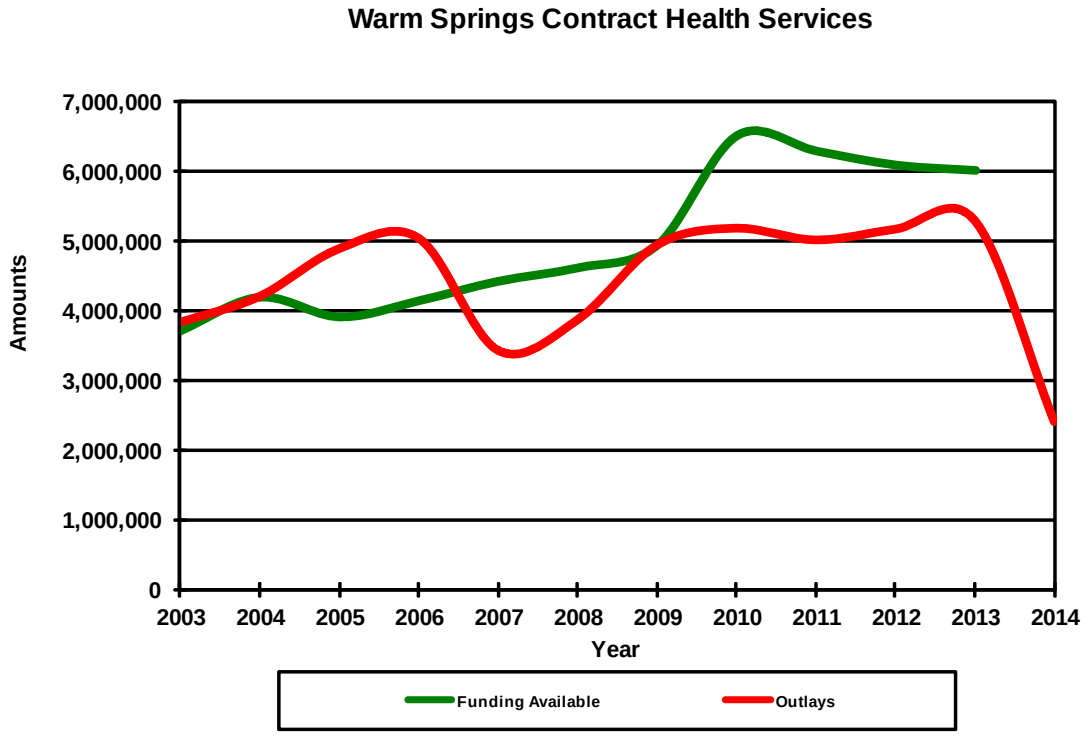


Figure 4-8

* 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.

Purchased/Referred Care – Spending, Continued

Interpretation: The data in Figure 4-8 illustrates fluctuations in MCP total costs, as well as seven components of that total cost, over twelve years. Even with the implementation of Priority I's in July 2005, costs 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 $5,302,207 in 2013. However, with $303,870 Obligated but not yet Paid for 2014, the projected $2,726,209 2014 MCP Healthcare Costs are only 51% of 2013! Medicaid Expansion is making a significant positive contribution to the financial health of MCP.

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 MCP.

Relevance: Purchased/Referred Care (PRC) funds are limited and managed on a priority basis. Patterns of utilization and costs must be monitored to support resource decisions and program priorities.

	2013			2014		
	Units	**Total Cost**	**Cost per Unit**	**Units**	**Total Cost**	**Cost per Unit**
Hospital Days	667	$1,786,179	$ 2,678	483	$693,170	$ 1,435
Emergency Room Visits	1,146	$817,277	$ 713	773	$227,272	$ 294

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 28% decrease in Hospital Days from 2013 to 2014, there was an even greater 46% decrease in Hospital Cost per Unit for this same period of time.

There was a 33% decrease in Emergency Room Visits from 2013 to 2014, and an even greater 59% decrease in Emergency Room Cost per Unit.

While the data in the table indicates the Cost per Unit for Hospital Days in 2014 was $1,435, more detailed information is found in Figure 2-16 for each of the two major hospitals that serve the community. The most significant impact from 2013 to 2014 was the implementation of Medicaid Expansion effective January 1, 2014.

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.

2014		
Priorities*	**Cases Deferred**	**Estimated Cost**
Priority 1	0	-
Priority 2	0	-
Priority 3	2,000	350,000.00
Priority 4	0	-
	2,000	350,000.00

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 $200,000. There were an estimated 350 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 $150,000. There were an estimated 1750 scripts at $150 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: e.g. immediate threat to life or limb.
Priority II: Preventive Care Services: e.g.. Screening Mammograms
Priority II: Primary & Secondary Care Services: e.g.. Specialty Consultations
Priority IV: Chronic Tertiary & Extended Care Services: e.g. Hip/Knee Replacement

CHS – Catastrophic Health Emergency Fund

Purpose: To identify the numbers of cases qualifying for Catastrophic Health Emergency Fund (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
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	1,272,006	28	25,000	572,006	149,087	242,717	391,804	180,202
2014	526,609	6	25,000	376,609	375,550	0	375,550	1,059
Totals	**$ 11,388,287**	**211**		**$ 6,117,187**	**$ 2,670,460**	**$ 1,812,787**	**$ 4,483,247**	**$ 1,633,940**

Figure 4-11

*2009 $91,274 was received on a very high cost CHEF case. Several months later, upon appeal, the OHP retroactively covered for DOS including CHEF costs. This money paid back to IHS via Budget Mod Amendment Adjustment.

Interpretations: The IHS 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. Twenty-five thousand dollars has been the threshold for the last 9 years.

The CTWS MCP operates on a calendar year fiscal year. However, the IHS operates on an October through September fiscal year. Historically, the IHS CHEF was exhausted about 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 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 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 a 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. An additional significant major impact in 2014 was Medicaid Expansion effective January 1, 2014. Not since 2007, the year Medicare-Like Rate (MLR) took effect, has the number of CHEF cases been measured in single digits. Virtually all the $376,609 due MCP for 6 CHEF cases in 2014 was reimbursed by IHS.

In the ten years from 2005-2014, there were a total of 211 cases qualifying for CHEF reimbursements of $6,117,187. Total reimbursement of $4,483,247 was received from IHS, leaving a shortfall of $1.6 million to be absorbed by the MCP in addition to the $5,271,100 initially paid out to meet the threshold.

Medicare-Like Rate Savings

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

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

	2011	2012	2013	2014
St. Charles - Madras				
Inpatient	1,060,954	942,724	542,778	197,225
Outpatient	1,163,798	1,109,233	1,019,541	783,786
Mixed	145,678	57,508	35,705	53,710
Total	**$2,370,430**	**$2,109,465**	**$1,598,024**	**$1,034,721**
Other CAH & Surgery Centers				
Inpatient	10,511	15,482	14,916	0
Outpatient	5,299	14,651	28,930	26,788
Mixed	0	0	0	0
Total	**$15,810**	**$30,133**	**$43,846**	**$26,788**
Hospitals that Bill on DRG Rates				
Inpatient	1,898,748	1,534,274	1,761,944	978,753
Outpatient	395,179	440,190	473,532	329,322
Mixed	29,551	22,312	13,108	0
Total	**$2,323,478**	**$1,996,776**	**$2,248,584**	**$1,308,075**
TOTAL MLR SAVINGS	**$4,709,718**	**$4,136,374**	**$3,890,454**	**$2,369,584**

Figure 4-12

Interpretation: After exhausting $1 million in reserves three years in a row (2004-2006), and beginning in 2007 with only $500,000 in reserves, the huge positive effect of MLR cannot be overemphasized.

The Federal Medicare-Like Rates legislation basically states that any IHS PRC or Tribally contracted plan which operates PRC 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 July 5, 2007 which resulted in significant savings for MCP. Savings resulting from MLR implementation 7 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. IHS 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 $15.1 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 $1,520,871 (39%) from $3,890,454 (2013) to $2,369,584 (2014). This 39% decrease was consistent across all three categories: 35% - St. Charles-Madras (Critical Access Hospital reimbursement); 39% - Other CAH & Surgery Centers; 42% - Hospitals reimbursed on Diagnostic Related Groups (including St. Charles Bend/Redmond).

The $2,369,584 Total MLR Savings in 2014 is extremely positive for the reasons mentioned above. However, this one year drop from 2013-2014 of 39% ($1,520,870) follows the previous year's drop of 6% ($245,920) which followed a drop of 12% ($573,344) from the year before that (2011). 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.

The main reason for the 39% decrease from 2013-2014 lies with the huge positive impact of Medicaid Expansion effective January 1, 2014 which resulted in significantly lower billings to MCP, and thus payments by MCP.

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	2011	2012	2013	2014
Grant Amount				
Diabetes Grant (Tribe)	$ 193,268	$ 193,268	$ 510,846	$ 519,818
State Women, Infants, and Children (WIC)	84,578	78,355	79,391	80,842
Woman's Wellness Conference				
CHET Dental Project				
Senior Fitness Enhancement				
Tobacco Pilot Site				
State Tobacco Prevention	74,262	73,821	73,821	72,902
USDA Commodity Warehouse	79,136	39,918	79,636	78,636
State Alcohol & Drug	230,000	125,000		
State Alcohol Prevention	105,000		62,500	
State Mental Health	278,366	381,733	362,466	362,466
State Youth Suicide Prevention		26,000		
Influenza Pandemic				
Vocational Rehablilitation	328,458	232,742		
Meth Prevention Project	140,032			
Total	**$ 1,513,100**	**$ 1,150,837**	**$ 1,168,660**	**$ 1,114,664**
Grant Expenditures				
Diabetes Grant (Tribe)	$ 96,192	$ 129,719	$ 83,549	$ 157,600
State Women, Infants, and Children (WIC)	70,962	84,061	23,200	44,874
Woman's Wellness Conference Grant				
CHET Dental Project Grant				
Senior Fitness Enhancement Grant	3,278			
Tobacco Pilot Site Grant				
State Tobacco Prevention Grant	78,464	54,516	24,746	54,396
USDA Commodity Warehouse Grant	82,019	71,905	17,440	78,465
State Alcohol & Drug Grant	188,479	172,187		
State Alcohol Prevention Grant	111,478	79,897	-	
State Mental Health Grant	234,837	144,006	80	341,263
State Youth Suicide Prevention Grant		25,094		
Influenza Pandemic	12,548	3,219		
Vocational Rehabilitation Grant	380,723	266,919		
Meth Prevention Project Grant		13,813		
Total	**$ 1,258,980**	**$ 1,045,336**	**$ 149,015**	**$ 676,598**

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 four 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			2014 FTE			2014 Enrolled TM		
	Tribal	**IHS**	**Total**	**Tribal**	**IHS**	**Total**	**Tribal**	**IHS**	**Total**
Clinical Services									
Medical		26.0	**26.0**		29.0	**29.0**		6.0	**6.0**
Dental		15.0	**15.0**		14.0	**14.0**		4.0	**4.0**
Optometry		2.0	**2.0**		2.0	**2.0**		1.0	**1.0**
Pharmacy		6.0	**6.0**		6.0	**6.0**		0.0	**0.0**
Medical Records		9.0	**9.0**		6.0	**6.0**		2.0	**2.0**
Medical Lab		4.0	**4.0**		5.0	**5.0**		0.0	**0.0**
X-Ray		3.0	**3.0**		1.0	**1.0**		0.0	**0.0**
Diabetes - Clinic		4.0	**4.0**		5.0	**5.0**		1.0	**1.0**
Community Health									
Community Health Dept.	2.0		**2.0**	3.0		**3.0**	3.0		**3.0**
Health Education	1.0		**1.0**	1.0		**1.0**			**0.0**
CHET	4.0		**4.0**	3.0		**3.0**	3.0		**3.0**
Com. Health Resource Center				3.0					
Maternal Child Health	2.0		**2.0**	2.0		**2.0**	1.0		**1.0**
Early Intervention Services				2.0		**2.0**			
Community Health Rep.				5.0		**5.0**	3.0		**3.0**
WIC Program	1.0		**1.0**	2.0		**2.0**	2.0		**2.0**
Wellness Coordinator	3.0		**3.0**	1.0		**1.0**			**0.0**
Diabetes Grant (Tribal)				2.0		**2.0**			**0.0**
SDPI Grant (IHS)						**6.0**		5.0	**5.0**
Environmental Health	2.0		**2.0**			**0.0**	1.0		**1.0**
Community Health Nursing		6.0	**6.0**	3.0		**3.0**	1.0		**1.0**
Nutrition		3.0	**3.0**	2.0		**2.0**			**0.0**
Medical Social Work	3.5	1.0	**4.5**	2.0		**2.0**	1.0		**1.0**
Physical Therapy	1.0		**1.0**	0.0		**0.0**			**0.0**
Senior Wellness Center				7.0					
Community Wellness Center					7.0	**7.0**	7.0		**7.0**
Community Counseling									
Community Counseling	5.0		**5.0**		6.0	**6.0**	3.0		**3.0**
Mental Health	6.0		**6.0**		7.0	**7.0**	1.0		**1.0**
Alcohol & Substance Abuse	12.0		**9.0**		7.0	**7.0**	4.0		**4.0**
Prevention						**0.0**			**0.0**
Administrative Support									
Facilities	11.0	2.0	**13.0**		11.0		10.0		
Security	2.0		**2.0**		1.0	**1.0**	1.0		**1.0**
Health Administration		14.0	**14.0**		8.0	**8.0**		4.0	**4.0**
Personnel		2.0	**2.0**		1.0	**1.0**		1.0	**1.0**
Procurement		1.0	**1.0**		2.0	**2.0**		2.0	**2.0**
Business Office		6.0	**6.0**		8.0	**8.0**		6.0	**6.0**
Data Systems					3.0	**3.0**		1.0	**1.0**
Transportation									**0.0**
Quality Assurance					1.0	**1.0**		0.0	**0.0**
Registration					2.0	**2.0**		0.0	**0.0**
Other									
Managed Care	8.5		**8.5**	8.0		**8.0**	3.0		**3.0**
Ambulance				32.0		**32.0**	6.0		**6.0**
JV/JHC				4.0		**4.0**	3.0		**3.0**
Total	**64.0**	**104.0**	**168.0**	**82.0**	**132.0**	**214.0**	**53.0**	**33.0**	**86.0**

Figure 4-14

Staffing, Continued

Interpretation: The Tribe and IHS staffing has shifted with the assumption of the Public Health Nursing, Mental Health Social Worker and Nutrition. With new policies in the Government background check and the Human Resources Regionalized; it slowed down the process of filling positions.

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
Paving Medical Mobile Unit Driveway	HWC	$ 15,000	2015	2015
Crack Seal, Sealcoat and Stripe Parking Lot	HWC	$ 20,000	2015	2015
Install irrigation and plant grass on bare land around clinic	HWC	$ 40,000	2015	2015
Security key pads for 3 Medical Doors	HWC	$ 3,000	2015	2015
Install new intercom system in Medical	HWC	$ 10,000	2015	2015
Replace 5 security cameras and DVR	HWC	$ 7,000	2015	2015
Install additional camera and security window glass in pharmacy	HWC	$ 5,000	2015	2015
Purchase backup cooling tower spray motor	HWC	$ 1,500	2015	2015
Replace computer for HVAC control system	HWC	$ 3,000	2015	2015
Replace carpet in 2 front entry doors	HWC	$ 5,000	2015	2015

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
Dental Autoclave	11,950	Dental	Mar-14	4/24/2014
Optometry Slit lamps (2)	15,980	Optometry	Mar-14	6/5/2014

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.

	2011	2012	2013	2014
Tribe - Self Determination Contract				
Program Savings and Carryover				
Community Health	1,095,354	1,414,810	610,642	11,606
Community Counseling	1,306,703	1,265,756	1,618,168	250,809
Managed Care	4,976,885	5,576,844	4,997,555	3,218,639
Ambulance	9,486	-	-	-
	309,752	303,995	-	
Environmental Health	199,057	269,833	300,492	368,113
Indirect Contract Support Costs	3,096,251	3,611,566	3,426,341	4,195,800
Reserves				
M & I Reserve Wellness Center	900,391	789,779	749,267	960,807
M & I Reserve Community Counseling	344,883	236,294	146,494	146,494
Equipment Replacement	108,029	6,189	2,090	127,570
Projects				
Joint Venture - Clinic Remodel	226,578	-		
Other JV Projects	282,491	66,424		
Total - Tribal	**12,855,860**	**13,541,490**	**11,851,049**	**9,279,838**
Indian Health Service				
Medicare/Medicaid	2,940,379	1,964,000	576,802	1,208,187
Private Insurance	331,789	101,000	182,884	145,639
FSA & M&I	254,037	340,000	272,723	245,792
Equipment	97,712	30,000	30,425	42,597
Total - Indian Health Service	**3,623,917**	**2,435,000**	**1,062,834**	**1,642,215**
Grants				
Diabetes-competitive grant		485,145	193,268	-
Diabetes-competitive grant - prior years		114,000	317,578	326,550
Diabetes Grant - Clinical (IHS operation)	165,390	-	455,596	415,841
Suicide Prevention		293,811	-	
Meth/Suicide		3	126,571	79,679
Diabetes-Noncompetitive grant		62,054	-	-
Domestic Violence		-	38,697	
Red Talon HIV/AIDS		15,000		
Total - Grant	**165,390**	**970,013**	**1,131,710**	**822,070**
Grand Total	**16,645,167**	**16,946,503**	**14,045,593**	**11,744,123**

Figure 4-17

Savings and Reserves, Continued

Interpretation: The cumulative savings for all accounts decreased by $4,901,044 from 2011 to 2014. 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 decreased savings of $2,571,211 over the totals of the previous year. This includes program savings, carryover, reserves and projects. The most notable changes occurred in Community Health and Community Counseling which had significant decreases of $599,036 and $1,367,359, respectively. Managed Care also had a decrease of $1,778,916 while Indirect Contract Support increased by $769,459.

The IHS accounts have limited carryover opportunities. Collections and Maintenance & Improvement are the only categories where savings can accrue. The ending balance of these savings shows an increase of $567,209 from the ending balance of the prior year (2013).

The total Grant savings has decreased by $309,640. 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 IHS 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.

Summary and Highlights

The Warm Springs Health & Wellness Center continues to achieve some of the highest GPRA performance measures in the country.

Patient satisfaction surveys continue to show positive response from patients.

Accreditation has been maintained at the facility and recommendations by the accrediting body are addressed quickly.

The cost per unit of service provided by the programs is not currently being measured or reported. The Indian Health Service financial system does not attribute many costs to the program level. It is considered a vital measure efficiency, which can point to needed cost control in a system that relies on federal money and other resources to deliver care. Efforts need to be undertaken to collect and report costs of services.

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 IHS 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 Warm Springs Health and Wellness Center 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.