The Confederated Tribes of the Warm Springs Reservation of Oregon

and

The Indian Health Service

Annual Health System Report

for the

Warm Springs Indian Reservation

November 3, 2016

2016 Edition
Reporting Information through 2015

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 2015 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 have trended upward. The national deficit is expected to limit increases in the coming years The system will rely 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 Indian Health Service has adopted Government Performance and Results Act (GPRA) measures to provide for evaluation of services. Accreditation reviews by outside bodies that are skilled and evaluation the quality of operations are also conducted. These reports point to high quality in services provided and highlight a high degree of patient satisfaction with services received. (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, 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 Indian Health Service entered into a Memorandum of Understanding, creating the Warm Springs Joint Health Commission to oversee the ongoing development of the health care system and the implementation of the Joint Comprehensive Plan for the Delivery of Health Services to the Warm Springs Indian Reservation.

The Tribal Health and Welfare Committee retain its role as liaison addressing community member access and concerns to the health system and Tribal Council. It also maintains a role in addressing regional and national health care issues and developments.

The health care system is confronted with all of the complexities of the national health care system, including inability of federal and state governments, industry and individuals to keep up with the rising cost of health care. The demographics of the nation reflect an aging population, demonstrating longer life expectancy. This creates increasing demand on the system as the older population uses a proportionally higher share of the overall health care systems. This national demographic is also present in

the Warm Springs community, in that the local population also reflects increasing portions of the total population in the older age groups.

Advances in technology and new therapies create additional demand, and while more effective against disease, bring a much higher price tag. The U.S. system continues to be based on curative care, with only a modest proportion devoted to prevention.

At Warm Springs, there has been recognition of the need to improve health status and wellness. Resources have been channeled to health promotion and disease prevention. There has long been recognition that the community can't "cure" its way to good health. One major advantage to the partnership forged with the Indian Health Service, over that of other communities, is the ability to coordinate all health system efforts to better serve and educate the community.

Although the Tribes' plan calls for a shift from curative to a more preventive orientation, the payoff is a long term proposition. Therefore the design of programs and the allocation of resources must be carefully examined to ascertain the most effective approaches. This report has been mandated to ensure evaluation and measurement of progress.

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

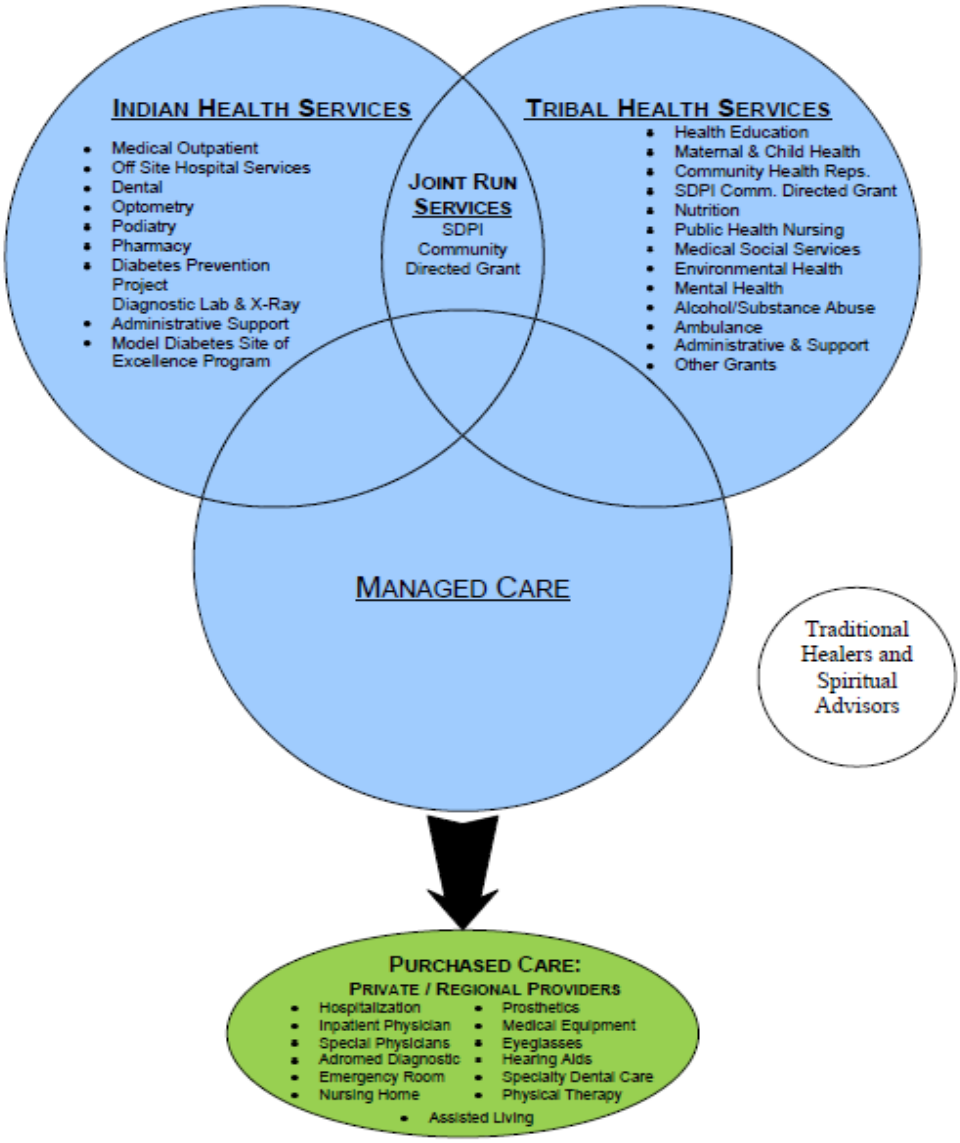
Throughout the years, the Tribe has contracted various portions of the Indian Health Service financed community health programs, mental health and alcohol and substance abuse programs, completing that transition in 2008. The Tribe has also appropriated tribal resources and sought and received grants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

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

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

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

Warm Springs Health Delivery System



SECTION 2

Customers

How do we best know and focus on our customers?

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

Summary and Highlights

The demographic profile of the customers of the Warm Springs Health Programs remains very stable in terms of the number of patients, age breakdown, residence and tribal affiliation (Figures 2-1, 2-2, 2-3 and 2-4). This stability is an important asset as programs continue to plan services, deploy resources and evaluate.

One of the most positive trends affecting the customers of service is the availability of Alternate Resources (Figure 2-5). From 2012-2015, the number of patients with Alternate Resources has increased by 1,032 (31% improvement). Medicaid only eligibility increased by an astonishing 69% over that same period. Duel eligibility for Medicaid and Private Insurance increased by 41%. This has resulted in not only a significant increase in the potential for billable services, but significant reduction of expenditures of the Purchased/Referred Care (PRC) Program which is operated by the Tribe through a Contract with Indian Health Service (IHS).

The Vital Statistics of the Tribal Members have improved dramatically over the last few years. Infant and child mortality rates have declined significantly over the past three years. The average age of death for the Warm Springs population continues to rise, but overall it is still negatively impacted by deaths early in life. The rate of progress at Warm Springs is however noteworthy. Since 1987, the life expectancy at Warm Springs has increased by 17.5 years whereas in the U.S. All Races population has increased by 3.9 years over that same period of time. This is the ultimate indicator of an improving health status. (Figures 2-9, 2-10)

Leading causes of death in the 3 year period (Figure 2-11) were Cirrhosis, Accidents and Diabetes. These were the same leading causes in the previous 3 years. Each of these conditions is amenable to prevention efforts, but the individual is ultimately responsible for necessary behavior modification. While there has been significant improvement in accidental deaths as a result of Seat Belt Laws, too many accidental deaths are still occurring. Alcohol Abuse and Hepatitis C are major contributors to Cirrhosis Deaths. Diabetes is not only a leading cause of death but a contributor to related heart disease or kidney failure.

There has been remarkable progress with respect to the number of high risk teen pregnancies. From 1996 through 2011, there were a total of 178 births averaging twenty per year to mothers nineteen and younger, which represented 24% of all births in those years. From 2012 through 2015, there were 36 births (9 per year) to that group of mothers, which represents 10% of total births. (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 as active on the Diabetes Register was 402 in 2014 and 2015. The patients with controlled blood sugar improved to 62% from 54% in 2012 (Figure 2-4). There were 16 patients in 2015 on dialysis. The number of dialysis patients has been on the rise since 2011.

In 2015 there was an alarming increase in the number of hospitalizations for the Warm Springs patients (524 admissions vs. 342 in the previous year). That represents over a 50% increase and that increase occurred in practically every category. Hospital days increased even more dramatically (1,837 vs. 1,051 in 2014). The cost per day at Madras also increased by nearly 30%. Fortunately, a large share of the hospitalizations were covered by alternate resources; resulting in a 58% cost reduction for the PRC program. Last year would have been a catastrophic year financially, if PRC did not have the level of alternate resources that were employed. The importance of alternate resource utilization became very evident when spikes in hospitalization occur as was the case in 2015.

There is no recent available data on the health risk factors of the community (Figure 2-19). Another Behavioral Risk Factor Survey is being planned so that comparisons can be made to the study completed 10 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
2015	198	6444	5737

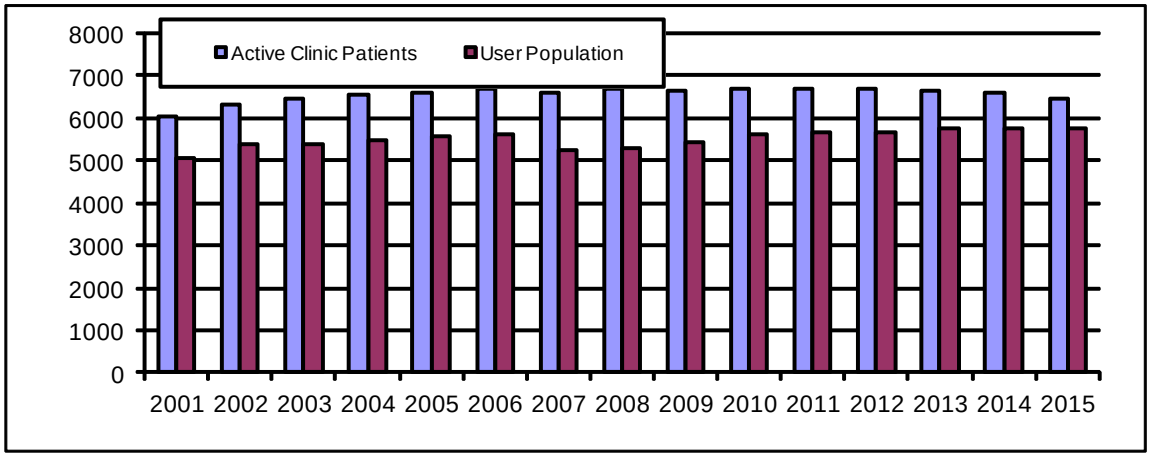


Figure 2-1

Customers That Use the Services, Continued

Interpretation: Between 2001 and 2015, new patient registrations have decreased by approximately 42%. During that timeframe, new patient registrations peaked in 2008 at 370. Over the past two years, there has been a swift decline in new patients; this is most likely due to the Affordable Care Act. In 2015, new patient registrations reached their lowest point since tracking started in 2001 at 198 registrations. In this 15 year time span, the user population has increased from 5,057 to 5,737 (12%) and the population of active clinic patients has increased by 8%. The user population and active clinic population have followed the same trends over time averaging a change within 1% in either direction. 2007 had the most significant value change; a decrease of 7.2% for the active user population.

Customers Served by Year

Purpose: To identify our patients by community of residence, tribal affiliation and the associated trends.

Relevance: While services are generally planned and financed for those who reside on or near the reservation (service area), a significant number reside outside the service area. Changes in the make-up of visits can impact access and resources.

Patients Served by Fiscal Year

By Community of Residence	2012	2013	2014	2015	Chg(14-15)
Warm Springs Indian Reservation	3,536	3,630	3,679	3,741	62
Madras/Redmond/Bend	1,266	1,263	1,234	1,162	(72)
Maupin/The Dalles/Hood River	93	85	77	80	3
Portland/Salem	104	110	84	85	1
Other Oregon	427	443	428	427	(1)
Outside Oregon	200	185	195	194	(1)
TOTAL	**5,626**	**5,716**	**5,697**	**5,689**	(8)

By Tribal Affiliation	2012	2013	2014	2015	Chg(14-15)
Warm Springs Member	3,955	4,048	4,038	3,670	(368)
Other Oregon Tribes	218	225	219	175	(44)
All Other Tribes	1,364	1,350	1,352	1,756	404
Non-Indians	89	93	88	88	0
TOTAL	**5,626**	**5,716**	**5,697**	**5,689**	(8)

Figure 2-2

Interpretation: Trends have remained stable from 2012 to 2015 with approximately 66% of our patients being Warm Springs Tribal Members (WSTM) and approximately 65% of our patients residing on the Warm Springs Indian Reservation (WSIR):

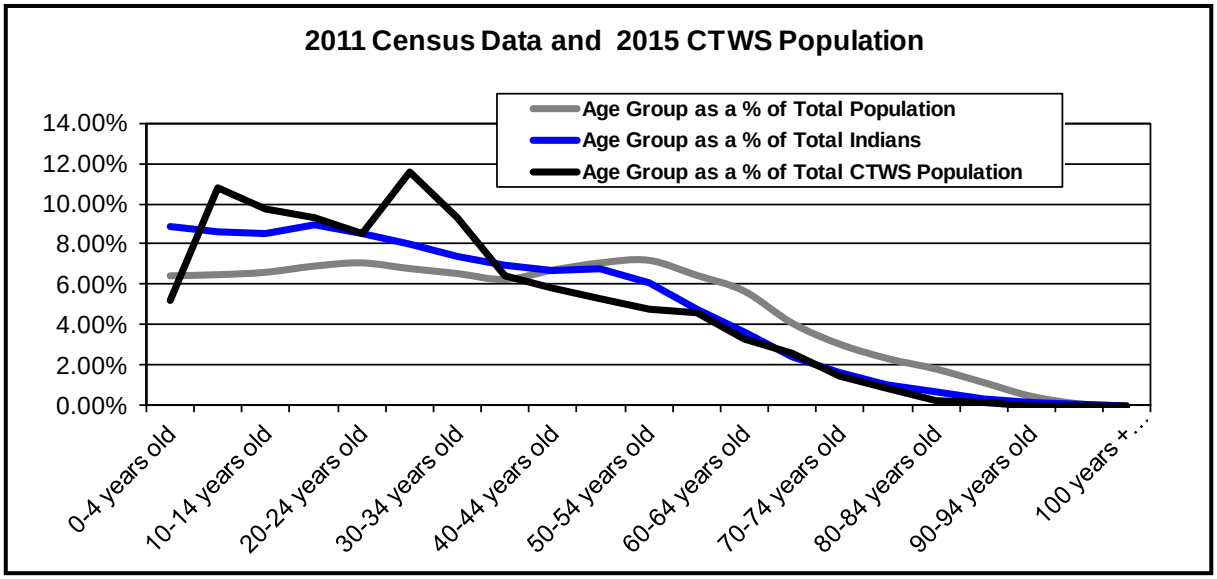
- 2008 – 68% WSTM; 64.1% residing on the WSIR.
- 2010 – 69.1% WSTM; 65% residing on the WSIR.
- 2012 – 70.3% WSTM; 62.7% residing on the WSIR.
- 2015 – 66% WSTM; 65% residing on the WSIR.

From 2012 to 2014 there was a small increase in patients who are WSTM. In 2015, there was a slight decrease of WSTM of 9%, but an increase of 1% that live on the Reservation. Between 2012 and 2015, there was an increase of approximately 6% of patients who reside on the WSIR. As of 2015, over 86% of patients resided on the WSIR or in the Madras/Redmond/Bend areas.

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

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

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



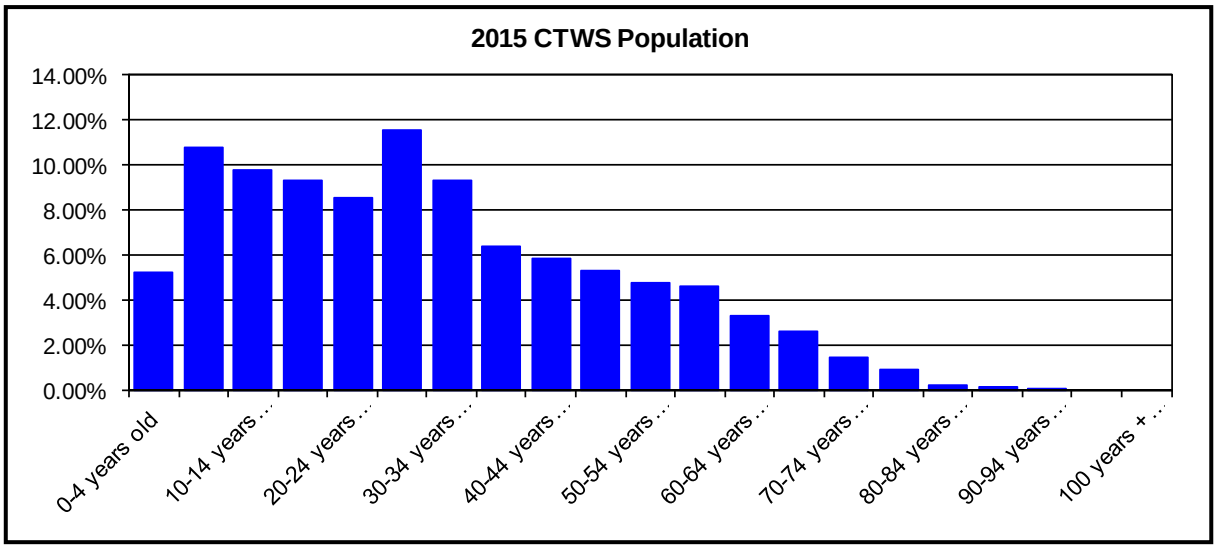


Figure 2-3

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

Interpretation: The CTWS population has a higher percentage of its population in younger age groups and fewer persons in older age groups than the U.S. general and Native American populations.

Age of Patients

Purpose: To display the age profile of patients who utilize the services over several different periods.

Relevance: Different age groups place different types of demands on the health system for services, and require different strategies. Trends advise planning for such strategies as well as resource allocation.

Patients by Age Group

Age Group	FY 2000 Patients	2012 Patients	2013 Patients	2014 Patients	2015 Patients
0-4	543	699	588	618	566
5-9	460	545	532	562	540
10-19	1,367	968	984	981	1,017
20-29	971	1,082	1,025	963	905
30-39	912	725	700	714	722
40-49	738	699	659	643	622
50-59	440	633	615	579	627
60-69	204	449	424	441	460
70-79	98	180	166	180	194
80+	40	62	63	57	54
TOTAL, Patients	**5,773**	**6,042**	**5,756**	**5,738**	**5,707**

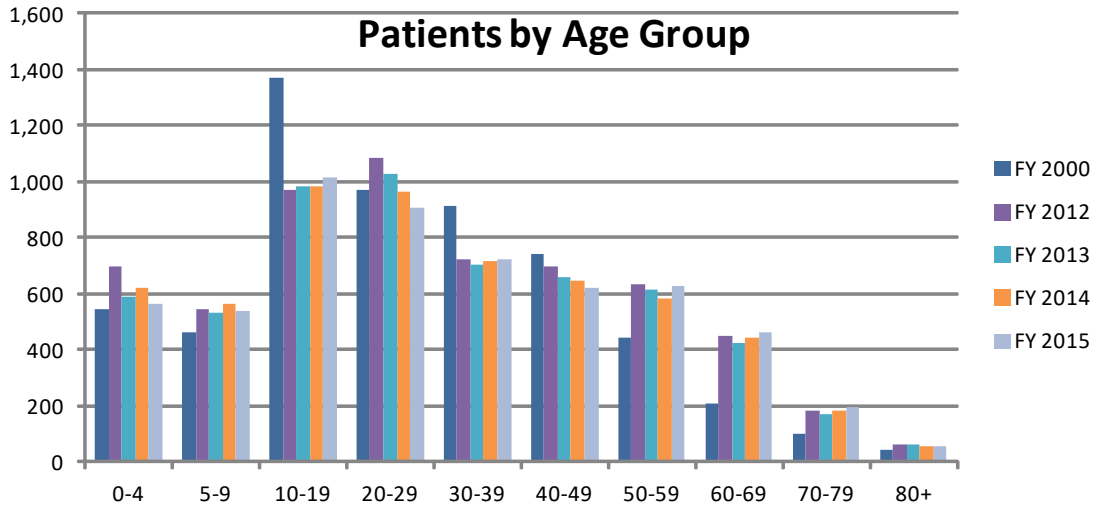


Figure 2-4

Interpretation: The total number of patients seen in 2015 closely approximates the number of patients seen back in the year 2000. However, patients over 50 years of age increased by 71%. All other age groups have declined with the exception of the 0-9 age group which has increased slightly.

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) Purchased/Referred Care (PRC), 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 2012	FY 2013	FY 2014	FY 2015
Medicaid Only	1,455	1,637	2,264	2,487
Private Insurance Only	1,263	1,313	1,109	853
Medicare A Only	33	29	29	27
Medicare B Only	-	-	-	-
Medicare Part A & B Only	138	126	142	139
Medicare Part D	200	217	230	249
Medicaid & Medicare	35	28	35	33
Medicaid & Private Ins.	736	663	1,119	1,067
Medicare & Private Ins.	142	159	150	136
Medicaid, Medicare, & PI	6	7	7	7
Total	4,008	4,179	5,085	5,252
Non-Billable				
Tribal Employee Self-Insurance	224	52	67	254
No Alternate Resource	2,276	2,277	1,926	1,626
Total	2,500	2,329	1,993	1,880
Total Patients	**6,508**	**6,508**	**7,078**	**7,132**

Figure 2-5

Interpretation: From 2012 to 2015 the number of patients with Alternate Resources has increased by 1,244 or 31%. Medicaid Only eligibility increased by an astonishing 1,032 or 71% over that same period. The duel eligibility of Medicaid & Private Insurance increased by 45%. Those with no Alternate Resources designated decreased by 29%. Medicare numbers were fairly stable.

This presents a very positive picture of a population and a staff who have worked together to take full advantage of the expansion of Medicaid and the Affordable Care Act. It will pay dividends in terms of collections and ensure the viability of the PRC Program that is administered by the Tribe.

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
2015	0	11	20	32	22	4	89
Total	**0**	**214**	**366**	**293**	**168**	**74**	**1115**
% of Total	**0.0%**	**19.2%**	**32.8%**	**26.3%**	**15.1%**	**6.6%**	**100.0%**

Figure 2-6

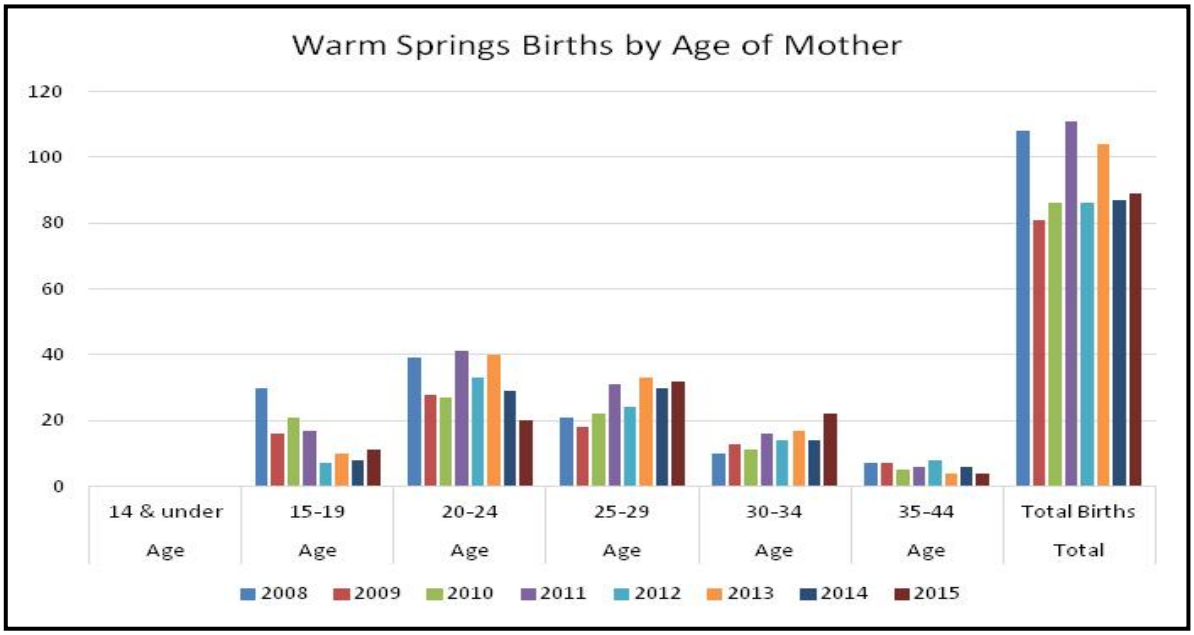


Figure 2-7

Tribal Member Births by Age of Mother, Continued

Interpretation: From 1996 through 2011 there were a total of 178 births to mothers 19 and younger, which was 24% of all births during that time period. From 2012 through 2015, there were a total of 36 births to that group of mothers which represents 10% of all births during that particular period. That means the high risk pregnancies have been lowered considerable in a relatively short time. The total births in 2015 were 89, which is only 2 greater that births that occurred in 2014. (Figures 2-6, 2-7)

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.

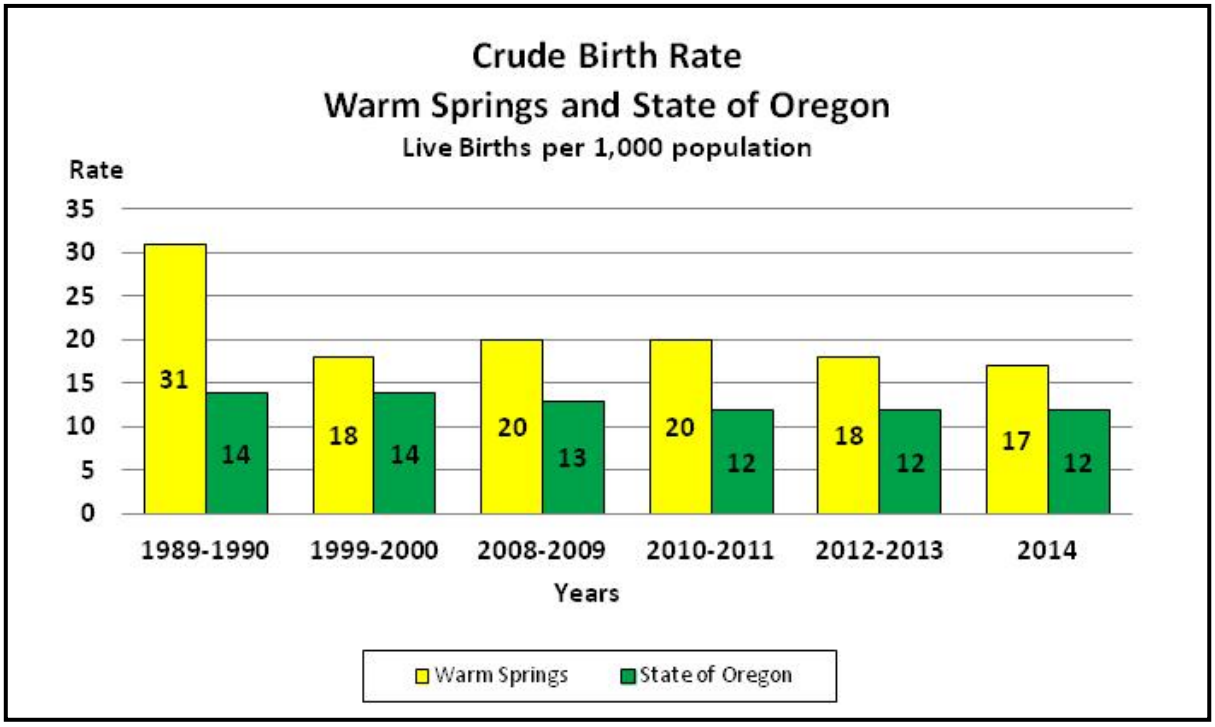


Figure 2-8

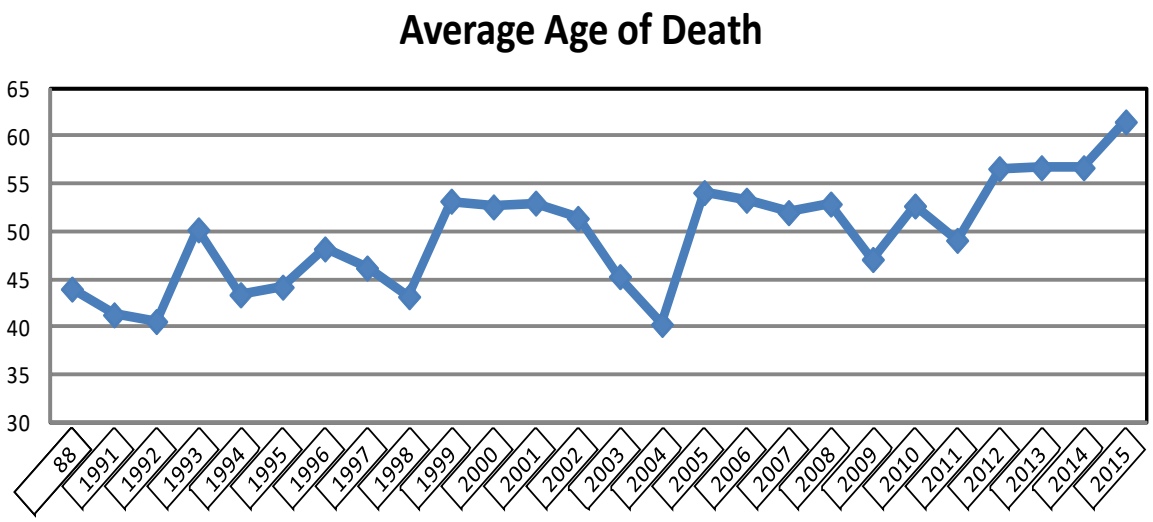
Interpretation: Past reports reflected a substantially higher birth rate in Warm Springs than the general Oregon population. The difference reduced by the 2000 report but has remained fairly consistent since then with a slight decrease noted in 2012 – 2014 to an average of 17 live births per 1,000 population.

The statistics for the 2015 Birth Rate Comparison will be finalized through the State of Oregon Vital Statistics Department in August 2016 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	2015
Number of Deaths	83	84	111	103	121	155	117	44
Crude Death Rate	502	482	608	524	605	774	587	683
Years of Productive Life Lost	1,889	1,877	1,794	2,141	1,906	2,898	1,594	442

Figure 2-9

Interpretation: This report reflects a significant loss of life at earlier ages than is reflected in the general U.S. population, where the average life expectancy was 78.8 in 2014. The average age at death continues to increase. Deaths early in life continue to have a disproportionately high impact on the local population, but the impact is decreasing. Since 1987 the life expectancy in the US, all races population, has increased 3.9 years compared to 17.5 years in the local population.

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
2013-2015	2	6.5	1	5.1	1	5.2

Leading Cause of Death 2003-2015

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
Homicide

Teen:

Cause 1: Accidents
Cause 2: Malignant neoplasms
Cause 3 Intentional Self Harm (suicide)

Figure 2-10

Child Mortality Rates, Continued

Interpretation: This report reflects the changing nature of infant mortality in the past decade. In 1987-88, there were four deaths due to sudden infant death syndrome (SIDS). In the last decade, there have only been 2 deaths due to SIDS. Despite the decline in SIDS, infant deaths have been increasing, primarily due to accidental death and birth defects. Since 2010, we are seeing this trend reverse.

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

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 2015 , IHS 2013, US 2014)

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

*-Tied

Trends in the Leading Causes of Death (3-yr average), Warm Springs, 1994-2015

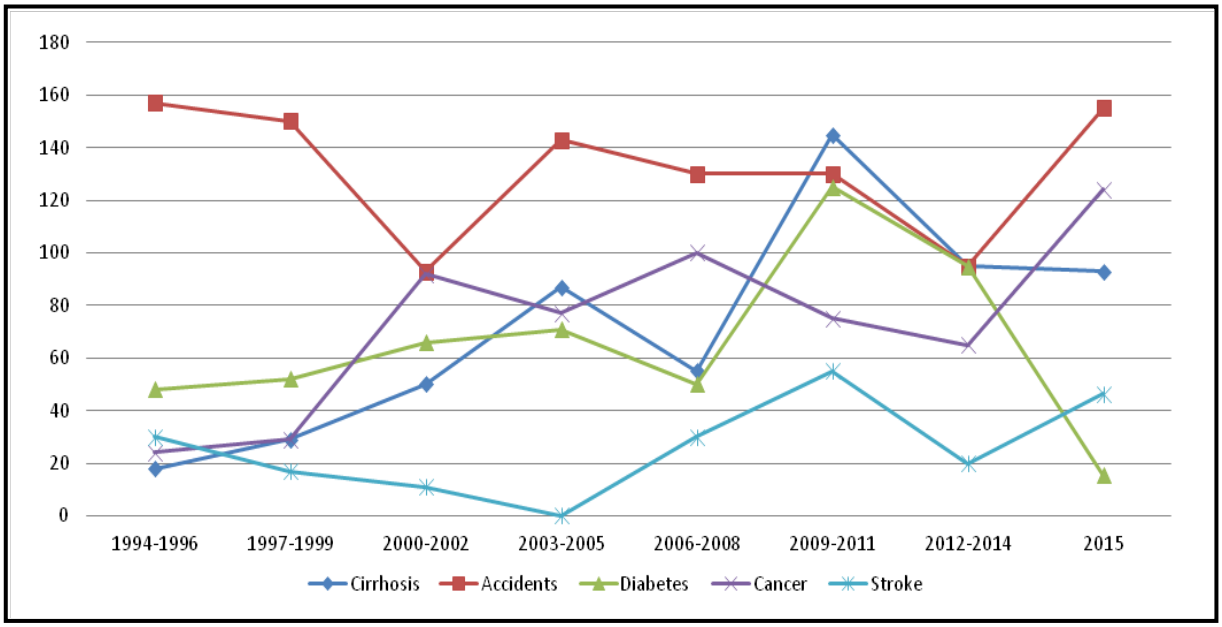


Figure 2-11

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

Cause of Death, Continued

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

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

Prevalence of Major Chronic Diseases

Purpose: To highlight the prevalence of chronic disease by major condition.

Relevance: This information is vital to understanding the extent of each condition and the development of effective responses. Chronic diseases account for 70% of all deaths in the United States. The medical care costs of people with chronic diseases account for more than 75% of the nation's medical care costs. Chronic diseases account for one-third of the years of potential life lost before age 65.

Patients Identified with Chronic Disease in 2012 - 2015

Condition	FY 2012	FY 2013	FY 2014	FY 2015
Diabetes	605	622	627	631
Ischemic Heart Disease (IHD)	100	104	108	109
Hypertension 18-85 w/HTN DX	503	510	512	495
Asthma	286	272	276	225
Prediabetes/Metabolic Syndrome	904	881	515**	428
Rheumatoid Arthritis	81	76	78	88

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 Diabetes Prevention Program (DPP) to identify and engage people at risk for diabetes over the past several years. We have engaged in community education and events to promote personal health activities in order to prevent chronic diseases. It is important to continue providing resources to more effectively engage all people in identifying lifestyle factors that contribute to chronic disease and to provide support for self health management.

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.

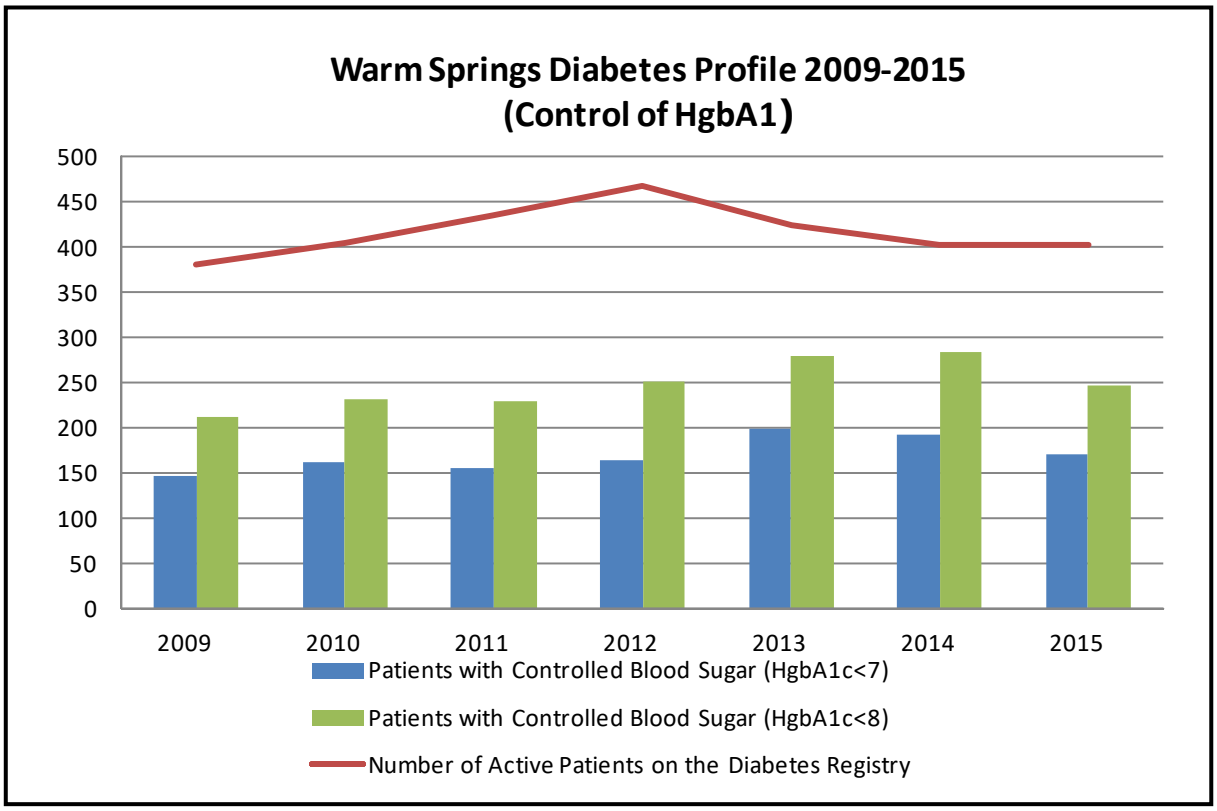


Figure 2-13

Customer Diabetes Profile, Continued

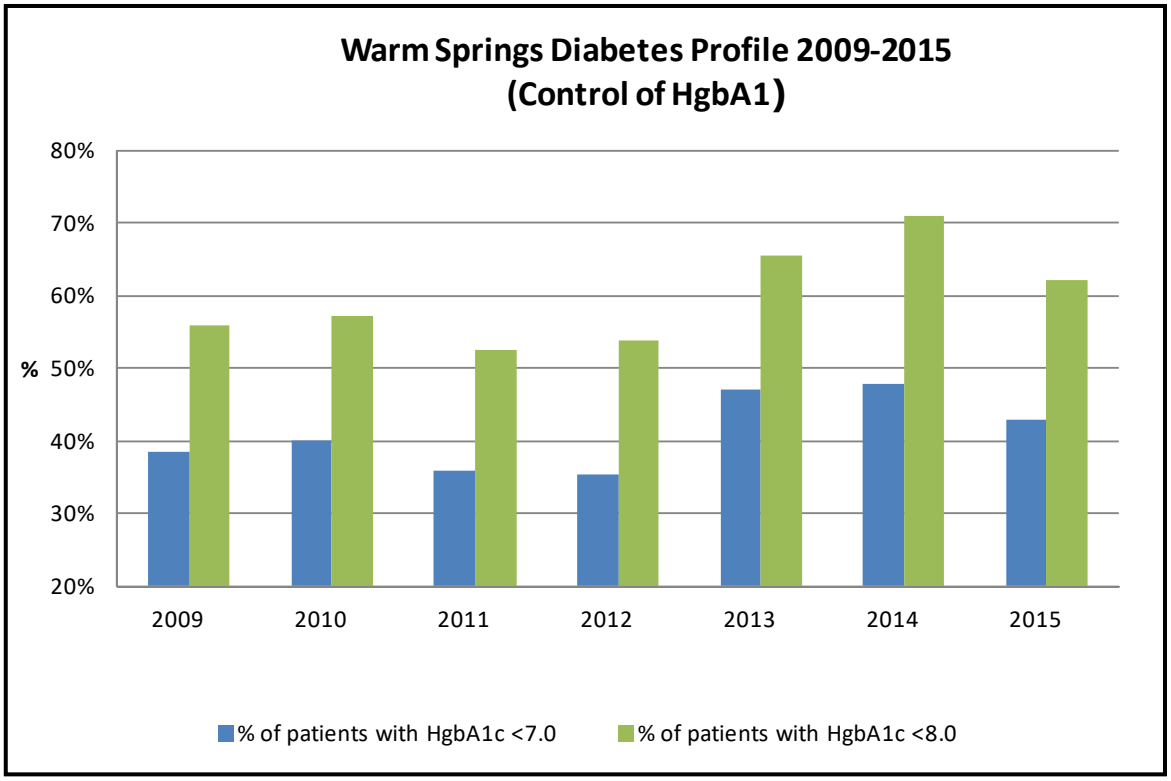


Figure 2-14

Interpretation: The number of patients in the diabetes registry remained at 402. 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 WSHWC (i.e. VA or private physician) are not included as active in the diabetes registry. Ideal control of HgbA1c (<7%) decreased between 2014 and 2015 from 47.8% to 43% 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%) decreased from 70.9% in 2014 to 63% in 2015.

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.

Purchased/Referred Care Financed Hospitalization

Inpatient Indicators	2013 - 2015		
	2013	2014	2015
Total Admissions	185	118	159
Average Length of Stay	3.61	4.09	4.50
Total Hospital Days	667	483	715
Average Daily Patient Load	1.83	1.32	1.96
Emergency Room Visits	1,146	773	540

Purchased/Referred Care Hospitalizations and Those Paid by Other Resources
Warm Springs Patients by Primary Diagnosis

Condition	2013		2014		2015			
	# of Admits	# of Hosp. Days	# of Admits	# of Hosp. Days	Number of Admits	% of Admits	Number of Hospital Days	% of Hosptial Days
Obstetrics	107	216	115	231	135	25.8%	344	18.7%
Motor Vehicle Accidents	3	7	2	2	3	0.6%	8	0.4%
Other Accidents/Injuries	27	120	17	97	53	10.1%	292	15.9%
Cancer	3	12	7	42	1	0.2%	2	0.1%
Heart and Circulatory	28	78	24	92	36	6.9%	141	7.7%
Respiratory	44	193	40	112	88	16.8%	340	18.5%
Renal	18	54	16	69	26	5.0%	70	3.8%
Digestive	47	133	44	115	60	11.5%	153	8.3%
Infectious Disease	40	205	36	143	54	10.3%	300	16.3%
Diabetes	6	17	7	41	9	1.7%	27	1.5%
Substance Abuse	12	30	13	40	16	3.1%	38	2.1%
Mental Health	3	7	8	14	9	1.7%	26	1.4%
All Other	11	29	13	53	34	6.5%	96	5.2%
TOTALS	**349**	**1,101**	**342**	**1,051**	**524**	**100%**	**1,837**	**100%**

Figure 2-15

Interpretation: These two tables (Figure 2-15) describe the hospitalization experience in two different ways. The first table describes the cases for which the Purchased/Referred Care (PRC) Program provided payment. The second table is all

Hospitalization of Customers, Continued

inclusive covering cases that were paid by the PRC plus all other cases that were financed by other alternate resources.

The Purchased/Referred Care Caseload (first table)

- The number of hospital admissions increased by 41 (26%) from the experience of the prior year.
- The Average Length of Stay increased by 0.41 (9%) from the prior year.
- The Total number of hospital days increased by 232 (32%) from the previous year.
- The total number of Emergency Room Visits decreased by 233 (30%) from the previous year.

The above statistics in hospital admissions, average length of stay and total hospital days represent a reversal of the improving pattern of PRC financed hospitalization. These spikes in hospitalization will occur from time to time which is why a healthy reserve is necessary to maintain. It is fortunate to this program that Medicare Like Rates are in place so that the cost per day offset the increase in hospital days.

In 2015, 73% of the total admissions were financed by the Oregon Health Plan (Medicaid) and other Alternate Resources, which compares very favorably with the prior year when 66% of admissions were covered by others.

This performance resulted in the lowest exposure to the highest cost item in the Health Service Budget. This is nearly a $2.5 million dollar decrease from costs experienced in 2010-2012. (See detail in the Resource Section of this report).

Total Hospitalization Caseload regardless of payment source (second table)

This table identifies Total Admissions and the associated number of hospital days for the last three years by category. For the latest year, the breakdown also includes the percentages within each category.

The actual number of admissions for patients in 2015 regardless of payment source increased from the prior year (524 vs. 342; a 53% increase). Overall hospital days increased from 1051 to 1837 (75%).

The PRC Program covered 30% of hospital admissions and 39% of hospital days in 2015. In the previous year (2014), 34% of all admissions and 46% of hospital days were covered. This is also a significant factor in reducing financial obligations for hospital care.

The total admissions and days by category help us understand which conditions are the sources of hospitalizations. As in 2014, the number of obstetrical cases led in both total admissions (26% - 2015) and days (19% - 2015).

Hospitals Utilized and Expenditures

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

Relevance: While this represents an incomplete picture of total hospitalization, it does highlight where PRC resources are being expended.

Hospitals Utilized
2015

Hospital	Admissions	Hospital Days	Total Cost $	Cost per Day
St. Charles-Madras	83	296	$315,836	$1,067.01
St. Charles-Redmond	9	32	$8,149	$254.66
St. Charles-Bend	65	378	$51,312	$135.75
Legacy Emanual	1	8	$32,441	$4,055.16
All Other	1	1	$20,258	$20,258.22
Totals	**159**	**715**	**$427,996**	
			Total Cost per Day	**$598.60**

Figure 2-16

Interpretation: This table reflects the total cost of hospitalizations PRC paid for in 2015, and the number of admissions and hospital days that comprised this cost at the three major hospitals utilized. St. Charles-Madras accounts for 74% of the total hospital costs, compared to 27% last year, with St. Charles-Bend accounting for 12%, compared to 20% last year.

When comparing 2015 to 2014, an increase of 41 occurred in the number of hospital admissions financed by the PRC was noted. There was also a corresponding increase of 232 in the number of hospital days covered by the PRC.

The cost per day figures report above can be somewhat misleading. The cost per day can reflect some admissions that are partially paid by another resource. In the future efforts will be made to try to separate admissions, so only those cases that are fully paid by PRC are used to compute cost per day.

The effective use of alternate resources has decreased PRC's expenditures and the Medicaid Expansion, implemented in 2014, has created cost savings. Since the inception of Medicare Like Rates and Medicaid Expansion, PRC has seen dramatic savings and believes that this trend has reached a plateau and steady savings for the program will continue to be seen, which in turn shall benefit future health delivery cost. Resources are still vulnerable due to unusually high rates of hospitalization as was the case in 2015.

Emergency Room Utilization

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

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

EMERGENCY ROOM VISITS

	2012	2013	2014	2015
Allergic Reaction	14	10	10	8
Cardiovascular	49	80	45	35
Cellulititis/Infections (impetigo)	78	83	47	22
Chronic Conditions	31	31	19	24
Communicable Disease	12	22	4	4
Dental	30	23	25	11
Dermatology (includes spider bites)	19	18	10	12
Drug/Alcohol	59	76	30	15
ENT (ear, nose, throat)	85	79	43	33
Eyes	7	11	8	6
GI	106	134	82	57
GU	80	73	56	43
Headaches	35	29	14	12
MEDS Only/ Dressing Changes	4	2	1	0
Miscellaneous	28	46	29	27
NeurologyEUROLOGY	12	14	21	17
OB-GYN	9	22	15	13
Orthopedic (musculoskeletal)	187	201	99	72
Pulmonary	70	78	89	45
Psychiatric (Mental Health)	20	19	10	8
Snake Bite	0	1	1	0
Trauma				1
Assault	22	13	3	0
Gunshots	1	1	0	1
Lacerations/Burns/Contusions	131	159	90	47
MVA	22	11	4	0
Poisons (ingested/breathed)	10	10	0	4
Sexual Assault	1	1	1	0
Drowning	0	0	0	0
Other	18	6	1	0
Triage Only	0	0	0	0
Viral Syndrome	13	9	23	23
Vascular (blood) - anemia/hem	0	1	0	0
TOTALS	**1,109**	**1,239**	**773**	**540**
COST (As Of 4/22/16)	$739,859	$880,062	$227,272	$256,999
COST PER VISIT	$667	$710	$294	$476

Figure 2-17

Emergency Room Utilization, Continued

Interpretation: The ER cost for the years 2014 and 2015, show that from 2013 to 2014 there was a decrease of $416 per visit to $294. This is a 241% decrease. From 2014 to 2015 there was an increase of $182 per visit to $476. This is a 62% increase. This large increase seems to be from diagnosis of injury rather than increased medical costs.

The 2014 reversal in cost is still trending into 2015 as Medicaid Expansion has reduced costs exponentially. Since January 1, 2014, costs have significantly decreased by $652,790, a 74% decrease. Continuing into 2015, those costs maintained with savings over 2013 at $623,063, a 71% decrease.

PRC 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 PRC is not responsible (i.e. OHP), while the "COST" is the total amount paid by PRC for ER claims.

EMERGENCY ROOM VISITS - TIMES / DAYS

	2012	2013	2014	2015
0800-2000,weekdays (8:00am-8:00pm)	490	500	298	188
2000-2400, weekdays (8:00pm-midnight)	226	267	175	152
2400-0800, weekdays (midnight-8:00am)	60	74	31	32
0800-1600, sat, sun (8:00am-4:00pm)	136	154	82	51
1600-2400, fri, sat, sun (4:00pm-midnight)	84	130	90	46
2400-0800, sat, sun, mon (midn-8:00am)	113	114	97	71
TOTALS	**1,109**	**1,239**	**773**	**540**

Figure 2-18

Interpretation: Emergency care is a critical component of the overall healthcare system. However, there has been a national trend towards increased utilization of emergency room services provided for what would be more appropriately cared for in 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 four years, with ER visits on weekdays between 0800-2000 hours ranging within a narrow margin from a low of 188 in 2015 to a high of 500 in 2013, with this year's total of 188 below the four year average of 369.

Major Community Health Risk Factors

Purpose: To highlight community health risk factor surveys most recently identified through behavioral risk factor surveys conducted in 2006.

Relevance: Behavioral risk factor survey is a scientific method of quantifying risks. The prevention orientation of the program requires on-going examination and program and strategy adjustments which relate to changes identified.

Health Risks Most Recently Identified:	Estimated % of Population Affected*
• Motor Vehicle Accidents	45.0%
• Tobacco Use	44.0%
• Alcohol and other Drug Use	45.0%
• Overweight/Obesity	75.0%
• Hypertension	24.5%
• Diabetes	18.6%
• High Cholesterol	21.7%
• Arthritis	26.4%
• Mental Health / Suicidal thought	14.0%
• Abuse (various)	30.0%
• Unintentional Injury	71.1%
Perceived Health Status: Poor	4.4%
Perceived Health Status: Fair	29.1%

Figure 2-19

***** 2006 – Behavioral Risk Factor Survey

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

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

SECTION 3

Services

How do we design and deliver high quality responsive health services?

The comprehensive health plan anticipates an ongoing review of services being provided and other information that will aid in understanding the deployment of resources to provide them. Workload measures aid in understanding how patients are accessing the health system.

This section describes the workload associated with each of the health care components. The workload is a function of patient demand and available staff. The information is useful to determine staffing priorities and what adjustments need to be made to better provide more access to services. The efficiency of various services can also be evaluated. For example, how well does the workload conform to the priorities identified by the Health Commission? How effective and efficient has been the extension of clinic hours? How has the outpatient work load changed since August 15, 2013, when the doctors transitioned out of inpatient coverage at St. Charles Hospital – Madras.

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

Areas of Focus that Supports Improved Patient Care:

- Since summer of 2013, the WSH&WC has been working with the Community Health Nurses to provide health care throughout the community in the Mobile Health Clinic.
- Along with community partners, a review will be conducted of the professional staff needs and necessary changes will be made.
- With focus on care provided at the WSH&WC, it is anticipated that there will be increased access to provider appointments each day.
- The service unit will continue to work closely with the St. Charles Hospital – Madras to ensure that our community patient needs are met.

A significant portion of program information has not been maintained for items to be reported. New reporting mandates are being implemented to assure that the needed information will be available to future reports.

In an effort to improve accessibility to outpatient care, there have been a number of changes made. A new Medical Mobile Unit (MMU) had its first full year of operation. In 2015 the MMU provided 464 medical visits, 578 dental visits and 9 community health visits (Figure 3-38). It is anticipated that this workload will continue to increase as the community gets more familiar with the operation schedule. The WSH&WC continues to offer extended hours (196 days in 2015), but the workload remains stubbornly low at 2.1 patients per hour. (Figure 3-1)

Now that physicians no longer provide care to patients in the hospital, it was assumed that physician workload at the clinic would increase. That, however, was not the case in 2015 as both physician and mid-level practitioner visits actually declined. (Figure 3-1)

Productivity of clinicians is a complicated issue but it is important to examine all the related factors so that the situation can be improved. Some of the factors that may impact patient visits include: excess administrative requirements, the appointment system and patient compliance, support staff in terms of number and skill set, facility restrictions, Mobile Unit impact and of course, patient demand may be falling off. Physicians choose their profession to “see patients”. It appears as though they are absorbing a great deal of work that may be related, but is detracting from their primary responsibility. This situation is not unique to Warm Springs, as studies from the Journal of Medical Economics indicate patient visits per week per family practice provider have dropped from 99 to 89 in the period 2013-2014. These calculated rates are much lower (2183 average visits per physician per year divided by 46 available weeks = 47 patients per week). (Figure 3-1)

During 2015, the Podiatry Program was without a Podiatrist for the majority of the year, thus the workload presented (Figure 3-2) included only a month of operations. This important program now has hired a Podiatrist and continues to have a Nurse/CMA; therefore it is resuming full time operation.

In 2015 the Dental Program experienced its best year in terms of patient visits. Both Dental and Hygienist visits were up 18% over the previous year. The total number of identified problems that were treated was also up 20%. (Figure 3-3)

The Optometry Program had another banner year in terms of patient visits (44% increase) despite a 20% missed appointment rate. (Figure 3-7)

Pharmacy filled 77,177 prescriptions in 2015, which is less than a 1% increase over the previous year. The average cost of a prescription increased nearly 15% (Figure 3-4). The staffing also increased in 2015 as therapy management services, adult immunizations and additional consulting services expanded.

Community Health Nursing visits increased by 26% in 2015 but the number of services declined by 29% (Figure 3-9). With an average of 10 visits per day for a staff of three brings into question the productivity and expectations of the program.

The Maternal Child Health Program identified 89 births in 2015 of which 79 were Tribal Members. A total of 43 (48%) were determined to be high-risk pregnancies and 39 high-risk infants were closely followed (Figure 3-10). The management of high-risk cases is having a very positive impact and a key component responding to the strategic principles set out by the Health Commission.

The Community Health Representatives Program visits declined by 44% in 2015. Several components of service, which were previously reported, did not indicate any activity. This is another program that needs to look at their services and productivity. (Figure 3-12)

The Diabetes Program experienced a decline in visits during 2015. There was a Nurse Practitioner vacancy for nearly half of the year, which negatively impacted the workload figures (Figure 3-13). Diabetes remains a very high priority across all health programs and progress is occurring.

The Mental Health Program is in transition as it experienced a retirement, three resignations and the loss of the part-time psychiatrist. This resulted in a loss of critical services and a corresponding reduction in revenue. This is a great need that requires more attention. Despite these handicaps, the program increased its preventive services by three fold. (Figure 3-17)

The Alcohol & Substance Abuse Program also lost a number of seasoned counselors between 2014-2015, which resulted in a decrease in visits and days of service (Figure 3-18). The Health Commission is well aware of the seriousness of these problems and the inadequacy of the response. There is a need for an improved information system and more talented staffing in all areas of Behavioral Health.

The Ambulance Service experienced a small decline in ambulance calls but an increase in the number of patients transported. A total of 93% of the calls and transports were for Tribal Members and Dependents. Calls with a Substance Abuse Factor accounted for 211 calls, which was a substantial increase from the previous year.

The Purchased/Referred Care Program experienced an outstanding year attributed to a very effective pursuit of alternate resources. The number of obligations processed was a new low of 6,206. More importantly the funds obligated were also at a new low of $2,094,865 which was $630,000 less than last year and $3.3 million less than 2013 (Figure 3-8). It is remarkable that this occurred despite a significant increase in hospital days in 2015.

KWSO and Spilyay Newspaper both continue their very appreciated support of all the Health Programs. KWSO broadcasted 15,266 Public Service Announcements (PSA) pertaining to health matters. The Spilyay continued their great support with 232 articles and 428 announcements. These are both extremely valuable allies in efforts to improve the health status of the community.

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.

Medical Department

	FY2012	FY2013	FY2014	FY2015
Medical Visits by Provider				
Physicians	11,459	10,057	8,600	7,639
Mid Level Practitioners	3,920	5,297	5,933	4,837
Nursing Staff	3,961	4,249	4,357	6,063
Total Medical Visits	**19,340**	**19,603**	**18,890**	**18,539**
Workload Factors				
Clinic Days	250	250	250	250
Average Visits Per Clinic Day	77	78	76	74
Total FTE's In Medical Department	22	22	21	21
Physician FTE's	5.0	4.0	4.0	3.5
Mid-Level Practitioner FTE's	2	2.5	2.5	2.5
Avg Annual Visits Per FTE	879	891	900	883
Avg Annual Visits Per Physician FTE	2,292	2,514	2,150	2,183
Avg Annual Visits Per Mid-Level FTE	1,960	2,119	2,373	1,935
Extended Hours of Service				
Days of Late Clinic	202	114	201	196
Hours of Service (M-Th, 7pm)	404	228	402	392
Visits	902	741	851	831
Visits Per Hour of Service	2.2	3.3	2.1	2.1
Hospital Patient Count	381	325	2	-
Hospital Visit Count	1,654	1,378	2	-
Average Hospital visits per patient	4.3	4.2	N/A	N/A
Average Hospital patients per day	1.0	0.9	N/A	N/A
Average Hospital visits per day	4.5	3.8	N/A	N/A

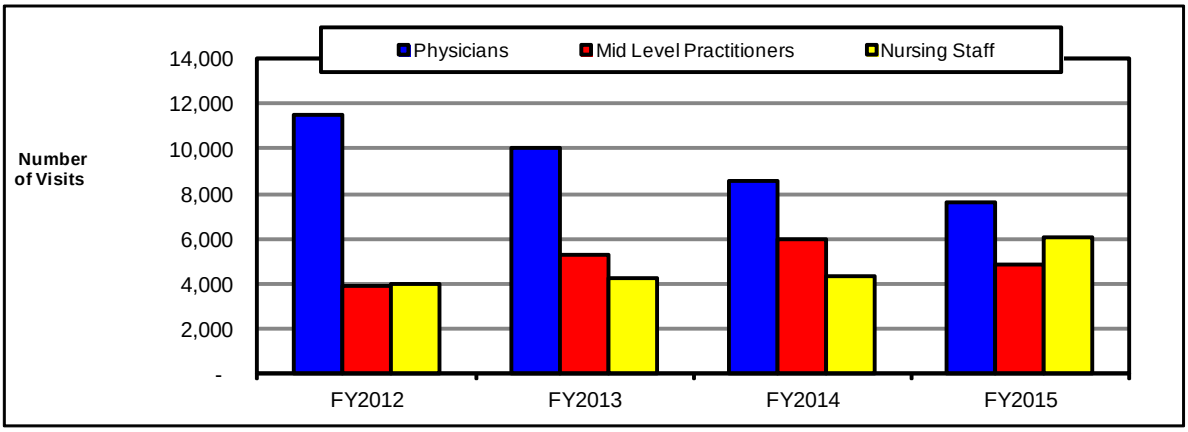


Figure 3-1

Medical Services, Continued

Interpretation: The number of medical clinic visits in 2015 totaled 18,539 or an average of 74 visits per clinic day (250 days open). The breakdown by provider of care was as follows: physicians 41%, mid-level practitioners 26% and nursing staff 33%.

Each physician provided an average of 1,909 visits. This was lower than anticipated as the physicians transitioned out of hospital service in August 2013. The number of visits serviced by mid-level practitioners also declined in 2015.

The Clinical Director and Quality Improvement Supervisor are looking into a better way to capture the data to more thoroughly show the day to day workload/responsibilities of all providers.

Quality of care is dependent upon spending an adequate amount of time with patients so that may be factor in the lower number of visits. The recent addition of a Medical Mobile Unit (MMU) may also play into why there was a lower rate of visits.

IN 2015, the clinic was open late 196 days for extended hours from 5pm to 7pm. During those times, the late clinic averaged 2.1 medical visits per hour.

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

Podiatry Program

Purpose: To identify the Podiatry 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.

Podiatry Department

	FY2012	FY2013	FY2014	FY2015
Podiatry Visits				
Physican Visits	1,608	1,751	1,976	154
Nurse/CMA visits				224
Missed Appointment Rate	21%	24%	23%	
Workload Factors				
Physican Clinic Days	143	143	155	28
Average Visits per Clinic Day	11	12	13	6
Nurse/CMA Clinic Days*				90
Average Visits per Clinic Day				2
Nature of Visits				
PT visit with Diabetes	615	808	886	220
PT visit with Open Wound	223	297	359	
Comprehensive or Annual DM Ft Exam	105	108	133	
Office Procedure Performed	376	464	508	
OR Case	4	15	9	2
Hospital Patient	19	87	2	
Other Visit Reasons	503	433	469	
Total Podiatry Visits (Some patient visits include multiple problems)	**1,685**	**1,824**	**1,987**	

Figure 3-2

Interpretation: For the majority of 2015, there was not a Podiatrist to provide needed services in Warm Springs. A new Podiatrist was hired late in the year, thus the huge drop in visits from 2014 to 2015. There were also coding issues that will be corrected for the 2016 report. The newly hired Podiatrist and Nurse/CMA will continue to reduce the "No Show" rate.

Dental Services

Purpose: To identify the Dental Program workload by provider category. For each year, to determine the impact of broken appointments, to identify the categories of care provided.

Relevance: Workload measures are useful to describe overall program growth and plan resources – particularly personnel requirements. Broken appointments represent a loss of resource capability and waste of health resources. The categories of care describe the patient service needs.

Dental Department

	FY2012	FY2013	FY2014	FY2015
Dental Visits by Provider				
Dentist Visits	4,657	4,558	4,203	4,955
Hygienist Visits	713	818	899	1,062
Total Dental Visits	5,370	5,376	5,102	6,017
Missed Appointments				
No Shows (Broken Appointments)	265	664	956	631
Broken Appointments vs Total Visits	5%	11%	16%	9%
Workload Factors				
Clinic Days	250	249(snow day)	250	250
Average Visits Per Clinic Day	21	22	20	24
Total FTE's	13	12	12	11
Average Annual Visits Per FTE	413	448	425	547
Categories of Care				
Preventive	6,950	7,295	8,030	10,692
Restorative including Crowns	2,856	2,888	2,556	2,451
Dentures including Bridges	115	169	85	44
Surgical	985	1,106	826	1,063
Orthodontic	8	27	7	12
Endodontic	324	251	270	244
Diagnostic	6,749	6,700	7,111	8,191
Total Identified Problems Treated	17,987	19,193	18,885	22,697

Figure 3-3

Interpretation: For FY 2015, Broken Appointments decreased by 20%; a quick call list and list of employees that are in need of exams are utilized, which has helped keep chairs full. Visits to Dental Providers are up 18% in both categories. The Total of Identified Problems that has been treated is up 20% from 2014.

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	FY2012	FY2013	FY2014	FY2015	Previous Year (%)	Previous 3 years (%)
New Prescriptions	53980	53415	50464	50609	0.3	-3.8
Refills	27211	26125	26479	26568	0.3	-0.1
Total Prescriptions	**81,191**	**79,540**	**76,943**	**77,177**	0.3	-2.6
Workload Factors						
Clinic Days	250	253	251	250	-0.4	-0.5
Avg Prescriptions per Clinic Day	325	314	306	309	1.0	-1.9
Visits to the Pharmacy	33,688	33,622	33,975	32,848	-3.3	-2.7
Prescriptions per Pharmacy Visit	2.41	2.36	2.26	2.35	4.0	0.3
Total FTE's	6.0	6.8	6.8	8.25	21.3	26.6
Avg Annual Prescriptions Per FTE	13,532	11,697	11,315	9,354	-17.3	-23.2
Pharmaceuticals						
Total Expenses	$ 784,700	$ 791,276	$ 753,909	$ 868,828	.	
Avg Cost Per Perscription	$ 9.66	$ 9.95	$ 9.79	$ 11.25		
Rx for Patients outside Service Area	Unavailable	Unavailable	Unavailable	Unavailable		

Figure 3-4

Interpretation: Workload in FY 2014 as compared to FY 2015 remains stable to the previous three years in the number of prescriptions filled (down 2.6%). The number of prescriptions per FTE decreased by 17.3% from the previous year, and decreased 23.2% from the previous three years. The decrease in the number of prescription per FTE is related to increased FTE (from 6.8 to 8.25). Drug costs as compared to the previous year have increased, primarily due to the inclusion of Enbrel (etanercept). Average cost per prescription has therefore increased. The average number of prescriptions filled per day remains consistent for the last five years. Pharmacy staff 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. Pharmacy works closely with Tribal Programs including Community Health Nursing, High Lookee Lodge, Warm Springs Corrections, Community Counseling Center and the Senior Program to provide drug information, education on proper drug storage and administration.

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

	FY2012	FY2013	FY2014	FY2015
Imaging Exams				
Total X-Ray Exams	1,649	1,711	1,713	1,378
Workload Factors				
Clinic Days	250	250	251	250
Average Exams per Clinic Day	6.60	6.84	6.82	5.51
Total Patients	1,468	1,493	1,606	1,249
Average Exam per Patient	1.12	1.15	1.07	1.10
Total PCPV's	14,980	16,568	15,757	13,041
Average Exams per PCPV	0.11	0.10	0.11	0.11
Total FTE's	1	1	1	1
Exams per FTE	1,649	1,711	1,713	1,378

Figure 3-5

Interpretation: Between 2014 and 2015, there was a 20% decrease in X-ray images performed at the clinic. This decrease was due to not having a Podiatrist on staff from 11/25/2014 to 9/30/2015. Throughout that time span there was an average of 5.5 X-ray images per day completed. The average patient visits per patient have been consistently around 1.1 over the past four years.

Diagnostic Services, Continued

Diagnostic Services - Medical Laboratory

	FY2012	FY2013	FY 2014	**3/31/15-9/30/15	**FY 2015
Medical Lab Tests					
Tests collected in the Lab	77,797	76,743	59,257		N/A
Tests collected outside the Lab	3,407	3,173	12,570		N/A
Tests performed off-site	6,422	5,473	19,332 *		6,065
Total Lab Tests Ordered	**87,626**	**85,389**	**71,827**		**N/A**
Workload Factors					
Clinic Days	250	250	250		250
Tests Ordered per Clinic Day	351	342	287		116
Total Primary Care Provider Visits	15,379	16,568	15,757		13,041
Average Tests per Visit	5.7	5.2	4.6		0.5
Total FTE's	5.0	5.0	5.0		4-4.5?
Tests per FTE	17,525	17,078	14,365		7,224
Category of Tests Ordered					
Hematology	25,707	19,491	7,981	1,696	3,392
Chemistry	55,936	60,491	39,610	8,120	16,240
Bacteriology	831	939	1,752	76	152
Urinalysis	5,152	4,468	3,152	1,993	3,986
Sub total:				**11,885**	**23,770**
Quest					5,125
St. Charles Hospital				77	154
Oregon State Laboratory				470	940
Total Referred Procedures (send Outs)			19,332		6,219
Total Lab Tests Ordered	**87,626**	**85,389**	**71,827**		**36,208**

Figure 3-6

*Tests performed Off-Site are not counted in the Medical Lab Tests Total.
**Data collected for 6 months, there was a purge on 3/29/15, so a full year was not available.
6 month data was multiplied by two (2) to get the Fiscal Year report.

Interpretation: Due to multiple RPMS Laboratory Patches, the data for workload has changed and is most likely counting different matrixes then in the past. A new way to find meaningful matrixes and sources is being looked at.

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			
	FY2012	**FY2013**	**FY2014**	**FY2015**
Optometry Visits				
Clinic Visits	1,663	1,941	2,912	4,190
Missed Appointment Rate	16%	18%	22%	20%
Workload Factors				
Clinic Days	220	220	220	220
Average Visits per Clinic Day	8	9	13	19
Total FTE's	2.0	2.0	2.0	2.0
Nature of Visits				
Refractions	821	832	1,034	1,141
Diabetic Eye Exam	308	309	266	308
Contact Lens Visit	56	39	66	143
Medical Visit	-	-	-	
Early Childhood Education Visits	53	60	-	86
Glasses Repair/Adjustment	372	338	732	639
Other	53	363	814	1,518

Figure 3-7

Interpretation: The Optometry department continues to see an increase in the number of patient visits from year to year, even without the full time placement of a fourth year Optometry student. The Optometry Student Program is in the process of being re-established.

The rate of patients who did not keep appointments is slightly down from the past year; if walk-in numbers are used to counter for the no shows, then the Missed Appointment Rate is only 9%.

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

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

Purchased and Referred Care

Purpose: To identify workload of the Purchased/Referred Care (PRC).

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
2015	7	6,206	$2,094,865

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 PRC reserves accumulated through Medicare-Like Rate savings; thus the increase seen from 2007 through 2010. 2010 marked the expansion of Priority I's back to full coverage of Priority I-IV's. Significant personnel time was involved in the implementation of Medicare-Like Rates reimbursement, but was time well spent as exhibited by the documented savings found in Figure 4-12. The implementation of Medicaid Expansion on 1/1/14 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 Federal Health Insurance Exchange for potential 2013 October enrollment, and, more importantly, January 2014 Medicaid Expansion, has greatly increased the complexity of PRC processes. New complexities are emerging with changes in the Medicaid system to the potential of Federal Medical Assistance Percentages (FMAP).

Community Health Nursing Services

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

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

Services Provided by Category	2012	2013	2014	2015
Prenatal	-	-	-	
Post Partum	-	-	-	
Well Child	34	42	58	42
Immunization	1,274	1,380	1,137	983
Diabetes			12	23
Cardiovascular			48	
Mental Health			60	
Sexually Transmitted Infections	66	145	202	206
Family Planning	135	213	201	203
Phone Contact/Follow-ups	213	219	261	313
Other Activity	614	898	1,537	726
Total Services Provided	2,336	2,897	3,516	2,496
Visits by Location				
Out of Clinic Visits	742	892	1,100	1,729
Clinic Visits	666	1,039	886	767
Total Community Health Nurse Visits	1,408	1,931	1,986	2,496
Total Days of Service	250	250	250	250
Average Visits Per Day	5.6	7.7	7.9	10.0
Total FTE's	1.8	2.0	3.0	3.0
Average Visits per FTE per year	782	966	662	832

Figure 3-9

Interpretation: The Community Health Nursing Program was fully staffed for 8 months of 2015 with 3 full-time nurses. They provided services in a variety of community areas including Warm Springs Corrections, Child Protection Services Group Home, Warm Springs K-8 Academy along with home and clinic visits.

The goals for the program, that was started in 2014, are to reduce hospital readmissions and provide a network of services to support the community members to return back to optimum health after a serious illness have been achieved.

Community Health Nursing Services, Continued

The top 10 leading Purposes of Visit managed through the Community Health Nursing 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 activities includes case review/coordination, education provided, screening and physician ordered treatments.

Maternal and Child Health (MCH) Program

Purpose: Maternal Child Health (MCH) data is collected to identify the number of births and those to tribal members. It is also used to determine the number of high risk pregnancies and high risk infants. Data is also used to determine the workload and needs of the program.

Relevance: The Maternal Child Health (MCH) Program workload is directly related to the 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)

	2012	2013	2014	2015
Total number of births	86	104	87	89
Total number of births (Tribal members)	72	82	70	79
Number of high risk pregnancies	43	33	37	43
Number of high risk infants identified*	43	39	36	39
Prenatal Home Visits	56	52	80	218
Post-Partum Home Visits	143	150	91	64
Other Home/Office Visits	565	399	327	300
Number of Hospital Visits	115	72	57	39
Number of Birthing Classes	45	43	43	43
Total Number of Participants	157	181	162	141
Infant Immunization level**	84.4%	83.5%	90.7%	85.0%

Figure 3-10

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

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

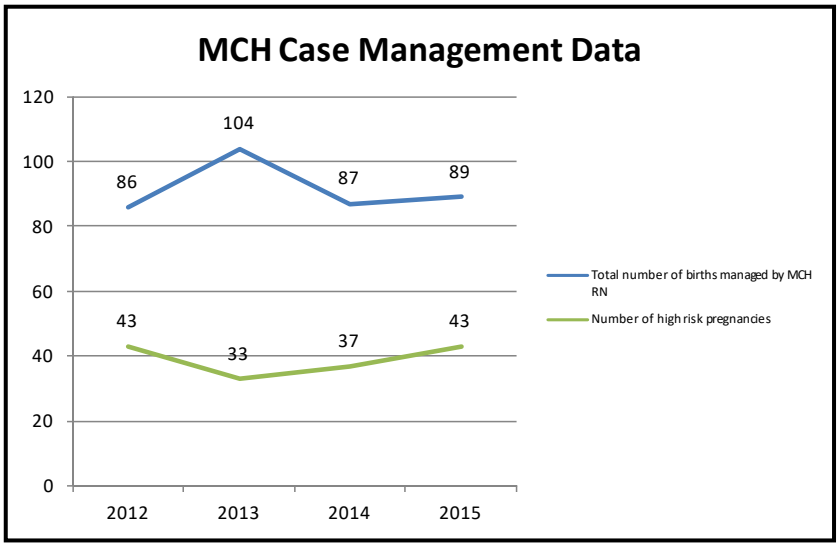


Figure 3-11

Maternal and Child Health (MCH), Continued

Interpretation: In 2015, the birth rate for the MCH Program decreased to 89 deliveries case managed by the program, 79 of which were to Tribal Member mothers. 43% 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

	2012	2013	2014	2015
Caseload by category:				
- Transports	274	467	634	677
- Patient Care	412	1395	1364	638
- Case Findings/Screening	428	52		
- Monitoring Patient	284	45		
- Case Management	109	21		
- Health Education	32			
- Other	445	119	126	156
Total Client Encounters	**1,984**	**2,099**	**2,124**	**1,471**
Total Days of Service	250	250	250	250
Average Number of Encounters per Day	7.9	8.4	8.5	5.9
Total FTE's	3.0	3.4	4.0	4.0
Average Number of Encounters per FTE per Year	661	617	531	368

Figure 3-12

Interpretation: In 2015, the CHR Program remained consistent in the amount of patient transport requests with the previous year.

For most of 2015, the program provided dialysis transportation five days per week for 2-6 clients per trip. In the fall of 2015, dialysis services began to be provided locally in the Madras area which offers more convenient scheduling for patients. This decreased dialysis transportation services to three days a week with an early and late drop-off for 1-10 patients.

Diabetes Program Services

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

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

Diabetes Program

	FY2012	FY2013	FY2014	FY2015
Diabetes Program Visits				
Clinician Clinical Visits	4,156	4,729	5,254	4,316
Community Encounters	1,531	1,752	2,414	1,997
Total Visits	**5,687**	**6,481**	**7,668**	**6,313**
Workload Factors				
Clinic Days	250	250	250	250
Average Clinical Visits per Clinic Day	16.6	18.9	21.0	17.3
Total Clinical FTE's	4.0	4.0	4.0	3.5
Average Clinical Visits Per FTE	1,039	1,182	1,314	1,233
Categories of Service				
Diabetes Clinical Encounters	1,922	2,630	2,868	2,429
Diabetes Case Management Encounters	2,334	2,099	2,386	1,887
Diabetes Community Education Contacts	559	1,559	2,083	1,997
Diabetes Screening Community Contacts	972	193	331	0
Patients in Dialysis				
Number of Patients	13	17	19	16

Figure 3-13

Interpretation: The Warm Springs Diabetes Program Nurse Practitioner position was vacant until June 2015. Staff includes the Program Coordinator, Nurse Practitioner, RN, Certified Diabetes Educator and Administrative Assistant. Major educational events for 2015 included Diabetes Awareness Day Conference, Heart Smart Dinner, Pi-Ume-Sha Health Fair, Senior Center Diabetes Support Group Dinners, Youth Support Group, Food Demo and Support Group. H.O.P.E. (Healthy Outcomes Promoted by Education) diabetes education program is accredited by the American Association of Diabetic Educators through July 2016. Community screening for Diabetes prevention education has been transitioned to Diabetes Prevention Program Staff to increase the number of clinical appointments in the Diabetes Program. Monthly Diabetes Group Visits and Diabetes Mobile Clinic Visits are included in the clinician clinical visit statistics.

Women and Infant Children (WIC)

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)

	2012	2013	2014	2015
Infants and children under 5 years of age	550	534	482	470
Pregnant, breastfeeding and postpartum women	211	187	192	181
Total number of Women, Infants and Children served	761	721	674	651

Figure 3-14

Interpretation: The number of Women, Infants and Children served by the WIC Program remained relatively stable for the past 4 years with the exception of 2014 and 2015. In those years, Warm Springs noted a decline in women/children seeking WIC services. This is not a unique issue for Warm Springs, 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 2015, 98% of new mothers start out breastfeeding and 39% of the families served are working families. Both of these rated increased in 2015.

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
	2015
Program Health Education Team	
No. of Educational Encounters	58
Direct Time Spent Educating	80.5
No. of Participants	1815
No. of PSA's generated	4
No. of Newspaper Articles	4
General Health	
My Future My Choice; 5 Sessions (Sexuality Education)	120
Girlz Club (8-11 year olds); Hygiene, Leadership, Wellness	30
Million Hearts Campaign	100
Great American Smokeout	65
Wellness of Warm Springs; 10/12 Classes	525
Pi-Ume-Sha Health Fair	450
Heart Smart Dinner	150
Employment and Life Skills Training	100
Alcohol and Drug Prevention	
FASD Awareness Day	
3D Project	included in WOWS
Cultural Prevention	
Craft Classes	8 classes
Jewlery Making	9 classes
General Prevention	
Trunk or Treat	275
HIV/AIDS	
World Aids Day	

Figure 3-15

Community Health Education Program, Continued

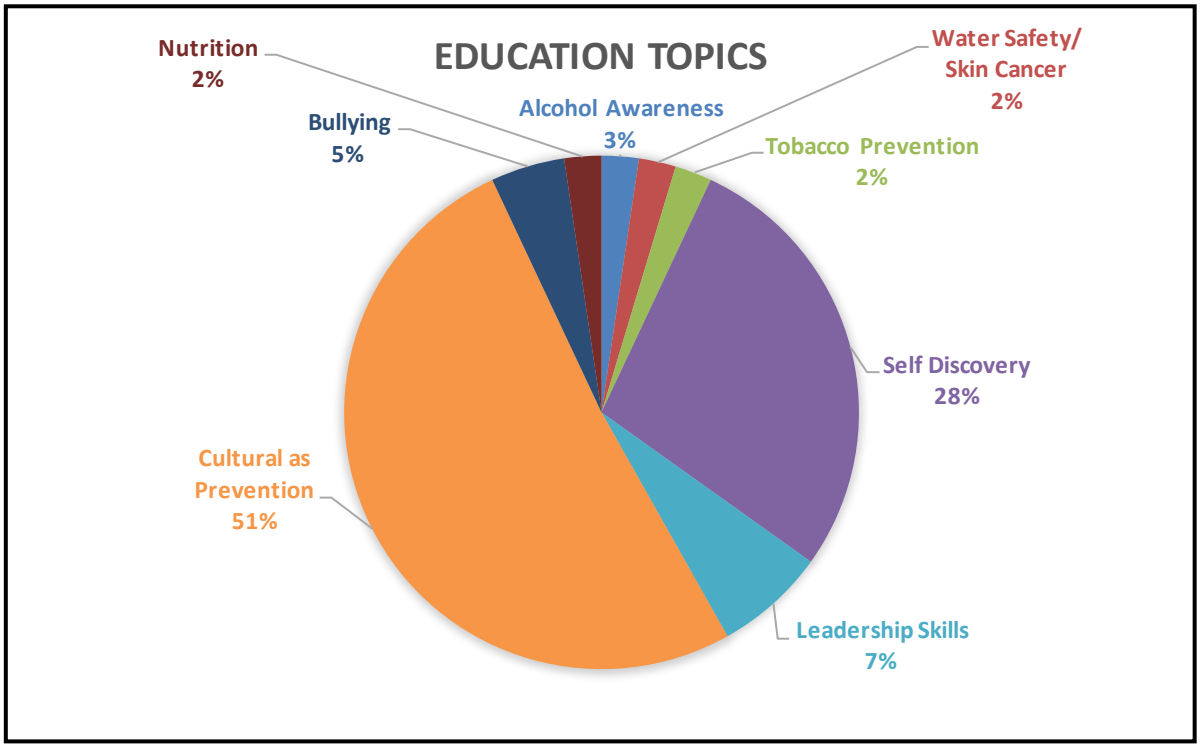


Figure 3-16

Interpretation: In 2015, the Community Health Education Program was able to participate in many onetime events such as the Great American Smoke Out and the Pi-Ume-Sha Health Fair as well as many ongoing classes such as Wellness of Warm Springs and Soaring Butterflies/Warrior Spirit. The topics of education were wide ranging from the Art of Storytelling to alcohol awareness and leadership skills.

Mental Health

Purpose: To identify the caseload and the number of visits by age and service category.

Relevance: Understanding patient demand and workload is necessary to determine appropriate resources and staffing. Mental Health service provision has become a valued resource for the Tribes and for the Warm Springs Community. Additionally, it has become a significant source of legitimate revenue.

Mental Health

	2012	2013	2014	2015
Visits & Clients Served				
Number of Adult and Child Visits				1,274
Number of Clinic Days				244
Average Visits per Clinic Day				5
Total Visits	3,012	2,539	1,494	1,274
Categories of Service				
Crisis Management Visits	204	270	219	193
Jail			94	193
Total	204	270	313	386
Service Hours				
Client Contact Hours	3,216	3,703		2,016
Prevention Services				
Soaring Butterflies/Warrior Spirit	NA	300	53	982
Positive Indian Parenting Participants (5)	48	48	0	33 *
Elvis Birthday Bash	70	NA	-	n/a
MSPI Madras High School Presentations	0	46	-	n/a
QPR Trainings (5)	3	3	100	100
Sock-Hop Event	30	83	-	n/a
All Night Lock-In	0	98	-	n/a
He-He Butte Prevention Camp	61	22 -		n/a
Oregon Native Youth Survey	24	NA	-	n/a
Halloween Party	500	100	300	600
Prevention Basics Power Point	60	NA	-	n/a
Christmas Light Parade & Event	500	600	600	500
Spring Into Action (Prev. Coalition)	49	NA	-	n/a
Penny Carnival	80	178	200	n/a
Rez Olympics	50	48	-	n/a
Street Dance	60	75	65	n/a
GONA Training	100	NA	-	n/a
ASIST Workshop				32
MSPI & Child Initiative Against Violence				85
THRIVE				3
Rick Schimmel Motovational Speaker				250
Holiday Gift Making				30
Soaring Butterflies/Warrior Spirit Planing Meetings (10)				50
Soaring Butterflies/Warrior Spirit Event at Museum				75
Soaring Butterfly Year End Camp				40
Community Clean Up Project				40
Protecting Your Child				60
Drugasors Prevention Classes				75
Drugasours at Jamboree				200
Survivors of Suicide Conference				15
Spring Break Prevention classes at Recreation				217
WOW Lunch Meth Presentation				7
Total Prevention Services Attendance	1,635	1,601	1,318	3,394

* (with 15 graduates)

Figure 3-17

Mental Health, Continued

Interpretation: The 2015 calendar year has been a time of continued transition for the mental health program. A reduction of mental health counselors/therapists was experienced including the retirement of a .6 FTE and three full-time employees that left this program. Two of those positions were filled after vacancies occurred. Community Counseling Center also lost the part-time psychiatrist that was contracted. This resulted in the loss of critical services that could be provided to the Community and a reduction in revenue.

Note that despite the challenges, the number of total crisis visits provided in 2015 is nearly double the number of crisis responses in 2012.

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 the community. Evaluation of A&D treatment is essential to see what is working and not working in our treatment program.

Alcohol and Substance Abuse

	2012	2013	2014	2015
Encounters - Outpatient Treatment				
Number of Visits	2,501	1,793	1,567	1,495
Number of Clinic Days	254	251	252	244
Average Visits per Clinic Day	9	8	6	6
Relapse Anger Resolution Grp (Quarterly)	28	25	5	20
Jail Groups	334	425	375	81
Service Hours				1,871
Aftercare				
Healing from Grief & Trauma - 1 day conf.	40	87	23	15
Recovery Month Dinner	100	100	100	n/a
A&D Prev B-Ball "And 1" (Street Ball tour) all ages	NA	36	-	n/a
Community Grief/Trauma Gathering (2 workshops)	NA	50	23	n/a
Healing Family Circle Conference	NA	NA	-	n/a
Winter Nights Round Dance				400
Spirit Fest Friday Night Dinner				200
White Bison Recovery Event				40
Total				655

Figure 3-18

Interpretation: Co-morbidity exists when events, situations or dynamics occur at the same time. For instance, the majority of substance abusing individuals also experience some form of associated mental health issue(s). Often times, co-morbid factors include loss, grief, trauma (sometimes from decades earlier) and family of origin conflicts. It is often difficult to accurately determine which problem area is the primary issue; in these statistics much effort has been made to avoid duplication of numbers and to most accurately identify the primary area of concern in each client's life.

The number included under "Encounters" for the jail groups is the total number of inmates that participated in non-crisis group services. The 2015 total is down specifically due to difficulties of staff getting into the jail to conduct groups. Those issues have been resolved. For calendar year 2016, there have been regular groups held with relatively large attendance in both men's and women's groups.

Alcohol & Substance Abuse, Continued

It is also important to note that Community Counseling Center lost four of the seasoned substance abuse counselors between 2014 and 2015. Two interns were hired and have been in a training capacity and those employees typically carry a smaller caseload while they are in a training capacity. The other two positions remain open and hopefully will be filled in the near future.

Adolescent Aftercare

Purpose: Collect data related to the Adolescent Aftercare Program to track the services available for youth, adolescents and adults to determine if the activities available provide the best services to clients.

Relevance: Data helps to evaluate the program and determine that necessary services are being provided to community members.

Adolescent Aftercare

	2012	2013	2014	2015
Outpatient Visits		30	43	128
Prevention Youth Dance		72	236	116
Teen Craft Night		32	45	n/a
Rez Head Youth Conference		34	-	n/a
Baseball Camp		31	36	28
Suicide Prevention Camp	68	38	18	n/a
Healing Wounded Spirits Camp	46	NA	-	n/a
Winter Youth Conference	n/a	NA	-	n/a
Movie Nights	416	384	480	421
Wii Bowling	112	NA	-	n/a
Hoop Camp	73	36	89	49
Madras Bowling	88	79	96	75
Wellness walk	84	204	224	147
All Night Sobriety Party	n/a	n/a	-	n/a
Kids Bingo	26	196	159	52
Red Road to Recovery/Boys Circle	0	93	61	44
Tribal Youth Leadership	24	22	46	38
Respect Club				22
Jude Schimel Hoop Camp				160
Sobriety Pow Wow				150
Total	1,187	1,251	1,533	1430

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 that can help individuals build coping skills and resilience services are provided to clients leaving treatment. Through this program additional support is provided to program participants who are in danger of relapsing with positive, supportive interactions of others. Services are also provided to clients returning from residential treatment facilities to help them successfully transition back into their community.

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 to determine the state of this program, how it's being used, where it can be improved and where focus is needed.

Community Health & Prevention Resource Center

Resource Center Usage	2012	2013	2014	2015
Number of patrons that checked out materials	486	339	300	280
Number of materials checked out	1,358	949	792	810
Health related materials checked out	80	81	30	27
Native American materials checked out	215	160	156	120
Circulations*	3,015	1,679	1,438	1,372
Number of visits	9,351	8,936	11,147	9,601
Patron cards issued	378	144	123	230
Graphic Design Requests				
Posters/Banners printed	197	99	66	159

Figure 3-20

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

Interpretation: 280 people checked out material from the Community Health & Prevention Resource Center (CHRC) in 2015, continuing a downward trend. Although fewer people borrowed from the CHRC in 2015, they borrowed more on average (2.9 items/person) than in previous years. CHRC issued the most patron cards since 2011, and had its second highest number of visits. Overdue/lost items continue to be an issue and are a contributing factor in the declining circulations and number of borrowers. People with lost/overdue items are prohibited from borrowing any more items until they return or pay for their items. On a positive note, the fact that people who are able to check out items have been checking out more on average, and the fact that almost twice the amount of patron cards were issued as last year, indicates that the selection of materials is relevant and useful.

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

	2012	2013	2014	2015
Housing & Energy Assistance				
Number of Clients Served		248	292	318
Total Vouchers Processed		248	292	202
Total $ Value of Vouchers	86,131	87,346	94,843	114,429
Medical Travel				
Number of Clients Served	458	336	420	946
Total Vouchers Processed	458	336	420	946
Total $ Value of Vouchers*	12,200	9,709	12,480	27,785
Disability				
New Clients pursuing claims for SSI/SSDI	78	67	105	95
Number of clients currently checking on Survivorship/widow benefits	16	10	12	19
Number of Clients inquiring about Retirement Benefits	24	20	32	40
Number of Clients that have been denied	36	23	28	35
Number of Clients that just filed their 1st Appeal	20	15	15	30
Number of Clients that are in the middle of Appeal	33	17	24	27
Number of Clients in Court Hearings	8	20	16	16
Commodities				
Number of Families Served	259	278	75	87
Number of Individuals Served	494	749	166	197
Number of Warm Springs Tribal Members**			137	174

Figure 3-21

**For 2012 & 2013 Tribal Member data was not recorded.

Interpretation: The Low Income Housing Energy Assistance Program (LIHEAP) served 44 more client households with assistance. In addition, the program also distributed 40 cooling fans, 40 heaters and 36 homes received weatherization kits.

Medical Travel funded 525 more clients in 2015 with assistance to Medical appointments. This program serves all Indian Health Service eligible clients with no priority levels currently in place.

Social Services, Continued

Clients seeking services through the Disabilities Coordinator continue to fluctuate based on need. The Disabilities Coordinator has increased home visits as well as outreach and is working closer with the Senior Disability clients.

The Commodities Program increased its participation level from 137 to 174 in 2015. A tracking system is being used to count the actual number of individual households, as well as the 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 (i.e. seat belt use). Patients serviced by alternate resource measures collection potential of this enterprise.

Ambulance Activity Summary

SUMMARY OF AMBULANCE ACTIVITY

Reason for Call	Calls		Patients Transported		Calls w/Substance Factor	
	2014	2015	2014	2015	2014	2015
Motor Vehicle Accident	88	77	30	35	4	19
Other Accident	-	-	-	-	-	-
Assault and Battery	66	48	21	11	21	20
Suicides/Attempts	22	17	13	15	8	8
Corrections	379	385	40	49	75	128
Pediatric	222	280	67	91	5	1
Cardiac	149	98	69	71	11	5
Respiratory	148	137	82	73	2	14
Other Illness	134	145	60	74	9	16
Total	**1,208**	**1,187**	**382**	**419**	**135**	**211**

TRIBAL AFFILIATION RELATED TO CALLS

Reason for Call	Calls Dispatched		Patients Transported		Calls w/Substance Factor	
	2014	2015	2014	2015	2014	2015
Members and Dependents	1,625	1,714	623	702	227	344
Other Eligible Indian	0	0	0	0	0	0
Non Tribal	126	156	48	58	2	10
Total	**1,751**	**1,870**	**671**	**760**	**229**	**354**

Figure 3-22

Interpretation: Between 2014 and 2015, there really was no significant difference in the reasons for calls. In 2015, a new form was used to calculate the number of alcohol related Motor Vehicle Calls (MVCs), which has lead a better actual count of alcohol related calls and therefore has raised the count significantly for Motor Vehicle Accidents (MVAs).

Ambulance Services, Continued

Nearly 93% of the calls were for Tribal Members and Dependents in 2015. 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 its treaty with the Unites States government. Tracking this data is important for planning and implementing outreach efforts and developing relevant materials.

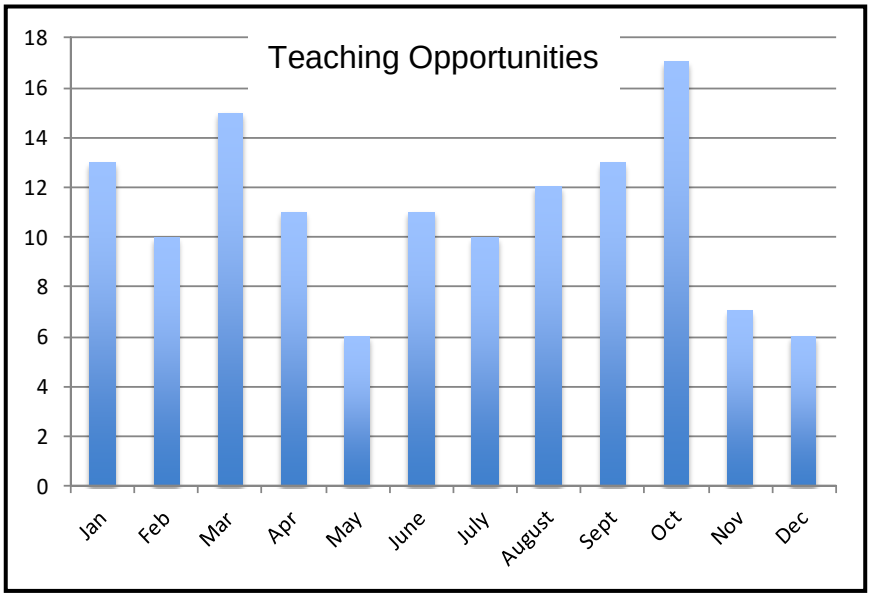


Figure 3-23

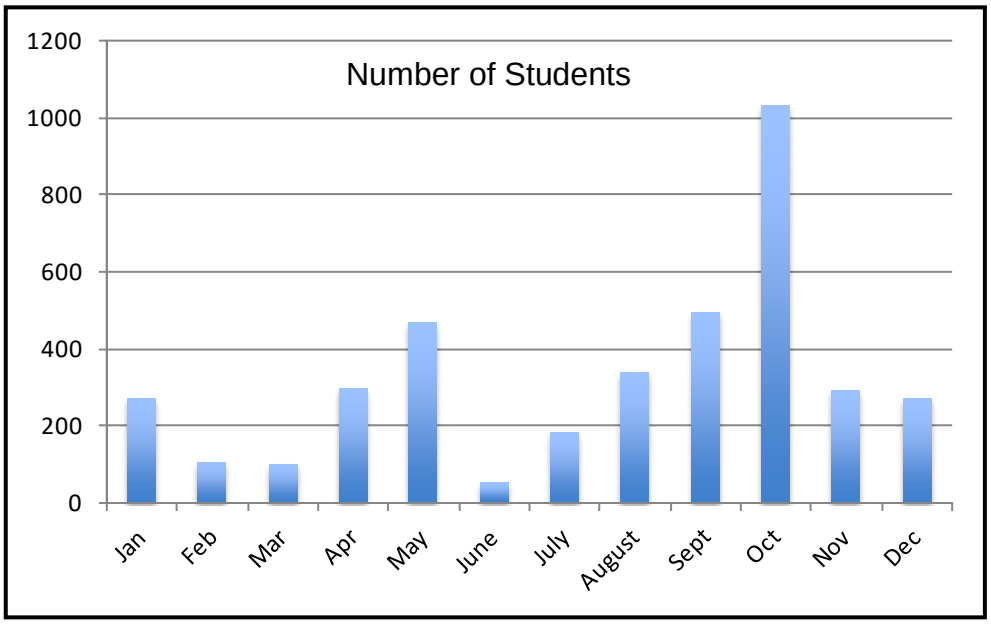


Figure 3-24

Culture and Heritage Language Program, Continued

Interpretation:

The fall is the busiest time of year for the Culture and Heritage program. Staff attends several community events. The largest way for the program to share its knowledge is through dances, language and history that it shares with local schools and the Warm Springs community. These opportunities allow for information distribution via language materials for home that will help support the effort to reach out to school age children.

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

- Autni Ichishkin Sapsikwat (pre-school)
- Autni Ichishkin Sapsikwat (k-8)
- Out-of-school classes (morning and pm)
- Leadership Conference Opportunities
- Language Bowl Classes (prep for annual event)
- Rites of Passage
- Traditional and Spiritual Events

Contributing to this number is outreach presentations to non-member communities that request our services including:

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

KWSO

Purpose: KWSO is a non-commercial radio station with programming focused on meeting the needs of the Warm Springs Community. Information and Education is offered through on-air live calendar reads, pre-recorded public service announcements, in local news stories and in locally produced news magazine segments.

Relevance: Public Service Announcements are categorized for the purpose of identifying our broadcast efforts to the Guidance from Joint Health Commission strategies. KWSO 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	2015
Health Education	2,718	2,110
Community Event	1,988	2,231
Health Insurance	1,405	680
Mental Health Education	1,263	1,959
Health Related Event	1,261	1,543
Diabetes Education		1,360
Violence Prevention	825	538
FASD Awareness	822	
Child Development/Parenting	732	715
Cultural Event	709	557
Child Mental Health	467	1,044
Youth Education	374	
Child Abuse Prevention	319	282
Child Health	312	376
Youth Health Related Event		419
Youth Opportunity Information		263
School Related Event	291	446
Elder Event	124	121
Mental Health Event	118	128
Youth Employment	82	156
Safety		115
Veteran Support		96
Veteran Event		89
Disabilities		38
Education	40	
	13,850	15,266

Figure 3-25

KWSO, Continued

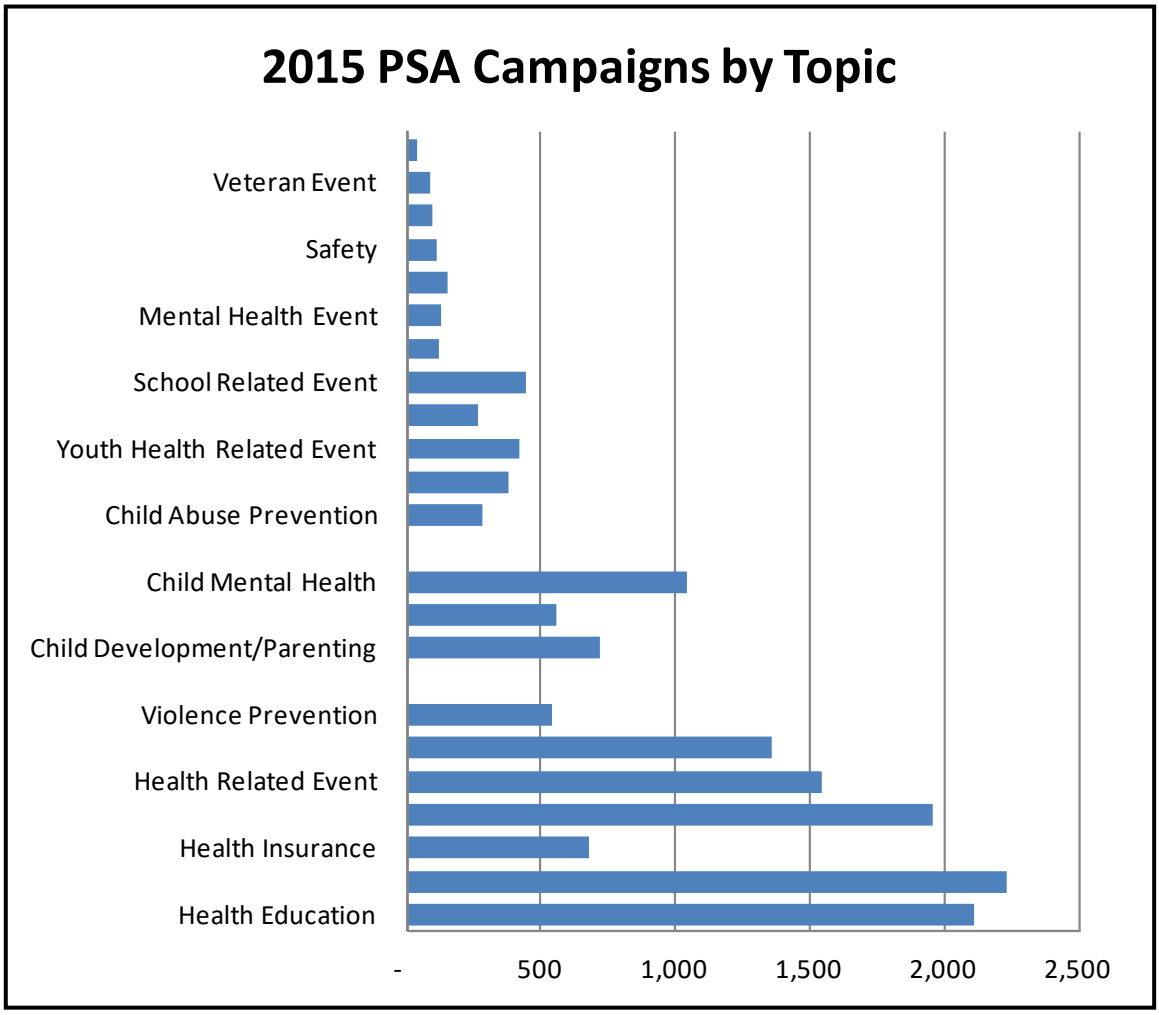


Figure 3-26

Interpretation: This data is focused on the Public Service Announcements (PSAs) broadcast 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 Education; Mental Health; Diabetes Education; Child Mental Health; Child Development/Parenting and Health Insurance.

Overall –"Events" (which included: Community Events; Health Related Events; Cultural Events; School Related Events; Elder Events; and Mental Health Events) was the strategy most often broadcast in the Public Service Announcements.

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

A total of 15,266 PSAs (60 seconds or less) were broadcast – that were health related and relevant to the Joint Health Commission strategies.

That is a value of $305,320 (at $20/spot).

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.

Spilyay Tymoo

Article/Announcement Category	2014		2015	
	Article	Announcements	Article	Announcements
Child Development/FASD	1	5		13
Early Childhood/Child Development	6	26	5	30
Youth Fitness	78	104	88	104
Youth Mental Health	13	26	6	30
Youth Health Education	20	26	26	13
Youth Support	13	13	26	52
Education & Job Opportunity Events	26	52	13	26
Health Services Information	26	52	26	52
Tribe's Health Education & Health Support	26	52	13	52
Elders	13	26	13	26
Health System	19	26	16	30
Total # of Articles/Announcements	241	408	232	428

Figure 3-27

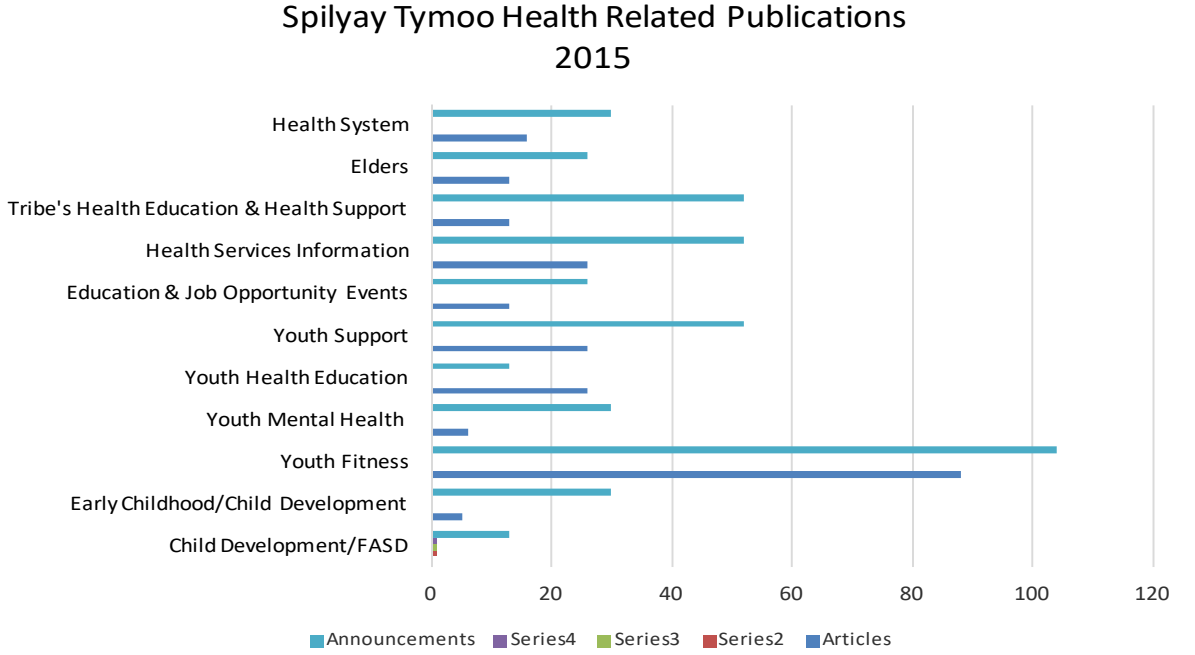


Figure 3-28

Spilyay Tymoo Newspaper, Continued

Interpretation: The Spilyay Tymoo publishes a newspaper every two weeks. Every issue 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: The tracking of case load data allows for the determination of the success rates of consumers/clients from initial contact until their case is closed. Ultimately, this data is reported to the Tribe, Joint Health Commission and the main funding source for this program to determine if VR is fulfilling the annual programmatic goals for the number of consumers served under an Individual Plan of Employment (IPE) and the number of cases closed due to being successfully rehabilitated. This data is both a reflection of the consumer's participation level and the programmatic service delivery effectiveness.

Vocational Rehabilitation

	FY2013*	FY2014*	FY2015*
Orientations	59	145	174
Intakes	26	61	85
Files Closed	34	13	36
New Cases Opened	19	44	34
Mo. Average Pending Eligibity	3	11	12

Figure 3-29

**Vocational Rehabilitation uses a Fiscal Year (October – September) for data collection.*

Interpretation: Consumer/Client data: Attendance at VR Orientations (Warm Springs, Madras and Portland) was 174, compared to 145 and 59 in the previous years. Intakes and Files Closed, also increased. New Cases Opened decreased and there was little change in the number of Individuals Pending Eligibility each month. The data guides VR to areas within the case management system that may need to be addressed by the VR team. An example of this would be determining the effectiveness of the program outreach by the number of attendees at orientations; tracking the ability of staff to secure medical documentation as a measure of eligibility determination; tracking the eligible consumer's files that are closed "successfully rehabilitated" or closed "other" status. An electronic database of eligible clients is also utilized to break data down further.

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

Vocational Rehabilitation, Continued

The data also provides “Consumer Self Sufficiency” and “Community Collaboration” indicators. These indicators assist in determining the level of cooperation of the health, human, social and economic service providers that serve common consumers/clients. “Comparable Benefits” are services contributed to IPE’s by the consumer or other service providers. In 2015, while the program was not actively tracking Comparable Benefits, $5,544 were recorded. This number will increase substantially in 2016, as the program will actively be tracking Comparable Benefits for all consumers, to demonstrate the services leveraged through IPE’s. Comparable Benefits is also a measure of consumer self sufficiency, as consumers seek out other services and personally contribute to their IPE employment plans.

Other relevant training, education and employment data: In 2015, the target number to achieve an employment outcome was 25. The actual number of clients to achieve successful employment outcome was 14; all working full time and 0 were self-employed. This was 64% of the target goal and a 56% increase from 2014. A total of 47 clients served under an IPE. The total number whose employment resulted in earnings was 38, with an average of $360/week at the time of being determined eligible. The average earnings at the time of achieving/completing the program was $536/week with 10 still employed 3 months and 8 still employed six months after completing the program. In 2015, 11 consumers were enrolled in an educational training program, primarily in Bend and Portland. One client attained a post secondary degree and two started GED programs.

High Lookee Lodge Adult Living Facility (HLL)

Purpose: High Lookee Lodge (HLL) Assisted 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 guidelines established by the State of Oregon License as an ALF.

Relevance: HLL provides care to elder and disable adults who are no longer capable of living on their own. Serviced 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			2015		
	Resident Count	Private Pay	Medicaid	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	17	4	9
February	19	4	15	21	6	15	20	5	15	19	4	14
March	19	5	14	22	6	16	21	5	16	18	4	14
April	19	5	14	22	7	15	21	5	16	18	4	14
May	19	5	14	24	6	18	20	5	15	18	4	14
June	18	5	13	25	6	19	20	5	15	18	4	14
July	20	5	15	24	7	17	20	5	15	18	4	14
August	19	5	14	24	7	17	19	5	14	21	4	17
September	21	6	15	22	7	15	19	6	13	21	4	17
October	20	6	14	22	7	15	17	5	12	22	4	18
November	20	6	14	20	6	14	17	4	13	22	4	18
December	20	6	14	20	5	15	18	4	14	22	4	18
Avg Number of Residents	**19**			**22**			**19**			**20**		

Figure 3-30

Interpretation: In 2015, HLL averaged 20 patients per month. The ALF is able to house 36 total residents. In addition to the patients that receive Medicaid, HLL averages 4 private pay residents per month.

Children's Protective Services

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

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

Children's Protective Services

	FY2013	FY2014	FY2015
Visits/Contact			
Total Number of Services Provided to Children		5,116	4,879
Total Number of At-Risk Children		325	389
Total Number of Child Abuse/Neglect	379	476	402
Children Placed in Emergency Shelter	129	97	207
Average Length of Time in Emergency Shelter prior to being placed (days)		90	120
Average time in Foster Care (days)		270	285

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 2015 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 2015, the average time was 285 days which is significantly longer than the program goal of 180 days. There are several contributing factors for CPS not achieving this goal including issues with staff vacancies, lack of family involvement with becoming certified as relative foster care providers, lack of general Tribal foster homes on the Reservation and reunification with parents have not occurred in a consistent and timely manner.

Family Preservation

Purpose: The goal of the Family Preservation (FP) program is to enable families to properly care for their children, while maintaining the safety of the child in the home. FP assists families in coping with problems that interfere with successful parenting, and helps families to find and use resources, and support. This program is not designated to "fix" everything in the family but to help the family learn the skills necessary to provide a safe and caring environment for the child.

Family Preservation objectives are:

1. To protect the child from further harm within his or her own home
2. To strengthen and maintain client families
3. To help families recognize and enhance their own strengths
4. To prevent family breakup
5. To prevent further removal of children who have been reunified with their own families
6. To reduce client dependency on social services by promoting family self sufficiency.

Relevance: The programs data collected allow FP to evaluate the strengths and weakness in the program. The data allows FP to make necessary changes for overall improvement showing the amount of clients that are being seen before they are in danger of child removal.

Family Preservation Program

	FY2015*
Visits/Contact	
Total Number of Children Served (not counting CPS monitor)	131
Children Also Receiving Counseling/Social Worker Services	15
Total Number of Families Served	56
Total Number of Children transferred into CPS	20
Total Number of Children served in-home to prevent Placement disruption	131

Figure 3-32

** Data from June to December 2015 only.*

Interpretation: The data above is from the Months June through December due to program change. Family Preservation was originally a part of Warm Springs Child Protective Services but in June, Family Preservation transferred into Warm Springs Community Health Services. Family Preservation works with the family rather than focusing just on the child. The program's caseloads are per family rather than per child. Children who have been transferred from Family Preservation into Child Protective Services are either due to: Court Orders, family's unwillingness to work with FP, strong drug or alcohol relapse, or child in need of supervision. Family Preservation works in collaboration with Community Health Clinical Social Worker.

Tribal Day Care Program

Purpose: The Tribal Day Care Program provides child care services to children ages 6 weeks to 12 years of age. Children are provided a clean, healthy, safe-learning environment as well as age-appropriate curriculum to educate them in early learning and health-related curriculum. Day Care Staff 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 Indian Health Services. Dental screenings are provided to those children whose parents give 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	FY2015
Visits/Contact		
Dental Screenings	60	70
Medical Exclusions	80	127
Injuries/Accidents:		
Transport	6	7
Non-Transport	102	112
Head Lice Exclusions	56	72
Immunizations	1	0
Ages & Stages Questionnaire	60	44

Figure 3-33

Interpretation: In 2015, there was an increase in Medical Exclusions due to Respiratory Syncytial Virus (RSV) and other viruses. Injuries/Accidents increased from 108 to 119 with 94% of these incidents not being severe enough that the child needed to be transported for medical care.

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 Tribal Day Care meets 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 and community benefit as well as personnel requirements for the Community Wellness Center (CWC).

Community Wellness Center

	FY2014	FY2015
Summary of Activity		
Youth and Community Activity		
Recreation Field Trips (incl. Chaperones)	437	368
Sports/Athletic Program Attendance (all)	49,872	35,739
Game Room Attendance	2,333	2,614
Snack Attack	4,071	3,186
After Shool Programs/Community Activities	9,426	9,363
Total Program Participation	66,139	51,270
Signed Weight Room Waivers	402	428

Figure 3-34

Interpretation: The CWC continued to serve large numbers of community members through the programs in 2015, the majority of which were in the Sports/Athletics programs. After School Programs/Community Activities also had strong participation numbers as did the "snack attack" program which provided a healthy afterschool snack option for youth.

Some of the major activities provided in 2015 included: Youth field trips, Arts & Crafts, Board Games, Halloween Activities, popcorn and movie, holiday craft projects, carnivals, parades, Christmas Bazaar, community yard sales, Christmas activities, and Penny Carnival.

Medical Social Worker (MSW)

Purpose: To identify the workload associated with the Medical Social Worker (MSW).

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

Medical Social Worker

	2015
Patients Seen	149
Chart Reviews	15
Telephone	129
Ambulatory Visits	132
Total Days of Service	250
Average Visits Per Day	0.53
Total FTE's	1
Average Visits per FTE per year	132

Figure 3-35

Interpretation: The MSW provides many types of services including mental health counseling for individuals and families. Classes are offered on Negative Thinking for the Diabetes Prevention Program. The MSW is a member of the Fetal Alcohol Spectrum Disorder Coalition. A close relationship is maintained with the Family Preservation Program to provide social work services and teach Conscious Discipline to families.

The Top Ten Purposes of Visits managed by the MSW include:

- Administrative Encounter
- Family Circumstances
- Counseling
- Economic Problem
- Posttraumatic Stress Disorder (PTSD)
- Other Specified
- Inadequate Housing
- Psychological Stress
- Family Health Problems

Medical Mobile Unit (MMU)

Purpose: To provide an overall summary of the use of the Medical Mobile Unit (MMU) in the community.

Relevance: The MMU travels to different areas of the reservation to deliver primary medical and dental services.

Medical Mobile Unit
2015

Location	Visits
Sidwalter	10
Seekseequa	2
Administration Building	4
Campus	4
Community Center	8
Senior Center	4
ECE	3
Corrections	1
WSK8 (Dental)	40
Agency (specific location unknown)	4
Fire Management (Physicals)	2

Figure 3-36

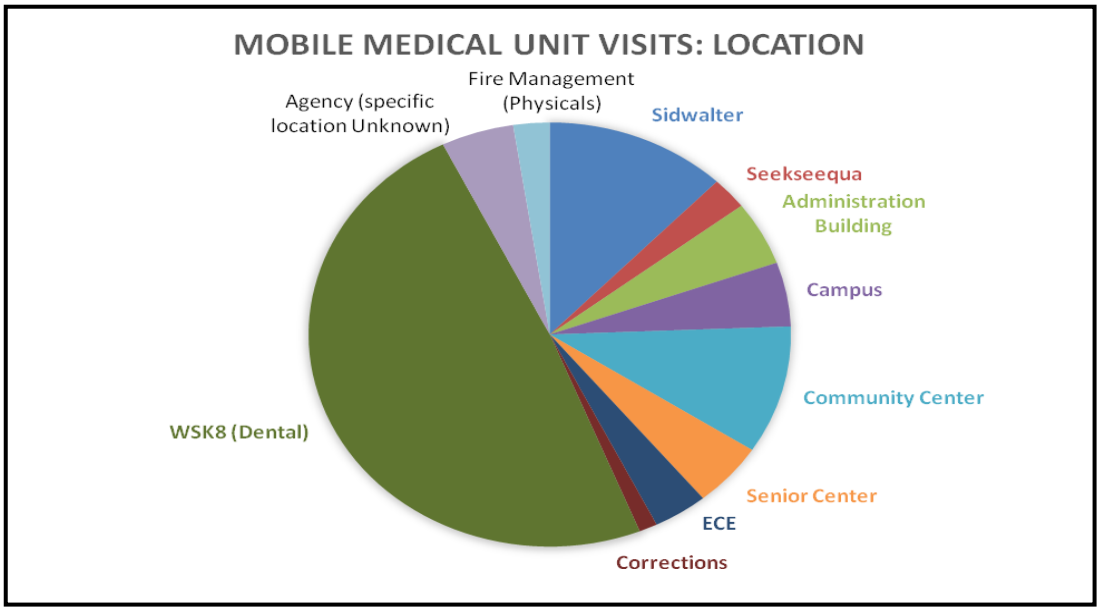


Figure 3-37

Medical Mobile Unit (MMU), Continued

Mobile Medical Unit Patient Visits
2015

Department	Visits	No Shows	Walkins
I.H.S Medical	464	73 (16%)	48 (10%)
I.H.S Dental	578		
Community Health	9		

Figure 3-38

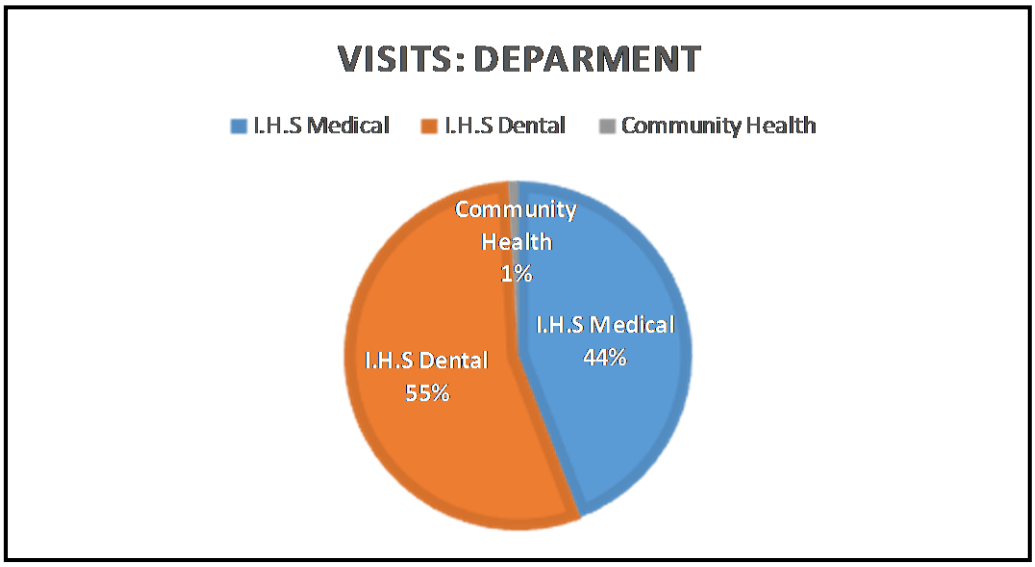


Figure 3-39

Interpretation: The MMU is scheduled for primary care clinics on Tuesdays. Once a month it is scheduled for outlying areas. Dental screenings are provided at the Warm Springs K-8 Academy for a couple weeks in the fall and spring. The MMU is also used for specialty clinics such as annual physicals for children starting Head Start or for fire fighters working with Fire Management. It was anticipated that the MMU would be used for flu shot clinics but due to changes in scheduled events and difficulty with connectivity, it was decided not to use the MMU.

Summary of Grants (Their Purpose etc.)

Purpose: Education and assistance for Native Americans to pursue optimal health.

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): Heightened community awareness regarding diabetes risk reduction strategies, physical activity education and family involvement in fitness activities. The SDPI Wellness Program co-sponsors multiple diabetes/physical fitness activities and events throughout the grant year. Target youth ages 6-12 who are at-risk for diabetes. Provide funding and incentives for youth sports-related activities and sports camps in the community to provide exercise opportunities for Tribal youth.

Maternal Child Health (MCH): Provide high quality, Tribal Best practices home visiting based services to pregnant women and families with young children aged birth to kindergarten. One Tribal Best Practice that has been supported since 1995 is Back to Boards, which teaches how to complete baby boards for the infants first year, receiving instruction and education on the dangers of tobacco, drugs and alcohol use of the fetus.

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: Utilize the same principles stated in A&D Prevention and to provide on-going projects that concentrate on promoting policy such as having smoke free buildings, events and worksites.

Alcohol & Drug Prevention: Provide prevention services targeting populations by following the continuum of care model (universal, selective and indicated) and the six Center Substance Abuse Prevention strategies (information dissemination, education, alternative activities, community base, environmental/policy and early identification and referral).

Coordinated Tribal Assistance Solicitation: Provides expanded A&D services and specialized treatment for sex offenders.

Domestic Violence: This is a project that is coordinated with Victims of Crime and Prosecution. Provides expanded A&D services and specialized treatment for domestic violence victims.

Juvenile Crime Prevention: Substance Abuse Counselor/Part time position will screen youth and identify early indicators of problem behaviors and provide case management.

Strategic Prevention Framework/Partners For Success (SPF/PFS): The SPF/PFS is a community-wide program that requires a high level of communication, collaboration, and involvement on the part of those involved. The SPF-PFS initiative allows Warm Springs SPF/PFS to plan and implement strategies to prevent substance abuse in the

Summary of Grants (Their Purpose etc.), Continued

community. The program is responsible for assessment, capacity building, planning, implementing, and evaluating activities associated with the PFS priorities.

Mental Health Initiative: Following 3 programs:

- **Mental Health Promotion and Prevention:** Transformational Change using Conscious Discipline (CD). Folds mental health promotion and prevention into existing tribal prevention system so departments can identify early indications of problems and foster mental health.
- **Jail Diversion:** Wellbriety Program (Tribal jail Diversion). Expands services to keep people with mental illness and other behavior problems from unnecessary incarceration in local jails.
- **System of Care and Wraparound:** Warm Springs Family Preservation Program. Increase the availability of wraparound services, providing intensive care coordination for family and children with emotional and behavioral disorders.

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

NARA Youth Suicide Prevention): This grant operated off of a scope of work agreed upon annually with our funders, NARA. The main focus is with youth encouragement of self-worth and family values. Hosting community events that provide family activities and developing the Tribal Youth Council.

Influenza Pandemic: Provide policy guidance within the emergency preparedness plan for fast response with all disease prevention and treatment. Follow the same process indicated with Alcohol & Drug Prevention above.

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

Meth/Suicide Prevention (MSPI): Develop the Health and Human Service Infrastructure to address suicide prevention, intervention and post/vension and to educate community members & provider partners.

Interpretation: Grants provide needed services that compliment base dollars we receive through our 638 annual funding agreement and base dollars received by the State of Oregon. Programs are tracked within the Annual Health Report, mandated grant reports and collectively have shown reductions in numerous areas. The Wellbriety program has diverted 33 cases that would have had to face fines or jail time; they are receiving treatment as a diversion. Back to Boards has reduced SIDS, and other health problems, which are complicated to prove since, true prevention means the consequence of poor chooses does not occur. More than 500 youth and community members have been trained locally with QPR (question, persuade and refer) again reducing suicide attempts.

SECTION 4

Resource Availability and Use

How do we deploy and maximize resources toward a healthier community?

This section provides an overview of all the resources that have been devoted to the provision of health care including Indian Health Service, State of Oregon, awarded grants and those resources allocated by the Warm Springs Tribe. The resources are compared to the national medical inflation factors to determine our status. The information also identifies expenditures by program. Detailed history of collected revenue is captured by year and by program. Since almost one quarter of all health care resources is absorbed by Managed Care, it is important that the system continue to monitor total costs and unit costs of all those services that are purchased. The staffing levels of each program are identified and further reviewed to determine the extent of tribal member employees. An accounting of carryover funds and reserves is also maintained.

The vast majority of the resources that are provided annually are associated with ongoing programs and services, leaving only limited resources to add new services or address special needs. Implementing the comprehensive health plan anticipates a careful examination of resources and careful priority setting for available resources. This section highlights the available resources for the past several years, as well as the spending patterns.

Resources that are not expended in a given year are, for the most part, available to the subsequent year. Some, but not all, may be available to re-allocate to other purposes.

This section also indicates that federal funding has lagged medical inflation for many years. Purchasing power is diminished when this happens. Increases in 2009 and 2010 have helped to close this gap. However, the federal budget deficit will place pressure on federal budgets for many years to come.

Summary and Highlights

Overall funding of the Health System in 2015 remained at the same level as the previous year (just over $28 million).

While the total resources from the Indian Health Service declined by 3%, the recurring funding actually increased by 4.2% in 2015, benefiting the health service portion of the budget. (Figure 4-1)

Indian Health Service collections increased by $250,000 or 5.5%. The Tribal collections decreased slightly from the previous years experience due to a change in billing policy. In previous years, the biller would bill for a year back. In 2014, the biller caught up with all past billing and they are now current. The 2015 collection amount should be a more standard amount received from now on. There was a substantial increase in collections by Community Health Nursing (nearly tripling from the 2014 level). Together the Indian Health Service and Tribe collected $6.5 million (a record high). (Figure 4-1)

The resources through appropriations in 2015 increased by 4.2% which is a little above the medical inflation rate reported. This was much better than what was experienced in 2013 and 2014.

The actual expenditures for health services declined by $2.6 million in 2015. (Figure 4-3). The declines are explained in the text of this chart. Purchased/Referred Care, Facilities, Health Administration, Pharmacy and Podiatry were the areas with the most notable declines.

Purchased/Referred Care had another banner year in terms of resource utilization, primarily due to the effective use of alternate resources and the medicare negotiated hospital rates. This is despite a large increase in admissions and hospital days that occurred in 2015.

A substantial increase in grant funding brought the total to nearly $5 million over the past four years.

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

	2012	2013	2014	2015
Indian Health Service				
Recurring Funding	17,348,813	16,135,780	16,248,026	16,927,090
Non-Recurring Funding	510,231	603,603	1,236,741	81,181
Total IHS Funding	**17,859,044**	**16,739,383**	**17,484,767**	**17,008,271**
Collections IHS				
Medicaid	2,522,740	2,630,125	3,876,758	4,093,398
Medicare	99,349	265,122	285,257	302,669
Private Insurance	503,833	420,342	361,643	377,431
Total IHS Collections	**3,125,922**	**3,315,589**	**4,523,658**	**4,773,498**
Collections Tribe				
Ambulance	146,086	358,739	329,823	386,582
Community Counseling	567,466	944,058	1,196,976	658,195
Community Health	398,428	462,844	228,950	680,023
Total Tribal Collections	**1,111,980**	**1,765,641**	**1,755,749**	**1,724,799**
Grant Awards	1,650,982	2,133,838	1,114,664	1,511,893
Tribal Employee Group Insurance (Est)	1,901,827	2,231,557	3,091,229	2,648,623
Tribal Appropriations	1,682,649	396,905	477,754	547,417
Total	$27,332,404	$26,582,913	$28,447,821	$28,214,501

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.

While the total resources from IHS declined by 3%, it is worth noting that the recurring funding actually increased by 4.2% in 2015 over the previous year benefitting the operational budget.

Health System Funding by Major Source, Continued

IHS collections increased by $250,000 or 5.5% in 2015 and established another new record. Tribal collections decreased slightly from the previous year's experience. A huge decline (50%) in the collections of the Community Counseling (decrease of $538,781) was experienced in 2015 and that situation must be corrected. On the other hand, the Community Health Nursing Program increased its collections by $451,073 or nearly tripling its total. The ambulance program increased collections by 1% from the prior year.

Grant awards increased by $397,229 from the previous year. Tribal appropriations increased by $69,663 over that same period. Tribal Employee Group Health expenditures were estimated at $2,648,623, which represents a decrease of $442,606.

The overall total Health Program Funding for 2015 was slightly less than in 2014. The decrease was somewhat less than 1%. Without the decrease in non-recurring funding experienced in 2015, actual health services money increased slightly.

Base Health System Funding Versus Inflation

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

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

	Annual IHS Base Funding	Base Increase	Medical Inflation
1998	9,570,435	1.0%	2.9%
1999	9,955,164	4.0%	3.5%
2000	10,428,865	4.8%	4.1%
2001	10,716,132	2.8%	4.6%
2002	11,102,601	3.6%	4.7%
2003	11,836,295	6.6%	4.0%
2004	11,914,200	0.7%	4.4%
2005	12,072,614	1.3%	4.2%
2006	12,454,591	3.2%	4.0%
2007	12,833,003	3.0%	4.4%
2008	13,340,464	4.0%	3.7%
2009	13,995,065	4.9%	3.2%
2010	16,174,897	15.6%	3.4%
2011	16,284,305	0.7%	3.0%
2012	17,348,813	6.5%	3.7%
2013	16,135,780	-7.0%	2.5%
2014	16,248,026	0.7%	3.0%
2015	16,927,090	4.2%	2.6%

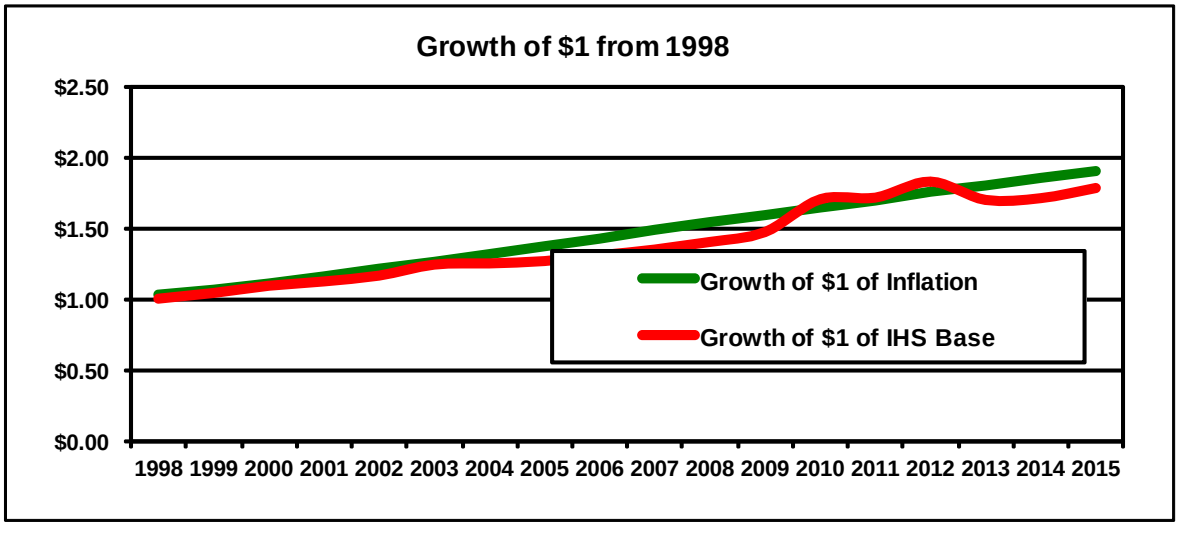


Figure 4-2

Base Health System Funding Versus Inflation, Continued

Interpretation: Funding increases provided by the Congress in 2009, 10 and 12 addressed deficiencies in bringing the funding in line with inflation. The national budget sequester in 2013 stripped funding, thereby reducing the benefits realized from those increases. The reductions were restored in 2014. Funding has just kept pace with inflation but does not account for population growth over the past 15 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.

	2012	2013	2014	2015
Clinical Services				
Medical	2,229,705	2,875,284	2,653,814	2,747,835
Dental	1,217,056	1,217,823	1,314,421	1,341,744
Optometry	287,891	240,219	221,051	195,204
Pharmacy	1,122,677	1,492,054	1,631,774	1,224,359
Podiatry	107,033	101,993	344,842	171,583
Medical Lab	749,719	640,333	775,851	860,922
X-Ray			111,181	92,431
Diabetes - Clinic	797,546	680,280	483,737	462,312
Community Health				
Community Health Dept.	415,384	364,932	277,899	198,781
Health Education	221,757	299,954	816,638	743,194
WIC Program	64,620	63,190	40,020	53,856
Diabetes Grant (Tribal)	142,075	193,268	184,296	165,049
Environmental Health	56,113	46,624	94,400	94,090
Public Health Nursing	941,253	644,482	650,440	820,840
Community Center	214,402	293,289	174,291	258,955
Community Counseling				
Community Counseling	1,055,718	1,164,795	480,416	380,237
Mental Health	321,245	197,119	442,326	737,596
Adolescent Aftercare	79,931	85,647	130,052	136,649
Vocational Rehabilitation/Social S	552,314	411,200	66,509	91,332
Prevention Projects	337,782	423,370	419,615	132,230
Administrative Support				
Facilities	986,419	263,269	1,071,288	473,883
Security	22,891	-		24,280
Medical Records			394,679	393,689
Health Administration	1,264,624	1,007,004	1,291,843	1,379,464
Business Office	947,236	462,821	646,238	557,516
Quality Assurance	106,017	-	110,678	141,251
Data Systems	269,888	107,336	482,681	478,445
Indirect Costs	1,314,107	492,258	1,335,157	1,190,811
Other				
Managed Care	5,566,489	5,836,686	3,048,409	2,160,842
Ambulance	1,071,369	300,000	325,021	337,353
Quarters	-	-	-	
Clinic Equipment	123,740	51,865	176,684	67,621
Total	**23,204,464**	**19,957,095**	**20,196,251**	**18,114,356**

Figure 4-3

Health System Spending by Program, Continued

Interpretation: From 2014 to 2015 the overall spending on total health services has decreased by $2,615,821 (13%). Most of the decrease is easily explained.

The expenditures in Managed Care were nearly $900,000 less than the previous year and are a reflection of the effective use of alternate resources and the Medicare rates now available for hospitalizations.

The reduction in spending for the Pharmacy Program was primarily because of two factors: Intermittent Pharmacy costs were down by $58,000 and more importantly drug costs dropped by $336,000. This was attributed to one of the top ten expensive medications now being available as a generic drug. It is anticipated that in 2016, drug costs will again rise due to an additional expensive drug (etanercept) being added to the formulary.

Podiatry expenditures declined by $174,000 in 2015. This was mainly due to the vacancy created when the Podiatrist retired. It took several months to recruit a new Podiatrist.

Most of the other programs and activities had expenditures that were in line with the previous years. Vacancies can account somewhat for the variances in most of the other categories.

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.

	2012	2013	2014	2015
Visits Billed				
Medical	10,208	10,320	12,179	11,743
Dental	2,190	2,296	3,308	3,333
Pharmacy	22,189	21,159	25,771	30,223
Optometry	387	467	689	1,021
All Other	3,275	2,232	2,469	2,389
Total Visits Billed	**38,249**	**36,474**	**44,416**	**48,709**

	2012	2013	2014	2015
Collections				
Medical	$ 2,213,237	$ 2,465,486	$ 3,081,135	$ 2,998,233
Dental	395,382	414,088	734,752	609,708
Pharmacy	535,153	480,071	617,569	956,958
Optometry	75,514	107,595	98,224	138,160
All Other	205,794	189,182	116,865	104,653
Total Collected	**$ 3,425,080**	**$ 3,656,422**	**$ 4,648,545**	**$ 4,807,712**

	2012	2013	2014	2015
Source				
Medicaid	2,624,016	2,908,078	3,923,674	4,093,398
Medicare	268,149	277,127	291,374	302,669
Private Insurance	506,060	449,167	390,379	377,431
Other (Workmen's Comp, VA, etc)	26,855	22,050	43,118	34,214

Figure 4-4

Interpretations: Total Medical visits billed have increased by 13% over the last 4 years with an average of 11,113 visits a year. Pharmacy visits has increased by 27% over the last four years, with a 15% increase in the last year. Total visits billed have increased 21.5% since 2012 then, with a 9% increase in the last year. The largest area of billing growth was in Pharmacy.

In 2015, Medical billed out for 11,743 visits and received $2,998,233 (an average of $255 a visit). Medicaid accounted for approximately 85% of collections, Medicare around 6.3% and Private Insurance makes up 8%.

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.

	2012	2013	2014	2015	
Incidents/Visits Billed					
Ambulance	594	636	690	854	
Alcohol & Substance/ Mental Health	1,896	2,938	3,532	1,888	*
Community Health	2,075	1,502	839	1,943	
Other					
Total Incidents/Visits Billed	**4,565**	**5,076**	**5,061**	**4,685**	

	2012	2013	2014	2015
Collections				
Ambulance	146,086	358,739	329,823	377,077
Alcohol & Substance/ Mental Health	567,466	944,058	1,196,976	657,265
Community Health	398,428	462,830	228,950	680,022
Other				
Total Collected	**$ 1,111,980**	**$ 1,765,627**	**$ 1,755,749**	**$ 1,714,364**

	2012	2013	2014	2015
Source				
Medicaid	1,000,140	1,519,144	1,548,191	1,508,888
Medicare	1,099	112,256	77,849	93,580
Private Insurance	98,325	115,964	110,224	101,439
Workers Comp	9,980	11,317	15,013	4,092
Other	2,437	6,946	4,472	

Figure 4-5

Interpretation: Since 2010, when the Tribe added Billing Staff, Collections have continued to increase even though there was a small decrease from 2014-2015. In 2015 collections saw a decrease of $41,385 from the previous year. The big decline in Community Counseling was due to a change in Policy and Procedures.

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.

OUTLAYS AND FUNDING	2014	2015
Outlays		
Allocated Salaries and Benefits	255,258	255,602
Medical Supplies	16,786	19,848
Other Supplies & Expenses	13,930	19,764
Vehicle Expenses	38,583	40,963
Equipment	463	1,176
Vehicle & Equip. Depreciation	5,795	5,795
Total	**$ 330,816**	**$ 343,148**
Average Direct Cost Per Transport	**$ 479**	**$ 402**

Figure 4-6

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

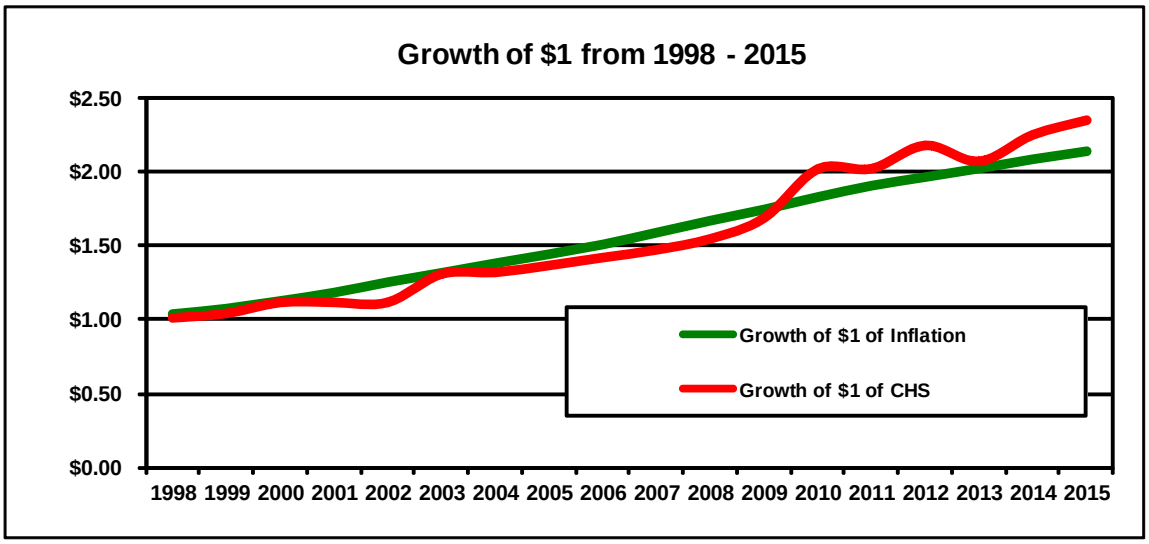
Interpretations: The collections for ambulance services increased by $47,254 or 14% in 2015. At the same time the expenses also increased by $12,332 or 4%. The cost of Medical Supplies and Vehicle maintenance accounted for this increase. The average cost per transfer decreased by $77 or 16%.

Contract Health Services – Funding

Purpose: To compare annual CHS base funding to medical inflation and to report on all CHS Funding.

Relevance: Identifies gap between medical inflation and funding.

	CHS Annual Funding Base	N/R & Deferred Services	CHEF	Total	Base Increase	Medical Inflation
1998	2,716,800	78,547	193,567	2,988,914	1.8%	3.2%
1999	2,798,596		23,857	2,822,453	3.0%	3.7%
2000	2,997,244		259,696	3,256,940	7.1%	4.9%
2001	2,997,244	431,485	115,450	3,544,179	0.0%	5.2%
2002	2,997,244	436,886	71,117	3,505,247	0.0%	6.0%
2003	3,511,606	32,831	166,859	3,711,296	17.2%	5.2%
2004	3,538,505	180,023	479,118	4,197,646	0.8%	5.0%
2005	3,665,746	90,206	155,406	3,911,358	3.6%	4.6%
2006	3,807,490	97,119	239,859	4,144,468	3.9%	4.6%
2007	3,947,624	79,971	397,960	4,425,555	3.7%	5.4%
2008	4,148,016		470,258	4,618,274	5.1%	5.2%
2009	4,522,779		422,971	4,945,750	9.0%	4.6%
2010	5,409,429	243,152	867,507	6,520,088	19.6%	4.9%
2011	5,414,309	206,376	675,421	6,296,106	0.1%	4.3%
2012	5,838,361		255,088	6,095,461	7.8%	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%
2015	6,289,399		36,896	6,328,310	4.3%	2.6%



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

Figure 4-7

Contract Health Services – Funding, Continued

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

Purchased/Referred Care - Spending

Purpose: To provide a report of major categories of spending for the Purchased/Referred Care (PRC) 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	
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	2,109,445	1,981,981	879,032	161,423	14,592	32,833	114,451	5,293,757	
2014	819,201	1,115,817	267,291	177,025	18,402	45,493	150,146	2,593,375	*
2015	427,996	773,800	256,999	203,861	19,744	36,403	156,306	1,875,109	*

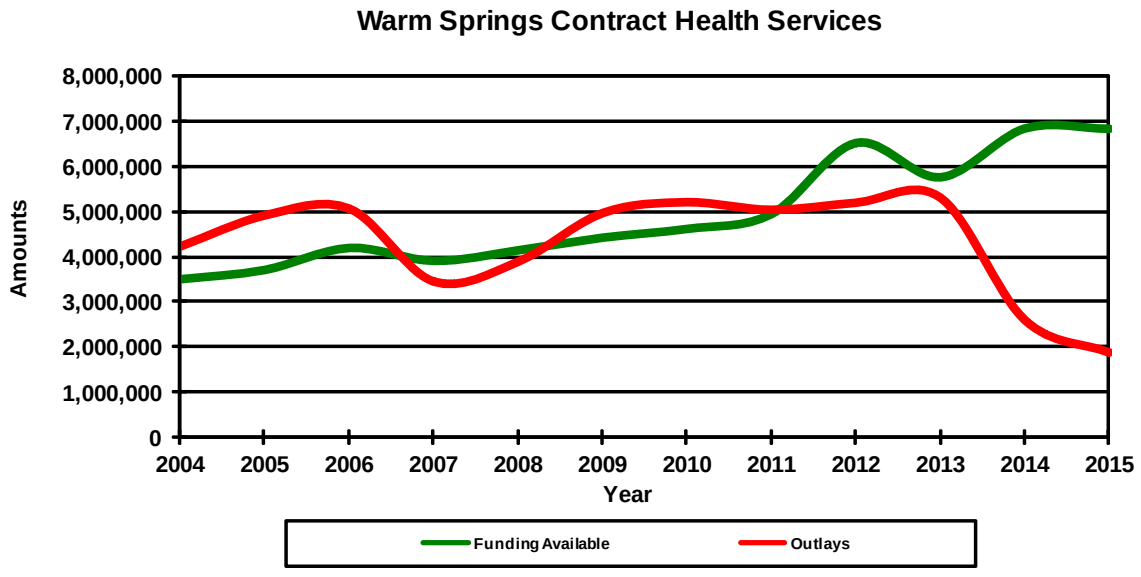


Figure 4-8

*There are Obligations for Services that have not been finalized. Final payment amounts will vary.
*There is an additional $995 Obligated but not yet paid for 2014.
*There is an additional $216,756 Obligated but not yet paid for 2015.

Purchased/Referred Care – Spending, Continued

Interpretation: Illustrates fluctuations in PRC 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 had a huge positive impact as costs fell by roughly $600-700K for both In-Patient and Out-Patient. The rise in Out-Patient in 2008, 2009 and 2010 is the result of the $500K 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 $5,296,757 in 2013. However, with $216,756 Obligated but not yet Paid for 2015, added to the $1,875,109 paid for 2015, the projected $2,091,865 2015 PRC Healthcare Costs are 19% less than 2014.

Since Medicaid Expansion came into effect at the beginning of 2014, PRC healthcare costs have receded by 65%. While the opportunity is present, Purchased/Referred Care may explore other Specialty Clinics to improve the health of the community.

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 Purchased/Referred Care (PRC) Program.

Relevance: 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.

	2014			2015		
	Units	**Total Cost**	**Cost per Unit**	**Units**	**Total Cost**	**Cost per Unit**
Hospital Days	483	$693,170	$ 1,435	715	$427,996	$ 599
Emergency Room Visits	773	$227,272	$ 294	540	$256,999	$ 476

Figure 4-9

Interpretation: This table reflects the units, total cost and cost per unit for both Hospital Days and Emergency Room Visits that PRC paid only a small percentage of the actual costs. Other alternate resources picked up the majority of the costs. Although there was a 68% increase in Hospital Days from 2014 to 2015, there was an even greater 58% decrease in Hospital Cost per Unit for this same period of time.

There was a 30% decrease in Emergency Room Visits from 2014 to 2015, but an increase of 62% for Emergency Room Cost per unit.

While the data in the table indicates the Cost per Unit for Hospital Days in 2015 was $599, more detailed admissions information is found in Figure 2-16 for the two major hospitals that serve the community.

Deferred Services

Purpose: To identify the number of cases and estimated costs for recommended care that could not be purchased under current circumstances.

Relevance: It is important that the program maintain a record of these cases and track progress.

2015		
Priorities*	**Cases Deferred**	**Estimated Cost**
Priority 1	0	-
Priority 2	0	-
Priority 3	2,400	500,000.00
Priority 4	0	-
	2,400	500,000.00

Figure 4-10

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

In April 2010, PRC was able to expand coverage beyond Priority I's to Priority II-IV coverage once again. PRC was able to cover Priority I-IV throughout 2011 & 2013, and had minimal "Deferred Services" as defined as those which PRC had covered pre-2005. The data above was based on numbers compiled by the PRC Case Manager in conjunction with the Portland Area Office (PAO) Contract Health Services (CHS) Manager for a report requested by PAO last year.

For Dental, PRC covers emergent conditions such as abscesses and Priority I situations, in addition to dentals and partials. PRC will cover dentures and partials automatically for an elder, but per approval through the PRC Review Team, PRC will cover a patient in any age group determined on a case by case basis. PRC is also covering more procedures this year based on dental recommendation and PRC 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 a pediatric dental surgeon; e) an anomaly that could possibly be a cancerous situation will be sent out to

Deferred Services, Continued

an Oral Surgeon for complete evaluation. Working with IHS dental, PRC emphasis has been towards Elders and the children of the Reservation. A pediatric dental surgeon performs about two dental restorations a week at SCMC-Bend.

The approximate cost for dental services that were deferred is about $300,000. There were an estimated 400 dental cases deferred in 2015.

For Pharmacy, PRC covers only emergent conditions, in addition to anti-rejection drugs, chemotherapy, anti-coagulant after heart surgery, or knee and hip replacement surgery. PRC 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 was deferred is $200,000. There were an estimated 2000 scripts @ 170 per month average deferred.

Both Dental and Pharmacy were determined by estimating from pre-2005 when MCP was able to cover more Pharmacy and Dental, and both are higher than last year due to the increase in population and need, as well as a decrease in drugs in IHS formulary.

Priority I: Emergent/Acutely Urgent Care Services: i.e. immediate threat to life or limb.
Priority II: Preventive Care Services: i.e. Screening Mammograms
Priority II: Primary & Secondary Care Services: i.e. Specialty Consultations
Priority IV: Chronic Tertiary & Extended Care Services: i.e. Hip/Knee Replacement

CHS – Catastrophic Health Emergency Fund (CHEF)

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
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	650,624	9	25,000	425,624	375,550	49,032	424,582	1,042
2015	272,088	7	25,000	188,596	62,570	64,135	126,705	61,891
Totals	**$ 11,784,390**	**221**		**$ 6,354,797**	**$ 2,733,030**	**$ 1,925,954**	**$ 4,658,984**	**$ 1,695,813**

Figure 4-11

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

Interpretations: The IHS Catastrophic Health Emergency Fund (CHEF) exists to reimburse for high cost cases that exceeds a given threshold, thus limiting financial risk to that threshold until the CHEF is exhausted for a given year. $25k has been the threshold for the last 9 years.

The CTWS PRC operates on a calendar year fiscal year. However, the IHS operates on an October – 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 2015 as an example, 12 CHEF cases resulted in $188,596 due CTWS PRC; $62,570 was reimbursed in 2015, and $64,135 has been reimbursed so far in 2016.

CHS – Catastrophic Health Emergency Fund, Continued

Timely application for CHEF is very important, and the PRC 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 Medicare Like Rates (MLR) nationwide, the CHEF has the potential to last longer than May/June. An additional significant major impact in 2014 was Medicaid Expansion effective 1/1/14. Not since 2007, the year MLR took effect, has the number of CHEF cases been measured in single digits. Of the $188,596 due to PRC $126,705 of the 12 CHEF cases in 2015 has been reimbursed by IHS.

In the ten years from 2006-2015, there was a total of 221 cases qualifying for CHEF reimbursements of $6,354,797. Total reimbursement of $4,658,984 was received from IHS, leaving a shortfall of $1.7 million to be absorbed by the PRC program in addition to the $5,429,593 initially paid out to meet the threshold.

Medicare-Like Rate (MLR) Savings

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

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

	2012	2013	2014	2015
St. Charles - Madras				
Inpatient	942,724	542,778	197,225	105,808
Outpatient	1,109,233	1,019,541	783,786	479,276
Mixed	57,508	35,705	53,710	109,537
Total	**$2,109,465**	**$1,598,024**	**$1,034,721**	**$694,622**
Other CAH & Surgery Centers				
Inpatient	15,482	14,916	0	5,136
Outpatient	14,651	28,930	26,788	7,800
Mixed	0	0	0	0
Total	**$30,133**	**$43,846**	**$26,788**	**$12,935**
Hospitals that Bill on DRG Rates				
Inpatient	1,534,274	1,761,944	978,753	240,655
Outpatient	440,190	473,532	329,322	149,851
Mixed	22,312	13,108	0	46,205
Total	**$1,996,776**	**$2,248,584**	**$1,308,075**	**$436,711**
TOTAL MLR SAVINGS	**$4,136,374**	**$3,890,454**	**$2,369,584**	**$1,144,268**

Figure 4-12

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

The Federal Medicare-Like Rates legislation basically states that any Indian Health Services Purchased/Referred Care (PRC) or Tribally contracted plan which operates PRC locally may reimburse a Medicare contracted hospital no more that the total reimbursement the hospital would have received from Medicare.

MLR became effective 7/5/07 which resulted in significant savings for PRC. Savings resulting from MLR implementation 7 ½ years ago not only was responsible for halting the erosion of PRC reserves, but allowed PRC to add non-Priority I services through

Medicare-Like Rate (MLR) Savings, Continued

specified “carve-out” of $500k under strict criteria in 2009. After a $250k “carve-out” to begin 2010, the decision was made effective April 1, 2010 to cover Priority II, III & IV under Committee Review and methodical implementation. I.H.S. physicians and Health & Welfare Committee were consulted and they gave input on services to add back. As seen in the table on the previous page, MLR savings have resulted in $15.1 million to PRC and thus potential healthcare referrals over the last four years.

PRC 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 PRC 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 PRC 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 $1,225,316 (48%) from $2,369,584 (2014) to $1,144,268 (2015). This 48% decrease was consistent across all three categories: 33% - St. Charles-Madras (Critical Access Hospital reimbursement); 52% - Other CAH & Surgery Centers; 67% - Hospitals reimbursed on Diagnostic Related Groups (including St. Charles Bend/Redmond). The Diagnostic Related Groups (DRG) showed the most significant decrease of the three categories.

The $1,144,268 Total MLR Savings in 2015 is extremely positive for the reasons mentioned above. The MLR Savings are dependent on the Medicare reimbursement determined by the Centers for Medicare & Medicaid Services (CMS), PRC has to be prepared to react and adjust depending on future impact of CMS decisions.

Grants Received

Purpose: To monitor the availability and funding levels of grants received to support the health care system.

Relevance: Grants represent an important part of the health care system's financing, and are frequently targeted at key risk factors and national priorities. Numerous grants finance ongoing staff and programs at Warm Springs.

Grant Names	2012	2013	2014	2015
Grant Amount				
Diabetes Grant (Tribe)	$ 193,268	$ 510,846	$ 519,818	$ 193,268
State Women, Infants, and Children (WIC)	78,355	79,391	80,842	75,497
Woman's Wellness Conference				
CHET Dental Project				
Senior Fitness Enhancement				
Tobacco Pilot Site				
State Tobacco Prevention	73,821	73,821	72,902	66,616
USDA Commodity Warehouse	39,918	79,636	78,636	85,175
State Alcohol & Drug	125,000			
State Alcohol Prevention		62,500		152,500
State Mental Health	381,733	362,466	362,466	506,432
State Youth Suicide Prevention	26,000			
Influenza Pandemic				
Vocational Rehablilitation	232,742			
Meth Prevention Project				
Total	**$ 1,150,837**	**$ 1,168,660**	**$ 1,114,664**	**$ 1,079,488**
Grant Expenditures				
Diabetes Grant (Tribe)	$ 129,719	$ 83,549	$ 157,600	$ 78,024
State Women, Infants, and Children (WIC)	84,061	23,200	44,874	25,614
Woman's Wellness Conference Grant				
CHET Dental Project Grant				
Senior Fitness Enhancement Grant				
Tobacco Pilot Site Grant				
State Tobacco Prevention Grant	54,516	24,746	54,396	23,690
USDA Commodity Warehouse Grant	71,905	17,440	78,465	85,175
State Alcohol & Drug Grant	172,187			
State Alcohol Prevention Grant	79,897	-		-
State Mental Health Grant	144,006	80	341,263	-
State Youth Suicide Prevention Grant	25,094			
Influenza Pandemic	3,219			
Vocational Rehabilitation Grant	266,919			
Meth Prevention Project Grant	13,813			
Total	**$ 1,045,336**	**$ 149,015**	**$ 676,598**	**$ 212,503**

Figure 4-13

Grants Received, Continued

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

Staffing

Purpose: To provide an overall summary of personnel devoted to healthcare, and the number of Warm Springs tribal members employed in the system.

Relevance: Staffing represents the single largest use of health resources. Tracking the number of enrolled members reports against a key objective of the health plan.

	2000 FTE			2015 FTE			2015 Enrolled TM		
	Tribal	**IHS**	**Total**	**Tribal**	**IHS**	**Total**	**Tribal**	**IHS**	**Total**
Clinical Services									
Medical		26.0	**26.0**		24.0	**24.0**		7.0	**7.0**
Dental		15.0	**15.0**		11.0	**11.0**		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**		3.0	**3.0**
Medical Lab		4.0	**4.0**		4.0	**4.0**		0.0	**0.0**
X-Ray		3.0	**3.0**		1.0	**1.0**		0.0	**0.0**
Diabetes - Clinic		4.0	**4.0**		4.0	**4.0**		0.0	**0.0**
Community Health									
Community Health Dept.	2.0		**2.0**	4.0		**4.0**	3.0		**3.0**
Health Education	1.0		**1.0**			**0.0**			**0.0**
CHET	4.0		**4.0**	2.0		**2.0**	2.0		**2.0**
Com. Health Resource Center				3.0			3.0		
Maternal Child Health	2.0		**2.0**	2.0		**2.0**			**0.0**
Early Intervention Services				2.0		**2.0**			
Community Health Rep.				5.0		**5.0**	4.0		**4.0**
WIC Program	1.0		**1.0**	1.0		**1.0**	1.0		**1.0**
Wellness Coordinator	3.0		**3.0**			**0.0**			**0.0**
Diabetes Grant (Tribal)				3.0		**3.0**			**0.0**
SDPI Grant (IHS)					6.0	**6.0**			**5.0**
Environmental Health	2.0		**2.0**	1.5		**1.5**	1.0		**1.0**
Community Health Nursing		6.0	**6.0**	3.0		**3.0**			**0.0**
Nutrition		3.0	**3.0**	2.0		**2.0**			**0.0**
Medical Social Work	3.5	1.0	**4.5**	1.0		**1.0**	1.0		**1.0**
Physical Therapy	1.0		**1.0**			**0.0**			**0.0**
Senior Wellness Center				7.0			4.0		
Community Wellness Center				7.0		**7.0**	7.0		**7.0**
Community Counseling									
Community Counseling	5.0		**5.0**	4.0		**4.0**	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**	8.0		**8.0**	8.0		**8.0**
Prevention				5.0		**5.0**	5.0		**5.0**
Administrative Support									
Facilities	11.0	2.0	**13.0**	11.0			10.0		
Security	2.0		**2.0**			**0.0**			**0.0**
Health Administration		14.0	**14.0**		4.0	**4.0**		2.0	**4.0**
Personnel		2.0	**2.0**		2.0	**2.0**		1.0	**1.0**
Procurement		1.0	**1.0**		3.0	**3.0**		2.0	**2.0**
Business Office		6.0	**6.0**		8.0	**8.0**		7.0	**7.0**
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**		1.0	**1.0**
Other									
Managed Care	8.5		**8.5**	8.0		**8.0**	5.0		**5.0**
Ambulance				21.0		**21.0**	3.0		**3.0**
JV/JHC				4.0		**4.0**	3.0		**3.0**
Total	**64.0**	**104.0**	**168.0**	**111.5**	**87.0**	**198.5**	**64.0**	**29.0**	**93.0**

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.

Fire & Safety employs full time positions and numerous part time positions, only the full time ones are noted in this figure.

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
Security key pads for 3 Medical Doors	HWC	$ 3,000	2015	2015
Replace 5 security cameras and DVR	HWC	$ 7,000	2015	2015
Purchase backup cooling tower spray motor	HWC	$ 1,500	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
Vacuum Pump	14,417	Dental	Nov-14	12/19/2014
Exam Lights	8,504	Medical Tx Room	Jan-15	5/29/2015

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.

	2012	2013	2014	2015
Tribe - Self Determination Contract				
Program Savings and Carryover				
Community Health	1,414,810	610,642	11,606	312,308
Community Counseling	1,265,756	1,618,168	250,809	238,688
Managed Care	5,576,844	4,997,555	3,218,639	4,347,498
Ambulance	-	-	-	
	303,995	-		
Environmental Health	269,833	300,492	368,113	421,012
Indirect Contract Support Costs	3,611,566	3,426,341	4,195,800	4,320,616
Reserves				
M & I Reserve Wellness Center	789,779	749,267	960,807	1,067,582
M & I Reserve Community Counseling	236,294	146,494	146,494	146,494
Equipment Replacement	6,189	2,090	127,570	135,431
Projects				
Joint Venture - Clinic Remodel	-			
Other JV Projects	66,424			
Total - Tribal	**13,541,490**	**11,851,049**	**9,279,838**	**10,989,628**
Indian Health Service				
Medicare/Medicaid	1,964,000	576,802	1,208,187	1,203,255
Private Insurance	101,000	182,884	145,639	186,500
FSA & M&I	340,000	272,723	245,792	245,792
Equipment	30,000	30,425	42,597	42,597
Total - Indian Health Service	**2,435,000**	**1,062,834**	**1,642,215**	**1,678,144**
Grants				
Tribal Diabetes-competitive grant	485,145	193,268	-	28,219
Tribal Diabetes-competitive grant-prior years				316,519
Diabetes-competitive grant - prior years	114,000	317,578	326,550	455,496
Diabetes Grant - Clinical (IHS operation)	-	455,596	-	-
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	**970,013**	**1,131,710**	**406,229**	**800,234**
Grand Total	**16,946,503**	**14,045,593**	**11,328,282**	**13,468,006**

Figure 4-17

Interpretation: The cumulative savings for all accounts has been decreasing since 2012. With the exception of 2015, when there was an increase from the previous year of $2,139,724. Yet, even this increase is still $3,479,497 short of the 2012 funding level. While savings in some categories can be reprogrammed to other priorities, other savings must be spent within the program that generated the savings. Examples

Savings and Reserves, Continued

include Managed Care, M&I and certain grants. Nevertheless there are opportunities to reprogram some resources.

The tribal directed accounts show decreased savings of $1,595,154 over the totals of the previous year. This includes program savings, carryover, reserves and projects. Community Health increased their savings by $300,702 and Community Counseling has a decrease of $12,121. Managed Care an increase of $1,128,859 as did Indirect Contract Support by $124,816.

The Indian Health Service accounts have limited carryover opportunities. Collections and Maintenance & Improvement are the only categories where savings can accrue. The ending balance of these savings shows an increase of $35,929 from the ending balance of the prior year (2014).

The total Grant savings has increased by $394,005. These funds generally must apply to the respective grant so they are not available for redistribution.

SECTION 5

Evaluation

How do we evaluate our progress and our effectiveness?

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

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

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

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

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

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

Accreditation Information

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

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

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

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

Cost versus Value of Service

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

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

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

Figure 5-1

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