KARUK TRIBE
ANNUAL HEALTH BOARD MEETING AGENDA
Thursday, August 8, 2013, **3 PM,** *Yreka, CA*

A) CALL MEETING TO ORDER – PRAYER - ROLL CALL

AA) HEALTH MISSION STATEMENT

The mission of the Karuk Tribal Health Program is to provide quality healthcare for Native Americans, and other people living in the communities we serve as resources allow. Our purpose is to appropriately assess or reassess conditions of illness, disease, or pain, provide culturally appropriate educational, preventative, and therapeutic services in an environment of continuous quality improvement.

CH) APPROVAL OF THE AGENDA

EE)APPROVAL OF THE MINUTES *(July 18, 2013)*

F) GUESTS *(Ten Minutes Each)*

1.

H) OLD BUSINESS *(Five Minutes Each)*

1.

I) DIRECTOR REPORTS *(Ten Minutes Each)*

1. Annie Smith, Director of Community Services (written report)
2. Lester Alford, TANF Program (written report)
3. Rondi Johnson, Deputy Director (written report)
4. Eric Cutright, IT Director (written report)
5. Lessie Aubrey, Executive Director of Health & Human Services (written report)
6. Patricia White, RPMS Site Manager (written report)
7. April Attebury, Children and Family Services
8. Carolyn Ash, Dental Director
9. Laura Mayton, CFO

II) REQUESTS *(Five Minutes Each)*

1.

K) INFORMATIONAL *(Five Minutes Each)*

1.

M) CLOSED SESSION *(Five Minutes Each)*

1. CHS (dinner break)

2. Dr. Shearer
3. Tribal Council Members

N) SET DATE FOR NEXT MEETING ***(Thursday, September 12, 2013** *at 3 PM in Happy Camp)*

OO) ADJOURN

Karuk Tribe – Health Board Meeting
July 18, 2013 – Meeting Minutes

Meeting called to order at 3:02pm, by Buster Attebery

Present:
Russell "Buster" Attebery, Chairman
Michael Thom, Vice-Chairman
Joseph "Jody" Waddell, Secretary / Treasurer
Amos Tripp, Member at Large
Charron "Sonny" Davis, Member at Large
Elsa Goodwin, Member at Large
Dora Bernal, Member at Large

Absent:
Alvis "Bud" Johnson, Member at Large (excused)

Crispen McAllister read the Health Mission Statement aloud and Sonny Davis provided a prayer.

Agenda:
Michael Thom moved and Sonny Davis seconded to approve the agenda, 7 haa, 0 puuhara, 0 pupitihara.

Minutes of June 13, 2013:
Sonny Davis moved and Crispen McAllister seconded to approve the minutes of June 13, 2013, 6 haa, 0 puuhara, 1 pupitihara (Elsa Goodwin).

Guests:

1.) **Laura Olivas, Bookkeeper:**
Laura is present to seek approval of two funding resolutions for PSA Area Agency on Aging. One is for 13-R-092 in the amount of $7,408.00

Amos Tripp moved and Sonny Davis seconded to approve resolution 13-R-092, 7 haa, 0 puuhara, 0 pupitihara

She then sought approval of an additional resolution 13-R-093 in the amount of $21,087.

Amos Tripp moved and Michael Thom seconded to approve resolution 13-R-093, 7 haa, 0 puuhara, 0 pupitihara.

Director Reports:

1.) **Annie Smith, Director of Community Outreach:**
Annie is present to provide her report. The diabetes grant is being submitted and it has been revised each year but always takes into consideration the best service for the patients. She has completed the draft documents and ensures its completion each year to hand off to the grant writers to submit.

There was a busy month with a lot of Elder issues. There have been several Elders out ill and the staff has been working diligently on assisting them. She did receive messages to ensure services in Orleans and she assigned this to Michelle. Melodee has been working with Michelle to ensure services are provided to several Elders.

She updated the Health Board on the teen pregnancy prevention grant and how it is working with the youth in the area. She is still working with Tom Fielden on the continuity of operations plan for elders if there is an emergency. She still has not met with Tom because of hectic schedules but they will get to that. Flo's car is back on the road.

She received 12 computers donated by a friend of hers and IT is working with Head Start on passing some of those on to the Head Start program.

She went to a FEMA meeting with Tom Fielden as one of the IC staff. She went to training with Tom and was provided with intense training on an incident and when it was over they were seriously involved in the training that they were still feeling on task.

Michael Thom moved and Jody Waddell seconded to approve Annie's report, 7 haa, 0 puuhara, 0 pupitihara.

2.) **Lester Alford, TANF Director:**
Lester is present to review his report with the Health Board. He updated the Health Board on the tasks of the program. Work participation is up significantly from last year.

He has one action item. He would like to attend the TANF Tribal Summit in Denver CO, August

Elsa Goodwin moved and Crispen McAllister seconded to approve Lester to attend the TANF Summit in Denver CO, 7 haa, 0 puuhara, 0 pupitihara.

Lester commented that the TANF program is operating fairly smooth and he has been checking on the work from MCWC that are using the TANF van. It was nice to see the outreach working well.

Lester reported that 100% attendance was done for Yreka Cheerleading and the lady that is overseeing it is that she was very surprised at the parent participation and he was as well.

Feeding the children in Orleans in connection with the Food program for the summer is going well. They are providing 35 Orleans.

There is SAC (Substance Abuse Counseling) offered three days a week in Happy Camp. This is a little higher but it's a service that is needed so Clarence Hostler has been providing the service for the area.

Crispen McAllister moved and Jody Waddell seconded to approve Lester's report, 7 haa, 0 puuhara, 0 pupitihara.

3.) **Rondi Johnson, Deputy Director:**
Written report provided, on travel.

Michael Thom moved and Dora Bernal seconded to approve Rondi's report, 7 haa, 0 puuhara, 0 pupitihara.

4.) **Eric Cutright, IT Director:**

Eric is present to review his report. He has no action items. He provided an update to the Health Board on the activities of the IT department. He has been working with the Orleans Wellness Center which has been a good training opportunity for his team.

The backups that are being done in Happy Camp reportedly failed and they are receiving false positives for the backup. He tested another system which was a good price but not service. He will be working on procurement for services and bring that next month.

Last week he was contacted by the Public Utilities Commission and he received word that they are very positive to receive the 6million dollar funding. He believes that this is good news.

Amos Tripp moved and Elsa Goodwin seconded to approve Eric's report, 7 haa, 0 puuhara, 0 pupitihara.

5.) Lessie Aubrey, EDHHS:

Vickie Simmons is present for Lessie Aubrey to present her action items.

An invoice for the Darrel Hostler Fund distribution has come in and is for $10,000.

Amos Tripp moved and Michael Thom seconded to approve the Darrell Hostler Contribution of $10,000 to CRIHB, 7 haa, 0 puuhara, 0 pupitihara.

Vickie Simmons then sought approval of contact 13-C-036 with Barbara North.

Amos Tripp moved and Michael Thom seconded to approve contract 13-C-036 with Barbara North, 7 haa, 0 puuhara, 0 pupitihara.

She then presented a "conflict of interest" statement for the Council to sign.

The Health Organizational Chart was reviewed with staff and Council Members which was not discussed further with the Council.

There is a doctor who is interested in becoming the Tribes Medical Director. The interview hasn't been set up to date but it will be shortly.

Fabian Alvarado has resigned. The Veteran's Contract was not complete as noted in Lessie's report, so it is not presented for approval.

Elsa Goodwin moved and Crispen McAllister seconded to approve Lessie's report, 7 haa, 0 puuhara, 0 pupitihara.

6.) Patti White, RPMS Site Manager:

Patti is present to review her report. She is requesting out of state travel to Denver CO., August 13-15, 2013 for the 14th Annual Indian Health Services National Partnership Conference.

Amos Tripp moved and Crispen McAllister seconded to approve out of state travel for Patti White to Denver CO, 7 haa, 0 puuhara, 0 pupitihara.

Michael Thom moved and Amos Tripp seconded to approve Patti's report, 7 haa, 0 puuhara, 0 pupitihara.

7.) **April Attebery, Children and Family Services:**
April is not present, no report provided. She had taken today off for the Reunion day.

8.) **Dr. Ash, Dental Director:**
Not present, written report provided.

Michael Thom moved and Sonny Davis seconded to approve Dr. Ash's report, 7 haa, 0 puuhara, 0 pupitihara.

9.) **Laura Mayton, CFO:**
Laura is present to provide the health Program Assets, liabilities and equity report. She provided information on the grants that are received, funding that they have generated and then funding that Indian Health Services has provided. The annual budget was provided as well that includes revenue. There are slight adjustments made to the budgets and governmental accounting. The IHS Compact information was provided slightly adjusts based on a small amount they fund. The health program has some carry over but they also spend.

Laura commented that HRSA wants this report to be very careful about ratios on accounts receivable. This is because most facilities that HRSA funds do not have similar grants and cash on hand for months. HRSA watches and monitors what those facilities spend and would like a report to the Health Board that those facilities need, but the Karuk Tribal Health Program is slightly different with government grants and Indian Health Services. She is however, able to provide a four page financial report which covers all information that the Health Board needs to provide oversight of the finances of the health program.

Amos commented that an overall summary of the entire Tribe would be helpful to see how this budget fits into the overall finances of the Tribe.

Crispen McAllister moved and Sonny Davis seconded to approve Laura's report, 7 haa, 0 puuhara, 0 pupitihara.

Closed Session:
Amos Tripp moved and Michael Thom seconded to accept the new rate of increase of 25% to Medical Services, 7 haa, 0 puuhara, 0 pupitihara.

Dora Bernal moved and Jody Waddell seconded to approve moving the August 8th 2013 Health Board Meeting to Yreka, 7 haa, 0 puuhara, 0 pupitihara.

Next Meeting Date: August 8, 2013 at 3pm in Yreka CA

Crispen McAllister moved and Amos Tripp seconded to adjourn the Health Board Meeting at 4:12pm, 7 haa, 0 puuhara, 0 pupitihara.

Respectfully Submitted,

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Russell "Buster" Attebery, Chairman

Recording Secretary, Barbara Snider

Karuk Tribe

Karuk Tribal Health and Human Services

Community Health Outreach

Health Board Report: August 8, 2013

Annie Smith PHN

Action Items:

- I request permission for Michelle to travel to Oklahoma for the CHR training class for one week. She was previously accepted for this class and the class was cancelled/postponed. She has been accepted to this limited class because of her previous qualified application. Our Team has the funding in our budget. (See attached copy of E-mail.)

July Items:

- Our Team worked very hard this year to give a splendid Health Fair booth full of giveaways and information. All of us talked and taught health all day. We had a great crowd and were able to talk with many Tribal members that are from out of town as well as our locals.

- We have had some very serious illnesses and injury cases this month. Our Team has met every need possible for our patients and their families.

- Flo has been out on and off this month due to family illness. I look forward to her return this next week.

- I have had to reschedule the last BART Pregnancy Prevention Class due to some unforeseen issues that have come up. Carol, Clarence and I are working on the reschedule of that last class.

- We are coming up on Flu immunization time. Would any Tribal Council Members volunteer to get their picture taken getting their flu vaccine so we can promote immunizations for our Elders and children?

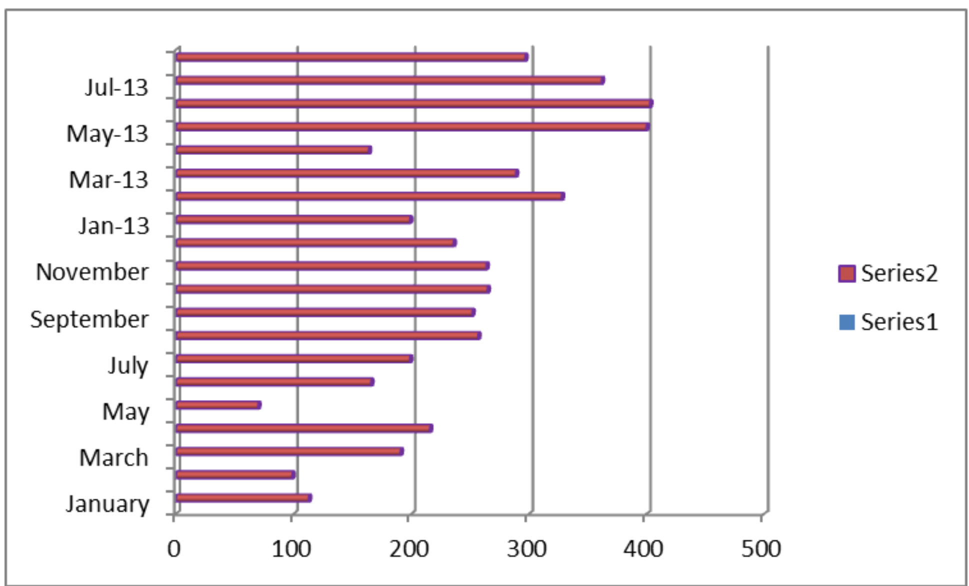
- Diabetic Retinopathy screenings continue. We are still scheduling on Tuesdays in Yreka and will begin this month in Happy Camp and Orleans area. Our numbers continue to climb of how many have been screened.

- Thank you to Lessie, Rondi and Laura Olivas, I have finalized my budget proposal. This is not something that comes easy to me, so I really appreciate their help.

- The Special Diabetes Prevention and Treatment grant application was finalized and submitted to IHS, and Grant Solutions. I received notification they received the application.

- The recent fire in Orleans taxed all of our resources and staff. I was able to apply all the information I learned at the week-long ICS class you sent me to last month. Everyone rose to the challenge and I felt it all went according to needs and plans. I am continue to monitor the air quality issues and will continue to make daily reports to and through Tom Fielden. I am thankful the Tribe hired such an experienced person. All of the Elders have been monitored and anyone with any diagnosis of any respiratory illness or condition has now received an air filter for their homes. Those with air-conditioning have filtering through their units. Those with only swamp coolers need air filters. If anyone needs assistance please call me. The Orleans medical clinic extended their hours for two days and then all stayed on-call. I arranged for clean air respite areas as well.

Workload Report:



Flo was off work on and off during the month due to family illness and I have not received her report as of the date of this report. Also with the work of the reunion, our staff was busy planning and prepareing.

Financial Report:

	Unencumbered Balance	*Percent Used*
IHS Diabetes Grant 2012:	$ 78,862.58	49.95%
Public Health Nurse:	$ 30,389.05	63.83%
CHR:	$ 50,717.69	79.49%

I am below budget for all accounts.

DEPARTMENT OF QUALITY MANAGEMENT

Karuk Tribal Health Board Meeting
August 8, 2013
Rondi Johnson
July Report

ACTION ITEMS: None

JULY ACTIVITIES:

1. Yreka Clinic visit July 3rd, P&T/CHS MANAGED CARE Meeting July 10th, ACQI Meeting July 10th, Front Office/Billing Meeting July 11th, ED Meeting July 23rd, Safety & Infection Control Meeting July 24th, Yreka Clinic visit July 31st

JULY TRAININGS/CONFERENCES & WEBINARS:

AAAHC WEBINAR July 10th, NRHA Conference July 15-20th, PQRS Webinar July 25th, HRSA Grant Agreement Conference Call July 26th, HRSA Conf Call July 29th, Immunization Webinar July 30th, VA Conf Call July 31st

ACQI COMMITTEE MEETING:

The July 10th, ACQI meeting agenda, minutes, performance improvement projects, and reports are attached.

BUDGETS:

See below. Budget through 7/31/13. At this time I'm well under budget.

Program	**CQI**
Budget Code	300002
Program Year	2012-2013
Expenses to Date	$93,233.85
Balance	$120,268.63
Percent Used	43.71%
Period Usage	10 months

Respectfully Submitted,
Rondi Johnson
Deputy Director of Health & Human Services

Karuk Tribal Health & Human Services Program
ACQI Committee Meeting/Conference Call
Meeting Minutes
KCHC Teleconference Room
July 10, 2013
9:00 am-10:00 am

1. **Meeting Called to Order by Rondi Johnson at 9 am**

2. **Roll Call/Sign In** – Vickie Walden:
   2.1. Happy Camp: Vickie Simmons, Lessie Aubrey, , Dr. Brassea, Chelsea Chambers, Patti White, Rondi Johnson, Suzanna Hardenburger, Susanna Greeno, and Vickie Walden
   2.2. Yreka: Mike Lynch, Dr. Ash, Dr. Milton, Annie Smith, Amy and Jessica Courts.
   2.3. Orleans: Fabian Alvarado

3. Agenda approved with a motion made by Lessie Aubrey, 2nd by Suzanna Greeno. Motion caries with no abstentions or objections.

4. Minutes for June 12, 2013. Approved with corrections/changes, motion made by Susanna Greeno, 2nd by Dr. Ash, motion caries with no objections and Vickie Walden absenting.

5. Performance Improvement Reports Due
   5.1. **BMI PROJECT** – Patti White/Dr. Milton
   5.1.1. Patti went over her written report, there was group discussion on: the project and report was based on HRSA guidelines and we are going to do a BMI at every visit. Patti said that we are doing well getting the BMI's and counseling/follow-up done on adults; the BMI's for children are being done but we need to do better in counseling/follow-up area for children. There was more discussion on how: the data is being entered; captured; if medical assistants could do the counseling/follow-up and enter it into the system; and how the system captures the data. Patti said that we are on target to meet the goal for the adults. Dr. Milton said that he has been working with some of his patients and are finding them receptive to the idea of weight loss. There was discussion on what codes should be used for counseling i.e. physical exercise, nutritional education, and Fabian asked if literature given to the patients could counted as counseling, Patti said she would check on it, that is depends on the coding criteria. Lessie she could see that Patti put in a lot of hard work on this project, but it needs to be simpler, will work with Patti on this project. Lessie said that we are not just answering to HRSA; we could expand it to improve our data and patient care.
   5.1.2. Amy said there is a national clinical reminder (for all patients) called activates screen and has a dialog associated with it. It can be used for patents ages 5 to 110, what this reminder asks is activity level; has check box for education provided with a template to document the education; and it will populate most fields in the patients record. Amy went on to say that the new patch 11 will enable us to create a specific reminder to calculate BMI. Patti explained a little about patch 11 and the install date was Saturday July 20 and she will have the server install completed on July 22, 2013. Chelsea asked Amy if they could have the BMI charts that show the healthy ranges and where the patients are within range. Amy said no, what they could run a graph under the vitals tab. Amy said that patch 11 will deploy a number of graphing futures, which are going to be useful for the providers when doing patient education.
   5.1.3. Patti and Dr. Milton's Written Report is attached to this report.

   5.2. **HIV/AIDS** – Mike Lynch said the report needed to be tabled due to the absence of Lisa and mike said the Dr. Hess will be doing the next HIV/AIDS Clinic.

5.3. **Dental Records – Happy Camp** – Cheryl Tims was absent from the meeting. Rondi asked Vickie Walden wanted to do Cheryl's report and she said that she had not reviewed the report, but did have a comment about the report format. That report was missing graphs usually used for tracking each quarter in the reporting period. That Cheryl needed to use the correct reporting format and include graphs in her report. The written report is attached to the meeting packet.

5.3.1. **Dental Records – Yreka – Tabled**- Susan Beatty was absent and Jessica was scheduled going to do the Yreka Dental Report. Jessica was not in the meeting and Dr. Ash went to get her. Jessica had to leave the meeting and Rondi ask Dr. Ash is she wanted to do the report to talk with Rondi about it later, they will review the report later.

5.4. **HTN** – Fabian reported: That we need to correct the date on his report to, July 10, 2013.

5.4.1. To determine the proportion of adult hypertensive patients, 18 to 85 years of age, that had an adequately controlled blood pressure (less than 140/90) at the time of the last reading. If improvement is needed, recommendations will be made. The goal is to have the blood pressure (BP) of all adult hypertensive patients adequately controlled. Short of that, our target will be to improve over the previous year by at least 10%. Second quarter data for 2013 show a slight decline in the proportion of uncontrolled hypertensive patients when compared to cumulative data for 2012, but the proportion is the same as compared to cumulative data for 2011. In order to improve long term outcomes for our hypertensive patients, we need to (1) distinguish between transiently elevated BP measurements and actual uncontrolled hypertension. Next, we need a process by which we can (2) effectively address uncontrolled hypertension in those patients that are more than just transiently elevated due to acute illness. It was decided at the time of the last report that the Orleans clinic alone should implement the recommendations as a pilot project to ascertain their feasibility and effectiveness. We found that convincing patients to make follow up appointments simply for blood pressure checks was difficult enough but getting the patients to keep those appointments was an insurmountable challenge. At the end of the quarter we compiled a list of those patients and enlisted the CHR to do home visit BP checks. Most patients were not found at home but of the 4 patients we were able to check, all had persistently elevated BPs. As a result the CHR urged them to make appointments to address their uncontrolled hypertension but this was apparently unsuccessful since no follow up appointments have been made to date. Of note, the number of uncontrolled hypertensive patients (as determined using the above criteria) at Orleans clinic number 14. Given this extremely low sample size it would be inaccurate to draw conclusions about whether or not most of the Karuk Tribal Health Program patients that meet the criteria had a BP that was only transiently elevated at their last visit. Further, the number of patients in Orleans that meet the criteria is too low to impact the figures for the entire health program. In order to accurately evaluate the effectiveness of the quality improvement measures, they need to be implemented by all clinics. Feasibility can be measured qualitatively by the medical staff and we will continue to audit our patient records quarterly for the remainder of 2013. Moreover, tracking how many of the follow-up BP checks and/or appointments are kept by the patients would provide a way to evaluate the practicality of and interest in the above recommendations from the patients' perspective. Unfortunately, to my knowledge there is no way to retroactively query the schedule based on the type of visit. Fabian said that when working with Patti on collecting the data for this project was a little time consuming. That since the quarry that Patti uses to collect this data is for all patients, his recommendation is that we do this PI Project organizational wide, Fabian said that he would to see data analyzes using a larger sampling of patients. Patti White said that with at least a weeks' notice she can sort the data better. There was more discussion on how the data was collected and if there was a need to modify the process used for collection. Annie what process was being used in the clinics to notify the providers when an abnormal reading was found; conclusion of this discussion was that the medical assistants do have a close communications with the providers. The discussion went on to review the current process being used at the various clinics for scheduling the follow-up appointments. Happy Camp and Orleans are either walking the patients to the front to re-schedule or sending out a routing slip. Mike said that Yreka has routing slips but are not using them; he will address this at their next staff meeting. Lessie said that we are losing our focus on the subject matter for this project, that so many times when doing PI Projects, questions and comments come up during the presentation of our PI reports, we lose focus on what we were trying to do and change the direction of the PI project. Lessie said we need to say on track when doing our PI Projects from beginning to end.

5.4.2. In conclusion Fabian said that is seems feasible for: Orleans and Happy Camp to have someone notify the front desk that they need to schedule the patient a follow-up appointment before they leave the clinic;

and the routing slips may work for the Yreka Clinic. If the patient does not want to return to the clinic for the BP follow-up, Lessie suggested that a referral be done to the CHR supervisor and she could schedule a CHR to do the Blood Pressure follow-up check.

6. **GPRA Reports**
   6.1. Clinical Benchmarking – Vickie Simmons
   6.1.1. The unofficial GPRA 4 quarter report is attached to the meeting packet. Vickie said the she has not turned in the official report yet. The unofficial report shows that we met 7 measures, did not meet 6 measures and are at baseline on 9 measures. We need to work on LDL Assessed, Nephropathy Assessed, Retinopathy Exam, FAS Prevention, Prenatal Screening, and Childhood Weight Control. Vickie S said the measures we are close to meeting now, may be met after she submits the final report. Vickie said the he is currently monitoring and reporting on Mammograms, but since we have met that measure she may choose another measure to monitor.
7. **New Business**
   7.1. Complaints/Incidents/Suggestions –Rondi Johnson – We have had a few complaints and incidents but there is nothing to report at this time they are under review and/or being processed.
   7.2. **Patient Satisfactory Surveys** – Rondi Johnson
   7.2.1. Update on the ongoing patient Satisfaction Surveys. The graphs she attached to this meeting packet show our survey return rate for: Yreka 20, Happy Camp 45, and Orleans 0. The number of surveys needed is around 450. The original survey periods was March through June 2013, but do to the lack of surveys returned, the survey is being extended to for another three months. Rondi asked that the clinic staff work very diligent at getting these completed and returned to her as soon as possible. Lessie Aubrey said because the survey returns were so low, she worked with Rondi and did a PI Project review. They found that we did not meet our goal, that staff /receptionists as not cooperating (by not handing out or collecting the surveys, this is probably unintentional), and that some patients refused (now we need to track how many refused and why). Lessie said that we need to find out the reasons for the low return and work on ways to fix the problems. Mike Lynch said that he sat town and wrote out a process for improving on what Yreka was doing to see if they could increase the returns. Rondi and Mike will meet and follow-up on this.

   7.2.2. **Policy Review**- Dr. Ash reviewed her request for changes to this policy, with the group. After some discussion it was decided that Lessie and Rondi would do the follow-up research on the requested changes in the wording in section E. Walk-in Patients and all other changes in wording and suggested deletions presented by Dr. Ash were approved with a motion made by Patti White, 2nd by Vickie Simmons motion caries with no objections or abstentions. Dr. Ash will re-type the policy and send it to Rondi or Lessie to complete and present to the Health Board. Lessie excused herself from the meeting to attend another function.

   7.3. **Suzanna Hardenburger – Quality Improvement**
   7.3.1. Suzanna said that over the past five years we could have been paid an extra 1 ½ % from Medicare for doing quality improvement coding but she was told that we did not want to do it at that time. Now they are going to start collecting a 1 ½ % from us for not doing quality improvement coding. Suzanna said it is a matter of entering the appropriate codes. Suzanna said since we are reporting on all patients for HRSA, it should be easy to do and the coders can help the providers with the coding. Suzanna said that she has to start this next month. The consensus of the group was that this was something we should start doing.
8. **Old Business**
   8.1. Review Policy Approval Changes: Policy #07-002-210 – Michael Lynch
   8.1.1. Mike was re-presenting this policy for review. The policy was re-reviewed and approved with a motion made by Vickie Walden and 2nd by Chelsea Chambers, motion caries with no abstentions or objections.
   8.2. Review Policy #14-003-305 Scheduling the Dental Emergencies- Dr. Ash
   8.3. Eligibility Report – Yreka – Sharon Denz
   8.3.1. Sharon Denz- Written report is attached to this meeting packet and was presented by Mike Lynch. Mike said that the data pulled showed; Problems: Not getting the clients to sign up for MediCal, CMSP, and Medicare Part D., that they are going to Human Resources Office in Yreka. The data shows that she processed 3 Medicare Part D applications during the first quarter of 2013. There was discussion on the

change to Medical Managed Care, where we were at in signing up patients for that program and what impact that might have if we are not pro-active in getting people to sign up with our clinics. Rondi will get with Mike and follow-up on his questions on how the medical managed care was going to be handled for children going to a pediatrician and our tribal clinic. She thinks that we are going to have business agreements with the other providers.

8.4. CHDP Callback Report – Happy Camp – Chelsea Chambers **(Tabled)**

8.5. Diabetes Report – Annie Smith **(Tabled)**

8.6. Dentrix Update – Patti White- Patti reported about four weeks ago they had a time set with Cimarron and Sullivan Schein to build the HL7 interface and the Dentrix Tech was a no show. She has sent them an email and received no response. She is going to call the Sullivan Schein Administrator/Supervisor and see if they can set up a new date and insure that their technician keeps the appointment this time. Mile Lynch asked about the Webinar for the BMW scheduling package and who needs to attend. Patti said that they are ready and waiting on I.H.S. to the install. Patti said that there will be more training coming soon, that the one key front desk staff member should attend the training on Friday so that they are aware of the changes are coming soon.

9. Next Meeting August 14, 2013 at 8:15 am
10. Adjourned at 10:50 am with a motion made by Patti White, 2nd by Vickie Walden, motion caries with no objections or abstentions.

Meeting Minutes Respectfully Submitted by Vickie Walden on August 1, 2013

Karuk Tribal Health & Human Services Program
ACQI Committee
Meeting/Conference Call
KCHC Teleconference Room
July 10, 2013
9:00 am-10:00 am

1. Call Meeting to Order – Rondi Johnson

2. Roll Call/Sign In – Vickie Walden

3. Approve Agenda – Rondi Johnson

4. Approve Minutes of June 12, 2013. – Rondi Johnson

5. Performance Improvement Reports Due
   - 5.1 BMI PROJECT – Patti White/Dr. Milton
   - 5.2 HIV/AIDS – Mike Lynch (Tabled)
   - 5.3 Dental Records – Happy Camp – Cheryl Tims
   - 5.4 Dental Records – Yreka – Susan Beatty (Tabled)
   - 5.5 HTN - Fabian

6. GPRA Reports
   - 6.1 Clinical Benchmarking – Vickie Simmons

7. New Business
   - 7.1 Complaints/Incidents/Suggestions –Rondi Johnson
   - 7.2 Patient Satisfactory Surveys – Rondi Johnson
   - 7.3 Review Policy change #14-003-305 – Dr.Ash

8. Old Business
   - 8.1 Review Policy Approval Changes: Policy #07-002-210 – Michael Lynch
   - 8.2 Eligibility Report – Yreka – Sharon Denz
   - 8.3 CHDP Callback Report – Happy Camp – Chelsea Chambers (Tabled)
   - 8.4 Diabetes Report – Annie Smith – (Tabled)

9. Next Meeting August 14, 2013 at 8:15 am

10. Adjourn

Karuk Tribe ACQI Meeting Minutes for June 12.2013

1. Meeting called to Order by Rondi Johnson at 8:40 AM

2. **Roll Call-** In Happy Camp-Lessie Aubrey, Nadine McElyea, Dr. Brassea, Vickie Simmons, Cheryl Tims, Chelsea Chambers, Vickie Walden, Patti White, Rondi Johnson, and Susanna Greeno. In Yreka: Mike Lynch and Dr. Ash. In Orleans Fabian Alvarado.

3. **Mike** reports that the Yreka Clinic received news this morning; that the husband of an Yreka provider was killed in an airplane accident this morning. This accident has greatly impacted the Yreka Clinic staff and they may be closed for part of today. That he would like to do his report now, the group agreed to hear his report now.
   - 3.1. **Policy Change to #07-002-210** - Mike reviewed policy #07-002-210 Anaphylactic Reaction section. He suggest revising the language to read as follows:
   - 3.1.1. Epinephrine: "0.01 mg per kg every 15 minutes, up to 0.3 mg per dose, and up to three administrations".
   - 3.1.2. Diphenhydramine: "1 mg/kg IM, IV, or oral solution, up to 50 mg".
   - 3.1.3. Since many of us do not easily convert kilograms to pounds, He also suggests a kilogram to pound conversion chart. He presented two chart examples and the providers choose the Epinephrine Primary Treatment Option and Diphenhydramine Secondary Treatment Option, which contain, age range, weight, and dosage.
   - 3.2. Review of the High/Low refrigerator temperatures: Mike review Yreka's process for reading and recording the refrigerator temperatures.

4. Approve Agenda

5. Approve Minutes of April 10, 2013, May 8, 2013.
   - 5.1. May 8, 2013 meeting minutes were approved with corrections, motion made by Lessie Aubrey approved by consensus of the committee members present at the meeting.
   - 5.2. Vickie Simmons made a motion to approve the April 10 meeting, Patti White abstained and motion was approved by consensus of the committee members present at the meeting.

6. During the review of the meeting minutes Dr. Ash asked about the type of shoes allowed in the new purposed dress code and our cell phone policy.
   - 6.1. Question about Open Toed Shoes: Rondi said that the policy is a work in progress and the changes have not been made yet but she is purposing that clinical staff not be allowed to ware open toed showed in the clinics.
   - 6.2. Question about our cell phone policy. There was discussion on what our current policy was and Lessie asked Dr. Ash if she was having issues cell phones usage. She said yes people are spending a lot of time on their phones texting and doing other activities. Conclusion, Lessie will contact some other people and see they have any policies they can share with us.

7. Performance Improvement Reports Due

7.1. Eligibility Report – Happy Camp/Orleans – Nadine McElyea

7.1.1. Nadine reports that during the reporting period she submitted one SSI/SSD application; reconsideration request for one person; did follow-up actions for three other people; submitted four new on line MediCal applications; and one MediCal recertification application. All SSI applications are continuing. All the applications for MediCal in the reporting period were approved. The requests for services have decreased each quarter. Nadine commented: it can take a long time to get an SSI application approved, that they just approved one she's been working on for two years. That she thinks that there's enough work in our area to have a dictated full time person to find the people in need, do the SSI applications and the follow-up needed to complete the process for to get SSI. Nadine reviewed and explained property/assets restrictions/limitations that may make a person ineligible for MediCal and CMSP. Nadine said the limit is $3200.00 in assets.

7.1.2. Patti White said that she has a family member transiting to Medicare this year. Nadine said she that's something that she does not do, that we should send staff to the HICAP training so they can assist people with their Medicare application process. Nadine said that the best time for her to do this kind of work is Wednesday and Friday because that's the days she has no provider.

7.1.3. Nadine said that a big barrier to SSI & SSD applicants is that they get sent out of town for Mental Health and Medical appointments and they do not have a way to get to their appointments, that transportation is a huge problem.

7.1.4. Training report – On March 28th Nadine attended an excellent SSD/SSI training in Medford, Oregon.

7.2. Tabled - Eligibility Report – Yreka – Sharon Denz

7.3. Tabled - CHDP Callback – Happy Camp – Chelsea Chambers

7.3.1. Chelsea said she needs to talk with someone about this project.

7.4. Tabled - Diabetes Report– Annie Smith

7.5. GPRA Reports-

7.5.1. Improve Childhood Immunization Rates – Vickie Simmons reports it is time we review this project and come up with a new plan and goals. That we are really going nowhere with our immunizations. We have not been able show any improvement in this area. There was group discussion and the consensus of the group that one of the big problem areas is the addition of the rotavirus to the HRSA requited reporting. There was more discussion on how we can be more pro-active in getting our children immunized: Lessie suggest we send parents with new babies a welcome care package that includes clothes and baby care items; Fabian said that he thinks there may be a problem with being able to contact the parents and make sure they do not miss the appoints; Lessie said maybe we survey the parents to find out why they are not able to get their children's immunizations done and keep them up to date maybe we can find out why it's not being done; Mike said that he thinks we've not found the right plan of action yet, that he and Annie are both willing to go to the patients and do the immunizations; Lessie said that we need the CHR to do more home visits, and find these people instead of doing so much transportation. Conclusion of the discussion was that we need a different plan and to be more pro-active.

7.5.2. Vickie Walden made a motion to discontinue this immunization project and have Vickie Simmons do a new performance project on immunizations. The

motion was 2nd by Mike Lynch motion carries with no abstentions or objections.

8. New Business-
   8.1. Complaints/Incidents/Suggestions –Rondi Johnson
   8.1.1. **Complaints**-Rondi said that she is getting quite a few complaints about: no one answering the clinic phones, that she would appreciate it if the clinic supervisors would review this with the front desk people staff and make sure they are doing their best to see that phones do not go to voice mail.
   8.1.2. **Complaints**- Rondi said that supervisors also need to make sure they check voicemail and return phone calls in a timely manner.
   8.1.3. **Complaints** about the clinic front desk staff being rude to people. Rondi asks that the supervisors review this with front office staff and insure staff acknowledges people when they come to the window and that they are polite when assisting patients.
   8.1.4. There was discussion and comments on the complaints about the phone calls. In conclusion Rondi ask that we be a little more vigilant in answering the phones and being courteous to patients when they come to the front desk.
   8.2. **Patient Satisfactory Surveys** – Rondi Johnson
   8.2.1. Rondi said the return on the patient satisfaction survey is very low. That she would appreciate it if the front desk staff would please hand out and collect the surveys. Cheryl said she was not given any surveys and Rondi said she will send her some.
   8.3. **Policy Changes** -Vickie Simmons has some policy changes to Policy #02-002-065 and #02-001-045, there was discussion on the recommended policy changes.
   8.3.1. The changes and additions to policy #02-002-065 were approved with a motion made by Patti White and 2nd by Nadine, motion carried with no objections or abstentions.
   8.3.2. The changes to policy #02-001-045 under the conflict of interest statement in policy were approved with a motion made by Patti White and 2nd Chelsea Chambers, motion caries with no objections or abstentions.

9. **Old Business**
   9.1. Follow-up with Suzanna Hardenburger from a previous meeting regarding the collection of the medical patient education data. Vickie Walden said that if she is remembering it correctly, the question Fabian had for Suzanna was: Did the medical data staff read provider visit notes and entered/coded data that the providers missed? Fabian said yes that was the question he had and Suzanna said yes they do. Fabian said they are documenting the patient education under the wellness tab, but there are many places in EHR they can document patient education and that he had asked Amy to do a short patient education pick list for the important items so it's easier for the providers document the information correctly, this hasn't been done yet. There was more discussion capturing patient education data for GPRA and UDS, was in the taxonomy set up wrong or was the documentation being placed in an area that was not being not picked up for the reports. Suzanna, Patti White, Amy and Fabian will follow up on this.

   9.2. **Tabled** - Yreka Dental – Susan Beatty Written report

9.3. Happy Camp Dental – Cheryl Tims –Written Report will be attached to this meeting packet. Cheryl reported that all areas reviewed in the Happy Camp Dental Records are 100% complete.

9.4. Patti White mentioned that we are getting ready to bridge from RPMS to Dentrix soon and she want to make sure we were had the same information in both Dentrix and RPMS. Vickie Walden said that we are doing triple scheduling and double data entry until we have the bridge in place.

10. Next Meeting July 10, 2013 at 9:00 am

Meeting was adjourned at 9:12 am.

Meeting minutes typed and respectfully submitted by Vickie Walden on July 1, 2013

Karuk Tribal Health & Human Services
Performance Improvement Project
Prepared for July 10, 2013 ACQI Meeting

BMI/Obesity Project 2013

1. **Purpose of the Study:** To address the failure of appropriate data collection, assessment, and treatment of obesity.

   a) Problem: An international—National—Karuk Medical Care Problem. An epidemic of obesity is present, serious, and, increasing.

   b) Importance: Obesity is directly related to serious medical disease states including:
      i) Diabetes
      ii) Cardiovascular Disease
      iii) Renal Failure
      iv) Diminished self-esteem---mental disorders---general dysfunction
      v) Others

2. **Goal of this Performance Improvement Project**
   a) Collection of BMI data: "BMI at every visit" with appropriate follow up for those with BMI outside normal parameters. (HRSA guidelines)
      i) Children 3 through 17-BMI over 25
         - Documented nutrition counseling
         - Document counseling for physical activity.
      ii) Adults 18 to 65-BMI over 25
         - Documented follow up plan
      iii) Adults over 65-BMI over 30
         - Document follow up plan
   b) Analysis of data available-Reports will be ran and an evaluated against the startup percentage of those with BMI outside normal range and those with appropriate follow up documentation.

3. **Description of Data-Baseline data ran for CY 2012.** Quarterly reports will be ran and compared to the baseline data and previous quarter's data. UDS reports for Weight Assessment and Counseling for Children and Adolescents and Adult with screening and follow-up. From RPMS a listing of patients with BMI will be ran and sorted by age and BMI.

4. **Evidence of Data**

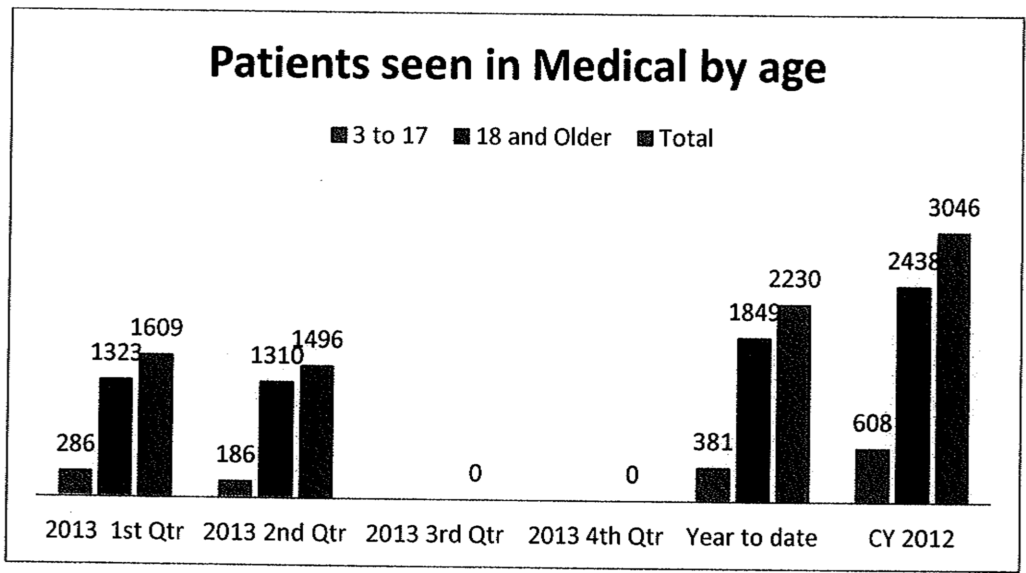
a) Data Collected on patients seen in Medical

i) **Ages 3-17**

- **CY 2012**-Full year 608 patients seen in Medical between the ages of 3 and 17.
- **First Quarter CY2013** - 286 patients between the ages of 3 and 17 were seen in medical.
- **Second Quarter CY2013** – 186 patients between the ages of 3 and 17 were seen in medical.
- **To date CY2013** - 381 patients between the ages of 3 and 17 were seen in medical.

ii) **Ages 18 and older**

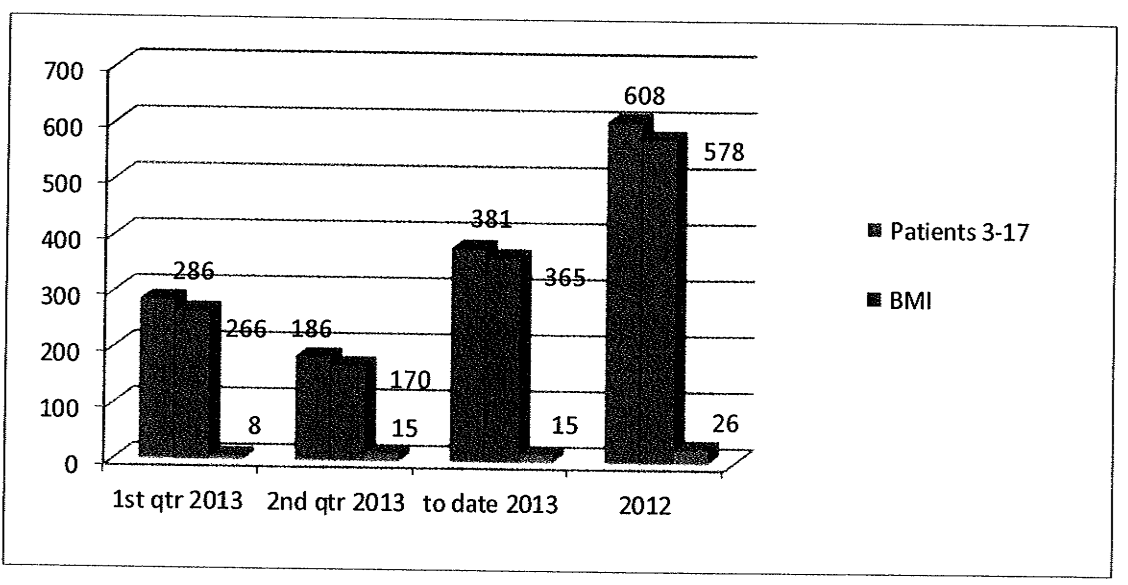
- **CY 2012**-Full year 2438 patients 18 and older were seen in medical.
- **First Quarter CY2013** – 1323 patients 18 and older were seen in medical.
- **Second Quarter CY2013** – 1310 patients18 and older were seen in medical.
- **To date CY2013** – 1849 patients 18 and older were seen in medical



b) Data collected on BMI's

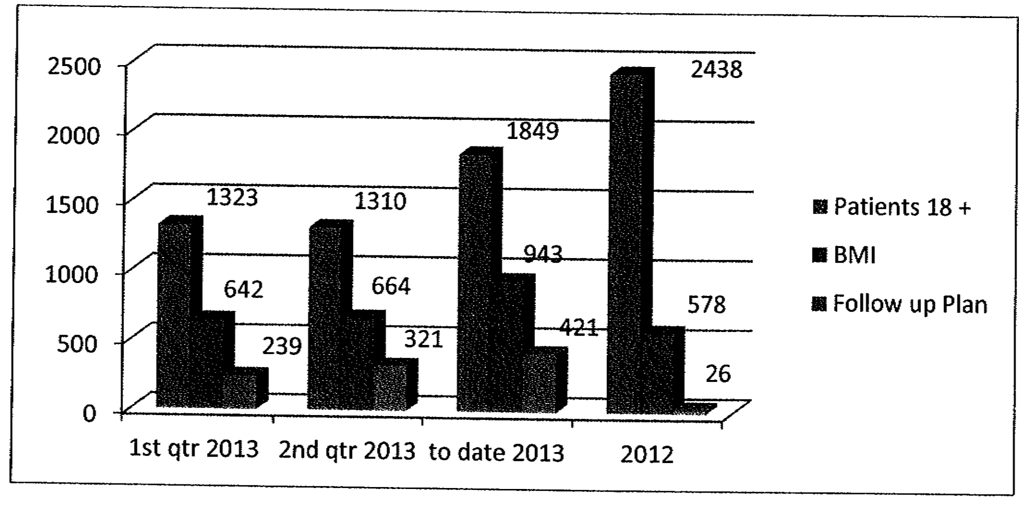
i) Ages 3-17

- CY 2012, 578 of the 608 patients 3-17 had a BMI. Of those only 26 were counseled about nutrition or physical activity.
- First Quarter CY2013 266 of 286 patients 3-17 had a BMI. Of these only 8 were counseled.
- Second Quarter CY2013 170 of 186 patients 3-17 had a BMI. Of these only 7 were counseled.
- Year to Date CY 2013- 365 of 381 patients 3-17 had a BMI. Of these only 15 were counseled.



ii) Ages 18 and older

- CY 2012 - 1068 of 2438 patients 18 and older had a BMI. Of these only 252 had a plan documented.
- First Quarter CY2013 – 642 of 1323 had a BMI. Of these 239 had a plan documented.
- Second Quarter CY2013 – 664 of 1310 had a BMI. Of these 321 had a plan documented.
- Year to Date CY 2013 – 943 of 1849 had a BMI. Of these 421 have a plan documented.



5. Data Analysis

a) UDS Data

i) Children 2-17

- 60% with BMI in 2012 and 5% counseled on nutrition and physical activity
- 96% patients 3-17 have had BMI in 2013. 5% have had a plan documented

ii) Adult's 18 and older-

- 47% with BMI in 2012 and 24% with a follow up plan.
- 39% patients over 18 have had a BMI in 2013. 45% of those have had a follow up plan.

6. Comparison-

a) **Children/Adolescents 2-17 years of age**: We have increased the number of these patients receiving BMI measurements. We are 96% for those receiving a BMI in 2013 compared to 60% in 2012. However we still are at 5% for parents of these patient or patients receiving any nutrition and activity counseling. For us to meet the measurement for HRSA this must be documented. From UDS manual 2012:

i) "**Weight assessment and counseling for children and adolescents:** *If* clinicians ensure that their patients' Body Mass Indicator Percentile is recorded, and *if* patients (and parents) are counseled on nutrition and physical activity (regardless of the patient's weight) *then* the likelihood of obesity and its sequela will be reduced."

ii) **PERFORMANCE MEASURE:** The performance measure is "Percentage of patients aged 2[10] through 17 who had evidence of BMI *percentile* documentation **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year." Note that, while this indicator is titled "2 through 17," grantees should only review the charts of children who were at least 3 years old during the measurement year. This is calculated as follows: [10] This

- • **Numerator:** Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year **AND** who had documentation of counseling for nutrition **AND** who had documentation of counseling for physical activity during the measurement year.
- • **Denominator:** Number of patients who were one year after their second birthday (i.e., were 3 years of age) through adolescents who were aged up to one year past their 16th birthday (i.e., up until they were 17) at some point during the measurement year, who had at least one medical visit during the reporting year, and seen prior to their 17th birthday **OR** a sample of these patients. For measurement year 2012, this includes patients with a date of birth between January 1, 1995 and December 31, 2009.

b) **Adults 18 and older:** We are doing exceptionally well with this portion of the measurement. In 2012 only 47% patients 18 and older had a BMI. For 2013, 39% have had a BMI so we are on track to meet and exceed the number of adults receiving BMI this year. Also in 2012 only 24% of those receiving a BMI had a follow-up plan. This year 45% of the adults being measured have had a follow up plan documented. Great work providers.

7. **Implementation of Corrective Actions to Resolve-**
   Have a BMI documented at each visit. Data can be collected by the Medical Assistant and by Nurses rooming the patients and taking vitals. They may need instructions.
   We need to make sure that when a child or adolescent has a BMI that the parents or the patient are counseled on nutrition and activity and this is documented. Documentation can be done by using codes 97802-97804-15 minutes or more of nutrition counseling and using ICD-9 Code V65-41 for physical activity counseling. Codes V85.5x are used for recording the BMI percentile.

8. **Re-measure-**
   Data and reports will be done on a quarterly basis and compared to previous data.

9. **Implementation of Additional corrective Actions if Performance Goals are not Met-**
   N/A at this time

10. **Communication to Governing Body-**Evidence of the PI project will be included in ACQI information that is reported to the Health Board each month.

Submitted by Patti White

Karuk Dental Records Report
ACQI Meeting Date 7/10/13
2ND Quarter Report of 2013 by Cheryl Tims

1. **Purpose of the report.**
   We would like to ensure that we have a complete, well organized Dental Record, which includes:
   a. Patient identifiers and contact information,
   b. Patient medical information including but not limited to: health history, allergies, dental history, medications and etc.
   c. Accurate visit documentation including provider signatures, visit dates, and POV-Purpose of visit.
      i. Documentation of appropriate oral evaluations and re-evaluations: that include; existing oral conditions, periodontal evaluations, cancer/soft tissue evaluation, x-rays, findings, diagnosis, treatment plans and/or treatment, oral hygiene instruction, referrals & follow, treatment rendered and recommendations, and etc.
      ii. Indicators and Contra Indicators for Treatment
   d. Informed consents
   e. Treatment Plans
   f. Patient Consents

2. **Description Data Collection**
   a. I reviewed and collected data from ten adult dental records.
   b. I reviewed and collected data from ten children dental records
3. **Evidence of Data**
   The data was collected from the visits in the second quarter of calendar year 2013

Ten Adult Charts

		Record Count	complete	incomplete	N/A	Percent
1	Full name and health record number on outside tab of chart	10	10	0	0	100%
2	Current Face sheet (Within last 12 months)	10	10	0	0	100%
3	Medical history updated within 12 months + Update review box initialed within Quarter	10	10	0	0	100%
4	Patient Health Summary in paper chart & current(dated within 5 days of visit)	10	10	0	0	100%
5a	Medical Alerts	10	10	0	0	100%
5b	Medications	10	8	0	2	100%
5c	Allergic to	10	3	0	7	100%
5d	Pain Level	10	0	0	10	100%
5e	NKA	10	7	0	3	100%
5f	Pre-Med noted	10	1	0	9	100%
6	Dental Examination for patients that have exam within reporting period is complete	10	3	0	7	100%
7	Completed Tx Plan	10	3	0	7	100%
8	All Chart entries include provider and/or staff initials	10	10	0	0	100%
9	Dentrix Clinic notes show provider who saw patient & signed	10	10	0	0	100%
10	Local anesthesia used	10	7	0	3	100%

11	X-rays label complete	10	5	0	5	100%		
12	Informed consents completed & signed by patients and providers	10	10	0	0	100%		

Ten Child charts		Record Count	complete	incomplete	NA	Percent
1	Full name and health record number on outside tab of chart	10	10	0	0	100%
2	Current Face sheet (Within last 12 months)	10	10	0	0	100%
3	Medical history updated within 12 months + Update review box initialed within Quarter	10	10	0	0	100%
4	Patient Health Summary in paper chart & current(dated within 5 days of visit)	10	10	0	0	100%
5a	Medical Alerts	10	5	0	5	100%
5b	Medications	10	0	0	10	100%
5c	Allergic to	10	2	0	8	100%
5d	Pain Level	10	0	0	10	100%
5e	NKA	10	8	0	2	100%
5f	Pre-Med noted	10	0	0	10	100%
6	Dental Examination for patients that have exam within reporting period is complete	10	5	0	5	100%
7	Completed Tx Plan	10	5	0	5	100%
8	All Chart entries include provider and/or staff initials	10	10	0	0	100%
9	Dentrix Clinic notes show provider who saw patient & signed	10	10	0	0	100%
10	Local anesthesia used	10	0	0	10	100%
11	X-rays label complete	10	4	0	6	100%
12	Informed consents completed & signed by patients and providers	10	10	0	0	100%

4. I do believe that we are still at 100% on both adult and child charts, as far as I can tell. I believe that since we have started using EDR (aka Dentrix), all charts have all the correct information being entered into EDR & the paper chart.

Karuk Tribal Health and Human Services Program
Hypertension Project 2012-13
~~April 10, 2012~~ July 10, 2013

Assesment of Quality Improvement Measures Instituted

1. Purpose of the Study: To determine the proportion of adult hypertensive patients, 18 to 85 years of age, that had an adequately controlled blood pressure (less than 140/90) at the time of the last reading. If improvement is needed, recommendations will be made. These baseline data will be used to evaluate the effectiveness of quality improvement measures instituted.

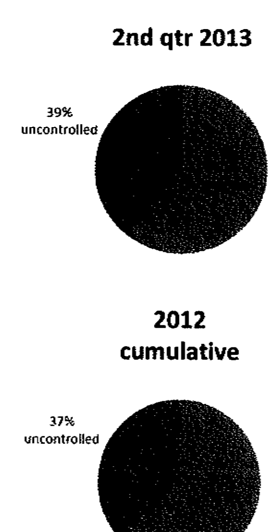
2. Goal of this Performance Improvement Study: The goal is to have the blood pressure (BP) of all adult hypertensive patients adequately controlled. Short of that, our target will be to improve over the previous year by at least 10%.

3. Description Data: Proportion of adult patients, 18 to 85, diagnosed with hypertension (HTN) whose BP was less than 140/90 at the time of last reading. (Although we may use different measures for quality assurance process for diabetic and other patient groups, for the purpose of Uniform Data Systems (UDS) reporting, the 140/90 measure must be used.)

   a. Numerator: Number of patients with last systolic blood pressure measurement <140 mm Hg and diastolic blood pressure <90 mm Hg during the measurement year among those patients included in the denominator

   b. All patient 18 to 85 years of age as of December 31 of measurement year with a diagnosis of HTN, who have been *seen for medical services at least twice during the reporting year, and who had a diagnosis of hypertension before June 30 of the measurement year.*

4. Data Analysis: For the first quarter 2013, of **336** patients seen for medical services at least twice in 2013, and who had a diagnosis of hypertension before June 30, 2013, **71%** had a last systolic blood pressure measurement <140 mm Hg and diastolic blood pressure <90 mm Hg. For the second quarter 2013, of **282** patients seen for medical services at least twice in 2013, and who had a diagnosis of hypertension before June 30, 2013, **61%** had a last systolic blood pressure measurement <140 mm Hg and diastolic blood pressure <90 mm Hg. Cumulative data for 2013 were not available.



5. Comparison: Second quarter data for 2013 show a slight decline in the proportion of uncontrolled hypertensive patients when compared to cumulative data for 2012, but the proportion is the same as compared to cumulative data for 2011.

6. Discussion: Previous recommendations have suggested that we address high BP measurements on the same day. This is not likely to produce significant results for several reasons. First, if the BP is only transiently elevated, addressing it is pointless and could potentially harm the patient by putting them at risk for excessively low BP. Second, most of these visits were scheduled for

another reason and often there is not enough time to address secondary concerns in the same visit. Third, if the patient is acutely ill, they are less likely to be receptive to discussing their blood pressure at the same visit. Lastly, our providers are probably already addressing secondary concerns ad infinitum at every visit to the extent possible.

In order to improve long term outcomes for our hypertensive patients, we need to (1) distinguish between transiently elevated BP measurements and actual uncontrolled hypertension. Next, we need a process by which we can (2) effectively address uncontrolled hypertension in those patients that are more than just transiently elevated due to acute illness.

Previously I made a recommendation that every time a patient with a prior diagnosis of hypertension has a BP over 140/90, the MAs should automatically schedule those patients for a BP recheck nursing visit 2 weeks later. If the subsequent BP is within normal limits the previous high BP can be dismissed as transient and the data will show a normal BP at the last visit. On the other hand, if the patient's BP is still elevated, the MA should then schedule the patient for a follow-up hypertension visit. At the follow-up visit another BP would be taken which, if still elevated, would provide additional evidence that the patient's hypertension is, in fact, not well controlled.

7. Implementation of quality improvement measures: It was collectively decided at the time of the last report that the Orleans clinic alone should implement the recommendations as a pilot project to ascertain their feasibility and effectiveness. We found that convincing patients to make follow up appointments simply for blood pressure checks was difficult enough but getting the patients to keep those appointments was an insurmountable challenge. At the end of the quarter we compiled a list of those patients and enlisted the CHR to do home visit BP checks. Most patients were not found at home but of the 4 patients we were able to check, all had persistently elevated BPs. As a result the CHR urged them to make appointments to address their uncontrolled hypertension but this was apparently unsuccessful since no follow up appointments have been made to date. Of note, the number of uncontrolled hypertensive patients (as determined using the above criteria) at Orleans clinic number 14. Given this extremely low sample size it would be inaccurate to draw conclusions about whether or not most of the Karuk Tribal Health Program patients that meet the criteria had a BP that was only transiently elevated at their last visit. Further, the number of patients in Orleans that meet the criteria is too low to impact the figures for the entire health program.

8. Recommendation: In order to accurately evaluate the effectiveness of the quality improvement measures, they need to be implemented by all clinics. Feasibility can be measured qualitatively by the medical staff and we will continue to audit our patient records quarterly for the remainder of 2013. Moreover, tracking how many of the follow-up BP checks and/or appointments are kept by the patients would provide a way to evaluate the practicality of and interest in the above recommendations from the patients' perspective. Unfortunately, to my knowledge there is no way to retroactively query the schedule based on the type of visit. Perhaps this will be a realistic option with the new scheduling software.

9. Communication to Governing Body: This information is being shared with the Karuk Tribal Health Board each quarter in Clinical Operations Administrators Report.

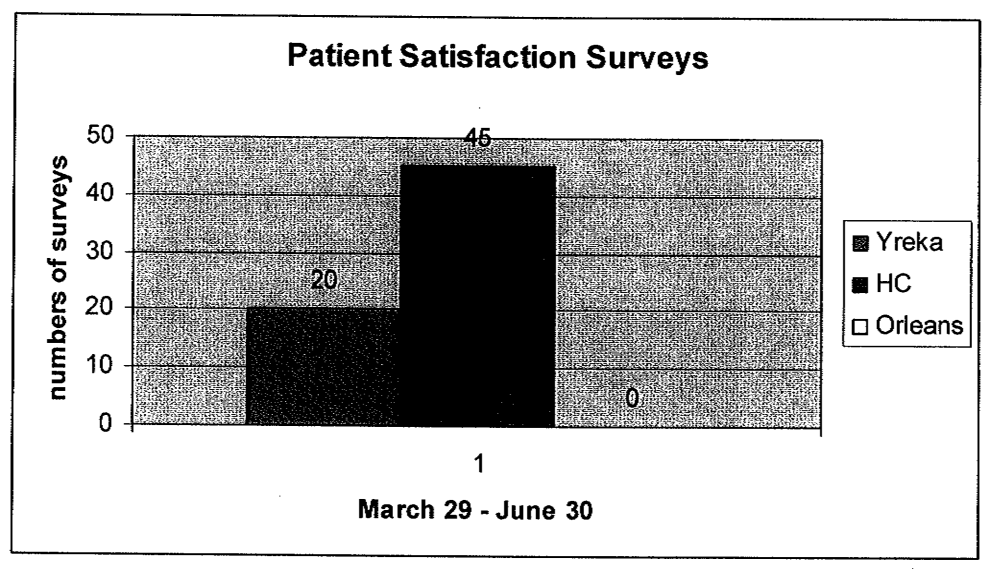
Submitted by Fabian Alvarado

Karuk Dashboard
2013 - ~~3rd~~ Qtr. 4th
GPRA Report Unofficial

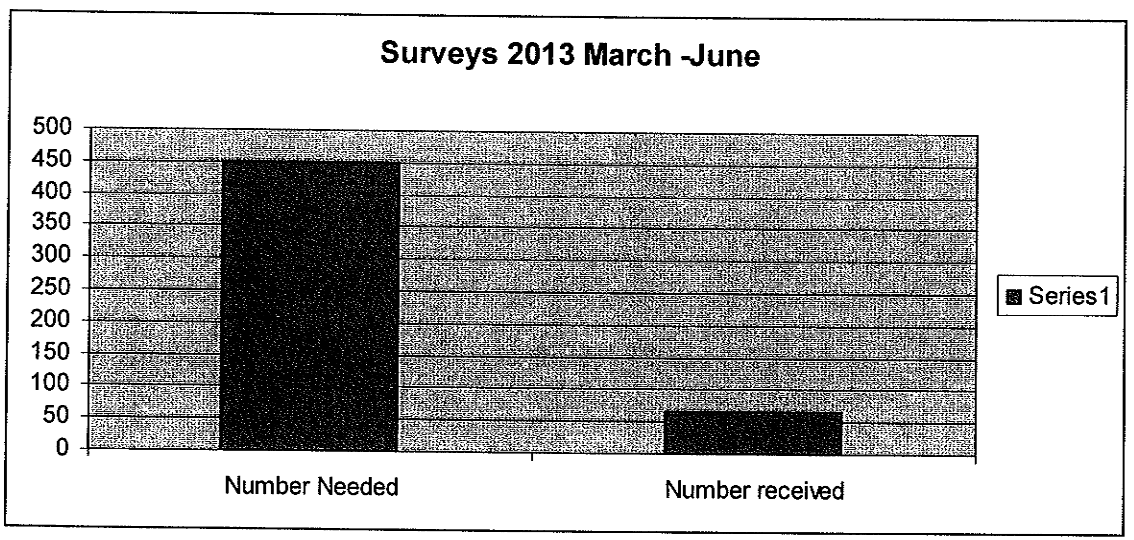
TO: ACQI Committee
FROM: Vickie Simmons, GPRA Officer
DATE: July 3, 2013
SUBJECT: GPRA 4th Quarter Report 2013
Please find the **unofficial** 2013 GPRA 4th Quarter Report below.

GY2013 4th Qtr. Dashboard DIABETES	End of Year Karuk 2012	End of Year National Avg. 2012	End of 4th Qtr. Karuk 2013	GPRA13 Target	Goal 2013	2013 End of 4th Qtr. Results - Karuk
Diabetes Dx Ever	8.7%	13.4%	8.9%	N/A		
Documented HbA1c	86.3%	84.9%	85.9%	N/A		
Good Glycemic Control <8	46.0%	33.2%	53.9%	Baseline		TBD
Controlled BP <140/90	36.0%	38.9%	70.3%	Baseline		TBD
LDL Assessed	69.8%	71.0%	58.6%	68.0%		
Nephropathy Assessed	61.9%	66.7%	55.5%	64.2%		
Retinopathy Exam	41.7%	55.7%	42.2%	56.8%		
DENTAL						
General Access	40.4%	45.3%	39.0%	26.9%		MET
Sealants	464	470	9.9	Baseline		TBD
Topical Fluoride- Patients	427	503	26.3	Baseline		TBD
IMMUNIZATIONS						
Influenza 65+	53.4%	44.2%	64.6%	62.3%		MET
Pneumovax 65+	87.0%	83.1%	91.5%	84.7%		MET
Childhood Izs	45.5%	57.1%	47.8%	Baseline		TBD
PREVENTION						
Pap Screening	54.4%	55.4%	60.9%	Baseline		TBD
Mammogram Rates	45.4%	44.1%	52.1%	49.7%		MET
Colorectal Cancer Screening	57.0%	52.4%	35.9%	Baseline		TBD
Tobacco Cessation	39.0%	33.8%	44.6%	Baseline		TBD
FAS Prevention	71.0%	66.4%	60.5%	61.7%		
IPV/DV Screen	65.5%	62.5%	58.6%	58.3%		MET
Depression Screening	66.0%	62.6%	61.0%	58.6%		MET
Comp. CVD-related Assessment	27.6%	25.0%	43.4%	32.3%		MET
Prenatal HIV Screening	28.6%	6.3%	37.5%	82.3%		
Childhood Weight Control	23.1%	24.3%	21.8%	24.0%		
Breastfeeding Rates	N/A	N/A	100.0%	Baseline		TBD
						TBD = 9 *Measures Met = 7* *Measures Not Met = 6*

Karuk Tribal Health and Human Services
Survey Data
March – June 2013



Karuk Tribal Health and Human Services
Patient Satisfaction Surveys



Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 (X) 15 () 16 ()	05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()	09() 10 () 11 () 12 () 21 () 22 ()
Function: Dental	**Policy #:** 14-003-305	**Policy Title:** Scheduling the Dental Emergencies
Tribal Chairman: **Date:** 04/12/2012 **Signature:**	**Dental Director:** **Date:** 03/21/2012 **Signature:**	**Cross References:**
Supersedes Policy DD-10-031-110 dated 09/10/2009		

Policy: To see all "acute" dental emergency[1] patients within the times allotted, for emergency care, in order to minimize the waiting time for both the scheduled and the emergency patient.

Procedures:

A. Traumatic dental emergencies or life threatening dental emergencies will be seen immediately upon arrival at the clinic by the dentist. If the dentist is not available the patient will be referred to an appropriate provider to receive emergency treatment and the follow up care will be done when the dentist is available.

C B. It is the goal of the clinic to see all assessed acute emergency patients as soon as possible on the same day that they call. If the dentist is not available the patient will be referred to an appropriate provider to receive emergency treatment and follow up care will be done when the dentist is available.

D C. We welcome walk in patients to register by 8:00 am to 8:30am on Tuesdays and Thursdays at the Yreka Dental Clinic; and between 8:00 AM and 2:30 PM Monday through Friday at the Happy Camp Dental Clinic. When calling for an emergency appointment the patient will be scheduled dependent upon degree of emergency as follows:

[1] Definition of "acute" dental emergency: an abrupt disorder of oral health that requires dental/or medical attention including broken, loose, avulsed teeth caused by trauma, infections and inflammations, swelling of soft tissues of the mouth and complications of Oral Surgery such as dry socket.

Reviewed and update on 2/2/2012 by:
Rick Schoen, DDS
Donita Hill, RDH

i. In slots where patients have cancelled.

ii. In the set emergency hours.

iii. Fit into the schedule where the schedule allows.

iv. [illegible]

D. Each emergency days' dental schedule for the dental clinics has been arranged so as to provide the maximum amount of dental work for the most patients, and emergency patients may, at the doctor's discretion, [illegible] be worked into the schedule (which may require that an emergency patient will wait until a time slot is available).

E. **Walk-in patients.** These patients will be instructed to come in during the set emergency hours unless they are a child under 12 years of age~~, an elder or Karuk Tribal member~~. Then they will be seen as quickly as possible. [illegible]

F. Minor children will not be seen for emergency treatment without a parent, guardian, or non-custodial person (with the authority to assume responsibility for the minor) present before and during the treatment procedure.

G. **Triage- Guidelines for Determining a Dental Emergency.**

i. A dental emergency should include one of the following:

a. **High Priority Emergencies.**

1. Severe pain that started within the last two to three days.
2. Severe pain that keeps them awake at night or wakes them up once asleep.
3. Visible (sizable) swelling in the face due to an abscessed tooth.
4. Fever due to an abscessed tooth.
5. Excessive bleeding from a recent extraction site.
6. Teeth that might have recently been knocked out or broken off.
7. A facial injury with possible maxillary or mandiblar fracture.

8. A lesion or tumor in the oral cavity of sudden onset.

9. Child in pain

b. **Lower Priority Emergencies.**

1. A broken full or partial dentures.

2. Lost crown on an endodontic tooth.

3. Lost temporary or broken temporary.

4. Lost crown with no pain.

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 (X) 08 () 17 () 18 () 19 () 20 ()	09() 10 () 11 () 12 () 21 () 22 ()
Function: Safety	**Policy #:** 07-002-210	**Policy Title:** Emergency Procedures
Tribal Chairman: **Date: 05/10/2012** **Signature:**	**Medical Director:** **Date: 04/16/2012** **Signature:**	**Cross References:**
Supersedes policy 07-000-305 dated 07/30/2009 and 06/09/2011		

PURPOSE: To establish and describe the primary responsibilities of the Medical/Dental Staff in case of medical emergencies.

POLICY: The Karuk Medical/Dental Clinics will follow standardized procedures in case of a medical emergency inside the clinic.

PROCEDURE:

Priorities of care include:

1. The recognition and treatment of life threatening conditions.
2. Activating the Emergency Medical System (911) when appropriate.
3. Further treatment within the capabilities of the staff and of the facility.
4. Stabilization of the patient's condition.
5. Preparation of the patient for safe transport to more definitive treatment or evaluation.
6. Assisting outside emergency personnel as needed.
7. Documentation of the care given and the patient's response to this treatment.
8. Assuring the safety of other patients and staff during an emergency.

Specific Objectives of Emergency Care.

1. Activate the Emergency Medical System (911) when appropriate.

2. Perform basic patient assessment: Airway, Breathing, Circulation, and severe bleeding.
3. Secure the airway, assist respiration if needed or begin rescue breathing.
4. Evaluate and restore cardiac output as needed – use AED if available.
5. Control bleeding and treat for shock.
6. Splint/immobilize suspected fractures, including injuries to the cervical spine.
7. Check for medic alert bracelets or other emergency medical information.
8. Document all the patient care given along with any medications given; transfer this information to other care providers that you will be passing this patient to.

Specific Emergency Care Procedures

Primary Survey

Head Tilt – Chin Lift: Place fingers of one hand under the bony part of the lower jaw, bringing the chin forward while gently pressing on the forehead with the other hand to tilt the head.

Breathing Assessment: Check for breathlessness. Place ear over the victim's mouth and nose, looking toward victim's stomach for 10 seconds, watching to see if the chest rises and falls, listening for exhaled air, while feeling for breath.

Management: Breath for patient as required (adults 1 breath lasting for 1 second for every 5 second.) 2 minutes of rescue breathing equals 40 breaths. Pinch nostrils closed with thumb and index finger of the hand that is supporting the forehead. Cover the victim's mouth with yours, forming a tight seal and give one full rescue breath lasting 1 second. Use just enough air to make the chest rise.

Choking

Assessment: Weak ineffective cough, inability to speak or breath, possible collapse.

Management: **Give 5 Back Blows** with heel of your hand between should blades, standing to the side of patient with your right arm on their left shoulder, to support them from falling to the floor, if still choking give **5 abdominal thrusts** (Heimlich) standing behind the patient put right arm around their waist just above

their navel, making a fist place your left arm around them holding onto your right fist and give 5 inward and upward abdominal thrust. If patient is still choking repeat these steps.

Repeat thrusts until the object comes out or the patient becomes unconscious.

If the patient becomes unconscious:

Use jaw lift to open the mouth – look for an object.
(For all ages you must see an object before sweeping).

Open the airway and try to breathe (use head tilt-chin lift). Look, listen, and feel for 10 seconds. If nothing reposition the head, then look listen and feel for 10 seconds, if no signs of breathing; begin CPR in this manner:

Give 2 rescue breaths, if they do not go in, reposition and give 2 rescue breaths, then place the palm on one hand on the breast bone in the center of the chest, (using armpit as guide) place the other hand on top. Press down on the chest 30 times (same technique as in CPR). Open the mouth by using your thumb and forefinger grabbing the tongue and jaw lifting upward, look into the mouth if there is a visible object, and you know you can retrieve the object then try to remove it with a finger sweep. If no visible object or unable to remove, continue to give 2 breaths and repeat 30 chest compressions. Continue the combination 30 chest compressions and 2 breaths just the same as CPR.

Circulation

Assessment: Check for signs of circulation (including carotid pulse).

Management: Start CPR if no signs of circulation – Bring AED to patient if available.

Kneel as closely as possible to one side of the patient's chest. Place heel of one hand in middle of the chest, (using the armpit as a guide for correct placement). Place other hand on top of the first, with the fingers of both hands directed away from you. Using your weight, while keeping the arms straight and the elbows locked, quickly and forcefully depress the lower half of the chest 1 ½ to 2 inches and release the pressure, allowing the chest to return to its normal position.

Compressions should be smooth, regular and uninterrupted.

If alone, compress the chest 30 times and then give two rescue breaths (ratio 30:2 compressions to breaths), continue. If partner is available, compress the chest 30 times and pause briefly while the second rescuer gives 2 slow rescue breaths each breath lasting 1 second.

After 5 cycles of CPR about 2 minutes, attach leads of AED – follow steps and deliver shock if directed. If no shock indicated, reevaluate patient for airway, breathing and circulation and continue CPR until help arrives.

Bleeding: Always use gloves or place a barrier over the wound. Apply firm pressure over the bleeding area. Almost all bleeding can be stopped by direct pressure. Call 911 or have someone call 911. When the bleeding is controlled, apply a firm pressure dressing.

Shock

Assessment: Confusion, restlessness, decreased blood pressure, increased pulse rate, cold clammy skin, thirst, prostration, injury suggesting bleeding.

Management: Establish and maintain an airway – administer oxygen. Call 911, control bleeding, elevate the feet 6-12 inches (not for persons with suspected leg fractures or head injury) and preserve body heat (goal is to prevent person from getting too cold do not to make them hot). Room temperature - warm.

Activation of EMS System:

Happy Camp	911	or	493-2643
Yreka	911	or	842-2468
Orleans	911	or	627-3344

Be prepared to give the following information:

Your location with cross streets, the address on building, or give directions.
Your phone number, tell them cell phone or land line.
What happened, only if you know, never assume.
The patient's condition, as you see it.
What first aid has been given.

Make sure you hang up last – in case there are any questions.

Anaphylactic Reaction: Prevention is the key.

Ask patients about any previous allergic reactions to any medications. Do they have prescribed Epinephrine and Diphenhydramine on hand?

Assessment: Common symptoms include but are not limited to:

Respiratory:	Shortness of breath, wheezing, stridor.
Skin:	Flushing, itching, hives, facial swelling, cyanosis.
Cardiac:	Rapid or slow heartbeat, decreased blood pressure.
Stomach:	Nausea, vomiting, abdominal pain, diarrhea.

Management: Call 911 when appropriate – assess airway, breathing and circulation.

Have patient lie down – however if the patient has breathing, position the patient upright. Treatment options include:

Administer Subcutaneous Epinephrine 1:1000

Adults	0.3 mg every 15 minutes up to 3 times
Pediatric	0.01 mg per kg every 15 minutes up to 3 times

Administer nebulized albuterol or inhaler if patient is wheezing.

Administration of Benadryl:

Adults	50 mg IM or IV
Pediatric	1 mg/kg IM or IV or oral solution

Administer oxygen, by nasal cannula or face mask.

If indicated, obtain IV access with Normal Saline. Administer fluid if patient is hypertensive.

Provide continuous monitoring and care within the capabilities of the staff consistent with the primary responsibilities of the Medical/Dental staff of the Karuk Clinics.

Potential Error in Policy # 07-002-210

There appears to be two potentially dangerous errors in the Management section of the Anaphylactic Reaction section of policy #07-002-210 (page 5 of 5). Using the pediatric dosage directions for epinephrine or diphenhydramine could result in an overdose.

For epinephrine, the pediatric dosage is "0.01 mg per kg every 15 minutes up to 3 times". This is appropriate up to 30 kg (≈66 lbs.). Over that weight, the calculated exceeds the maximum 0.3 mg dosage for adults.

For diphenhydramine, the pediatric dosage is "1 mg/kg IM or IV or oral solution". This is appropriate up to 50 kg (≈110 lbs.). Over that weight, the calculated dosage exceeds the maximum 50 mg dosage for adults.

I suggest revising the language to read as follows:

- Epinephrine: "0.01 mg per kg every 15 minutes, up to 0.3 mg per dose, and up to three administrations".
- Diphenhydramine: "1 mg/kg IM, IV, or oral solution, up to 50 mg".

Since many of us do not easily convert kilograms to pounds, I also suggest a kilogram to pound conversion chart. I have created one that is presented below.

As an alternative to the language currently in the policy, I have modified a conversion chart found on the Immunization Action Coalition's (IAC) website. The IAC works with the CDC to create vaccination-related documents for use by medical professionals and patients. This alternative schedule is also attached. It has two advantages: 1) it uses age ranges and/or weight ranges to make the dosage estimation easier; and 2) it allows for the use of Epi-Pen and Epi-Pen Jr. We have both at the Yreka clinic.

Thank you,
mike lynch

Epinephrine Kilogram to Pound Dosage Conversion Chart

Kilograms	Pounds per Kilogram	Epinephrine Dose in mg
1	**2.20**	**0.01**
2	**4.41**	**0.02**
3	**6.61**	**0.03**
4	**8.82**	**0.04**
5	**11.02**	**0.05**
6	**13.23**	**0.06**
7	**15.43**	**0.07**
8	**17.64**	**0.08**
9	**19.84**	**0.09**
10	**22.05**	**0.1**
11	**24.25**	**0.11**
12	**26.46**	**0.12**
13	**28.66**	**0.13**
14	**30.86**	**0.14**
15	**33.07**	**0.15**

Kilograms	Pounds per Kilogram	Epinephrine Dose
16	**35.27**	**0.16**
17	**37.48**	**0.17**
18	**39.68**	**0.18**
19	**41.89**	**0.19**
20	**44.09**	**0.2**
21	**46.30**	**0.21**
22	**48.50**	**0.22**
23	**50.71**	**0.23**
24	**52.91**	**0.24**
25	**55.12**	**0.25**
26	**57.32**	**0.26**
27	**59.52**	**0.27**
28	**61.73**	**0.28**
29	**63.93**	**0.29**
30+	**66.14+**	**0.3**

Diphenhydramine Kilogram to Pound Dosage Conversion Chart

Kilograms	Pounds per Kilogram	Diphenhydramine Dose in mg
1	**2.20**	**1**
2	**4.41**	**2**
3	**6.61**	**3**
4	**8.82**	**4**
5	**11.02**	**5**
6	**13.23**	**6**
7	**15.43**	**7**
8	**17.64**	**8**
9	**19.84**	**9**
10	**22.05**	**10**
11	**24.25**	**11**
12	**26.46**	**12**
13	**28.66**	**13**
14	**30.86**	**14**
15	**33.07**	**15**
16	**35.27**	**16**
17	**37.48**	**17**
18	**39.68**	**18**
19	**41.89**	**19**
20	**44.09**	**20**
21	**46.30**	**21**
22	**48.50**	**22**
23	**50.71**	**23**
24	**52.91**	**24**
25	**55.12**	**25**

Kilograms	Pounds per Kilogram	Diphenhydramine Dose in mg
26	**57.32**	**26**
27	**59.52**	**27**
28	**61.73**	**28**
29	**63.93**	**29**
30	**66.14**	**30**
31	**68.34**	**31**
32	**70.55**	**32**
33	**72.75**	**33**
34	**74.96**	**34**
35	**77.16**	**35**
36	**79.37**	**36**
37	**81.57**	**37**
38	**83.78**	**38**
39	**85.98**	**39**
40	**88.18**	**40**
41	**90.39**	**41**
42	**92.59**	**42**
43	**94.80**	**43**
44	**97.00**	**44**
45	**99.21**	**45**
46	**101.41**	**46**
47	**103.62**	**47**
48	**105.82**	**48**
49	**108.03**	**49**
50+	**110.23+**	**50**

Emergency Dosage Chart for Epinephrine and Diphenhydramine

Note: Dosage by body weight is preferred, if known; otherwise dosing by age is acceptable.

Epinephrine
Primary Treatment Option

Age	Weight	Epinephrine (1:1000) Injectable (1 mg/mL)	Epi- Pen Jr. (0.15 mg) Epi-Pen (0.30 mg)
1 - 6 months	9-19 lbs.	0.05 mL or mg	off label
7 – 36 months	20 – 32 lbs.	0.1 mL or mg	off label
37-59 months	33 – 39 lbs.	0.15 mL or mg	0.15 mg
5 – 7 years	40 – 56 lbs.	0.20 – 0.25 mL or mg	0.15 mg
8 – 10 years	57 – 76 lbs.	0.25 – 0.30 mL or mg	0.15 or 0.3 mg
11 -12 years	77 – 99 lbs.	0.35 – 0.40 mL or mg	0.3 mg
13 years and older	100 or more lbs.	0.5 mL or mg	0.3 mg

Diphenhydramine
Secondary Treatment Option

Age	Weight	Injectable (50mg/mL)
7 – 36 months	20 – 32 lbs.	10 mg – 20 mg (0.2 mL – 0.4 mL)
37-59 months	33 – 39 lbs.	15 mg – 30 mg (0.3 mL – 0.6 mL)
5 – 7 years	40 – 56 lbs.	20 mg – 30 mg (0.4 mL – 0.6 mL)
8 – 12 years	57 – 99 lbs.	30 mg (0.6 mL)
13 years and older	100 or more lbs.	50 mg (1.0 mL)

Activity

Progress Report 1st Quarter
January, February and March 2013

Title: Eligibility Report

Purpose: To be able to help clients establish Medi-Cal, CMSP, and Medicare Part D

Problems: Not getting clients to sign up for Medi-Cal, CMSP they are going to Human Resources office here in Yreka.

Data pulled from the number of clients that I had processed for the various programs, i.e.,;
Medi-Cal, CMSP, Medicare Part D 1st quarter

Findings: Total of applicants for 1st quarter is

January 2013 (0) for Medi-Cal, CMSP (3) for Medicare Part D
February 2013 (0) for Medi-Cal, CMSP
March 2013 (0) for Medi-Cal, CMSP

Sharon Denz
Eligibility Worker for Yreka
07/10/2013

Karuk Tribal Health & Human Services Program
ACQI Sign-In Sheet
Date: 7-10-13

1. Lessie Aubrey
2. Randi L. Johnson
3. [illegible] Dr. Brassea
4. [illegible]
5. [illegible]
6. Susanna [illegible]
7. [illegible]
8. Suzanna Hardenburger
9. [illegible]
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20.

Teleconferenced in from Yreka:

1. Annie
2. Dr. Ash
3. Dr. Milton
4. Mike Lynch
5. Amy Capman
6.
7.
8.
9.
10.

Teleconferenced in from Orleans:

1. Fabian
2.
3.

IT Department Health Board Report **August 1, 2013**
Eric Cutright, IT Director

Pending Action Items:

- Phone System Automated Response Agreement
- Bay Alarm Fire & Security Monitoring Agreement for Happy Camp IT Room
- Agreement with KTHA for IT Services
- Change order 2 for contract 12-C-044
- Resolution for project management for the CASF Grant if awarded
- Contract for installation of a communications tower in Orleans

Current Activities:

- The Verizon phone lines in Orleans for the Medical Clinic and DNR failed 372 times in July. This is consistent with the annual pattern in which warmer weather causes more outages. Amazingly enough, only 19 of these outages occurred during the recent fire activity in Orleans. The phones and internet in Orleans stayed operational for most of the firefighting activity.
- The Orleans Broadband Project is proceeding well. The remaining permits needed to begin construction are from Humboldt County and the Forest Service. The Humboldt County Building Permit application was approved on July 18. The final permit required from Humboldt County is a right-of-way permit for a short section of the project along Ishi Pishi road.
- IT is continuing to test backup software solutions to find one that fits. The latest test is with a system call Acronis Backup, and it has been working effectively for almost all servers for a couple of weeks now. If Acronis tech support can fix one last error, I will present this product for purchase.
- The new phone service for the Yreka offices has been installed. To address the problems with faxing, separate analog lines have been ordered for all the faxes in the clinic. IT is still working on a solution for the faxes in TANF and Head Start.
- IT has been working with the Project and Construction Managers for the new Orleans Health and Wellness Center. The servers for the clinic are still being prepared. IT has worked with Verizon to install phone service, and now we are waiting for AT&T to install the internet service. AT&T has not yet set an installation date. I have tried to escalate the installation, but the fire may have delayed the process.
- The Yreka offices are currently experiencing a network issue that is causing delays during scanning, e-mail access, and sometimes connecting to remote servers like EHR and Dentrix. IT has been troubleshooting this issue
- IT is working with the Disaster Preparedness Department to deploy internet and phones at their new office in Happy Camp. We are going to use secure wireless connections to keep the cost down.

Current project priorities for the IT department:

1) Dealing with real-time outages and emergencies
2) Implementing a new backup software that is more reliable than before
3) Completing the IT infrastructure for the Orleans Health & Wellness Center
4) Troubleshoot and repair ongoing issues at the Yreka Clinic
5) Deploy internet for the new Disaster Preparedness office in Happy Camp
6) Orleans Broadband Project, getting ready for deployment in summer of 2013
7) Repair or replace the tape backup unit in the Admin building
8) Fiber optic deployment on the HC Admin Campus
9) Closeout of the Fiber Project in Happy Camp
10) Upgrading all computers and servers before the old versions expire in 2014

Budget Report for 1020-15 for July, 2013

- Total annual budget: $308,001.59
- Expenses to date: $240,886.37
- Balance: $67,155.22
- Percent Used: 78.20%
- Percent of Fiscal Year: 83.33%

Budget Report for USDA RUS Community Connect Grant 2061-00 for July, 2013

- Total budget: $1,141,870.00
- FY 2012 expenses: $ 102,405.30
- FY 2013 expenses to date: $ 182,239.15
- Balance: $ 857,225.55
- Percent Used: 24.92%
- Percent of Project Period: 61.11%

Attachments:

Cell phone usage log

****

Veterans MOU

I am not happy with the Veterans MOU. It's way more than just providing the veteran with a primary care service and then billing for it. They have requirements we must follow which include quality measures, meetings, sharing of patient records and much more. In my opinion, this is a repeat of accreditation, HRSA, and Partnership Health Plan, Meaningful Use, and GPRA. All I want to do is provide the care and bill; nothing else. The projection of eligible veterans is only about 20. You must be American Indian, have a military acquired condition, and make less than 35,000 per year. The question is, "is it worth it?" I will have to check into this more.

****

Fire Response

I was called to the response and I responded here in Happy Camp and the next day in Orleans.

Chicago Rural Health Conference

These people were some of the nicest people I have met for a long time. Very good information was received. Infections acquired in a hospital are a real thing, and in one family within 6 months three of her family members acquired infections with one fatality. Health workers need to be more careful and hand washing is the key. National Drug Strategy: Addiction is now considered a chronic disease; a brain disease. The number of deaths have surpassed traffic fatalities; 38,00 – 22,000 to prescription drug overdoses. They are seeing an increase in heroin, while chronic marijuana is down 8%. We will see treatment being offered to drug users through the insurance program in the Health care Exchange. Keep your eyes open for Innovation Awards for the treatment of AOD. The next round is a billion dollars. The date for ICD 10 is October 1, 2014 and this date will stay solid. More internal and external testing must be done, as well as staff training. This coding system is more complex than ICD 9. The most challenging standards for the Joint Commission were another topic of the conference. A lot of the standards were safety standards. Quality: Care will be more patient centered. Changing incentives:

- Prevention and Population Health
- Community well being
- Bundled payments – Value Purchasing
- Value Based purchasing
- Managed care organization Accountable care organization

$$\text{Value} = \frac{\text{quality + experience}}{\text{Cost}}$$

Triple Aim
Better Care
Better health
Lower Cost
Safe
effective
Patient Centered
Timely
Efficient
Equitable
Improve quality and reduce cost

IN regards to the Affordable care Act we will need 90,000 additional physicians. First step to quality is having health coverage. The next is workforce.

ACA- the transformation period will be painful. Expect to see expansion to transformation of primary care. primary care medical home as organization framework. The world of health is changing.
****

Budget Reviews

This year budget reviews will be held with Laura Olivas. We began on the 31st of July with the outreach program.
****

HRSA

HRSA wants more grant conditions revised and completed within 60 days. This will consume much of our time. However, several of the grant conditions were met satisfactorily. This grant supports the CFS program by paying the salaries of the LCSW's, AOD Counselors, and receptionist.
****

CRIHB

I have been hearing some rumblings about CRIHB Care/Options and the administrative fee that is being charged. Other Health Program Directors' a5re quite dissatisfied with CRIHB right now. This is all I've heard and I will need to check into it more. Please let me know if you have heard anything.
****

Quality Improvement Training

I have been taking time during the day to work with Rondi on quality improvement training. We have been reviewing all the Performance Improvement Projects revising them or offering suggestions. We will begin working with AAAHC standards when I return from vacation.
****

Fabian Alvarado FNP/Orleans

Fabian recently submitted his resignation and his last day will be September 27, 2013. We are now looking for a provider to work in the Orleans clinic. He stated that his relocation will be better for his family's goals. We wish him well.

HRSA Site Visit

We have spent a lot of time working on the deficiencies of the site visit. We now have several formal agreements with providers and hope to get several more. The patient's satisfactions survey is still in progress and I am excited to see the results. Laura is now providing profit and loss statements to me and the health board. It is the site visit that added to our grant conditions.
****

IHS Budget Reviews

I met with Laura Mayton and Jaclyn Goodwin to discuss our funding agreements for 2013-2014. Travis Coleman joined us on a conference call to walk us through the agreement. There is sequestration involved that I'm sure will be brought up in our budget reviews.
****

	MONTHLY REVENUE REPORT			**BUSINESS OFFICE**		
	July-13	**Happy Camp**	**Yreka**	**Orleans**	**KTHP**	
	Revenue Medical	$34,483.20	$74,772.57	$11,533.56	$120,789.33	
	Revenue Dental	$19,080.12	$52,386.30		$71,466.42	
	Revenue Mental Health	$1,138.76	$2,194.70	$459.50	$3,792.96	
	Revenue Grand Total	**$54,702.08**	**$129,353.57**	**$11,993.06**	**$196,048.71**	
		Happy Camp	**Yreka**	**Orleans**	**KTHP**	
	Billing July Medical	$43,422.42	$ 95,323.17	$10,597.50	$149,343.09	
	Billing July Dental	$100,010.00	$ 114,314.00		$214,324.00	
	Billing July Mental Health	$4,589.55	$ 3,560.92	$1,768.10	$9,918.57	
	Billed Grand Total	**$148,021.97**	**$ 213,198.09**	**$12,365.60**	**$373,585.66**	
	BILLING DEPARTMENT BUDGET JUNE 2013					
					AVAILABLE %	
PROGRAM	YEAR END ANNUAL	EXPENSES TO			Could be spent	
YEAR	BUDGET	DATE	BALANCE	% USED	at this date	
FY 2013	**$460,955.78**	**$310,868.73**	**$150,051.70**	**67.45%**	**75.06%**	

KARUK TRIBAL HEATLH PROGRAM

BUSINESS OFFICE HEALTH BOARD REPORT

MEETING DATE AUGUST 8, 2013

I continue to attend Partnership Healthplan of California (PHC) meetings in order to attempt to make this new world of Medi-cal managed care as easy as possible. At a minimum we will be producing twice to three times as many claims for each medi-cal visit now; requiring more and more from the billing and A/R staff. I have begun to attempt to figure out how we might reorganize our existing staff to accomplish this new transition. I have taken a trip down to Orleans to work Orleans to work with Isha and I spent some time with Gina in Yreka to help them understand this PHC transition paperwork.

I attended a "Meet and Greet" session this past week with our new Medicare carrier Nordian. They are using as much of the previous company, Palmetto GBAs information as possible in hopes to NOT have to force us to accomplish even more complex application process. We will begin transitioning to the electronic format for Noridian during August, with Its assistance.

Sheila Super is off on medical leave for a maximum of 3 months and I will make every attempt to be sure the data entry stays as up to date as possible.

Respectfully submitted

Suzanna Hardenburger, CCS-P

RPMS
Karuk Tribal Health and Human Services Program
Health Board Meeting
August 8, 2013
Patricia White, RPMS Site Manager

Action Item:

VistA Imaging Agreement with IHS-Attached Draft (I do not have copy back from Contract Compliance and Finance at the time of this writing. I will send out as soon as I get back from them.) VistA Imaging is the program we have selected for scanning and storing medical information. With this program, we will be able to scan reports from other providers, x-ray reports and other information about our patients. The information will be stored on a server at IHS in Sacramento and will be accessible from the EHR/RPMS.

User Assistance and Requests

There were a total of 42 tasks or requests documented for support for HHS users during July:

- 18 were assigned to Amy Coapman – 21 completed and closed including 8 from previous months with 5 pending.
- 24 were assigned to Patti White - 26 completed and closed including 4 from previous months with 2 pending.

These are requests for reports, patient data, password, computer access issues, and other IT support.

Workload reports

Attached is the June 2013 *Operations Summary* along with Tribal Statistics. During May we had 1692 visits at all locations. This is up by 131 visits from May. 870 of these visits were for Native American patients (52%). Graphs are also included with this report.

Meeting / Conference Calls and other Activities – July 2013

July 10, 2013	ACQI Committee Meeting 1 ½ hours
July 10, 2013	UC Davis Call to test telemedicine connection 20 Minutes
July 12, 2013	Practice Management Application (BMW) training webinar 3 hours
July 12, 2013	Lab interface Conference Call 15 minutes
July 15, 2013	ECRI Institute Training Call – Managing Short Term Disruptions- 1 hour
July 18, 2013	Health Board Meeting - 2-hours
July 20, 2013	EHR Patch 11 installation call with IHS
July 23, 2013	Executive Directors Advisory Committee Meeting - 2 hours
July 25, 2013	RPMS/EHR Office Hours 1 ½ hours
July 25, 2013	PQRS (Physician Quality Reporting System) 2013 Reporting Conference Call - 1 hour
July 30, 2013	CAIR (California Immunization Registry) Immunization Portal Webinar – 1 hour

RPMS – EHR - EDR

- BMW- As reported last month, Dale has configured the Practice Management web server for scheduling and patient registration. We are waiting for a call back from

the IHS coordinator at California Area Office to proceed. On July 30th, I submitted a support ticket to IHS regarding this item.

- We are still working out the issues for Quest Bi-directional lab interface. After a time of working well, we began see that labs are going out to Quest and results coming back in, but found a lot of missing results. Amy emailed the programmers and found that a links option was not working. We were given instructions on how to turn the link back on if this occurs again. 154 lab results filed in after the fix. We will monitor this on a daily basis.
- The HL7 (a standard for exchanging information between medical applications) was installed on the Dentrix Server this month. Henry Schein techs are to begin testing between RPMS and Dentrix with Tom Love of Cimarron Medical Informatics this month. Once the testing is done, Tom will complete building the interface to RPMS. When completed, the dental information will cross from Dentrix into RPMS without the double data entry that the dental staff are now doing.
- The dental fee schedule has been loaded into RPMS' billing package and also entered into the Dentrix program.
- I am currently preparing the new Medical Fee Schedule to upload into RPMS. This should be completed by the time of this meeting.

Budget: Period ending July 31, 2013. We are under budget for this time period having only used 66.75% of the total budget and are 5/6 (84%) through the year.

Program	RPMS
Budget Code	3000-75
Program Year	2012-2013
Appropriation	$235,220.84
Expenses to Date	157,003.60
Balance	78,217.24
Percent used	66.75%

Respectfully Submitted,

Patricia C White, RPMS Site Manager

OPERATIONS SUMMARY FOR KARUK TRB HP Service Unit
FOR JUNE 2013
Prepared for August 8, 2013 Health Board Meeting

(Note: In parentheses following each statistic is the percent increase or decrease from the same time period in the previous year. '**' indicates no data is present for one of the two time periods.)

PATIENT REGISTRATION

There are 17,727 (+4.8) living patients registered at this SU. This number does not represent the 'Active User Population' which is found elsewhere in PCC Reports. There were 87 (+52.6) new patients, 1 (-80.0) births, and 3 (-62.5) death(s) during this period. Data is based on the Patient Registration File.

THIRD PARTY ELIGIBILITY

There were 2,666 (-0.2) patients enrolled in Medicare Part A and 2,548 (+0.0) patients enrolled in Part B at the end of this time period.

There were 87 (+16.0) patients enrolled in Medicare Part D.

There were also 5,944 (+1.2) patients enrolled in Medicaid and 4,374 (+2.4) patients with an active private insurance policy as of that date.

CONTRACT HEALTH SERVICES

Total CHS expenditures (obligations adjusted by payments) for this period were 53,993.6 (-8.2). The number and dollar amount of authorizations by type were:

Type	Number	Amount
57 - DENTAL	5	2687
64 - NON-HOSPITAL SERVICE	794	51306.6

DIRECT INPATIENT

[NO DIRECT INPATIENT DATA TO REPORT]

AMBULATORY CARE VISITS

There were a total of 1,692 ambulatory visits (-5.4) during the period for all visit types except CHS.

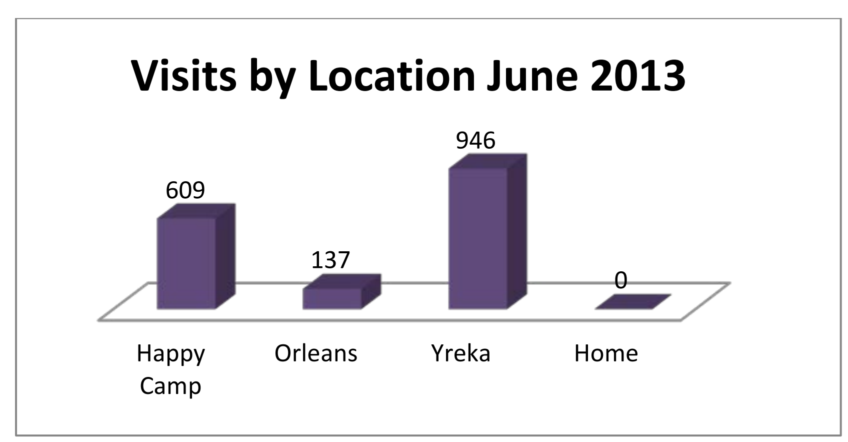
They are broken down below by Type, Location, Service Category, Clinic, Provider Discipline and leading Diagnoses. These do not equate to 'official' APC Visits which are identified in other PCC Reports.

By Type:

TRIBE-638 PROGRAM	1,692	(-5.4)

By Location:

YREKA	946	(-3.0)
KARUK COMM HEALTH CLINIC	609	(-6.7)
ORLEANS	137	(-14.9)

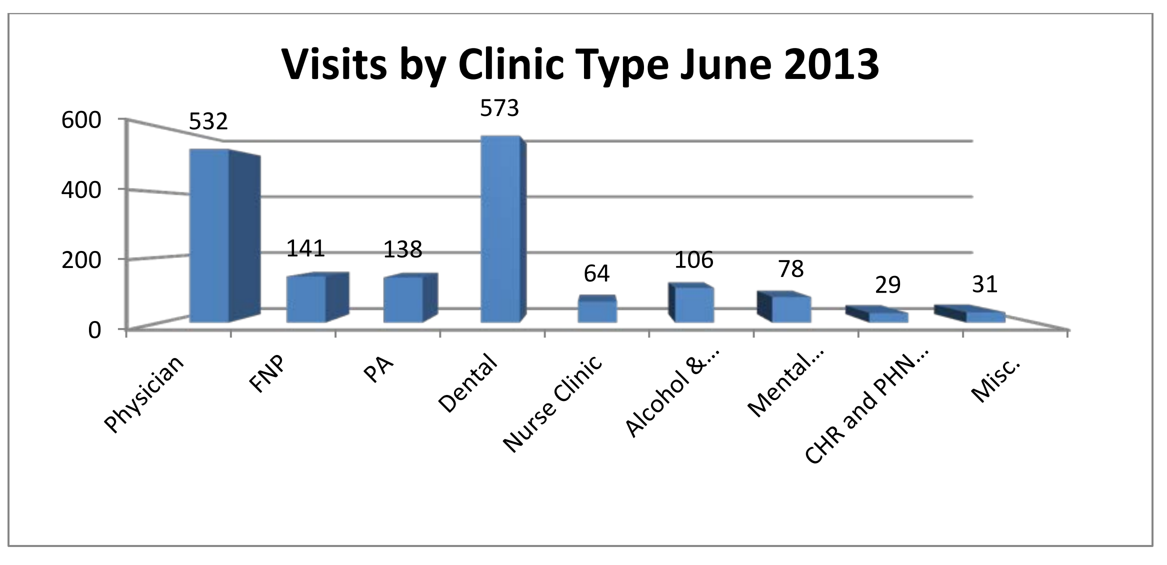


By Service Category:

AMBULATORY	1,669	(-5.7)
TELECOMMUNICATIONS	23	(+21.1)

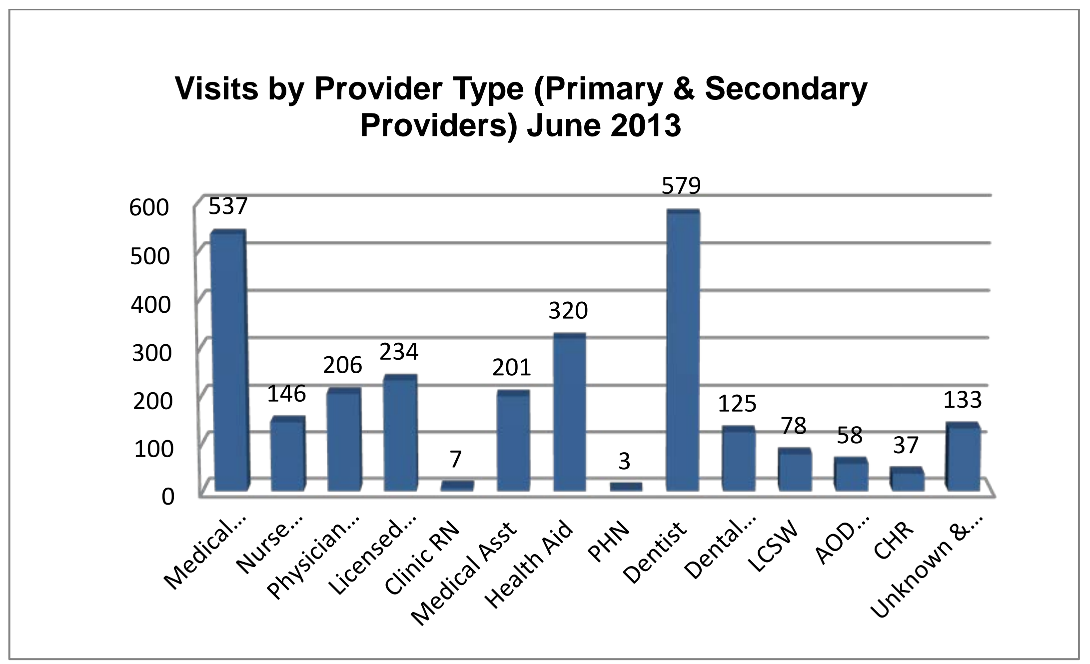
By Clinic Type:

DENTAL	573	(+16.2)
PHYSICIAN	532	(+13.0)
FAMILY NURSE PRACTITIONER	141	(-60.5)
PHYSICIAN ASSISTANT	138	(-18.8)
ALCOHOL AND SUBSTANCE	106	(+8.2)
MENTAL HEALTH	78	(+21.9)
NURSE CLINIC	64	(-21.0)
CHR	27	(-18.2)
TRANSPORT	11	(+266.7)
CHART REV/REC MOD	9	(+800.0)
TELEPHONE CALL	7	(-12.5)
PHARMACY	3	(-62.5)
PHN CLINIC VISIT	2	(**)
HOME VISIT	1	(**)



By Provider Type (Primary and Secondary Providers):

DENTIST	579	(+17.0)
MD	537	(+3.7)
HEALTH AIDE	320	(-49.0)
LICENSED PRACTICAL NURSE	234	(-27.8)
PHYSICIAN ASSISTANT	206	(-1.9)
MEDICAL ASSISTANT	201	(+89.6)
NURSE PRACTITIONER	146	(-60.3)
DENTAL HYGIENIST	125	(+7.8)
HEALTH RECORDS	84	(+1,100.0)
LICENSED CLINICAL SOCIAL WORK	78	(+21.9)
ALCOHOLISM/SUB ABUSE COUNSELOR	58	(-44.2)
UNKNOWN	49	(**)
COMMUNITY HEALTH REP	37	(+2.8)
CLINIC RN	7	(**)
PUBLIC HEALTH NURSE	3	(+50.0)



The ten leading purposes of ambulatory visits by individual ICD Code are listed below. Both primary and secondary diagnoses are included in the counts.

By ICD Diagnosis

1).	DENTAL EXAMINATION	573	(+16.2)
2).	HYPERTENSION NOS	101	(-38.0)
3).	OBESITY NOS	84	(+171.0)
4).	LUMBAGO	72	(+50.0)
5).	ALCOHOL ABUSE-UNSPEC	69	(+21.1)
6).	DIETARY SURVEIL/COUNSEL	63	(**)
7).	DMII WO CMP NT ST UNCNTR	50	(-30.6)
8).	HYPERLIPIDEMIA NEC/NOS	49	(-24.6)
9).	TOBACCO USE DISORDER	48	(+2.1)
10).	DEPRESSIVE DISORDER NEC	45	(-10.0)

CHART REVIEWS

There were 1,016 (-28.8) chart reviews performed during this time period.

INJURIES

There were 95 visits for injuries (+30.1) reported during this period. Of these, 28 were new injuries (-15.2). The five leading causes were:

1).	FALL STRIKING OBJECT NEC	4	(+300.0)
2).	NONVENOM ARTHROPOD BITE	2	(+0.0)
3).	OVERXRT-SUDN STREN MVMT	2	(**)
4).	LOSS CONTROL MV ACC-DRIV	1	(+0.0)
5).	OTH OFF-ROAD MV ACC-DRIV	1	(**)

EMERGENCY ROOM

[NO EMERGENCY ROOM VISITS TO REPORT]

DENTAL

There were 461 patients (+16.7) seen for Dental Care. They accounted for 573 visits (+16.2). The seven leading service categories were:

1).	PATIENT REVISIT	458	(+21.2)
2).	HYPERTENSION SCREENING	225	(+25.0)
3).	LOCAL ANESTHESIA IN CONJUNCTION WIT	176	(+67.6)
4).	INTRAORAL - PERIAPICAL FIRST RADIOG	137	(-19.4)
5).	PREVENTIVE PLAN AND INSTRUCTION	123	(+25.5)
6).	FIRST VISIT OF FISCAL YEAR	118	(-1.7)
7).	TOPICAL APPLICATION OF FLUORIDE VAR	95	(+48.4)

IN-HOSPITAL VISITS

[NO IN-HOSPITAL VISITS TO REPORT]

PHARMACY

There were 1,481 new prescriptions (-9.4) and 2 refills (-33.3) during this period.

END

KTHHSP Tribal Statistics for June 2013

	Registered Indian Patients	Indian Patients Receiving Services June 2013	APC Visits by Indian Patients June 2013
Karuk	2048	392	461
Descendants residing in CA	1854	203	252
All other Tribes	2120	135	157
Total	6022	730	870

Karuk Community Health Clinic
64236 Second Avenue
Post Office Box 316
Happy Camp, CA 96039
Phone: (530) 493-5257
Fax: (530) 493-5270

Karuk Tribe

Administrative Office
Phone: (530) 493-1600 • Fax: (530) 493-5322
64236 Second Avenue • Post Office Box 1016 • Happy Camp, CA 96039

Karuk Dental Clinic
64236 Second Avenue
Post Office Box 1016
Happy Camp, CA 96039
Phone: (530) 493-2201
Fax: (530) 493-5364

REQUEST FOR CONTRACT/ MOU/ AGREEMENT

Check One:
- ☐ **Contract**
- ☐ **MOU**
- ☑ **Agreement**
- ☐ **Amendment**

Karuk Tribe Number Assigned: ______
Funder/Agency Assigned: ______
Prior Amendment: ______

REQUIRED → ***Procurement Attached** ☑ ***Budget Attached** ☐
***System for Award Management (SAM) (CONTRACTS ONLY)** ☐
***KCDC/ KTHA Notification/ review required** ☐ **Yes** ☐ **No**

Requestor: **Patricia C. White** **Date: July 18, 2013**

Department/Program: **RPMS/EHR**

Name of Contractor or Parties: **Indian Health Services**

Effective Dates (From/To): **June 21, 2103** **November 30, 2014**

Amount of Original: **$7,125.00 ($1900.00 per provider FTE per year)**
Amount of Modification:
Total Amount: **$7,125**

Funding Source: **(Meaningful Use)**

Special Conditions/Terms:

Brief Description of Purpose:
Implementation of VistA Imaging at the KTHHSP, a proprietary scanning program housed at California Area Office of Indian Health Services.

**** REQUIRED SIGNATURES ****

Patricia C White (signature) — Requestor — Date: 7-18-13

______ **Chief Financial Officer — Date ______

______ **Director, Administrative Programs & Compliance — Date ______

______ **Director of Self Governance(MOU/MOA) or TERO (Contracts) — Date ______

______ Other — Date ______

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Phone: (530) 493-2201
Fax: (530) 493-5364

Requestor: Patricia C. White **Date: July , 2103**

Dept/Program: RPMS/EHR **Funding Source:** (Use Fund Account Code)

Check One:
- ☐ Small Purchase (less than $5,000)
- ☐ Construction Contract
- ☐ Independent Contractor Under $2,000
- ☐ Independent Contractor Over $2,000**
- ☑ Large Purchase (more than $5,000)**
- ☐ Other:

***Tribal Council approval is required for: all purchases exceeding $5,000, all Agreements and all Contracts exceeding $2,000.**

Procurement #/Type: ______ ☑ Three quotes ☐ Sealed Bid ☐ Competitive Proposal

COMPARATIVE SUMMARY *(Minimum of Three Required)*				
Company Name	**Date**	**Price**	**Contact/Phone**	**Indian Y/N**
Laser Fiche	4/132012	62,441.66 + $6,000 per year licensing fee		
VistA Imaging (If we purchased)	7/1/2013	$ 399,000.00		
Vista Imaging (IHS Sacramento)	7/1/2013	$7,125.00/per year		

Name of Selected Vendor: ______

Basis:
- ☑ Lowest Price
- ☐ Superior Product/Service
- ☐ Based on Annual Price Comparisons
- ☐ Sole Source Provider *(MUST Attach Detailed Justification)*
- ☐ Only Qualified Local Provider Due to Geographic Disadvantage
- ☐ Best Qualified Vendor
- ☐ Delivery Service Provided

Comments: ______

**** REQUIRED SIGNATURES ****

*** By affixing your signature, you acknowledge that you have reviewed the attached documentation for presentation to Tribal Council.*

Patricia CWhite 7-18-13

Requestor Date

**Chief Financial Officer Date

**Director, Administrative Programs & Compliance Date

**Director of Self Governance(MOU/MOA) or TERO (Contracts) Date

Other Date

A DIVISION OF THE RAY MORGAN COMPANY

Quote #: PITQ4721

Laserfiche Implementation

Customer

Name	Karuk Tribe Of California
Address	64236 Second Ave
City	Happy Camp
Phone	(530) 598-8006
ZIP	96039 **Fax**

Rep	Bob Andrews 530-226-4434 bandrews@raymorgan.com
Date	04/13/12

Contact: Eric Cutright **EMAIL:** ecutright@karuk.us

Qty	Description	Unit Price	TOTAL
	Rio System - Pilot Program		
50	**Rio Full Named User Licensing** Rio Licensing will included the following: - Unlimited Laserfiche Servers - Workflow - Adv. Audit Trail with Watermark feature - Web Administration Console - Digital Signatures - Web Acces, Email & Snapshot Included *Includes Lf Mobile for iPhone, Web Access Light and SharePoint integration	$723.00	$36,150.00
1	**Laserfiche Import Agent** - A capture tool that can bring files into a Laserfiche repository from the Windows file system -	$1,485.00	$1,485.00
1	**Laserfiche Quick Fields Core** - Identify, catergorize and index documents based on their content -	$4,895.00	$4,895.00
1	**DocuNav Software for Application Integration**	$2,061.66	$2,061.66
	LSAP Annual Software Maint. & Support		
50	**Rio Full Named User Licensing LSAP**	$120.00	$6,000.00
1	**Import Agent LSAP**	$300.00	$300.00
1	**Laserfiche Quick Fields Core LSAP**	$1,000.00	$1,000.00
1	**DocuNav Software for Application Integration Support**	$300.00	$300.00
1	**Professional Services To Include:** **- Project Kick-Off Meeting** **- Test Period with Service Documentation & End User Q&A** **- Project Completion Meeting with Letter of Substantial Operability** *** Any Labor Not Defined Above to be Billed Separately *** *** See Attached Scope of Work for Deliverables and Expectations *** - Optional Payment Plan ($1 Dollar Buyout) - 36 month payment of $2,048 60 month payment of $1,339	$10,250.00	$10,250.00

Laserfiche Software Assurance Program entitles clients to the following
- New product relases and all product updates
- 24/7 access to the Knowledge Base articles, discussion forums and educational resources on the Support

Required Deposit: ***$52,191.66***

A required deposit based upon 100% of the quoted Product & Materials will be due at time of signing. This deposit is mandatory and required to be paid in full in order for any purchasing or project implementation to occur. The required deposit amount is valid for 30 days from date of issue.

Terms: ***Fixed Price Quote***

Fixed Price Project: The total project price will be no more or less. Any possible exceptions will be noted. Project change orders will be billed separately above the project amount. This quote is valid for 30 days from date of issue.

Product	$52,191.66
Tax	
Labor	$10,250.00
Shipping	$0.00
TOTAL	$62,441.66

Accepted By: **Date Accepted:**

Title: **Rep:**

Laserfiche
Authorized Reseller

PROIT EQUIPMENT ORDER - TERMS AND CONDITIONS

The terms on this Equipment Order Form constitute the entire agreement between the purchaser and the seller. No other representation, statements, or warranties not contained herein shall be relied upon by the buyer (or seller) unless made by mutually agreed upon written amendment to this agreement. This is a binding order, not subject to cancellation.

The Buyer grants to PROIT a security interest in the above described goods to secure payment of the purchase price. Buyer authorizes PROIT to file a UCC-1 Financing Statement, and authorizes PROIT, as Buyer's attorney-in-fact, to execute and file the financing statement. Buyer agrees to pay all of Professional IT Solution's (PROIT) costs in the collection of any amount due hereunder in the recovery of any property, pursuant hereto or in the enforcement of its right against Buyer, including reasonable attorney's fees, whether or not suit be brought. Customer agrees that in the event of any default of this agreement, PROIT may remove products affected by the default from customer's premises with or without process of law.

Payment terms are upon receipt of invoice (URI) unless otherwise specified. Late charges of 1.5% per month on the outstanding balance will be added if payments are not received within 15 days of the invoice date. The minimum late charge is $9.50. Late charges will not exceed the maximum permitted by law. Buyer agrees to pay seller a returned check charge of $25.00 per occurrence if any of buyer's checks are returned to seller unpaid. Upon default of any payment or any other aspect of this agreement, seller may, at its option, declare the entire outstanding balance immediately due and payable.

Other than the obligations set forth herein, PROIT disclaims all warranties, express or implied, including any implied warranties of merchantability, fitness for use, or fitness for a particular purpose. PROIT shall not be responsible for direct, incidental, or consequential damages, including but not limited to damages arising out of the use or performance of the equipment or the loss of use of the equipment.

PROIT shall be temporarily relieved of its obligation in the event that labor disturbance, acts of God, unavailability of product, or other circumstances beyond PROIT's control prevent PROIT from fulfilling the terms of this agreement.

No goods may be returned without PROIT's approval or prior written consent. A) Only consumable goods invoiced within 60 days will be considered for return. B) On authorized returns, buyer agrees to pay a restocking charge equivalent to 30% of the purchase price. C) Merchandise returned without authorization may not be accepted at the receiving dock, and is the sole responsibility of the buyer. D) All non-saleable merchandise (that has been partially used or opened) will be deducted from any credit amount due the buyer.

All claims regarding shipments and receipt of goods must be made within 7 days of delivery. Applicable taxes shall be added to the purchase price unless the customer has supplied a tax exemption or resale certificate (prior to shipment) acceptable to the proper taxing authorities.

INSTALLATION AND ELECTRICAL REQUIREMENTS

Buyer acknowledges that they have been informed of the manufacturers recommended space and electrical requirements for the equipment listed above. Failure to comply with the manufacturer specifications may void any warranties. Customer has been informed that a surge protector is recommended to protect their electronic investment from power disturbances. Said surge protector should have network protection for systems installed in a networked configuration. Customer will be responsible for damage sustained due to inadequate protection form power disturbances.

I acknowledge the following Terms & Conditions: X__________________________ Date:______________________________

California Area VistA Imaging Implementation Costs

Category	Description	Quantity	Subsequent Years				
Year 1 Costs - 2010			2011	2012	2013	2014	Comments
Hardware							
Vista Imaging Servers*	Vista Imaging SAN and Gateway Configuration - 4TB usable RAID 5 storage HP SAN Management Server; HP Gateways Servers; HP Cluster Servers; Storage Subsystem; LT04 Tape Library; Plasmon Archive Appliance 60GB UDO Drives.	$ 165,000	-	-	-	$ 165,000	Lifecyle of the Vista Imaging hardware is approximately 3-5 years with replacement planned for 2014.
Offsite Permanent Storage*	Vista Imaging requires offsite permanent storage for images and scanned documents. An offsite storage cluster has been established in the California Area, Redding Office.	$ 75,000	-	-	-	$ 75,000	
Total Initial Cost		$ 240,000	0	0	0	$ 240,000	
Annual Licensing Fees							
HP Help Desk Support	The Hewlett Packard helpdesk support service provides technical support and assistance on how to configure and streamline Vista Imaging hardware, beyond the standard extended warranty.	$ 42,000	$ 42,000	$ 42,000	$ 42,000	$ 42,000	This is an annual fee. The Office of Information Technology (OIT) covered the first year with ARRA funds. (An Indian Health Service (IHS) contract for these services, for 12 Areas is $500,000 = $42,000 per Area). It is not clear whather OIT will fund subsequent years.
Accusoft License Fee*	Accusoft is a required software package for Vista Imaging that assists with the clinical capture of images and scanned documents.	$ 9,000	$ -	$ -	$ -	$ 9,000	This is an one time cost at year five.
Accusoft Annual License Fee*	Accusoft is a required software package for Vista Imaging that assists with the clinical capture of images and scanned documents. The annual fee is approximately 20% of initial fee, which is $1,800.	$ 1,800	$ 1,800	$ 1,800	$ 1,800	$ 1,800	This is an annual fee.
Total Initial Cost*		$ 52,800	$ 43,800	$ 43,800	$ 43,800	$ 52,800	
Software							
Software License*	Vista Imaging Software Public Domain	$ -		$ -	$ -	$ -	There is no charge for public domain software.
Total Initial Cost*		$ -	Total at Next Buy-Back Period			$ -	
Technical Support							
Initial Vista Imaging Training*	Vista Imaging trainer, from the Veterans Health Adminisration spend five days assisting sites configure their scanners and use the Vista Imaging software.	$ 3,000	N/A	N/A	N/A	N/A	This is a one-time training with VA trainer at the California Area Office.
Staff and Maintenance Fees*	The Vista Imaging Coordinator, Clinical Application Coordinator (CAC), and California Area Office Information Technology (IT) staff will provide maintenance and support of the Vista Imaging software, via onsite support, WebEx trainings, phone calls, and e-mails during the implementation of the system. This line item also includes the cost of Health Information Management (HIM) support in providing recommendations on scanning policies and procedures. Also the costs of a Vista Imaging FTE, fringe benefits, administration fees, and travel are included.						
	Vista Imaging FTE	$ 150,000	$ 150,000	$ 150,000	$ 150,000	$ 150,000	
Total Initial Cost		$ 153,000	$150,000	$150,000	$150,000	$150,000	
Total VistA Imaging Program Costs		$ 445,800	$ 193,800	$ 193,800	$ 193,800	$ 442,800	
*Paid by IHS OIT		$ 295,800	$ 43,800	$ 43,800	$ 43,800	$ 43,800	Depends on IHS OIT funding
Total Remaining Program Cost		$ 150,000	$ 150,000	$ 150,000	$ 150,000	$ 399,000	Year 5 increase is for hardware replacement.

2013 VistA Imaging Cost Calculation

	Weekly Hrs	FTE	Location
FNP			
Lisa Rugg	30	0.8	Yreka
Fabian Alvarado	32	0.8	Orleans
PA-C			
Chelsea Chambers	40	1.0	Happy Camp
MD			
Robert Milton	40	1.0	Yreka
Barbara North	10	0.3	Yreka
Michael Hess	20	0.5	Yreka
Locum Tenens	40	1.0	Happy Camp
	110	**3.8**	

2013 VistA Imaging Cost (Per FTE) **$1,900**

Total Annual Program Cost **$7,125**

IHS Area Office Or Indian Health Medical Facility Agreement

Department of Veterans Affairs
VistA Software Development
VistA Imaging
Clinician Desktop Service

Indian Health Service
VistA Imaging
Program Office

VistA Imaging Site Agreement

1 Purpose

This is an agreement to implement VistA Imaging at Karuk Tribe. The VistA Imaging implementation described in this document is based on the organization's imaging goals and the result of the Systems Analysis Phase of the VistA Imaging Implementation Process. This proposal will:

- identify the FDA Statement
- be used to obtain the IHS VistA Imaging Program Office approval of Site's VistA Imaging Implementation so that the site can receive the VistA Imaging software
- list implementation site contacts and the implementing organization's coordinators
- provide architecture and technical details of the planned VistA Imaging implementation so that the site may be approved to receive the released VistA Imaging software
- include information for vendor quote estimate(s)
- state what documents will be used by the site to guide the implementation.

This VistA Imaging Site Implementation Proposal is written to ensure mutual understanding of the terms of software used by each proposed imaging facility (the Site or IHS Area) and the IHS VistA Imaging Program Office. Our aim is to guarantee correct operation and efficient support of the system, thus assuring patient safety. **The system is legally a medical device. All users must comply with the Quality System Requirements (QSR) of the Food and Drug Administration (FDA) to legally and safely operate the imaging system.**

Clear communication between users and the IHS VistA Imaging Program Office will allow efficient correction of any problem and the incorporation of new features identified by the field users.

The following VistA Imaging System components comprise a complete system:

- MS Windows based file servers
- Optical disk jukebox
- Network
- Background Processor (for the storage, retrieval and management of images)
- DICOM Text Gateway (providing information to non-VistA systems and image acquisition devices)
- DICOM Image Gateway (for image acquisition)
- Clinical Capture Workstations
- Clinical Display Workstations
- MUSE ECG (EKG) Interface to Clinical Display
- VistARad

A site or IHS Area may choose not to install and run all of the components listed.

- After initial installation and associated training, Medical Facilities (or IHS Areas, for regional installations) may field the imaging system at their pace.
- Medical Facilities (or IHS Areas, for regional installations) must submit post-initial installation and configuration information and notification of any additional modalities interfaced, image quality certifications, and Dictionary file listings to the IHS VistA Imaging Program Office. These notifications will be recorded in IHS VistA Imaging Program Office FDA file.

3 Documentation Requirements

These requirements apply to sites with existing VistA Imaging systems and to sites with new installations of VistA Imaging.

Under the VistA Imaging IHS Program Office's approved quality system, in order to obtain the VistA Imaging V3.0 software and released patches, all of the following must be on file with the IHS VistA Imaging Program Office:

- Site Contacts
- Site System Information
- Image Acquisition Technical Datasheet For Devices Using DICOM Devices (one for each DICOM image acquisition device)
- Image Acquisition Technical Datasheet For Devices Using Clinical Capture Devices (one for each clinical capture device that captures images)
- Image Quality Certification (one for each image acquisition device)

These documents are included in Technical Site Profile (an MS Excel spreadsheet) that can be obtained from the IHS VistA Imaging Program Office. Please send a signed copy of this document, along with the following documents, to the IHS VistA Imaging Program Office:

- a completed Technical Site Profile
- the quote or purchase order for the core Imaging equipment (servers, BP, gateway, jukebox, raid, etc).

A copy of the above will be returned by email after the agreement has been approved. If you want a copy of the agreement with original signatures, please send two signed copies and the second copy will be returned by mail. If you have any questions about this document or need additional copies of these forms, please contact the VistA Imaging IHS Program Office at 928-214-3927.

The information in the Technical Site Profile must be kept up to date. This documentation may be audited by regulatory agencies at any time. Complete and current information is a QSR condition established by the Veterans Health Administration for continued use of the imaging system.

signals is needed to interface devices through the video capture workstations or other devices.

6 Responsibilities of the Medical Facility or IHS Area Office Installing a VistA Imaging Server Cluster

The responsibilities of any site running VistA Imaging on a server cluster include:

a. Maintaining System patches and upgrades
b. Network traffic analysis
c. Monitoring disk space
d. Hardware maintenance and upgrades
e. Regional VistA Imaging Support/Training for facilities

7 Responsibilities of any Medical Facility or IHS Area Installing VistA Imaging Software on local RPMS Servers

When a facility or IHS Area installs the VistA Imaging software on servers supporting RPMS databases, it accepts the following responsibilities:

a. Changes (patches) distributed to the Imaging site by the VistA Imaging staff must be installed in a timely manner. It is recommended that sites keep their Imaging configuration patched to the current patch release levels.

b. The Site will provide necessary additional hardware and software in order to support the Imaging System installed.

c. All problems encountered while using the system shall be reported to the IHS VistA Imaging Program Office.

d. It is recommended that sites inform the IHS VistA Imaging Program office of all installations or upgrades of modalities, commercial PACS Systems, VistA Radiology Software, operating systems, and VistA Imaging equipment.

e. If a site is an Alpha or Beta Test Site of any component, the VistA Imaging support staff at the Site is expected to participate in regularly scheduled conference calls dealing with the VistA Imaging System.

f. Sites are responsible for purchasing software licenses and maintenance agreements for the use of embedded commercial software, as needed (presently used on the clinical workstations, the Background Processor and DICOM gateways).

g. Sites are responsible for purchasing maintenance agreements for hardware and software. In many cases, this is handled regionally through IHS Areas. If maintenance agreements are not in place, it is difficult to provide support for the Site and excessive downtime may be experienced.

h. Sites are responsible for producing a written contingency plan governing the operations in case of failure of any VistA Imaging component.

10 Signature Page

Your concurrence is required to approve your site as a Release Site for VistA Imaging software. Individual agreements must be in place for every site installing either VistA Imaging server cluster hardware or VistA Imaging software on RPMS servers.

Please feel free to contact the IHS VistA Imaging Program Office (928-214-3927) if you have any questions or concerns regarding this agreement.

SITE NAME: Karuk Tribe

CONCUR

Eric Cutright

Medical Facility Chief Information Officer Signature and printed name **Date**

Medical Facility Health Information Management Director and printed name **Date**

Robert Milton, MD

Medical Facility Clinical Director Signature and printed name **Date**

Lessie Aubrey

Medical Facility CEO Signature and printed name **Date**

Russell Attebery

Chairman, Karuk Tribe **Date**

Marilyn Freeman

IHS/CAO VistA Imaging Coordinator Signature and printed name **Date**

Robert Gemmell, CIO

IHS/CAO CIO/Information Systems Coordinator and printed name **Date**

Margo Kerrigan

IHS/CAO Area Director and printed name (if an IHS Area installation) **Date**

Catherine Moore

IHS Vista Imaging Program Office Manager **Date**

VistA Imaging Site Agreement

Clinical Capture is the Image Acquisition Technical Datasheet for Clinical Capture Devices and is required for each of the exact make/model of a device that captures or displays images that are stored in VistA Imaging.

Modalities is the Image Acquisition Technical Datasheet for DICOM Devices and is required for each of the exact make/model of a device that captures or displays DICOM images that are stored in VistA Imaging. This worksheet contains information about the modalities that can only be completed after VistA Imaging has been installed at a site. Complete the required information before submitting the Site Proposal for approval and then update the additional information after you have completed the Imaging installation. Port Numbers

Worksheets to be completed after the initial installation of Imaging

Accounts contains a lists of accounts created for use by VistA Imaging.

The **Software Versions** worksheet contains a list of the versions of the Imaging software and RPMS packages and patches that are installed at a site.

IP Information contains a list of the IP addresses of a site's Imaging components.

The **IQC** worksheet contains an Image Quality Certification form. One form is needed for each device that captures or displays images from VistA Imaging. Images for medical devices must be certified by a medical technician or doctor. Images for document scanners can be certified by non-medical or non-technical personnel. Since this form requires a signature, we could not include it in the Technical Site Profile. The form is available in the Technical Site Profile or from the IHS VistA Imaging Program Office. To use the form in the Technical Site Profile, print, complete and sign the form and then fax it to the IHS VistA Imaging Program Office (928-214-3924).

Approved Devices

The list of approved devices and specifications for VistA Imaging components is available from the IHS VistA Imaging Program Office.

If a site plans to interface a non-approved device, contact the IHS VistA Imaging Program Office for assistance in starting the validation process.

BUYBACK AGREEMENT
BETWEEN
CALIFORNIA AREA OFFICE
AND
KARUK TRIBE

1. This is a Buyback Agreement between the California Area Office (CAO), hereafter referred to as CAO, and KARUK TRIBE hereafter referred to as Tribe/Tribal Organization, to buy back services from the CAO under its Indian Self-Determination and Education Assistance Act (ISDEAA) contract/compact and Annual Funding Agreement/Funding Agreement (AFA/FA) to cover implementation of the Vista Imaging system, a secondary component of the Resource and Patient Management System (RPMS) Electronic Health Record (EHR).

2. This Buyback Agreement is authorized by the Department of Interior, Environment and Related Agencies Appropriations Act of 2009. The purpose of this Buyback Agreement is to establish the roles and responsibilities of the CAO and Tribe/Tribal Organization in implementing Vista Imaging successfully. The CAO will provide a reasonable means of assistance to fully implement Vista Imaging at the tribal health facility. Tribe/Tribal Organization agrees to commit the necessary resources to implement the Vista Imaging system. Tribe/Tribal Organization understands and agrees that the Indian Health Service (IHS) is entitled to full reimbursement for the costs it incurs in implementing and maintaining Vista Imaging under the Buyback Agreement.

3. **Responsibilities of the Parties**:

   A. The CAO agrees to:

   (1) Designate a Vista Imaging coordinator to assist with the implementation strategies and recommendations for onsite/offsite training, workflow processes, and special programming needs.

   (2) Coordinate the scheduling of all Office of Information Technology (OIT) and Veterans Health Administration (VHA) sponsored trainings of Tribe/Tribal Organization staff in the use of Vista Imaging.

   (3) Maintain Vista Imaging application assistance during normal CAO business hours, and provide limited support on weekends and federal holidays.

   (4) Make good faith effort to notify Tribe/Tribal Organization of any technical difficulties and server failures related to the Vista Imaging system by most timely and efficient means available.

C. Mutual Obligations of CAO and Tribe/Tribal Organization:

(1) CAO and Tribe/Tribal Organization will design a Vista Imaging implementation plan (i.e., by provider, clinic, function, or combination) to include timelines, training, contingency planning during downtimes, and productivity risk assessment before Vista Imaging implementation takes place. The parties will ensure the plan allows for full implementation within a 24-month period.

(2) Within 60 days, but no later than 30 days prior to the end of the first year of this buy back agreement, the parties will meet to discuss the progress of the Vista Imaging program.

(3) CAO and Tribe/Tribal Organization will develop a mutually acceptable plan for sharing costs among the participating tribes associated with implementing and maintaining Vista Imaging.

(4) When a new tribal health program is ready and willing to participate in the Vista Imaging program and their request to participate is approved by the CAO Vista Imaging Coordinator as being technically ready to do so, they will be allowed to enter into this Agreement using the same formula as the other programs who initially participated in this Buyback Agreement. The amount charged to these programs will be pro-rated based on the day the Agreement is signed by the new participant. At the end of the yearly funding cycle, the funds from these "new" programs will be credited to all previously participating programs (based upon the FTE formula). At the "year-end meeting," the program representatives will meet (as outlined in #2) to decide the distribution formula for the coming year. If the participating tribal health programs cannot agree on the distribution of costs for the coming year, then the distribution will continue to be based on the provider FTE formula established in the initial year. (Reference Attachments)

(5) CAO and Tribe/Tribal Organization agree that if a participating tribal program declines to continue participating in the Vista Imaging arrangement, or is unwilling or unable to pay its share of costs for any reason, the parties will meet and confer to determine whether to re-apportion the costs among the remaining participating tribal programs, and failing that, whether to terminate the agreement (in accordance with the 180 day advance notice set forth below).

(6) Provide 180 days advance notice of its intention to terminate participation in this Buyback Agreement, or an alternative notice period mutually agreeable to the parties.

and confer or mediation of any dispute, the Agreement will continue in effect pending conclusion of the dispute resolution process.

8. The parties must ensure that this Buyback Agreement is interpreted, understood, and carried out by all those involved. This document does not supersede or cancel any previous agreements between the signatories.

_______________________________		_______________________________	
Contracting Officer DHHS/PHS/IHS/California Area Office	Date	Tribe/Tribal Organization	Date

2013 VistA Imaging Cost Calculation

	Weekly Hrs	FTE	Location
FNP			
Lisa Rugg	30	0.8	Yreka
Fabian Alvarado	32	0.8	Orleans
PA-C			
Chelsea Chambers	40	1.0	Happy Camp
MD			
Robert Milton	40	1.0	Yreka
Barbara North	10	0.3	Yreka
Michael Hess	20	0.5	Yreka
Locum Tenens	40	1.0	Happy Camp
	110	**3.8**	

2013 VistA Imaging Cost (Per FTE) **$1,900**

Total Annual Program Cost **$7,125**

California Area VistA Imaging Implementation Costs

Category	Description	Quantity	Subsequent Years				
Year 1 Costs - 2010			2011	2012	2013	2014	Comments
Hardware							
Vista Imaging Servers*	Vista Imaging SAN and Gateway Configuration - 4TB usable RAID 5 storage HP SAN Management Server; HP Gateways Servers; HP Cluster Servers; Storage Subsystem; LT04 Tape Library; Plasmon Archive Appliance 60GB UDO Drives.	$ 165,000	-	-	-	$ 165,000	Lifecyle of the Vista Imaging hardware is approximately 3-5 years with replacement planned for 2014.
Offsite Permanent Storage*	Vista Imaging requires offsite permanent storage for images and scanned documents. An offsite storage cluster has been established in the California Area, Redding Office.	$ 75,000	-	-	-	$ 75,000	
Total Initial Cost		$ 240,000	0	0	0	$ 240,000	
Annual Licensing Fees							
HP Help Desk Support	The Hewlett Packard helpdesk support service provides technical support and assistance on how to configure and streamline Vista Imaging hardware, beyond the standard extended warranty.	$ 42,000	$ 42,000	$ 42,000	$ 42,000	$ 42,000	This is an annual fee. The Office of Information Technology (OIT) covered the first year with ARRA funds. (An Indian Health Service (IHS) contract for these services, for 12 Areas is $500,000 = $42,000 per Area). It is not clear whather OIT will fund subsequent years.
Accusoft License Fee*	Accusoft is a required software package for Vista Imaging that assists with the clinical capture of images and scanned documents.	$ 9,000	$ -	$ -	$ -	$ 9,000	This is an one time cost at year five.
Accusoft Annual License Fee*	Accusoft is a required software package for Vista Imaging that assists with the clinical capture of images and scanned documents. The annual fee is approximately 20% of initial fee, which is $1,800.	$ 1,800	$ 1,800	$ 1,800	$ 1,800	$ 1,800	This is an annual fee.
Total Initial Cost*		$ 52,800	$ 43,800	$ 43,800	$ 43,800	$ 52,800	
Software							
Software License*	Vista Imaging Software Public Domain	$ -		$ -	$ -	$ -	There is no charge for public domain software.
Total Initial Cost*		$ -	Total at Next Buy-Back Period			$ -	
Technical Support							
Initial Vista Imaging Training*	Vista Imaging trainer, from the Veterans Health Adminisration spend five days assisting sites configure their scanners and use the Vista Imaging software.	$ 3,000	N/A	N/A	N/A	N/A	This is a one-time training with VA trainer at the California Area Office.
Staff and Maintenance Fees*	The Vista Imaging Coordinator, Clinical Application Coordinator (CAC), and California Area Office Information Technology (IT) staff will provide maintenance and support of the Vista Imaging software, via onsite support, WebEx trainings, phone calls, and e-mails during the implementation of the system. This line item also includes the cost of Health Information Management (HIM) support in providing recommendations on scanning policies and procedures. Also the costs of a Vista Imaging FTE, fringe benefits, administration fees, and travel are included.						
	Vista Imaging FTE	$ 150,000	$ 150,000	$ 150,000	$ 150,000	$ 150,000	
Total Initial Cost		$ 153,000	$150,000	$150,000	$150,000	$150,000	
Total VistA Imaging Program Costs		$ 445,800	$ 193,800	$ 193,800	$ 193,800	$ 442,800	
*Paid by IHS OIT		$ 295,800	$ 43,800	$ 43,800	$ 43,800	$ 43,800	Depends on IHS OIT funding
Total Remaining Program Cost		$ 150,000	$ 150,000	$ 150,000	$ 150,000	$ 399,000	Year 5 increase is for hardware replacement.