

KARUK TRIBE
HEALTH BOARD MEETING AGENDA
Thursday, March 12, 2015 3 PM, Orleans, 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 (*February 12, 2015*)

F) GUESTS (*Ten Minutes Each*)

1. Patricia Hobbs, Clinical Supervisor CFS

H) OLD BUSINESS (*Five Minutes Each*)

- 1.

I) DIRECTOR REPORTS (*Ten Minutes Each*)

1. Rondi Johnson, Deputy Director (written report)
2. April Attebury, Interim Director of Children and Family Services (written report)
3. Lessie Aubrey, Deputy Director of Quality Management/Compliance (written report)
4. Patricia White, RPMS Site Manager (written report)
5. Raul Recarey, Health CEO (written report)
6. Eric Cutright, IT Director

II) REQUESTS (*Five Minutes Each*)

- 1.

K) INFORMATIONAL (*Five Minutes Each*)

- 1.

M) CLOSED SESSION (*Five Minutes Each*)

1. CHS (dinner break)
2. Laura Mayton
3. Barbara Snider
4. Tribal Council Members

N) SET DATE FOR NEXT MEETING (Thursday, April 9, 2015 at 3 PM in Yreka CA.

OO) ADJOURN

**Karuk Tribe – Health Board Meeting
February 12, 2015 – Meeting Minutes**

Meeting called to order at 3pm, by Chairman Buster Attebery

Present:

Russell “Buster” Attebery, Chairman
Joseph “Jody” Waddell, Secretary/Treasurer
Charron “Sonny” Davis, Member at Large
Alvis “Sonny” Davis, Member at Large
Josh Saxon, Member at Large
Renee Stauffer, Member at Large
Elsa Goodwin, Member at Large
Arch Super, Member at Large

Absent:

Robert Super, Vice-Chairman (travel/excused)

Sonny Davis completed a prayer and Buster Attebery read the Mission Statement for the audience.

Agenda:

Arch Super moved and Elsa Goodwin seconded to approve the agenda, 7 haa, 0 puuhara, 0 pupitihara.

Minutes of January 8, 2015:

Arch Super moved and Renee Stauffer seconded to approve the minutes, 7 haa, 0 puuhara, 0 pupitihara.

Guests:

1.) Lester Alford, TANF Director:

Lester is present to review an action item for the Tribal Council. Lester presented an MOU with Department of Education to assist in tutoring costs. Elsa asked if there was one in place prior to this one. Lester noted that there was another one made which only required his and the other Directors signature. Josh noted that there needs to be a correction in paragraph (1) of the MOU.

Elsa inquired about tutoring reports that are done. Lester noted that there is a form that is used to report the outcome of the child’s tutoring and commented that it is used as documentation. Elsa noted that the Council wants to help every child that needs help but the Council wants to ensure the children’s grades are coming up and the contractors are not just babysitting. There are teachers and volunteers who do tutoring after hours and then at the schools after hours, to provide services to the children.

There will be an updated MOU for the next school year. Renee asked about the pay range and how that works in terms of determines who gets paid which amount. Lester clarified that the \$12 per hour is for persons not in school and over 18 years of age. 15-M-002

Jody Waddell moved and Josh Saxon seconded to approve MOU 15-M-002 with changes, 7 haa, 0 puuhara, 0 pupitihara.

CSD has been received so he is eligible to begin charging tribal member needs to the funding line item.

2.) Jeremy Jabai, Tribal Member:

Tribal Member Charles and Descendant Jeremy Jabai are present to provide a proposal to the Tribal Council. It is a proposal to begin a business in the medical marijuana field. Jeremy owns and operates two in California at this time. Jeremy's advised that the Federal Government has advised that Tribes may work with States on their property and this is interesting because business development can now take place on Tribal land for dispensary options. He noted that the project could easily provide millions and they are offering the Tribe 51% of the operations. There are a lot of persons that are going to approach the Tribe but their specific business is eco-friendly, will provide the Tribe the business opportunity with Tribal Members in the business and generate revenue. He proposes that if they do a joint venture then it will be highly beneficial. He would like to form a relationship and develop a process that creates funding. He would like to only hire Native Americans and if they could find a botanist that was a Tribal Member, and then it would be beneficial. He noted that they will do an eco-friendly concept and green house. He uses less water and his botanist is very eco-friendly and well off but interested in the healing of medicinal marijuana. Allowing his current company to go Federal would put his company in the forefront of the industry.

He added that doctors are now prescribing marijuana as opposed to chemical based prescriptions.

He noted that there aren't too many negatives to this type of operation and now that the Federal Government has provided this opportunity.

Buster noted that the Tribe has heard about the determination for the Tribes to consider this growing operation on Tribal land. Buster noted that they will stay in touch.

Sonny asked if there would be cartel issues and Jeremy doesn't believe there will be. Buster reiterated the continued water issues for the Karuk to ensure the coho have what they need to succeed is imperative and any business development would need to take that priority into consideration.

Renee asked about how many operations he has. Jeremy noted that he has been doing this since 1996 and has business in several shops.

3.) Emma Lee Perez, Grant Writer/Resource Developer:

Emma Lee is present to seek approval of resolution 15-R-021 for the CRIHB for the ACORNS mini-grant.

Arch Super moved and Jody Waddell seconded to approve resolution 15-R-021, 7 haa, 0 puuhara, 0 pupitihara.

4.) Vickie Walden, Dental Program:

Vickie is present to seek approval of the dental program scope of services. Vickie noted that it has been approved but not signed.

Elsa inquired if Vickie responded to Raul about his inquiries on the policy. Vickie noted that the policy was drafted some time ago and she did note his comments.

Jody Waddell moved and Sonny Davis seconded to approve the Karuk Dental Program and Overview of Dental Services, 7 haa, 0 puuhara, 0 pupitihara.

5.) Eileen Tiraterra, Billing Department:

Eileen is present to review an action item it is bad debts write-off 25.5 section of the fiscal policy manual. She noted that once patients are sent to collections she would like patients to make payment arrangements with Eileen prior to being seen at the clinics for non-emergency visits. It will not affect Native American patients.

Josh inquired about HRSA compliance in relation to having this policy in place. Eileen noted that the language is in-line with what HRSA requires.

Arch Super moved and Josh Saxon seconded to approve the revised fiscal policies, section 25.5, 7 haa, 0 puuhara, 0 pupitihara.

Director Reports:

1.) Rondi Johnson, Deputy Director:

Rondi has one action item. It is a renewal of Dr. North's contract with the Tribe. It is contract 15-C-051.

Arch Super moved and Sonny Davis seconded to approve contract 15-C-051 between the Karuk Tribe and Barbara North, MD, 7 haa, 0 puuhara, 0 pupitihara.

Rondi then noted that she provided her ACQI reports, minutes, performance improvement reports, her training reports, and meetings she attended.

Buster asked about the low numbers in the medication report. Vickie Walden explained that this is an ongoing issue because there is no one that specializes in Dentrix. The group went on to explain they have not had training on the system. Renee asked when the goal will be 100% and not 90%. Vickie went on to clarify that with all projects they can be set at 90% or 100% and that can be revised at any given time, there are issues with the systems, and it's up to the staff to meet the standards prior to adjusting the goal. Lessie then commented that working on continuous quality improvement projects is an ongoing effort; they can move and reset the goals each time with movement of the program. Lessie noted that improvement projects don't meet 100% because quality improvement is an ongoing project to meet goals and verify quality of each goal and standard. This helps to identify needs and advances that provide improvement in the program.

Jody Waddell moved and Renee Stauffer seconded to approve Rondi's report. 7 haa, 0 puuhara, 0 pupitihara.

2.) Lessie Aubrey, DQMC:

Lessie is present to seek approval of a Tribal VISA. This will be taken care of. She then went on to discuss a large car pool. She commented that there needs to be a vehicle for the health CEO. Lessie noted that there needs to be a vehicle for him to access.

She then provided a position description for Medical Records Clerk. Lessie noted that there are needs to move toward electronic records and the position needs to have this technical responsibility.

There are discussions on preferred. James commented that if there is confusion on a job posting to reference the heading. He noted that those are all requirements. That line shall be moved under the qualifications section. The removal of maintain harmonious relationships shall be put back in as well.

Elsa Goodwin moved and Arch Super seconded to approve the position description with changes, Health Information Clerk, 7 haa, 0 puuhara, 0 pupitihara.

Lessie then noted that the Tribe has been blessed to have the CRIHB options program. For years there have been issues but she is happy for CRIHB options because it provided funding when it was cut.

Lessie then presented agreement 13-A-043 amendment (1) between the Karuk Tribe and CRIHB.

Arch Super moved and Elsa Goodwin seconded to approve amendment (1) to agreement 13-A-043, 7 haa, 0 puuhara, 0 pupitihara.

Lessie went on to discuss the Senior Nutrition Center and as noted in her report she no longer needs approval to add staff hours to the program.

Elsa thanked Lessie and the staff's assistance in serving the senior nutrition center.

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

Elsa inquired about a replacement for Sharon Meager and then Elsa commented that she was sorry to see Dr. Vasquez move to the Yreka Clinic.

3.) Patty White, RPMS Site Manager:

Patty is present to review her report. She would like to request the Indian Health Services to be mandatory.

Elsa Goodwin moved and Jody Waddell seconded to approve making the Indian Health Services HIPPA training as mandatory, 7 haa, 0 puuhara, 0 pupitihara.

Patty noted that she has two days to submit the UDS report to HRSA. She is hoping to meet the deadline and will work necessary hours to complete it.

Arch Super moved and Josh Saxon seconded to approve Patty's report, 7 haa, 0 puuhara, 0 pupitihara.

4.) Eric Cutright, IT Director:

Eric first presented contract 15-C-010 modification (1) to bring communications back to Orleans. They were on-site in November and made revisions to prepare for fiber optic cable. Verizon came up with a list of work that was needed.

Josh Saxon moved and Elsa Goodwin seconded to approve contract 15-C-010 (1), 7 haa, 0 puuhara, 0 pupitihara.

He then sought approval of agreement 15-A-027 of a non-disclosure agreement to provide a survey for the Orleans school. This may lead to revenue however the agreement provides safety in the information that is shared so the data is not released outside of the Tribe.

Josh Saxon moved and Renee Stauffer seconded to approve agreement 15-A-027, 7 haa, 0 puuhara, 0 pupitihara.

Eric then went on to seek approval of a position description for the shared position of Kelly Worchester and KTHA.

Arch Super moved and Josh Saxon seconded to approve the Network Technician position description, 5 haa, 0 puuhara, 2 pupitihara (Arch & Elsa).

He then sought permission to order Raul a smartphone.

Josh Saxon moved and Sonny Davis seconded to approve a smart phone for Raul, 7 haa, 0 puuhara, 0 pupitihara.

Eric updated that the new satellite is scheduled to be installed at DNR. Eric updated the Council and noted that he is not going to make any changes to Somes Bar until the Council provides direction in that direction.

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

5.) Raul Recarey, Health CEO:

Raul is present to make an introduction. He has been spending time working with the health program staff and getting familiar with the staff. He noted that he was impressed with initial meetings. The Tribal Council thanked Raul and explained that they have already heard great things. He plans on working very closely with the Tribal Council. His initial objectives were provided to him and he is excited to work toward those. He noted that he will work and be transparent in his decision making, working closely with the Health Board. He will work with the staff and provide structure and organize the staff. Working together this will achieve great things. He noted that from his end he works very closely with the Board and the Council and he hopes they approach him with any pending items as they work toward goals together.

6.) April Attebery, Children and Family Services:

Pat is present to review April's report. She noted that there are no action items but she highlighted April's report. Pat went on to note that she will be providing services to the Orleans area and she will email those dates so clients will know when.

Elsa Goodwin moved and Arch Super seconded to approve April's verbal report, 7 haa, 0 puuhara, 0 pupitihara.

Elsa asked about the PHN position description, Raul noted that he would like time to review this and he would like to possibly expand it but at this time he would like work with James on this.

Closed Session:

Arch Super moved and Josh Saxon seconded to approve paying CHS Case #262, 7 haa, 0 puuhara, 0 pupitihara.

Josh Saxon moved and Jody Waddell seconded to approve a VISA for Raul Recarey for \$5,000, 7 haa, 0 puuhara, 0 pupitihara.

Consensus: meeting with employee #RR confirmed that full evaluation on reporting structure, evaluation of staff, and operations will be taken into review.

Arch Super moved Jody Waddell seconded to approve employee #TB to work from home and \$500 limit in supplies to upgrade her home office needs to meet requirements, 6 haa, 1 puuhara (Elsa Goodwin), 0 pupitihara.

Consensus: to develop a resolution authorizing Raul to participate and be the Tribes Health Program point of contact for consultation.

Consensus: to set up a small list of employees to evaluate the recent memo from Department of Justice on marijuana on tribal land. (Scott, Arch, Jaclyn, Karen, DNR rep, Raul, KTHA rep).

Next Meeting Date: March 12, 2015, Orleans CA.

Arch Super moved and Renee Stauffer seconded to adjourn at 8:20pm, 7 haa, 0 puuhara, 0 pupitihara.

Respectfully Submitted,

Russell “Buster” Attebery, Chairman

Recording Secretary, Barbara Snider

DEPARTMENT OF QUALITY MANAGEMENT

Karuk Tribal Health Board Meeting

March 12, 2015

Rondi Johnson

February Report



ACTION ITEMS: None

FEBRUARY ACTIVITIES:

AAAHC Workgroup Meeting February 4th, HC Clinic Ofc meeting February 5th, Meaningful Use Meeting with CEO February 10th, ACQI Meeting February 11th, End of Month Billing Meeting February 11th, HC Clinic Ofc Meeting February 12th, Health Board Meeting February 12th, Worked in Yreka Clinic February 13th – 17th, AAHC Workgroup Committee February 18th – 19th, ED Meeting February 24th,

FEBRUARY TRAININGS/CONFERENCES & WEBINARS:

Rural Outreach & Enrollment Peer webinar February 3rd, CRIHB Options webinar February 9th, HRSA Conf Call February 11th,

ACQI COMMITTEE MEETING:

The February 11th, ACQI meeting agenda, performance improvement projects, and reports are attached.

BUDGETS:

See below. Budget through 2/28/15. At this time I'm well under budget.

Program	CQI
Budget Code	300002
Program Year	2013-2014
Expenses to Date	\$78,229.86
Balance	\$165,057.43
Percent Used	32.19%
Period Usage	5 months

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

**Karuk Tribal Health & Human
Services Program
ACQI Committee
Meeting/Conference Call
KCHC Teleconference Room
February 11, 2015
9:00 am-10:00 am**



1. Call Meeting to Order – Rondi Johnson
2. Roll Call/Sign In – Debbie Bickford
3. Approve Agenda – Rondi Johnson
4. Approve Minutes of January 14, 2015 – Rondi Johnson
5. Performance Improvement Reports Due
 - 5.1 HTN – Jennifer Cronin - Table
 - 5.2 KCHC Medical Records Audit – Susanna Greeno
 - 5.3 Orleans Medical Records Audit – Babbie Peterson
 - 5.4 Yreka Medical Records Audit – Charleen Deala - Tabled
 - 5.5 EHR Reminders – Annie Smith
6. GPRA Reports
 - 6.1 Increase Pap Smear Project – Vickie Simmons
7. New Business
 - 7.1 Complaints/Incidents/Suggestions –Rondi Johnson
 - 7.2 Memo
8. Old Business -
 - 8.1 Flu Vaccine Report – Jennifer Jones
 - 8.2 KCHC Medical Records Audit (Jul-Sep) – Susanna Greeno
9. Next Meeting March 11, 2015 at 9:00 am
10. Adjourn

Performance Improvement Report

Karuk Tribal Health Program

Happy Camp-Medical Records Audit

3rd Quarter; July-August-September 2014

Purpose:

Identify areas for improvement in the Electronic Health Records Management and documentation processes.

Goals:

Identify problems and find ways to make changes to improve them.

Data:

A collection of 15 charts were selected at random for each provider, 5 males, 5 females and 5 pediatric patients.

Problems:

This is my first attempt at this Medical Record Audit, and I do not have the previous audit to compare it to. I still have some questions on the collection of the data, I was unsure if the Health Questionnaire reviewed section meant that a H.Q. was done at that visit and reviewed by the provider or if there was one done within the year. Also not sure of the Documentation and F/U of missed appointments, what exactly we need to look for? Dr Vasquez had a few visits that he didn't document that he reviewed the problem and med lists, not sure what happened there. I see we need to be more vigilant on getting patients to do their Health Questionnaires prior to seeing the provider so they can review them at the time of visit and address any relevant findings.

With the new update of E.H.R. we are all trying our best to navigate through it and so I expect there will be more errors on the next report.

Findings:

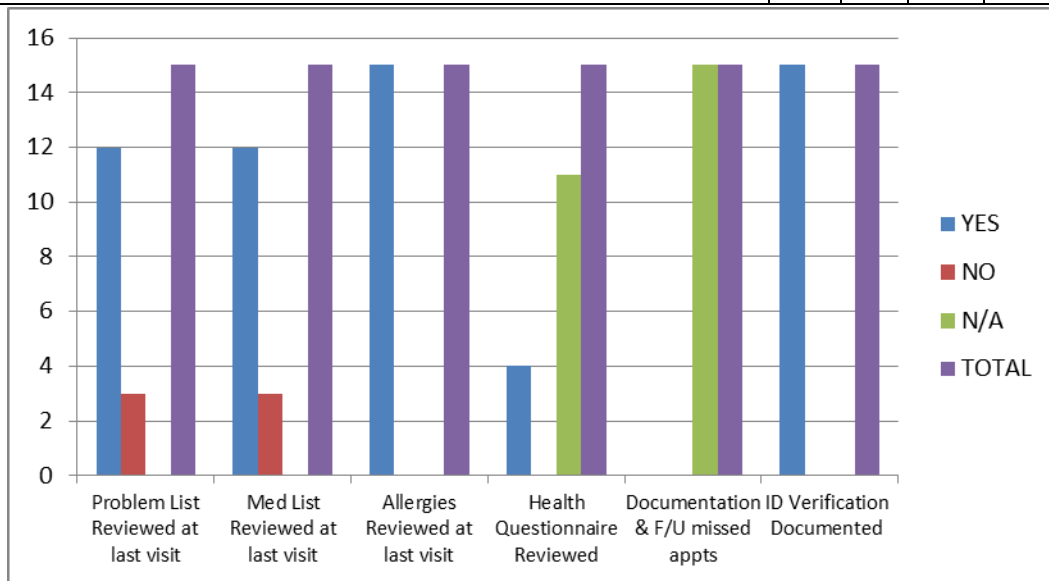
Dr Vasquez had 3 patient visits that he didn't review any of the Problem List, Medications or Allergies, these seemed to be during the month of July when he was also covering for Dr Milton at the Yreka Clinic.

Chelsea's Medical Assistant missed documenting ID Verificaiton, Vitals and verifying an order correctly, I did not look to see who it was or when and why it failed to happen.

After compiling the data I had to ask Nick Hillman to do the graphs for this report, hopefully we will have our Medical Records Clerk Position filled by the time the next report is due.

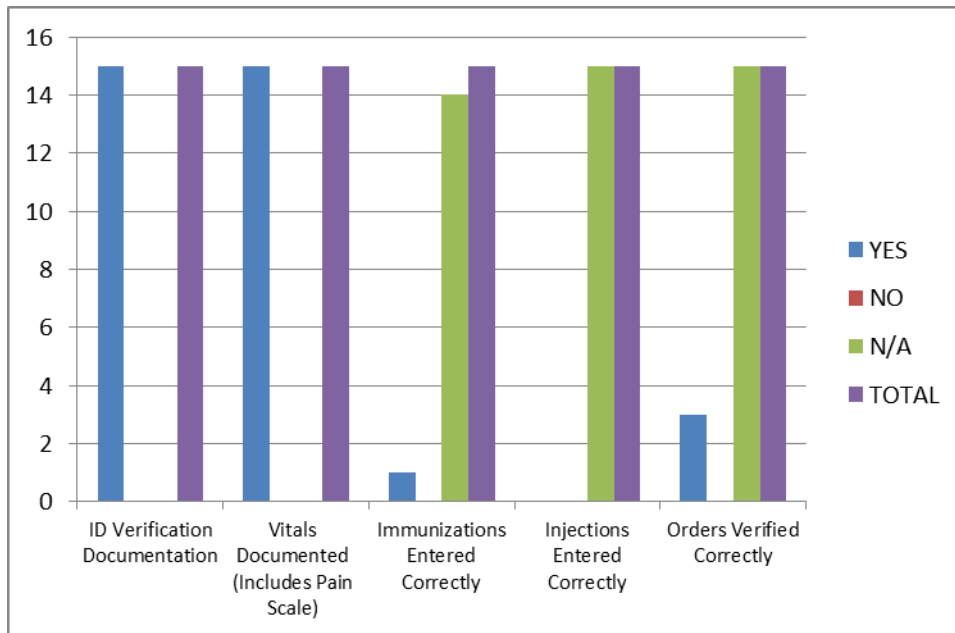
Dr Vasquez Record Audit

Dr Vasquez Record Audit	YES	NO	N/A	TOTAL
Problem List Reviewed at last visit	12	3	0	15
Med List Reviewed at last visit	12	3	0	15
Allergies Reviewed at last visit	15	0	0	15
Health Questionnaire Reviewed	4	0	11	15
Documentation & F/U missed appts	0	0	15	15
ID Verification Documented	15	0	0	15



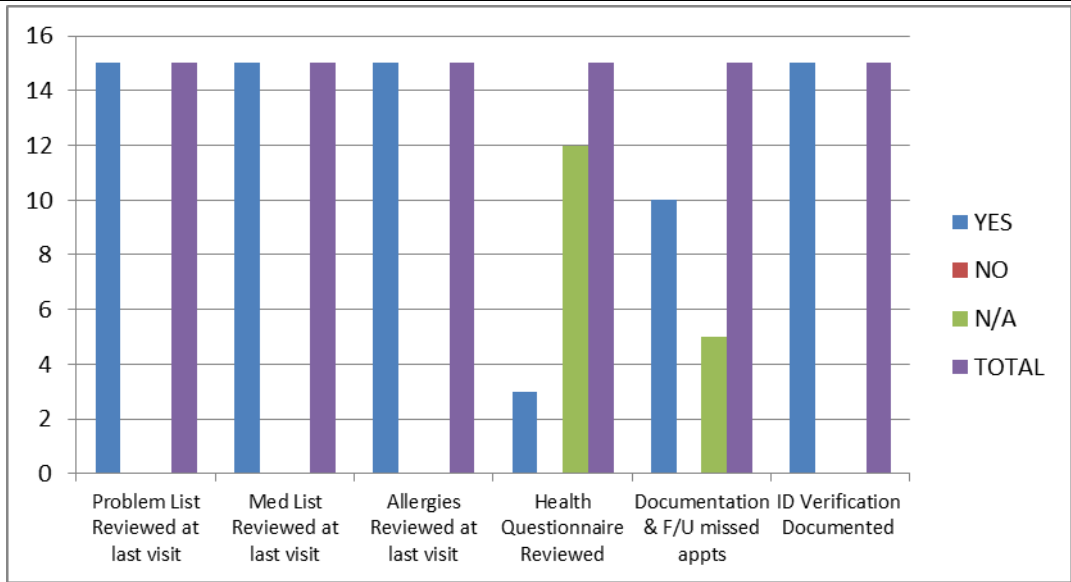
Nurses/Medical Assistants Audit

Nurses/Medical Assistants Audit	YES	NO	N/A	TOTAL
ID Verification Documentation	15	0	0	15
Vitals Documented (Includes Pain Scale)	15	0	0	15
Immunizations Entered Correctly	1	0	14	15
Injections Entered Correctly	0	0	15	15
Orders Verified Correctly	3	0	15	15



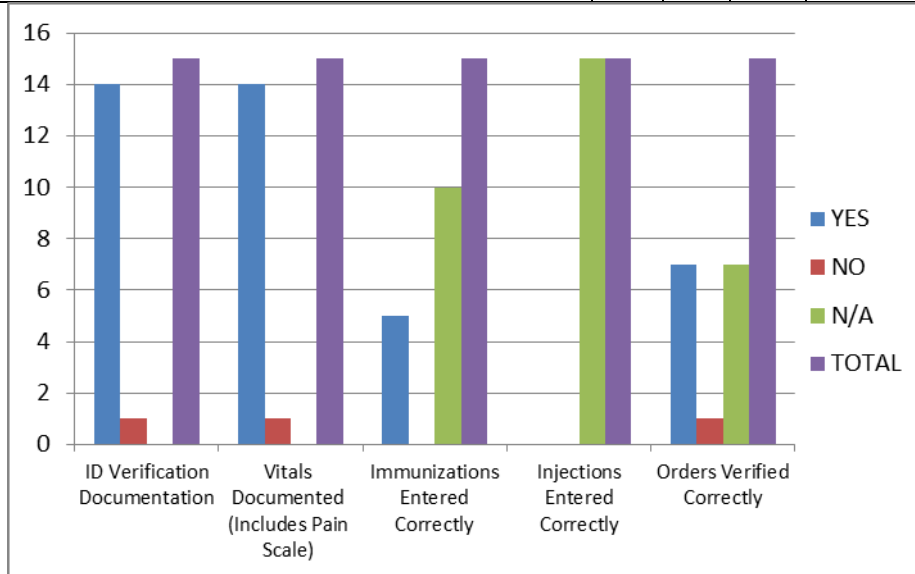
Chelsea Chambers, PA-C Record Audit

Chelsea Chambers, PA-C Record Audit	YES	NO	N/A	TOTAL
Problem List Reviewed at last visit	15	0	0	15
Med List Reviewed at last visit	15	0	0	15
Allergies Reviewed at last visit	15	0	0	15
Health Questionnaire Reviewed	3	0	12	15
Documentation & F/U missed appts	10	0	5	15
ID Verification Documented	15	0	0	15



Nurses/Medical Assistants Audit

Nurses/Medical Assistants Audit	YES	NO	N/A	TOTAL
ID Verification Documentation	14	1	0	15
Vitals Documented (Includes Pain Scale)	14	1	0	15
Immunizations Entered Correctly	5	0	10	15
Injections Entered Correctly	0	0	15	15
Orders Verified Correctly	7	1	7	15



Communication:

These findings will be shared with the AQCI Committee, the staff at Karuk Community Health Clinic as well as the Karuk Tribe Health Board.

Respectfully Submitted by

Susanna Greeno,

Clinic Supervisor/Medical Assistant

1-14-15

Karuk Tribe



**Karuk Tribal Health & Human Services Program
ACQI Committee Meeting/Conference Call
KCHC Teleconference Room
January 14, 2015**

Minutes

1. The meeting was called to order at 9:02 am by Rondi Johnson.

2. Attendance:

Happy Camp: Vickie Simmons, Patti White, Vickie Walden, Dr. Brassea, Suzanna Hardenburger, Elsa Goodwin, Debbie Bickford, Cheryl Asman, Chelsea Chambers, Lessie Aubrey, and Rondi Johnson

Yreka: Amy Coapman, Chris Rotin, Susan Beatty, and Dr. Millington

Orleans: none

3. Motion was made by Vickie Walden and seconded by Patti White to approve the agenda with the following changes: No Partnership report today as per email from Amy (5.5), also table Jennifer Jones report (5.6).

4. Motion made by Vickie Walden and seconded by Chelsea Chambers to approve the Minutes of December 10, 2014 with changes: per Vickie Simmons – Item # 6 3rd bullet point, please strike comment that “immunizations are horrible”. Abstain: Cheryl Asman, Patti White, Suzanna Hardenburger, and Elsa Goodwin

5. Performance improvement Reports Due:

5.1. BMI (Patti White)

- 7/1/2014 – 9/30/2014 (3rd qtr report) total of 888 patients with BMI over 30.
- 1184 Patients with BMI over 30, comparison in # 6, up to 9/30/2014, we are about 5% below last year.
- Compare to visits, 2013 3,000 medical patients with visits, only 1,414 had BMI. After 9/30/2014, 2774 patients, already 2481 have had BMI done, so # has increased. This is big improvement. Staff doing more, will help with this report. Reports on patients seen and how many had BMI done.

5.2 HIV/AIDS (Chris Rotin)

- Last quarter, saw 19 HIV clients, which included 5 female, 13 male, and one transgender from male to female. Also one in Oregon, hard to get here for appointments.
- All 19 are on ART regiment, 2 new to program, one new diagnosis, 1 repeat, 16 out of 19 are non-detectable (which is the goal). This makes it less possible to spread disease.
- All had high CD4 count. One full blown AIDS case, all others had good CD4 levels.

- Screening: Osteoporosis for Vitamin D, level down without HIV meds, so all are on a Vitamin D supplementation.
- 2014 15/19 received flu shots. The other 4 did not get shot or did not report getting the shot.
- HEP C – Partnership covers meds.
- Please see written report for more information.

5.3 Yreka Dental Records (Susan Beatty)

- See attached notes sent this morning. Training will help increase the numbers.
- Taking BP is not consistent.
- Vickie W. suggested need to have staff meeting to review chart information needed, should be holding once per month. Yreka is not holding staff meetings at this time.
- Patti mentioned that working with Dentrix could resolve problems. All meds and allergies are not on the list. Need a “maintenance person” to work on adding the ones missing.

5.4 Happy Camp Dental Records (Cheryl Asman)

- Lessie requested Cheryl add Happy Camp to the title of her report and Vickie Walden requested she also put page numbers on it.
- Cheryl happy to report they are back to 100%. There were some hygiene issues, medical histories needing to be reviewed and updated by hygienists.
- Lessie also requested that a method be developed for both clinics, so they are doing everything the same way.
- Cheryl requested help on learning how to make graphs to be included in her report, willing to learn.

5.4 Partnership (Amy Coapman)

- A Patient Satisfaction Survey for 2014 was sent out a few weeks ago, but has gotten no responses. Rondi stated she has the results. These need to be to Partnership by the 31st. Questions such as: Ease of access? Follow-Up Phone calls, after hours, waiting room experience, would they recommend ? These need to include goals as well by the 31st of January. Rondi asked if they need to be site specific, to which Amy responded “yes”, both Medical and Dental. Amy noted also need Operations Data. Last year received money last year for this (Medical only) information.

6.GPRA Reports (Vickie Simmons – see attached report)

- Please see written report.
- We are half way through the GPRA year. We still have 6 months to get our numbers up. NA (Native American) patients from all three communities are included in these reports.
- End of 2nd Qtr, 2015 :
 - Diabetes /Retinopathy – improvement goal for Diabetic grant. Diabetic audit year has ended, will be submitted March 16. Referrals? And see if results have been entered in the right spot to improve numbers ??
 - Influenza shot for 55+, but this year, everyone 6 mnths and older should get flu shot. Webinar this morning – IHS going over flu shots and anti-viral shot. (TAMIFLU info)
 - Pap Smears at about 50%, okay.
 - Mammography should be able to meet goal.
 - Colon Rectal Screen numbers are on target.
 - Smoke Cessation (noted as smoker and we gave them cessation information) numbers are low. Client must come in during GPRA year. Some may not be coming in – GPRA considers one visit in 2 years, to be active.
 - Vickie W commented Dental Code also includes Smoke Cessation and Counseling and that it should be added to Staff Agenda and also that we need to come up with a plan to improve our low numbers.

- GPRA and HRSA have different requirements. Some numbers are low but we are making progress.
- Lessie requested that Vickie S meet with providers to see what we need. They may have suggestions and give good feedback. Could be a phone call.

7. New Business –

7.1. Complaints / Incidents/ Suggestions (Rondi Johnson)

- The only complaints have been the waiting time to see providers.
- There was an incident in Orleans when the door would not open with a key. Also, a gentleman ran into the curb with his car, nothing major.
- Vickie: Our new CEO will join us on Feb. 5. His name is Raul Rakari and will operate from Yreka. Experience with Health Exchange in Illinois and Missouri, and also hospital administration.
- Elsa – what happened with Yreka clinic with heating system? Lessie said they are working on it now. A wire was in backwards but they are in process of taking care of situation. Also ducts and missing filter, but is starting to warm up now (per Susan).
- Patti after certified EHR patch, how much work Amy has done. Trying week for both. Patti did pre-install stuff, she spent the weekend getting the clinic ready for Monday. Kudos from Rondi for all the extra work during transition!

8. Old Business (tabled)

Next meeting is Wed, Feb. 11, 2014 at 9:00 am. Motion to adjourn the meeting at 10:02 am was made by Vickie W and seconded by Lessie.

KARUK TRIBAL HEALTH CLINIC
Orleans Clinic-Medical Records Report
(CHARTS PULLED- Oct., Nov., Dec. 2014)
Meeting Date 02/11/2015

PURPOSE of Study:

Identify areas for improvement in the Electronic Health Records Management and documentation processes.

GOALS of this Performance Improvement Study:

Description Data:

Evidence of Data for Oct., Nov., and Dec. 2014

DATA Analysis: See attached Graphs

Comparison

Implementation of Corrective Actions to Resolve

Re-measure

Implementation of additional Corrective Actions if Performance Goals re not met

Communication of Governing Body:

Submitted by:
Babbie Peterson
Clinic Manager
February 11, 2015

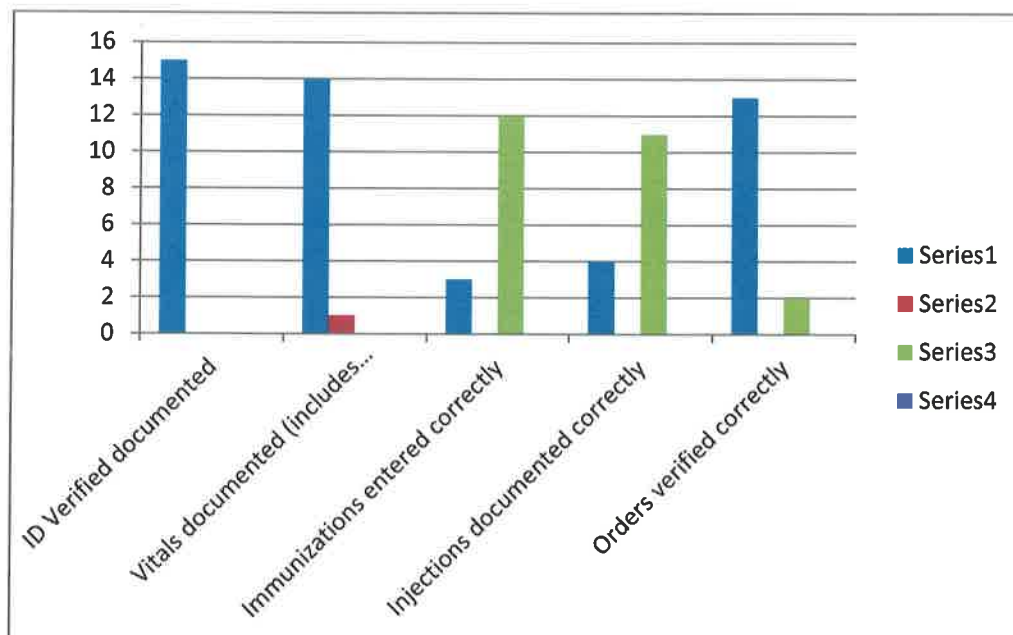
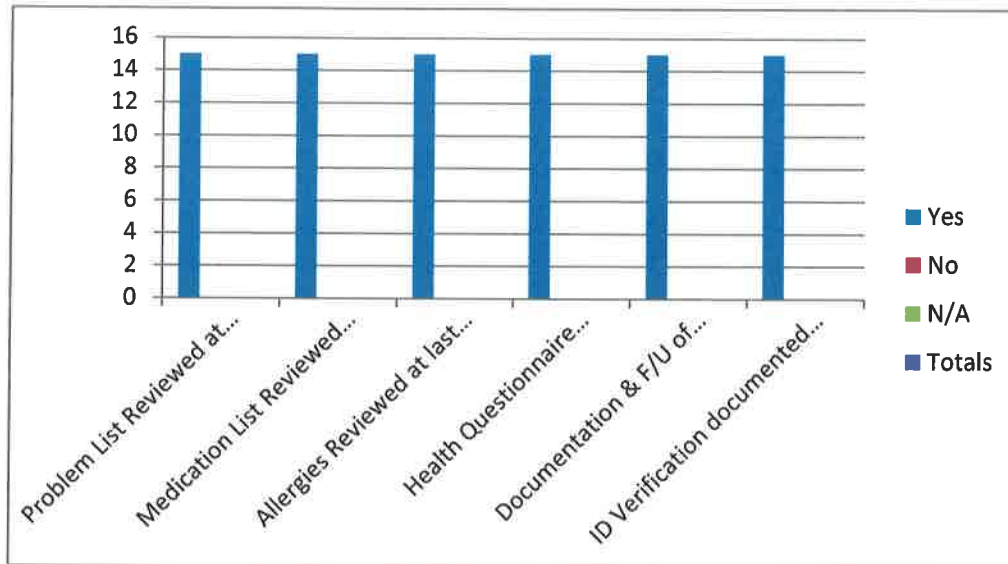
Dr. Chuck Colas, D.O.
Record

	Yes	No	N/A	Totals
Problem List Reviewed at last visit	15			
Medication List Reviewed at last visit	15			
Allergies Reviewed at last visit	15			
Health Questionnaire Reviewed	15			
Documentation & F/U of missed appts	15			
ID Verification documented by provider	15			

Nurses/Medical Assistants

	Yes	No	N/A	Totals
ID Verified documented	15			
Vitals documented (includes pain scale)	14	1		
Immunizations entered correctly	3		12	
Injections documented correctly	4		11	
Orders verified correctly	13		2	

October, November, December 2014
Orleans Clinic



OCTOBER, NOVEMBER, DECEMBER 2014
ORLEANS Clinic

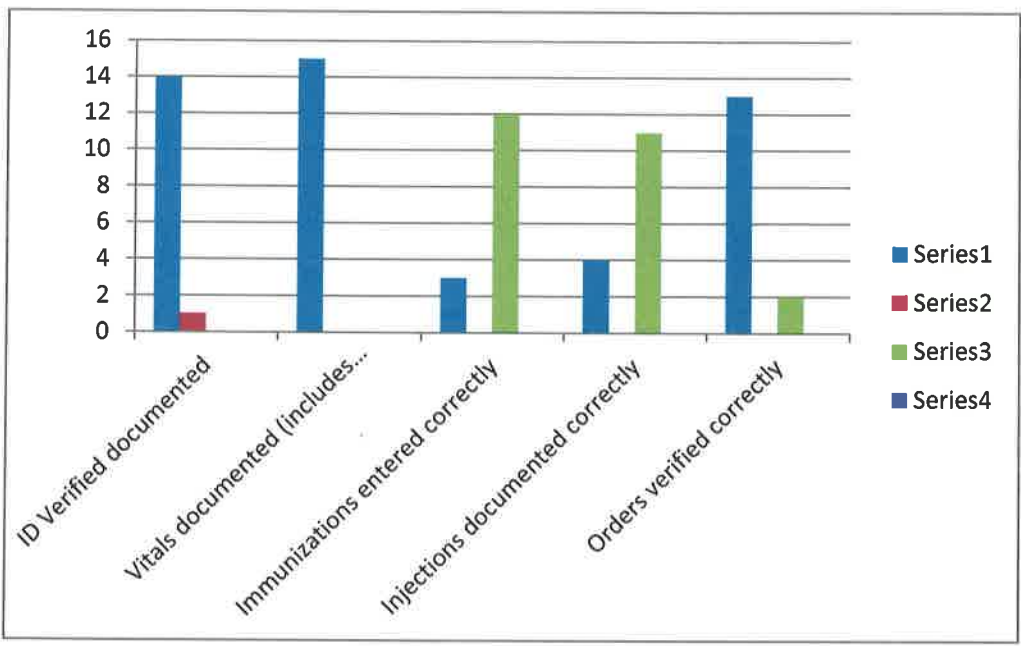
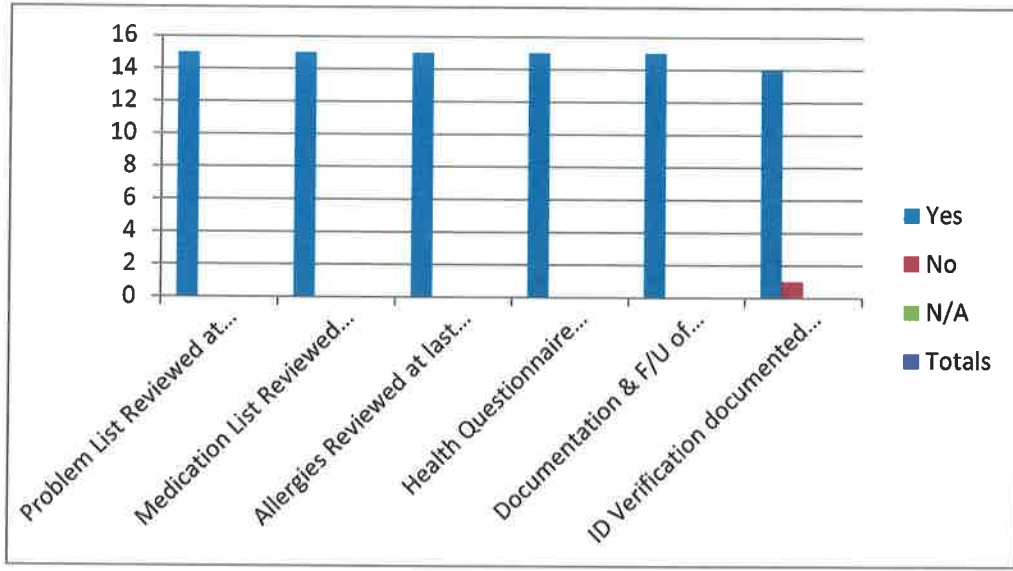
Dr. Chuck Colas, D.O.
Record

	Yes	No	N/A	Totals
Problem List Reviewed at last visit	15			
Medication List Reviewed at last visit	15			
Allergies Reviewed at last visit	15			
Health Questionnaire Reviewed	15			
Documentation & F/U of missed appts	15			
ID Verification documented by provider	14	1		

Nurses/Medical Assistants

	Yes	No	N/A	Totals
ID Verified documented	14	1		
Vitals documented (includes pain scale)	15			
Immunizations entered correctly	3		12	
Injections documented correctly	4		11	
Orders verified correctly	13		2	

3rd Quarter 2014
ORleans Clinic



3rd Quarter 2014
 Orleans Clinic

Karuk Tribal Health Program

ACQI Report, February 2015

EHR Clinical Reminders

Providers Report

Purpose:

To improve the consistency of use and awareness of EHR health reminders which will result in improved quality of care.

Goals and Objectives:

We are currently following six (6) EHR reminders for our Providers. The goal is to select several of the reminders with the highest level of non-performance. The reminders we are tracking are as follows; Colon Cancer, Mammogram 40-49, Mammogram 50-74, Mammogram 75-100, Pap smear 21-29, and Pap smear 30-65.

For the purpose of this report we will be addressing the three reminders that are the most significant in need of improvement. These three are; Colon CA, Mammogram 40-49 and Mammogram 50-74.

Colon Ca screenings average 17% overall. With the lowest % resolved at 9% and the highest % resolved at 35%.

Mammogram 40-49 screenings average 45% overall. With the lowest % resolved at 30% and the highest % resolved at 71%.

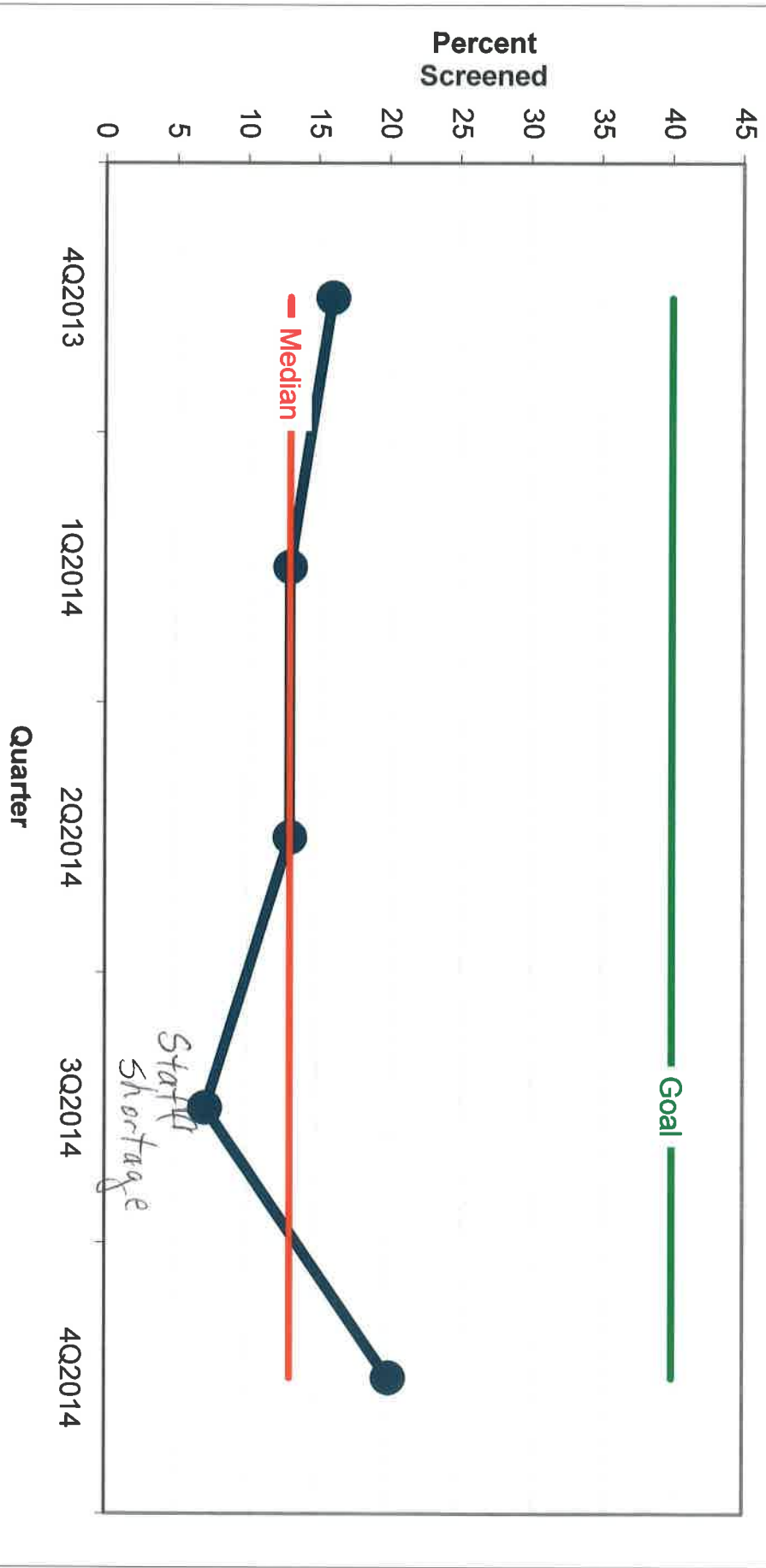
Mammogram 50-74 screenings average 46% overall. With the lowest % resolved at 36% and the highest % resolved at 56%.

All other providers were either unimproved or stayed the same. The difference was from Happy Camp and Dr. Milton, calling the patients to secure patient compliance was done. In the case of all three providers the increase was three fold.

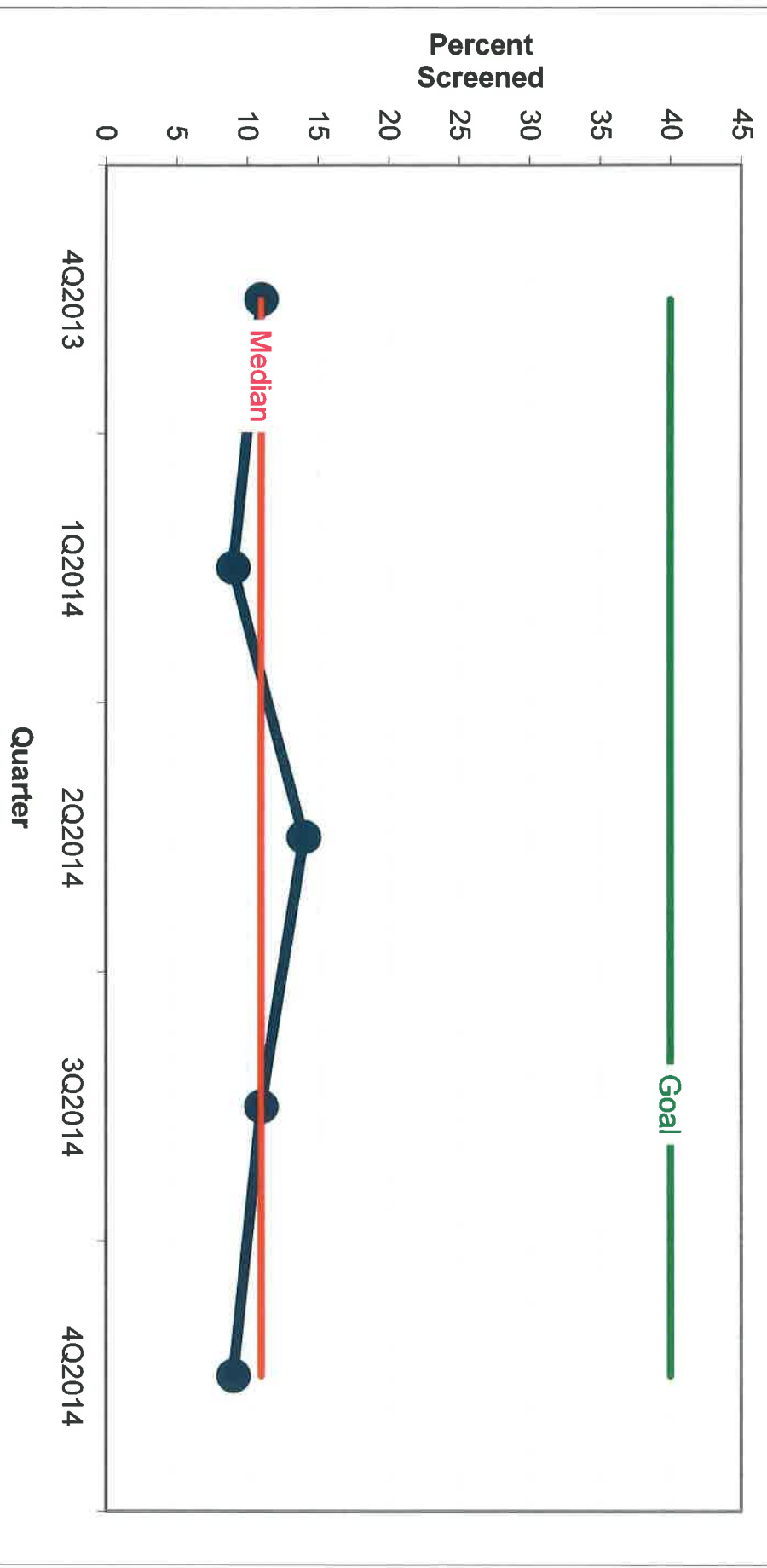
The plan:

Continue the calling plan for all of our Providers in the system. The significant increase in these outcomes was clear. We will recheck the statistics in 3 months on all providers. We have stats on all the other providers but they have not been here long enough to get a good picture. Staffing issues of critical support staff also directly affected the screening results.

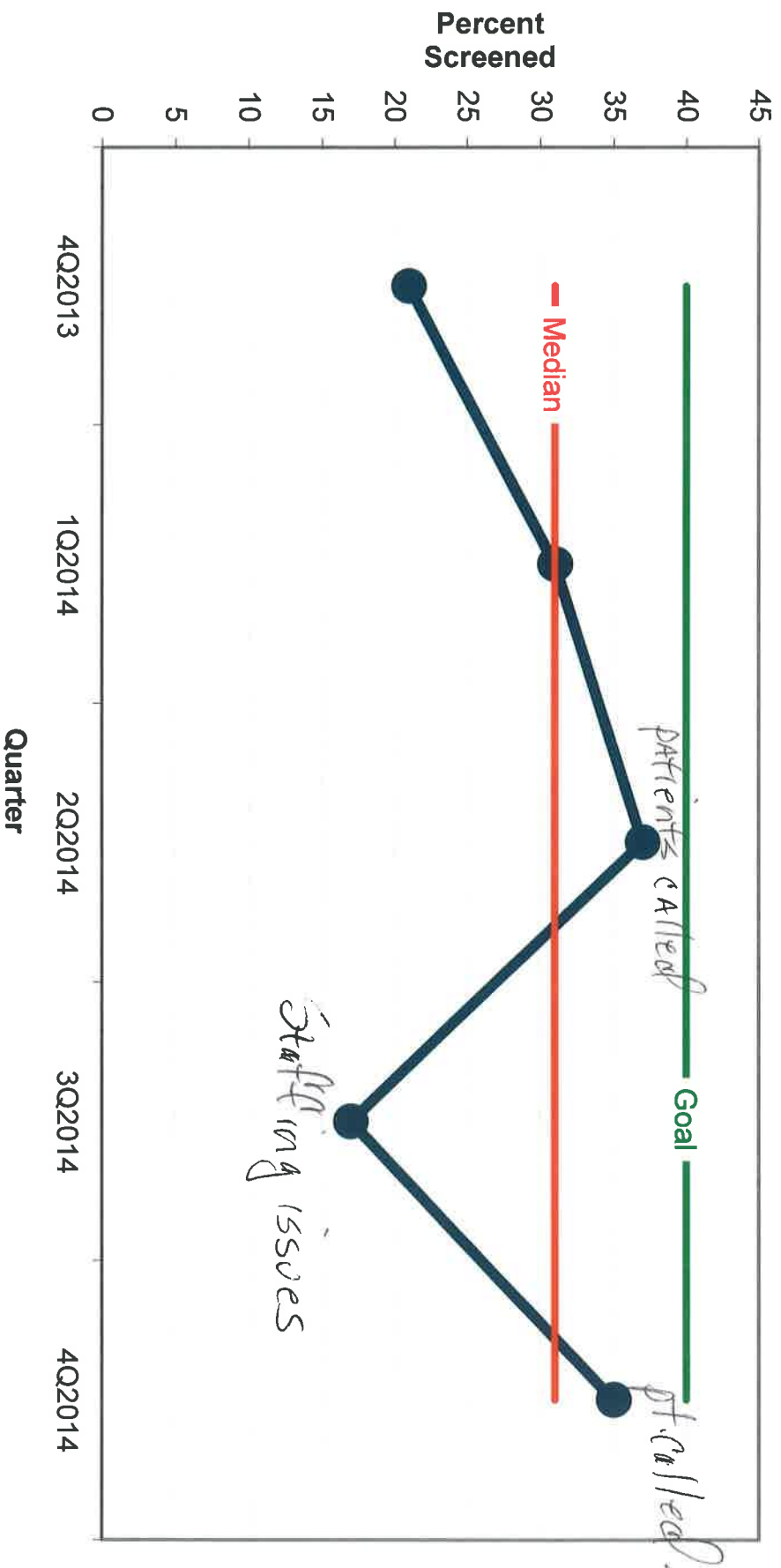
Colon Cancer Screening - Milton



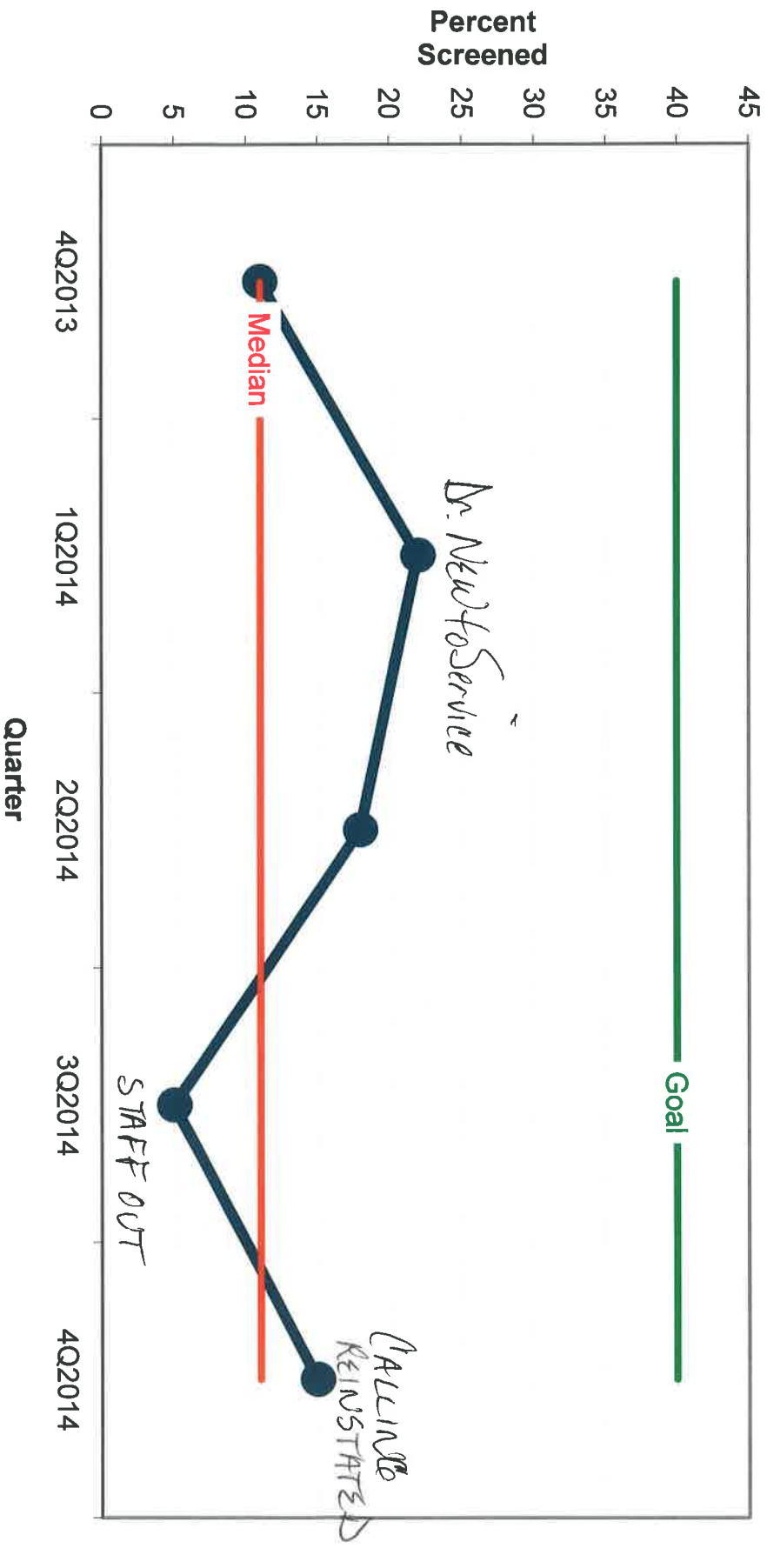
Colon Cancer Screening - North



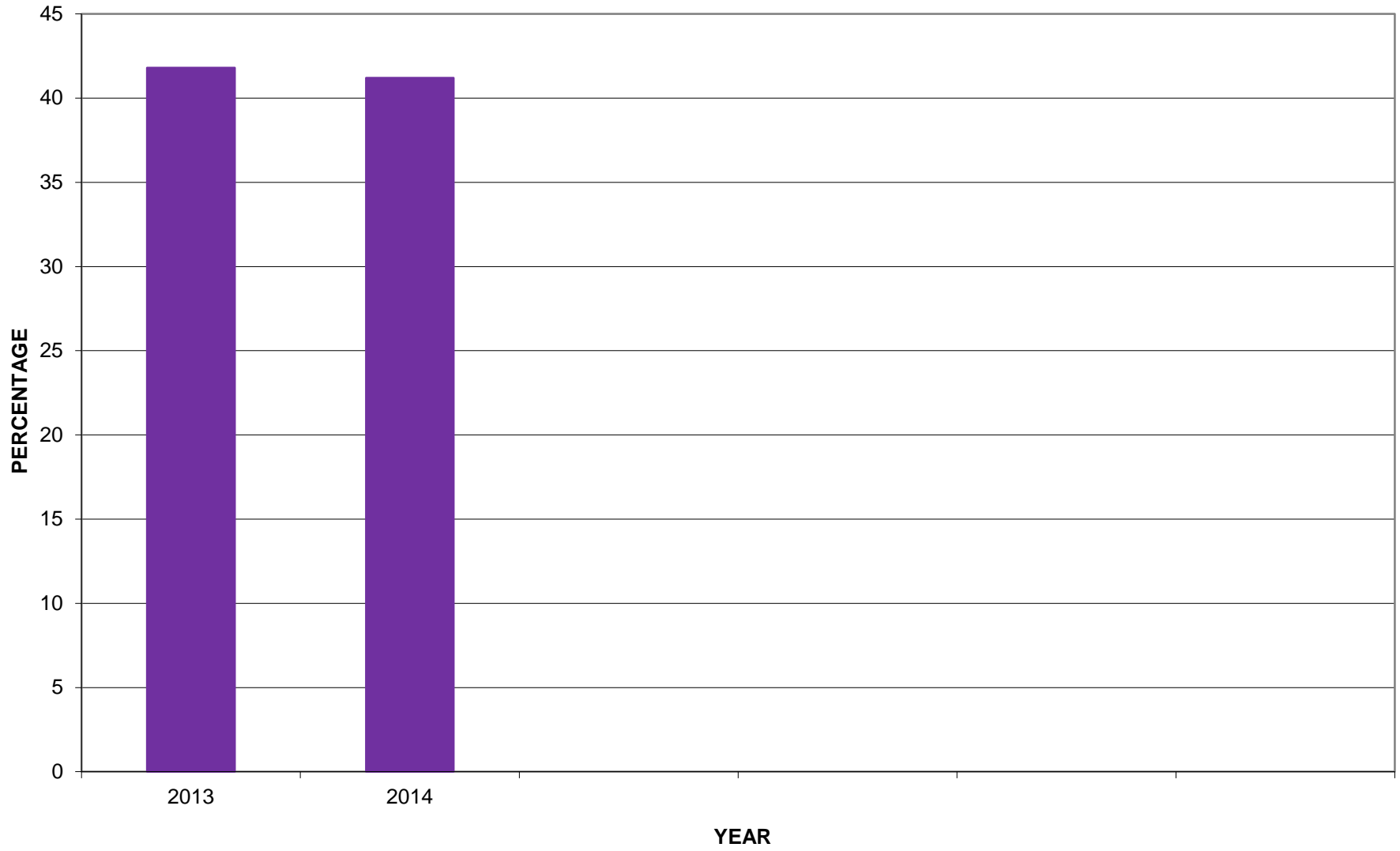
Colon Cancer Screening - Chambers



Colon Cancer Screening - Vasquez



UDS: KARUK PAP SMEAR RATES



KARUK TRIBAL HEALTH AND HUMAN SERVICES PROGRAM

November 6, 2014

Major Change to CQI Project in 2013

Pap Smear Rates: Will increase by 2% per year for women 24 to 64 years of age

I. Purpose of Study

The purpose of this performance improvement project is to increase by 2% per year the number of women who receive a Pap smear once every three years or in the case of women age 30 to 64 years every five years if accompanied by an HPV test. This is a HRSA goal (for all women **ages 24 to 64**). See attached.

II. Identification of the Performance Goal

The goal is to increase our UDS Cervical Cancer Screening results by 2% each year. Past data indicates that this may be possible. However, the 2013 Cervical Cancer Screening Measure has changed and so 2013 will be our baseline year.

Past Data: The UDS report for 2008 indicated that 36% (**41.5% in 2009, 45.2% in 2010, 53.2% in 2011, 48.6% in 2012, 41.8% in 2013 and 41.2% in 2014**) of our female population received a pap smear. The Karuk Tribal Health and Human Services (KTHHSP) program serviced 935 (**853 in 2009, 757 in 2010, 767 in 2011, 771 in 2013, 780 in 2014**) female patients between the ages of 24 and 64 in 2008. A Pap test can save a woman's life. Pap tests can find the earliest signs of cervical cancer. If caught early, the chance of curing cervical cancer is very high. Pap tests also can find infections and abnormal cervical cells that can turn into cancer cells. Treatment can prevent most cases of cervical cancer from developing.

Getting regular Pap tests is one service KTHHSP providers can do for our female patients to prevent cervical cancer. In fact, regular Pap tests have led to a major decline in the number of cervical cancer cases and deaths.

III. Description of the Data

The baseline data for this performance improvement project will be taken from the 2013 final UDS Report.

IV. Evidence of Data Collection

We will use 2013 data as our baseline for future reports. The KTHHSP computer system has the capability of monitoring Pap test data. The program will use the UDS report data to track our Pap smear rates.

V. Data Analysis

We will use the 2013 result of 41.8% as our baseline for future reports.

VI. Comparison of Current Performance Against Performance Goal

Patti White pulled a 2014 UDS report. Our Pap rate was **41.2%**. Our 2013 baseline was 41.8%. We did not meet our goal of a 2% increase, in fact, we decreased by 0.6%.

VII. Implementation of Corrective Actions to Resolve Identified Problem

The following key steps will be instituted with the intended result that our Pap smear rates will increase by 2% per year

- Define when pap smears are due (i.e. every three years or every 5) and define parameters for providers.
- Identify women needing Paps. (**EHR reminders, lists, WH package**)
- Contact patients in need of Paps by phone/letter to schedule appointment during Pap clinics.
- Update the list of women who have had hysterectomies.
- Send out letters explaining the importance of cancer screens and offering incentives to women who are compliant each year; small non-coercive incentives. Begin as soon as possible.

VIII. Re-Measurement

At the designated re-measurement time, repeat steps IV and V. Compare the results of the second round of data collection and analysis to the performance goal identified in step II, and determine whether the corrective actions have achieved the desired performance goal.

IX. Implementation of Additional Corrective Actions if Performance Goals Not Met

If the initial corrective actions did not achieve and/or sustain the desired improvement in performance, implementation of additional corrective actions and continued re-measurement will be instituted until the problem is resolved.

X. Communication to Governing Body

All performance improvement projects are reported monthly to our ACQI Committee and to the Tribal Council.

Respectfully Submitted by Vickie Simmons

Karuk Tribal Health Program
Performance Improvement Activity
Progress Report
01/14/2014

Title: Influenza report

Purpose/Problem: The purpose of this study is to keep accurate data on the Influenza vaccine. The current population served, current numbers of patients receiving the influenza vaccine within our clinics. Explaining the available options in the service area. The establishment of continuous quality improvement.

Explain: Reports from RPMS show we have increased the numbers of patients getting vaccines from our clinics. We have given a total 957 out of a population of 3,527 active patients, Influenza vaccine this flu year. We have had a total of 133 patients refuse the influenza vaccine this year. These patients are asked if they would like it at every visit.

Objective(s)/ Goals: We are implementing ways to raise awareness in the community about the Influenza, to track patients within our service area, documenting when and where they receive their Influenza immunizations, in some instances we get notification from local pharmacies. We were able to distribute information to the patients in our service area. Presenting different options in helping the patient make the decision of their health care needs. Come up with a plan for flu clinics, transportation for elders and disabled. Making room on the schedule's for walk-in flu shots.

Plan for the whole community.

Determine:

1. We ask each patient if they would like the Influenza vaccine at the time of the visit. We then document if they receive it from our clinics, at another facility, and if they refuse the flu shot and why.
2. We give pamphlets and handouts on the Influenza Vaccine. We also verbally inform the patient about the vaccine. We hope to encourage the flu shot by holding a random drawing every month for \$25.00. We informed the community at our annual health fair, in hopes to raise awareness. In connection we did a random drawing for thermometer and distributed hand sanitizer.
3. We have received supplemental vaccines from VFC and have traded between clinics to ensure that every patient who wants an immunization can receive one.

Data: We have gathered baseline data from all three clinics: log sheets, Electronic Health Record, RPMS, Siskiyou County Public Health, Family Resource Center and the patients themselves. We will collect and store all data on Influenza Immunizations in a central location so that it may be accessed by those who need it. Study and find out what

are the problems associated with getting Influenza immunizations in the communities. Availability of the Influenza vaccine and procurement.

B. We order all Influenza based on statistics from the prior year. We adjust and order what we think we will need for the year and then reorder if additional is needed.

C. We have received all information requested from the clinics. Each clinic inputs all data, where the vaccine came from, lot numbers, expiration dates. This is all put into RPMS.

Evidence of Data Collection

The data will be taken from past years 2010 through present. We will develop a program to enter all Influenza information into. We will then track our patients to find when and where they receive the influenza shot and if not why. We will track all data including barriers such years with limited supplies, short expiration dates etc. We will analyze all data for quarterly reports to present to the committee

Re-measure: What are the problems and what do we do to change them. Implement new processes, procedures. Run reports for comparison with last report to determine if goals are being met and implemented.

Additional Corrective Action Audit information will be reevaluated on a quarterly basis with any changes or problems, exposed and corrected. Performance goals will be set and reevaluated at quarterly audits. Determine if plan is working are we seeing results.

Communication: Communication findings of each quarter's data to ACQI. This information will then be shared with the Karuk Tribal Health Board via Clinical Administrator.

Respectfully Submitted by Jennifer Jones



**Karuk Tribal Health Board Report
For March 12, 2015 Meeting**



Dental Department February 2015 Report

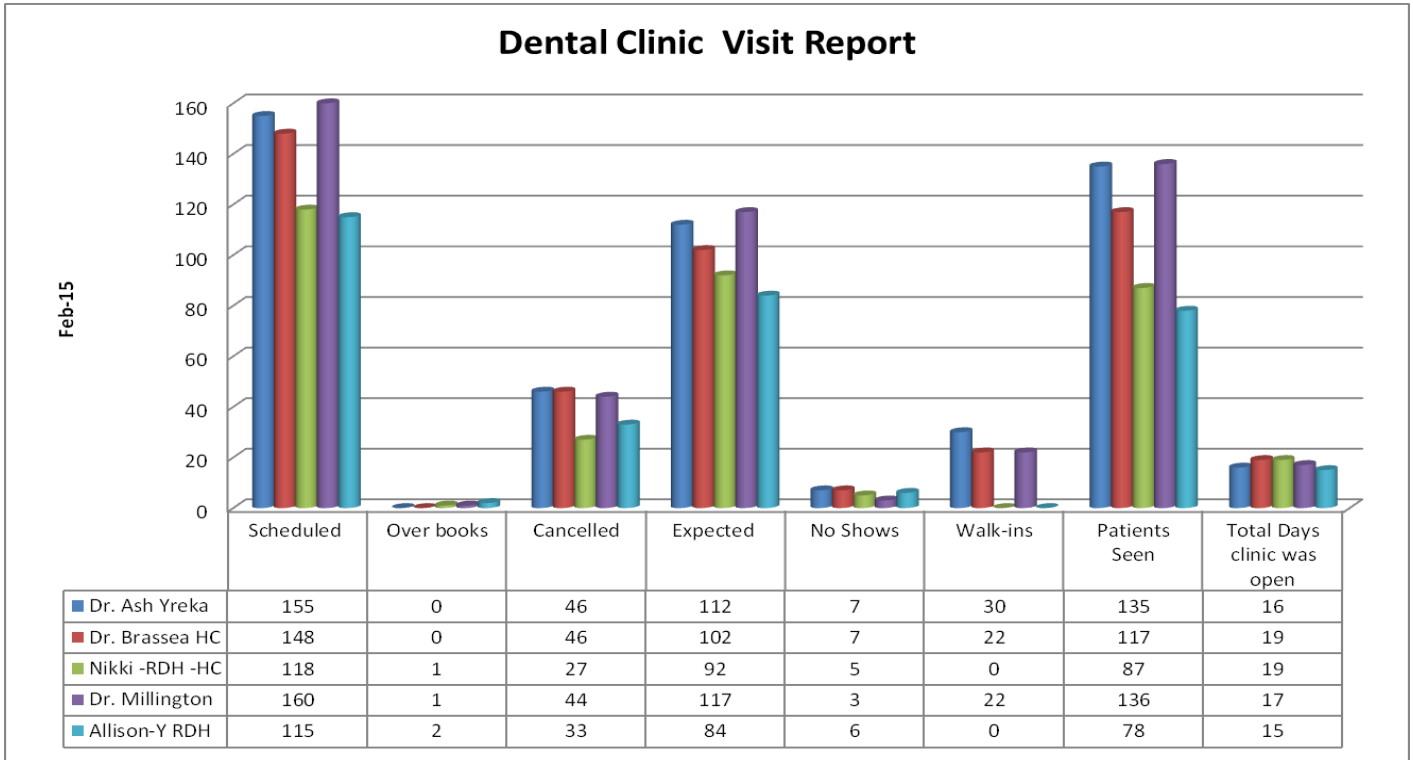
1. Staffing Updates
 - a. We have hired a third dentist for the Yreka Clinic. Dr. Benjamin Jeffries DDS will start at the Yreka Dental Clinic in March 4, 2015.
 - b. Start date for Bridget Koons DA at the Happy Camp dental Clinic was March 2, 2015.
 - c. Yreka DA Kayla Bridwell withdrew her resignation and will continue working as a DA at the Yreka Dental Clinic.
2. Dental Department Activities
 - a. We have started conducting our dental provider peer reviews.
 - b. Dental Training 2015.
 - i. In order to get their CE units some of the Dental staff will need to attend one of these conferences:
 1. The Annual I.H.S Dental Conference is scheduled for May 11th, 12th, 13th, and 14th. This year they are offering 30+ Continuing Education units for dental staff.
 2. The California Dental Association's conference in Anaheim CA is being held April 30 through May 2nd.

3. Dental Budget Report

- Follow-up on HRSA Budget fiscal coding errors -According to The HRSA Dental budget EE & A report line items are spent. I sent out an email to all the dental staff that we were out of funds and could no longer offer some dental procedures under our discount program. Vickie Walden just finished her review of the HRSA EE&A's and PO Requests. She has made recommendations for fiscal coding corrections and will be handing this project over to fiscal staff so they can adjust the funding account codes.
- **I.H.S. 3000-41 Yreka Dental – Budget Appropriations** **\$ 1,150,028.54**
 - Year to Date Expenditures \$ 227,15.12
 - Outstanding Encumbrances \$ 590.29
 - Unencumbered Balance \$ 922,323.13 19.80% Used
- **I.H.S. 3000-42 Happy Camp – Budget Appropriations** **\$ 648,960.38**
 - Year to Date Expenditures \$ 207,304.48
 - Outstanding Encumbrances \$ 115.16
 - Unencumbered Balance \$ 441,540.74 31.96% Used
- **Third Party 3900-00-7600.00 Dental Lab Indian – Budget Appropriations** **\$ 120,000.00**
 - Year to Date Expenditures \$ 26,141.77
 - Outstanding Encumbrances \$ 18,546.27
 - Unencumbered Balance \$ 75,311.96 37.24% Used
- **Third Party 3900-00-7606.06 Yreka Dental Supplies Budget Appropriations** **\$ 75, 000.00**
 - Year to Date Expenditures \$ 12,659.30
 - Outstanding Encumbrances \$ 7,402.12
 - Unencumbered Balance \$ 54,938.58 26.75% Used
- **Third Party 3900-00-7606.07 HC Dental Supplies Budget Appropriations** **\$25,000.00**
 - Year to Date Expenditures \$ 4,211.36
 - Outstanding Encumbrances \$ 98.80
 - Unencumbered Balance \$ 20, 689.84 17.24% Used
- **Third Party 3900-00-7601.00 Dental Lab Non-Indian– Budget Appropriations** **\$12,000.00**

▪ Year to Date Expenditures	\$ 4,716.75	
▪ Outstanding Encumbrances	\$ 2,368.36	
▪ Unencumbered Balance	\$ 4,914.89	59.04% Used

1. Dental Clinic Visit Report for February 2015. Data Taken from the RPMS Scheduling Package Work Load Report Patients Scheduled vs. Patients Seen.



Report Respectfully Submitted by Vickie Walden RDA on March 3, 2015

BEHAVIORAL HEALTH PROGRAMS

- Karuk Mental Health (Clinical Social Work) Services (BIA/HRSA/Billing)
- Karuk Substance Abuse Program (KSAP) (Calworks;BIA;HRSA/Fees)
 - Karuk Batterers Intervention Program (BIP) (non AOD/non Health)
 - Karuk Driving Under the Influence Program (DUI)(non AOD/non Health)

STANDING SCHEDULE

Mondays I am in Yreka and working with Tanya Busby pertaining to Judicial System and Programs and we travel to Hoopa/Orleans on the second Monday of each month.

I check in with Behavioral Health Office staff in Yreka 7:50-8:30 and am available by phone and email as needed.

Tuesdays and Thursdays *usually* find me scheduled to be in Happy Camp and or Orleans.

The exception would be if a Council Meeting was scheduled to be in Yreka then I would remain in Yreka on that Thursday. (I am available to Behavioral Health Staff by phone or email as needed)

I have set aside the first Tuesday of each month for Judicial Staff Meeting (10:30-12:00) and Pikyav Advisory Meeting (12:00-1:30) in Happy Camp.

The second Tuesday of each month is set aside to attend the Yav Pa Anav Meeting 12:00-1:30 and the Child Welfare Services Program Staff Meetings from 2:00 p.m.-4:00 p.m.

Third Tuesday of each month 11:00-1:00 the ICW Committee Meetings are normally held in Happy Camp.

Health Board Meetings (CFS Department) are held at 3 PM each month (the second Thursday) with locations rotating each month.

Tribal Council Meetings (Judicial System and Programs) are held the fourth Thursday of every month at 3PM. The location rotates between Yreka, Happy Camp, and Orleans

PROGRAM UPDATES

Mental Health Services			
Clinic	Yreka	Happy Camp	Orleans
Mental Health	87	66	3
Psychiatry	6	3	2
Total	93	69	5

The Karuk Mental Health Program provided services to 167 individual community members during the month of February.

We have developed and sent for review and approval policies and procedures for the program as part of the AAAHC requirements for the Karuk Tribe Health and Human Services Department.

Our program continues to participate in Provide/Compliance Audit committee and the AAAHC Workgroup.

Clinical Supervision is also provided by our program for the Child Welfare Services Program Social Workers and Karuk Alcohol and Drug Program staff. We are working with April Attebury, Administrator to formalize internal agreements outlining these relationships.

A list of our clinic dates for our Mental Health staff is listed below:

Staff Member	Area	Day
Patricia Hobbs LCSW	Happy Camp	Tuesday
Patricia Hobbs LCSW	Orleans	Wednesday
Patricia Hobbs LCSW	Yreka	Monday, Thursday
Kareena Walter LCSW	Happy Camp	Wednesday, Thursday
Kareena Walter LCSW	Yreka	Tuesday, Friday

Karuk Substance Abuse Program/BIP and DUI Program

Board Report January 2015

AOD	Total Number of client for each area	BIP	Total Number of client for each area
Yreka	8	Yreka	18
Happy	8	Happy	0
Orleans	2	Orleans	1
Total Number of AOD clients 18		Total Number of BIP clients 19	

DUI	Total Number of client for each area
Yreka	2
Happy Camp	8
Total Number of DUI clients	10

Currently, the AOD/BIP/DUI staff travel down river two times a week:

1. Tuesdays, providing DUI and AOD services in Happy Camp and Orleans.

Cheryl Bearchild , AOD Counselor, provides services in Happy Camp and Angela Baxter, Program Coordinator/ BA, CADC II provide services in Orleans.

2. The Counselor Position for Down River remains vacant.

Budget Summary for AOD/Cal-Works Grant and BIP&DUI Revenues

<i>Program: DUI</i> <i>Term Dates: 10/1/2014 to 9/30/2015</i>	<i>Code</i>	<i>Budget Dependent upon revenues</i>	<i>Expended to Date</i>	<i>Balance</i>	<i>% Expended</i>
	6400-10				
<i>Program: BIP</i> <i>Term Dates: 10/1/2014 to 9/30/2015</i>	<i>Code</i>	<i>Budget Dependent upon revenues</i>	<i>Expended to Date</i>	<i>Balance</i>	<i>% Expended</i>
	6400-05				
<i>Program: CAL Works</i> <i>Term Dates: 7/1/2014 to 6/30/2015</i>	<i>Code</i>	<i>Budget</i>	<i>Expended to Date</i>	<i>Balance</i>	<i>% Expended</i>
	6400.15	\$53,950.00	\$23,669.38	\$30,280.62	44%

SEEKING APPROVAL OF THE ATTACHED
POLICIES AND PROCEDURES

Child and Family Services

Behavioral Health Services

Purpose. Behavioral health services are provided or made available to meet the needs of tribal and community clients living within our service area or for American Indians and Alaska Natives (AI/AN) individual who are eligible for direct care services at our clinic.

Background. American Indians and Alaska Natives have a long and fruitful history of supporting emotionally healthy behaviors and defining emotionally deviant behaviors. This body of knowledge will be used in a cooperative and integrative manner with Western attitudes and practices as is consistent with the unique belief systems of the various tribes and the specific amalgam of belief systems of the individuals and families with whom the Karuk Tribe Behavioral Health staff comes into contact.

Goal. The goal of Karuk Tribe Behavioral Health Department is to promote, provide, and manage a comprehensive system of behavioral health services which offer American Indian and Alaska Natives and community members registered at our clinic sites a diverse range of culturally sensitive services at all levels of mental health needs.

Objectives. The Karuk Tribe behavioral health program is an integral part of the total health care system. The objectives of the Karuk Tribe behavioral health program are:

1. To offer a range of clinical and community behavioral health services.
2. To promote positive behavioral health services including efforts aimed at primary prevention of mental and emotional disorders.
3. To promote broad social and health goals to enhance the emotional security of AI/AN individuals and groups.
4. To offer early intervention at the onset of mental, emotional, and behavioral disorders to restore and improve patient/client level of functioning.
5. To offer educational, consultative, and other support services focused on AI/AN, mental health issues to a full range of tribal, governmental, educational, legal, institutional and health agencies.
6. Provide services to the AI/AN population by licensed mental health providers.
7. Address local biological, medical, psychological and sociological factors presented by the varied AI/AN service population groups through efforts of qualified, interdisciplinary mental health teams.
8. Provide optimal continuum of care utilizing a broad spectrum of mental health techniques in an outpatient setting.
9. Assist clients in accessing crisis intervention and emergency services when identified and appropriate..
10. Provide and identify consultative and outreach services as appropriate and needed.
11. Refer clients to higher levels of care or specialty mental health services when identified and appropriate.

Patient Intake and Screening

Purpose: The Karuk Child and Family Services Behavioral Health Program is responsible for the intake and screening of all patients presented or referred for services. Intake services are activities aimed at determining the need for or the establishment of service relationships between client and provider, Screening is the initial process of contacting and assessing potential clients by providers. Intake and screening activities constitute the process for entry of clients into the service delivery system.

Policy: Initial screening is conducted by licensed mental health professionals.

Intake and screening ensure that the needs of the individual match the scope of services provided by the Karuk Child and Family Services Behavioral Health Program staff.

Procedure:

1. When an individual request services or is referred to services the receptionist will document the request, collect contact information as appropriate and forward to the clinical supervisor or other mental health professional as appropriate.
2. Each request for services will be written on a log containing the name of the individual requesting services, the date of the request and the initial disposition.
3. The receptionist will confirm eligibility of the individual for services in our clinic (i.e. current registered client or Alaskan Native/American Indian eligible for direct care).
4. The receptionist will print a face sheet and confirm insurance eligibility
5. The request and/or referral will be provided to the clinical supervisor or other mental health professional for follow up.

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()	09 () 10 () 11 () 12 () 21 () 22 ()
Function: Behavioral Health	Policy #: 17-000-xxx	Policy Title: Informed Consent
Tribal Chairman: Date: HB meeting date Signature:	Medical Director: Date: 02/20/2015 Signature:	Cross References:
Dated 02/20/15		

Purpose: To ensure that mental health services are provided to clients only in the context of a professional relationship based, when appropriate, on valid informed consent.

Informed consent means to provide adequate information to the client and/or parent or legal guardian to ensure that they understand what is expected, how the information divulged will be used, and the freedom to choose whether, and with whom, they will enter into a counseling relationship.

Policy: Mental Health providers shall obtain a client’s signed Informed Consent Form prior to commencement of treatment with the client.

Procedure:

Professional mental health providers and/or mental health interns shall involve their clients, parent/guardian or legal representative in services. This shall include:

- The therapist’s clinical impressions and treatment recommendations
- Frequency of sessions
- Length of treatment
- Benefits, risk, and alternate treatment or procedures
- The risk of non-treatment
- Information regarding the value of patient cooperation and collaborative participation in the treatment process

This information will be reviewed verbally with client and and/or parent/guardian or other legal representative. Informed consent will be acknowledged in writing

by the client and/or parent, guardian or legal representative. The completed Informed Consent document shall be retained in the client's health record.

The informed consent shall include:

- Information concerning the fee to be charged for the services, or the basis upon which that fee will be computed, and that collection services are used for unpaid fees
- If the provider is an intern or trainee, he or she must inform each client prior to performing any professional services that he or she is unlicensed and under the supervision of a licensed clinical social worker, licensed psychologist, or licensed physician
- Relative risks and benefits associated with therapy
- Limits of confidentiality including mandated reporter status for child abuse, elder abuse, and therapist's duty to warn/protect
- Information regarding the therapist's availability, including of emergency services when the therapist is not available
- Policies related to termination of treatment for lack of cooperation (client no-shows, unpaid fees, etc.)
- Voluntary nature of services
- The right to refuse services at any time
- The right of client to ask questions and receive answers regarding their treatment
- The right of client to receive information in their primary language and in a manner consistent with their literacy status
- Limits to services because of the requirements of a third-party payer
- In instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of client's right to refuse services
- Parents and legal guardians are informed about the confidential nature of the counseling relationship. Mental health counselors embrace the diversity of the family system and the inherent rights and responsibilities parents/guardians have for the welfare of their children. Mental health counselors therefore strive to establish collaborative relationships with parents/guardians to best serve their minor clients.
- Informed consent is ongoing and needs to be reassessed throughout the counseling relationship
- Provider's signature
- Patient, parent or guardian's signature

EXCEPTIONS UNDER NORMAL CONDITIONS:

1. An individual who is in immediate need of emergency mental health attention and irreparable harm and even death may result from the mental health provider's hesitation to provide treatment.

2. In situations where the client lacks the capacity to provide informed consent, professional mental health staff should protect clients' interests by seeking permission from an appropriate third party, informing clients in a manner consistent with the clients' level of understanding. In such instances social workers should seek to ensure that the third party acts in a manner consistent with the client's wishes and interests. Professional mental health staff members should take reasonable steps to enhance such client's ability to give informed consent.

3. The exception and reason shall be noted in the client's health record.

NOTE:

The emergency doctrine is a form of implied consent and only lasts as long as the emergency. Formal consent must be obtained for procedures performed after the emergency has passed.

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 () 08 () 17 () 18 () 19 () 20()	09() 10 () 11 () 12 () 21() 22()
Function: Behavioral Health	Policy #: 17-001-01	Policy Title: Behavioral Health Services
Tribal Chairman: Date: HB meeting date Signature:	Medical Director: Date: 02/20/2015 Signature:	Cross References:
Dated 02/20/15		

Purpose: Behavioral health services are provided or made available to meet the needs of tribal and community clients living within our service area or for American Indians and Alaska Natives (AI/AN) individual who are eligible for direct care services at our clinic.

Background: American Indians and Alaska Natives have a long and fruitful history of supporting emotionally healthy behaviors and defining standards of behavior that are acceptable in their communities. This body of knowledge will be used in a cooperative and integrative manner with Western attitudes and practices as is consistent with the unique belief systems of the various tribes and the specific amalgam of belief systems of the individuals and families with whom the Karuk Tribe Behavioral Health staff comes into contact.

Goal: The goal of Karuk Tribe Behavioral Health Department is to promote, provide, and manage a comprehensive system of behavioral health services which offer American Indian and Alaska Natives and community members registered at our clinic sites a diverse range of culturally sensitive services at all levels of mental health needs.

Objectives: The Karuk Tribe behavioral health program is an integral part of the total health care system. The objectives of the Karuk Tribe behavioral health program are:

1. To offer a range of clinical and community behavioral health services.
2. To promote positive behavioral health services including efforts aimed at primary prevention of mental and emotional disorders.

3. To promote broad social and health goals to enhance the emotional security of AI/AN individuals and groups.
4. To offer early intervention at the onset of mental, emotional, and behavioral disorders to restore and improve patient/client level of functioning.
5. To offer educational, consultative, and other support services focused on AI/AN, mental health issues to a full range of tribal, governmental, educational, legal, institutional and health agencies.
6. Provide services to the AI/AN population by licensed mental health providers.
7. Address local biological, medical, psychological and sociological factors presented by the varied AI/AN service population groups through efforts of qualified, interdisciplinary mental health teams.
8. Provide optimal continuum of care utilizing a broad spectrum of mental health techniques in an outpatient setting.
9. Assist clients in accessing crisis intervention and emergency services when identified and appropriate.
10. Provide and identify consultative and outreach services as appropriate and needed.
11. Refer clients to higher levels of care or specialty mental health services when identified and appropriate.

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()	09 () 10 () 11 () 12 () 21 () 22 ()
Function: Behavioral Health	Policy #: 17-001-02	Policy Title: Outpatient Services
Tribal Chairman: Date: HB meeting date Signature:	Medical Director: Date: 02/20/2015 Signature:	Cross References:
Dated 02/20/15		

Purpose: Outpatient behavioral health services are clinical services made available to adults and children and comprises the majority of services provided by the Karuk Tribe Child and Family Services behavioral health program. Clinical services include assessment of physical, emotional, behavioral, social, legal, developmental, vocational and cultural factors, diagnosis of the full range of psychiatric disorders, psychological evaluation, treatment planning, use of a variety of treatment modalities, referral and follow-up.

Standards: Behavioral Health services are provided in accordance with all ethical practices, professional standard and legal regulations.

Procedure:

1. Individuals requesting or referred for behavioral health services will participate in a complete biopsychosocial assessment with a licensed or waived mental health provider.
2. Services are provided to individuals who meet the following criteria:
 - a. The individual has a DSM diagnosis from the most recent DSM or ICD code list.
 - b. The individual, as a result of a mental disorder must have at least, one of the following criteria:
 - A significant impairment in an important area of life functioning
 - A probability of significant deterioration in an important area of life functioning

- A probability that the child will not progress developmentally as individually appropriate

3. Must meet the intervention criteria listed below:

- a. The focus of the proposed intervention is to address the condition identified
- b. The expectation is that the proposed intervention will do, at least one of the following:
 - Significantly diminish the impairment
 - Prevent significant deterioration in an important area of functioning
 - Allow the child to progress developmentally as individually appropriate
 - Correct and/or ameliorate the condition

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()	09 () 10 () 11 () 12 () 21 () 22 ()
Function: Behavioral Health	Policy #: 17-001-03	Policy Title: Patient Intake and Screening
Tribal Chairman: Date: HB meeting date Signature:	Medical Director: Date: 02/20/2015 Signature:	Cross References:
Supersedes 17-000-01 dated 02/20/15		

Purpose: The Karuk Child and Family Services Behavioral Health Program is responsible for the intake and screening of all patients presented or referred for services. Intake services are activities aimed at determining the need for or the establishment of service relationships between client and provider, Screening is the initial process of contacting and assessing potential clients by providers. Intake and screening activities constitute the process for entry of clients into the service delivery system.

Policy: Initial screening is conducted by licensed mental health professionals. Intake and screening ensure that the needs of the individual match the scope of services provided by the Karuk Child and Family Services Behavioral Health Program staff.

Procedure:

1. When an individual request services or is referred to services the receptionist will document the request, collect contact information as appropriate and forward to the clinical supervisor or other mental health professional as appropriate.
2. Each request for services will be written on a log containing the name of the individual requesting services, the date of the request and the initial disposition.
3. The receptionist will confirm eligibility of the individual for services in our clinic (i.e. current registered client or Alaskan Native/American Indian eligible for direct care).

4. The receptionist will print a face sheet and confirm insurance eligibility.
5. The request and/or referral will be provided to the clinical supervisor or other mental health professional for follow up.

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()			05 () 06 () 07 () 08 () 17 () 18 () 19 () 20()				09() 10 () 11 () 12 () 21() 22()			
Function: Behavioral Health			Policy #: 17-001-04				Policy Title: Assessment			
Tribal Chairman: Date: HB meeting date Signature:			Medical Director: Date: 02/20/2015 Signature:				Cross References:			
Supersedes 17-001-02 dated 02/20/15										

Purpose: The purpose of client assessment is to understand the behavioral health needs of an individual and development of a treatment plan with the individual. The client assessment will consider an individual's cultural and social dynamics which may affect interpretation of psychological symptoms and test results.

Policy: A comprehensive biopsychosocial assessment will be completed within 30 days for each client accepted in to treatment by the Karuk Tribe Child and Family Services behavioral health program.

Procedure: An assessment interview will be conducted by licensed behavioral health staff for each individual who enters care. Family members and/or significant others will be interviewed when appropriate. The behavioral health assessment will be documented utilizing the appropriate assessment form. The assessment form must be legible to other providers and auditors.

The mental health assessment will include:

1. The presenting problem, including the primary complaint, history of presenting problem(s), including current level of functioning; relevant family history and current family information
2. Relevant conditions and psychosocial factors affecting the individual's physical health and mental health; including, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma
3. Medical and Psychiatric History

Treatment records contain the individual's medical and psychiatric history including:

- a. Previous dates of treatment
- b. Names of providers
- c. Therapeutic interventions
- d. Effectiveness of previous interventions
- e. Sources of clinical information
- f. Relevant family information
- g. Results of relevant laboratory tests
- h. Previous consultation and evaluation reports

4. Medications

- a. Current and past medications prescribed from medical providers. Length of time taking medications
- b. Effectiveness of medications
- c. Absence or presence of allergies or adverse reactions to medications
- d. Documentation of informed consent for medications

5. Substance Exposure/Use information

- a. History of current and/or past use of tobacco, alcohol, caffeine, complementary and alternative medications and illicit and over the counter drugs
- b. Exposure to substances or toxins in utero

6. Adolescent Depression Information

Documentation for any member 13 - 18 years who was screened for depression:

- a. If yes, was a suicide assessment conducted?

b. Was the family involved in treatment?

7. Attention Deficit Hyperactivity Disorder Information

Documentation that members aged 6 - 12 years were assessed for ADHD

a. Was family involved in treatment?

b. Is there evidence of the client receiving psychopharmacological treatment?

8. Diagnostic Information

Documentation including:

a. Risk management issues (e.g. imminent risk of harm, suicidal ideation/intent, and elopement potential) are prominently documented and updated according to provider procedures.

b. All relevant medical conditions are clearly documented and updated as appropriate.

c. Member's presenting problems and the psychological and social conditions that affect their medical and psychiatric status. A complete mental status evaluation is included in the treatment record which documents the individual's:

- Affect
- Speech
- Mood
- Thought control, including memory
- Judgment
- Insight
- Attention/concentration
- Impulse control
- Initial diagnostic evaluation and DSM diagnosis that is consistent with the stated presenting problems, history, mental status evaluation and/or relevant assessment information
- Diagnoses updated at least quarterly

9. Client strengths and challenges in achieving client plan goals.

10. A complete developmental history for children and adolescents must include the

Following information:

- a. Physical, including immunizations
- b. Psychological
- c. Social
- d. Intellectual
- e. Academic
- f. Prenatal and perinatal events are noted

11. A complete diagnosis from the most current DSM, or a diagnosis from the most current ICD-code, consistent with the presenting problems, history, mental status examination and other clinical data.

12. All pertinent records which may include medical records, school records, and legal status are to be obtained and reviewed. Required releases of information will be obtained.

13. When additional assessment is required to understand a patient's condition and to make a diagnosis, it is the provider's responsibility, with consultation if necessary, to perform the additional assessment or to make an appropriate referral. Additional assessment procedures can include physical examination, specialized neurological or other examinations, laboratory tests, radiological examinations, and psychological testing.

14. The completed mental health assessment for will be retained in the client chart.

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()			05 () 06 () 07 () 08 () 17 () 18 () 19 () 20()				09() 10 () 11 () 12 () 21() 22()			
Function: Behavioral Health			Policy #: 17-001-05				Policy Title: Client Plan			
Tribal Chairman: Date: HB meeting date Signature:			Medical Director: Date: 02/20/2015 Signature:				Cross References:			
Dated 02/20/15										

Purpose: Client plans are developed to assist the client and provider in understanding the proposed treatment goals, to monitor for progress and plan for discharge. In addition, client plans are developed to meet the regulatory and contractual requirements of third party payers.

Policy: The client plan process will be initiated following screening and assessment for all mental health treatment provided directly by our staff. An individual who does not remain in treatment prior beyond the third visit does not require a formal plan.

Procedure:

1. Clients requiring ongoing care will have an initial client plan developed by the mental health professional by the third visit.
2. Goals will be specific, observable and quantifiable.
3. Interventions will focus and address the identified functional impairments as a result of a mental disorder.
4. Interventions will be consistent with client plan goal objectives.
5. Client plan goals will include the frequency and duration of interventions.
6. Client plans will take into consideration the spiritual/cultural orientation of the client and may include goals related to the cultural needs of the client.

7. Client plans will include documentation that the client participated in the development of the plan.
8. Client plans will be signed by the client or a written explanation will be documented when a client refuses to sign the client plan.
9. Client plans are signed by the licensed staff member treating the client.
10. Client plans will be updated at least annually for adults.
11. Client plans for youth will be updated every six months.
12. Client plans will be updated when there are significant changes in the client's condition.
13. The client will be provided/offered a copy of the client plan.

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()	09 () 10 () 11 () 12 () 21 () 22 ()
Function: Behavioral Health	Policy #: 17-001-06	Policy Title: Discharge
Tribal Chairman: Date: HB meeting date Signature:	Medical Director: Date: 02/20/2015 Signature:	Cross References:
Supersedes 17-001-06 Dated 02/20/15 or Updated 02/20/15		

Purpose: The purpose of discharge planning is for the management of caseloads in the behavioral health department and to mitigate the risk of maintaining an open chart for individuals who either have discontinued attending sessions or are not adhering to treatment recommendations.

Policy: It is the policy of the Karuk Tribe Child and Family Services Behavioral Health Department to discharge clients when the following occurs:

1. When mutually agreed upon goals have been met,
2. The symptoms that originally brought the client/family into treatment no longer have the potential to interfere with the day to day functioning,
3. The client's symptoms have improved sufficiently to achieve a stable baseline level of functioning,
4. The client stops attending or the client is not adhering to the recommendations for treatment,
5. Despite attempts at intervention, patient continues to not adhere to recommendations regarding medications, treatment plan or both
6. The client requires a higher level of care

Procedure:

1. Each mental health professional shall prepare a discharge summary for each client no longer receiving services.

2. Ideally discharge planning begins at initiation of services with the client.
3. When the client has stopped attending sessions, efforts shall be made to make contact with the client. If this effort fails, a certified letter may be mailed to the client informing him/her of the intent to discharge from services. Efforts to contact the client will be documented in the RPMS system.
4. Discharge will be considered for clients who fail to attend appointments for a period of 30 days.
5. Discharge summaries must be filed in the clinical record within one month of the date of the client's formal discharge from services or within two months of the date of the client's last service when no formal discharge occurs.
6. The discharge summary will include:
 - a. The reason for discharge
 - b. A summary of the services provided by the behavioral health professional including recommendations for aftercare services and referrals to other services, if applicable
 - c. An evaluation of the client's progress as measured by the client plan and the impact of the services provided by the mental health provider
 - d. The signature of the staff member who completed the discharge summary
7. For cases left open when a client has not received services for over 30 days, documentation must be entered into the record indicating the reason for leaving the case open.

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 () 08 () 17 () 18 () 19 () 20()	09() 10 () 11 () 12 () 21() 22()
Function: Behavioral Health	Policy #: 17-007-07	Policy Title: Crisis Intervention
Tribal Chairman: Date: HB meeting date Signature:	Medical Director: Date: 02/20/2015 Signature:	Cross References:
Supersedes 17-001-07 Dated 02/20/15		

Purpose: Crisis intervention services are provided to a person for the purpose of stabilizing or preventing a sudden, unanticipated, or potentially dangerous behavioral health condition, episode or behavior. Crisis intervention services are provided in the clinic or office setting or over the telephone.

Policy: Child and Family Services mental health staff provide limited crisis intervention services to individuals presenting with a behavioral health crisis in the communities we serve.

Procedure:

1. Mental health professionals will assist individuals who present with a mental health crisis in obtaining the necessary services to address their needs during regular business hours. This may include screening, triage and arranging for the provision of additional crisis services, assessing, evaluating or counseling to stabilize the situation, observation and/or follow up to ensure stabilization, and/or other therapeutic and supportive services to prevent, reduce or eliminate the crisis situation.
2. When it is determined that the individual is in imminent danger of harm to self or others or is determined to be gravely disabled, the mental health provider may arrange for transport to the nearest hospital emergency room for further evaluation.
3. At the time mental health crisis intervention services are provided, a person's enrollment or eligibility status may not be known. However, crisis intervention services may be provided.

4. Telephone crisis intervention services, including a toll-free number is available through the Siskiyou County Behavioral Health Department 24 hours, seven days per week. The number is:
 - Siskiyou County 1-800-842-8979
 - Humboldt County 1-888-849-5728
5. Each mental health office and individual provider will include the crisis line information on their telephone message.
6. The crisis line information will be posted at clinic sites in an area readily observable by the public.

Karuk Health and Human Services Policy Manual

Policy Reference Code: 01 () 02 () 03 () 04 () 13 () 14 () 15 () 16 ()	05 () 06 () 07 () 08 () 17 () 18 () 19 () 20 ()	09 () 10 () 11 () 12 () 21 () 22 ()
Function: Behavioral Health	Policy #: 17-001-08	Policy Title: Responding to a Mental Health Emergency
Tribal Chairman: Date: HB meeting date Signature:	Medical Director: Date: 02/20/2015 Signature:	Cross References:
Dated 02/20/15		

Purpose: The purpose of this procedure is:

1. To define what constitutes a mental health emergency, and
2. Describe how non-clinically trained staff should respond when on duty and confronted with a patient or community member experiencing a mental health emergency.

Definition: Mental Health Emergency

An individual may be experiencing a mental health emergency when he or she is feeling overwhelmed by internal or external stresses that result in a feeling of helplessness. Coping with those stresses or feelings of helplessness may lead an individual to behave in ways that might create a danger to the individual or to other people.

Examples include:

1. Someone considering self-harmful behavior; like suicide or self-injury.
2. Someone behaving in a manner likely to cause death or injury to another person.
3. Someone who, because of mental illness, may be unable to care for self in a safe manner.
4. Someone who may be severely impaired by drugs or alcohol.

5. Someone behaving in a highly erratic or unusual way, indicating an inability to care for themselves.

Procedure:

- When a health care employee, while on duty, has reason to believe that any patient or potential patient may be experiencing a mental health emergency, the employee should alert the mental health professional on staff.
- If a mental health staff member is not available, the employee should call 9-1-1, or refer the patient to the nearest emergency room.
- If an emergency room is not within a practical distance, the employee should alert emergency responders by dialing 9-1-1.
 - Please see the appendix for contact numbers.
- The health care employee should not offer treatment advice, or attempt to manage the situation themselves without contacting resources as described above, but may offer supportive comments or otherwise engage the patient while another employee alerts the emergency response system by dialing 9-1-1.

Special Circumstances:

If the person in Mental Health Emergency is calling by telephone:

1. Attempt to get the person's name, phone and location (street address and community).
2. Keep the person on the phone, while you get a co-worker's attention and depending on the level of urgency, contact appropriate assistance.

Mental Health Emergency Resources

Yreka and Happy Camp:

- Siskiyou County Mental Health Crisis Line: 1-800-842-8979
- Fairchild Medical Center
444 Bruce Street
Yreka, California 96097
530 842-4121

Orleans:

- Humboldt County Mental Health Crisis Line: 1- 888-849-5728 or
(707)-445-7715
- St Joseph's Hospital
2700 Dolbeer Street
Eureka, California
(707) 269-4250
- Mad River Community Hospital
3800 Janes Road
Arcata, California 9552
(707) 822-3621



You Gussed It!

Yes

I am in

Hawaii

Vacationing

I am going to try and base this report on what I heard you wanted in the Management Team meeting. Of course, Erin’s template doesn’t fit the Health Programs contract, but may with specific grants>

Required:	Status	Date/
1. 340 B Recertification	Completed	Feb 2015
2. Registration Renewal		
Nat Practitioner Data Bank	Completed	Feb 2015
3. HRSA Change in Scope	in Process	Feb/March

Summary:

I reviewed Capture Rx with Raul. For the period 10/01/13 to 09/30/2014 we received a total of \$171, 423.56. This is the balances left after the 340 B price of medications.

The construction is moving along in the Yreka Clinic but I understand it’s unnerving to the staff and patients. It has to be done regardless.

Attended meeting at the Health Alliance of Northern CA (HANC). This is where I learned of the Fiscal Cliff, which will bring a 60-70% reduction in our HRSA Funding. See attachment provided by HANC.

I’m happy to know that Raul is very interested in Telehealth. I believe it will extend specialty services to our communities. In order to prepare for Telehealth several of the staff will be attending the Telehealth Summit in April at Olympic Valley.

Much work has been done on recruitment. I was hoping to get a PA on board for Orleans, but HR and the PA kept playing phone tag and really not getting anywhere. I’d like to see her come to work here, and interviewed a Physician I’m interested in for Happy Camp.

May we have permission to use discretionary money to purchase an Indian Blanket from the People Center for Dr. Milton’s retirement? His last day is March 13, 2015.

Executive Director of Health and Human Services

Board Report

March 11, 2015

Lessie Aubrey, EDHHS

	MONTHLY REVENUE REPORT			BUSINESS OFFICE	
	FEBRUARY 2015	Happy Camp	Yreka	Orleans	KTHP
	Revenue Medical	\$56,070.97	\$83,535.08	\$6,869.18	
	PHC Capitation	\$7,495.05	\$10,810.96	\$2,250.85	
	HPSA Quarterly Incentive	\$0.00	\$0.00	\$0.00	
	Revenue Dental	\$23,920.50	\$39,066.57	\$0.00	
	Revenue Mental Health	\$2,736.15	\$9,664.62	\$20.00	
	REVENUE TELEMED	\$0.00	\$104.30	\$0.00	
	Revenue Total	\$90,222.67	\$143,181.53	\$9,140.03	
		Happy Camp	Yreka	Orleans	KTHP
	Billing FEBRUARY Medical	\$120,268.22	\$ 172,573.28	\$25,565.03	
	Billing FEBRUARY Dental	\$52,852.00	\$ 140,913.59	0	
	Billing FEBRUARY Mental Health	\$9,491.30	\$ 35,745.34	\$436.00	
	Billed Grand Total	\$182,611.52	\$ 349,232.21	\$26,001.03	
	BILLING DEPARTMENT BUDGET 2015				
					AVAILABLE %
PROGRAM	YEAR END ANNUAL	EXPENSES TO			Could be spent
YEAR	BUDGET	DATE	BALANCE	% USED	at this date
FY 2015	\$504,963.97	\$167,737.67	\$336,749.30	33.31%	41.70%

KARUK TRIBE HEALTH AND HUMAN SERVICES
BUSINESS OFFICE HEALTH BOARD REPORT
MARCH 12, 2015

During a recent conference call I finally obtained the supervisors contact information and hopefully this will ease our situation. She did acknowledge that she is aware of the situation. We have again sent all claims and instead of electronic method we sent them registered mail, so they cannot state they were not received since we now have written proof. Beacon/Chipa (managed medi-cal) for the Behavioral Health visits continues to have payment problems. After Beacon's agreement to allow us to back bill to January 1, 2014 we have begun receiving small payments. Beacon has apologized and they are aware their payment system is behind and hope to have it caught up to date in the near future. The biggest problem is that to resubmit these older claims over again requires an appeal process. But eventually it should all work correctly.

The Data Analyst's office at the Yreka clinic has been relocated closer to the front, nearer to reception and the patient lobby. This should give her easier access to the staff and patients. It's my understanding an actual sliding window will soon be placed between she and the lobby so patient's will have more access to her with patient registration questions or insurance updates.

All, except one provider, are now enrolled with all our third party payers.

The OSHPD 2014 report has now been completed and submitted. Next year we will no longer be required to submit that annual report.

Mr. Recarey is beginning to contact me, opening our line of communication. Lessie asked me to listen to a webinar and now I am reading the information for the Veteran's Choice Program. We have had local Veteran's inquire if we are planning to become a supplier of care for this program specifically. Our carrier for this program would be TriWest. Triwest is sending me their contracting information and we can make our decision at that time. Meanwhile we may treat the Veteran's as an out-of-network provider.

I will be taking my AHIMA annual recertification test during the week of March 9-15th. I will begin sending out small emails to the providers to get them thinking more about ICD-10 that begins October 1st this year. It will be a challenge but we will all work together to make as smooth a transition as possible.

The financial reports are attached.

Respectfully submitted,
Suzanna Hardenburger, CCS-P

RPMS
Karuk Tribal Health and Human Services Program
Health Board Meeting-Orleans
March 12, 2015
Patricia White, RPMS Site Manager



Workload reports

Attached is the January 2015 “Operations Summaries” including Tribal Statistics. During January 2015 there were 1932 visits at all locations. This is an increase of 124 visits over December 2014 numbers. Yreka and Happy Camp visits were up while Orleans went down from previous month. 973 of these visits were for Native American Patients (51%). See chart at the end of the operations summary.

Meeting / Conference Calls and other Activities February 2015

- 02/11 – RPMS/EHR Office Hours
- 02/11 – Health Board Meeting/Happy Camp
- 02/18 to 2/19 – Policy Group-reviewing health policies for accreditation

Projects in process

• **HIPAA 2015:**

I sent out the notice for the HIPAA training and I am receiving certificates daily.

• **UDS Report-**

At the time of this writing, the 2014 UDS Report is in review with HRSA and there is request for change. HRSA is asking for verification on ten items. When I complete the review request, I will provide a copy of the completed report to you.

This is a labor intensive report, taking over a month to compile. The business office staff and fiscal were significant in putting this report together. I especially want to thank Suzanna Hardenburger and Eileen Tiraterra for their assistance in gathering the patient related revenue data. I also want to thank Laura Mayton who gathered all the fiscal data relating to financial costs and other revenues (grants and contracts). In 2005, the first year the report was done; there were 10 tables with one quality measure. This year there were 12 tables that include 12 quality measures plus 3 outcome measures based on race/ethnicity. The report now takes a joint effort from many to put together.

Budget: At the time of this writing I am under budget for the current fiscal year.

Program	RPMS
Budget Code	3000-75
Program Year	2014-2015
Appropriation	\$235,336.60
Expenses to Date	70,121.97
Balance	165,194.64
Percent used	29.80%

Respectfully Submitted,

Patricia C White, RPMS Site Manager

OPERATIONS SUMMARY FOR KARUK TRB HP Service Unit
FOR JAN 2015
Prepared for March 12, 2015
Health Board Meeting-Orleans CA

(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 18,861 (+3.8) living patients registered at this SU. This number does not represent the 'Active User Population' which is found elsewhere in PCC Reports. There were 66 (+1.5) new patients, 0 (**) births, and 1 (-80.0) death(s) during this period. Data is based on the Patient Registration File.

THIRD PARTY ELIGIBILITY

There were 2,836 (+0.2) patients enrolled in Medicare Part A and 2,712 (+0.4) patients enrolled in Part B at the end of this time period.

There were 103 (+4.0) patients enrolled in Medicare Part D.

There were also 6,972 (+4.4) patients enrolled in Medicaid and 6,100 (+8.0) 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 51,619.71 (-2.6). The number and dollar amount of authorizations by type were:

57 - DENTAL	6	\$ 2674.15
64 - NON-HOSPITAL SERVICE	824	\$ 48945.56

DIRECT INPATIENT

[NO DIRECT INPATIENT DATA TO REPORT]

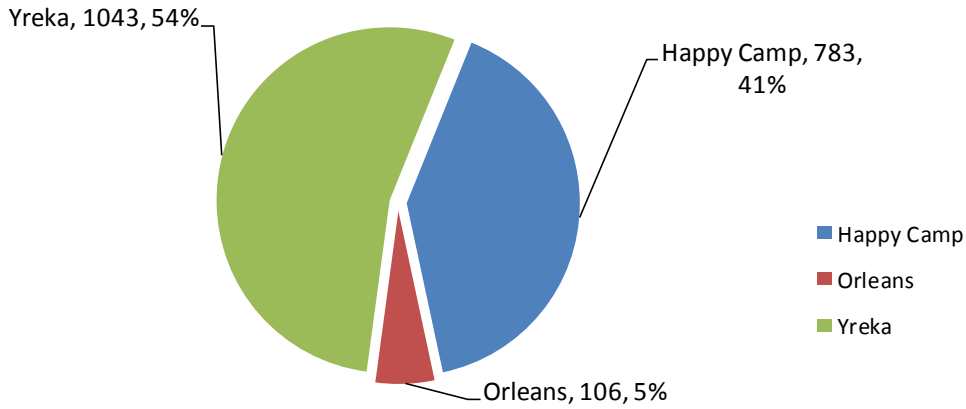
AMBULATORY CARE VISITS

There were a total of 1,932 ambulatory visits (+0.9) 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	1,932	(+0.9)
By Location:		
YREKA	1,043	(+0.8)
KARUK COMMUNITY HEALTH CLINIC	783	(-6.8)
ORLEANS	106	(+171.8)

Visits by Location January 2015



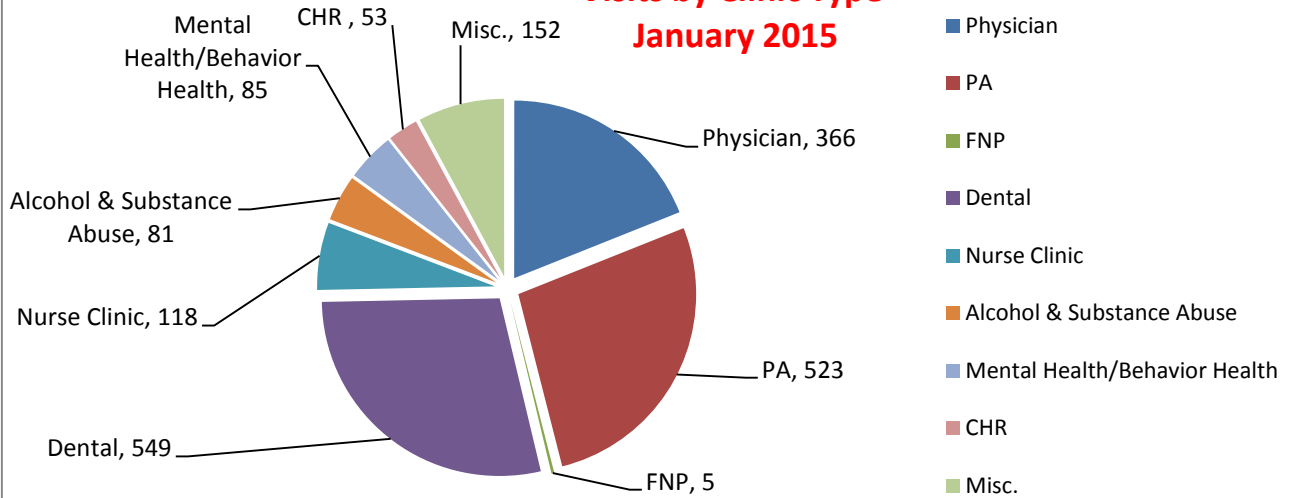
By Service Category:

AMBULATORY	1,868	(+0.1)
TELECOMMUNICATIONS	63	(+34.0)
TELEMEDICINE	1	(**)

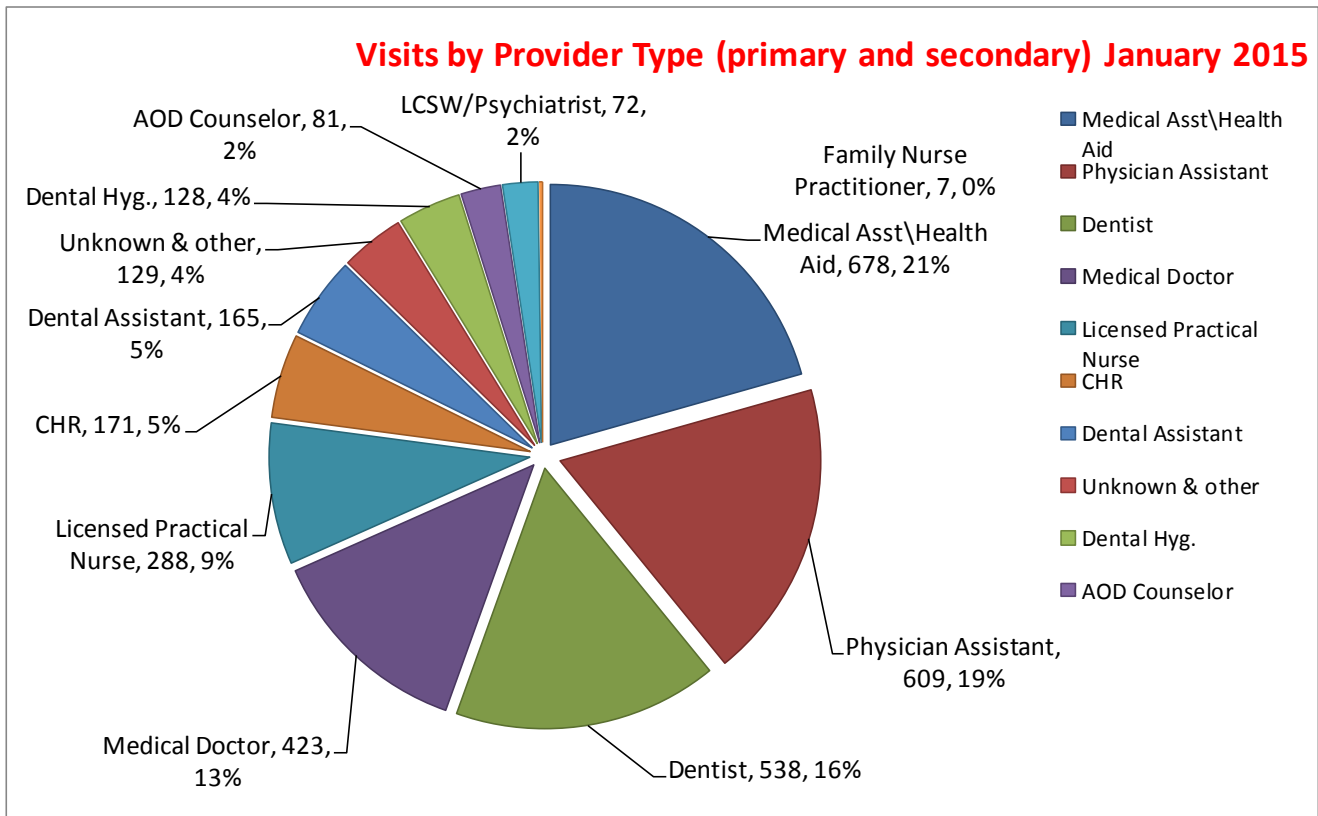
By Clinic Type:

DENTAL	549	(-10.9)
PHYSICIAN ASSISTANT	523	(+178.2)
PHYSICIAN	366	(-34.8)
TRANSPORT	119	(+52.6)
NURSE CLINIC	118	(-4.1)
MENTAL HEALTH	85	(+102.4)
ALCOHOL AND SUBSTANCE	81	(-35.2)
CHR	53	(+130.4)
TELEPHONE CALL	13	(-13.3)
CHART REV/REC MOD	11	(+1,000.0)
TELEMEDICINE	9	(+200.0)
FAMILY NURSE PRACTITIONER	5	(-96.3)

Visits by Clinic Type January 2015



By Provider Type (Primary and Secondary Providers):		
PHYSICIAN ASSISTANT	609	(+110.7)
DENTIST	538	(+14.7)
MEDICAL ASSISTANT	454	(-42.6)
MD	423	(-27.2)
LICENSED PRACTICAL NURSE	288	(+154.9)
HEALTH AIDE	224	(+2,140.0)
COMMUNITY HEALTH REP	171	(+69.3)
DENTAL ASSISTANT	165	(+334.2)
DENTAL HYGIENIST	128	(-16.9)
ALCOHOLISM/SUB ABUSE COUNSELOR	81	(-35.2)
UNKNOWN	77	(**)
LICENSED CLINICAL SOCIAL WORK	72	(+71.4)
HEALTH RECORDS	32	(-73.8)
ADMINISTRATIVE	20	(**)
NURSE PRACTITIONER	7	(-95.3)



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	544	(-13.9)
2). OTHER SPECIFD COUNSELING	199	(+73.0)
3). HYPERTENSION NOS	102	(-6.4)
4). LUMBAGO	62	(+8.8)
5). DEPRESSIVE DISORDER NEC	61	(+56.4)
6). HYPERLIPIDEMIA NEC/NOS	58	(+11.5)
7). THERAPEUTIC DRUG MONITOR	53	(+10.4)
8). VACCIN FOR INFLUENZA	53	(-70.9)
9). LABORATORY EXAM NEC	51	(+1,600.0)
10). LONG-TERM USE ANTICOAGUL	50	(+2.0)

CHART REVIEWS

There were 879 (-31.8) chart reviews performed during this time period.

INJURIES

There were 100 visits for injuries (+88.7) reported during this period. Of these, 14 were new injuries (+75.0). The five leading causes were:

- 1). FALL ON STAIR/STEP NEC 2 (**)
- 2). STRUCK BY FALLING OBJECT 2 (**)
- 3). FALL FROM SLIPPING NEC 2 (**)
- 4). FALL NOS 2 (**)
- 5). MV COLLISION NOS-DRIVER 1 (**)

EMERGENCY ROOM

[NO EMERGENCY ROOM VISITS TO REPORT]

DENTAL

There were 425 patients (-2.3) seen for Dental Care. They accounted for 549 visits (-10.9). The seven leading service categories were:

- 1). PATIENT REVISIT 353 (+83.9)
- 2). HYPERTENSION SCREENING 209 (+137.5)
- 3). FIRST VISIT OF FISCAL YEAR 170 (-7.1)
- 4). INTRAORAL - PERIAPICAL FIRST RADIOG 150 (+18.1)
- 5). INTRAORAL - PERIAPICAL EACH ADDITIO 148 (+89.7)
- 6). LOCAL ANESTHESIA IN CONJUNCTION WIT 138 (-11.5)
- 7). PREVENTIVE PLAN AND INSTRUCTION 123 (-27.6)

IN-HOSPITAL VISITS

[NO IN-HOSPITAL VISITS TO REPORT]

PHARMACY

There were 1,612 new prescriptions (+6.7) and 0 refills (**) during this period.

TRIBAL STATISTICS JANUARY 2015

	Registered Indian Patients January 2015	Indian Patients Receiving Services January 2015	APC Visits by Indian Patients January 2015
Karuk	2091	432	580
Descendants residing in CA	1898	200	262
All other Tribes	2193	111	131
Total	6182	743	973

Health Board Update
Raul Recarey – 03/12/2015

REPORTING: I've met with various members of staff and happy to report that starting next month, we will be augmenting the information supplied to Council which I believe you will find helpful in getting a better understanding of our clinic operations. Future monthly reports will include:

- **Patient Satisfaction Results** – we will begin tracking patient satisfaction and keeping score by clinic.
- **Patient Visit Statistics** – reported daily to management and monthly totals to Council showing: a: Scheduled|cancelled|no-shows|walk-ins.
- **Clinic Performance Statistics** – we will report clinic performance metrics to this Council that include: Number of patients seen|Average patient wait times|Average Cost per Encounter|
- **Provider Performance Statistics** – Same information as tracked by Clinic will be tracked per provider.

PROVIDER MEETINGS: Monthly provider meetings will now include a discussion on provider performance metrics. Our primary emphasis will focus on three (3) main areas: 1) Improving Quality Health Care; 2) Improving Patient Satisfaction and 3) Reducing Appointment Wait Times.

MEDI-CAL MEETING UPDATE: Council member Arch Super and I attended a Medi-Cal meeting in Sacramento and were able to obtain important information that can be very beneficial to Karuk HHS:

- Identified possible ways to increase our Medicare and Medicaid rate of revenue.
- Confirmed Medi-Cal's focus on quality health care and its relationship to reimbursement.
- Developed a direct connection to participate in future discussions about possible pilot projects.
- Learned of a new agency (OHE – Office of Health Equity) that may be a vehicle to help us obtain needed changes to current policies to our ultimate benefit. We will be participating in future meetings as a member of their newly formed ADVISORY COMMITTEE.
- Learned about the progress of TeleHealth, including Tele-Dentistry as a way to obtain expert consultation remotely.

POSSIBLE GRANT WITH POLYCOM – several staff and I met with Polycom to discuss a possible equipment grant from the FDA to purchase medical equipment and advanced TeleHealth video equipment for all clinics. We will follow the customary process with evaluating grants but it appears we may be able to take advantage of favorable grant dollars for this important service. Advancing TeleHealth services will greatly enhance our ability to provide specialty care to our folks living remotely. We are also looking at the options of expanding primary care using TeleHealth.

MEETINGS – Scheduled meetings for the near future are as follows:

- March 25: Siskiyou Healthcare Collaborative – in Yreka. This will be an important opportunity to meet with area trading partners and promote the use of electronic communication among us – all part of Meaningful Use strategy.
- April 1-2: HHS Region IX Consultation Meetin - This year's Region IX Tribal Consultation will consist of opportunities for individual Tribes to meet one-on-one with HHS representatives on April 1 and a full-day Consultation session for all Region IX Tribes on April 2.