KARUK TRIBE
HEALTH BOARD MEETING AGENDA
Thursday, June 11, 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 *(May 14, 2015)*

F) GUESTS *(Ten Minutes Each)*

1.

H) OLD BUSINESS *(Five Minutes Each)*

1.

I) DIRECTOR REPORTS *(Ten Minutes Each)*

1. Patricia Hobbs, Children & Family Services (written report)
2. Patricia White, RPMS Site Manager (written report)
3. Eric Cutright, IT Director (written report)
4. Lessie Aubrey, Grants, Compliance, Accreditation Manager (written report)
5. Vickie Walden, Dental Office (written report)
6. Raul Recarey, Health CEO (written report)

II) REQUESTS *(Five Minutes Each)*

1.

K) INFORMATIONAL *(Five Minutes Each)*

1.

M) CLOSED SESSION *(Five Minutes Each)*

1. CHS (dinner break)
2. Troy Hockaday
3. Raven Celari
4. Barbara Snider
5. Tribal Council Members

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

OO) ADJOURN

Karuk Tribe – Health Board Meeting
May 14, 2015 – Meeting Minutes

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

Present:
Russell "Buster" Attebery, Chairman
Alvis "Bud" Johnson, Member at Large
Charron "Sonny" Davis, Member at Large
Josh Saxon, Member at Large
Arch Super, Member at Large

Absent:
Joseph "Jody" Waddell, Secretary/Treasurer (excused)
Elsa Goodwin, Member at Large (excused)
Renee Stauffer, Member at Large (excused)
Robert Super, Vice-Chairman (excused)

Sonny Davis completed a prayer for the audience and a moment of silence was observed for Tribal Member Elders who have recently passed. After a moment of respect, Buster went on to read the Mission Statement for the health program.

Agenda:
Arch Super moved and Bud Johnson seconded to approve the agenda with changes, 4 haa, 0 puuhara, 0 pupitihara.

Minutes from April 9, 2015:
Bud Johnson moved and Sonny Davis seconded to approve the minutes of April 9, 2015, 4 haa, 0 puuhara, 0 pupitihara.

Guests:

1.) **Emma Lee Perez, Grant Writer/Resource Developer:**
Emma Lee is present to seek approval of a grant proposal to FEMA, under resolution 15-R-060. The proposal will be to fund the emergency preparedness program in the amount of $965,664.

Josh Saxon moved and Bud Johnson seconded to approve resolution 15-R-060, 4 haa, 0 puuhara, 0 pupitihara.

The likelihood of receiving this funding is low but it is noted that it is a realistic budget.

2.) **Tina Hockaday-Weldin, HR Director:**
Tina is present to seek approval of moving the reunion to the Tribes parking administration complex. Tina provided a list of items that the planning committee considered the pros of moving the location.

Consensus: to move the 2015 Tribal Reunion to the Administrative office.

3.) **Dion Wood, TERO/Childcare:**
Dion is present to seek approval to release the Karuk Tribes Caltrans MOU to Smith River and Yurok Tribe. It is the Tribes policy to seek Council approval prior to releasing documents to other agencies.

Josh Saxon moved and Arch Super seconded to approve sharing the Karuk Tribe's Caltrans MOU with the Smith River Tribe and the Yurok Tribe, 4 haa, 0 puuhara, 0 pupitihara.

4.) Laura Mayton, CFO:

Laura provided a hardcopy of the FY16 indirect cost proposal. Josh had some clarification questions on position titles. Laura will update the position titles in the document.

Josh Saxon moved and Arch Super seconded to approve the FY16 Indirect Cost Rate proposal with changes, 4 haa, 0 puuhara, 0 pupitihara.

5.) Jaclyn Goodwin, Self-Governance Coordinator:

Jaclyn is present to seek approval of nomination to the Health and Human Services STAC. It is to nominate Buster Attebery to deal with issues that will affect Indian Country. There is a priority to get Chairman, Vice-Chairman and then staff. If using Buster or Robert then it would be more likely to be competitive.

Josh Saxon moved and Arch Super seconded to approve the nomination of Buster Attebery to HHS STAC, 4 haa, 0 puuhara, 0 pupitihara.

6.) Angela Baxter, Substance Abuse Program Coordinator:

Angela is present to seek approval of her policies and procedures. They are updated to reflect current language. The Tribes current seal will be included on the documents. The changes were reviewed by Angela and April. Angela did work with Rondi on them and then took them to the policy committee, but was referred back to her department. They policies were approved but there was no place for them in the health program manuals. These policies still have minor grammar changes.

Josh Saxon moved and Bud Johnson seconded to approve the Karuk Tribe's Substance Abuse policies and procedures manual with changes, 4 haa, 0 puuhara, 0 pupitihara.

7.) Debbie Bickford, outreach/Education:

Debbie Bickford is present to seek approval to have a Karuk Ambassador Youth representative. This person would be able to assist in bridging communication.

This will be discussed at a later time.

She then went on to submit a request for a smart phone. This will assist in her checking email and working from satellite offices.

Director Reports:

1.) **Patricia Hobbs, Children & Family Services**:

Patricia is present to review her report. She has a few action items. She first presented a request to approve funding under resolution 15-R-043. She also has resolution 15-R-044 for the other portion of funding for Title IVB funds under two subparts. These require two separate resolutions for the two funding sources, until Title IVB.

Arch Super moved and Josh Saxon seconded to approve resolution 15-R-043, 4 haa, 0 puuhara, 0 pupitihara.

Josh Saxon moved and Bud Johnson seconded to approve resolution 15-R-044, 4 haa, 0 puuhara, 0 pupitihara.

She also then sought approval of a revised position description for the Orleans Counselor position. She reviewed the changes, which include more hours, supervision status and reference to the organization structure. Josh inquired about the title and the classification of part-full time. It was noted to post as part time and then work within the budget.

Josh Saxon moved and Arch Super seconded to approve the revised position description for the revised Social Worker, 4 haa, 0 puuhara, 0 pupitihara.

Angela introduced Anthony Ballard to the organization. The Council welcomed Anthony.

Arch Super moved and Josh Saxon seconded to approve Pat's report, 4 haa, 0 puuhara, 0 pupitihara.

2.) Patricia White, RPMS Site Manager:

Patty is present to review her report. She reviewed her data reports including patient visits, employee contacts, meetings/conference calls, and preparation for AAAHC. The increase of visits is up and it's anticipated for some loss with no providers. Patty's reports are from two months previous. Josh asked about Patty's budget appropriations. Patty noted that her budget is Patty and Amy salaries, travel/training, equipment, supplies, etc. Josh asked if there was anything on the horizon that is coming up regarding technologies that they should be preparing for. Patty noted that they look for outside funding for those opportunities for equipment needs. Laura and Raul commented that some system requirements get funded through IHS due to shares that are left with them. Large concepts as designed by the Tribe, review options for grant funding.

Josh Saxon moved and Sonny Davis seconded to approve Patty's report, 4 haa, 0 puuhara, 0 pupitihara

3.) Eric Cutright, IT Director:

Eric is present to review his report. He has a few action items. One action item is a contract for the broadband project. It is for trenching related to providing power to the site. It will require monitor services once the work begins.

Sonny Davis moved and Bud Johnson seconded to approve contract 15-C-093, 4 haa, 0 puuhara, 0 pupitihara.

He then commented that there was a broadband project planning meeting last week. He inquired about naming the business. He noted that having a name may be advantageous but then it may also have requirements for a fictitious business name application. He provided samples of suggested names. The Council will review those.

Arch Super moved and Bud Johnson seconded to approve Eric's report, 4 haa, 0 puuhara, 0 pupitihara.

4.) Lessie Aubrey, Grants Compliance & Accreditation Manager:

Lessie is present to review her report and policies attached to it that she is seeking approval for. She reviewed each policy. The policies, once approved, will be attached to the FQHC application that is required.

Josh noted some title changes that are needed in the policies; such as the C&P Committee Membership.

Josh Saxon moved and Arch Super seconded to approve the attached policies with changes to Lessie's report; 04-001-166, 04-001-168, 12-000-686, 02-001-045, 02-001-052, Claims Management, 12-000-685, 07-001-111, 04-004-190, KTHHS Personnel Policy, Provider Recruitment and Retention Plan, 4 haa, 0 puuhara, 0 pupitihara.

Lessie provided the Council a performance report on the CQI activities so it gets in the minutes. She overviewed the dental records report, medications in the electronic records, happy camp dental audit was 100%, unofficial GPRA report is at 30% meeting the 2-15 goals, review of the patient satisfaction survey from 2013 and that identified overall good standing by the patients that answered the survey.

Arch Super moved and Bud Johnson seconded to approve Lessie's report, 4 haa, 0 puuhara, 0 pupitihara.

5.) Vickie Walden, Dental Office:

Vickie is present to review her report. She noted that the third party budget for non-native American lab is in the "red" and she provided a justification for that including that it is a moving target. The Native American lab has increased significantly and she watches that quite often. She is hoping to have some changes seen in that soon.

The dental program has a dental office closures scheduled for July 23rd which will be both dental offices being closed. Most of the dental staff will be off on training to maintain their CEU's in the near future as well. She noted that they are going to be working on a policy to address training needs to ensure staff is present to see the patients when needed or in case of an emergency.

Josh Saxon moved and Arch Super seconded to approve the dental privileges, 4 haa, 0 puuhara, 0 pupitihara.

An upgrade to Dentrix is happening and they are hoping for this service to be better.

Arch Super moved and Josh Saxon seconded to approve the HC dental clinic office closure on July 23rd, 4 haa, 0 puuhara, 0 pupitihara.

Arch Super moved and Bud Johnson seconded to approve Vickie's report, 4 haa, 0 puuhara, 0 pupitihara.

6.) Raul Recarey, Health CEO:

Raul is present to seek approval of a Tele-medicine grant which will fund opportunities in TeleHealth which is the direction in which the tribe's health program is moving in.

Arch Super moved and 15-A-057 and Sonny Davis seconded to approve the agreement, 4 haa, 0 puuhara, 0 pupitihara.

He then sought approval of CaptureRX. The 340B processing provides funding for prescriptions. The exclusivity clause needs removed to ensure CaptureRX provides an option for the health program to have more flexibility in obtaining reduced priced medications and serving the patient population.

Josh Saxon moved and Bud Johnson seconded to approve agreement 15-A-059, 4 haa, 0 puuhara, 0 pupitihara.

Raul then provided an overview of his report. He noted that Orleans had the highest rating, Yreka's wait times was the highest, how satisfied with the providers was highest in Yreka. The high rating in Orleans was a result of the use of TeleHealth. Dr. Vasquez attends two days a month. All providers have to participate in TeleHealth which previously there was only one provider using the service. This allows maximum service by the providers.

He then provided an Indian Health Services update. He has concerns of Indian Health Services having a grasp on the big picture. They are looking at changes to RPMS in a basic term, which isn't good for the health program long term. Medical and other folks are moving aggressively in health reform and with Indian Health Services not being aggressive with an alternative they will not provide the tools necessary to keep up with the pace. Josh inquired why and if this is a Leadership issue, legislative authorities, funding levels, etc. Raul noted that his feeling is that Indian Health Services doesn't get it and there may be a limitation of resources, but he has not delved into this exactly. Raul participated in a short meeting with IHS, but was not feeling warm and fuzzy on the service and their outlook on advancing healthcare. Raul would like to participate in the sub-committees to change the outlook on services, because the rest of the world has tools for advancement but they need to be proactive in getting involved in some changes for the Tribe and in turn that will provide cost savings.

Laura cautioned the Tribe about not going with RPMS, for example the dental program chose to go to Dentrix which doesn't work, the tribe spent money and now they are looking to go to RPMS.

The staff agrees that there are issues within Indian Health Services and there isn't enough manpower. California needs to provide faster service. Eric reiterated that the update for meaningful use is that the national level it isn't working. There are some issues on getting more services and faster services to the RPMS systems and what works for the Tribes. Raul noted that the issues are separate. He is discussing the strategic thinking and planning.

He updated the Council on payment reform. They will not be participating in this pilot program. The pilot capitation is not a better service. Fee for service will eventually go away, and the Tribe needs to be prepared for that. For now, the group will stay as is.

Arch Super moved and Sonny Davis seconded to approve Raul's report, 4 haa, 0 puuhara, 0 pupitihara.

Pat Hobbs had one item that she had forgotten. It is a letter that needs submitted by next Tuesday. The comments have been developed by the NCTCC.

Consensus: to approve the letter with possible additional language regarding a possible Karuk Indian case.

Closed Session:
Josh Saxon moved and Arch Super seconded to cancel the collection agency services for billing, 4 haa, 0 puuhara, 0 pupitihara.

Consensus: to have Eileen Tiraterra draft some revisions to the fiscal policies and have that brought back to the Council for approval.

Consensus: to support the ongoing recruitment needs of the health program and possibly have an outside agency assist in brochure creation.

Consensus: to work with KTHA on home availability for the health program to put a provider in Orleans.

Josh Saxon moved and Bud Johnson seconded to approve the Summit Meeting Minutes 11/14/2014 and 2/19/2015, 4 haa, 0 puuhara, 0 pupitihara.

Bud Johnson moved and Sonny Davis seconded to appoint Tribal Member #LH to the PCAC Committee, 4 haa, 0 puuhara, 0 pupitihara.

Josh Saxon moved and Bud Johnson seconded to approve up to $2,500 through BIA for elder services #VS after review of BIA then discretionary will be accessed. Verifiecation of the BIA regulations will be done and a full report provided to the Tribal Council, 4 haa, 0puuhara, 0 pupitihara.

Consensus: to refer issue to Health CEO regarding double-booking of providers and to also seek a full time provider immediately.

Next Meeting Date: June 11, 2015 at 3pm in Orleans, CA.

Sonny Davis moved and Josh Saxon seconded to adjourn at 5:32pm, 4 haa, 0 puuhara, 0 pupitihara.

Respectfully Submitted,

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Russell "Buster" Attebery, Chairman

Recording Secretary, Barbara Snider

Karuk Child and Family Services Health Board Report - May

Submitted June 3, 2015

Patricia Hobbs MSW LCSW – Director Child and Family Services

Action Items: No action items on the report.

Updates and Information

Child Welfare Services

- Human Resources is coordinating interviews for Social Worker position.
- Justina Harrison continues to work on the Foster Care Program.
- The department received and responded to 15 ICW inquires during the month of May from various communities throughout the United States.

Mental Health

- Kareena Walter LCSW and Patricia Hobbs LCSW attended the following trainings:

  5/19/15 Anxiety Disorders – Redding

  Online CalGETS Problem Gambling (need clarification)

- Kareena Walter, LCSW - Siskiyou County Office of Education Panel discussion.
- Both LCSW's - Town Hall meeting in Happy Camp with Sheriff Lopey, Siskiyou Co Behavioral Health, Siskiyou County Probation and others on 5/20/2015.

Alcohol and Other Drug Program

- Two staff members will be in training with CRIHB 6/8 – 6/12
- There are two individuals who have completed the program in Happy Camp AOD.
- Two individuals were discharged in Orleans due to lack of attendance.

Attachments: Client data for each department by site.

Client Data

Mental Health				
Clinic	Yreka	Happy Camp	Orleans	Total
Mental Health	62	43	13	118
Psychiatry	13	4	1	19
Total	75	51	14	168

Alcohol and Other Drug				
Clinic	**Yreka**	**Happy Camp**	**Orleans**	**Total**
AOD	16	6	3	25
BIP	18	0	0	18
DUI	2	5	Not offered	7
Total	36	11	3	50

Child Welfare		
Area	**Humboldt County**	**Siskiyou County**
ICW	9	9
Voluntary /Family Preservation	5	2
Total	14	11

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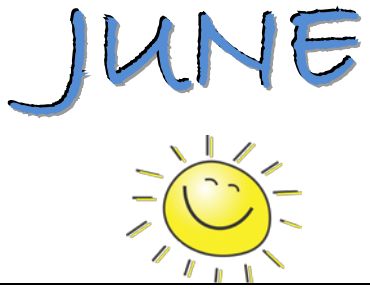
RPMS
Karuk Tribal Health and Human Services Program

Health Board Meeting-Orleans
June 11, 2015
Patricia White, RPMS Site Manager



Action Item:

VistA Imaging Policy- New 2015 Policy # 06-007-300

Workload reports

Below is the April 2015 "Operations Summaries" and Tribal Statistics. During April 2015 there were 2,260 visits at all locations. This is a decrease of 292 visits over March 2015 numbers. All locations were down during this period; Yreka (-68), Happy Camp (-196) and Orleans (--28). 727 of these visits were for Native American Patients (33%) See chart at the end of the operations summary.

User Assistance and Requests

During May2015 Amy and I had 13 documented requests for support. Two of these remain open. The requests were for user end support and reports this month.

Meeting / Conference Calls / Training May 2015

- 05/06 - AAAHC committee Meeting
- 05/06 - VistA Imaging Webinar
- 05/07 – Directors Monthly Meeting
- 05/07 – IT staff meeting
- 05/13 – ACQI Committee Meeting
- 05/14 - RPMS/EHR IHS Office Hours Call
- 05/14 – Health Board Meeting – Happy Camp
- 05/19 - Dentrix Test Instance Call/Henry Schein
- 05/20 – ECRI Institute Webinar - Data Driven QI
- 05/21 - RPMS/EHR IHS Office Hours Call
- 05/26 – Dentrix Live update/Henry Schein
- 05/28 – RPMS/EHR IHS Office Hours Call

Projects in Process

- **AAAHC**- We continue to prepare for accreditation, by reviewing health program policies. I continue to assist Lessie with the 2015 policy manual as needed.
- **Dentrix**-The Dentrix upgrade to the newest version occurred on May 21, 2015. The Dental staff was only offline for two hours. The week prior, Henry Schein had installed a test instance of the upgrade in database copy that Eric had created for this purpose. The test instance allowed for users to view what the changes would be before the live update. All went smoothly.

Budget: Report as of June 1, 2015. Eight months into the fiscal year.

Program	RPMS
Budget Code	3000-75
Program Year	2014-2015
Appropriation	$235,336.60
Expenses to Date	120,863.96
Balance	114,472.64
Percent used	51.36

Respectfully Submitted,
Patricia C White, RPMS Site Manager

OPERATIONS SUMMARY FOR KARUK TRB HP Service Unit
FOR APR 2015
Prepared for the June 11, 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 19,085 (+4.1) living patients registered at this SU. This number does not represent the 'Active User Population' which is found elsewhere in PCC Reports. There were 82 (+34.4) new patients, 0 (**) births, and 2 (+100.0) death(s) during this period. Data is based on the Patient Registration File.

THIRD PARTY ELIGIBILITY
There were 2,874 (+0.5) patients enrolled in Medicare Part A and 2,741 (+0.4) patients enrolled in Part B at the end of this time period.

There were 115 (+9.5) patients enrolled in Medicare Part D.

There were also 7,191 (+4.3) patients enrolled in Medicaid and 6,338 (+8.7) 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 58,799.51 (+22.3). The number and dollar amount of authorizations by type were:

57 - DENTAL	10	8937
64 - NON-HOSPITAL SERVICE	824	49862.51

DIRECT INPATIENT
[NO DIRECT INPATIENT DATA TO REPORT]

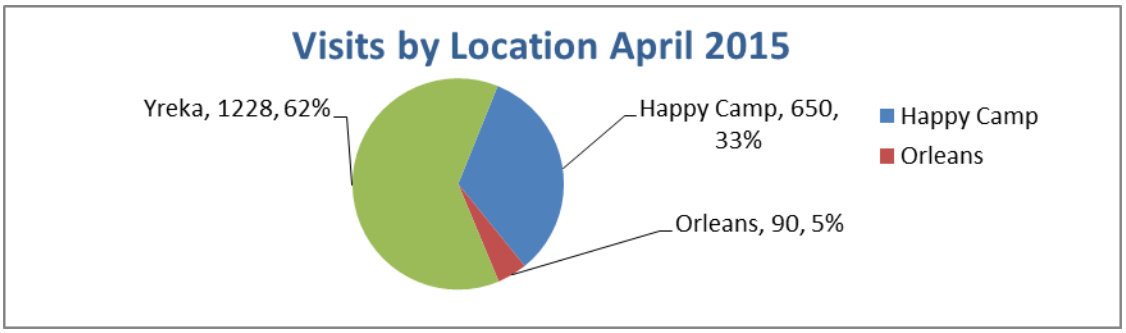
AMBULATORY CARE VISITS
There were a total of 1,968 ambulatory visits (+2.0) during the period for all visit types except CHS.
They are broken down below by Type, Location, Service Category, Clinic, Provider Discipline and leading Diagnoses. These do not equate to 'official' APC Visits which are identified in other PCC Reports.

By Type:

TRIBE-638 PROGRAM	1,968	(+2.0)

By Location:

YREKA	1,228	(+24.9)
KARUK COMMUNITY HEALTH CLINIC	650	(-18.9)
ORLEANS	90	(-38.4)

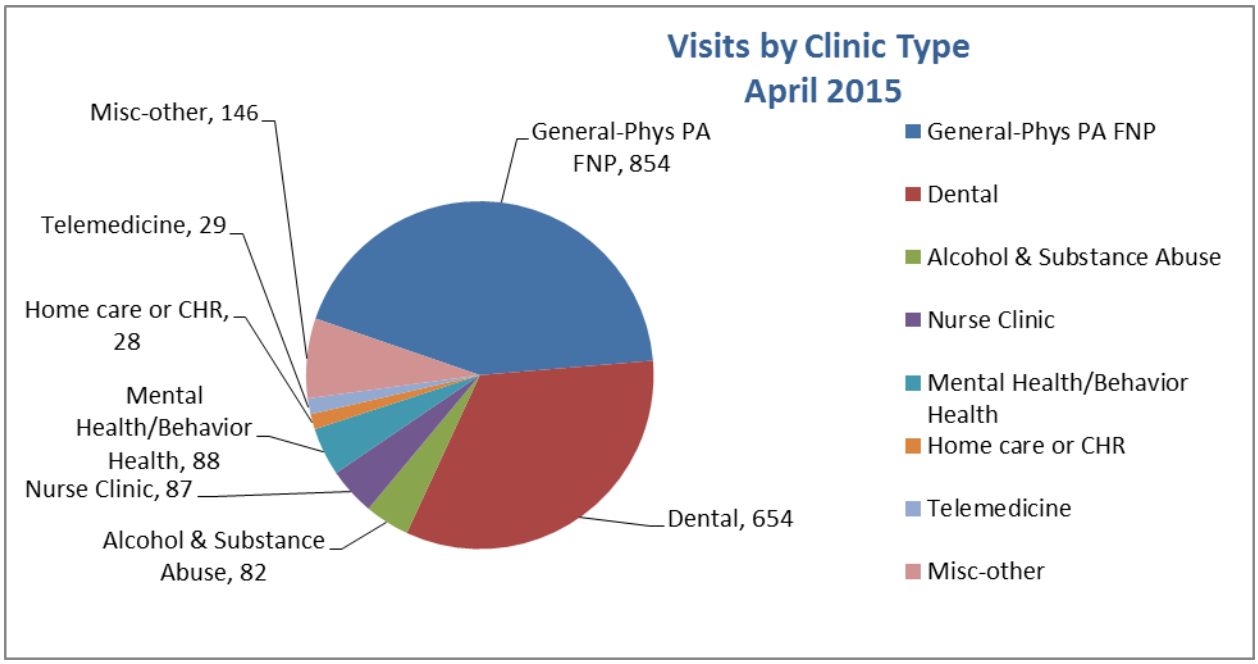


By Service Category:

AMBULATORY	1,885	(+0.9)
TELECOMMUNICATIONS	83	(+36.1)

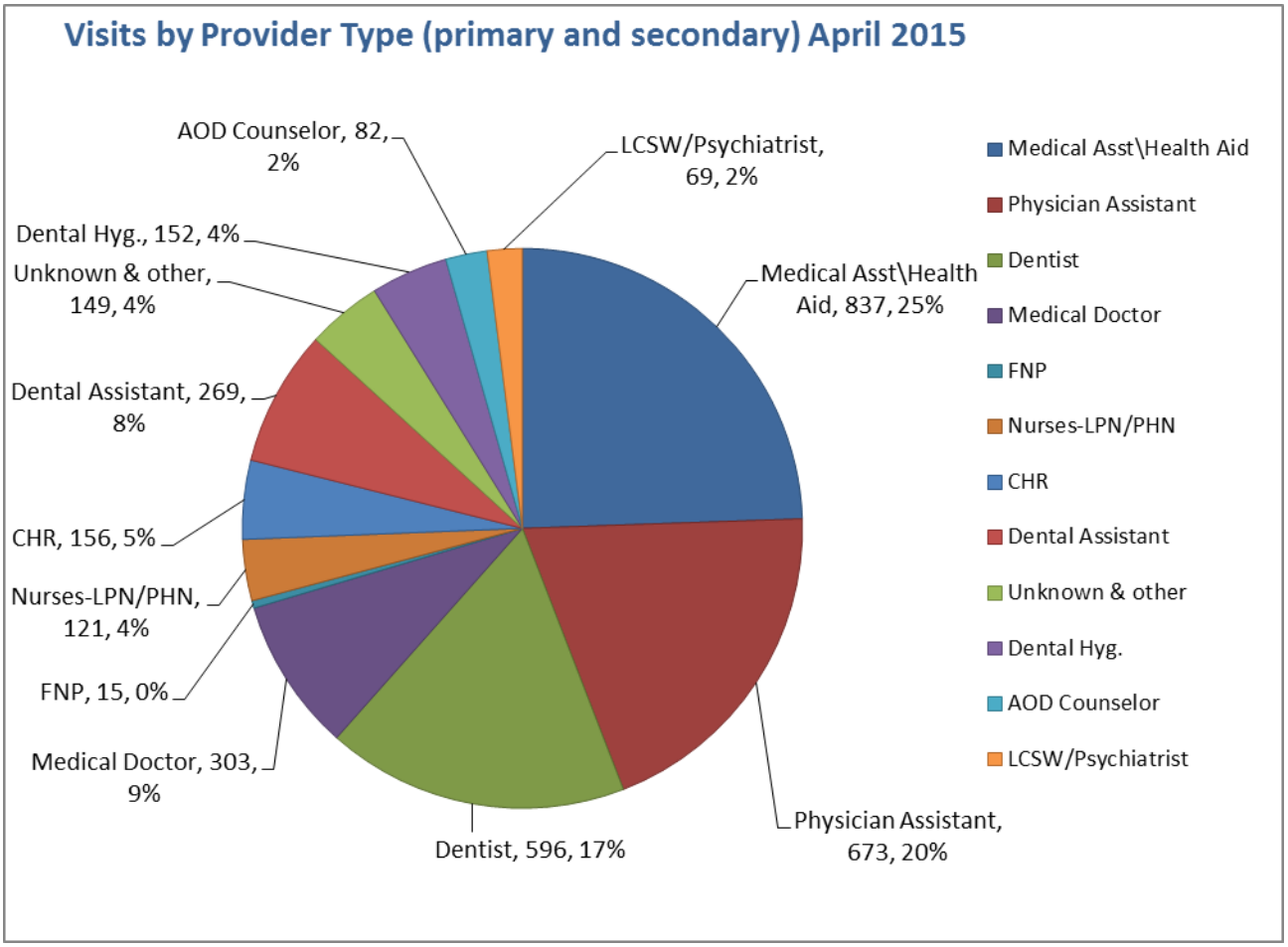
By Clinic Type:

GENERAL	854	(+57.0)
DENTAL	654	(+16.0)
OTHER	128	(+47.1)
NURSE CLINIC	87	(-20.2)
ALCOHOL AND SUBSTANCE	82	(-47.4)
MENTAL HEALTH	53	(-7.0)
BEHAVIORAL HEALTH	35	(+337.5)
TELEMEDICINE	29	(**)
HOME CARE	28	(+133.3)
PHYSICAL THERAPY	10	(+150.0)
TELEPHONE CALL	4	(-84.6)
CHART REV/REC MOD	2	(+0.0)
NO CLINIC	1	(+0.0)
PHARMACY	1	(+0.0)



By Provider Type (Primary and Secondary Providers):

PHYSICIAN ASSISTANT	673	(+171.4)
MEDICAL ASSISTANT	624	(+15.1)
DENTIST	596	(+16.9)
MD	303	(-34.4)
DENTAL ASSISTANT	269	(+166.3)
HEALTH AIDE	213	(+17.7)
COMMUNITY HEALTH REP	156	(+57.6)
DENTAL HYGIENIST	152	(+10.1)
LICENSED PRACTICAL NURSE	108	(-40.7)
UNKNOWN	102	(**)
ALCOHOLISM/SUB ABUSE COUNSELOR	82	(-50.0)
LICENSED CLINICAL SOCIAL WORK	69	(+50.0)
HEALTH RECORDS	45	(-51.6)
NURSE PRACTITIONER	15	(-92.4)
PUBLIC HEALTH NURSE	13	(+160.0)
ADMINISTRATIVE	2	(**)



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	661	(+16.8)
2). OTHER SPECFD COUNSELING	183	(+77.7)
3). HYPERTENSION NOS	97	(-24.2)
4). LUMBAGO	75	(+11.9)
5). LABORATORY EXAM NEC	74	(+1,750.0)
6). HYPERLIPIDEMIA NEC/NOS	67	(+8.1)
7). DMII WO CMP NT ST UNCNTR	58	(+3.6)
8). THERAPEUTIC DRUG MONITOR	53	(+32.5)
9). LONG-TERM USE ANTICOAGUL	52	(+33.3)
10). OBESITY NOS	43	(-33.8)

CHART REVIEWS

There were 861 (-30.3) chart reviews performed during this time period.

INJURIES

There were 89 visits for injuries (-11.0) reported during this period. Of these, 22 were new injuries (-37.1). The five leading causes were:

1). ACC-CUTTING INSTRUM NOS	17	(**)
2). NONVENOM ARTHROPOD BITE	3	(+0.0)
3). DOG BITE	2	(+100.0)
4). ANIMAL BITE NEC	2	(**)
5). HOT SUBSTANCE ACCID NEC	2	(**)

EMERGENCY ROOM

[NO EMERGENCY ROOM VISITS TO REPORT]

DENTAL

There were 487 patients (+5.0) seen for Dental Care. They accounted for 654 visits (+16.0). The seven leading service categories were:

1).	PATIENT REVISIT	447	(+16.1)
2).	HYPERTENSION SCREENING	254	(+36.6)
3).	LOCAL ANESTHESIA IN CONJUNCTION WIT	207	(+41.8)
4).	INTRAORAL - PERIAPICAL FIRST RADIOG	175	(+24.1)
5).	INTRAORAL - PERIAPICAL EACH ADDITIO	158	(+95.1)
6).	SEALANT - PER TOOTH	146	(+139.3)
7).	PREVENTIVE PLAN AND INSTRUCTION	131	(-7.1)

IN-HOSPITAL VISITS

[NO IN-HOSPITAL VISITS TO REPORT]

PHARMACY

There were 1,624 new prescriptions (+10.3) and 0 refills (**) during this period.

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TRIBAL STATISTICS APRIL 2015

	Registered Indian Patients	Indian Patients Receiving Services April 2015	APC Visits by Indian Patients April 2015
Karuk	2098	408	367
Descendants residing in CA	1904	226	171
All other Tribes	2210	119	102
Total	6212	753	640

Policy Reference Code: **01 () 02 () 03 () 04 ()** **13 () 14 () 15 () 16 ()**	**05 () 06 (X) 07 () 08 ()** **17 () 18 () 19 () 20()**	**09() 10 () 11 () 12 ()** **21() 22()**
Function: **Clinical Records and Health Information**	**Policy #:** **06-007-300**	**Policy Title:** **VistA Imaging**
Tribal Chairman: **Date:** **Signature:**	**Medical Director:** **Date:** **Signature:**	**Cross References:** **Approved Scanning list** **VistA Document Error Form** **VistA Deletion Log**
New Policy 2015		

I. **PURPOSE:**

To establish policies, procedures, and responsibilities for scanning inside and outside - clinical and administrative documents into the Vista Imaging program that can then be accessed through the Resource and Patient Management System Electronic Health Record (RPMS-EHR). Documents that originate within the clinic but which cannot be found within RPMS-EHR will be scanned or imported into the Clinical or Administrative portion of VistA by Records/Reception Staff.

Non-clinical documents, such as Insurance Cards, Photo Id's, Verification of Insurance Coverage, and Face Sheet – as well as any other miscellaneous **Administrative** documents such as Birth certificates, Death Certificates, Native Verification, or any other legal documents shall be scanned into the Administrative portion of VistA by Medical Records/Reception Staff.

Clinical documents originating from other facilities will be scanned or imported into the **Clinical** portion of VistA by Records Staff. These documents include, but are not limited to: Imaging reports, EKG/Cardio reports, Labs, Diagnostic Tests, Health History, and Outside Orders.

After scanning and quality assurance, the document is filed according to Patient Business Office policy, which states that the paper copy, which has been stamped "Scanned" or "Scanned Illegible", shall be filed for a time period of **30 days**, then shredded and disposed of in accordance with medical records policy.

All scanned documents will be made available to all clinical and support staff who have appropriate authorization to access the RPMS EHR via EHR and VistA Display Software.

II. **POLICY:**

The Karuk Tribe is committed to creating an environment that promotes and fosters the use of the RPMS-EHR by defining policies, objectives, and responsibilities for the scanning of documents related to patient care. To establish policies and outline procedures for scanning documents into the VistA Imaging program, it is important to define which documents will be

scanned into VistA Imaging and how these documents will be indexed. All staff members with scanning responsibilities are properly trained in Standard Operating Procedures (SOPs) as they relate to scanning and the use of scanning equipment. Staff members scanning documents will ensure that the document is attached to the appropriate progress note title and patient, and that image quality meets necessary standards. The Karuk Tribe has decided that we **will do a limited amount of backwards scanning**. Those documents will be limited to a few select documents listed in Appendix A, or if a provider marks a document from the past with a sticky note that he/she would like scanned into the patient's record. All new patients will be in the EHR and have any relevant administrative/clinical documents scanned into VistA Imaging.

A patient chart will not be created unless it is needed during the time of transition into VistA Imaging (a blank manila folder with the patient's name and chart number vs. a full chart.)

All patient data that is currently input into EHR by Records/Reception Staff still must be entered, just as it was/has been done in the past before the implementation of scanning documents. This should be done by the Records Staff/Scanning Specialist before the document is scanned (if need be) into the system and filed away until it can safely be shredded.

Prescription refills that are written shall be filed away in a working accordion file after the refill has been processed by the Provider and Records department. These documents shall **not** be scanned into VistA Imaging. A refill through E-RX eliminates the need for this procedure, as it will be done electronically. The exception is for written prescriptions for controlled substances. All written prescriptions for schedule II substances will be scanned into VistA Imaging under the MEDS button.

Laboratory results are scanned in to VistA under the LAB button. Lab results that come from outside lab sources need to be scanned into VistA unless the result is filed through the bidirectional interface with Quest. lab results that are filed electronically into the EHR through the Quest Bi-directional interface do not need to be scanned as this creates a duplicate of what is already filed in EHR.

Patient records received from outside providers via DIRECT Mail will be received and reviewed in the relevant DIRECT Mail account by medical records personnel at each clinic and then imported into the correct record using VistA's import capability. The appropriate provider will be added as 'additional signer' on the note to alert them to view the records. The email message will be filed electronically in the clinic's DIRECT mailbox and securely deleted after a period of **30 days**.

In the case of a Provider's absence, another Provider will receive notifications from VistA Imaging when the Scanning Specialist decides a Provider needs to receive a notification that a Lab or other clinical document is back and has been scanned into the system. Normal procedure would be to deliver the Lab or clinical document to the Provider, have them sign off that they have viewed/acted on it, and return it to the Records department for scanning and filing away for 30 days.

If the Scanning Specialist would like to send **a notification to the Provider** or other staff member, they must simply change the "Author" when performing the scan to display the name of the recipient and scan the document into VistA Capture.

III. **RESPONSIBILITIES:**

1. The **Records Supervisor(s**) or designee will be responsible for tracking and monitoring quality/quantity of scanned documents into the EHR according to facility policy.
2. The **Records Supervisor(s**) or designee will be the only staff members that are responsible for, and will have the functionality to, delete a scanned image and retract the note the image was attached to.
3. The **Records Supervisor(s)** or designee will be responsible for ensuring that all departmental staff members with scanning responsibilities are properly trained in Standard Operating Procedures (SOP) as they relate to scanning and in the use of scanning equipment. Initial training will be done by the IT department in initial set-up.
4. The **Clinical Applications Coordinator and RPMS Site Manager** will be responsible for supporting the Records Supervisors and giving them the tools to support their scanning staff. The CAC and RPMS Site Manager will be responsible for assigning security keys and secondary menus.
5. The **Scanning Specialist** will ensure that documents to be scanned are authenticated with the patient's name, medical record number, date of birth or other identifying information. The Scanning Specialist will ensure that each scanned document is attached to the appropriate progress note title, patient, and area of the medical record, all dates are correct, and that the image quality meets necessary standards.
6. The **IT Department** (Information Technology), **CAC** or **RPMS Site Manager** will be responsible for supporting hardware (scanners) and software (VistA) installations and maintenance on an ongoing basis.

IV. **PROCEDURE FOR SCANNING:**

1. Any document received by a scanning specialist will be **checked against the approved scanning list** for suitability before scanning the documents. (See list of approved documents). The list will be updated as needed by Records Supervisor and/or designee.
2. If the scanning specialist encounters a document that is not listed on the approved scanning list or questions a document he/she receives, the form will be referred to the Records Supervisor(s) or designee for a decision on whether the document is appropriate for scanning.
3. All documents/images that are deemed "clinical" that will be scanned into the VistA Imaging program will be attached to the appropriate text integration utility (TIU) EHR note title according to their designation on the approved scanning list.
4. All documents/images that are deemed "non-clinical" or for administrative purposes will be scanned into the administrative portion of the VistA Imaging program according to their designation on the approved scanning list.
5. The scanning specialist will review each document for legibility and completeness before scanning, then according to the approved scanning list - choose the appropriate button to scan the document to and fill out all appropriate information such as, but not limited to, image description and date.
6. The Note Date is the date of the document that is being scanned in and Doc/Image Date is the date the document was created or the date of service.
7. If the document being scanned is of poor quality, the scanning specialist will attempt to obtain a better copy by requesting this from the original source. If this is not possible, the image will be enhanced as best as possible with the tools available, within the VistA Imaging System.
8. If a legible replacement is not obtainable, all illegible areas will be stamped "Original illegible" in the margin as close as possible, to each area that is not legible.
9. If scanning multiple pages with information on both sides (front and back), and one page

does not have any information, stamp the page "**Blank**" prior to scanning.

10. Written documentation completed during the computer down time will be scanned into the record with a progress note "wet" signed by the scanning specialist that describes the reason for the scanned documents. (i.e. during power outages, or servers offline).
11. Once scanned, the external (hard copy) documents will be stamped "**Scanned**", dated, initialed on the top right side of the document by the staff member who scanned the document, and filed in a tickler file by date of scan. These documents will be held until all audits are completed but no less than 30 days and then shredded.
12. Quality checks of the scanned image will be conducted by the document scanner at the time of scanning for adjustment of image resolution, positioning, and legibility. This will be accomplished by viewing the scanned image on the screen before clicking "Image ok" then after by selecting the patient and picking the image that was stored after the "Image ok" button has been clicked. If the scan is not legible or is of poor quality, the first scan shall be discarded and the document shall be re-scanned.
13. An initial audit of the document scanned will be done by the scanner by viewing the image in "Latest Patient Images" within the VistA Capture program.
14. **Quality checks** will also be done via a validation process established within the Medical Records department and may consist of the following:
    a. Document imaging reports will be run from VistA Display, per facility policy to identify scanned documents.
    b. One hundred percent of the scans will be audited for each staff person scanning and will be reviewed for quality. This will include review of positioning, legibility, size, descriptors, and proper use of resolution to enhance the image quality. This will be done by running the "QA Review" function on the "Utilities" menu of VistA Capture client and selecting a time period, captured by, and % to return.
    c. At such time as a level of proficiency is reached, then the amount of auditing could lowered for the staff scanning but no less than three percent will be audited.
15. In the event a scanned document is scanned to the incorrect chart, incorrect VistA Note Title, or a document/image needs to be **deleted** from the system and/or a note title retracted, it will be reported to the Records Supervisor(s). Errors noted by the staff located both inside and outside of Health Records, will be brought to the attention of the Records Supervisor(s) or designee. The Records Supervisor(s) or designee will be the only staff members that are responsible for and will have the functionality to delete a scanned image and retract the note the image was attached to.

V. PROCEDURE FOR DOCUMENT SCANNING ERRORS:

1. The person identifying any scanning error will document the error on a scanning error form or other acceptable method and report the error to the Record Supervisor to correct the error as soon as possible.
    a. By interoffice mail
    b. By Spark messaging
2. The Records Supervisor(s) or designee will delete the image(s).
3. The Records Supervisor(s) or designee will document that the image has been deleted in the unsigned note or add an addendum to a signed note.
4. The Records Supervisor(s) or designee will retract the signed progress note.
5. The scanning error form or other method will be completed by the Records Supervisor(s) or designee.
6. All scanning errors will be tracked as a part of the scanning quality assurance protocol.

VI. PROCEDURE FOR RECORDS SUPERVISOR(S) QUALITY ASSURANCE REVIEW:

1. All Scanning Specialists must successfully process 10 consecutive documents of various types before being allowed to scan independently.

2. Quality Assurance audits will be performed by the Records Supervisor(s), or designee, consisting of the following:

    a. Document imaging report will be run from VistA for each facility/user to identify all scanned documents.
    b. A percentage or an absolute number of the scanned documents from VistA (QA review) of each scanning specialist, per division, will be reviewed for quality. This will include review of patient identification accuracy, note title accuracy, document positioning, document legibility, and proper use of resolution to enhance the image quality.
    c. If accuracy is insufficient, the sample size will be increased for a more focused review until the problem is resolved.
    d. The results of the audits will be reported to the ACQI Committee on a regular basis.

ATTACHMENTS:

- Approved Scanning list - Will be updated as needed. Current version will be adjacent to this policy in the KTHHSP Policy Manual
- VistA Document Error Form-found in the Forms folder
- VistA Deletion Log-Found in the Forms folder

Eric Cutright Information Technology Health Board Report
June 5, 2015

Expenditure/ Progress Chart – IT Dept Indirect Budget May 31, 2015

Program	Code	Total Budget	Expensed to date	Balance	% Expended
IT Systems	1020-15	$336,073.60	$220,198.49	$115,875.11	65.52%
Term Dates	**Total Months**	**Month # for report period**	**# Months Remaining**	**% Completed.**	**Extension Option Y/N**
10/1/2014 to 9/30/2015	12	8	4	67%	N
Comments:					
This is the budget to maintain the IT Department and the IT resources spread throughout tribal offices. The majority of the budget goes to salaries for IT personnel.					

IT Department Activities:

- The Karuk Health and Human Services program is looking at submitting a grant for telemedicine equipment. The grant is the Distance Learning and Telemedicine program, issues by the USDA Rural Utility Services. The grant only pays for equipment, and the health program can use the new equipment to expand our distance services, both between clinics, and to specialists all over the world. The deadline for applications is July 6.
- The consultant redesigning the Karuk website has completed a draft of the new website. Once complete, there will be some new features that I think will make the website friendlier and more appealing.
- On May 26 the Electronic Dental Records server was upgraded to the latest version, with support from the software vendor.
- Microsoft has announced that they will stop supporting Windows Server 2003 with security updates on July 14. IT has slowly been upgrading all of the Karuk servers to version 2008. Of the approximately 70 Windows servers operated by Karuk, only 10 are left to upgrade.
- For the reunion, IT will run the horseshoe tournament. IT is coordinating with maintenance to dig 4 new horseshoe courses in the trailer park to use during the reunion.

Project Title: Happy Camp Server Room Equipment Failure and Repair

Deliverables:
Task One – Replace Data Storage System in Happy Camp IT Room

1. The data storage system in the IT server room in Happy Camp is getting close to its natural end of life. Also, storage space on the system is nearly full.
2. Testing of the new storage server is now complete
3. Installation of the new storage is planned for June 8.
4. Transition of services to the new storage will occur gradually over the next few months.

Project Title: Orleans Broadband Project

Expenditure/ Progress Chart – USDA Community Connect Grant

Program	Code	Total Budget	Expensed to date	Balance	% Expended
USDA RUS	2061-00	$1,141,870.00	$728,307.39	$413,562.61	63.78%
Term Dates	**Total Months**	**Month # for report period**	**# Months Remaining**	**% Completed.**	**Extension Option Y/N**
10/24/2011-10/24/2017	72	43	29	59.72%	N
Progress Report Due Date	**Completed?**	**Date Completed.**	**Fiscal Report Due Date**	**Completed?**	**Date Completed.**
03/31/2015	Yes		10/17/2017	No	
Comments:					
This grant funds the construction of broadband infrastructure to Orleans.					

Construction Progress:

- The fiber optic installation contractor started work on April 7, and the pole attachment on the Verizon poles is complete. The fiber contractor is scheduled to return the first week July to perform the splicing and connect the fiber to Siskiyou Telephone.
- The communications tower and accompanying equipment hut are fully constructed. The tower still needs a generator and utility power installed. Utility Power has been purchased from PG&E, and installation has started. The trench required for power has excavated. PG&E is planning on installing power the 2nd week in July.
- The installation of the core wireless network is scheduled to begin once power is installed, but some preparatory work may begin in late June.
- All construction must be complete and the network fully functional by October 24, 2015, else the Karuk Tribe cannot meet the requirements of the USDA RUS grant agreement.

Reimbursement Status:

- $736,049.39 has been spent. $430,889.00 has been reimbursed.
- The fourth reimbursement request for $272,540.09 was submitted on June 5.

Permitting Services:

- All government permits in hand as of December, 2013.
- All extensions to existing permits have been filed and received to match the current construction schedule.

Project Title: Klamath River Rural Broadband Initiative (KRRBI)

Deliverables:
Project Management Services:

- 2nd quarter report due July 10, 2015.

Engineering Services:

- Fiber engineering field survey completed on April 9. The GPS data from the trip is currently being processed, and installation methods determined for the entire route.
- Wireless engineering primarily consists of distribution for the town of Orick. Orick site visit complete, engineering is under way.

Environmental Review:

- National Environmental Protection Act (NEPA):
  - Because both state and federal environmental compliance is required on this project, to save costs, a joint environmental document will be prepared that meets the standards of both NEPA and CEQA.
- California Environmental Quality Act (CEQA):
  - The funding agency, the California Public Utilities Commission (CPUC) is responsible for CEQA compliance on this project. The CPUC has hired a contractor to review the CEQA compliance. A preliminary field visit is being scheduled with this contractor and the CEQA and NEPA teams. The NEPA lead, BIA, is in the process of hiring a new agent who will handle the environmental aspects of this project.
- CEQA Cost concerns:
  - On March 19 the Karuk Tribe received a letter from the CPUC describing the process to address the unbudgeted and increased costs for CEQA compliance. The CPUC recommends that the Karuk Tribe submit for a modified funding resolution from the CPUC once the environmental process costs are fully known.

Permitting Services:

- Required Federal permits:
  - USDA Forest Service Special Use Permit – Application submitted
  - National Park Service Special Use Permit – Application submitted, revisions in progress
  - US Army Core of Engineers Klamath River Crossing Consultation – May not be necessary
  - BIA is acting as the federal lead agency for NEPA compliance
- Required State Permits:
  - CalTrans Encroachment Permit – Application waiting on fiber engineering
  - CEQA State of California Environmental Report – Waiting on environmental assessment
  - California State Parks Special Use Permit – waiting on fiber engineering
  - California State Lands Commission Easement – waiting on fiber engineering
  - California Dept Fish and Wildlife Endangered Species Impact Report – Waiting on fiber and wireless engineering

- Cultural Resources Reports:
  - SHPO Cultural Resources Approval – Waiting on cultural survey
  - Yurok THPO Cultural Resources Approval - Waiting on cultural survey
  - Karuk THPO Cultural Resources Approval - Waiting on cultural survey
- Required County Permits:
  - Humboldt County Special permit for tower construction – Waiting on wireless engineering
  - Humboldt County Building permit for tower construction – Waiting on wireless engineering
  - Humboldt County MOA for Right-of-Way Amendment – Waiting on fiber engineering
  - Humboldt County Encroachment Permit for County Roads – Waiting on fiber engineering
- Required Tribal Permits:
  - Karuk Resource Advisory Board Approval – Waiting on fiber and wireless engineering
  - Yurok Tribe Transportation Encroachment Permit – Waiting on fiber engineering
- Other Required Permits:
  - Right-of-Way Easements with Independent Landowners – Waiting on fiber engineering

Expenditure/ Progress Chart – KRRBI – California Advanced Services Fund (CASF)

Program	Code	Total Budget	Expensed to date	Balance	% Expended
KRRBI - CASF	6661-00	$6,602,422.00	$148,779.00	$6,453,643.00	0.02%
Term Dates	**Total Months**	**Month # for report period**	**# Months Remaining**	**% Completed.**	**Extension Option Y/N**
10/17/2013-10/17/2015	24	19	5	75%	Y
Progress Report Due Date	**Completed?**	**Date Completed.**	**Fiscal Report Due**	**Completed?**	**Date Completed.**
07/10/2015	No		At 25% Expended	No	
Comments:					
This grant expands on the Orleans Broadband Project and partners with the Yurok Tribe to provide internet service to several unserved and under-served communities in Northern Humboldt County.					

Report Attachments:

- Cell phone usage report for May 2015 billing period

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: Quality of Care Provided	**Policy #:** 04-001-164	**Policy Title:** Pediatric Policy
Tribal Chairman: **Date:** **Signature:**	**Medical Director:** **Date** **Signature:**	**Cross References:**

Purpose/Background: The Karuk Tribal Health and Human Service Program is a service provider of all age groups. This policy addresses the Pediatric patient's special needs.

Policy:

Pediatric Patients: Our patients are considered Pediatric patients until they reach 18 years of age. At this time the patient is old enough to give informed consent for treatment.

Consent to Treat: We will see all children under the age of 18 years with parental or guardian consent. Parents or guardians are encouraged to accompany their children while treatment is rendered.

Child Health History: You will be given a Child Health History form to complete on your child. Accurate information will help ensure that your child receives quality care

Visits to Clinic when Child has a Fever, Cough, or Rash such as Measles or Chicken Pox:

- Please do not enter the waiting room or the building.
- Please call this office before entering the building, or stay in your vehicle and notify the clinic staff to see the patient before entering the clinic.

After Hours Call: For Happy Cam and Yreka: After hour and weekend emergencies please refer to the Fairchild Medical Center located at: 444 Bruce Street, Yreka, CA 96097
Phone: 530-842-4121
Report emergency visits to Contract Health Services within 72 hours.

Childhood Health and Disability Prevention (CHDP): The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment. Low income children, under age 19, with family incomes up to 200 percent of the federal guidelines may be eligible.

Immunizations: KTHHSP believes that childhood immunizations are important to the preventive health of your child and the community. Before the age of three your child will be required to receive: 4DTaP, 3IPV, 1MMR, 3Hib, 3HepB, 1VZV, 4PCV.

Ages 3 -18 will receive immunization updates according to CDC Guidelines.

Descriptions of vaccines:

DTaP – Protects against diphtheria, tetanus, and pertussis (whooping cough)
IPV – Protects against polio
MMR – Protects against measles, mumps and rubella
Hib – Protects against *Haemophilus influenzae* type b.
HepB – Protects against Hepatitis B
VZV – Protects against chickenpox
PCV – Protects against pneumococcal disease

State Registry: KTHHSP participates in CAIR. The California Automated Immunization Registry (CAIR) is a secure, confidential, statewide computerized immunization information system for California residents. Its goal is to raise immunization rates for children. The application stores and tracks childhood vaccination records and recommends dates when vaccinations are due. It hopes to increase the number of California's immunized children, reduce the number of unnecessary immunized children, and help insure that children's immunizations are kept current. It is accessed online to help providers and other authorized users track patient immunization records, reduce missed opportunities, and help fully immunize Californians of all ages. California law allows health care providers to share patient immunization information with an immunization registry as long as the patient (or patient's parent) is informed about the registry, including their right to 'lock' the record in CAIR so that immunization information is not shared with other CAIR users (though the data remains available to the patient's provider).

Referral: Based on the individual needs of the patient for additional required services that are unavailable at Karuk clinics.

Transportation: Transporters may transport your child to specialty services but parent or guardian must accompany them and remain with child during treatment or exam. It is your responsibility to bring your child's car seat and it must meet all safety standards.

Conduct: It is the patient's responsibility to control their children and keep them quiet, and while parent or surrogate is being treated to seek care for the children prior to his/her visit. It is a parent's responsibility to understand that staffs are unable to watch children during clinic hours.

Karuk Tribe

Karuk Tribal Health Board Report
For June 11, 2015 Orleans Meeting

Dental Department May 2015

1. *Dental Action Items*

   a. **Approvals for Dental Policy**
      i. **Policy # 06-006-295 Dental Record Chart Order.** Assigned to Vickie Walden. For updating, revision done, policy reviewed and approved by dental staff, and policy committee.

      ii. **Policy #14-004-450 Protocols for Dental Restorations** reviewed and update by Dr. Brassea DDS, then reviewed and approved by policy committee.

      iii. **New Policy # 14-001-010 Dental Scope of Services: Written by Vickie Walden, copies sent to Mr. Recarey, Dr. Millington DDS, and Nikki Hokanson RDH for review and feedback. I got responses from Nikki and Mr. Recarey made changes to the procedures.**

2. *Vickie Walden's Projects* and Tasks
   a. No update on Installing Dental Intra-Oral Cameras – This is on the It project/work list and is not a high priority.

   b. Preparing for AAAHC Survey – I continue working on my assigned Health Policies, reviewing clinical procedures and AAAHC standards to see if we are in compliance.

   c. Dentrix/Electronic Dental record updates were completed on schedule.

   d. Digital X-Rays – No update on this project, still a work in progress.

   e. Orleans Hygiene - The Clinic was a success in spite of the Dental EDR problems we encountered, those problems are being resolved.

   f. Dental visit entry is an everyday on going task

3. No Dental Budgets concerns this month, we currently working within our 2014/2015 FY budget.

Report Respectfully Submitted by Vickie Walden RDA on June 4th 2015

Attachments:
1. Current Policy # 06-006-295 Dental Record Chart Order
2. Revised Policy # 06-006-295 Dental Record Chart Order
3. Policy #14-004-450 Protocols for Dental Restorations
4. New Policy # 14-001-010 Dental Scope of Services

Draft Revision of the Dental Chart Order Policy

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: **01 () 02 () 03 () 04 ()** **13 () 14 () 15 () 16 ()**	**05 () 06 (X) 07 () 08 ()** **17 () 18 () 19 () 20 ()**	**09() 10 () 11 () 12 ()** **21 () 22 ()**
Function: **Clinic Records and Health Information**	**Policy #:** **06-006-295**	**Policy Title:** **Dental Record Chart Order**
Tribal Chairman: **Date: 05/17/2012** **Signature:**	**Medical Director:** **Date: 05/11/2012** **Signature:**	**Cross References:**
Supersedes Policy 06-007-290 dated 7/30/2009		

POLICY: *During our transfer from paper health records into an electronic dental record;* ~~The~~ Our ~~D~~*d*ental chart*s* shall be maintained ~~in a set order in a manila folder~~ *in the Computerized Dentrix Office Management System known as our Dental EDR and in a set order within a manila colored paper chart.*

PROCEDURE:

1. The *Paper* Chart will have two dividers and two pockets on the inside of the front flap of section 1, an extra-large pocket in the back of section 3 and all information filed in the following order:
    a. **Section One-Left Side contains:**
        - ~~Face sheet~~ (this can be viewed in the RPMS system no reason to print it)
        - Original patient registration form(s) *will be placed here until we are able to scan them into the patient's electronic health record.*
        - Indian verification form(s) *will be placed here until we are able to scan them into the patient's electronic health record.*
        - Two x-rays pockets *for PAX's, Bite wings, and/or a combination of these films.*

    b. **Section One-Right Side Contains:**
        - Patient medical and *dental oral health* history form *will be placed here until we are able to scan them into the patient's electronic health record.*
        - *If not available in the patient's E.D.R or E.H.R.* Patient medication information *will be placed here.*

    c. **Section Two-Left Side contains:**
        - *Patients Medical* and Dental ~~Oral~~ Health History *will be placed here until we can scam a signed copy into patient's electronic health record. Or until we can have the a electronic form and signature* ~~and examination records,~~ including *but not limited to:*
        - Allergies
        - Medication alerts
        - ~~Full Mouth Periodontal charting as needed.~~

    d. **Section Two-Right Side Contains:**
        - ~~Encounter Forms~~

- Referrals *and Outside Provider Reports will be placed here until we are able to scan them into the patient's electronic health record.*

e. **Section Three-Left side Contains:**
   - Consents *will be placed here until we are able to scan them into the patient's health electronic record.*
   - Broken Appointment/Phone Message consent form *will be placed here until we are able to scan them into the patient's electronic health record.*
   - Medication Prescriptions *will be placed here until we are able to scan them into the patient's electronic health record.*

f. **<u>Section Three-Right Side Contains:</u>**
   - All billing information *will be placed here until we are able to scan them into the patient's electronic health record.*
   - ~~Medi-Cal,~~
   - ~~Medicare,~~
   - ~~Blue Cross/Shield,~~ Private Insurances
   - ~~CHS~~
     1. Sliding Fee Discount *applications and income verification (for security reasons the patients income information/verification will not be scanned).* ~~documentation~~
   - Dental Lab Prescriptions / PO's / Invoices
   - ~~Referral Information~~
   - Miscellaneous
   - HIPAA Tab
     1. Disclosure Log
     2. HIPAA Form
     3. *Records Release information.*
   - Extra-large pocket ~~for large full mouth set of x-rays and panoramic x-rays~~ *in the back cover of the paper dental record.*
     1. *Panoramic X-Rays*
     2. *Full Mouth Set of X-Rays*

2. *Electronic Dental Record- Dentrix Enterprise's Dental Practice Management System, is comprised of many modules and is user friendly. Users have easy access to each module through short cut menus.*

a. *Family File modules is where we find and manage patient information such as name, health record number, address, phone number (this information crosses over on a link RPMS), notes and continuing care (recall) information.*
b. *Patient Chart modules are where we enter, find and manage a patient's clinical information and health assessment. We can post existing, completed, and recommended procedures. Additionally, you can keep extensive and detailed notes regarding patient care.*
c. *The Ledger- Procedures completed in the patient chart are automatically posted in the ledger. Currently the ledger module is used for viewing procedure data and upon request, printing walkout statements.*
d. *Office Manager Module offers useful, customized reports, lists and contains a set of utilities we can use to customize Dentrix Enterprise to fit our needs. This is where we can enter and manage dental procedure codes and fee schedules.*
e. *Appointment Book Module-*

- *For Scheduled patients we can enter and see appointment dates, times (including a patients appointment status), procedures to be done, and patient alerts and flags for: medical alerts, allergies, pre-medication patients, broken appointments, and access the ASAP, and Unscheduled patient lists*
- *Scheduling Events such as holidays, training, and etc.*

f. *Other Dentrix Enterprise Features:*

- *Treatment Planner*
- *Perio (Periodontal) Charting*
- *Continuing Care List*
- *Patient Alerts*
- *Office Journal*
- *DXOne Reporting*
- *Document Center*
- *Patient Questionnaires*

Karuk Tribal Health and Human Services Policy Manual

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Tribal Chairman: **Date: 6/11/2015** **Signature:**	**Medical Director:** **Date: 6/11/2015** **Signature:**	**Cross References:**
Supersedes Policy 06-007-290 dated 7/30/2009-revised 5/21/2015		

POLICY: During our transfer from paper health records into an electronic dental record; Our dental charts shall be maintained in the Computerized Dentrix Office Management System known as our Dental EDR and in a set order within a manila colored paper chart.

PROCEDURE:

1. The Paper Chart will have two dividers and two pockets on the inside of the front flap of section 1, an extra-large pocket in the back of section 3 and all information filed in the following order:
    a. **Section One-Left Side contains:**
        - Original patient registration form(s) will be placed here until we are able to scan them into the patient's electronic health record.
        - Indian verification form(s) will be placed here until we are able to scan them into the patient's electronic health record.
        - Two x-rays pockets for PAX's, Bite wings, and/or a combination of these films.
    b. **Section One-Right Side Contains:**
        - Patient medical and dental oral health history form will be placed here until we are able to scan them into the patient's electronic health record.
        - If not available in the patient's E.D.R or E.H.R. Patient medication information will be placed here.
    c. **Section Two-Left Side contains:**
        - Patients Medical and Dental Health History will be placed here until we can scam a signed copy into patient's electronic health record. Or until we can have the a electronic form and signature including but not limited to:
        - Allergies
        - Medication alerts
    d. **Section Two-Right Side Contains:**
        - Caries Risk Assessment form, Referrals and Outside Provider Reports will be placed here until we are able to scan them into the patient's electronic health record.
    e. **Section Three-Left side Contains:**
        - Consents will be placed here until we are able to scan them into the patient's health electronic record.

- Broken Appointment/Phone Message consent form will be placed here until we are able to scan them into the patient's electronic health record.
- Medication Prescriptions will be placed here until we are able to scan them into the patient's electronic health record.

f. **<u>Section Three-Right Side Contains:</u>**
   - All billing information will be placed here until we are able to scan them into the patient's electronic health record.
   - Outside Provider Reports will be placed here until we are able to scan them into the patient's electronic health record.
     1. Sliding Fee Discount applications and income verification (for security reasons the patients income information/verification will not be scanned).
   - Dental Lab Prescriptions / PO's / Invoices
   - Miscellaneous
   - HIPAA Tab
     1. Disclosure Log
     2. HIPAA Form
   - Extra-large pocket in the back cover of the paper dental record.
     1. Panoramic X-Rays
     2. Full Mouth Set of X-Rays

2. Electronic Dental Record- Dentrix Enterprise's Dental Practice Management System, is comprised of many modules and is user friendly. Users have easy access to each module through short cut menus.

a. Family File modules is where we find and manage patient information such as name, health record number, address, phone number (this information crosses over on a link RPMS), notes and continuing care (recall) information.
b. Patient Chart modules are where we enter, find and manage a patient's clinical information and health assessment. We can post existing, completed, and recommended procedures. Additionally, you can keep extensive and detailed notes regarding patient care.
c. The Ledger- Procedures completed in the patient chart are automatically posted in the ledger. Currently the ledger module is used for viewing procedure data and upon request, printing walkout statements.
d. Office Manager Module offers useful, customized reports, lists and contains a set of utilities we can use to customize Dentrix Enterprise to fit our needs. This is where we can enter and manage dental procedure codes and fee schedules.
e. Appointment Book Module-
   - For Scheduled patients we can enter and see appointment dates, times (including a patients appointment status), procedures to be done, and patient alerts and flags for: medical alerts, allergies, pre-medication patients, broken appointments, and access the ASAP, and Unscheduled patient lists
   - Scheduling Events such as holidays, training, and etc.
f. Other Dentrix Enterprise Features:
   - Treatment Planner
   - Perio (Periodontal) Charting
   - Continuing Care List
   - *Patient Alerts*
   - *Office Journal*
   - *DXOne Reporting*
   - *Document Center*
   - *Patient Questionnaires*

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: **01 () 02 () 03 () 04 ()** **13 () 14 (X) 15 () 16 ()**	 **05 () 06 () 07 () 08 ()** **17 () 18 () 19 () 20 ()**	 **09() 10 () 11 () 12 ()** **21 () 22 ()**
Function: **Dental**	**Policy:** **14-004-450**	**Policy Title:** Protocols For Dental Restorations
Tribal Chairman: **Date: 04/12/2012** **Signature:**	**Dental Director:** **Date: 03/21/2012** **Signature:**	**Cross References:**
Supersedes Policy DD 10-034-113 dated 09/10/2009		

POLICY. ***The Karuk Dental Providers will abide by and work within the following clinical treatment procedures criteria.***

PROCEDURES.

1. ***Criteria for*** **Amalgam Restorations**.
   ~~a.~~ The dentist ***will remove decay***, fill all cavities, replace an old filling with recurrent decay or replace a damaged filling, as conservatively as possible. ~~If a tooth is strong enough to receive a silver amalgam filling, that is the type of restoration that will be done.~~ Silver amalgams ~~fillings~~ ***may be*** ~~are what the dentist generally recommends~~ ***recommended*** ~~for~~ ***to***: restore posterior teeth, teeth with root caries or teeth that support partial dentures. ~~Other restoration materials are sometimes used as determined by the dentist.~~
   b. Teeth

2. ***Criteria for*** **Composite Restorations.** The dentist will recommend that the white composite filling be used to restore the anterior teeth whenever possible. However, the buccal surface of the posterior teeth may be filled with a composite filling if better esthetics demands it. The composite filling can be used in treating small lesions in posterior teeth.

3. ***Criteria for*** **Glassionomer Cement or filling material:** This may be used where the minimal preparation of the tooth is desired (i.e. root abrasion, root caries, broken filling with no decay) or where the fluoride release from the material is desired to resist recurrence of caries.

4. ***Criteria for*** **Temporary Sedative Filling.** A sedative filling may be placed in a tooth for the following reasons:

   a. For a period of six weeks, or more, when the dentist has concerns that there might be a chance of nerve damage.
   b. For longer or shorter periods to protect and medicate a tooth before the final fillings are completed. The final fillings can be placed as soon as the patient is free of any symptoms.

5. ***Criteria for*** **Crown and crown & bridge restorations.** The dentist will recommend a crown restoration when:

    a. There isn't enough tooth structure to safely hold an amalgam or composite filling.
    b. When the decay is deep and undermines the tooth structure making the tooth too weak to withstand the forces of chewing without breaking.
    c. A crown will be recommended as a final restoration for most endodontically treated teeth.
    d. A stainless steel crown is recommended as a final restoration in the treatment of deciduous teeth or for a temporary emergency adult restoration.

6. ***Criteria for*** **Removable** Prosthodontics, and fixed crown and bridge. ~~when:~~

    a. It will provide support to the remaining teeth in the dental arch.
    b. It will prevent drifting caused by missing teeth and aid in maintaining stabilization of the occlusion.
    c. It will provide dentition needed to masticate food by replacing missing teeth.
    d. It will simulate the supporting tissues of the adjacent teeth and of the teeth in the opposing arch.
    e. It will provide acceptable esthetics for the patient.

7. ***Criteria for*** Referrals

    a. Internal and external referrals must be written by a Karuk Clinic Dentist and entered into the RPMS referral system for processing and tracking.
        i. In order for referred services to paid by Karuk Contract Health Services (CHS), the referred services must be listed the CHS approved levels of care and the patient must comply with the approved CHS Policies
    b. Referral Procedures:
        i. Referral is.

Karuk Tribal Health and Human Services Policy Manual

Policy Reference Code: **01 () 02 () 03 () 04 ()** **13 () 14 () 15 () 16 ()**	**05 () 06 () 07 (X) 08 ()** **17 () 18 ()**	**09() 10 () 11 () 12 ()**
Function: Dental	**Policy #:** **14-001-010**	**Policy Title:** Karuk Dental Scope Of Services
Tribal Chairman: **Date:** **Signature:**	**Medical Director:** **Date:** **Signature:**	**Cross References:**

Purpose / Introduction: The Karuk Clinics provide care under the direct supervision of the Karuk Health Program CEO and the Karuk Health Board.

Oral diseases are a significant health problem in our communities. Access to all aspects of health care such as: promoting a healthy life style, preventive health education, early diagnosis and treatment, play a key role in our goal to improve oral health in our communities. This scope of services prioritizes the oral health services available in the Karuk Dental Clinics.

The Karuk Tribal Health Program has organizational wide guidelines, protocols, criteria, policies, and set process for all services i.e. patient services, travel and training, ordering supplies and conducting other routine business. The health program works within and strives to maintain the approved fiscal year budget, which is based on I.H.S funding, other available resources, along with their projected revenue. The program offers an income based discount program for some preventive and restorative dental services.

The Karuk Dental Employees will do their best to provide equal access to: emergency evaluations; preventive care; basic restorative: limited periodontal treatment and maintenance and limited/simple endodontic procedures.

The Clinics will maintain adequate flexibility in their appointment scheduling systems for evaluation of emergency problems, walk-in patients, patients with special problems, and new patients. It being understood that should demand for care exceed a clinic's capability to provide such care, measures to place limitations on the availability and type care, may be necessary and appropriate.

The Karuk Dental Providers must always recommend the best treatment options for every patient. This scope of services includes a list conditions, procedures and things that will be used as treatment modifiers when developing and presenting treatment options to patients. When a patient chooses or asks for a treatment option not offered at a Karuk Dental Clinic, the provider will give the patient a written referral to an appropriate outside provider.

Professional care is to be provided by qualified staff working together within; the scope of their licenses', which governed by The California Dental Practice Act; the programs current budget; and by adhering to the Karuk Tribes current program policies.

Policy Statement: *All Karuk Dental employees must comply with and work within the Karuk Dental Scope of services. This policy will be reviewed by, signed and dated by all dental employees.*

Guidelines and Procedures

Treatment Modifiers -

-Arch Integrity
-Patients behavior or motivation
-Disease Activity
-Periodontal Status -Teeth w/Poor Prognosis
-Diabetes or other Health conditions
-Patients Oral Hygiene
-Patients dependability
-Treatment Longevity > 5 years

Procedural Scope of Services-

Level I – Acute Emergency Services:

Includes those dental services which are necessary to relieve pain or control acute oral conditions, such as serious bleeding, a potentially life-threatening difficulty, maxillo-facial fractures, and swelling, severe pain, or signs of infection. Such as:

-Diagnosis
-Tooth Extractions
-Temporary Restorations
-Periodontal Therapy
-Endodontic Access
-Pulp Therapy
-Palliative Treatment
-Fillings
-Prescriptions of Medications
-Other conditions that require urgent attention e.g. prosthodontic repairs, denture adjustments, and etc.

Temporary/Locum Tenens are limited to providing Level 1 Emergency Services, Level II Primary, and/or Level III Secondary Care.

Level II – Primary Care

The procedures classified as primary care are:

-Patient & Community Education on Self Maintenance and Disease Prevention
-Dental Sealants -Topical Fluorides- -Supplemental prescriptions
-Prophylaxis (Cleaning)
-Pediatric Screenings to access need
-Tobacco Education & Cessation
-Sports Mouth Guards
-Periodontal Maintenance
-Group Education
-Nutrition Education
-Occlusal Guards for Bruxism
-Periodontal Debridement to enable Comp. Exam and Diagnosis-

Level III – Secondary Dental Care

The procedures deemed necessary for routine diagnosis and treatment. Most of these procedures are not complicated in nature, and one or more of these services can usually be completed in one to two appointments and/or can be completed by another general dentist.

-Comprehensive Exam
-Limited Oral Exams
-Periodontal Scaling and Root Planing
-Amalgam fillings
-Stainless Steel Crowns
-Periodic Exams
-X-ray-
-Composite Fillings
-Space Maintainers

-Therapeutic Pulpotomy (primary teeth only) -Biopsy, excision of lesion
-Endodontic Therapy on Anterior teeth -Diagnostic casts

Level IV – Limited Rehabilitation

Rehabilitative care is that which restores oral structures in an improved condition and form. Limited rehabilitation is defined by the Karuk Tribe as those dental procedures which are more complex and costly to provide then Level III care in controlling disease and restoring function.

-1 to 6 Single Full Cast crowns with or without porcelain, per exam and treatment plan-
-Non-Cosmetic Labial Veneer- -Direct (in-house) Post and Core restoration
-Direct (in-house) Crown Build-ups- -Gingivalplasty / Gingivectomy
-Bicuspid Endodontic Tx. (two canals) - Indirect or Lab processed Post and Core

Level V – Rehabilitation

The dental services classified in this level are rehabilitative procedures which require more Clinical chair time, additional knowledge and skill of care provider, and usually greater expense Then the limited rehabilitative services listed in Level IV care. Level V services usually require multiple appointments to complete, are usually associated with a rehabilitative plan for the entire mouth and could require a substantial patient copayment to cover professional fees in dental insurance and other third party programs.

Restrictions: Patients must have: all their restorative fillings done, healthy gums & good oral hygiene, good and/or maintained Periodontal health, be in routine recall, and a good prognosis for long term retention for the tooth/teeth being treated (3> 7) years, before for fixed partial dentures (bridges) and endodontic treatment can be done.

-Non- Emergency Surgical Extractions-
-Molar Endodontic treatment-
-Acid Etch Bridge (Maryland)-
-Removable Complete Dentures (including Immediate)-
-Removable Acrylic Partial Dentures-
-Removable Cast Partial Dentures (Not included in the tribal discount program)-
-Fixed Partial Dentures (3-6 Unit Bridges) (Not included in the tribal discount program)-

Level VI – Complex Rehabilitation

The dental services classified in this level are rehabilitative procedures which require more Clinical chairtime, additional knowledge and skill of care provider, and usually greater expense Then the limited rehabilitative services listed in Levels VI and V care. A substantial portion of the patients may require referral to a specialist for complex rehabilitative treatment.

-Cephalometric X-Rays- -Complete Occlusal Adjustment-
-Overdentures- -Bony Impaction Surgical Extractions-

Level VII - Program Exclusions – Dental Treatment Procedures not done in Karuk Dental Clinics

- Removal of existing Amalgam Fillings if they are intact and have no recurrent decay.
- Most Cosmetic Procedures, including external bleaching
- Initial and/or Replacement Inlays, Onlays and Veneers when used as a single restorative or as part of a fixed partial denture (bridge).

- Endodontic re-treatment
- Endodontic Apicoectomy / Periradicular Procedures
- Limited, Interceptive and Comprehensive Orthodontic Treatment Procedures
- Any treatment plan that calls for 7 or more single full cast crowns
- Any Fixed partial denture (Bridge) that includes 6 or more unit's i.e. 4 full cast crowns (retainers) and/or 3 Pontics.
- Full Mouth Rehabilitation
- TMJ Treatment Procedures other than minor occlusal adjustments or occlusal guards
- Bone Grafts
- Tissue Grafts
- Osseous Surgical Procedures –(Other than when done in conjunction with Surgical Extractions)
- Implants and implant prosthetics

Employee

Print Name:_____ Date_____

Signature:_____ Date_____

Staff Person doing Orientation

Signature:_____ Date_____

Karuk Tribe

Provider Team Performance Report

May 2015

Measure	Rotin	Cronin	North	Vasquez	Chambers
	Provider Name				
	% Resolved (Reminders that are DONE)				
DM Hgb A1c	87%	92%	83%	74%	80%
DM Nephropathy Screen	65%	53%	67%	58%	75%
DM Eye Exam	36%	25%	66%	23%	53%
DM Foot Exam	63%	76%	78%	76%	74%
DM EKG	59%	61%	34%	57%	75%
DM ACE/ARB	81%	67%	73%	58%	92%
TSH Test	76%	85%	67%	100%	92%
Hepatitis C Screening	62%	58%	28%	68%	74%
Osteoporosis Screening	0%	17%	0%	0%	19%
Activity Screen	76%	82%	74%	74%	74%
Lipid Screening	73%	81%	64%	77%	86%
Colon Cancer Screening	18%	7%	37%	29%	22%
Pap Smears	46%	49%	42%	71%	62%
Mammograms	31%	29%	36%	40%	55%
Depression Screening	72%	80%	74%	75%	70%
Average Completed:	56%	57%	55%	59%	67%

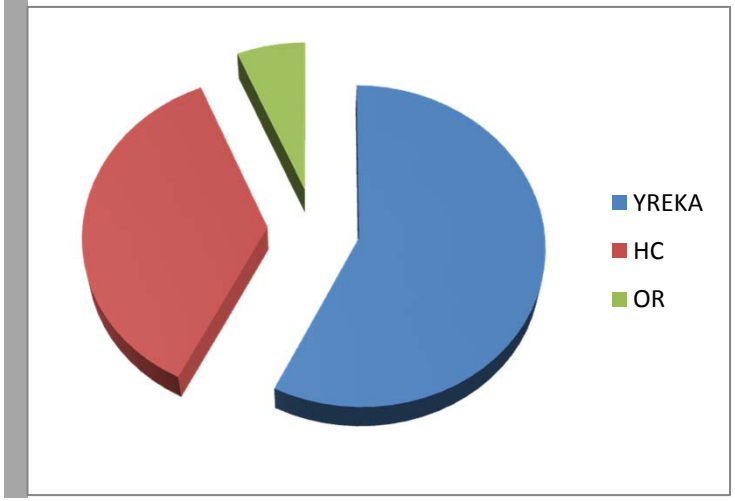
Improved
Worsened
Same

Average Visit Time:	1:43	1:26	1:22	0:57	0:47	May
Average Patients Daily:	8	9	6	12	10	May
Average Visit Time:	1:26	1:16	1:31	0:48	0:48	April
Average Patients Daily:	7	9	6	11	12	April
Average Visit Time:	1:26	1:11	1:14	0:40	0:46	March
Average Patients Daily:	9	10	6	12	12	March
Average Visit Time:	1:28	1:20	1:36	0:47	0:42	February
Average Patients Daily:	9	8	5	9	10	February

Patient Visits by Clinic by Month

Month	YREKA	HC	OR	MONTHLY TOTALS
Jan	497	332	66	895
Feb	515	336	77	928
Mar	593	332	67	992
Apr	455	253	37	745
May	425	318	30	773
Jun	0	0	0	0
Jul	0	0	0	0
Aug	0	0	0	0
Sep	0	0	0	0
Oct	0	0	0	0
Nov	0	0	0	0
Dec	0	0	0	0
Total	2,485	1,571	277	4333

Total Patient Volume by Clinic



Chambers Team	• Of the 15 quality metrics we're tracking, Chelsea Team IMPROVED scores on 12 of these. Still leading the group with an overall 67% average completed score. • Dropped from 12 to 10 average patients per day – 1 week she was gone affected her score by an average of 2 per day. • Average patient time improved slightly. • Lowest score on depression screening – need to work with MA's to get this number up.
Vazquez Team	• 2nd highest improvement of quality scores, improving 10 out of 15 metrics, with 2 worsening and 2 remaining the same. • Highest team score for TSH test – 100% • Average patients seen went UP to 12 from last month, despite being out for 2 weeks!
North Team	• In 3rd place with our push on improving quality metrics, improving 9 out of 15 but 6 metrics went **South**. • Average patient time IMPROVED. • Average patients seen remained the same and has stayed constant for last 3 months.
Cronin Team	• 6 metrics improved, 9 metrics worsened. • Average time worsened by 10 minutes • Highest team average metric for completed (80%) depression screening! • Average patients seen remained the same as last month. • Clinic manager: please setup a meeting, I'd like to meet with the team and discuss what we can do to improve these scores for next month.
Rotin Team	• 11 quality metrics worsened, 3 metrics improved and 1 stayed the same • Average patient time worsened by 17 minutes • Average number of patients seen went up from 7 to 8 • Clinic manager: please setup a meeting, I'd like to meet with the team and discuss what we can do to improve these scores for next month.
Chau Team	• New team member started this month – no stats yet!

I met with the Siskiyou Healthcare Collaborative for the first time on May 27th at Merci Hospital in Mt. Shasta. I believe it was a productive event that provided an opportunity to begin developing closer ties with our trading partners. The Executive Director for the Northern Region - Partnership Health Plan (Margaret Kisliuk) was there and I had opportunity to discuss at length PHC's incentive payments program for improving quality care metrics. Let me tie quality metrics with dollars and cents: We receive incentive payments for meeting quality standards. Last year, payments received from PHC were as follows:

PHC Incentive Payments – 2013/2014 Fiscal Year			
Yreka	**Happy Camp**	**Orleans**	**Total**
$23,293	$17,657	$5,907	**$46,857**

The current PHC formulas for calculating exact amounts of incentive dollars is based on a series of POINTS – this current program makes it impossible to pre-calculate what the incentive amount will be for any particular action. This is compounded by the fact that actual amounts are also dependent on what all providers as a community are able to attain. Net result: actual amounts are calculated at the end of the year as a final tally (copy of last year's report is attached).

PROPOSAL: Economic incentives are very effective influencing behavior. Allow us to create a bonus program for all clinic staff & provider teams that are **directly responsible** for us attaining higher scores and hence producing higher incentive payments back to Karuk HHS. Fiscal years end on July 31st and reports + bonus dollars are received approximately in October. I propose taking 50% of what we receive in next year's bonus payment as a fund to payout for improvement in quality health care. If we receive a similar amount this year to what we received last year, this should equate to approximately $23,000 available for incentive/ bonus payments to our staff and providers.

Orleans Clinic Provider Search Update:
Thank you for approving the provider search agreements – while we develop our own internal capability to one day not need to rely on these services, I believe we have negotiated very reasonable rates for these services of identifying viable candidates. We are not just looking for coverage but looking for permanence with the providers. To this end, we are placing special emphasis on trying to locate candidates that have an active outdoor lifestyle compatible with our area. I have had extensive conversations about this with the search companies and have incorporated this as a key theme in the interview questioning.

We have an interesting prospect that has applied for Orleans – her name is: **Pamela Hassler, PA-C**
She completed the Department of Family and Community Medicine, Primary Care Physician Assistant Program in August 2006 and has been practicing ever since. She is licensed and holds a Certification from the National Commission of Physician Assistants. She is:

- Board Certified Physician Assistant
- Active CA license in good standing
- Available to start in the middle of June
- Approximately 3 years of primary care experience and 5 years of experience in pain management.
- Knows the area well and has family not far from Happy Camp and Orleans

Negotiations are ongoing – I will apprise the Health Board of developments as they occur.

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PARTNERSHIP HEALTHPLAN of CALIFORNIA

Quality Improvement Program Statement

Fiscal Year 2013/2014
Payment Period: September 2013 - June 2014
Measurement Period: December 2013 - June 2014
FINAL Report

PCP: KARUK TRIBAL HEALTH CLINIC
PracticeType: Family Practice
County: SISKIYOU

Dec-Jun Total MMs for Measures (excl. Adult Expansion) [2]: 2,745

Total Due to PCP: $ 23,293.78

Sep-Jun Total MMs for Pymt. (excl. Adult Expansion) [1]: 3,735

Criteria	Desired Position	50th Percentile Target	QIP Score [3]	Total Potential Points	Points Earned YTD
A. HEDIS Scores					
• Cervical Cancer Screening (ages 21-64)	≥	69.1%	17.5%	20.00	-
				20.00	**-**
TOTAL POINTS CLINICAL DOMAIN					**-**

Criteria	Desired Position	Target	Results	Total Potential Points	Points Earned YTD
B. Appropriate Use of Resources					
• Generic Prescriptions **OR**	≥	85%	92%	40.00	40.00
Formulary Compliance (PCP Rx's only)	≥	98%	99%		
TOTAL				**40.00**	**40.00**
C. Access & Operations					
• Avoidable ED Visits	≤	35.51	74.73	10.00	-
• PCP Office Visits	≥	2.60	1.97	10.00	-
• 3rd Next Available Apptmt. + 1 Oper. Measure		2 QTRS.	0	10.00	-
• # of Qtrs. Practice "open" to PHC mbrs.		10.00	10.00	10.00	10.00
TOTAL				**40.00**	**10.00**
TOTAL POINTS NON CLINICAL DOMAIN					**50.00**

Total Quality Improvement Program Unadjusted Points Earned	**50.00**

Quality Improvement Program Funds Distribution

	Adj. Points Earned YTD [4]	Adj. Max Points Possible [4]
Total Quality Improvement Points {Unadj. Pts. Earned/Adj. Max Points Possible x 100}	**50.00**	**100.00**
(a.) QIP Adj. Points Earned x Sep-Jun Member Months		186,750.00
(b.) QIP Adj. Points Earned x Sep-Jun Member Months for all PCPs		51,984,268.52
(c.) Total Amount of QIP Fund {$5.50 x Sep-Jun Member Months for all PCPs} [1]		$ 4,336,816.00
(d.) PCP's Share of Fixed Pool QIP Fund {a/b} x c		**$ 15,577.84**
(e.) QIP PMPM		4.17
(f.) Adult Expansion MMs		925
(g.) Adult Expansion add'l QIP {e x 2} x f		**$ 7,715.93**
Total QIP Fixed Pool Payment Due {d+g}		**$ 23,293.78**
Final QIP PMPM		**6.35**

Optional Unit of Service Measures	
PCMH Certification	-
Peer-led Self Mgmt. Support Groups	-
CAIR	-
Advance Care Planning	-
Total Optional Unit of Service Measures	**$ -**

Total QIP Fixed Pool + Total Unit of Service	**$ 23,293.78**

Notes:

(1.) The QIP fixed pool total payment is based on QIP eligible September-June member months for all PCPs.
(2.) The QIP scores are based on QIP eligible December-June member months.
(3.) If your QIP Score is N/A, you had 0 members in the denominator and your Points Earned are listed as N/A (final score is readjusted to account for 0 members in the denominator).
(4.) Final points adjusted for N/A values in Points Earned YTD. Formula: (Unadj. Points Earned/Adj. Max Points Possible) x 100 = Adj. Points Earned YTD

For questions regarding the Quality Improvement Program (QIP), please contact us at* ***QIP@partnershiphp.org.*

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PARTNERSHIP HEALTHPLAN of CALIFORNIA

Quality Improvement Program Statement

Fiscal Year 2013/2014
Payment Period: September 2013 - June 2014
Measurement Period: December 2013 - June 2014
FINAL Report

PCP: KARUK COMMUNITY HEALTH CLINIC
PracticeType: Family Practice
County: SISKIYOU

Dec-Jun Total MMs for Measures (excl. Adult Expansion) [2]: 1,973

Total Due to PCP: $ 17,657.18

Sep-Jun Total MMs for Pymt. (excl. Adult Expansion) [1]: 2,746

Criteria	Desired Position	50th Percentile Target	QIP Score [3]	Total Potential Points	Points Earned YTD
A. HEDIS Scores					
• Cervical Cancer Screening (ages 21-64)	≥	69.1%	19.6%	20.00	-
				20.00	**-**
TOTAL POINTS CLINICAL DOMAIN					**-**

Criteria	Desired Position	Target	Results	Total Potential Points	Points Earned YTD
B. Appropriate Use of Resources					
• Generic Prescriptions **OR**	≥	85%	88%	40.00	40.00
Formulary Compliance (PCP Rx's only)	≥	98%	97%		
TOTAL				**40.00**	**40.00**
C. Access & Operations					
• Avoidable ED Visits	≤	36.10	24.63	10.00	10.00
• PCP Office Visits	≥	2.63	2.40	10.00	-
• 3rd Next Available Apptmt. + 1 Oper. Measure		2 QTRS.	0	10.00	-
• # of Qtrs. Practice "open" to PHC mbrs.		10.00	10.00	10.00	10.00
TOTAL				**40.00**	**20.00**
TOTAL POINTS NON CLINICAL DOMAIN					**60.00**

Total Quality Improvement Program Unadjusted Points Earned **60.00**

Quality Improvement Program Funds Distribution

	Adj. Points Earned YTD [4]	Adj. Max Points Possible [4]
Total Quality Improvement Points {Unadj. Pts. Earned/Adj. Max Points Possible x 100}	**60.00**	**100.00**
(a.) QIP Adj. Points Earned x Sep-Jun Member Months		164,760.00
(b.) QIP Adj. Points Earned x Sep-Jun Member Months for all PCPs		51,984,268.52
(c.) Total Amount of QIP Fund {$5.50 x Sep-Jun Member Months for all PCPs} [1]		$ 4,336,816.00
(d.) PCP's Share of Fixed Pool QIP Fund {a/b} x c		**$ 13,743.37**
(e.) QIP PMPM		5.00
(f.) Adult Expansion MMs		391
(g.) Adult Expansion add'l QIP {e x 2} x f		**$ 3,913.81**
Total QIP Fixed Pool Payment Due {d+g}		**$ 17,657.18**
Final QIP PMPM		**7.47**

Optional Unit of Service Measures

PCMH Certification	-
Peer-led Self Mgmt. Support Groups	-
CAIR	-
Advance Care Planning	-
Total Optional Unit of Service Measures	**$ -**

Total QIP Fixed Pool + Total Unit of Service **$ 17,657.18**

Notes:

(1.) The QIP fixed pool total payment is based on QIP eligible September-June member months for all PCPs.
(2.) The QIP scores are based on QIP eligible December-June member months.
(3.) If your QIP Score is N/A, you had 0 members in the denominator and your Points Earned are listed as N/A (final score is readjusted to account for 0 members in the denominator).
(4.) Final points adjusted for N/A values in Points Earned YTD. Formula: (Unadj. Points Earned/Adj. Max Points Possible) x 100 = Adj. Points Earned YTD

For questions regarding the Quality Improvement Program (QIP), please contact us at* ***QIP@partnershiphp.org.*

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PARTNERSHIP HEALTHPLAN of CALIFORNIA

Quality Improvement Program Statement

Fiscal Year 2013/2014
Payment Period: September 2013 - June 2014
Measurement Period: December 2013 - June 2014
FINAL Report

PCP: KARUK ORLEANS MEDICAL CLINIC
PracticeType: Family Practice
County: HUMBOLDT

Dec-Jun Total MMs for Measures (excl. Adult Expansion) [2]: 633

Total Due to PCP: $ 5,907.56

Sep-Jun Total MMs for Pymt. (excl. Adult Expansion) [1]: 978

Criteria	Desired Position	50th Percentile Target	QIP Score [3]	Total Potential Points	Points Earned YTD
A. HEDIS Scores					
• Cervical Cancer Screening (ages 21-64)	≥	69.1%	16.7%	20.00	-
				20.00	**-**
TOTAL POINTS CLINICAL DOMAIN					**-**

Criteria	Desired Position	Target	Results	Total Potential Points	Points Earned YTD
B. Appropriate Use of Resources					
• Generic Prescriptions **OR**	≥	85%	88%	40.00	40.00
Formulary Compliance (PCP Rx's only)	≥	98%	98%		
TOTAL				**40.00**	**40.00**
C. Access & Operations					
• Avoidable ED Visits	≤	35.38	19.48	10.00	10.00
• PCP Office Visits	≥	2.51	1.61	10.00	-
• 3rd Next Available Apptmt. + 1 Oper. Measure		2 QTRS.	0	10.00	-
• # of Qtrs. Practice "open" to PHC mbrs.		10.00	10.00	10.00	10.00
TOTAL				**40.00**	**20.00**
TOTAL POINTS NON CLINICAL DOMAIN					**60.00**

Total Quality Improvement Program Unadjusted Points Earned	**60.00**

Quality Improvement Program Funds Distribution

	Adj. Points Earned YTD [4]	Adj. Max Points Possible [4]
Total Quality Improvement Points {Unadj. Pts. Earned/Adj. Max Points Possible x 100}	**60.00**	**100.00**
(a.) QIP Adj. Points Earned x Sep-Jun Member Months		58,680.00
(b.) QIP Adj. Points Earned x Sep-Jun Member Months for all PCPs		51,984,268.52
(c.) Total Amount of QIP Fund {$5.50 x Sep-Jun Member Months for all PCPs} [1]		$ 4,336,816.00
(d.) PCP's Share of Fixed Pool QIP Fund {a/b} x c		**$ 4,896.27**
(e.) QIP PMPM		5.01
(f.) Adult Expansion MMs		101
(g.) Adult Expansion add'l QIP {e x 2} x f		**$ 1,011.29**
Total QIP Fixed Pool Payment Due {d+g}		**$ 5,907.56**
Final QIP PMPM		**8.05**

Optional Unit of Service Measures

PCMH Certification	-
Peer-led Self Mgmt. Support Groups	-
CAIR	-
Advance Care Planning	-
Total Optional Unit of Service Measures	**$ -**

Total QIP Fixed Pool + Total Unit of Service	**$ 5,907.56**

Notes:

(1.) The QIP fixed pool total payment is based on QIP eligible September-June member months for all PCPs.
(2.) The QIP scores are based on QIP eligible December-June member months.
(3.) If your QIP Score is N/A, you had 0 members in the denominator and your Points Earned are listed as N/A (final score is readjusted to account for 0 members in the denominator).
(4.) Final points adjusted for N/A values in Points Earned YTD. Formula: (Unadj. Points Earned/Adj. Max Points Possible) x 100 = Adj. Points Earned YTD

For questions regarding the Quality Improvement Program (QIP), please contact us at* ***QIP@partnershiphp.org.*