DEPARTMENT OF HEALTH & HUMAN SERVICES
Indian Health Service/California Area Office

Annual Report 2011

Improving the Health Status of American Indians and Alaska Natives







Indian Health Service

The Indian Health Service (IHS), a federal agency within the Department of Health and Human Services, is responsible for providing health services to American Indians and Alaska Natives (AI/AN). The provision of health services to members of federally-recognized Tribes grew out of the special government-to-government relationships between the Federal government and Indian Tribes. This relationship, established in 1787, is based on Article I, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders. The IHS is the principal federal health care provider and health advocate for Indian people, and its our goal to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for approximately 1.9 million AI/ANs who belong to 564 federally-recognized Tribes in 37 states.

California Area Office

The California Area Office (CAO) supports tribal governments and urban Indian communities in the development and administration of comprehensive health care delivery systems that meet the needs of Indian people.

Services

Medical
Dental
Behavioral Health
Nursing
Diabetes
Health Promotion Disease Prevention
Improving Patient Care
Contract Health Services
Business Office

Health Insurance Portability & Accountability Act
Information Resource Management
Health Information Management
Electronic Health Record
Vista Imaging
Telemedicine
Environmental Health Services
Sanitation Facilities Construction
Health Facilities Engineering

Our Core Values...

Excellence
Innovation
Respect
Ethics
Leadership

Contents

For additional information not contained in this publication, please visit the IHS/CAO website at: http://www.ihs.gov/California/

Four Priorities of the Indian Health Service

1. **To renew and strengthen our partnership with tribes**
2. **To reform the IHS**
3. **To improve the quality of and access to care**
4. **To make all of our work accountable, transparent, fair and inclusive**

The Indian Health Care System:

- IHS direct health care services - IHS services are administered through a system of 12 Area offices and 157 IHS and tribally managed service units
- Tribally-operated health care services - Tribal facilities are operated under the authority of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), Titles I and V. There are 82 Title V compacts, funded through 107 Funding Agreements, totaling approximately $1.35 billion.
- Urban Indian health care services and resource centers - There are 33 urban programs serving approximately 600,000 AI/AN residing in urban areas

Population Served:

IHS serves 2 million American Indians and Alaska Natives, members of 566 federally recognized Tribes.

Facilities:

- IHS Facilities: 29 hospitals, 68 health centers, 41 health stations
- Tribal Facilities: 16 hospitals, 258 health centers, 166 Alaska village clinics, 74 health stations

Human Resources:

IHS employees 15, 920 people (70% are American Indian/ Alaska Native), including 2,590 nurses, 860 physicians, 660 pharmacists, 640 engineers/sanitarians, 340 physician assistants/nurse practitioners, and 310 dentists.

Annual Patient Services (*Tribal and IHS facilities*):

- Inpatient Admissions: 51,097
- Outpatient Visits: 11,778,527
- Dental Services: 3,584,873

Indian Health Service in Action







List of Acronyms

AI/AN	American Indian/Alaska Native
ARRA	American Recovery and Reinvestment Act
BIA	Bureau of Indian Affairs
CAO	California Area Office
CATAC	California Area Tribal Advisory Committee
CHIS	California Health Interview Survey
CHS	Contract Health Services
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid Services
CPS	Child Passenger Safety
CRIHB	California Rural Indian Health Board
DDTP	Division of Diabetes Treatment and Prevention
EDO	Escondido District Office
EDR	Electronic Dental Record
EHR	Electronic Health Record
EHS	Environmental Health Services
EPA	Environmental Protection Agency
FAS	Fetal Alcohol Syndrome
FDA	Food and Drug Administration
FEHB	Federal Employee Health Benefits Program
GPRA	Government Performance and Results Act
HD/DP	Health Promotion and Disease Prevention
HFE	Health Facilities Engineering
HIP	Housing Improvement Program
HIPAA	Health Insurance Portability & Accountability Act
HITECH	Health Information Technology
HITRC	Health Information Technology Research Center
IHS	Indian Health Service
IPC	Improving Patient Care Initiative
IST	Improvement Support Team
IT	Information Technology
M&I	Maintenance and Improvement of Tribal Healthcare Facilities
MU	Meaningful Use
NAHASDA	Native American House Assistance and Self-Determination Act
NGST	National GPRA Support Team
NHTSA	National Highway Traffic and Safety Association
NIHB	National Indian Health Board
O&M	Operation & Maintenance
OEH&E	Office of Environmental Health & Engineering
OMS	Office of Management Support
ONC	Office of the National Coordinator for Health Information Technology
OPH	Office of Public Health
REC	Regional Extension Center
RPMS	Resource Patient Management System
SAP	Small Ambulatory Program
SDS	Sanitation Deficiency System
SFC	Sanitation Facilities Construction
USDA	United States Department of Agriculture
YRTC	Youth Regional Treatment Center

California's Youth Regional Treatment Centers…
creating an environment for youth to heal, learn, and restore the balance and harmony in mind, body, and spirit.

A LETTER FROM THE AREA DIRECTOR

Dear Tribal Officials and Healthcare Partners,

I am pleased to present your 2011 Annual Report. As I reflect on the year just passed, we have made long strides in expanding our outreach to tribal governments. This year, the IHS/CAO funded 562,372 outpatient visits and 202,973 dental visits for 80,438 active users from tribal clinics and 10,087 active users from urban clinics. The IHS/CAO budget for FY 2011 was $198 million. Area office administrative overhead remains under 6%. In addition, we have reached significant milestones in the evolution of the California Youth Regional Treatment Center (YRTC) project. We are closer than ever to building two YRTCs in California; one in the north and one in the south.

I am very proud of our progress in 2011 towards making the California YRTCs a reality. The Indian Health Service/California Area Office (IHS/CAO), in partnership with tribal governments, accomplished two important goals. First, the IHS purchased the future site of the southern California YRTC in Riverside County. This event marks the beginning of the design phase to construct the southern YRTC. Second, we selected an excellent site for the northern YRTC – 12 acres near D-Q University, California's former tribal college in Yolo County. The D-Q University Trustees agreed to return the 12-acre site back to the Federal government (General Services Administration), specifically for IHS/CAO to establish the YRTC.

Building the YRTCs is the top priority for the IHS/CAO. The new YRTCs will be an important step to helping hundreds of Indian youth in California who need residential treatment. I remain confident that, in 2012, we will continue our momentum and the Area-wide focus on establishing these inpatient facilities. The YRTCs will be the first IHS facilities to be constructed in California since IHS was transferred to the U.S. Public Health Service in 1955. We will continue working closely with tribal governments to establish the YRTCs.

Our mission includes helping Indian youth find healthy directions in life. Our goal, in establishing the two YRTCs, is to provide youth and their families a range of behavioral healthcare services that integrate traditional healing, spiritual values, and cultural identification. Our YRTCs will be state-of-the-art, therapeutic, and substance-free environments where youth and their families can receive quality healthcare. This is our responsibility, and my personal commitment, to ensure that Indian youth and their families heal from the suffering caused by chemical dependence.

One of the ways that I am improving quality of care is by sponsoring the IHS National GPRA Support Team (NGST). The NGST, located at the California Area Office, collects GPRA data regarding the 21 IHS GPRA Performance Measures from direct IHS, urban Indian and tribal health facilities across the entire United States. Then, the NGST organizes the data into reports for use by clinicians, health program directors, Area Office staff, Headquarters staff, and ultimately, for review by the President's Office of Management and Budget and members of Congress. Additionally, the NGST provides education and technical assistance to health programs and other Area Office staff regarding performance data management as well as healthcare quality. FY 2011 is the first time IHS met or exceeded all GPRA measures. Our performance is directly linked to the IHS budget and Congress' confidence in the IHS has grown immensely.

I facilitate access for our patients via the development of partnerships. One major partnership, which we are in the process of implementing in the California Area, is the strategic partnership with the Veterans' Administration (VA). In response to the October 1, 2010 Memorandum of Understanding between IHS Director, Dr. Yvette Roubideaux, and VA Undersecretary for Health Dr. Robert Petzel, I initiated the following activities with the VA and Veterans' organizations in the California Area:

- American Indian Veterans Association (AIVA) of Central California Meeting- September 14, 2011 in Pala. I delivered a presentation to AIVA members and meeting participants, providing them with information about the IHS and previous collaborations in which services were provided by a tribal health program in California to dual-eligible American Indian Veterans

- Meeting with staff of Indian Health Council about access to VA healthcare services for AI/AN Veterans in San Diego County. We discussed the desirability to conduct a local study to determine the number of dual eligible AI/AN Veterans in this geographic region. Additionally, we discussed possible solutions to billing the VA for services to AI/AN Veterans

- Meeting with VISN 22 Director Kenneth Clark at VISN 22 Office in Long Beach on July 28. I discussed strategies for determining the number of dual eligible AI/AN Veterans as well as possible models of shared services for this population. VISN 22 covers most of southern California

- Meeting with VISN 21 Director Sheila Cullen at VISN 21 Office in Mare Island on July 29, 2011. I discussed strategies for determining

numbers of eligible AI/AN Veterans as well as possible models of shared services for this population. VISN 21 covers most of northern California

- Invited the State of California Acting Secretary of Veterans' Affairs Rocky J. Chavez to the Annual Tribal Consultation in Coursegold on March 17, 2011. He presented about the services provided by his Department and provided strategies to improve outreach to Indian Veterans across California. Specifically, he discussed the State's plan to deploy outreach workers into California Indian country

Adequate access to quality health service requires well-trained and motivated health professionals staffing our urban Indian and tribal health programs. However, urban Indian and tribal health programs sometimes have difficulty in attracting and retaining these high-quality health professionals. The Indian Health Service made a very positive step forward in recruitment and retention capacity in FY11 by partnering with the Health Resources and Services Administration and the National Health Service Corps (NHSC). The NHSC has a very robust Loan Repayment Program (LRP) which tribal and urban Indian health programs are now able to participate in as LRP sites. Though I have encouraged this partnership for the last several years, it has been made much easier with the efforts of IHS Headquarters staff. Headquarters staff facilitated the establishment of automatic Health Professional Shortage Area scores, upon which LRP eligibility is dependent. During the last year, we made sure that all of our urban Indian and tribal health program staff became aware of this excellent opportunity.

In the first quarter of FY 2011, I distributed a self-assessment document to all nine tribal health program full-service pharmacies in the California Area. The purpose of this assessment is to guarantee that medications, especially controlled medications, are being dispensed in a manner which is well-monitored and in compliance with all applicable state and Federal laws and regulations. No irregularities were found; however, I received two telephone inquiries from the Federal Bureau of Investigation concerning possible inappropriate distribution of controlled substances by providers at tribal health programs with pharmacies.

During FY 2011, our Office of Environmental Health & Engineering (Sanitation Facilities Construction, Health Facilities Engineering, and Environmental Health Services), was reviewed by teams from IHS Headquarters. The reviews, conducted every three years, identified no major deficiencies/weaknesses in any of the three programs.

The Sanitation Facilities Construction (SFC) program received annual appropriations (IHS and EPA) of $8.5 million to support 25 community sanitation facilities projects serving 1,678 Indian homes. The SFC program completed 19 of 20 American Recovery and Reinvestment Act (ARRA) construction projects and continues to manage the largest Environmental Protection Agency (EPA)/IHS ARRA project in the nation, on the Tule River Reservation; seven miles of sewer main and a state-of-the-art wastewater treatment facility that will serve 371 Indian homes at a total cost of $11.6 million.

The Health Facilities Engineering (HFE) provided $3,332,000 to tribal healthcare programs for maintenance, construction, and medical equipment. HFE completed 100% of ARRA construction/medical equipment projects. HFE staff conducted deficiency assessments at 100% of tribal health facilities and met on-site with 27 tribal health program directors to discuss plans for future projects.

The Environmental Health Services (EHS) program conducted 393 environmental health surveys in Indian communities and tribal health programs. The EHS trained 60 tribal staff to become State-certified community water system operators, and provided oversight for IHS-funded Tribal Injury Prevention Cooperative Agreements, $1.16 million dollars over five years, for four tribal entities in California. The EHS purchased and distributed 640 child safety seats, 550 bicycle helmets, and 500 smoke detectors (total value of $40,000) to 22 tribal health programs.

I would fail in my duty if I did not acknowledge and thank the hardworking men and women of IHS/CAO for their commitment and dedication to the mission of the Indian Health Service. They have contributed immeasurably to our progress in the past and will help lead the way to the future. I think this year has been a turning point which lays the edifice for how we will continue to serve the Indian tribes of California for generations to come.

Be well,

/Margo Kerrigan/

Margo Kerrigan, MPH
Director
Indian Health Service/California Area Office
February 21, 2012

2010-2011 SERVICE HIGHLIGHTS

- During the week of April 23, 2011 the IHS/CAO and the California Rural Indian Health Board, Inc. co-hosted the Medical Providers' Best Practices & GPRA Measures Conference in Sacramento. This continuing medical education and formalized collaboration on improving quality and access to care was designed for Indian health program physicians and mid-level providers

- During the week of May 2, 2011, the IHS/CAO and the California Rural Indian Health Board, Inc. co-sponsored the Annual Dental Conference in Sacramento. The continuing dental education courses met all of the required annual continuing dental education courses necessary for state licensure renewal for dentists, dental hygienists, and registered dental assistants

- The IHS/CAO hosted two virtual Learning Sessions for California healthcare programs involved in the Improving Patient Care Initiative

- The IHS/CAO staff, in an effort to improve quality and access to health care, conducted site visits to five tribal programs . The site visits focused on effective communication, teamwork, customer service, GPRA, and improving patient care

- To improve performance on the Dental Access measure, the IHS/CAO offered modest financial incentives through the Dental Support Center to tribal and urban health programs that improved access by two percent or more

- The IHS/CAO published and distributed four quarterly "IHS/CAO Patient Newsletters" to all California tribal and urban healthcare programs for further dissemination to patients in healthcare facility waiting areas

- To make all our work accountable, transparent, fair, and inclusive, the IHS/CAO published and distributed two "Indian Health Service/California Area Office Quarterly Highlights" to all California Tribal Leaders to describe Area activities

- During FY 2011, the Division of Sanitation Facilities Construction (SFC) program received annual appropriations (IHS and contributed) of $8.5 million to support 25 community sanitation facilities projects serving 1,678 homes

- The SFC program continues to provide project management for 20 American Recovery and Reinvestment Act (ARRA) construction projects. Seventeen projects have been completed and 45% of ARRA funds have been disbursed. Three remaining ARRA projects are under construction and two will be completed in the Spring of 2012

- The SFC program is managing the largest Environmental Protection Agency/IHS ARRA funded project in the nation, on the Tule River Reservation. The project consists of seven miles of sewer main and a state-of-the-art wastewater treatment facility to serve 371 Indian homes, at a total cost of $11.6 million. This project is scheduled for completion in 2013

- The SFC program is developing a multi-year initiative to increase the sustainability of tribal drinking water and wastewater systems, protect public health, and protect federal investments in Indian communities throughout California. Many tribes have expressed interest in participating in this initiative, which has been funded at $100,000/year for the first two years. The goal is to ensure tribes are successfully managing their utility organizations and that responsibilities for routine maintenance, emergency repairs, and new construction are defined and carried out by the responsible parties

- We congratulate Lieutenant Matt Mergenthaler who was selected as the IHS/CAO, 2011 Project Engineer of the Year, in recognition of his outstanding accomplishments toward the attainment of SFC program objectives

- The Division of Health Facilities Engineering (HFE) provided $3,332,000 to tribal health programs to address facilities engineering and routine medical equipment needs. $1,431,000 was distributed for routine maintenance and improvement (M&I) activities, $472,000 for facility improvement projects, $804,000 for annual medical equipment needs, and $625,000 for tribal healthcare program equipment based on new clinic space

- The HFE implemented a project to assess the facility condition and energy usage for all tribal health programs in California. This study will be completed in early 2012 and will provide information that will be used for planning future facilities improvement/construction projects

- HFE staff presented the IHS Health Facilities Engineering program services to 27 tribal health program directors in California. The face-to-face meetings included discussions on future health facility construction projects and need for HFE technical assistance

- The Division of Environmental Health Services (EHS) re-established its institutional environmental health program, prioritized services, developed a program plan, standardized survey forms and processes, and conceptualized an Area-wide institutional environmental health project. The EHS staff completed 23 radiological equipment surveys, conducted 15 comprehensive environmental health surveys at tribal health care facilities, and will evaluate nitrous oxide use at tribal health programs in fiscal year 2012

- The EHS program conducted 370 surveys in fiscal year 2011, to identify environmental health risks and hazards in community facilities and make recommendations for their resolution. Surveys were conducted at the following tribal facilities: food service operations (268), head start programs (17), Indian gaming facilities (17), health care facilities (15), day care centers (8), swimming pools (6), and other facilities (39)

- The EHS program sponsored four courses to train tribal water system operators to build tribal capacity, manage tribal utility systems, and/or become State-certified community water system operators. More than 60 participants from tribal communities attended these courses

- The EHS program provided technical assistance/oversight to the following participants of the IHS Tribal Injury Prevention Cooperative Agreement: California Rural Indian Health Board, Indian Health Council, Tule River Tribe, and Greenville Rancheria. These projects were funded for $1.16 million dollars over five years, to hire an injury prevention coordinator at each location and to conduct “best practices” that address motor vehicle collisions and elder falls

- The EHS program awarded injury prevention “mini-grants” to 22 tribal health programs. In 2011, more than 640 child safety seats, 550 bicycle helmets, and 500 smoke detectors were distributed in tribal communities, with a value of $40,000

Youth Regional Treatment Center (YRTC)

The IHS/CAO is purchasing two sites for the YRTCs. The southern YRTC (Taylor Ranch) property will be in Riverside County, near the town of Hemet. Taylor Ranch is a beautiful 20-acre site with pastoral views. In October 2011, the IHS concluded two years of due diligence and, with tribal participation, will dedicate the land for the new YRTC. Steps are already underway to design the southern California YRTC in FY 2012.

The northern YRTC will be in Yolo County, near Davis, located on Federal government land held in-trust by D-Q University, California’s former tribal college. On October 28, D-Q University agreed to revert 12 acres from its trust, expressly for the IHS/CAO to purchase the property and to establish the northern California YRTC. Pursuant to the Federal Property Transfer Act, the IHS/CAO will pay fair-market value for the 12 acres and could take as little as 90 days to complete the transfer; no escrow period will be required.

On December 23, the President signed the final 2012 appropriation bill into law, authorizing $2 million for site development and design of the southern California YRTC. The total budget for design and construction of the two YRTCs is approximately $39 million. The IHS/CAO will request that IHS Headquarters obligate the entire amount in FY 2013. Design and construction of the two YRTCs could be completed 18-24 months after Congress authorizes funding.

Future site of southern California YRTC

A LETTER FROM THE AREA DEPUTY DIRECTOR

Dear Tribal Officials and Healthcare Partners,

Reflection is a powerful technique that puts actions into perspective. The ritual of putting together the annual report forces me to stop and think about the purposeful activities the IHS/CAO engaged in during fiscal year (FY) 2011 towards achieving the agency's mission. I am so pleased IHS/CAO took the initiative during FY 2010 to engage all California Area staff and forge an internal strategic plan. The strategy process is an important map to the work we do; it frames the output of all resources in a thoughtful and comprehensive manner.

Since 2001, the California Area Office has used various financial resources to provide video conferencing equipment to health programs. Telemedicine services for nine health programs have been established using the video conferencing technology. During fiscal year 2011, the IHS/CAO received $557,770 of American Recovery and Reinvestment Act funding used to purchase information technology (IT) equipment for California tribal and urban Indian health programs. The IHS/CAO delivered video-conferencing equipment, which was defined as the highest priority, to create a more inclusive and transparent environment for tribal consultations and meetings between the IHS and tribal governments, and tribal and urban Indian health care organizations. There is now the opportunity to expand usage of the video-conferencing equipment.

During FY 2011, the IHS/CAO finance office assumed the function of cash management (i.e. the payment process). The cash management transition began to take form during FY 2009 with the IHS/CAO finance office completing conversion with the accounts payable function from the IHS/Albuquerque Area Office during FY 2010. The cash management conversion to the IHS/CAO finance office is the last function needing to be converted that allows the IHS/CAO to become an independent accounting office. The significance of converting all the accounting functions to the IHS/CAO and becoming an independent accounting office is to prepare for the eventual construction/management of Youth Regional Treatment Centers in California.

As I reflect, I realize the significance of each milestone achieved and the importance of accumulated impact. Watching the successes add up to an accomplishment of a big goal is one of the most gratifying aspects of my job as Deputy Director of the IHS/CAO. As you go through this report, you will read about milestones, the steps the IHS/CAO are taking to achieve a big five-year and/or longer goal. Maybe the milestone may seem insignificant by itself, please keep in mind there is an accumulated impact. After all, our job is about results and how we impact the lives of people we serve.

Warm Regards,

/Beverly Miller/

Beverly Miller
Deputy Director
Indian Health Service/California Area Office

BEVERLY MILLER, CPA, MBA, MHA
Deputy Director
Indian Health Service/California Area Office

OFFICE OF THE CHIEF MEDICAL OFFICER

The Chief Medical Officer (CMO) advises the Area Director and other IHS/CAO staff regarding health-related activities conducted by the IHS/CAO, including: development of Area health priorities, implementation of IHS Headquarters initiatives, health quality and compliance, medical malpractice, public health, health data, emergency preparedness, behavioral health and Government Performance and Results Act. Additionally, the CMO provides information and technical assistance to tribal and urban Indian health programs on these activities. The CMO vision is for AI/AN people in California to receive high-quality, customer-focused, whole-person health care through the tribal and urban Indian healthcare programs in the California Area.

HEALTH PROGRAM TECHNICAL ASSISTANCE

The CMO provides on-site and remote technical assistance to health program administrators and medical staff on a range of issues. The issues include: health care quality and metrics, provider credentialing, provider productivity, compliance with healthcare industry standards, healthcare finance, and health care delivery systems. Technical assistance is provided in the form of face-to-face meeting presentations with site support as well as on-site program review.

INFORMATION DISSEMINATION

The CMO works closely with the health program executive directors. In 2011, two program directors meetings were held at which a number of topics were discussed including healthcare finance, meaningful use, healthcare quality and risk management, and disease surveillance. The CMO also distributes periodic GPRA bulletins that focus on key clinical GPRA measures and best practices for improving performance.

ANNUAL CALIFORNIA MEDICAL PROVIDERS' CONFERENCE

The IHS/CAO hosted a California Medical Providers' Conference for medical providers in Indian healthcare settings, May 23-26, 2011 in Sacramento. This annual conference focused on overriding issues of mutual concern to healthcare providers in California, such as management of chronic disease, prevention, the role of behavioral health in the primary care setting and performance measurement. The conference provides a forum for discussion and breakout sessions for specialty areas. The objectives of the conference are to improve quality of care and provide required continuing medical education.

TREATMENT OF YOUTH SUBSTABCE ABUSE

The CMO assists health programs in facilitating the appropriate treatment modalities for youth with substance abuse problems through review of cases and facilitation and funding of referrals for residential treatment. This is done in conjunction with the CMO's role as organizer of the Youth Regional Treatment Center (YRTC) Task Force. The CMO has been a technical consultant for the IHS/CAO's Federal YRTC development team.

CURRENT AND FUTURE INITIATIVES

In recognition of the role of mental well-being and lifestyle habits in our patients' overall health, one of the major initiatives for the CMO has been advocating for, and facilitation of, the integration of behavioral health and primary care services. One important aspect of this initiative is to enhance the detection of behavioral health conditions in the primary care setting.

Another initiative is to expand the use of telemedicine to help address the lack of specialty services in remote areas. Through recent activities, over 80 percent of the tribal health programs which provide direct services in the California Area now have telemedicine capacity. The next phase of this initiative will be to help programs organize their service delivery mix to best take advantage of this technology.

DAVID SPRENGER, MD
Chief Medical Officer
Indian Health Service/California Area Office

OFFICE OF PUBLIC HEALTH

DENTAL

Steve Riggio, DDS
Dental Consultant

TECHNICAL ASSISTANCE AND RECRUITMENT

The IHS/CAO Dental Consultant provides technical assistance to tribal and urban programs regarding oral health issues. The Dental Consultant also answers inquiries from the public on oral health related questions. The IHS/CAO publishes a quarterly newsletter which features articles on gum disease, oral cancer, early childhood caries, and oral hygiene. The IHS/CAO website contains a dental page which has valuable information for patients and program staff. In 2011, the IHS/CAO Dental Consultant assisted in the hiring of a number of dentists at California Area tribal and urban programs.

CLINICAL CONTINUING DENTAL EDUCATION COURSES

The IHS/CAO sponsors hands-on clinical courses designed to improve the skills of dentists. In 2011, a total of 35 tribal and urban dental staff participated in three hands-on courses about the placement of mini-implants. Mini-implants are an inexpensive and effective way to stabilize dentures, which can dramatically improve the function of dental appliances.

ANNUAL DENTAL CONFERENCE

The IHS/CAO sponsors an annual dental conference which includes lectures, panel discussions, and hands-on courses that focus on the public health model of care. The conference provides all the required annual continuing dental education courses necessary for state licensure renewal for dentists, hygienists, and registered dental assistants. The multi-day conference allows dental staff from the California Area to meet, learn, and share knowledge and experiences. The May 2011 conference was attended by 300 dental staff representing 33 tribal and urban programs with a dental clinic.

ELECTRONIC DENTAL RECORD (EDR)

An EDR incorporates digital radiography and imaging, providing for a comprehensive, integrated patient record leading to increased productivity, improved efficiency, and decreased medical errors. Dentrix is a commercial, off-the-shelf dental, clinical, and practice management software application. A Resource and Patient Management System (RPMS) interface allows patient registration, billings, appointment scheduling, and clinical notes to be coordinated with the electronic health record (EHR). Dentrix can also be used as a stand-alone application by programs that do not utilize RPMS. In 2011, EDR was implemented at three tribal facilities. Currently, 15 Indian healthcare programs use some form of EDR.

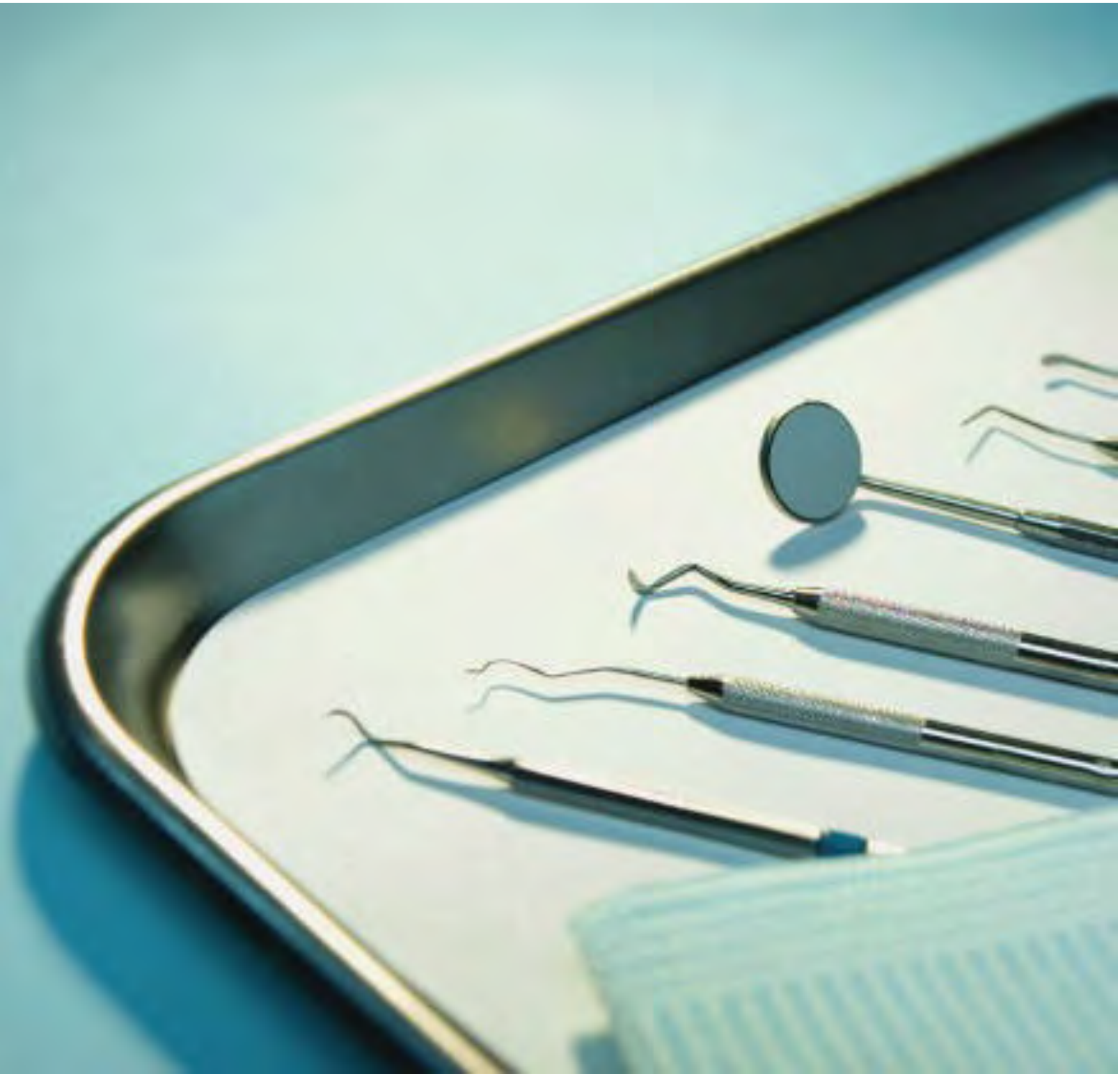
DENTAL ADVISORY COMMITTEE

The Dental Advisory Committee is composed of dental professionals representing tribal and urban programs in the California Area. The committee participates in monthly calls and bi-annual meetings to advise the Area Dental Consultant on oral health issues impacting our communities. The committee members' clinical experience and expertise is an invaluable resource and ensures that dental funds are spent wisely and meet the oral health needs of the AI/AN patient population. The committee also acts as the steering committee for the Dental Support Center located at the California Rural Indian Health Board.

DENTAL SUPPORT CENTER

The California Dental Support Center (DSC) combines resources and infrastructure with IHS Headquarters and the IHS California Area Office in order to provide technical assistance and resources. Assistance is provided for local and Area clinic-based and community-based oral health promotion/disease prevention initiatives, including the following:

- Early Childhood Caries Initiative
- Mini-Grants
- Head Start trainings
- Registered Dental Assistant certifications
- Distribution of education materials
- Trainings to dental staff



IMPROVING PATIENT CARE (IPC)

The aim of the Improving Patient Care (IPC) Initiative is to change and improve the Indian healthcare system. IPC Initiative develops high-performing and innovative healthcare teams to improve the quality of and access to care. Improved clinical care, patient self-care support, prevention of chronic illness, cost containment, and positive patient experience are the focus of improvement activities in the IPC Initiative. The result will be a "patient-centered medical home" that sets new standards for healthcare delivery and advances the health and wellness of AI/AN people. The Patient-Centered Medical Home (PCMH) is a better way to give patients the best and safest care possible. In certified PCMH clinics, the patient and family are fully informed by the medical team, helping to decide what is best for themselves with the support of the doctor.

CALIFORNIA AREA IMPROVEMENT SUPPORT TEAM

The IHS/CAO Improvement Support Team (IST) consists of a Registered Nurse, Certified Physician Assistant, Registered Health Information Administrator, and Public Health Analyst. The IST lead has been trained as an Improvement Advisor. All members of the CAO IST have received training in teamwork facilitation and coaching programs in healthcare improvement.

CALIFORNIA AREA IPC INITIATIVE SUCCESSES

The following four California programs are currently participating in the IPC Initiative:

- K'ima:w Medical Center (Hoopa Valley)
- Lassen Indian Health Center (Susanville)
- Riverside/San Bernardino County Indian Health
- Sacramento Native American Health Center

These sites are actively redesigning their healthcare system patient processes. Medical providers who comprise these IPC teams have attended national IPC Learning Sessions to build skills in making small changes with lasting beneficial results. The CAO IST hosted two Learning Sessions in Sacramento to provide a forum where these four California programs could build relationships and share innovative ideas for healthcare system redesign.

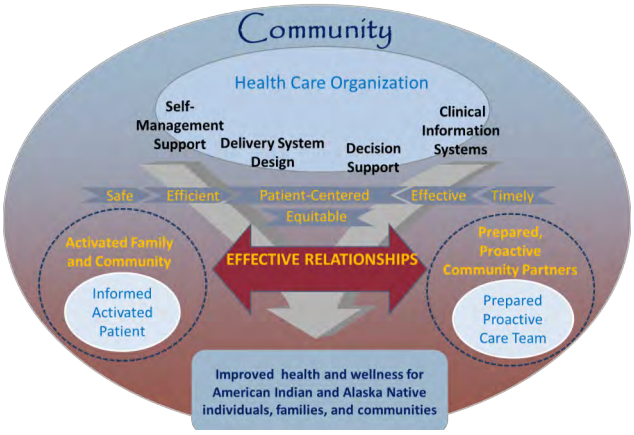
IMPROVEMENT WORK

IPC Initiative results include:

- Improved rates in cancer screenings (including colorectal cancer) and high risk screenings (such as alcohol misuse and depression)
- Decreased number of patient no-shows
- Improved patient and staff satisfaction

The IHS anticipates that all of its programs will participate in the IPC Program by 2015. The work of the CAO IST is vital in the pursuit of this goal in partnership with all California tribal and urban Indian healthcare programs.

Care Model for the Indian Health System



The IPC Care Model is adapted from the Care Model developed by the MaColl Institute. This model identifies the essential elements of healthcare systems that provide safe, efficient, patient-centered, effective, timely, and equitable care. At the heart of this model are the relationships between a prepared, proactive healthcare team and an informed, active patient. The model can be applied to a variety of chronic illness, preventive services, healthcare settings, and targeted to special populations.

Clockwise from top left: IPC team from Lassen Indian Health Center, IPC team from K'ima:w Medical Center (Hoopa Valley), IPC team from Sacramento Native American Health Center, Inc., IPC team from Riverside/San Bernardino County Indian Health

Pictured below: Wave 10 IHS Improvement Advisors

DIABETES

Helen Maldonado, PA-C
Diabetes Consultant

Diabetes is an epidemic among American Indians and Alaska Natives (AI/AN). In 2009, 16.1% of AI/AN adults (age 20+) were reported to have diagnosed diabetes. From 1994 to 2009, 110% more youth aged 15-19 were diagnosed with diabetes. Congress has provided grant funds to fight this chronic condition; it is called the Special Diabetes Program for Indians (SDPI). The purpose of the SDPI is to treat and prevent diabetes in AI/AN. 36 tribally-operated and urban-designated health care facilities in California receive this grant. This allows for increased attention, education, self-management support, and clinical and specialty care for persons battling diabetes.

CALIFORNIA AREA DIABETES CONSULTANT AND TEAM

The Area Diabetes Consultant (ADC) is a medical provider with clinical experience from a tribal health program. Her efforts in FY 2011 focused on healthcare quality improvement in the California clinics, providing supplementary educational support to the programs and sharing current medical approaches through public speaking engagements.

Two professional contractors provide data technical assistance, grant-writing assistance, and face-to-face training for the tribal and urban Indian healthcare program medical staff.

CALIFORNIA AREA DIABETES PROGRAM SUCCESSES

The national rate of diabetes for AI/ANs is 16.3%. In California, the prevalence rate is 10.7%, according to 2011 final GPRA results. The Annual Diabetes Care and Outcomes Audit (January 1 through December 31) is a patient chart audit to check for the level of care provided during patient medical visits. The electronic audit looks at patient examinations, education, treatment options, mental health, immunizations and lab data for the calendar year. California Area is 100% electronic in submission of the audit.

In FY 2011, the IHS/CAO focused on improving these six GPRA measures:

- HbA1c at goal (<7%) **- 42%** (target not met)
- Blood Pressure at goal (<130/80) - **38%** (target exceeded)
- Eye Exams - **59%** (target met)
- Diet/Nutrition education - **74%** (target exceeded)
- Exercise education - **67%** (target exceeded)
- Depression screening - **74%** (target exceeded)

Collaboration between the California programs has become stronger, sharing challenges and successes with each other so that all may improve.

MEETINGS AND TRAININGS

The Tribal Leaders Diabetes Committee (TLDC) is a national IHS committee comprised of tribal representatives from each of the 12 IHS Areas. California's representatives have worked tirelessly on behalf of the California programs, traveling to Rockville, Maryland for meetings with the IHS Director.

The IHS/CAO ADC provided bi-monthly educational webinars to all California tribal and urban Indian healthcare providers as well as a second annual "Diabetes Day" conference.

The IHS Headquarters Division of Diabetes Treatment and Prevention (DDTP) provides monthly diabetes related webinars with CME/CE units as well as question and answer sessions prior to quarterly grant submission deadlines.

Resource and Patient Management System (RPMS) Diabetes Management System (DMS) on-going training and orientation is provided annually for new users.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NURSING

Susan Ducore, RN
Nurse Consultant

The IHS/CAO works to elevate the quality of healthcare provided to AI/AN people by working to promote excellence in the delivery of nursing services. The Area Nurse Consultant is an active member of the Office of Public Health, California Area Improvement Support Team, and IHS National Nurse Leadership Council. The Area Nurse Consultant also coordinates the Area Immunization and Community Health Representative programs.

NURSING LEADERSHIP

The Area Nurse Consultant co-chaired the Elder Falls Subgroup and co-authored the draft elder falls program guidance, in an effort to develop IHS approved guidance for providers. The document draft was distributed to all tribal and urban Indian healthcare programs for comment early in FY 2011.

IMMUNIZATION PROGRAM

The IHS/CAO encourages comprehensive immunization coverage for all age groups. The California Area Nurse Consultant works with tribal and urban Indian healthcare immunization staff to ensure comprehensive data collection and reporting. Some of the FY 2011 improvement activities offered through the Area Immunization Program were:

- Monitored and facilitated tribal and urban Indian healthcare program participation in IHS quarterly immunization reporting
- Collaborated with the National GPRA Support Team on development and promotion of California Area childhood and adult immunization improvement initiatives; provided technical assistance related to adult and childhood immunization GPRA measure improvement; and, provided incentive resource materials
- Hosted RPMS Immunization Package Training
- Purchased and distributed 12th Edition of Epidemiology and Prevention of Vaccine-Preventable Disease" (Pink Book) resource guide to each California tribal and urban Indian healthcare program
- Facilitated immunization data exchange projects between two tribal healthcare programs and the California Automated Immunization Registry (CAIR)

TRAININGS/CONFERENCES

The Area Nurse Consultant collaborated with national programs to fund on-site immunization assessments and training for six tribal health programs in California.

AREA COMMUNITY HEALTH REPRESENTATIVE (CHR) COORDINATION

The IHS/CAO hosted a week-long CHR Coding and Documentation training in Sacramento in July. The California Area Nurse Consultant also provides ongoing technical assistance to CHR programs related to scope of work, practice, and coding/documentation. California Community Health Representatives are pictured below.

California Community Health Representatives

CONTRACT HEALTH SERVICE (CHS)

Toni Johnson
CHS Officer

MEDICARE-LIKE RATES FOR CONTRACT HEALTH SERVICE

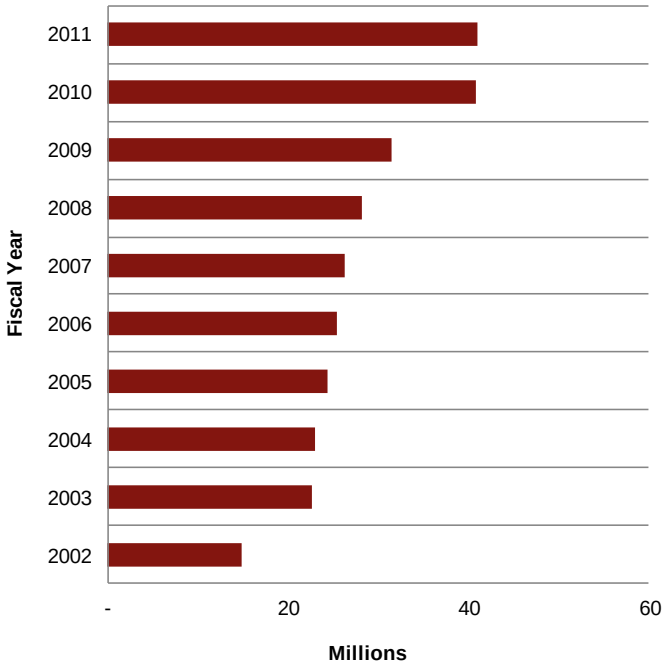
The passage of Section 506 of the Medicare Prescription Drug, Improvement, and Moderation Act, established a requirement for hospitals that participate in the Medicare program to accept Medicare-like rates as payment in full when providing services to Indian patients. The regulations place a cap on the amount hospitals may charge for patients who are authorized by Contract Health Service programs. These rates are about 60-70% of full billed charges. The individual physicians and other practitioners paid under Medicare Part B are not included in this provision. The savings derived from the Medicare-like rates allow Indian health programs to purchase additional health care services. Since the regulation became effective on July 5, 2007, Tribes are experiencing increased purchasing power due to payment savings.

Not all Tribes are taking full advantage of these cost savings. Because hospitals are not required to bill at the Medicare-like rate, Contract Health Service staff need specialized training to be proficient at re-pricing inpatient and outpatient health care claims.

Improving Business Practices with CHS Budgeting

If CHS had unlimited funding, it could pay for all referrals. However, since our CHS budget is limited, IHS/CAO must follow regulations and the law to determine which referrals can be authorized for payment. The regulations tell us how to make sure the limited funding goes to those who need it the most. There are also other considerations when funding is not available for all referrals, including timely notification of emergency room visits, prior approval and authorization for payment for referrals, the need to identify if patients are eligible for other healthcare coverage such as private insurance, Medicare or Medicaid. By law, other healthcare coverage pays before IHS. Available funding to pay for the referral is based on medical priorities. Every program should implement a monitoring system to track the CHS spending rate on a weekly or monthly basis will safeguard against overspending and depleting funds.

To improve the quality and access to care, the California Area Contract Health Service Officer provides general consultation for the CHS regulations (42 CFR 136) and technical guidance on CHS operating guidelines, policies and procedures to Tribal staff and outside agencies. She reviews and processes all Area Catastrophic Health Emergency Fund (CHEF) cases. CHS education and training opportunities include, but are not limited to: CHS 101, Medicare-Like Rate overview and calculations, health board presentations, and CHS claims processing.



HEALTH PROMOTION/DISEASE PREVENTION (HP/DP)

Beverly Calderon, RD, CDE
HP/DP Consultant

DIGITAL STORYTELLING

To promote and encourage creativity and innovation, the IHS/CAO hosted five Digital Storytelling workshops between January and October 2011, in collaboration with the Healthy Native Communities Partnership (HNCP). The workshops included a process for combining first person narratives with digital media for promotion of social change and action. The workshops built the capacity of five tribal and urban Indian healthcare programs to produce digital stories to support social change, native culture, and community advocacy. To further support community-based health promotion and disease prevention efforts, all workshop participants were encouraged to review the community wellness planning resource manual, *Restoring Balance Community-Owned Wellness*. Tribal and urban community and staff members produced a total of 36 digital stories (stories on video).

EMPLOYEE WELLNESS

The IHS/CAO HP/DP consultant promoted employee wellness through activities aimed to increase awareness and sponsor employee access to prevention services and physical activity. The *Just Move It 2011 California Challenge* (March - July) promoted physical activity. This annual employee wellness challenge incorporated the President's Challenge for documentation of physical activity. The total activity accumulated points equated to 4,581 miles traveled, which represents the distance between all California tribal and urban Indian healthcare programs. The IHS/CAO HP/DP Consultant presented live briefings to staff and created newsletter articles to deliver education on the following key topics:

- President's Challenge website
- National *Let's Move!* initiative
- National *Just Move It!* campaign
- Department of Health & Human Services 2008 Physical Activity Guidelines for Americans
- United States Department of Agriculture (USDA) MyPlate
- Centers for Disease Control & Prevention (CDC) Tobacco Cessation

JUST MOVE IT CHALLENGE

In support of renewing and strengthening partnerships with Tribes, the IHS/CAO promoted the sixth *Just Move It California Challenge*. The challenge supported tribal and urban Indian healthcare programs in the promotion of physical activity in the communities they serve. The campaign supported 64% of tribal and urban programs serving 77 Tribes and seven urban Indian communities. The IHS/CAO hosted a *Just Move It* walk during the Medical Providers' Best Practices & GPRA Measures Conference in May 2011.

HP/DP SESSIONS DURING CONTINUING MEDICAL EDUCATION

The IHS/CAO and the California Rural Indian Health Board (CRIHB) jointly sponsored four Community Outreach presentations covering Community Advocacy and Physical Activity during the conference. The presenters delivered training on community-based work aimed to improve and promote wellness and assist those working to change systems of care. This event provided networking opportunities among California tribal and urban Indian healthcare programs, with a focus on community, promoting what works, and sharing successes with others. The IHS/CAO HP/DP Consultant promoted the *Physical Activity Toolkit* as a resource during the session on physical activity. Presenters encouraged routine assessment and documentation of physical activity among all patients who are six years of age and older in RPMS/EHR.

BEHAVIORAL HEALTH

Dawn Phillips, RN, CDE
Behavioral Health Consultant

The mission of the California Area is to collaborate and share best practices which promote a holistic approach for mental and/or behavioral health problems. This incorporates the overall mission of the IHS, to raise the health status of each person to the highest spiritual, physical, mental, and social wellness.

METHAMPHETAMINE AND SUICIDE PREVENTION INITIATIVE FUNDS

The California Area Behavioral Health Consultant collaborates with more than 46 tribal and urban health programs to address behavioral and mental health, domestic violence (DV), methamphetamine use, and suicide. Each of the tribal and urban healthcare programs offer some type of behavioral health services and/or program depending on the individual needs of the community. In 2009, the IHS received special funding to address some of the behavioral health problems like suicide, methamphetamine use, and domestic violence.

There are eight tribal and urban programs that receive methamphetamine and suicide prevention initiative (MSPI) funds. In addition, seven tribal and urban programs receive DV funding. Because of these monies, there has been an increased awareness and development of community prevention programs. One program that is successful is the "Walk and Talk" Program with the San Manuel Band of Mission Indians. Once a week, the psychologist spends time walking and talking with adolescents. Another successful program is the DV prevention program at Sonoma County Indian Health. This tribal healthcare program collaborates with Sonoma County government and provides education and training for persons convicted of domestic violence assault.

BEHAVIORAL HEALTH WEBEX SESSIONS

The Behavioral Health Consultant coordinates with IHS Headquarters quarterly through WebEx conferencing or calls. In addition to hearing about national success stories, the California Area tribal and urban healthcare programs share information about promising "best practices" developing within their community as a result of DV and MSPI funding.

YOUTH REGIONAL TREATMENT CENTERS

The California Area Behavioral Health Consultant partners with tribal and urban Indian healthcare programs by sponsoring monthly calls. The YRTC Task Force is made up of psychologists, behavioral health specialists, alcohol counselors, and psychiatrists. In FY 2011, more than 40 youths received residential treatment through the YRTC Risk Pool.

UNIVERSAL BEHAVIORAL HEALTH SCREENING INCENTIVES

The IHS/CAO advocates for "universal screening" for the behavioral health GPRA clinical measures. The three behavioral health screenings include depression for all adults 18 and over; alcohol use for women of child-bearing years; and, domestic/intimate partner violence screening for women ages 15-40 years old. In 2011, performance-based awards were given to tribal and urban Indian healthcare programs that increased screening on all three GPRA measures by 50% over the previous year. Four tribal and urban programs received this award. The Veterans Administration has demonstrated that "universal screening" increases screening rates and removes the stigma associated with behavioral health screenings.

ELECTRONIC HEALTH RECORD (EHR)

Steven Viramontes, PHN
Clinical Applications Coordinator

The electronic health record (EHR) is intended to help providers manage all aspects of patient care electronically. By moving most data retrieval and documentation activities to an electronic environment, patient care activities and access to the record can occur simultaneously at multiple locations without dependence on availability of a paper chart. Point-of-service data entry ensures that the record is always up-to-date for all users.

The Resource and Patient Management System (RPMS) EHR combines the powerful database capabilities of RPMS with a familiar and comfortable presentation layer, or graphical user interface. Integration of various RPMS components into the user interface allows providers to obtain a more comprehensive view of the clinical process. Access to patient information is available via "point and click," rather than the user having to log in and out of separate RPMS applications to retrieve different types of data.

Currently, there are 23 tribal and urban Indian healthcare programs utilizing EHR. Fourteen clinics are using the RPMS/EHR and ten clinics are using other commercial EHR products. The California Area supports sites with RPMS/EHR for deployment, and provides all sites with technical assistance for meaningful use. In 2010, the IHS/CAO coordinated EHR implementation at six clinics.

A strategy for training has been developed that targets EHR education for clinics based on their current needs related to EHR deployment and enhancement. This teaching strategy depends on two factors: clinical application coordinators (CACs) and the use of technology for remote training, including WebEx and televideo conferencing.

TYPES OF SERVICES

The IHS/CAO works with tribal and urban Indian healthcare programs through the entire process of adopting, implementing, and using the RPMS/EHR. IHS/CAO staff assist sites in assessing current workflows, performing EHR set-up, and training clinic staff in EHR use.

2011:

The RPMS/EHR software has successfully completed certification through the Authorized Testing and Certification Body. Certification indicates that any clinics using the RPMS/EHR in year one will qualify for meaningful use incentives, provided they meet the patient volume test. The IHS/CAO provides RPMS/EHR support so that clinic programs can qualify for meaningful use incentives. EHR training was held at the CAO; real time remote technical support by our CAC Mentors, pharmacy consultants, and lab consultants; and, on-site end user "go live" training. In 2011, IHS/CAO coordinated RPMS/EHR implementation of the last three clinic programs in the Area. The IHS/CAO projects that all 23 RPMS/EHR clinic programs will have EHR fully implemented by May 2012.

One of the most powerful features of the RPMS/EHR software is the reminders package, which performs an automated chart review and alerts clinic staff to the healthcare needs of patients. This allows providers and clinic staff to receive patient care reminders. These alerts are interactive so that patient care reminders can be acted upon by ordering tests, medications, or by conducting a health screening. In 2011, the IHS/CAO EHR team, in collaboration with the Government Performance and Results Act (GPRA) team, initiated a GPRA reminder support program. Fourteen GPRA measures were identified and will be installed into all 23 tribal and urban Indian healthcare programs' RPMS/EHR. Training will also be provided locally for tribal and urban Indian healthcare program providers to develop protocols for each GPRA measure. The goal is to increase GPRA performance rates which will translate to improved care for IHS-eligible patients.

2012:

The IHS/CAO continues to support clinic programs to configure RPMS/EHR to meet Meaningful Use standards. This requires training for all medical providers on Meaningful Use standards, ICD-10 coding and billing, and lab and pharmacy interfaces. The IHS/CAO projects completion of the GPRA reminder support training by June 2012.

TELEMEDICINE

Telemedicine helps to improve both quality and access to care by eliminating transportation challenges, geographic barriers, financial constraints, and time restrictions which frequently interfere with timely delivery of healthcare services. Telemedicine provides the vehicle for:

- Clinics to partner with major universities anywhere in the world to get technical assistance for local community health interventions
- Improved availability of specialty care for patients with diabetes such as endocrinology, screening for retinopathy, and nutrition education
- Increased access to behavioral health services such as psychiatric care, mental health counseling, and pain and addiction management

The IHS/CAO has established relationships with U.C. Davis specialists to offer various telemedicine services including retinal screening, methamphetamine use prevention, and suicide prevention.

Currently, nine Indian healthcare programs offer telemedicine specialty care for their patients. There are two modalities for telemedicine visits: “store and forward” and “real time”. Store and forward is a method of capturing an image to be “stored” and then “forwarded” to a specialist. Retinal screening and dermatology are examples of store and forward telemedicine. Ten additional tribal healthcare programs installed retinal screening cameras in 2010. This brings the total to 31 retinal cameras being utilized. Real time visits are interactive and take place over video conferencing equipment, that allows a patient-doctor visit in real time.

2010:

During 2010, the IHS/CAO received four video conferencing units, paid for by ARRA funding. Two of the units are desktop models and the other units are mobile to allow anyone in the office to utilize the equipment for meetings or trainings. In addition, the IHS/CAO acquired ten portable video conferencing cameras that consultants and staff can use off-site to conduct training and/or meetings at clinic sites. The portable units are as small as Web cameras, but have the ability to push content like PowerPoint presentations. These were also ARRA funded items. In 2010, the video conferencing infrastructure was shored up for seamless use by IHS/CAO staff and Indian healthcare program staff members.

2011:

The IHS/CAO recruited three new real time telemedicine clinic sites. Actual service will begin sometime in 2012. Video conferencing services are slowly increasing in the Area.

VIDEO CONFERENCING

The IHS/CAO deployed televideo conferencing endpoints to tribal and urban healthcare program medical providers, allowing the IHS/CAO to:

- Meet with administrators, clinical staff, and Tribal Governments
- Provide training and mentorship to medical providers on various projects
- Increase attendance at IHS-sponsored meetings through the use of video conferencing

The IHS/CAO purchased televideo conferencing system to host multiple conference attendees and to archive meetings/trainings for web delivery, thereby establishing a true multimedia knowledge base.

Televideo conferencing technology makes telemedicine possible for specialty care in isolated tribal health programs. In addition, video conferencing capability creates a virtual office environment for the Area Office and clinic sites. In this environment, meetings and trainings take place without the burden and expense of travel.

During 2010, the IHS/CAO was able to increase the number of outfitted clinics with televideo conferencing equipment and retinal cameras. Seven clinic sites received televideo conferencing equipment paid for by methamphetamine & suicide prevention funds. Nineteen clinic sites received televideo conferencing equipment paid for by ARRA funding. This brings the total to 35 video conferencing units in the California Area.

Televideo conferencing meetings are becoming more common and the IHS/CAO has been experimenting with new calls as needs arise. The IHS/CAO have outfitted six of our engineering field offices with televideo conferencing equipment and they are now able to attend monthly staff meetings virtually as well as meeting with each other. IHS/CAO staff have been able to attend various meeting through portable cameras connected to their laptops. IHS/CAO has supported this effort through infrastructure changes and technical support before and during video calls. This year, the IHS/CAO increase its bandwidth to accommodate the extra demand on the network. This is money well spent when travel time cost savings are considered.

VISTA IMAGING

Marilyn Freeman, RHIA
Clinical Applications Coordinator

Vista Imaging helps to provide a completed electronic health record (EHR) by incorporating external records (printed or electronic) into the EHR through scanning or import. The California Area Vista Imaging servers and Archive Appliance were installed and put into operation during April 2010. The servers were prepared for use by the five initial Vista Imaging partner programs during May 2010. Scanning training was provided during June 2010. Four programs (Feather River Tribal Health, Riverside/ San Bernardino County Indian Health, Santa Ynez Tribal Health Program, and Southern Indian Health Council) were live on Vista Imaging by July 2011. Lake County Tribal Health Consortium began actively using Vista Imaging following the program's move to a new facility a few months later.

CURRENT STATUS UPDATE

Two programs implemented Vista Imaging during FY 2011:

1. Shingle Springs Tribal Health Program April 2011
2. Tuolumne Me-Wuk Indian Health Center August 2011

Additional programs signed Vista Imaging agreements, but delayed implementation due to priorities. A total of seven California programs were actively using Vista Imaging at the end of FY 2011.

The following programs are expected to implement Vista Imaging during FY 2012:

1. American Indian Health and Services (Santa Barbara)
2. Consolidated Tribal Health Project (Ukiah)
3. K'ima:w Medical Center (Hoopa Valley)
4. Lassen Indian Health Center (Susanville)
5. Northern Valley Indian Health (Willows)
6. Round Valley Indian Health Center (Covelo)
7. Sacramento Native American Health Center
8. San Diego American Indian Health Center
9. Toiyabe Indian Health Project (Bishop)
10. United American Indian Involvement, Inc. (Los Angeles)

Implementation of Vista Imaging at these ten sites will result in a total of seventeen California programs using Vista Imaging by the end of FY 2012.

Vista Imaging can serve as a picture archiving and communication system (PACS) in combination with digital imaging equipment. Several programs have expressed interest in this and K'ima:w Medical Center is currently exploring this option.

PROGRAM PARTICIPATION COSTS

Vista Imaging program costs are calculated based on the number of provider FTEs. The number of medical provider FTEs has increased by 45% since the program's beginning, resulting in a significant per FTE cost decrease. The per FTE cost has declined as followed: $4,054 in FY 2010, $3,200 in FY 2011, and $1,900 in FY 2012.

HEALTH INFORMATION TECHNOLOGY (HITECH)

The Health Information Technology for Economic and Clinical Health (HITECH) Act seeks to improve American health care delivery and patient care through an unprecedented investment in health information technology. Its provisions are specifically designed to provide the necessary assistance and technical support to providers; enable coordination and alignment within and among states; establish connectivity to the public health community in case of emergencies; and, assure the workforce is properly trained and equipped to be meaningful users of electronic health records (EHRs).

CMS EHR INCENTIVE PROGRAMS

The Medicare and Medicaid EHR Incentive Programs will provide incentive payments to eligible professionals, hospitals, and critical access hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The Medicare EHR Incentive Program is administered by CMS.

The Medicaid EHR Incentive Program is offered and administered voluntarily by states and territories. The California Department of Health Care Services (DHCS) is using a staged approach for implementation of the Medicaid EHR Incentive program beginning with inpatient hospitals, continuing with provider groups, and finishing with individual providers. In order to expedite the process, DHCS requested and received approval to prequalify eligible providers using Office of Statewide Health Planning and Development (OSHPD) data. Some Indian health programs are exempt from licensure and OSHPD reporting requirements because they operate on tribal land. The IHS/CAO and the California Rural Indian Health Board (CRIHB) provided comparable data for non-OSHPD reporting sites to prequalify those programs for the incentives. Read more about CMS financial incentive programs at http://www.cms.gov/EHRIncentivePrograms.

HITECH EXTENSION PROGRAM

The Office of the National Coordinator (ONC) has funded 62 Regional Extension Centers (RECs) throughout the country. The RECs have been established to help more than 100,000 primary care providers achieve meaningful use of EHRs.

The National Indian Health Board (NIHB) AI/AN National REC is the only national Regional Extension Center. Its goal is to provide technical assistance throughout the Indian health system to support EHR implementation. The REC will use health information technology to assist the Meaningful Use of certified EHRs.

MILESTONE 1 — Secure signed REC agreements from up to 3,000 IHS providers

MILESTONE 2 — Assist with implementation of certified EHR software by enrolled providers

MILESTONE 3 — Verify meaningful use of certified EHRs by enrolled providers

HITECH WORKFORCE DEVELOPMENT PROGRAM

As the nation moves toward a more technologically advanced health care system, providers need highly skilled health IT experts to support them in the adoption and meaningful use of electronic health records. To help address this growing demand, the Office of the National Coordinator has funded the Health IT Workforce Development Program. The goal is to train a new workforce of health IT professionals who will be ready to help providers implement electronic health records to improve healthcare quality, safety, and cost-effectiveness. Educational programs are available at the community college and university level. More information is available at http://healthit.hhs.gov.

CALIFORNIA AREA SITE SUPPORT

The IHS/CAO spearheaded the effort to enroll providers with the NIHB AI/AN National REC in collaboration with the California Rural Indian Health Board. Meaningful Use assessments of CRIHB programs have been conducted jointly with the CRIHB EHR implementation team. As needs are identified, IHS/CAO and CRIHB staff work together to identify solutions, including making area clinical application coordinators as well as laboratory and pharmacy contractors available when appropriate. The IHS/CAO and CRIHB staff are also teaming up to insure that California Area tribal and urban Indian healthcare programs are prepared for ICD-10 implementation.

2011 TRIBAL LEADERS' CONSULTATION CONFERENCE

Registration table at Coarsegold Casino

All four regions held private caucuses.

Twenty-nine tribal leaders drafted and signed a letter to the chairwoman of the D-Q University Board of Trustees, urging them to revert 12 acres of land to the Federal government so the IHS can build the northern California YRTC.

Presentation from the Area Director

To improve the quality of and access to care, the Area Director addressed the CHS unmet need at the conference on March 15. She summarized different measures of CHS unmet need and the Indian Health Care Improvement Fund (level of need funded) methodology. The IHS/CAO estimates that the CHS unmet need for the California Area is between $120 and 135 million.

Herb Schultz, HHS Region IX Director

Dr. Susan Karol, IHS Chief Medical Officer, on right

James Crouch, Executive Director,
California Rural Indian Health Board

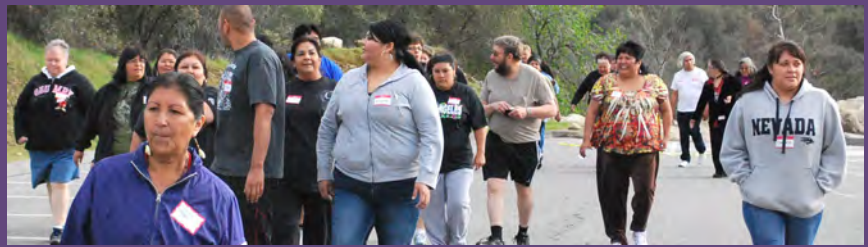
Veteran's Affairs' Office of Rural Health presented on the current status of the VA/IHS Memorandum of Agreement (MOA) and the changes in the current MOU compared to the previous version. Revised VA/IHS MOU was distributed to all tribal leaders in attendance.

Award Ceremony

Debra Ramirez (Redwood Valley)

John Green (Elk Valley)

Peter Masten Jr. (Hoopa Valley)



Fun Run/Walk

OFFICE OF ENVIRONMENTAL HEALTH & ENGINEERING

DIVISION OF HEALTH FACILITIES ENGINEERING

The Division of Health Facilities Engineering (DHFE) funded $3,332,000 towards tribal healthcare program facilities engineering and medical equipment needs. Of the maintenance and improvement funding, IHS/CAO distributed $1,431,000 to tribal healthcare programs for routine maintenance activities and $472,000 for facility improvement projects. Also, $804,000 in annual medical equipment funds and $625,000 in general tribal equipment funds for new clinic space were distributed to the tribal healthcare programs.

Tribal healthcare programs that received maintenance and improvement funds for facility projects were Northern Valley, Hoopa Valley, Pit River, Toiyabe, and Greenville. DHFE managed a project that surveyed the condition of tribal healthcare facilities and their energy usage. This study will be completed in early 2012 and will be used for planning future healthcare facilities improvement projects. Space and program planning services were provided to Consolidated Tribal Health, Riverside/San Bernardino, and Karuk tribal healthcare programs to support expansion/replacement of existing clinics. Shingle Springs, Paskenta, and Northern Valley opened new facilities during FY 2011.

Edwin Fluette, Associate Director, OEH&E
Indian Health Service/California Area Office

The DHFE presented IHS health facilities program information to 27 tribal healthcare program directors in California, ensuring that they have access to IHS documents and an understanding of the available services from the IHS. DHFE also identified each tribal health program's plans and their need for technical assistance with future facilities engineering projects. These presentations were in person with each of the tribal healthcare program directors.

During these meetings, DHFE identified future facilities projects as follows:

- Eight maintenance and improvement projects
- Six programs intend to automate their preventive maintenance scheduling
- Five programs are expecting to complete accreditation surveys in the next year
- Eight programs are requesting planning services to assist with development of new or replacement facilities

In the next five years:

- Eleven programs plan to replace facilities
- Four programs plan to expand their facilities
- Twelve tribal healthcare programs plan to construct/establish satellite clinics to improve the quality of and access to healthcare for their patients

Engineers CDR Paul Frazier and Nathan Wong

CDR Paul Frazier, Staff Engineer; CAPT Richard Wermers, PE, Director of Health Facilities Engineering, with Vinay Behl, CFO discussing the facilities/maintenance and improvement budget

DIVISION OF ENVIRONMENTAL HEALTH SERVICES

ENVIRONMENTAL HEALTH SURVEYS

The DEHS staff conducted 370 surveys in FY 2011, to identify environmental health risks and hazards in community facilities and make recommendations for their resolution. Surveys were conducted at the following tribal facilities:

- Food service facilities (268)
- Head Start programs (17)
- Indian gaming facilities (17)
- Health care facilities (15)
- Daycare facilities (8)
- Swimming pools (6)
- Other facilities (39)

INSTITUTIONAL ENVIRONMENTAL HEALTH PROGRAM

The DEHS staff reestablished its institutional environmental health program. The DEHS prioritized services, developed a program plan, standardized survey forms and processes, and established an Area-wide institutional environmental health project. As a result, the DEHS staff completed 23 x-ray surveys and conducted 15 comprehensive environmental health surveys at tribal healthcare facilities. The DEHS will work with tribal health programs to ensure safe nitrous oxide delivery processes in FY 2012.

EMERGENCY MANAGEMENT

The DEHS staff completed the following emergency management activities:

- Coordinated the distribution of 48 satellite phones provided free of charge to tribal Indian healthcare programs
- Provided technical assistance and support to the Native American Alliance for Emergency Preparedness, to strengthen partnerships between Indian health programs and local emergency response organizations
- Reviewed emergency evacuation plans for tribal healthcare programs

The DEHS staff will continue to provide support for these important initiatives in FY 2012.

TRAINING

The DEHS sponsored training courses throughout California to build tribal capacity in environmental health related areas. Four courses were provided to train tribal water system operators to manage tribal utility systems and/or become certified community water system operators. More than 60 participants from tribal communities attended these IHS-sponsored courses.

RABIES VACCINATION CLINICS

The DEHS staff assisted the U.S. Army's Veterinarian Program to provide multiple rabies vaccination clinics in tribal communities. More than 100 dogs and cats were vaccinated, at a value of $5,000.

Injury Prevention Specialist, LT Lisa Nakagawa, installing a child safety seat at a car seat checkpoint

California Division of Environmental Health Services staff (left to right): CDR Gordon Tsatoke, Ed Fluette-OEH&E Director, LT Lisa Nakagawa, CDR Mary Weber, CDR Martin Smith, LCDR Charles Craig (Not Pictured: CDR Brian Lewelling)

INJURY PREVENTION

Identification of hazards resulted in playground equipment upgrades and installation of fall protection at a Head Start

TRAINING

The DEHS co-sponsored an IHS "Introduction to Injury Prevention" course and a National Highway Traffic Safety Administration "Child Passenger Safety Technician" course, with the California Rural Indian Health Board. These courses provided instruction on basic and advanced approaches and strategies that have been proven to effectively prevent and reduce community injuries. Thirty-two health program staff and/or injury prevention advocates from tribes across California attended. Six individuals were certified as child passenger safety technicians to serve as experts in their respect communities.

PROJECTS

The DEHS staff provided technical assistance and guidance to the Head Start Programs to implement *Ride Safe* and *Sleep Safe* national initiatives, funded by the IHS Injury Prevention Program. The objectives of the programs were to: 1) reduce the rate of motor vehicle injuries by promoting motor vehicle child restraint use; and 2) reduce fire/burn injuries by installing smoke alarms in the homes of Head Start students. The Ride Safe/Sleep Safe is a grant program operated out of IHS Headquarters.

This injury prevention initiative will continue annually. Ongoing education about the importance of child passenger safety and residential fire safety prevention for parents and students will continue through the end of the school year.

The DEHS staff continued to provide technical assistance and support to the Tribal Injury Prevention Programs funded by the IHS Tribal Injury Prevention Cooperative Agreement Program. Community demonstration projects were established to hire an injury prevention coordinator to conduct "best practices" that address unintentional motor vehicle injuries and elder falls. Project participants were: California Rural Indian Health Board, Indian Health Council, Tule River Indian Health Center, and Greenville Rancheria. These injury prevention projects were funded for continuation in FY 2012 and at a value of $1.16 million dollars over five years.

The DEHS awarded injury prevention "mini-grants" to 22 tribal health programs. These evidence-based projects are intended to reduce the health risks often associated with unintentional injuries. In 2011, more than 640 child safety seats, 550 bicycle helmets, and 500 smoke detectors were distributed in tribal communities, with a value of $40,000.

Helmets from the "min-grants" being properly fitted at a bicycle rodeo

Tribal health program staff attend an IHS sponsored “Introduction to Injury Prevention” Course held in Sacramento

SFC PREVENTIVE HEALTH PROJECT

The SFC Program provided water treatment monitoring equipment for three remote public water systems on the Yurok Reservation—Kepel, Wautec, and Weitchpec. These three public water systems have been out of compliance with the Environmental Protection Agency (EPA)'s Surface Water Treatment Rule for over six years. The EPA requires turbidity, chlorine, pH, and temperature data to monitor every four hours to ensure pathogenic microorganisms are removed from drinking water supplies.

Providing monitoring equipment for the three public water systems was very challenging since no electrical power or telephone communication services exist in the three rural and remote communities.

Eight solar panels (125 watt) were installed at each remote site to power global positioning system (GPS) and water treatment monitoring equipment. The monitoring equipment transmits data to satellites managed by the National Oceanic and Atmospheric Administration (NOAA). The satellites then transmit the data to GPS receivers at the Yurok Tribal Office.

The Yurok Tribe has access to the real time water quality data and can make necessary and real time treatment adjustments to ensure that the treatment process is removing *Cryptosporidium* and other disease-causing microorganisms in drinking water supplies. This preventive health project was funded by IHS and the EPA for $349,151 and served 127 homes.

SFC SUSTAINABILITY INITIATIVE

Safe and adequate water supply and wastewater disposal systems play a vital role in the daily lives of California Indians. Indian communities across California are facing sustainability challenges with their water and wastewater systems. Adequate operation and maintenance of these systems has a profound impact on public health, reliability of service, and tribal sovereignty.

The IHS/CAO is developing a multi-year initiative to increase the sustainability of tribal drinking water and wastewater systems. This effort will ensure the protection of public health, federal investments, water quality, and Indian communities. The first step in the initiative process is to assess the technical, financial, and managerial capacity of tribal utility organizations that operate and maintain tribal systems.

Water and wastewater infrastructure can only be sustainable if the communities served by these systems are self-sufficient. Such self-sufficiency requires that local decision-makers and end users support effective utility management practices for operating and maintaining water and wastewater infrastructure systems.

The IHS/CAO has been funded $100,000 a year for two years for the sustainability initiative project.

Water storage tank

SFC PROJECT ENGINEER OF THE YEAR

We are proud of Lieutenant (LT) Matt Mergenthaler for being selected as the California Area Sanitation Facilities Construction (SFC) Project Engineer of the Year, recognizing his outstanding accomplishments toward the attainment of SFC Program objectives.

LT Mergenthaler was called to active duty on February 1, 2009 to the Fresno Field Office. From day one, he was involved with project planning for American Recovery and Reinvestment Act (ARRA) funded projects. Within his first few months, several complex ARRA-funded community sanitation facilities projects were assigned to LT Mergenthaler.

Within the past year, he has met all of the deadlines for assigned ARRA projects and has continued to make progress with all other assigned projects and field office responsibilities.

LT Mergenthaler currently manages projects in various stages of planning, design and construction totaling over $14 million, and which provide service to over 1,000 Indian homes.

Following is a list of ARRA funded projects that LT Mergenthaler has moved through planning, design, and into construction in one year.

- CA 09-M37: Big Sandy Rancheria, Uranium Treatment and Water System Improvements. Total funding amount: $639,000 to serve 35 homes. Work included a uranium treatment system, a new treatment building, a water storage tank, and booster pumps. The design involved a detailed evaluation of several uranium treatment processes.

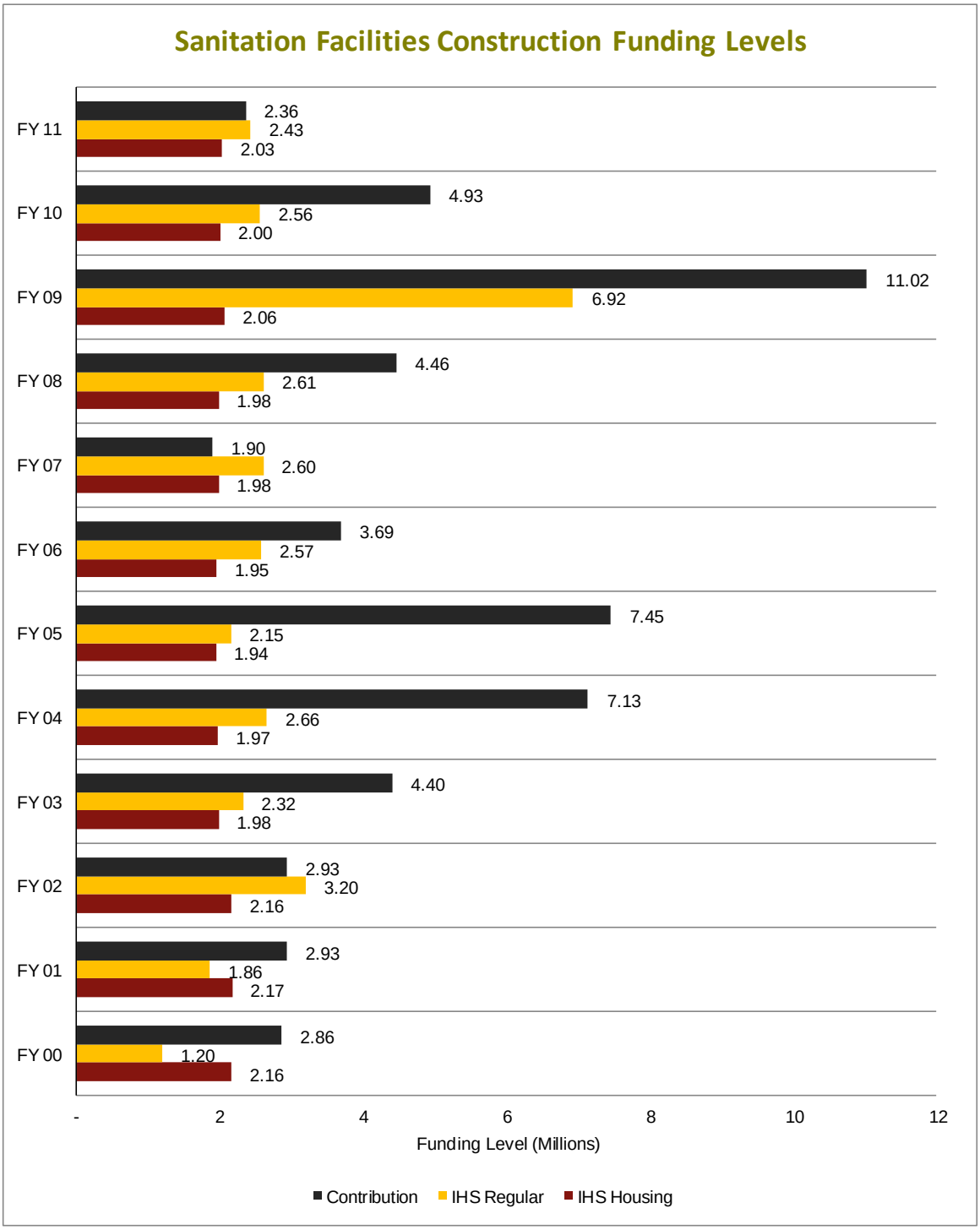
- CA 09-M32: White Blanket Allotment, Water System Improvements. Total funding amount: $134,635 to serve eight homes. Work included a well, constructing a treatment building, and a water storage tank. The groundwater well source had complex water chemistry and required a series of unit operations to treat the water.

- CA 09-M38: Tule River Reservation, Apple Valley Water Storage Tank. Total funding amount: $108,000 to serve nine homes. Combined with $512,000 in projects funds from CA 05-L54 for the construction of an additional water storage tank on the Tule River Reservation.

LT Mergenthaler also made significant progress on seven other community projects including two large EPA Safe Drinking Water Act projects: $870,000 project on the Cold Springs Rancheria and a $1.2 million project on the Santa Rosa Rancheria.

LT Mergenthaler has positively impacted the Indian communities and has demonstrated exceptional project management skills. He possesses the capacity to learn and understand complex technical topics, and continues to seek out new engineering challenges. LT Mergenthaler is an outstanding young engineer and is very deserving of the California SFC Project Engineer of the Year. Congratulations!

Lieutenant Matt Mergenthaler,
California Area SFC Project Engineer of the Year



Funding levels for sanitation facilities construction for fiscal years 2000-2011

OEH&E LOCATIONS

DISTRICT OFFICES

Sacramento District Office

Redding District Office

Escondido District Office

The IHS/CAO, Office of Environmental Health & Engineering manages four field offices and three district offices, strategically located throughout California to ensure quick and convenient access to Indian homes, communities, and healthcare programs. Staffing at these locations includes professional engineers, engineer technicians, environmental health specialists, utility consultants, and administrative support.

FIELD OFFICES

Ukiah Field Office

Arcata Field Office

Clovis Field Office

Porterville Field Office

OFFICE OF MANAGEMENT SUPPORT

GOVERNMENT PERFORMANCE AND RESULTS ACT (GPRA)

The Government Performance and Results Act (GPRA) requires each Federal agency to have performance measures to show Congress how effectively its funds are spent. Indian Health Service had a total of thirty-three GPRA measures in FY 2011. Twenty-one of these measures track health care provided at the individual clinic level. Tribal governments and community members can review these twenty-one measures to see how well their healthcare program provides basic preventive care and care for patients with diabetes and heart disease with a high return-on-investment. The clinical measures that GPRA tracked in FY 2011 and will track in FY 2012 are:

- Diabetes: Poor Glycemic (Blood Sugar) Control (A1c > 9.5)
- Diabetes: Ideal Glycemic (Blood Sugar) Control (A1c < 7.0)
- Diabetes: Controlled Blood Pressure (<130/80)
- Diabetes: Dyslipidemia (Cholesterol) Assessed
- Diabetes: Nephropathy (Kidney Disease) Assessed
- Diabetes: Retinopathy (Eye Disease) Exam
- Access to Dental Services
- Dental Sealants
- Dental Fluoride Treatment
- Influenza Vaccination for Patients Age 65+
- Pneumovax Vaccination for Patients Age 65+
- Childhood Immunizations (age 19-35 months)
- Cervical Cancer Screening
- Mammography (Breast Cancer) Screening
- Colorectal Cancer Screening
- Tobacco Cessation
- Alcohol Screening (Fetal Alcohol Syndrome Prevention)
- Domestic/Intimate Partner Violence Screening
- Depression Screening
- Cardiovascular Disease Assessment
- Prenatal HIV Screening

Indian healthcare programs that score well on these measures are:

- Performing screenings that can identify many preventable conditions requiring interventions or further treatment
- Providing protection for elders and young children from many vaccine preventable diseases
- Helping patients with diabetes to manage their blood sugar levels and blood pressure

NATIONAL GPRA SUPPORT TEAM (NGST)

The National GPRA Support Team, located within the Office of Management Support, is primarily responsible for GPRA activities at both the national and area levels. At the national level, the team supports national IHS GPRA program by collecting, analyzing, and reporting on GPRA data from every participating IHS, tribal, and urban clinic throughout Indian country. At the California Area level, the team assists all California clinics by providing regular feedback about performance and assisting with improvement efforts. Dashboards that graphically display national, area, and clinic level performance data are provided on a regular basis, so that each tribal and urban Indian healthcare program can monitor performance and identify measures that need improvement.

GPRA PERFORMANCE IN FY 2011

Overall, California Area tribal and urban Indian healthcare programs only met eight of 19 measures in FY 2011. (The measures for dental fluorides and dental sealants do not have area level targets.) Achieving improvements is particularly important because these measures reflect the care that clinic patients are receiving and because these targets are not very aggressive. For example, the target for Influenza Vaccination in FY 2011 was to vaccinate 58.5% of elder patients 65 years of age and older.

National GPRA Support Team (left to right): Rachel Pulverman, Christine Brennan, Elaine Brinn, Wendy Blocker (Not Pictured: Amy Patterson)

California missed this target, with only 53.3% of elders vaccinated in FY 2011. California missed three other measures by more than five percentage points: Cervical Cancer Screening, Depression Screening, and Prenatal HIV Screening.

ANNUAL CALIFORNIA AREA REPORT

While California only met eight of 19 measures on average, at the individual clinic level, performance varied widely. Some clinics did very well, with the best performing clinic meeting seventeen of 19 measures. Some did very poorly, with the lowest performing clinic meeting only three measures. Information about individual clinic performance on these measures is available in the annual California Area Report. This report shows individual clinic performance for each measure for two years and shows California average performance from 2003 to the present year. This report is prepared each March. The most current version is for FY 2010 and is available on the California Area website or upon request.

FY 2012 ACTION PLAN

There is still a need to improve GPRA performance and to properly document the provision of preventive healthcare. The National GPRA Support Team has developed a FY 2012 action plan to support and promote GPRA quality improvement efforts at each clinic. The plan includes providing feedback on performance, offering trainings, providing improvement challenges, hosting WebEx meetings to share information about successful practices, and providing technical assistance to individual clinics with specific needs. The team will work throughout the coming year to support improvement in a variety of ways.

CONTRACTING

Karen Nichols, Supervisory Contracting Officer and Travis Coleman, Contract Specialist, discussing Title V Compacts

CONTRACT ADMINISTRATION

The contracting office is responsible for award and administration of all contracts issued by the IHS/CAO. This includes P.L. 93-638 contracts, Title V urban contracts, and commercial contracts of various types including those in support of the Sanitation Facilities Construction programs. This office issues purchase orders and delivery orders using simplified acquisition procedures to support IHS/CAO operations as well as support the tribal and urban Indian healthcare programs. These include services such as diabetes review, alcohol counselor certification, and activities in support of the information technology function.

SELF-GOVERNANCE COMPACT ADMINISTRATION

The contracting office is also responsible for the local administration of Self -Governance compacts. There are currently nine Self-Governance compactors in the California Area. One tribe currently has a planning cooperative agreement for Self-Governance.

TRAINING AND TECHNICAL ASSISTANCE

The contracting office provides training and technical assistance to tribal and urban Indian healthcare programs. Contracting also has the responsibility for resolution of A-133 financial (single) audits of tribal and urban organizations. The contracting staff is responsible for tracking contract support costs needs, funding, and shortfall for the IHS/CAO.

ANNUAL FUNDING AGREEMENTS

Over the past year, contracting staff renewed 32 P.L. 93-638 contracts. Most of these were Annual Funding Agreements (AFA) renewals; however, 11 of these were new contracts. In addition, two new P.L. 93-638 contracts were awarded. Numerous modifications were issued to all of the ongoing contracts and AFAs, adding funds for various program increases received during the year as well as non-recurring funding awarded to tribal and urban Indian healthcare programs. In addition, contracting staff awarded 13 contracts to urban Indian organizations for healthcare, alcoholism services, or a combination of both. The contracting office also administers a contract to a Native Hawaiian organization for services to American Indians/Alaska Natives residing in Hawaii. Contracting issued three requirement contracts for construction of sanitation facilities and exercised options on three additional contracts.

CONTRACTING FOR YOUTH REGIONAL TREATMENT CENTERS

The contracting office has been involved in the planning and preparation for the Youth Regional Treatment Centers in California. Contracting has worked with IHS Engineering Services - Dallas for architect and engineering services.

Contracting staff working on Area Shares tables

HUMAN RESOURCES

ACCESS TO FEDERAL INSURANCE

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act. Section 10221 of the Affordable Care Act incorporated and enacted S. 1790, the Indian Health Care Improvement Reauthorization and Extension Act of 2009. This resulted in the addition of § 409 to the Indian Health Care Improvement Act (IHCIA). IHCIA § 409 (now codified at 25 U.S.C. § 1647b) allows eligible Indian tribes, tribal organizations, and urban Indian organizations to purchase Federal Employees Health Benefits (FEHB) and Federal Employees' Group Life Insurance (FEGLI) coverage, rights and benefits for their employees. Tribes or tribal organizations carrying out programs under the Indian Self-Determination and Education Assistance Act (ISDEAA) and urban Indian organizations carrying out programs under Title V of the IHCIA are entitled to purchase coverage for their employees, provided that the necessary employee deductions are made and contributions are paid. This access to federal insurance provides a new option for many tribes to purchase coverage for employees who might otherwise have difficulty accessing affordable insurance coverage in the private market. The U.S. Office of Personnel Management (OPM) administers FEHB and FEGLI for Federal employees. OPM has entered into consultation with tribes, tribal organizations, and urban Indian organizations to assist them with access to FEHB and FEGLI coverage. The OPM is excited to announce that Indian tribes, tribal organizations and urban Indian organizations may purchase FEHB coverage for their employees beginning in Spring of 2012. The earliest effective date of coverage for these employees is **May 1, 2012**. Tribes, tribal organizations and urban Indian organizations may also purchase FEHB coverage effective after this date.

Jeanne Smith, Regional Human Resources Specialist
Indian Health Service/California Area Office

IHS JOBS WEBSITE

The recently revamped IHS Jobs website is up and running at full speed. When a Tribe decides to fully contract for its recruitment services (line item #124 previously provided by IHS) under the Indian Self-Determination & Education Assistance Act (ISDEAA), the Tribe no longer is able to use the IHS Jobs Website as IHS has no responsibility to provide recruitment assistance associated with those funds. The bottom line is, if a Tribe wants to use the IHS Jobs website for recruiting purposes, they must have left their line item #124 shares with IHS, or enter into a buy-back agreement. For further information on this, please contact Travis Coleman at (916) 930-3981, Ext. 319 or Jeanne Smith (916) 930-3981, Ext. 335.

Virginia Myers (Yurok/Karuk) with her son, Peygoy Hedrick, participating in the fun run/walk at the 2011 Annual Tribal Consultation

FINANCIAL REPORT

FISCAL YEAR 2010-2011

FROM THE DESK OF THE CHIEF FINANCIAL OFFICER

Vinay Narjit Singh Behl | Director- DFAS, OMS

Chief Financial Officer - IHS California Area Office

Certified Public Accountant | Certified Government Finance Manager

Chartered Accountant | Certified Government Audit Professional

CMA,CFE,CIA,CISA,CITP,AICWA,CF,CIFRS,CAPM,MS,MBA

Dear Tribal Leaders and Partners,

It gives me great pleasure in presenting to you the financial report for FY 2011.

The financial market crash recently contributed to the rapid buildup of federal debt held by public. The greatest challenge for the government is to stimulate the growth engine and at the same time reduce spending and deficit financing. A large budget deficit is always a problem for the economy as rising borrowing costs will result in increased interest rates and a higher tax burden on the tax payer. Further spending in areas such as healthcare may reduce as government has to spend more on fixed costs such as borrowings. However Budget Control Act of 2011 improved the federal government fiscal outlook by providing for a $ 2.1 trillion deficit reduction from 2012 through 2021. The core challenges before the federal government are rising healthcare costs and the aging U.S. population which will create budgetary pressure. The Budget Control Act sets limits on discretionary spending for FY 2012-2021 and created the Joint Select Committee on Deficit Reduction. The deficit reduction may be achieved by changes in tax structure and spending patterns.

Under the Consolidated Appropriations Act, 2012 to carry out the provisions of Indian Self-Determination Act and Education Assistance Act (ISDAEAA), the Indian Health Care Improvement Act, and Titles II and III of the Public Health Service Act with respect to the Indian Health Service, an amount of $3.8 billion has been provided, out of which $844.9 million is for contract medical care, including $51.5 million for the Indian Catastrophic Health Emergency Fund. The Act also provides that of the funding provided for information technology activities and, notwithstanding any other provision of law, $4 million shall be allocated at the discretion of the Director of the IHS: and out of the funds provided, up to $36 million shall remain available until expended for implementation of the Loan Repayment Program under Section 108 of the Indian Health Care Improvement Act.

It is further provided in this Act that $472.19 million shall be for payments to tribes and tribal organizations for contract or grant support costs associated with contracts, grants, self-governance compacts, or annual

funding agreements between the Indian Health Service and a tribe or tribal organization. This is pursuant to the ISDEAA of 1975, as amended, prior to or during fiscal year 2012, of which not to exceed $10 million may be used for contract support costs associated with new or expanded self-determination contracts, grants, self-governance compacts, or annual funding agreements.

For construction, repair, maintenance, improvement, and equipment of healthcare and related auxiliary facilities; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of modular buildings, and purchases of trailers; and for provision of domestic and community sanitation facilities for Indians, as authorized by Section 7 of the Act of August 5, 1954 (42 U.S.C. 2004a), the ISDEAA, and the Indian Health Care Improvement Act, and for expenses necessary to carry out such Acts and titles II and III of the Public Health Service Act with respect to environmental health and facilities support activities of the Indian Health Service, $441 million will remain available until expended. The Act further provides for across the-board rescissions, an amount equal to 0.16 percent of the budget authority provided for fiscal year 2012.

Federal budget and appropriation process (See Figure 1A) has the longest cycle time and takes up to 22 months to complete. It has four phases, beginning with planning, where budget formulation workgroup discuss what worked well and what did not work well, develop recommendations for improvement and develop timeline for the upcoming budget cycle.

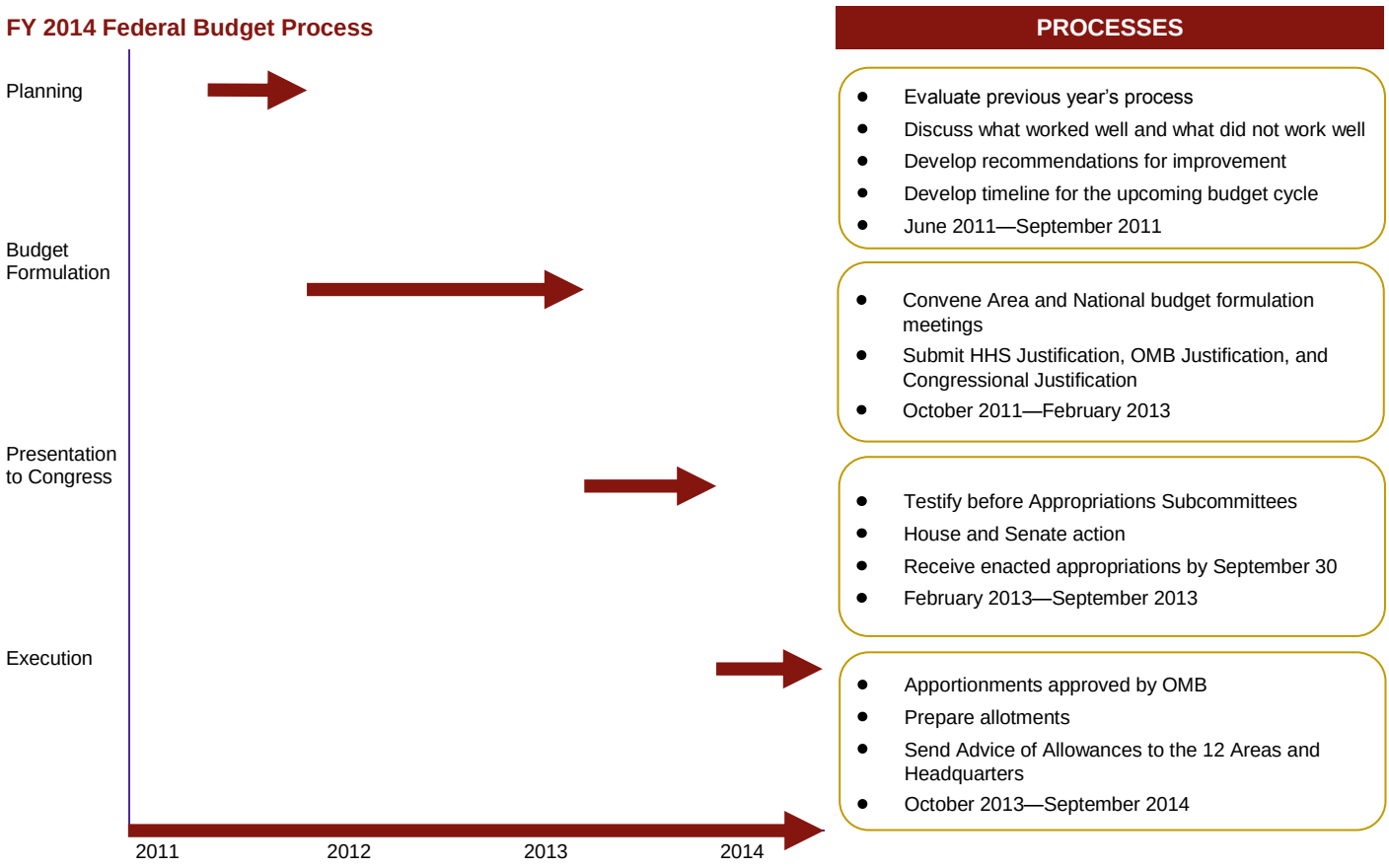


Figure 1A

The budget formulation phase begins with IHS, tribal and urban (ITU) area budget teams meeting in 12 areas. This phase typically takes place in October through December. The delegates determine health problems/ priorities and budget recommendations. The area recommendations are then submitted to headquarters. The next stage is the national budget work sessions to be held in January. Two delegates are invited from each area who are typically tribal leaders. These delegates agree on a set of overall budget/health priorities. In March the following year, a budget workgroup member is selected to prepare and present tribal testimony on the national budget recommendations and concerns to DHHS. Tribal/ Urban/Nat'l Indian Organizations Leadership meet with OMB, if they choose, any time after the National budget formulation meeting.

This is followed by Formulation of Rules-Based Budgets (also known as embargoed phase) until the President releases his request to Congress.

IHS develops its budget request per HHS and OMB budget parameters during May. Thereafter, the HHS Justification, which includes IHS Budget Request, is submitted to the HHS in early June and may include responses to follow-up questions, preparation and presentation to Secretary's Budget Council and receiving secretarial passback in July. This effort is followed by preparing the HHS budget justification for submission to OMB. During September, OMB responds with follow-up questions and a passback. This continues until late November. Budget justification is prepared from mid-December to the end of January when the President presents the budget to Congress by the first Monday of February. There follows a period of Congressional testimonies and briefings where the agency testifies before the House and Senate Appropriation Subcommittees during March and April. Outside witnesses (tribal and urban, Indian organizations, friends of ITU, etc.) testify before Appropriations Subcommittees and Authorizing Committees, at the President's request, for IHS during March. After responding to House and Senate questions and inquiries during June and July, House and Senate action is received. Conference committees act on the budget and Conference Committee action is received by mid-September. Enacted appropriation is received by September 30th before the commencement of the fiscal year. The last phase is the budget execution phase where approved apportionments are received from OMB and warrants from the Treasury Department are followed by allotments by headquarters to area offices so that funds can be obligated.

We had a successful budget formulation session here, convened by Ms. Margo Kerrigan, Area Director for the IHS California Area Office. The participating tribal governments identified the following health priorities in order of sequence:

- YRTC
- Contract Health Services
- Indian Health Care Improvement Fund
- Behavioral Health
- Sanitation Facilities Construction / Maintenance & Improvement

Please refer to Figure 1B for top five tribal priorities in the past six years.

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
1	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes	Contract Health Service - Pharmaceuticals
2	Cancer	Cancer	Cancer	Cancer	Cancer	Indian Health Care Improvement Fund - Pharmaceuticals
3	Heart Disease	Heart Disease	Heart Disease	Behavioral Health	Behavioral Health	Behavioral Health
4	Alcohol/ Substance Abuse	Alcohol/ Substance Abuse	Alcohol/ Substance Abuse	Heart Disease/ Stroke	Health Promotion/ Disease Prevention	Cancer
5	Mental Health/ Behavioral Health	Mental Health/ Behavioral Health	Mental Health/ Behavioral Health	Health Promotion/ Disease Prevention	Heart Disease/ Stroke	Health

Figure 1B

Under the initiative to reform and increase functions in IHS, Office of Management Support for California programs is evaluating opportunities for Finance function improvement methodology. This methodology uses a diagnostic approach to evaluate core finance and accounting functions, develop more robust processes and implement them with buy-in from process owners (stakeholders) through a consultative approach. Our foremost objective was to optimize processes and focus on control environment/change management. Standard Operating Procedures (SOP's) were developed to document and standardize processes to ensure internal checks and improve efficiency. This ensures that staff are trained and up-to-date on these processes. A key finance function objective is to protect assets and ensure critical controls, policies and procedures are always in place, while at the same time, not creating bottlenecks in the organization. An organization-wide effort is underway to document SOP's and their interaction with other non-finance processes. This effort will help ensure minimal disruption to services in case of a change in resources by developing SOP's for all processes in finance and accounting.

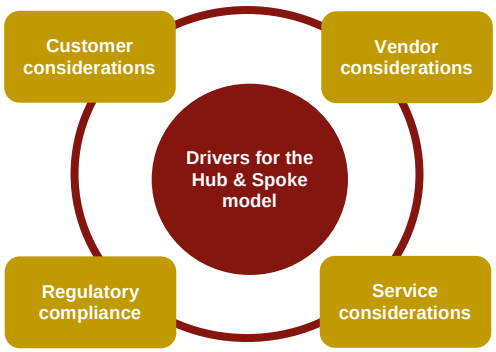
After taking over the office of Area Chief Financial Officer, my foremost challenge was to implement the vision of our Area Deputy Director, Ms. Beverly Miller, to optimize available technology. Accordingly, I was engaged in a feasibility analysis and system study to determine an appropriate system to help increase throughput in payment cycle while, at the same time, provide a data warehouse for mining finance data for future budgeting and analysis. This approach ensures processes are appropriately enabled by technology and new functionality is constantly incorporated into existing processes in a controlled manner. Thus, the manual spending plan process is being automated and a spending plan database has been chartered to keep all procurement stakeholders informed of the process and also provide a database for audits.

Another key objective of the finance function is creating value. This is possible through appropriate reporting, information visibility and designing performance measurement and management systems for the organization. Feedback and measurement of performance is possible only through an effective reporting system. As Ms. Miller encourages us to use reflection as a tool, we institute it in our daily processes. Performance management was made possible through various highly customized executive and dashboard reports.

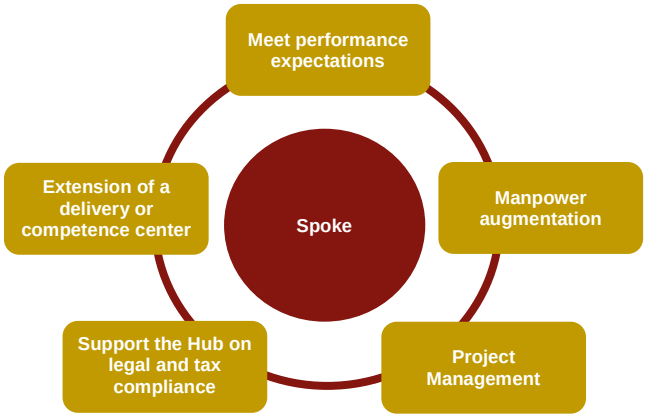
I have laid a strong emphasis on robust compliance as efficiently and cost effectively as possible. OMB Circular No. A-123 defines management's responsibility for internal controls in Federal agencies. A re-examination of the existing internal control requirements for Federal agencies was initiated in light of the new internal control requirements for publicly-traded companies contained in the Sarbanes-Oxley Act of 2002. Circular A-123, and the statute it implements, the Federal Managers' Financial Integrity Act of 1982, are at the center of the existing Federal requirements to improve internal control. This circular reflects policy recommendations developed by a joint committee of representatives from the Chief Financial Officer Council (CFOC) and the President's Council on Integrity and Efficiency (PCIE). The policy changes in this circular are intended to strengthen the requirements for conducting management's assessment of internal control over financial reporting. The circular also emphasizes the need for agencies to integrate and coordinate internal control assessments with other internal control-related activities. This Circular provides guidance to Federal managers on improving the accountability and effectiveness of Federal programs and operations by establishing, assessing, correcting, and reporting on internal control. The attachment to this Circular defines management's responsibilities related to internal controls and the process for assessing internal control effectiveness along with a summary of the significant changes. The Circular provides updated internal control standards and new specific requirements for conducting management's assessment of the effectiveness of internal control over financial reporting (Appendix A). This Circular emphasizes the need for integrated and coordinated internal control assessments that synchronize all internal control-related activities. We will review the application of this circular at IHS/CAO level and devise internal checks and controls to implement the recommendations of the circular.

The Division for Finance and Accounting Services in California is actively engaged in preparing strategies for restructuring the finance department to handle accounting and financial services for YRTC's in the next two years. This will entail hiring new staff, training existing staff and greater efficiency in working to handle more transactions cost effectively.

Key drivers for the Hub & Spoke model



Responsibilities of a Spoke



The Hub & Spoke model is used in the context of multi location sourcing wherein a central consolidator called the "Hub" provides a single face to the customer while seamless extensions called "Spokes" are leveraged to provide the services, distributed across multiple locations. In a wider role, the Hub is expected to take on management responsibilities including those of customer, quality, risk and performance management, training & development, manpower management and regulatory compliance.

I am working on a hub and spoke model for organizing the finance department. The model provides an attractive cost proposition to the agency at the same time, enabling finance resources to deliver seamless service. It provides flexibility in service delivery in a way that we can scale up or down operations based on workload.

In accordance with our commitment to increased service levels to tribal and urban healthcare programs and better control over finance, we have transitioned cash management functions from the Albuquerque Area Office to CAO in-house. With the start of FY 2012 on October 1, the IHS/CAO commenced operation of a full function finance and accounting department. Previously, the Albuquerque Area Office processed all California payments and submitted them to U.S. Treasury for disbursement. During the fourth quarter of FY 2011, the Albuquerque Area Office transferred the cash management operation to the CAO. This involved six to eight months of planning and intense training for CAO staff. The transfer process is now complete. This change means that the CAO has full control over the processing of IHS payments to tribal and urban Indian healthcare programs and submits payments directly to the U.S. Treasury for disbursement. The benefits of this change to our stakeholders are quicker turnaround time for IHS payments, greater local control over the quality and accuracy of these transactions, and improved external customer service.

One project that is being keenly followed is the development of an effective reporting mechanism for all the projects in environmental health, SFC and facilities to enable OEHE engineers to make informed financial decisions and track project status. This development will also help agencies granting contributions, like EPA, to monitor fund usage.

We remain committed to using good corporate governance processes to implement plans, policies and procedures that enable IHS/CAO to continue to serve tribal governments and improve the health status of American Indians and Alaska Natives

Best regards,

/Vinay Behl/

Vinay N S Behl

FINANCIAL INFORMATION INDEX

FINAL FINANCIAL REPORT—SUMMARY

ACTIVITY	ALLOWANCE	OBLIGATION	BALANCE
CLINICAL SERVICES			
Hospital & Clinics	$74,519,967	$74,519,967	-
Dental	1,852,320	1,852,320	-
Mental Health	1,796,239	1,796,239	-
Alcohol	11,443,407	11,443,407	-
Reimbursements	30,410	30,410	-
Total Clinical Services:	89,642,343	89,642,343	-
PREVENTIVE HEALTH			
Public Health Nursing	745,188	745,188	-
Health Education	316,067	316,067	-
Community Health Representative	2,120,293	2,120,293	-
Total Preventive Health:	3,181,548	3,181,548	-
URBAN	7,091,289	7,091,289	-
DIRECT OPERATIONS	2,340,319	2,340,319	-
CONTRACT SUPPORT COSTS	38,208,925	38,208,925	-
CONTRACT HEALTH CARE	40,951,901	40,951,901	-
SPECIAL DIABETES PROGRAM FOR INDIANS—DIRECT	259,000	19,765	239,235
CATASTROPHIC FUND	736,362	736,362	-
SPECIAL DIABETES PROGRAM FOR INDIANS	200,000	-	200,000
SELF-GOVERNANCE	100,000	100,000	-
FACILITIES & ENVIRONMENTAL HEALTH SUPPORT			
Environmental Health Support	3,799,570	2,723,209	1,076,361
Facilities Health Support	949,731	683,060	266,671
OEHE Support	13,362	13,223	139
Reimbursements	662	662	-
Total Facilities & Environmental Health Support:	4,763,325	3,420,154	1,343,171

ACTIVITY	ALLOWANCE	OBLIGATION	BALANCE
INDIAN HEALTH FACILITIES			
Equipment	804,146	804,146	-
Maintenance and Improvement	2,841,474	1,938,068	903,406
Total Indian Health Facilities:	3,645,620	2,742,214	903,406
SANITATION FACILITIES			
Housing	2,039,000	2,039,000	-
Regular	2,438,000	2,438,000	-
Total Sanitation Facilities	4,477,000	4,477,000	-
INTER-AGENCY FUNDS			
Contributions	2,111,045	2,111,045	-
Total Contributions Facilities	2,111,045	2,111,045	-
AREA GRAND TOTAL	**$197,708,677**	**$195,022,865**	**$2,685,812**

Figure 1

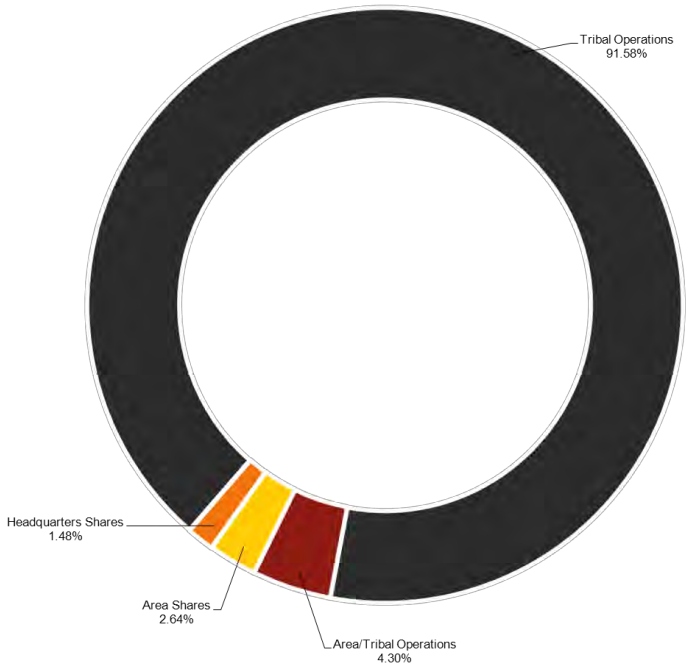


Figure 1 represents total area funding, made up of area shares, tribal operations, Area/tribal operations, and headquarters shares.

CLINICAL SERVICES
Hospital & Clinics

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$10,200
Cabazon Band of Mission Indians	69,314
California Rural Indian Health Board, Inc.	8,563,527
Central Valley Indian Health, Inc.	4,450,673
Chapa-De Indian Health Program, Inc.	3,992,184
Cold Springs Tribal Council	167,264
Colusa Indian Health Community Council	212,487
Coyote Valley Tribal Council	199,638
Feather River Tribal Health, Inc.	2,801,745
Greenville Rancheria	1,104,899
Guidiville Indian Rancheria	132,657
Hopland Band of Pomo Indians	152,871
Indian Health Center of Santa Clara Valley, Inc.	1,500
Lake County Tribal Health Consortium	3,969,386
Native American Health Center, Inc.	10,000
Paskenta Band of Nomlaki Indians	13,997
Pinoleville Band of Pomo Indians	39,684
Pit River Health Services, Inc.	1,060,722
Quartz Valley Indian Reservation	165,959
Round Valley Indian Health Center, Inc.	892,463
Sacramento Native American Health Center, Inc. -Alco	25,000
San Diego American Indian Health Center, Inc.	45,200
San Manuel Tribal Admin	1,400
Santa Ynez Band of Mission Indians	951,462

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Scotts Valley Band of Pomo Indians	$185,907
Sherwood Valley Band of Pomo Indians	153,298
Shingle Springs Rancheria	863,316
Southern Indian Health Council, Inc.	2,976,431
Strong Family Health Center	275,967
Sycuan Band of Mission Indians	196,925
Table Mountain Rancheria	92,690
Toiyabe Indian Health Project, Inc.	2,337,671
Tule River Indian Health Center, Inc.	2,191,748
Tuolumne Me-Wuk Indian Health Center, Inc.	419,462
United American Indian Involvement, Inc. -Public Health	70,000
United American Indian Involvement, Inc. -Bakersfield	1,250
United American Indian Involvement, Inc. -Aftercare	2,434
United American Indian Involvement, Inc. -Fresno	1,000
Consolidated Tribal Health Project	1,747,500
Hoopa Valley Tribe	1,848,770
Indian Health Council	4,151,578
Karuk Tribe of California	1,195,571
Northern Valley Indian Health	1,375,958
Redding Rancheria	3,330,441
Riverside-San Bernardino Indian Health	10,219,875
Susanville Indian Rancheria	853,927
Total Tribal Operations:	**63,525,951**

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$1,045
Central Valley Indian Health, Inc.	248,700
California Rural Indian Health Board, Inc.	935,600
Chapa-De Indian Health Program, Inc.-PFSA	190,800
Feather River Tribal Health, Inc.	153,450
Greenville Rancheria	19,000
Paskenta Band of Nomlaki Indians	500
Pit River Health Services, Inc.	41,000
Santa Ynez Band of Mission Indians	20,500
Shingle Springs Rancheria	41,100
Southern Indian Health Council, Inc.	186,900

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Strong Family Health Center	$13,600
Toiyabe Indian Health Project, Inc.	165,900
Consolidated Tribal Health Project	133,600
Hoopa Valley Tribe	174,500
Indian Health Council	271,400
Karuk Tribe of California	85,500
Northern Valley Indian Health	54,300
Redding Rancheria	265,800
Riverside-San Bernardino Indian Health	581,400
Susanville Indian Rancheria	47,800
Total Tribal Operations- Area Shares:	**3,632,395**

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$1,350
California Rural Indian Health Board, Inc.	177,862
Central Valley Indian Health, Inc.	61,435
Feather River Tribal Health, Inc.	74,941
Greenville Rancheria	44,554
Pit River Health Services, Inc.	28,584
Santa Ynez Band of Mission Indians	13,613
Shingle Springs Rancheria	8,406
Southern Indian Health Council, Inc.	77,285
Strong Family Health Center	9,354

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Toiyabe Indian Health Project, Inc.	51,964
Consolidated Tribal Health Project	38,269
Hoopa Valley Tribe	45,110
Indian Health Council	215,608
Karuk Tribe of California	29,034
Northern Valley Indian Health	28,875
Redding Rancheria	138,861
Riverside-San Bernardino Indian Health	359,892
Susanville Indian Rancheria	15,213
Total Tribal Operations Headquarters Shares:	**1,420,210**

MOA OPERATION EXPENDITURES	FUNDED AMOUNT
Personnel Services	$1,326,903
Transportation	20,505
Total MOA Operation Expenditures:	**1,347,408**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$2,223,934
Travel	204,543
Transportation	30
Rent, Comm., Util.	1,122,765
Printing	23,395
Contractual Services	586,645
Training	50,332
Supplies	211,354
Equipment	167,795
Insurance Claims and Indemnities	3,210
Total Area & Tribal Operation Expenditures:	**4,594,003**

TOTAL OBLIGATIONS—HOSPITAL & CLINICS	$74,519,967

CLINICAL SERVICES
Dental Services

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$13,000
American Indian Health & Services Corporation	1,000
Central Valley Indian Health, Inc.	1,000
Chapa-De Indian Health Program, Inc.	75,983
Colusa Indian Health Community Council	1,000
Feather River Tribal Health, Inc.	124,371
Greenville Rancheria	31,858
Lake County Tribal Health Consortium	70,000
Native American Health Center, Inc.	4,000
Paskenta Band of Nomlaki Indians	4,629
Pit River Health Services, Inc.	2,600
Quartz Valley Indian Reservation	3,000
Round Valley Indian Health Center, Inc.	5,000
Sacramento Native American Health Center, Inc. -Alco	8,500
San Diego American Indian Health Center, Inc.	1,000
Santa Ynez Band of Mission Indians	$1,000
Shingle Springs Rancheria	1,000
Southern Indian Health Council, Inc.	130,356
Table Mountain Rancheria	1,000
Toiyabe Indian Health Project, Inc.	1,000
Tule River Indian Health Center, Inc.	1,000
Tuolumne Me-Wuk Indian Health Center, Inc.	1,000
Consolidated Tribal Health Project	1,000
Hoopa Valley Tribe	1,000
Indian Health Council	1,000
Karuk Tribe of California	6,000
Northern Valley Indian Health	58,954
Riverside-San Bernardino Indian Health	804,571
Susanville Indian Rancheria	1,000
Total Tribal Operations:	**1,356,822**

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$40
California Rural Indian Health Board, Inc.	36,800
Central Valley Indian Health, Inc.	3,500
Chapa-De Indian Health Program, Inc.-PFSA	8,100
Feather River Tribal Health, Inc.	6,700
Greenville Rancheria	300
Toiyabe Indian Health Project, Inc.	7,400
Pit River Health Services, Inc.	600
Santa Ynez Band of Mission Indians	300
Shingle Springs Rancheria	1,900
Southern Indian Health Council, Inc.	8,100
Strong Family Health Center	600
Consolidated Tribal Health Project	6,000
Hoopa Valley Tribe	7,900
Indian Health Council	10,500
Northern Valley Indian Health	2,400
Redding Rancheria	10,100
Riverside-San Bernardino Indian Health	24,100
Susanville Indian Rancheria	2,100
Total Tribal Operations—Area Shares:	**137,440**

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$34
California Rural Indian Health Board, Inc.	6,079
Central Valley Indian Health, Inc.	2,261
Feather River Tribal Health, Inc.	4,448
Greenville Rancheria	1,023
Pit River Health Services, Inc.	545
Santa Ynez Band of Mission Indians	955
Shingle Springs Rancheria	254
Southern Indian Health Council, Inc.	4,588
Strong Family Health Center	281
Toiyabe Indian Health Project, Inc.	1,604
Consolidated Tribal Health Project	1,895
Hoopa Valley Tribe	3,061
Indian Health Council	6,760
Karuk Tribe of California	1,867
Northern Valley Indian Health	517
Redding Rancheria	3,762
Riverside-San Bernardino Indian Health	4,671
Susanville Indian Rancheria	903
Total Tribal Operations—Headquarters Shares:	**45,508**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$161,655
Travel	7,303
Contractual Services	41,201
Supplies	14,257
Equipment	88,134
Total Area & Tribal Operation Expenditures:	**312,550**

TOTAL OBLIGATIONS—DENTAL	$1,852,320

CLINICAL SERVICES
Mental Health

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$193,745
Central Valley Indian Health, Inc.	85,566
Chapa-De Indian Health Program, Inc.	62,787
Feather River Tribal Health, Inc.	42,748
Greenville Rancheria	10,709
Lake County Tribal Health Consortium	180,434
Paskenta Band of Nomlaki Indians	219
Pit River Health Services, Inc.	51,548
Round Valley Indian Health Center, Inc.	53,008
Santa Ynez Band of Mission Indians	14,439
Shingle Springs Rancheria	20,593
Southern Indian Health Council, Inc.	71,901
Strong Family Health Center	8,006
Table Mountain Rancheria	$1,548
Toiyabe Indian Health Project, Inc.	62,444
Tule River Indian Health Center, Inc.	75,462
Tuolumne Me-Wuk Indian Health Center, Inc.	13,808
Consolidated Tribal Health Project	63,936
Hoopa Valley Tribe	59,285
Indian Health Council	90,159
Karuk Tribe of California	58,342
Northern Valley Indian Health	19,438
Redding Rancheria	76,040
Riverside-San Bernardino Indian Health	194,578
Susanville Indian Rancheria	52,274
Total Tribal Operations:	**1,564,017**

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$5
California Rural Indian Health Board, Inc.	4,400
Central Valley Indian Health, Inc.	1,300
Chapa-De Indian Health Program, Inc.-PFSA	900
Feather River Tribal Health, Inc.	800
Greenville Rancheria	200
Pit River Health Services, Inc.	200
Santa Ynez Band of Mission Indians	200
Shingle Springs Rancheria	200
Southern Indian Health Council, Inc.	900
Toiyabe Indian Health Project, Inc.	800
Consolidated Tribal Health Project	700
Hoopa Valley Tribe	900
Indian Health Council	1,300
Karuk Tribe of California	600
Northern Valley Indian Health	200
Redding Rancheria	1,200
Riverside-San Bernardino Indian Health	2,800
Susanville Indian Rancheria	200
Total Tribal Operations—Area Shares:	**17,805**

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$61
California Rural Indian Health Board, Inc.	22,547
Central Valley Indian Health, Inc.	8,388
Feather River Tribal Health, Inc.	7,733
Greenville Rancheria	2,281
Pit River Health Services, Inc.	2,022
Santa Ynez Band of Mission Indians	1,659
Shingle Springs Rancheria	940
Southern Indian Health Council, Inc.	7,975
Strong Family Health Center	1,044

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Toiyabe Indian Health Project, Inc.	5,943
Consolidated Tribal Health Project	4,225
Hoopa Valley Tribe	5,323
Indian Health Council	11,752
Karuk Tribe of California	1,051
Northern Valley Indian Health	1,913
Redding Rancheria	6,541
Riverside-San Bernardino Indian Health	18,659
Susanville Indian Rancheria	1,569
Total Tribal Operations—Headquarters Shares:	**111,626**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$83,760
Transportation	18,058
Printing	973
Total Area & Tribal Operation Expenditures:	**102,791**

TOTAL OBLIGATIONS—MENTAL HEALTH	$1,796,239

CLINICAL SERVICES
Alcohol

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$12,299
California Rural Indian Health Board, Inc.	868,451
Central Valley Indian Health, Inc.	717,710
Chapa-De Indian Health Program, Inc.	172,758
Colusa Indian Health Community Council	92
Feather River Tribal Health, Inc.	319,483
Friendship House Association	829,993
Greenville Rancheria	28,364
Guidiville Indian Rancheria	43,676
Indian Health Center of Santa Clara Valley, Inc.	9,535
Ke Ola Mao	50,000
Lake County Tribal Health Consortium	253,311
Native American Health Center, Inc.	10,237
Native Directions, Inc.	412,567
Paskenta Band of Nomlaki Indians	537
Pit River Health Services, Inc.	79,682
Quartz Valley Indian Reservation	5,160
Round Valley Indian Health Center, Inc.	281,382
Sacramento Native American Health Center, Inc.—Hlth	171,710
Sacramento Native American Health Center, Inc.—Alco	43,929
San Diego American Indian Health Center, Inc.	11,876
Santa Ynez Band of Mission Indians	118,748
Scotts Valley Band of Pomo Indians	44,042
Sherwood Valley Band of Pomo Indians	190

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Shingle Springs Rancheria	$57,038
Sierra Tribal Consortium	675,795
Southern Indian Health Council, Inc.	184,506
Strong Family Health Center	60,146
Sycuan Band of Mission Indians	104
Table Mountain Rancheria	4,333
Toiyabe Indian Health Project, Inc.	405,466
Tule River Indian Health Center, Inc.	34,335
Tule River Tribal Council	527,561
Tuolumne Me-Wuk Indian Health Center, Inc.	83,851
United American Indian Involvement, Inc.—Aftercare	407,345
United American Indian Involvement, Inc.—Women	446,746
United American Indian Involvement, Inc.—Bakersfield	4,968
United American Indian Involvement, Inc.—Public Health	374
Consolidated Tribal Health Project	169,697
Hoopa Valley Tribe	365,964
Indian Health Council	381,006
Karuk Tribe of California	158,806
Northern Valley Indian Health	209,637
Redding Rancheria	247,555
Riverside-San Bernardino Indian Health	963,902
Susanville Indian Rancheria	89,240
Total Tribal Operations:	**9,964,107**

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$197
California Rural Indian Health Board, Inc.	182,800
Central Valley Indian Health, Inc.	57,700
Chapa-De Indian Health Program, Inc.-PFSA	39,900
Feather River Tribal Health, Inc.	33,300
Greenville Rancheria	4,600
Pit River Health Services, Inc.	9,600
Santa Ynez Band of Mission Indians	5,700
Shingle Springs Rancheria	9,000
Southern Indian Health Council, Inc.	39,800
Strong Family Health Center	3,000

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Toiyabe Indian Health Project, Inc.	$36,500
Consolidated Tribal Health Project	29,400
Hoopa Valley Tribe	39,200
Indian Health Council	51,700
Karuk Tribe of California	23,100
Northern Valley Indian Health	12,000
Redding Rancheria	50,100
Riverside-San Bernardino Indian Health	119,800
Susanville Indian Rancheria	10,600
Total Tribal Operations—Area Shares:	**757,997**

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$128
California Rural Indian Health Board, Inc.	14,006
Central Valley Indian Health, Inc.	8,713
Feather River Tribal Health, Inc.	16,234
Greenville Rancheria	3,839
Pit River Health Services, Inc.	2,098
Santa Ynez Band of Mission Indians	3,485
Shingle Springs Rancheria	969
Southern Indian Health Council, Inc.	16,743
Strong Family Health Center	1,084

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Toiyabe Indian Health Project, Inc.	6,171
Consolidated Tribal Health Project	7,059
Hoopa Valley Tribe	10,690
Indian Health Council	24,668
Karuk Tribe of California	6,361
Northern Valley Indian Health	1,987
Redding Rancheria	13,730
Riverside-San Bernardino Indian Health	39,169
Susanville Indian Rancheria	3,294
Total Tribal Operations—Headquarters Shares:	**180,428**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$268,377
Travel	4,175
Contractual Services	266,127
Equipment	2,196
Total Area & Tribal Operation Expenditures:	**540,875**

TOTAL OBLIGATIONS—ALCOHOL	$11,443,407

CLINICAL SERVICES
Reimbursements

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$1,741
Chapa-De Indian Health Program, Inc.	450
Feather River Tribal Health, Inc.	45
Greenville Rancheria	500
Lake County Tribal Health Consortium	3,500
Pinoleville Band of Pomo Indians	2,000
Round Valley Indian Health Center, Inc.	1,122
Shingle Springs Rancheria	75

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Toiyabe Indian Health Project, Inc.	2,000
Tule River Indian Health Center, Inc.	2,000
Tuolumne Me-Wuk Indian Health Center, Inc.	700
Hoopa Valley Tribe	1,500
Karuk Tribe of California	1,500
Northern Valley Indian Health	350
Redding Rancheria	1,100
Total Tribal Operations:	**18,583**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Travel	$9,202
Rent, Comm., Util.	10
Contractual Services	2,615
Total Area & Tribal Operation Expenditures:	**11,827**

TOTAL OBLIGATIONS—REIMBURSEMENTS	$30,410

Figure 2

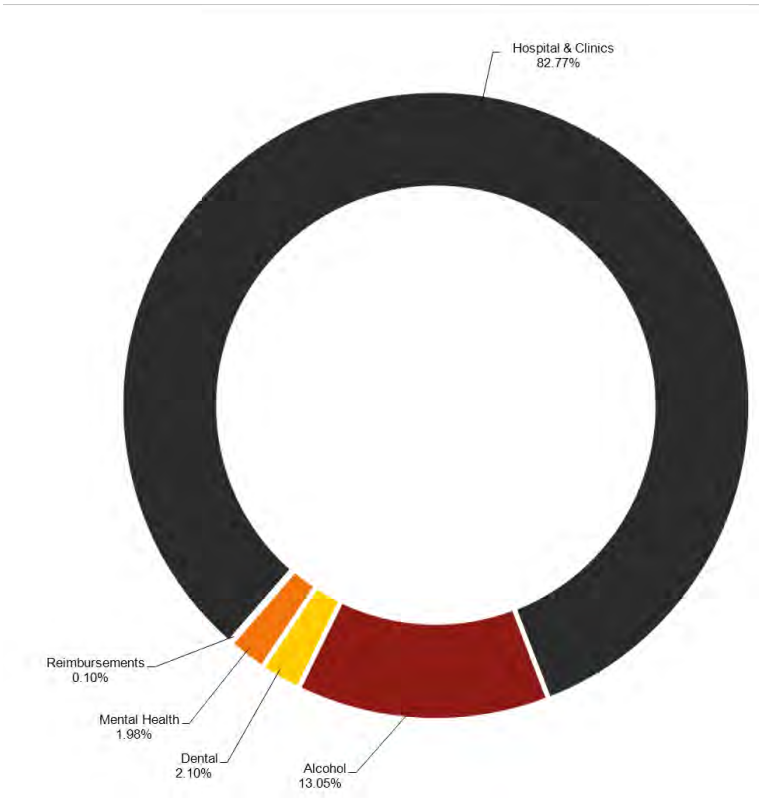


Figure 2 represents total funding to clinical services including hospital & clinics, dental, mental health, alcohol, and reimbursements.

PREVENTIVE HEALTH
Public Health Nursing

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$64,026
Central Valley Indian Health, Inc.	48,308
Lake County Tribal Health Consortium	141,115
Pit River Health Services, Inc.	50,374
Table Mountain Rancheria	607
Tule River Indian Health Center, Inc.	50,975

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Consolidated Tribal Health Project	62,056
Hoopa Valley Tribe	25,586
Indian Health Council	89,996
Riverside-San Bernardino Indian Health	157,923
Susanville Indian Rancheria	13,327
Total Tribal Operations:	**704,293**

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$24
California Rural Indian Health Board, Inc.	9,572
Central Valley Indian Health, Inc.	3,554
Feather River Tribal Health, Inc.	3,103
Greenville Rancheria	936
Shingle Springs Rancheria	401
Southern Indian Health Council, Inc.	3,200
Strong Family Health Center	444
Toiyabe Indian Health Project, Inc.	2,518

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Consolidated Tribal Health Project	1,733
Hoopa Valley Tribe	2,135
Karuk Tribe of California	1,303
Northern Valley Indian Health	810
Redding Rancheria	2,624
Riverside-San Bernardino Indian Health	7,487
Susanville Indian Rancheria	630
Total Tribal Operations—Headquarters Shares:	**40,474**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Travel	$421
Total Area & Tribal Operation Expenditures:	**421**

TOTAL OBLIGATIONS—PUBLIC HEALTH NURSING	$745,188

PREVENTIVE HEALTH
Health Education

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$2,000
Central Valley Indian Health, Inc.	2,996
Lake County Tribal Health Consortium	2,996
Pit River Health Services, Inc.	2,996
Quartz Valley Indian Reservation	2,997
Round Valley Indian Health Center, Inc.	1,900
San Diego American Indian Health Center, Inc.	2,000
Shingle Springs Rancheria	2,997

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Southern Indian Health Council, Inc.	500
United American Indian Involvement, Inc.—Fresno	1,000
United American Indian Involvement, Inc.—Bakersfield	500
United American Indian Involvement, Inc.—Public Health	3,200
Indian Health Council	1,000
Northern Valley Indian Health	2,400
Susanville Indian Rancheria	500
Total Tribal Operations:	**29,982**

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$56
California Rural Indian Health Board, Inc.	51,800
Central Valley Indian Health, Inc.	16,400
Chapa-De Indian Health Program, Inc.-PFSA	11,300
Feather River Tribal Health, Inc.	9,400
Greenville Rancheria	1,300
Pit River Health Services, Inc.	2,700
Santa Ynez Band of Mission Indians	1,500
Shingle Springs Rancheria	2,500
Southern Indian Health Council, Inc.	11,300
Strong Family Health Center	900
Toiyabe Indian Health Project, Inc.	$10,300
Consolidated Tribal Health Project	8,300
Hoopa Valley Tribe	11,100
Indian Health Council	14,500
Karuk Tribe of California	6,500
Northern Valley Indian Health	3,400
Redding Rancheria	14,200
Riverside-San Bernardino Indian Health	33,800
Susanville Indian Rancheria	2,800
Total Tribal Operations—Area Shares:	**214,056**

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$30
California Rural Indian Health Board, Inc.	11,486
Central Valley Indian Health, Inc.	4,346
Feather River Tribal Health, Inc.	3,901
Greenville Rancheria	1,164
Pit River Health Services, Inc.	1,048
Santa Ynez Band of Mission Indians	836
Shingle Springs Rancheria	484
Southern Indian Health Council, Inc.	4,024
Strong Family Health Center	541
Toiyabe Indian Health Project, Inc.	3,080
Consolidated Tribal Health Project	2,155
Hoopa Valley Tribe	2,685
Indian Health Council	5,927
Karuk Tribe of California	1,639
Northern Valley Indian Health	992
Redding Rancheria	3,300
Riverside-San Bernardino Indian Health	9,412
Susanville Indian Rancheria	792
Total Tribal Operations—Headquarters Shares:	**57,842**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Printing	$2,817
Contractual Services	11,370
Total Area & Tribal Operation Expenditures:	**14,187**

TOTAL OBLIGATIONS—HEALTH EDUCATION	$316,067

PREVENTIVE HEALTH
Community Health Representative

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$294,471
Central Valley Indian Health, Inc.	109,501
Chapa-De Indian Health Program, Inc.	48,337
Cold Springs Tribal Council	35,446
Coyote Valley Tribal Council	30,717
Feather River Tribal Health, Inc.	32,838
Greenville Rancheria	8,457
Hopland Band of Pomo Indians	30,687
Lake County Tribal Health Consortium	39,394
Paskenta Band of Nomlaki Indians	169
Pinoleville Band of Pomo Indians	30,043
Pit River Health Services, Inc.	32,660
Quartz Valley Indian Reservation	9,781
Round Valley Indian Health Center, Inc.	44,783
Santa Ynez Band of Mission Indians	32,593
Sherwood Valley Band of Pomo Indians	31,455

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Shingle Springs Rancheria	$16,081
Southern Indian Health Council, Inc.	72,103
Strong Family Health Center	57,726
Table Mountain Rancheria	1,988
Toiyabe Indian Health Project, Inc.	168,719
Tule River Indian Health Center, Inc.	52,541
Tuolumne Me-Wuk Indian Health Center, Inc.	10,942
Consolidated Tribal Health Project	40,857
Hoopa Valley Tribe	92,786
Indian Health Council	119,318
Karuk Tribe of California	92,748
Northern Valley Indian Health	15,046
Redding Rancheria	58,867
Riverside-San Bernardino Indian Health	311,703
Susanville Indian Rancheria	35,727
Total Tribal Operations:	**1,958,484**

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$17
California Rural Indian Health Board, Inc.	15,100
Central Valley Indian Health, Inc.	5,100
Chapa-De Indian Health Program, Inc.	3,300
Greenville Rancheria	400
Pinoleville Band of Pomo Indians	200
Pit River Health Services, Inc.	800
Santa Ynez Band of Mission Indians	500
Shingle Springs Rancheria	800
Southern Indian Health Council, Inc.	3,500
Strong Family Health Center	300
Toiyabe Indian Health Project, Inc.	$3,100
Consolidated Tribal Health Project	2,397
Feather River Tribal Health, Inc.	2,800
Hoopa Valley Tribe	3,200
Indian Health Council	4,000
Karuk Tribe of California	1,900
Northern Valley Indian Health	1,000
Redding Rancheria	4,200
Riverside-San Bernardino Indian Health	9,900
Susanville Indian Rancheria	299
Total Tribal Operations—Area Shares:	**62,813**

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$62
California Rural Indian Health Board, Inc.	24,493
Central Valley Indian Health, Inc.	8,373
Feather River Tribal Health, Inc.	8,062
Shingle Springs Rancheria	1,012
Strong Family Health Center	1,132
Pinoleville Band of Pomo Indians	690
Southern Indian Health Council, Inc.	8,313
Consolidated Tribal Health Project	-
Hoopa Valley Tribe	2,875
Indian Health Council	12,250
Karuk Tribe of California	3,389
Northern Valley Indian Health	2,077
Redding Rancheria	6,818
Riverside-San Bernardino Indian Health	19,450
Susanville Indian Rancheria	-
Total Tribal Operations—Headquarters Shares:	**98,996**

TOTAL OBLIGATIONS—CHR	**$2,120,293**

Figure 3

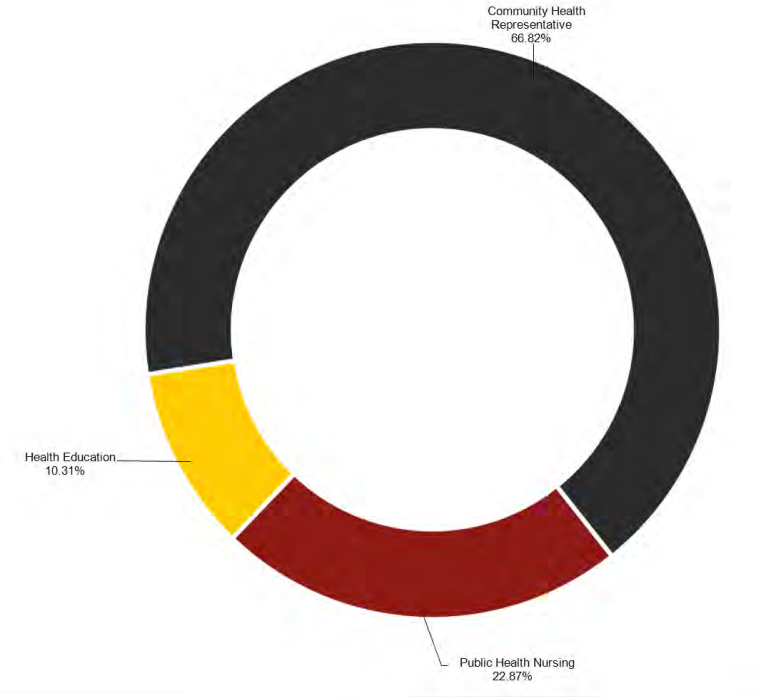


Figure 3 represents total area funding to preventive health including public health nursing, health education, and community health representative.

URBAN HEALTH PROJECTS

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$553,597
Friendship House Association	658,902
Indian Health Center of Santa Clara Valley, Inc.	563,451
Native American Health Center, Inc.	1,061,155
Sacramento Native American Health Center, Inc.—Hlth	706,176
Sacramento Native American Health Center, Inc.—Alco	282,252
San Diego American Indian Health Center, Inc.	761,604
United American Indian Involvement, Inc.—Aftercare	150,768
United American Indian Involvement, Inc.—Bakersfield	421,623
United American Indian Involvement, Inc.—Fresno	475,028
United American Indian Involvement, Inc.—PubHlth	1,333,411
Total Tribal Operations:	**6,967,967**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Travel	$18,847
Contractual Services	104,475
Total Area & Tribal Operation Expenditures:	**123,322**

TOTAL OBLIGATIONS—URBAN HEALTH PROJECTS	$7,091,289

DIRECT OPERATIONS

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$443
California Rural Indian Health Board, Inc.	143,895
Central Valley Indian Health, Inc.	52,847
Feather River Tribal Health, Inc.	47,488
Greenville Rancheria	14,279
Pit River Health Services, Inc.	13,594
Santa Ynez Band of Mission Indians	10,190
Shingle Springs Rancheria	5,953
Southern Indian Health Council, Inc.	48,976
Strong Family Health Center	6,603

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Toiyabe Indian Health Project, Inc.	$37,490
Consolidated Tribal Health Project	26,228
Hoopa Valley Tribe	32,687
Indian Health Council	81,854
Karuk Tribe of California	19,940
Northern Valley Indian Health	13,068
Redding Rancheria	46,121
Riverside-San Bernardino Indian Health	128,348
Susanville Indian Rancheria	9,640
Total Tribal Operations—Headquarters Shares:	**739,644**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$1,492,448
Travel	29,090
Printing	(1,899)
Contractual Services	76,158
Training	4,330
Equipment	548
Total Area & Tribal Operation Expenditures:	**1,600,675**

TOTAL OBLIGATIONS—DIRECT OPERATIONS	$2,340,319

CONTRACT SUPPORT COST

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$67,739
California Rural Indian Health Board, Inc.	7,301,915
Central Valley Indian Health, Inc.	2,078,769
Chapa-De Indian Health Program, Inc.	1,787,775
Chapa-De Indian Health Program, Inc.	51,023
Colds Springs Tribal Council	46,025
Colusa Indian Health Community Council	21,723
Coyote Valley Tribal Council	82,154
Feather River Tribal Health, Inc.	957,324
Greenville Rancheria	255,804
Guidiville Indian Rancheria	149,420
Hopland Band of Pomo Indians	42,856
Lake County Tribal Health Consortium	921,364
Paskenta Ban of Nomlaki Indians	617
Pinoleville Band of Pomo Indians	10,367
Pit River Health Services, Inc.	558,269
Quartz Valley Indian Reservation	85,363
Round Valley Indian Health Center, Inc.	403,708
Santa Ynez Band of Mission Indians	420,880
Scotts Valley Band of Pomo Indians	58,488

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Sherwood Valley Band of Pomo Indians	$38,947
Shingle Springs Rancheria	323,147
Sierra Tribal Consortium	375,345
Southern Indian Health Council, Inc.	1,980,735
Strong Family Health Center	394,733
Sycuan Band of Mission Indians	66,924
Table Mountain Rancheria	14,548
Toiyabe Indian Health Project, Inc.	1,012,515
Tule River Indian Health Center, Inc.	929,496
Tule River Tribal Council	100,754
Tuolumne Me-Wuk Indian Health Center, Inc.	190,010
Consolidated Tribal Health Project	1,478,542
Hoopa Valley Tribe	1,199,604
Indian Health Council	2,751,454
Karuk Tribe of California	1,246,498
Northern Valley Indian Health	592,763
Redding Rancheria	2,906,270
Riverside-San Bernardino Indian Health	6,604,334
Susanville Indian Rancheria	700,723
Total Tribal Operations:	**38,208,925**

TOTAL OBLIGATIONS—CONTRACT SUPPORT COST	**$38,208,925**

CONTRACT HEALTH CARE

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$8,509
California Rural Indian Health Board, Inc.	7,208,598
Central Valley Indian Health, Inc.	2,955,320
Chapa-De Indian Health Program, Inc.	2,355,000
Colusa Indian Health Community Council	62,440
Coyote Valley Tribal Council	86,375
Feather River Tribal Health, Inc.	1,851,065
Greenville Rancheria	644,774
Guidiville Indian Rancheria	8,264
Lake County Tribal Health Consortium	955,256
Paskenta Band of Nomlaki Indians	10,716
Pinoleville Band of Pomo Indians	11,702
Pit River Health Services, Inc.	553,954
Quartz Valley Indian Reservation	53,391
Round Valley Indian Health Center, Inc.	697,871
Santa Ynez Band of Mission Indians	475,320
Scotts Valley Band of Pomo Indians	10,381
Sherwood Valley Band of Pomo Indians	34,829

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Shingle Springs Rancheria	$525,336
Southern Indian Health Council, Inc.	1,237,350
Strong Family Health Center	187,601
Sycuan Band of Mission Indians	75,407
Table Mountain Rancheria	24,038
Toiyabe Indian Health Project, Inc.	1,509,144
Tule River Indian Health Center, Inc.	1,998,721
Tuolumne Me-Wuk Indian Health Center, Inc.	238,411
Consolidated Tribal Health Project	1,423,450
Hoopa Valley Tribe	1,786,859
Indian Health Council	2,495,760
Karuk Tribe of California	1,095,852
Northern Valley Indian Health	953,334
Redding Rancheria	2,149,644
Riverside-San Bernardino Indian Health	6,377,394
Susanville Indian Rancheria	476,624
Total Tribal Operations:	**40,538,690**

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$55
California Rural Indian Health Board, Inc.	51,100
Central Valley Indian Health, Inc.	16,100
Chapa-De Indian Health Program, Inc.	11,200
Feather River Tribal Health, Inc.	9,300
Greenville Rancheria	1,200
Pit River Health Services, Inc.	2,700
Santa Ynez Band of Mission Indians	1,600
Shingle Springs Rancheria	2,500
Southern Indian Health Council, Inc.	11,100
Strong Family Health Center	900

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Toiyabe Indian Health Project, Inc.	$10,200
Consolidated Tribal Health Project	8,300
Hoopa Valley Tribe	11,000
Indian Health Council	14,500
Karuk Tribe of California	6,400
Northern Valley Indian Health	3,400
Redding Rancheria	14,000
Riverside-San Bernardino Indian Health	33,500
Susanville Indian Rancheria	3,000
Total Tribal Operations—AREA SHARES:	**212,055**

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$73
California Rural Indian Health Board, Inc.	89,012
Central Valley Indian Health, Inc.	10,528
Feather River Tribal Health, Inc.	9,448
Greenville Rancheria	2,819
Pit River Health Services, Inc.	2,493
Santa Ynez Band of Mission Indians	2,028
Shingle Springs Rancheria	1,091
Southern Indian Health Council, Inc.	9,746
Strong Family Health Center	1,287

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Toiyabe Indian Health Project, Inc.	7,460
Consolidated Tribal Health Project	5,221
Hoopa Valley Tribe	6,505
Indian Health Council	14,360
Karuk Tribe of California	3,969
Northern Valley Indian Health	2,403
Redding Rancheria	7,993
Riverside-San Bernardino Indian Health	22,801
Susanville Indian Rancheria	1,919
Total Tribal Operations—Headquarters Shares:	**201,156**

TOTAL OBLIGATIONS—CONTRACT HEALTH CARE	**$40,951,901**

SELF GOVERNANCE

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Equipment	$100,000
Total Area & Tribal Operation Expenditures:	**100,000**

TOTAL OBLIGATIONS—SELF GOVERNANCE	$100,000

SPECIAL DIABETES PROGRAM FOR INDIANS (SDPI)
Direct

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$19,765
Total Area & Tribal Operation Expenditures:	**19,765**

TOTAL OBLIGATIONS—SDPI—DIRECT	$19,765

CATASTROPHIC FUND

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Greenville Rancheria	$43,720
Toiyabe Indian Health Project, Inc.	69,623
Consolidated Tribal Health Project	225,709
Indian Health Council	292,943
Redding Rancheria	104,367
Total Tribal Operations:	**736,362**

TOTAL OBLIGATIONS—CATASTROPHIC HLTH EMERG. FUND	$736,362

Figure 4

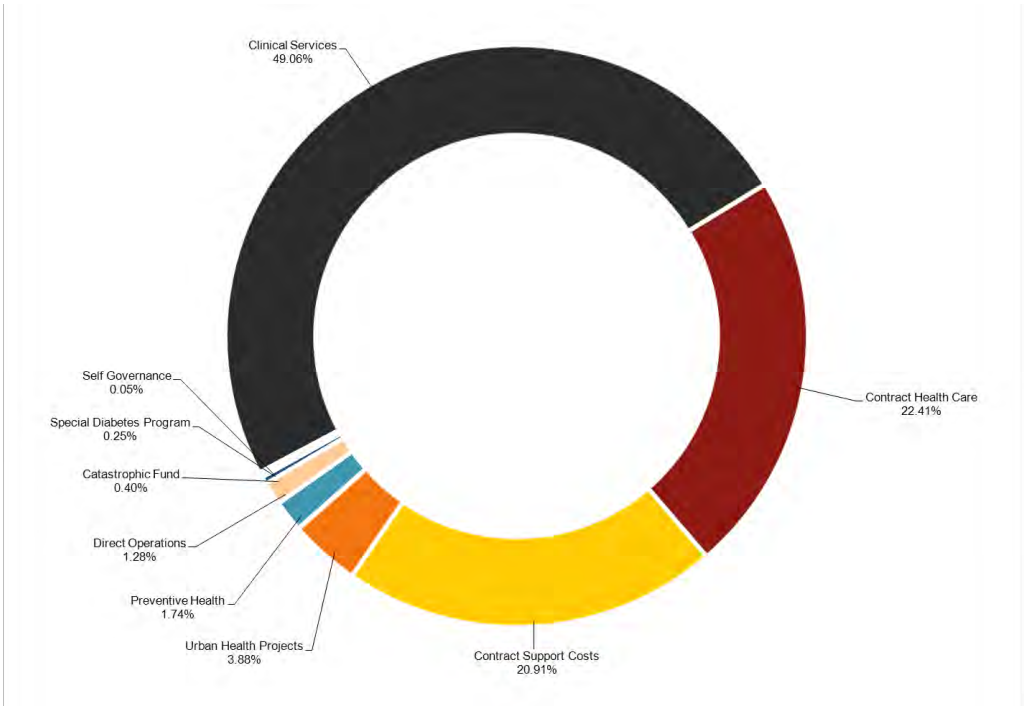


Figure 4 represents total area funding to clinical services, preventive health, urban health projects, direct operations, contract support costs, contract health care, special diabetes program, catastrophic fund, and self governance.

ENVIRONMENTAL HEALTH SUPPORT

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$240
California Rural Indian Health Board, Inc.	15,008
Central Valley Indian Health, Inc.	1,328
Chapa-De Indian Health Program, Inc.	7,024
Feather River Tribal Health, Inc.	13,837
Greenville Rancheria	7,774
Hopland Band of Pomo Indians	250
Indian Health Center of Santa Clara Valley, Inc.	938
Lake County Tribal Health Consortium	10,701
Native American Health Center, Inc.	600
Paskenta Band of Nomlaki Indians	78
Round Valley Indian Health Center, Inc.	1,513
Sacramento Native American Health Center, Inc.—Hlth	5,190

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Santa Ynez Band of Mission Indians	$188
Shingle Springs Rancheria	600
Strong Family Health Center	330
Tule River Indian Health Center, Inc.	1,410
United American Indian Involvement, Inc.—Bakersfield	630
United American Indian Involvement, Inc.—Fresno	1,110
United American Indian Involvement, Inc.—PubHlth	1,200
Hoopa Valley Tribe	4,863
Indian Health Council	5,850
Karuk Tribe of California	870
Northern Valley Indian Health	8,944
Susanville Indian Rancheria	1,200
Total Tribal Operations:	**91,676**

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$2,183
Southern Indian Health Council, Inc.	6,969
Hoopa Valley Tribe	64,619
Riverside-San Bernardino Indian Health	82,811
Total Tribal Operations—Area Shares:	**156,582**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$1,934,770
Travel	23,241
Transportation	30,426
Rent, Comm., Util.	7,116
Contractual Services	116,424

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Training	15,337
Supplies	9,489
Equipment	338,148
Total Area & Tribal Operation Expenditures:	**2,474,951**

TOTAL OBLIGATIONS—ENVIRONMENTAL HLTH. SUPPORT	$2,723,209

FACILITIES HEALTH SUPPORT

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Lake county Tribal Health Consortium	$417,350
Total Tribal Operations:	**417,350**

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$85,124
Total Tribal Operations—Headquarters Shares:	**85,124**

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Southern Indian Health Council, Inc.	$17,141
Indian Health Council	28,696
Total Tribal Operations—Area Shares:	**45,837**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$102,967
Travel	13,182
Transportation	12,304
Rent, Comm., Util.	325
Printing	2,172

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	3,162
Training	161
Supplies	356
Equipment	120
Total Area & Tribal Operation Expenditures:	**134,749**

TOTAL OBLIGATIONS—FACILITIES HLTH. SUPPORT	$683,060

OEHE SUPPORT

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Consolidated Tribal Health Project	$237
Hoopa Valley Tribe	4,663
Indian Health Council	1,386
Northern Valley Indian Health	326
Redding Rancheria	584
Riverside-San Bernardino Indian Health	5,861
Susanville Indian Rancheria	166
Total Tribal Operations—Headquarters Shares:	**13,223**

TOTAL OBLIGATIONS—OEHE SUPPORT	$13,223

FACILITIES & ENVIRONMENTAL HEALTH SUPPORT
Reimbursements

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$662
Total Tribal Operations—Headquarters Shares:	**662**

TOTAL OBLIGATIONS—FAC.&ENV. HLTH SUP.-REIM.	$662

EQUIPMENT

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$140,096
Central Valley Indian Health, Inc.	35,682
Chapa-De Indian Health Program, Inc.	63,188
Colusa Indian Health Community Council	1,874
Feather River Tribal Health, Inc.	104,050
Greenville Rancheria	25,729
Lake County Tribal Health Consortium	29,432
Strong Family Health Center	3,599
Pit River Health Services, Inc.	13,552
Quartz Valley Indian Reservation	2,252
Round Valley Indian Health Center, Inc.	18,440
Santa Ynez Band of Mission Indians	12,861
Shingle Springs Rancheria	8,627
Sierra Tribal Consortium	5,577

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Southern Indian Health Council, Inc.	33,516
Sycuan Band of Mission Indians	6,343
Toiyabe Indian Health Project, Inc.	1,730
Tuolumne Me-Wuk Indian Health center, Inc.	13,238
Consolidated Tribal Health Project	21,373
Hoopa Valley Tribe	36,761
Indian Health Council	49,022
Karuk Tribe of California	30,968
Northern Valley Indian Health	29,355
Redding Rancheria	18,421
Riverside-San Bernardino Indian Health	87,123
Susanville Indian Rancheria	11,337
Total Tribal Operations:	**804,146**

TOTAL OBLIGATIONS—INDIAN HLTH. FACILITIES—EQUIP.	$804,146

MAINTENANCE AND IMPROVEMENT

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board	$627,148
Feather River Tribal Health, Inc.	33,234
Sierra Tribal Consortium	24,590
Southern Indian Health Council, Inc.	130,896
Toiyabe Indian Health Project, Inc.	151,000
Consolidated Tribal Health Project	27,140
Hoopa Valley Tribe	44,386

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Indian Health Council	174,117
Karuk Tribe of California	58,696
Northern Valley Indian Health	261,163
Redding Rancheria	64,300
Riverside-San Bernardino Indian Health	142,890
Susanville Indian Rancheria	21,350
Total Tribal Operations:	**1,760,910**

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$177,158
Total Area & Tribal Operation Expenditures:	**177,158**

TOTAL OBLIGATIONS—INDIAN HEALTH FACILITIES—M&I	$1,938,068

SFC HOUSING

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Transportation	$23
Rent, Comm., Util.	2,690
Printing	5,133
Contractual Services	2,011,355

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Training	2,633
Supplies	9,232
Equipment	7,934
Total Area & Tribal Operation Expenditures:	**2,039,000**

TOTAL OBLIGATIONS—SFC HOUSING	$2,039,000

SFC REGULAR

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Transportation	$160
Rent, Comm., Util.	3,517
Printing	2,554
Contractual Services	2,423,315

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Training	698
Supplies	5,203
Equipment	2,553
Total Area & Tribal Operation Expenditures:	**2,438,000**

TOTAL OBLIGATIONS—SFC REGALAR	$2,438,000

CONTRIBUTIONS

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$2,111,045
Total Area & Tribal Operation Expenditures:	**2,111,045**

TOTAL OBLIGATIONS—CONTRIBUTIONS	$2,111,045

Figure 5

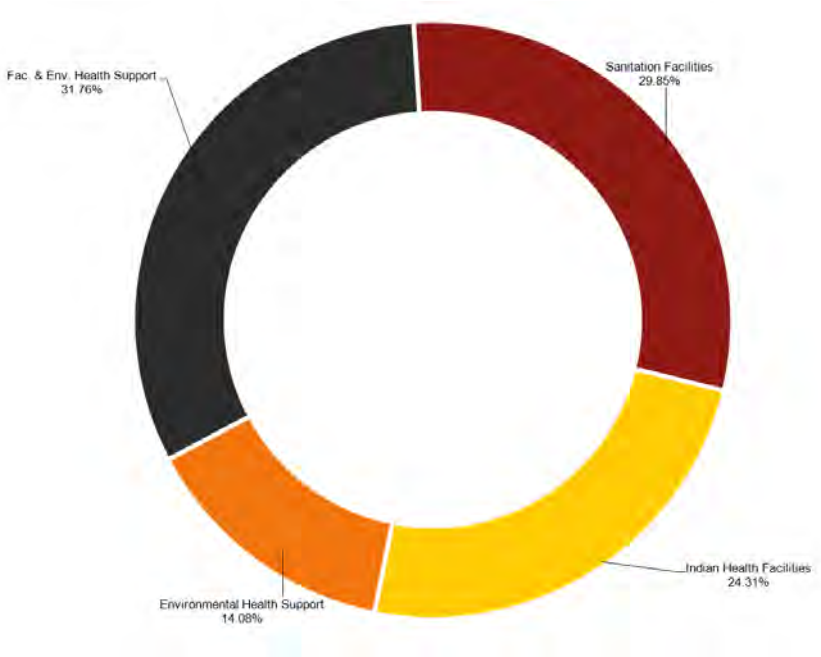


Figure 5 represents total area funding to environmental health support, facilities & environmental health support, sanitation facilities, and Indian health facilities.

EXECUTIVE STAFF

Executive Staff (left to right): Jeanne Smith, Edwin Fluette, Beverly Miller, Margo Kerrigan, Steve Riggio, Elaine Brinn

Margo D. Kerrigan, MPH began her career with the Indian Health Service in 1979 at the California Program Office, Office of Program Operations. She also served at the Phoenix Area, Office of Third Party Health Resource Management, followed by an assignment to the Office of the Director in the Nashville Area. From 1989 to 1996, she served as the Director of the Division of Management Policy, Office of Administration and Management, at IHS Headquarters in Rockville, MD. Presently, Ms. Kerrigan serves as the Director of the California Area Indian Health Service. Ms. Kerrigan holds a Bachelor of Arts degree in Human Biology from Stanford University, Palo Alto, CA, and a Master of Public Health degree in health administration, planning, and policy from the University of California at Berkeley. She is a member of the White Earth (Mississippi) Band of the Minnesota Chippewa Tribe. As Area Director, she manages a unique ambulatory health care program provided entirely through contracts/compacts as allowed by the Indian Self-Determination and Education Assistance Act, Public Law 93-638, where Tribes establish and maintain responsibility for the development and operation of their health facilities, programs, and services.

Beverly Miller, CPA, MBA, MHA joined the Indian Health Service in 1993 as a financial management officer and served in various senior executive management positions. Ms. Miller has over 25 years of experience in government and private industry. Ms. Miller is a financial and management expert having worked in public accounting and also provided her expertise in financial process engineering to San Juan Unified School district. Ms. Miller is a Certified Public Accountant and a member of the American Institute of Certified Public Accountants. She has a Master of Business Administration degree from Golden Gate University and a Master of Health Administration degree from the University of Southern California. Presently Ms. Miller is working as the Deputy Area Director for the California Area Office providing financial and management expertise in guiding and developing health care policies and programs. She is a member of the Cherokee Nation of Oklahoma.

CAPT David Sprenger, MD serves as the Chief Medical Officer of the California Area Indian Health Service. As the Chief Medical Officer, Dr. Sprenger provides technical assistance and coordinates a number of activities within the medical and behavioral health fields. He coordinates the Youth Regional Treatment Center Task Force and disaster preparedness program, and serves as a project officer for a number of health programs. In addition to his duties as the Chief Medical Officer, Dr. Sprenger is a practicing psychiatrist, treating patients in person at a Sacramento area Tribal health program, and via telemedicine at several tribal health programs throughout northern California. He is Board Certified in both General Psychiatry and in Child and Adolescent Psychiatry.

Steve Riggio, DDS began his career with the California Area Office in 2005 as the Dental Officer, and presently serves as the Associate Director for the Office of Public Health. Prior to his current position, he owned a private dental practice and managed a preschool and day care facility. From 2002 to 2005, Dr. Riggio served as the Executive Director of the M.A.C.T. Health Board where he oversaw 12 clinics in four rural counties. He obtained his Bachelor's degree from the University of San Diego and a Doctor of Dental Surgery degree from the University of Southern California. He is also certified in early childhood education from the University of California at Los Angeles. As the Associate Director of Public Health and Dental Consultant, Dr. Riggio works extensively with Indian Tribes and health clinics throughout California, particularly relating to dental care.

Elaine Brinn has held several Federal government and private industry positions before joining the Indian Health Service in 1999. She began her Federal career as a management intern with the Office of Personnel Management and later served as their Administrative and Personnel Officer. She also worked in private industry, managing the investor relations and human resources functions for a public company. She has led the National GPRA Support Team since 2004 and presently serves as the Associate Director for the Office of Management Support. She obtained her Bachelor's degree in Political Science from the University of New Hampshire.

Edwin J. Fluette, Ret. Capt., REHS, MPH began his career with the Indian Health service in 1978 as Service Unit Sanitarian at the Fort Belknap Indian Reservation in Harlem, MT. After serving six years in Montana, Mr. Fluette transferred to Anchorage, AK working year round in isolated Alaska Native villages on the Aleutian Islands, Kodiak Island, Lake Iliamna, and the highway villages of the Anchorage Service Unit. He also served as Safety Officer at the Alaska Native Medical Center. He transferred to Sacramento in 1987 to serve as the District Environmental Health Officer, and was promoted to Chief, Environmental Health Services in 1988. He presently serves as Associate Director, Office of Environmental Health & Engineering (OEH&E). Mr. Fluette earned his Master of Public Health degree in Environmental Health from the University of Hawaii, Manoa in Honolulu, HI. He is a member of the Little Traverse Bay Band of Odawa Indians in Petoskey, Michigan.

IHS/CAO STAFF

First Row (L to R): Jeanne Smith, Rachel Pulverman, Edna Lorimer, Susan Rey, Elaine Brinn, Beverly Miller, Margo Kerrigan, Myrtle Larocque, Jeannette Reynolds, Angie Singh, Marilyn Freeman, Kelly Stephenson
Second row (L to R): Robert Gemmell, Ana Chavez-Alvarez, Marie Lowden, Jean Reynolds, Dawn Phillips, Vinay Behl, Harry Weiss, Christine Brennan, Karen Nichols, Phil Church, Nancy Dewees, Kurt Nelson, Julie Morrow

Last Row (L to R): Josh Newcom, Toni Johnson, Richard Wermers, Susan Ducore, Steven Lopez, Travis Coleman, Chris Brady, Gary Ball, Gordon Tsatoke, Edwin Fluette, Don Brafford, Gary Mosier, Wendy Blocker, Steve Riggio, Dave Mazorra, Michael Hodahkwen, Luke Schulte, Nathan Wong, Lisa Nakagawa, Michelle Martinez, Steve Viramontes

Not Pictured: David Sprenger, Mona Celli, Helen Maldonado, Beverly Calderon, Amy Patterson, Linda Wilson, Martin Smith, Cordell Bailey, Steven Zerebecki, Bob Johnson, Lolita Brinkley-Nunn, Trisha Sutherland

OFFICE DIRECTORY

OFFICE OF THE AREA DIRECTOR

Margo Kerrigan, MPH; Director

Beverly Miller, Deputy Director

CAPT David Sprenger, MD; Chief Medical Officer

Travis Coleman, Indian Self-Determination Program Manager (Acting)

Jeanne Smith, Regional Human Resources Specialist

OFFICE OF PUBLIC HEALTH

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CAPT Steven Lopez, RHIA; Medical Records Consultant

Helen Maldonado, PA-C; Diabetes Consultant

Dawn Phillips, RN, CDE; Behavioral Health Consultant

Steven Viramontes, PHN; Clinical Applications Coordinator/Telemedicine Coordinator

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Toni Johnson, IT Specialist/Business Office Coordinator/CHS Officer

Kelly Stephenson, IT Specialist/Telecommunications Liaison

Gary Mosier, IT Specialist/RPMS Database Administrator

Paula Taylor, IT Specialist/Applications Administrator

Theresa Weber, IT Specialist/Systems Administrator

Michelle Martinez, IT Specialist/ICD-10 Consultant

Edna Lorimer, Computer Assistant

Steven Zerebecki, YRTC Planner

OFFICE OF MANAGEMENT SUPPORT

Elaine Brinn, Associate Director

Finance

Vinay Narjit Singh Behl, CA, CPA, MS, MBA; Chief Financial Officer

Linda Wilson, Budget Analyst

Kurt Nelson, CPA; Accountant

Ana Chavez-Alvarez, Accountant

Julie Morrow, Accounting Technician

Marie Lowden, Management Analyst

Ronald Moody, Accountant

Angie Singh, Project Accountant

Contracting

Karen Nichols, Supervisory Contracting Officer

Harry Weiss, Contract Specialist

Cordell Bailey, Contract Specialist

Travis Coleman, Contract Specialist

Michael Hodahkwen, Contract Specialist

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Mona Celli, Management Analyst

Myrtle La Rocque, Administrative Support Assistant

Jean Reynolds, Receptionist

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Susan Rey, Secretary

Jeannette Reynolds, Admin. Assistant

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CAPT Richard Wermers, PE; DHFE Director

Gary Ball, Architect

CDR Paul Frazier, Staff Engineer

Nathan Wong, Facilities Engineer

Division of Environmental Health Services (DEHS)

CDR Gordon Tsatoke, MPH; DEHS Director

CDR Martin Smith, RS; Environmental Health Specialist

LT Lisa Nakagawa, MPH; Environmental Health Specialist/Injury Prevention Specialist

CDR Brian Lewelling, Environmental Health Specialist (Escondido)

LCDR Charles Craig, Environmental Health Specialist (Redding)

CDR Mary Weber, Tribal Utility Consultant (Ukiah)

Division of Sanitation Facilities Construction (DSFC)

CAPT Don Brafford, PE; DSFC Director

CAPT Christopher Brady, PE; DSFC Deputy Director

CDR Luke Schulte, PE; Environmental Engineer Consultant

Joshua Newcom, Technical Writer/Editor

Lolilta Brinkley-Nunn, Office Automation Assistant

CDR David Mazorra, Engineer (Sacramento)

Bob Johnson, Engineer Technician (Sacramento)

Trisha Sutherland, Administrative Assistant (Sacramento)

LCDR Sean Bush, Environmental Engineer (Fresno)

LT Matt Mergenthaler, Engineer (Fresno)

J.J. Garcia, Engineer Technician (Fresno)

Robert Rutherford, Engineer Technician (Porterville)

Steve Poitra, Engineer Technician (Porterville)

Darrell Vera, Office Automation Clerk (Porterville)

LT Charles Thompson, Environmental Engineer (Ukiah)

Anthony Tooley, Engineer Technician (Ukiah)

Thomas Campbell, Engineer Technician (Ukiah)

Aaron Oliver, Engineer Technician (Ukiah)

Liz Oliver, Office Automation Assistant (Ukiah)

CDR Jonathan Rash, Engineer (Escondido)

LT Roger Hargrove, Sr. Environmental Engineer (Escondido)

Nancy Dewees, Sr. Environmental Engineer (Escondido)

John Jeng, Engineer Technician (Escondido)

Keith Bailey, Engineer Technician (Escondido)

Talat Mahmood, Engineer Technician (Escondido)

Michele Blackowl, Admin. Support Assistant (Escondido)

Andrew Huray, Engineer (Redding)

Dwayne Cordray, Engineer (Redding)

Vanissa Laahty, Engineer (Redding)

Pattigail Whitehouse, Administrative Assistant (Redding)

Barry Jarvis, Environmental Engineer (Arcata)

LT Travis Sorum, Environmental Engineer (Arcata)

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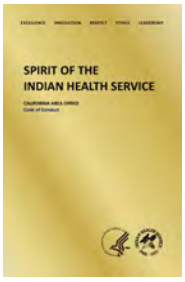
Internet Information

Information on the CAO's financial results and its products and services is available on the internet at http://www.ihs.gov/California.

Code of Conduct

For a copy of the California Area Office Code of Conduct, contact email your request to rachel.pulverman@ihs.gov.



Financial Information

The CAO Annual Report is available electronically at http://www.ihs.gov/california/Universal/PageMain.cfm?p=32

Inquiries

For general information, you may reach the CAO by phone at (916) 930-3927.

Mission

The overall mission of the IHS is to raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level.

Goal

The main goal of the IHS is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indians and Alaska Natives.

Foundation

The IHS foundation is to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native communities and cultures, and to honor and protect the inherent sovereign rights of Tribes.

Vision

The vision of the IHS/CAO is to raise the health status of American Indians and Alaska Natives to the highest possible level by supporting tribal governments and urban communities in the development and administration of comprehensive healthcare delivery systems that meet the needs of Indian people.


DEPARTMENT OF HEALTH & HUMAN SERVICES USA
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1798