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

Annual Report
2012

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 it's 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. The CAO provides services for all of the following categories:

- 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

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

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

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

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"While we are in a time of uncertainty, I know that the partnership between the IHS and Tribes is more important than ever. The work of the past few years has clearly established that we must work together to continue our efforts to change and improve the IHS so that our patients and communities receive the quality health care that they need and deserve." – Yvette Roubideaux

List of Acronyms

AAAHC	Accreditation Association for Ambulatory Health Care
ACA	Affordable Care Act
AI/AN	American Indian/Alaska Native
ARRA	American Recovery and Reinvestment Act
CAC	Clinical Applications Coordinator
CAO	California Area Office
CATAC	California Area Tribal Advisory Committee
CHEF	Catastrophic Health Emergency Fund
CHS	Contract Health Services
CHSDA	Contract Health Services Delivery Area
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid Services
CRIHB	California Rural Indian Health Board
CRS	Clinical Reporting System
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
GPRAMA	GPRA Modernization Act
GSA	General Services Administration
HD/DP	Health Promotion and Disease Prevention
HFE	Health Facilities Engineering
HHS	Health and Human Services
HIPAA	Health Insurance Portability & Accountability Act
HITECH	Health Information Technology for Economical and Clinical Health
ICD-10	International Classification of Disease, 10th Revision
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
IPC	Improving Patient Care Initiative
ISDEAA	Indian Self-Determination and Education Assistance Act
IST	Improvement Support Team
IT	Information Technology
M&I	Maintenance and Improvement of Tribal Healthcare Facilities
MSPI	Methamphetamine & Suicide Prevention Initiative
MU	Meaningful Use
NGST	National GPRA Support Team
O&M	Operation & Maintenance
OEH&E	Office of Environmental Health & Engineering
OMB	Office of Management and Budget
OMS	Office of Management Support
OPH	Office of Public Health
PCMH	Patient-Centered Medical Home
QILN	Quality and Innovation Learning Network
REC	Regional Extension Center
RPMS	Resource Patient Management System
SDPI	Special Diabetes Program for Indians
SFC	Sanitation Facilities Construction
TIPCAP	Tribal Injury Prevention Cooperative Agreement Program
UFMS	Unified Financial Management System
VA	Veteran's Administration
YRTC	Youth Regional Treatment Center

A Letter from the Area Director

Dear Tribal Officials and Healthcare Partners,

I am pleased to present your 2012 Annual Report. As I reflect on the year just passed, we have made great strides in expanding our outreach to tribal governments and healthcare programs. 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.

2012 will go down in Indian Health Service (IHS) history as an extraordinary year for our achievements and how well we have positioned ourselves to serve American Indian people. Of particular note was the announcement by the IHS Director of the purchase of land for both the northern and southern future California Youth Regional Treatment Centers.

Youth Regional Treatment Centers

IHS/California Area Office (IHS/CAO) will soon build California's first IHS-operated Youth Regional Treatment Centers (YRTCs); one in the north and one in the south. The YRTCs will provide culturally appropriate chemical dependence treatment services to American Indian/Alaska Native youth ages 12-17. The new YRTCs will expand and complement existing IHS-funded, tribally-managed behavioral health services in California. Each YRTC will have 32 beds (16 male & 16 female) and five suites for families to participate in their treatment. The YRTCs will provide comprehensive and holistic care, including:

- behavioral health and basic primary healthcare services
- individualized treatment plans
- structured chemical dependence programs
- individual, group, and family therapy
- academic education and vocational training
- activities to meet spiritual and cultural needs

Nationwide, IHS operates five YRTCs and the tribes operate six. The YRTCs share one mission; to provide quality holistic behavioral health care for American Indian/Alaska Native adolescents and their families in a substance-free, residential environment that integrates traditional healing, spiritual values, and cultural identification.

The southern California YRTC property is in Taylor Ranch in Riverside County, near the town of Hemet. Taylor Ranch is a beautiful 20-acre site with pastoral views and a peaceful pond. October 2011, IHS/CAO concluded over two years of due diligence on Taylor Ranch, and IHS purchased the property. After IHS purchased Taylor Ranch in FY 2012, IHS/CAO sponsored a tribal event to dedicate the land for the new YRTC. In February 2012, IHS/CAO sought proposals from design professionals to design the southern California YRTC facility. The successful firm, BBCK JV, a joint venture located in Sacramento and led by an American Indian owned architectural firm, began design in October 2012. On December 23, 2012, President

Barack Obama signed the final 2012 appropriation bill into law, authorizing $2 million for design and site grading of the southern California YRTC property. The total budget for design and construction of the two YRTCs is approximately $39 million. IHS/CAO will request IHS Headquarters to obligate the total funds for design and construction in 2013.

The northern California YRTC will be in Yolo County, near Davis. The 12-acre site is located on federal government land held in-trust by D-Q University – the former tribal college. The historic site is near a community of qualified health care providers and offers easy access to transportation. On October 28, D-Q University agreed to revert 12 acres from its trust expressly for IHS/CAO to establish the northern California YRTC. D-Q University's cooperation and agreement successfully concluded nine months of negotiations. Acquisition of the Yolo County site was approved and finalized in January 2013. Pursuant to the Federal Property Transfer Act, IHS/CAO paid fair-market value for the 12 acres. The U.S. General Services Administration transferred the funds directly from IHS to the U.S. Treasury, and then transferred the 12 acres to IHS. A dedication ceremony is planned for late spring. IHS/CAO will engage a design firm for the north once funding for design of the northern site is Congressionally appropriated. Design and construction of the two YRTCs could be completed 18-24 months after funds are Congressionally appropriated

Annual Tribal Consultation

The IHS/CAO hosted the Annual Tribal Consultation on March 7-9 in Pala, with 42 elected tribal officials or their designees and 233 attendees. I provided a brief update on the summary of accomplishments in 2011. I discussed the agency priorities, the budget, the contract health services program, and funding for the design of the YRTC in southern California. I also announced that the VA and IHS are initiating a consultation on the main points of the draft agreement for the VA to reimburse IHS and tribal healthcare programs for care provided to dual eligibles.

The Annual Tribal Consultation also included the introduction of California Governor Jerry Brown's first Tribal Liaison, Cynthia Gomez. The policy analyst from the California Rural Indian Health Board presented on the Affordable Care Act. The Chief Financial officer from IHS Headquarters presented by tele-video on the 2012 budget/2013 President's budget and discussed the area's health priorities. We conducted a Listening Session on Contract Health Services. The following issues were stated by California tribal officials during this session:

- the need for a good working relationship between the Veteran's Administration (VA) and Indian healthcare programs clinics
- the need for increasing contract health services (CHS) funds because there are no IHS-funded hospitals in California
- the need to bring back traditional medicine

A critical component of Indian healthcare is in meeting the needs of those who served in our

military. As such, I attended the Department of Veterans Affairs, Office of Tribal Government Relations, Western Region Conference on April 10-11. The workshop goals were to increase:

- veteran's access to healthcare benefits
- utilization of Native American Direct Home Loan Program
- utilization of Post 9/11 GI Bill
- access to Compensation and Pension
- access to federal employment opportunities
- tribal consultation

National Indian Health Board Consumer Conference

I attended the National Indian Health Board Consumer Conference in Denver, Colorado on September 23-27. Some of the plenary workshops I attended included:

- Medicare/Medicaid changes as a result of the Affordable Care Act
- healthcare reform implementation, including legal considerations in health care reform implementation, regulatory concerns and their impact on tribal healthcare
- diabetes and the Special Diabetes Program for Indians
- behavioral health
- federal/tribal/state relations
- health information technology and electronic medical records
- public health issues
- accreditation

All of these programs and issues have bearing on how the IHS/CAO serves its customers.

Continuing Medical and Dental Education

Continuing education for healthcare providers ensures that California's Indian population will continue to receive the best in medical and dental care. The IHS/CAO and the Dental Support Center at CRIHB jointly hosted the Annual Dental Continuing Education Conference on May 14-17 in Sacramento. More than 300 dentists, dental hygienists, and dental assistants attended, from most of the California Area tribal and urban Indian healthcare programs. The conference offered 29 IHS-sponsored continuing dental education units for courses designed and selected to enhance the clinical skills of dentists, dental hygienists, and dental assistants through the IHS Clinical Support Center. The 300 attendees earned over 5,000 hours of continuing dental education credits/units.

To improve the quality of care provided in California tribal and urban Indian healthcare programs, the IHS/CAO also sponsored an area-wide "Diabetes Day" on April 26 for medical providers in tribal and urban Indian healthcare programs. The event included updates on the most recent psychological and physiological research, diabetes care and prevention, diabetes case management, patient care plans, and grants management for the Special Diabetes Program for Indians (SDPI). A total of six American Medical Association PRA Category 1 Credits were

offered to physicians and nurses through the IHS Clinical Support Center. Physicians, mid-level practitioners, and nurses returned to their respective healthcare programs with new knowledge and skills to treat Indian patients with diabetes. IHS/CAO hosted a poster board session on the evening of April 25 to highlight Diabetes Best Practice successes from California's 38 tribal and urban Indian healthcare programs.

IHS/CAO provided remote meeting facilities and information technology support for the national Virtual Improving Patient Care, Cycle 3 (IPC 3) learning session for the following four California sites October 25-27:

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

Pursuant to the recommendations by IHS Director's Workgroup on improving CHS, the IHS/CAO conducted a CHS listening session during the area-wide budget formulation for FY 2014 held on December 14, 2011 in Sacramento. The Area Director described to tribal government officials a flow chart of the CHS program processes, a recent Government Accountability Office investigation and findings on CHS, and an analysis of different estimates of CHS unmet need.

Program Prioritization and Budgeting

Consultation with tribes is the foundation of the IHS budget formulation process. The IHS budget formulation forum for FY 2014 began with the area level tribal consultation meeting held on November 15, 2012 at the IHS/CAO. The IHS/CAO invited all tribal chairpersons, Indian health program directors, and members of the California Area Tribal Advisory Committee (CATAC) to a budget formulation workshop presentation for tribal officials on the federal budget process, Government Performance and Results Act (GPRA) performance measures and outcomes, and the IHS budget. California tribal officials interacted, deliberated, and ranked their health priorities.

The following five health priorities were recommended by California tribal officials:

- contract health services
- diabetes/obesity
- behavioral health
- youth regional treatment centers (YRTCs)
- Indian Health Care Improvement Fund

The FY 2015 budget formulation timeline calls for a national budget formulation session and a rules based budget that is prepared by IHS headquarters.

Electronic Health Records

IHS/CAO assisted in implementing the Resource and Patient Management System (RPMS) electronic health record (EHR) and meaningful use at four urban Indian healthcare programs in California to meet the Adoption/Implementation/Upgrade requirements for the CMS EHR Medicaid program:

- San Diego American Indian Health Center
- Sacramento Native American Health Center, Inc.
- American Indian Health and Services in Santa Barbara
- United American Indian Involvement in Los Angeles
- The benefits of the electronic health record include:
- automation of labs and medication ordering practices
- ensuring patient safety through electronic searches/checks that look for patient food allergies, drug allergies, drug interactions, and drug incompatibilities
- sharing patient health information with the patient or another healthcare provider

Contract Health Services

To improve and promote current CHS business practices, the IHS/CAO identified and nominated staff from tribal healthcare CHS programs to join a national IHS technical workgroup to develop curriculum for CHS staff, including orientation, education materials, core competencies, and best practices for tribal CHS programs.

The IHS/CAO is currently developing a web "portal" as a point of access to comprehensive information for tribal CHS programs. The CHS portal will allow IHS subject matter experts to meet and exchange information. We look forward to the launch of the CHS portal system 2013. The following features will be included in this portal:

- contact information for all portal members (subject matter experts)
- CHS best practices
- frequently asked questions
- easy one-stop access to documents and forms
- on-line training modules
- on-line meeting capabilities

To improve the quality of and access to care, in March 2012, I addressed the CHS unmet need during a CHS Listening Session at the Annual Tribal Consultation. I 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 $ 120-135 million per year.

The IHS/CAO developed a uniform tool for documenting CHS deferrals and denials at tribal healthcare programs that are not utilizing the IHS RPMS CHS/Management Information System. P.L. 93-638 contractors and compactors are not mandated to comply with deferral and

denial data reporting requirements. However, 24 of 38 tribally administered CHS programs voluntarily collected and submitted deferral and denial data to the IHS/CAO for FY 2011 and continued to do so in 2012. Through technical assistance, the quality of tribal healthcare program deferral and denial data reported in FY 2011 dramatically improved. Using FY 2011 deferral and denial data projections, the unmet CHS need estimate exceeds all previous measures of unmet CHS need. The IHS/CAO sponsored a webinar on the importance of collecting CHS deferral and denial data on May 17.

Improving Patient Care

To promote the implementation of the IPC program, the IHS/CAO:

- Conducted two site-visits to promote the application of IPC at Sonoma County Indian Health Project, Inc. and Northern Valley Indian Health
- Addressed California program directors on March 6 regarding the importance of the IPC initiative
- Promoted the theme of the IHS/CAO 2012 Best Practices Conference: Creating a Patient-Centered Medical Home
- Coordinated a keynote presentation by Dr. Sam Romeo, leading expert on the patient-centered medical home, at the 2012 IHS/CAO Best Practices Conference
- Promoted the Indian Health Medical Home model throughout all healthcare program disciplines during OPH site visits
- Utilized IPC tools and methods to improve efficiency, customer service, and effective teamwork for internal IHS reform
- Promoted participation in the IPC initiative during site visits, GPRA webinar sessions, and individual contacts
- Provided area level insight to the national IPC team during the IPC application process and evaluation

ICD-10

The IHS/CAO has created a multi-disciplinary team to implement the International Statistical Classification of Disease and Health-Related Problems Clinical Modification/Procedural Coding System (ICD-10-CM/PCS) at tribal and urban Indian healthcare programs. A CAO implementation team collaborates with the CRIHB to offer joint training opportunities. Three of the four team members of the area ICD-10 implementation team are members of the national IHS ICD-10 Steering Committee and its sub-groups.

Environmental Health & Engineering

The IHS/CAO, Office of Environmental Health & Engineering manages an annual budget of $15 million and 50 employees, with field offices strategically located throughout California. Direct service is provided 104 federally- recognized tribes, unaffiliated tribal members, and 29 Indian health programs, through the Sanitation Facilities Construction, Health Facilities Engineering,

and Environmental Health Services programs.

Sanitation Facilities Construction (SFC) - Since March 2000, the IHS/CAO, SFC program completed 414 construction projects, served 28,511 Indian homes at a cost of $142,000,000. Those projects entailed the installation/construction of 100 miles of water/sewer mains, 30 miles of roadway restoration, 100 miles of water/sewer service lines, 800 water wells, 30 water treatment buildings, 20 water storage tanks, 15 wastewater treatment plants, 10 pump stations, 20 community septic tank/drain field (ST/DF) systems, and 1800 individual septic tank/drain field systems. Since March 2000, the SFC program established strong relationships with outside funding agencies, resulting in contributions of $42.1 million and service to 8,000 Indian homes. In addition to effectively managing the SFC annual appropriation of $8 million, the SFC program is near completion of 20 additional construction projects, funded for $12.4 million under the American Recovery and Reinvestment Act (ARRA) projects, which will serve 763 Indian homes. This undertaking was also in addition to ongoing management of 196 projects, valued at $77.2 million, currently under construction throughout California.

Health Facilities Engineering (HFE) - The HFE program provided technical support and construction oversight to all Indian health programs in California in FY 2012. Significant activity included: project management for design/construction projects, scopes of work development, selection of architect/design/construction firms, and review of work submittals/progress for new, expanded, and renovated Indian health facilities. Facility condition assessments were conducted at all Indian health facilities (107 buildings), which serves as the basis and justification for Maintenance & Improvement (M&I) projects. As a result of these activities, three facility replacement projects will be completed in FY 2013 and eleven healthcare programs are planning to expand or replace their existing healthcare facilities.

At the beginning of FY 2012, the IHS/CAO funded a study to establish regional Indian healthcare facilities in California, to provide technical and secondary healthcare services that are currently not provided by local Indian healthcare programs. Establishment of these facilities would provide specialty healthcare services to Indian people and reduce the dependency on scarce contract health service funds. Progress on the study has been presented to the California Area Tribal Advisory Committee and Indian health program directors on two occasions and will be presented to all tribal leaders for the first time at the Annual Tribal Leaders' Consultation in March 2013. The study will be completed in FY 2013.

Environmental Health Services (EHS) - In FY 2012, the EHS program increased their program staff to six and for the first time ever, assigned one environmental health officer to Ukiah, to provide direct technical service to tribes and Indian health programs in the Mendocino/Lake County area. In FY 2012, the EHS program conducted 391 surveys, which included: food service facilities (318), head start programs (13), swimming pools (9), healthcare facilities (9), grocery/convenience stores (7), and other facilities (35). In addition, the EHS program provided

the following technical services to all Indian health programs in California: risk assessments (26), accreditation support surveys (9), radiation protection surveys (7), and industrial hygiene assessments (2).

As you can see, throughout the year we made great strides by bringing technology and patient care initiatives to IHS funded healthcare programs. The key to our success is our people. IHS/CAO has extraordinary executive talent and a focused work force which places a very high emphasis on customer service. We understand the business we are in and take it very seriously as our service reaches out to thousands of Indian patients in need.

I am proud to lead a very capable team. Through continuous improvement and promotion of innovation and technology, we continue to move forward to improve the health status of American Indians and Alaska Natives in California.

/Margo Kerrigan/

Margo D. Kerrigan, MPH, Director
Indian Health Service, California

March 01, 2013

2011-2012
Service Highlights

- The Tule River Reservation tribal construction crew made substantial progress on construction of the $8.2 million community sewage collection and treatment system. The tribe installed 12,000 lineal feet of sewer main and 55 manholes, which will be connected to a newly constructed package sewage treatment plant in 2013. Project challenges include installation of facilities in 14-foot deep subsurface rock conditions. Once completed, the system will initially serve 350 tribal members. The project is being managed by IHS/SFC staff from the Clovis Field Office

- The IHS has completed construction of a $1.3 million project to improve the existing drinking water and sewage disposal systems on the Santa Rosa Rancheria. The IHS installed 9,000 lineal feet of new water main on the community water system and installed two new sewage lift stations on the community sewage disposal system. These improvements will increase the reliability of service to 800 tribal members. The project is being managed by IHS/SFC staff from the Clovis Field Office

- The Stewarts Point Rancheria collects their drinking water from an infiltration gallery located in the streambeds of the Wheatfield Fork of the Gualala River in Northern California. Drinking water from the infiltration gallery is pumped from a 40 gallon per minute wet well station through a 4-inch transmission main, more than 6,000 feet in length and 1,000 feet in height, to the treatment building located on the Rancheria. In 2012, the Indian Health Service renovated the wet well component of the community water system. System improvements included a new precast access riser and hatch, plumbing, and watertight well caps, at a cost of $46,000

- To improve Indian healthcare facilities throughout California, the HFE provided $5,619,000 in funding. Of that total, $3,073,000 was received for Maintenance & Improvement (M&I) projects, $814,000 for annual medical equipment needs. Seven Indian health programs received an additional $1,618,000 for medical equipment, based on construction of new health facility space. All Indian health facilities in California receive their proportionate share of the M&I and medical equipment funds annually

- The HFE completed an Area-wide project that surveyed the conditions of 107 buildings for 29 tribal healthcare programs. Upon completion, the condition survey reports were presented to Indian healthcare program leadership to plan and prioritize future improvement projects

- The HFE provided space and program planning services to support expansion or replacement of two existing health facilities and completed five site-specific facility condition inspections in collaboration with the IHS Division of Environmental Health Services staff, to evaluate compliance with accreditation standards

- The HFE provided technical assistance and oversight for:
    - eight facility improvement projects using M&I funds

- five new facility construction/expansion projects
- planning and design services for three Indian healthcare facility construction projects
- planning/design for four new facility construction projects for FY 2013

- The DEHS is currently staffed with six Environmental Health (EH) Officers. In addition to each officer providing a wide range of general EH services, three of the individuals have the training, education, and experience to serve in dual technical capacities for injury prevention, emergency management, and institutional EH. For the first time in FY 2012, the IHS established a new EH position in the Ukiah Field Office, to serve the local tribes and Indian healthcare programs

- The DEHS conducted 391 EH surveys in FY 2012, to identify environmental health risks and hazards in community facilities and make recommendations for their resolution. Environmental health surveys were conducted at the following tribal facilities:
  - Food Service Establishments (318)
  - Head Start Programs (13)
  - Swimming Pools (9)
  - Healthcare Facilities (9)
  - Grocery/Convenience stores (7)
  - Other Facilities (35)

- The DEHS provided institutional EH services such as safety and occupational health training, safety program development, accreditation support, radiation protection surveys, risk assessments, industrial hygiene, policy development, and Occupational Safety and Health Administration compliance support. In FY 2012, the DEHS staff completed the following institutional EH services:
  - Risk assessments (26)
  - Accreditation support surveys (9)
  - Radiation protection surveys (7)
  - Industrial hygiene assessments (2)

- The DEHS sponsored or conducted 24 training courses for 430 participants in tribal communities throughout California, to build tribal capacity in EH related areas:
  - General Food Safety (22)
  - Occupational safety and health (1)
  - Tribal Water System Operator Certification (1)

- The DEHS conducted an investigation of two confirmed cases of Legionnaire's Disease in a tribal facility. The DEHS met with the facility's managers to determine a course of action to complete an epidemiological investigation. In addition, the facility hired an independent consultant to complete a thorough environmental assessment of the establishment. The "after action" report specified control measures to reduce the risk of Legionnaires Disease in the establishment and no subsequent cases of Legionnaires have been reported

- The DEHS and the CRIHB co-sponsored two "Child Passenger Safety Technician Certification" courses in Sacramento and Crescent City. These courses provided advanced instruction to 20 attendees on the proper use of child safety seats so they can serve as child passenger safety experts in their respective tribal communities

- The DEHS staff provided technical assistance, support, and oversight to the tribal injury prevention programs funded by the IHS Tribal Injury Prevention Cooperative Agreement Program (TIPCAP). Project participants were CRIHB, Indian Health Council, Tule River Indian Health Center, and Greenville Rancheria. These TIPCAP projects were funded for continuation in FY 2013 at a value of $1.16 million over a five-year period. These projects were established to promote hiring of an injury prevention coordinator at the community level, and to conduct "best practices" that reduce or prevent unintentional motor vehicle injuries and elder falls

- During the week of April 23, 2012, the IHS/CAO and the California Rural Indian Health Board, Inc. (CRIHB) 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 14, 2012, the IHS/CAO and CRIHB 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 staff, in an effort to improve quality and access to health care, conducted site visits to three 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 CRIHB 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 Indian 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 four "Indian Health Service/California Area Office Quarterly Highlights" to all California Tribal Leaders to describe Area activities

- The IHS/CAO has purchased two sites for California's first IHS-operated YRTCs. The southern YRTC is in Riverside County, near the town of Hemet. In FY 2012, IHS/CAO purchased the property for the southern YRTC and began the design phase. The northern YRTC is in Yolo County, near Davis. In FY 2013, the IHS acquired the land for the northern YRTC and planning for the dedication of the land is underway

A Letter from the Deputy Area Director
To Our Healthcare Partners

Dear Tribal Officials and Healthcare Partners:

How often have we heard "in these turbulent economic times?" The news is awash in stress-inducing stories of hard times. While I'd like to say that the tough times are behind all of us, many of the fiscal headwinds carried from FY 2012 are still with us in FY 2013. I've characterized FY 2012 as the beginning of a re-focus period in which the CAO will be making hard decisions that will position us to pursue consistent delivery of services and training that you've all come to expect.

As times change, the way we do business also needs to adapt. As you read through this annual report you will see how digital technology is integrated to capitalize on efficiencies and resources. I realize the innovation that we all seek is not the result merely of technology, or even the combination of ideas and execution, but the result of integrated efforts to do an excellent job at creating value and also reducing friction. CAO inspired thinking can be seen in the way our people apply their expertise to help make your communities be a healthier and better place to live and work.

As we move forward into the future, the opportunity to figure out ways to do *more with less* is becoming a reality. The CAO will respond to the challenge; we will seize the initiative to innovate to achieve exponential benefits. Together, great things will happen.

Warm Regards,

/Beverly Miller/

Beverly Miller
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 offers information and technical assistance to tribal and urban Indian health programs on these activities. The CMO's vision is for AI/AN people in California to receive high-quality, customer-focused, whole-person health care through all 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
- health care delivery systems

Technical assistance is offered in the form of face-to-face meeting presentations, webinars, site consultations and reviews as well as informal phone consultations.

To enhance the responsiveness of the CMO and Office of Public Health (OPH) staff to program directors' needs, the CAO once again distributed a Customer Satisfaction Survey in 2012. The survey was distributed to determine the current level of satisfaction of the health program executive directors about the quality of technical assistance provided by the IHS/CAO. The overall satisfaction rating for the IHS/CAO was 4.41 on a 5 point Likert scale, indicating that respondents were generally very satisfied with the quality of technical assistance provide by the IHS/CAO.

Information Dissemination

The CMO works closely with the health program executive directors. In 2012, IHS held two program directors meetings during
which the following were discussed:

- healthcare finance
- meaningful use
- improving health care access for AI/AN veteran (dual-eligible) beneficiaries

The CMO also distributes periodic GPRA bulletins that focus on key clinical GPRA measures and best practices to improve clinical performance. The CMO also meets via tele-conference and webinar with tribal and urban Indian healthcare program medical directors and behavioral health directors to discuss current health and wellness and their activities and initiatives.

Annual Medical Providers' Continuing Education

The CAO now hosts the California Medical Providers' Conference for medical providers in

Indian healthcare settings. This annual conference focuses on overriding issues of mutual concern to healthcare providers. 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 courses necessary to maintain professional licensure.

The 2012 conference was held during the week of April 23 in Sacramento, and was attended by over 150 tribal and urban Indian healthcare program staff. Topics covered included enhancing access and quality, improved outcome data and the role of psychosocial factors and how it contributes to physical disease.

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 is 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, such as kiosks in patient waiting areas.

Our future poses many challenges but many opportunities are shining brightly on the horizon as well. Critical improvements will need to be made in processes and procedures at our clinics to ensure we can take full advantage of these promising opportunities. To address the challenges we will need to carefully examine and revise many of our standard practices. We must also be willing to step out of our comfort zones and carefully consider new ways of providing care to the people we serve.

Perhaps these processes can begin in earnest by placing ourselves in the shoes of our patients and other customers, truly seeing the environment as it exists from their eyes. We also need to clearly understand the new realities that are developing in health care as the Affordable Care Act (ACA) is implemented. Some key principles form the foundation of this new beginning, including a clinic environment that enhances our ability to address the needs of our patients efficiently and effectively. A new infrastructure that facilitates acquisition, analysis and reporting/summarizing critical information is also essential in this setting. In addition, clinical staff must broaden their horizons as they are asked to expand and modify their roles.

Once these and other basic foundations are established, we can begin to implement standards of practice, evidence-based guidelines, and formally measure patient outcomes to assess our effectiveness. We will also continue to assess our customer service and explore new ways to enhance communication with the communities.

These are some of the goals we will set for our clinics and ourselves in 2013, striving for full implementation before 2014. I am convinced we can be successful if we work together and remain focused – always considering the perspective of the patient.

Of course, we are also entering a new frontier for the CAO – potentially seeing our first YRTC in operation before we venture into 2015. This will also be a high priority, and as we learn valuable lessons in the midst of improving our clinics as the ACA implementation progresses,

we will apply these lessons to the YRTC as well. Creating a setting that is comfortable for the patient and renders state-of-the art treatment modalities in a culturally appropriate environment will be our persistent mantra.

I anticipate the above activities will serve us well in greatly enhancing our ability to render clinical care in our traditional outpatient settings as well as the new inpatient facilities. However, we would be remiss if we felt content with these accomplishments. There is at least one other critical arena we must pursue; assessing and implementing considerably more primary prevention activities in community settings. This is an area our customers understand quite well, routinely noting in YRTC meetings how wonderful it would be to prevent substance use so that the YRTCs may eventually have far fewer patients. We have had some notable success in this area with injury prevention programs, but over the next two years we need to assess other community priorities, develop new collaborative possibilities and advance additional primary prevention efforts.

I look forward to a series of fascinating journeys as medicine and public health potentially undergo major transformations over the next few years. It is our hope that you will join us and enjoy the adventure as well.

Office of Public Health (OPH)

The California Area OPH consists of health professional consultants in the following areas:

- Medical
- Dental
- Nursing
- Diabetes
- Behavioral Health
- Health Promotion/Disease Prevention
- Medical Records/HIPAA
- VistA Imaging
- Meaningful Use
- Electronic Health Records
- Telemedicine
- Resource & Patient Management System
- Business Office
- Information Resource Management
- Mock Accreditation Surveys

These professionals work with tribal and urban Indian healthcare programs to meet nationally accepted standards of care for healthcare organizations.

Dental

The mission of the IHS Dental Program is to protect and promote oral health and prevent oral disease among all Indian beneficiaries. The following principles underlie this stated mission:

- Oral health is an essential component of total health
- All people should have the opportunity to achieve sound oral health
- All people should have the right and responsibility to participate, individually and collectively, in the planning and implementation of their oral health care

Technical Assistance and Recruitment

To improve customer service, the IHS/CAO Dental Consultant provided technical assistance to tribal and urban Indian healthcare programs on oral health. Technical assistance is available for a number of dental clinical topics including, but not limited to chart reviews, the peer review process, credentialing and privileging, and clinical efficiency. The Dental Consultant is also available for dental program reviews.

The IHS/CAO is dedicated to distributing the most current information on oral health issues. The IHS/CAO publishes a patient newsletter quarterly which features articles on oral health issues including 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 healthcare program staff. The website also lists all the California Area healthcare programs offering dental services.

Recruitment and retention of dental personnel is critical to the provision of dental services. In 2012, the IHS/CAO Dental Consultant assisted in the hiring of dentists at California Area tribal and urban Indian healthcare programs. The IHS has a loan repayment program which is available to dental providers employed at tribal and urban Indian healthcare programs. Loan repayment is a valuable tool in the retention of recent dental school graduates.

In 2012, the Dental Consultant and other IHS/CAO health professional consultants took an active role in assisting healthcare program dentists to qualify for Meaningful Use financial incentives.

Annual Dental Continuing Education

The IHS/CAO sponsors an annual dental continuing education which includes lectures, panel discussions, and hands-on courses that focus on the public health model of dental care. The conference offers 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 Office o meet, learn, and share knowledge and experiences. The May 2012 conference was attended by 300 dental staff representing 33 tribal and urban programs with a dental clinic. Over 5,000 hours of continuing dental education credits were earned.

Dental Billing and Coding Compliance Training

To improve clinic income streams, the IHS/CAO held a Dental Billing and Coding Training for tribal and urban Indian healthcare program staff. Proper dental billing requires billing staff and

providers to communicate to insure proper and timely billing. For this reason, both program billing staff and dental providers were invited to attend the May 2012 training. The training covered third party billing and an updated on Denti-Cal. Accurate and timely dental billing is essential to tribal and urban Indian healthcare programs which rely on third party income or revenue to supplement IHS funding.

Government Performance and Results Act (GPRA) Measures

To improve the quality of and access to care, the Dental Consultant in partnership with the Dental Support Center, encourages tribal and urban Indian healthcare programs to meet and/or exceed the national GPRA measure targets for dental access, application of topical fluorides, and placement of dental sealants. In 2012, IHS established two dental GPRA challenges to improve GPRA measure results. The ultimate intention was to improve the oral health status of the California Area AI/AN population:

- Improve on the 2011 dental access measure result by 2% or more
- Improve on the 2011 result on all GPRA dental measures by 2% or more

Electronic Dental Record (EDR)

An EDR incorporates digital radiography and imaging, offering a comprehensive, integrated patient record leading to increased productivity, improved efficiency, and decreased dental errors. Dentrix is a commercial, off-the-shelf dental, clinical, and practice management software application. A Resource and Patient Management System (RPMS) interfaces with patient registration, billing, appointment scheduling, and clinical notes to be submitted to the electronic health record (EHR). Dentrix can also be used as a stand-alone application by tribal healthcare programs that do not utilize RPMS. In 2012, the EDR was installed at three tribal facilities. Currently, 28 California Indian healthcare programs use some form of EDR.

Dental Advisory Committee

The Dental Advisory Committee is composed of dental professionals representing tribal and urban Indian healthcare 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 in ensuring 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 (CRIHB).

Dental Support Center

The California Dental Support Center (DSC) combines resources and infrastructure with IHS Headquarters and the IHS/CAO to offer technical assistance and expertise to all the California Area healthcare programs. The Dental Advisory Committee acts as the steering committee for the DSC.

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 dental education materials
- Training for dental staff
- IHS Basic Screening Survey
- Tobacco cessation training
- Co-sponsorship of hands-on clinical courses
- Co-sponsorship of the annual dental continuing education

Improving Patient Care

The aim of the Improving Patient Care (IPC) Initiative is to change and improve the Indian healthcare system. The 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) has been expanded to consist of a registered nurse, certified physician assistant, registered health information administrator, a public health analyst, a facilities engineer, and an environmental health service officer. The IST lead has been trained as an Improvement Advisor. The Improvement Advisor program is a 10-month development and support program whose goal is for participants to become highly effective leaders in helping their organization accomplish strategic improvement plans. The California Area Improvement Support Team is highly involved, continues to meet regularly, and is supporting not only the IPC healthcare teams in the California Area, but also collaborating with other Area IST's as well as the National IST.

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 (Morongo)
- American Indian Health & Services Corporation (Santa Barbara)

Three sites are part of the Quality and Innovation Learning Network (QILN). Their programs were involved in the previous IPC collaborative. All sites are actively redesigning their healthcare system patient processes. Members of the healthcare team attend national Action Period webinars as well as face-to-face Learning Sessions to build skills quality improvement. The CAO IST hosted two Learning Sessions in Sacramento providing a forum where these four California programs could build relationships and share innovative ideas for healthcare system redesign.

IPC Initiative Results

- 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 participation goal in partnership with all California tribal and urban Indian healthcare programs.

California Area QILN Teams

K'ima:w Medical Center—Dr. Chase, Dr. Smith, E. Yennyemb, Amber Brooks, Mandee McCullough, Susan Walsh, Evette Lewis, Crystal Masten, Peggy Peterson, Mary Lou Marshall, Melissa Cabrera, Mary Ann Colegrove, Debra Carpenter

Lassen Indian Health Center—Sherry Gage, Debra Sokol, Laura Bates, Ellie Brown

Riverside/San Bernardino County Indian Health, Inc.—Karen Davis, Jasmin Hernandez, Maria Perez, Quinten Rowley, Rosario Chin, Teierra Dunkle, Kendall Shumway, Jean Solomon (Not Pictured: Amanda Rodriguez)

California Area IPC4 Team

American Indian Health & Services (Santa Barbara)
Dr. Drew Preston, Dr. John McNeil, Dr. Bradley Hope, Dr. Julia Delgado, Dr. Hollanda Leon, Dr. Erica Lambert, Dr. Jennifer Hone, Angel Speltz, Magdalena Sunshine Serrano, Angelica Cuellar, Edith Santamaria, Sylvia Cisneros, Christina Varni, Victoria Abarca, Myrielle Ramirez, Deonna Perez, Joseph Quiroga, Cynthia Perez, Donald Todd Sr., Merin McCabe, Diane Contreras, Brent Gonsalves, Roy Shultze, Tony Alvarez, Scott Black, Juanita Paramo
(Not Pictured: Dr. Jennifer Kissinger, Dr. Linda Chu, Hannah Brigham, Andrea Carnaghe, Alma Sierra, Fantasy Windsong, Christina Guadarrama, Richard Ramirez)

Diabetes

The California Area has 38 tribal and urban Indian diabetes programs. These programs are funded in part by the Special Diabetes Program for Indians (SDPI). SDPI includes the Community-Directed, Healthy Heart, and Diabetes Prevention grants. The source of this money is based on funding that Congress appropriates annually. Due to the economic condition of our country, the SDPI has been only approved one additional year through FY 2014. Since the inception of the SDPI in 1998, diabetes has been affected in a positive manner. The devoted work of the staff in every California program has not only improved the quality of life for Indian people battling this disease, but has also prevented diabetes from occurring in people at high risk.

Diabetes Prevention Programs

There are currently six diabetes prevention programs in California:

- Chapa-De Indian Health Program (Auburn)
- Indian Health Center of Santa Clara Valley (San Jose)
- K'ima:w Medical Center (Hoopa)
- Sonoma County Indian Health Project, Inc. (Santa Rosa)
- United American Indian Involvement (Los Angeles)
- United Indian Health Services, Inc. (Arcata)

These programs are working collaboratively to produce a toolkit to help other tribal and urban Indian healthcare programs to develop their own diabetes prevention programs.

SDPI Healthy Heart Programs

There are currently six SDPI Healthy Heart programs in California:

- Redding Rancheria
- K'ima:w Medical Center (Hoopa)
- Riverside/San Bernardino County Indian Health, Inc. (Banning)
- Indian Health Council, Inc. (Pauma Valley)
- Toiyabe Indian Health Project, Inc. (Bishop)
- Lake County Tribal Health Consortium (Lakeport)

These programs have been successful at preventing complications in people with diabetes and are developing a toolkit to offer training to other Indian healthcare programs in developing their own Healthy Heart program.

Both the Diabetes Prevention and Healthy Heart initiatives offer patients a 16 week intensive healthy lifestyle course alongside of lifestyle coaches. Participants describe the group support and individualized lifestyle coaching as great motivation for developing healthy habits.

Trainings

The IHS/CAO provided webinar trainings on the following topics:

- Using the Assessment of Chronic Illness Care Tool to Evaluate Your Program's Readiness to Provide Chronic Care
- Imbedded Therapist Model in Primary Care (Behavioral Health Integration in Primary Care)

- Preventing Diabetes and Healing from Within: A Community Perspective
- Patient Centered Medical Home—Accreditation Association for Ambulatory Health Care (AAAHC) Certification Information

IHS Diabetes Audit

The IHS Diabetes Audit Report must be submitted annually by programs receiving SDPI Community-Directed funds. This report evaluates adherence to established standards for diabetes care and education. Statistics and data are used as a guide to steer the direction of decisions made by health care teams, but they don't tell the full story. The following health care outcomes have been specifically targeted for improvement by CAO. These data measures reflect the health status of all of the diabetic patients in the California Area (most recent data are from calendar year 2011):

TARGETED MEASURES	2009 AUDIT REPORT RESULT	2012 AUDIT REPORT RESULT (FOR CY 2011)	COMPARE TO ALL-IHS 2012 AUDIT RESULTS
Number audited	5172	6020	140,251
Blood sugar control at goal	44%	44%	36%
Blood Pressure at goal (<130/<80)	36%	36%	39%
Eye exams	57%	57%	55%
Nutrition education	67%	72%	48%
Exercise education	64%	65%	41%
Depression screening	65%	77%	76%

Building meaningful, trusting relationships are the foundation to providing excellent care, and these numbers represent people and their lives.

Nursing

The IHS/CAO strives to elevate the quality of healthcare provided for American Indian/Alaska Native (AI/AN) people through efforts that promote excellence in the delivery of evidenced-based, culturally considerate healthcare services. Nurses across the California Area play major roles in the delivery of these services as they provide care in clinic-based, public health, and referral settings. The Area Office works to ensure that nurses are prepared to practice at the top of their licensure, regardless of role or practice setting. They must be equipped with leadership skills necessary to overcome the challenges of addressing the needs of those they serve in a new era of health care reform.

Activities, Accomplishments, and Improvement Projects

Our Area Nurse Consultant represented IHS tribal and urban Indian healthcare program nurses nationwide during her tenure as 2012 National Nurse Leadership Council (NNLC) Chair, a national level leadership role that included:

- Hosting monthly council business calls
- Representing NNLC on IHS leadership calls
- Chairing the planning of the June 2012 Nurse Leaders in Native Care conference
- Co-chairing the July 2012 National Combined Councils meeting

On April 23, the IHS/CAO hosted a one-day continuing education offering for California Area nurses working in Indian health (in conjunction with the 2012 California Area GPRA/Best Practices Conference). Nurses attending these sessions were awarded IHS-sponsored continuing education units by the American Nurse Credentialing Center. The agenda included presentations from the following agencies:

- California Department of Public Health, Immunization Branch
- California Department of Health Services, Indian Health Program
- California State University, Sacramento (CSUS) School of Nursing
- IHS/Aberdeen Area Office
- IHS/Nashville Area Office

Nurses from California Area healthcare programs worked alongside nurses from across the Indian health system in the planning and delivery of the 2012 Nurse Leaders in Native Care conference that was held in San Diego, California during the week of June 12. Of the 100 attendees representing nurses from across the Indian health system, 28 nurses from the California Area earned a combined 400+ hours of IHS-sponsored continuing nursing education.

The IHS/CAO hosted and facilitated interagency meetings that included nurses from the following entities representing interests of AI/ANs in California:

- Indian Health Service
- California Area Indian Health Board
- California Rural Department of Health Care Services

Each of the identified organizations has a similar mission; to improve the health of American Indians who seek and rely on services from California tribal and urban Indian healthcare programs. Such interagency nursing meetings provide an opportunity for these nurse leaders to

gain a mutual understanding of the various organizations, exchange information about upcoming continuing education events, and identify areas of mutual interest for collaboration.

With the intent of promoting comprehensive immunization coverage for AI/AN receiving care at California tribal and urban Indian healthcare programs, the Area Nurse Consultant collaborated with the IHS Performance and Evaluation Program and the IHS National Immunization Program to offer clinic staff resources and guidance targeted to improve their immunization coverage outcomes. Immunization staff from each of the following California tribal healthcare programs received six hours of on-site and virtual immunization performance improvement assessment and training:

- Karuk Tribal Health
- Northern Valley Indian Health
- Riverside/San Bernardino County Indian Health
- Sonoma County Indian Health

A total of 40 nurses participated in the immunization performance improvement sessions.

Area Immunization Program Coordination

The IHS/CAO encourages comprehensive immunization coverage for all age groups. The following are some of the immunization improvement activities that were offered in 2012 through the Area Immunization Program:

- Monitored Area immunization reporting to ensure comprehensive, timely, and accurate data reporting for IHS quarterly reports
- Provided technical assistance and resources to improve the adult and childhood immunization GPRA measures
- Distributed incentive-based challenge resource materials
- 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
- Initiated and coordinated immunization data exchange projects between two tribal healthcare programs and the California Automated Immunization Registry (CAIR). We anticipate expanding to addiction program sites in 2013
- Partnered with Sacramento Native American Health Center to host an influenza vaccination clinic for IHS/CAO staff

Related RPMS-Based Trainings

The IHS/CAO coordinated the following RPMS-based trainings in FY 2012:

- CHR Coding and Documentation
- RPMS Immunization Package
- Public Health Nursing Coding and Documentation

Contract Health Services

The CHS Program is for medical/dental care provided away from a tribal healthcare facility. CHS is not an entitlement program and an IHS referral does not imply the care will be paid. If IHS is requested to pay, then a patient must meet the residency requirements, notification requirements, medical priorities, and use of alternate resources.

CHR Training Sessions, 2012:

Dates	Participants	Subject(s)
March 7	Tribal Leaders and tribal healthcare program staff	CHS unmet need
May 24	Tribal healthcare program staff	Education and outreach on federal healthcare programs for IHS eligible including Medicare and Medicaid, State Children's Health Insurance Program, and veterans' benefits
June 19-21	Tribal healthcare program directors	CHS staff core competencies, roles and responsibilities, staff development for claims processing, opportunities for improved communication, and training for private sector providers
August 13-15	Forty-three tribal healthcare program staff	CHS staff core competencies, roles and responsibilities, private sector CHS vendors, customer services, CHEF, Medicare-like Rates, and third-party billing procedures
Three 3-day sessions	Sixty-four tribal healthcare program staff and healthcare professionals including coders, billers, accounting clerks, and CHS technicians	Medical billing and coding workshops, credentialed coders earned 14 continuing education units from the American Academy of Professional Coders

CHS Improvement Initiatives in FY 2012

The IHS/CAO offered training and education to tribal CHS programs, including up-to-date information on CHS best practices and recent regulatory changes (see table below). For example, IHS/CAO assisted tribal healthcare programs with the re-pricing outpatient services pursuant to Medicare-like rate regulation. IHS/CAO funded the $499 registration fee for 15 tribal CHS staff to attend a Medicare-like rate workshop.

IHS/CAO encourages all tribal healthcare programs to fully document CHS unmet need. Denied/Deferred services reports document medical services that are either denied or deferred and therefore not payable by IHS. The information from the denied/deferred services reports provides Congress and OMB a way to determine unfunded CHS services to be used to justify increases in the CHS budget provided by Congress. The data is extracted from the Resources and Patient Management System (RPMS) CHS application or manual logs.

To improve quality of and access to care, the California Area Contract Health Services Officer provides general consultation for CHS regulations (42 CFR 136) and technical guidance on CHS operating guidelines as well as policies and procedures to tribal staff and outside agencies. The CHS Officer also 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.

IHS Director's Messages

The IHS Director's second priority, to reform IHS, includes the implementation of CHS reform. To encourage CHS reform, the following were submitted onto the IHS Director's Blog: **Understanding the Contract Health Service Program**:

Part 1 (Posted on September 19, 2011)

This posting is the beginning of a series of postings on understanding the Contract Health Service Program (CHS). When IHS is unable to provide certain types of healthcare services directly in our hospitals and clinics, we may refer patients to receive services in the private sector. These referrals are paid for by the CHS program appropriations to IHS. However, the IHS CHS budget does not have enough funding to pay for all referrals that our healthcare providers make and our patients need. We are working actively with Congress to help them understand the enormous need for CHS funding to pay for needed referrals and to request increases in our appropriations for this purpose. The CHS budget is currently $779 million. That sounds like a lot, but the additional need for CHS referrals beyond what the budget pays for is an additional $861 million. Last year, we received a $144 million increase in CHS funding, and that has helped us pay for more referrals, but there still is a great need. We only received a small increase this year. We know that patients are upset that we cannot pay for all referrals, but we do try to pay for the most urgent referrals possible through our medical priority system. The next blog posts on this topic will explain the eligibility for CHS, what we do to determine if we can pay for a referral, and the medical priority system.

Part 2 (Posted on September 20, 2011)

IHS eligibility was established through legislation and IHS regulations. In general, American Indians and Alaska Natives who are members or descendants of federally-recognized Tribes are eligible for IHS direct services, which are services provided at our clinics and hospitals. However, the eligibility for the CHS Program (referrals to the private sector) is different. Years ago, Tribes wanted the limited budget of the CHS Program to benefit the patients who lived nearest to the clinical or hospital first. Therefore, CHS Program eligibility is based on IHS eligibility plus residence in the area around the clinic or hospital that is designated as eligible for CHS (also called the CHS Delivery Area, or CHSDA). That is why referrals are generally not approved for tribal members who don't live on the reservation or tribal lands associated with the hospital or clinic. Patients are upset that they lose their CHS eligibility if they move away from the reservation or tribal lands and reside outside of the CHSDA. Again, this eligibility rule was put in place to make sure that the limited CHS funds benefit those who live closest to the clinic or hospital. Some say that we should make the CHS eligibility the same as IHS eligibility - that would mean more patients would be eligible. However, that would not mean that more patients would get referrals approved for payment because we still would have the same amount of

funding in the CHS budget to use for more patients. And it could mean that individuals could travel to the clinic from another state, get CHS referrals paid for, and then travel back to the other state, potentially leaving no funding for patients who live in the tribal community. Without additional funding, changing eligibility for CHS is a challenge. The next blog will cover how CHS referrals get approved for payment.

Part 3 (Posted on September 21, 2011)

Patients often wonder why even though their doctor made a referral for them to see a specialist or have a surgical procedure, it is not authorized for payment by the Contract Health Program. IHS has regulations and policies that govern how to determine whether to pay for a referral or service in the private sector for our patients. If we had unlimited funding, we could pay for all referrals. However, since our CHS budget is limited, we must follow our regulations and the law to determine which referrals can be authorized for payment. In the simplest terms, the regulations tell us how to make sure the limited funding goes to those that need it the most. In a previous blog we discussed CHS eligibility, which is based on residence near the facility. 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, because by law they pay first before IHS, and whether funding is available to pay for the referral based on medical priorities. Here is a diagram that helps understand the steps that occur to determine if IHS can pay for a referral or outside healthcare services. (Visit http://www.ihs.gov/ to view diagram.) Clearly it is a complicated process and we are working on improving our business practices in this area.

Part 4 (Posted on September 22, 2011)

When a healthcare provider makes a referral for a patient to receive services outside the facility, the referral is reviewed to determine its relative medical priority. IHS regulations require that when funding is limited, referrals should be approved based on available funding and their medical priority. The CHS medical priorities are determined by a local committee that includes healthcare providers and administrators and meets weekly. In the past several years, due to funding limitations, IHS has in general only had enough funds to pay for the highest medical priority – Priority 1, or life or limb conditions. Patients who have referrals that rank below Priority 1 in general have not gotten their referrals authorized for payment due to limited funding. However, the increase in CHS funding we received last year has helped some patients with referrals in the category of Priority 2 get their referrals authorized for payment. Patients have expressed concern that some random administrator or employee is approving and denying referrals based on such factors as for relatives or friends. However, the CHS committee includes both clinical and administrative staff and they are to make decisions based on the medical reason for the referral. Some patients think we don't want to pay for referrals; however, we would gladly pay for all referrals if we had enough funding to pay for them since we know that all referrals are medically needed. However, we must use the medical priority system to make sure that the limited funding is used for those most in need.

Part 5 (Posted on September 23, 2011)

There have been some claims that IHS has not paid its bills to outside providers when they

provide services to American Indians and Alaska Natives. While we are working on improving our payment process, it is important to understand that IHS does not pay for all American Indians and Alaska Natives who receive services in the private sector, and IHS also does not authorize all referrals or services for payment. Just like all other healthcare coverage, there are rules and regulations that require we ensure that we only pay referrals for eligible individuals and that those referrals were approved for payment through our process that includes the medical priority system. In addition, IHS is the "payer of last resort" by law, so IHS cannot pay for services unless any other possible healthcare insurance or coverage, such as private insurance, Medicare or Medicaid, has been applied for and/or used. We also enter into agreements with outside providers for special rates and services, and we do not pay full billed charges. We are working on making sure that outside providers understand we do not pay full billed charges and we do not pay for any services an American Indian or Alaska Native receives without prior authorization, confirmation of eligibility and payment from all other sources of coverage first. Patients should make sure that they understand if their referral or services are authorized for payment and, if not, work with our staff to make sure they have followed all the rules. Outside providers should work with IHS on understanding what we do and do not pay. This is a part of the business of healthcare – and all medical providers understand that not all billed charges are paid by insurance or other healthcare coverage and that there are rules to abide by. We will continue to work with our outside providers on improving the payment process; however, we will not pay for services that are not authorized for payment through our process and according to our policies and regulations. For more information, go to the Indian Health Manual, Part 2, Chapter 3.

Part 6 (Posted on September 26, 2011)

Improving the Contract Health Service (CHS) Program is a top priority and after consultation with Tribes, a federal/tribal workgroup has developed some recommendations for improvements. These recommendations include ensuring we document the total need for CHS funding, sharing best practices and improving the way we do business in CHS, understanding the impact of the CHS distribution formula when we get funding increases, and the need for more education about the program. In addition to the original recommendations submitted, the workgroup will be providing additional recommendations in the near future for consideration by the IHS Director.

Health Promotion/Disease Prevention

The Health Promotion/Disease Prevention (HP/DP) program was initiated in 2005 to address challenges related increasingly to health conditions and chronic diseases which are impacted by lifestyles issues such as obesity, physical inactivity, poor diet, substance abuse, and injuries. Working with tribal and urban Indian healthcare programs, the HP/DP program coordinates services that enhance prevention health approaches.

Digital Storytelling

Digital Storytelling engages tribal communities and strengthens a patient's commitment toward health and wellness. It is a low-cost, powerful, and compelling way to promote social change and action based on creating first-person narratives combined with digital media. To encourage creativity, the IHS/CAO supported six Digital Storytelling workshops, October 2011-July 2012. These workshops supported expanding the capacity in the California Area to use digital storytelling as a community wellness tool. They assisted tribal and urban healthcare programs, their tribes and communities to share their local stories by merging traditional storytelling with current day technology. The workshops introduced 47 individuals to the fundamentals of digital storytelling. An additional 13 individuals were trained to use the workshop facilitation process, a community-based participatory approach developed by Healthy Native Communities Partnership. All workshops included culturally focused hands-on learning, and effective teamwork, and encouraged networking and supported communities to take action for positive change. In 2012, the workshops provided over $31,806.00 in cost savings to California tribal and urban Indian healthcare programs when compared to commercially available digital storytelling trainings. The goal of the workshops is to build local capacity among interested tribal and urban Indian healthcare programs using a community-based approach to wellness.

Program Highlights:

- Northern Valley Indian Health Inc. (Willows) in partnership with their tribal community partners hosted a digital storytelling workshop in collaboration with a grant project. The stories had tremendous impact by offering authentic perspectives on community-based participatory research and methods
- Riverside/San Bernardino County Indian Health Inc. (Banning) included their screening staff using community created digital stories. The stories shared an authentic community voice, focused on diabetes, personal health, heart health, family and the next generation
- The Indian Health Center of Santa Clara Valley (San Jose), in partnership with Stanford University, incorporated digital stories into their American Indian Community Action Board development and presented on their collaborative at the2012 American Public Health Association Meeting in San Francisco
- Fresno American Indian Health Project, Inc. is expanding digital storytelling workshops in partnership with the Owens Valley Career Development Center
- United American Indian Involvement, Inc.'s (Los Angeles) enthusiasm and creativity around the use of digital storytelling includes training to India youth in their community, using it as part of treatment for patient care. It will be part of community outreach to de-stigmatize mental health treatment

In addition to IHS/CAO's efforts, a Native American Indian Health Media Center, established in 2011, supports their · organizational mission and offers digital storytelling workshops to their respective communities and partners

Community Wellness Presentations

The FY 2012 IHS/CAO Best Practices/Medical Providers Conference included two community-centered presentations. Sacramento Native American Indian Health Center Inc.'s, *Wellness Program Model,* presentation focused on listening to and engaging the community in wellness planning around healthy eating and physical activity. It highlighted Indian clinic-community support of the Let's Move in Indian Country, a process for establishing healthy food habits, and promoting breastfeeding and physical activity. Northern Valley Indian Health Inc.'s, *Community Advocacy,* presentation focused on the formation of a Community Diabetes Action Council designed to go hand-in-hands with the Special Diabetes Program for Indians Community Advocacy Best Practice. Central to the presentation was their vision to engage and work with the community. The significance of a community-centered approach to diabetes treatment and prevention was illustrated in their achievements.

Employee Wellness

IHS/CAO continued to promote employee wellness, focusing on increasing awareness of healthy eating and physical activity for disease prevention. The *Just Move It 2011 California Challenge* (July-September) promoted physical activity. This annual employee wellness challenge used the President's Challenge to document physical activity. Reported physical activity was converted to virtual miles needed to walk around the state to all tribal or urban Indian healthcare programs. Wellness briefings and newsletters included President's Challenge website, National *Let's Move! initiative* and *Just Move It!* Campaigns. The impact of physical activity, health eating, and body composition gave a balanced approach to person wellness and an overview of metabolism.

Just Move It Challenge

The seventh *Just Move It 2012 California Challenge* renewed and strengthened partnerships with tribal and urban partners by promoting physical activity at the local level. Current and new *Just Move It* partners from California posted success stories to the national website (www.justmoveit.org). The California challenge involved 64% of tribal and urban Indian healthcare programs representing 77 tribes. It established community-based walks, fitness initiatives and physical activity. In FY 2012, materials for an online virtual training website were completed and include short videos that introduce *Just Move It*, the IHS *Physical Activity Toolkit*, and an overview of the national Physical Activity Guidelines for Americans. Once activated, the website will support remote trainings accessible by all of tribal and urban Indian healthcare programs.

Telenutrition

The *IHS/CAO Telenutrition Guidelines* were presented to program directors in March. This resource was developed to promote quality telenutrition among tribal and urban Indian healthcare programs. As with other telehealth services, telenutrition provides access and convenience to communities unable to obtain these services locally. Clinical nutrition services provided by a registered dietitian include Medical Nutrition Therapy, which is a recognized component essential to comprehensive healthcare. This supports the medical provider in

delivery of patient-centered care and the patient in managing or preventing disease. Telenutrition can offer nutrition services to individuals, groups, or as staff for educational training. In late FY 2012, San Diego American Indian Health Center and American Indian Health & Services (Santa Barbara) initiated a pilot test to evaluate implementation of the nutrition guidelines. When completed in the spring of 2013, results of the pilot test will be assessed and shared to further implement clinical nutrition services and medical nutrition therapy networking between tribal and urban Indian healthcare programs.

Behavioral Health

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 physical, mental, social, and spiritual health of American Indians/Alaska Natives to the highest level.

Methamphetamine and Suicide Prevention Initiative Funds

The IHS/CAO collaborates with more than 46 tribal and urban Indian healthcare programs to address behavioral and mental health, domestic violence, methamphetamine use, and suicide. Each of these programs offers some type of behavioral and/or mental health services and/or program depending on the individual needs of the community. In 2009, the IHS distributed limited special funding to address some of the behavioral health problems such as suicide, methamphetamine use, and domestic violence.

Eight tribal and urban Indian healthcare programs rely on methamphetamine and suicide prevention initiative funds. Additionally, seven programs receive domestic violence funding. Because of this funding, there has been an increased awareness and development of community prevention programs. One successful program is "Fathers as Leaders" located in Bishop, California. Bishop is home to Toiyabe Indian Health Project, Inc. which serves seven different tribes and has a user population of more than 2,290. Bishop is an extremely rural community located in Inyo County, about 250 miles north of Los Angeles County. The Sierra Nevada Mountains create the west border which makes driving from Northern California in the winter a challenge. Toiyabe is extremely proud of the "Fathers as Leaders" group which meets every Sunday. As the Behavior Health Director states, "These fathers are seen as community leaders and this program is community driven." Each one of these fathers suffered from an addiction disorder and is now "clean and sober". More recently, Toiyabe Indian Health Project, Inc. expanded suicide prevention services and partners with elementary and high schools within Inyo County. This partnership teaches educators to recognize early behaviors for youths at risks and includes training for immediate interventions. In addition, all of the Toiyabe healthcare program staff has been trained on recognizing early signs of suicide and effective immediate intervention techniques.

Another successful program is the domestic violence prevention program at Sonoma County Indian Health (Santa Rosa). This tribal healthcare program collaborates with the Sonoma County government and provides education and training for offenders convicted of domestic violence. In November 2011, Sonoma County expanded these services to include two male groups and one female group. These sessions are 52 weeks long and use the best practice "Duluth Model" Curriculum. Since the domestic violence prevention initiative expanded, nine women have been enrolled and two have successfully completed the program. Currently, five women are enrolled. The training for men has expanded as well and more than 46 men have registered and eight graduated. Currently, 22 men are enrolled.

Behavioral Health Webinar Sessions

The IHS/CAO coordinates with IHS Headquarters monthly through webinar sessions and/or conference calls. In addition to hearing about national success stories, the California Area tribal

and urban Indian healthcare programs share information about promising best practices developed within their communities as a result of domestic violence and methamphetamine and suicide prevention initiative funding.

Alcohol and Substance Abuse Treatment Program

The IHS/CAO coordinates with tribal and urban Indian healthcare programs to support alcohol and substance abuse prevention programs. There are more than 124 alcohol and substance abuse counselors employed by the tribal and urban Indian healthcare programs. For the past few years, the California Area has expanded training and education to certify and re-certify alcohol and substance abuse counselors. The majority of the Indian healthcare program alcohol and substance abuse counselors are certified by the Indian Alcoholism Commission of California. Each counselor must obtain 30 units of continuing education every two years to maintain their certification. In addition, the Indian healthcare program counselors are surveyed each year. The top two subjects requested were ethics and Native American treatment modalities. This past December, more than 38 alcohol and substance abuse counselors attended the two-day training which addressed American Indian culture, "Medicine Wheel-Red Road: Alcohol and Other Drugs as Self-medication and What to do About it." During each training, the counselors complete an on-site course evaluation, and results show positive overall satisfaction.

Youth Regional Treatment Centers

In FY 2012, more than 44 youths received residential treatment through the YRTC Risk Pool administered by the California Area Office. The YRTC Task Force consults with psychologists, behavioral health specialists, alcohol counselors, and psychiatrists.

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. The Veterans Administration has demonstrated that "universal screening" in behavioral health increases screening rates and removes the stigma associated with behavioral health screenings. In 2012, performance-based awards were offered to tribal and urban Indian healthcare programs that increased screening on all three GPRA measures by 50% over the previous year. The four tribal programs that received the award are Northern Valley Indian Health, Inc. Willows), Pit River Health Service, Inc. (Burney), Quartz Valley Program (Fort Jones), and Round Valley Indian Health Center, Inc. (Covelo).

Government Performance and Results Act

The Government Performance and Results Act (GPRA) requires each federal agency to have performance measures that shows Congress how effectively it spends its funding. Indian Health Service had a total of thirty-three GPRA measures in FY 2012. 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.

In FY 2012, California Area tribal healthcare programs improved in 15 of 19 measures compared to FY 2011 and met the national targets for 8 of 19 GPRA performance measures. The largest improvements were seen in the following five measures:

- Prenatal HIV Screening
- Depression Screening
- Domestic/Intimate Partner Violence Screening
- Alcohol Screening (FAS Prevention)
- Tobacco Cessation

In FY 2012, California Area urban Indian healthcare programs improved on 11 of 16 reported measures compared to FY 2011. The largest improvements for the urban programs were seen with the following five measures:

- Prenatal HIV Screening
- Childhood Immunizations
- Colorectal Cancer Screening
- Mammography Screening
- LDL Assessment

The large improvement on the Prenatal HIV Screening measure among both tribal and urban programs is significant. Virtually all tribal and urban programs refer patients out for prenatal care, which means that programs must make a special effort to collect prenatal screening data from a third-party source. In FY 2011, the California Area produced a GPRA resource guide for programs that included many resources and tips for collecting prenatal HIV screening data; this guide was distributed to all programs, and helped programs improve data collection for this measure.

National GPRA Support Team (NGST)

The National GPRA Support Team, located within the Office of Public Health, supports GPRA activities at both the national and area levels. At the national level, the team leads the 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 Office level, the team assists all California tribal and urban 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 health measures that need improvement.

GPRA Performance in FY 2012

Under Titles I and V of P.L. 93-638, California tribal and urban Indian healthcare programs are not mandated to track and/or submit GPRA data to the IHS and OMB, however most do so on a voluntary basis. Many tribal and urban Indian healthcare programs in California are small and because they experience high staff turnover, they need regular training on GPRA measure logic and targets.

To assist California tribal and urban Indian healthcare programs in achieving FY 2012 GPRA targets, the IHS/CAO:

- Hosted seven national GPRA improvement webinar training sessions that California Area tribal and urban program staff were encouraged to attend to improve GPRA performance and the quality of clinical care
- Hosted six improvement webinar sessions for California tribal and urban Indian healthcare program staff, which included updates on California's GPRA performance, IHS/CAO improvement initiatives, and best practices from high-performing sites in California
- Provided technical assistance during monthly GPRA "office hours" calls, in which healthcare program staff asked questions about GPRA, the Clinical Reporting System (CRS), and shared improvement strategies with other sites
- Sponsored an Influenza and Pneumococcal vaccination challenge and a Childhood Immunization challenge with financial incentives for improved performance measure results
- Sponsored a Behavioral Health challenge to promote universal screening for three behavioral health GPRA measures (depression screening, alcohol screening to prevent Fetal Alcohol Syndrome, and domestic/intimate partner violence screening)
- Created and distributed a GPRA Resource Guide which contains instructions, informational materials, and resources to assist tribal and urban Indian healthcare programs with improving clinical care and performance measure results
- Published and distributed a California 2011 GPRA Report booklet, which includes a summary of California Area performance on 19 GPRA performance measures, trend graphs, and a comparison of performance by individual tribal and urban Indian healthcare programs
- Hosted the California Annual Medical Providers' Best Practices & GPRA Measures Continuing Education April 24-25 in Sacramento
- Established California Area GPRA listserv to allow healthcare programs to ask questions regarding GPRA or the Clinical
- Reporting System and share improvement strategies via e-mail

2012 Final National Dashboard (IHS/Tribal)

DIABETES	2011 Target	2011 Final	2012 Target	2012 Final	2012 Final Results
Poor Glycemic Control	19.4%	19.1%	18.6%	19.8%	Not Met[1]
Ideal Glycemic Control	30.2%	31.9%	32.7%	33.2%	Met[2]
Controlled BP <130/80	35.9%	37.8%	38.7%	38.9%	Met: Baseline in 2013[3]
LDL (Cholesterol) Assessed	63.3%	68.7%	70.3%	71.0%	Met: Baseline in 2013
Nephropathy Assessed	51.9%	56.5%	57.8%	66.7%	Met
Retinopathy Exam	50.1%	53.5%	54.8%	55.7%	Met
DENTAL					
Dental: General Access	23.0%	26.9%	26.9%	28.8%	Met
Sealants	257,261	276,893	276,893	295,734	Met: Baseline in 2013[3]
Topical Fluoride - Patients	135,604	161,461	161,461	169,083	Met: Baseline in 2013[3]
IMMUNIZATIONS					
Influenza 65+	58.5%	62.0%	63.4%	65.0%	Met
Pneumovax 65+	79.3%	85.5%	87.5%	88.5%	Met
Childhood Immunizations	74.6%	75.9%	77.8%	76.8%	Not Met: Baseline in 2013[2]
PREVENTION					
(Cervical) Pap Screening	55.7%	58.1%	59.5%	57.1%	Not Met: Baseline in 2013[2,4]
Mammography Screening	46.9%	49.8%	51.7%	51.9%	Met
Colorectal Cancer Screening	36.7%	41.7%	43.2%	46.1%	Met: Baseline in 2013[2]
Tobacco Cessation	23.7%	29.4%	30.0%	35.2%	Met: Baseline in 2013[3]
Alcohol Screening (FAS Prevention)	51.7%	57.8%	58.7%	63.8%	Met
Domestic Violence/Intimate Partner Violence Screening	52.8%	55.3%	55.3%	61.5%	Met
Depression Screening	51.9%	56.5%	56.5%	61.9%	Met
Cardiovascular Disease Comprehensive Assessment	33.0%	39.8%	40.6%	45.4%	Met
Prenatal HIV Screening	73.6%	80.0%	81.8%	85.8%	Met
Childhood Weight Control	N/A	24.1%	N/A	24.0%	Discontinued in 2013
Breastfeeding Rates	N/A	N/A	N/A	N/A	To be added in 2013
Public Health Nursing Encounters	454,679	447,642	424,203	Pending	N/A
Suicide Surveillance (forms completed)	1,784	1,930	1,807	Pending	N/A

Measures Met: 18
Measures Not Met: 3
Measures Pending: 2

[1]Not met, but measure eliminated to focus on "Good Glycemic Control" next year.
[2]Measure revised in 2013 according to new standard of care.
[3]Measure logic revised for 2013.
[4]Frequency of screening has changed from 2012 to 2013 which needs a new baseline in 2013.

Annual California Area GPRA 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 15 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 2011 and is available on the California Area website or upon request.

FY 2013 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 2013 action plan to support and promote GPRA quality improvement efforts at each tribal an urban Indian healthcare program. The plan includes providing feedback on performance, offering trainings, providing improvement challenges, hosting Webinar 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.

FY 2013 GPRA Changes (GPRAMA)

On January 4, 2011 President Barack Obama signed into law the GPRA Modernization Act of 2010 (GPRAMA), Public Law 111-352. The GPRAMA strengthens the Government Performance & Results Act of 1993 (GPRA), Public Law 103-62 by requiring federal Agencies to use performance data to drive decision making. As a result, as of FY 2013, the IHS will report six measures, which will be known as GPRAMA measures.

These six measures are:

- Proportion of adults age 18 and older who are screened for depression
- American Indian and Alaska Native patients with diagnosed diabetes achieve good glycemic control (A1c less than 8.0%)
- American Indian and Alaska Native patients, age 22 and older, with coronary heart disease are assessed for five cardiovascular disease (CVD) risk factors (Note: the denominator for this measure is no longer patients with ischemic heart disease)
- American Indian and Alaska Native patients, aged 19—35 months, receive childhood immunizations (vaccine series 4313*314)
- 100% of hospitals and outpatient clinics operated by the Indian Health Service are accredited (excluding tribal and urban facilities)
- Implement recommendations from tribes annually to improve the tribal consultation process

The remaining GPRA measures will be reclassified as “budget measures” and will continue to be reported nationally in the IHS annual budget request. The IHS will monitor our agency’s performance by quarter and report final budget measure results in the annual IHS budget request and the Congressional Justification. Even though their designation has changed from GPRA measures to budget measures, they are still considered national performance measures.

2012 Final California GPRA Dashboard

DIABETES	CALIFORNIA AREA 2012 – FINAL	CALIFORNIA AREA 2011 – FINAL	NATIONAL 2012 – FINAL	NATIONAL 2012 – FINAL	2012 FINAL RESULTS - CALIFORNIA
Poor Glycemic Control	10.7%	10.7%	13.4%	N/A	N/A
Ideal Glycemic Control	85.1%	84.1%	84.9%	N/A	N/A
Controlled BP <130/80	15.4%	15.2%	19.8%	18.6%	Met
LDL (Cholesterol) Assessed	38.3%	36.2%	33.2%	32.7%	Met
Nephropathy Assessed	34.4%	33.9%	38.9%	38.7%	Not Met
Retinopathy Exam	70.4%	69.6%	71.0%	70.3%	Met
DENTAL	58.7%	54.3%	66.7%	57.8%	Met
Dental: General Access	52.2%	47.4%	55.7%	54.8%	Not Met
Sealants					
Topical Fluoride - Patients	39.9%	41.4%	28.8%	26.9%	Met
IMMUNIZATIONS	12,698	14,307	295,734	276,893	N/A
Influenza 65+	11,032	10,671	169,083	161,461	N/A
Pneumovax 65+					
Childhood Immunizations	54.9%	53.3%	65.0%	63.4%	Not Met
PREVENTION	83.7%	82.0%	88.5%	87.5%	Not Met
(Cervical) Pap Screening	71.3%	70.2%	76.8%	77.8%	Not Met
Mammography Screening					
Colorectal Cancer Screening	48.5%	49.1%	57.1%	59.5%	Not Met
Tobacco Cessation	43.9%	45.4%	51.9%	51.7%	Not Met
Alcohol Screening (FAS Prevention)	40.7%	35.5%	46.1%	43.2%	Not Met
Domestic Violence/Intimate Partner Violence Screening	30.4%	25.1%	35.2%	30.0%	Met
Depression Screening	53.0%	47.5%	63.8%	58.7%	Not Met
Cardiovascular Disease Comprehensive Assessment	55.5%	48.1%	61.5%	55.3%	Met
Prenatal HIV Screening	53.5%	46.0%	61.9%	56.5%	Not Met
Childhood Weight Control	47.1%	44.7%	45.4%	40.6%	Met
Breastfeeding Rates	72.1%	64.4%	85.8%	81.8%	Not Met
Public Health Nursing Encounters	22.8%	23.0%	24.0%	N/A	N/A
Suicide Surveillance (forms completed)	10.7%	10.7%	13.4%	N/A	N/A

Measures Met: 8
Measures Not Met: 11

[a]Long-term measure as of FY 2009, next reported FY 2013

Information Resource Management (IRM)

The California Area Information Technology (IT) staff provide technical support to the tribal and urban Indian healthcare programs in the state of California. The majority of support provided is for and about the Resource and Patient Management System databases maintained by each of our tribal & urban health programs.

IT staff also provides assistance for the following areas:

- Electronic Health Record
- Information Security
- Office Automation
- Telecommunications
- Website

Electronic Health Record

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 providers.

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 (MU). 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 and the use of technology for remote training, including WebEx and tele-video conferencing.

Types of Services

The IHS/CAO works with tribal and urban Indian healthcare programs throughout 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 certified by 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 2013.

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 reminder notices. These alerts are interactive to remind providers to order tests, medications, and conduct health screenings. In 2011, the IHS/CAO EHR team, in collaboration with the GPRA team, initiated a GPRA reminder support program. Fourteen GPRA measures were identified and were 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 RPMS/EHR Team is comprised of individuals from varied backgrounds, all with expertise in the RPMS/EHR as well as Indian healthcare programs. Together, the team works with all tribal and urban Indian healthcare programs to ensure RPMS/EHR is functional, secure, and improves patient care.

The IHS/CAO continues to support clinic programs to install and configure RPMS/EHR to meet Meaningful Use (MU) and GPRA standards. The IHS/CAO completed 8 RPMS/EHR installs this year so that all 23 programs using RPMS now have EHR installed. Lab interfaces have been installed at 15 sites and e-prescribing interfaces are now installed at 13 programs. Maintaining the RPMS/EHR requires training for clinic program staff on MU and GPRA reminders.

EHR "Go Lives" in FY 2012:

- Consolidated Tribal Health Project (Redwood Valley) - September 2011
- American Indian Health & Services (Santa Barbara) - December 2011
- Sacramento Native American Health Center - January 2012
- Toiyabe Indian Health Project (Bishop) - January 2012
- Sonoma County Indian Health Project (Santa Rosa) - March 2012
- Pit River Health Service (Burney) - April 2012
- Anav Tribal Health Clinic (Quartz Valley) - August 2012

California Area RPMS/EHR Team:

Name	Duties
Steven Viramontes	Coordinates RPMS/EHR support
Marilyn Freeman, RHIA	Coordinates Vista Imaging support and Health Information Systems Supports
Robert Gemmell, CIO	Responsible for all Aspects Network Operation
Gary Mosier	Patch maintenance, Interface configuration for e-prescribing and bidirectional lab, Help Desk
Michelle Martinez	Patch maintenance, Help Desk, ICD-10 Area Coordinator
Tim Campbell	Supports Area programs to meet Meaningful Use measures
Natalie Klier, CCS-P	Supports all aspects of EHR, Mentor for all program CACs needing support, Help Desk
Emmanuel Yennyemb, MBA, CSAP	Supports all aspects of EHR, Mentor for all program CACs needing support, Help Desk
Kelly Stephenson	Network support, Help Desk
Denise Vermilyea, PharmD	Prepares RPMS/EHR drug files for e-prescribing and performs monthly updates, creates quick orders
Toni Johnson	Business Office Consultant, Contract Health Officer, Billing Specialist, Help Desk
Edna Lorimer	Help Desk coordinator, sets up Electronic classrooms
Paula Taylor	Sets up Electronic Classrooms

VistA Imaging

History

The IHS/CAO began its VistA Imaging program in FY 2010. VistA Imaging hardware and software were prepared and installed during April-May 2010. Scanning training was conducted 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) went live on VistA Imaging in the first half of July 2011. Lake County Tribal Health Consortium began using VistA Imaging following the program's move to a new facility a few months later.

The VistA Imaging program grew to seven when two more clinics (Shingle Springs Tribal Health Program and Tuolumne Me-Wuk Indian Health Center) began using the software during FY 2011.

Current Status

Seventeen California Area clinics used and/or began implementing VistA Imaging during FY 2012:

- American Indian Health and Services Corporation (Santa Barbara)
- Consolidated Tribal Health Project, Inc. (Redwood Valley)
- Feather River Tribal Health, Inc. (Oroville)
- K'ima:w Medical Center (Hoopa)
- Lake County Tribal Health Consortium, Inc. (Lakeport)
- Lassen Indian Health Center (Susanville)
- Northern Valley Indian Health, Inc. (Willows)
- Riverside/San Bernardino County Indian Health (Banning)
- Round Valley Indian Health Center, Inc. (Covelo)
- Sacramento Native American Health Center
- San Diego American Indian Health Center
- Santa Ynez Tribal Health Program
- Shingle Springs Tribal Health Program (Placerville)
- Southern Indian Health Council, Inc. (Alpine)
- Toiyabe Indian Health Project, Inc. (Bishop)
- Tuolumne Me-Wuk Indian Health Center
- United American Indian Involvement, Inc. (Los Angeles)

Program Support and Expansion

The IHS/CAO assists sites with implementation of VistA Imaging software through remote technology and on-site visits. On-going support is provided through monthly calls offering demonstration of software functionality as well as reporting of needs and successes. Software issues are addressed by the Area VistA Imaging Coordinator and through the CAO Help Desk.

The IHS/CAO continues to pursue VistA Imaging implementation with the following California programs which use the RPMS EHR in FY 2013:

- Central Valley Indian Health, Inc. (Clovis)

- Chapa-De Indian Health Program, Inc. (Auburn)
- Karuk Tribe (Happy Camp)
- Pit River Health Service, Inc. (Burney)
- Quartz Valley Program (Fort Jones)
- Sonoma County Indian Health (Santa Rosa)

A second Plasmon Archive Appliance was purchased in September 2012 when our office was notified that maximum capacity for the device is twelve volumes. Addition of a second Plasmon Archive Appliance allows the VistA Imaging program to accommodate up to 24 health clinics.

Premium Costs

VistA Imaging program costs exceeded budget during FY 2011 and FY 2012 due to unanticipated hardware and maintenance costs. Maintenance agreements for the two Plasmon Archive Appliances have been incorporated into the annual budget. FTE costs have decreased over the first three years of the program due to increased numbers of medical providers using VistA Imaging. A slight decrease in per full-time equivalent (FTE) cost is anticipated for 2013.

Meaningful Use

The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted to improve American healthcare delivery and patient care through an unprecedented investment in health information technology. The CMS EHR Financial Incentive Program and Regional Extension Centers (RECs) are two of the programs created as a result of this legislation. Information about HITECH programs including health information exchange and workforce development can be found online at http://healthit.hhs.gov.

The term "Meaningful Use" (MU) is frequently used in relation to the Medicare and Medicaid EHR incentive programs. These incentive programs are broken into three stages with two or more years in each stage. Participation requirements for eligible providers increase with each stage. Stage one requirements addressing data capture and sharing were released in July 2010. Stage two requirements strive to improve patient care through better clinical decision support, care coordination, and patient engagement. The Stage 3 MU Requirements will target improved outcomes.

The Medicare and Medicaid EHR incentive programs vary in many ways including program life spans, requirements, eligibility, and incentive totals. Read more about CMS financial incentive programs at http://www.cms.gov/EHRIncentivePrograms.

HITECH funded 62 Regional Extension Centers (RECs) to assist healthcare providers with adoption and meaningful use of health information technology during Stage 1 Meaningful Use. REC funding was released based on achievement of the following milestones by enrolled providers:

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.

As a sub-recipient of the National Indian Health Board Regional Extension Center, CRIHB collaborates with the IHS/CAO to provide EHR technical assistance to California tribal and urban Indian healthcare programs using RPMS EHR and Commercial-off-the-shelf (COTS) software. The MU Team includes the Meaningful Use Coordinator, EHR Clinical Applications Coordinator (CAC), and the MU Consultant. Regular conference calls, on-site meaningful use assessments, training conferences, and remote and onsite assistance are used to support eligible California tribal and urban Indian healthcare providers in their pursuit of meaningful use (which is REC Milestone 3). Available REC services include pharmacy, lab, and EHR consultants. These consultant services can be accessed without cost by enrolled eligible providers through September 2013.

Many California AI/AN eligible providers chose to participate in the Medicaid EHR incentive program which provides payments of up to $63,750 over six years of program participation. The Medicaid program allowed eligible providers to qualify for the stage one, year one payment ($21,250) through attestation to the Adoption, Implementation, or Upgrade (A/I/U) of a certified EHR. A large number of California tribal healthcare professionals participated in the program under this provision during CY 2011. Total payment of more than $4.5 million were received by

area healthcare programs during CY 2012.

While the programs were still waiting for MU stage one, year one payments, the California MU team worked to prepare eligible providers for reporting and attestation of meaningful use for CY 2012. Approximately 15 eligible providers at three California tribal healthcare programs are expected to attest for Stage 1 Year 2 incentive payments during CY 2012. The California MU team is working with remaining providers to complete MU stage one, year two reporting and attestation during CY 2013.

The CMS EHR Financial Incentive Programs will continue for several more years; however, the Regional Extension Center program will end in September 2013. All California Area healthcare programs are currently using an electronic health record. Local and area resources will be critical for all eligible providers as they strive to meet Stage one, two, and three meaningful use requirements and collect financial incentives during remaining years of CMS EHR financial incentive programs.

ICD-10

The International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (known as "ICD-10-CM") is a classification system for the coding of medical diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury of diseases, as published by the World Health Organization (WHO).

ICD-10-CM is already used in almost every country in the world, except the United States. The IHS and tribal/urban Indian healthcare programs still rely on ICD-9-CM. The conversion towards ICD-10-CM from ICD-9-CM allows for better analysis of disease patterns and treatment outcomes. These same details will make the initial patient claim easier for third party payers to understand and reimburse. Many improvements have been made to coding in ICD-10-CM. For example, a single code can report a disease and its current manifestation. ICD-10-CM will affect information technology and software.

As Health Insurance Portability and Accountability Act (HIPAA) covered entities, all IHS, tribal, and urban Indian healthcare programs are required to use the International Classification of Disease, 10th Revision codes (ICD-10 CM/PCS) on all HIPAA electronic transactions (claims, etc.) by October 1, 2013. The current, Ninth Revision (ICD-9) is obsolete and no longer meets current health care data needs. Furthermore, it does not support the transition of an interoperable health data exchange in the United States.

The California Area Office has successfully completed Phase 1 of the ICD-10 Implementation Process guided by the Office of Information Technology:

Building of a Project Management Plan

The project management plan outlines the purpose of ICD-10 implementation. The plan describes what IHS/CAO wants to achieve, who will take part ,and how to implement it to:

- Achieve consensus and support within the membership ensuring a multidisciplinary approach
- Provide program management support that ensures software analysis, design and planning
- Be an advocate for Tribes and Urban Programs.
- Create best practices for implementation approaches and alternatives
- Meet mandatory timelines established by CMS.
- Provide the tribal and urban Indian healthcare programs with a variety of training strategies
- Address implementation risks and issues

Creating an IHS/CAO ICD-10 Team

The IHS/CAO has convened a multi-disciplinary team that consists of:

- IT specialists
- business office
- contract health services
- clinical applications coordinator

- telemedicine and eHealth coordinator
- area nurse consultant

IHS/CAO has formed a collaborative with CRIHB. Members include:

- health information manager
- compliance manager
- compliance auditor
- PMCC instructor
- Health systems development director

In addition to this strong team, IHS/CAO has identified at least one ICD-10 point of contact for over 30 tribal and urban Indian healthcare programs.

Generating ICD-10 Awareness

IHS/CAO has been a leader in providing outreach and training activities. IHS/CAO has provided ICD-10 awareness at the CMS IHS Area Outreach and Education Training, Program Directors' Meeting, Medical Best Practices Conference and the annual Medical Billing and Coding Workshops. The IHS/CAO offered two clinical documentation improvement webinars.

Conducting Impact Assessments

A readiness survey is a high-level assessment of a clinic's readiness and commitment to implement ICD-10. The readiness survey was distributed to all of the tribal and urban Indian healthcare programs in California.

IHS/CAO received approximately 30 responses from 22 healthcare programs. Over half indicated that they have not made any preparations for ICD-10. There was overwhelming interest in training for Medical Terminology/Anatomy and Physiology/ICD-10/ICD-10 for providers.

The survey identified and summarized strengths and shortcomings in terms of implementation readiness. The information was used by the IHS/CAO ICD-10 Implementation Team to ensure healthcare programs are prepared for the changes ICD-10-CM/PCS will bring. The information gathered in the survey assisted in the development and determination of specific training and communication plans necessary for the implementation of ICD-10.

Building a Training Plan

Education is a critical success factor in successful implementation of ICD-10-CM/PCS. A comprehensive ICD-10-CM/PCS education and training program has become necessary to meet the needs of the tribal and urban Indian healthcare programs in its efforts to implement the new code set to:

- Build coding awareness across each healthcare program
- Maximize and take advantage of all educational opportunities
- Engage healthcare program staff and sustain their interest in ICD-10-CM/PCS
- Promote collaboration with other staff and outside organizations to continue to enhance knowledge of ICD-10-CM/PCS

Ensuring RPMS Readiness

The transition from ICD-9-CM to ICD-10-CM/PCS will be significant for the Resource and Patient Management System (RPMS). Logic changes will have to be evaluated and changes to diagnosis and procedure algorithms will have to be revised and tested.

The ICD-10 implementation process also required a transition to version 5010 of the electronic health standards for HIPAA transactions. This transition was necessary because version 4010 of the standards originally named in HIPAA, which was passed in 1996, are outdated and cannot accommodate the new ICD-10.

The changes required to RPMS to support the conversion to ICD-10 are extensive. It is likely that multiple patches will need to be installed. It is critical that RPMS applications are up-to-date with all patches, including security requirements.

Telemedicine

Telemedicine improves both quality and access to care by eliminating transportation challenges, geographic barriers, financial constraints, and time restrictions which frequently interfere with timely and local delivery of healthcare services.

Telemedicine improves both quality and access to care by eliminated 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 clinical 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 medical 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. Real time visits are interactive and take place over video conferencing equipment, that allows a patient-doctor visit in real time.

2012:

Nine clinic programs currently provide telemedicine services in the areas of endocrinology, psychiatry, nutrition, and dermatology. Thirty-one clinics currently provide retinal screening onsite. Images are captured and then stored on a web-based reporting form at www.EyePacs.org. The retinal specialist can download the images for reading and then upload their findings.

Videoconferencing

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

- Virtually meet with administrators, clinical staff, and tribal governments
- Virtually provide training and mentorship to medical providers on various projects
- Virtually increase attendance at IHS-sponsored meetings through the use of video conferencing

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

Tele-video 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 tele-video conferencing equipment and retinal cameras. Seven clinic sites received tele-video conferencing equipment paid for by methamphetamine & suicide prevention funds. Nineteen clinic sites received tele-video conferencing equipment paid for by ARRA funding. This brings the total to 35 video conferencing units in the California Area.

Tele-video 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 tele-video 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.

Portal System

The IHS/CAO provides training and technical assistance to 46 tribal and urban Indian healthcare programs scattered throughout an enormous geographic area. This training and technical assistance is provided by a small staff of IHS healthcare professionals and information technology specialists through site visits, e-mail, and both traditional and virtual meetings. This combination of methodologies does not fully meet the training and technical assistance needs of the 2,000+ healthcare staff employed by tribal and urban healthcare programs. The myriad of healthcare services being provided by these programs (primary and specialty medical care, dental care, behavioral health, pharmacy, and outreach) are complex and multi-disciplinary in nature.

After considerable analysis, the CAO team concluded that the problem would be best addressed by the IHS/CAO Portal System (portal). The portal is an IT system with discrete online communities that are connected to each other and the IHS website through a common management framework. What differentiates the portal from other available technologies, such as Microsoft SharePoint, Yammer, and Facebook, is it requires no licensing or expensive client access licenses, it reaches beyond federal intranets, and it supports the agency's required level of customization. The portal contains a number of discipline specific sub-portals (diabetes, GPRA, RPMS site managers, nursing, immunizations, behavioral health, dental, etc.). Each discipline specific sub-portal offers one-stop access for all healthcare programs' training and technical assistance needs including links to documents and other information, knowledge base articles, training videos, peer-to-peer support chat functions, calendar of events, and frequently asked questions. Membership access to each portal is permission based and managed by the subject matter expert at the CAO.

The Portal is an extremely cost effective, novel, and easily accessible warehouse of information that assists programs to not only pose questions, but provide solutions in a peer-to-peer virtual environment. In these times of budget constraints and reductions, the savings in time and expense will enhance patient care.

Impact

An example of the impact and value of the IHS/CAO Portal System is best evidenced by the CAO Site Managers Portal. The RPMS Site Managers Portal has participation from the site managers at many of the tribal and urban Indian healthcare programs in the California Area. This Portal allows CAO IT staff to share knowledge of the RPMS, the EHR, and the Ensemble database management system with the RPMS site managers. For example, the portal disseminates knowledge about RPMS, which is a derivative of a patient management system used by the VA. The IHS adaptation of this system is unique and challenging to learn. Unfortunately, there are no commercial or public educational centers that offer training for RPMS—no universities and no tech schools. Until now, the only way to receive RPMS training was at IHS training facilities. The CAO IT staff has created a number of training videos that can now be accessed through the portal. This eliminates the need to train in person and frees up CAO IT staff for other duties. The tribal and urban Indian healthcare programs also save time and expense in travelling to Sacramento to be present at these trainings in-person.

Other key components of the RPMS Site Managers Portal are a ticket management system with

helpdesk functionality, a structured forum, and a member's profile area that fosters peer collaboration.

When the portal system is complete(Spring 2013), it is estimated that a minimum of at least a dozen discipline specific Portals will be in operation. Further, this system leverages the expertise of the tribal and urban Indian healthcare program staff by creating a peer support environment.

What makes the IHS/CAO Portal System unique is that it creates new value from existing web technologies by extending the capabilities of an open source content management system (Mura) that requires no licensing, and can be supported by the internal CAO IT staff.

One of the key features of the system is that it utilizes web technologies that are being deployed throughout the IHS. This web technology, Mura Content Management, is also currently in use by the U.S. Senate, U.S. Marine Corps., U.S. Environmental Protection Agency (EPA), U.S. Food & Drug Administration (FDA), U.S. General Services Administration (GSA), Homeland Security, National Aeronautics and Space Administration (NASA), and a Health and Human Services program (through a collaborative effort with the Baylor School of Medicine.). In fact, the HHS Effective Health Care Program web pages are built utilizing the Mura Content Management System.

The CAO Portal System supports the key principles of the HHS Open Government Plan: transparency, collaboration, and participation. By creating a workspace for federal employees, tribal and urban staff members and non-affiliated clinical and technical professionals to "contribute their ideas and share in the co-creation of solutions, we can harness the energy and expertise both inside and outside the government to achieve our goals." More specifically, the CAO Portal System supports the intent of the HHS Open Government Plan Flagship Initiative *Innovation Fellows Program—Promoting Collaboration and Partnerships to Address Important Mission-related Opportunities*.

Information about this innovation is publicly accessible from the California Area of the Indian Health Service website: www.ihs.gov/california.

Office of Environmental Health & Engineering

The services provided by the California Area OEH&E are categorized into four individual organizational components:

Health Facilities Engineering (HFE)
Environmental Health Services (EHS)
Injury Prevention Program (IPP)
Sanitation Facilities Construction (SFC)

Traditionally, each component offers specific health services. In California, the OEH&E is structured so that each component and staff work together to ensure comprehensive, high quality service to Indian people

Division of Environmental Health Services

The Division of Environmental Health Services (DEHS) provides a broad range of technical services consistent with its mission "to reduce environmentally related disease and injury among American Indians through preventive measures." DEHS services provided to tribal communities include surveys, investigations, technical assistance, training, and sampling. Program emphasis includes safe drinking water, food safety, institutional environments, solid waste, epidemiology, and injury prevention.

The DEHS is currently staffed with six Environmental Health Officers (EHOs). LT Lisa Nakagawa serves as the Area Injury Prevention Specialist and EHO for the Sacramento District. LCDR Charles Craig serves as the District EHO for northern California. CDR Martin Smith serves as the Deputy DEHS Director and Area Emergency Management Coordinator. CAPT Brian Lewelling serves as the District EHO for southern California. CAPT Gordon Tsatoke serves as the DEHS Director.

A new staff member has recently joined the DEHS. LTJG Tim Shelhamer will provide environmental health services to California tribes from the Ukiah Field Office. This is the first time that the DEHS has been staffed with six full-time EHOs.

Environmental Health Surveys

The DEHS staff conducted 391 surveys in FY 2012, to identify environmental health risks and hazards in community facilities and make recommendations for their resolution. Environmental health surveys were conducted at the following tribal facilities:

- Food service facilities (318)
- Head Start programs (13)
- Swimming pools (9)
- Healthcare facilities (9)
- Grocery/convenience stores (7)
- Other facilities (35)

Institutional Environmental Health

The DEHS provided institutional environmental health services such as safety and occupational health training, safety program development, accreditation support, radiation protection surveys, risk assessments, industrial hygiene, policy development, and Occupational Safety and Health Administration compliance support.

In FY 2012, the DEHS staff completed the following institutional environmental health services:

- Risk assessments (26)
- Accreditation support surveys (9)
- Radiation protection surveys (7)
- Industrial hygiene assessments (2)

Training

The DEHS staff sponsored or provided 24 training courses in tribal communities throughout California to build tribal capacity in environmental health related areas. Courses were offered in

general food safety (22) and occupational safety and health (1). In addition, one special course was provided to train tribal water system operators to manage tribal utility systems and/or become certified community water system operators. More than 430 tribal participants from tribal communities benefitted from these environmental health courses.

Rabies Vaccination Clinics for Dogs & Cats

The DEHS staff assisted the U.S. Army's Veterinarian Program to provide a rabies vaccination clinic serving multiple tribes in southern California. More than 140 dogs and cats were vaccinated for rabies at no cost to tribal members.

Epidemiology

The DEHS assisted with the investigation of two confirmed cases of Legionnaire's Disease in a tribal facility at the request of tribal leadership. Legionnaire's Disease is characterized by severe pneumonia, headache, and a dry cough. The DEHS staff contacted the facility and met with the facility's managers to discuss the issue and determine a course of action necessary to complete an epidemiological investigation. Subsequently, the facility hired an independent consultant to complete a thorough environmental assessment of the establishment. These efforts resulted in an after action report that specified control measures the facility could implement to reduce the risk of Legionnaires in the establishment. No subsequent cases of Legionnaires were identified or reported following the investigation.

Injury Prevention

The DEHS co-sponsored, with the California Rural Indian Health Board (CRIHB), two "Child Passenger Safety Technician Certification" courses in Sacramento and Crescent City. These courses instructed 20 trainees on the proper use of child safety seats so they can serve as child passenger safety experts in their respective communities and assure the safety, well-being, and healthy development of American Indian children and youth riding in motor vehicles.

The Injury Prevention Program provided $47,000 in min-grant funding for child safety seats, smoke detectors, and bicycle helmets to 22 tribal and urban Indian healthcare programs. These evidence-based projects are intended to reduce the health risks often associated with unintentional injuries.

Lisa Nakagawa graduated from the IHS Injury Prevention Epidemiology Fellowship. The fellowship was a year-long program with six weeks in-person classwork and an injury prevention project. Lisa's fellowship project was an evaluation of the mini-grants program to determine if these resources are useful tools for IHS/CAO tribal healthcare programs. It was found that the tribal healthcare programs are satisfied with the mini-grants, but they identified that additional injury areas need to be addressed. These injury areas will be addressed through pilot mini-projects over the upcoming 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 CRIHB, Indian Health Council, Tule River Indian Health Center, and Greenville Rancheria. These injury prevention projects were funded for continuation in FY 2013 at a value of $1.16 million over five years.

Division of Sanitation Facilities Construction

The Division of Sanitation Facilities Construction (DSFC) serves 104 federally recognized tribes and bands throughout the state of California. The DSFC staff is divided among the Area Office, three districts (Sacramento, Escondido, and Redding) and four field offices (Ukiah, Arcata, Porterville, and Clovis). The 34 employees constituting the DSFC include 14 engineers, 14 engineer technicians, and six administrative staff.

Tule River Reservation—Sewer Collection System Project

The tribal construction crew continues to install large diameter sewer main and manhole facilities with a total budget of $5 million. Project challenges include installation of facilities in 14-foot deep subsurface rock conditions. The tribe installed approximately 12,000 lineal feet of sewer main and 55 manholes. Once completed, the system will initially serve 350 tribal members. The project is being managed by IHS/SFC staff from the Clovis Field Offices.

Santa Rosa Rancheria—Water and Sewer System Improvement Project

The IHS is completing design and tribal solicitation for a $1.3 million project to construct 9,000 lineal feet of new water main and two new sewage lift stations, which will provide more reliable service to 800 tribal members. The project is being managed by IHS/SFC staff from the Clovis Field Office.

Stewarts Point Rancheria

The Stewarts Point Rancheria collects their drinking water from an infiltration gallery located in the streambeds of the Wheatfield Fork of the Gualala River in Northern California. Drinking water from the infiltration gallery is pumped from a 40 gallon per minute wet well station through a 4-inch transmission main, more than 6,000 feet in length and 1,000 feet in height, to the treatment building located on the Rancheria. In 2012, the Indian Health Service renovated the wet well station.

Division of Health Facilities Engineering

The Division of Health Facilities Engineering (DHFE) works with California tribal organizations, as well as federal, state, county, and private agencies, to ensure effective construction, operation, maintenance, and repair of tribally owned and operated healthcare facilities.

The DHFE program combines architectural and engineering support from the CAO, IHS/Headquarters, and IHS/Division of Engineering Services to provide:

- Project Management assistance for design and construction of clinics that include development of scopes of work, assistance with selection of design and construction firms, and review of work submittals and progress. This includes construction of new facilities, expansion to existing facilities, renovation, maintenance, and environmental compliance
- To identify facilities deficiencies, facility condition assessments are conducted. This survey is a tool used to prioritize and budget maintenance funding
- Assist with facility planning to identify health program space needs with a detailed formulation of facility size broken down to the room by room detail. Site selection and cost estimating services are also provided
- Collect data such as facility location, size, type of construction, and deficiencies are used to provide vital information that quantifies eligibility for recurring funding of facility maintenance and medical equipment replacement
- Assist in the development of healthcare facilities' preventive maintenance programs that maximize their effectiveness

In each of the past two years, HFE representatives have visited each of the healthcare programs to provide information about the services that are available from the IHS. The following topics were also discussed:

- Funding for healthcare facilities maintenance and improvement projects
- Funding for medical equipment
- Ongoing and upcoming construction projects
- Preparation for accreditation surveys
- Facility condition assessments

As a result of these meetings, eleven healthcare programs are planning to expand or replace existing healthcare facilities. There are three ongoing facility replacement projects that will be completed in FY 2013.

Accomplishments

The HFE provided $5,619,000 in funding towards health facilities engineering and medical equipment needs. Of the maintenance and improvement funding, $1,421,000 was distributed to tribal healthcare programs for routine maintenance activities and $1,652,000 was distributed for facility improvement projects. Also, $814,000 in annual medical equipment funds and $1,618,000 in general tribal equipment funds for new clinic space were distributed to the healthcare programs.

Significant HFE activities and accomplishments include:

Program Support

- Completion of an Area-wide project that surveyed the conditions of 107 buildings for 29 tribal healthcare programs. The condition survey reports were subsequently presented to tribal healthcare program leadership to plan and prioritize future improvement projects
- space and program planning services to two tribal healthcare programs to support planning efforts for expansion or replacement of existing health facilities
- Completion of five site-specific facility condition inspections. Three of the surveys, in collaboration with the Division of Environmental Health Services, focused on safety and environmental care
- Coordinated a maintenance management system webinar demonstration for tribal healthcare programs

Projects

- Eight tribal healthcare programs received maintenance and improvement pool funds for facility improvement
- Five tribal healthcare programs completed existing facility expansions or opened new facilities
- Seven tribal healthcare programs received general tribal equipment funds for new healthcare facility space
- Three tribal healthcare programs started planning, design, or construction projects over $500,000 and anticipate construction completion in the next fiscal year
- Four tribal healthcare programs will start planning, design, or new construction of facility improvement projects valued over $500,000 in FY 2013

Training

The IHS/CAO hosted a three-day training session, July 31 through August 2, to unveil the newest version of the IHS Health Systems Planning software. The training session presented the planning process used by IHS for developing documents that justify healthcare services and define facility space. Area Planning Officers from across the nation and California tribal healthcare program officials attended the training. Two other IHS Area Offices (Aberdeen and Albuquerque) participated in the presentation by live tele-video conferencing. This provided substantial savings in travel expenses for many attendees. It also made the training available to a larger group.

Feasibility Study on Regional Ambulatory Surgical and Referral Centers in California

In November of 2011, the California Area engaged The Innova Group in a strategic effort to quantify the potential demand for ambulatory surgical and regional referral service.

The Innova Group created multiple site scenarios as depicted in **picture '1'** and identified the resulting resource demands (space, staff, and cost). The ensuing process has been rewarding. This is the beginning of something new for California.

Certain critical assumptions could guide the project from day one:

- California regional centers could offer culturally appropriate secondary level care that is currently not available anywhere in the state from the IHS network
- Regional services would be exclusively for American Indians, especially California tribes
- A regional center would offer services by referral only (no walk-ins)

- A regional center must be near a full-service hospital
- Regional centers would provide medical/surgical specialty, dental specialty, acute/overnight (medical, surgical, pediatrics, ICU), and surgical care
- Regional centers would not provide services for delivering babies, dialysis, or major surgeries
- Regional centers could or could not offer acute/overnight care, depending on the supportability of the service, but at least one would always offer that service
- Regional services will be projected using IHS supported planning assumptions, benchmarks, and efficiencies

Regional services do not include primary care because of its dominating presence at the local service area. This, of course, is different than what is typical for California and IHS. Regional services are not intended to take away any resources from the local service area, but rather supplement what local service areas offer, completing the continuum of care with a culturally appropriate response that also stretches critically limited CHS resources.

In order to appropriately project services without the presence of primary care, a market share projection was developed based on factors considered in **picture '2'** and refined that considers the many variables affecting who might come to regional locations for care, such as third party insurance coverage, alternative care options en route, population segments relative to their reliance on regional care, aggressive use of telemedicine, the impact of healthcare reform (the Affordable Care Act), and a patient's personal choice.

These variables were considered to help answer this simple, but critically important question: "*is there any reason why a California Native would not travel to a Regional Center for free secondary care?*" The answer of course is "*Yes, there are several reasons*!" This market share projection methodology helped define a measurable "more aggressive" and "less aggressive" answer for use in services projection.

Locations Have Also Been Considered

Healthcare is a population based service. In other words, larger populations support more

services; smaller populations support fewer services. So while location is of great importance to remote Indian populations, finding an appropriate "shared" location for Regional Care that serves larger populations supports more of the services is more challenging. Please refer to **picture '3'** (page 65) for analysis of populations currently being served by various California health programs and how they compare to the total IHS eligible population.

This, however, creates a kind of balancing act:

- The more regional care is distributed across the state, the smaller the populations are that are served at each location, resulting in less variety of specialty services
- Conversely, the more regional care is consolidated into fewer locations, the greater the populations are that are served at each, resulting in greater variety of specialty services

Picture '4' indicates the level of care that is justifiable given a user population range. In order to demonstrate this, three different location scenarios were developed and analyzed for their relative success in balancing the delivery of desired regional care with distributing that care across the state to make it accessible to all service areas based on 4, 3, and 2 locations.

Resulting services, staff, space and costs were identified and compared first by the Area Office and then by the CATAC and Health Program Directors at their November 2012 meeting in Sacramento. Beneficial, constructive feedback, and non-constructive feedback was generated from participants during each conversation.

The Planning Effort Continues

The project focuses next on quantifying the impact of Regional Centers reducing the CHS burden for local service areas as well as understanding of existing travel patterns to secondary care relative to the various proposed locations. This additional analysis provides invaluable perspective on the anticipated suitability of regional care for the American Indian population in California.

2013 Presentation of Findings to Tribal Officials

This is a historic opportunity to clearly define a defensible statement of the demand for regional services to IHS and Congress. The comprehensive nature of this analysis will serve California Indians well in advancing the overwhelming need for additional Indian health resources in our state, the form/scope those resources could take in serving healthcare demand, and building on past strategic planning efforts such as the Area Health Services Master Plan to complete the continuum of care for all Native Americans in a culturally appropriate manner.

Office of Management Support (OMS)

The California Area OMS provides support in the following areas:

- Human resources
- Financial management
- Acquisition management
- Property management
- General administrative services

Human Resources

Access to Federal Employee Health Benefits Insurance for Tribal Employees

The federal Office of Personnel Management (OPM) has the Tribal Federal Employee Health Benefits (FEHB) program up and running. Several tribal programs in the California Area participate in FEHB and many more are considering options. The Tribal FEHB program is available to eligible employees of federally-recognized tribes, tribal organizations, and urban Indian organizations (under the Affordable Care Act's incorporation of the Indian Health Care Improvement Reauthorization and Extension Act of 2009). It also covers eligible family members of such employees. For tribal benefits officers, FEHB training is available the 2nd Tuesday of each month at OPM, in Washington, DC. You are welcome to contact the Tribal Desk at TribalPrograms@opm.gov for additional information.

IHS Extern Program for Students

The IHS Extern Program provides health professions students with an opportunity during non-academic periods to gain practical, hands-on experience in a clinical setting for 30 to 120 workdays per calendar year. Health Professions Scholarship Program recipients are entitled to an externship and, therefore, receive priority placement. Students are assigned to Indian health programs in their chosen health or allied health career categories. This opportunity provides students with a hands-on, instructional experience that complements the knowledge and skills developed while studying the health professions. The California Area is considering placing 1-2 externs at select tribal healthcare programs for the 2014 academic year. If you are interested in hosting an extern, please call Mona Celli at (916) 930-3981, extension 311. Keep in mind that hosting an extern requires a committed preceptor, mentoring time and considerable coordination effort for both the California Area and the tribal healthcare program.

Referrals to Tribal Health Programs

The California Area Office fields many calls from job seekers regarding medical position vacancies. Here is the standard responses in these cases:

> *Thank you for your interest in the Indian Health Service in California. All California IHS vacancies are listed in the IHS Job Vacancies Database at http://www.ihs.gov/JobsCareerDevelop/CareerCenter/Vacancy/Index.cfm and at the general U.S. government website www.usajobs.opm.gov. At this time we do not have any vacancies that fit your qualifications/experience.*
>
> *You should also know that the IHS does not directly operate any hospitals or clinics in California. All healthcare services are provided through tribal and/or contract health facilities. As a result, California IHS employs very few health professionals directly. Those that do work for us are in consultative roles in the area office, providing advice or oversight to the facilities that do provide direct care.*
>
> *The tribal/contract healthcare facilities hire independently and they are encouraged to list their jobs at* http://www.ihs.gov/JobsCareerDevelop/CareerCenter/Vacancy/Index.cfm*, but many do not. The best way to find out about how they advertise openings and what opportunities exist is to contact California tribal and urban Indian healthcare programs*

directly. You can find a list of these facilities on our website at http://www.ihs.gov/california/index.cfm/health-programs/california-health-programs/.

Acquisition Management

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. The office assures that correct and timely payments are generated by the finance office.

Tribal 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 and one tribal organization currently have planning cooperative agreements 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; 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 with a Native Hawaiian organization for healthcare services to American Indian/Alaska Natives residing in Hawaii. Contracting issued a number of requirements and Indefinite Delivery/Indefinite Quantity contracts for construction of sanitation facilities and exercised options on three additional contracts. Other construction projects were contracted uunder purchase orders.

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 the IHS Dallas Office for architect and engineering services.

PHS Meritorious Service Medal

CAPT Donald E. Brafford, Retd.

CAPT Donald E. Brafford was highly recommended for the U.S. Public Health Service (PHS), Meritorious Service Medal, based on leadership, superior technical management, dedication, and public health impact since June 1984.

CAPT Brafford held a series of increasingly responsible positions through eight IHS assignments, beginning in 1984 on the Rocky Boy Reservation in Montana. He is a registered professional engineer in New Mexico and California and earned a Masters Degree in Civil Engineering from California State University-Sacramento, in 1997.

Since becoming SFC Director in March 2000, CAPT Brafford directed a program that provides essential sanitation facilities to 103 federally-recognized tribes in California. He effectively manages 36 staff and an annual construction budget of $10 million. CAPT Brafford managed his workforce from eight field offices to effectively accomplish peak and shifting workloads and to keep projects on schedule. He commonly engages in technical field work to mentor junior engineers and to keep his personal engineering skills current.

From April-August 2005 and August-December 2010, the Escondido and Redding District Engineer positions were vacant. CAPT Brafford established himself as Acting District Engineer to ensure continuity of construction and oversight of staff. CAPT Brafford kept all construction projects on schedule while effectively performing his SFC Director duties.

In FY 2009, the IHS/CAO received $9.6 million in annual SFC appropriations. An additional $12.4 million in IHS/EPA American Recovery and Reinvestment Act (ARRA) funds was received to support 20 additional SFC projects/763 homes. All funds were obligated by established deadlines and all reporting requirements were met by the end of FY 2011.

Since March 2000, CAPT Brafford completed 385 construction projects, served 26,486 Indian homes, at a cost of $133,823,000. Those projects entailed 100 miles of water/sewer mains, 30 miles of roadway restoration, 100 miles of water/sewer service lines, 800 water wells, 30 water treatment buildings, 20 water storage tanks, 15 wastewater treatment plants, 10 pump stations, 20 community septic tank/drain field systems and 1800+ individual septic tank/drain field systems, accomplishments not usually attained in an entire career, let alone in an 11-year period.

CAPT Brafford established strong relationships with outside funding agencies over the past 11 years, resulting in contributions of $39.5 million and SFC service to 7,177 Indian homes. He has earned the respect of DHHS Region IX EPA officials by efficiently managing the contributed resources and providing much greater services than what the IHS annual appropriations alone could support.

CAPT Brafford served as the emergency operations supervisor in response to three major disasters. In January 2006, devastating floods and mudslides caused damage to Indian water and waste systems (950 homes impacted) on three Indian reservations in northwest California. In October 2007, 23 wild fires devastated five Indian reservations in southern California. In July

2008, three tribes in northwest California declared public health emergencies as a result of dangerous air quality from nearby wildfires. CAPT Brafford deployed up to 12 OEH&E staff in each disaster, separate from official deployments by the IHS and the commissioned corps Office of Force Readiness and Deployment (OFRD). In July 2010, CAPT Brafford was deployed for two weeks to the Rocky Boy Reservation in Montana to provide engineering assistance to flood impacted areas.

The IHS Headquarters implemented an SFC strategic planning initiative in 2003 and CAPT Brafford immediately implemented the initiative in California. He conducted presentations at each IHS district/field office to ensure staff participation and buy-in. CAPT Brafford's vision was for organizational re-alignment, maximum resource utilization, and reduced project durations. CAPT Brafford developed a management system with three core functions and assigned Area staff to manage each function. One key outcome was the assignment of a senior engineer to manage the "Area Scattered Site Program", allowing district engineers to focus on community-based SFC projects. As a result, project durations have decreased and quality of service has increased.

In 2005, CAPT Brafford established a contract with an Architect/Engineer consulting firm, for feasibility studies and engineering design services for four IHS sanitation facilities projects. CAPT Brafford coordinated $390,000 of Architect/Engineer services to expedite delivery of $4 million in SFC projects. Project duration was reduced from four years to two or three years. This achievement has a benefit-to-cost ratio of over 10, a highly cost-effective undertaking by the IHS.

When the IHS converted from the CORE accounting system to the Unified Financial Management System (UFMS) in FY 2009, CAPT Brafford worked aggressively to learn the system and took a lead role in developing SFC/UFMS guidance. He required SFC staff to learn the system and provided ongoing training to engineers, area office finance, and administrative support. CAPT Brafford is an "in-house" expert on the UFMS.

CAPT Brafford has exemplified leadership and commitment to the mission of the Indian Health Service, which has made his service a cornerstone of the SFC Program and a role model among his staff/peers. His extraordinary knowledge, expertise, creativity, and dedication have contributed to elevating the health status of Indian people to the highest possible level. Foremost, his contributions as SFC Director have had a major positive impact on the lives, health, and well being of thousands of Indian people throughout California.

National IHS Director's Awards

The IHS Director recognizes individuals or groups of employees whose special efforts and contributions, beyond regular duty requirements, have resulted in significant benefits to IHS programs, priorities, or beneficiaries and fulfillment of the IHS mission.

Examples of such efforts/contributions include exceptional initiative or leadership in carrying out activities to improve IHS program operations to benefit the IHS environment; unusual competence, compassion, or heroism; outstanding contribution to a special committee or task force dealing with IHS-wide policies, procedures, or operations; outstanding efforts in applying technical or clerical support skills to accomplish the IHS mission; skill and leadership in administration, knowledge or skill building, knowledge dissemination, or technology transfer; and notable competence and resourcefulness in improving the knowledge building or knowledge application capacity of IHS.

The IHS/CAO employees on the following pages were awarded IHS Director's Awards for FY 2012.

Vinay Narjit Singh Behl

Vinay Narjit Singh Behl is Chief Financial Management Officer for IHS California Area Office. He is responsible for overseeing finance, accounting, and audit of operations in California and Hawaii. Mr. Behl is also involved with evaluating and improving the effectiveness of risk management, control, and governance processes. He has 18 years of extensive multi-national experience and has worked in India, Singapore, and the United States for public accounting firms. Mr. Behl is a Chartered Accountant, Certified Public Accountant, Certified Cost & Works Accountant, Certified Internal Auditor, Certified Fraud Examiner, Certified Management Accountant, Certified Internal Auditor, Certified Information Systems Auditor, Certified Information Technology Professional, Certified Associate in Project Management, Certified in International Financial Reporting Standards, Certified Government finance Manager, Certified Government Auditing Professional and certified in Corporate Finance. Mr. Behl also has a masters in International Financial Management and Masters in Business Administration with concentration in Finance and Strategic Management from University of California, Davis. Mr. Behl has attended Executive Healthcare leadership program at Cornell University and Federal Tax Program at University of California, Los Angeles. Mr. Behl has extensive experience in a senior finance executive role with full financial planning and analysis, revenue recognition, external and management reporting, forecasting, Investment trade offs. He has managed large projects and functional teams across global operations in Europe, US, South East Asia and India. Mr. Behl serves on the advisory board of American Institute of Certified Public Accountants as Government Performance and Accountability Committee member. Mr. Behl also serves on the prestigious nominating committee of Association of Government Accountants in Sacramento. Mr. Behl joined United States Civil Service in 2010.

Mr. Behl's specialties include financial closing and reporting, technical accounting, financial planning and analysis, risk management, internal audit, mergers and acquisitions, due diligence, cost and management accounting, valuation, compensation systems, business process engineering, forensic accounting, and fraud detection.

Vinay Behl is recognized for his contribution to accounting and finance. Mr. Behl has made significant contributions in financial operations :

- Developed budgeting models enabling a shift from a backward- to a forward-looking approach through financial, performance and risk information analysis to better project future program performance
- Enabled the organization to better utilize all modules of the Unified Financial Management System (UFMS) thereby drastically improving the performance of the finance function which is demonstrated by the XO and FMO dashboard metrics reports
- Moved the finance organization from a reactive, compliance focused to a tactically and strategically collaborative position with agency and department leaders
- Improved working relationship with office of Environmental Health and Engineering reducing response time for information requests by 35 percent
- Led the effort to convert the accounting function in-house providing complete technical guidance and restructuring of finance team to handle added responsibilities
- Provided leadership and vision in standardizing automating a variety of accounting functions
- Provided leadership and initiative to launch audit of health programs in California and Hawaii.
- Integrated financial and performance measurement to more tightly link planning, budget formulation and executing activities
- Successfully completed conversion of accounting from Albuquerque to in-house for all cash management operations
- He is currently participating in a work effort under an HQ initiative to implement Hyperion which is a budget execution tool to be integrated with UFMS. Mr. Behl is assisting in system analysis and system design

CAPT Christopher Brady

CAPT Chris Brady was selected as the 2012 Responder of the year for the U.S. Public Health Service. CAPT Brady serves as the Sanitation Facilities Construction Deputy Director for the California Area and is the team leader for the Applied Public Health Team #2 responsible for overall recruitment, planning, coordinating and leading the team of 60 officers with capacity to deliver environmental public health, epidemiology, and preventive medical services.

CAPT Brady provided leadership for the following emergency response exercises:

- June 2011 Public Health Partnership Field Training Exercise, Kentucky: Collaborated with the state and local health authorities in four counties to plan and execute nine public health-focused projects.
- January- June 2011 Peru Medical Readiness Exercise Training Events (PMRETE): Developed concept of operations, public health-focused interventions, and coordinated with planning partners including: U.S. Naval Medical Research Unit 6, U.S. Military Assistance Advisory Group, and the host nation Ministry of Health and Peruvian Navy. CAPT Brady was commended by the Surgeon General on August 8, 2011 for his leadership abilities for the PMRETE exercise.
- CAPT Brady provided leadership and disaster response and recovery assistance to over 3,000 residential homes in flood-impacted areas in Minot, North Dakota in July 2011. He effectively coordinated operations with state and local partners, and provided direction

and oversight of the team during the response. Applied Public Health Team #2 provided technical expertise regarding general clean-up activities, pumping out flooded basements, wastewater contamination and disinfection, mold issues, proper household hazardous material disposal and risks, asbestos, safe use of generators, and personal health precautions.

Maureen A. Harrington

Ms. Maureen Harrington is a civil technician in the Arcata Field Office for the HIS/SFC/CAO, and manages the scattered sites program for 11 Indian Tribes. She has provided exceptional service in implementing the new SFC initiative to inventory and assess Indian homes' water and sanitation deficiency levels. Ms. Harrington demonstrated a highly systematic and effective approach to the initiative by collaborating with the Tribes, and to-date has completed assessments of 200 Indian homes, many in remote areas. On the Yurok Indian Reservation, she partnered with the Tribal Planning Department who were about to undertake a separate project to obtain Reservation-wide data for emergency preparedness. Ms. Harrington and the Tribe coordinated efforts for a unified approach that included community-based public informational meetings, one-stop assessments of the homes, and data sharing. By building a resource-efficient partnership, the initiative has gathered information on needs that will support the development of future projects, tribal priorities, and funding schemes. In addition, Ms. Harrington greatly improved efficiency and reliability by utilizing hand-held Global Positioning System (GPS) units to register the position of the homes and input data. The information will be managed within the SFC database. She also has established best-practice protocols and procedures that are being used throughout the Area, and always finds time to assist other offices with the initiative. Along with successfully collecting data, she has achieved broader positive outcomes by collaborating with many different tribal departments making this Indian Health Services initiative important and relevant to all.

National IHS Customer Service Award

Michelle Blackowl

Ms. Michelle Blackowl serves as an Administrative Assistant in the Escondido District Office, Office of Environmental Health and Engineering. Michelle performs her duties in an exemplary manner and takes on additional duties that contribute significantly to the well-being of California Indians/co-workers.

Michelle volunteered to assist the Area's employee wellness program and prepared a monthly wellness newsletter. She prepared numerous marketing materials for the IHS/CAO "Just Move It" campaign and other Health Promotion/Disease Prevention (HD/DP) activities that increased participation and awareness of tribal-based wellness activities. These marketing materials included CD's, wellness manuals, digital stories and pictures. Michelle completed complicated travel orders in a timely manner for IHS staff temporarily attached to IHS/CAO for HD/DP-related activities.

Michelle played a leading role in organizing the Area's southern YRTC dedication ceremony since the property was purchased on October 31, 2011. For the last two months of 2011, and into CY 2012, Michelle secured local vendors to prepare the southern YRTC site for the

dedication ceremony, designed posters, created maps to the site, and served as the primary on-site contact for many vendors. Her familiarity with the area, vendors, and tribal leaders was a true asset.

Michelle exemplifies excellent customer service with a pleasant disposition, positive attitude, and genuine concern for her customers' needs. She is consistently reliable and provides extraordinary support to ensure customer participation with valued results. Michelle willingly contributed many hours of additional work toward this effort while still performing her California Area duties in her usual outstanding and efficient manner.

Financial Report
FY 2011-2012

From the Desk of the Chief Financial Officer

Dear Tribal Leaders and Partners

It gives me great pleasure in presenting to you our financial report for FY 2012.

Federal Fiscal Outlook

Government accountability office projects that public debt will continue to grow as a share of gross domestic product (GDP) over the long term. The fundamental imbalance between estimated revenue and spending cannot alone be controlled by limiting discretionary spending which is driven by the aging population and rising health care costs. The patient protection Act and Affordable care Act (PPACA) slows the growth of health care spending and federal debt assuming cost containment mechanisms are effective and fully implemented. According to GAO's simulations current fiscal policy is unsustainable over the long term. Federal budgetary flexibility will become increasingly constrained if reform is not brought to retirement and health programs—including Social Security, Medicare, and Medicaid. According to GAO, assuming no changes to projected benefits or to revenues, spending on these programs will drive unsustainable federal deficits and debt as the baby boom generation retires.

A sustainable budget will require looking at the entire spectrum of federal activities both discretionary and entitlement programs. GAO has identified opportunities for the federal government to reduce potential duplication in government programs, save tax dollars, and enhance revenue. As we move forward, the federal government will need to make tough choices in setting priorities and linking resources to results. This guidance has been taken from GAO's federal fiscal outlook.

Agency Specific Budget

Moving from federal budget to agency specific budget, the Indian Health Service (IHS), agency of the U.S. Department of Health and Human Services, is the principal federal agency charged with the mission of raising the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/ANs) to the highest possible level.

The IHS provides comprehensive primary health care and disease prevention services to approximately 2.1 million AI/ANs through a network of over 650 hospitals, clinics, and health stations on or near Indian reservations/rancherias. Health facilities are predominantly outpatient, located in a rural primary care setting, and managed by IHS, tribal, and urban Indian health programs. The IHS provides a wide range of clinical, public health and community services primarily to members of 565 federally recognized tribes. The IHS has approximately 15,700 employees, including 2,700 nurses, 900 physicians, 400 engineers, 600 pharmacists, 300 dentists, and 300 sanitarians.

The provision of federal health services to AI/ANs is based on a special relationship between Indian tribes and the United States. The Indian Commerce Clause of the United States Constitution, as well as numerous treaties and court decisions, have affirmed this special relationship and the plenary power of Congress to create statutes that benefit Indian people. Principal among these statutes is the Snyder Act of 1921, which provides the basic authority for

health services provided by the federal government to AI/AN populations.

In the 1970s, federal Indian policy was re-evaluated leading to adoption of a policy of Indian self-determination. This policy promotes tribal administration of federal Indian programs, including health care. Self-determination does not lessen any federal obligation, but instead provides an opportunity for tribes to assume the responsibility of providing health care for their members.

The Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), as amended, and the Indian Health Care Improvement Act of 1976 (IHCIA), as amended, provided new opportunities for the IHS and tribes to deliver care. The recently enacted Patient Protection and Affordable Care Act builds upon these laws by including provisions to modernize and update the IHS and expands the current health insurance system to further improve the quality of health care and make it more accessible and affordable for AI/AN populations.

The IHCIA includes specific authorizations for providing health care services to urban Indian populations for administering an Indian health professions program, and the authority to collect from Medicare/Medicaid and other third party insurers for services rendered at IHS or tribal facilities. Under the ISDEAA, many tribes have assumed the administrative and program direction roles that were previously carried out by the federal government. Tribes currently administer over one-half of IHS resources through ISDEAA contracts and compacts. The IHS administers the remaining resources and manages facilities where tribes have chosen not to contract or compact health programs.

Funding FY 2010-FY 2012

ALL FUNDS	FY 2010	FY 2011	FY 2012
H&C	72,585,142	74,519,967	75,563,496
Dental	1,844,803	1,852,320	2,070,363
Mental Health	1,733,666	1,796,239	2,156,310
Alcohol	11,442,765	11,443,407	11,447,382
Public Health Nursing	722,188	745,188	991,550
Health Education	325,499	316,067	321,554
CHR	2,110,122	2,120,293	2,128,396
Urban	7,263,224	7,091,289	7,230,471
Direct Operations	2,353,104	2,340,319	2,640,058
Contract Support Cost	37,277,108	38,208,925	46,026,209
Contract Health Care	40,913,273	40,951,901	45,105,547
Special Diabetes-Direct	259,000	259,000	259,000
Special Diabetes-Reim	-	200,000	200,000
Self-Governance	-	100,000	-
Catastrophic	101,243	736,362	291,580
Domestic Violence Prevention	-	-	223,000
Alcohol & Substance Abuse - Meth Prev	889,000	-	889,000
Reim	89,049	30,410	542
Environmental Hlth	3,778,338	3,799,570	3,761,500

Facilities Hlth	697,638	949,731	1,244,721
OEHE Support	14,458	13,362	15,911
OEHE Reim	10,201	662	-
Equipment	799,883	804,146	814,197
Maintenance & Improvement	2,699,993	2,841,474	3,073,230
Housing	2,008,000	2,039,000	1,534,000
Regular	2,558,455	2,438,000	2,380,000
Contributions	461,050	2,111,045	151,000
New and Replacement	-	-	1,996,800
EPA CWA IAG	-	-	2,371,557
ARRA	17,061,293	-	-
Totals	**214,887,374**	**197,708,677**	**209,998,495**

Agency Priorities

In 2009, IHS Director established four agency priorities to lead, manage, improve and support the delivery of health care services to AI/AN populations:

1. Renew and strengthen our partnership with tribes
2. Bring reform to the IHS
3. Improve the quality of and access to care
4. Make all our work accountable, transparent, fair and inclusive

These priorities guide the work of agency staff and their partnerships with external stakeholders, including tribes. The priorities emphasize the goal to change and improve the IHS, and significant improvements have been accomplished to date under each of the priorities. The priorities have served as a common language to communicate about agency activities, improvements and accomplishments among agency staff, patients and tribes. The IHS budget request includes narratives that highlight how its programs and services advance progress on agency priorities and ensure a consistent focus on change and improvement in all IHS activities.

Overview of Indian Health Service Budget Request FY 2013

Tribal consultation is fundamental to the IHS budget process and, at its core, is the priorities and recommendations developed by tribes through an annual budget formulation process. The IHS budget request incorporates tribal priorities and recommendations. The FY 2013 President's Budget request for IHS is $4.422 billion: an increase of $115.9 million over the FY 2012 enacted level. The request includes funds to support activities including increasing resources for the Contract Health Services program; funding contract support costs shortfall; addressing essential health information technology activities; and, providing routine facility maintenance. Overall, the budget request addresses the need to sustain the Indian health system, expand access to care, and continue to improve oversight and accountability in key administrative areas.

Specifically, this request includes the following:

- **CURRENT SERVICES (+$85.6 million)**

  Federal Commissioned Officer Pay Costs (+$2.4 million) - The budget request projects a 1.7 percent pay raise for Commissioned Officers.

Inflation for Contract Health Services (+$34.0 million) - Inflationary costs help maintain the current level of services and offset the rising cost in providing health care. The $34 million is the calculated need to address a 3.6 percent medical inflation rate for the Contract Health Services program.

Staffing and Operating Costs for New Facilities (+$49.2 million) - This request will fund the staffing and operating costs for six newly constructed health centers scheduled to open in FY 2013, including three joint venture (financial co-share) projects. In addition, the request will complete the funding requirements to staff and operate two joint venture projects scheduled to open in FY 2013.

- **PROGRAM INCREASES / DECREASES (+$30.3 million)**

Contract Health Services (+$20 million) - The increase provides for additional health care services for the AI/AN population by purchasing approximately 848 inpatient admissions, 31,705 outpatient visits and 1,116 one-way transportation services. Contract Health Services (CHS) funds are necessary to purchase health care services from the private sector where direct IHS and tribal health care is non-existent or unavailable and supplemental funds are needed to provide comprehensive patient care.

Health Information Technology (HIT): **ICD-10 and Electronic Dental Record (+$6 million)** The largest portion of the IHS's major IT investments is its HIT systems, which are a critical and necessary component for the delivery of patient care services at the numerous IHS and tribal hospitals and ambulatory clinics and Urban Indian Health Programs serving 2.1 million AI/ANs. The HIT systems capture patient and performance data for statistical reporting and decision-making, and comprise the billing and collection system for third party reimbursements. The $6 million HIT increase will support mandatory ICD-10 (International Classification of Diseases) implementation and provide $1 million in support for the Electronic Dental Record (EDR) program. These increases for HIT and EDR will allow IHS, tribally managed, and urban Indian health programs, to improve billing for third party revenues, address the accuracy of patient medical records and health information systems, improve patient safety overall and improve the quality of, and access to, care across the Indian health care system.

Direct Operations (+$1.1 million) - The increase was used to: (a) maintain improvements and reforms made to date and to continue enhancements of the IHS' capacity for providing comprehensive oversight and accountability in key administrative areas such as human resources, property, financial management, performance management, and CHS program improvements developed through CHS consultation recommendations on improving business practices related to CHS and third party reimbursements (b) address recent Congressional oversight and reports issued by the General Accountability Office and the Office of Inspector General which recommended improvements in management of IHS programs, such as the CHS program (c) address unfunded mandates for national initiatives associated with privacy requirements, facilities, and personnel security; and, (d) improve responsiveness to external authorities such as Office of Management and Budget (OMB) and Congress including, but not limited to, reforms related to oversight recommendations and the implementation and continuing accountability for new permanent authorities of the reauthorization of the Indian

Health Care Improvement Act (IHCIA).

Contract Support Costs (+$5 million) - The increase will be applied to the Contract Support Costs shortfall associated with ongoing contracts and compacts with tribes and tribal organizations under the Indian Self-Determination and Educational Assistance Act.

Maintenance and Improvement (+$1.7 million) - The increase was used to provide routine maintenance funding for tribal healthcare facilities.

Health Care Facilities Construction (-$3.6 million) - The FY 2013 request represents a decrease of $3.6 million from the FY 2012 appropriated base level for healthcare facilities construction. The funding was used to continue construction on health facility construction projects already underway.

FY 2015 Budget Formulation

California Area tribes have debated various program increases (or program enhancements) that they feel are essential to address the health disparities and high priority health needs that their health programs face. The funding increases for the line items listed here are far short of what was actually needed. It was decided, however, to highlight these program increases given the significant health disparities in the AI/AN population.

The President's FY 2013 budget request provides $4.42 billion for the IHS, and is a $115 million increase: 2.69%, in funding above the FY 2012 enacted level. The FY 2015 budget request is a 17% increase over the FY 2013 president's budget.

California tribes further recommend $587 million in additional "program" increases to address growing health needs and diminished services due to the lack of sufficient funding increases and the California Area tribes estimate that it will take at least $163 million (3.7% increase) to maintain current services (inflation and population growth) for IHS health programs in FY 2015. Current services estimates identify mandatory cost increases necessary to maintain the current level of services. These "mandatories" are unavoidable and include medical and general inflation, pay costs, staff for recently constructed facilities, and population growth. This is the amount necessary to fund inflation, population growth, and fully fund contract support costs. Anything less will continue the trend of denied health care services.

During the deliberations in the tribal leaders' consultation, the requests for Youth Regional Treatment Center (YRTC) funds were clearly prominent. **The YRTC increase, in terms of priority, was rated number 1.** Not included in the $ 19.9 million (.45% increase) allocated for YRTCs is a short fall of $ 16 million (.36% increase) to fund new staffing at the California YRTCs which California tribes have very strongly recommended. The proposed centers will provide residential chemical dependency treatment for AI/AN youth, ages 12-17. There are 12 similar IHS-funded centers around the country.

The treatment programs are usually 3-4 months in duration and incorporate mental health services, medical care, education, aftercare planning, and family therapy. Each facility will offer services for as many as 32 youth at a time. The U.S. Congress authorized the California YRTCs

in the Indian Health Care Improvement Act. In 1992, Congress amended the land authorizing IHS to construct and operate two YRTCs in California, one to serve northern California, and one to serve the remainder of the state. Currently, most of California's Indian youth who receive residential chemical dependency treatment are sent to out-of-state facilities. The new YRTCs in California will be an important step to helping thousands of Indian youth in California who need residential care. **In terms of budget increases, it ranked number 4.**

The California tribes have requested increases in Contract Health Service budgets of $ 216 million (4.89% increase). This will help address the significant backlog of deferred services, and the growing number of denied services. **In terms of budget increases, this activity ranked number 1.**

The tribes' request for hospitals and clinics includes $19.9 million (.45% increase) for the Indian Health Care Improvement Fund. This distribution of funds is used to reduce funding disparities between Indian health programs. **The increases ranked number 5.**
Further, in hospitals and clinics funding, tribes have requested $ 39.9 million (.90% increase) for obesity/diabetes. **The increases ranked number 2.**

The tribes have requested a $ 36.6 million (.82%) increase for alcohol funds. California recorded 53% in alcohol screening against a national target of 58.7%. For California depression screening was 53.5% against a national target of 56.5%. **The increases ranked number 3**.

The high rates of alcohol and substance abuse, mental health disorders, suicide, violence, and behavior-related chronic diseases in AI/AN communities is well documented. Each of these serious behavioral health issues has a profound impact on the health of individuals, families, and communities. For example, AI/ANs are significantly more likely to report past-year alcohol and substance use disorders than any other race, and suicide rates for AI/AN people are 1.7 times higher than the U.S. all-races rate. Domestic violence rates are also alarming, with 39% of AI/AN women experiencing intimate partner violence—the highest rate in the U.S. These statistics are shocking and communicate the critical importance of mental health needs to be addressed in Indian Country.

Top five tribal priorities in the past eight years:

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
1	Diabetes	Diabetes	Diabetes	Diabetes	Diabetes	Contract Health Services - Pharmaceuticals	Contract Health Services	Contract Health Services
2	Cancer	Cancer	Cancer	Cancer	Cancer	Indian Health Care Improvement Fund - Pharmaceuticals	Indian Health Care Improvement Fund	Diabetes/ Obesity
3	Heart Disease	Heart Disease	Heart Disease	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health

4	Alcohol/ Substance Abuse	Alcohol/ Substance Abuse	Alcohol/ Substance Abuse	Heart Disease/ Stroke	Health Promotion/ Disease Prevention	Cancer	Health Facilities Construction	Youth Regional Treatment Centers
5	Mental Health/ Behavioral Health	Mental Health/ Behavioral Health	Mental Health/ Behavioral Health	Health Promotion/ Disease Prevention	Heart Disease/ Stroke	Health	Youth Regional Treatment Centers	Indian Health Care Improvement Fund (IHCIF)

Hyperion Planning Tool

California was selected, in FY 2012, as the lead stakeholder for implementation of Hyperion, a budget planning tool. Oracle Hyperion Planning is a centralized, Excel and web-based planning, budgeting and forecasting solution that integrates financial and operational planning processes and improves business predictability. Oracle Hyperion Planning provides an in-depth look at business operations and its related impact on financials, by tightly integrating financial and operational planning models. Using Oracle Hyperion Planning makes it possible to meet immediate financial planning needs while maintaining a platform for future cross-functional expansion and automated process integration.

Oracle's Hyperion Planning – System 9 allows for decision makers and front-line managers to communicate the course of action and collaborate with budget holders to optimize the planning process. Planners have the flexibility to adapt rapidly, ensuring plans are relevant and useful. The benefits of the software include:

- Facilitating collaboration, communication, and control across multi-divisional global enterprises
- Providing a framework for perpetual planning, with attention to managing volatility and frequent planning cycles
- Providing ease of use and deployment through the Web or Oracle's Hyperion® Smart View for Office
- Lowering the total cost of ownership through a shorter roll out and implementation phase, and easier maintenance for applications
- Enhancing decision-making with reporting, analysis, and planning
- Promoting modeling with complex business rules and allocations
- Integrating with other systems to load data

Asset Management

The property management officer (PMO) had set a target date of June 30, 2012 and completed the IHS/CAO annual inventory using the Property Management Information System. Physical inventory at the CAO started on May 30, 2012 on an on-going basis until completed for all staff including six Office of Environmental Health and Engineering (OEHE) field offices.

On April 5, 2012, the IHS/CAO conducted its annual e-waste recycling event in which electronic equipment, such as servers, desktops, and laptops that had exceeded their life expectancy and were considered obsolete, were removed from the office. All equipment met the requirements of the "Certification of Removal of Device, Media and/or Data" IHS Form F06-11d. IHS/CAO has

a memorandum of agreement with General Services Administration (GSA) within the Moss Federal Building in Sacramento to provide removal and disposal services at no cost to the IHS/CAO.

To improve and effectively control all aspects of personal property management, IHS/CAO decentralized the responsibilities to the asset center representative (ACR) of each custodial location for the six Office of Environmental Health & Engineering field and district offices. Each ACR is designated responsible for the proper use, maintenance, and protection of property entrusted to their possession, or charged to the custodial location. The ACR's will continue to be trained in FY 2013 as a part of furthering the IHS priority to reform the IHS. To ensure a smooth transition of property management responsibilities from the area office to the six IHS field locations, the IHS/CAO is developing a policy and procedure to assist the newly designated ACRs, who began performing key property management functions in FY 2012.

The IHS/CAO established an internal sharepoint website platform as a central location for the property management officer and information technology staff to retrieve data concerning the life expectancy of personal equipment. All equipment is tagged when it is received in IHS and issued to the user the same day. The new property tool tracks this activity.

Under the initiative to reform functions in IHS, the Office of Management Support for California has implemented finance function improvement methodology. Our foremost objective was to optimize processes and focus on control environment/change management. We continue to update standard operating procedures and standardize processes to ensure internal check and improve efficiency. This will also ensure staff is trained and up-to-date on these processes. A key finance function objective is to protect assets, ensure critical controls, policies and procedures are always in place, but at the same time not creating bottlenecks in the organization.

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. Executive dashboards and performance metrics continue to be used on a daily basis to identify bottlenecks in the system and increase efficiency.

In FY 2012, we continue to lay strong emphasis on robust compliance as efficiently and cost effectively as possible. OMB Circular No. A-123 defines management's responsibility for internal control 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 controls.

Finance teams to serve the upcoming YRTC's is being restructured and trained across different skill sets. Hyperion planning tool will go a long way in managing budgets of these service units.

In accordance with our commitment to increase service levels to tribal programs and improve

control over finance, we successfully completed our first year since going live with cash management functions in-house. In short, this change means 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 is quicker turnaround time for IHS payments, greater local control over the quality and accuracy of these transactions, and improved external customer service.

Among several projects, one challenging project that came to fruition was the development of an effective financial reporting mechanism for all the projects in the Department of Environmental Health Services, Department of Sanitation Facilities Construction, and Department of Health Facilities Engineering. This systems allows OEHE engineers to make informed, real-time, financial decisions and track project status. This also helps granting agencies, like the Environmental Protect Agency, to monitor fund usage.

These are exciting times for all of us in federal healthcare as we innovate and continuously improve our processes. We are poised to serve effectively and efficiently.

Best regards,

/Vinay Behl/

Vinay Narjit Sing Behl
March 01, 2013

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Final Financial Report – Summary

ACTIVITY	ALLOWANCE	OBLIGATION	BALANCE
CLINICAL SERVICES			
Hospital & Clinics	$75,563,496	$75,563,496	-
Dental	2,070,363	2,070,363	-
Mental Health	2,156,310	2,156,310	-
Alcohol	11,447,382	11,447,382	-
Reimbursements	542	542	-
Total Clinical Services:	91,238,093	91,238,093	-
PREVENTIVE HEALTH			
Public Health Nursing	991,550	991,550	-
Health Education	321,554	321,554	-
Community Health Representative	2,128,396	2,128,396	-
Total Preventive Health:	3,441,500	3,441,500	-
URBAN HEALTH PROJECTS	7,230,471	7,230,471	-
DIRECT OPERATIONS	2,640,058	2,640,058	-
CONTRACT SUPPORT COSTS	46,026,209	46,026,209	-
CONTRACT HEALTH CARE	45,105,547	45,105,547	-
DOMESTIC VIOLENCE PREVENTION INITIATIVE	223,000	223,000	-
ALCOHOL & SUBSTANCE ABUSE/METH PREVENTION	889,000	474,333	414,667
SPECIAL DIABETES PROGRAM FOR INDIANS—DIRECT	259,000	-	259,000
SPECIAL DIABETES PROGRAM FOR INDIANS—REIMBURSEMENT	200,000	-	200,000
CATASTROPHIC FUND	$291,580	$291,580	-
FACILITIES & ENVIRONMENTAL HEALTH SUPPORT			
Environmental Health Support	3,761,500	2,733,094	1,028,406
Facilities Health Support	1,244,721	1,176,119	68,602
OEHE Support	15,911	14,742	1,169
Total Facilities & Environmental Health Support:	5,022,132	3,923,955	1,098,177
INDIAN HEALTH FACILITIES			
New & Replacement	1,996,800	1,209,396	787,404
Equipment	814,197	801,890	12,307
EPA CWA IAG	2,371,557	2,371,557	-
Maintenance and Improvement	3,073,230	1,983,613	1,089,617
Total Indian Health Facilities:	3,887,427	2,785,503	1,101,924
INTER-AGENCY FUNDS			
Contributions	2,371,557	2,371,557	-
Total Contributions Facilities	151,000	151,000	-
SANITATION FACILITIES			
Housing	1,534,000	1,534,000	-
Regular	2,380,000	2,380,000	-
Total Sanitation Facilities	3,914,000	3,914,000	-
AREA GRAND TOTAL	$209,407,017	$206,747,916	$2,659,101

Clinical Services
Hospital & Clinics

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$10,250
Cabazon Band of Mission Indians	69,728
California Rural Indian Health Board, Inc.	8,609,992
Central Valley Indian Health, Inc.	4,642,472
Chapa-De Indian Health Program, Inc.	3,587,880
Cold Springs Tribal Council	172,023
Colusa Indian Health Community Council	219,951
Coyote Valley Tribal Council	205,650
Greenville Rancheria	1,142,738
Guidiville Indian Rancheria	133,193
Hopland Band of Pomo Indians	162,408
Indian Health Center of Santa Clara Valley, Inc.	14,500
Lake County Tribal Health Consortium	3,977,906
Native American Health Center, Inc.	11,026
Paskenta Band of Nomlaki Indians	14,082
Pinoleville Band of Pomo Indians	42,962
Pit River Health Services, Inc.	1,072,282
Quartz Valley Indian Reservation	158,395
Round Valley Indian Health Center, Inc.	910,174
Sacramento Native American Health Center, Inc. -Hlth	12,300
San Diego American Indian Health Center, Inc.	8,750
Santa Ynez Band of Mission Indians	994,217
Scotts Valley Band of Pomo Indians	186,595
Sherwood Valley Band of Pomo Indians	161,975
Shingle Springs Rancheria	905,217
Southern Indian Health Council, Inc.	2,981,920
Strong Family Health Center	268,899
Sycuan Band of Mission Indians	200,498
Table Mountain Rancheria	102,580
Toiyabe Indian Health Project, Inc.	2,283,528
Tule River Indian Health Center, Inc.	2,213,205
Tuolumne Me-Wuk Indian Health Center, Inc.	438,930
United American Indian Involvement, Inc. -Public Health	72,800
Consolidated Tribal Health Project	1,790,729
Feather River Tribal Health, Inc.	2,931,020
Hoopa Valley Tribe	1,965,863
Indian Health Council	4,157,894
Karuk Tribe of California	1,260,940
Northern Valley Indian Health	1,966,886
Redding Rancheria	3,347,864
Riverside-San Bernardino Indian Health	10,301,435
Susanville Indian Rancheria	827,909
Total Tribal Operations:	64,539,566

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$1,043
Central Valley Indian Health, Inc.	248,400

California Rural Indian Health Board, Inc.	933,900
Chapa-De Indian Health Program, Inc.-PFSA	160,700
Greenville Rancheria	22,500
Paskenta Band of Nomlaki Indians	500
Pit River Health Services, Inc.	41,000
Santa Ynez Band of Mission Indians	23,300
Shingle Springs Rancheria	41,100
Southern Indian Health Council, Inc.	186,700
Strong Family Health Center	13,600
Toiyabe Indian Health Project, Inc.	165,300
Consolidated Tribal Health Project	133,400
Feather River Tribal Health, Inc.	153,100
Hoopa Valley Tribe	174,200
Indian Health Council	270,800
Karuk Tribe of California	90,100
Northern Valley Indian Health	54,100
Redding Rancheria	265,500
Riverside-San Bernardino Indian Health	580,500
Susanville Indian Rancheria	47,800
Total Tribal Operations- Area Shares:	3,607,543

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	**FUNDED AMOUNT**
Cabazon Band of Mission Indians	$1,434
California Rural Indian Health Board, Inc.	176,490
Central Valley Indian Health, Inc.	60,913
Chapa-De Indian Health Program, Inc.-PFSA	8,619
Greenville Rancheria	47,299
Pit River Health Services, Inc.	29,507
Santa Ynez Band of Mission Indians	13,541
Shingle Springs Rancheria	9,891
Southern Indian Health Council, Inc.	76,793
Strong Family Health Center	9,340
Toiyabe Indian Health Project, Inc.	46,211
Consolidated Tribal Health Project	37,976
Feather River Tribal Health, Inc.	74,466
Hoopa Valley Tribe	44,956
Indian Health Council	226,882
Karuk Tribe of California	28,935
Northern Valley Indian Health	22,481
Redding Rancheria	147,346
Riverside-San Bernardino Indian Health	379,876
Susanville Indian Rancheria	15,114
Total Tribal Operations Headquarters Shares:	1,458,070

MOA OPERATION EXPENDITURES	**FUNDED AMOUNT**
Personnel Services	$1,316,144
Transportation	1,518
Contractual Services	931
Total MOA Operation Expenditures:	1,318,592

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	**FUNDED AMOUNT**
Personnel Services	$2,194,721

Travel	181,453
Transportation	14,329
Rent, Comm., Util.	989,562
Printing	25,804
Contractual Services	852,144
Training	47,908
Supplies	101,848
Equipment	231,957
Total Area & Tribal Operation Expenditures:	4,639,725

TOTAL OBLIGATIONS—HOSPITAL & CLINICS	**$75,563,496**

Clinical Services
Dental

TRIBAL OPERATIONS CONTRACTOR	**FUNDED AMOUNT**
California Rural Indian Health Board, Inc.	$41,000
American Indian Health & Services Corporation	1,000
Central Valley Indian Health, Inc.	1,000
Chapa-De Indian Health Program, Inc.-PFSA	60,035
Colusa Indian Health Community Council	1,000
Greenville Rancheria	31,809
Lake County Tribal Health Consortium	268,131
Native American Health Center, Inc.	8,200
Paskenta Band of Nomlaki Indians	7,628
Pit River Health Services, Inc.	1,000
Quartz Valley Indian Reservation	1,000
Round Valley Indian Health Center, Inc.	5,000
Sacramento Native American Health Center, Inc. -Hlth	3,500
San Diego American Indian Health Center, Inc.	2,000
Santa Ynez Band of Mission Indians	1,000
Shingle Springs Rancheria	3,000
Southern Indian Health Council, Inc.	133,151
Table Mountain Rancheria	1,000
Toiyabe Indian Health Project, Inc.	1,000
Tule River Indian Health Center, Inc.	3,000
Tuolumne Me-Wuk Indian Health Center, Inc.	1,000
Consolidated Tribal Health Project	1,000
Feather River Tribal Health, Inc.	127,182
Hoopa Valley Tribe	26,250
Indian Health Council	1,000
Karuk Tribe of California	6,000
Northern Valley Indian Health	66,158
Redding Rancheria	1,000
Riverside-San Bernardino Indian Health	810,290
United American Indian Involvement, Inc. -Public Health	3,000
Sycuan Medical Dental Center	6,000
Susanville Indian Rancheria	1,000
Total Tribal Operations:	1,624,334

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	**FUNDED AMOUNT**

Cabazon Band of Mission Indians	$40
California Rural Indian Health Board, Inc.	36,700
Central Valley Indian Health, Inc.	3,500
Chapa-De Indian Health Program, Inc.-PFSA	6,800
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.	8,000
Strong Family Health Center	600
Consolidated Tribal Health Project	5,900
Feather River Tribal Health, Inc.	6,700
Hoopa Valley Tribe	7,800
Indian Health Council	10,400
Karuk Tribe of California	1,400
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:	137,040

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	**FUNDED AMOUNT**
Cabazon Band of Mission Indians	$34
California Rural Indian Health Board, Inc.	6,069
Central Valley Indian Health, Inc.	2,257
Chapa-De Indian Health Program, Inc.-PFSA	277
Greenville Rancheria	1,022
Pit River Health Services, Inc.	548
Santa Ynez Band of Mission Indians	954
Shingle Springs Rancheria	300
Southern Indian Health Council, Inc.	4,580
Strong Family Health Center	284
Toiyabe Indian Health Project, Inc.	1,601
Consolidated Tribal Health Project	1,892
Feather River Tribal Health, Inc.	4,440
Hoopa Valley Tribe	3,057
Indian Health Council	6,750
Karuk Tribe of California	1,864
Northern Valley Indian Health	554
Redding Rancheria	3,756
Riverside-San Bernardino Indian Health	4,664
Susanville Indian Rancheria	902
Total Tribal Operations Headquarters Shares:	45,805

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	**FUNDED AMOUNT**
Personnel Services	$156,902
Travel	10,765
Contractual Services	95,352
Supplies	165
Total Area & Tribal Operation Expenditures:	263,185

TOTAL OBLIGATIONS—DENTAL	$2,070,363

Clinical Services
Mental Health

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$193,422
Central Valley Indian Health, Inc.	120,345
Chapa-De Indian Health Program, Inc.	77,467
Greenville Rancheria	10,692
Lake County Tribal Health Consortium	535,769
Paskenta Band of Nomlaki Indians	219
Pit River Health Services, Inc.	51,466
Round Valley Indian Health Center, Inc.	52,924
Santa Ynez Band of Mission Indians	15,993
Shingle Springs Rancheria	20,560
Southern Indian Health Council, Inc.	71,787
Strong Family Health Center	7,993
Table Mountain Rancheria	1,546
Toiyabe Indian Health Project, Inc.	62,344
Tule River Indian Health Center, Inc.	75,342
Tuolumne Me-Wuk Indian Health Center, Inc.	13,801
Consolidated Tribal Health Project	63,834
Feather River Tribal Health, Inc.	42,680
Hoopa Valley Tribe	59,190
Indian Health Council	90,015
Karuk Tribe of California	58,249
Northern Valley Indian Health	25,951
Redding Rancheria	75,919
Riverside-San Bernardino Indian Health	194,457
Susanville Indian Rancheria	52,190
Total Tribal Operations:	1,974,155

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$5
California Rural Indian Health Board, Inc.	4,300
Central Valley Indian Health, Inc.	1,300
Chapa-De Indian Health Program, Inc.-PFSA	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
Feather River Tribal Health, Inc.	800
Hoopa Valley Tribe	900
Indian Health Council	1,200
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:	17,505

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$61
California Rural Indian Health Board, Inc.	22,511
Central Valley Indian Health, Inc.	8,374
Chapa-De Indian Health Program, Inc.-PFSA	1,164
Greenville Rancheria	2,278
Pit River Health Services, Inc.	2,031
Santa Ynez Band of Mission Indians	1,656
Shingle Springs Rancheria	1,114
Southern Indian Health Council, Inc.	7,962
Strong Family Health Center	1,050
Toiyabe Indian Health Project, Inc.	5,933
Consolidated Tribal Health Project	4,217
Feather River Tribal Health, Inc.	7,721
Hoopa Valley Tribe	5,314
Indian Health Council	11,734
Karuk Tribe of California	1,050
Northern Valley Indian Health	2,051
Redding Rancheria	6,531
Riverside-San Bernardino Indian Health	18,629
Susanville Indian Rancheria	1,566
Total Tribal Operations Headquarters Shares:	112,947

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$30,632
Travel	2,706
Contractual Services	18,365
Total Area & Tribal Operation Expenditures:	51,703

TOTAL OBLIGATIONS—MENTAL HEALTH	$2,156,310

Clinical Services
Alcohol

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$7,000
California Rural Indian Health Board, Inc.	1,052,333
Central Valley Indian Health, Inc.	304,624
Chapa-De Indian Health Program, Inc.	152,636
Friendship House Association	830,739
Greenville Rancheria	29,409
Guidiville Indian Rancheria	47,086
Indian Health Center of Santa Clara Valley, Inc.	10,000
Ke Ola Mao	197,192
Lake County Tribal Health Consortium	208,701
Native American Health Center, Inc.	10,000
Native Directions, Inc.	410,407
Paskenta Band of Nomlaki Indians	586

Pit River Health Services, Inc.	90,079
Quartz Valley Indian Reservation	5,000
Round Valley Indian Health Center, Inc.	314,178
Sacramento Native American Health Center, Inc.-Hlth	122,240
Sacramento Native American Health Center, Inc.-Alco	43,859
San Diego American Indian Health Center, Inc.	10,000
Santa Ynez Band of Mission Indians	164,292
Scotts Valley Band of Pomo Indians	47,482
Shingle Springs Rancheria	60,533
Sierra Tribal Consortium	675,795
Southern Indian Health Council, Inc.	215,871
Strong Family Health Center	64,840
Table Mountain Rancheria	4,676
Toiyabe Indian Health Project, Inc.	418,876
Tule River Indian Health Center, Inc.	5,436
Tule River Tribal Council	526,717
Tuolumne Me-Wuk Indian Health Center, Inc.	87,053
United American Indian Involvement, Inc. -Aftercare	859,204
Consolidated Tribal Health Project	180,500
Feather River Tribal Health, Inc.	394,231
Hoopa Valley Tribe	391,877
Indian Health Council	377,956
Karuk Tribe of California	169,530
Northern Valley Indian Health	125,126
Redding Rancheria	175,798
Riverside-San Bernardino Indian Health	939,854
Susanville Indian Rancheria	95,256
Total Tribal Operations:	9,826,972

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	**FUNDED AMOUNT**
Cabazon Band of Mission Indians	$196
California Rural Indian Health Board, Inc.	182,500
Central Valley Indian Health, Inc.	57,500
Chapa-De Indian Health Program, Inc.	33,700
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
Toiyabe Indian Health Project, Inc.	36,500
Consolidated Tribal Health Project	29,300
Feather River Tribal Health, Inc.	33,300
Hoopa Valley Tribe	39,100
Indian Health Council	51,700
Karuk Tribe of California	22,100
Northern Valley Indian Health	12,000
Redding Rancheria	50,100
Riverside-San Bernardino Indian Health	119,500
Susanville Indian Rancheria	10,600
Total Tribal Operations- Area Shares:	749,796

TRIBAL OPERATIONS—HEADQUARTERS SHARES	**FUNDED AMOUNT**

CONTRACTOR	
Cabazon Band of Mission Indians	$129
California Rural Indian Health Board, Inc.	13,984
Central Valley Indian Health, Inc.	8,736
Chapa-De Indian Health Program, Inc.	1,460
Consolidated Tribal Health Project, Inc.	7,108
Feather River Tribal Health, Inc.	16,369
Greenville Rancheria	3,866
Hoopa Valley Tribe	10,778
Indian Health Council	24,870
Karuk Tribe of California	6,412
Northern Valley Indian Health	2,140
Pit River Health Services, Inc.	2,117
Redding Rancheria	13,843
Riverside-San Bernardino County Indian Health	39,491
Santa Ynez Band of Mission Indians	3,514
Shingle Springs Rancheria	1,161
Southern Indian Health Council, Inc.	16,881
Strong Family Health Center	1,095
Susanville Indian Rancheria	3,321
Toiyabe Indian Health Project, Inc.	6,161
Total Tribal Operations Headquarters Shares:	183,436

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS	FUNDED AMOUNT
Personnel Services	$321,262
Travel	22,200
Transportation	13,520
Contractual Services	330,196
Total Area & Tribal Operation Expenditures:	687,178

TOTAL OBLIGATIONS—ALCOHOL	**$11,447,382**

Clinical Services
Reimbursements

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS) AMOUNT	FUNDED AMOUNT
Travel	$542
Total Area & Tribal Operation Expenditures:	542

TOTAL OBLIGATIONS—REIMBURSEMENTS	**$542**

Preventive Health
Public Health Nursing

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$64,923
Central Valley Indian Health, Inc.	48,231
Lake County Tribal Health Consortium	375,512
Northern Valley Indian Health	2,500
Pit River Health Services, Inc.	50,293

Round Valley Indian Health Center, Inc.	1,000
Table Mountain Rancheria	608
Toiyabe Indian Health Project, Inc.	1,000
Tule River Indian Health Center, Inc.	50,893
Tuolumne Me-Wuk Indian Health Center, Inc.	1,000
Consolidated Tribal Health Project	61,957
Hoopa Valley Tribe	25,545
Indian Health Council	91,352
Riverside-San Bernardino Indian Health	158,669
Susanville Indian Rancheria	13,306
Total Tribal Operations:	946,789

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$23
California Rural Indian Health Board, Inc.	9,538
Central Valley Indian Health, Inc.	3,548
Chapa-De Indian Health Program, Inc.	871
Greenville Rancheria	935
Shingle Springs Rancheria	472
Southern Indian Health Council, Inc.	3,195
Strong Family Health Center	444
Toiyabe Indian Health Project, Inc.	2,514
Consolidated Tribal Health Project	1,731
Feather River Tribal Health, Inc.	3,097
Hoopa Valley Tribe	2,132
Karuk Tribe of California	1,301
Northern Valley Indian Health	870
Redding Rancheria	2,620
Riverside-San Bernardino Indian Health	7,474
Susanville Indian Rancheria	629
Total Tribal Operations Headquarters Shares:	41,394

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$3,367
Total Area & Tribal Operation Expenditures:	3,367

TOTAL OBLIGATIONS—PUBLIC HEALTH NURSING	$991,550

Preventive Health
Health Education

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Indian Health Center of Santa Clara Valley, Inc.	$1,500
United American Indian Involvement, Inc. -Fresno	1,500
Indian Health Council	8,000
Northern Valley Indian Health	1,000
Total Tribal Operations:	12,000

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$56

California Rural Indian Health Board, Inc.	51,600
Central Valley Indian Health, Inc.	16,300
Chapa-De Indian Health Program, Inc.	9,600
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
Feather River Tribal Health, Inc.	9,400
Hoopa Valley Tribe	11,100
Indian Health Council	14,600
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	3,000
Total Tribal Operations- Area Shares:	212,356

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	**FUNDED AMOUNT**
Cabazon Band of Mission Indians	$29
California Rural Indian Health Board, Inc.	11,448
Central Valley Indian Health, Inc.	4,340
Chapa-De Indian Health Program, Inc.	1,066
Greenville Rancheria	1,163
Pit River Health Services, Inc.	1,053
Santa Ynez Band of Mission Indians	835
Shingle Springs Rancheria	578
Southern Indian Health Council, Inc.	4,018
Strong Family Health Center	544
Toiyabe Indian Health Project, Inc.	3,074
Consolidated Tribal Health Project	2,152
Feather River Tribal Health, Inc.	3,896
Hoopa Valley Tribe	2,682
Indian Health Council	5,920
Karuk Tribe of California	1,636
Northern Valley Indian Health	1,064
Redding Rancheria	3,296
Riverside-San Bernardino Indian Health	9,399
Susanville Indian Rancheria	791
Total Tribal Operations Headquarters Shares:	58,984

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	**FUNDED AMOUNT**
Contractual Services	$38,214
Total Area & Tribal Operation Expenditures:	38,214

TOTAL OBLIGATIONS—HEALTH EDUCATION	**$321,554**

Preventive Health
Community Health Representative

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$294,000
Central Valley Indian Health, Inc.	102,689
Chapa-De Indian Health Program, Inc.	40,773
Colds Springs Tribal Council	35,386
Coyote Valley Tribal Council	30,665
Greenville Rancheria	8,443
Hopland Band of Pomo Indians	30,635
Lake County Tribal Health Consortium	41,780
Paskenta Band of Nomlaki Indians	169
Pinoleville Band of Pomo Indians	29,992
Pit River Health Services, Inc.	32,604
Quartz Valley Indian Reservation	9,764
Round Valley Indian Health Center, Inc.	44,707
Santa Ynez Band of Mission Indians	32,538
Sherwood Valley Band of Pomo Indians	31,402
Shingle Springs Rancheria	16,054
Southern Indian Health Council, Inc.	71,980
Strong Family Health Center	57,631
Table Mountain Rancheria	1,985
Toiyabe Indian Health Project, Inc.	168,432
Tule River Indian Health Center, Inc.	52,451
Tuolumne Me-Wuk Indian Health Center, Inc.	10,923
Consolidated Tribal Health Project	40,792
Feather River Tribal Health, Inc.	32,782
Hoopa Valley Tribe	92,638
Indian Health Council	119,127
Karuk Tribe of California	92,600
Northern Valley Indian Health	20,059
Redding Rancheria	58,767
Riverside-San Bernardino Indian Health	311,204
Susanville Indian Rancheria	35,670
Total Tribal Operations:	1,948,642

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$17
California Rural Indian Health Board, Inc.	16,000
Central Valley Indian Health, Inc.	5,100
Chapa-De Indian Health Program, Inc.	3,000
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.	3,200
Consolidated Tribal Health Project	2,600
Feather River Tribal Health, Inc.	2,900
Hoopa Valley Tribe	3,400
Indian Health Council	4,500
Karuk Tribe of California	2,000

Northern Valley Indian Health	1,000
Redding Rancheria	4,400
Riverside-San Bernardino Indian Health	10,500
Susanville Indian Rancheria	900
Total Tribal Operations—Area Shares:	66,017

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$62
California Rural Indian Health Board, Inc.	24,435
Central Valley Indian Health, Inc.	8,359
Chapa-De Indian Health Program, Inc.	2,232
Shingle Springs Rancheria	1,209
Southern Indian Health Council, Inc.	8,300
Strong Family Health Center	1,139
Pinoleville Band of Pomo Indians	670
Feather River Tribal Health, Inc.	$8,050
Hoopa Valley Tribe	2,870
Indian Health Council	12,232
Karuk Tribe of California	3,381
Redding Rancheria	6,809
Riverside-San Bernardino Indian Health	19,420
Total Tribal Operations Headquarters Shares:	99,168

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$14,569
Total Area & Tribal Operation Expenditures:	14,569

TOTAL OBLIGATIONS—CHR	**$2,128,396**

Urban Health Projects

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$521,603
Friendship House Association	650,529
Indian Health Center of Santa Clara Valley, Inc.	568,950
Native American Health Center, Inc.	1,087,174
Native Directions, Inc.	40,000
Sacramento Native American Health Center, Inc.-Hlth	963,921
San Diego American Indian Health Center, Inc.	847,954
United American Indian Involvement, Inc. -Fresno	476,005
United American Indian Involvement, Inc. –LA (PubHlth)	1,308,247
United American Indian Involvement, Inc. –Bakersfield	422.269
United American Indian Involvement, Inc. –Aftercare	119,234
Total Tribal Operations:	7,005,886

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$38,365
Travel	14,671
Contractual Services	142,749
Equipment	28,800

Total Area & Tribal Operation Expenditures:	224,585

TOTAL OBLIGATIONS—URBAN HEALTH PROJECTS	**$7,230,471**

Direct Operations

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$442
California Rural Indian Health Board, Inc.	143,380
Central Valley Indian Health, Inc.	52,823
Chapa-De Indian Health Program, Inc.	1,946
Greenville Rancheria	14,256
Pit River Health Services, Inc.	13,624
Santa Ynez Band of Mission Indians	10,174
Shingle Springs Rancheria	7,231
Southern Indian Health Council	48,898
Strong Family Health Center	6,619
Toiyabe Indian Health Project, Inc.	37,421
Consolidated Tribal Health Project	$26,189
Feather River Tribal Health, Inc.	47,412
Hoopa Valley Tribe	32,636
Indian Health Council	81,723
Karuk Tribe of California	19,908
Northern Valley Indian Health	12,941
Redding Rancheria	46,047
Riverside-San Bernardino Indian Health	128,112
Susanville Indian Rancheria	9,625
Total Tribal Operations Headquarters Shares:	741,407

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$1,685,072
Travel	608
Rent, Comm., Util.	147,167
Contractual Services	65,641
Training	164
Total Area & Tribal Operation Expenditures:	1,898,651

TOTAL OBLIGATIONS—DIRECT OPERATIONS	**$2,640,058**

Contract Support Costs

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$48,408
California Rural Indian Health Board, Inc.	10,186,968
Central Valley Indian Health, Inc.	2,891,595
Chapa-De Indian Health Program, Inc.	1,687,728
Colds Springs Tribal Council	57,388
Colusa Indian Health Community Council	21,688
Coyote Valley Tribal Council	82,023
Greenville Rancheria	279,807
Guidiville Indian Rancheria	166,167

Hopland Band of Pomo Indians	33,539
Lake County Tribal Health Consortium	1,115,040
Paskenta Band of Nomlaki Indians	617
Pinoleville Band of Pomo Indians	14,962
Pit River Health Services, Inc.	595,685
Quartz Valley Indian Reservation	103,606
Round Valley Indian Health Center, Inc.	495,707
Santa Ynez Band of Mission Indians	420,207
Scotts Valley Band of Pomo Indians	62,995
Sherwood Valley Band of Pomo Indians	53,441
Shingle Springs Rancheria	328,123
Sierra Tribal Consortium	399,898
Southern Indian Health Council, Inc.	2,223,754
Strong Family Health Center	$394,101
Sycuan Band of Mission Indians	68,840
Table Mountain Rancheria	14,524
Toiyabe Indian Health Project, Inc.	1,038,706
Tule River Indian Health Center, Inc.	1,231,676
Tule River Tribal Council	105,180
Tuolumne Me-Wuk Indian Health Center, Inc.	208,463
Consolidated Tribal Health Project	1,797,141
Feather River Tribal Health, Inc.	1,111,261
Hoopa Valley Tribe	1,585,918
Indian Health Council	3,334,874
Karuk Tribe of California	1,258,617
Northern Valley Indian Health	1,100,952
Redding Rancheria	3,314,622
Riverside-San Bernardino Indian Health	7,440,561
Susanville Indian Rancheria	751,427
Total Tribal Operations:	46,026,209

TOTAL OBLIGATIONS—CONTRACT SUPPORT COST	**$46,026,209**

Contract Health Care

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$8,785
California Rural Indian Health Board, Inc.	8,019,751
Central Valley Indian Health, Inc.	3,301,439
Chapa-De Indian Health Program, Inc.	2,223,756
Colusa Indian Health Community Council	68,471
Coyote Valley Tribal Council	93,184
Greenville Rancheria	704,611
Guidiville Indian Rancheria	8,533
Lake County Tribal Health Consortium	1,065,325
Paskenta Band of Nomlaki Indians	11,065
Pinoleville Band of Pomo Indians	14,082
Pit River Health Services, Inc.	604,971
Quartz Valley Indian Reservation	61,129
Round Valley Indian Health Center, Inc.	764,568
Santa Ynez Band of Mission Indians	527,780
Scotts Valley Band of Pomo Indians	12,718
Sherwood Valley Band of Pomo Indians	35,962

Shingle Springs Rancheria	578,422
Southern Indian Health Council, Inc.	1,374,593
Strong Family Health Center	199,704
Sycuan Band of Mission Indians	81,859
Table Mountain Rancheria	26,820
Toiyabe Indian Health Project, Inc.	1,640,447
Tule River Indian Health Center, Inc.	2,149,727
Tuolumne Me-Wuk Indian Health Center, Inc.	245,580
Consolidated Tribal Health Project	1,556,634
Feather River Tribal Health, Inc.	2,088,686
Hoopa Valley Tribe	1,972,901
Indian Health Council	2,764,430
Karuk Tribe of California	1,196,494
Northern Valley Indian Health	1,364,160
Redding Rancheria	2,352,433
Riverside-San Bernardino Indian Health	7,010,811
Susanville Indian Rancheria	538,498
Total Tribal Operations:	44,668,329

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$57
California Rural Indian Health Board, Inc.	52,800
Central Valley Indian Health, Inc.	16,600
Chapa-De Indian Health Program, Inc.	9,800
Greenville Rancheria	1,300
Pit River Health Services, Inc.	2,700
Santa Ynez Band of Mission Indians	1,600
Shingle Springs Rancheria	2,700
Southern Indian Health Council, Inc.	11,400
Strong Family Health Center	900
Toiyabe Indian Health Project, Inc.	10,500
Consolidated Tribal Health Project	8,600
Feather River Tribal Health, Inc.	9,600
Hoopa Valley Tribe	11,300
Indian Health Council	15,000
Karuk Tribe of California	6,700
Northern Valley Indian Health	3,400
Redding Rancheria	14,500
Riverside-San Bernardino Indian Health	34,500
Susanville Indian Rancheria	3,100
Total Tribal Operations—Area Shares:	217,057

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$75
California Rural Indian Health Board, Inc.	92,025
Central Valley Indian Health, Inc.	10,893
Chapa-De Indian Health Program, Inc.	2,675
Greenville Rancheria	2,917
Pit River Health Services, Inc.	2,620
Santa Ynez Band of Mission Indians	2,098
Shingle Springs Rancheria	1,449
Southern Indian Health Council, Inc.	10,084

Strong Family Health Center	1,354
Toiyabe Indian Health Project, Inc.	7,448
Consolidated Tribal Health Project	5,402
Feather River Tribal Health, Inc.	9,776
Hoopa Valley Tribe	6,730
Indian Health Council	14,858
Karuk Tribe of California	4,107
Northern Valley Indian Health	2,669
Redding Rancheria	8,270
Riverside-San Bernardino Indian Health	23,591
Susanville Indian Rancheria	1,985
Total Tribal Operations Headquarters Shares:	211,026

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	**FUNDED AMOUNT**
Contractual Services	$9,135
Total Area & Tribal Operation Expenditures:	9.135

TOTAL OBLIGATIONS—CONTRACT HEALTH CARE	**$45,105,547**

Domestic Violence Prevention Initiative

TRIBAL OPERATIONS CONTRACTOR	**FUNDED AMOUNT**
California Rural Indian Health Board, Inc.	$77,000
Hopland Band of Pomo Indians	34,500
Indian Health Council	77,000
Northern Valley Indian Health	34,500
Total Tribal Operations:	223,000

TOTAL OBLIGATIONS—DOMESTIC VIOLENCE PREVENTION INITIATIVE	**$223,000**

Alcohol & Substance Abuse/Meth Prevention

TRIBAL OPERATIONS CONTRACTOR	**FUNDED AMOUNT**
California Rural Indian Health Board, Inc.	$260,120
Riverside-San Bernardino County Indian Health, Inc.	80,584
Round Valley Indian Health Center, Inc.	96,855
San Diego American Indian Health Center, Inc.	4,800
Santa Ynez Band of Mission Indians	31,974
Total Tribal Operations:	474,333

TOTAL OBLIGATIONS—ALCOHOL & SUBSTANCE ABUSE/METH PREVENTION	**$474,333**

Catastrophic Fund

TRIBAL OPERATIONS CONTRACTOR	**FUNDED AMOUNT**
Chapa-De Indian Health Program, Inc.	$1,722
Northern Valley Indian Health	507
Santa Ynez Tribal Health Clinic	6,286

Consolidated Tribal Health Project	195,500
Redding Rancheria	87,565
Total Tribal Operations:	291,580

TOTAL OBLIGATIONS—CATASTROPHIC HEALTH EMERGENCY FUND	**$291,580**

Facilities & Environmental Health Support
Environmental Health Support

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$126
California Rural Indian Health Board, Inc.	18,154
Central Valley Indian Health, Inc.	1,050
Chapa-De Indian Health Program, Inc.	6,426
Consolidated Tribal Health Project	600
Greenville Rancheria	7,576
Indian Health Center of Santa Clara Valley, Inc.	1,193
Lake County Tribal Health Consortium	10,340
Native American Health Center, Inc.	1,950
Paskenta Band of Nomlaki Indians	78
Pit River Health Services, Inc.	1,650
Round Valley Indian Health Center, Inc.	782
Sacramento Native American Health Center, Inc.-Hlth	8,273
Santa Ynez Band of Mission Indians	675
Shingle Springs Rancheria	600
Tule River Indian Health Center, Inc.	1,365
United American Indian Involvement, Inc. -PubHlth	3,578
Feather River Tribal Health, Inc.	13,845
Hoopa Valley Tribe	3,863
Indian Health Council	4,140
Northern Valley Indian Health	16,063
Susanville Indian Rancheria	1,050
Total Tribal Operations:	103,377

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$2,208
Southern Indian Health Council, Inc.	6,969
Hoopa Valley Tribe	62,006
Riverside-San Bernardino Indian Health	90,986
Total Tribal Operations—Area Shares:	162,169

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Southern Indian Health Council, Inc.	$384
Total Tribal Operations Headquarters Shares:	384

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$2,015,580
Travel	123,007
Transportation	127,003

Rent, Comm., Util.	27,150
Printing	232
Contractual Services	53,884
Training	37,610
Supplies	23,326
Equipment	59,372
Total Area & Tribal Operation Expenditures:	2,467,164

TOTAL OBLIGATIONS—ENVIRONMENTAL HEALTH SUPPORT	**$2,733,094**

Facilities & Environmental Health Support
Facilities Health Support

TRIBAL OPERATIONS CONTRACTOR	**FUNDED AMOUNT**
Lake County Tribal Health Consortium	$721,682
Total Tribal Operations:	721,682

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	**FUNDED AMOUNT**
California Rural Indian Health Board, Inc.	$72,530
Indian Health Council	25,404
Southern Indian Health Council, Inc.	15,175
Total Tribal Operations—Area Shares:	113,109

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	**FUNDED AMOUNT**
Southern Indian Health Council, Inc.	$378
Total Tribal Operations Headquarters Shares:	378

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	**FUNDED AMOUNT**
Personnel Services	$280,230
Travel	22,322
Transportation	13,237
Rent, Comm., Util.	1,669
Contractual Services	16,724
Training	785
Supplies	5,984
Total Area & Tribal Operation Expenditures:	340,950

TOTAL OBLIGATIONS—FACILITIES HEALTH SUPPORT	**$1,176,119**

Facilities & Environmental Health Support
OEHE Support

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	**FUNDED AMOUNT**
Consolidated Tribal Health Project	$103
Feather River Tribal Health, Inc.	449
Hoopa Valley Tribe	3,588
Indian Health Council	2,015

Northern Valley Indian Health	517
Redding Rancheria	1,438
Riverside-San Bernardino Indian Health	6,428
Susanville Indian Rancheria	204
Total Tribal Operations Headquarters Shares:	14,742

TOTAL OBLIGATIONS—OEHE SUPPORT	**$14,742**

Indian Health Facilities
New & Replacement

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	**FUNDED AMOUNT**
Equipment	$1,209,396
Total Area & Tribal Operation Expenditures:	1,209,396

Indian Health Facilities
Equipment

TRIBAL OPERATIONS CONTRACTOR	**FUNDED AMOUNT**
California Rural Indian Health Board, Inc.	$130,975
Central Valley Indian Health, Inc.	34,276
Chapa-De Indian Health Program, Inc.	57,454
Colusa Indian Health Community Council	1,841
Greenville Rancheria	21,013
Lake County Tribal Health Consortium	29,692
Pit River Health Services, Inc.	12,895
Quartz Valley Indian Reservation	3,121
Round Valley Indian Health Center, Inc.	17,332
Santa Ynez Band of Mission Indians	12,727
Shingle Springs Rancheria	17,659
Sierra Tribal Consortium	5,398
Southern Indian Health Council, Inc.	36,105
Strong Family Health Center	3,495
Sycuan Band of Mission Indians	6,121
Toiyabe Indian Health Project, Inc.	51,841
Tuolumne Me-Wuk Indian Health Center, Inc.	12,259
Consolidated Tribal Health Project	21,628
Feather River Tribal Health, Inc.	53,192
Hoopa Valley Tribe	34,498
Indian Health Council	47,483
Karuk Tribe of California	28,825
Northern Valley Indian Health	28,562
Redding Rancheria	28,706
Riverside-San Bernardino Indian Health	91,808
Susanville Indian Rancheria	12,984
Total Tribal Operations:	801,890

TOTAL OBLIGATIONS—INDIAN HEALTH FACILITIES - EQUIPMENT	**$801,890**

Indian Health Facilities
EPA CWA IAG

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$2,371,557
Total Area & Tribal Operation Expenditures:	2,371,557

TOTAL OBLIGATIONS—INDIAN HEALTH FACILITIES – EPA CWA IAG	**$2,371,557**

Indian Health Facilities
Maintenance and Improvement

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$550,000
Feather River Tribal Health, Inc.	653,975
Consolidated Tribal Health Project	28,247
Hoopa Valley Tribe	18,815
Indian Health Council	177,133
Karuk Tribe of California	24,613
Lake County Tribal Health Consortium	38,819
Northern Valley Indian Health	56,814
Redding Rancheria	152,812
Riverside-San Bernardino Indian Health	150,317
Santa Ynez Band of Mission Indians	86,807
Susanville Indian Rancheria	45,261
Total Tribal Operations:	1,983,613

TOTAL OBLIGATIONS—INDIAN HEALTH FACILITIES – M&I	**$1,983,613**

Inter-Agency Funds
Contributions

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$151,000
Total Area & Tribal Operation Expenditures:	151,000

TOTAL OBLIGATIONS—CONTRIBUTIONS	**$151,000**

Sanitation Facilities
Housing

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$1,534,000
Total Area & Tribal Operation Expenditures:	1,534,000

TOTAL OBLIGATIONS—SFC HOUSING	**$1,534,000**

Sanitation Facilities
Regular

INCLUDES ALL OTHER EXPENDITURES	FUNDED AMOUNT

(AREA & TRIBAL OPERATIONS)	
Contractual Services	$2,380,000
Total Area & Tribal Operation Expenditures:	2,380,000

TOTAL OBLIGATIONS—SFC REGULAR	**$2,380,000**

Executive Staff

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 authorized 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 healthcare 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.

Charles Magruder, M.D. is a graduate of University of Kansas School of Medicine. He completed residencies in Preventive Medicine, and Psychiatry from Walter Reed Army Institute of Research and a Masters' of Public Health from Harvard University School of Public Health. Dr. Magruder has extensive experience in public health, medical epidemiology, primary care and medical administration. Dr. Magruder is a military active reservist, and has worked for numerous government agencies including the U.S. Army, the U.S. Air Force, Centers for Disease Control and Prevention and as a county public health officer.

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, Montana. After serving six years in Montana, Mr. Fluette transferred to Anchorage, 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 in Honolulu. He is a member of the Little Traverse Bay Band of Odawa Indians in Petoskey, Michigan.

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 healthcare clinics throughout California, particularly relating to dental care.

Jeanne Smith, MPA began her career in the federal government in 1983 and presently serves as the Acting Associate Director for the Office of Management Support and Executive Officer. She has worked in the Human Resources field for many years and has also served in the Veterans Administration, Department of the Army, Department of the Interior, and the Department of Agriculture. Ms. Smith earned her Master's in Public Administration at the University of Southern California in May 1992, and her Bachelor's degree in Psychology/Journalism at the California State University- Sacramento in December 1986.

Our Staff

Office of the Area Director

Margo Kerrigan, MPH, Director

Beverly Miller, CPA, MHA, MBA, Deputy Director

CAPT David Sprenger, MD, Behavioral Health/Psychiatric Consultant

Charles Magruder, MD, Chief Medical Officer

Office of Public Health

Steve Riggio, DDS, Associate Director

Government Performance and Results Act

Amy Patterson, PhD, Public Health Analyst

CDR Wendy Blocker, MSN, Public Health Analyst

Christine Brennan, MPH, Public Health Analyst

Rachel Pulverman, Student Trainee (Public Health Analyst)

Health Professional Consultants

Beverly Calderon, RD, CDE, Health Promotion Disease Prevention Consultant

Susan Ducore, RN, MSN, PHN, Nurse Consultant/Immunization Coordinator

Marilyn Freeman, RHIA, Clinical Applications Coordinator/VistA Imaging Coordinator/Meaningful Use Coordinator

Helen Maldonado, PA-C, Diabetes Consultant

Dawn Phillips, RN, CDE, Behavioral Health Consultant

Steven Viramontes, PHN, Clinical Applications Coordinator/Telemedicine Coordinator

Information Resource Management Office

Robert Gemmell, Computer Information Officer/Information Security Systems Officer/Information Services Coordinator

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

Kelly Stephenson, IT Specialist/Telecommunications Liaison/Web Content Manager

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

Marcella Begaye, IT Specialist

Edna Lorimer, Computer Assistant

Ron Byers, Computer Assistant

Office of Management Support

Jeanne Smith, MPA, Acting Associate Director/Acting Executive Officer/Regional Human Resources Specialist

Finance

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

Linda Wilson, Budget Execution

Kurt Nelson, OEH&E Accounting

Ana Chavez-Alvarez, Cash Management

Julie Morrow, Property Management

Marie Lowden, Accounts Payable

Angie Singh, Project Accountant

Caroline Martinez, Accounts Payable

Contracting

Karen Nichols, Supervisory Contracting Officer

Harry Weiss, Contract Specialist

Cordell Bailey, Contract Specialist

Travis Coleman, Contract Specialist/Acting Indian Self-Determination Program Manager

Michael Hodahkwen, Contract Specialist

Administrative Management

Mona Celli, Management Analyst/Scholarships Coordinator

Myrtle LaRocque, Administrative Support Assistant

Jean Reynolds, Receptionist

Office of Environmental Health & Engineering

Office of the Associate Director

Edwin Fluette, REHS, MPH, Associate Director

Susan Rey, Secretary

Jeannette Reynolds, Administrative Assistant

Division of Health Facilities Engineering (DHFE)

CAPT Richard Wermers, MEM, PE, DHFE Director

Gary Ball, Architect

CDR Paul Frazier, Staff Engineer

Division of Environmental Health Services (DEHS)

CAPT Gordon Tsatoke, MPH, DEHS Director

CDR Martin Smith, RS, Environmental Health Specialist

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

CAPT Brian Lewelling, Environmental Health Specialist (Escondido)

LCDR Charles Craig, Environmental Health Specialist (Redding)

Tim Shelhamer, Environmental Health Officer (Ukiah)

Division of Sanitation Facilities Construction (DSFC)

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CAPT Christopher Brady, MS, PE, DSFC Deputy Director

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LCDR Sean Bush, MS, Environmental Engineer (Clovis)

LT Matt Mergenthaler, Engineer (Clovis)

Bianca Ruelas, Office Automation Clerk (Clovis)

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Nancy Dewees, Sr. Environmental Engineer (Escondido)

LT Roger Hargrove, Sr. Environmental Engineer (Escondido)

LCDR Mark Hench, Sr. Environmental Engineer (Escondido)

John Jeng, Engineer Technician (Escondido)

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Michele Blackowl, Administrative Support Assistant (Escondido)

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Scott Brooks, Engineer Technician (Redding)

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Barry Jarvis, Environmental Engineer (Arcata)

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Organization Information

Corporate Information
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Area Information
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Internet Information
Information on CAO's financial analysis 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, email your request to rachel.pulverman@ihs.gov.

Financial Information
The CAO Financial 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 healthcare 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.

California Tribes

Agua Caliente Band of Cahuilla Indians of the Agua Caliente Indian Reservation ◦ Alturas Indian Rancheria ◦ Augustine Band of Cahuilla Indians ◦ Barona Group of Capitan Grande Band of Mission Indians of the Barona Reservation ◦ Bear River Band of the Rohnerville Rancheria ◦ Berry Creek Rancheria of Maidu Indians of California ◦ Big Lagoon Rancheria ◦ Big Pine Paiute Tribe of the Owens Valley ◦ Big Sandy Rancheria of Western Mono Indians of California ◦ Big Valley Band of Pomo Indians of the Big Valley Rancheria ◦ Bishop Paiute Tribe ◦ Blue Lake Rancheria ◦ Bridgeport Indian Colony ◦ Buena Vista Rancheria of Me-Wuk Indians of California ◦ Cabazon Band of Mission Indians ◦ Cachil DeHe Band of Wintun Indians of the Colusa Indian Community of the Colusa Rancheria ◦ Cahto Tribe ◦ Cahuilla Band of Mission Indians of the Cahuilla Reservation ◦ California Valley Miwok Tribe ◦ Campo Band of Diegueno Mission Indians of the Cahuilla Reservation ◦ Cedarville Rancheria ◦ Chemehuevi Indian Tribe of the Chemehuevi Reservation ◦ Cher-Ae Heights Indian Community of the Trinidad Rancheria ◦ Chicken Ranch Rancheria of Me-Wuk Indians of California ◦ Cloverdale Rancheria of Pomo Indians of California ◦ Cold Springs Rancheria of Mono Indians of California ◦ Colorado River Indian Tribes of the Colorado River Indian Reservation ◦ Cortina Indian Rancheria of Wintun Indians of California ◦ Coyote Valley Reservation ◦ Death Valley Timbi-sha Shoshone Tribe ◦ Dry Creek Rancheria Band of Pomo Indians ◦ Elem Indian Colony of Pomo Indians of the Sulphur Bank Rancheria ◦ Elk Valley Rancheria ◦ Enterprise Rancheria of Maidu Indians of California ◦ Ewiiaapaayp Band of Kumeyaay Indians ◦ Federated Indians of Graton Rancheria ◦ Fort Bidwell Indian Community of the Fort Bidwell Reservation of California ◦ Fort Independence Indian Community of Paiute Indians of the Fort Independence Reservation ◦ Fort Mojave Indian Tribe of Arizona, California, and Nevada ◦ Greenville Rancheria ◦ Grindstone Indian Rancheria of Wintun-Wailaki Indians of California ◦ Guidiville Rancheria of California ◦ Habematolel Pomo of Upper Lake ◦ Hoopa Valley Tribe ◦ Hopland Band of Pomo Indians ◦ Iipay Nation of Santa Ysabel ◦ Inaja Band of Diegueno Mission Indians of the Inaja and Cosmit Reservation ◦ Ione Band of Miwok Indians of California ◦ Jackson Rancheria of Me-Wuk Indians of California ◦ Jamul Indian Village of California ◦ Karuk Tribe ◦ Kashia Band of Pomo Indians of the Stewarts Point Rancheria ◦ La Jolla Band of Luiseno Indians ◦ La Posta Band of Diegueno Mission Indians of the La Posta Indian Reservation◦ Little River Band of Pomo Indians of the Redwood Valley Rancheria ◦ Lone Pine Paiute-Shoshone Tribe ◦ Los Coyotes Band of Cahuilla and Cupeno Indians ◦ Lower Lake Rancheria ◦ Lytton Rancheria of California ◦ Manchester Band of Pomo Indians of the Manchester Rancheria ◦ Manzanita Band of Diegueno Mission Indians of the Manzanita Reservation ◦ Mechoopda Indian Tribe of Chico Rancheria ◦ Mesa Grande Band of Diegueno Mission Indians of the Mesa Grande Reservation ◦ Middletown Rancheria of Pomo Indians of California ◦ Mooretown Rancheria of Maidu Indians of California ◦ Morongo Band of Mission Indians ◦ North Fork Rancheria of Mono Indians of California ◦ Pala Band of Luiseno Mission Indians of the Pala Reservation ◦ Paskenta Band of Nomlaki Indians of California ◦ Pauma Band of Luiseno Mission Indians of the Pauma & Yuima Reservation ◦ Pechanga Band of Luiseno Mission Indians of the Pechanga Reservation ◦ Picayune Rancheria of Chukchansi Indians of California ◦ Pinoleville Pomo Nation ◦ Pit River Tribe ◦ Potter Valley Tribe ◦ Quartz Valley Indian Community of the Quartz Valley Reservation of California ◦ Quechan Tribe of the Fort Yuma Indian Reservation ◦ Ramona Band of Cahuilla ◦ Redding Rancheria ◦ Resighini Rancheria ◦ Rincon Band of Luiseno Mission Indians of the Rincon Reservation ◦ Robinson Rancheria Band of Pomo Indians ◦ Round Valley Indian Tribes, Round Valley Reservation ◦ San Manuel Band of Mission Indians ◦ San Pasqual Band of Diegueno Mission Indians of California ◦ Santa Rosa Band of Cahuilla Indians ◦ Santa Rosa Indian Community of the Santa Rosa Rancheria ◦ Santa Ynez Band of Chumash Mission Indians of the Santa Ynez Reservation ◦ Scotts Valley Band of Pomo Indians of California ◦ Sherwood Valley Rancheria of Pomo Indians of California ◦ Shingle Springs Band of Miwok Indians ◦ Smith River Rancheria ◦ Soboba Band of Luiseno Indians ◦ Susanville Indian Rancheria ◦ Sycuan Band of the Kumeyaay Nation ◦ Table Mountain Rancheria of California ◦ Tejon Indian Tribe ◦ Torres Martinez Desert Cahuilla Indians ◦ Tule River Indian Tribe of the Tule River Reservation ◦ Tuolumne Band of Me-Wuk Indians of the Tuolumne Rancheria of California ◦ Twenty-Nine Palms Band of Mission Indians of California ◦ United Auburn Indian Community of the Auburn Rancheria of California ◦ Utu Utu Gwaitu Paiute Tribe of the Benton Paiute Reservation ◦ Viejas Group of Capitan Grande Band of Mission Indians of theViejas Reservation ◦ Washoe Tribe of Nevada and California ◦ Wilton Rancheria ◦ Wiyot Tribe ◦ Yocha Dehe Wintun Nation ◦ Yurok Tribe of the Yurok Reservation