

CALIFORNIA AREA REPORT

Measuring healthcare quality to improve patient care

2015



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ACKNOWLEDGMENTS

California Area Data collection and support
provided by:

Tribal and Urban Health Program Staff
Information Technology Staff
Project Officers

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INTRODUCTION

This 2015 California Area Report contains detailed performance results for all clinical Government Performance Results Act (GPRA) and Government Performance and Results Modernization Act (GPRAMA) measures collected from 34 (26 tribal and 8 urban) California programs. In FY 2015, 28 of 34 programs used Clinical Reporting System (CRS) 15.1 software to report results. The 12-month GPRA collection period for FY 2015 ran from July 1, 2014 through June 30, 2015.

The California Area Report includes detailed results for 22 clinical GPRA/GPRAMA measures reported in FY 2015. Tribal programs reported all 22 measures. Urban programs were required to report on 16 of these measures; however, this report includes data for all 22 measures from urban programs reporting via CRS. Measure results are displayed in two graphs. The first graph displays California Area aggregate tribal results from 2008-2015 (or beginning the first year in which the current measure was reported), as well as the FY 2015 IHS national average. The second graph displays results for each reporting California Indian health program for FY 2015. The first two rows under each graph show the percentage of patients meeting the measure in 2014 and 2015. The “n” row shows the number of patients who qualified for each measure, i.e. the “denominator,” in 2015.

Using the data in this report, health programs can review changes in their own performance from FY 2014 to FY 2015, compare their performance with other California programs and with national averages, and assess their progress toward achieving long-term goals. Page five of this document displays a 2015 GPRA User Population table for all reporting California Indian health programs. This table is organized by population so programs can compare their progress with programs of similar size.

In FY 2015, California tribal programs met 6 of 22 clinical measures. California Area tribal programs also exceeded the IHS national average on 6 of 22 measures. California tribal programs improved on 18 measures between FY 2014 and FY 2015. Nephropathy Assessed increased by 8.6 percentage points, Breastfeeding Rates increased by 5.2 percentage points, and Comprehensive CVD Assessment increased by 5.1 percentage points compared to FY 2014. A dashboard summary of results can be found on page A-1.

In FY 2015, California urban programs reporting via CRS improved over their aggregate FY 2014 results on 6 of 16 measures, and performed above the national average for urban programs on 6 measures. Breastfeeding Rates increased by 17.0 percentage points, Prenatal HIV Screening increased by 13.6 percentage points, and Nephropathy Assessment and Controlled Blood Pressure in patient with Diabetes each increased by 4.6 percentage points compared to FY 2014.

PROGRAM LEGEND

Abbr.	Site Name	ASUFAC	Abbr.	Site Name	ASUFAC
BAK	BAKERSFIELD IHC	648655	RED*/**	REDDING RANCHERIA	661910
CDE	CHAPA-DE	661010	RSB	RIVERSIDE/SAN BERNARDINO	661810
CON	CONSOLIDATED	662210	RVL	ROUND VALLEY	662710
CVL	CENTRAL VALLEY	661110	SAC	SACRAMENTO NATIVE AMER HEALTH	648310
FRS	FRESNO	648510	SBR	SANTA BARBARA IHC	648755
FRV	FEATHER RIVER INDIAN HEALTH	663610	SDG	SAN DIEGO IHC	648110
GVL*/**	GREENVILLE RANCHERIA TRIBAL HEALTH	663510	SIH	SO. INDIAN HEALTH COUNCIL	662110
HPA	HOOPA	661210	SJO*/**	SAN JOSE	648210
IHC	INDIAN HEALTH COUNCIL	661610	SON	SONOMA	662010
KRK	KARUK	661355	SS	SHINGLE SPRINGS TRIBAL HEALTH	663410
LAK	LAKE	662930	SYC	SYCUAN	663230
LAS	LASSEN INDIAN HC	663030	SYZ	SANTA YNEZ	662830
MAC*/**	MACT HEALTH BOARD CLINIC	662510	TOI	TOIYABE	662310
NVL	NORTHERN VALLEY	661557	TUL	TULE RIVER CLINIC	662410
OAK*/**	OAKLAND NATIVE AMER HC/SAN FRAN	648410	TUO	TUOLUMNE ME-WUK CLINIC	664110
PIT	PIT RIVER	661710	UAI	UNITED AMERICAN INDIAN INVOLVEMENT	645060
QTZ	QUARTZ VALLEY	663855	VIHS*/**	UNITED INDIAN HEALTH SERVICES	662610

****2014/**2015 data reported from non-RPMS System; data not validated by CRS software equivalent***

Urban Indian Health Program

2015 GPRA USER POPULATION, BY PROGRAM

Population
Scale

> 4000	4000-2000	2000-1000	< 1000
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Health Program	GPRA User Population
Riverside/San Bern (RSB)	13,915
Central Valley (CVL)	8,184
United Indian Health Services (UIHS)	6,934
Chapa De (CDE)	5,739
Sonoma (SON)	5,549
Feather River (FRV)	4,886
Indian Health Council (IHC)	4,880
Redding (RED)	4,109
Northern Valley (NVL)	3,249
Hoopa (HPA)	3,229
Consolidated (CON)	3,115
Toiyabe (TOI)	3,080
Tule River (TUL)	2,610
Southern Indian Health (SIH)	2,396
Karuk (KRK)	2,061
United Amer. Indian Inv. (UAI)	2,051
San Diego (SDG)	2,015

Health Program	GPRA User Population
Lake (LAK)	1,986
Sacramento NAHC (SAC)	1,650
MACT (MAC)	1,860
Oakland/San Francisco (OAK)	1,616
Shingle Springs (SS)	1,320
Round Valley (RVL)	1,268
Santa Ynez (SYZ)	1,128
Susanville (LAS)	957
Greenville (GVL)	956
Pit River (PIT)	955
San Jose (SJO)	850
Fresno (FRS)	718
Santa Barbara (SBR)	603
Bakersfield (BAK)	443
Tuolumne Me-Wuk (TUO)	238
Quartz Valley (QTZ)	210
Sycuan (SYC)	122

GPRA MEASURES

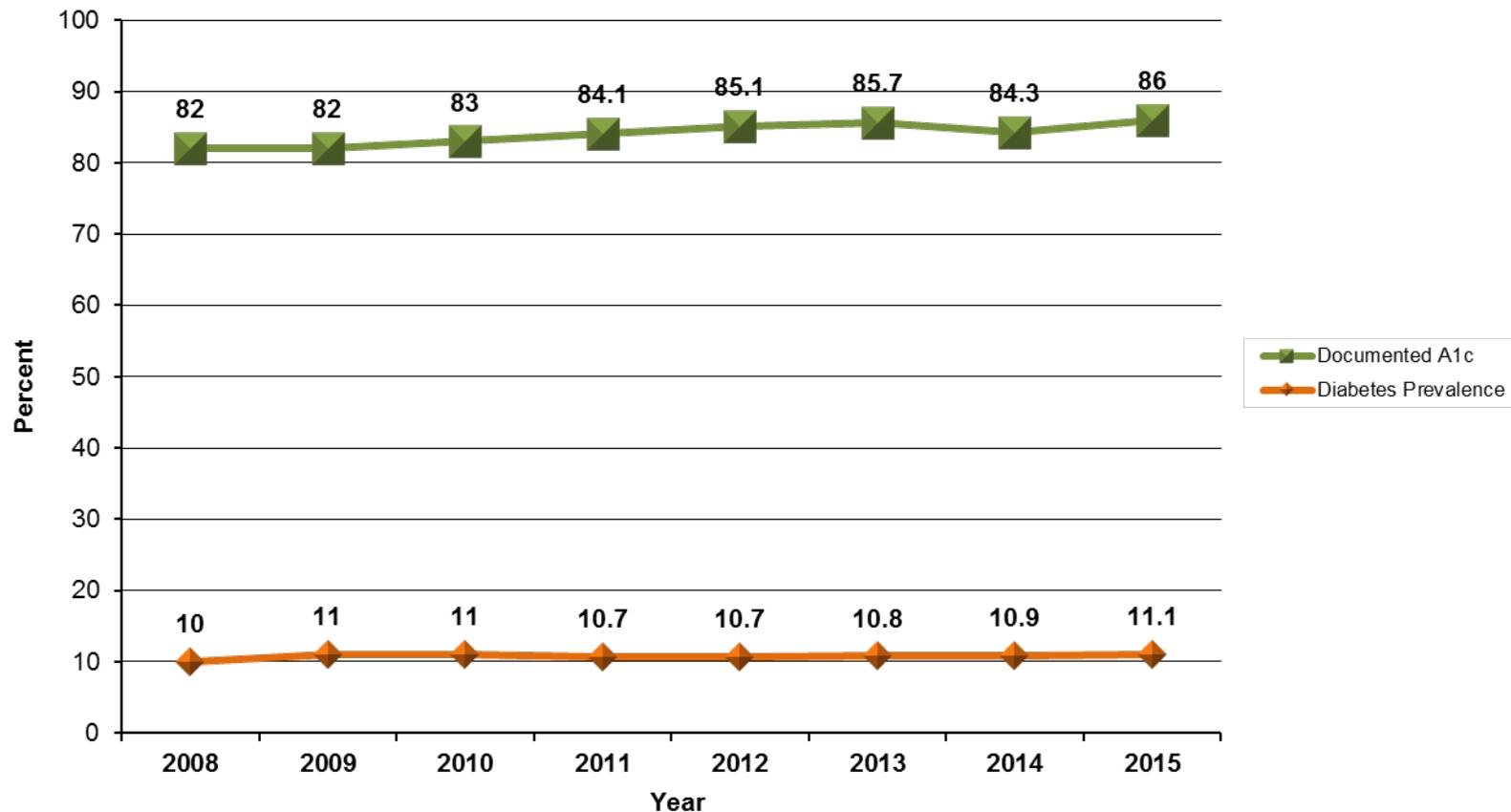


California Area Trends (2008-2015)
and
Results by Program (2014 & 2015)

DIABETES: PREVALENCE AND DOCUMENTED A1C

Measure(s): Prevalence: Percentage of patients with diagnosed diabetes prior to the end of the report period.
Documented A1c: Percentage of patients with hemoglobin A1c documented during the Report Period, regardless of result. These are not GPRA measures but are provided for context.

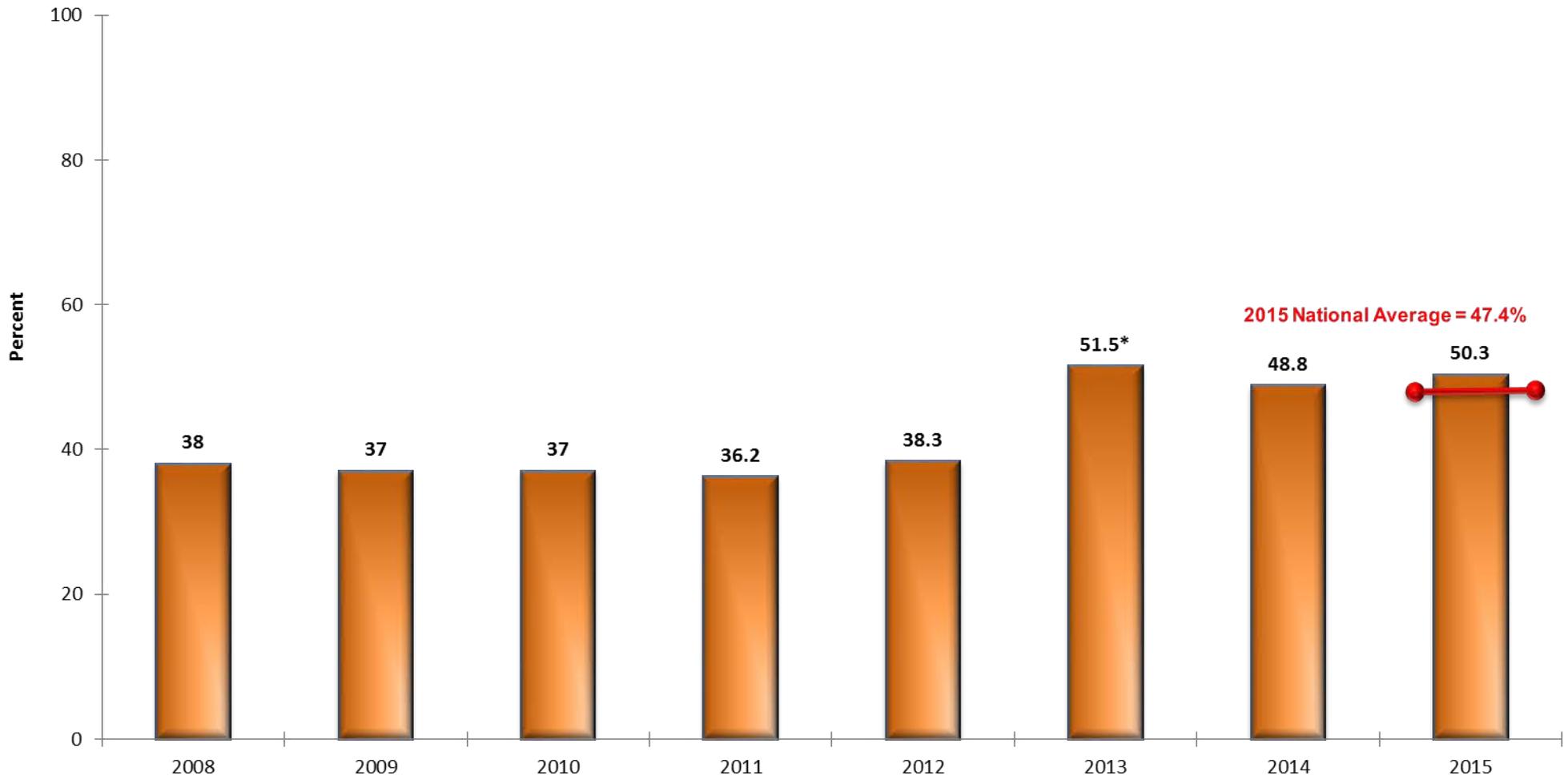
Importance: *Diabetes leads to many health complications and is one of the leading causes of death among AI/AN people. Diabetes is also a major risk factor for cardiovascular disease, and CVD is the leading cause of death for American Indians. “Documented A1c” refers to a blood test called the Hemoglobin A1c, which determines blood sugar levels in patients with diabetes. This test can be used to determine a patient’s level of “glycemic control,” or how well blood sugars are controlled.*



DIABETES: GOOD GLYCEMIC CONTROL

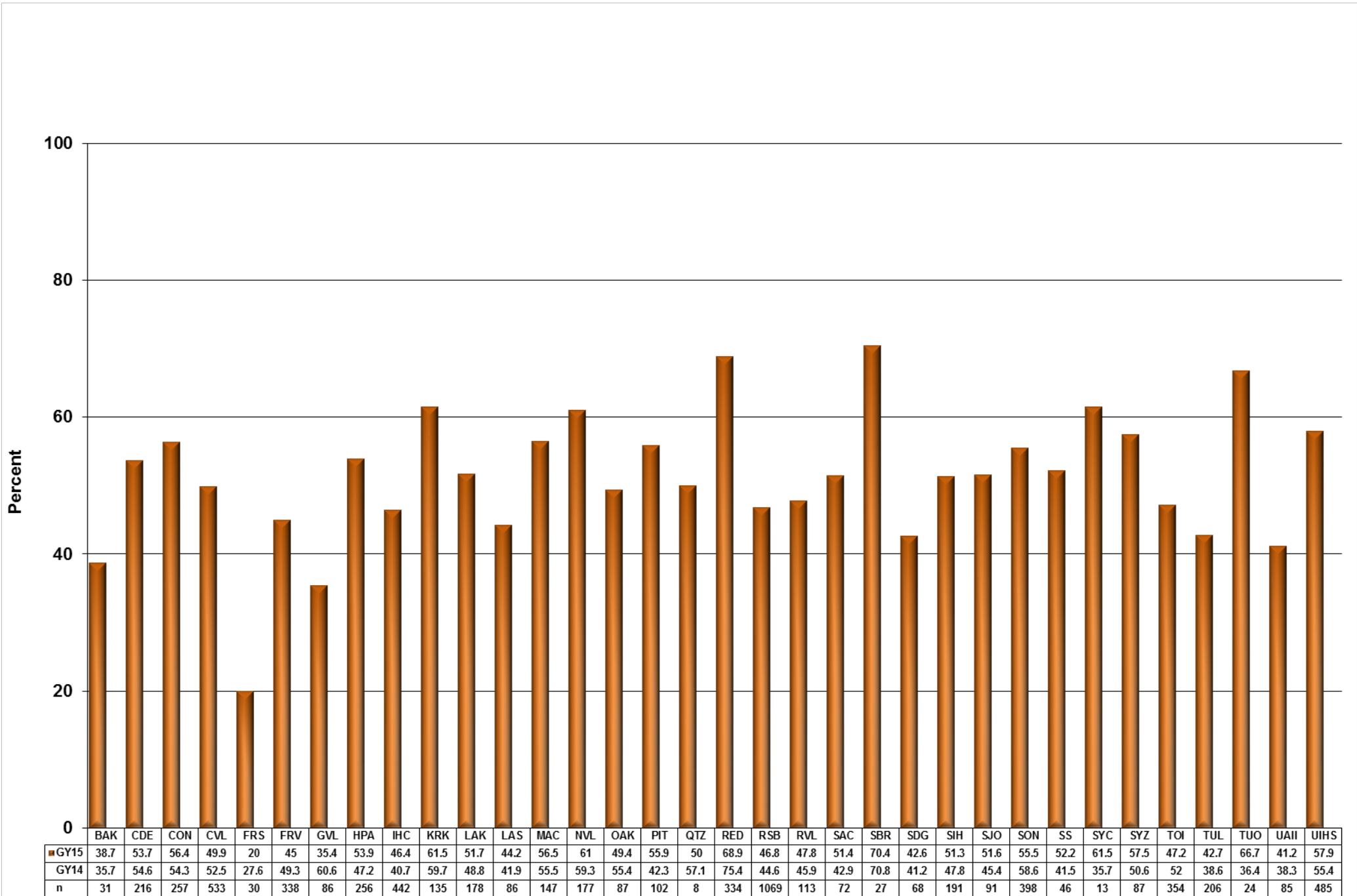
Measure: Percentage of patients with diagnosed diabetes with good glycemic control (A1c<8.0).

Importance: *Keeping blood sugar levels under 8 can slow or prevent the onset and progression of eye, kidney, and nerve disease caused by diabetes. Clinical studies have shown that keeping glycemic levels in the “good” range (below 8) results in a significantly reduced risk of eye disease, kidney disease, nerve disease, heart attack, and stroke.*



*Prior to FY 2013, this measure reported the percentage of diabetic patients with ideal glycemic control (A1c < 7.0).

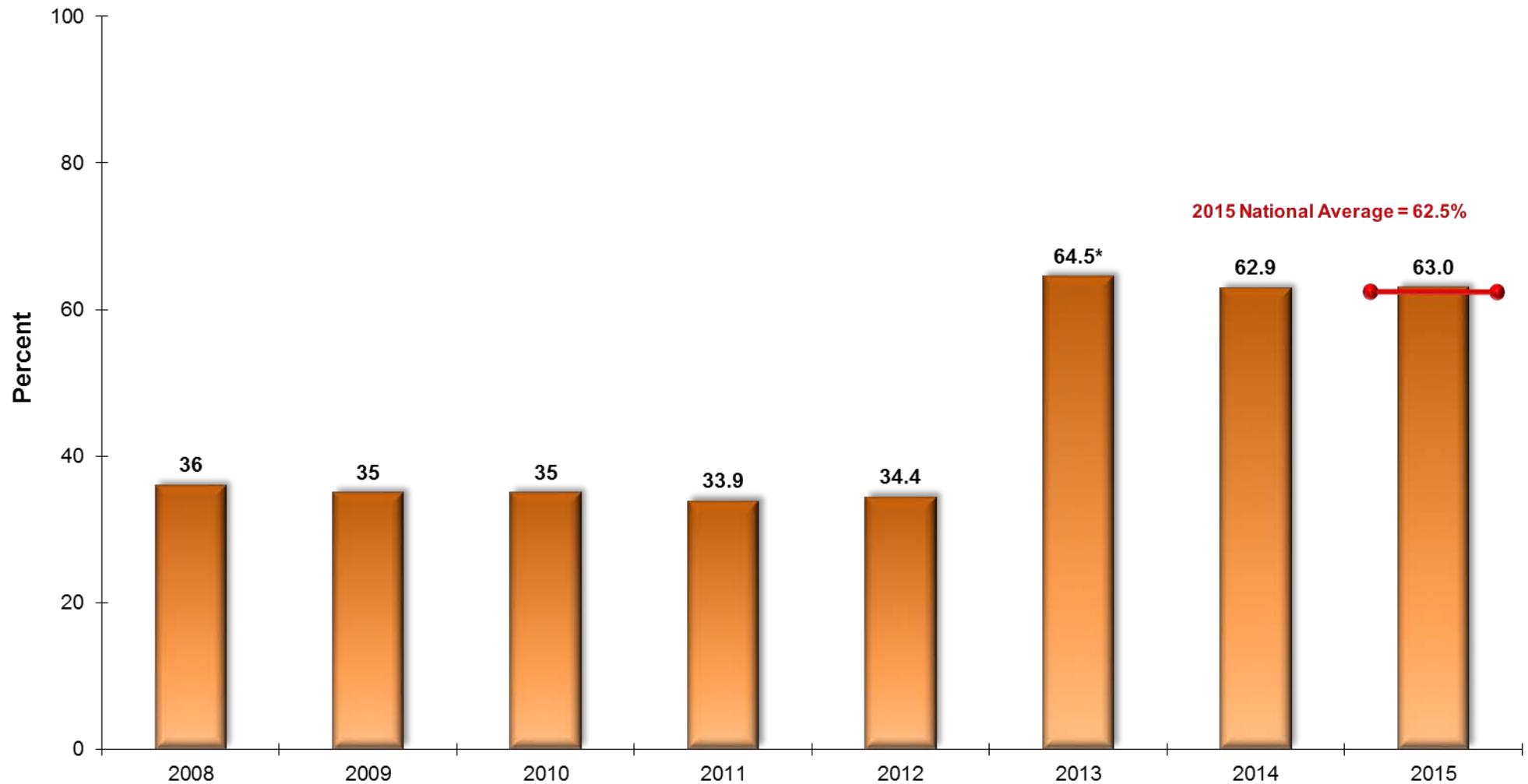
DIABETES: GOOD GLYCEMIC CONTROL



DIABETES: BLOOD PRESSURE CONTROL

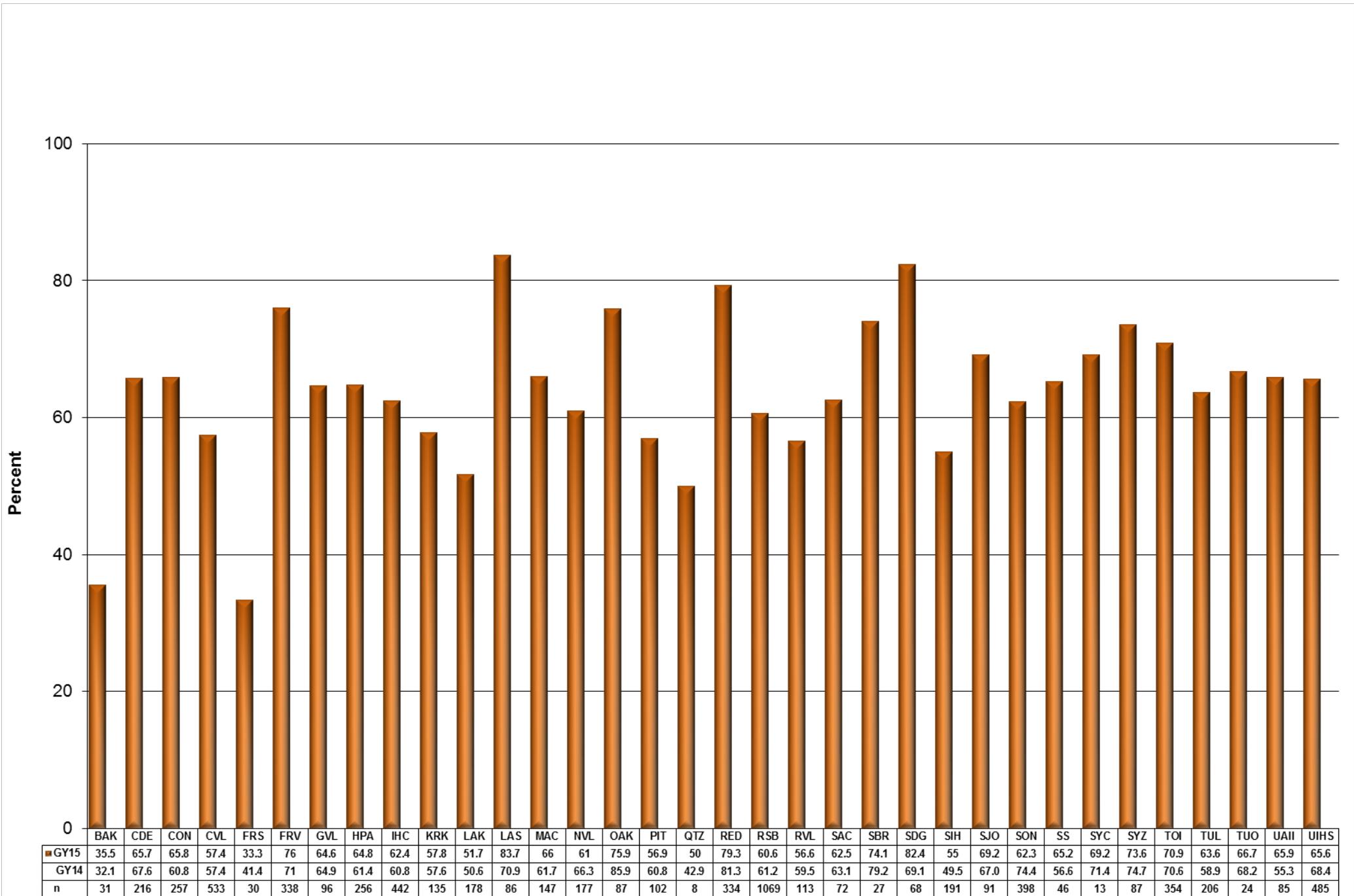
Measure: Percentage of patients with diagnosed diabetes that have achieved blood pressure control (BP < 140/90).

Importance: *Good blood pressure control can reduce the risk of complications from diabetes. A large clinical study found that diabetics with blood pressure kept under control had a significantly reduced risk of death, heart attack and stroke.*



*Prior to FY 2013, this measure reported the percentage of diabetic patients with controlled blood pressure (<130/80).

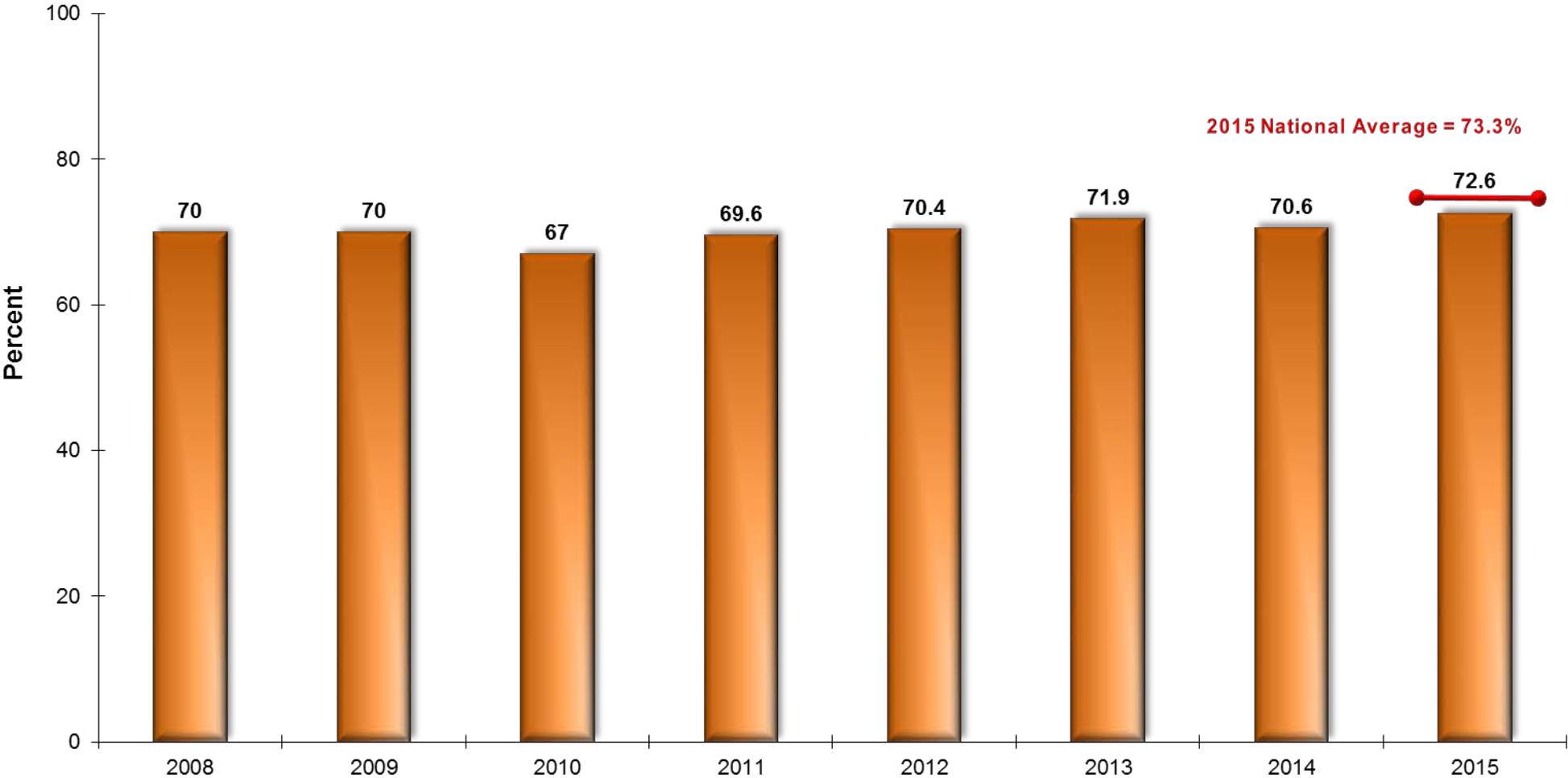
DIABETES: BLOOD PRESSURE CONTROL



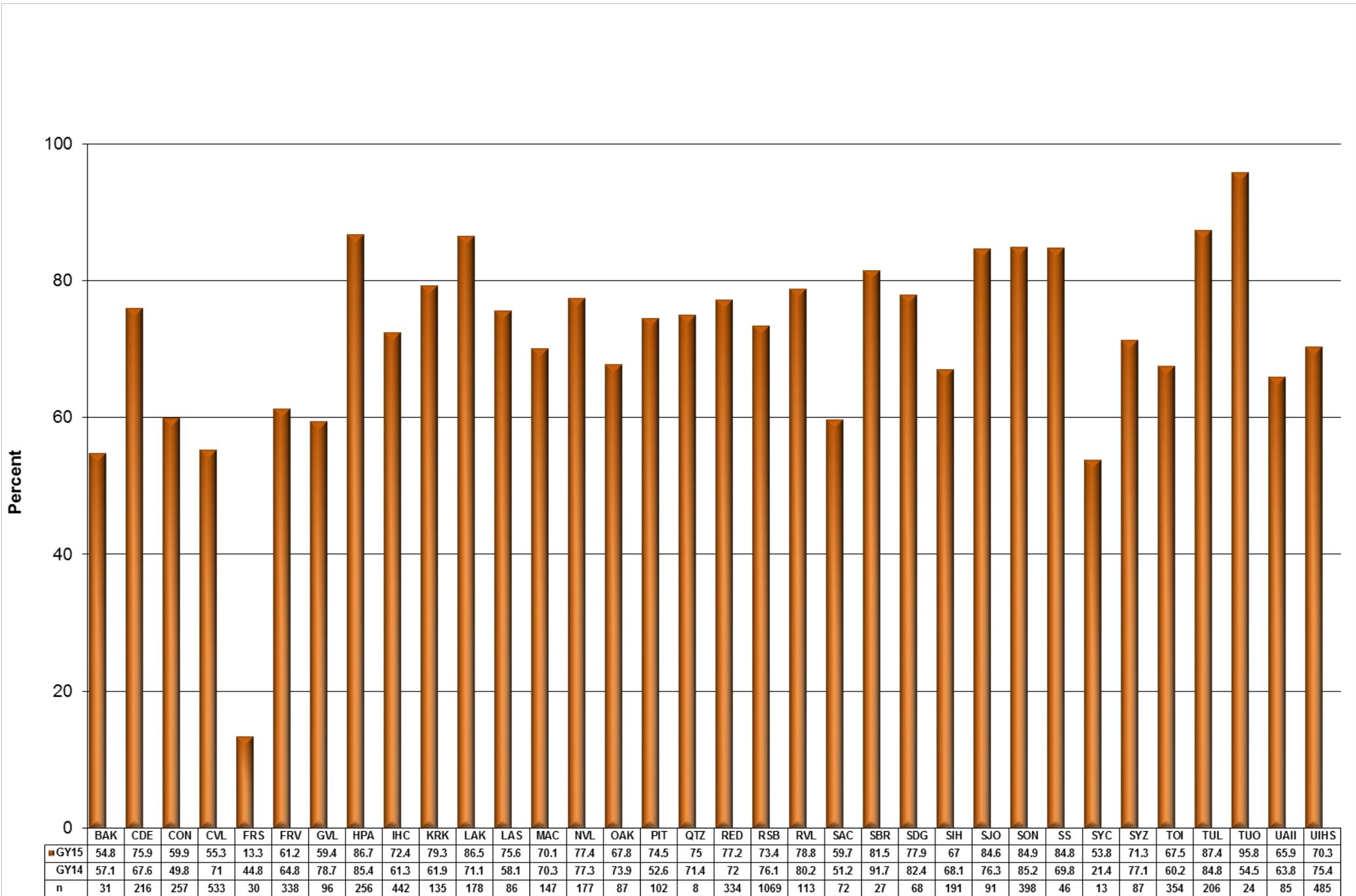
DIABETES: DYSLIPIDEMIA ASSESSMENT

Measure: Percentage of patients with diagnosed diabetes assessed for dyslipidemia.

Importance: *Dyslipidemia refers to having high LDL (bad) cholesterol and low HDL (good) cholesterol. Controlling cholesterol levels in people with diabetes reduces the risk of complications like heart attack and stroke. National standards recommend that people with diabetes keep their total cholesterol levels below 200 mg/dl, and their LDL cholesterol levels below 130 mg/dl and ideally below 100 mg/dl.*



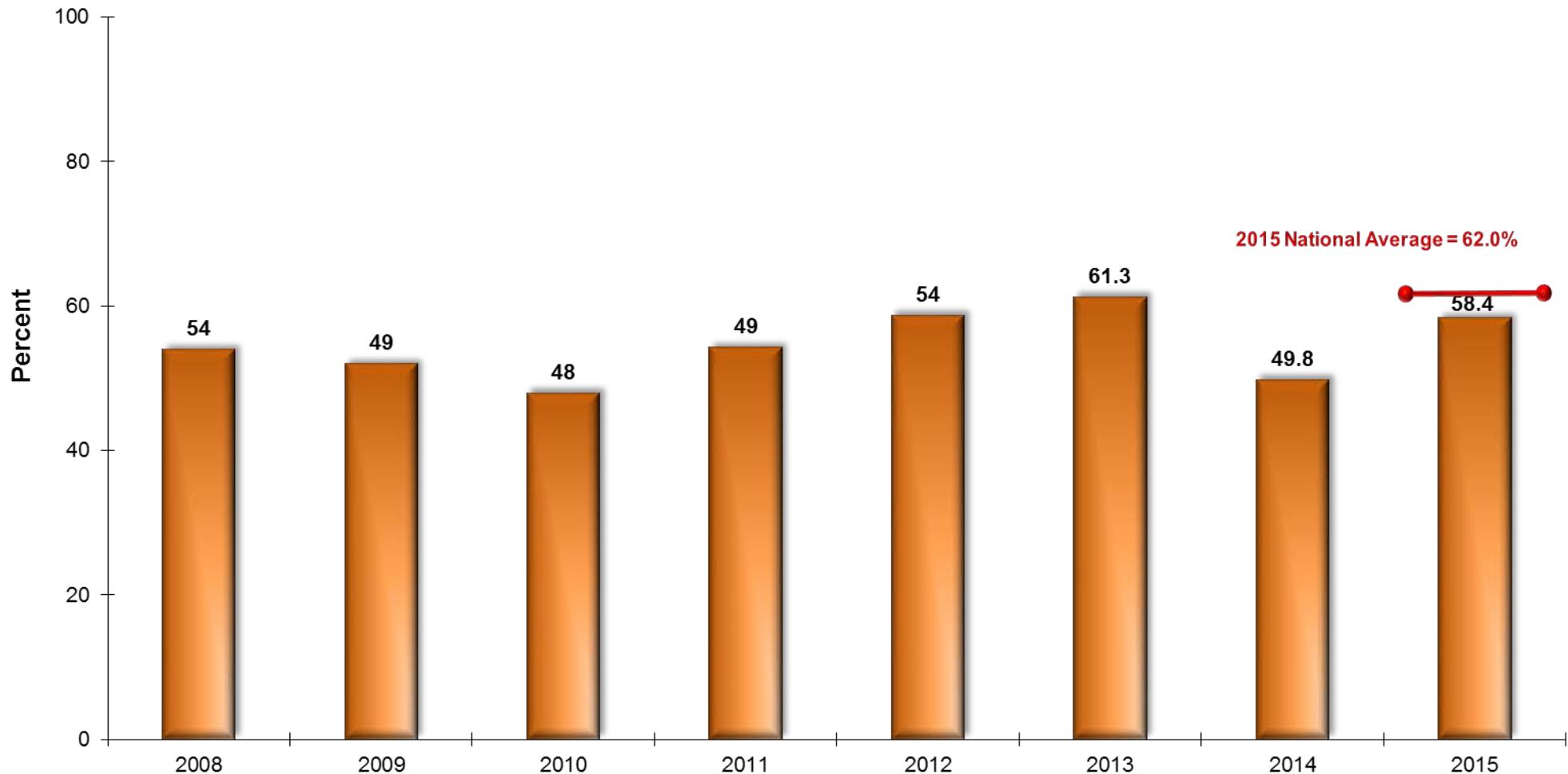
DIABETES: DYSLIPIDEMIA ASSESSMENT



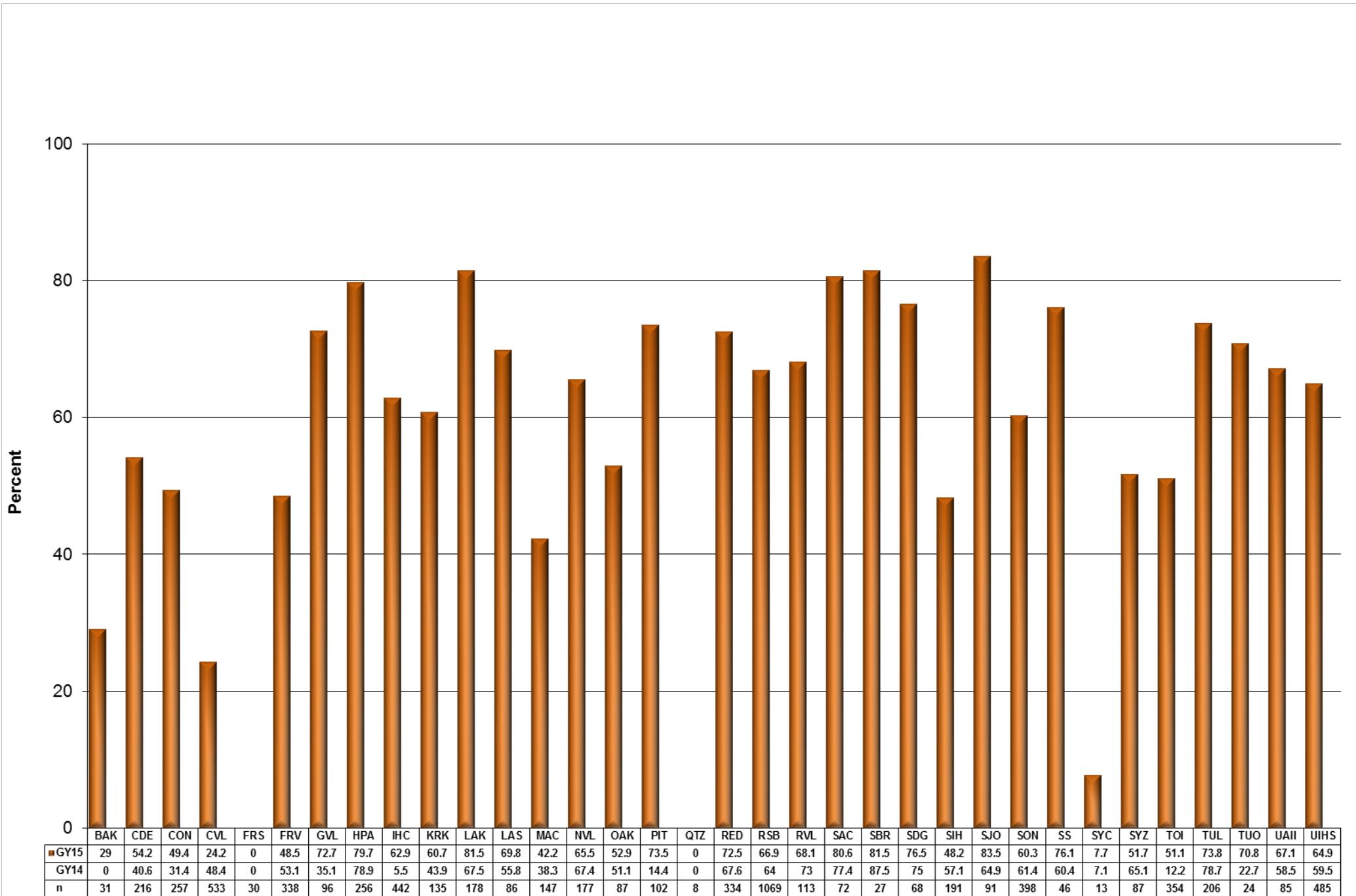
DIABETES: NEPHROPATHY ASSESSMENT

Measure: Percentage of patients with diagnosed diabetes assessed for nephropathy.

Importance: *Diabetes can cause kidney disease by damaging the parts of the kidneys that filter out wastes. Diabetic nephropathy, or kidney disease, can eventually lead to kidney failure. Diabetes is the leading cause of end stage renal disease (ESRD), which is a significant and growing problem in American Indian communities. Early identification of at-risk patients may help prevent or delay the need for costly care such as dialysis or transplants.*



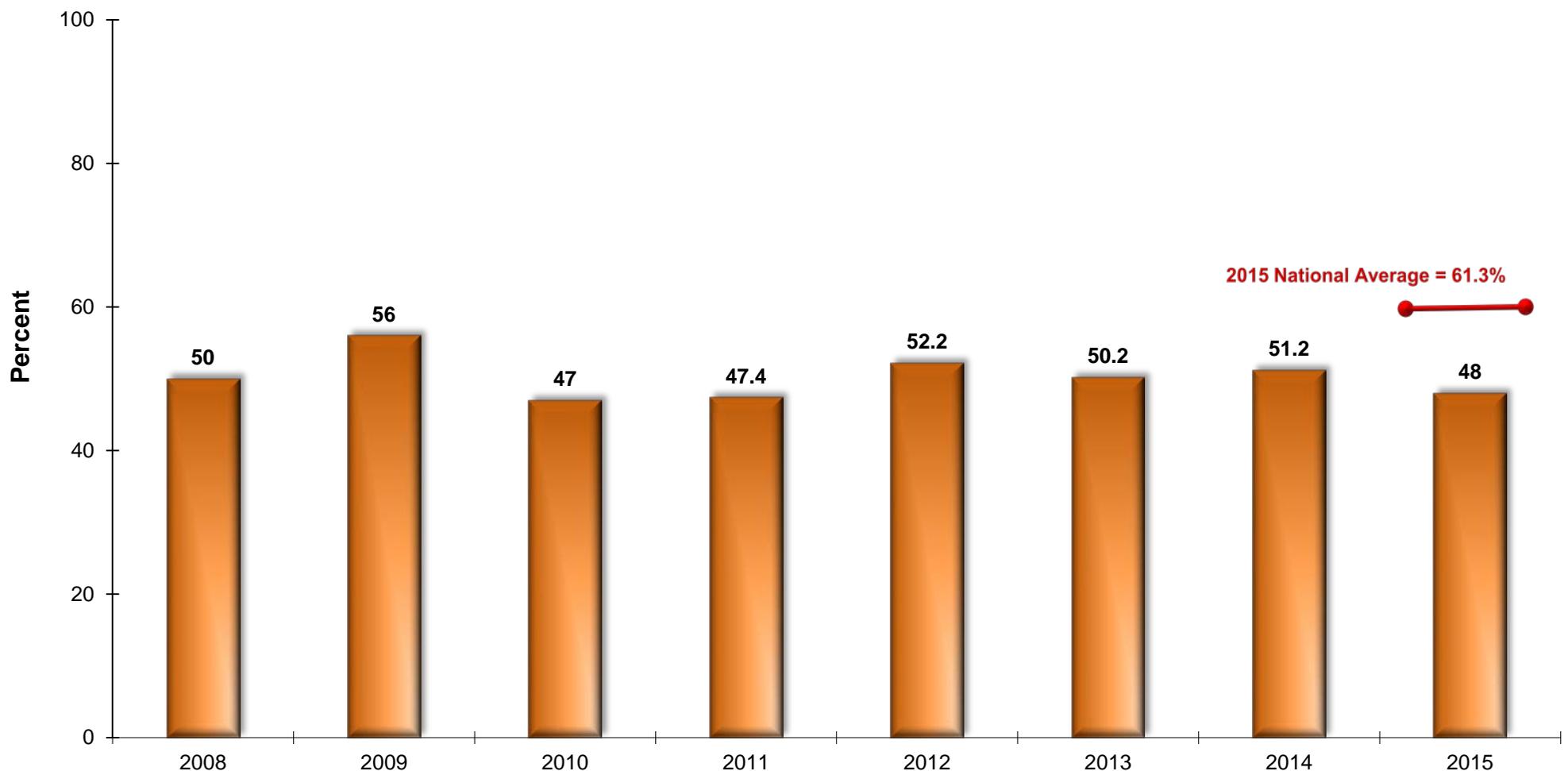
DIABETES: NEPHROPATHY ASSESSMENT



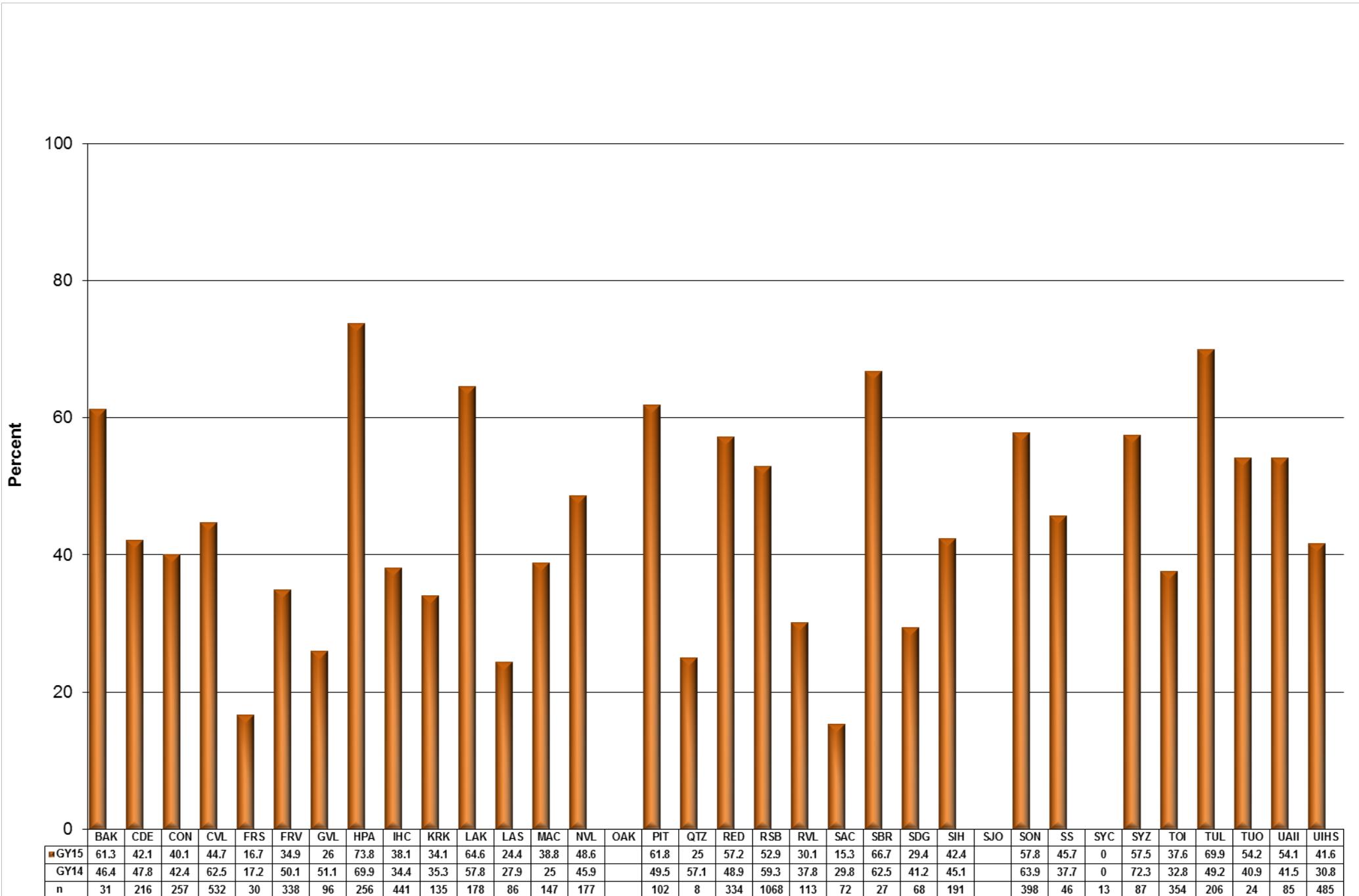
DIABETES: RETINOPATHY

Measure: Percentage of patients with diagnosed diabetes who receive an annual diabetic retinal examination.

Importance: *Diabetes can affect sight by damaging the blood vessels inside the eye, a condition known as “diabetic retinopathy.” Diabetic eye disease is a leading cause of blindness in the United States. Early detection of diabetic retinopathy (DR) helps to reduce vision problems in diabetic patients. A treatment known as “laser photocoagulation” can be effective, but only if the problem is identified early.*



DIABETES: RETINOPATHY

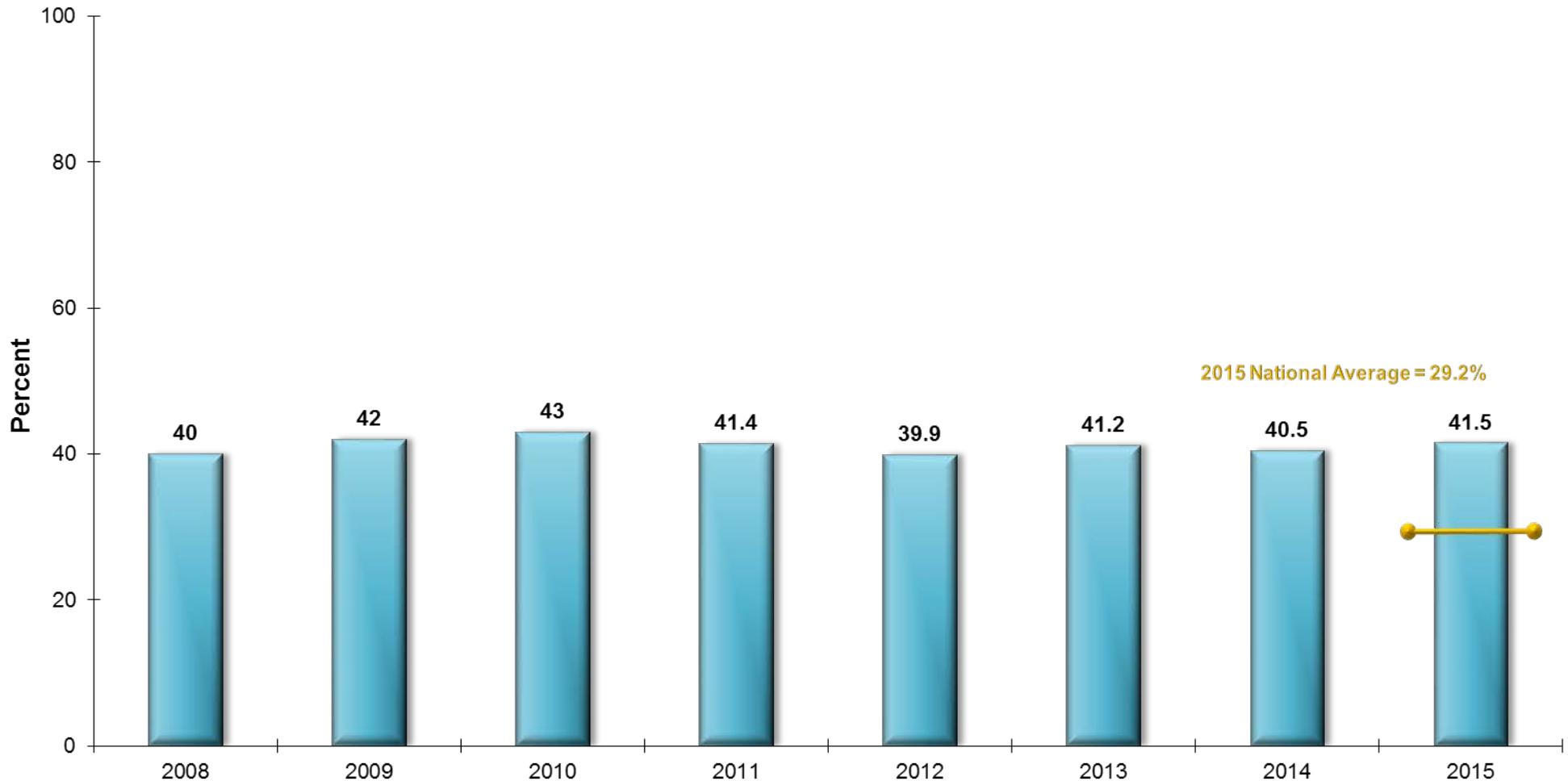


Note: Urban health programs are not required to report on this measure.

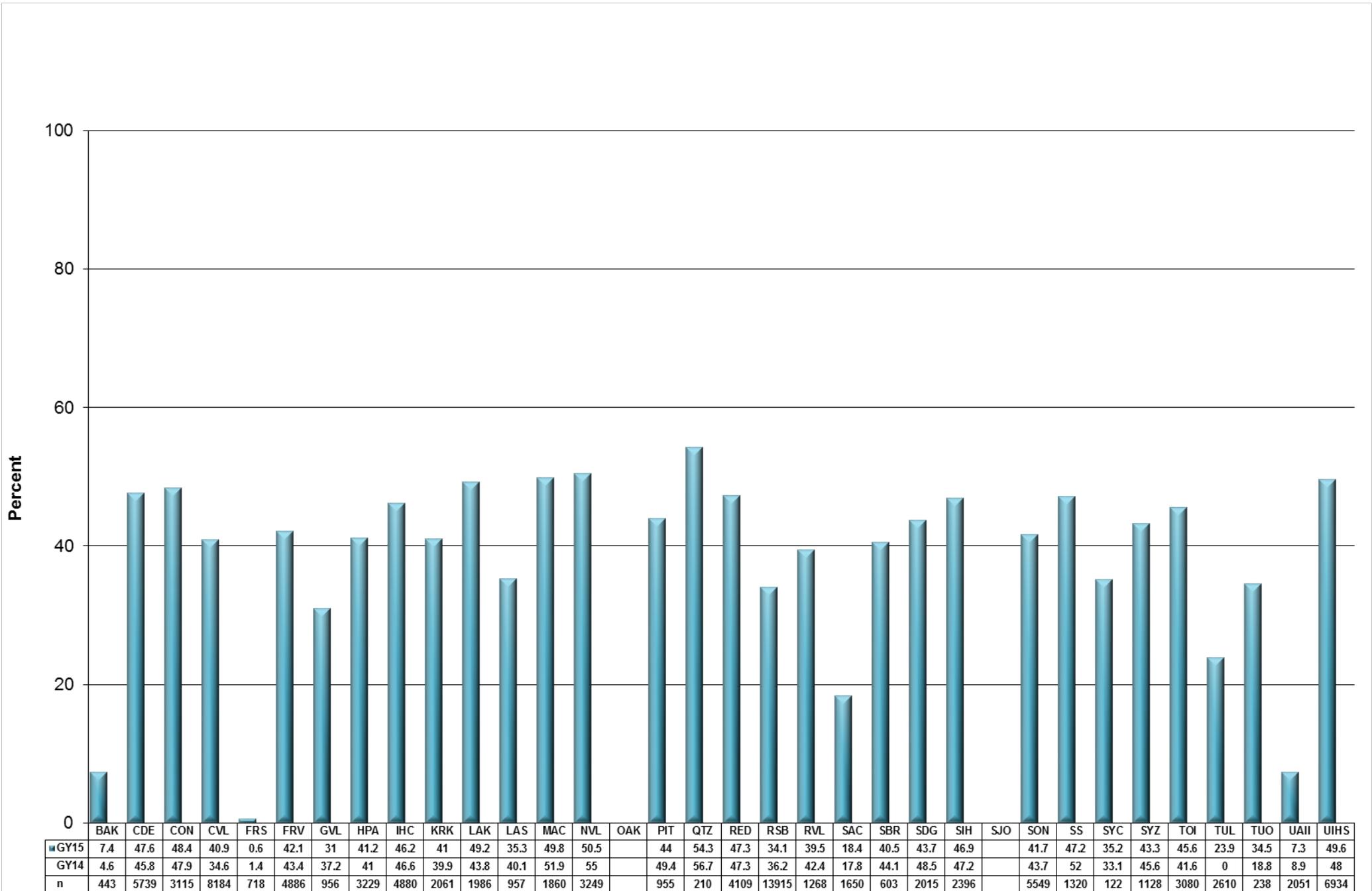
DENTAL: GENERAL ACCESS

Measure: Percentage of patients who obtain access to dental services.

Importance: *American Indians and Alaska Natives are less likely to receive regular dental care compared to non-Hispanic whites. Untreated tooth decay can cause many complications, including abscesses, infections, and pain, and can lead to other health problems. Access to dental care improves the oral health as well as the overall health of AI/AN people.*



DENTAL: GENERAL ACCESS

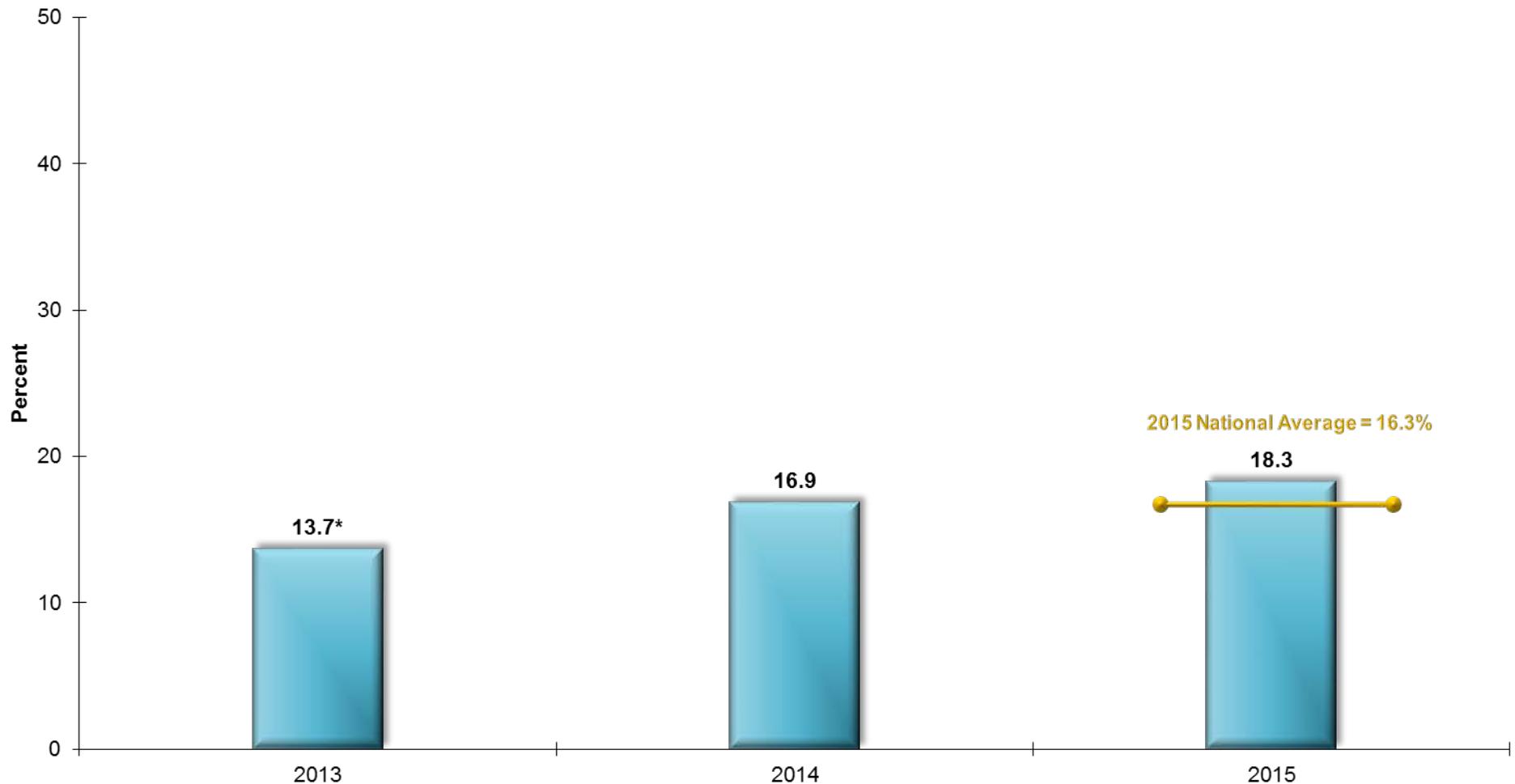


Note: Urban health programs are not required to report on this measure.

DENTAL: SEALANTS

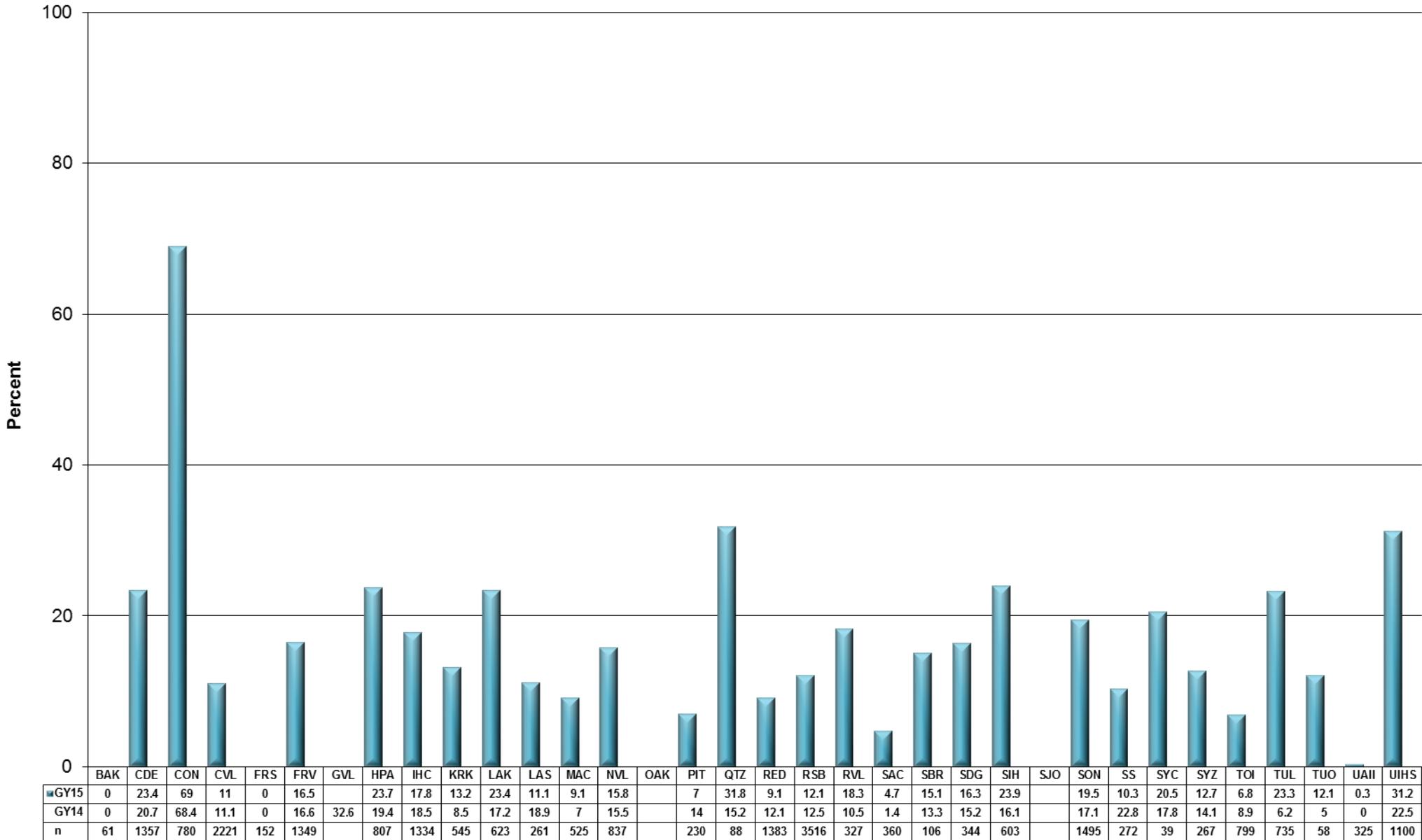
Measure: Percentage of AI/AN patients ages 2 to 15 years who have intact sealants

Importance: *American Indian and Alaska Native children have significantly higher dental decay rates than the general U.S. population. Dental sealants are an effective way to reduce decay and can be applied for a relatively low cost. Sealants can provide 100% protection from dental decay, and can prevent decay from continuing once it has started.*



*Prior to FY 2013, this measure reported on a count of the number of sealants placed.

DENTAL: SEALANTS

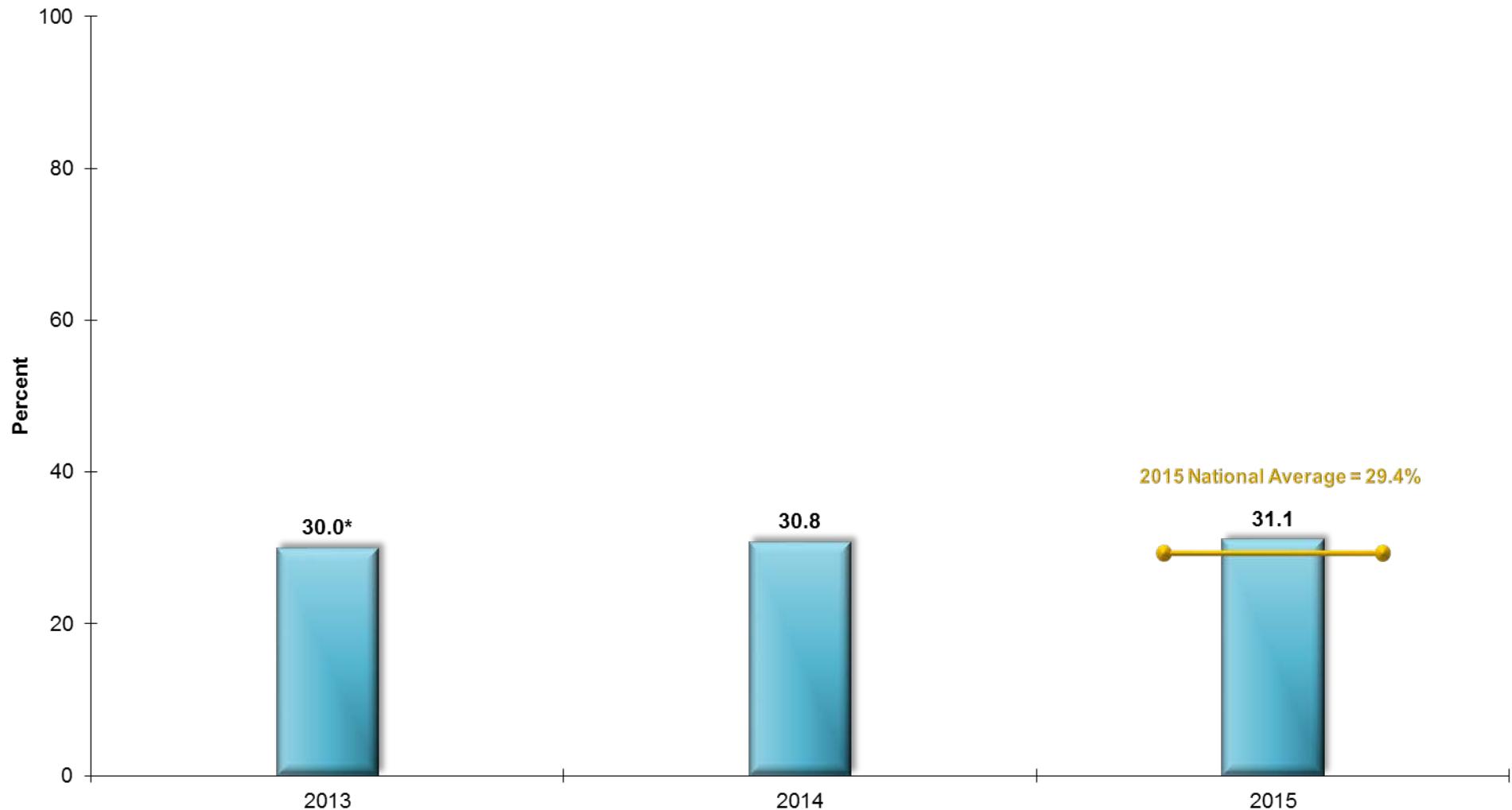


Note: Urban health programs are not required to report on this measure.

DENTAL: TOPICAL FLUORIDES

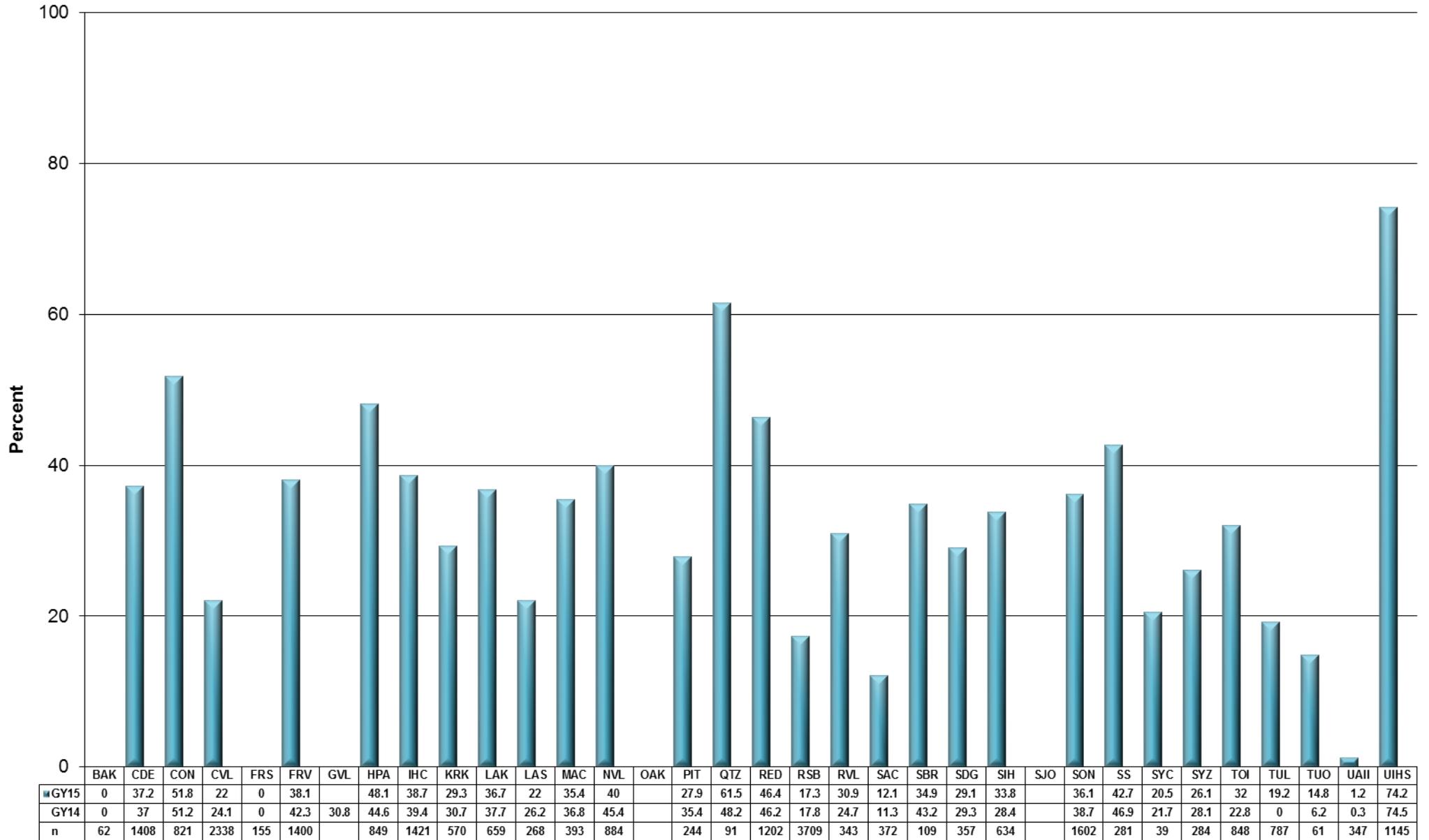
Measure: Percentage of AI/AN patients ages 1 to 15 years with one or more topical fluoride treatments during the report period

Importance: *The topical application of fluoride helps prevent cavities and is appropriate for children, adolescents, and adults. Patients who receive at least one fluoride application have fewer new cavities, which reduces the cost of providing dental care, and improves the oral health of patients.*



*Prior to FY 2013, this measure reported the number of patients receiving one or more fluoride applications during the report period.

DENTAL: TOPICAL FLUORIDES



Note: Urban health programs are not required to report on this measure.

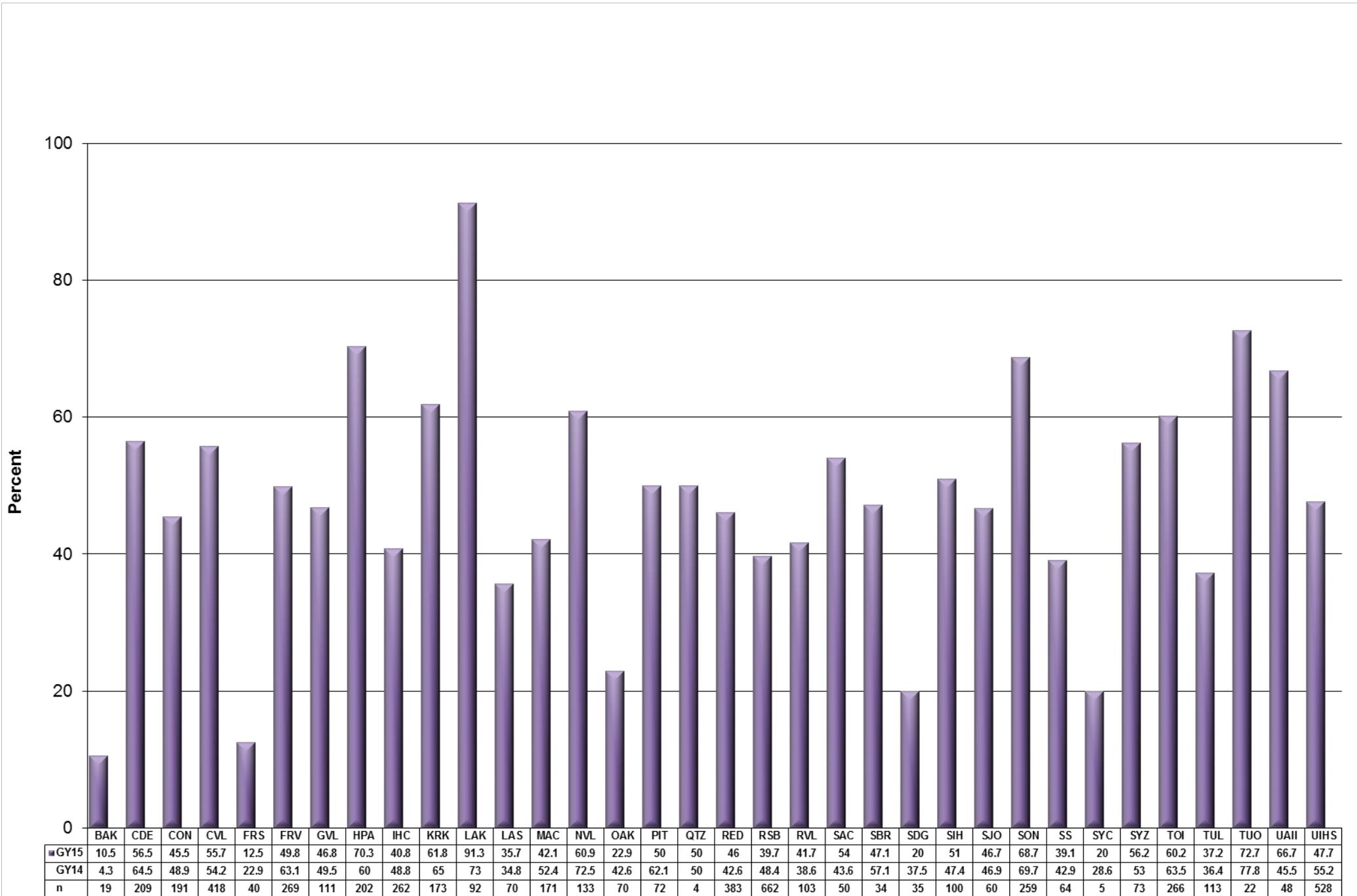
IMMUNIZATIONS: INFLUENZA

Measure: Influenza vaccination rates among adult patients age 65 years and older.

Importance: *Influenza (the “Flu”) is a highly contagious respiratory illness that can cause life-threatening complications. People aged 65 and older are especially vulnerable. Adults age 65 and older account for 90% of the deaths each year from complications related to influenza, and most of the hospitalizations from influenza-related illness. The best way to prevent influenza and its associated complications is to get an annual flu vaccination.*



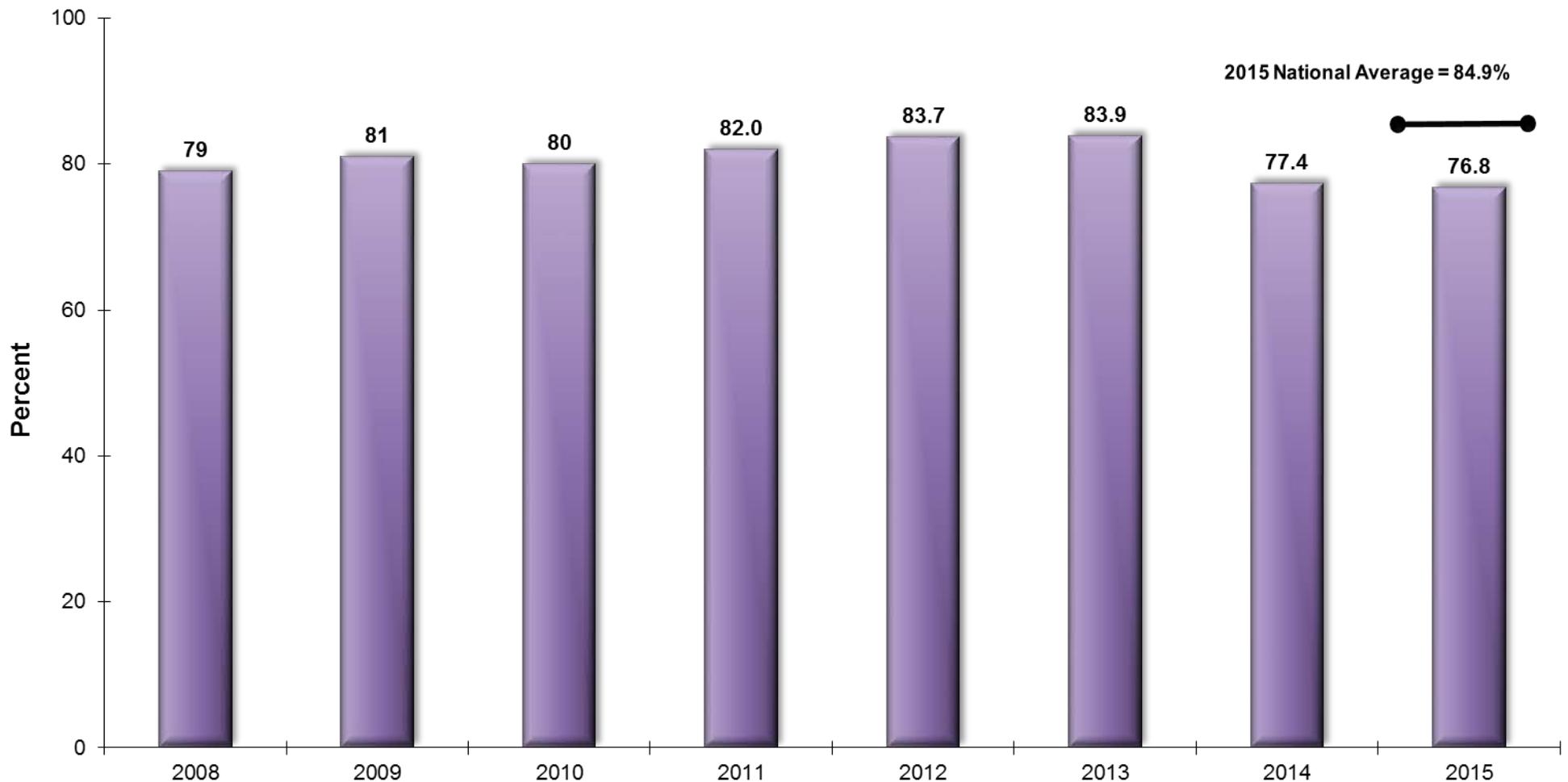
IMMUNIZATIONS: INFLUENZA



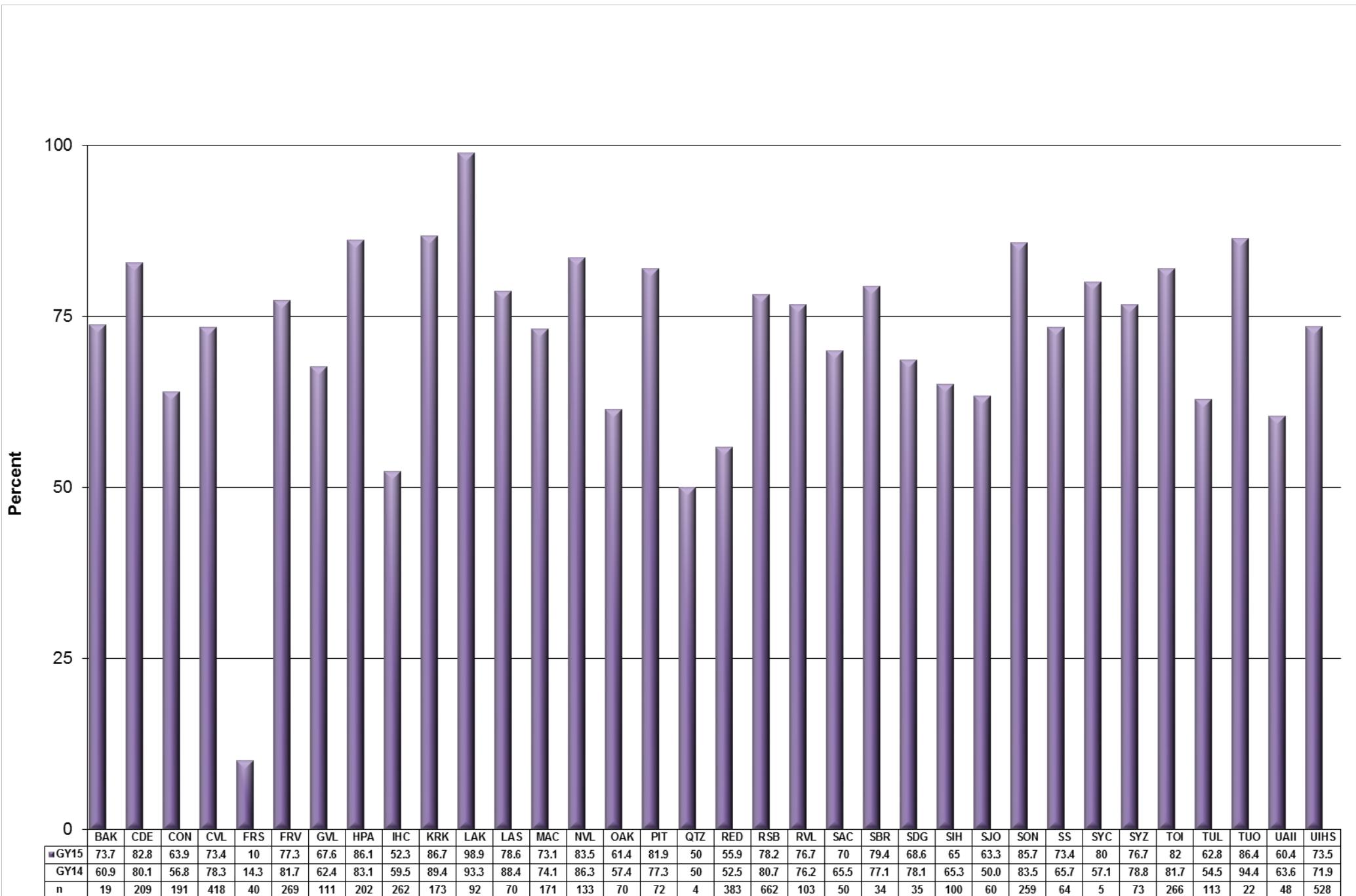
IMMUNIZATIONS: PNEUMOCOCCAL

Measure: Pneumococcal vaccination rates among adult patients aged 65 years and older.

Importance: *Pneumococcal disease is a bacterial infection that can lead to meningitis, pneumonia, and other serious infections. Most of the people who die from pneumococcal disease are older adults. The risk of death and complications from the disease can be greatly reduced by a single pneumococcal vaccination once a person reaches the age of 65.*



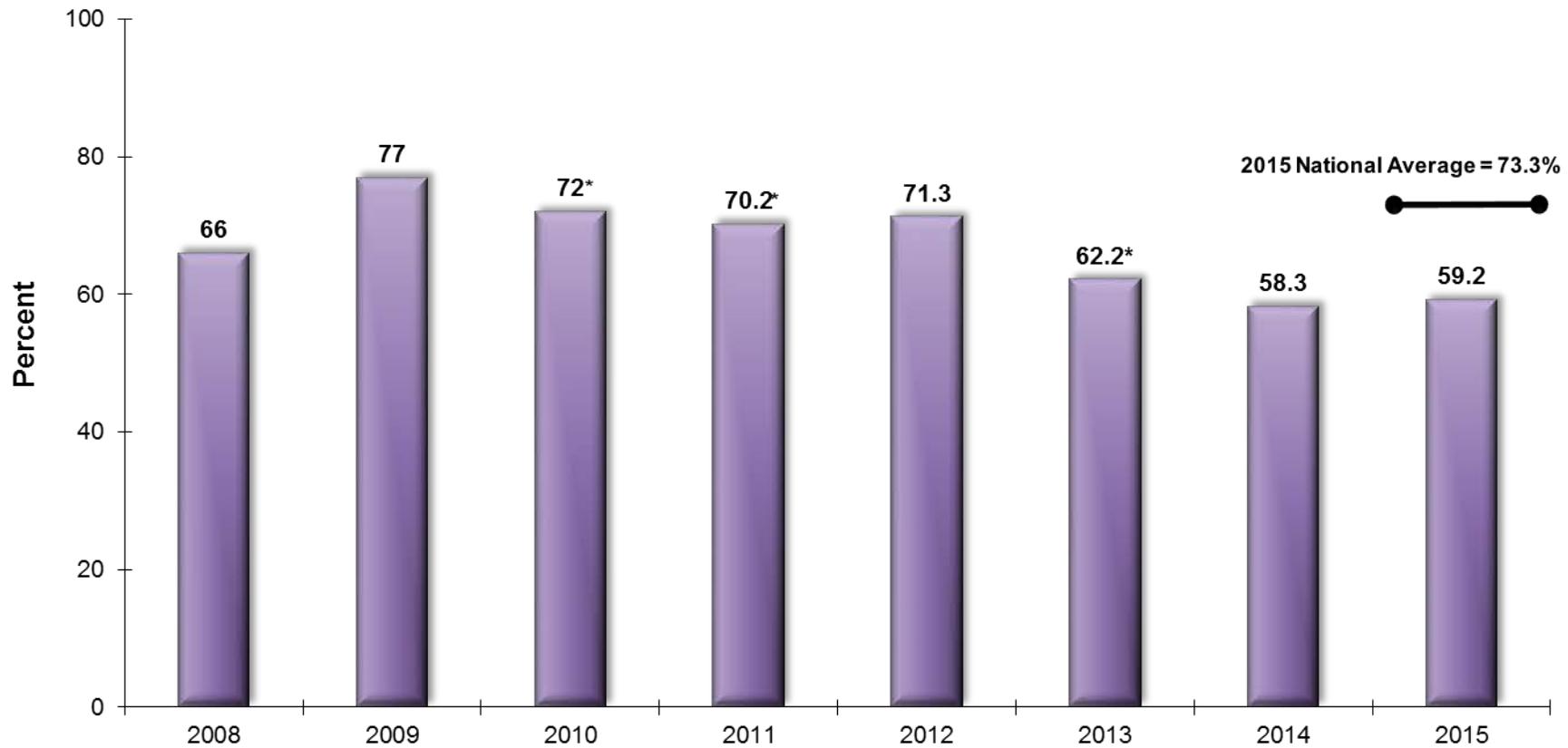
IMMUNIZATIONS: PNEUMOCOCCAL



IMMUNIZATIONS: CHILDHOOD (19 – 35 months)

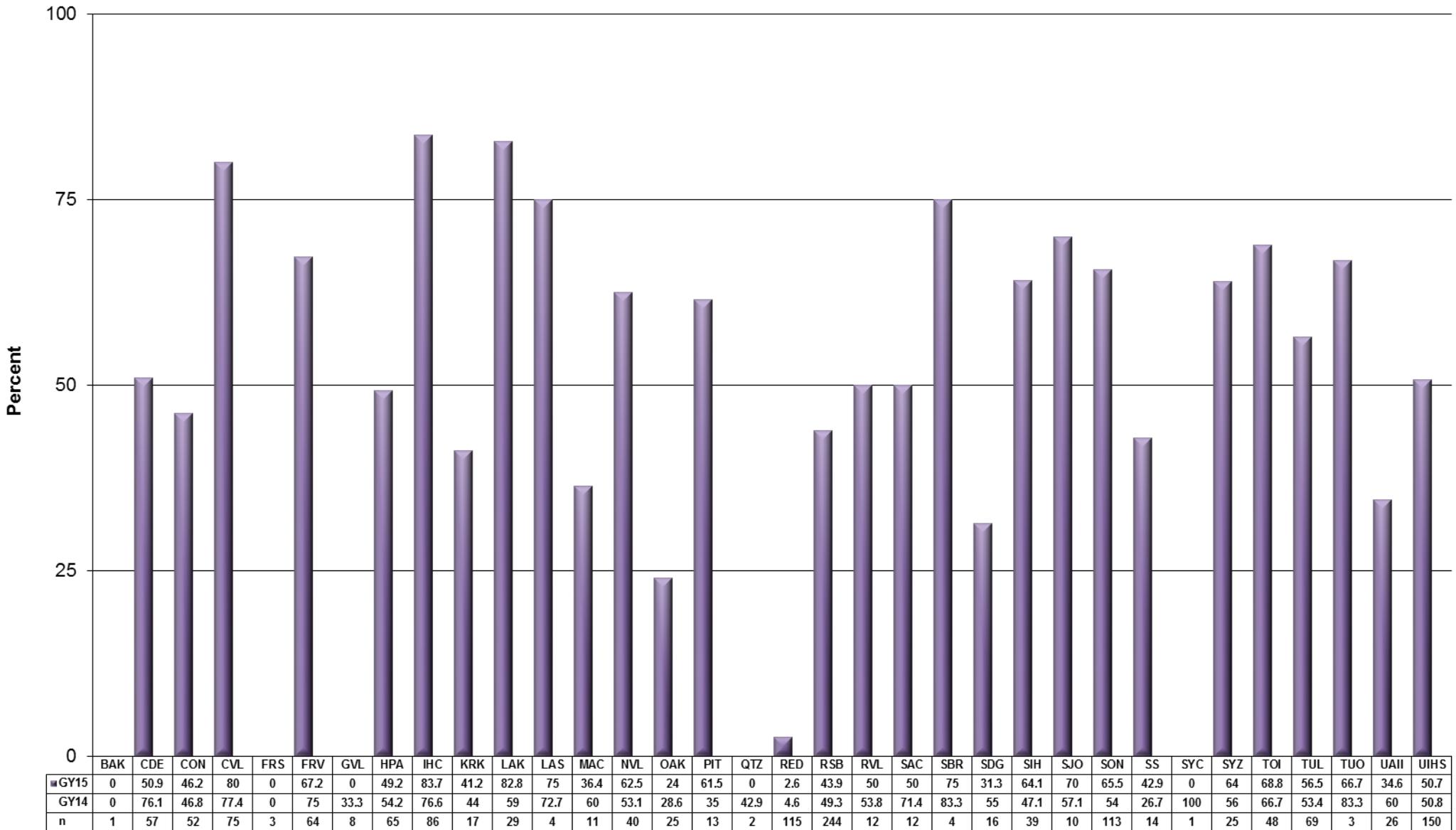
Measure: Combined (4:3:1:3*:3:1:4) immunization rates for AI/AN patients aged 19-35 months.

Importance: *Immunizations significantly improve the health of children, and stop the spread of disease within communities. The Healthy People 2020 goal is 80% coverage for the combined 4:3:1:3:3:1:4 series, which includes 4 doses of DTaP (Diphtheria/Tetanus/Pertussis-Whooping Cough), 3 doses of IPV (Polio), 1 dose of MMR (Measles/Mumps/Rubella), 3 or 4 doses of Hep B (Hepatitis), 3 doses of Hib (Haemophilus Influenzae- a cause of meningitis), one dose of Varicella (Chicken Pox), and 4 doses of PCV (Pneumococcal Conjugate). IHS measured the 4:3:1:3:3 measure prior to FY 2010; the 4:3:1:3:3:1 series in FY 2010, and the 4:3:1:3:3:1:4 series as of FY 2011. In FY 2013, the measure reported the 4:3:1:3*:3:1:4 series (where * indicates 3 or 4 doses of HiB vaccine depending on the vaccine brand).*



* Varicella vaccine added to childhood immunization series in FY 2010 and four pneumococcal conjugate vaccines added in FY 2011.

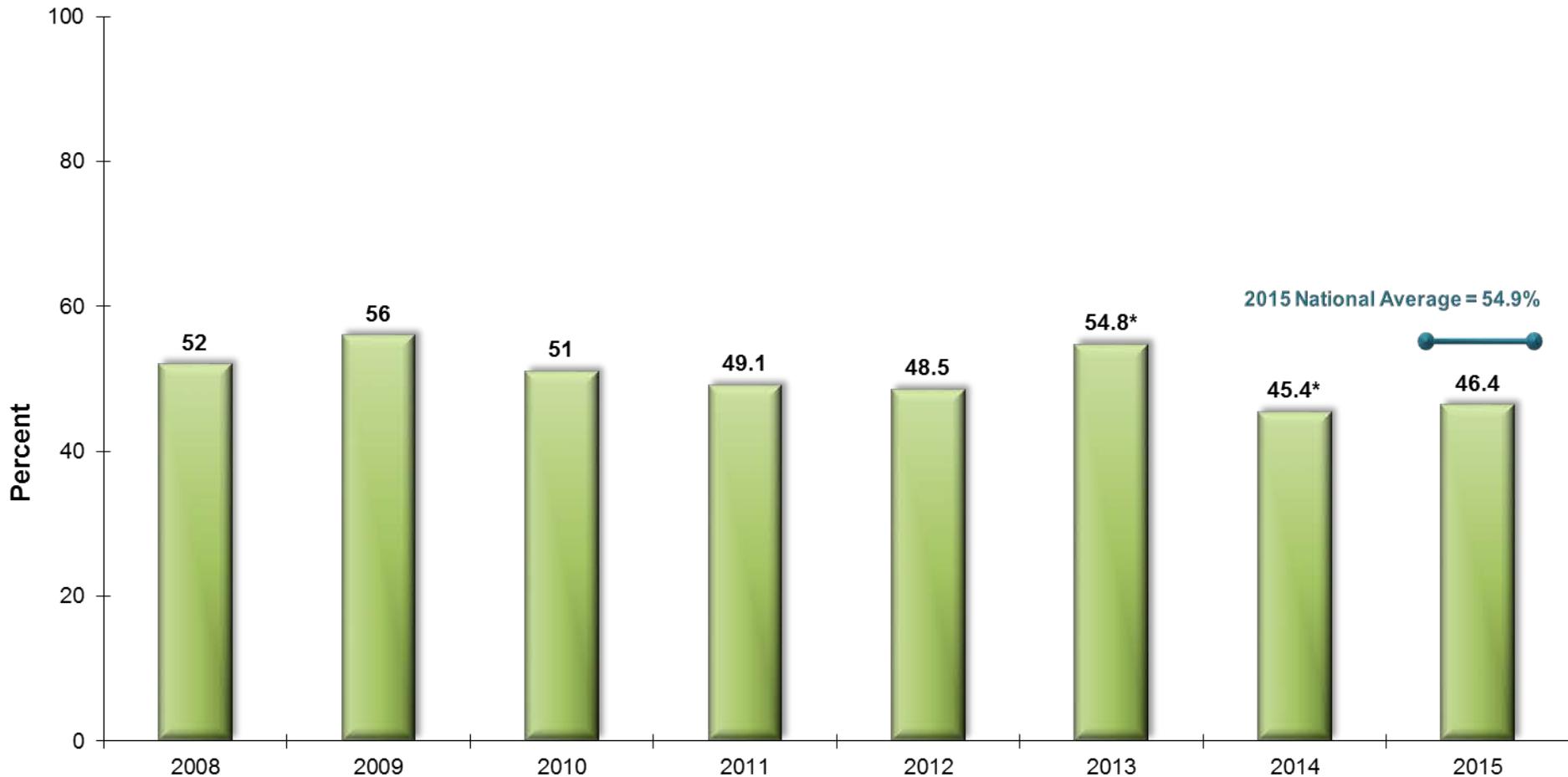
IMMUNIZATIONS: CHILDHOOD (19 – 35 months)



CANCER SCREENING: CERVICAL (PAP SMEAR)

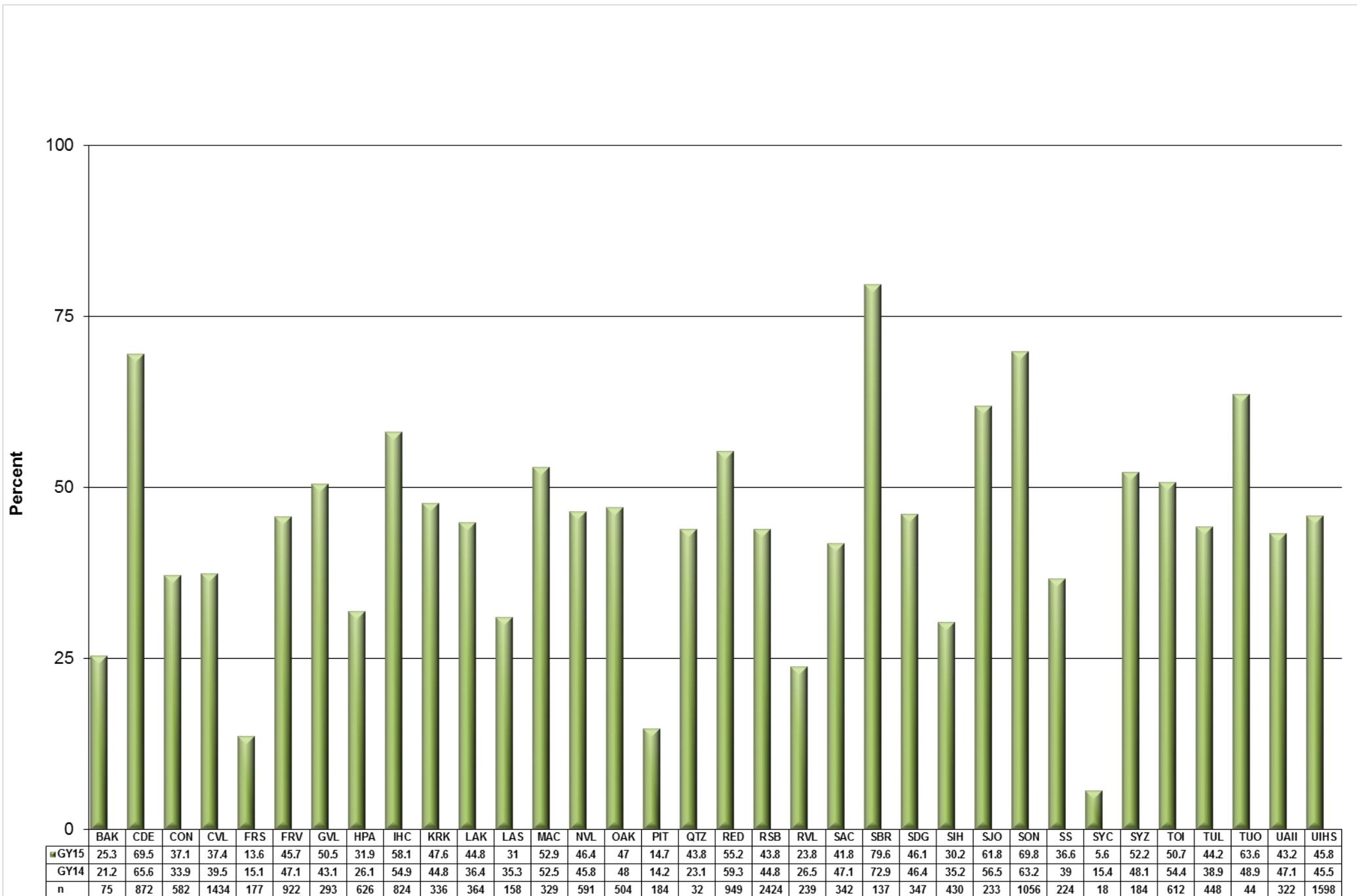
Measure: Percentage of female patients age 24-64 who have had a Pap screen within the past three years, or women age 30-64 with a Pap Screen and an HPV DNA in the past five years.

Importance: *More American Indian women report having never had a Pap screen than any other racial or ethnic group. Regular screening with a Pap screen lowers the risk of developing cervical cancer by detecting pre-cancerous changes. If cervical cancer is detected early, the likelihood of survival is almost 100 percent with appropriate treatment and follow up.*



*Prior to FY 2013, this measure reported the percentage of women 21 to 64 with a Pap Screen in the past three years. In FY 2013, measure reported the percentage of women 25 to 64 with a Pap Screen in the past four years. ** In FY 2014, measure reported on the percentage of women 24-64 with a Pap Screen in the past three years, or women 30-64 with a Pap Screen and an HPV DNA in the past five years.

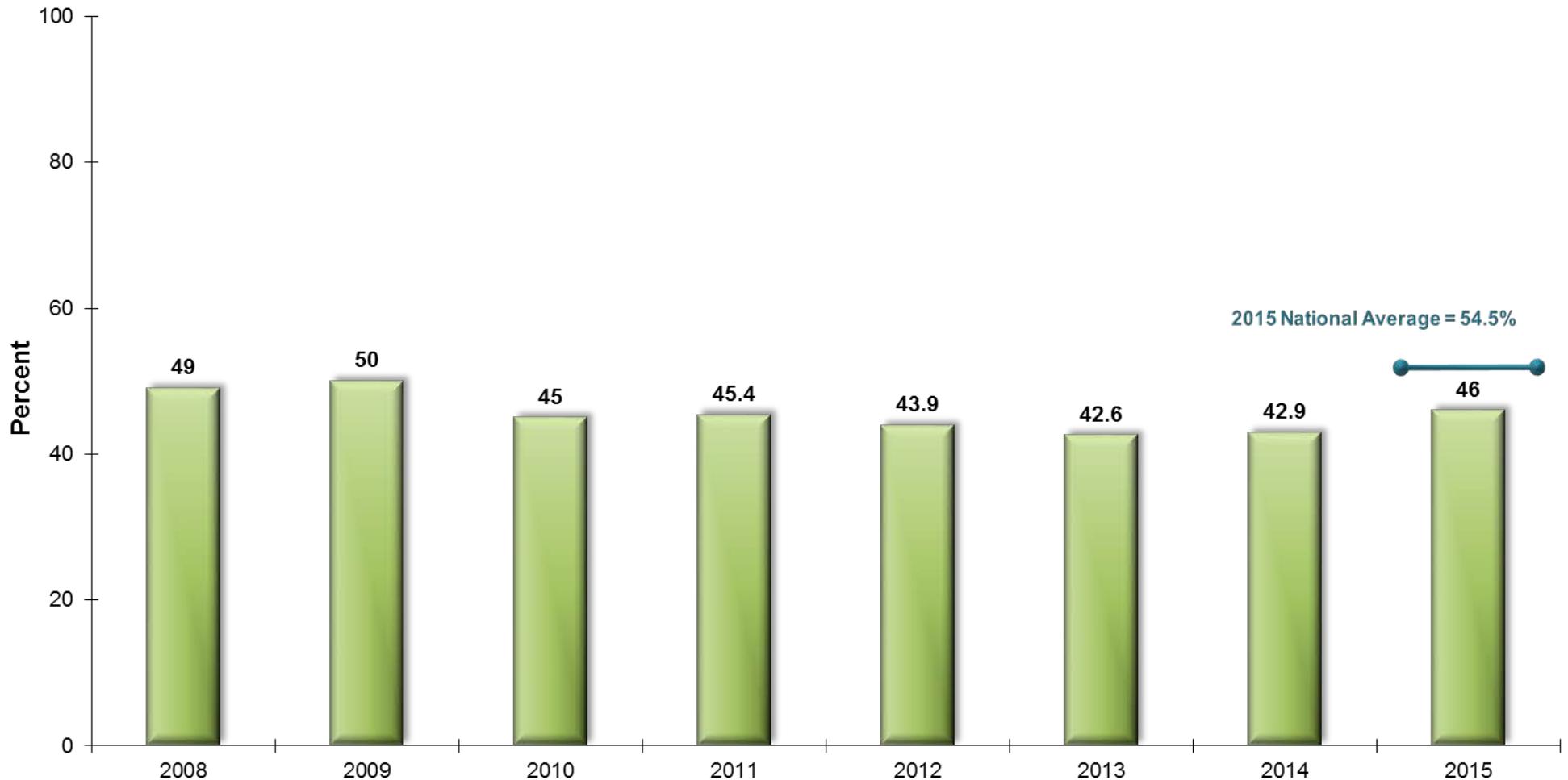
CANCER SCREENING: CERVICAL (PAP SMEAR)



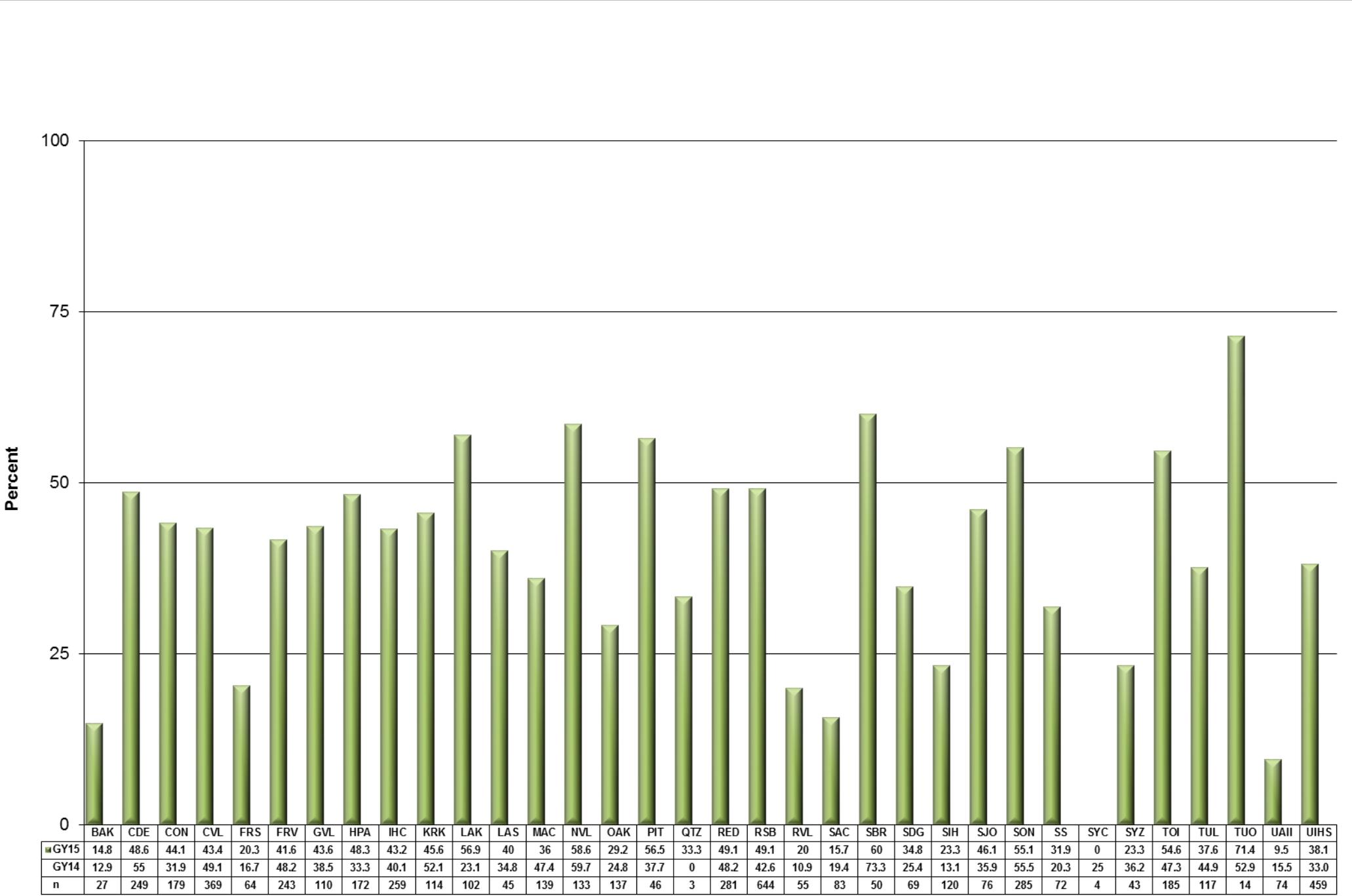
CANCER SCREENING: BREAST (MAMMOGRAPHY)

Measure: Percentage of eligible women who have had mammography screening within the previous two years.

Importance: *Screening women between the ages of 50 and 69 every other year has been shown to decrease the risk of death from breast cancer. Breast cancer is the second leading cause of cancer death among U.S. women (lung cancer is first). Although there has been overall improvement in breast cancer death rates since 1990, AI/AN women have not shared these gains. AI/AN women diagnosed with breast cancer have lower likelihood of surviving for five years compared to almost all other groups, mainly because their cancers are less likely to be found at an early stage, where they can be treated effectively.*



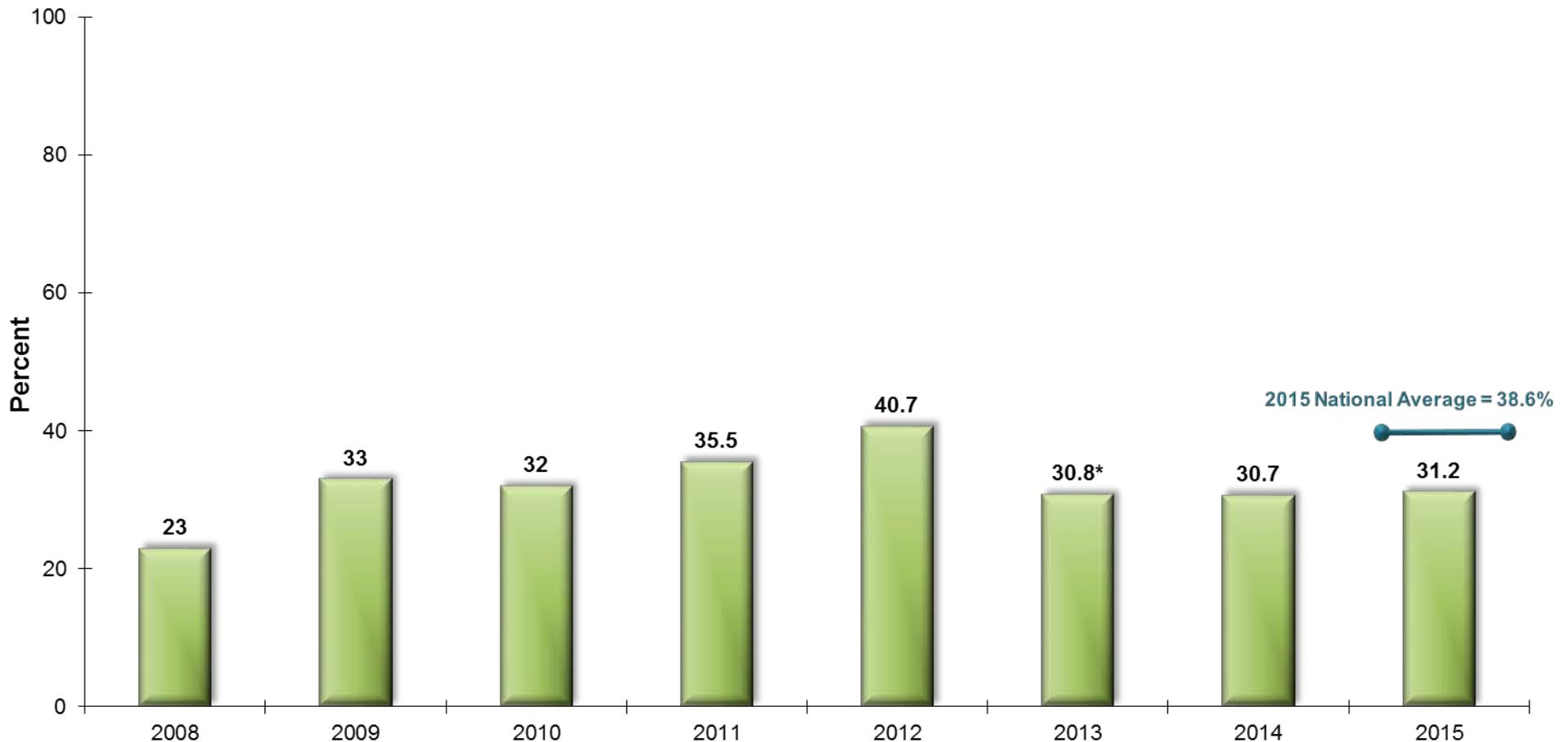
CANCER SCREENING: BREAST (MAMMOGRAPHY)



CANCER SCREENING: COLORECTAL

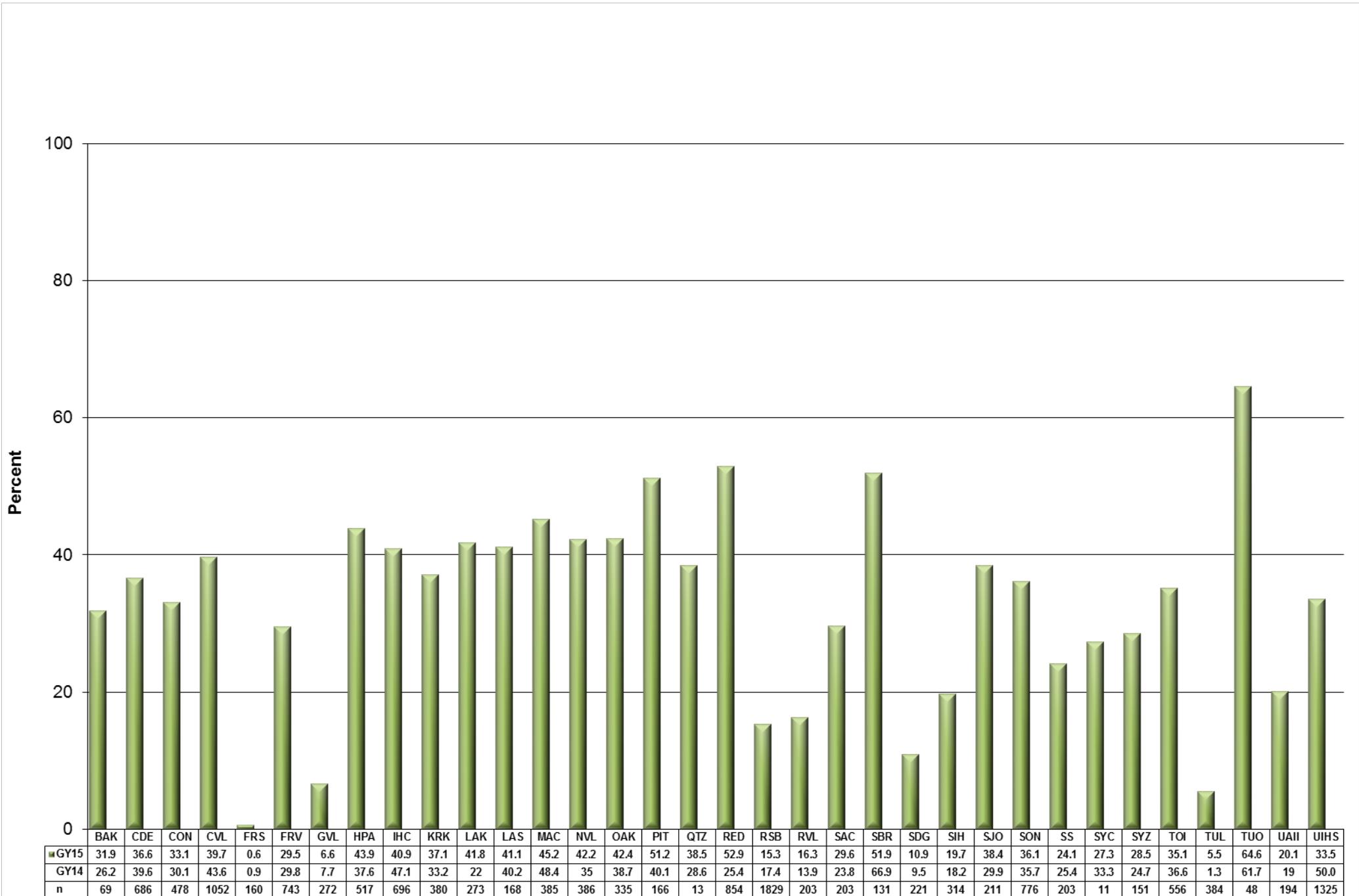
Measure: Percentage of eligible patients who have had appropriate colorectal cancer screening.

Importance: *Colorectal cancer is more common among Alaska Native and Northern Plains American Indians than among other groups, and the risk of death is higher than the national average. Screening improves the chance that colorectal cancer will be detected at an earlier stage, when it is more likely to be cured. Patients diagnosed at an early stage are 90% likely to survive for five years, but patients diagnosed at later stages have lower survival rates. The risk of colorectal cancer increases with age; 9 of 10 cases of colorectal cancer are found in individuals aged 50 and older.*



*Prior to FY 2013, this measure included patients 51-80 with Colorectal Cancer Screening and included double contrast barium enema in the numerator.

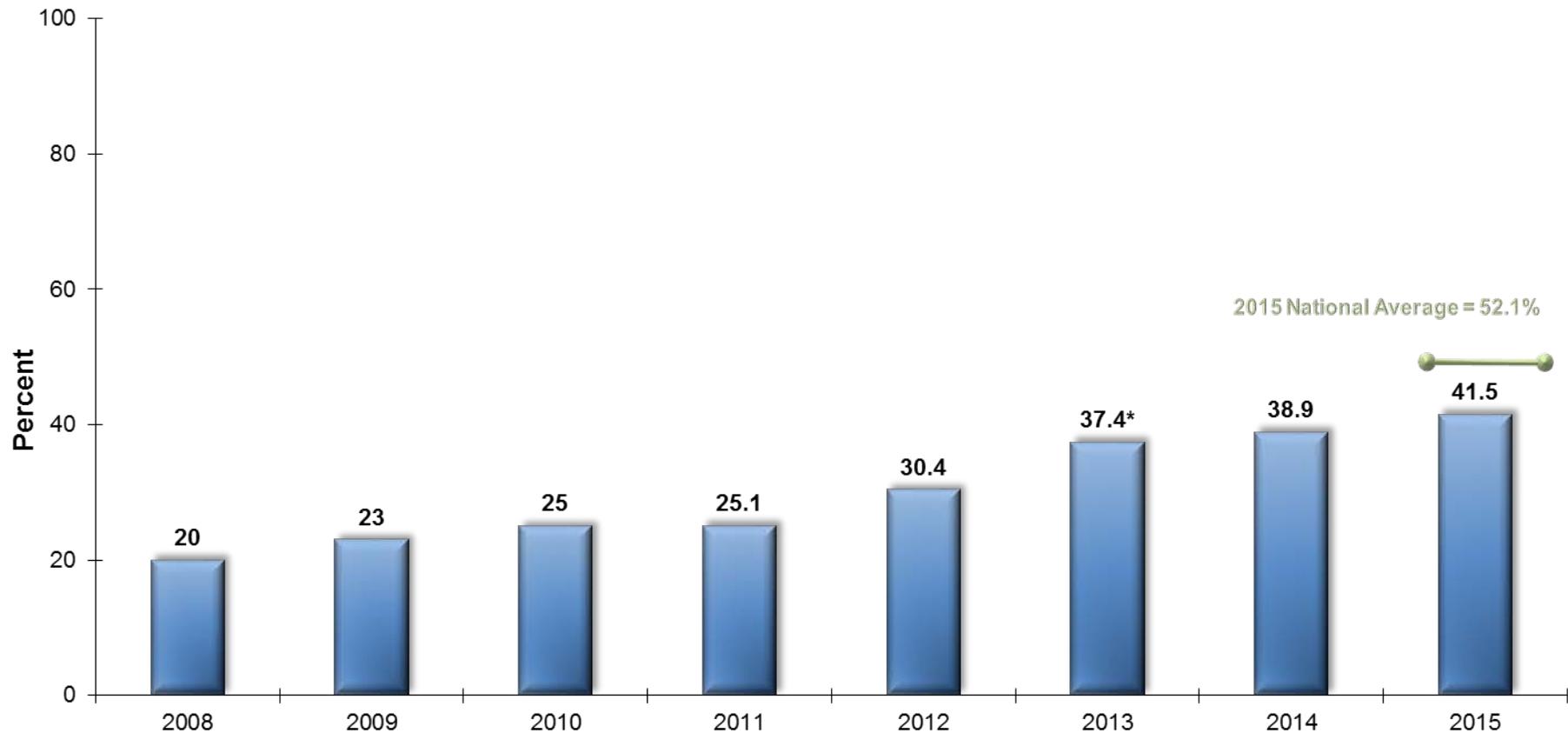
CANCER SCREENING: COLORECTAL



TOBACCO CESSATION

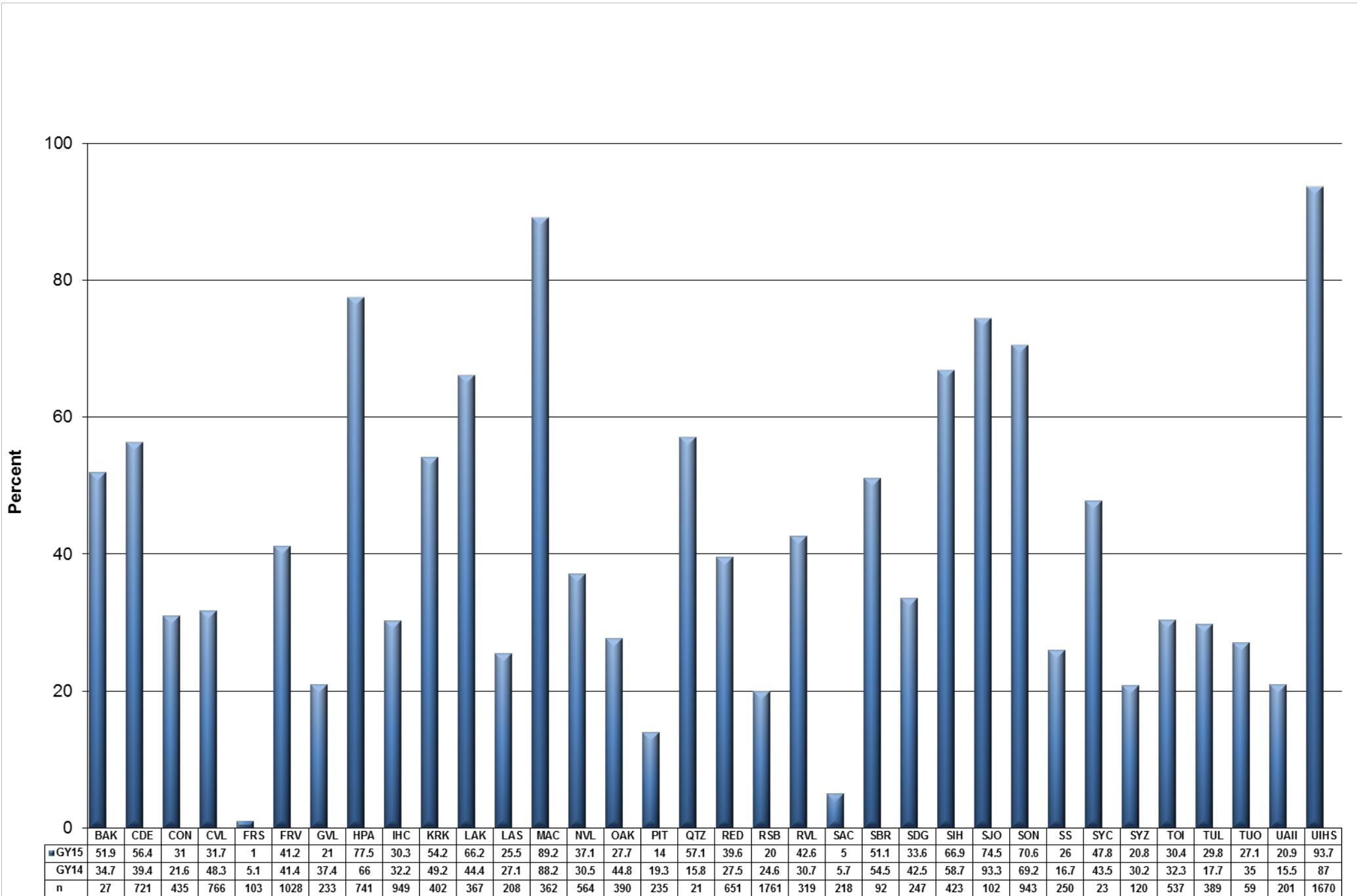
Measure: Percentage of tobacco-using patients that receive tobacco cessation intervention or quit.

Importance: *Cigarette smoking is the leading preventable cause of death in the United States, resulting in an estimated 443,000 premature deaths each year. American Indians and Alaska Natives have the highest prevalence of current cigarette smoking (30%) of any other racial/ethnic group in the U.S., and are more likely to smoke compared to other groups. Tobacco users who quit enjoy longer and healthier lives, on average, than those who do not. Even long-time smokers can significantly reduce their risk of heart disease and other complications by quitting. This measure assesses how many patients using tobacco are receiving advice and support to quit. Advice from doctors, and group and individual counseling have been shown to help smokers quit.*



*Prior to FY 2013, this measure did not include tobacco users who had quit during the report period in the numerator.

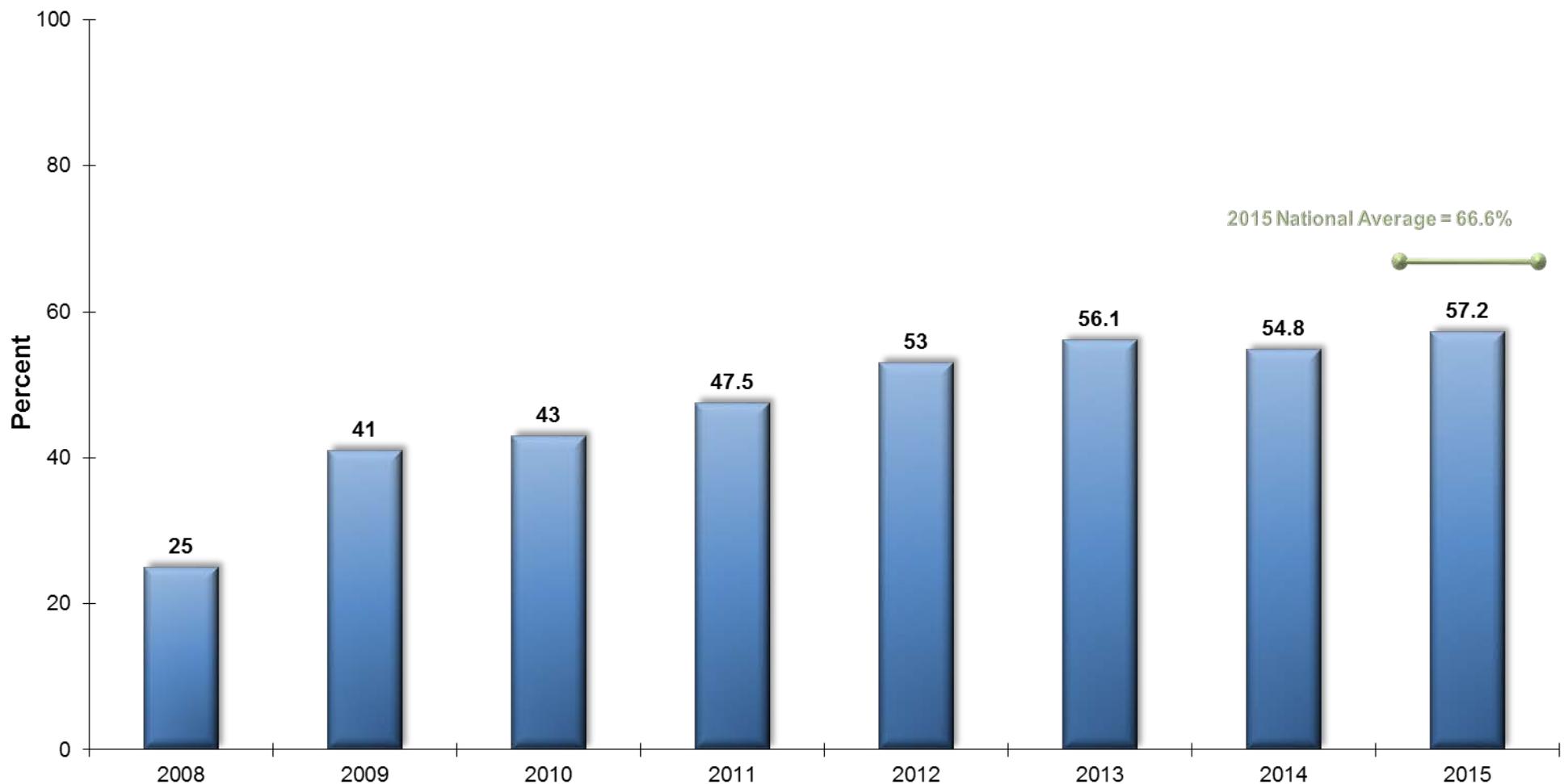
TOBACCO CESSATION



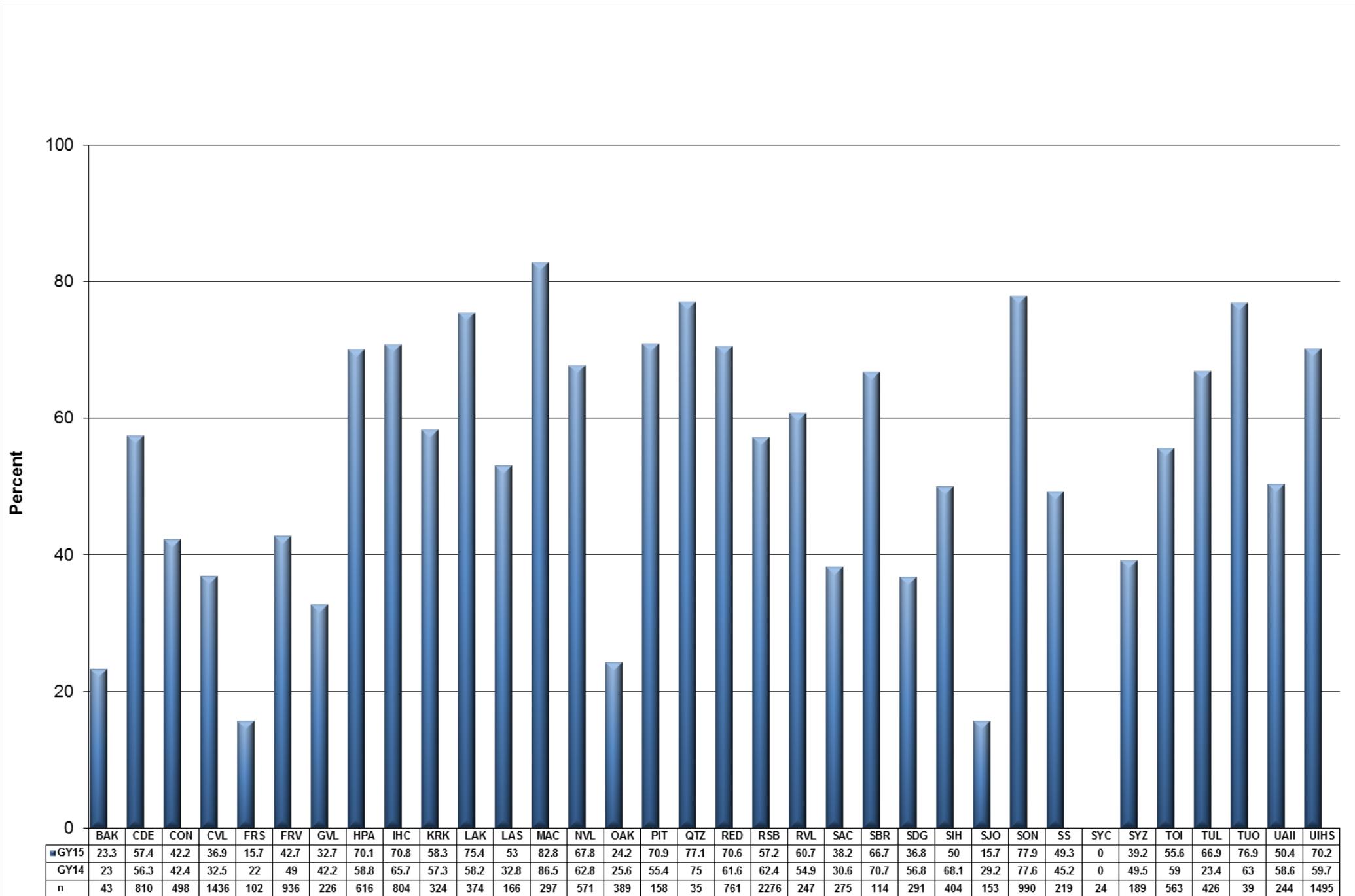
ALCOHOL SCREENING (FAS PREVENTION)

Measure: Percentage of women screened for alcohol use (to prevent Fetal Alcohol Syndrome)

Importance: *Heavy drinking during pregnancy can cause significant birth defects, including Fetal Alcohol Syndrome (FAS). FAS is the most common, and preventable, cause of mental retardation. Rates of FAS are higher among American Indians and Alaska Natives than the general population, and AI/AN women consume alcohol at greater rates than the national average. Screening women of childbearing age, and offering help to reduce or quit drinking, can lower the rate of FAS and related birth complications.*



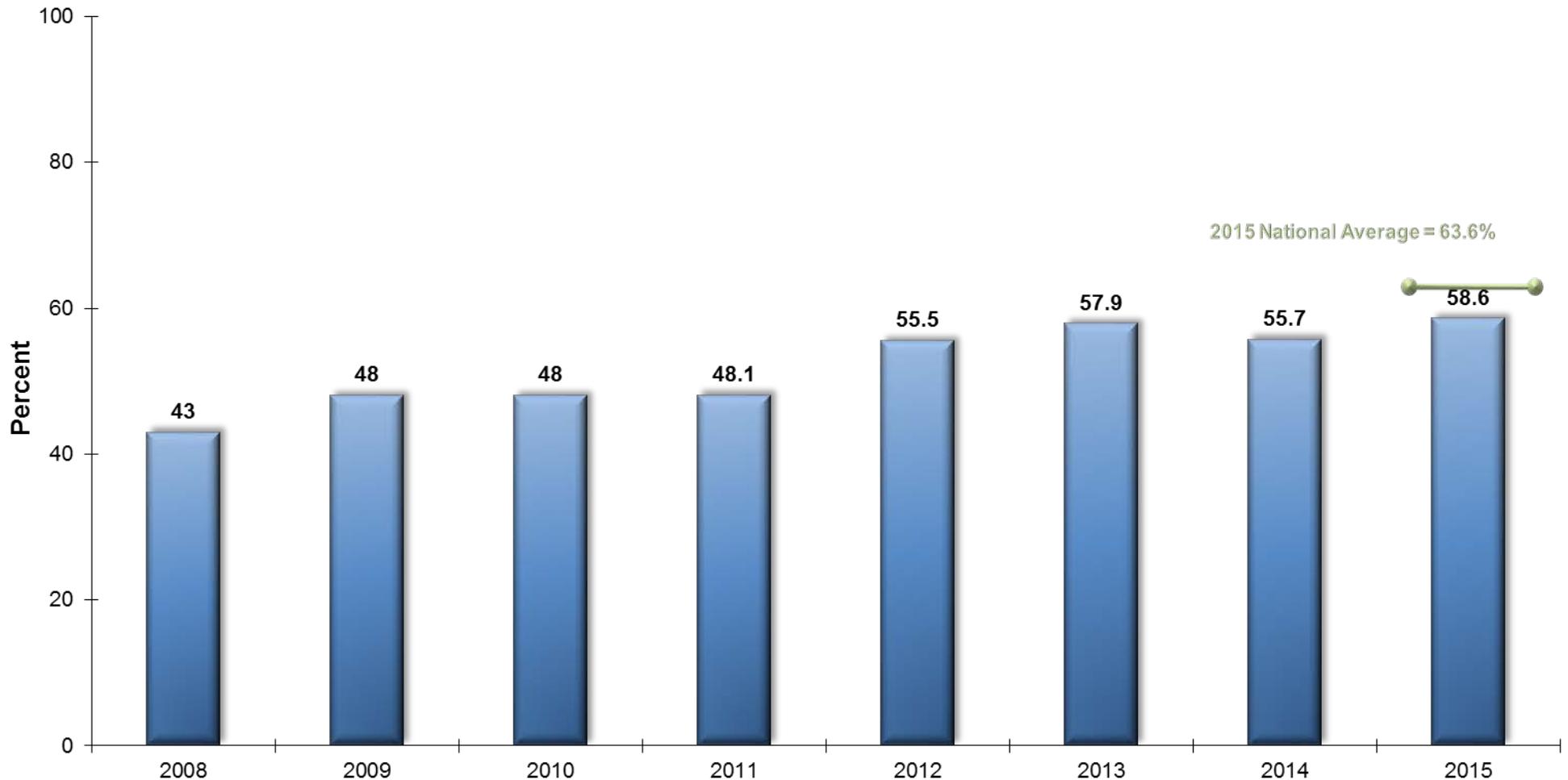
ALCOHOL SCREENING (FAS PREVENTION)



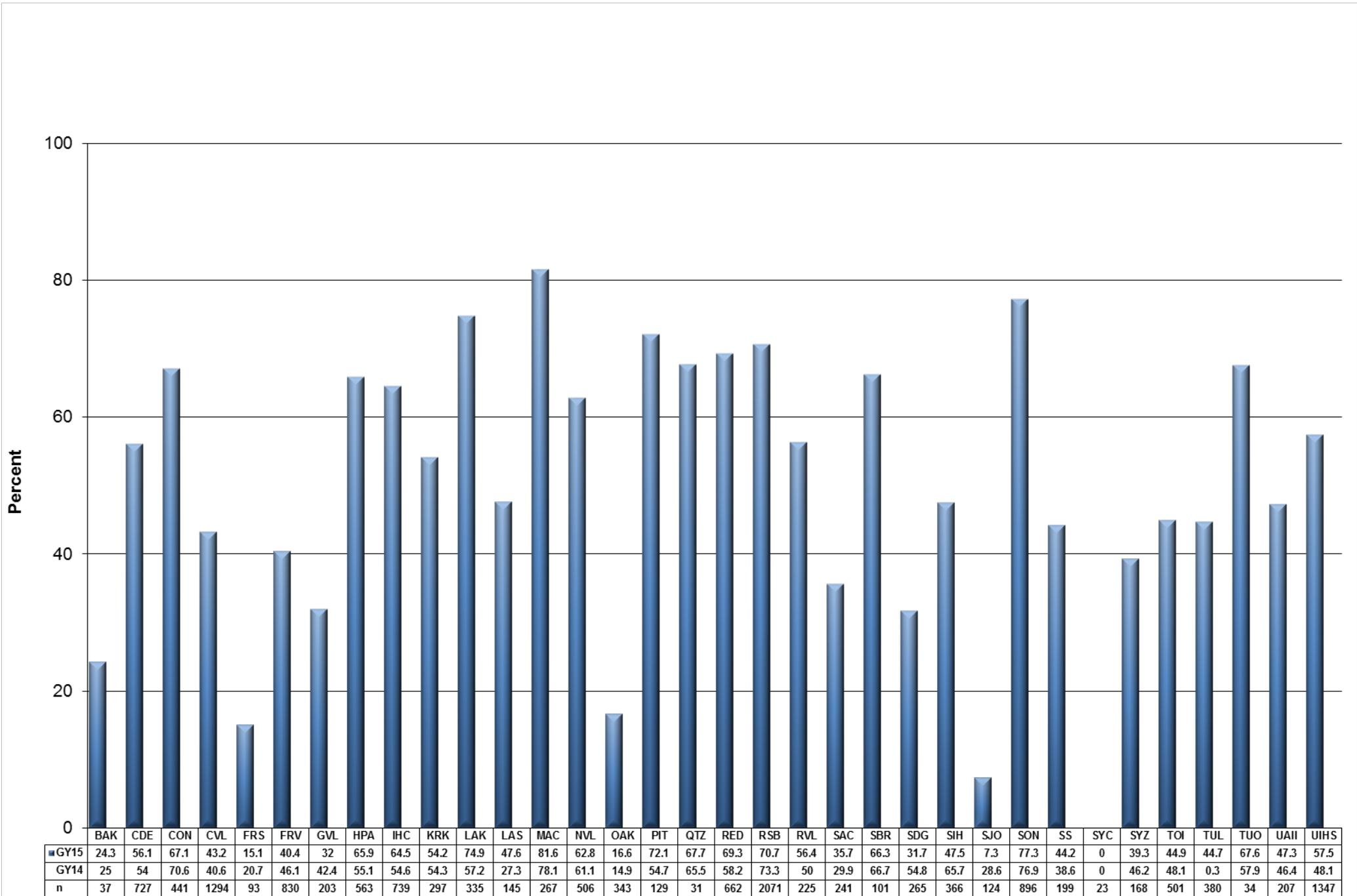
DOMESTIC VIOLENCE/INTIMATE PARTNER VIOLENCE SCREENING

Measure: Percentage of women who are screened for domestic violence at health care facilities.

Importance: *It is estimated that one in three American Indian/Alaska Native women have experienced domestic or intimate partner violence during their lives. Surveys at Indian Health hospitals have found even higher rates. Women who experience domestic violence are more often victims of nonconsensual sex and have higher rates of smoking, chronic pain syndromes, depression, anxiety, substance abuse, and Post-Traumatic Stress Disorder. Screening and offering help for victims of domestic violence will help to reduce this problem in Indian country.*



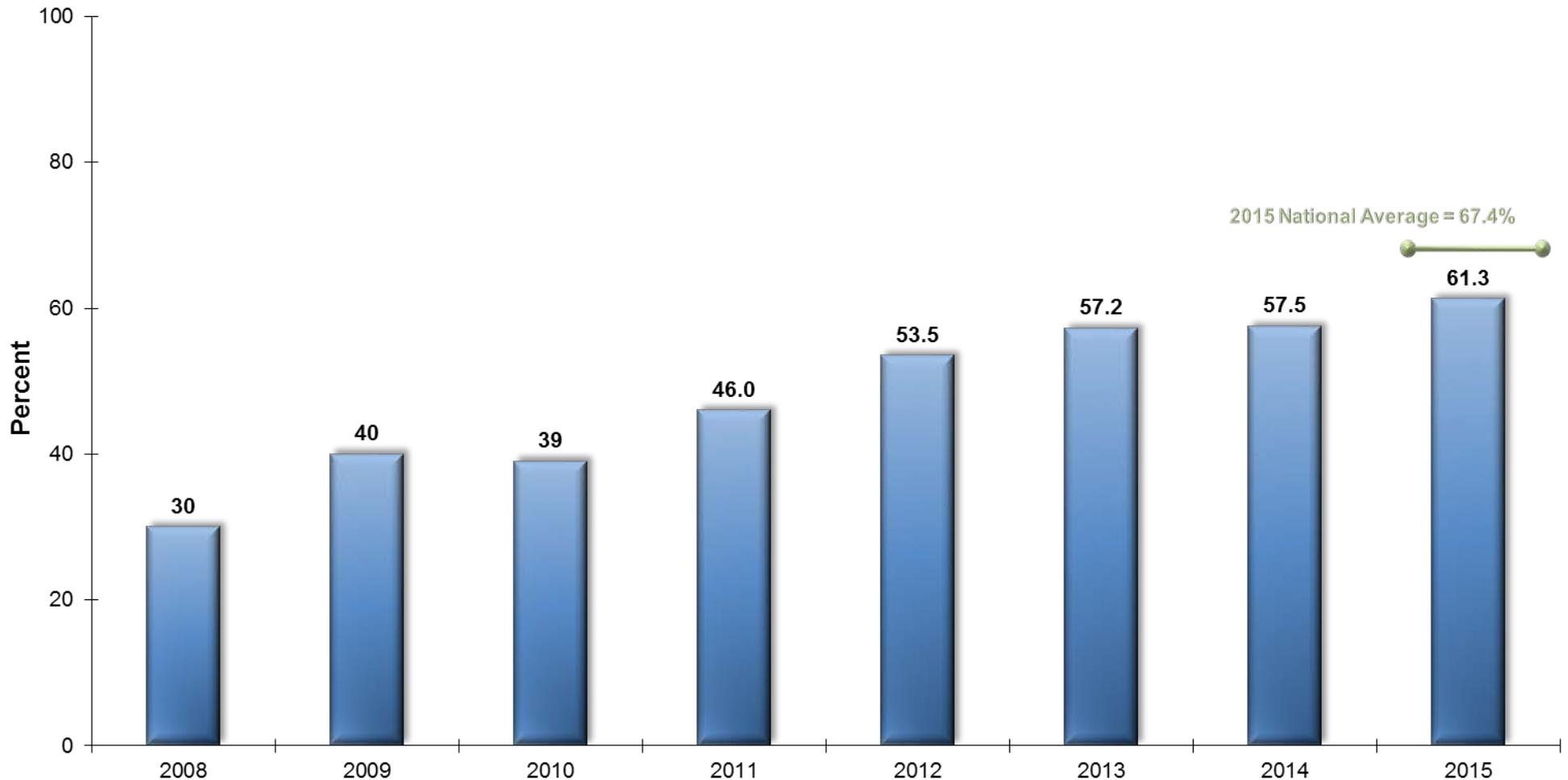
DOMESTIC VIOLENCE/INTIMATE PARTNER VIOLENCE SCREENING



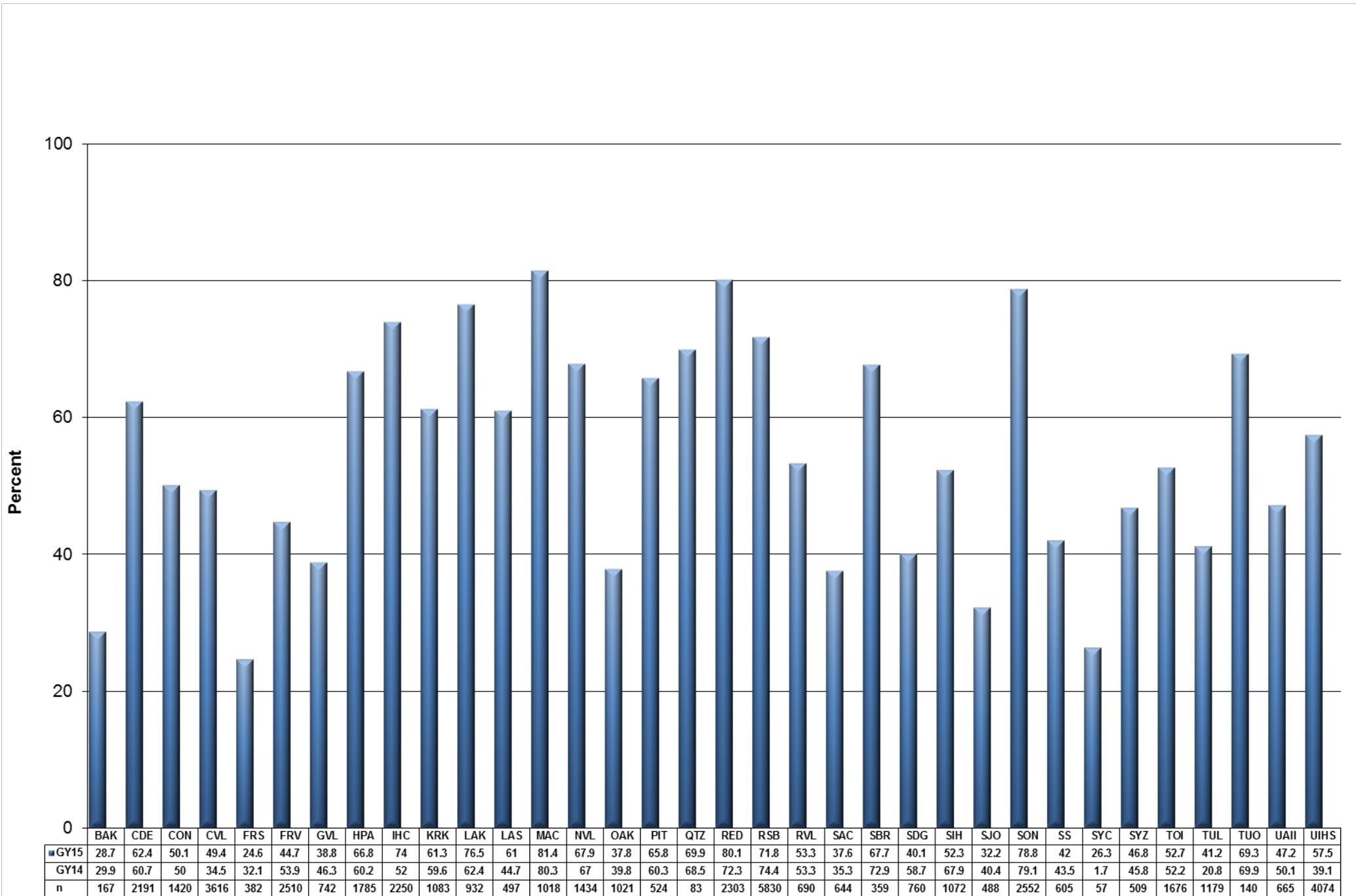
DEPRESSION SCREENING

Measure: Percentage of adults ages 18 and older who receive depression screening.

Importance: *Almost one in six U.S. adults experience major depression during their lifetime. Depression and anxiety disorders may affect heart rhythms, increase blood pressure, and lead to elevated blood sugar and cholesterol levels. Depression also frequently increases the risk of suicidal behavior. The risk of suicide attempts among patients with untreated major depressive disorder is one in five. Screening for depression is the first step toward identifying patients who need intervention, treatment, and follow up.*



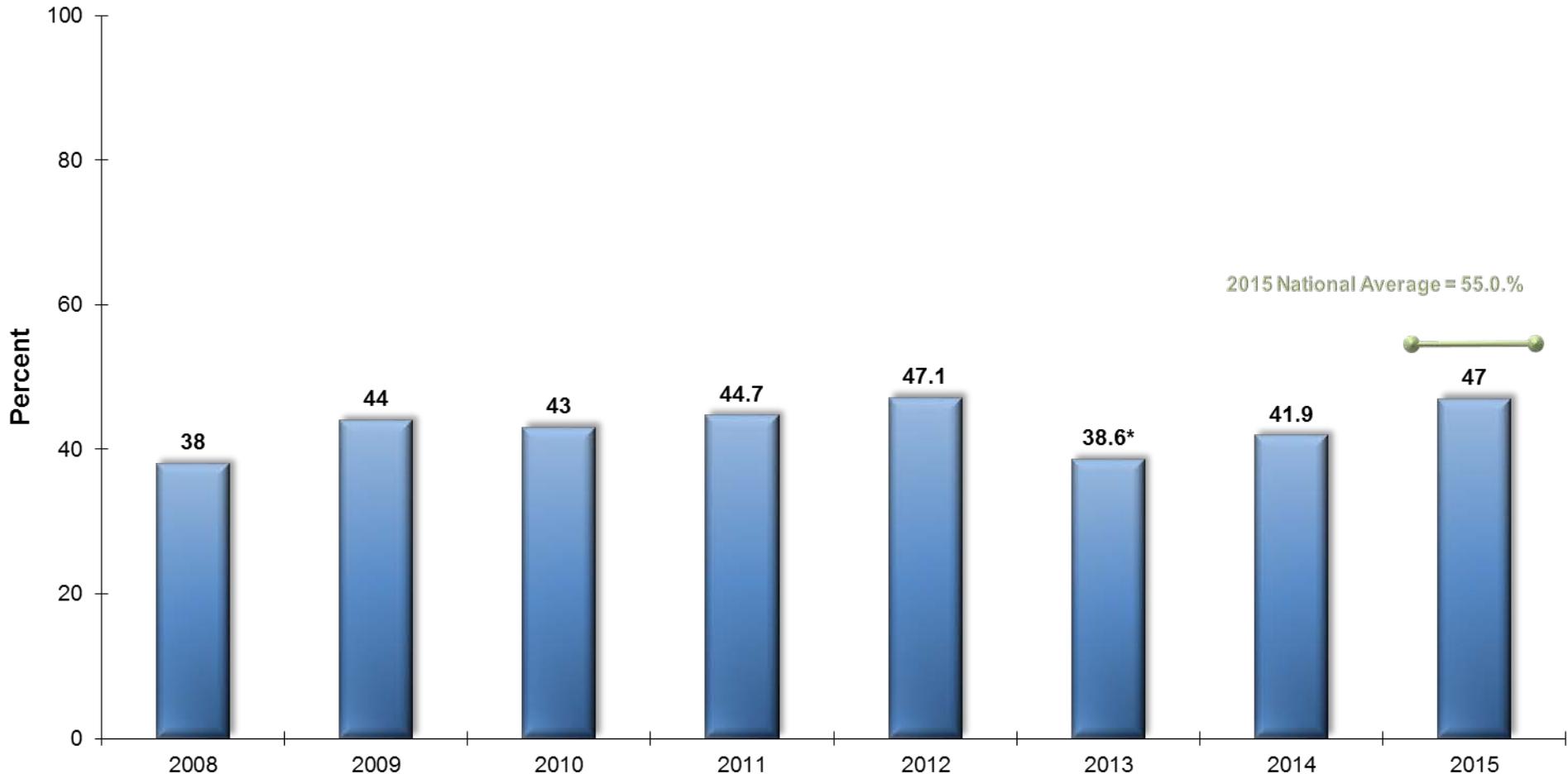
DEPRESSION SCREENING



CVD PREVENTION: COMPREHENSIVE ASSESSMENT

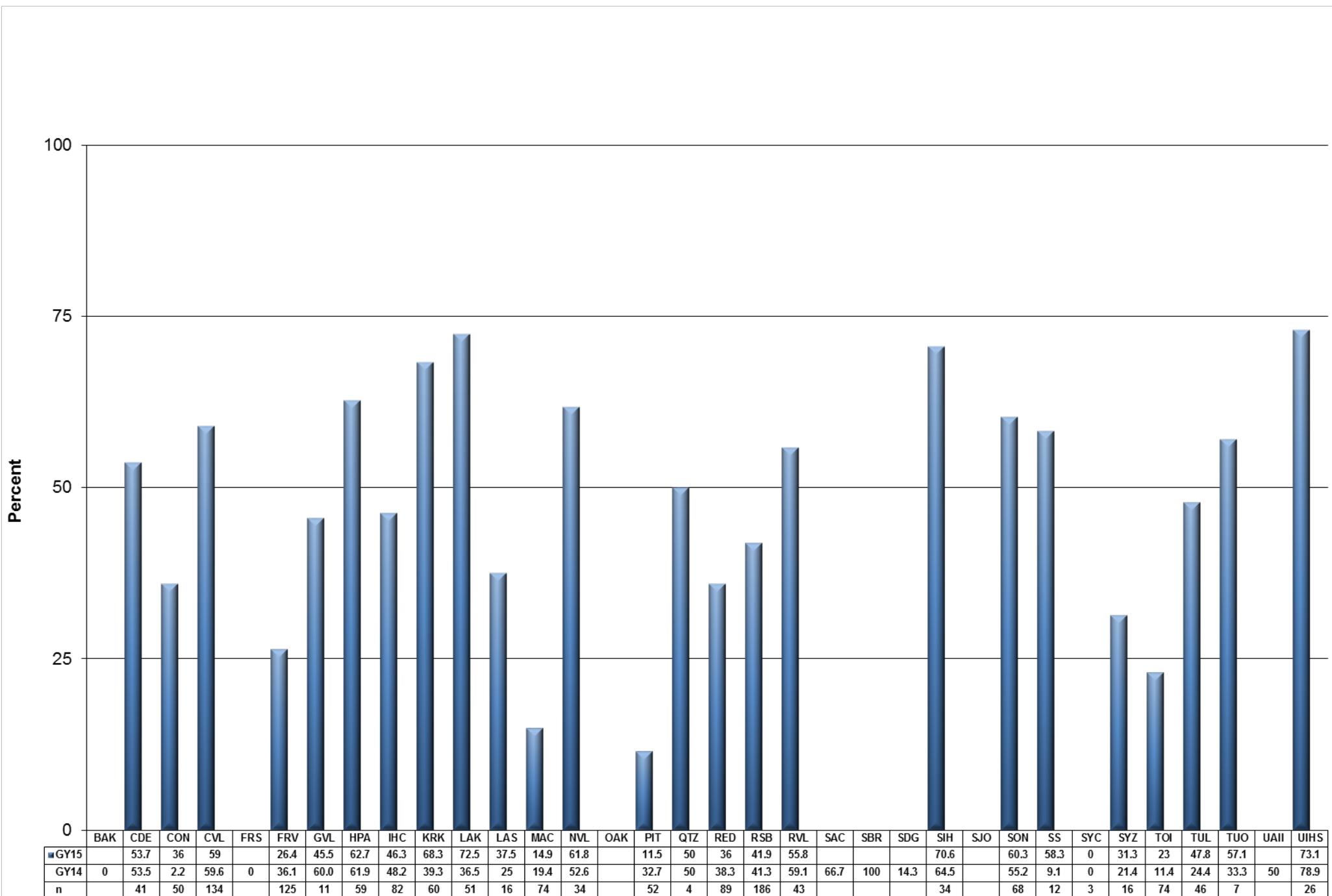
Measure: Percentage of CHD (Coronary Heart Disease) patients who have a comprehensive assessment for five CVD-related risk factors.

Importance: *Cardiovascular disease (CVD) is the leading cause of death for American Indian and Alaska Native people over age 45. Unlike other racial and ethnic groups, American Indians appear to have a growing rate of cardiovascular disease, likely because of the high rate of diabetes among American Indians. This measure addresses the major risk factors for CVD: high blood pressure, high cholesterol, smoking tobacco, excessive body weight, and physical inactivity.*



*Prior to FY 2013, this measure reported the percentage of IHD patients with a comprehensive CVD assessment and only required and LDL assessment once in the previous five years.

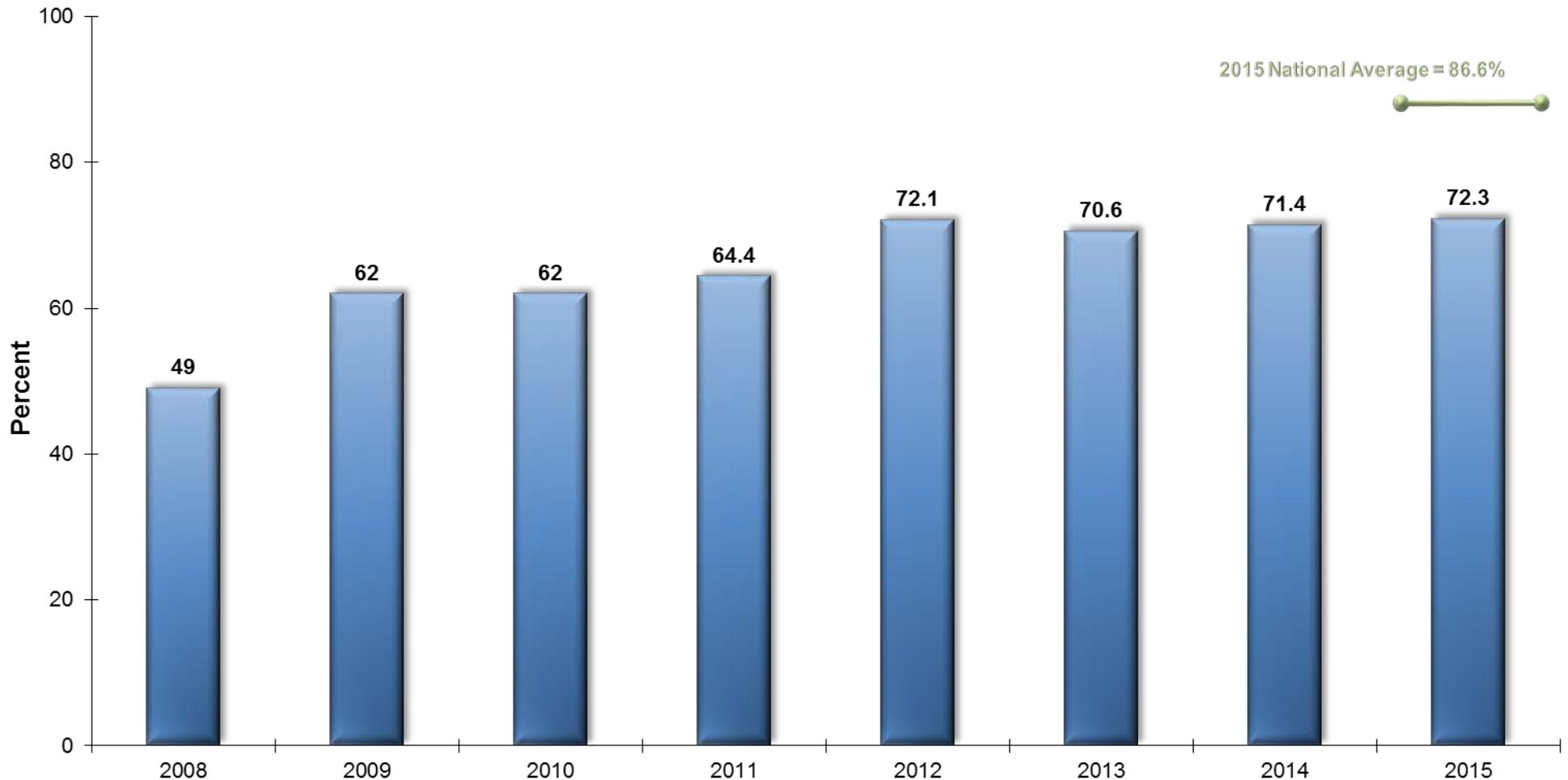
CVD PREVENTION: COMPREHENSIVE ASSESSMENT



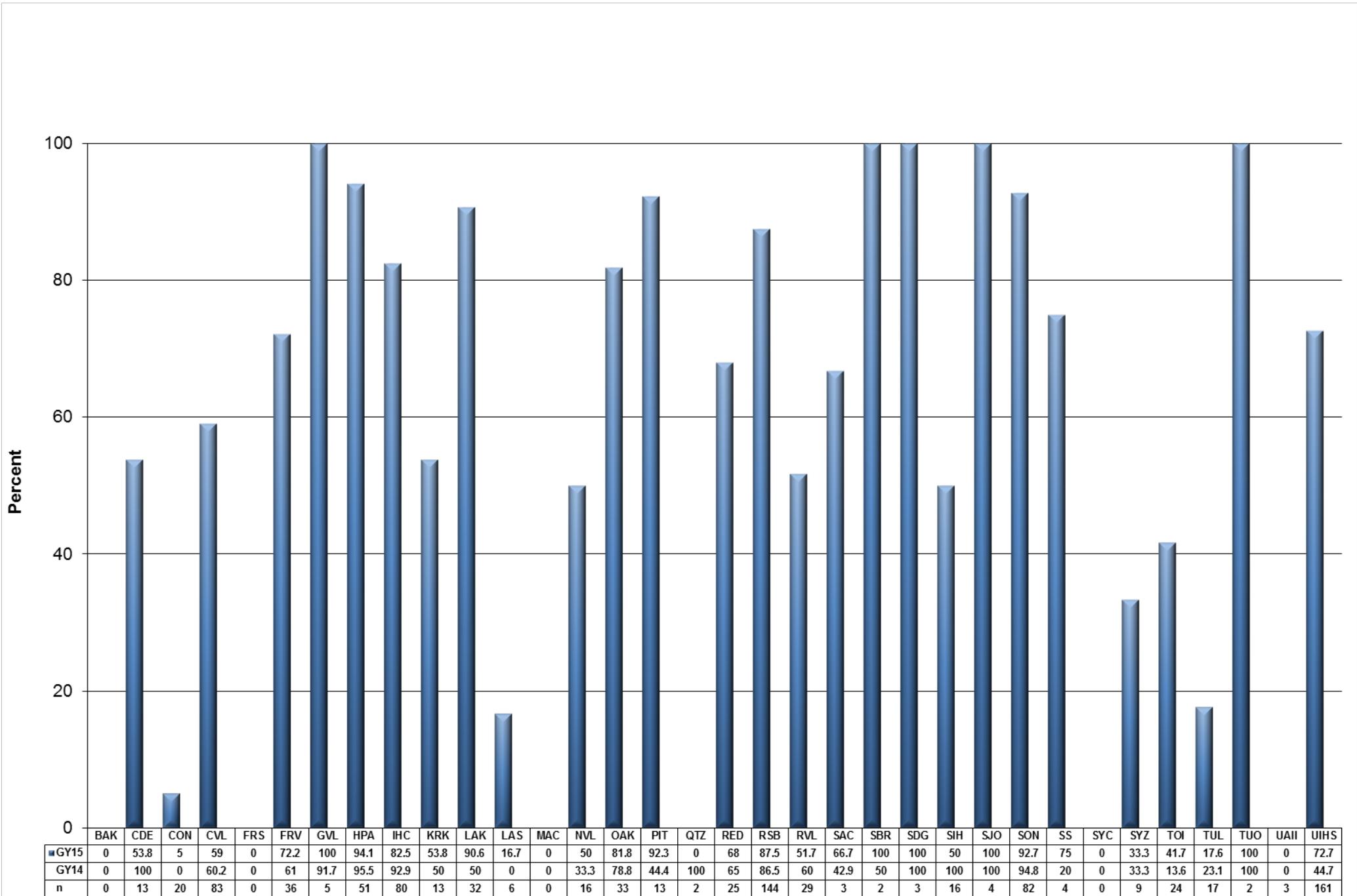
PRENATAL HIV SCREENING

Measure: Percentage of pregnant women screened for HIV.

Importance: *The HIV/AIDS epidemic is a significant issue for American Indian and Alaska Native women of childbearing age. Women account for almost one in three of all HIV/AIDS diagnoses among AI/ANs. Women with HIV can transmit the disease to their newborn children. There are drugs that can be taken during pregnancy to reduce the transmission rate to 2% or less; without these drugs, the rate is 25%. Routine prenatal HIV testing of all pregnant women is the best way to avoid passing HIV from mother to infant.*



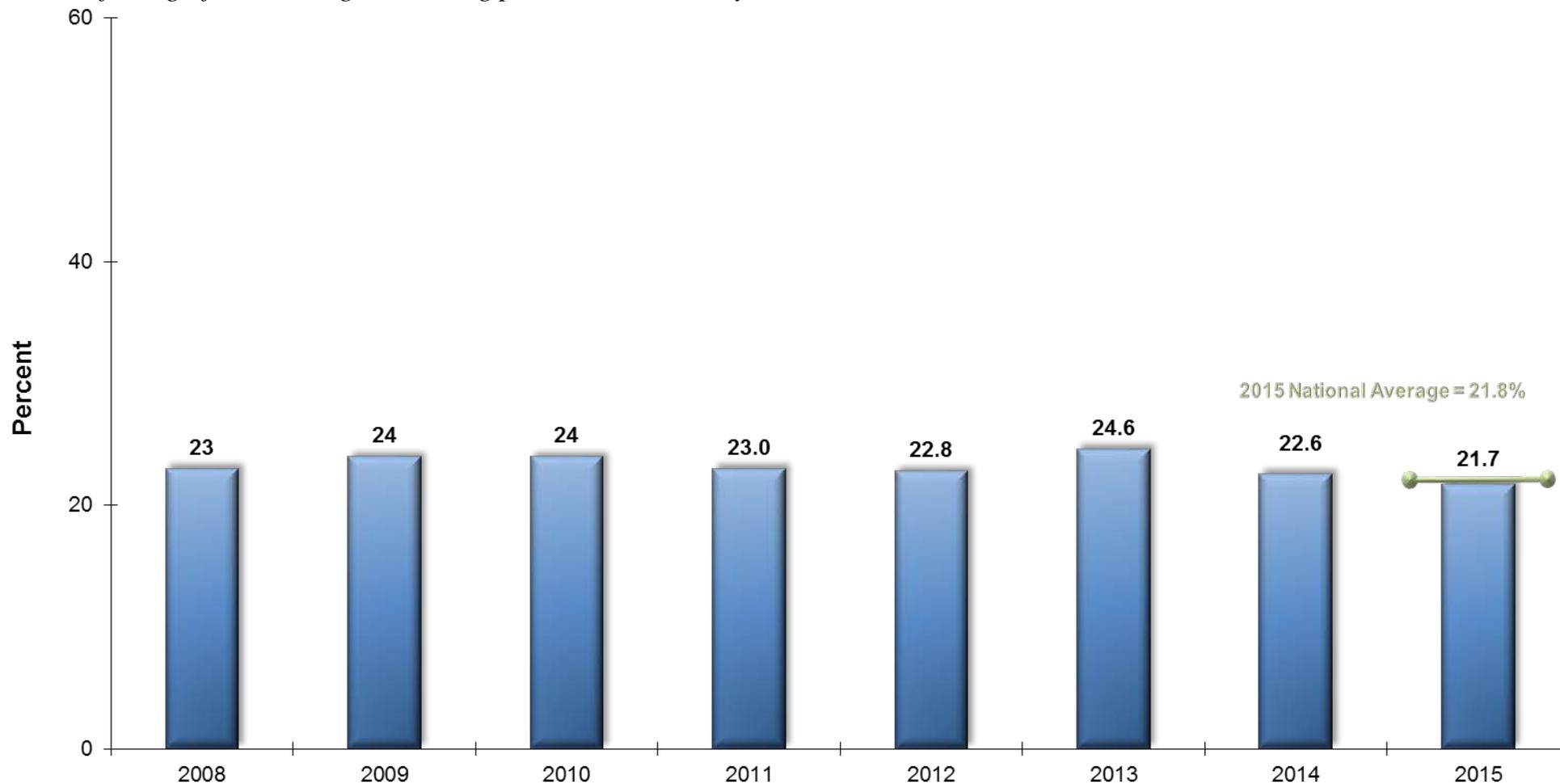
PRENATAL HIV SCREENING



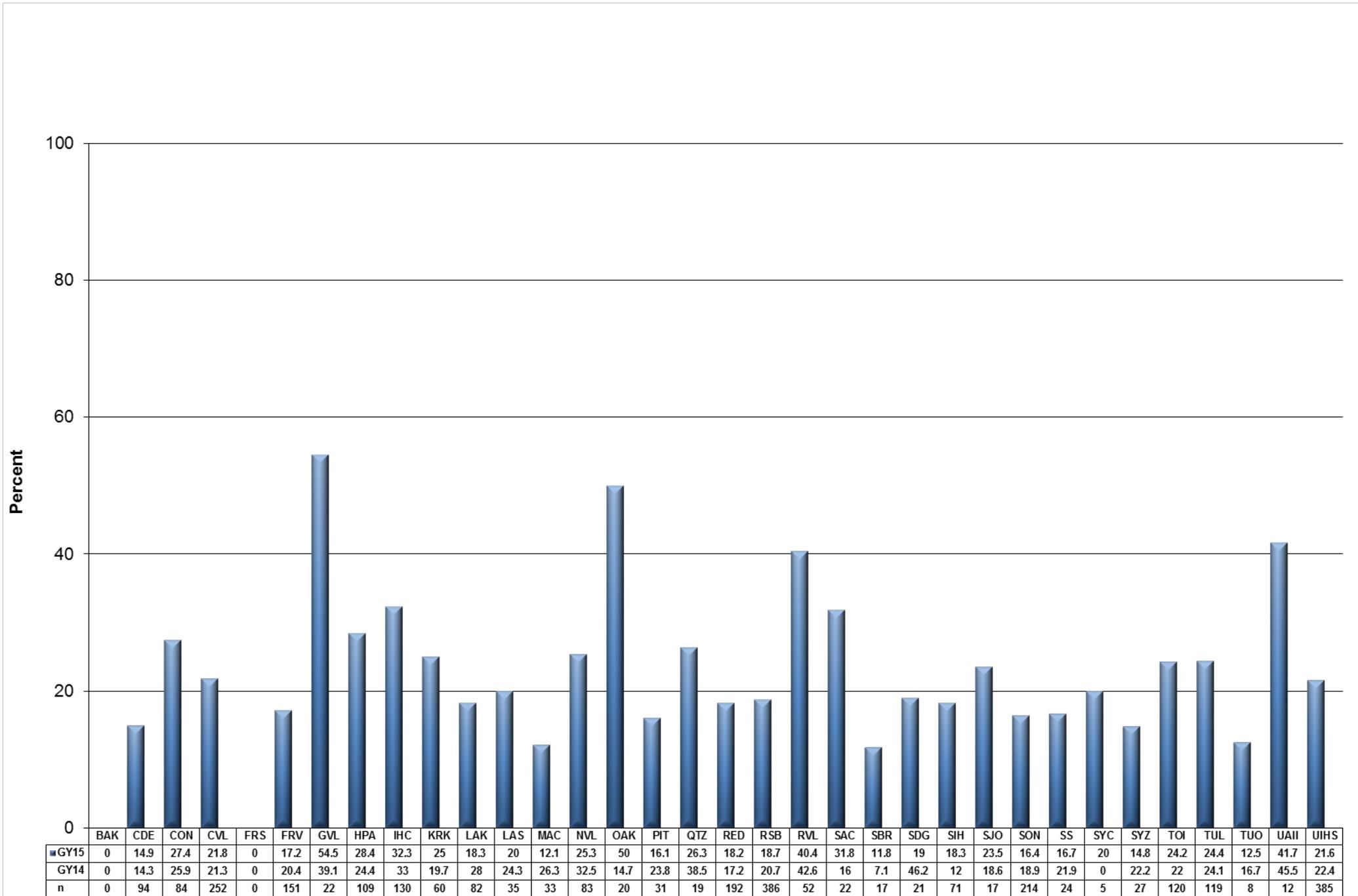
CHILDHOOD WEIGHT CONTROL

Measure: Percentage of children ages 2-5 years with a BMI at the 95th percentile or above.

Importance: *Rates of overweight among American Indian and Alaska Native children exceed the national averages. Overweight among children is defined as a Body Mass Index (BMI) at the 95th percentile or above. Children who are overweight often have elevated blood pressure, cholesterol, and insulin levels. They are at greater risk of developing type 2 diabetes. They are also at risk for shame, self-blame, and low self-esteem, all of which may affect how well they perform in school, and get along with their peers. This measure assesses the rate of obesity among 2-5 year olds, when there is still ample time for significant changes in eating patterns and activity levels.*



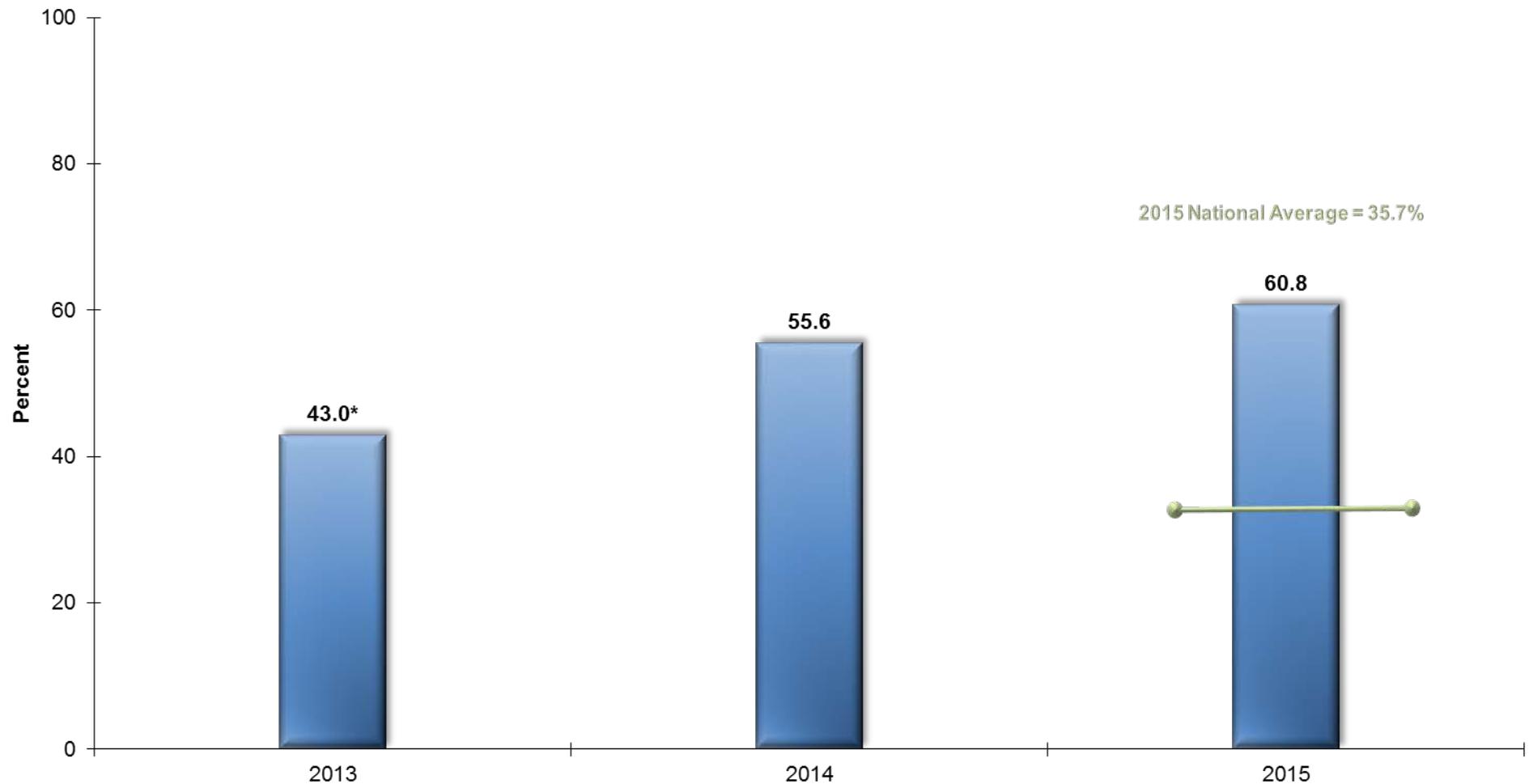
CHILDHOOD WEIGHT CONTROL



BREASTFEEDING RATES

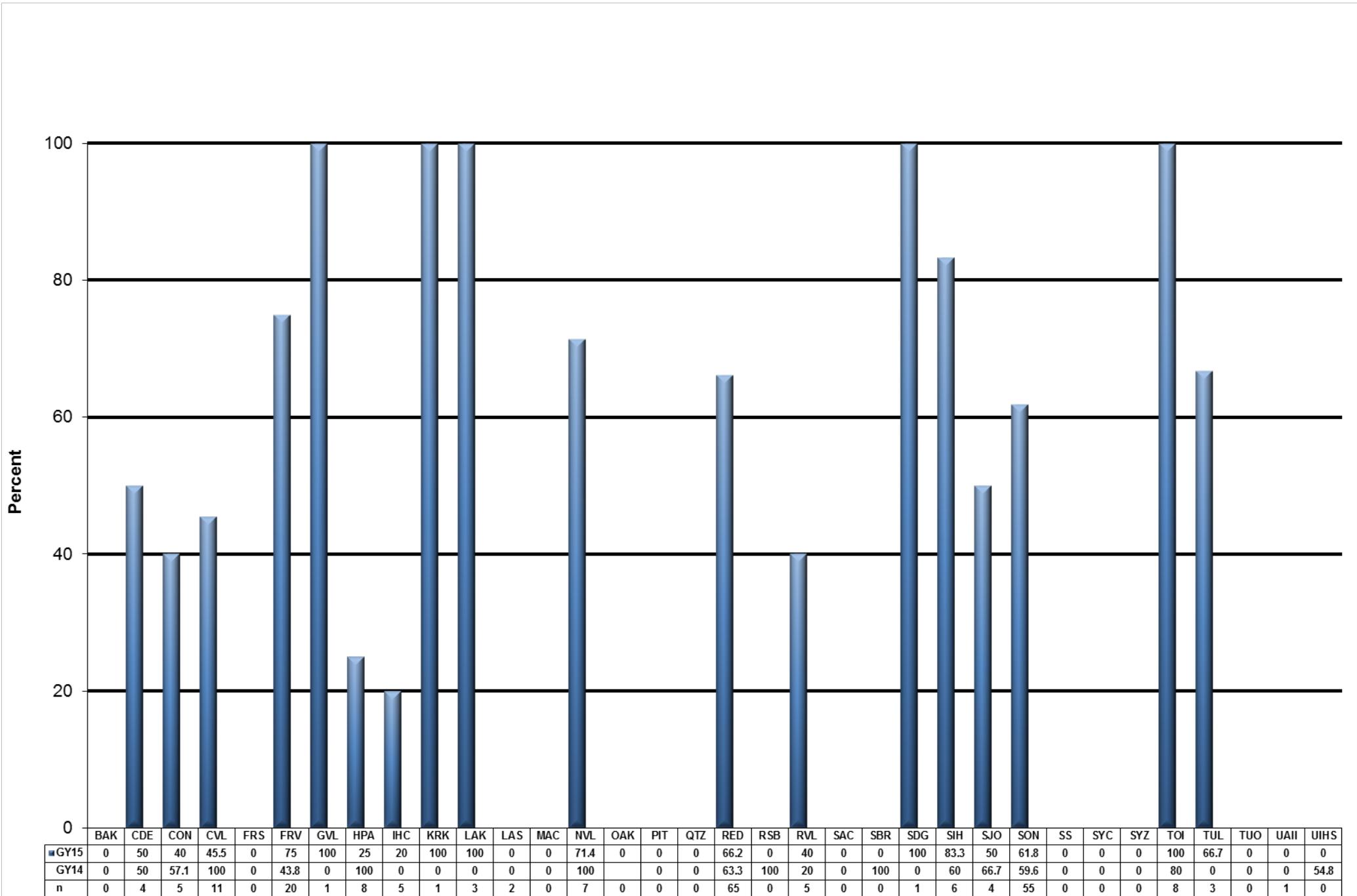
Measure: Percentage of patients who are exclusively or mostly breastfed at 2 months of age.

Importance: *Breastfeeding has been shown to have positive outcomes for both the mother and child. Breastfed children show lower incidences of obesity, Type 1 and Type 2 Diabetes, respiratory tract infections and ear infections. Studies have shown that mothers who breastfeed for at least three months may lose more weight than non-breastfeeding mothers, have a reduced risk of breast and ovarian cancer, and may have a reduced risk of osteoporosis. Breastfeeding can also help new mothers bond with their infants.*



*Prior to FY 2013, this measure was only reported for federal IHS health programs.

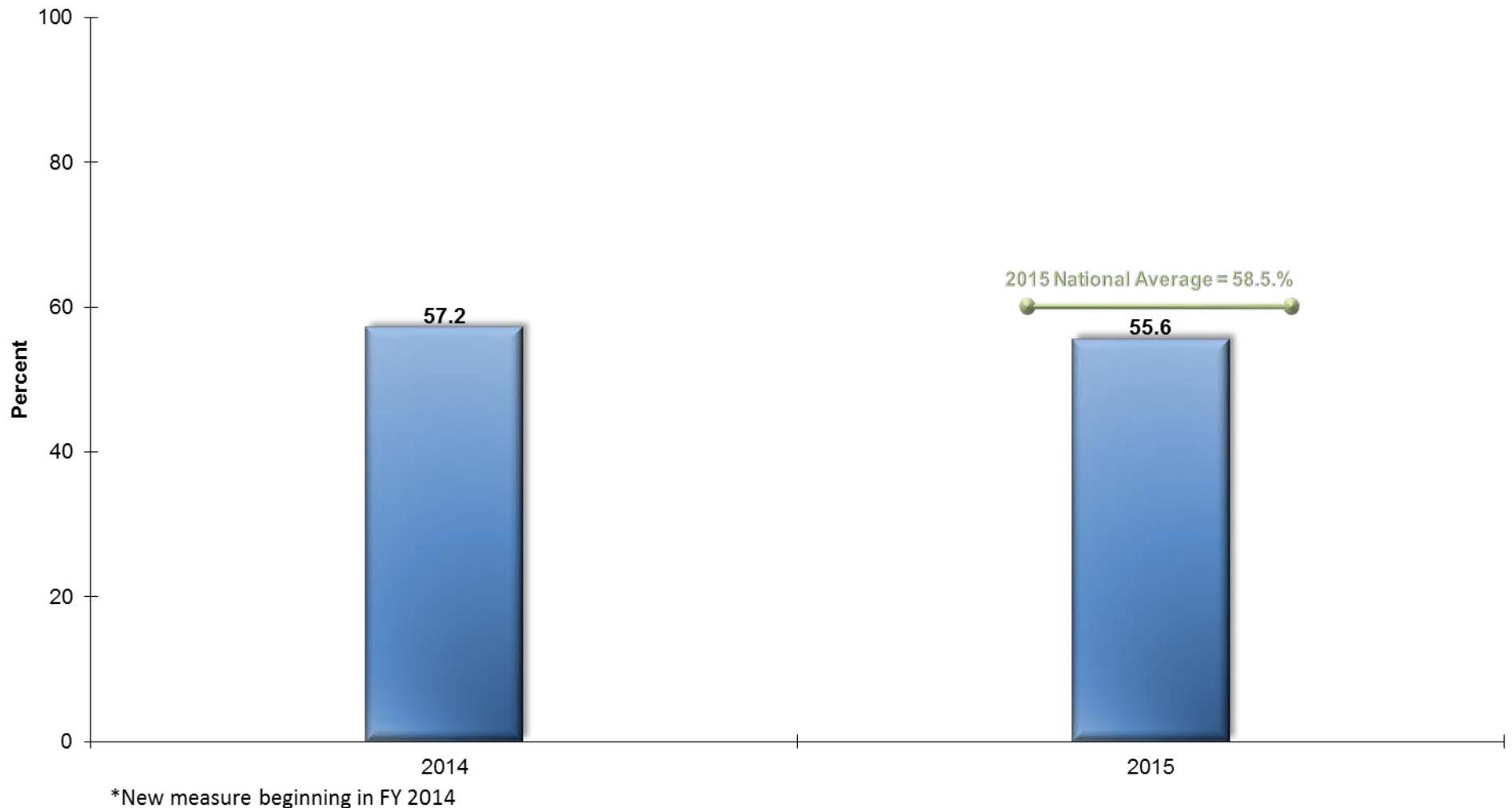
BREASTFEEDING RATES



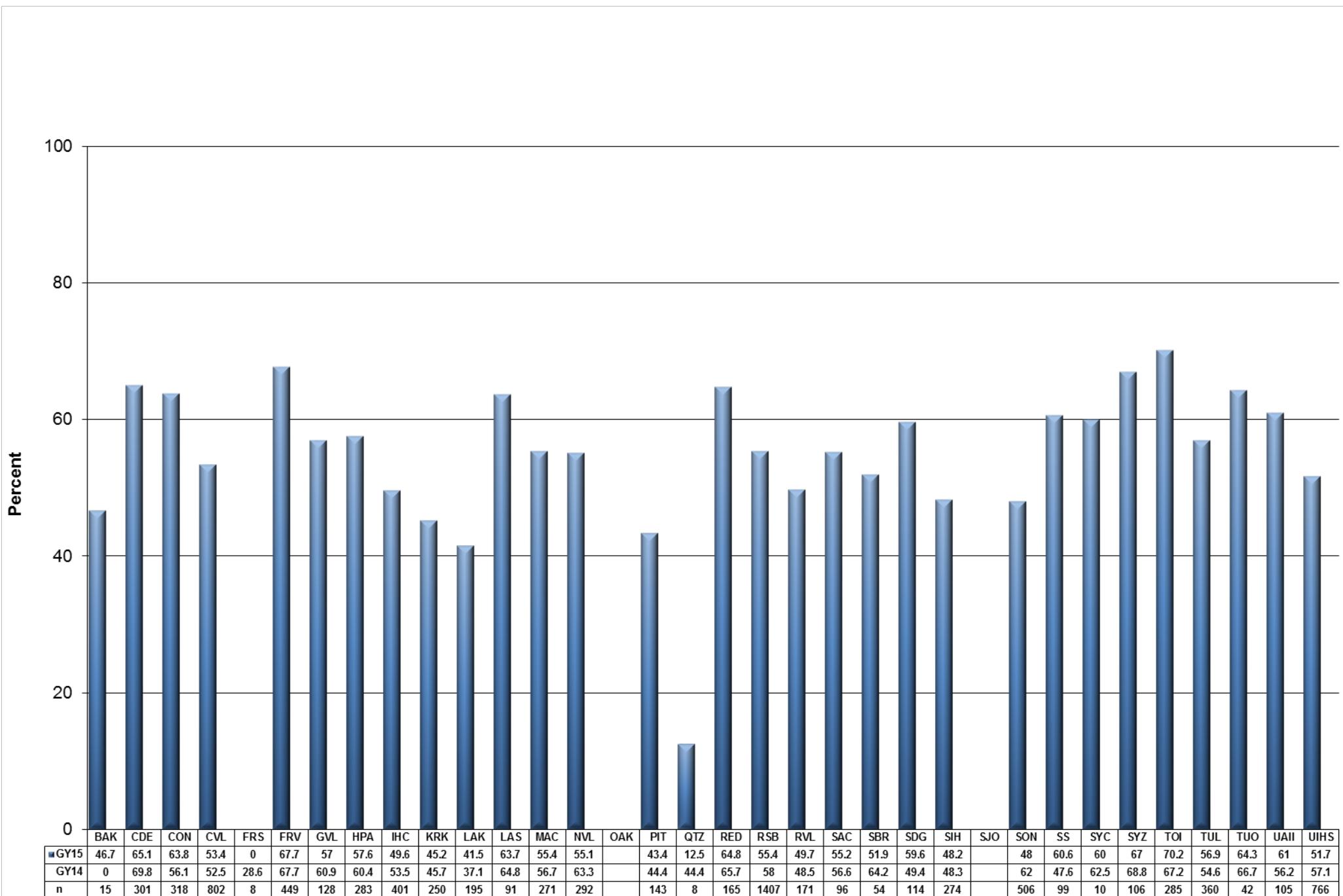
CONTROLLING HIGH BLOOD PRESSURE (MILLION HEARTS)

Measure: Percentage of patients with diagnosed hypertension who have achieved blood pressure control (<140/90).

Importance: *Million Hearts (MH) is a national initiative started by the U.S. Department of Health and Human Services in 2011 to prevent 1 million heart attacks and strokes by 2017. Blood Pressure Control is one of the quality measures reported for this initiative, and is the only MH measure reported by IHS. Uncontrolled high blood pressure greatly increases the risk of heart attack, stroke, aneurysm, and heart failure. Studies have shown that keeping blood pressure controlled lowers the risk of heart attack by 20%, lowers the risk of stroke by 35%, and lowers the risk of heart failure by 50%.*



CONTROLLING HIGH BLOOD PRESSURE (MH)





TRIBAL
DASHBOARD

CALIFORNIA AREA TRIBAL DASHBOARD

2015 Final GPRDA Dashboard					
DIABETES	California Area 2015 Final	California Area 2014 Final	National 2015 Final	National 2015 Target	2015 Final Results - California Area
Diabetes Dx Ever	11.1%	10.9%	14.4%	N/A	N/A
Documented A1c	86.0%	84.3%	84.7%	N/A	N/A
Good Glycemic Control	50.3%	48.8%	47.4%	47.7%	Met
Controlled BP <140/90	63.0%	62.9%	62.5%	63.8%	Not Met
LDL Assessed	72.6%	70.6%	73.3%	71.8%	Met
Nephropathy Assessed ^a	58.4%	49.8%	62.0%	60.0%	Not Met
Retinopathy Exam	48.0%	51.2%	61.3%	60.1%	Not Met
DENTAL					
Dental Access	41.5%	40.5%	29.2%	27.9%	Met
Sealants	18.3%	16.9%	16.3%	14.1%	Met
Topical Fluoride	31.1%	30.8%	29.4%	26.4%	Met
IMMUNIZATIONS					
Influenza 65+	52.5%	55.7%	65.4%	67.2%	Not Met
Pneumococcal Vaccination 65+ ^a	76.8%	77.4%	84.9%	85.7%	Not Met
Childhood IZ	59.2%	58.3%	73.3%	73.9%	Not Met
PREVENTION					
Pap Screening ^a	46.4%	45.4%	54.9%	54.6%	Not Met
Mammography Screening	46.0%	42.9%	54.5%	54.8%	Not Met
Colorectal Cancer Screening	31.2%	30.7%	38.6%	35.2%	Not Met
Tobacco Cessation	41.5%	38.9%	52.1%	46.3%	Not Met
Alcohol Screening (FAS Prevention)	57.2%	54.8%	66.6%	66.7%	Not Met
DV/IPV Screening	58.6%	55.7%	63.6%	61.6%	Not Met
Depression Screening	61.3%	57.5%	67.4%	64.3%	Not Met
CVD-Comprehensive Assessment	47.0%	41.9%	55.0%	47.3%	Not Met
Prenatal HIV Screening	72.3%	71.4%	86.6%	86.6%	Not Met
Childhood Weight Control ^b	21.7%	22.6%	21.8%	N/A	N/A
Breastfeeding Rates	60.8%	55.6%	35.7%	29.0%	Met
Controlling High Blood Pressure (MH) ^c	55.6%	57.2%	58.5%	59.5%	Not Met
^a Measure logic revised in FY 2014 ^b Long-term measure as of FY 2009, next reported in FY 2016 ^c New measure reported by federal and tribal programs as of FY 2014 Measures in red are GPRAMA measures					Measures Met = 6 Measures Not Met = 16

