2013 ANNUAL REPORT

DEPARTMENT OF HEALTH & HUMAN SERVICES
CALIFORNIA AREA OFFICE

Our agency's mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest possible level. Our goal is to assure that comprehensive culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people. Our foundation is to uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of tribal governments.

Our core values:

- Excellence
- Innovation
- Respect
- Ethics
- Leadership

About the IHS

INDIAN HEALTH SERVICE
The Indian Health Service (IHS), a federal agency within the Department of Health and Human Services, is responsible for providing health care services to American Indians and Alaska Natives (AI/AN). The provision of health care services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and individual 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 Presidential Executive Orders. The IHS is the 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 overall provides a comprehensive health care service delivery system for approximately 1.9 million AI/ANs who belong to 564 federally-recognized tribes in 37 states.

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

ANNUAL PATIENT SERVICES

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

CALIFORNIA AREA OFFICE
The California Area Office (CAO) supports tribal governments and urban Indian communities in the development and administration of comprehensive healthcare delivery systems that meet the needs of Indian people. The IHS/CAO provides technical assistance services for 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

About the California Area Office

IHS 2013 Profile Data

The Indian Health Care System in California:

- **Tribally-operated healthcare 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 10 Title V compacts, funded through 10 Funding Agreements, totaling $63 million. These compacts represent 42 Tribes, which is 35% of all the federally recognized Tribes in California. There are also 35 programs contracted under Title I serving 67 Tribes, with a total funding amount of $88 million. Overall, approximately 94% of the IHS budget authority appropriation is administered by Tribes through Self-Determination contracts or Self-Governance compacts.
- **Urban health care services and resource centers**
  There are 8 Urban programs, ranging from community health to comprehensive primary healthcare services.
- **Alcohol Treatment Services**
  There are 8 alcohol treatment programs. Their services range from referral and counseling to residential services.

Population Served:

- Members of 104 federally-recognized tribes
- 86,959 American Indians and Alaska Natives residing on or near reservations/rancherias
- 6,833 American Indians in Urban clinics (users)
- 167,066 potential AI/AN users in CHSDA and 195,735 potential users not in a CHSDA (2010 census)

Annual Patient Services (in Tribal Facilities):

- Inpatient Admissions: N/A
- Outpatient visits: 532,557
- Dental visits: 198,519

Appropriations:

- FY 2011 Area Office budget appropriation: $182,711,687
- FY 2012 Area Office budget appropriation: $195,566,945

Third-party collections:

- N/A for P.L. 93-638

Per capita personal health care expenditures comparisons:

- CAO user population: $2,018 (excludes OEHE $)
- IHS user population: 2,690
- Total U.S. population: 7,026 (CMS Report)

About the California Area Office

Human Resources:

- Total IHS employees: 97 (35% are Indian; excludes medical professionals listed below)

	Comm. Corps	Civil Service	Total	Health Professionals Vacancy Rates
All employees	24	71	95	
Indian	3	38	41	
Non-Indian	21	36	57	
Physicians	2	1	3	0%
Nurse	2	2	4	0%
Dentists	0	1	1	0%
Pharmacists	0	0	0	0%
Engineers	12	4	16	0%
Sanitarians	6	1	7	0%

Facilities

	Hospitals	Health Centers	Alaska Village Clinics	Health Stations	Residential Treatment Centers
IHS Tribal	—	45	—	10	5

Key Facts about the IHS California Area Office funding

Funding Summary
$ millions, unless otherwise stated

	2013	2012	2011
Clinical Services			
Hospital & Clinics	$71,447,365	$75,563,496	$74,519,967
Dental	1,940,436	2,070,363	1,852,320
Mental Health	2,039,695	2,156,310	1,796,239
Alcohol	10,832,337	11,447,382	11,443,407
Third Party Reimbursements	-	542	30,410
Total Clinical Services:	86,259,833	91,238,093	89,642,343
Preventive Health			
Public Health Nursing	929,600	991,550	745,188
Health Education	302,185	321,554	316,067
Community Health Representatives	2,007,334	2,128,396	2,120,293
Total Preventive Health:	3,239,119	3,441,500	3,181,548
Urban Health Projects	6,674,127	7,230,471	7,091,289
Direct Operations	2,475,474	2,640,058	2,340,319
Contract Support Costs	43,737,231	46,026,209	38,208,925
Tribal Self-Governance	65,150	-	100,000
Indian Health Professions	12,660	-	-
Purchased/Referral Care (Contract Health Care)	42,837,066	45,105,547	40,951,901
Catastrophic Health Emergency Fund	89,718	$291,580	736,362
Domestic Violence Prevention Initiative	223,000	223,000	-
Alcohol & Substance Abuse/Methamphetamine Prevention	889,000	889,000	-

Funding Summary
$ millions, unless otherwise stated

	2013	2012	2011
Special Diabetes Program for Indians—Direct	160,000	259,000	259,000
Special Diabetes Program for Indians—Reimbursement	200,000	200,000	200,000
Facilities & Environmental Health Support			
Environmental Health Support	3,582,075	3,761,500	3,799,570
Health Facilities Support	1,179,793	1,244,721	949,731
OEHE Support	19,211	15,911	13,362
Reimbursements	-	-	662
Total Facilities & Environmental Health Support:	4,781,079	5,022,132	4,763,325
Indian Health Facilities			
New & Replacement		1,996,800	
Equipment	781,879	814,197	804,146
Maintenance and Improvement	2,850,048	3,073,230	2,841,474
Total Indian Health Facilities:	3,631,927	5,884,227	3,645,620
Sanitation Facilities			
Housing	1,454,000	1,534,000	2,039,000
Regular	1,904,000	2,380,000	2,438,000
Total Sanitation Facilities	3,358,000	3,914,000	4,477,000
Inter-Agency Funds			
EPA CWA IAG Contributions	2,775,992	2,371,557	2,111,045
Other Contributions	-	151,000	-
Total Contributions Facilities	2,775,992	2,522,557	2,111,045
Area Grand Total	**$201,409,376**	**$214,887,374**	**$197,708,677**

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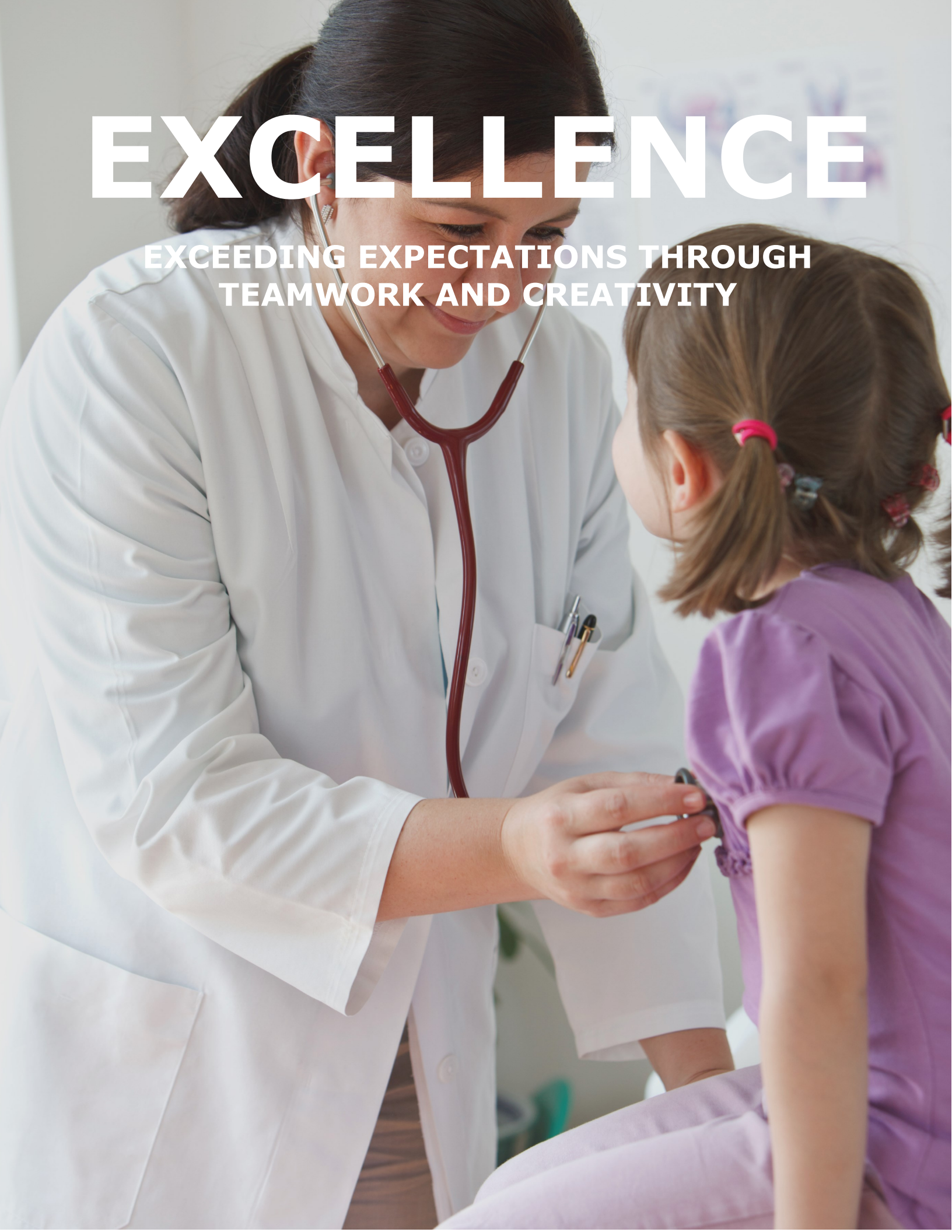
24.1%

APPROXIMATELY 24.1% OF MEN AGES 18 AND OLDER SMOKE CIGARETTES. QUITTING SMOKING CAN LEAD TO IMPROVED QUALITY OF LIFE. WITHIN 48 HOURS, DAMAGED NERVE ENDINGS WILL START TO REGROW AND SMELL AND TASTE WILL BEGIN TO RETURN TO NORMAL.

List of Acronyms

AAAHC	Accreditation Association for Ambulatory Health Care
ACA	Affordable Care Act
AI/AN	American Indian/Alaska Natives
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 (PRC)	Formerly Contract Health Services (Purchased and Referred Care)
CHSDA	Contract Health Services Delivery Area
CMS	DHHS/Centers for Medicare & Medicaid Services
CRIHB	California Rural Indian Health Board
CRS	Clinical Reporting System
EDR	Electronic Dental Record
EHR	Electronic Health Record
EHS	IHS/CAO Environmental Health Services
EPA	U.S. Environmental Protection Agency
FAS	Fetal Alcohol Syndrome
FDA	DHHS/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	IHS/CAO Health Facilities Engineering
HHS	U.S. Department of 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	P.L. 93-638 as amended Indian Self-Determination and Education Assistance Act
IST	Improvement Support Team for Improving Patient (IPC)
IT	Information Technology
M&I	Maintenance and Improvement of Tribal Healthcare Facilities
MSPI	Methamphetamine & Suicide Prevention Initiative
MU	Meaningful Use of Electronic Health Records
NGST	IHS National GPRA Support Team
O&M	Operation & Maintenance
OEH&E	IHS/CAO Office of Environmental Health & Engineering
OMB	President's Office of Management and Budget
OMS	IHS/CAO Office of Management Support
OPH	IHS/CAO Office of Public Health
PCMH	Patient-Centered Medical Home
PRC	Purchased and Referred Care (formally CHS)
QILN	Quality and Innovation Learning Network
RPMS	Resource Patient Management System
SDPI	Special Diabetes Program for Indians
SFC	IHS/CAO Sanitation Facilities Construction
TIPCAP	Tribal Injury Prevention Cooperative Agreement Program
UFMS	IHS Unified Financial Management System
VA	Veteran's Administration
YRTC	Youth Regional Treatment Center


EXCELLENCE
EXCEEDING EXPECTATIONS THROUGH
TEAMWORK AND CREATIVITY

«At the IHS, we are continuing our efforts to change and improve the IHS, guided by our four agency priorities. These priorities are based on tribal consultation input.»

Yvette Roubideaux, MD, MPH
Director, Indian Health Service

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

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

These priorities guide the work of agency staff and their partnerships with external stakeholders, including tribal governments. 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.

1.9 M

IN THE UNITED STATES, 1.9 MILLION WOMEN ARE PHYSICALLY ASSAULTED ANNUALLY. GET HELP TODAY BY CALLING THE NATIONAL DOMESTIC VIOLENCE HOTLINE AT 1-800-799-SAFE.

13 To Our Stakeholders

Letter from the Area Director

Dear Tribal Officials and Indian Healthcare Partners:

How often have we heard, "in these turbulent economic times?" The news is awash with 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 IHS/CAO is making hard decisions that will position us to deliver consistent technical assistance and training that you have come to expect.

As times change, the way we do business also changes. 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 of creating value and reducing friction. At IHS/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 IHS/CAO will respond to the challenge; we will seize the initiative to innovate and to achieve exponential results. Together, great things will happen.

Warm Regards,

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

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

Service Highlights

- During the week of May 20, 2013 the IHS/CAO and the California Rural Indian Health Board, Inc. co-hosted the Medical Providers' Best Practices & GPRA Measures Conference in Sacramento. This continuing medical education and formalized collaboration for improving quality and access to care was designed for Indian health program physicians and mid-level providers

- During the week of May 6, 2013, the IHS/CAO and the California Rural Indian Health Board, Inc. co-sponsored the Annual Dental Conference in Sacramento. The continuing dental education courses met all of the required annual continuing dental education courses necessary for state licensure renewal for dentists, dental hygienists, and registered dental assistants

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

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

- The IHS/CAO published and distributed four quarterly "IHS/CAO Patient Newsletters" to all California tribal and urban 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 reflect care newsletter, quarterly highlights, and employee health newsletter to all California Tribal Leaders to describe Area activities
- LCDR Sarah Snyder transferred from the Phoenix Area IHS, to serve as the Sacramento District Environmental Health Officer. She provides environmental health services to tribal governments/tribal health programs throughout northern and central California.
    - Ensure access to quality, culturally competent healthcare for the AI/AN population of California, comparable to care provided at IHS owned/ operated hospitals and clinics
    - Maximize scarce purchased and referred care (PRC) funds for other Priority 1 healthcare
    - Increase the level of need funded from 54% to possibly 94%
    - Components of the study included:
        - Current PRC trends
        - Population projections
        - Market share analysis
        - Strategic location review
        - Specialty services justification
        - Construction and staffing cost estimates

Service Highlights cont'd

Environmental Health Surveys (EHS)

In FY 2013, EHS staff conducted 388 surveys, 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 (278)
- Head Start programs (17)
- Healthcare facilities (15)
- Swimming pools (11)
- Grocery/convenience stores (11)
- Indian gaming facilities (25)
- Motels/hotels (5)
- Other facilities (44)

Training
The EHS staff sponsored and conducted 28 training courses in tribal communities throughout California to build tribal capacity in environmental health related areas. Courses were offered in general food safety (23) and occupational safety and health (5). More than 356 tribal participants from tribal communities benefitted from these environmental health courses.

INJURY PREVENTION (IPP)

Tribal Injury Prevention Cooperative Agreement Programs
The IPP served as project officer and provided technical assistance and support to Tribal IPPs funded through the IHS Tribal Injury Prevention Cooperative Agreement. 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. The CRIHB, Indian Health Council, and Tule River Indian Health Center were funded for continuation in FY 2014 at a value of $1.6 million over five years.

Sanitation Facilities and Health (SFC)

SFC Initiative – HITS
The IHS is required by Congress to conduct an annual assessment and inventory of Indian homes, determine associated SFC deficiency levels, and identify sanitation needs. This information, compiled in the IHS Sanitation Tracking and Reporting System (STARS) database, is used to determine the levels and types of services needed by Indian communities and as supporting documentation to fund future projects.

As a result of the ongoing effort to improve services to California Indians, the SFC Program updated the STARS database to allow tracking of individual homes, including geographical data (latitude and longitude). In the current system, homes are aggregated into non-geographically referenced housing groups called Community Deficiency Profiles (CDP). The updated information will be managed within STARS in the Housing Inventory and Tracking System (HITS) database and will provide a geographical description of each home, more accurate description of SFC deficiencies, and improved accuracy of the total number of Indian homes.

As a result of this 2013 SFC program initiative, 40,172 individual homes were identified and entered into the HITS database, whereas, 13,464 homes were listed in the old CDP system. An additional 26,708 Indian owned homes were identified and listed in HITS for future justification and funding.

Service Highlights cont'd.

Health Facilities Engineering (HFE)

Regional Ambulatory Surgical and Specialty Referral Healthcare Facilities – Feasibility Study
The Area Director initiated a feasibility study titled, "Development of IHS-Operated Regional Ambulatory Surgical and Specialty Referral Healthcare Facilities in California". If funded, these facilities would:

- Ensure access to quality, culturally competent healthcare for the AI/AN population of California, comparable to care provided at IHS owned/operated hospitals and clinics
- Maximize scarce contract health services (CHS) funds for Priority 1 healthcare
- Increase the level of need funded from 54% to possibly 94%

Components of the study included:

- Current CHS trends
- Construction and staffing cost estimates
- Population projections
- Market share analysis
- Strategic location review
- Specialty services justification

The IHS/CAO presented this study to the California Area Tribal Advisory Committee (CATAC) members on two occasions and to Indian healthcare program directors during a bi-annual meeting. Based on feedback, initial findings were presented at the Annual Tribal Consultation in March 2013 in Pala, CA. The final report and executive summary will be finalized in 2014.

Youth Regional Treatment Centers
The IHS/California Area Office (IHS/CAO) has made significant progress toward opening two IHS-operated Youth Regional Treatment Centers (YRTCs) in California. One facility will be constructed in the south and one in the north.

Southern YRTC
A team of technical staff from the IHS California Area Office, IHS Headquarters, and Engineering Services –Dallas, along with elected tribal officials from southern California, began design work in October 2012. These parties met with the primary contractor (BBCK-JV) several times to refine a dynamic, aesthetically pleasing, and culturally meaningful facility on the 20-acre parcel in western Riverside County. The construction project will soon be out to bid and construction of the southern YRTC is scheduled to begin in 2014 and is expected to take 14 months, resulting in the facility opening around November 2015.

Northern YRTC
Substantial progress was also made on constructing a YRTC in northern California. The IHS identified a parcel of land in Yolo County, which consists of twelve acres at the northeast corner of the D-Q University, the California's only Tribal College near Davis, California. The D-Q University Board of Trustees agreed to revert a portion of their federal trust land expressly for IHS/CAO to establish the northern California YRTC. The Area Director held a "Dedication of the Land Ceremony" for the northern YRTC property on July 16th. Approximately 120 attended the ceremony. The Director of Indian Health Service, Dr. Yvette Roubideaux, attended and shared her support and recognition for the outstanding effort of the D-Q Board and Indian Health Service, in acquiring the property. Upon completion of a geotechnical study, which must be performed during the rainy season, the IHS/CAO will finalize the Program of Requirements and request design and construction funding for the northern YRTC in the fiscal year 2015 budget.

Dr. Yvette Roubideaux and Ms. Margo Kerrigan

Southern YRTC

Northeast Aerial View of Southern YRTC

Southwest Aerial View of Southern YRTC

North Court of Southern YRTC

Southeast Court View of Southern YRTC

2013 Annual Tribal Consultation

Hosted by Indian Health Service/California Area Office, Pala Band of Mission Indians, and Indian Health Council, Inc.

Left: Margo Kerrigan, IHS/CAO Director, providing the welcoming address

Below: Stacy Dixon, Chairman, Susanville Indian Rancheria

Reports from California representatives to national IHS workgroups (clockwise from top left): Mary Benedict, Johnny Hernandez, Michael Thom, Rosemary Nelson, Molin Malicay, Robert Marquez, Peter Masten, Jr.

Above: Innova Group presenting the preliminary feasibility study for regional referral centers,

Gary Ball presenting on the status of California's future youth regional treatment centers

Above (L to R): Cheryl Seidner, Silver Galleto, Fern Bates, and Chris Devers during listening session

Above (L to R): Don McCovey Sr., David Lent, Dawn Hacket, Jim Crouch, Travis Coleman, Harry Weiss, Beverly Miller

100%

FETAL ALCOHOL SYNDROME (FAS) IS 100% PREVENTABLE AND THERE IS NO KNOWN SAFE AMOUNT OF ALCOHOL TO CONSUME WHILE PREGNANT. IF A WOMAN DOES NOT DRINK ALCOHOL WHILE PREGNANT, HER CHILD WOULD NOT HAVE FAS.

27 Office Reports

Office of Public Health (OPH)

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

- Medical
- Dental
- Nursing
- Diabetes
- Behavioral Health
- Health Promotion/Disease Prevention
- 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 also participates in IHS conducted 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 2013, 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 2013, the Dental Consultant and other IHS/CAO health professional consultants took an active role in assisting healthcare program dentists to qualify for Meaningful Use of the electronic dental record (EDR) and its financial incentives. The IHS/CAO offered two demonstrations to health program dental providers of the dental workflow that dentists and dental staff use at the Riverside/San Bernardino County Indian Health Program to satisfy Meaningful Use requirements.

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 of the required annual continuing dental education courses necessary for state licensure renewal for dentists, hygienists, and registered dental assistants. The multi-day conference allows dental staff from the California Area to meet, learn, and share knowledge and experiences. The May 2013 conference was attended by 300 dental staff representing 33 tribal and urban Indian healthcare 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 revenue 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 improve communicate to ensure proper and timely billing. For this reason, both program billing staff and dental providers were invited to attend the May 2013 training. The training covered third party billing and an update on Denti-Cal. Accurate and immediate dental billing is essential to tribal and urban Indian healthcare programs which rely on third party 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 2013, the IHS and Dental Support Center 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:

- Twelve programs met the goal of improving the dental access measure (for all age groups) result by 2% or more
- Eleven programs met the goal of improving the dental access measure (for 0-5 year olds) result 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 integrated with the Resource and Patient Management System (RPMS) the IHS patient data system. It 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. Dentrix Enterprise is now being utilized at 11 healthcare programs in the California Area, and a total of 28 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.

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 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

NURSING

Area Nurse Consultant Report
The IHS/CAO strives to elevate the quality of healthcare provided for American Indian/Alaska Native 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 consult, administer, and/or provide direct patient care through clinic-based, public health, and referral organizations. Area nurses work in a variety of settings and have various practice roles. The Area Nurse Consultant works to ensure that these nurses have available the knowledge, skills, and educational resources needed to practice at the top of their licensure. The Area Nurse Consultant also ensures that these nurses are equipped with leadership skills that are necessary when facing challenges that come about in an era of health care reform.

Activities, Accomplishments, and Improvement Projects
The IHS/CAO coordinated the following nursing topics during a Pre-conference Nursing Continuing Education Day on May 20 in conjunction with the 2013 California Providers' Best Practices & GPRA Measures Continuing Medical Education:

- State of California Board of Registered Nursing Regulations
- American Indian Infant Health Initiative
- Improving Immunization Practice
- Vaccine Hesitancy

Recognizing the value of both internal and external agency expertise, presenters were selected from IHS, tribal, and state -based healthcare organizations for subject matter expertise and an interest in partnering to improve health outcomes for AI/AN people. The IHS/CAO partnered with the IHS Clinical Support Center, an accredited provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation, to offer up to 27 hours each for nurses attending these events. Fifty-one nurses earned a total of 914 continuing education hours for their attendance.

The Area Nurse Consultant represented IHS, tribal and urban nurses across the Indian health system during her tenure as 2013 National Nurse Leadership Council (NNLC) Immediate Past Chair. This leadership role included frequent facilitation of monthly council calls and participating as both a planning committee member and as a moderator for the June 2013 Nurse Leaders in Native Care Conference.

The 2013 Nurse Leaders in Native Care Conference (NLiNC), sponsored by IHS Division of Nursing, was held as a virtual event June 3 - 7. The IHS/CAO Nurse Consultant represented the California Area on the planning committee and as a "virtual" session moderator. Based on the post-conference evaluation, the 2013 NLiNC was a big success. Upwards of 300 nurses, 16 of whom were from California tribal (11), urban (4), and IHS (1) facilities, attended. This conference included topics essential to nurses working within the IHS System, some of which were:

- Boardroom ready, data driven decision making
- Quality care for persons with dementia and their families
- Baby-Friendly ® Hospital Initiative
- Partnership for patients
- Managing immunization programs
- Developing competencies for nurse managers
- Incorporating evidenced based practice
- Emergency preparedness
- Insight from the boardroom

Thanks to the IHS Clinical Support Center, nurse attendees earned up to 12 continuing education hours.

Area Immunization Program Coordination

The IHS/CAO recommends comprehensive immunization coverage for all age groups. The IHS/CAO offers training and technical assistance to tribal and urban Indian healthcare immunization staff to ensure comprehensive immunization coverage, data collection, and reporting. The following are some of the activities performed by the Area Immunization Coordinator in 2013:

- Monitored Area immunization reporting to ensure comprehensive, timely, and accurate data reporting for IHS quarterly reports
- Attended quarterly IHS Immunization Program Manager led meetings
- Represented Area immunization interests at quarterly Immunization Coordination Meetings facilitated by California Department of Public Health Immunization Branch
- Provided technical assistance and improvement resources related to adult and childhood immunization GPRA measure improvement
- Initiated and led the coordination efforts for electronic immunization data exchange projects between tribal healthcare programs and the California Automated Immunization Registry

Susan Ducore accepted the IHS Director's Award on behalf of the National Nurse Leadership Council as 2012 Chair.

Related RPMS-Based Trainings

On April 14-16, the IHS/CAO Nurse Consultant traveled to Los Angeles to attend the 2013 California Immunization Coalition Summit and pre-conference workshop entitled "Vaccine Hesitancy: Building Solutions for California and Beyond". In addition to our Area Nurse Consultant, two nurses from Riverside/San Bernardino County Indian Health were among the 100 plus individuals attending the two day "summit". This annual event, sponsored by the California Immunization Coalition, promotes best practices in immunization. The California Immunization Coalition is a non-profit, public-private partnership dedicated to achieving and maintaining full immunization protection for all Californians to promote health and prevent serious illness. The Coalition provides networking and partnership opportunities for organizations and offers access to greater expertise by calling on a wide range of organizations and individuals. The Coalition has the ability to leverage resources and can advocate for change at the state, regional, and local levels.

On May 8, the IHS hosted a one-day RPMS Immunization 101 Training that was attended by a total of eight nurses and other immunization staff from the IHS/CAO and the following California tribal healthcare programs:

- Sonoma County Indian Health Project (3)
- Central Valley Indian Health, Inc. (2)
- Northern Valley Indian Health (2)
- Karuk Tribe of California (1)

The IHS/CAO was one of three satellite settings for this hands-on training. Based on the post training surveys, this course met the intended purpose of improving competencies related to use of the RPMS Immunization Package for Immunization practice, data management, and reporting.

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. Currently, there are 35 Community-Directed, seven Diabetes Prevention, and five Healthy Heart diabetes grants in California. The source of this money is based on funding that Congress appropriates annually. SDPI is funded only through FY 2014 at this time. 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.

The Area Diabetes Coordinator, Helen Maldonado, and two contractors are involved in multiple aspects of diabetes care and prevention in the California Area. Their overall mission is to support all California tribal and urban Indian healthcare programs in their efforts to provide excellent diabetes treatment and education, as well as the best interventions to prevent diabetes in Indian communities.

Diabetes care and prevention in Indian country is based on the strength of the relationships developed with tribal communities. Understanding each community's priorities is essential to improving the health status of Indian people. The challenge for medical providers is to listen, understand, and advise based on what the community wants. In an effort to address this challenge, the theme of the diabetes webinar series in FY 2012 was "Community". In addition, the Area diabetes contractors visited 37 tribal and urban Indian healthcare programs to provide on-site evaluation and guidance. Plus, the IHS/CAO hosted Diabetes Day on May 23 in conjunction with the Providers' Best Practices & GPRA Measures Continuing Medical Education.

California tribal and urban Indian healthcare programs were awarded SDPI Community-Directed grant funding create a diabetes care improvement plan each year based on what is needed in their clinic and community. These plans are called "Best Practices" as they are based on procedures and interventions known to be effective in diabetes care and in Indian country. The role of the Area Diabetes Coordinator and her staff is to provide guidance on the development and implementation of these Best Practices, ensuring that results that benefit communities are achievable and sustainable. Outcomes include both non-clinical measures, such as the number of health promotion policies adopted by a tribal organization, and clinical patient data reported in the annual IHS Diabetes Audit.

Ramin Naderi (Indian Health Council of Santa Clara Valley, Inc.) and Barbara Pfeifer (United Indian Health Services, Inc.) at Annual California Diabetes Day

IHS Diabetes Audit

The IHS Diabetes Audit report is an assessment of clinical care and education and must be submitted annually by programs receiving SDPI Community-Directed funds. The report is based on the IHS Diabetes Standards of Care. Statistics and patient data are used as a guide to steer the direction of decisions made by healthcare teams. The following healthcare outcomes have been specifically targeted for improvement by IHS/CAO. These data measures reflect the health status of all active patients with diabetes in the California Area (most recent data is from calendar year 2012):

TARGETED MEASURES	2010 AUDIT REPORT RESULT	2013 AUDIT REPORT RESULT (FOR CY 2012)	COMPARE TO ALL-IHS 2013 AUDIT RESULTS
Number audited	5538	6002	105,626
Blood sugar control at goal	42%	43%	35%
Blood Pressure at goal (<130<80)	37%	38%	39%
Eye exams	56%	58%	55%
Nutrition education	69%	73%	49%
Exercise education	64%	66%	45%
Depression screening	69%	84%	79%

For five of the six data measures in the table, California outcomes exceeded all IHS data standards.

Trainings

The IHS/CAO provided webinar trainings on the following topics based on the theme of 'Community':

- *"Preventing Diabetes and Healing from Within: A Community Perspective"* presented by Northern Valley Indian Health
- *"Patient Centered Medical Home"* presented by Sam Romeo, MD, MPH, Tower Health and Wellness Center

- *"Community Partnership"* presented by K'ima:w Medical Center, Hoopa Valley
- *"Changing the Way We Treat Diabetes: the New Era of Diabetes Targets"* presented by Ann Bullock, MD, Acting Director & Clinical Consultant , IHS Division of Diabetes Treatment and Prevention/Health and Medical Division, Eastern Band of Cherokee Indians
- *"Shared Decision Making and Patient Centered Diabetes Care"* presented by Victor Montori, MD, MSc, Mayo Clinic

This past year, the Area Diabetes Coordinator and contractors started development of content for the IHS/CAO Diabetes Portal. This is a secure website where diabetes programs will be able to view recorded trainings, download diabetes information, view data, and network with other California programs.

One of California's Diabetes contractors is now working for a tribal program and a new Grants Specialist contractor started in September 2013. Site visits to California programs will continue. A member of the IHS/CAO Diabetes Team continues to be available daily to answer diabetes-related questions from California tribal and urban Indian healthcare programs.

Candie Stewart (Round Valley Indian Health) with posterboard display at Annual California Diabetes Day

BEHAVIORAL HEALTH

The goal 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.

The funding to 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 Sonoma County Indian Health Program's "Warriors Creating Peace." Sonoma County Indian Health Program works in collaboration with the county to provide education and tools and resources for men who have problems with substance use, domestic violence and anger management. During the past 18 months, one participant with gang affiliations, in-and-out of prison for the past nine years, successfully completed the 52-week Batterers' Intervention program. This individual met all of the program's goals, including maintaining sobriety and staying drug free, and now speaks to new enrollees. As part of the program, participants are expected to pay $10 for each class.

The men that have been incarcerated can offset costs by applying for medical aid from the county. Otherwise, enrollees are expected to pay costs out-of-pocket or apply for tuition scholarships. In the first two months, the aforementioned individual obtained employment and, within three months, paid for his own weekly tuition. During 2013, 50 men enrolled in the program; nine have graduated and 13 are on track to complete the program. This highly successful program has expanded and now offers a similar track for women.

Behavioral Health Webinar Sessions
The IHS/CAO partners with IHS Headquarters to offer monthly webinar sessions and/or conference calls on behavioral health. 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 partners with tribal and urban Indian healthcare programs to support alcohol and substance abuse prevention programs. There are more than 83 alcohol and substance abuse counselors employed by the tribal and urban Indian healthcare programs and 71 are certified counselors. For the past few years, the California Area has expanded training opportunities and education to certify and re-certify alcohol and substance abuse counselors through a contract. The majority of the Indian healthcare program alcohol and substance abuse counselors are certified by the California Association of Alcoholism & Drug Abuse Counselors (CAADAC) and 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 Grief & Loss and Native American treatment modalities. Since January 2013, six addiction courses have been offered and an additional course is scheduled for December 2013. During each training, counselors complete an on-site course evaluation, and results show positive overall satisfaction.

Youth Regional Treatment Centers
In FY 2013, more than 52 youths received residential treatment through the YRTC Risk Pool administered by the California Area Office. The YRTC Risk Pool users collect non-protected health information which has provided a description of the youths who are treated using the YRTC Risk Pool funds. Of the 52 admissions, 38 were male with an average age of 15 years old. More than 82.6% of youths are dual-diagnosed and the number one drug of choice is alcohol. The MSPI funds have improved access to residential treatment and youths, on average, stay 150 days compared to 120 day programs. The tribal and urban Indian healthcare program alcohol counselors, YRTC Risk Pool staff, and behavioral health directors participate in conference calls about every six weeks.

Universal Behavioral Health Screening Incentives
The IHS/CAO "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 improves screening rates and removes the associated stigma. This past year, the IHS/CAO contracted with a health specialist to conduct on-site visits to eight tribal consultants and urban Indian healthcare programs. While on site, the consultant ensures all appropriate computer taxonomies are accurate and activated; ensures that the behavioral health screening bundle is operational; provides examples of validated screening tools; and the need to screen both males and females should begin at age 14.

HEALTH PROMOTION/DISEASE PREVENTION

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

Community Wellness Planning

The IHS/CAO offered four community-focused sessions at the 2013 California Providers' Best Practices & GPRA Measures Continuing Medical Education in May:

- "Wellness and Community – Lessons from the Field" plenary session included examples of what is working in wellness planning. The session engaged participants in sharing their successful strategies
- "Practice Tools for Community Engagement and Wellness Planning" breakout session, co-facilitated by Anav Tribal Health Clinic (Fort Jones), introduced the Talking Journey, a focused conversation process. This versatile process is a way to give structure to conversations that might otherwise lose focus and purpose. The process also saves time and energy, and minimizes potential power plays or hidden agendas. Because the process applies an inclusive structure to the listening process, it also promotes shared understanding, which is a best fit for community wellness planning efforts
- The California Division of the American Cancer Society introduced their Circle Of Life cancer education and resources during a special lunchtime session
- "Successful Strategies to Raise Mammography Rates" breakout session, presented by Northern Valley Indian Health, Inc. (Willows), included the healthcare program's successes and lessons learned as part of an American Cancer grant project

The IHS/CAO promoted participation in the Community Wellness Forum 2013, in order to increase health and wellness engagement among California American Indian/Alaska Native communities. Community Wellness Forum 2013 encouraged learning together, sharing what works, focusing on local efforts, engaging in conversations that matter, making new connections, and honoring community champions. California tribal and urban Indian community members and participated and worked with them in partnership. The forum included a general/adult track and a youth track that was made possible due to these partners:

- California Division of the American Cancer Society
- University of California Davis Health System
- University of California Los Angeles Center for American Indian/Indigenous Research & Education
- Healthy Native Communities Partnership
- Northern California Indian Development Council
- Sacramento Native American Health Center
- Indian Health Center Santa Clara Valley
- San Diego American Indian Health Center

Digital Storytelling

Digital storytelling capacity building efforts continued in FY 2013. It is a low-cost, powerful, and compelling way to engage tribal communities and strengthens a patient's commitment towards health and wellness. Digital storytelling can be used to promote social change and action, with first-person narratives combined with digital media. 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 and expand the use of digital storytelling as a community wellness tool. In FY 2013, the IHS/CAO supported five digital storytelling workshops. They provided introductory training on aspects of story development, image and video editing, and audio recording needed to create digital stories. The workshops introduced 35 individuals to the fundamentals of digital storytelling. In FY

2013, the workshops provided over $24,500 in cost savings to California tribal and urban Indian healthcare programs when compared to commercially available digital storytelling trainings. Hosting of local workshops expanded in 2013:

- Northern Valley Indian Health and Round Valley Indian Health Center hosted local digital storytelling workshops
- Fresno American Indian Health Project facilitated a workshop for the Tribal Temporary Assistance for Needy Families
- Riverside/San Bernardino County Indian Health, Inc. (Banning) created stories for clinic programs
- United American Indian Involvement, Inc. (Los Angeles) uses digital storytelling in their substance abuse program

Employee Wellness

IHS/CAO continued to promote employee wellness in FY 2013. The *Just Move It* employee wellness challenge promoted physical activity and healthy eating by establishing personal wellness goals. The IHS offered wellness briefings and newsletters through the President's Challenge website, National *Let's Move! Initiative*, and *Just Move It!* Campaigns.

***Just Move It* Challenge**

The seventh annual *Just Move It 2013 California Challenge* worked to promote physical activity at the local level and strengthen partnerships with tribal and urban partners. Current and new *Just Move It* partners from California were encouraged to post 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 promoted community-based walks, fitness initiatives, and physical activity. In FY 2013, the IHS launched an online virtual training website that included short videos that introduce *Just Move It*, the IHS Physical Activity Toolkit, and an overview of the national Physical Activity Guidelines for Americans.

Telenutrition

The IHS/CAO Telenutrition Guidelines, completed in 2012, were tested in a demonstration pilot. This resource was tested to assess usefulness in promoting quality telenutrition among tribal and urban Indian healthcare programs. Telenutrition provides access and convenience to communities unable to obtain nutrition services locally. San Diego American Indian Health Center provided Medical Nutrition Therapy (MNT) by a registered dietitian via telecommunication to American Indian Health & Services Corporation (Santa Barbara). The pilot test assessed what is needed to further implement clinical nutrition services and MNT networking between tribal and urban Indian healthcare programs. This pilot demonstrated telenutrition is beneficial and that the developed guidelines successfully outline what is required for effective telenutrition.

PURCHASED AND PREFERRED CARE (PRC)

The purchased and preferred care (PRC) program is for medical/dental care purchased outside of tribal healthcare facility. PRC is not an entitlement program and an IHS referral does not formally imply that referred care will be paid. If IHS is requested to pay, then a patient must meet the residency requirements, notification requirements, medical priorities, and apply for alternate of healthcare payment sources.

PRC Improvement Initiatives in FY 2013

IHS/CAO encourages all tribal healthcare programs to fully document PRC 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) PRC application or manual logs. The data however remains incomplete because non-PRMS programs do not submit data.

To improve quality of and access to care, the IHS/CAO PRC Officer provides general consultation for PRC regulations (42 CFR 136) and technical guidance on PRC operating guidelines as well as policies and procedures to tribal staff and outside agencies. The PRC Officer also reviews and processes all Area Catastrophic Health Emergency Fund (CHEF) cases. PRC education and training opportunities include, but are not limited to PRC 101, Medicare-Like Rate overview and calculations, health board presentations, and PRC claims processing.

Web-based PRC training curriculum is now available on the IHS website. The training curriculum was developed by a group of experts who work in both IHS and tribal PRC programs and provides a strong foundation of what PRC technicians need to know and do to run a successful PRC program.

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 is 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. The foundation of a Medical Home is the relationship between the patient, his/her family, as appropriate, and the primary point of care.

California Area Improvement Support Team

The IHS/CAO Improvement Support Team (IST) is multi-disciplinary and consists of a registered nurse, certified physician assistant, registered health information administrator, two public health analysts, 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 ten-month development and support program whose goal is for participants to become highly effective leaders in helping their organization accomplish strategic improvement plans. The Improvement Advisor currently serves as faculty on the National IPC Team. The California Area IST participates in all national IPC trainings and completed a two-day training on Accreditation Association for Ambulatory Health Care accreditation and with a focus on PCMH certification. Each member of the California Area IST transfers their knowledge of improvement methods into their daily tasks.

California Area IPC Initiative Successes

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

- K'ima:w Medical Center (Hoopa)
- Lassen Indian Health Center (Susanville)
- Riverside/San Bernardino County Indian Health (Morongo)
- American Indian Health & Services Corporation (Santa Barbara)

In FY 2013, three sites were part of the Quality and Innovation Learning Network (QILN) as their programs were involved in the previous IPC collaborative. The healthcare teams at these sites attended national webinar trainings to continue to build skills for quality improvement and serve as mentors for sites new to the IPC collaborative.

2013 Final National GPRA Dashboard (IHS/Tribal)

Diabetes	2012 Target	2012 Final	2013 Target	**2013 Final**	2013 Final Results
Good Glycemic Control[a]	32.7%	33.2%	Baseline	48.3%	Met
Controlled BP <140/90[a]	38.7%	38.9%	Baseline	64.6%	Met
LDL (Cholesterol) Assessed	70.3%	71.0%	68.0%	72.7%	Met
Nephropathy Assessed	57.8%	66.7%	64.2%	68.2%	Met
Retinopathy Exam	54.8%	55.7%	56.8%	57.6%	Met
Dental					
Dental: General Access	26.9%	28.8%	26.9%	28.3%	Met
Sealants[a]	276,893	295,734	Baseline	13.9%	Met
Topical Fluoride[a]	161,461	169,083	Baseline	26.7%	Met
IMMUNIZATIONS					
Influenza 65+	63.4%	65.0%	62.3%	68.0%	Met
Pneumovax 65+	87.5%	88.5%	84.7%	89.2%	Met
Childhood Immunization	77.8%	76.8%	Baseline	74.8%	Met
Prevention					
(Cervical) Pap Screening[a]	59.5%	57.1%	Baseline	61.7%	Met
Mammography Screening	51.7%	51.9%	49.7%	53.8%	Met
Colorectal Cancer Screening[a]	43.2%	46.1%	Baseline	35.0%	Met
Tobacco Cessation[a]	30.0%	35.2%	Baseline	45.7%	Met
Alcohol Screening (FAS Prevention)	58.7%	63.8%	61.7%	65.7%	Met
DV/IPV Screening	55.3%	61.5%	58.3%	62.4%	Met
Depression Screening	56.5%	61.9%	58.6%	65.1%	Met
CVD- Comprehensive Assessment[a]	40.6%	45.4%	32.3%	46.7%	Met
Prenatal HIV Screening	81.8%	85.8%	82.3%	87.7%	Met
Childhood Weight Control[b]	N/A	24.0%	24.0%	22.8%	Met
Breastfeeding Rates[c]	N/A	N/A	Baseline	29.0%	Met
Public Health Nursing Encounters	424,203	435,848	405,962	Pending	N/A
Suicide Surveillance[d] (forms completed)	1,807	1,709	1,376	Pending	N/A

[a]Measure logic changes in FY 2013

[b]Long-term measure as of FY 2009, reported in FY 2013

[c]As of FY 2013 this measure will be reported by IHS and Tribal health programs

[d]Measure data is submitted from 11 Areas

Measures in red are GPRAMA measures

Measures Met: 22

Measures Not Met: 0

IPC Initiative Results

As a result of participating in the IPC collaborative, many IHS, tribal, and urban Indian healthcare programs across the nation have experienced the following successes:

- Optimized clinic functionality – everyone does their job
- Reduced waste and duplication – processes are efficient
- Cost savings – makes other improvements possible
- Higher quality patient visits
- Increased patient/family engagement
- Improved screening rates
- Decreased patient no-shows
- Improved patient and staff satisfaction
- Increased opportunities for accreditation and certifications

GPRA

The Government Performance and Results Act (GPRA) of 1993 required each federal agency to have performance measures that show Congress how effectively it spends its funding. On January 4, 2011 President Barack Obama signed into law the GPRA Modernization Act of 2010 (GPRAMA), Public Law 111-352. GPRAMA strengthens GPRA by requiring federal agencies to use performance data to drive decision making. In FY 2013, the IHS began reporting six GPRAMA measures. Four of the GPRAMA measures are clinical measures reported through the Clinical Reporting System (CRS), including Good Glycemic Control, Childhood Immunizations, Depression Screening, and CVD Comprehensive Assessment. The remaining GPRA and IHS performance measures were reclassified as "budget measures" and will continue to be reported nationally in the IHS annual budget request. The IHS will monitor the 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.

IHS had a total of 90 budget measures in FY 2013. Twenty-two of these measures track health care provided at the individual clinic level and are reported through CRS; four of the 22 measures are the clinical GPRAMA measures. Results from each clinic are aggregated and a national rate is reported to Congress.

In FY 2013, California Area tribal healthcare programs, on average, improved on 8 of 13 measures for which comparable data existed in FY 2012 (8 of the 22 measures had significant logic changes in FY 2013 and one measure was new for tribal healthcare programs; these nine measures had "baseline" targets for FY 2013). California met the national targets for three of the 13 GPRA performance measures with specific targets. The largest improvements were seen in the following four measures:

- Depression Screening (GPRAMA measure)
- Alcohol Screening (FAS Prevention)
- Nephropathy Assessment
- Influenza immunizations 65+

California Area tribal healthcare programs met the target for 3 of the four clinical GPRAMA measures in FY 2013 (two of these measures had baseline targets):

- Good Glycemic Control: Met (Baseline)
- Childhood Immunizations: Met (Baseline)
- Depression Screening: Not Met
- CVD Comprehensive Assessment: Met

In FY 2013, California Area urban Indian healthcare programs improved on 7 of 10 measures for which comparable data existed in FY 2012. The largest improvements for the urban programs were seen with the following five measures:

- Pneumovax immunizations 65+
- Nephropathy Assessed
- Influenza immunizations 65+

- Prenatal HIV Screening
- Depression Screening

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 RPMS 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 illustrate national, area, and clinic level performance data are provided on a regular basis, so that each tribal and urban Indian healthcare program can monitor its own performance and identify and target health performance measures that need improvement.

GPRA Performance in FY 2013
Under Titles I and V of P.L. 93-638, California tribal Indian healthcare programs are not mandated to track and/or submit GPRA data to the IHS and OMB, however, most RPMS programs do so on a voluntary basis. Urban Indian healthcare programs are required, by contract, to track and submit GPRA data to the IHS. 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 2013 GPRA targets, the IHS/CAO:

- Hosted nine 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 ten improvement webinar sessions specifically for California tribal and urban Indian healthcare program staff, including updates on California's GPRA performance, IHS/CAO improvement initiatives, and best practices from high-performing sites in California
- Provided technical assistance via email or phone for California Area urban and tribal healthcare programs with issues or questions related to both GPRA and CRS
- Provided individual site trainings to five California healthcare programs
- Sponsored an Influenza and Pneumococcal vaccination challenge and a Childhood Immunization challenge to press for improve reporting for these measures
- Updated and distributed the 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 FY 2012 GPRA Report booklet, which includes a summary of performance on 19 GPRA performance measures, trend graphs, and performance comparisons by individual tribal and urban Indian healthcare programs
- Distributed quarterly dashboards with individual clinic results to each California healthcare program, identified performance measures that needed significant improvement to meet end-of-year targets, and shared this information in quarterly conference calls with California health programs
- Hosted the California Annual Medical Providers' Best Practices & GPRA Measures Continuing Education May 21-22 in Sacramento
- Created and distributed a survey for California GPRA coordinators to provide feedback on GPRA activities
- Created the California Area GPRA Portal allowing healthcare programs to access GPRA and CRS resources and training programs.

Annual California Area GPRA Report
While California tribal programs only met 12 of 22 measures on average in FY 2013, at the individual clinic level, performance varied widely. Some clinics did very well, with the best performing clinic meeting 13 of 13 measures with targets. Some did very poorly, with the lowest performing clinic meeting only two measures with targets. 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 2004 to the present year. This report is prepared each March. The most current version is for FY 2012 and is available on the California Area website or upon request. California urban program results are also included in the report.

FY 2014 Action Plan
There is still a need to lead and improve GPRA performance and to properly document the provision of preventive healthcare. The National GPRA Support Team has developed a FY 2014 action plan to support and promote GPRA quality improvements at each tribal and urban Indian healthcare program. The action plan includes offering feedback on performance, offering trainings, 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 2014 GPRA/GPRAMA Measure Changes
Three GPRA budget measures have been approved for measure logic changes in FY 2014 by the President's Office of Management and Budget (OMB). The three measures and their revised logic are:

- Nephropathy Assessment
  - Numerator: Patients with an estimated Glomerular Filtration Rate (GFR) and a Urine Albumin-to-Creatinine Ratio (UACR) during the report period or evidence of diagnosis and/or treatment of ESRD at any time before the end of the report period
  - Denominator: Active Diabetic Patients
- Pneumovax immunizations 65+:
  - Numerator: Patients with a pneumo vaccine or contraindication documented ever, and, if patient is older than 65 years, either a dose of pnuemovax after the age of 65 or a dose of pneumovax in the past five years
  - Denominator: Active Clinical population age 65+
- Pap Screening:
  - Numerator: Patients with a Pap smear documented in the past three years, or if the patient is 30 to 64 years of age, either a Pap smear documented in the past three years or a Pap smear and an HPV DNA documented in the past five years
  - Denominator: Female active clinical patients age 24 to 64 without a documented hysterectomy

2013 Final California Dashboard

Diabetes	**California 2013 Final**	California 2012 Final	National 2013 Final	National 2013 Target	2013 Final Results
Diabetes Dx Ever	10.8%	10.7%	13.9%	N/A	N/A
Documented A1c	85.7%	85.1%	85.2%	N/A	N/A
Good Glycemic Control[a]	51.5%	38.3%	48.3%	Baseline	Met
Controlled BP <140/90[a]	64.5%	34.4%	64.6%	Baseline	Met
LDL Assessed	71.9%	70.4%	72.7%	68.0%	Met
Nephropathy Assessed	61.3%	58.7%	68.2%	64.2%	Not Met
Retinopathy Exam	50.2%	52.2%	57.6%	56.8%	Not Met
Dental					
Dental Access	41.2%	39.9%	28.3%	26.9%	Met
Sealants[a]	13.7%	12,698	13.9%	Baseline	Met
Topical Fluoride[a]	30.0%	11,032	26.7%	Baseline	Met
Immunizations					
Influenza 65+	57.5%	54.9%	68.0%	62.3%	Not Met
Pneumovax 65+	83.9%	83.7%	89.2%	84.7%	Not Met
Childhood Immunization	62.2%	71.3%	74.8%	Baseline	Met
Prevention					
Pap Screening[a]	54.8%	48.5%	61.7%	Baseline	Met
Mammography Screening	42.6%	43.9%	53.8%	49.7%	Not Met
Colorectal Cancer Screening[a]	30.8%	40.7%	35.0%	Baseline	Met
Tobacco Cessation[a]	37.4%	30.4%	45.7%	Baseline	Met
Alcohol Screening (FAS Prevention)	56.1%	53.0%	65.7%	61.7%	Not Met
DV/IPV Screening	57.9%	55.5%	62.4%	58.3%	Not Met
Depression Screening	57.2%	53.5%	65.1%	58.6%	Not Met
CVD-Comprehensive Assessment[a]	38.6%	47.1% (40.8%)[c]	46.7%	32.3%	Met
Prenatal HIV Screening	70.6%	72.1%	87.7%	82.3%	Not Met
Childhood Weight Control[b]	24.6%	22.8%	22.8%	24.0%	Not Met
Breastfeeding Rates[a]	43.0%	N/A	29.0%	Baseline	Met

[a]Measure logic revised in FY 2013

[b]Long-term measure as of FY 2009, reported in FY 2013

[c]Developmental Comprehensive CVD measure result is shown in parenthesis. This measure is the GPRAMA measure in FY 2013.

Measure Met = 12

Measures Not Met = 10

Measures in red are GPRAMA measures

Information Resource Management (IRM)

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

IT staff also provides technical assistance for the following systems:

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

ELECTRONIC HEALTH RECORD

The electronic health record (EHR) helps 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.

Types of Services

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

The RPMS EHR software is 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 CAO offers RPMS EHR support so that clinic programs can qualify for meaningful use incentives.

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 unmet healthcare needs of patients. This allows providers and clinic staff to receive patient care reminder notices. These alerts are interactive and remind providers to order tests, medications, and conduct selected health screenings. The goal is to increase GPRA performance which will translate to improved care for IHS-eligible patients.

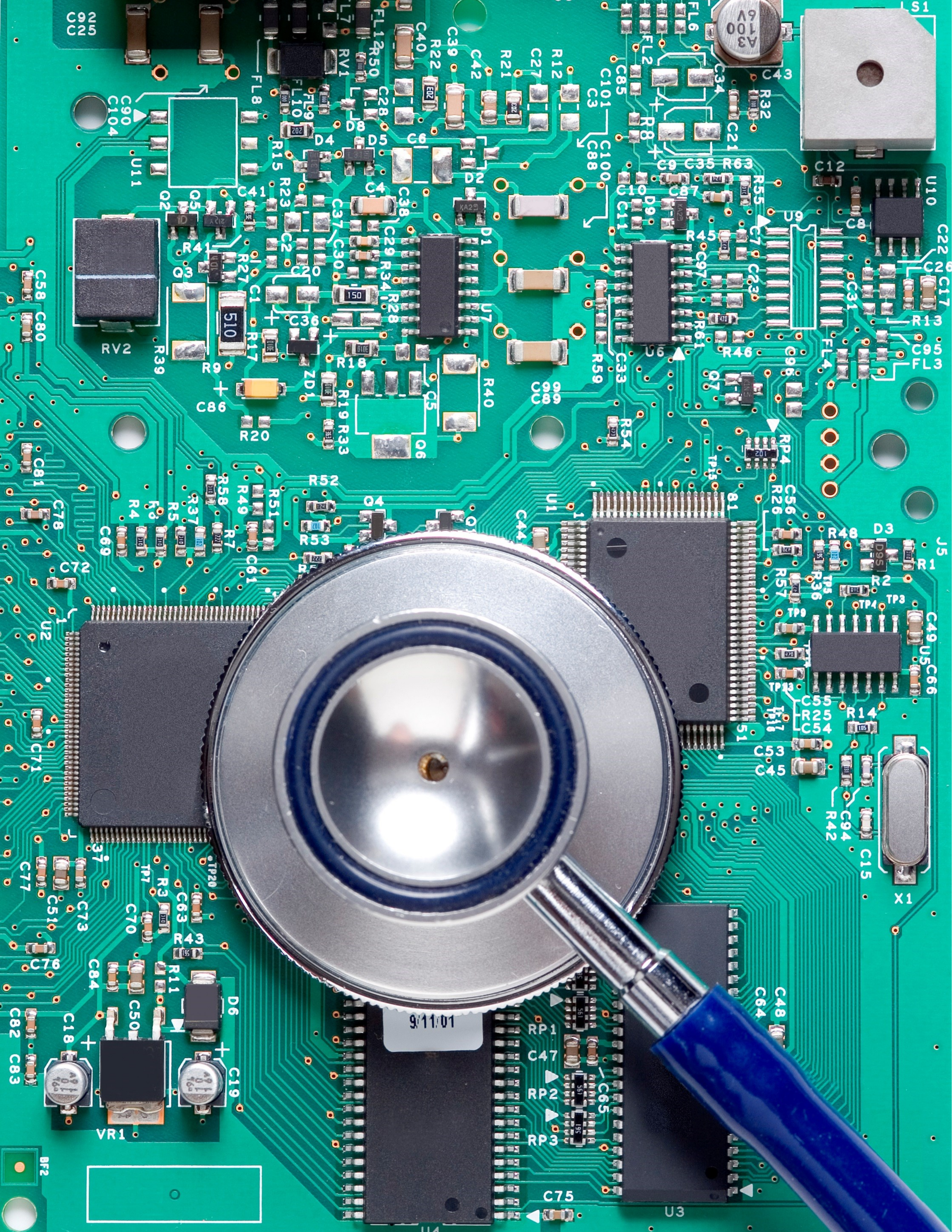
EHR "e-prescribing" Installs

With the exception of United American Indian Involvement, Inc. (Los Angeles), all programs without pharmacies have implemented e-prescribing with Sure Scripts. In FY 2013, four additional programs were converted to e-prescribing:

- Consolidated Tribal Health Project, Inc. (Redwood Valley) in October 2012
- Karuk Community Health Clinic (Happy Camp) in October 2012
- Round Valley Indian Health Center, Inc. (Covelo) in January 2013
- Central Valley Indian Health, Inc. (Clovis) in February 2013

This allows providers at 11 California healthcare programs to order medications from thousands of pharmacies nationwide using the RPMS EHR application. In 2014, the CAO will install and support e-prescribing capability to programs with pharmacies on-site. In FY 2014, two additional sites will go live with e-prescribing:

- Feather River Tribal Health, Inc. (Oroville) in January 2014
- Southern Indian Health Council, Inc. (Alpine) in February 2014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IHS/CAO EHR Team Site Visits
In FY 2013, the IHS/CAO EHR team visited 13 California healthcare programs:

- Santa Ynez Tribal Health Program in October 2012
- Chapa-De Indian Health Program, Inc. (Auburn) in December 2012
- Round Valley Indian Health Center, Inc. (Covelo) in February 2013
- Consolidated Tribal Health Project, Inc. (Redwood Valley) in February 2013
- Lassen Indian Health Center (Susanville) in March 2013
- Riverside/San Bernardino County Indian Health (Banning) in April 2013
- K'ima:w Medical Center (Hoopa) in May 2013
- Shingle Springs Tribal Health Program (Placerville) in June 2013
- Toiyabe Indian Health Project, Inc. (Bishop) in June 2013
- Quartz Valley Program (Fort Jones) in July 2013
- Pit River Health Service, Inc. (Burney) in July 2013
- San Diego American Indian Health Center in August 2013
- Feather River Tribal Health, Inc. (Oroville) in August 2013

During the visits, the team provided targeted support. All program staff were invited to give feedback on problems or concerns they are having with the RPMS EHR, and their responses were recorded so the team could address them on-site. A mock patient walk-thru was conducted so that the team can better understand how staff interact with the RPMS/ EHR when providing patient care. The CAO team then meets with staff to problem solve, reconfigure the EHR as needed, and create workflows (such as for patient visits, screening, and meaningful use of the EHR).

Bi-directional Lab Interfaces
The IHS/CAO currently has installed 12 bi-directional lab interfaces and 11 more remain installed. The last 11 programs are Quest reference lab sites. Currently, Quest is completing a code conversion project that is affecting all programs with Quest reference lab services. This should be completed by the end of 2013, at which point the IHS/CAO can resume installation of the bi-directional interfaces.

The California Area Lab Consultant is Kat Goodwin-Snyder. She is available to all California healthcare programs for lab file updates, quick order updates, and to help with installation of the bi-directional interfaces.

VISTA IMAGING

History
The IHS/CAO began its VistA Imaging program during FY 2010 in collaboration with five partner clinics:

- Feather River Tribal Health (Oroville)
- Lake County Tribal Health (Lakeport)
- Riverside/San Bernardino County Indian Health (Morongo)
- Santa Ynez Tribal Health Program
- Southern Indian Health Council (Alpine)

CAO Hardware was purchased, delivered, and installed A VistA Imaging coordinator was hired so software set-up was completed. Training was conducted; and, Indian healthcare programs began using the software during the first half of 2010.

This was the beginning of an effort to implement VistA Imaging at the 23 California area programs that use the RPMS electronic health record (EHR) . Software has been installed and on-site training has been delivered at 18 of the 23 California clinics using the RPMS EHR.

Current Status
VistA Imaging is now in use at the following California health clinics:

- 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)
- Sonoma County Indian Health Project (Santa Rosa)
- 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 Expansion
The following three clinics are currently in the process of implementing VistA Imaging:

- Anav Tribal Health (Quarter Valley)
- Karuk Tribe (Happy Camp)
- Pit River Health Service (Bumey)

The two remaining eligible California clinics (Central Valley, Clovis and Chap-De, Auburn) are expected to implement VistA Imaging by mid-2014.

Meaningful Use
IHS/CAO has identified VistA Imaging software for the purpose of meeting stage two meaningful use requirements to receive incoming Consolidated Clinical Documents (CCD). A certified EHR must have the ability to both transmit and receive the CCD in HyperText Markup Language (HTML) format when a patient experiences a transition of care (e.g. return to clinic following hospital discharge). The CCD requirement facilitates timely transfer of relevant patient clinical information between healthcare providers to insure continuity of patient care.

VistA Imaging software will receive and store the incoming CCD for review and use by healthcare providers. The modified VistA Imaging software will be available for installation and use during the 2014 Meaningful Use (MU) reporting period.

Vista Imaging Program Support
The IHS/CAO assists sites with installation and implementation of VistA Imaging software through remote technology followed by on-site training. The Vista Imaging Coordinator visits sites that are actively using VistA Imaging to evaluate software use, suggest needed adjustments, and offer additional training as needed.

Additional on-going support is provided through monthly calls with Area clinic staff 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 IHS/CAO Help Desk. Purchase of a second Plasmon Archive Appliance has enabled IHS/CAO to provide long term storage for all eligible clinics.

Premium Costs
The cost for California clinics to use VistA Imaging has decreased during all but one of the four fiscal years of operation. This is remarkable in light of unbudgeted costs during FY 2011 and FY 2012 as a result of unexpected hardware and maintenance costs. The initial cost of $4054 per

medical FTE during FY 2010 has been reduced dramatically to $1400 per medical FTE in FY 2014. This cost reduction is a result of two main factors:

- Increase in number of participating medical FTEs
- Reallocation of Vista Imaging Coordinator costs as a result of additional duties

Summary

The five initial partner programs are to be congratulated California Area VistA Imaging program nears the end of a successful implementation phase. Ongoing expansion will continue to occur during FY 2014 include the addition of new clinics and increased software functionality.

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 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 University of California, Davis medical specialists to offer various telemedicine services including retinal screening, methamphetamine use prevention, and suicide prevention.

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. Real time visits are interactive and take place over video conferencing equipment that allows a patient-doctor visit in real time. Retinal screening and dermatology are examples of store and forward telemedicine.

14 clinic programs currently provide telemedicine services in the areas of endocrinology, psychiatry, nutrition, and dermatology. This year there was an increase of 5 programs receiving psychiatric services for a total of seven sites. These programs are all clients of "Native American Mental Health Services." These new programs were outfitted with video/tele conferencing equipment using ARRA funding.

Thirty-two clinics currently provide retinal screening onsite. The IHS/CAO continues to support retinal screening training through a contract with U.C. Berkeley Eyepacs program. IHS/CAO Area Clinical Application Coordinators provide troubleshooting support and on-site trainings that include capturing images and developing strategies for increasing patient screening rates.

The IHS/CAO continues to maintain a calendar where programs can look at the telemedicine schedule for University of California, Davis Medical Center specialty care service. The calendar is updated monthly by the Area Telemedicine Coordinator. Clinic telemedicine program coordinators can then schedule patients into visit slots in real time.

Tele/Videoconferencing

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

- Virtually meet with health program 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 videoconferencing

The IHS/CAO purchased a televideo conferencing system to host multiple conference attendees and to archive meetings/ trainings for web delivery, thereby establishing a true multimedia knowledge base. Televideo-conferencing technology makes telemedicine possible to offer specialty care in isolated tribal health programs. In addition, televideo-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.

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

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 are two of the programs created as a result of this legislation

The term "Meaningful Use" (MU) is frequently used in relation to the Medicare and Medicaid EHR incentive programs. These incentive programs are broken into 3 stages with 2 or more years in each stage. Participation requirements for eligible providers increase with each stage. Stage 1 requirements addressing data capture and sharing were released in July 2010. Stage 2 requirements strive to improve patient care through better clinical decision support, care coordination, and patient engagement. The stage 3 MU requirements target improved outcomes.

At the close of FY 2013, many California area healthcare providers have completed stage 1 requirements for demonstration of MU and are preparing to move into stage 2 MU.

The National Indian Health Board (NIHB) Regional Extension Center (REC) is the only national REC. The remaining 61 RECs each serve a limited geographic area. The RECs were created to assist healthcare providers with adoption and meaningful use of health information technology during stage 1 meaningful use. The RECs received funding based on completion of three milestones:

- Milestone 1 - Secure signed REC agreements
- 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 REC, the California Rural Indian Health Board (CRIHB) has collaborated with the IHS/CAO to provide EHR technical assistance (including pharmacy, lab, and EHR consultants) to California tribal and urban Indian healthcare programs using RPMS EHR and commercial-off-the-shelf (COTS) software. The area MU team consists of the MU Coordinator, EHR Clinical Applications Coordinator (CAC), and the MU Consultant. Regular conference calls, on-site MU assessments, training conferences, and remote and on-site assistance have been provided to support eligible California tribal and urban Indian healthcare providers in their pursuit of their MU of the EHR (REC milestone 3).

The CMS EHR Financial Incentive Programs will continue for several more years; however, the REC program is nearing end of life with the close of stage 1 MU; the technical assistance provided by the NIHB REC will no longer be available. During this transition, the IHS/CAO is working with the IHS national office and CRIHB to retain adequate support staff to insure an orderly transition as California providers prepare to meet stage 2 and 3 MU requirements.

HEALTH INFORMATION TECHNOLOGY

The IHS/CAO has adopted a multi-pronged approach to improve quality of and access to care through timely, accurate, and accessible patient health information. All California health care clinics have adopted an electronic health record (EHR). 23 of the clinics use the Resource and Patient Management System (RPMS) EHR and the remainder use including NextGen and eClinical Works. The IHS/CAO provides technical support to all California clinics regardless of which EHR is used.

RPMS office hours are held weekly using remote meeting technology. These meetings are open to all interested individuals and include training announcements, discussions of EHR challenges and resolutions, and demonstrations of software functionality and/or workflow redesign.

Site managers are also made aware of current information and changes through a weekly site manager's message that is sent at the end of each week. These messages include advances and best practices identified by clinic and/or Area office staff.

Clinic staff are notified of health information management (HIM) training opportunities provided nationally and/or locally through the IHS as well as those offered through other organizations. Topics may include *Health Insurance Portability and Accountability Act (*HIPAA) privacy requirements and documentation improvement.

The IHS/CAO has built a multi-disciplinary EHR team that includes nursing, HIM, IT, coding, and MU expertise. This team routinely visits California clinics when invitated. The team conducts a visit workflow and also interviews EHR users to identify challenges and problems with use of the EHR.

ICD-10

The California Area Office has successfully completed Phase 2 of the ICD-10 Implementation Process presented by the IHS Office of Information Technology.

Continued ICD-10 Awareness and Communication

IHS/CAO continues to be a leader in providing outreach and training activities. IHS/CAO has provided ICD-10 awareness at the following events:

- Area outreach and education trainings
- Program Directors' Meeting
- Medical Providers' Best Practices & GPRA Measures Continuing Education
- Three "Have no Fear, ICDl-10 is Here" trainings

Refining the Training Plan

IHS/CAO reinforced the national deadline, October 1, 2014, ICD-10 Compliance Date. As a result, the training plan was refined to meet the compliance date.

Continued RPMS Readiness

IHS/CAO continues to monitor RPMS applications to ensure all are up-to-date with patches and security requirements.


Backspace
HEALTH

HHSInnovates Award

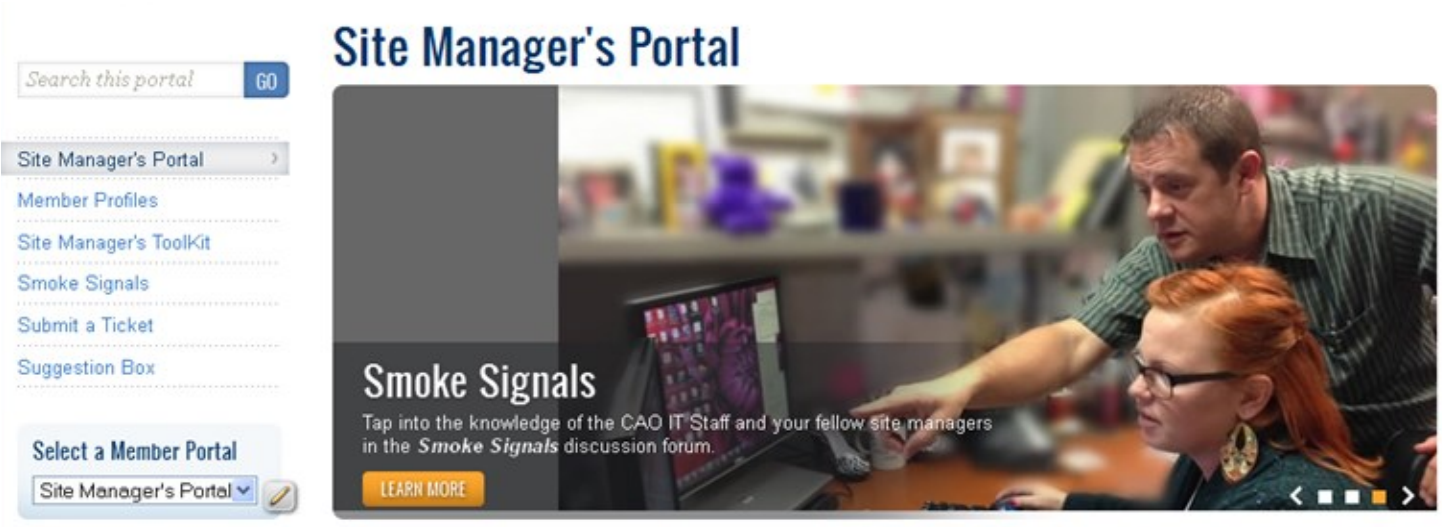
PORTAL SYSTEM

The California Area Office offers tribal and urban Indian healthcare programs knowledge and experience across all disciplines. IHS/CAO clinical and technical experts are available to support their counterparts throughout the California area. The IHS/CAO strives to improve customer service through these experts within the IHS/CAO Portal System.

The IHS/CAO Portal System is a novel but cost-effective and easily accessible tool that non-federal healthcare staff at remote locations such as Indian reservations and Rancherias throughout California use to access discipline-specific online communities. These clusters of subject matter experts offer one-stop access for IT training and technical assistance, including:

- custom helpdesk applications
- links to documents and information
- knowledge bases articles
- training videos
- peer-to-peer support chat functions
- calendar of events
- frequently asked questions
- issues

The IHS/CAO portal system received Honorable Mention as one of the six finalists in the U.S. Department of Health and Human Services 2013 HHSinnovates award contest. On March 19, four IHS/CAO staff attended a DHHS sponsored ceremony in Washington D.C. and were presented with the HHSinnovates award by DHHS Secretary Kathleen Sebelius.



Screenshot of IHS/CAO portal for California's Resource & Patient Management System Site Managers, Electronic Health Record Clinical Application Coordinators, and tribal and urban Indian healthcare program technical staff

HHS Innovates Award Ceremony

L to R: Steve Riggio, Kelly Stephenson, Yvette Roubideaux, Robert Gemmell, Beverly Miller

Office of Environmental Health & Engineering

The services provided by the Office of Environmental Health & Engineering (OEH&E) are categorized into four organizational components:

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

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

ENVIRONMENTAL HEALTH SERVICES (EHS)

The Environmental Health Services (EHS) component provides a broad range of technical services consistent with its mission "to reduce environmentally related disease and injury among American Indians through preventive measures." EHS 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 EHS is currently staffed with six environmental health officers (EHOs), including the newly established position serving the Mendocino and Lake County areas. EHOs are located in Redding, Ukiah, Sacramento (3), and Escondido.

Environmental Health Surveys
In FY 2013, EHS staff conducted 388 surveys, 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 (278)
- Head Start programs (17)
- Healthcare facilities (15)
- Swimming pools (11)
- Grocery/convenience stores (11)
- Tribal owned gaming facilities (25)
- Motels/hotels (5)
- Other facilities (44)

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

In FY 2013, the EHS staff completed the following institutional environmental health services:

- Accreditation support surveys (12)
- Industrial hygiene assessments (4)

In addition, EHS staff conducted four nitrous oxide evaluations in dental clinics at California tribal dental. The objectives of these surveys were:

- Investigate the condition of equipment used to administer nitrous oxide to patients
- Observe practices used by dental staff in setting up the equipment
- Inspect all system components for operational integrity and possible nitrous oxide leaks
- Make recommendations that ensure the use of safe nitrous oxide delivery processes

The EHS staff offered 18 recommendations to dental officers during these surveys to improve safe nitrous oxide delivery processes. Findings and recommendations were based on guidance outlined by the National Institute for Occupational Safety and Health in Publication 94-100—"Controlling Exposures to Nitrous Oxide During Anesthetic Administration".

Training
The EHS staff sponsored add coordinated 28 training courses in tribal communities throughout California to build tribal capacity in environmental health related areas. Courses were offered in general food safety (23) and occupational safety and health (5). More than 356 participants from tribal communities benefitted from these environmental and preventive health courses.

Rabies Vaccination Clinics for Dogs & Cats
The EHS staff assisted the U.S. Army's Veterinarian Program to provide a rabies vaccination clinic serving multiple tribes in southern California. More than 100 dogs and cats were vaccinated for rabies at no cost to tribal members

INJURY PREVENTION PROGRAM (IPP)

Training
The Injury Prevention Program (IPP) collaborated with the California Rural Indian Health Board, Inc. (CRIHB) to conduct one "Child Passenger Safety Technician Certification" course in Elk Valley, California. This course provided advanced instruction to 14 attendees 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 riding in motor vehicles.

In partnership with the CRIHB and California Department of Public Health, the IPP co-sponsored a "Tai Chi: Moving for Better Balance" Instructor Certification Course in Sacramento, California. This course provided advanced instruction to 15 attendees on the eight proper Tai Chi forms. Among older adults, strength and balance exercises, such as Tai Chi, can reduce falls by improving mobility, strength, and balance.

DEHS staff member conducting an assessment of a nitrous oxide unit at a tribal dental clinic

Projects
The IPP provided $38,000 in mini-grant funding for child safety seats, smoke detectors, and bicycle helmets to 18 tribal and urban Indian healthcare programs. These evidence-based projects are intended to reduce the health risks often associated with unintentional injuries.

Tribal Injury Prevention Cooperative Agreement Programs

The IPP served as project officer and provided technical assistance and support to Tribal IPPs funded through the IHS Tribal Injury Prevention Cooperative Agreement. 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. The CRIHB, Indian Health Council, and Tule River Indian Health Center were funded for continuation in FY 2014 at a value of $1.6 million over five years.

Ride Safe/Sleep Safe

The IPP provided technical assistance and guidance to one Head Start Program to implement the *Ride Safe* and *Sleep Safe* national initiatives, funded by the national IHS IPP. The objectives of these programs were: 1) reduce the rate of motor vehicle injuries by promoting motor vehicle child restraint use; and, 2) reduce fire/burn injuries by installing smoke alarms in the homes of Heat Start students. Ongoing education about the importance of child passenger safety and residential fire safety prevention for parents and students will continue through the end of the school year.

SANITATION FACILITIES CONSTRUCTION (SFC)

The Sanitation Facilities Construction (SFC) program, primarily staffed by engineers, engineer technicians, and administrative support staff, provides assistance to California Indian people by eliminating sanitation facilities deficiencies in Indian homes and communities. The SFC Program supports the IHS mission by providing engineering, technical, and financial assistance to Indian tribes for cooperative development and continued operation of safe water and wastewater disposal systems. The SFC Program provides service to California Indian homes and communities from offices located in Redding, Arcata, Ukiah, Sacramento, Clovis, and Escondido.

The SFC Program engages in a cooperative approach for providing sanitation facilities to Indian communities. During FY 2013, the SFC Program received and administered $5,201,890 in construction funds. Many tribes participated by contributing labor, materials, and administrative support to the construction projects.

In FY 2013, the SFC Program provided sanitation facilities to a total of 868 homes. These statistics are summarized In Table 1.

SFC Initiative – HITS

The IHS is required by Congress to conduct an annual assessment and inventory of Indian homes, determine associated SFC deficiency levels, and identify sanitation needs. This information, compiled in the IHS Sanitation Tracking and Reporting System (STARS) database, is used to determine the levels and types of services needed by Indian communities and as supporting documentation to fund future projects.

As a result of the ongoing effort to improve services to California Indians, the SFC Program updated the STARS database to allow tracking of individual homes, including geographical data (latitude and longitude). In the current system, homes are aggregated into non-geographically referenced housing groups called Community Deficiency Profiles (CDP). The updated information will be managed within STARS in the Housing Inventory and Tracking System (HITS) database and will provide a geographical description of each home, more accurate description of SFC deficiencies, and improved accuracy of the total number of Indian homes.

As a result of this 2013 SFC program initiative, 40,172 individual homes were identified and entered into the HITS database, whereas, 13,464 homes were listed in the old CDP system. An additional 26,708 Indian owned homes were identified and listed in HITS for future justification and funding.

TABLE 1
Sanitation Facilities Construction Program Statistics for FY 2013

SFC Program Budget:	
IHS/CAO SFC Appropriation	$3,412,203
EPA Contribution	$3,071,992
Total Funding in FY 2013	$6,484,195
Total IHS/CAO SFC Appropriation since 1963	$215,946,499
SFC Projects:	
Number of Projects Undertaken in 2013	23
Total Number of Projects Undertaken since 1963	1136
Homes Provided Sanitation Facilities in FY 2013:	
Number of New and Like New Homes Served	
BIA sponsored homes	19
Tribal and other homes	28
Subtotal	47
Number of Existing Homes Served	774
Total Number of homes served in 2013	868

Homes Provides Sanitation Facilities since 1963:	
Number of New and Like-New Homes	
BIA-sponsored homes	720
CDBG-sponsored homes	930
Tribal and other homes	2,820
Subtotal	4,470
Number of First Service Existing Homes	13,464
Total Number of Homes Served	52,314
Sanitation Deficiency System (SDS) Information:	
Total number cost of sanitation deficiencies	$199,072,844
Total estimated cost of feasible projects	$98,746,192
Total number of projects/phases identified	303
Number of feasible projects identified	256
Estimated total number of existing homes without potable water	843
Estimated total number of homes that lack either a safe supply or sewage disposal system or both (Deficiency Level 4 and 5)	2,271

Highlighted SFC Projects
Four SFC projects, which represent only a small portion of the total construction workload undertaken by the SFC Program, were selected to illustrate typical cooperative efforts undertaken by IHS, the tribes, and other federal agencies to provide safe water supply and sanitary sewage disposal facilities for California Indian homes and communities.

Water Mains and Community Well Projects: Santa Rosa Reservation
The Santa Rosa Reservation water system consisted of undersized (2 and 3 inch), older water mains that had frequent breaks and experienced pressure fluctuations and negative pressures. Drinking water is provided to the community from a 20 gallon-per-minute (gpm) groundwater well. The backup well for the water system is over 50 years old and produced less than 10 gpm.

Water Main Construction on the Santa Rosa Reservation

Utilizing $1.1 million in U.S. Department of Agriculture, Rural Development funding, the SFC program worked with the Santa Rosa Tribal Government to construct approximately five miles of water mains (4, 6, and 8 inch pipelines), installed metered water service connections, and drilled/equipped a new community drinking water well under IHS Project CA 09-Y04. This project served over 40 tribal homes and offices.

Operation and Maintenance Demonstration of a Fire Hydrant

Weitchpec Storage Tank: Yurok Reservation
IHS Project CA 09-M24 constructed a 100,000-gallon water storage tank to replace an existing 60,000-gallon redwood water storage tank. The existing redwood storage tank was constructed by IHS force account in cooperation with the Bureau of Indian Affairs equipment and operators in the late 1970s. The redwood material, originally purchased from Pacific Wood Tank Division, was deteriorating and susceptible

A backflow prevention assembly being installed for the Tribal Hall fire sprinkler protection system has a heated enclosure to protect from below freezing temperatures

to coliform contamination. The Weitchpec Water System, constructed under IHS Project CA 77-367, collects water from Gist Creek, treats it, and distributes it to the tribal community through 17,000 feet of water main.

Sewer Improvement Project: Colusa Rancheria

Construction is near completion with installing a gravity sewer collection system for the Colusa Rancheria to serve 27 homes. The project consists of installing an 8-inch gravity sewer main collection system, installing 4-inch sewer service lines, constructing a 6-foot diameter sewer lift station, and installing 1,700 feet of a 4-inch force main for transportation sewage to the Tribe's existing wastewater treatment plant. Current wastewater disposal for the 27 homes is provided by individual septic tank drainfield systems which have begun to fail due to high groundwater. All 27 septic tanks will be abandoned.

Concrete ring wall foundation construction

Weitchpec 100,000-gallon storage tank

Herlong Sewer Project—Susanville Rancheria

IHS Project CA 10-E06 replaced the existing sewer collection system serving 122 homes at the Susanville Indian Community of Herlong, California. Project funding was provided by the Environmental Protection Agency and IHS. Sanitary sewer construction consisted of 5,054 linear feet of 8-inch and 12-inch SDR 35 PVC; 6,038 linear feet of 4-inch and 6-inch SDR 35 PVC laterals; 35 48-inch inside diameter precast manholes; and, 7,532 square feet of asphalt pavement.

HEALTH FACILITIES ENGINEERING (HFE)

The Health Facilities Engineering (HFE) consists of three IHS staff and with the near future construction of the southern and northern youth regional treatment centers (YRTCs), the staff will increase to five. HFE services include planning and engineering for site selection, design, plan review, and construction inspection for maintenance and improvement (M&I) projects of existing facilities and new construction of tribal health care facilities in California.

Highlighted HFE Projects

Five HFE projects, which represent only a small portion of the total workload undertaken by the HFE program, were selected to illustrate typical cooperative efforts undertaken by IHS, the tribes, and tribal healthcare programs, to ensure a safe and pleasant environment for California Indian individuals and communities. Following are five projects that the HFE staff has been engaged in.

Consolidated Tribal Health Project, Inc.

The Consolidated Tribal Health Project. Inc. has leased space that will allow some staff to work off-site. This allows for

Installing 6-foot diameter concrete sections—Sewage Lift Station

renovation (additional examination rooms and provider workspace) to take place in the existing medical clinic. The next phase will expand the existing space by 5,000 square feet and is expected to be complete in FY 2014.

Northern Valley Indian Health, Inc.

Northern Valley Indian Health, Inc. will be constructing a new clinic in Chico to add to their ambulatory clinic capacity. Concurrently, the healthcare program will be renovating the clinic in Willows to meet new CMMS and ADA standards. The second phase of the Willows project will construct a new administration building in the near future. HFE also provided guidance regarding roof repairs and established an M&I project that refurbished the Woodland clinic parking lot and replaced clinic interior finishes.

Sewer Manhole Construction

Karuk Tribe

The HFE staff worked closely with the Karuk Tribe to get a the new, replacement clinic in Orleans completed. The new 10,000 square foot clinic is fully functional and providing healthcare for residents of Orleans and surrounding communities.

HFE staff has been working with a number of tribal healthcare programs that are planning to build new or replace existing healthcare facilities. These planning efforts will eventually allow the tribal health programs to provide sustainable services to a greater portion of the IHS beneficiaries than they already are.

CAPT Richard Wermers, Director,
Health Facilities Engineering

Regional Ambulatory Surgical and Specialty Referral Healthcare Facilities – Feasibility Study

The Area Director initiated a feasibility study titled, "Development of IHS-Operated Regional Ambulatory Surgical and Specialty Referral Healthcare Facilities in California". If funded, these facilities would:

- Ensure access to quality, culturally competent healthcare for the AI/AN population of California, comparable to care provided at IHS owned/operated hospitals and clinics
- Maximize scarce contract health services (CHS) funds for Priority 1 healthcare
- Increase the level of need funded from 54% to possibly 94%

Components of the study included: current CHS trends, construction and staffing cost estimates, population projections, market share analysis, strategic location review, and specialty services justification.

The IHS/CAO presented this study to the California Area Tribal Advisory Committee (CATAC) members on two occasions and to Indian healthcare program directors during a bi-annual meeting. Based on feedback, initial findings were presented at the Annual Tribal Consultation in March 2013 in Pala, CA. The final report and executive summary will be finalized in 2014.

Youth Regional Treatment Centers

The IHS/California Area Office (IHS/CAO) has made significant progress toward opening two IHS-operated Youth Regional Treatment Centers (YRTCs) in California. One facility will be constructed in the south and one in the north.

Southern YRTC

A team of technical staff from the IHS California Area Office, IHS Headquarters, and Engineering Services –Dallas, along with elected tribal officials from southern California, began design work in October 2012. These parties met with the primary contractor (BBCK-JV) several times to refine a dynamic, aesthetically pleasing, and culturally meaningful facility on the 20-acre parcel in western Riverside County. The construction project will soon be out to bid and construction of the southern YRTC is scheduled to begin in 2014 and is expected to take 14 months, resulting in the facility opening around November 2015.

Northern YRTC

Substantial progress was also made on constructing a YRTC in northern California. The IHS identified a parcel of land in Yolo County, which consists of twelve acres at the northeast corner of the D-Q University, the Tribal College near Davis, California. The D-Q University Board of Trustees agreed to revert this portion of their federal trust land expressly for IHS/ CAO to establish the northern California YRTC. The Area Director held a "Dedication of the Land Ceremony" for the northern YRTC property on July 16th. Approximately 120 attended the ceremony. The Director of Indian Health Services, Dr. Yvette Roubideaux, attended and shared her support and recognition for the astounding efforts of the D-Q Board and Indian Health Service, in acquiring the

property. Upon completion of a geotechnical study, which must be performed during the rainy season, the IHS/CAO will finalize the Program of Requirements and request design and construction funding for the northern YRTC in the fiscal year 2015 budget.

Child dancer (Wintun/Nomolaki)

Regional Ambulatory Surgical and Specialty Health Services Feasibility Study

IHS, California Area Office

Executive Summary

A Severe Shortfall

California American Indian/Alaska Natives experience a severe shortfall in secondary care, most often provided through PRC (CHS) referrals to the private sector for inpatient and specialty care. This is a hardship to an already challenged population.

IHS presents this preliminary study supporting two Regional Ambulatory Surgical & Specialty Centers for American Indian/Alaska Natives as a strategy for improving access to documented and needed secondary care, closing the Level of Need Funding (LNF) shortfall by as much as 39.8 percentage basis points, and providing a path for IHS to demonstrate its ability to build and operate culturally appropriate healthcare facilities.

A Regional Solution

This study suggests that two Regional Ambulatory Surgical & Specialty Centers, owned/operated by IHS, providing culturally-appropriate care, are the best solution, potentially increasing California Area's LNF from 54% to 93.8%:

- One facility centrally located for the central/northern region, such as Sacramento, to serve the referral needs of central and northern California tribal governments (300,715 square feet with 774 employees). (See Concept of Operation page 93)
- One facility centrally located in agreement with southern California tribal governments, such as Temecula, to serve the referral needs of the federally recognized tribes in southern California (119,369 building gross square feet with 269 FTE). (See Concept of Operation page 93)
- Each would provide an enhanced level of secondary healthcare for American Indian/Alaska Natives residing in California, including Medical & Surgical Specialty, Surgery, advanced Diagnostic Imaging, and Acute care, to name a few. Total project cost for both locations is estimated at $253.5 m. The annual operating cost for both locations is estimated at $134.6 m.

An Enhanced Level of Healthcare

These two Regional Ambulatory Surgical & Specialty Centers would enhance the level of healthcare for American Indian/Alaska Natives residing in California in at least five important ways.

1. First, these facilities would provide statewide access to needed healthcare. Appropriate locations for regional care in the north/central and southern parts of California would provide reasonable travel time to access consistent secondary care. The alternative, creating agreements with local hospitals, would result in inconsistent access and care for many tribal healthcare programs. (See Concept of Operation page 90)
2. Second, secondary services currently not accessible, but sponsored by IHS in other IHS areas, would be available. Other IHS areas have access to the levels of regional care identified in this study (examples include Phoenix Indian Medical Center in the Phoenix Area, Gallup Indian Medical Center in the Navajo Area, and Alaska Native Medical Center in the Alaska Area). Such facilities in California would not only help eliminate current gaps in the continuum of care for American Indian/Alaska Natives residing in California, but increase the level of access and presence of direct care services to what is currently available in other IHS areas.
3. Third, healthcare in a culturally-appropriate environment would be rendered. The provision of secondary care through contracts with local hospitals fails to address the need for cultural awareness. Providing needed services in a culturally appropriate environment will help raise the health of California American Indian/Alaska Natives to the highest possible level.
4. Fourth, they would make limited Contract Health Services funding more available for higher levels of acute care. Providing direct secondary care at regional centers allows local health programs to spend limited Contract Health Services dollars on other care that must be secured from the private sector, stretching those dollars while increasing access to higher level care.

5. Fifth, these facilities could close the disparity gap in Level of Need Funded. The 2010 national Level of Need Funding (LNF) benchmark is $3,510 per-user. California's present LNF is $1,895 per user, or 54% of the benchmark. The projected value of secondary care satisfied by these regional centers would significantly reduce the existing gap in LNF from 46% to 6.2%, a reduction of 39.8 percentage basis points. This represents an increase in LNF from $1,895 per- user to $3,294 per-user for American Indian/Alaska Natives residing in California, an additional $1,399 per-user for a projected 2025 area-wide user population of 102,745.

This LNF impact is calculated by relating total anticipated operational costs (operations plus depreciation) to the projected California Area user population to produce a per-user dollar value. This value reflects the LNF investment IHS is being asked to make in healthcare delivery for American Indian/Alaska Natives residing in California. This value also approximates the market cost of all referred healthcare demand projected to be satisfied at two Regional Ambulatory Surgical & Specialty Centers. (See Concept of Operation page 83)

A Forward Path
This study provides the concept, requirements, and guiding assumptions to begin the process of bringing Regional Care from recommendation to reality in improving health outcomes of American Indian/Alaska Natives residing in California to the highest possible level. Implementation requires active IHS/Tribal involvement and the following steps:

- Tribal and IHS adoption of this report
- IHS support in review and consideration of additional planning documentation
    - Comprehensive financial/revenue analysis
    - Competitor and risk analysis
    - Potential site availability and costs
- Support from the California tribal governments for the development of planning and project approval documentation, design, construction, and staffing.

Feasible Regional Healthcare Services

The Key Characteristic, or KC, is the single most important element in delivering a line of care. It is used for planning purposes. Examples include: Providers, Dentists, Imaging Rooms, Inpatient Beds, etc.	2 Regional Centers			
	Temecula		Sacramento	
	# of Key Characteristics	Department Gross Square Feet	# of Key Characteristics	Department Gross Square Feet
Ambulatory				
Audiology (Audiologist)	1.5	872	3.9	3,148
Dental Care - Specialty Only [1] (Chairs)	5.6	8,553	14.5	22,284
[1] Includes Pediatric, Endodontics, Orthodontics, Prosthodontics, Periodontics, Maxiofacial				
Specialty Care				
Medical Specialties (Providers)				
Cardiologists	0.0		2.4	
Dermatologists	0.0		1.8	
Neurologists	0.0		1.2	
Other Medical Specialists [2]	4.0		11.3	
[2] Includes Endocrinologist, Nephrologist, Allergist, Gerontologist, Rheumatologist, Gastroenterologist, Oncologist, Neurosurgeon, Pulmonologist, etc.				
Surgical Specialties (Providers)		9,052		27,907
General Surgeons	0.0		3.1	
Ophthalmologists	0.0		3.5	
Orthopedists	1.3		3.8	
Otolaryngologists	0.0		1.8	
Urologists	0.0		1.4	
Other Surgical Specialists [3]	0.9		2.4	
[3] Includes Thoracic, Plastic, Vascular, etc.				
Ancillary				
Outpatient Endoscopy (Suites)	0.0		2.0	
Outpatient Surgery Cases (OP ORs)	3.0	9,286	7.0	20,502
Short Stay / Observation (Beds)	1.0		1.0	
Laboratory (FTE)	3.0	2,158	16.0	4,187
Diagnostic Imaging				
Radiography (Rooms)	2.0		6.0	
Fluoroscopy (Rooms)	1.0		2.0	
Ultrasound (Rooms)	1.0	6,862	3.0	16,049
Mammography (Rooms)	1.0		3.0	
CT (Rooms)	1.0		2.0	
MRI (Rooms)	0.0		1.0	
Radiologist	1.7		5.1	
Pharmacy (Pharmacists)	4.5	2,400	20.8	9,115
Inpatient Care				
Pediatric (Beds)	2.6		7.3	
Adult Medical (Beds)	15.7	13,627	41.6	43,131
Adult Surgical (Beds)	7.0		31.2	
ICU (Beds)	4.4	2,357	12.9	6,932
Physical Rehab Services				
Occupational Therapist	2.0	938	5.4	2,537
Speech Pathologist	0.5		1.3	
Behavioral Health				
Psychiatry (Psychiatrists)	1.5	681	4.0	1,398
Other Programs				
Case Management (FTE's)	8.6	1,638	22.9	4,335
Pain Management (Specialists)	0.6	911	1.5	2,422
Summary				
Full Time Equivalent Employees	269		774	
Building Gross Square Feet	119,369		300,715	

Office of Management Support (OMS)

The California Area OMS provides advice to the Area Director and functional area managers on administrative and management policy and procedures requirements. This office provides support in the areas of:

- Acquisition Management
- Financial management
- Human Resources/General Administrative Services

ACQUISITION MANAGEMENT

The Contracting Office is responsible for award and administration of all contracts issued by the IHS/CAO. This includes P.L. 93-638 contracts and 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 ten Self-Governance compactors in the California Area Office. One tribal organization has a planning cooperative agreement and another tribe has a negotiations cooperative agreement.

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 30 P.L. 93-638 contracts. Most of these were Annual Funding Agreements (AFA) renewals; eight of these were new contracts. In addition one New P.L. 93-638 contracts were awarded. Numerous modifications were issued to all of the ongoing contracts and AFAs. In addition contracting staff awarded eight new contracts and exercised option on five 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 other contracts. Other construction projects were contracted under purchase orders.

FINANCIAL MANAGEMENT

The Finance Office is responsible for administering and directing the California Area IHS Financial Management Program including the coordination of budgeting, accounting, and financial management and program development, budget control and management-financial reporting, property management, and for developing, coordinating, advising on, and executing Area associated policies, procedures, and plans.

The Finance Management Officer (FMO) serves as technical financial advisor to the Area Director and Executive Staff; including providing the technical expertise and counsel on matters with financial implication required to establish organizational goals and objectives, manage programs, and to reach financial decisions. The FMO maintains active liaison with Area Management, IHS Headquarters Administrative and

Financial Management staff, Bureau of Indian Affairs, other government agencies, private companies, vendors, and others with whom the Area has a financial relationship.

HUMAN RESOURCES/GENERAL ADMINISTRATIVE SERVICES

The human resources (HR) office is responsible for all HR disciplines such as recruitment, employee relations, pay setting, position management, personnel security/suitability, performance management, scholarship program, and ethics. In 2013, the human resources function increased by one in anticipation of the future YRTC's that need to be staffed. The HR office continues to send direct care job seekers to the Tribal Health programs for possible employment. Many of these job seekers secure a Tribal position or provide services as a Commissioned Corps Officer under a memorandum of agreement.

The General Administrative services group is responsible for key functions such as records management, correspondence control, executive administration, reception, mail and files, and clerical support.

Jeanne Smith
Acting Human Resource Director, Regional Human Resource Specialist

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

Gary Ball received the Director's Award for unwavering determination and dedication to acquiring two parcels of real estate for the Northern and Southern California Youth Regional Treatment Centers. Mr. Ball has shown steadfast determination to ensure that the Youth Regional Treatment Center (YRTC) program authorized by Congress is moving forward. In the months from October 2011 to January 2013, the IHS has added two parcels of real estate to its inventory. Mr. Ball has been instrumental in the realization of these two parcels of real estate. Being assigned to these projects for the past 7 years, he has reviewed well over 150 sites and performed formal evaluations with multiple site selection evaluation teams. He developed many partnerships to work through and resolve issues having to do with site access, environmental concerns, community concerns and IHS needs. In furthering the IHS mission to provide this behavioral health program in California, Mr. Ball is now working with a design team on the Southern YRTC to move these two projects into construction as soon as funding is appropriated.

Stephen Riggio, DDS received the Director's Award for leadership in improving health care outcomes and ensuring a competent Indian health care workforce. Under Dr. Riggio's leadership, training and developing a competent Indian healthcare workforce in California has been a priority. The IHS/CAO investment in training and development programs has saved the Indian healthcare system at least $240,000 in fiscal year 2012. The training is tailored specific to the needs in Indian county. For example, at the Medical Providers Best Practice Continuing Education, Dr. Riggio works with the state of California to make sure the courses provided are in compliance for attendees to receive continuing education credits (CMEs). By inviting all the medical providers within the Indian Health Service contracted/compacted California clinics, Dr. Riggio capitalizes on economies of scale to produce CMEs at a reduced cost. As a result of the training and technical assistance, California tribal healthcare programs demonstrated significant improvement in 79% of the GPRA measures (15 of 19).

IHS/CAO Portal System
Ms. Beverly Miller accepted the Director's Award on behalf of the California Area for dedication and innovation in the creation of a portal system to support IHS staff and their customers. The California Area Office designed and created a portal system to connect IHS staff with their customers they support utilizing discrete online mini communities. Federal and non-federal subject matter experts can use IHS/CAO Portal web spaces to exchange ideas and share resources, bridging the gap between internal federal IHS communications systems and the IHS public website. The IHS/CAO Portal System is an extremely cost effective, novel, and is an easily accessible source of information that enables programs to not only pose questions , but provide solutions in a peer-to-peer environment. This innovative system will create efficient time management with limited staffing, and will produce cost savings which can be used to enhance patient care. The IHS/ CAO Portal System has been selected as a HHS Innovations Round 6 finalist.

David Mazorra received the Director's Award for high level performance in supervising multiple offices, accomplishing construction projects, and improving the living conditions of the tribes he selflessly serves. Mr. Mazorra supervises staff in four offices in a diverse region that covers a length that would take seven hours to drive from end to end. The project workload in these four offices was over $20 million and in the course of two years an astounding $8 million in relatively small contract expenditures. Mr. Mazorra is not only an extremely competent engineer providing engineering mentoring to his staff, he is also a caring individual that takes personal pride in mentoring his staff on the "soft" skills of personal interactions. Mr. Mazorra's customer service dedication is without equal. He meets with tribes and listens to their concerns and ensures a prompt response is made. Mr. Mazorra is not only a highly dedicated member of the IHS team, but is also someone that gives back to his community through volunteer efforts such as leading the "Water For Life" fundraiser four years in a row.

IHS Meritorious Service Medal

CAPT Christopher P. Brady has been awarded the Meritorious Service Medal for exceptional leadership, superior technical/ management abilities, and continuous service in public health.

CAPT Brady has established himself as a national expert in project development and construction management of sanitation facilities and as a national mentor to the U.S. Public Health Service (PHS) Office of Force Readiness and Deployment (OFRD). CAPT Brady is a registered Professional Engineer in Washington and California and is registered as Diplomat Environmental Engineer and as an Environmental Health Specialist.

Since 2003, CAPT Brady has been responsible for overseeing the design and completion of 242 construction projects, serving 18,996 Indian homes, at a cost of $85 million. Of these, 72 projects provided first time service to 2,279 Indian families with safe drinking water and sewer systems. Indian families receiving these first time facilities, often located in remote California locations, have required fewer medical visits for gastrointestinal infections and have placed fewer demands on the IHS and tribal primary health care delivery system. A review of IHS Resource and Patient Management System (RPMS) data from 14 tribal health centers over the same time period indicates a significant 35% decrease in patient visits for waterborne-related diseases with a total reduction of 156 visits per year.

In 2012, CAPT Brady was selected as the PHS Engineer and Category-wide Responder of the Year. Since 2006, CAPT Brady has actively served on the Applied Public Health Team (APHT) #2 team. In June 2009, CAPT Brady was selected as the team leader for APHT#2, and was responsible for overall recruitment, planning, and leading a team of 60 officers with a capacity to deliver environmental, epidemiology, and preventive medical services for disaster response.

A recent one-time impact on public health is exemplified by CAPT Brady's outstanding leadership in providing disaster response and recovery assistance for residential homes in flood -impacted areas in Minot, North Dakota in July 2011. Over 12,000 residents were impacted after being inundated by over 6 feet of water. OFRD deployed CAPT Brady to Minot as the on-site leader of a 16-member APHT#2 strike team where he effectively coordinated operations with state and local partners. As a result of CAPT Brady's coordination, over 3,000 residential home owners received immediate technical assistance, consultation, and critical environmental health information regarding post-flood home inspections and re-occupation, personal health precautions, and identification and mitigation of household risks including asbestos materials, electrical hazards, mold, open gas meters, and hazardous chemicals.

CAPT Brady has also served on numerous domestic and international missions providing engineering technical assistance, infrastructure assessments, and recovery plans for: the 2002 Typhoon Chata'an, Guam (USEPA); 2003 and 2007 Southern California Fires (IHS); 2004 Hurricane Ivan, Florida (OFRD); 2005 Hurricane Katrina, Mississippi (OFRD); 2006 California Floods (IHS); and 2007 USNS Comfort Humanitarian Assistance and Training Mission (OFRD).

CAPT Brady has exemplified the highest qualities of leadership and commitment to the PHS. His extraordinary knowledge, expertise, creativity and dedication have contributed to elevating the health status of American people.

CAPT Christopher Brady
Deputy Director, Division of Sanitation Facilities Construction
Indian Health Service/California Area Office

IHS Environmental Health Specialist of the Year

LT Lisa Nakagawa was awarded the IHS 2012 Environmental Health Specialist of the Year. Since 2009, she has served as an IHS Environmental Health Officer (EHO) providing direct environmental health services to 10 federally recognized American Indian tribes (5,488 population) in central California. She also serves as the Area Injury Prevention Program Manager and provides injury prevention leadership to four EHOs and 83 federally recognized American Indian tribes.

In 2012, LT Nakagawa made significant environmental health and injury prevention contributions in tribal communities. The following are examples of her special accomplishments:

- Injury Prevention Program: In 2012, LT Nakagawa graduated from the IHS Injury Prevention (IP) Specialist Fellowship. As a result of her participation, she elected to complete an evaluation of the California Area's IP min-grant program. Since 1991, the IHS/CAO IP program has provided funds to tribal healthcare programs for purchase of interventions that support use of evidence-based strategies. Interventions have included use of child safety seats, bicycle helmets, and smoke detectors. LT Nakagawa conducted key informant interviews and surveys with 19 tribal healthcare programs to determine the effectiveness of these resources. More than 37% of key informants identified carbon monoxide detectors, elder fall interventions, and enhanced training as significant needs in their communities. LT Nakagawa partnered with the California Department of Public Health (CDPH) to offer the first ever "Tai Chi: Moving for Better Balance" train-the-trainer course being held at the California Rural Indian Health Board (CRIHB). Approximately 15 representatives from the CRIHB, Greenville Rancheria, Karuk Tribe, Tule River, Reno Sparks Indian Colony, and the Sacramento Native American Health Center attended the course and received "Instructor Certificates". LT Nakagawa then selected one tribal healthcare program to participate in an elder fall prevention demonstration project in 2013. This pilot project will implement evidence-based strategies and the results will be used to make fall interventions a key part of the IHS/CAO IP min-grant program.

- Injury Prevention Racial Misclassification Study: While participating in the Fellowship, LT Nakagawa collaborated with the California Tribal Epi Center and initiated a descriptive injury research study. This study will describe injury deaths, hospitalizations, and emergency department admissions using data from the IHS and CDPH. The study will also identify a new racial misclassification adjustment factor since racial misclassification has historically been a significant issue in California. The results of this study will be used to public a new "Atlas of Injuries" for California in 2013.
- Program Support: LT Nakagawa completed one of the highest survey completion percentages of all IHS/CAO Environmental Health Specialists. The following are additional examples of her outstanding work:
  - Only staff member to complete EH surveys at 100% of assigned food service facilities
  - Served as Project Officer for three IHS Tribal IP Cooperative Agreement Program sites
  - Authorized multiple standard operating policies and procedures; resulted in written policies for conducting sanitary surveys and inspection of temporary food service establishments

IHS Health Care Facility Engineer of the Year

CDR Paul Frazier was awarded the IHS 2012 Health Care Facility Engineer of the Year. He demonstrated exemplary work as evidenced by specific engineering and related health care facility stewardship. CDR Frazier's work with the numerous tribes in California, in condition assessments, facilities improvements and repairs, and aid in the construction of new health centers greatly furthered the IHS mission and improved relationships with the tribes. This was all accomplished in close collaboration with tribal governments, fostering ongoing improvement in intergovernmental relationships that is crucial in accomplishing the mission of the Indian Health Service.

15.9%

DIABETES IS A GROWING PROBLEM IN INDIAN COMMUNITIES. THE MOST RECENT DIABETES PREVALENCE RATE CALCULATED BY IHS IS 15.9% (AGES 20 AND ABOVE) NATIONWIDE.

75 Financial Report


51.42
25.14
15.24
24.51

Financial Report

FY 2013

Letter from the Chief Financial Officer

Dear Tribal Leaders and Partners,

It gives me great pleasure in presenting to you our financial report for FY 2013.

Federal Fiscal Outlook

The fiscal guidance from Government Accountability Office states that ”long-term simulations continue to highlight the need to focus attention not only on the federal government's near-term budget outlook but also on its longer-term fiscal path. In the near term, deficits are expected to continue to decline from the recent historic highs as the economy recovers and actions taken by Congress and the President begin to take effect. Debt held by the public as a share of gross domestic product (GDP), however, remains well above historical averages. Debt held by the public at these high levels could limit the federal government's flexibility to address emerging issues and unforeseen challenges such as another economic downturn or large-scale natural disaster. Furthermore, the simulations indicate that, debt held by the public continues to grow as a share of GDP in the coming decades, indicating that the federal government remains on an unsustainable long-term fiscal path. Rising debt is driven by a fundamental imbalance between revenue and spending, which, on the spending side, is driven by the aging of the population and rising health care costs. Significant action to change the long-term fiscal path must be taken soon to minimize the risk that eventual policy changes will be disruptive to individuals and the economy, while also taking into account concerns about near-term economic growth.

The timing and the pace of the debt build-up—and therefore the size of action needed to address it—depend on the specific assumptions used. In simulations, which reflects the continuation of current law, debt as a share of GDP declines in the short term before turning up again. In the Alternative simulation, which assumes historical trends and policy preferences continue, federal debt as a share of GDP grows rapidly throughout the period.

Vinay Narjit Singh Behl
Director - DFAS, OMS| Chief Financial Officer
Certified Public Accountant
Certified Government Finance Manager, Chartered Accountant
Certified Government Audit Professional
CMA, CFE, CIA, CISA, CITP, AICWA, CF, CIFRS, CAPM, MS, MBA

It's time to fundamentally change the way that we do business in Washington. To help build a new foundation for the 21st century, we need to reform our government so that it is more efficient, more transparent, and more creative. That will demand new thinking and a new sense of responsibility for every dollar that is spent.

- President Barack Obama

The key change in this update is the enactment of American Taxpayer Relief Act (ATRA), which, among other changes, permanently extended many of the tax provisions that were previously set to expire under current law and limited the reach of the Alternative Minimum Tax. As a result, revenue in simulation is lower as a share of GDP than it was in the fall 2012 Baseline extended simulation but remains higher than the 40-year historical average after 2013.

In contrast, revenue increased in the first 10 years of the Alternative simulation as a result of changes in tax rates for high-income taxpayers enacted in ATRA. After the first 10 years, however, the Alternative simulation phases into the 40-year historical average for revenue. Therefore, the overall effects of ATRA on the longer-term outlook under this simulation are relatively small.

In both simulations spending for the major health and retirement programs will increase as a share of GDP in coming decades, putting greater pressure on the rest of the federal budget. For the first few decades this spending is driven largely by the aging of the population. The oldest members of the baby-boom generation are already eligible for Social Security retirement benefits and for Medicare. The number of baby boomers turning 65 is projected to grow in coming years from an average of about 7,600 per day in 2011 to more than 11,000 per day in 2029. As a result, the share of the population over the age of 65 is projected to increase from roughly 13 percent to over 19 percent during this time."

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.

Overview of Indian Health Service Budget Request FY 2014

Summary of Request – The FY 2014 President's Budget request for IHS is $4.430 billion in budget authority and $5.662 in program level, a total increase of $243.6 million over the FY 2012 Enacted level. The request includes funds to support activities identified by the Tribes as budget priorities including increasing resources for pay costs, funding medical inflationary costs for the Purchased/Referred Care program (formerly known as Contract Health Services); funding contract support costs shortfall; and staffing for new/ replacement facilities. Specifically, this request includes:

CURRENT SERVICES (+$118.3 million) Pay Costs (+$6.0 million)
The budget request includes pay increases for Federal and Tribal employees.

Medical Inflation for Purchased/Referred Care (+$35.0 million)
Medical inflationary costs help maintain the current level of services and offset the rising cost in providing health care. The $35 million is the calculated need to address a 3.7 percent medical inflation rate for the Purchased/Referred Care program.

Additional Staffing and Operating Costs for New Healthcare Facilities (+$77.3 million) This request will fund the staffing and operating costs for 10 newly constructed healthcare facilities scheduled to open in FY 2014, including 7 Joint Venture projects.

PROGRAM INCREASE (+$5.8 million) Contract Support Costs (+$5.8 million)
The increase will be applied to the Contract Support Costs (CSC) shortfall associated with ongoing contracts and compacts with Tribes and Tribal organizations under the Indian Self-Determination and Educational Assistance Act.

REIMBURSEMENT INCREASE (+$119.5 million)
IHS anticipates receiving a significant increase in third-party health insurance payments including an increase of +$95 million as a result of the Medicaid eligibility expansion included in the Affordable Care Act.

Also, a new VA/IHS National Reimbursement Agreement, to be executed over the coming year, will provide an estimated increase of +$52 million when fully implemented and represents a positive partnership to support improved coordination of care between tribal governments and the VA. There are an estimated 17,000 dual-eligible AI/AN veterans.

Agency Performance Accomplishments and Challenges - Historically, the IHS has succeeded in substantially improving the health status of the American Indian/Alaska Native (AI/AN) population, primarily by focusing on preventive and primary care services and developing a community-based public health system. For the AI/AN population, life expectancy, the

expected number of years that a person has to live, increased by 3.7 years between the time periods of 1999-2001 (72.3 years) and 2005-2007 (76.0 years). During that same time period, the life expectancy for U.S. All Races increased by 0.8 years from 2000 (76.9 years) to 2006 (77.7 years). IHS reports unintentional injury mortality rates, those who died by accidents, as an overarching performance measure. Between calendar years 1972 – 1974, the age-adjusted IHS unintentional injury mortality rate, one that best takes into account that the average AI/AN is younger than the average person in the U.S., was 223.2 per 100,000 population. The most current age-adjusted, unintentional injury mortality rate, for calendar years 2005 – 2007, was 94.8 per 100,000 population. Even though the unintentional injury mortality rate has declined, the AI/AN rate in the IHS Service Area is 2.4 times that of US all races.

Despite complex, ongoing challenges, the agency has made significant progress on some important indicators of health and clinical care. Early identification of diabetes and improved diabetes management has helped prevent or delay the need for renal dialysis, amputates, and transplants. Nephropathy (kidney disease) assessment is an essential diabetes management component. The agency has been measuring nephropathy assessment rates since it began reporting GPRA rates in FY 2002. The nephropathy assessment rate increased from 35 percent to 55 percent between FY 2002 and FY 2006, and after the new, more stringent standards of care were adopted, reached 66.7 percent in FY 2012. Such efforts support the President's stated goals of investing in prevention, wellness, and improving the quality of care.

Significant progress was also made in improving the pneumococcal vaccination rate for non-institutionalized adults over 65 years of age from 64 percent in FY 2002 to 88.5 percent in FY 2012. The improvement and maintenance of pneumococcal vaccination rates is important since AI/AN people are at high risk for this disease; the 2005-2007 AI/AN death rate from pneumonia and influenza was 1.3 times greater than the 2006 U.S. all-races death rate. Pneumococcal vaccination is a low-cost medical intervention that has been shown to prevent serious health complications among the elderly. This effort also supports the President's stated goals of investing in prevention, wellness, and improving the quality of care.

These preventive health approaches demonstrates our commitment to targeting measures via performance management. One concern is that certain screening rates (e.g., behavioral health assessments done in the primary care setting) may be easier to improve, compared to cost- intensive health interventions requiring medications and follow-up care. It is worth noting that the Agency's leadership is targeting all clinical measures in the Agency performance plan. There are additional factors that make the achievement of the proposed performance targets in the Agency performance plan challenging. Examples include:

- High vacancy rates for many provider groups may have significant negative impacts on access to care as well as the ability to achieve performance targets
- The continued growth in the prevalence and incidence of diabetes in the AI/AN population and its associated co-morbidities negatively impact the resources available for care

In light of these issues, the proposed performance targets in the budget request are ambitious. The IHS remains committed to improving efficiency and effectiveness through the appropriate use of technology and sharing of best practices. The CRS software provides the capability for local programs to identify patients requiring preventive screenings and/or care for a chronic condition. The nationally deployed Integrated Care (iCare) application, a more sophisticated case and population management tool, is also used by local programs to track patient care. The Improving Patient Care

(IPC) Initiative uses active networking to share information and material on successful programs, as well as technical assistance to identify ways to improve clinical business processes. The IHS hosts "best practices" conferences and WebEx presentations, which offer provider training opportunities to integrate medical standards of care with improved agency performance.

IHS performance improvement requires a concerted effort by all members of the Indian health system. This includes all clinic, hospital and community based programs, as well as federal, tribal, and urban programs, working together to improve agency performance on the comprehensive set of existing performance measures. The IHS will continue to evaluate interventions/methods to address the persistent health disparities facing the AI/AN population.

FY 2016 Budget Formulation for the IHS/CAO

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 2016 budget request provides $5.18 billion for the Indian Health Service, and is a $299.7 million or 7.26% increase, in funding above the FY 2014 President's budget. California Tribes further recommend $239 million in additional "program" increases to address growing health needs and diminished services due to the lack of sufficient funding increases by the previous Administration. The California Area Tribes estimate that it will take at least $188 million (3.7% increase) to maintain current services (inflation and population growth) for tribal health programs in FY 2016. Current service estimates calculate that mandatory cost increases are necessary to maintain the current level of service. 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 funds were clearly prominent. **The YRTC increase, in terms of priority, Tribal officials rated number 1. IHS/CAO will be constructing two YRTC's in the northern and southern California. The Southern YRTC is in design phase and will need $17.1 Million for construction and equipment. Further additional $16 million will be needed for staffing. Northern YRTC will need $18 Million out of which $1.5 million will be towards design costs and remainder for construction and equipment**. The need for YRTCs is exacerbated by the fact that California does not have any federal health facilities for American Indians. The proposed centers will provide residential chemical dependency treatment for American Indian/Alaska Native (AI/AN) youth, ages 12-17. There are 12 similar IHS-funded centers around the country. The treatment programs are usually 3 to 4 months in duration and incorporate mental health services, medical care, education, aftercare planning, and family therapy. In addition, YRTCs incorporate therapeutic activities to meet the unique spiritual and cultural needs of AI/AN youth. These facilities will be nationally accredited and state licensed. They will be staffed by a team of mental health care professionals, medical providers, and traditional healers who will work in concert to treat the whole person. Each facility will offer services for as many as 32 youth at a time. The U.S. Congress authorized the YRTCs in the Indian Health Care Improvement Act. In 1992, Congress amended the Act 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. Often, out-of-state programs do not address the unique cultural needs of Indian youth and cannot offer effective family therapy. These facilities do not have the capacity to meet the need in California and, often, Indian youth and their families experience long delays before they receive care. Some receive no residential treatment at all. The new YRTCs in California will be an important step to helping thousands of Indian youth in California who need residential care.

The California tribes have requested more increases in Purchased and Referred Care (PRC) budgets of $ 155.5 million (3.5% increase compared to FY 2014 President's budget) to reduce health disparities between American Indian /Alaska Natives and the general population. This will help address the significant backlog of deferred services, and the growing number of denied services (exhibit'2'). **In terms of increases, this activity ranked number 1.**

The California tribes' request for Hospitals and Clinics includes a request of $28.7 million (.64% increase compared to FY 2014 President's budget) for treatment and prevention of diabetes. This distribution of funds, if properly applied promises to reduce some of the funding disparities between Indian health programs by lifting the funding level of programs that, for historical and not well understood reasons are funded

Top five budge formulation tribal priorities in the past eight years

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
1	Diabetes	Diabetes	Diabetes	Diabetes	Contract Health Services - Pharmaceuticals	Contract Health Services	Contract Health Services	Contract Health Services
2	Cancer	Cancer	Cancer	Cancer	Indian Health Care Improvement Fund - Pharmaceuticals	Indian Health Care Improvement Fund	Diabetes/ Obesity	Diabetes/ Obesity
3	Heart Disease	Heart Disease	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health
4	Alcohol/ Substance Abuse	Alcohol/ Substance Abuse	Heart Disease/ Stroke	Health Promotion/ Disease Prevention	Cancer	Health Facilities Construction	Youth Regional Treatment Centers	Youth Regional Treatment Centers
5	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)	Indian Health Care Improvement Fund (IHCIF)

far below the average. California failed to meet most of the GPRA targets for diabetes. **The increases ranked number 2.**

The California tribes have requested a $26.3 million (.59% increase compared to FY 2014 president's budget) increase for behavioral health. 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 American Indian and Alaska Native (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.

Poor oral health care has been an issue in AI/AN communities for many years. The most recent study reported that the AI/AN population has the highest dental carries (decay in tooth or bone) rate in the country. The problem is attributed to a number of factors, including a lack of access to providers who understand and are committed to working in AI/AN communities (source 3). **The increase requested is $14.3 million (.32% increase compared to FY 2014 President's budget). This increase ranked number 4.**

Suicide and methamphetamine abuse continue to plague Indian country at substantially alarming rates. Not only does the act of suicide or addiction to methamphetamine affect the individual who is suffering, but it affects entire families, communities, and societies. For every young native person who has ended their life through suicide, for every methamphetamine house that is found in an Indian community, the physical, spiritual, emotional, and mental well being of the surrounding society is seriously affected. In the case of a suicide, Indian Country has experienced high numbers of cluster suicides following the event, including family members attempting or completing. At a minimum, families and communities surviving a suicide are left with anger, fear, and sadness of the loss of, way too often, young vibrant native people with a real potential for an even greater future. A suicide in Indian Country shakes the entire foundational belief of many tribal communities that we live in balance with the world around us. The effects may be even more shattering when it's a young person who is taking their own life in their hands through suicide, those who are so critical for the existence of our people. In the case of a Indian housing unit that has been the laboratory for methamphetamine production, the community around is left with more than just respiratory and other physical complications from breathing toxic air. The community is left with an aftermath of anger, fear, and sadness of the loss of their health, sometimes their lives, their own sense of security, and the broader impact on their existence through their children. **The California tribes requested $14.3 million (.32% increase compared to FY 2014 president's budget) to funding disparities in this sector. The increase ranked number '5'.**

Three new tribes have recently been federally recognized namely Tejon, Wilton Rancheria and Koi Nation. Funding was requested under the CHS activity.
The California tribes were also concerned that there are no regional treatment facilities and have after deliberation requested $253 million for Ambulatory and Specialty Care. Section 306 of the IHCIA, P.L. 94-437, authorizes the IHS to award grants to Tribes and/or Tribal organizations for

construction, expansion, or modernization of ambulatory health care facilities located apart from a hospital. Where non-Indians will be served in a facility, the funds awarded under this authority may be used only to support construction proportionate to services provided to eligible AI/AN people. The last year that IHS received appropriations to fund the Small Ambulatory Program was in 2006.

Participants in this program are selected competitively from eligible applicants who met the following criteria:

- Only federally recognized Tribes that operate non-IHS outpatient facilities under P.L. 93-638 contracts and compacts are eligible to apply for this program
- Facilities for which construction is funded under Section 301 or Section 307 of P.L. 94- 437 are not eligible for this type of grant
- Priority will be given to Tribal government that can demonstrate need for increased ambulatory health care services and insufficient capacity to deliver such services
- The completed facility will be available to eligible Indians without regard to ability to pay or source of payment
- The applicant can demonstrate the ability to financially support services at the completed facility

The completed facility will:

- Have sufficient capacity to provide the required services
- Serve at least 500 eligible AI/AN people annually
- Provide care for a service area with a population of at least 2,000 eligible persons

The Shingle Springs Health Center grant in FY 2006 is the most recent California tribal health program to receive a small ambulatory grant from IHS. California tribes have requested $85 million under the small ambulatory program.

Section 818 of the Indian Health Care Improvement Act, P.L. 94-437, authorizes the IHS to establish joint venture projects under which Tribes or Tribal organizations would acquire, construct, or renovate a health care facility and lease it to the IHS, at no cost, for a period of 20 years. Participants in this competitive program are selected from among eligible applicants who agree to provide an appropriate facility to IHS. The facility may be an inpatient or outpatient facility. The Tribe must use Tribal, private or other available (non-IHS) funds to design and construct the facility. In return the IHS will submit requests to Congress for funding for the staff, operations, and maintenance of the facility per the Joint Venture Agreement.

Proposals considered under this program are evaluated against the following criteria:

- Need for space at the location is verifiable when evaluated by using the criteria in the IHS planning methodologies;
- The Tribe is able to fund and manage the proposed project using its own (non-IHS) funds:
    - The project is consistent with the IHS Health Systems Planning program
    - The project is consistent with the IHS Area Health Facilities Master Plan

Additional consideration is given to Tribes that elect to fully fund the equipment for the facility. Lake County Tribal Health Consortium was awarded a Joint Venture Agreement in FY 2005, finished construction in 2010, and staffing and operations have been fully funded since FY 2012. Further tribal programs have requested additional $ 50 million for Joint venture program.

Hyperion Planning Tool

In FY 2013 IHS/CAO implemented Hyperion to its full

potential. 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 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 financial 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

On April 7, 2013, 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.

At the request of the property management officer (PMO) had set a target date of June 30, 2013 and completed the IHS/ CAO annual inventory using the Property Management Information System. Physical inventory at the CAO started on May 30, 2013 on an on-going basis until completed for all staff including six Office of Environmental Health and Engineering (OEHE) district field offices.

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 were trained in FY 2013 as a part of furthering the agency 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 developed a policies and procedures to assist the newly designated ACRs,.

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

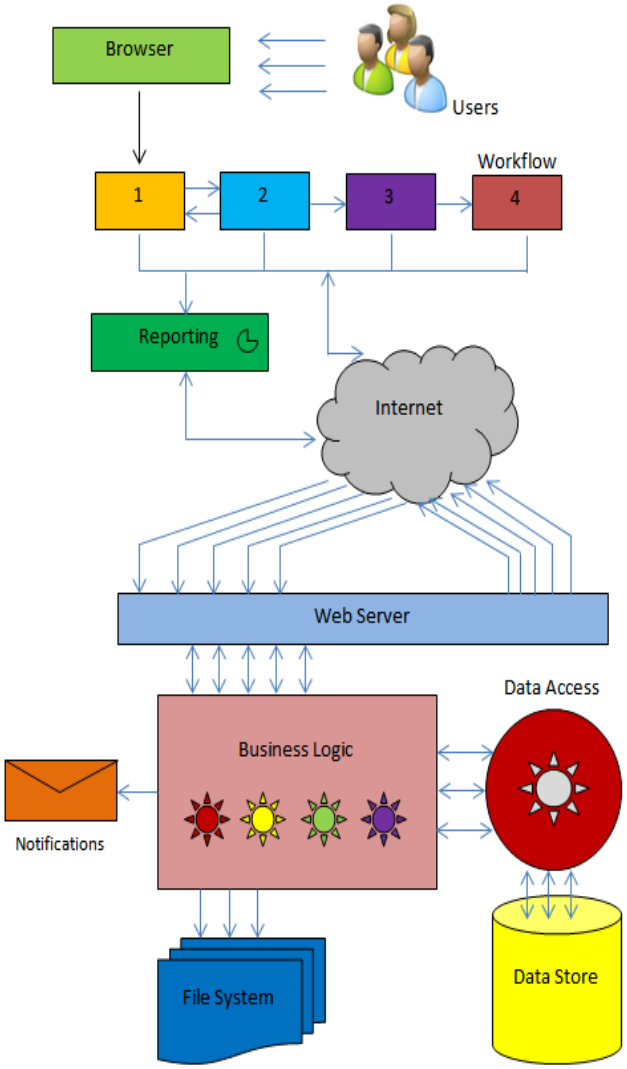
activity.

In the highly volatile climate we operate the, Chief Financial Officer is best suited to tackle the challenge posed by new regulatory environment and harness oceans of big data flooding different organizations. Finance is the corporation's original information management function: managing costs, monitoring the broader economy, steering the organization's investments. I see my role even going further: using a greater variety of data, along with advanced analytics, to prepare for change, uncover opportunity, and capitalize on both.

Federal Obligation Requisition Management System (FORMS)

FORMS is an ASP.NET web application with SQL Server data store which automates the workflow involved in the approval of the five federal spending plans (Tribal, Equipment, Federal, P-card and Training requests). FORMS uses a role based authentication & authorization to validate user credentials and provide users with pre-defined functional access. It enables users belonging to different roles to execute their respective approval/requisition/audit processes**.** It sends email notifications to the various users (roles) involved in the approval workflow to enable faster requisition processing. FORMS stores the relational data regarding these various types of requisitions into SQL Server database. This will enable the development of future business intelligence, analytics components and also facilitate audits. This will be an internal system for use of internal office staff only and will eventually reside in MURA environment through bridging technology. The FORMS can be accessed by any mobile device or smart phones using viewport technology. This will improve efficiency and transparency in requisitioning and approving spending plans and at the same time save valuable dollars.

We continue to employ nascent technologies to drive efficiency while positively impacting people's lives. We see consistent



FORMS Workflow

proof that technology solutions can be significant levers for business innovation and transformation, reaching beyond organization walls to partners and stakeholders.

Best regards,

/Vinay Narjit Singh Behl/
Vinay Narjit Singh Behl
March 01, 2014

Final Financial Report—Summary

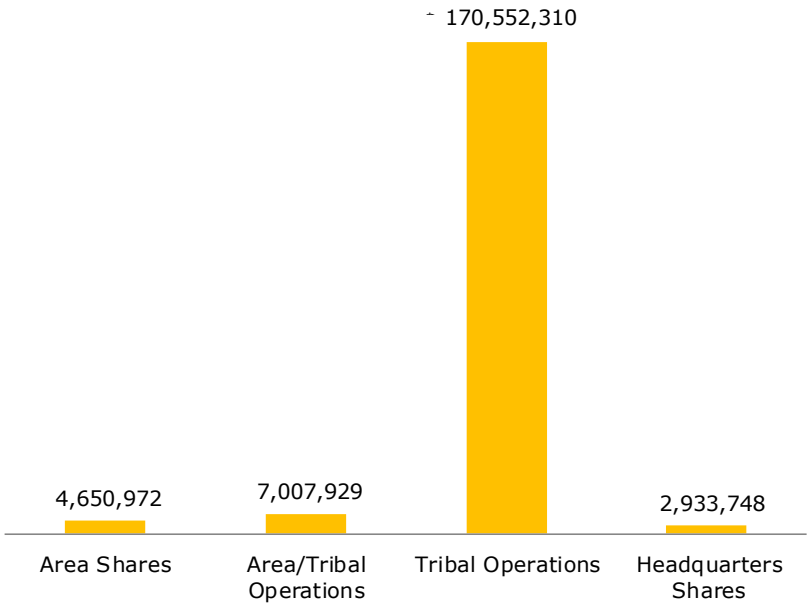
$ dollars, unless otherwise stated

	ALLOWANCE	OBLIGATION	BALANCE
Clinical Services			
Hospital & Clinics	$71,447,365	$71,439,975	$7,390
Dental	1,940,436	1,939,219	1,217
Mental Health	2,039,695	2,039,695	0
Alcohol	10,832,337	10,830,286	2,051
Total Clinical Services:	86,259,833	86,249,175	10,658
Preventive Health			
Public Health Nursing	929,600	929,600	0
Health Education	302,185	302,185	0
Community Health Representative	2,007,334	2,007,333	1
Total Preventive Health:	3,239,119	3,239,118	1
Urban Health Projects	6,674,127	6,674,127	0
Direct Operations	2,475,474	2,473,149	2,325
Contract Support Costs	43,737,231	43,737,231	0
Self-Governance	65,150	65,150	0
Indian Health Professions	12,660	0	12,660
Contract Health Care	42,837,066	42,837,066	0
Catastrophic Fund	89,718	89,718	0
Domestic Violence Prevention Initiative	223,000	223,000	0
Alcohol & Substance Abuse/Meth Prevention	889,000	710,981	178,019
Special Diabetes Program for Indians—Direct	160,000	2,999	157,001
Special Diabetes Program for Indians—Reimbursement	200,000	0	200,000
Facilities & Environmental Health Support			
Environmental Health Support	3,582,075	2,823,424	758,651
Facilities Health Support	1,179,793	1,108,502	71,291
OEHE Support	19,211	16,977	2,234
Total Facilities & Environmental Health Support:	4,781,079	3,948,903	832,176

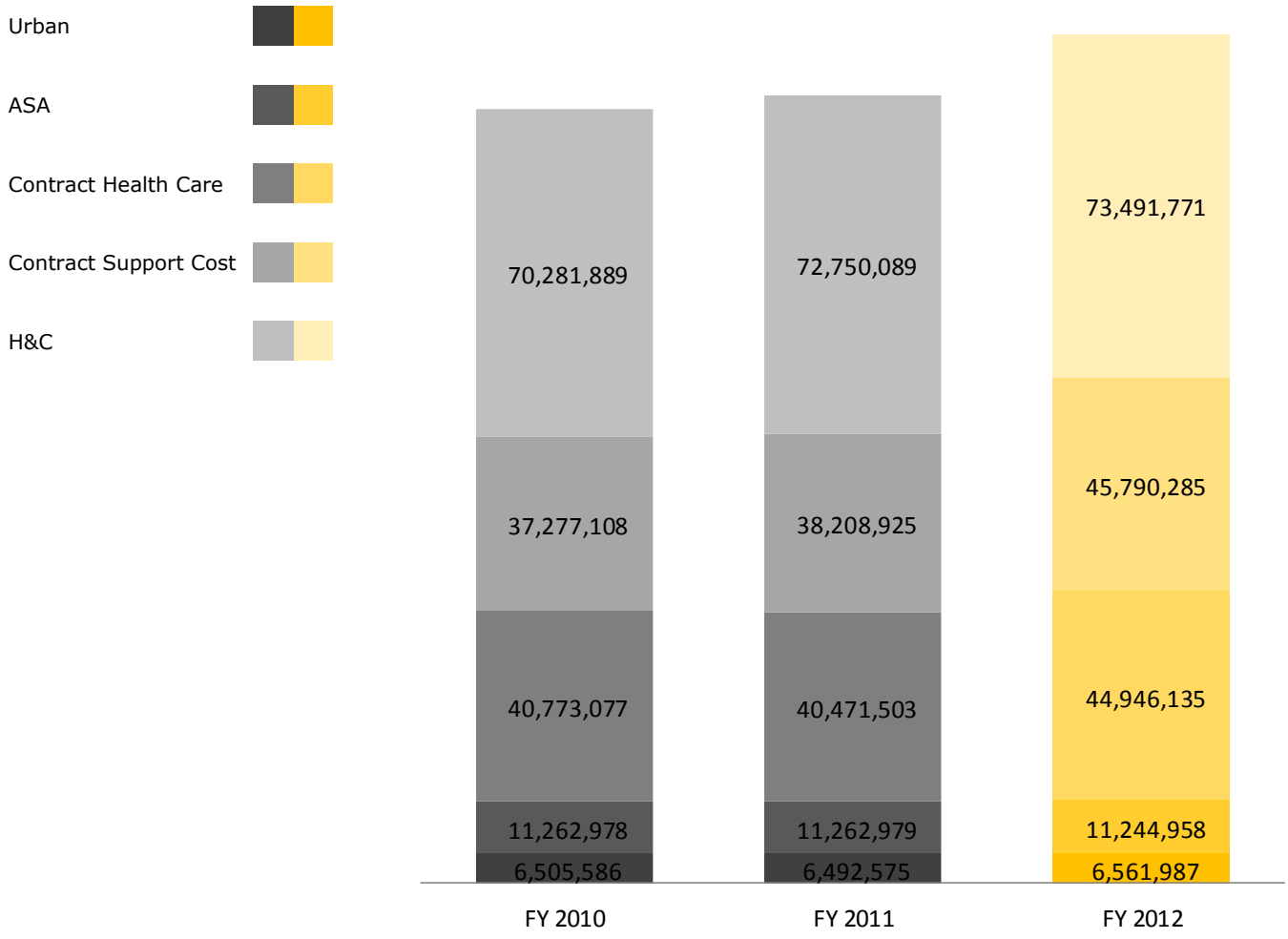
$ millions, unless otherwise stated

	ALLOWANCE	OBLIGATION	BALANCE
Indian Health Facilities			
Equipment	781,879	776,412	5,467
Maintenance and Improvement	2,850,048	1,749,507	1,100,541
Total Indian Health Facilities:	3,631,927	2,525,919	1,106,008
Sanitation Facilities			
Housing	1,454,000	1,454,000	0
Regular	1,904,000	1,904,000	0
Total Sanitation Facilities	3,358,000	3,358,000	0
Inter-Agency Funds			
Contributions	2,775,992	2,775,992	0
Total Contributions Facilities	2,775,992	2,775,992	0
Area Grand Total	**$201,409,376**	**$198,910,528**	**$2,498,848**

Area/Headquarters/Tribal Shares
$ Dollars

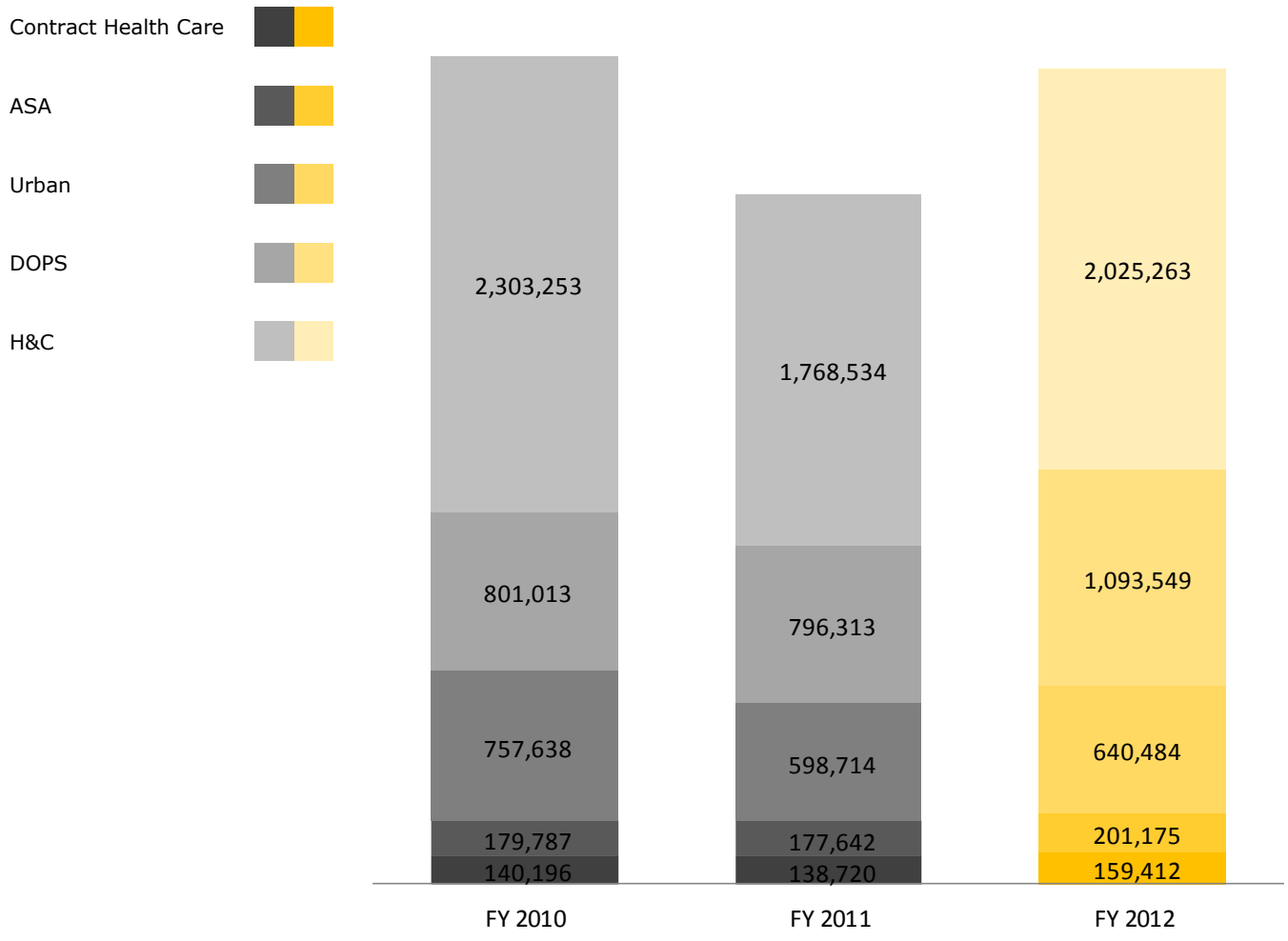


Recurring Funds



This graph does not include items funded at less than $6,000,000.

Non-Recurring Funds



This graph does not include items funded at less than $130,000.

Clinical Services
Hospital & Clinics

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$10,444
Cabazon Band of Mission Indians	65,675
California Rural Indian Health Board, Inc.	7,050,134
Central Valley Indian Health, Inc.	4,417,654
Chapa-De Indian Health Program, Inc.	1,105,046
Cold Springs Tribal Council	166,121
Colusa Indian Health Community Council	201,614
Coyote Valley Tribal Council	193,608
Fresno American Indian Health Project	1,658
Friendship House Assoc of Amarican Indians Inc.	1,658
Greenville Rancheria	1,085,445
Guidiville Indian Rancheria	125,502
Hopland Band of Pomo Indians	153,153
Indian Health Center of Santa Clara Valley, Inc.	1,658
Lake County Tribal Health Consortium	3,679,299
M.A.C.T. Health Board, INC	1,052,565
Native American Health Center, Inc.	1,658
Paskenta Band of Nomlaki Indians	13,291
Pinoleville Band of Pomo Indians	40,386
Pit River Health Services, Inc.	998,107
Quartz Valley Indian Reservation	148,697
Round Valley Indian Health Center, Inc.	844,890
Sacramento Native American Health Center, Inc.	350
San Diego American Indian Health Center, Inc.	16,658
Santa Ynez Tribal Health Clinic	$946,742
Scotts Valley Band of Pomo Indians	175,880
Sherwood Valley Band of Pomo Indians	152,610
Shingle Springs Rancheria	871,463
Southern Indian Health Council, Inc.	2,821,735
Strong Family Health Center	257,979
Sycuan Band of Mission Indians	186,133
Table Mountain Rancheria	89,691
Toiyabe Indian Health Project, Inc.	2,187,970
Tule River Indian Health Center, Inc.	2,090,760
Tuolumne Me-Wuk Indian Health Center, Inc.	405,261
United American Indian Involvement, Inc.	73,316
Chapa-De Indian Health Program, Inc.	2,224,677
Consolidated Tribal Health Project	1,669,484
Feather River Tribal Health, Inc.	2,782,229
Hoopa Valley Tribe	2,161,027
Indian Health Council	3,924,201
Karuk Tribe of California	1,252,075
Northern Valley Indian Health	2,038,874
Redding Rancheria	3,171,377
Riverside-San Bernardino Indian Health	9,716,483
Susanville Indian Rancheria	815,088
Total Tribal Operations:	***61,390,326***

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$700
California Rural Indian Health Board, Inc.	774,400
Central Valley Indian Health, Inc.	220,200
Chapa-De Indian Health Program, Inc	53,151
Greenville Rancheria	21,000
M.A.C.T. Health Board, INC	71,200
Paskenta Band of Nomlaki Indians	400
Pit River Health Services, Inc.	37,500
Santa Ynez Tribal Health Clinic	21,700
Shingle Springs Rancheria	38,300
Southern Indian Health Council, Inc.	172,715
Strong Family Health Center	12,700
Toiyabe Indian Health Project, Inc.	$139,300
Chapa-De Indian Health Program, Inc	100,133
Consolidated Tribal Health Project	123,200
Feather River Tribal Health, Inc.	145,400
Hoopa Valley Tribe	173,600
Indian Health Council	252,400
Karuk Tribe of California	97,700
Northern Valley Indian Health	49,900
Redding Rancheria	248,200
Riverside-San Bernardino Indian Health	538,400
Susanville Indian Rancheria	44,000
Total Tribal Operations- Area Shares:	***3,336,199***

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$1,356
California Rural Indian Health Board, Inc.	150,928
Central Valley Indian Health, Inc.	57,719
Chapa-De Indian Health Program, Inc.	24,260
Greenville Rancheria	42,823
Pit River Health Services, Inc.	28,205
Santa Ynez Tribal Health Clinic	12,832
Shingle Springs Rancheria	8,061
Southern Indian Health Council, Inc.	72,811
Strong Family Health Center	8,482
Toiyabe Indian Health Project, Inc.	43,502
Chapa-De Indian Health Program, Inc.	$1,547
Consolidated Tribal Health Project	35,982
Feather River Tribal Health, Inc.	70,555
Hoopa Valley Tribe	37,995
Indian Health Council	214,978
Karuk Tribe of California	25,121
Northern Valley Indian Health	21,447
Redding Rancheria	139,616
Riverside-San Bernardino Indian Health	359,947
Susanville Indian Rancheria	14,321
Total Tribal Operations- Headquarters Shares:	***1,372,488***

MOA OPERATION EXPENDITURES	FUNDED AMOUNT
Personnel Services	$1,155,048
Travel	1,706
Total MOA Operation Expenditures:	***1,156,754***

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$2,370,652
Travel	136,006
Transportation	9,687
Rent, Comm., Util.	728,782
Printing	8,243
Contractual Services	669,709
Training	36,859
Supplies	100,082
Equipment	124,187
Total Area & Tribal Operation Expenditures:	***4,184,207***

TOTAL OBLIGATIONS—HOSPITAL & CLINICS	**$71,439,975**

Clinical Services
Dental Services

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT	TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$2,275	Southern Indian Health Council, Inc.	$125,659
California Rural Indian Health Board, Inc.	20,825	Sycuan Medical Dental Center	5,275
Central Valley Indian Health, Inc.	2,275	Table Mountain Rancheria	2,275
Chapa-De Indian Health Program, Inc.	21,125	Toiyabe Indian Health Project, Inc.	2,275
Colusa Indian Health Community Council	2,275	Tule River Indian Health Center, Inc.	2,275
Greenville Rancheria	31,468	Tuolumne Me-Wuk Indian Health Center, Inc.	2,275
Indian Health Center of Santa Clara Valley, Inc.	2,275	United American Indian Involvement, Inc.	1,000
Lake County Tribal Health Consortium	252,024	Chapa-De Indian Health Program, Inc.	37,291
M.A.C.T. Health Board, INC	1,275	Consolidated Tribal Health Project	2,275
Native American Health Center, Inc.	5,275	Feather River Tribal Health, Inc.	119,152
Paskenta Band of Nomlaki Indians	4,595	Hoopa Valley Tribe	2,275
Pit River Health Services, Inc.	2,275	Indian Health Council	2,275
Quartz Valley Indian Reservation	4,775	Karuk Tribe of California	2,275
Round Valley Indian Health Center, Inc.	2,275	Northern Valley Indian Health	65,480
Sacramento Native American Health Center, Inc.	2,275	Redding Rancheria	2,275
San Diego American Indian Health Center, Inc.	2,275	Riverside-San Bernardino Indian Health	762,629
Santa Ynez Tribal Health Clinic	2,275	Susanville Indian Rancheria	2,275
Shingle Springs Rancheria	2,275	***Total Tribal Operations:***	***1,503,348***

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$29,300
Central Valley Indian Health, Inc.	10,400
Chapa-De Indian Health Program, Inc.	2,224
Greenville Rancheria	300
M.A.C.T. Health Board, INC	2,900
Toiyabe Indian Health Project, Inc.	5,900
Pit River Health Services, Inc.	500
Santa Ynez Tribal Health Clinic	300
Shingle Springs Rancheria	1,600
Southern Indian Health Council, Inc.	7,205
Strong Family Health Center	600

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$4,000
Consolidated Tribal Health Project	5,300
Feather River Tribal Health, Inc.	5,900
Hoopa Valley Tribe	7,100
Indian Health Council	9,300
Karuk Tribe of California	4,000
Northern Valley Indian Health	2,100
Redding Rancheria	9,100
Riverside-San Bernardino Indian Health	21,500
Susanville Indian Rancheria	1,900
Total Tribal Operations- Area Shares:	***131,429***

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$33
California Rural Indian Health Board, Inc.	5,840
Central Valley Indian Health, Inc.	2,958
Chapa-De Indian Health Program, Inc.	813
Greenville Rancheria	968
Pit River Health Services, Inc.	519
Santa Ynez Tribal Health Clinic	904
Shingle Springs Rancheria	244
Southern Indian Health Council, Inc.	4,343
Strong Family Health Center	268
Toiyabe Indian Health Project, Inc.	1,515

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$53
Consolidated Tribal Health Project	1,793
Feather River Tribal Health, Inc.	4,207
Hoopa Valley Tribe	2,897
Indian Health Council	6,395
Karuk Tribe of California	1,766
Northern Valley Indian Health	742
Redding Rancheria	3,559
Riverside-San Bernardino Indian Health	4,419
Susanville Indian Rancheria	854
Total Tribal Operations- Headquarters Shares:	***45,090***

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$165,078
Travel	5,172
Contractual Services	38,388
Supplies	50,714
Total Area & Tribal Operation Expenditures:	***259,352***

TOTAL OBLIGATIONS—DENTAL	**$1,939,219**

Clinical Services
Mental Health

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$143,408
Central Valley Indian Health, Inc.	81,893
Chapa-De Indian Health Program, Inc.	16,911
Greenville Rancheria	10,131
Lake County Tribal Health Consortium	504,639
M.A.C.T. Health Board, INC	39,372
Paskenta Band of Nomlaki Indians	208
Pit River Health Services, Inc.	48,765
Round Valley Indian Health Center, Inc.	50,147
Santa Ynez Tribal Health Clinic	13,659
Shingle Springs Rancheria	19,481
Southern Indian Health Council, Inc.	68,055
Strong Family Health Center	7,573
Table Mountain Rancheria	1,465

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Toiyabe Indian Health Project, Inc.	$59,073
Tule River Indian Health Center, Inc.	71,389
Tuolumne Me-Wuk Indian Health Center, Inc.	13,570
Chapa-De Indian Health Program, Inc.	33,457
Consolidated Tribal Health Project	60,484
Feather River Tribal Health, Inc.	40,441
Hoopa Valley Tribe	56,086
Indian Health Council	85,293
Karuk Tribe of California	55,193
Northern Valley Indian Health	27,603
Redding Rancheria	71,935
Riverside-San Bernardino Indian Health	184,254
Susanville Indian Rancheria	49,453
Total Tribal Operations:	***1,813,938***

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$3,600
Central Valley Indian Health, Inc.	1,300
Chapa-De Indian Health Program, Inc	270
Greenville Rancheria	100
M.A.C.T. Health Board, INC	400
Pit River Health Services, Inc.	200
Santa Ynez Tribal Health Clinic	200
Shingle Springs Rancheria	200
Southern Indian Health Council, Inc.	901
Toiyabe Indian Health Project, Inc.	800
Chapa-De Indian Health Program, Inc	533

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Consolidated Tribal Health Project	$600
Feather River Tribal Health, Inc.	800
Hoopa Valley Tribe	900
Indian Health Council	1,200
Karuk Tribe of California	500
Northern Valley Indian Health	200
Redding Rancheria	1,100
Riverside-San Bernardino Indian Health	2,700
Susanville Indian Rancheria	200
Total Tribal Operations- Area Shares:	***16,704***

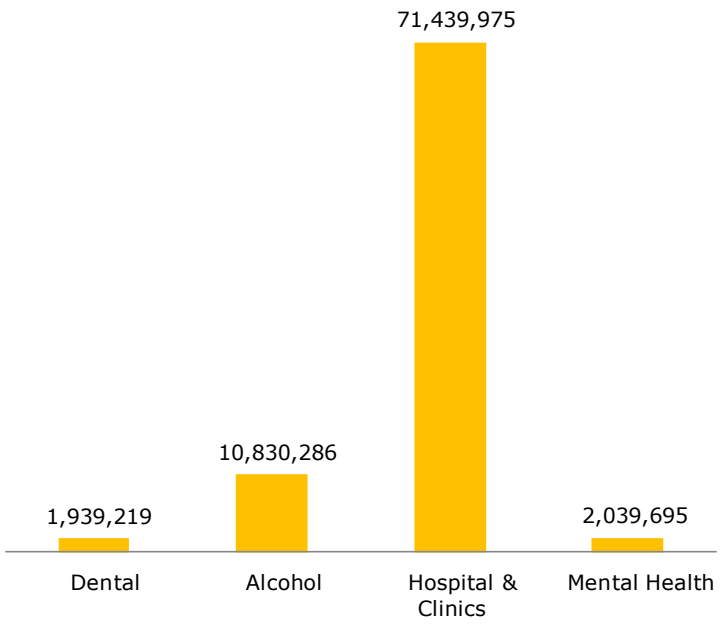
TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$58
California Rural Indian Health Board, Inc.	16,185
Central Valley Indian Health, Inc.	13,176
Chapa-De Indian Health Program, Inc	3,206
Greenville Rancheria	2,158
Pit River Health Services, Inc.	1,924
Santa Ynez Tribal Health Clinic	1,570
Shingle Springs Rancheria	908
Southern Indian Health Council, Inc.	7,549
Strong Family Health Center	994
Toiyabe Indian Health Project, Inc.	5,623

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc	$203
Consolidated Tribal Health Project	3,995
Feather River Tribal Health, Inc.	7,315
Hoopa Valley Tribe	5,036
Indian Health Council	11,117
Karuk Tribe of California	3,073
Northern Valley Indian Health	2,750
Redding Rancheria	6,187
Riverside-San Bernardino Indian Health	17,652
Susanville Indian Rancheria	1,484
Total Tribal Operations- Headquarters Shares:	***112,163***

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$13,460
Travel	1,556
Contractual Services	81,874
Total Area & Tribal Operation Expenditures:	***96,890***

TOTAL OBLIGATIONS—MENTAL HEALTH	**$2,039,695**

Clinical Services
$ Dollars



Clinical Services
Alcohol

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$6,000
California Rural Indian Health Board, Inc.	850,899
Central Valley Indian Health, Inc.	723,466
Chapa-De Indian Health Program, Inc.	45,129
Friendship House Association	790,610
Greenville Rancheria	27,082
Guidiville Indian Rancheria	43,359
Indian Health Center of Santa Clara Valley, Inc.	8,000
Ke Ola Mao	185,316
Lake County Tribal Health Consortium	168,468
M.A.C.T. Health Board, INC	94,761
Native American Health Center, Inc.	8,000
Native Directions, Inc.	397,915
Paskenta Band of Nomlaki Indians	537
Pit River Health Services, Inc.	78,347
Quartz Valley Indian Reservation	30,353
Round Valley Indian Health Center, Inc.	353,262
Sacramento Native American Health Center, Inc	82,958
San Diego American Indian Health Center, Inc.	16,000
Santa Ynez Tribal Health Clinic	99,238
Scotts Valley Rancheria	43,723
Shingle Springs Rancheria	$55,743
Sierra Tribal Consortium	697,683
Southern Indian Health Council, Inc.	181,027
Strong Family Health Center	59,709
Table Mountain Rancheria	4,303
Toiyabe Indian Health Project, Inc.	377,349
Tule River Indian Health Center, Inc.	35,791
Tule River Tribal Council	530,211
Tuolumne Me-Wuk Indian Health Center, Inc.	70,495
United American Indian Involvement, Inc.	832,509
Chapa-De Indian Health Program, Inc.	95,906
Consolidated Tribal Health Project	166,215
Feather River Tribal Health, Inc.	107,506
Hoopa Valley Tribe	384,478
Indian Health Council	368,389
Karuk Tribe of California	156,113
Northern Valley Indian Health	115,913
Redding Rancheria	195,803
Riverside-San Bernardino Indian Health	738,685
Susanville Indian Rancheria	87,716
Total Tribal Operations:	***9,314,967***

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$100
California Rural Indian Health Board, Inc.	153,300
Central Valley Indian Health, Inc.	54,300
Chapa-De Indian Health Program, Inc.	11,195
Greenville Rancheria	4,300
M.A.C.T. Health Board, INC	18,300
Pit River Health Services, Inc.	8,900
Santa Ynez Tribal Health Clinic	5,200
Shingle Springs Rancheria	8,500
Southern Indian Health Council, Inc.	37,325
Strong Family Health Center	2,800
Toiyabe Indian Health Project, Inc.	31,300

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$21,200
Consolidated Tribal Health Project	27,600
Feather River Tribal Health, Inc.	31,300
Hoopa Valley Tribe	36,700
Indian Health Council	48,700
Karuk Tribe of California	21,500
Northern Valley Indian Health	11,300
Redding Rancheria	47,000
Riverside-San Bernardino Indian Health	112,800
Susanville Indian Rancheria	9,800
Total Tribal Operations- Area Shares:	***703,420***

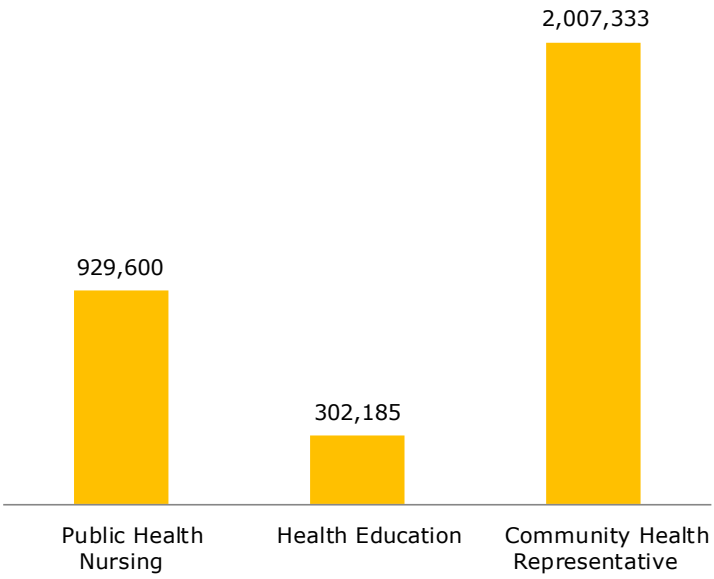
TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$123
California Rural Indian Health Board, Inc.	48,373
Central Valley Indian Health, Inc.	12,367
Chapa-De Indian Health Program, Inc.	3,687
Greenville Rancheria	3,663
Pit River Health Services, Inc.	2,008
Santa Ynez Tribal Health Clinic	3,328
Shingle Springs Rancheria	947
Southern Indian Health Council, Inc.	16,003
Strong Family Health Center	1,037
Toiyabe Indian Health Project, Inc.	5,865

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$227
Consolidated Tribal Health Project, Inc.	6,735
Feather River Tribal Health, Inc.	15,509
Hoopa Valley Tribe	10,312
Indian Health Council	23,564
Karuk Tribe of California	6,511
Northern Valley Indian Health	2,869
Redding Rancheria	13,115
Riverside-San Bernardino Indian Health	37,417
Susanville Indian Rancheria	3,146
Total Tribal Operations- Headquarters Shares:	***216,806***

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$242,206
Travel	6,939
Contractual Services	344,944
Equipment	1,004
Total Area & Tribal Operation Expenditures:	***595,093***

TOTAL OBLIGATIONS—HOSPITAL & CLINICS	**$10,830,286**

Preventive Health
$ Dollars



Preventive Health
Public Health Nursing

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$60,567
Central Valley Indian Health, Inc.	45,701
Lake County Tribal Health Consortium	355,811
Pit River Health Services, Inc.	47,653
Table Mountain Rancheria	576
Tule River Indian Health Center, Inc.	48,223
Consolidated Tribal Health Project	$58,706
Hoopa Valley Tribe	24,205
Indian Health Council	85,138
Riverside-San Bernardino Indian Health	149,397
Susanville Indian Rancheria	12,607
Total Tribal Operations:	***888,584***

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$22
California Rural Indian Health Board, Inc.	7,897
Central Valley Indian Health, Inc.	4,915
Chapa-De Indian Health Program, Inc.	1,888
Pit River Health Services, Inc.	815
Shingle Springs Rancheria	384
Southern Indian Health Council, Inc.	3,029
Strong Family Health Center	421
Toiyabe Indian Health Project, Inc.	2,382
Chapa-De Indian Health Program, Inc.	110
Consolidated Tribal Health Project	$1,640
Feather River Tribal Health, Inc.	2,935
Hoopa Valley Tribe	2,020
Karuk Tribe of California	1,233
Northern Valley Indian Health	1,166
Redding Rancheria	2,482
Riverside-San Bernardino Indian Health	7,081
Susanville Indian Rancheria	596
Total Tribal Operations- Headquarters Shares:	***41,016***

TOTAL OBLIGATIONS—PUBLIC HEALTH NURSING	**$929,600**

Preventive Health
Health Education

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$43,600
Central Valley Indian Health, Inc.	15,500
Chapa-De Indian Health Program, Inc.	3,184
Greenville Rancheria	1,200
M.A.C.T. Health Board, INC	4,400
Pit River Health Services, Inc.	2,500
Santa Ynez Tribal Health Clinic	1,500
Shingle Springs Rancheria	2,400
Southern Indian Health Council, Inc.	10,707
Strong Family Health Center	800
Toiyabe Indian Health Project, Inc.	8,900

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$6,000
Consolidated Tribal Health Project	7,900
Feather River Tribal Health, Inc.	8,900
Hoopa Valley Tribe	10,400
Indian Health Council	13,800
Karuk Tribe of California	6,200
Northern Valley Indian Health	3,200
Redding Rancheria	13,400
Riverside-San Bernardino Indian Health	32,100
Susanville Indian Rancheria	2,900
Total Tribal Operations– Area Shares:	***199,491***

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$28
California Rural Indian Health Board, Inc.	11,230
Central Valley Indian Health, Inc.	6,453
Chapa-De Indian Health Program, Inc.	2,309
Greenville Rancheria	1,102
Pit River Health Services, Inc.	998
Santa Ynez Tribal Health Clinic	792
Shingle Springs Rancheria	471
Southern Indian Health Council, Inc.	3,809
Strong Family Health Center	515
Toiyabe Indian Health Project, Inc.	2,914

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$135
Consolidated Tribal Health Project	2,039
Feather River Tribal Health, Inc.	3,691
Hoopa Valley Tribe	2,540
Indian Health Council	5,609
Karuk Tribe of California	1,551
Northern Valley Indian Health	1,426
Redding Rancheria	3,123
Riverside-San Bernardino Indian Health	8,905
Susanville Indian Rancheria	749
Total Tribal Operations- Headquarters Shares:	***60,389***

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$12,592
Contractual Services	29,713
Total Area & Tribal Operation Expenditures:	***42,305***

TOTAL OBLIGATIONS—HEALTH EDUCATION	**$302,185**

Preventive Health
Community Health Representative

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$246,886
Central Valley Indian Health, Inc.	97,301
Chapa-De Indian Health Program, Inc.	13,018
Cold Springs Tribal Council	33,529
Coyote Valley Tribal Council	29,057
Greenville Rancheria	8,000
Hopland Band of Pomo Indians	29,028
Lake County Tribal Health Consortium	37,264
M.A.C.T. Health Board, INC	31,268
Paskenta Band of Nomlaki Indians	161
Pinoleville Band of Pomo Indians	28,418
Pit River Health Services, Inc.	30,893
Quartz Valley Indian Reservation	9,251
Round Valley Indian Health Center, Inc.	42,362
Santa Ynez Tribal Health Clinic	30,831
Sherwood Valley Band of Pomo Indians	29,754
Shingle Springs Rancheria	15,212

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Southern Indian Health Council, Inc.	$68,238
Strong Family Health Center	54,607
Table Mountain Rancheria	1,880
Toiyabe Indian Health Project, Inc.	159,595
Tule River Indian Health Center, Inc.	49,699
Tuolumne Me-Wuk Indian Health Center, Inc.	10,350
Chapa-De Indian Health Program, Inc.	25,754
Consolidated Tribal Health Project	38,647
Feather River Tribal Health, Inc.	31,062
Hoopa Valley Tribe	87,768
Indian Health Council	112,877
Karuk Tribe of California	87,733
Northern Valley Indian Health	21,326
Redding Rancheria	55,684
Riverside-San Bernardino Indian Health	294,876
Susanville Indian Rancheria	33,795
Total Tribal Operations:	***1,846,124***

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$13,500
Central Valley Indian Health, Inc.	4,800
Chapa-De Indian Health Program, Inc.	994
Greenville Rancheria	400
M.A.C.T. Health Board, INC	1,700
Pinoleville Band of Pomo Indians	100
Pit River Health Services, Inc.	800
Santa Ynez Tribal Health Clinic	500
Shingle Springs Rancheria	800
Southern Indian Health Council, Inc.	3,302
Strong Family Health Center	300
Toiyabe Indian Health Project, Inc.	2,800

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$1,867
Consolidated Tribal Health Project	2,400
Feather River Tribal Health, Inc.	2,800
Hoopa Valley Tribe	3,300
Indian Health Council	4,300
Karuk Tribe of California	1,900
Northern Valley Indian Health	1,000
Redding Rancheria	4,200
Riverside-San Bernardino Indian Health	9,900
Susanville Indian Rancheria	900
Total Tribal Operations- Area Shares:	***62,563***

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$58
California Rural Indian Health Board, Inc.	17,763
Central Valley Indian Health, Inc.	13,071
Chapa-De Indian Health Program, Inc.	4,837
Feather River Tribal Health, Inc.	7,627
Shingle Springs Rancheria	985
Southern Indian Health Council, Inc.	7,869
Strong Family Health Center	1,078
Pinoleville Band of Pomo Indians	421

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Pit River Health Services, Inc.	$2,089
Chapa-De Indian Health Program, Inc.	282
Hoopa Valley Tribe	2,624
Indian Health Council	11,589
Karuk Tribe of California	3,203
Redding Rancheria	6,450
Riverside-San Bernardino Indian Health	18,400
Total Tribal Operations- Headquarters Shares:	***98,346***

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$300
Total Area & Tribal Operation Expenditures:	***300***

TOTAL OBLIGATIONS—CHR	**$2,007,333**

Urban Health Projects

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
American Indian Health & Services Corporation	$513,659
Fresno American Indian Health Project	459,008
Friendship House Association	580,818
Indian Health Center of Santa Clara Valley, Inc.	566,990
Native American Health Center, Inc.	1,004,927
Sacramento Native American Health Center, Inc.	$899,929
San Diego American Indian Health Center, Inc.	780,702
United American Indian Involvement, Inc.	1,793,777
Total Tribal Operations:	***6,599,810***

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$8,450
Travel	7,317
Contractual Services	58,549
Total Area & Tribal Operation Expenditures:	***74,317***

TOTAL OBLIGATIONS—URBAN HEALTH PROJECTS	**$6,674,127**

Direct Operations

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$419
California Rural Indian Health Board, Inc.	137,944
Central Valley Indian Health, Inc.	50,052
Chapa-De Indian Health Program, Inc.	12,666
Greenville Rancheria	13,508
Pit River Health Services, Inc.	12,904
Santa Ynez Tribal Health Clinic	9,641
Shingle Springs Rancheria	5,724
Southern Indian Health Council	46,362
Strong Family Health Center	7,498
Toiyabe Indian Health Project, Inc.	35,460

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$951
Consolidated Tribal Health Project	24,815
Feather River Tribal Health, Inc.	44,924
Hoopa Valley Tribe	30,923
Indian Health Council	77,435
Karuk Tribe of California	18,864
Northern Valley Indian Health	17,353
Redding Rancheria	43,631
Riverside-San Bernardino Indian Health	121,390
Susanville Indian Rancheria	9,119
Total Tribal Operations Headquarters Shares:	***721,583***

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$1,612,727
Transportation	1,200
Contractual Services	110,625
Training	5,627
Supplies	21,387
Total Area & Tribal Operation Expenditures:	***1,751,566***

TOTAL OBLIGATIONS—DIRECT OPERATIONS	**$2,473,149**

Contract Support Cost

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$45,914
California Rural Indian Health Board, Inc.	9,594,440
Central Valley Indian Health, Inc.	2,744,086
Chapa-De Indian Health Program, Inc.	536,609
Cold Springs Rancheria	48,838
Colusa Indian Health Community Council	20,602
Coyote Valley Tribal Council	77,922
Greenville Rancheria	265,916
Guidiville Indian Rancheria	158,069
Hopland Band of Pomo Indians	31,293
Lake County Tribal Health Consortium	1,261,676
M.A.C.T. Health Board, INC	63,997
Paskenta Band of Nomlaki Indians	586
Pinoleville Band of Pomo Indians	14,223
Pit River Health Services, Inc.	566,718
Quartz Valley Indian Reservation	98,191
Round Valley Indian Health Center, Inc.	469,397
Santa Ynez Tribal Health Clinic	399,357
Scotts Valley Rancheria	59,885
Sherwood Valley Band of Pomo Indians	50,759
Shingle Springs Rancheria	311,822
Sierra Tribal Consortium	$379,989
Southern Indian Health Council, Inc.	2,115,418
Strong Family Health Center	374,969
Sycuan Band of Mission Indians	65,402
Table Mountain Rancheria	13,798
Toiyabe Indian Health Project, Inc.	987,695
Tule River Indian Health Center, Inc.	1,167,312
Tule River Tribal Council	99,948
Tuolumne Me-Wuk Indian Health Center, Inc.	197,541
Chapa-De Indian Health Program, Inc.	1,061,583
Consolidated Tribal Health Project	1,703,546
Feather River Tribal Health, Inc.	1,053,326
Hoopa Valley Tribe	1,502,136
Indian Health Council	3,161,219
Karuk Tribe of California	1,177,173
Northern Valley Indian Health	927,896
Redding Rancheria	3,140,922
Riverside-San Bernardino Indian Health	7,072,978
Susanville Indian Rancheria	714,080
Total Tribal Operations:	***43,737,231***

TOTAL OBLIGATIONS—CONTRACT SUPPORT COST	**$43,737,231**

Self-Governance

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$7,616
Total Tribal Operations:	***7,616***

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$57,534
Total Tribal Operations:	***57,534***

TOTAL OBLIGATIONS—SELF-GOVERNANCE	$65,150

Contract Health Care

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$8,344
California Rural Indian Health Board, Inc.	6,622,426
Central Valley Indian Health, Inc.	3,135,817
Chapa-De Indian Health Program, Inc.	703,039
Colusa Indian Health Community Council	65,037
Coyote Valley Tribal Council	88,509
Greenville Rancheria	669,263
Guidiville Indian Rancheria	10,005
Lake County Tribal Health Consortium	1,002,384
M.A.C.T. Health Board, INC	975,611
Paskenta Band of Nomlaki Indians	10,510
Pinoleville Band of Pomo Indians	13,379
Pit River Health Services, Inc.	587,937
Quartz Valley Indian Reservation	58,063
Round Valley Indian Health Center, Inc.	726,212
Santa Ynez Tribal Health Clinic	501,303
Scotts Valley Rancheria	12,080
Sherwood Valley Rancheria	42,707
Shingle Springs Rancheria	549,404
Southern Indian Health Council, Inc.	$1,315,433
Strong Family Health Center	198,897
Sycuan Medical Dental Center	77,752
Table Mountain Rancheria	25,474
Toiyabe Indian Health Project, Inc.	1,558,152
Tule River Indian Health Center, Inc.	2,041,883
Tuolumne Me-Wuk Indian Health Center, Inc.	233,260
Chapa-De Indian Health Program, Inc.	1,389,833
Consolidated Tribal Health Project	1,450,488
Feather River Tribal Health, Inc.	1,963,562
Hoopa Valley Tribe	1,855,664
Indian Health Council	2,596,867
Karuk Tribe of California	1,136,470
Northern Valley Indian Health	1,427,672
Redding Rancheria	2,211,546
Riverside-San Bernardino Indian Health	6,659,103
Susanville Indian Rancheria	502,581
Total Tribal Operations:	***42,426,667***

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$44,700
Central Valley Indian Health, Inc.	15,600
Chapa-De Indian Health Program, Inc.	3,260
Greenville Rancheria	1,200
M.A.C.T. Health Board, INC	1,400
Pit River Health Services, Inc.	2,600
Santa Ynez Tribal Health Clinic	1,600
Shingle Springs Rancheria	2,500
Southern Indian Health Council, Inc.	11,007
Strong Family Health Center	900
Toiyabe Indian Health Project, Inc.	9,200

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$6,200
Consolidated Tribal Health Project	8,000
Feather River Tribal Health, Inc.	9,200
Hoopa Valley Tribe	10,700
Indian Health Council	14,100
Karuk Tribe of California	6,200
Northern Valley Indian Health	3,300
Redding Rancheria	13,800
Riverside-San Bernardino Indian Health	32,900
Susanville Indian Rancheria	2,800
Total Tribal Operations- Area Shares:	***201,167***

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$72
California Rural Indian Health Board, Inc.	61,615
Central Valley Indian Health, Inc.	16,535
Chapa-De Indian Health Program, Inc.	5,800
Greenville Rancheria	2,770
M.A.C.T. Health Board, INC	22,747
Pit River Health Services, Inc.	2,509
Santa Ynez Tribal Health Clinic	1,993
Shingle Springs Rancheria	1,184
Southern Indian Health Council, Inc.	9,583
Strong Family Health Center	1,296
Toiyabe Indian Health Project, Inc.	7,330

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$339
Consolidated Tribal Health Project	5,131
Feather River Tribal Health, Inc.	9,286
Hoopa Valley Tribe	6,392
Indian Health Council	14,112
Karuk Tribe of California	3,901
Northern Valley Indian Health	3,588
Redding Rancheria	7,855
Riverside-San Bernardino Indian Health	22,409
Susanville Indian Rancheria	1,885
Total Tribal Operations- Headquarters Shares:	***208,332***

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$900
Total Area & Tribal Operation Expenditures:	***900***

TOTAL OBLIGATIONS—CONTRACT HEALTH CARE	**$42,837,066**

Catastrophic Fund

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Strong Family Health Center	$36,434
Redding Rancheria	53,284
Total Tribal Operations:	***89,718***

TOTAL OBLIGATIONS—CATASTROPHIC HEALTH EMERG. FUND	**$89,718**

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 Prev.

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$218,760
Lake County Tribal Health Consortium	20,000
Quartz Valley Indian Reservation	30,182
San Manuel Tribal Administration	156,930
Toiyabe Indian Health Project, Inc.	107,500
Hoopa Valley Tribe	177,609
Total Tribal Operations:	***710,981***

TOTAL OBLIGATIONS—DOMESTIC VIOLENCE PREVENTION INITIATIVE	$710,981

Special Diabetes Program for Indians (SDPI) Direct

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$2,999
Total Area & Tribal Operation Expenditures:	***2999***

TOTAL OBLIGATIONS—SDPI—DIRECT	$2,999

Environmental Health Support

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$13,915
Central Valley Indian Health, Inc.	1,290
Chapa-De Indian Health Program, Inc.	1,897
Fresno American Indian Health Project	1,403
Greenville Rancheria	7,314
Indian Health Center of Santa Clara Valley, Inc.	3,165
Lake County Tribal Health Consortium	8,913
M.A.C.T. Health Board, INC	1,215
Native American Health Center, Inc.	1,200
Paskenta Band of Nomlaki Indians	74
Sacramento Native American Health Center, Inc	6,225

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
Santa Ynez Tribal Health Clinic	$465
Tule River Indian Health Center, Inc.	1,425
United American Indian Involvement, Inc.	2,258
Chapa-De Indian Health Program, Inc.	3,957
Feather River Tribal Health, Inc.	13,127
Hoopa Valley Tribe	4,290
Indian Health Council	4,305
Karuk Tribe of California	1,298
Northern Valley Indian Health	7,620
Susanville Indian Rancheria	975
Total Tribal Operations:	***86,331***

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$2,492
Southern Indian Health Council, Inc.	6,969
Feather River Tribal Health, Inc.	6,053
Hoopa Valley Tribe	96,766
Riverside-San Bernardino Indian Health	97,836
Total Tribal Operations- Area Shares:	***210,116***

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Cabazon Band of Mission Indians	$128
Southern Indian Health Council, Inc.	380
Total Tribal Operations- Headquarters Shares:	***508***

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$2,194,224
Travel	76,418
Transportation	109,067
Rent, Comm., Util.	20,999
Printing	6,166
Contractual Services	36,766
Training	51,131
Supplies	25,755
Equipment	5,944
Total Area & Tribal Operation Expenditures:	***2,526,469***

TOTAL OBLIGATIONS—ENVIRONMENTAL HEALTH SUPPORT	$2,823,424

Facilities Health Support

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$44,575
Lake County Tribal Health Consortium	721,682
Total Tribal Operations:	***766,257***

TRIBAL OPERATIONS—AREA SHARES CONTRACTOR	FUNDED AMOUNT
Indian Health Council	$22,874
Total Tribal Operations- Area Shares:	***22,874***

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Personnel Services	$283,642
Travel	17,019
Transportation	8,044
Rent, Comm., Util.	2,800
Contractual Services	4,614
Supplies	758
Equipment	2,493
Total Area & Tribal Operation Expenditures:	***319,371***

TOTAL OBLIGATIONS—FACILITIES HEALTH SUPPORT	**$1,108,502**

OEHE Support

TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT	TRIBAL OPERATIONS—HEADQUARTERS SHARES CONTRACTOR	FUNDED AMOUNT
Chapa-De Indian Health Program, Inc.	$562	Northern Valley Indian Health	$553
Consolidated Tribal Health Project	555	Redding Rancheria	1,222
Feather River Tribal Health, Inc.	787	Riverside-San Bernardino Indian Health	5,415
Hoopa Valley Tribe	5,444	Susanville Indian Rancheria	183
Karuk Tribe of California	556	***Total Tribal Operations Headquarters Shares:***	***16,977***
Indian Health Council	1,700		

TOTAL OBLIGATIONS—OEHE SUPPORT	$16,977

Equipment

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$131,940
Central Valley Indian Health, Inc.	32,125
Chapa-De Indian Health Program, Inc.	47,830
Colusa Indian Health Community Council	1,697
Greenville Rancheria	13,834
Lake County Tribal Health Consortium	27,027
Paskenta Band of Nomlaki Indians	7,376
Pit River Health Services, Inc.	11,604
Quartz Valley Indian Reservation	3,294
Round Valley Indian Health Center, Inc.	15,959
Santa Ynez Tribal Health Clinic	11,751
Shingle Springs Rancheria	17,206
Sierra Tribal Consortium	4,976
Southern Indian Health Council, Inc.	37,143
Strong Family Health Center	$3,505
Sycuan Band of Mission Indians	5,325
Toiyabe Indian Health Project, Inc.	47,465
Tuolumne Me-Wuk Indian Health Center, Inc.	18,492
Consolidated Tribal Health Project	19,657
Feather River Tribal Health, Inc.	51,733
Hoopa Valley Tribe	35,117
Indian Health Council	42,627
Karuk Tribe of California	26,262
Northern Valley Indian Health	42,240
Redding Rancheria	26,587
Riverside-San Bernardino Indian Health	81,365
Susanville Indian Rancheria	12,275
Total Tribal Operations:	***776,412***

TOTAL OBLIGATIONS—INDIAN HEALTH FACILITIES—EQUIPMENT	**$776,412**

Maintenance and Improvement

TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT	TRIBAL OPERATIONS CONTRACTOR	FUNDED AMOUNT
California Rural Indian Health Board, Inc.	$617,334	Hoopa Valley Tribe	$43,331
Greenville Rancheria	105,953	Indian Health Council	154,424
Pit River Health Services, Inc.	95,000	Karuk Tribe of California	63,132
Santa Ynez Tribal Health Clinic	98,655	Northern Valley Indian Health	74,069
Southern Indian Health Council, Inc.	5,579	Redding Rancheria	138,894
Sycuan Medial Dental Center	10,374	Riverside-San Bernardino Indian Health	142,332
Tuolumne Me-Wuk Indian Health Center, Inc.	1,624	Susanville Indian Rancheria	45,310
Consolidated Tribal Health Project	63,057	***Total Tribal Operations:***	***1,749,507***
Feather River Tribal Health, Inc.	90,439		

TOTAL OBLIGATIONS—INDIAN HEALTH FACILITIES—M&I	**$1,749,507**

SFC Housing

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$1,454,000
Total Area & Tribal Operation Expenditures:	***1,454,000***

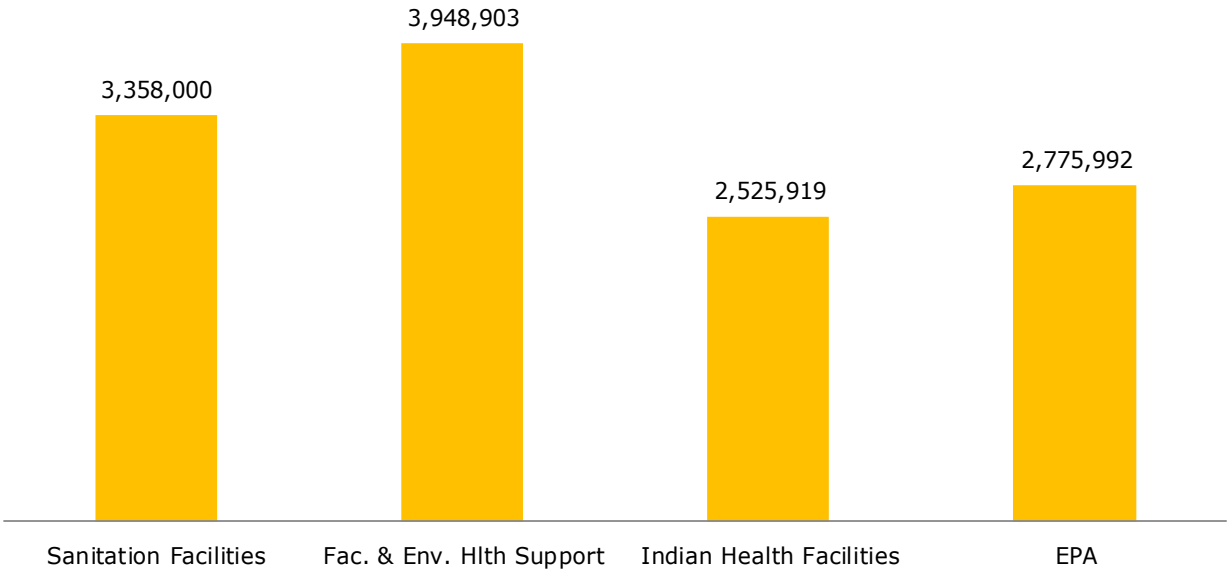
TOTAL OBLIGATIONS—SFC HOUSING	**$1,454,000**

SFC Regular

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$1,904,000
Total Area & Tribal Operation Expenditures:	***1,904,000***

TOTAL OBLIGATIONS—SFC REGULAR	$1,904,000

Sanitation Facilities
$ Dollars

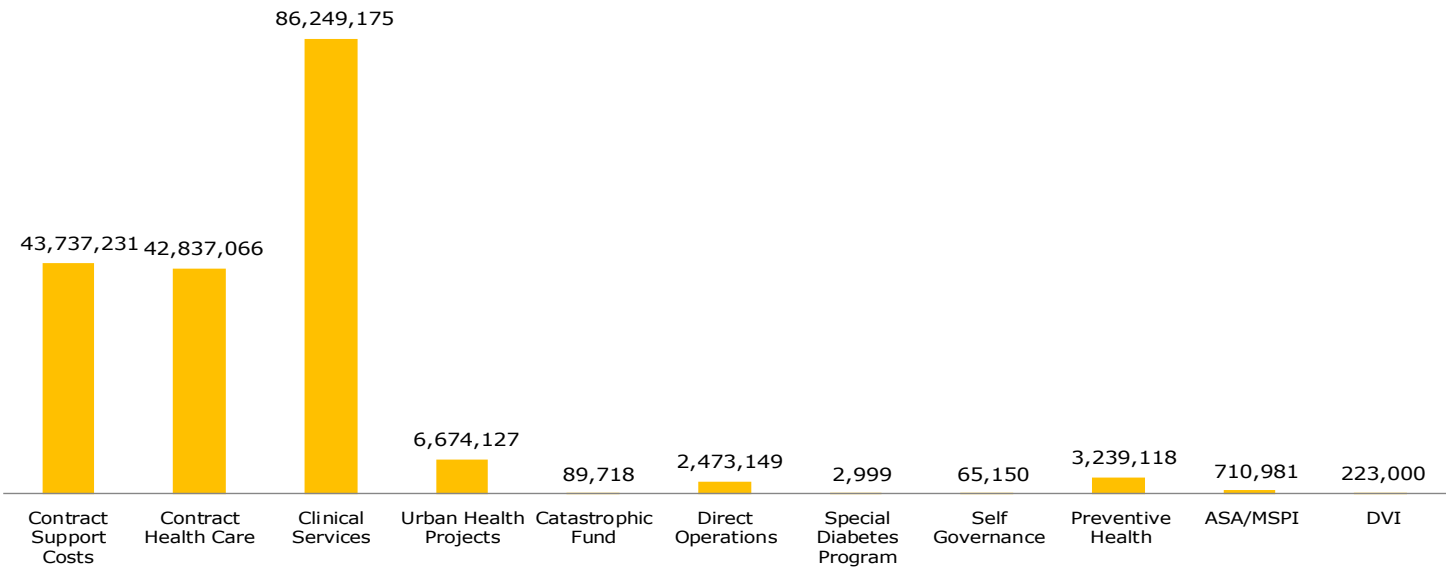


Contributions

INCLUDES ALL OTHER EXPENDITURES (AREA & TRIBAL OPERATIONS)	FUNDED AMOUNT
Contractual Services	$2,775,992
Total Area & Tribal Operation Expenditures:	***2,775,992***

TOTAL OBLIGATIONS—CONTRIBUTIONS	$2,775,992

Area Funding
$ Dollars



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CAPT Christopher Brady, MS, PE, DSFC Deputy Director

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Maureen Harrington, Engineer Technician (Arcata)

Denise O'Gorman, Engineer Technician (Arcata)

Dara Zimmerman, Engineering Student Trainee (Arcata)

In Memoriam

Steven Zerebecki came to the Indian Health Service (IHS) quite by accident. He had spent three years with the Department of Health and Human Services (DHHS), Office of Inspector General (OIG), studying, investigating and reporting on the efficacy of behavioral health services to Native American youth. After observing at our annual Tribal Consultation in March 2010, he worked himself into a "detail" assignment from OIG to come to Sacramento and assist the California Area Office with obtaining property to develop our two youth regional treatment centers. After 18 months, Steven took a position as Assistant to the Director, DHHS Region IX, in San Francisco. Within just months, Steven recaptured his passion for the youth in need of treatment and came to work full time for the IHS. In early 2013, he reduced his hours at IHS to pursue another life-long passion and opened a French cuisine restaurant. Steven left behind a sister and niece. His friends and associates are saddened by his passing.

Organization Information

CORPORATE INFORMATION

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Indian Health Service - Headquarters
801 Thompson Avenue
Rockville, MD 20852
www.ihs.gov

AREA INFORMATION

Department of Health and Human Services
Indian Health Service/California Area Office
650 Capitol Mall, Suite 7-100
Sacramento, CA 95814-4706

INTERNET INFORMATION

Information on IHS/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 IHS/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 IHS/CAO by phone at (916) 930-3927.

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


DEPARTMENT OF HEALTH & HUMAN SERVICES

INDIAN HEALTH SERVICE
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