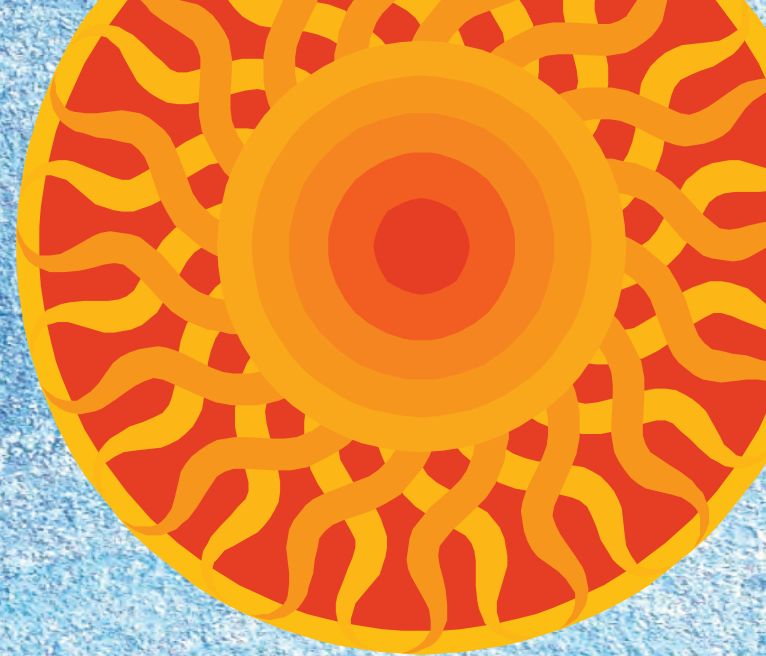


2014

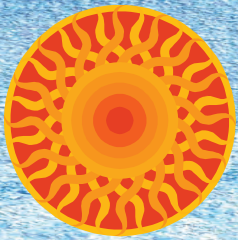


Indian Health Service  
Government Performance and Results Act (GPRA)/  
GPRA Modernization Act (GPRAMA)

# California Area Report

Measuring healthcare quality to improve patient care

This page is intentionally left blank.



## ACKNOWLEDGMENTS

**California Area Data collection and support  
provided by:**

**Tribal and Urban Health Program Staff  
Information Technology Staff  
Project Officers**

Special thanks for data analysis and report preparation: **Amy Patterson**, Public Health Analyst, CAO; **Christine Brennan**, Public Health Analyst, CAO; **Wendy Blocker**, Public Health Analyst, CAO; and **Rachel Pulverman**, Public Health Analyst, CAO.

In addition, this report would not be possible without all of the hard work and commitment of the clinical and support staff for all California programs. We thank you for all of your efforts!

### Area Contacts

#### **National GPRA Support Team**

- Christine Brennan
- Wendy Blocker
- Amy Patterson
- Rachel Pulverman

**(916) 930-3927**

**(916) 930-3981 ext. 333**

**(916) 930-3981 ext. 308**

**(916) 716-6929**

**(916) 930-3981 ext. 361**

**caogpra@ihs.gov**

christine.brennan@ihs.gov

wendy.blocker@ihs.gov

amy.patterson@ihs.gov

rachel.pulverman@ihs.gov

# TABLE OF CONTENTS

Introduction	3
Program Legend	4
User Population, by Program	5
Results	
Diabetes: Prevalence and Documented A1c	7
Diabetes: Good Glycemic Control	8
Diabetes: Blood Pressure Control	10
Diabetes: Dyslipidemia Assessment	12
Diabetes: Nephropathy Assessment	14
Diabetes: Retinopathy	16
Dental: General Access	18
Dental: Sealants	20
Dental: Topical Fluorides	22
Immunizations: Influenza	24
Immunizations: Pneumococcal	26
Immunizations: Childhood (19 – 35 months)	28
Cancer Screening: Cervical (Pap Smear)	30
Cancer Screening: Breast (Mammography)	32
Cancer Screening: Colorectal	34
Tobacco Cessation	36
Alcohol Screening: Fetal Alcohol Syndrome (FAS) Prevention	38
Domestic Violence/Intimate Partner Violence Screening	40
Depression Screening	42
CVD Prevention: Comprehensive Assessment	44
Prenatal HIV Screening	46
Childhood Weight Control	48
Breastfeeding Rates	50
Controlling High Blood Pressure (Million Hearts)	52
Appendix : Tribal Dashboard	
California Area Tribal Dashboard	A-1

# INTRODUCTION

This 2014 California Area Report contains detailed performance results for all clinical Government Performance Results Act (GPRA) and Government Performance and Results Modernization Act (GPRAMA) measures collected from 34 (26 tribal and 8 urban) California programs. In FY 2014, 28 of 34 programs used Clinical Reporting System (CRS) 14.0 software to report results. The 12-month GPRA collection period for FY 2014 ran from July 1, 2013 through June 30, 2014.

The California Area Report includes detailed results for 22 clinical GPRA/GPRAMA measures reported in FY 2014. Tribal programs reported all 22 measures. Urban programs were required to report on 16 of these measures; however, this report includes data for all 22 measures from urban programs reporting via CRS. Measure results are displayed in two graphs. The first graph displays California Area aggregate tribal results from 2006-2014 (or beginning the first year in which the current measure was reported), as well as the FY 2014 IHS national average. The second graph displays results for each reporting California Indian health program for FY 2014. The first two rows under each graph show the percentage of patients meeting the measure in 2013 and 2014. The “n” row shows the number of patients who qualified for each measure, i.e. the “denominator,” in 2014.

Using the data in this report, health programs can review changes in their own performance from FY 2013 to FY 2014, compare their performance with other California programs and with national averages, and assess their progress toward achieving long-term goals. Page five of this document displays a 2014 GPRA User Population table for all reporting California Indian health programs. This table is organized by population so programs can compare their progress with programs of similar size.

In FY 2014, California tribal programs met 9 of 22 clinical measures. Four of these nine measures had “baseline” targets in FY 2014 due to logic changes and the addition of the new Controlling High Blood Pressure measure. California Area tribal programs exceeded the IHS national average on 5 of 22 measures. California tribal programs improved on 9 measures with comparable FY 2013 data. Dental Sealants increased by 3.2 percentage points, Tobacco Cessation increased by 1.5 percentage points, and Breastfeeding Rates increased by 12.6 percentage points compared to 2013. A dashboard summary of results can be found on page A-1.

In FY 2014, California urban programs improved over their aggregate FY 2013 results on 9 of 13 measures with comparable data. California urban programs reporting via CRS had an average Childhood Immunization result of 61.0%, an impressive 21.2 percentage point increase over the average FY 2013 result. DV/IPV Screening improved by 5.8 percentage points, Colorectal Cancer Screening improved by 5.4 percentage points, Influenza immunization improved by 4.8 percentage points, Depression Screening improved by 4.7 percentage points, and Alcohol Screening improved by 4.3 percentage points.

# PROGRAM LEGEND

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

*\*2013/\*\*2014 data reported from non-RPMS System; data not validated by CRS software equivalent*

***Urban Indian Health Program***

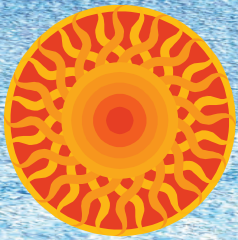
# 2014 GPRA USER POPULATION, BY PROGRAM

Population  
Scale

> 4000	4000-2000	2000-1000	< 1000
--------	-----------	-----------	--------

Health Program	GPRA User Population
Riverside/San Bern (RSB)	13,786
Central Valley (CVL)	8,405
United Indian Health Services (UIHS)	6,820
Chapa De (CDE)	5,826
Sonoma (SON)	5,618
Feather River (FRV)	4,806
Indian Health Council (IHC)	4,773
Redding (RED)	3,883
Hoopla (HPA)	3,238
Consolidated (CON)	3,132
Northern Valley (NVL)	3,129
Toiyabe (TOI)	3,018
Tule River (TUL)	2,679
Southern Indian Health (SIH)	2,380
United Amer. Indian Inv. (UAI)	2,152
San Diego (SDG)	2,121
Karuk (KRK)	2,108

Health Program	GPRA User Population
Sacramento NAHC (SAC)	2,018
Lake (LAK)	1,920
Oakland/San Francisco (OAK)	1,766
MACT (MAC)	1,739
Shingle Springs (SS)	1,286
Round Valley (RVL)	1,263
Santa Ynez (SYZ)	1,150
San Jose (SJO)	1,079
Susanville (LAS)	992
Greenville (GVL)	959
Pit River (PIT)	943
Santa Barbara (SBR)	623
Fresno (FRS)	622
Bakersfield (BAK)	585
Tuolumne Me-Wuk (TUO)	239
Quartz Valley (QTZ)	194
Sycuan (SYC)	127



# GPRA MEASURES

## *Results*

*California Area Trends (2006-2014)*

*and*

*Results by Program (2013 & 2014)*

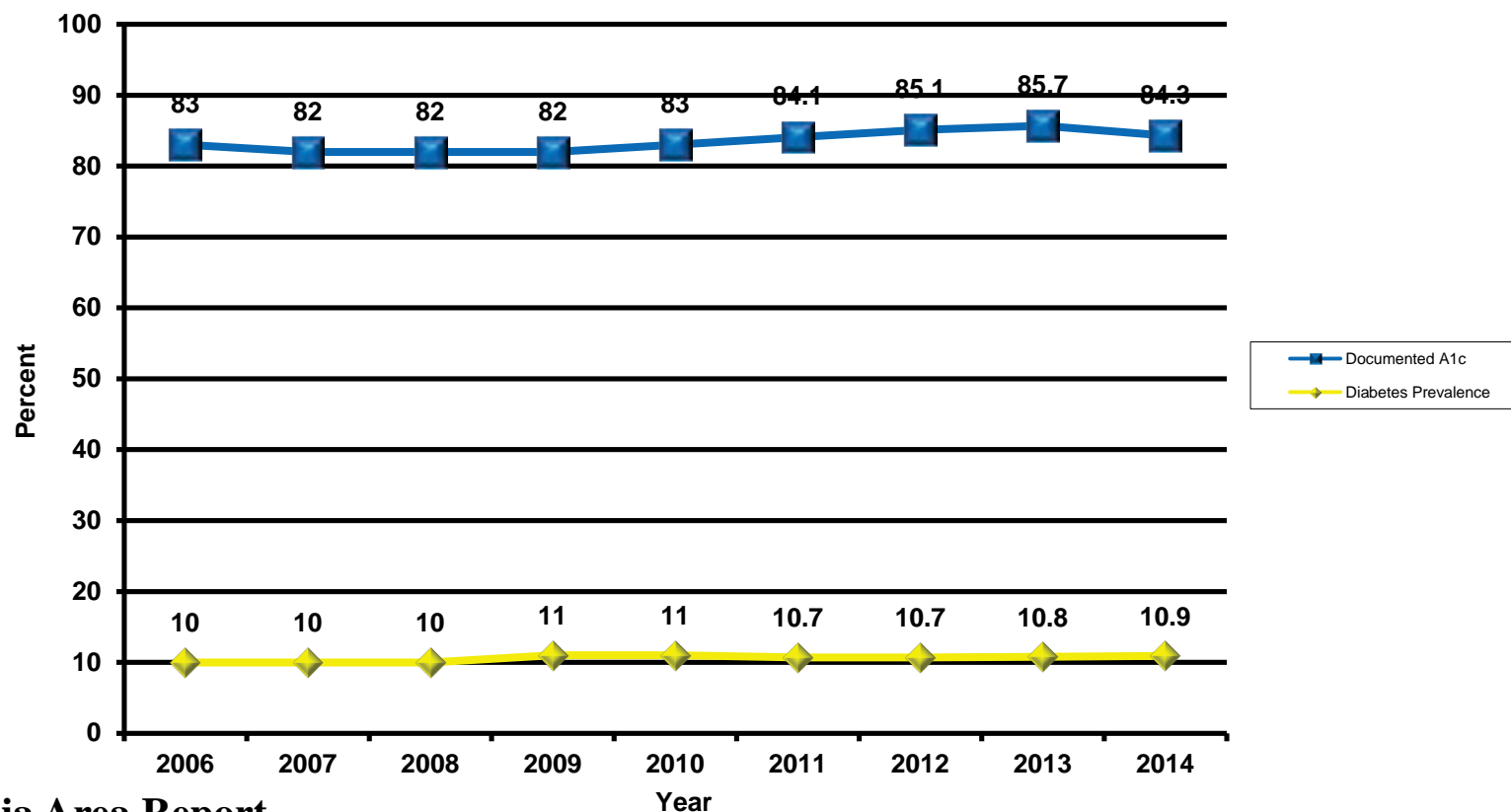


# DIABETES: PREVALENCE AND DOCUMENTED A1C

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

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

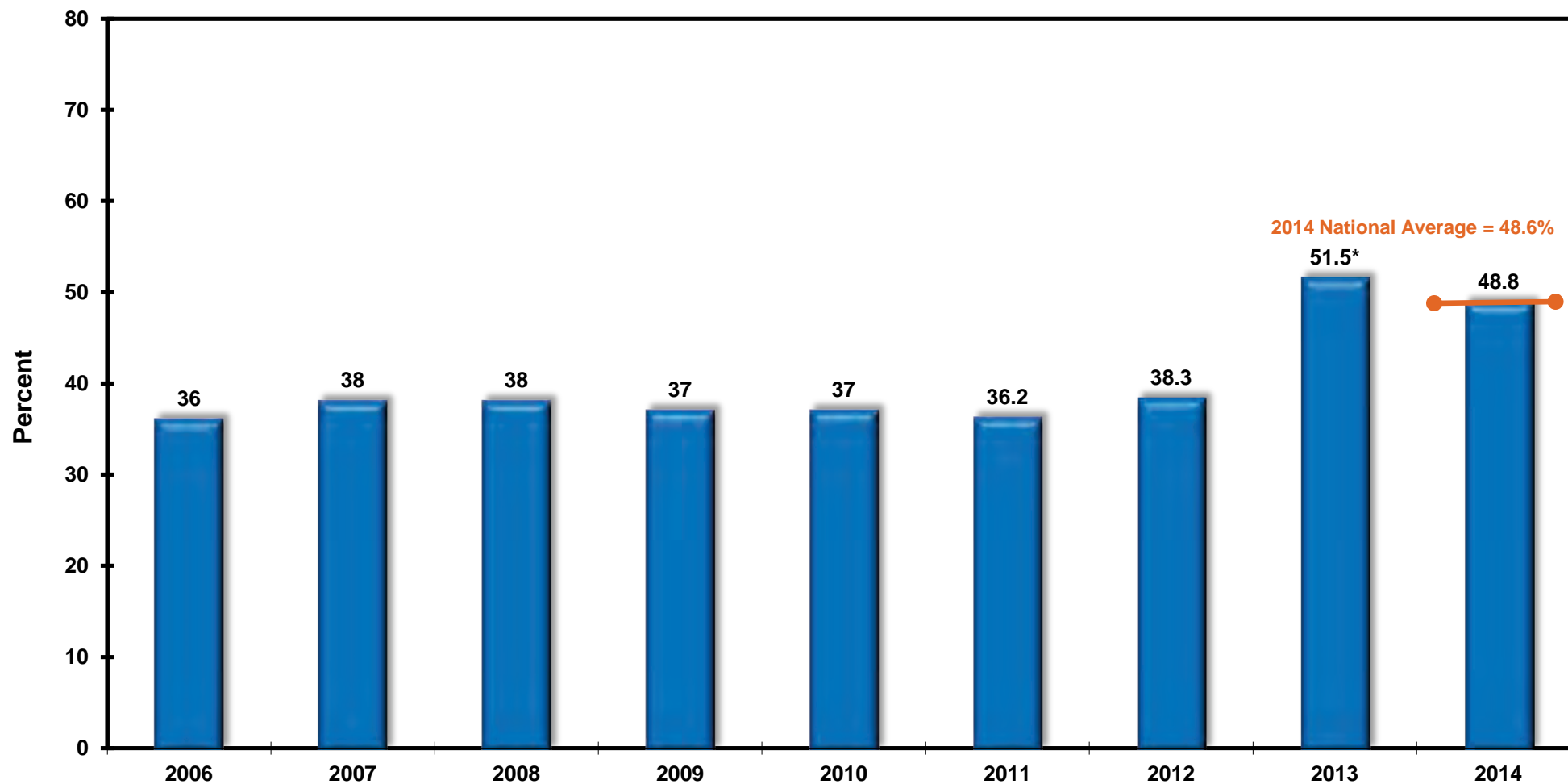
Diabetes: Prevalence and Documented A1c



# DIABETES: GOOD GLYCEMIC CONTROL

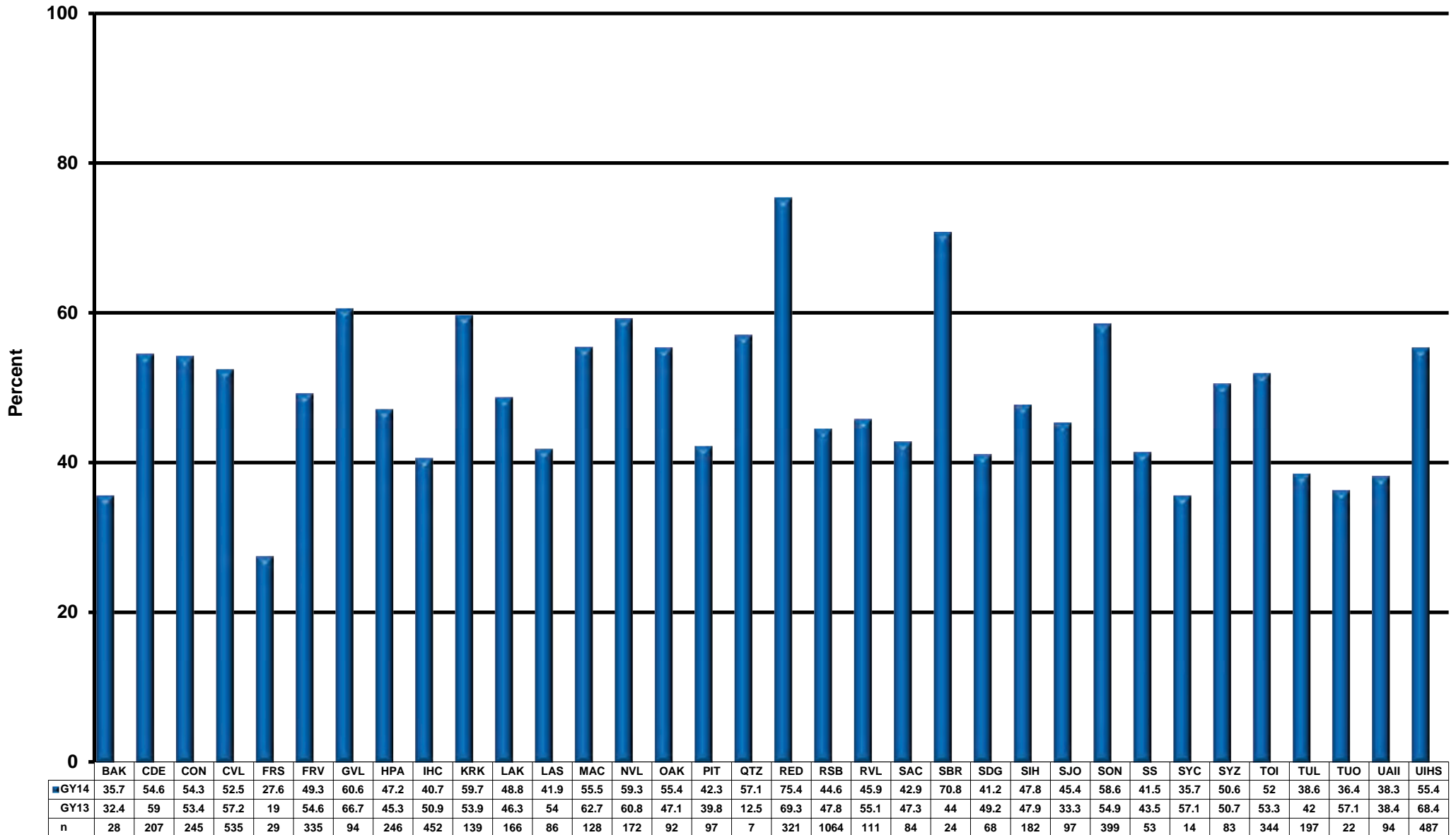
**Measure:** Percentage of patients with diagnosed diabetes with good glycemic control (A1c<8.0).

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



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

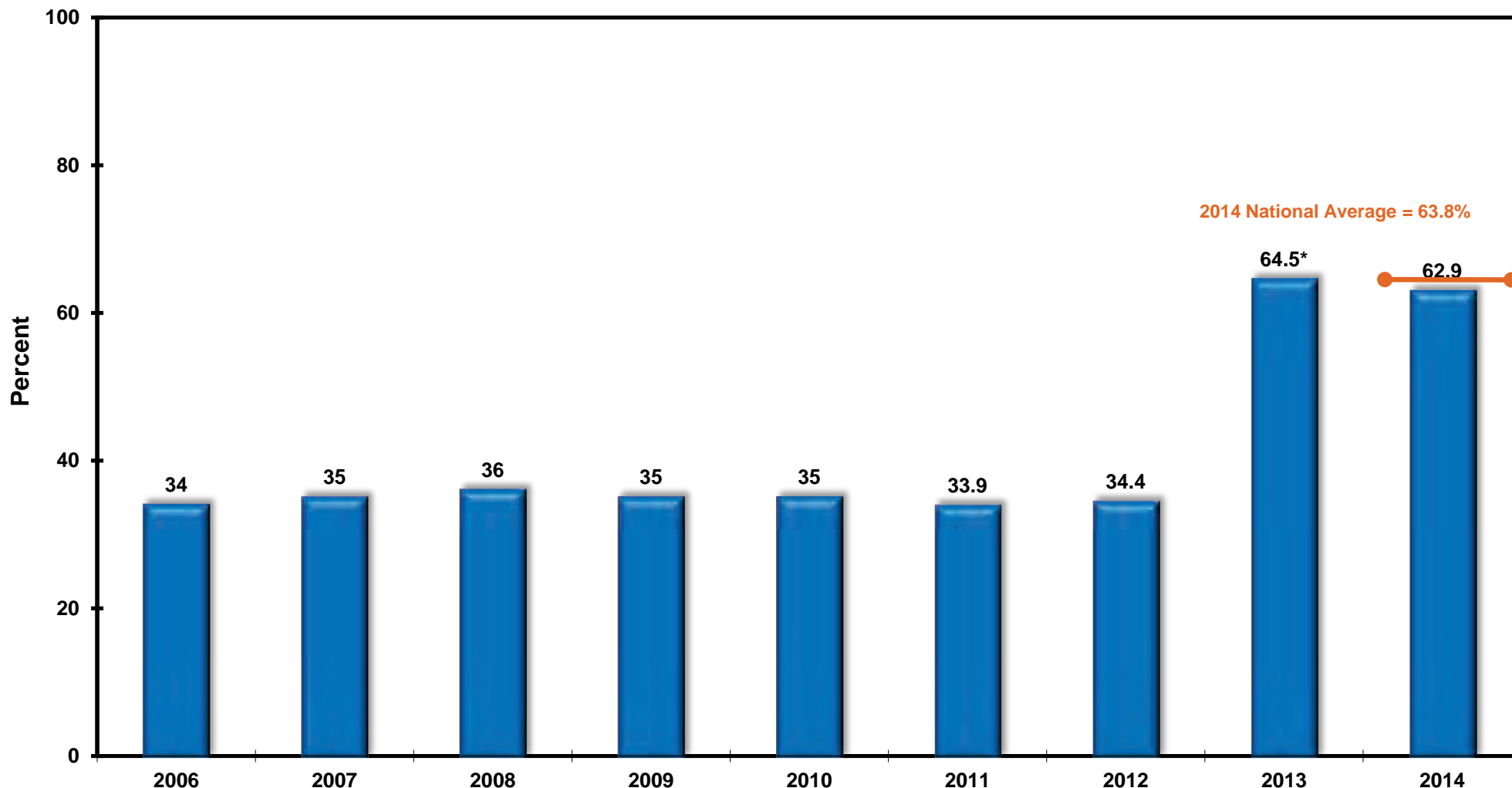
# DIABETES: GOOD GLYCEMIC CONTROL



# DIABETES: BLOOD PRESSURE CONTROL

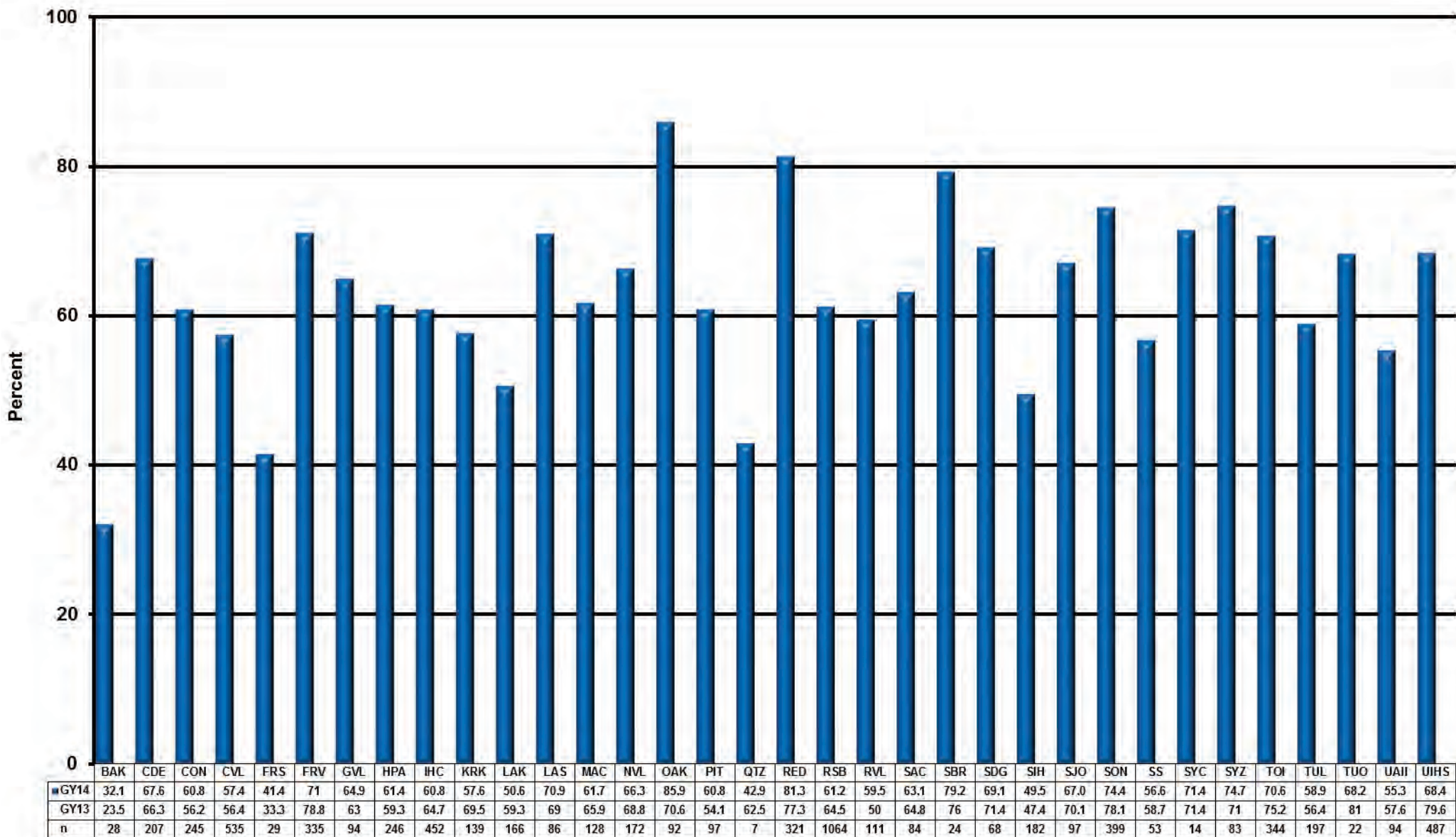
**Measure:** Percentage of patients with diagnosed diabetes that have achieved blood pressure control (BP < 140/90).

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



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

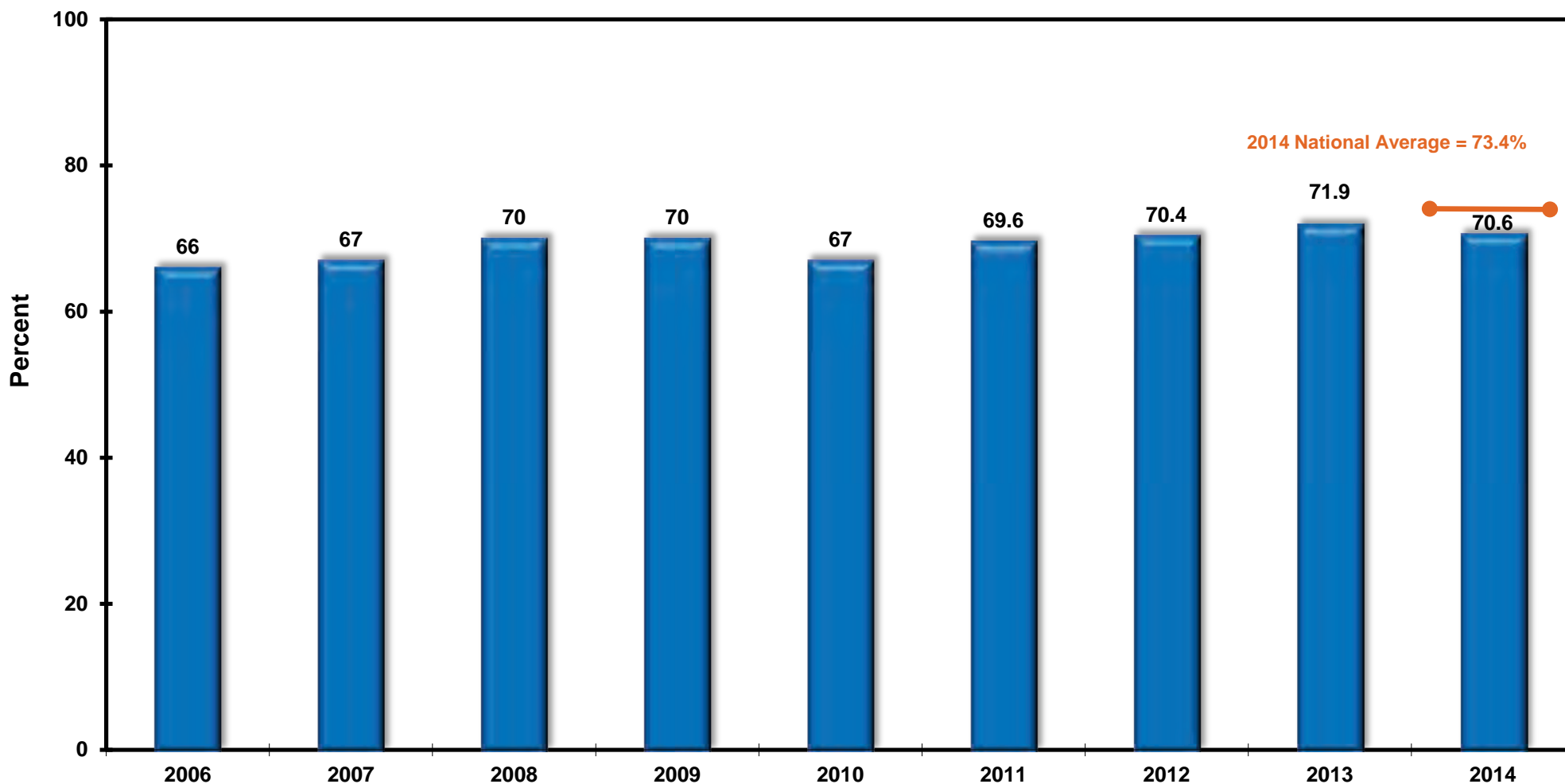
# DIABETES: BLOOD PRESSURE CONTROL



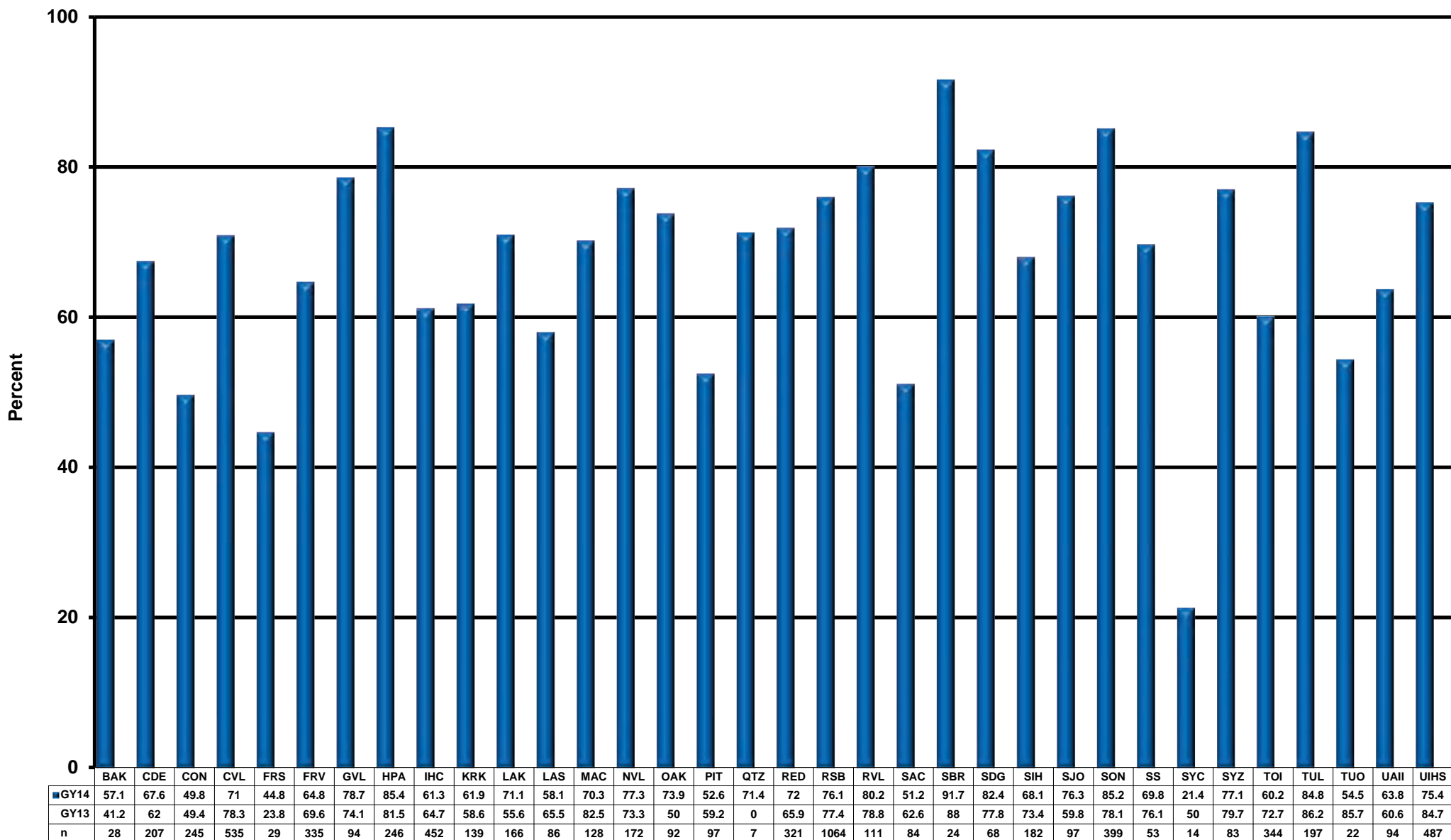
# DIABETES: DYSLIPIDEMIA ASSESSMENT

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

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



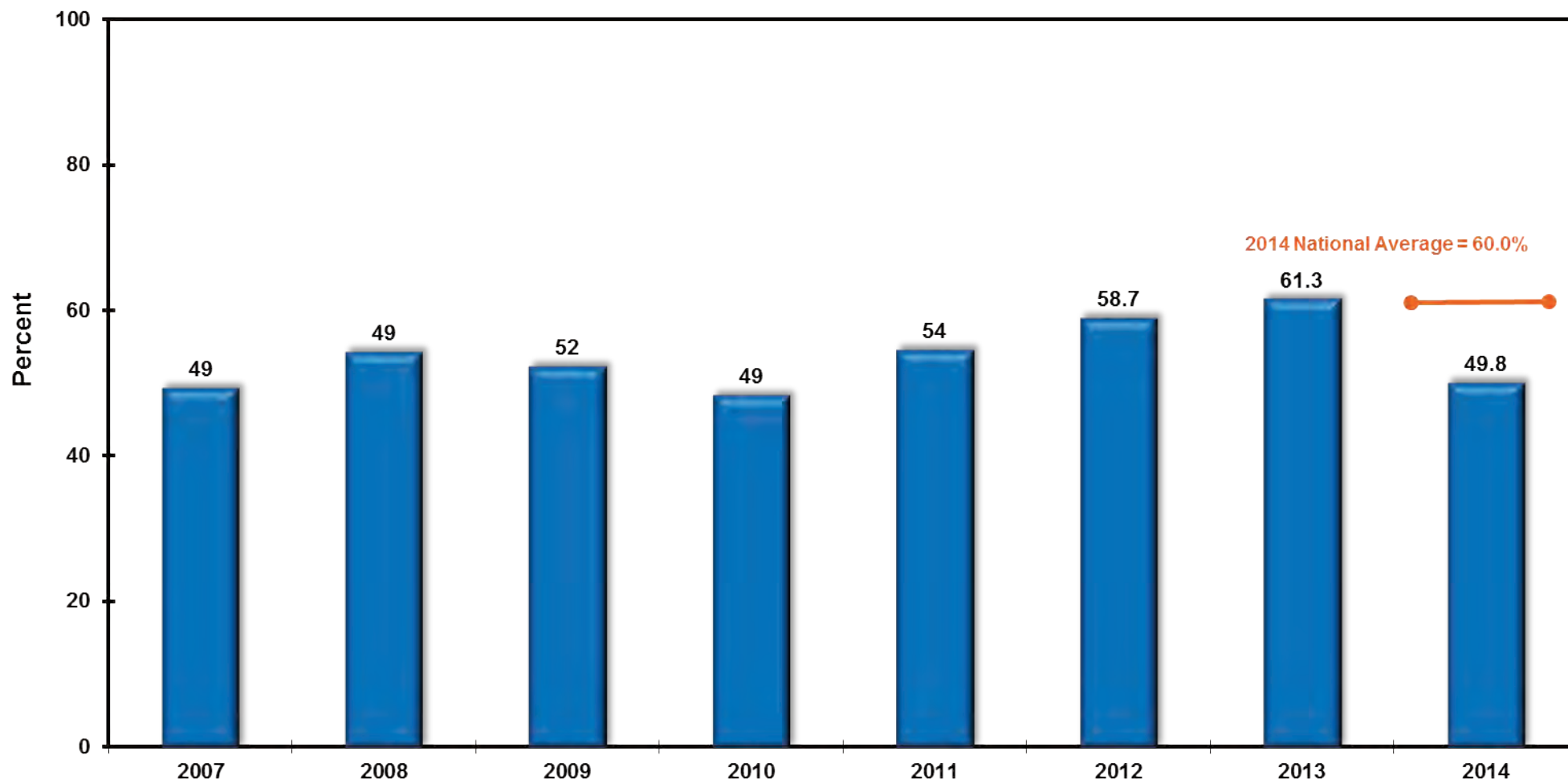
# DIABETES: DYSLIPIDEMIA ASSESSMENT



# DIABETES: NEPHROPATHY ASSESSMENT

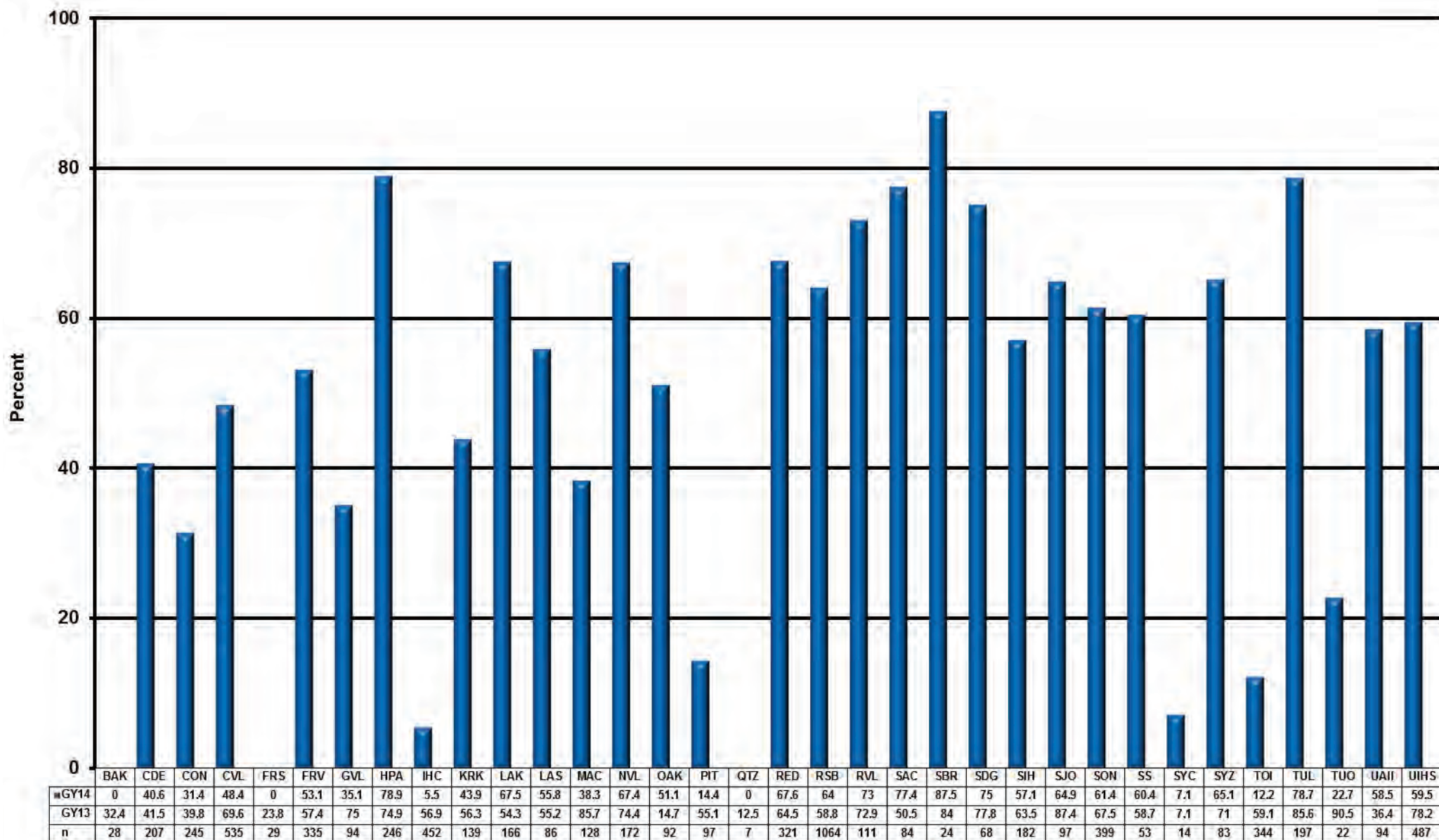
**Measure:** Percentage of patients with diagnosed diabetes assessed for nephropathy.

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





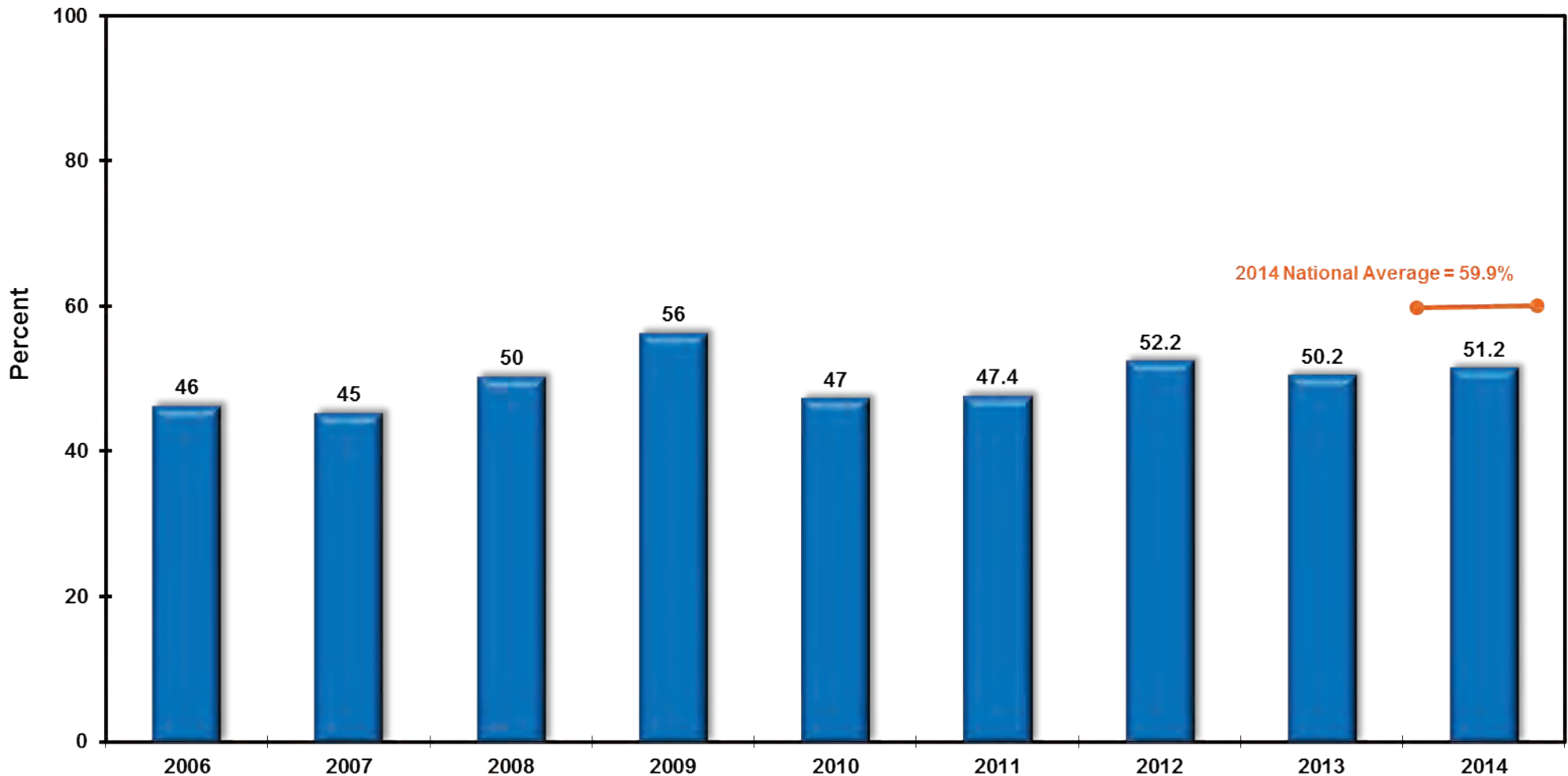
# DIABETES: NEPHROPATHY ASSESSMENT



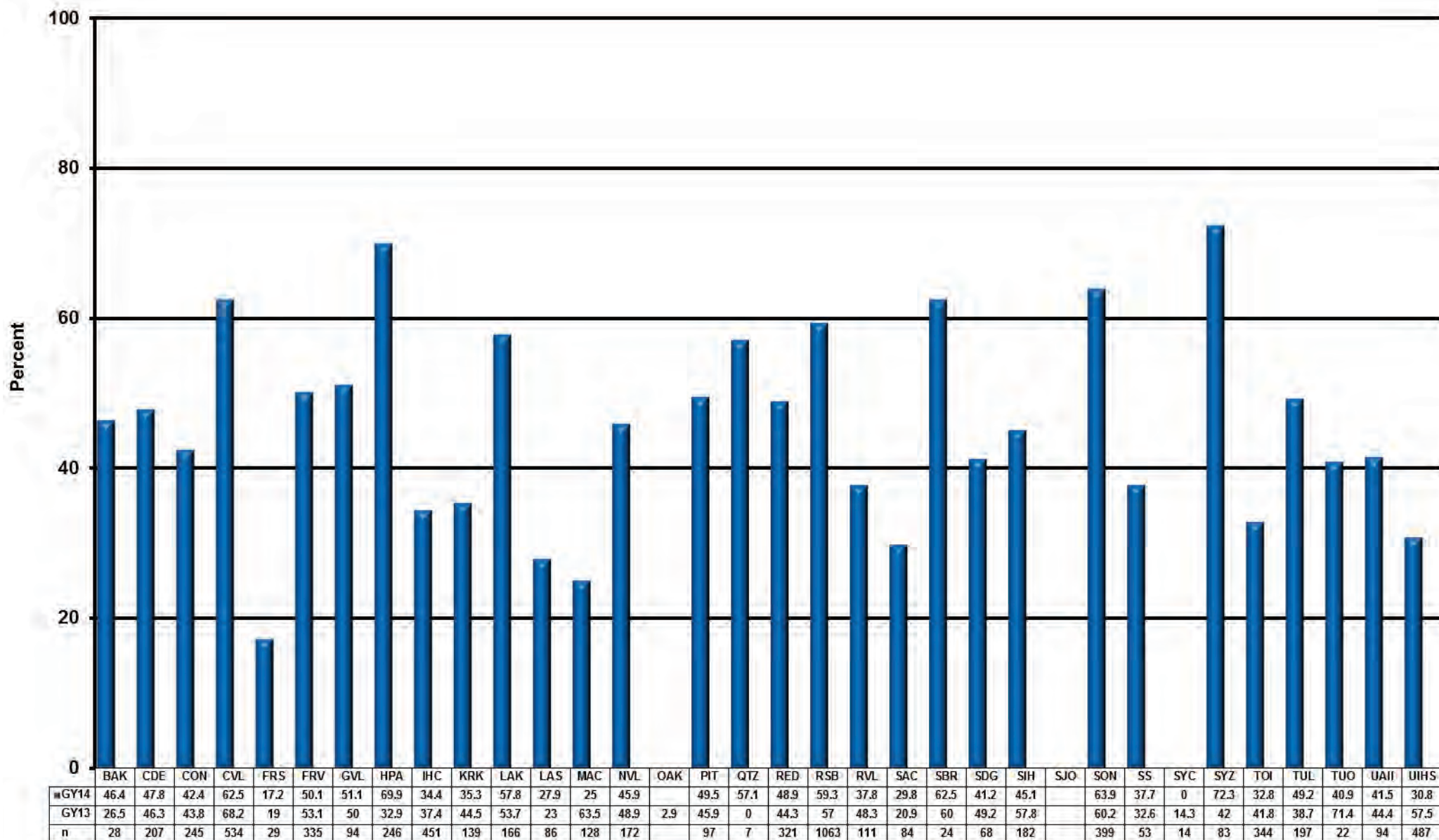
# DIABETES: RETINOPATHY

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

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



# DIABETES: RETINOPATHY

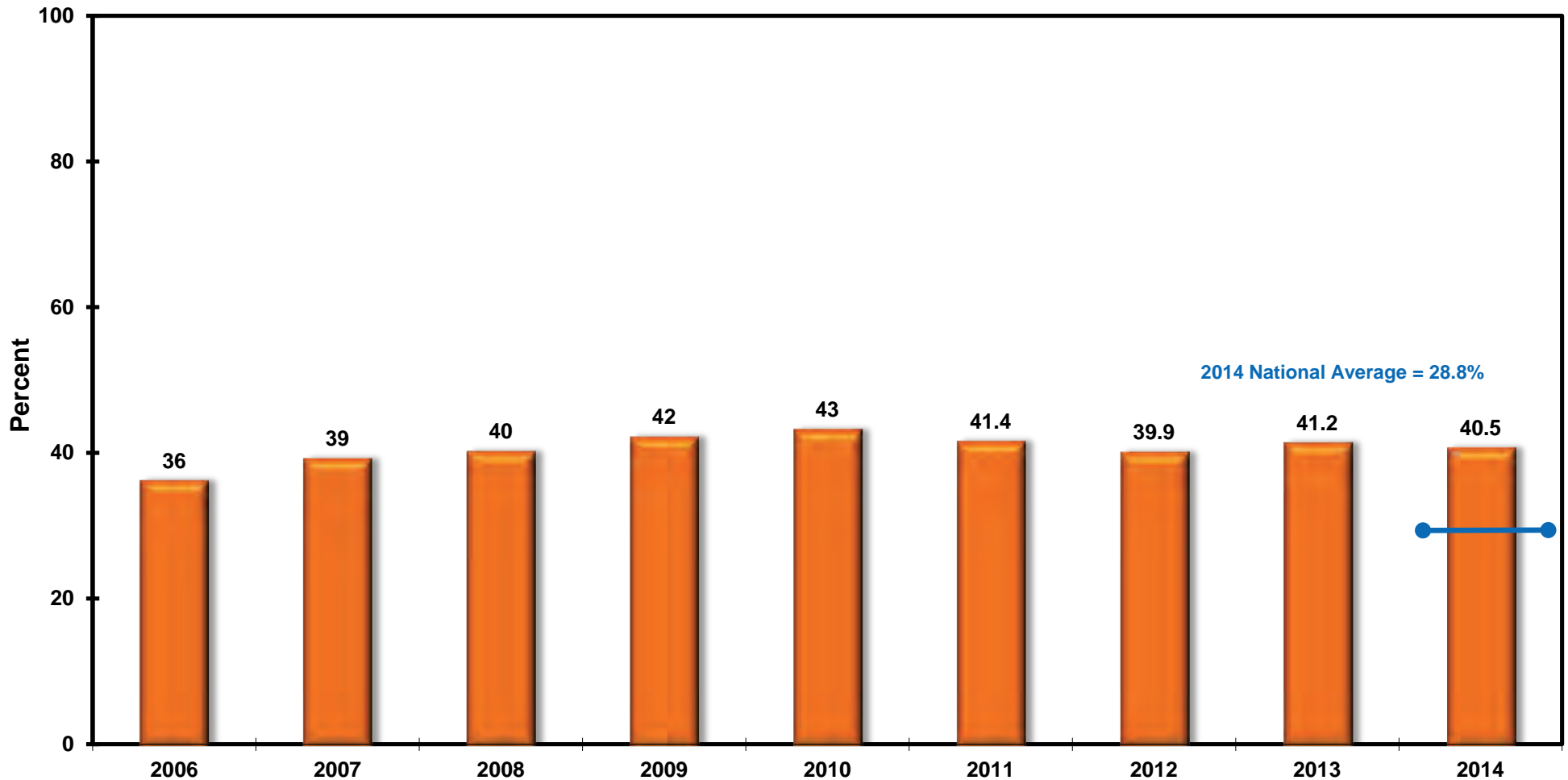


Note: Urban health programs are not required to report on this measure.

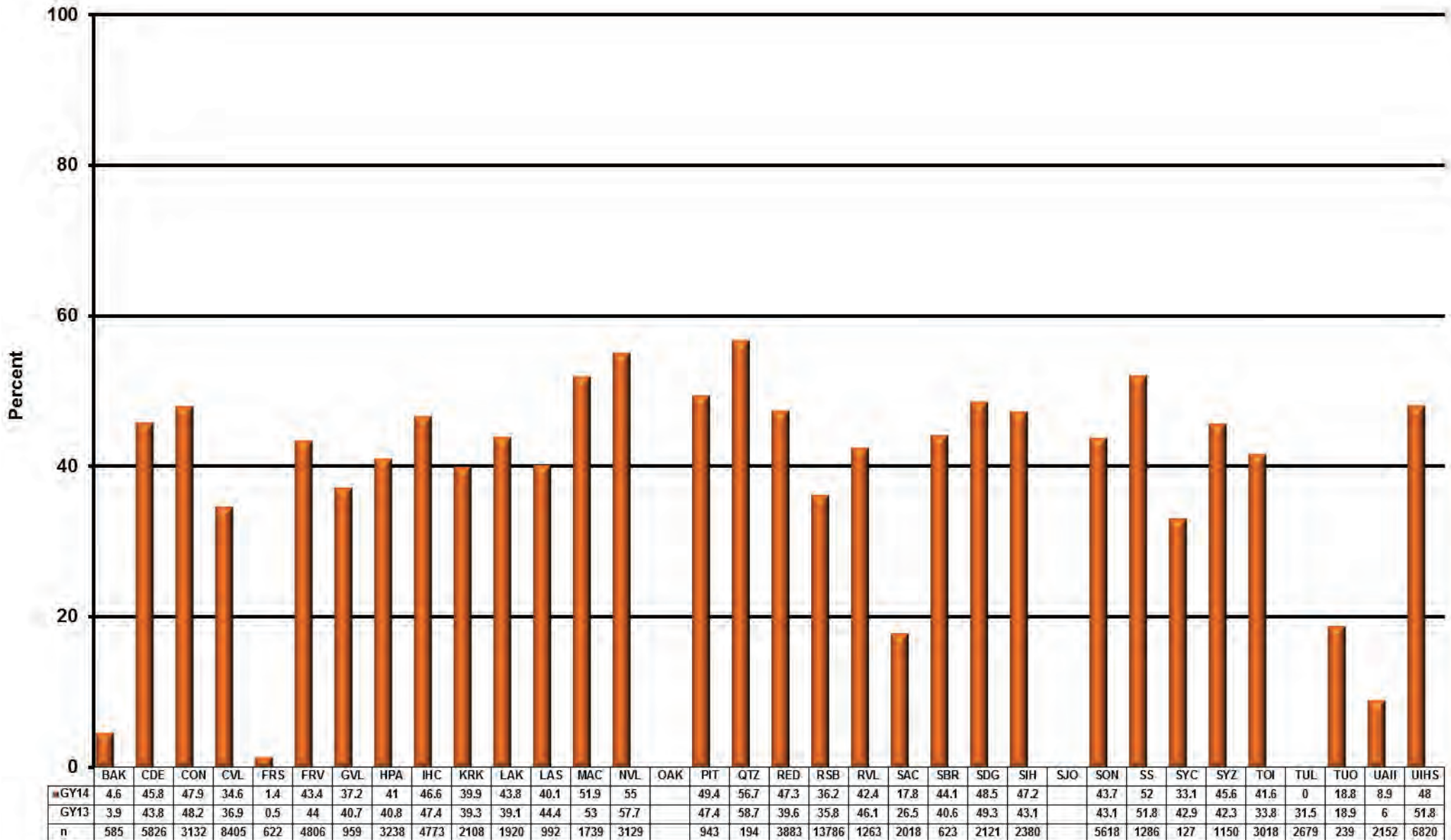
# DENTAL: GENERAL ACCESS

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

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



# DENTAL: GENERAL ACCESS

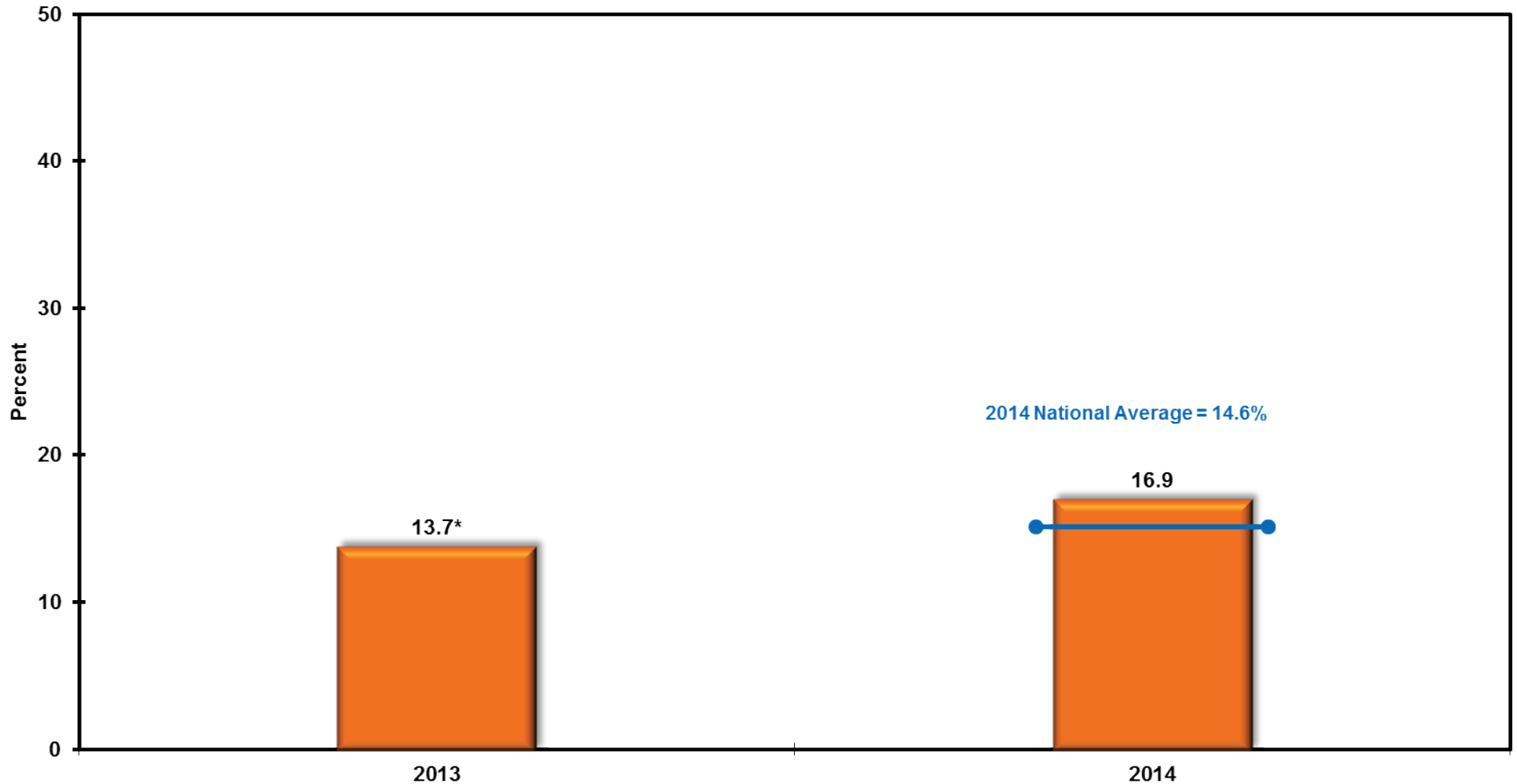


Note: Urban health programs are not required to report on this measure.

# DENTAL: SEALANTS

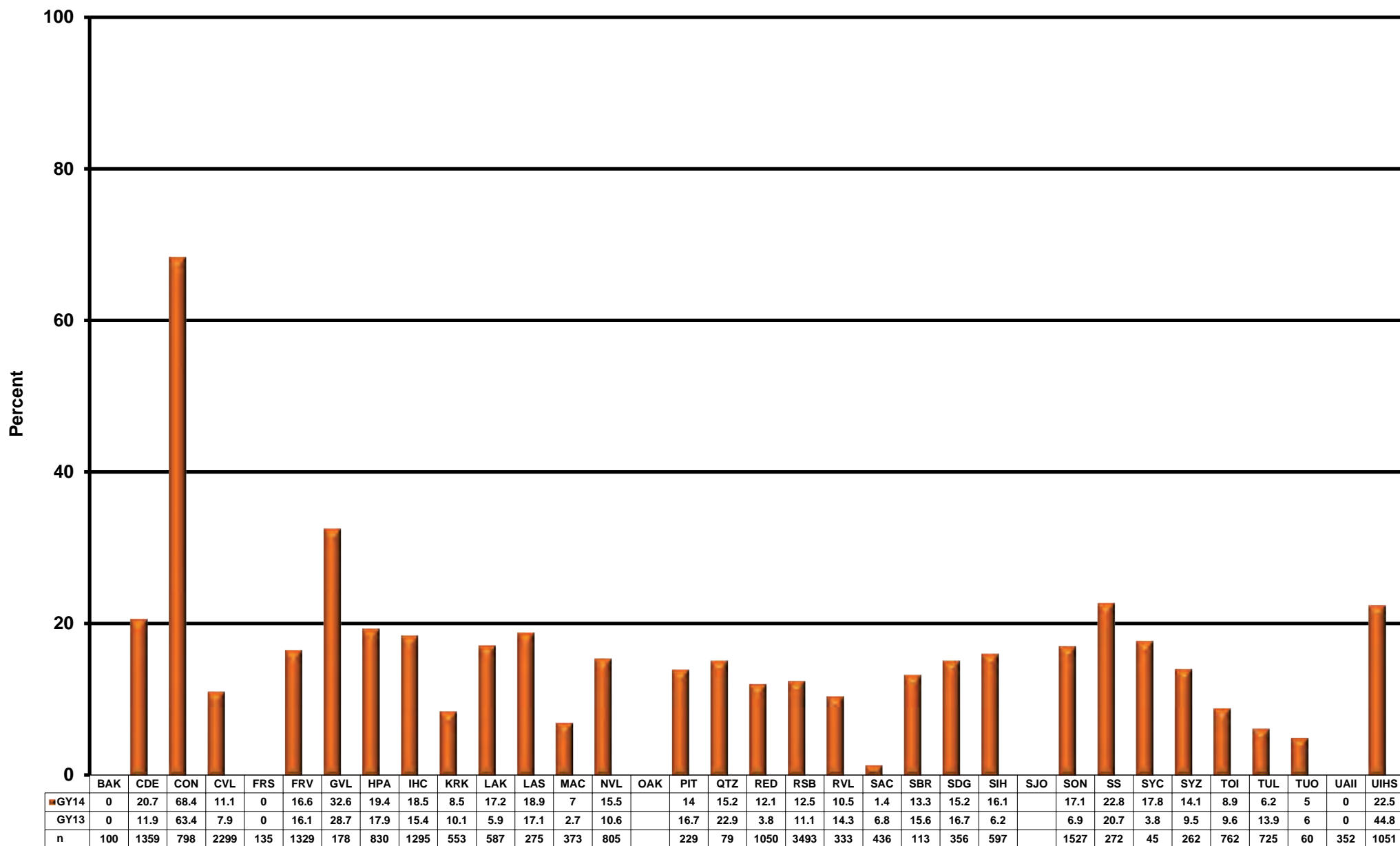
**Measure:** Percentage of AI/AN patients ages 2 to 15 years who have intact sealants

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



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

# DENTAL: SEALANTS

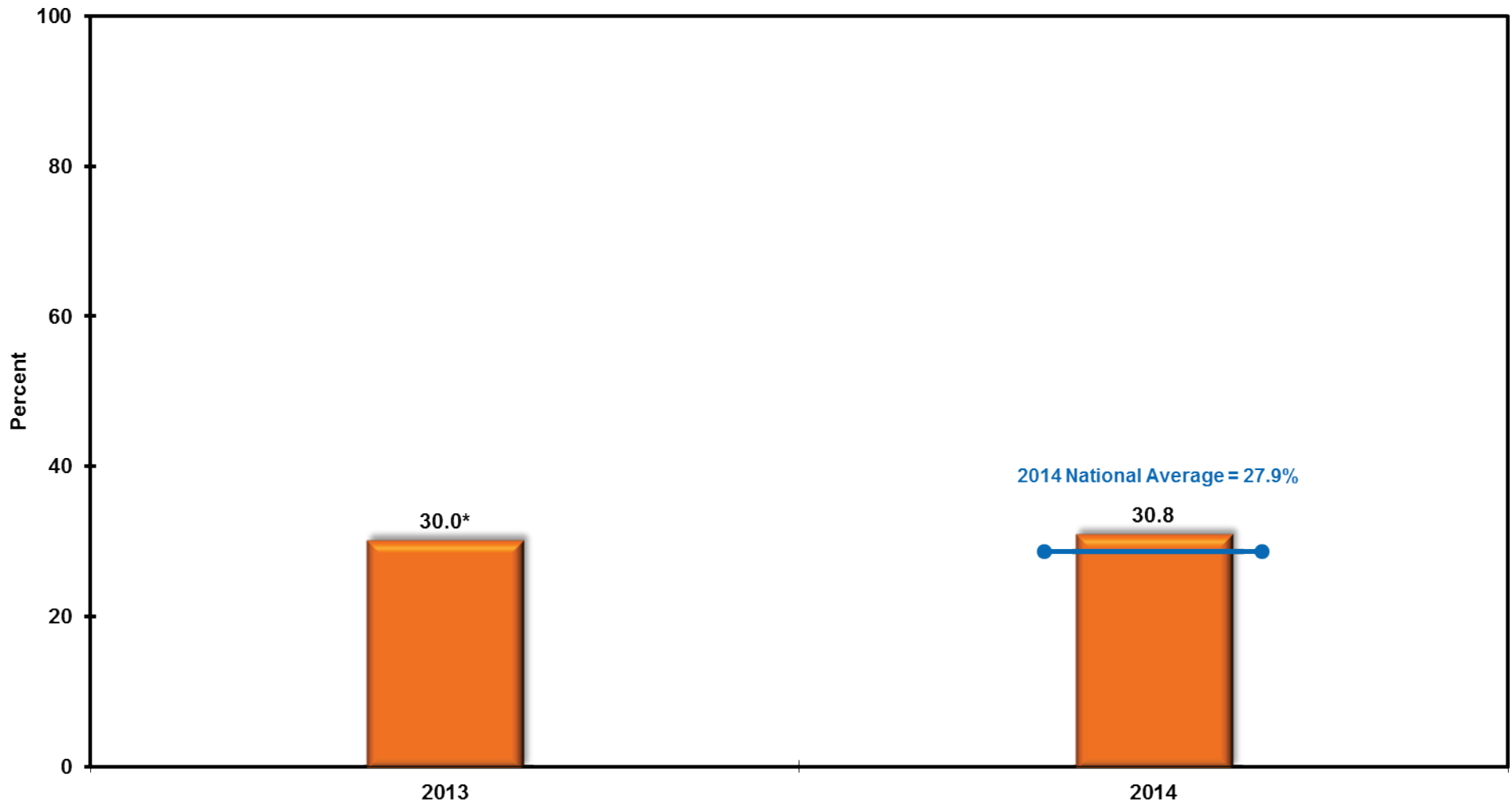


Note: Urban health programs are not required to report on this measure.

# DENTAL: TOPICAL FLUORIDES

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

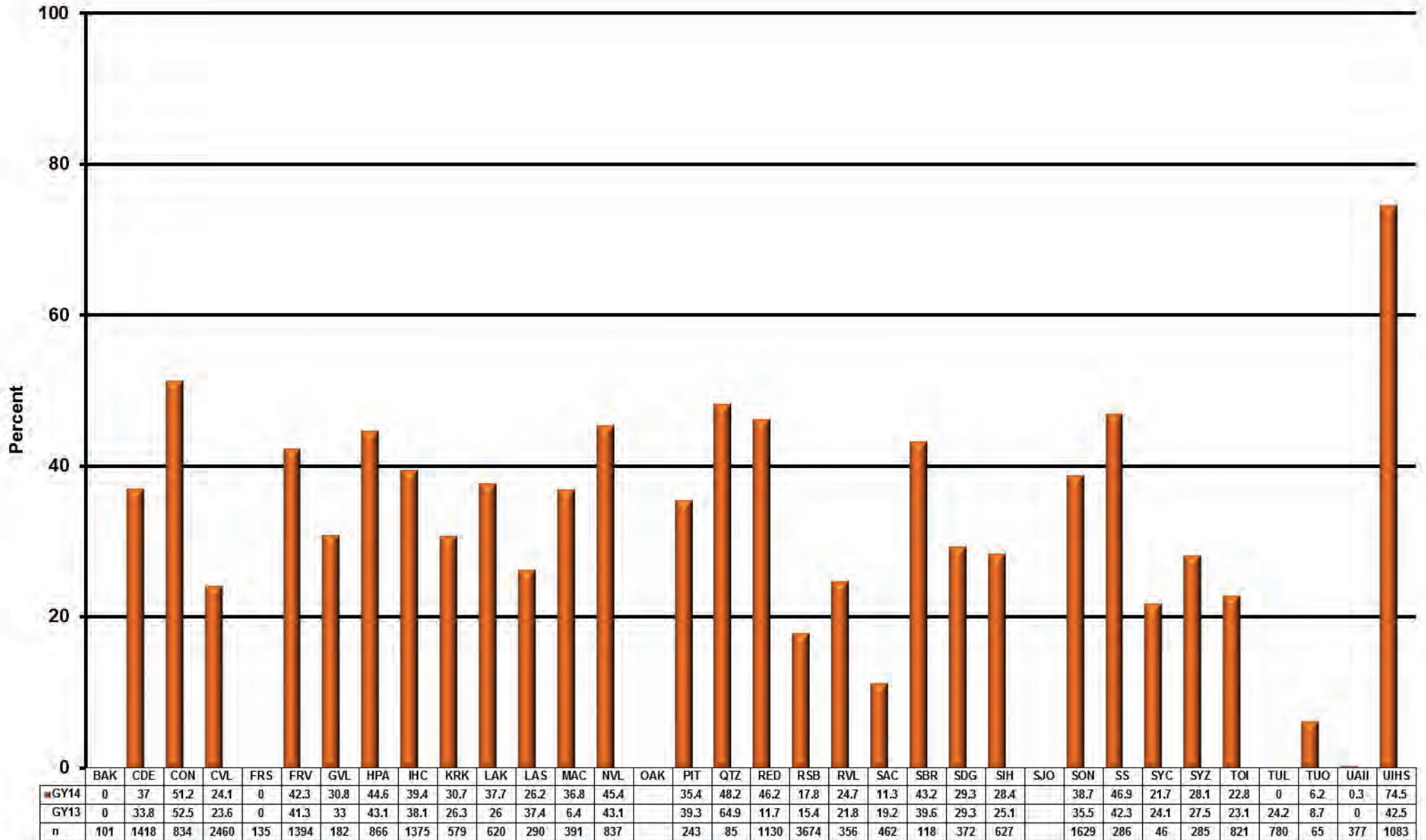
**Importance:** *The topical application of fluoride helps prevent cavities and is appropriate for children, adolescents, and adults. Patients who receive at least one fluoride application have fewer new cavities, which reduces the cost of providing dental care, and improves the oral health of patients.*



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



# DENTAL: TOPICAL FLUORIDES

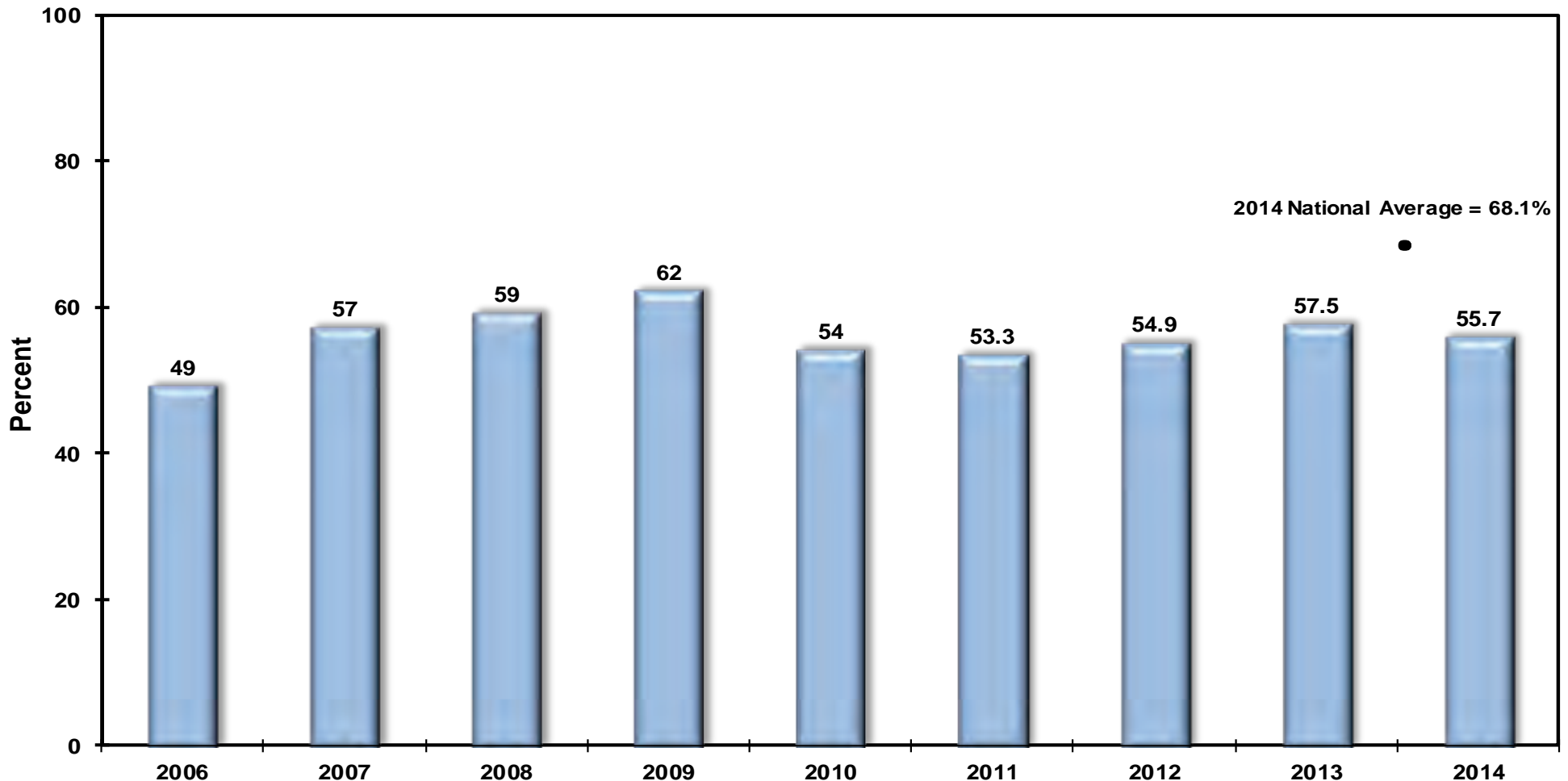


Note: Urban health programs are not required to report on this measure.

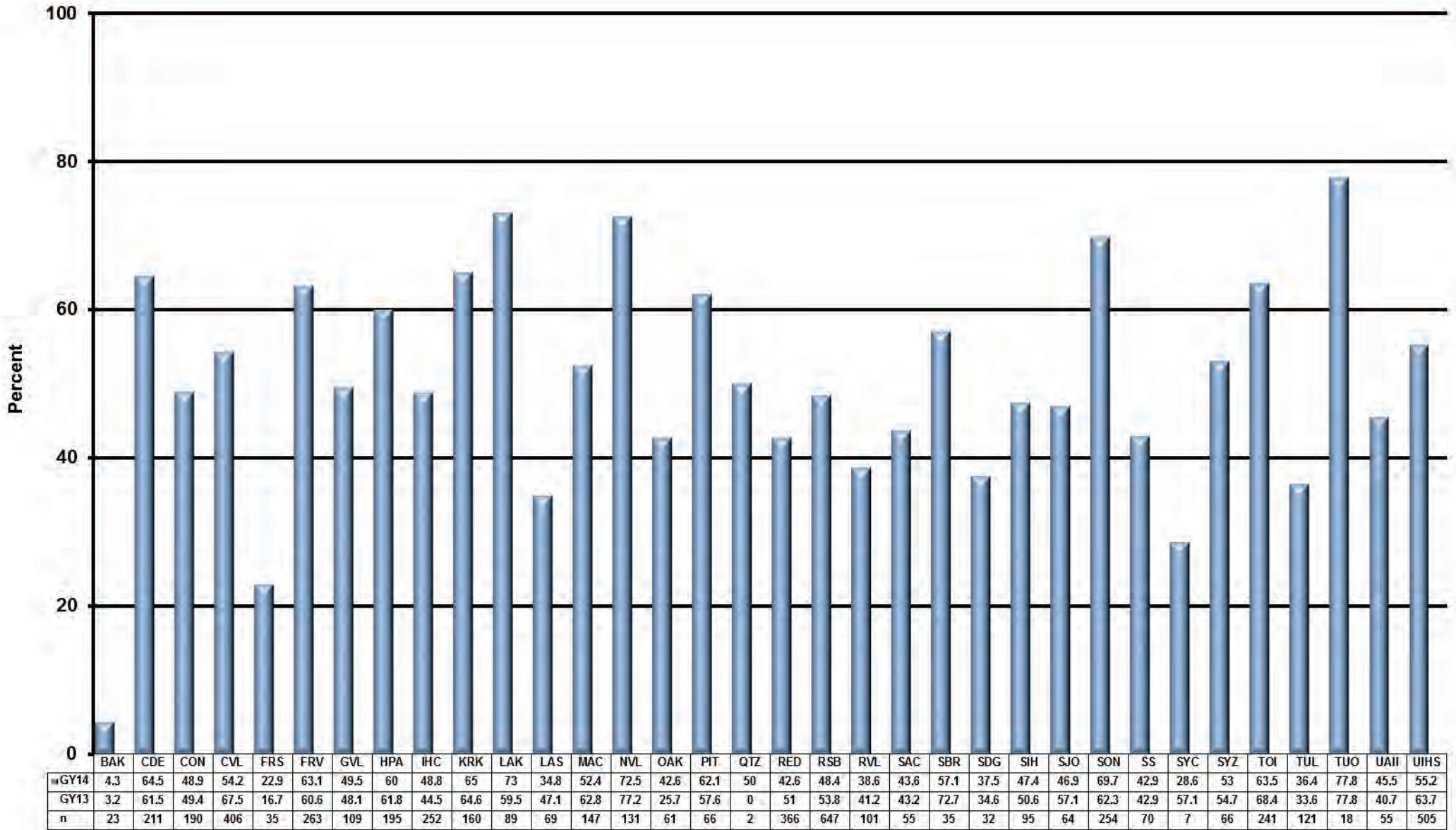
# IMMUNIZATIONS: INFLUENZA

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

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



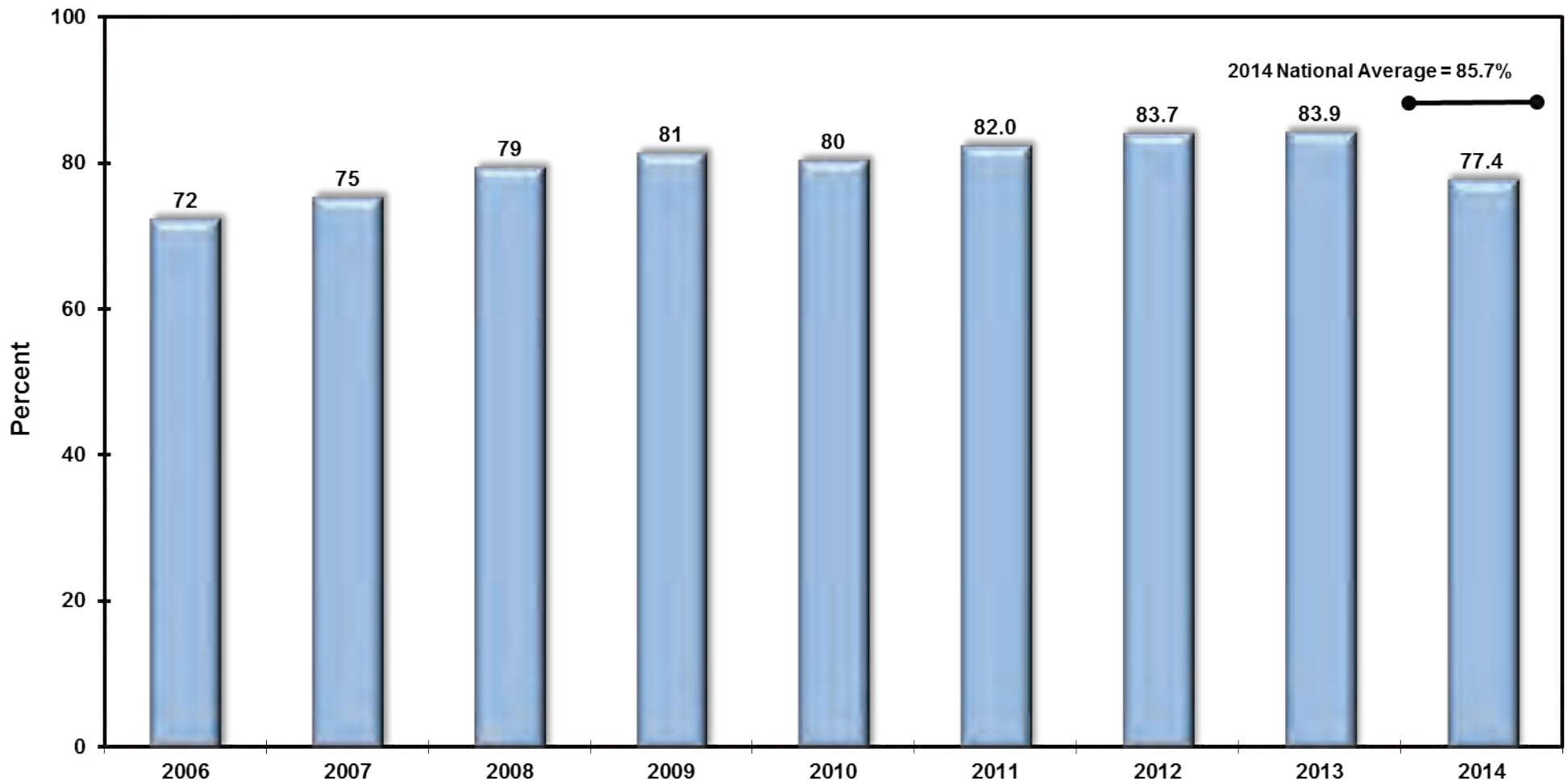
# IMMUNIZATIONS: INFLUENZA



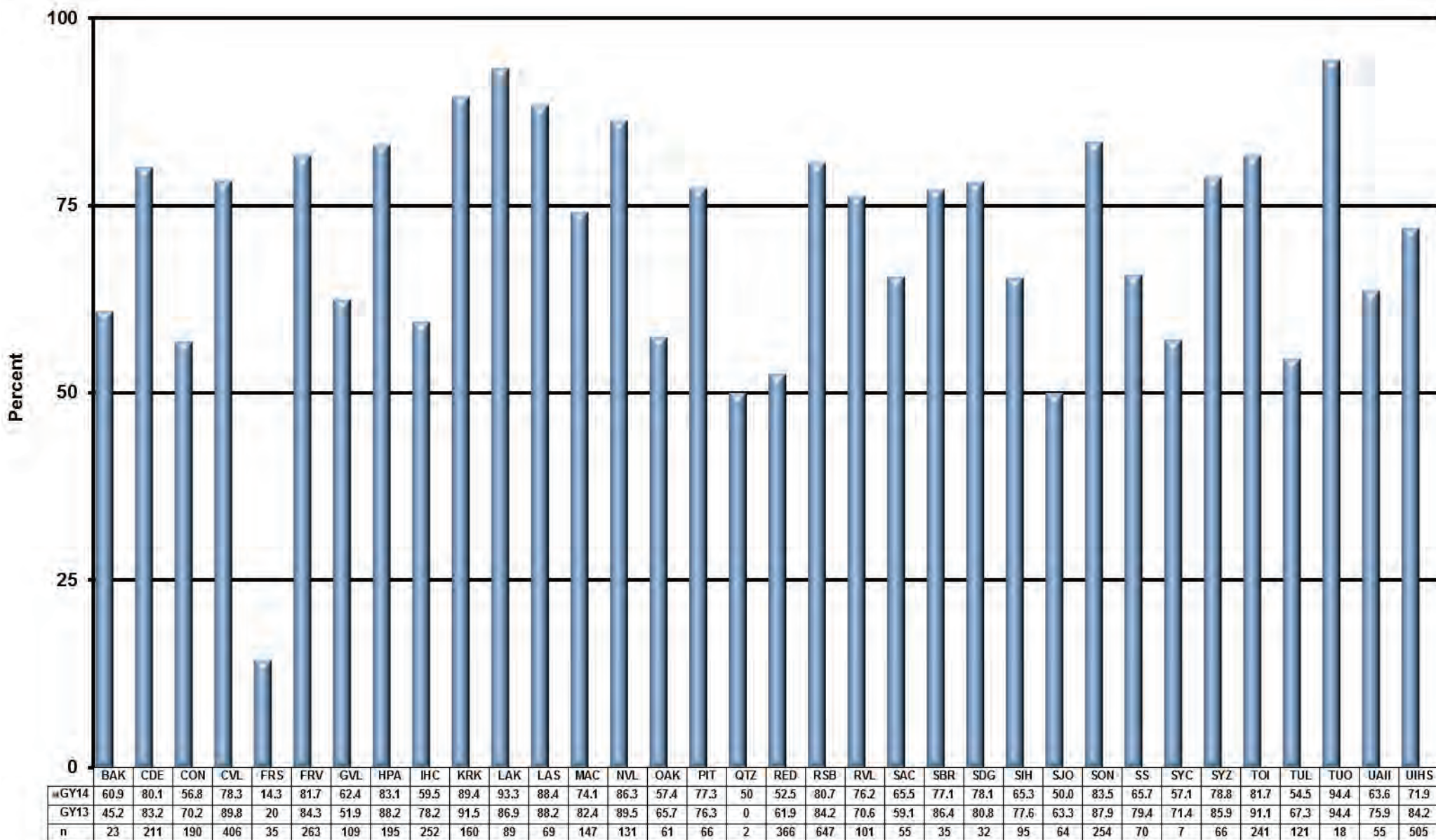
# IMMUNIZATIONS: PNEUMOCOCCAL

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

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



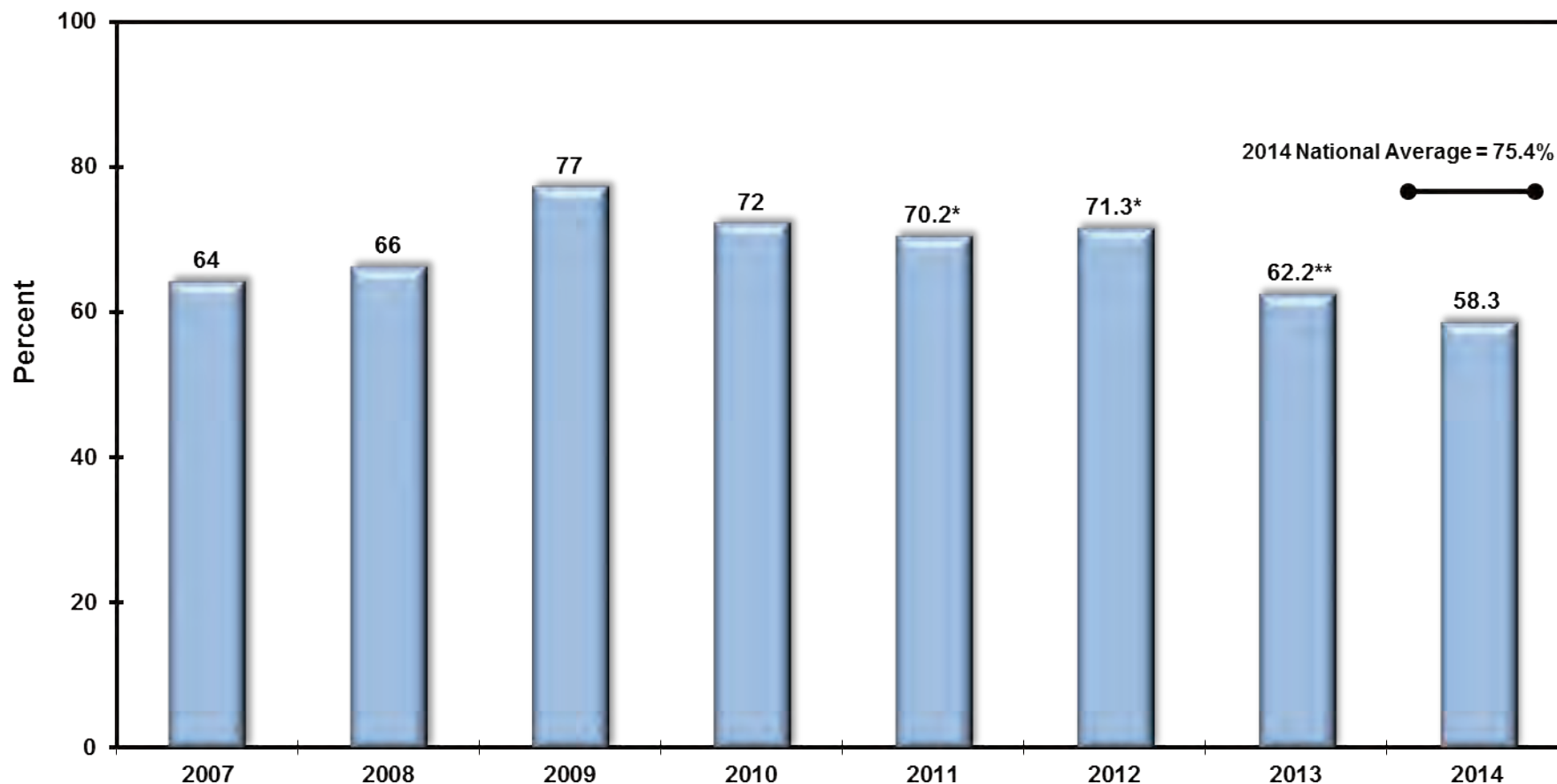
# IMMUNIZATIONS: PNEUMOCOCCAL



# IMMUNIZATIONS: CHILDHOOD (19 – 35 months)

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

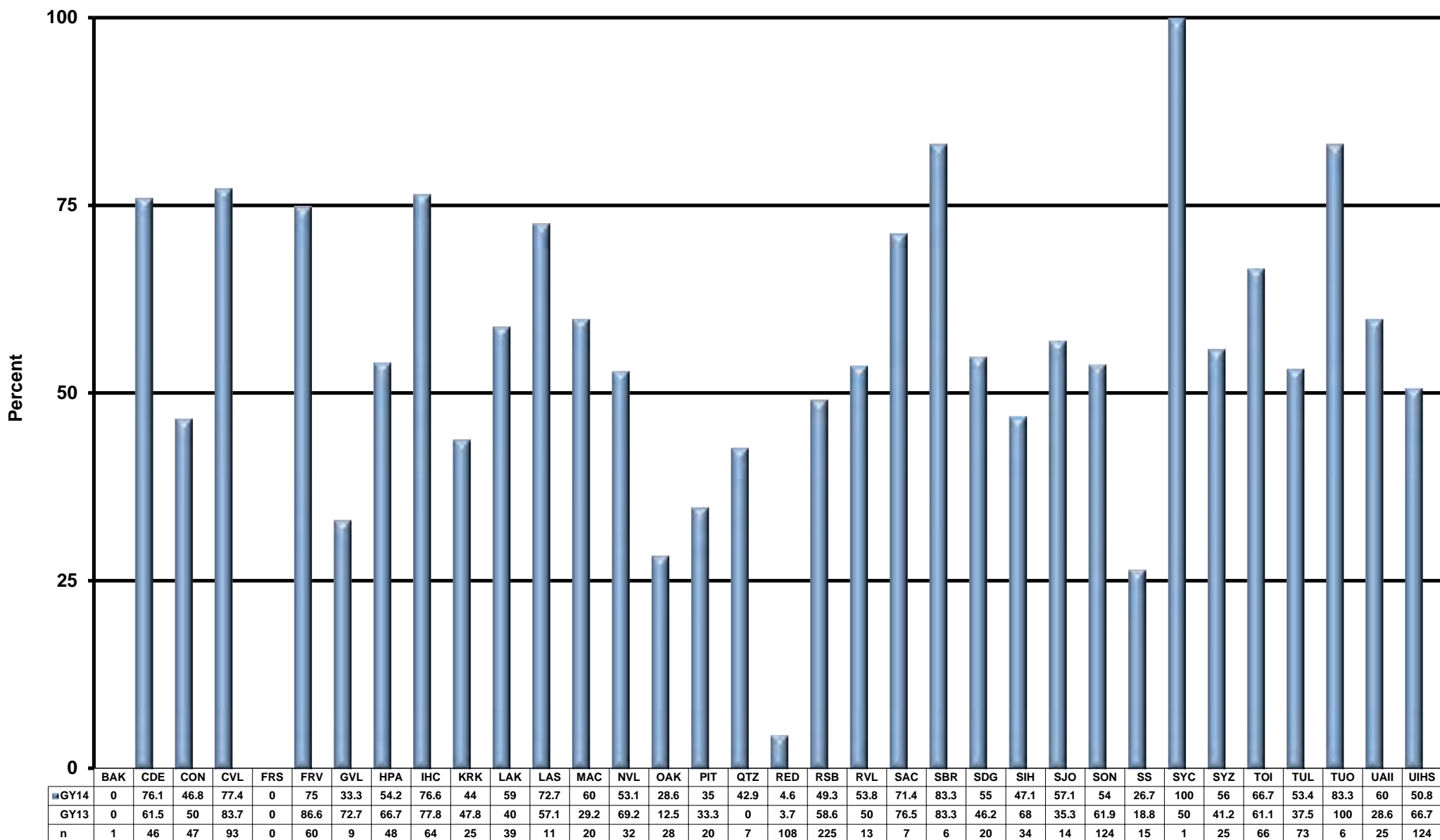
**Importance:** *Immunizations significantly improve the health of children, and stop the spread of disease within communities. The Healthy People 2020 goal is 80% coverage for the combined 4:3:1:3:3:1:4 series, which includes 4 doses of DTaP (Diphtheria/Tetanus/Pertussis-Whooping Cough), 3 doses of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



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

\*\* In FY 2013, the HiB vaccine requires either three or four vaccines depending on the brand.

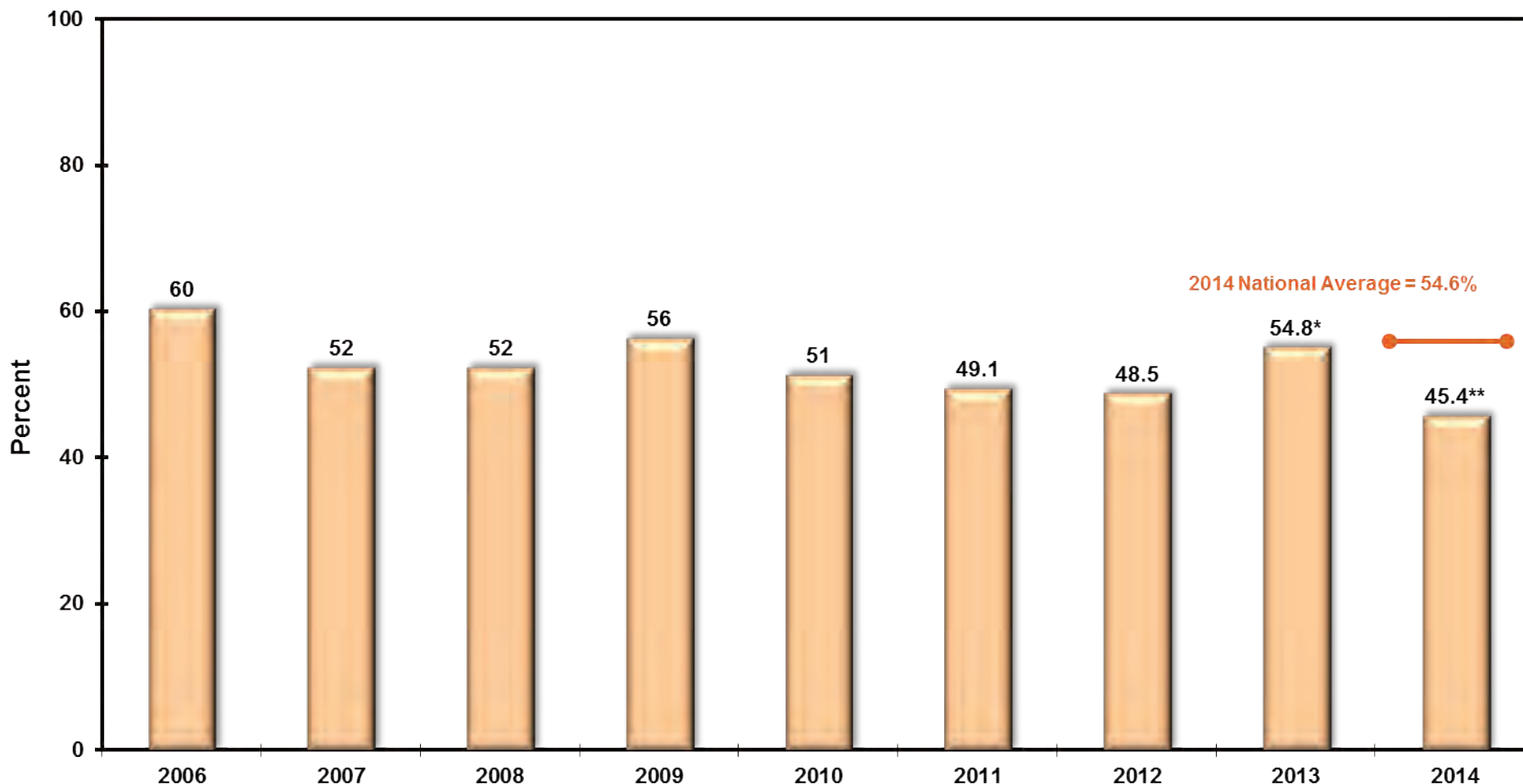
# IMMUNIZATIONS: CHILDHOOD (19 – 35 months)



# CANCER SCREENING: CERVICAL (PAP SMEAR)

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

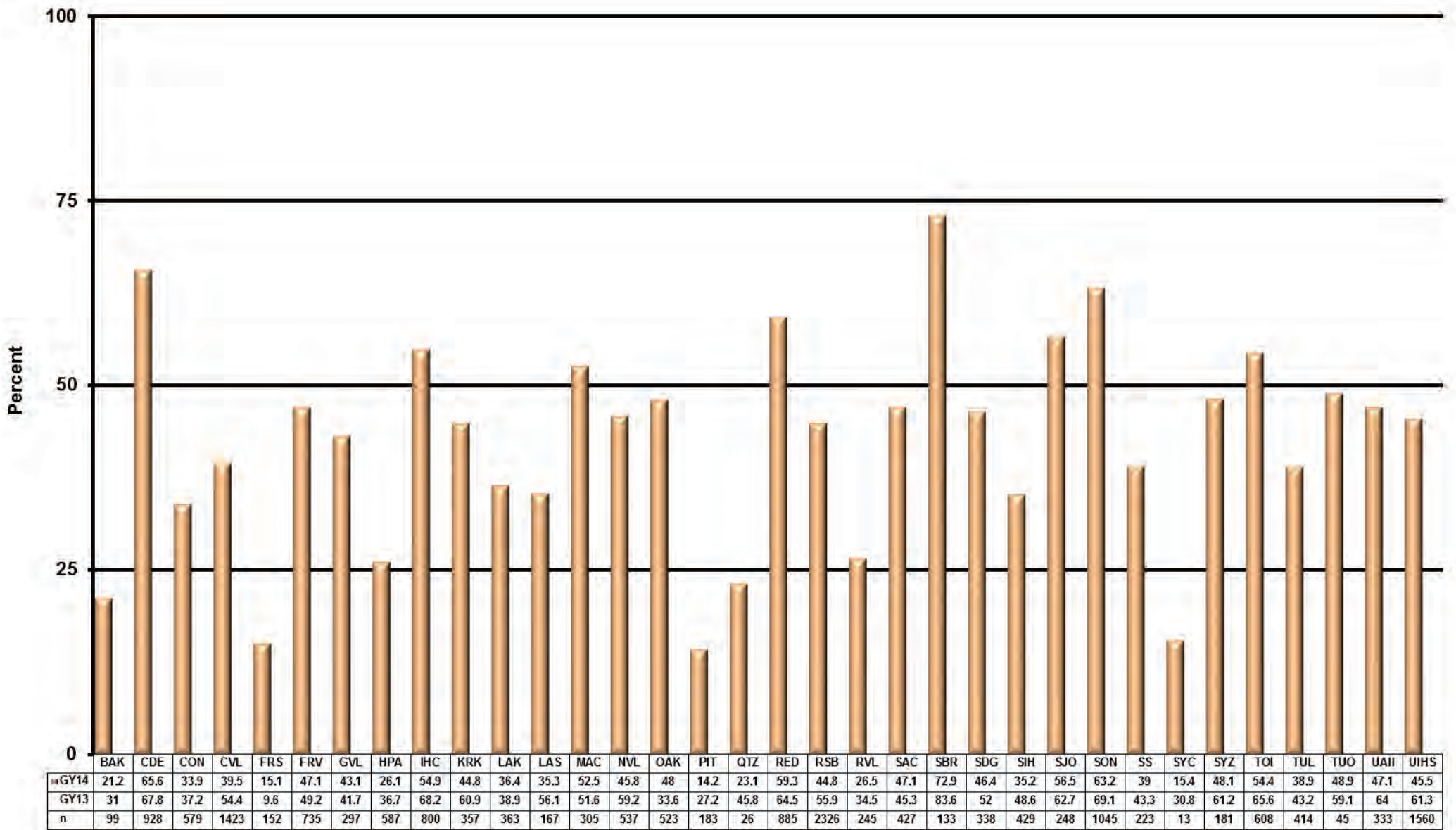
**Importance:** *More American Indian women report having never had a Pap screen than any other racial or ethnic group. Regular screening with a Pap screen lowers the risk of developing cervical cancer by detecting pre-cancerous changes. If cervical cancer is detected early, the likelihood of survival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



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



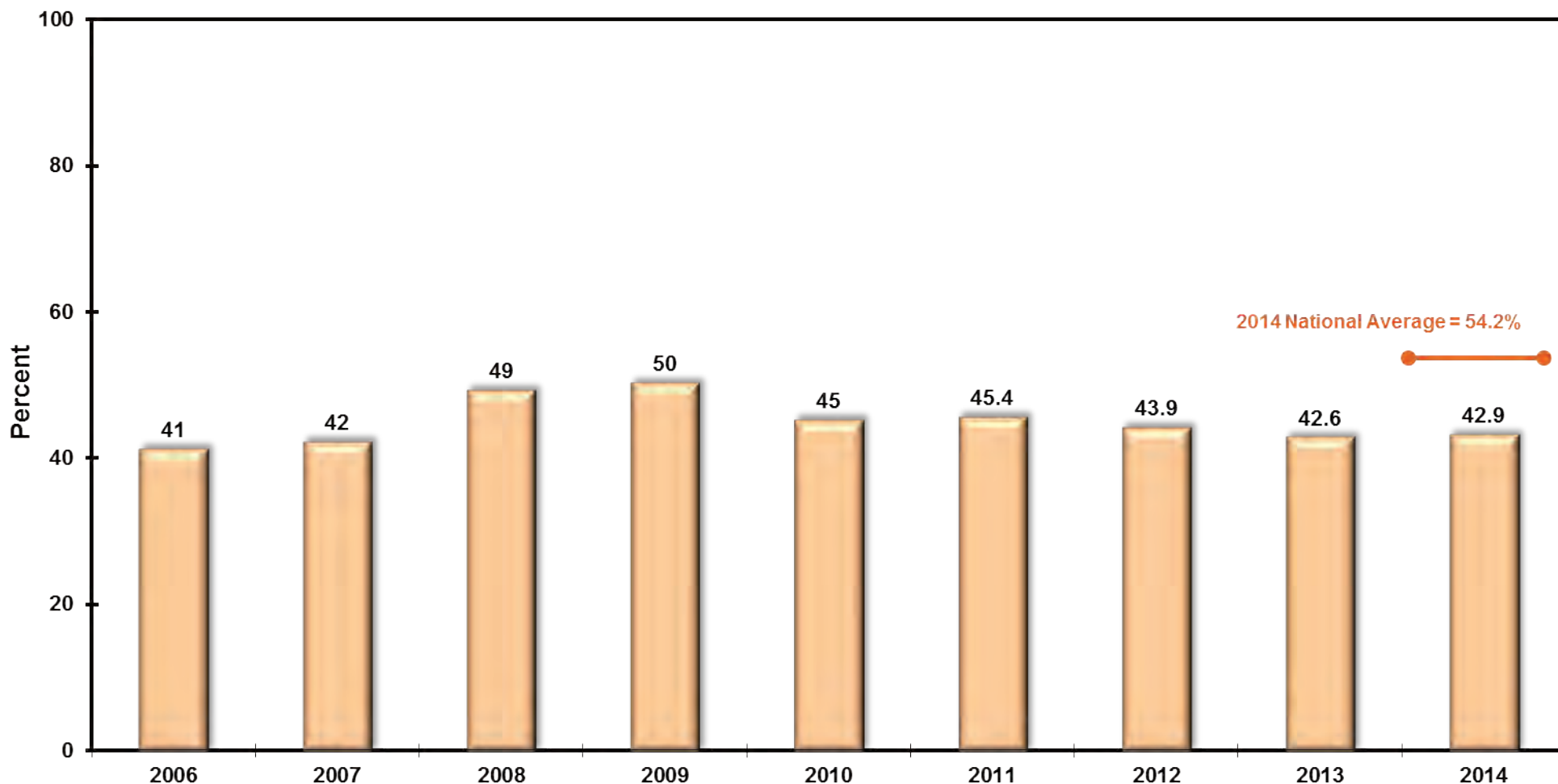
# CANCER SCREENING: CERVICAL (PAP SMEAR)



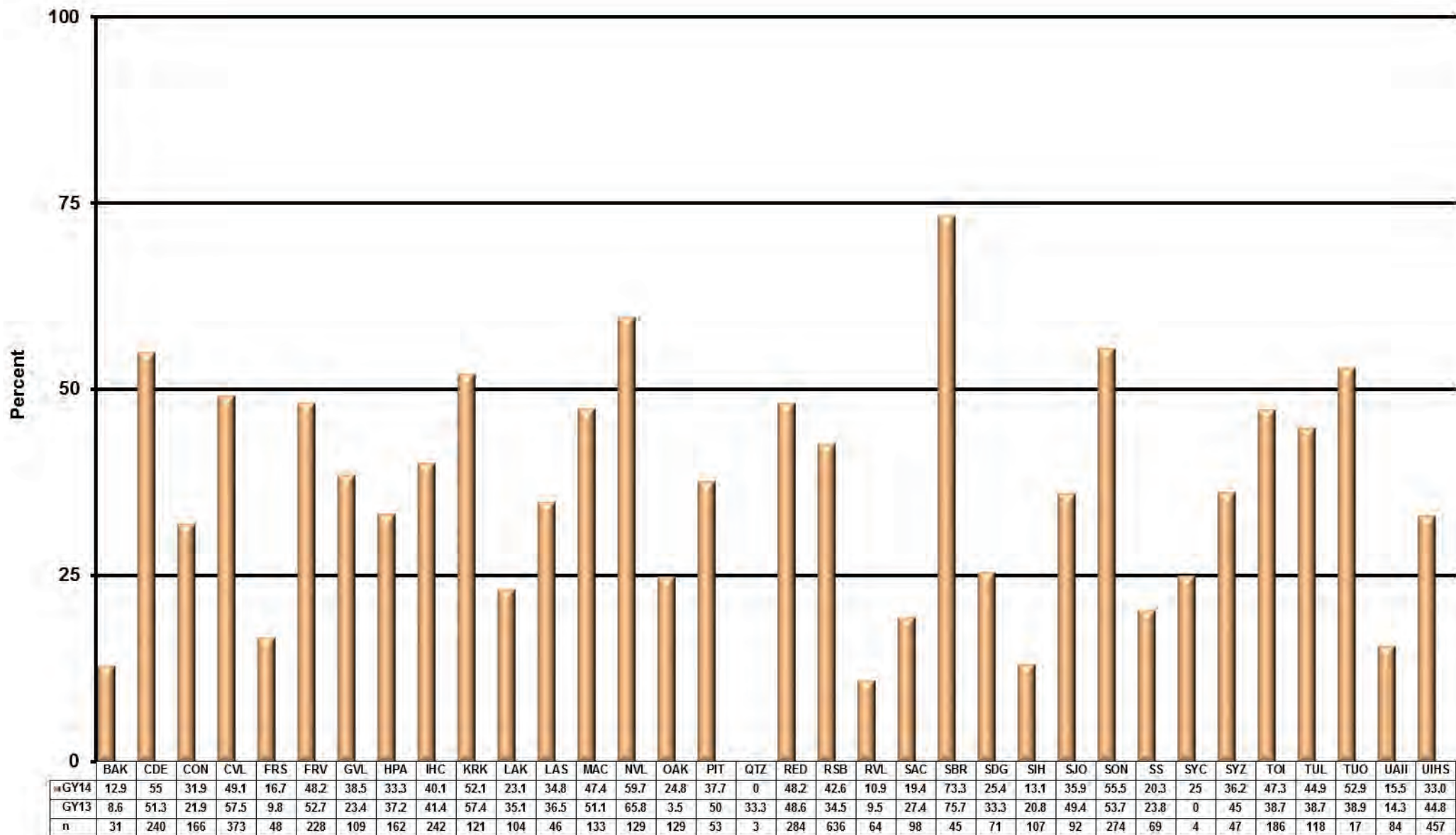
# CANCER SCREENING: BREAST (MAMMOGRAPHY)

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

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



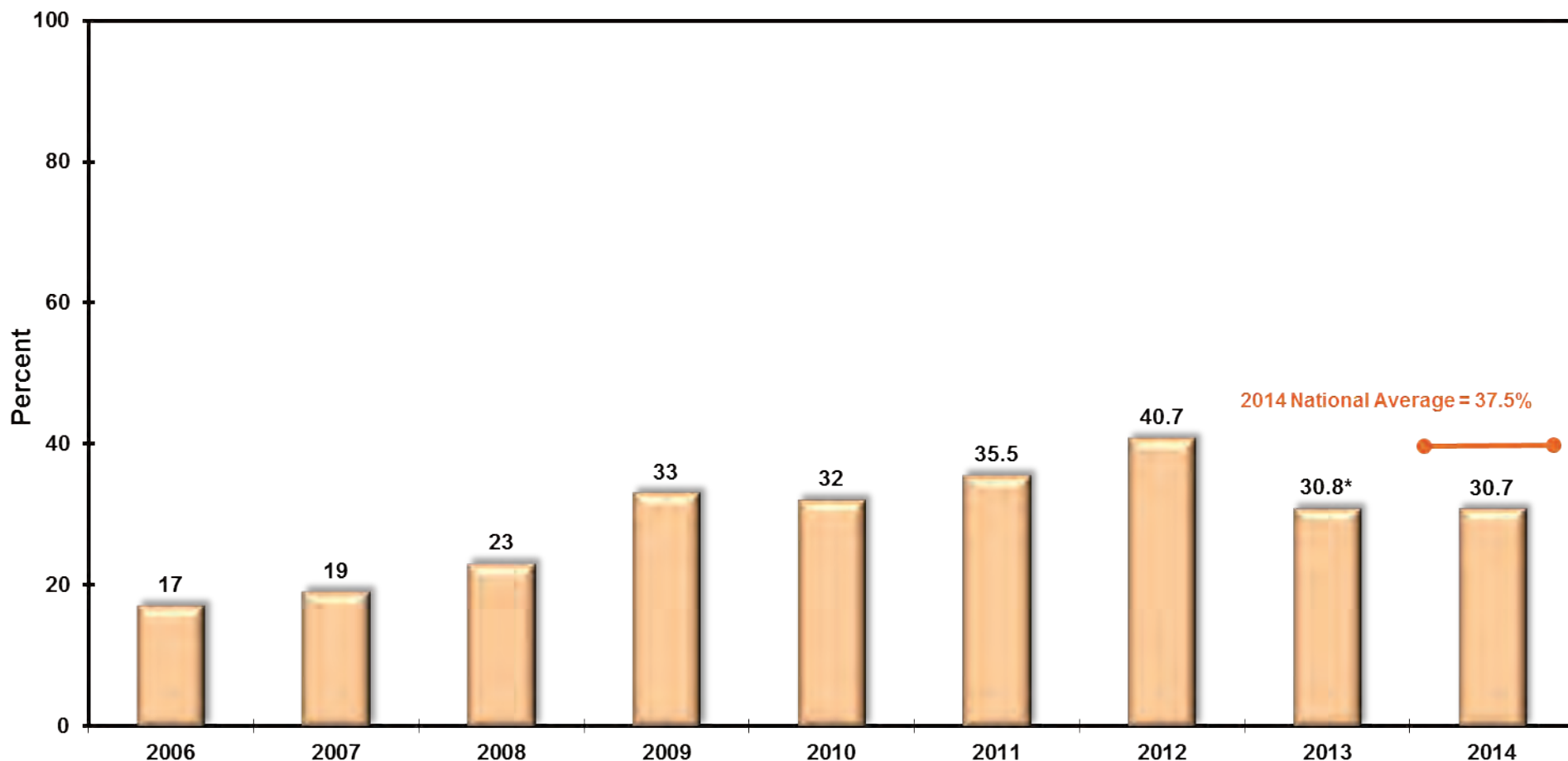
# CANCER SCREENING: BREAST (MAMMOGRAPHY)



# CANCER SCREENING: COLORECTAL

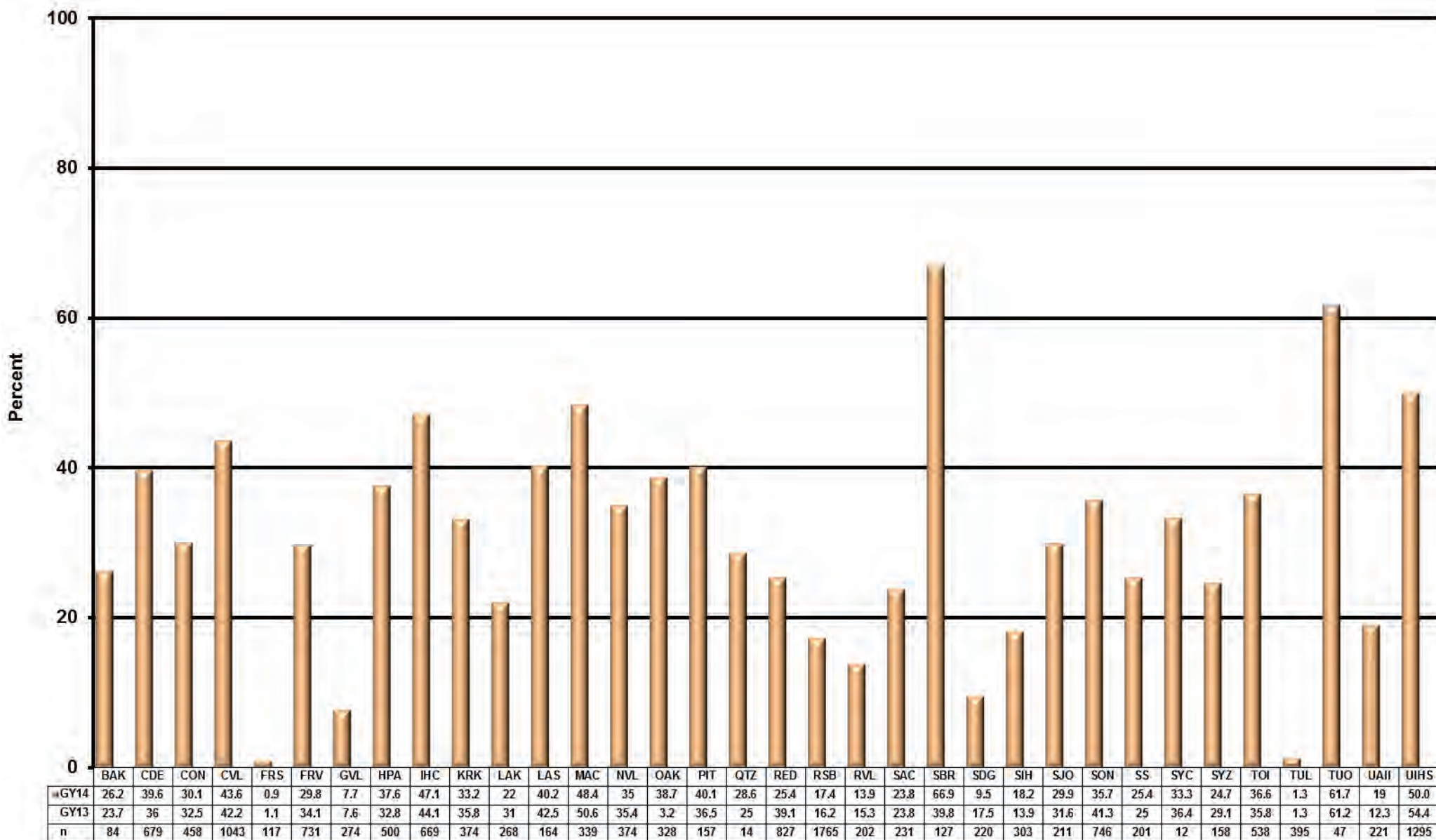
**Measure:** Percentage of eligible patients who have had appropriate colorectal cancer screening.

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



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

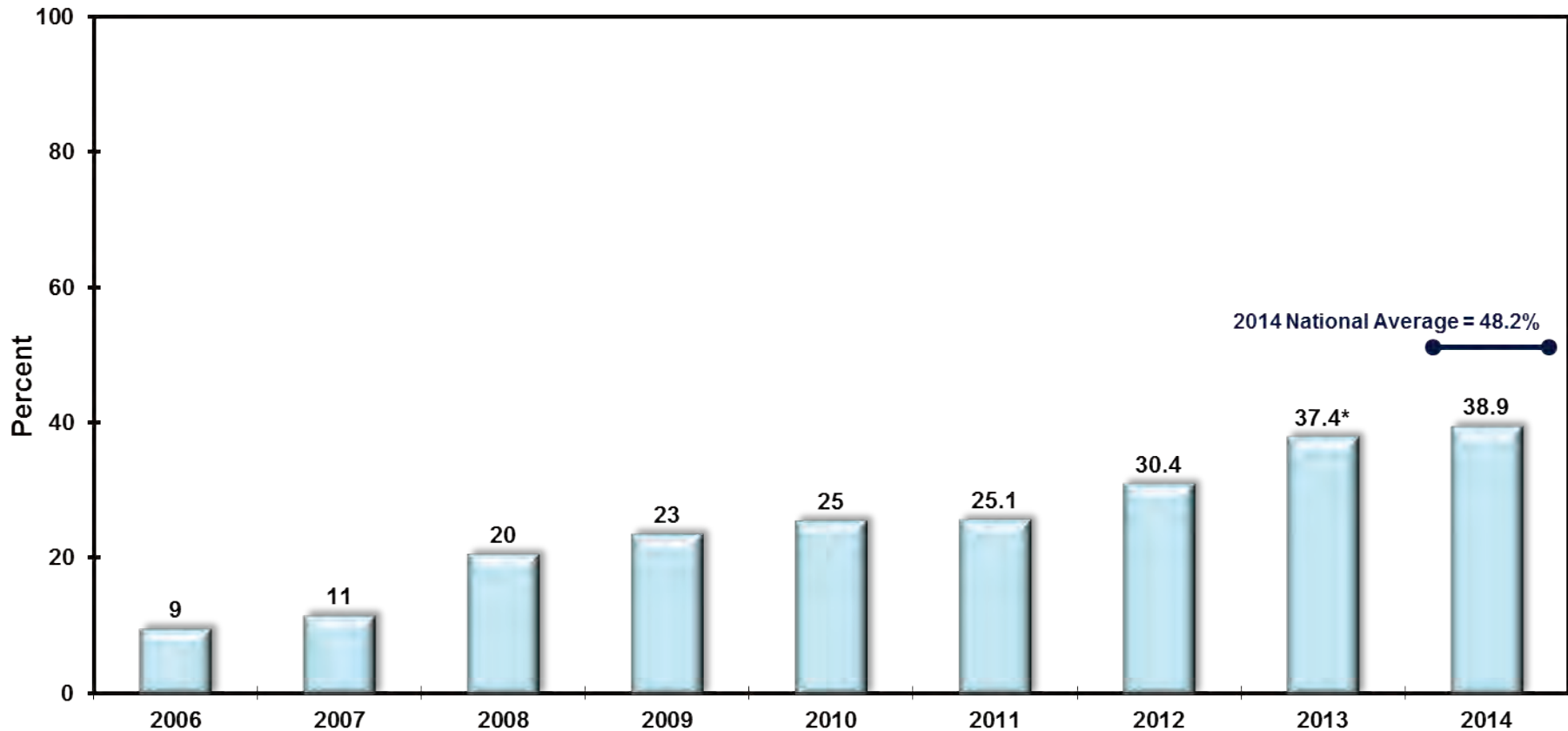
# CANCER SCREENING: COLORECTAL



# TOBACCO CESSATION

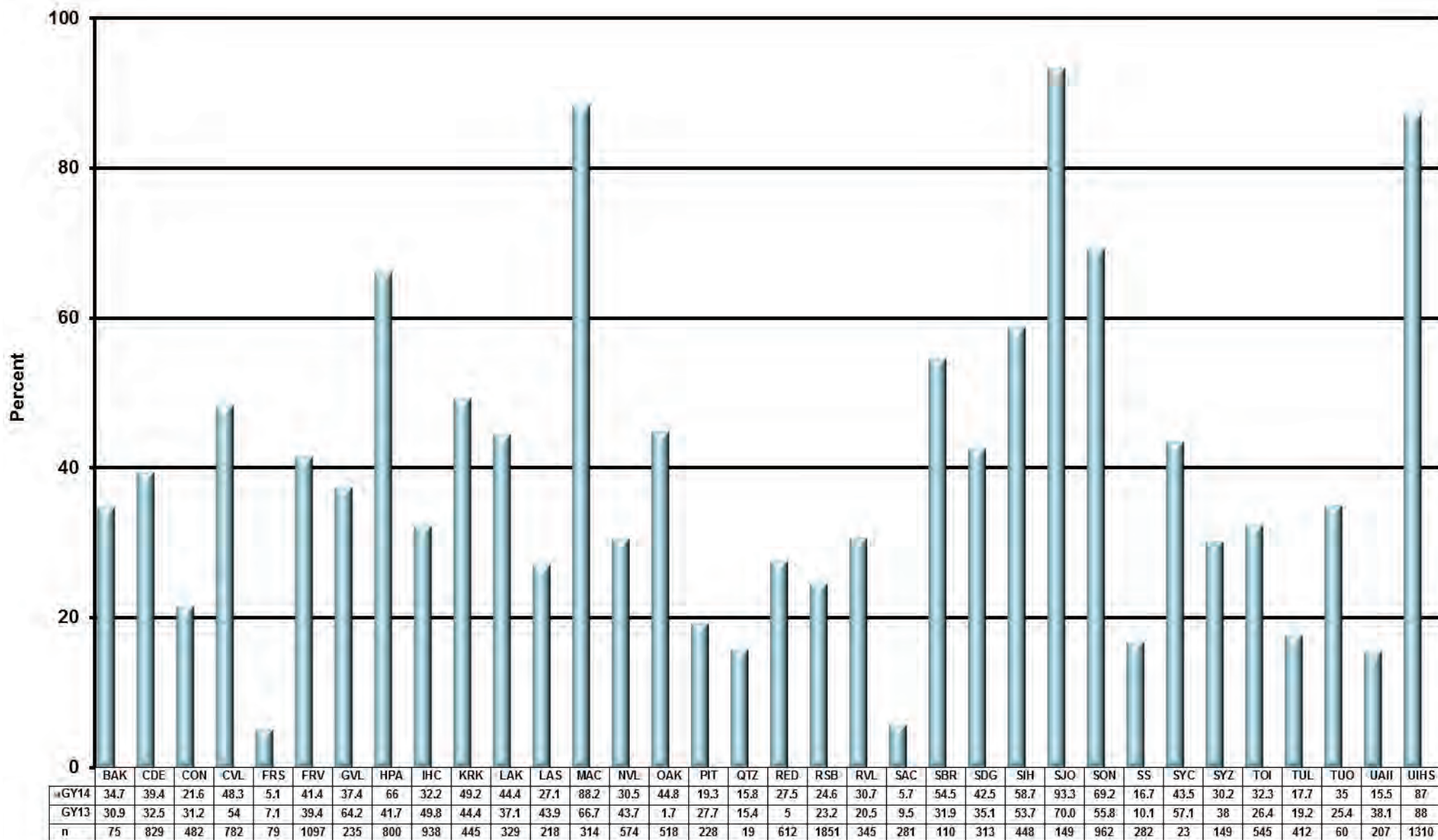
**Measure:** Percentage of tobacco-using patients that receive tobacco cessation intervention or quit.

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



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

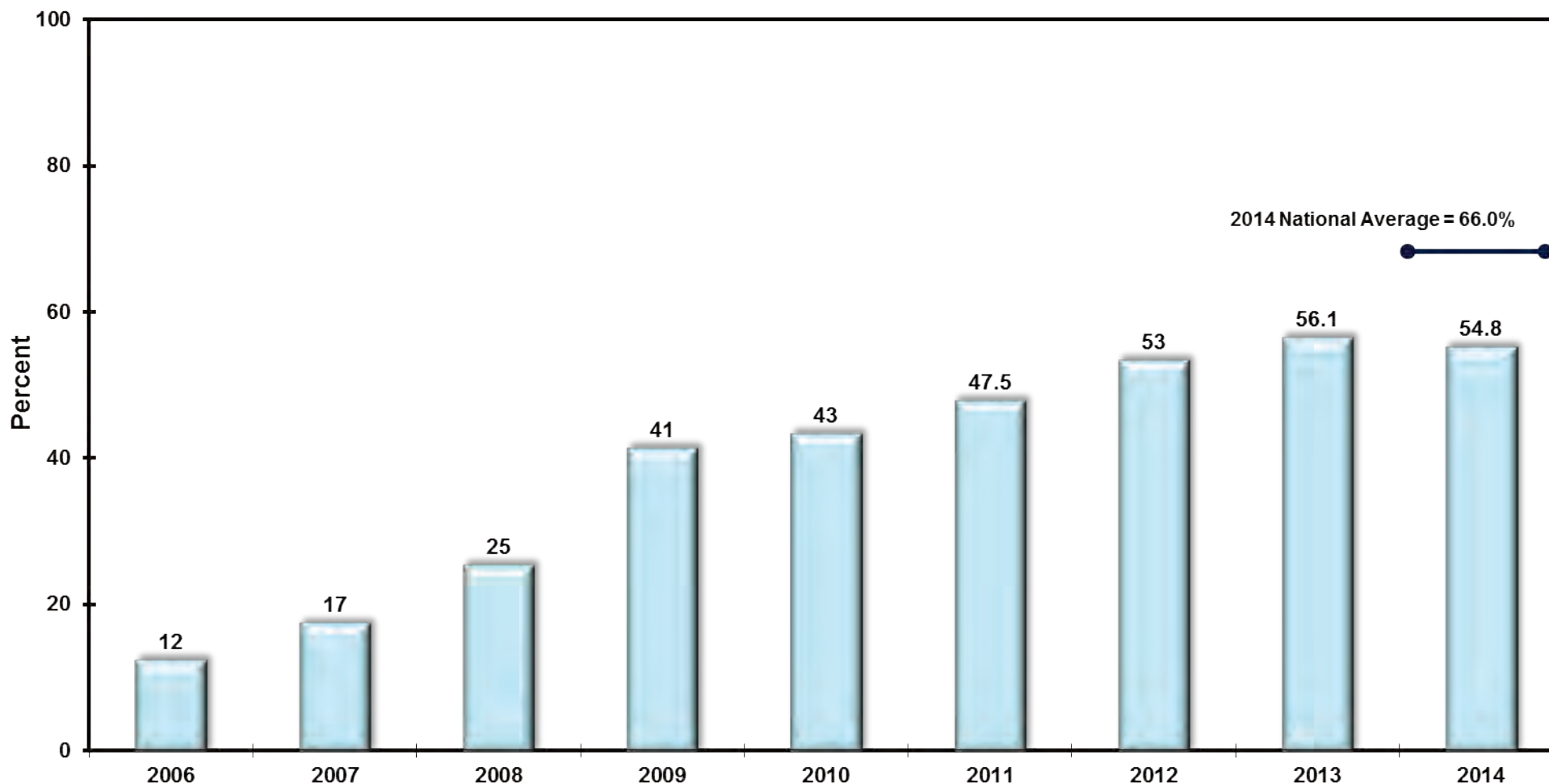
# TOBACCO CESSATION



# ALCOHOL SCREENING (FAS PREVENTION)

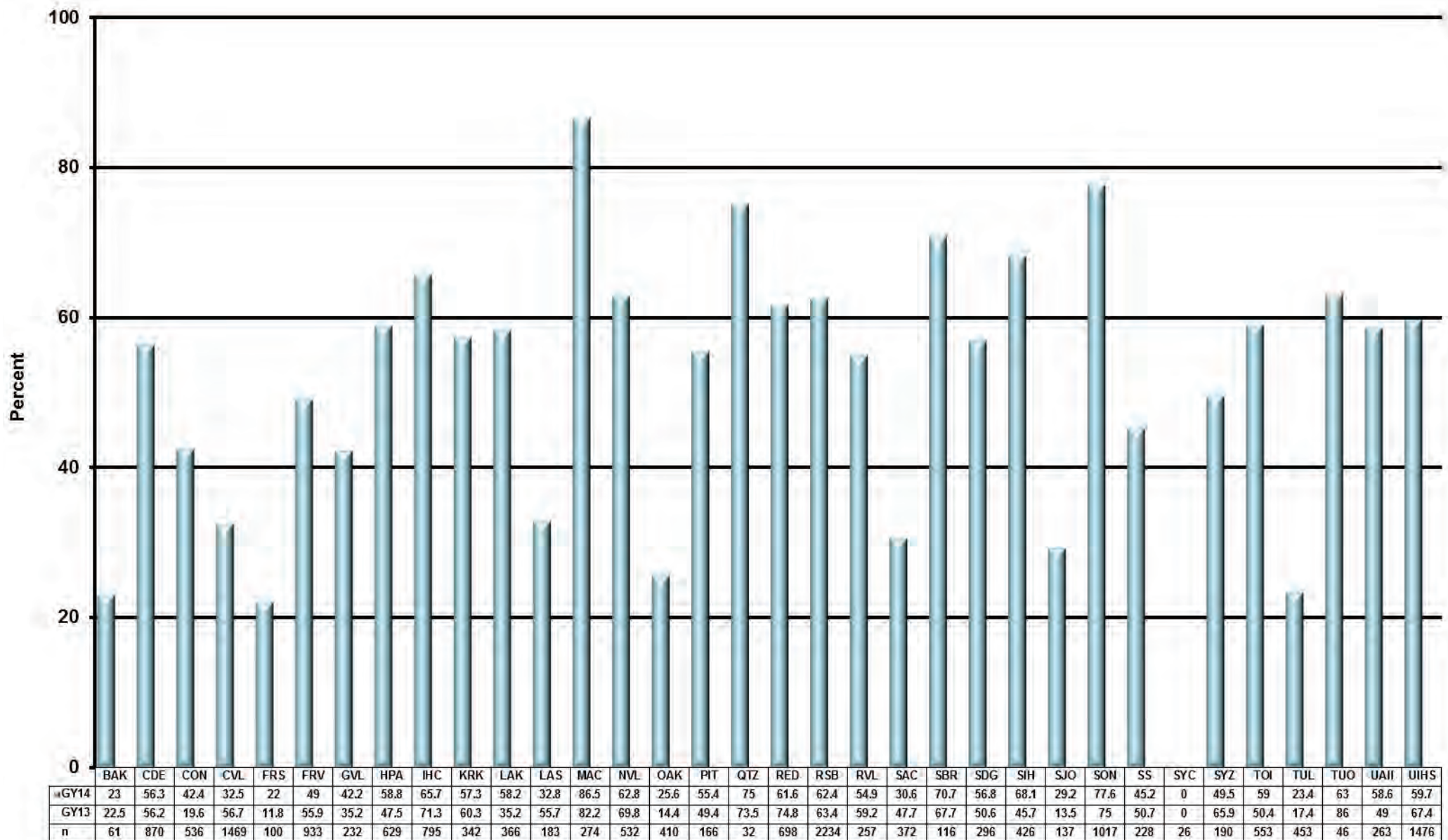
**Measure:** Percentage of women screened for alcohol use (to prevent Fetal Alcohol Syndrome)

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





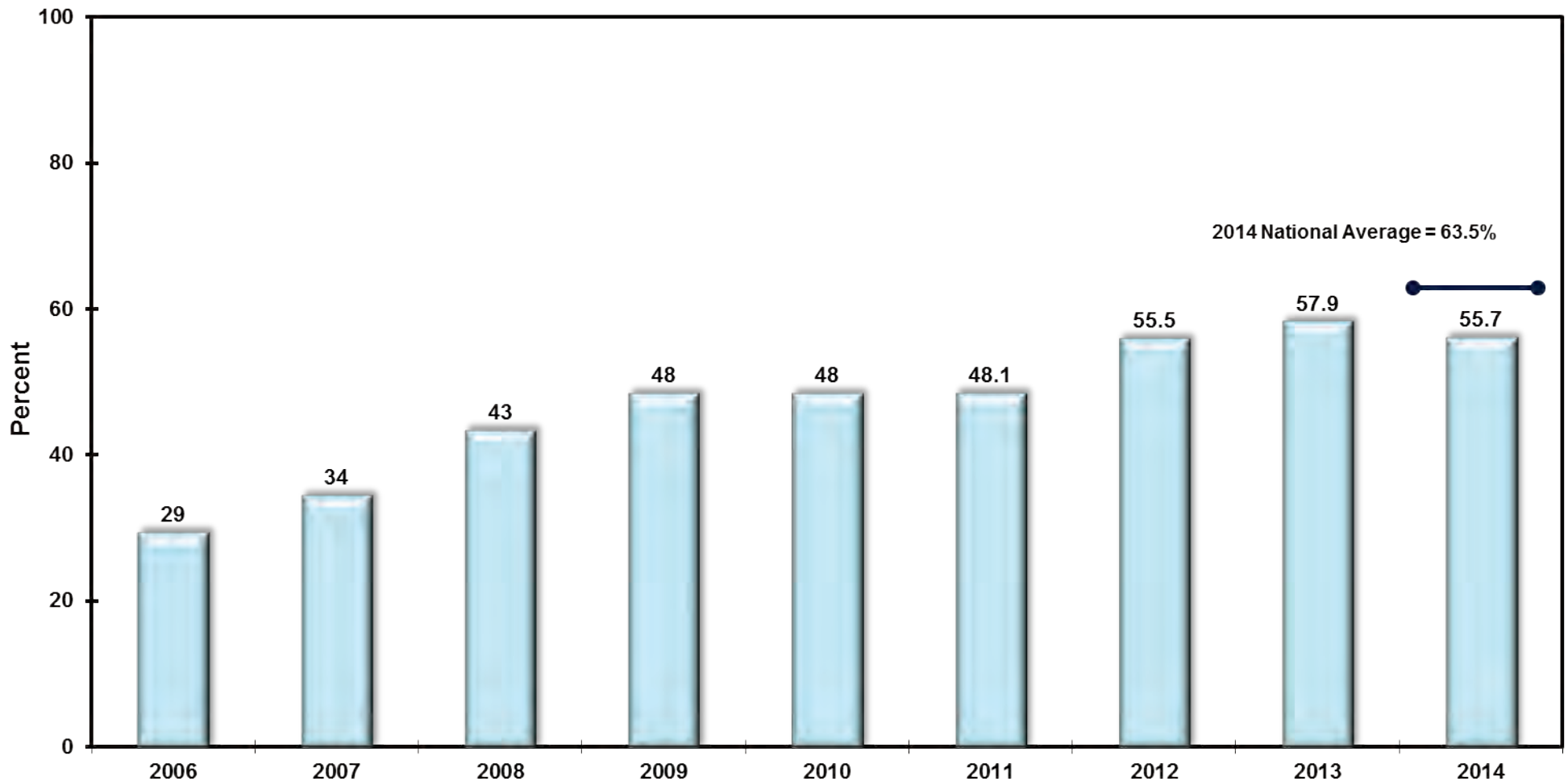
# ALCOHOL SCREENING (FAS PREVENTION)



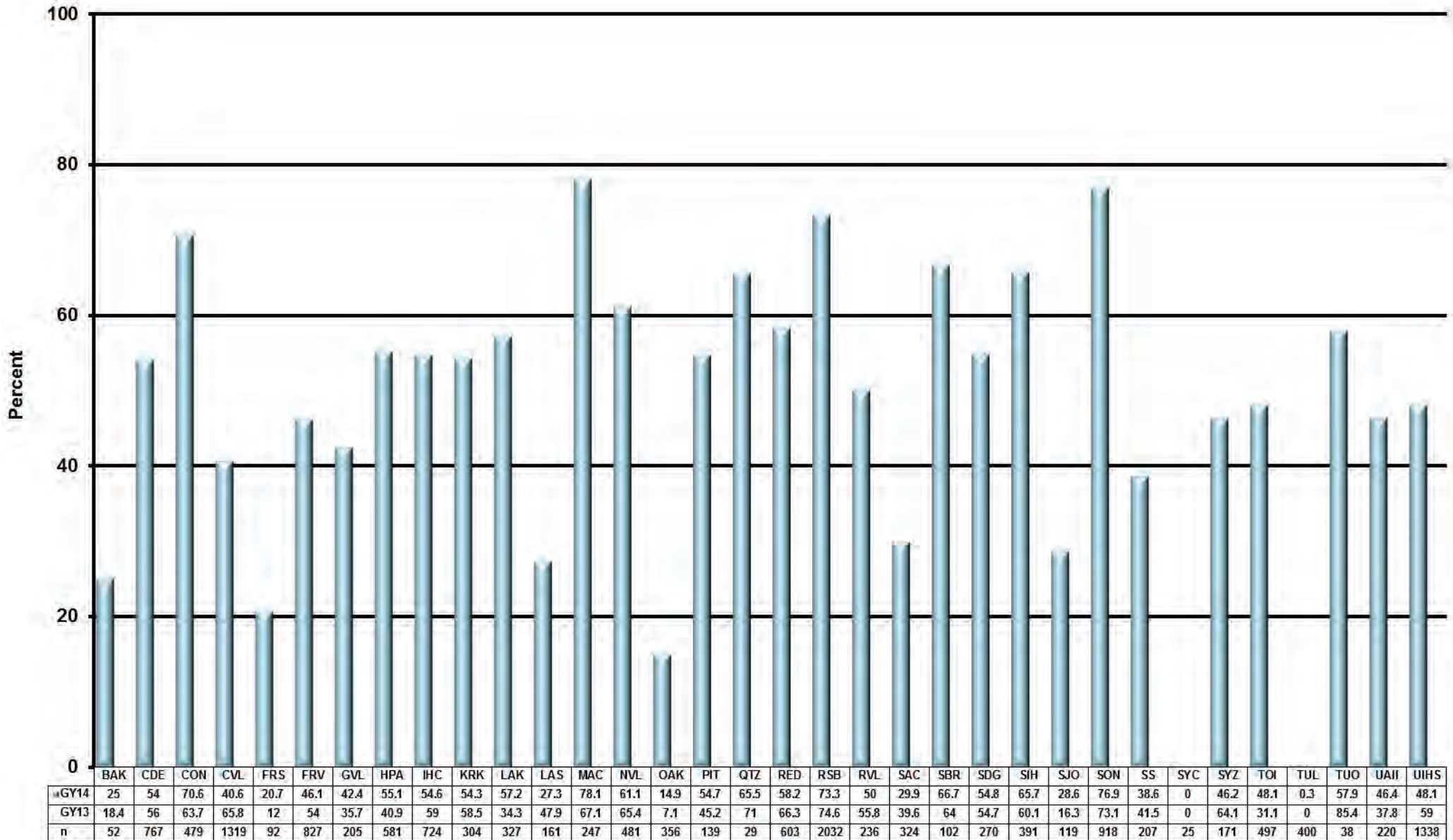
# DOMESTIC VIOLENCE/INTIMATE PARTNER VIOLENCE SCREENING

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

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



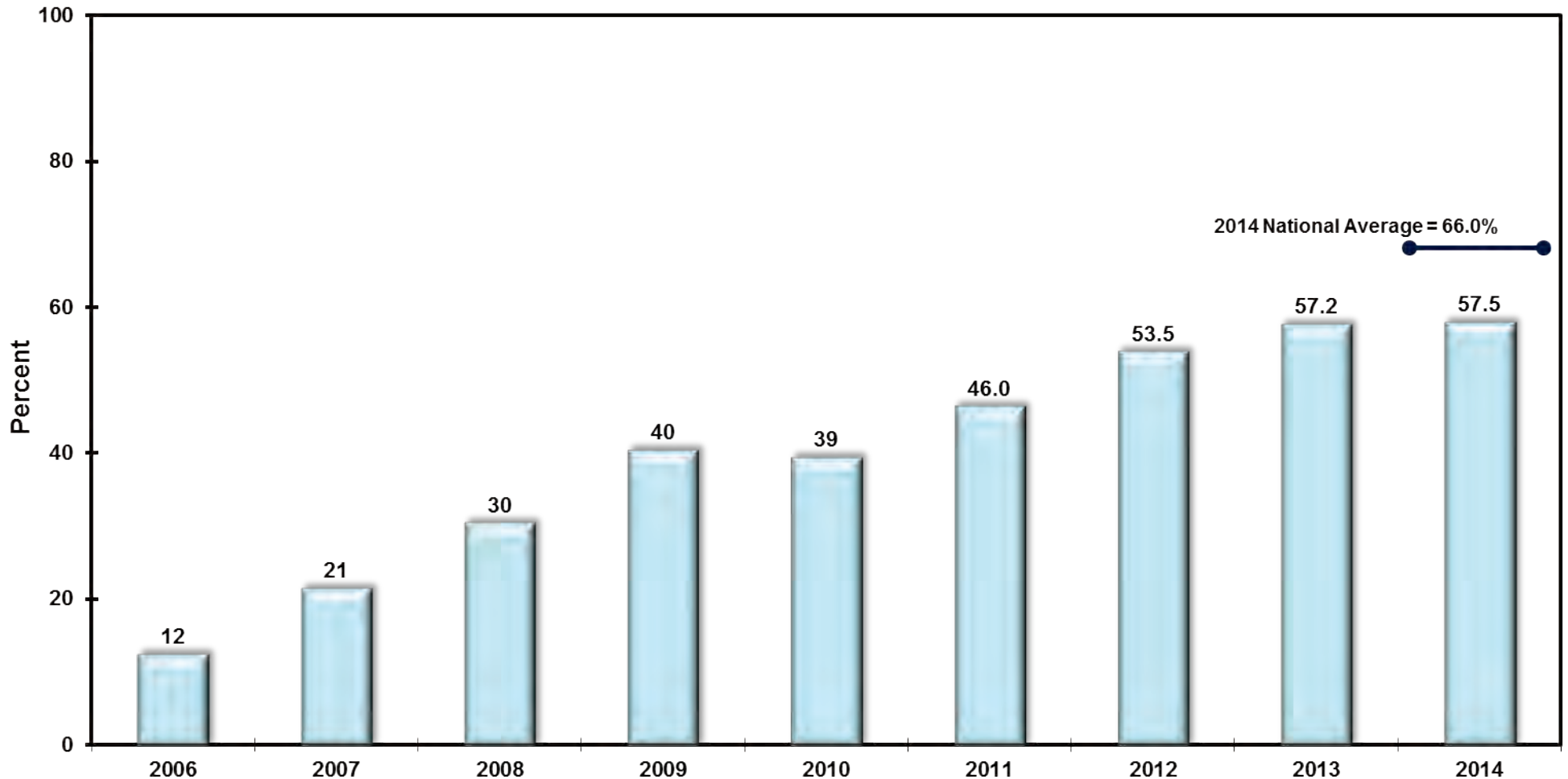
# DOMESTIC VIOLENCE/INTIMATE PARTNER VIOLENCE SCREENING



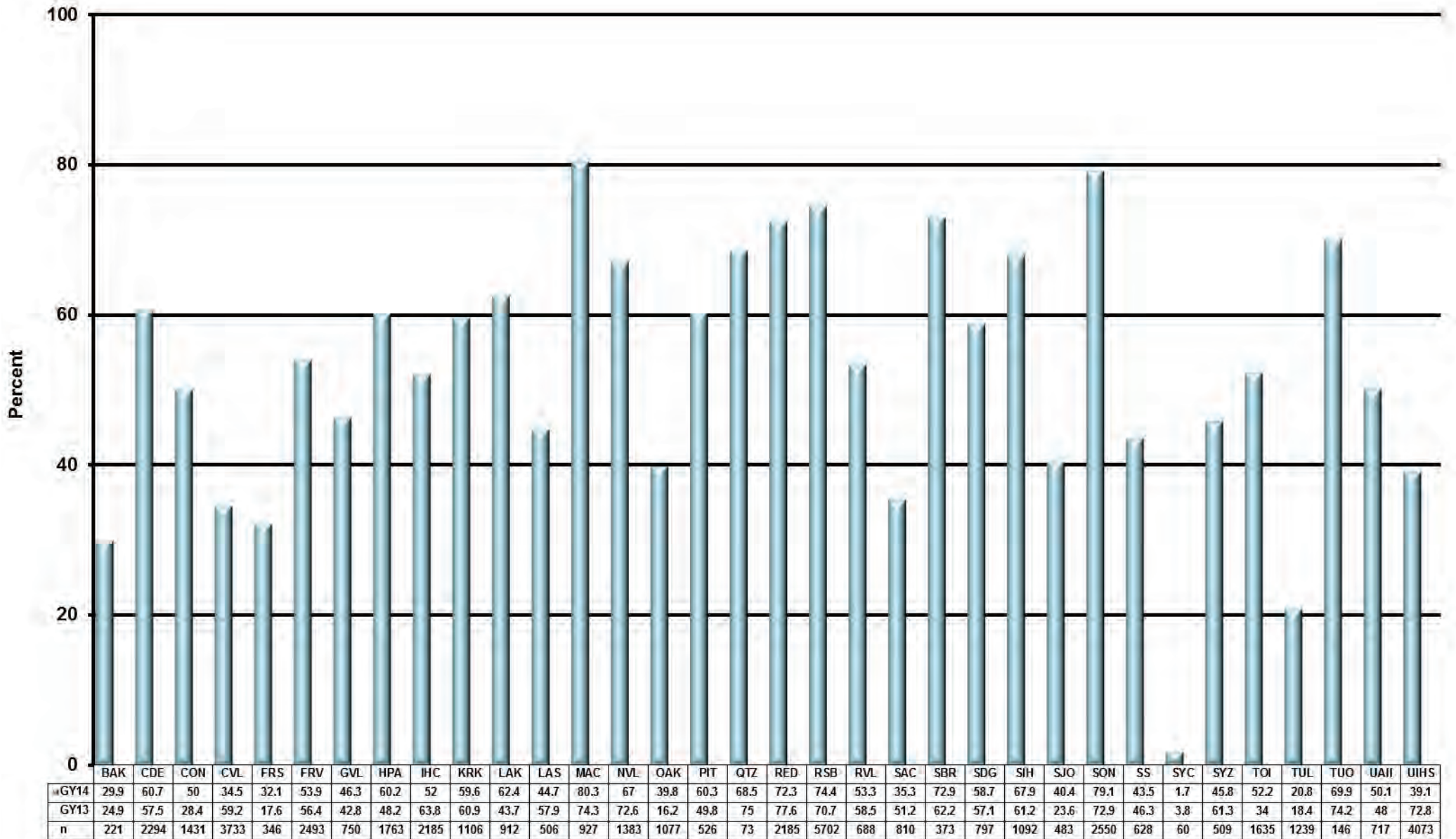
# DEPRESSION SCREENING

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

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



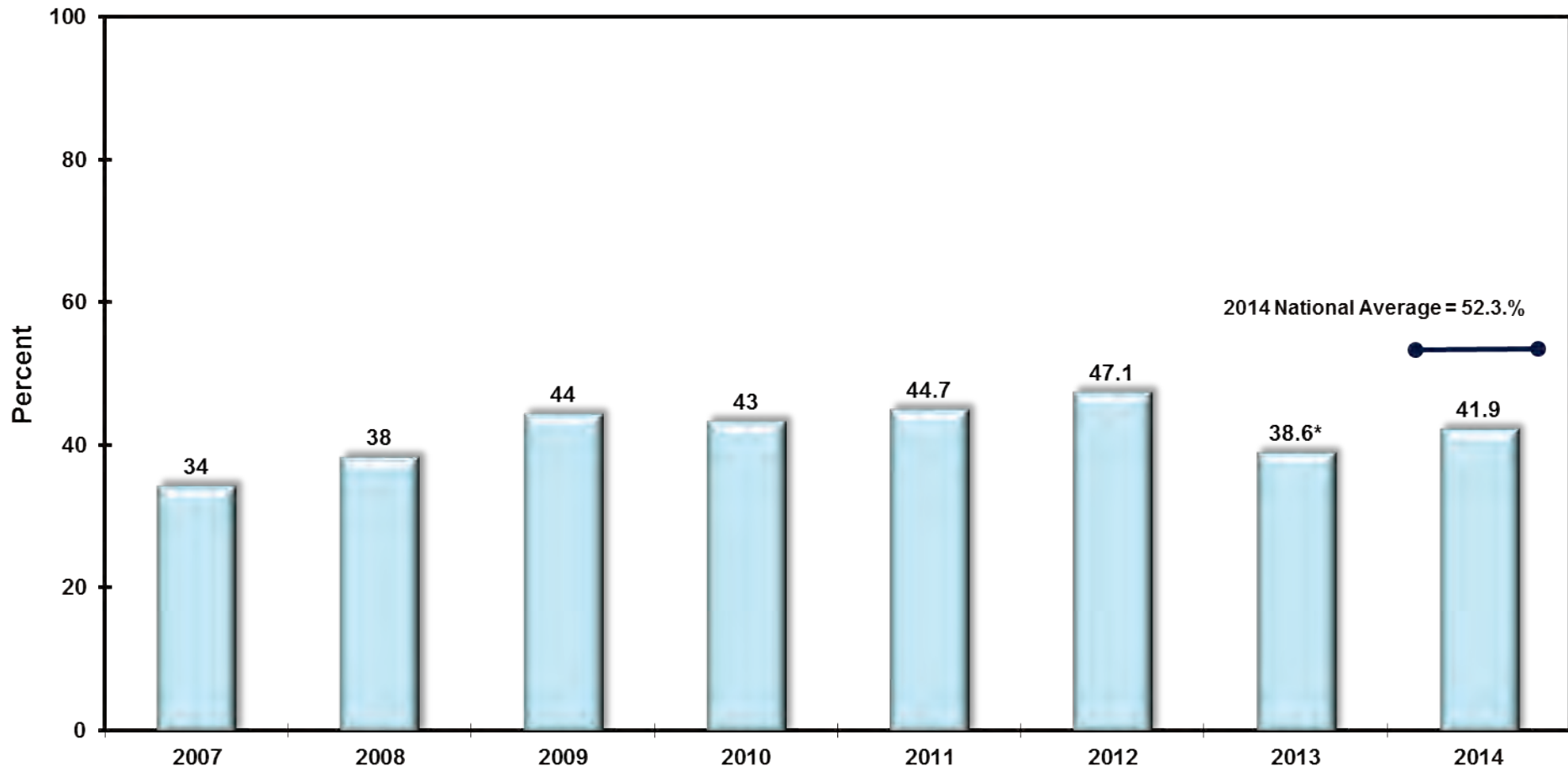
# DEPRESSION SCREENING



# CVD PREVENTION: COMPREHENSIVE ASSESSMENT

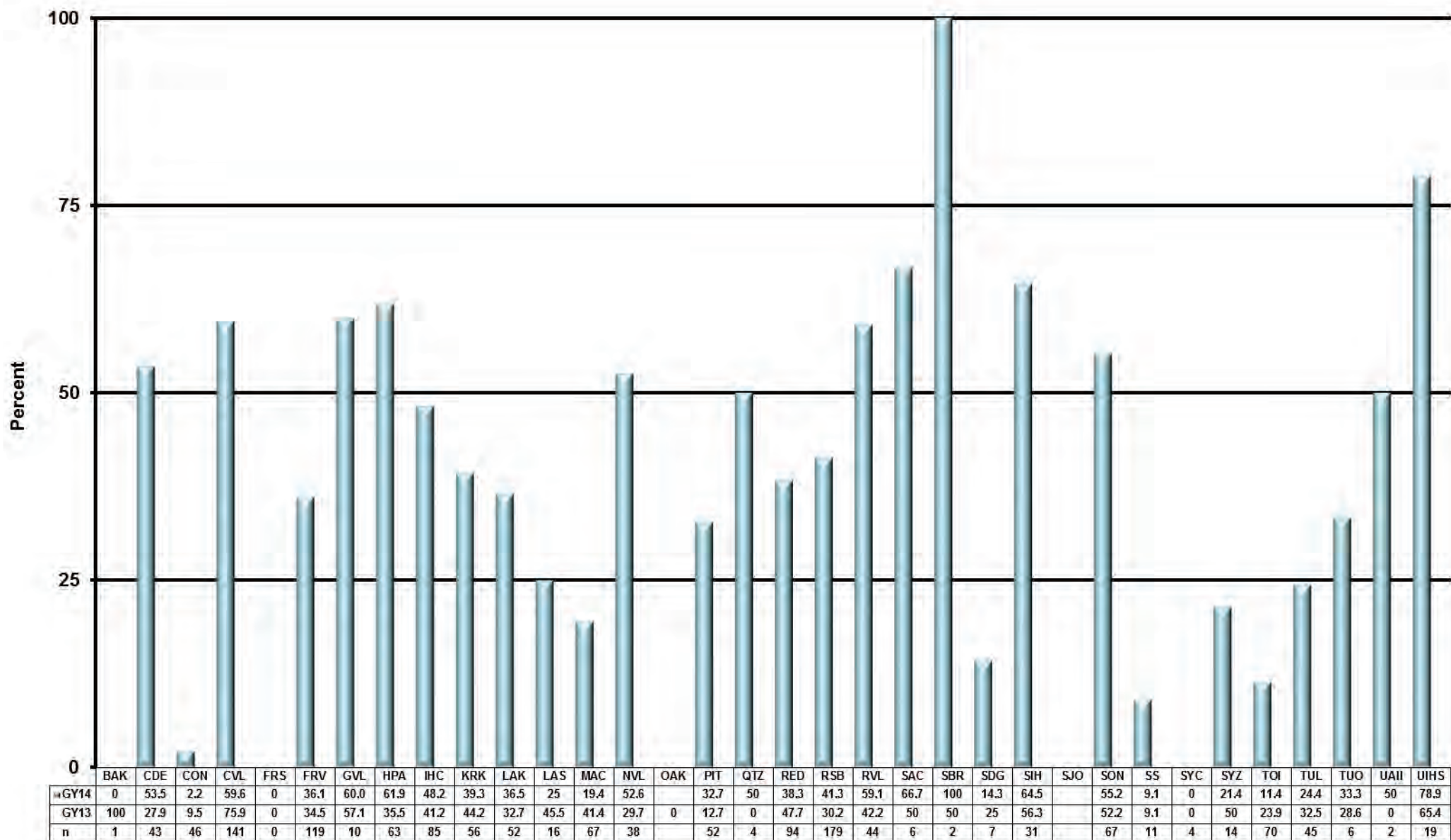
**Measure:** Percentage of CHD (Coronary Heart Disease) patients who have a comprehensive assessment for five CVD-related risk factors.

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



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

# CVD PREVENTION: COMPREHENSIVE ASSESSMENT

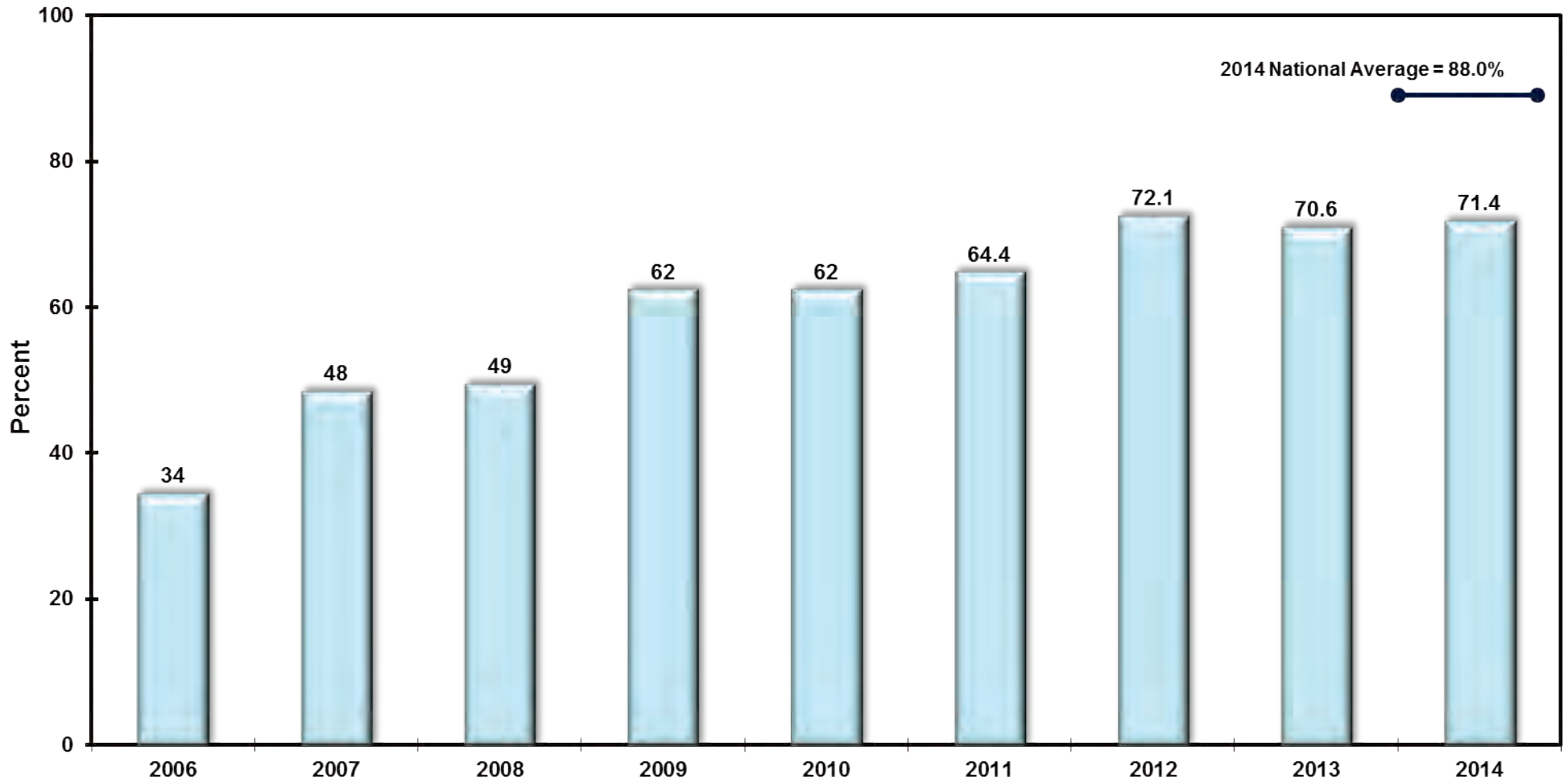


Note: Urban health programs are not required to report on this measure.

# PRENATAL HIV SCREENING

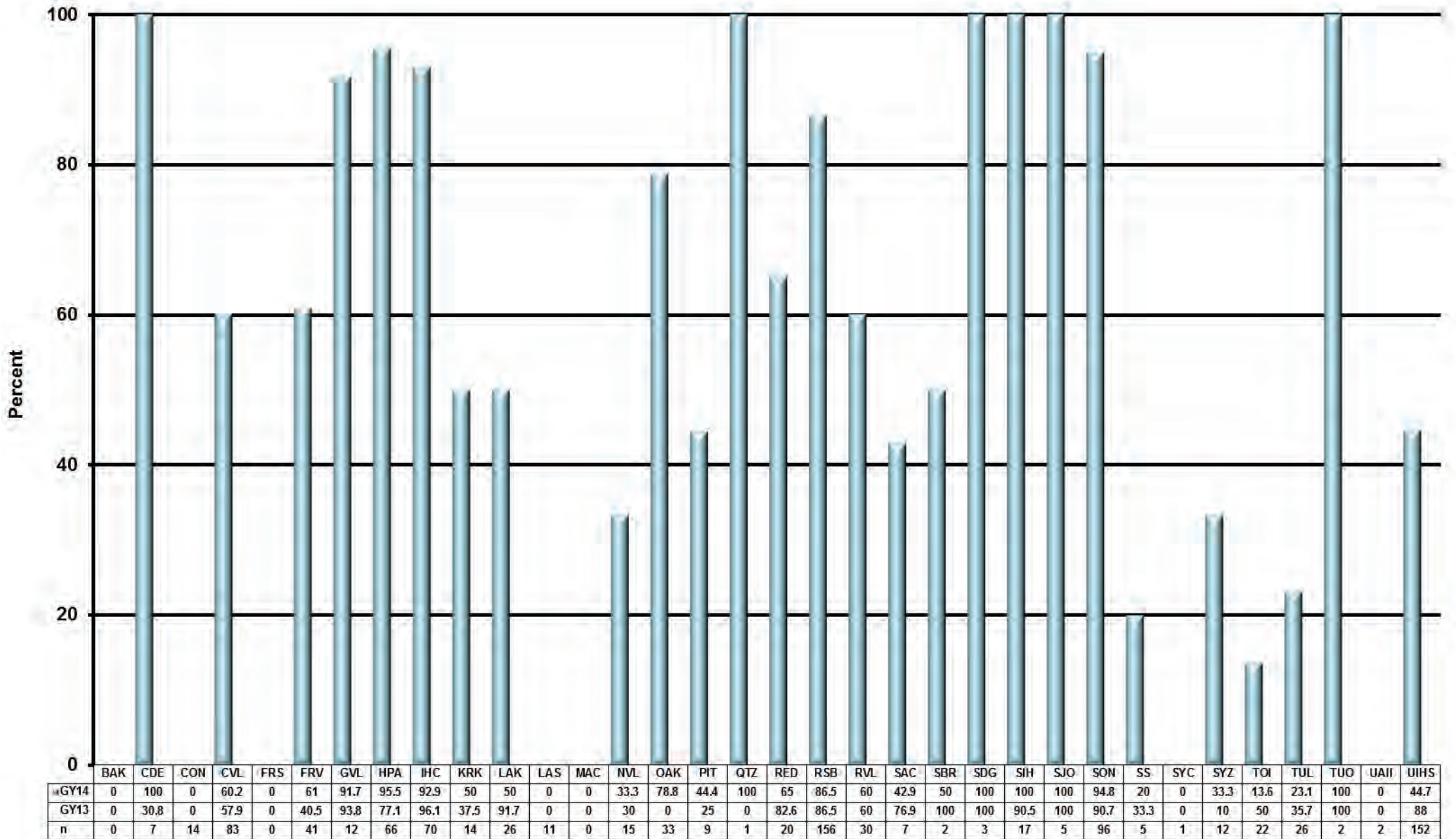
**Measure:** Percentage of pregnant women screened for HIV.

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





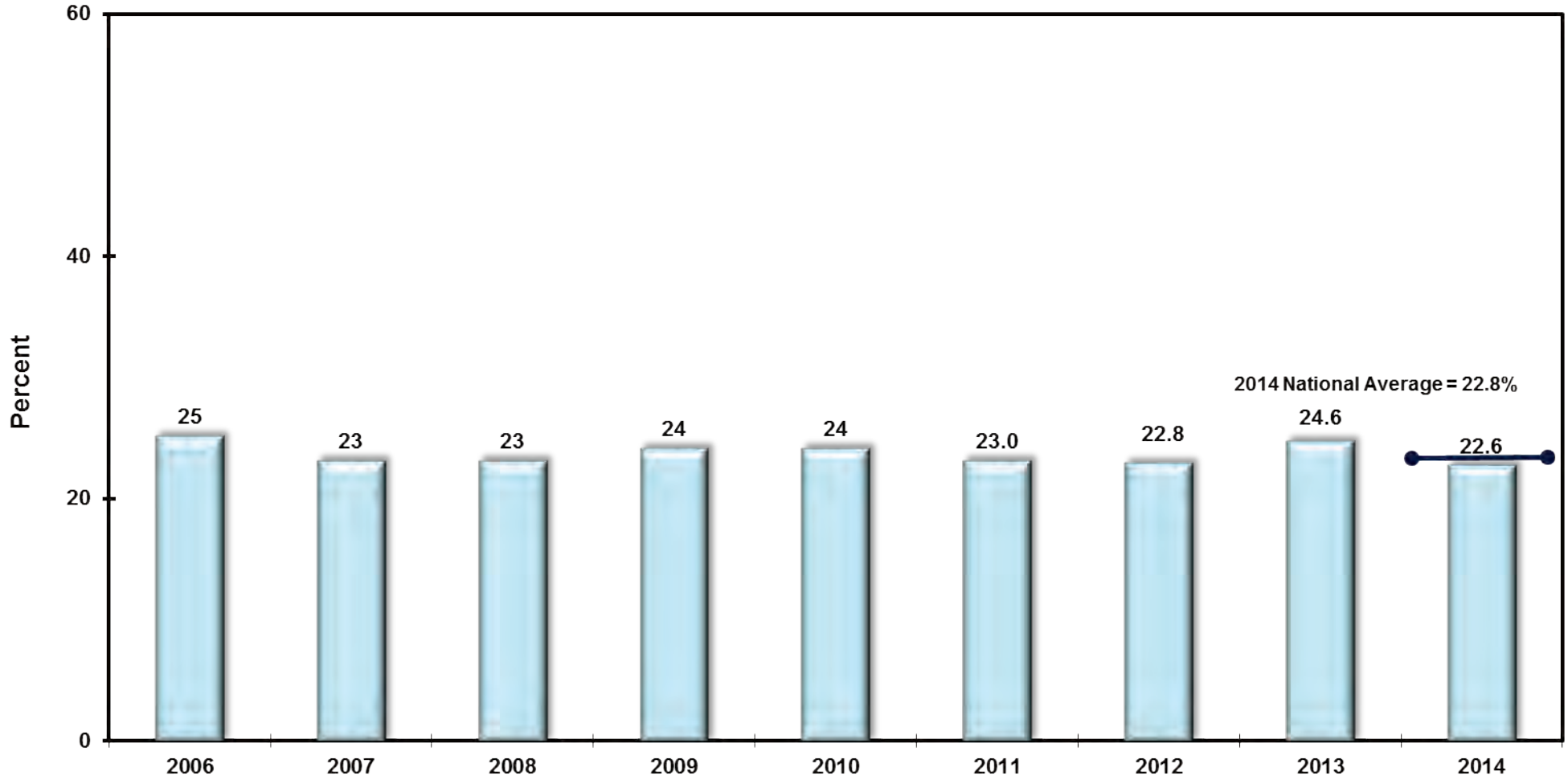
# PRENATAL HIV SCREENING



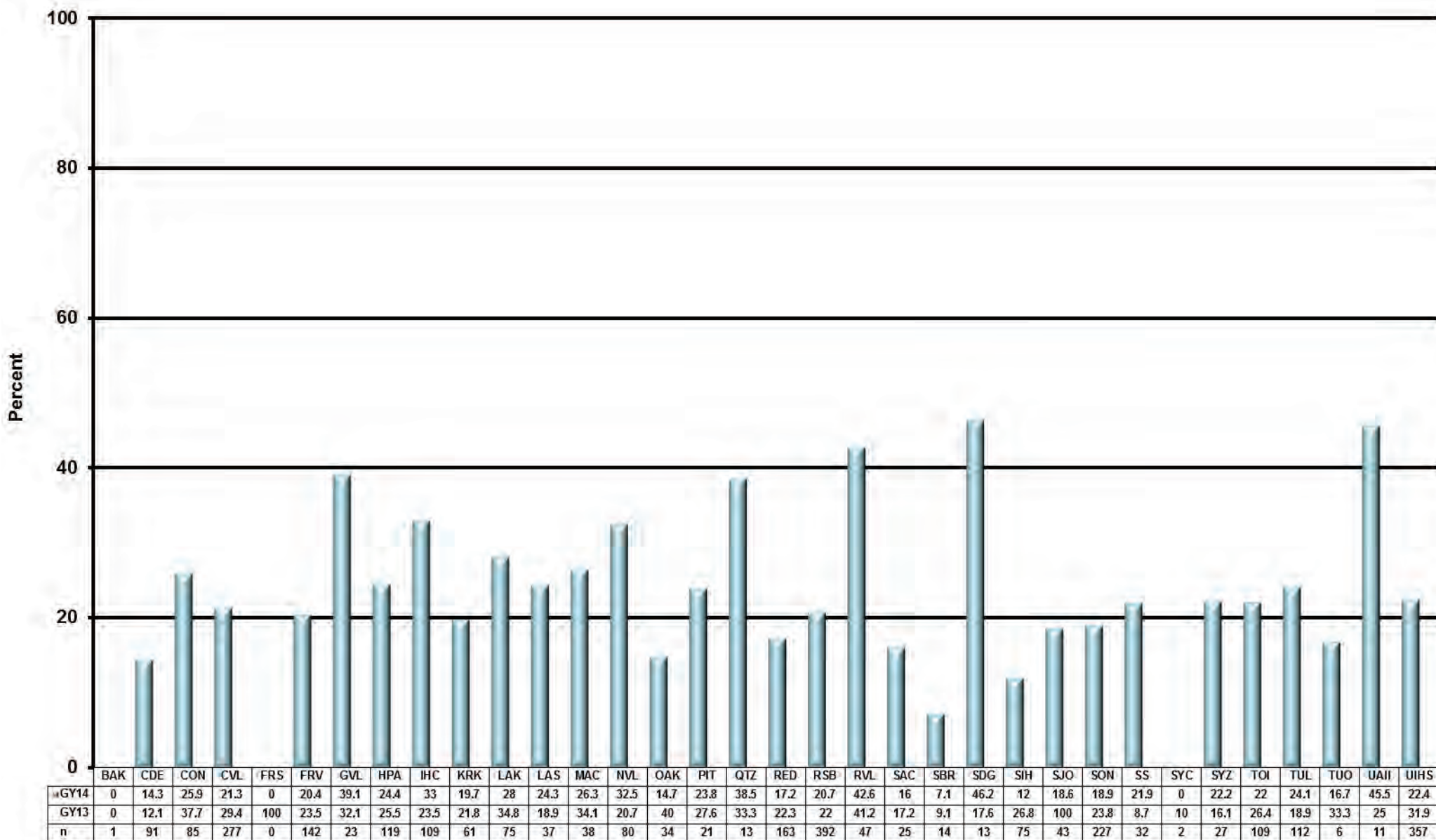
# CHILDHOOD WEIGHT CONTROL

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

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



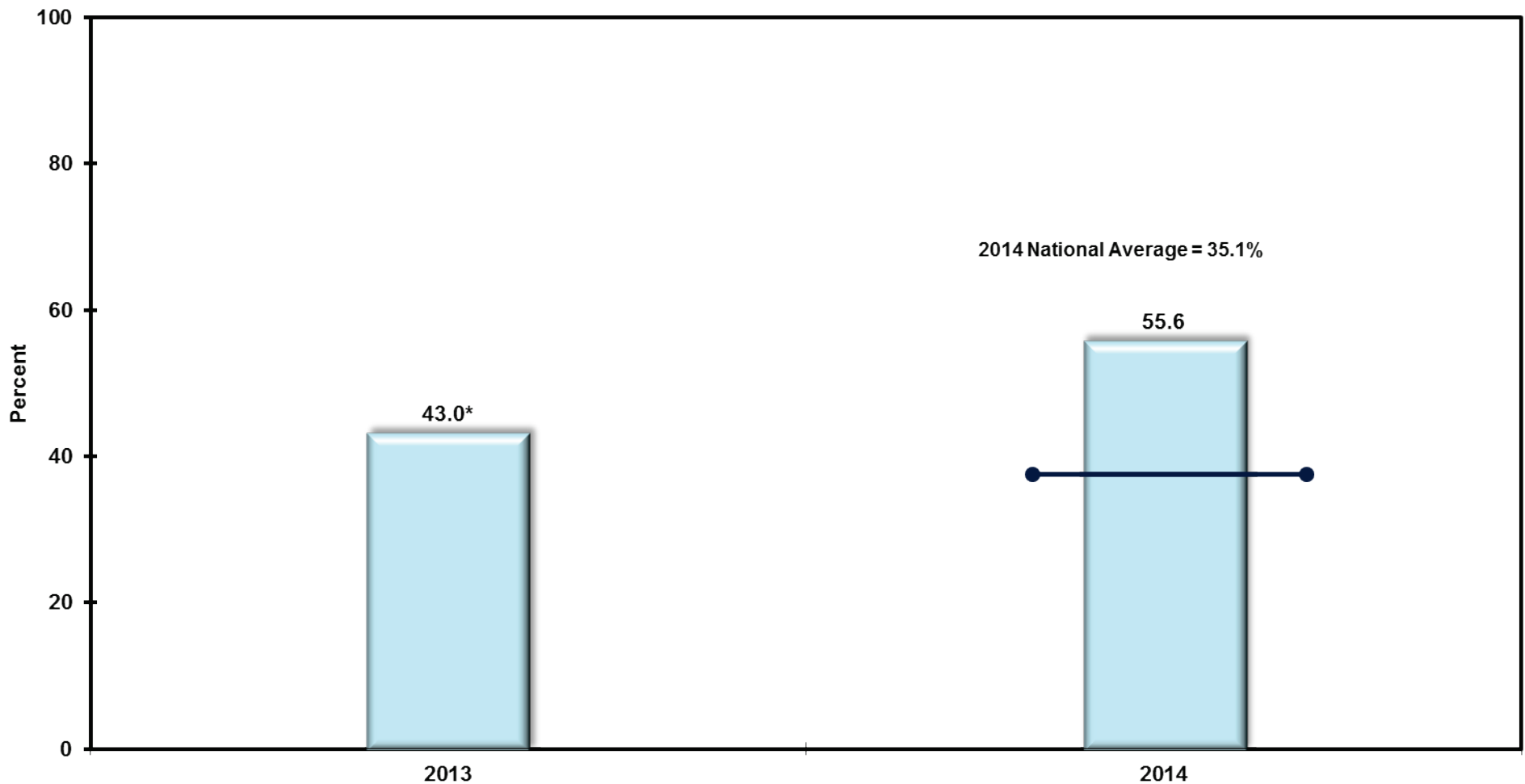
# CHILDHOOD WEIGHT CONTROL



# BREASTFEEDING RATES

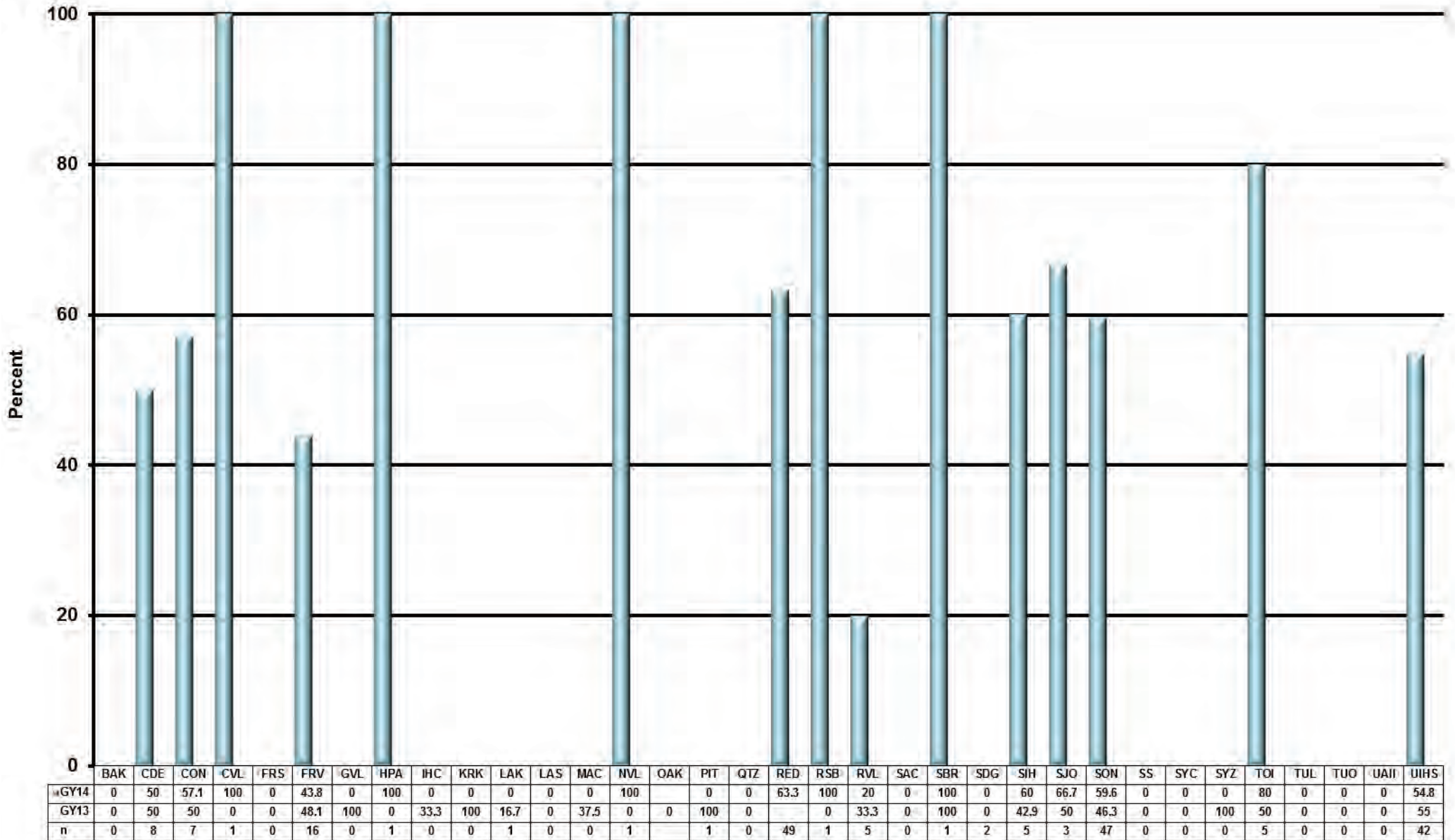
**Measure:** Percentage of patients who are exclusively or mostly breastfed at 2 months of age.

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



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

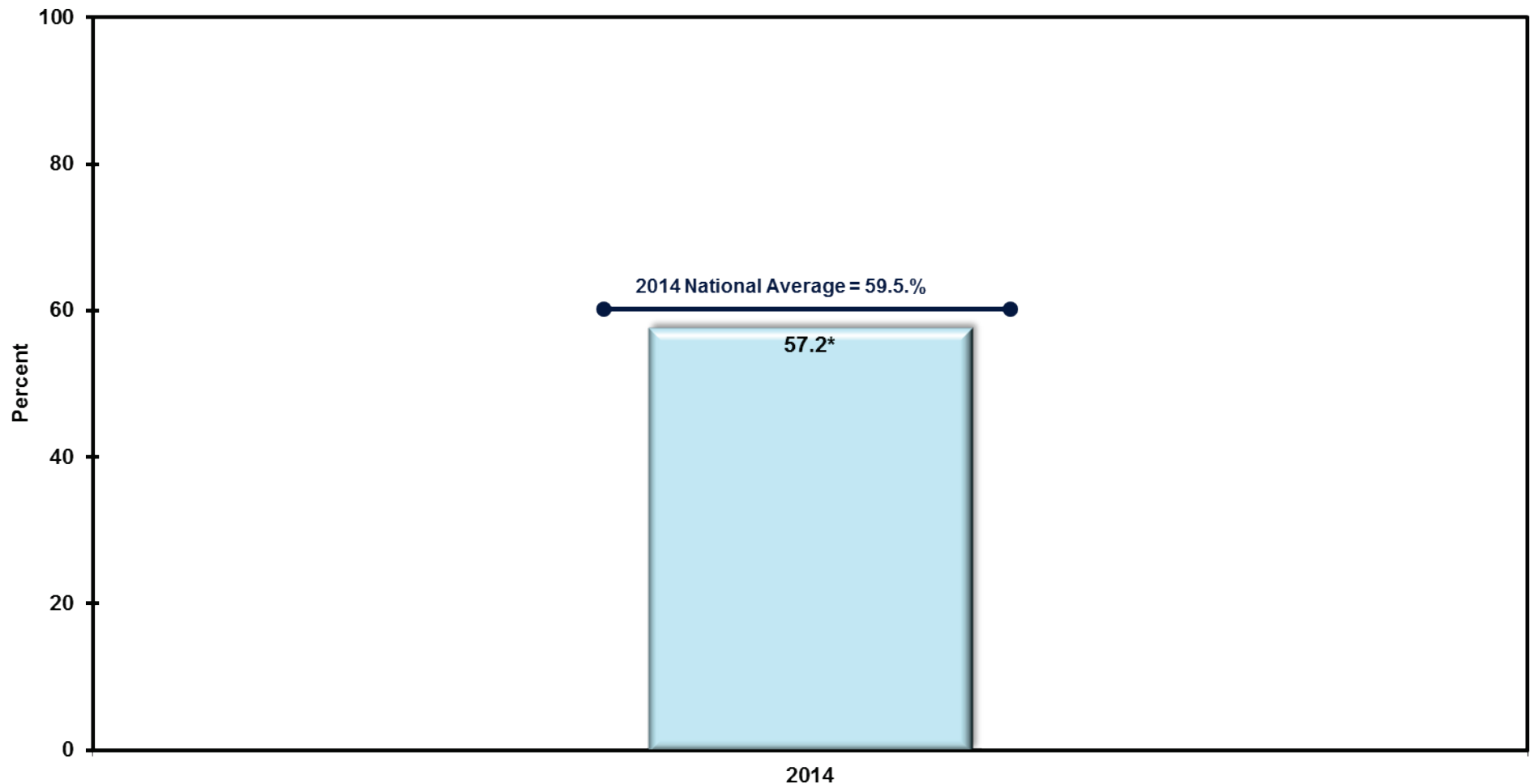
# BREASTFEEDING RATES



# CONTROLLING HIGH BLOOD PRESSURE (MILLION HEARTS)

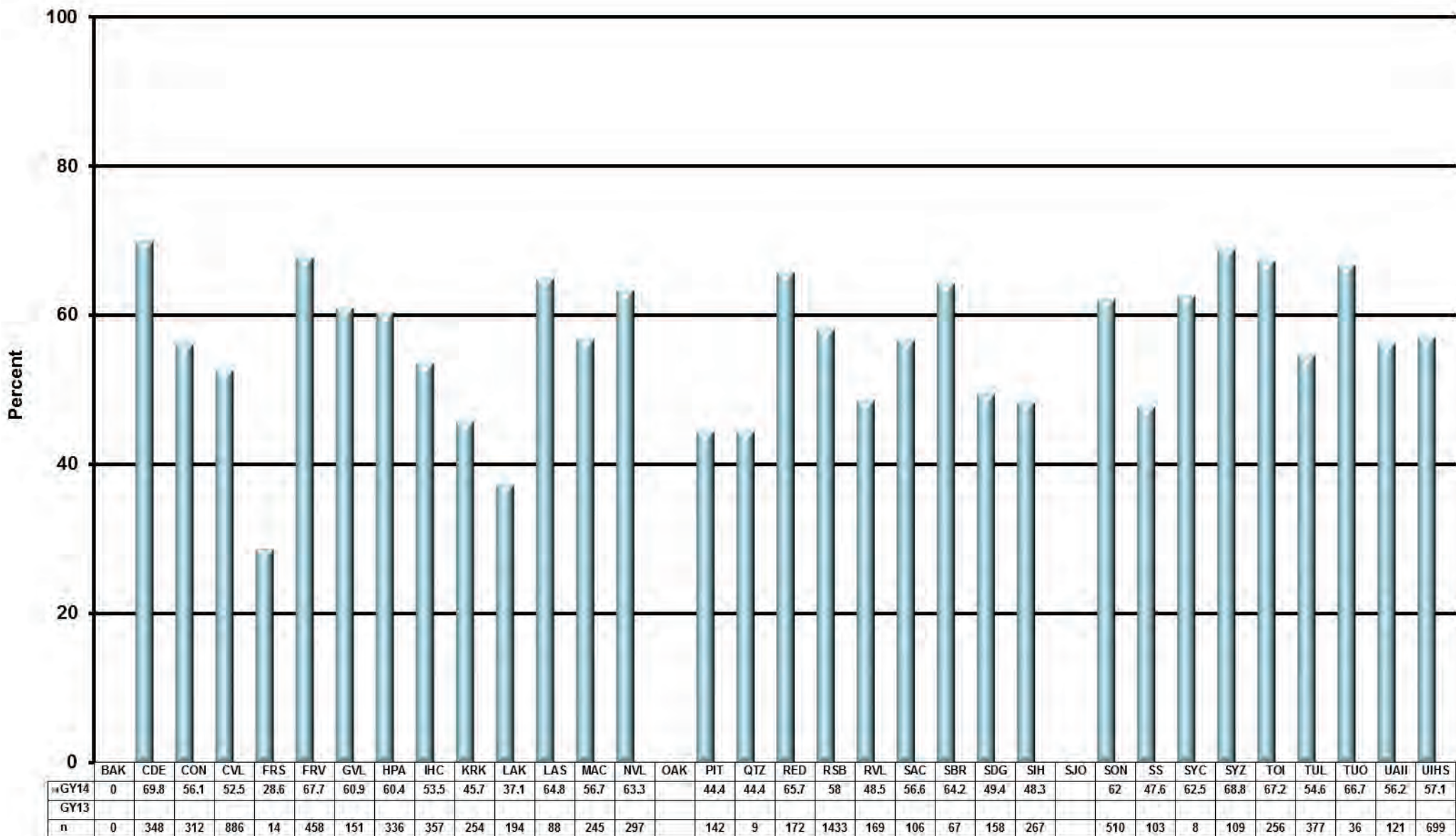
**Measure:** Percentage of patients with diagnosed hypertension who have achieved blood pressure control (<140/90).

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



\*New measure beginning in FY 2014

# CONTROLLING HIGH BLOOD PRESSURE (MH)



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



# APPENDIX

## TRIBAL DASHBOARD



# CALIFORNIA AREA TRIBAL DASHBOARD

2014 Final GPRA Dashboard					
	California Area	California Area	National	National	2014 Final
	2014 Final	2013 Final	2014 Final	2014 Target	Results - California Area
<b>DIABETES</b>					
Diabetes Dx Ever	10.9%	10.8%	14.0%	N/A	N/A
Documented A1c	84.3%	85.7%	85.7%	N/A	N/A
<b>Good Glycemic Control</b>	48.8%	51.5%	48.6%	48.3%	Met
Controlled BP <140/90	62.9%	64.5%	63.8%	64.6%	Not Met
LDL Assessed	70.6%	71.9%	73.4%	73.9%	Not Met
Nephropathy Assessed <sup>a</sup>	49.8%	61.3%	60.0%	Baseline	Met
Retinopathy Exam	51.2%	50.2%	59.9%	58.6%	Not Met
<b>DENTAL</b>					
Dental Access	40.5%	41.2%	28.8%	29.2%	Met
Sealants	16.9%	13.7%	14.6%	13.9%	Met
Topical Fluoride	30.8%	30.0%	27.9%	26.7%	Met
<b>IMMUNIZATIONS</b>					
Influenza 65+	55.7%	57.5%	68.1%	69.1%	Not Met
Pneumovax 65+ <sup>a</sup>	77.4%	83.9%	85.7%	Baseline	Met
<b>Childhood IZ</b>	58.3%	62.2%	75.4%	74.8%	Not Met
<b>PREVENTION</b>					
Pap Screening <sup>a</sup>	45.4%	54.8%	54.6%	Baseline	Met
Mammography Screening	42.9%	42.6%	54.2%	54.7%	Not Met
Colorectal Cancer Screening	30.7%	30.8%	37.5%	35.0%	Not Met
Tobacco Cessation	38.9%	37.4%	48.2%	45.7%	Not Met
Alcohol Screening (FAS Prevention)	54.8%	56.1%	66.0%	65.9%	Not Met
DV/IPV Screening	55.7%	57.9%	63.5%	64.1%	Not Met
<b>Depression Screening</b>	57.5%	57.2%	66.0%	66.9%	Not Met
<b>CVD-Comprehensive Assessment</b>	41.9%	38.6%	52.3%	51.0%	Not Met
Prenatal HIV Screening	71.4%	70.6%	88.0%	89.1%	Not Met
Childhood Weight Control <sup>b</sup>	22.6%	24.6%	22.8%	N/A <sup>b</sup>	N/A
Breastfeeding Rates	55.6%	43.0%	35.1%	29.0%	Met
Controlling High Blood Pressure	57.2%	N/A	59.5%	Baseline	Met
<sup>a</sup> Measure logic revised in FY 2014 <sup>b</sup> Long-term measure as of FY 2009, next reported in FY 2016					Measures Met = 9 Measures Not Met = 13
Measures in red are GPRAMA measures					





