California American Indian/Alaska Native Community Health Profile

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Attention:

All data in this report should be interpreted with caution and reported accurately. Some of the data are not reliable estimates due to low participant numbers/rates, and many confidence intervals overlap. For questions please contact CTEC staff at 916-929-9761 or epicenter@crihb.org.

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**IMPORTANT TERMS**

**Active User:** An American Indian or Alaskan Native enrolled member or descendant of a federally recognized tribe, who has had a reportable medical or dental visit to an Indian Health Service (IHS) system provider within the last three fiscal years.

**AIAN:** American Indian and Alaska Native.

**BRFSS:** Behavioral Risk Factor Surveillance System. This survey is conducted by the Centers for Disease Control and Prevention every year in multiple states.

**CDC:** Centers for Disease Control and Prevention.

**CHIS:** California Health Interview Survey. This survey is the nation's largest state health survey, and is conducted every two years on a wide range of health topics.

**CI:** 95% confidence interval. A confidence interval is an interval specifying a range within which the real value is estimated to be, showing the precision of the estimate. A 95% confidence interval means that if the data collection and analysis could be replicated, the CI should include within it the correct value 95% of the time. All confidence intervals contained in this report are 95% confidence intervals.

**Eligibility of California Indians:** California has additional, specific eligibility criteria in addition to national Indian Health Service criteria. In general, the following California Indians shall be eligible for health services provided by the Indian Health Service:

1. Any member of a federally recognized Indian Tribe.
2. Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant--
   A. Is a member of the Indian community served by a local program of the Service; and
   B. Is regarded as an Indian by the community in which such descendant lives.
3. Any Indian who holds trust interests in public domain, national forest, or reservation allotments in California.
4. Any Indian in California who is listed on the plans for distribution of the assets of rancherias and reservations located within the State of California under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

**Eligibility for Indian Health Service (IHS) Services:** A person may be regarded as within the scope of the Indian health program if they are not otherwise excluded by provision of law, and:

1. Is of American Indian and/or Alaska Native descent as evidenced by one or more of the following:
   A. Is regarded by the community in which he/she lives as an American Indian or Alaska Native;
   B. Is a member, enrolled or otherwise, of an American Indian or Alaska Native Tribe or Group under Federal supervision;
   C. Resides on tax-exempt land or owns restricted property;
   D. Actively participates in tribal affairs;
   E. Any other reasonable factor indicative of Indian descent; or
2. Is an Indian of Canadian or Mexican origin recognized by any Indian tribe or group as a member of an Indian community served by the Indian Health program; or
3. Is a non-Indian woman pregnant with an eligible Indian's child for the duration of her pregnancy through post partum (usually 6 weeks); or
4. Is a non-Indian member of an eligible Indian's household and the medical officer in charge determines that services are necessary to control a public health hazard or an acute infectious which constitutes a public health hazard

**Ethnicity:** A social group characterized by a distinctive social and cultural tradition, maintained within the group from generation to generation, a common history and origin; and a sense of identification with the group. Members of the group have distinctive features in their way of life, shared experiences, and often a common genetic heritage (Last, 2001). See also Race.

**Federal Trust Responsibility:** The federal government has a trust responsibility to provide health care for American Indians and Alaska Natives, based on multiple treaties, court decisions, and legislative acts (Roubideaux, 2002).

**IHS:** Indian Health Service. There are 12 IHS Administrative Areas in the United States.

**IHSPM:** IHS Performance Measure. A set of performance indicators developed by the IHS, as part of the Government Performance Results Act (GPRA) to measure the progress in improving the health status of AIAN.

**Race:** Having distinct physical characteristics. Biologic classification of human races is difficult because of significant genetic overlaps among population groups. Social scientists have challenged the biologic definition of race, arguing that the concept of race most often reflects social and ideological conventions. However, race is a useful concept from the public health perspective because some diseases are strongly correlated with race (Last, 2001). See also Ethnicity.

Race for AIANs can be classified by self-identification, tribal enrollment, Indian descendent, and many other factors. In this report, each data source defines AIAN in different ways. See “Notes on Data Sources” section at end of document.

**Sample Size (n):** the number of people included in a population sample.

**SDS:** Sanitation Deficiency System, part of STARS.

**STARS:** Sanitation Tracking and Reporting System. A web-based database used by IHS to track sanitation facilities projects to provide construction, development, technical assistance and continued operations of safe water, sewer, and solid waste systems.

**Statistically Unstable:** Data cannot be reliably estimated due to low participant numbers/rates and should be interpreted with caution.

**THP:** Tribal Health Program.

**UIHP:** Urban Indian Health Program.
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WHY A COMMUNITY HEALTH PROFILE?

In 2005, the California Tribal Epidemiology Center (CTEC) was established to assist California Tribes and Indian Health Programs in their efforts to improve wellness and prevent disease.

What can this Community Health Profile help you do?

- Better understand how data are collected and reported for AIAN living in California.
- Complete grant applications that require data, facts, and figures.
- Decide where your health program can focus its time, money, and efforts related to health issues.
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Background and Historical Context

There are currently 109 federally recognized Indian tribes, rancherias, and federations in the state of California and approximately 40 unrecognized tribes and 10 terminated tribes eligible for restoration, with 78 entities petitioning for recognition in California. It is estimated that there were over 100 distinct languages from five different language families spoken in California prior to contact. Traditionally, most California tribal communities lived in small, independent, self-governing villages or tribal communities located within boundaries established by many factors. Today, tribes are organized into their own sovereign governments. Tribes determine their membership by selecting enrollment criteria that may include ancestral lineage and ties to specific communities. Enrollment in a federally recognized tribe is a political distinction and therefore being AIAN is not solely a racial category, rather it is often a political grouping.

Due to the unique geography of the state ranging from rigid coastal lines, thick forested mountain ranges and dry desert areas, the cultural diversity through the state is vast. Religious and social structures of tribes in California are unique and can vary even between neighboring tribes.

The Spanish were the first outsiders to arrive in California in 1542 moving as far north as Santa Barbara. Beginning in 1769, their organized movements brought a devastating mission system, soldiers, labor camps, and destructive diseases to California, stretching from San Diego to Santa Rosa. White settlers and frontiersmen began to arrive in California during the Mexican War in 1846. While California was becoming a state, the Gold Rush started. Hordes of white “forty-niners” descended on the territory after the discovery of gold at Sutter’s Mill in 1848. The disease and violence brought by non-Native immigrants decimated the California Indian population.

California entered the Union on September 9, 1850. The new California legislature passed a series of laws legalizing both Indian murder and slavery. Under the policy that came from these laws, white
Californians could kill Indian parents and kidnap and indenture their children until they reached the age of thirty for males and twenty-five for females. California finally repealed this law in 1867, four years after President Lincoln's Emancipation Proclamation. In 1851 three federal commissioners were sent to California with orders to extinguish Indian land titles, in return, the Indians would get guaranteed reservations and would be protected from white encroachment.

The U.S. Government promised the California Indians 7.5 million acres of reserved land, along with assistance to help them “civilize” themselves in exchange for the Indians’ agreement to give up all their rights to the lands to the U.S. forever. Many governmental policies were aimed to “civilize” Indian people by making them individual land owners in an effort to diminish traditional communal land ownership. The 18 treaties signed by Indian leaders in 1851 were never ratified; therefore, many promises made in those treaties were not upheld.

Beginning in 1854, the federal government developed a somewhat more coherent Indian policy for California, and began establishing reservations. The 1887 Dawes (allotment) Act sought to further tear apart the close-knit structure of California’s tribal villages. Many tribes in California were forced to adapt to a “checkerboard” reservation where Indian lands were awarded in alternate square miles within the boundaries of a reservation. These small land awards are commonly referred to as individual allotments. These pieces of land were owned by an individual rather than the community, which forced assimilation when the U.S. Government sold the remaining plots to non-Indian settlers. Still many other tribes were essentially impounded on small plots, sometimes only large enough for a few houses and a garden plot, called rancherias on or near the original tribal lands.

One of the keys to survival of many California Indians’ way of life is that although they suffered many
of the same incursions and devastation that Indians elsewhere did and their land was stolen, many were not entirely uprooted or displaced from their ancestral lands. Despite a century of ordeals, in the mid-twentieth century, California’s Indians drew strength from the old ancestral sustenance of place. In the northwestern region of California, the villages of some dozen tribes lined the many rivers, lagoons, and bays. In the northeast, a handful of groups settled among the mountains in the west and the high deserts in the east. In the vast central part of the state, more than two dozen tribes put down deep roots in the grasslands and oak flats of the Central Valley or the pine blanketed coast. In Southern California, about a dozen tribes dwelled in the Mojave Desert or along the Coachella and Colorado River Valleys.

California Indians 1950s—Present

In June 1953, Public Law 83-280 was passed. This law gave the state jurisdiction over criminal and civil offenses on federal Indian lands. It allowed state and county law enforcement authority on tribal lands for the first time since the federal reservations were created. In 1958 the U.S. Congress passed Public Law 85-671, the California Rancheria Termination Act. This law called for the distribution of all the assets of reservations and rancherias to individual Indians resulting in the number of rancherias in California dropping from 117 to 78. Hundreds, if not thousands, of Indians lost federal recognition under this policy.

The Transfer Act of 1954 shifted responsibility for Indian health to the Public Health Service; a division of the Department of Health, Education and Welfare. Also during the 1950s, due to governmental Indian relocation policies and personal reasons, many Indians from other states came to large urban areas such as San Francisco and Los Angeles to find work.

In 1980 the Department of Health, Education and Welfare was renamed the Department of Health and Human Services (DHHS). The IHS is currently housed within DHHS and is organized into 12 service areas that cover the entire U.S., which vary in size and by American Indian/Alaska Native population. California is its own service area, though there are some counties inside of the state borders that are shared with other
IHS service areas. During the 1960’s Civil Rights movement, American Indian people across the nation formed the American Indian Movement (AIM). In 1969 over 100 college students and members of the AIM took over Alcatraz Island in the San Francisco Bay in an attempt to reclaim the land and the closed federal prison building for Indian use. The occupation of Alcatraz increased the visibility of American Indians in California as well as nationally.

The California Rural Indian Heath Board, Inc. (CRIHB) was formed by nine tribes in 1969 to provide a space for California tribes to advocate for their health needs and address common problems under a unified board. Other statewide tribal organizations were also formed during this time period, some of these including, California Indian Manpower Consortium, Inter-Tribal Council of California, and California Indian Legal Services. Like CRIHB, these statewide organizations were formed to help address the needs of all California Indian people in unity with other tribes.

In 1975, Public Law 93-638, also known as the Indian Self Determination and Education Assistance Act (ISDEA), was established because of tribes and tribal leadership nationally. The ISDEA requires federal agencies to contract and compact with tribes to administer, plan, and conduct programs that are provided by the federal government for the benefit of Indian people, including health care. In 1976, the Indian Health Care Improvement Act (IHCIA) was enacted by Congress for the purpose of providing "the highest possible health status to Indians and to provide existing IHSs with all resources necessary to effect that policy." In passing the Act, Congress noted the government's "unique legal relationship with, and resulting responsibility to" Indians, requiring the creation of a comprehensive health care system. Through the advocacy of strong Indian leadership, other laws were passed in the 1970s, such as the American Indian Religious Freedom Act and the Indian Child Welfare Act. These two laws, though serving separate needs, helped to reinforce tribal rights and tribal sovereignty.
In the 2000s, many legislative changes impacted health care for AIAN. In 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) was enacted. HITECH Act provided financial incentives for Indian health clinics to begin utilizing Electronic Health Records (EHR), which made it easier for clinics to transfer patient’s medical records to other clinics and hospitals. In 2010, the Government Performance and Results Act Modernization Act of 2010 (GPRAMA) was signed into law. This required that government agencies such as IHS to publish their strategic plans, goals, and data in computer-readable formats, which did not have to be published previously.

In 2010, the Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) was passed into law, and full implementation began in 2014. The ACA requires that all individuals have health insurance through employers, the subsidized marketplace, or through their state insurance program. This created greater opportunities for health insurance coverage for AIAN. The ACA also placed an emphasis on increasing prevention and wellness for individuals through their insurance benefits. Through ACA, the IHCIA was permanently reauthorized. The permanent IHCIA authorized new programs for IHS to increase the status of health of AIAN. It also allowed tribal clinics to begin serving veterans with direct care services, and be reimbursed for those services by the Department of Veteran’s Affairs (VA).

Although there have been challenges with AIAN health care in California, these challenges have been met through innovative programs and advocacy work. The California Great Recession brought budget cuts to many state programs and eliminated the state’s AIAN health program as well as optional benefit reimbursements to clinics, including dental, optical, chiropractic and other benefits for AIAN in California. CRIHB developed a demonstration project, CRIHB Care and CRIHB Options, that reimbursed THPs for certain Medi-Cal optional benefits provided to IHS eligible Medi-Cal beneficiaries.
As California geared up to implement ACA, Medi-Cal began moving into managed care programs. With the raising of income levels for Managed Care Programs (MCPs), more AIAN became eligible for services. Managed care programs originally did not certify THPs due to their physicians being licensed out-of-state, despite California law which recognizes out-of-state licensed doctors as eligible to practice at THPs. This meant that THPs could not be reimbursed by MCP. As of 2015 and after much advocacy work, all MCPs recognize and reimburse physicians for their work at THPs.

Due to the passage of many of these laws, health care for Indian people in California has improved. More AIAN have health insurance coverage. There are currently 46 Indian Health Programs in California that operate under contracts and compacts with the IHS. Of these, 33 are THPs, eight are UIHPs, four are substance abuse programs, and one is the IHS California Area Office. The 33 THPs provide direct health care services in rural California. Many of these rural programs are commonly supported and governed by a consortium of tribes. The IHS does not provide direct health care service in the California designated IHS area. The California IHS health care service area does not cover the entire state of California; only 43 of the 58 counties in the state are covered. California Indian lands designated by the federal government can intersect both county and state lines. Currently, the Federal Bureau of Land Management has documented that 592,000 acres in California are tribal lands where there is a federal trust responsibility.

The history of European contact, land acquisition, tribal government formation, assimilation, implications and federal policies, and health care service delivery is unique in many ways to California. Due to the size of California’s population and land mass, and along with diverse tribal cultures and languages that exist throughout the state, there exists a rich story of Indian people in California. California Indian tribes and tribal communities have endured a grueling history like many tribes throughout the nation, yet like other areas, tribes remain strong, self-governing, independent nations.
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California Timeline

1542—Captain Juan Rodriguez Cabrillo lands on the California coast and claims it for Spain.

1579—Sir Francis Drake lands on the California coast, spends five weeks with a local tribe, and claims the whole area for the British Crown before leaving.

1769—The Spanish founded the first California mission, Mission San Diego de Alcalá. The Spanish go on to create 21 missions where thousands of California Indians are forcibly removed from their traditional villages and homelands and brought to work as slaves in the missions.

1824-1847—The Mexican government issues over 800 land grants to Mexican citizens. The land grants includes the ancestral territories of many Indian tribes then enslaved at nearby missions.

1834—Governor Jose Figueroa begins secularizing all California missions. The process provides that half of all mission property would go towards the support of local Indian tribes.

1848—Treaty of Guadalupe Hidalgo ends the Mexican-American war in which Mexico cedes 525,000 square miles which includes the territory now known as California. The U.S. promises to uphold the Mexican land grants previously issued. Gold is also discovered during this time. This discovery sparks what is known as the Gold Rush.

1850—On September 9, California became a state.

1852—The ratification of 18 treaties that would have set aside nearly 7.5 million acres of California land for Indians was blocked in Senate meetings.

1875—President Ulysses S. Grant signs an Executive Order to establish reservations for the Santa Ysabel, Pala, Sycuan, La Jolla, Rincon, Viejas, and Capitan Grande bands.

1887—Congress passes the General Allotment Act (Dawes Act), which provides for the distribution of land to Indians for the various reservations, but also gives the federal government power to evict Indians from their current location.

1888—The Cupeños of Warner Springs challenges the Dawes Act in an effort to halt their eviction. In 1903, the U.S. Supreme Court decides against them, and they are evicted from their homes.

1893—Land allotments are made to the Rincon, Morongo, and Pala Reservations.

1894—Land allotments are made at the Round Valley Reservation.

1917—The California Supreme Court declares California Indians as citizens, stating: "That the granting of such citizenship shall not in any manner impair or otherwise affect the right of any to tribal or other property."

1924—Congress passes the Indian Citizenship Act, granting citizenship to all American Indians born in the U.S.
1928—The U.S. Congress passes the California Indian Jurisdictional Act (Lea Act). For the first time, California Indians have the support of the federal courts to file a land claim based on the 18 "lost treaties."


1944—The U.S. Court of Claims awards the California Indians a settlement of more than $17.8 million. However, by following the mandate stated in the Lea Act, benefits already granted by the government, which included the administrative costs of the Bureau of Indian Affairs in California, are excluded from the claim, leaving a net figure of $5 million.

1952—The Bureau of Indian Affairs enacts the policy of Termination -- the process of removing Indians and their land from federal trust. Several termination bills are introduced in Congress, and government assistance to Indians in California is prematurely halted.

1953—The U.S. Congress passes Public Law 83-280, which declares that crimes occurring on Indian land are no longer under the federal government's jurisdiction but are under the state’s jurisdiction.

1958—The Rancheria Termination Act is enacted. It transferred the title of rancheria land and assets from the government to individual Indians, resulting in the loss of federal recognition and tribal sovereignty for many tribes.

1959—The Indian Claims Commission issued an order stating that California Indians held title to 64 million acres of land west of the Sierra Nevada. A settlement was reached for $29,100,000 for the lands from which California Indians had been evicted.

1968—Indian Civil Rights Act enacted. It developed constitutional rights for individual Indians under tribal governance.

1969—The California Rural Indian Health Board is established by nine California Tribes. The occupation at Alcatraz Island begins.

1972—60,000 California Indians are compensated $633 each according to the settlement of the 18 "lost treaties."

1975—Indian Self Determination and Education Assistance Act is enacted by Congress.

1976—The Indian Health Care Improvement Act is enacted by Congress, ensuring the provision of health care to American Indians.


1988—Indian Gaming Regulatory Act is passed allowing tribes to operate casinos.

1990—Native American Languages Act and Native American Graves Protection and Repatriation Act are enacted reinforcing tribal rights and sovereignty.
The state of California is home to 109 federally recognized Indian Tribes, and 78 tribal communities which have petitioned for recognition but have not yet received recognition. All descendants of Indian ancestors residing in California from the 1852 rolls are eligible for services by California THPs. The 2010 Census reported that there were 723,225 self-identified AIAN who reported their race as either only AIAN or AIAN in combination with one or more other races. Of this group, 362,801 reported their race as being only AIAN. A total of 1.9% make up the population of California, however, California has the largest number of AIAN living in any state. Fourteen percent of the national AIAN population resides in California.
Median Household Income (ACS, 2009-2013)

The median household income of AIAN in California was lower than the median household income of non-Hispanic Whites (Whites). The AIAN median household income was $44,498 (Margin of Error +/- $1,419) while the median household for Whites income was $71,226 (Margin of Error +/- $256).

Below Poverty (ACS, 2009-2013)

In California, nearly 1 out of 4 AIAN (24%, Margin of Error +/- 1%) lived below the poverty line, in comparison to 1 out of 10 non-Hispanic Whites (Whites) (10%, Margin of Error +/- 0.1%) who lived below the poverty line.
During The Great Recession in California, AIAN experienced a higher rate of unemployment than non-Hispanic Whites (Whites), with approximately 18% of AIAN unemployed compared to about 10% of whites.

AIAN received food stamps at a higher rate than non-Hispanic Whites (Whites). Between 2009-2013, approximately 15% of AIAN received food stamps, while only about 4% of non-Hispanic Whites (Whites) received food stamps.

Note: Food Stamps are now known as the Supplemental Nutrition Assistance Program.
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A Healthy Spirit
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A healthy spirit is the basis and foundation for any aspect of health, whether it is body, mind, or community. Spirituality is one of the approaches that many traditional Native people and experts agree can help heal a number of health problems. A person with a healthy spirit is able to connect themselves to the world and to beings beyond themselves and the physical world. A healthy spirit, therefore, gives a person a sense of purpose and connection in life and allows them to draw from higher powers. This gives strength to live a balanced and well nourished life and without this, a truly healthy body, mind and community is not possible.

While California Native spirituality can vary from tribal nation to tribal nation, community to community, and among individuals, common themes are evident. Such themes include creation stories, deities, ceremonies, language and traditional foods and culture among many other activities and beliefs. Traditional Native culture encompasses many things but typically includes believing in a Creator or Creators. Many have a traditional leader, hero or trickster who teaches the people how to live in a proper way. Most have a strong reverence for their homelands. Many have genesis stories that are tied to specific and identifiable places. In general, traditional Native people believe they do not own the land, but are responsible for taking care of and deriving sustenance from the earth.

Brush Dances in the Northwest, Big Times in Central and Eastern California, and Bird Songs in the South are some examples of the ceremonies we as California Native people continue to practice as a way to keep our bodies, minds and communities healthy. Each tribe has unique ceremonies and religious beliefs that keep them grounded and reminds them how to live as healthy Native people. During many of our ceremonies we eat traditional foods that provide a well balanced nutritional diet which is much different from what is offered by mainstream America. Foods such as acorns are a significant food source for nearly all California Native peoples. Traditional healers play a key role in providing culturally appropriate health care. Traditional healers offer traditional healing methods, medicines, and spiritual guidance that have proven through generations to be effective in improving health.

Overall, the various practices of California Natives reveal a united worldview of the sacred and secular, of what is seen and unseen, all of which affects health and wellness.
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Practiced Traditional Healing in Past Year (CTBRFCS, 2012-2013)

In California, 31% (n=283) of AIAN visited a traditional healer, wise/medicine man, and/or had a ceremony for their own health and wellness.

Used Tobacco for Ceremonial, Prayer, or Traditional Use (CTBRFCS, 2012-2013)

In California, 44% (n=397) of AIAN used tobacco in a ceremonial way, in prayer, and/or other traditional uses.
A Healthy Body
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A healthy body is an important for overall health and wellness. Eating right, exercising, visiting the doctor regularly for screenings, and practicing safe behaviors helps to ensure that individuals, families, and communities have healthy bodies and live balanced, healthy lives.

This section will cover the topics of Diabetes; Heart Disease; Healthy Eating, Exercise, and Controlling Obesity; Cancer; Dental Health; Maternal and Child Health; and Personal Health. **Diabetes** can come in two forms: Type I and Type II. Type I is when the body cannot produce enough insulin to allow the body to turn sugars in food into usable energy for warmth, movement, and growth. Type I Diabetes is less common and is typically evident at an early age. The majority of people with diabetes have Type II Diabetes. Type II Diabetes occurs when cells in the liver, brain, muscles, and other organs are poorly responsive to insulin. This means that insulin does not allow cells to accept sugar needed for energy. The rate of diabetes is almost twice as high for AIAN than it is for the rest of the United States population. Having a healthy heart is also important for overall health and wellness, but **Heart Disease** is one of the leading causes of death of Native people. Heart disease includes narrowed or blocked coronary arteries as a result of high cholesterol and high blood pressure. Heart disease can lead to heart attacks (myocardial infarctions) and strokes. **Exercise, Controlling Obesity, and Eating Healthy** can help prevent diabetes and heart disease.

**Cancer** screening involves undergoing medical testing, which can help detect cancer before a patient has symptoms. Early detection through screening is crucial in improving treatment outcomes and survival. Furthermore, having annual gynecological exams and testing for sexually transmitted diseases can help keep individuals and communities safe. **Maternal and Child Health** indicators can provide information about individual, family, and community health. Examples of maternal health indicators include breastfeeding rates and the month prenatal care began during pregnancy. One of the most important preventative components to **Personal Health** involves regular screenings for sexually transmitted diseases. **Dental Health** is important as well. Research has shown that more and more diseases are related to poor tooth and gum hygiene, so brushing, flossing and visiting the dentist every six months promotes overall wellness.
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Diabetes is a chronic illness that can lead to heart disease, blindness, kidney disease, and amputations. It is the fourth leading cause of death for AIAN in the United States. Rising rates of obesity have contributed to the growing number of people diagnosed with diabetes. Early screenings and diabetic assessments can help identify the disease and reduce associated complications.

### Ever Diagnosed with Diabetes (CHIS, 2011-2012)

Almost 13% (CI: 8.9-16.5%) of California AIAN and 7% (CI: 6.3-7.2%) of non-Latino Whites (Whites) reported being diagnosed with diabetes. A little over 11% of California AIAN (CI:8.3-13.9%) reported being told that they have pre- or borderline diabetes. Almost 9% (CI: 8.0-9.0%) of non-Latino Whites (Whites) reported that they had pre- or borderline diabetes. Pre- or borderline diabetes is an impaired fasting glucose wherein the blood sugar level is higher than average is but not yet diabetic.

### Type I or Type II Diabetes (CHIS, 2011-2012)

Among those in California who reported being diagnosed with diabetes, 10% (CI: 4.4-15.7%) of AIAN had Type I Diabetes, compared to 12% (CI: 9.7-14.7%) of non-Latino Whites (Whites). A total of 88% (CI: 82.1-94.2%) of AIAN had Type II Diabetes, compared to 86% (CI: 83.9-89.0%) of non-Latino Whites (Whites). Type I Diabetes results from the body’s failure to produce insulin and is usually diagnosed in children and young adults. Type II Diabetes results from insulin resistance and is the most common form of diabetes.

### Ever Diagnosed with Diabetes During Pregnancy (CHIS, 2011-2012)

Having diabetes only while pregnant is known as gestational diabetes. For current non-diabetic adult women in California, almost 7% (CI: 3.0-13.9%) of AIAN and almost 3% (CI: 2.4-3.2%) of non-Latino Whites (Whites) reported they had been diagnosed with diabetes during pregnancy.
Good Glycemic Control (IHSPM, 2013-2014)

Good sugar (glycemic) control means keeping blood sugar (HbA1c) levels below eight. Having a hemoglobin A1c level below seven reflects ideal glycemic control and is essential in slowing or preventing diabetic complications of the eyes, kidneys, heart, and nerves. Of AIAN diabetic patients seen at reporting California IHS clinics, almost 49% (n=3271) had a A1c measure less than eight, which was comparable to the national average of approximately 49%.

Blood Pressure Control (IHSPM, 2013-2014)

Blood pressure control means achieving a pressure less than 140/90. Reaching this goal reduces the likelihood of person experiencing diabetic complications or other adverse health outcomes. Of AIAN diabetic patients seen at reporting California IHS clinics, 63% (n=4216) achieved blood pressure control, while approximately 64% achieved blood pressure control in the national sample.

Diabetic Assessments (IHSPM, 2013-2014)

Patients may reduce diabetic complications by undergoing comprehensive assessments. These assessments include tests for high cholesterol, kidney disease, and eye complications. The IHS aims to conduct three of these tests per person per year for at least 70% of all diabetic patients.

At total of 71% (n=4732) of AIAN diabetic patients seen at reporting California IHS clinics were screened for dyslipidemia (high cholesterol), compared to almost 73% of AIAN patients across all IHS areas. In California, 50% (n=3338) of AIAN diabetic patients were screened for nephropathy (kidney disease) compared to approximately 60% of AIAN patients in all IHS areas. Approximately 51% of AIAN patients (n=3333) had a retinopathy (eye complications) compared to 60% of individuals in all IHS areas.
Heart disease is one of the leading causes of death for AIAN. High blood pressure, high cholesterol, smoking, limited physical activity, and obesity can all contribute to the development of heart disease.

**Ever Diagnosed with Heart Disease (CHIS, 2011-2012)**

Almost 17% (CI: 11.2-22.2%) of AIAN and 8% (CI: 7.9-8.8%) of non-Latino Whites (Whites) in California reported being diagnosed with heart disease.

**Cholesterol Level Screening (BRFSS, 2011)**

A high level of cholesterol in the blood is a major risk factor for coronary heart disease or stroke. Having a cholesterol check can help determine whether medication or lifestyle changes are necessary. An ideal total cholesterol level is less than 200 mg/dL. The recommended national target for Healthy People 2020 is for at least 82.1% of adults to have a cholesterol screening. Approximately 69% (CI: 63.8-74.8%) of AIAN and nearly 76% (CI: 74.7-76.9%) of Whites in California had a cholesterol check in the past 5 years.

**Cardiovascular Disease Assessment (IHSPM, 2013-2014)**

Of AIAN patients seen at reporting California IHS clinics who had been diagnosed with coronary heart disease, nearly 42% (n=584) had a comprehensive cardiovascular disease assessment, compared to 52% of AIAN patients across all IHS areas. This assessment, which is recommended annually, includes the following tests: blood pressure, cholesterol levels, tobacco use, Body Mass Index (BMI), and lifestyle counseling. BMI is an estimated measure of body fat based on height and weight.
Healthy eating and regular physical activity are important for maintaining a healthy body and weight. Being overweight or obese increases the chances of high blood pressure and cholesterol, heart disease, Type II Diabetes, and arthritis. A balanced diet and physical activity are essential to maintaining a healthy weight.

**Level of Physical Activity (CHIS, 2011-2012)**

When asked about physical activity in a typical week, about 52% (CI: 40.5-64.1%) of AIAN and 52% (CI: 50.6-53.3%) of non-Latino Whites (Whites) in California reported that they got some physical activity. Moderate activity refers to activities that take moderate physical effort, including bicycling, swimming, dancing, and gardening at least 5 days a week for 30 minutes a day. Vigorous activity refers to activities that take hard physical effort, such as aerobics, running, soccer, fast bicycling, or fast swimming at least 3 days a week for 20 minutes a day.

**Proportion of Young Children with Age-Calculated BMIs At or Above the 95th Percentile (IHSPM, 2013-2014)**

Of children aged 2-5 years old, nearly 23% (n=647) served by reporting California IHS clinics and approximately 23% served across all IHS areas had an age-calculated BMI in the 95th percentile or higher. Children with BMIs in the 95th percentile are considered to be obese.
Over 13% (CI: 10.1-16.7%) of AIAN in California ate fast food four or more times in the past week compared to 10% (CI: 9.4-11.0%) of non-Latino Whites (Whites). Furthermore, nearly 29% (CI: 25.1-32.8%) of AIAN did not eat fast food in the past week compared to 41% (CI: 39.8-41.9%) of non-Latino Whites (Whites).

For children in California, nearly 55% (CI: 43.5-66.2%) of AIAN compared to 51% (CI: 47.9-53.9%) of non-Latino Whites (Whites) consumed five or more servings of fruits and/or vegetables daily. For teens in California, nearly 35% (CI: 14.2-55.1%*) of AIAN consumed five or more servings of fruits and/or vegetables daily compared to nearly 28% (CI: 29.6-31.2%) of non-Latino Whites (Whites).

*Includes statistically unstable data
Cancer is a leading cause of death among AIAN. Cancer screenings can detect early stages of cancer, prevent the onset of symptoms, reduce the severity of illness, and prevent disease-related death through identification and treatment at the earliest stages of the disease.

**Colon Cancer Screening (IHSPM, 2013-2014)**

The Healthy People 2020 screening goal aims for at least 70% of eligible patients completing the colorectal cancer screening series. Colorectal cancer screening is routinely performed through a high-sensitivity fecal occult blood test (annually), sigmoidoscopy (every 5 years), or colonoscopy (every 10 years). Of patients aged 50 years and older, 31% (n=4,320) of AIAN patients served by reporting California IHS clinics had a colorectal cancer screening compared to approximately 38% of AIAN patients in all IHS areas.

**Cervical Cancer Screening (IHSPM, 2013-2014)**

The Healthy People 2020 goal states that at least 93% of adult women aged 21 to 64 years old with a typical health history will have a pap smear to screen for cervical cancer in the past three years. For AIAN women aged 21 to 64 years old, 45% (n=7,951) of those served by reporting California IHS clinics had a pap smear to screen for cervical cancer at least once within the past three years compared to almost 55% of those served across all IHS areas.
Breast Cancer Screening (IHSPM, 2013-2014)

The Healthy People 2020 goal is that at least 81% of women aged 50 to 64 years old with a typical health history will have a mammogram screening for breast cancer every two years. Of AIAN women aged 50 to 64 years old, 43% (n=2,132) of those served by reporting California IHS clinics had a mammogram within the past two years compared to 54% of those served across all IHS areas.
Sexually transmitted diseases (STDs) are common in the United States. Women typically suffer more serious complications from STDs than men, including pelvic inflammatory disease, ectopic pregnancy, infertility, and cervical cancer. In addition, having an STD increases the likelihood of contracting or transmitting human immunodeficiency virus (HIV). Not knowing whether you are infected with HIV can lead to serious complications and increases the risk of transmitting infections to others. It is recommended by the CDC that everyone who is sexually active be tested for STDs and HIV.

HIV Screening During Pregnancy (IHSPM, 2013-2014)

Prenatal HIV screening is essential for reducing the risk of transmission from mother to child. Across all IHS areas, 88% of pregnant AIAN women were screened for HIV, while only 71% (n=845) of AIAN pregnant women were screened for HIV at reporting California IHS clinics.

Ever Tested for HIV (BRFSS, 2011)

In California, nearly 43% (CI: 36.6-48.6%) of AIAN adults reported ever being tested for HIV compared to nearly 39% (CI: 37.7-40.0%) of Whites.
In California, 324 non-Hispanic AIAN (AIAN) per 100,000 persons had Chlamydia compared to 168 non-Hispanic Whites (Whites) per 100,000 persons. A rate of 87 non-Hispanic AIAN (AIAN) per 100,000 had gonorrhea compared to 57 non-Latino Whites (Whites) per 100,000 persons. The rate of Syphilis diagnosis was 10 non-Hispanic AIAN (AIAN) per 100,000 compared to 6 non-Hispanic Whites (Whites) per 100,000 persons.

**Congenital Syphilis (CDPH, 2013)**

In California, nearly 169 non-Hispanic AIAN (AIAN) per 100,000 persons had Congenital Syphilis compared to approximately 6 non-Hispanic Whites (Whites) per 100,000 persons. Congenital Syphilis is syphilis that is present in utero and at birth, meaning that a child was born to a mother with syphilis.
Proper dental care improves oral health and contributes to overall health. Dental care is important for children because childhood tooth decay is a common and preventable chronic infectious disease.

**Dental Visits (IHSPM, 2013-2014)**

Approximately 41% (n=37,476) of AIAN who were patients at reporting California IHS clinics attended a dental visit during the past year compared to nearly 29% of AIAN patients across all IHS areas.

**Topical Fluoride Treatments (IHSPM, 2013-2014)**

Approximately 31% (n=7,368) of AIAN aged 1 to 15 years old who were patients at reporting California IHS clinics received one or more topical fluoride treatments during the past year compared to nearly 28% of AIAN patients aged 1 to 15 years old across all IHS areas.

**Dental Sealants (IHSPM, 2013-2014)**

An effective, low-cost way to prevent tooth decay is to apply dental sealants. Of AIAN children aged 2 to 15 years old who previously received dental sealants, a total of 17% (n=3,829) had intact dental sealants when examined at reporting California IHS clinics compared to 15% of AIAN children across all IHS areas.
Maternal and child health indicators are useful in understanding health across generations. Infant mortality is not only an important indicator of maternal and child health but also overall population health and is often used to demonstrate disparities between groups. Many of infant deaths are the result of preterm births and low birth weight, emphasizing the importance of receiving prompt prenatal care.

**Infant Mortality (NVSS, 2010-2012)**

In California, from 2010-2012, the incidence rate of infant mortality for all causes in AIAN was 694 per 100,000 people compared to 442 per 100,000 people for Whites.

**Low Birth Weight (NVSS, 2011-2013)**

Infants born under 2,000 grams (5.5 pounds) are considered to be at low birth weight. In California from 2011-2013, 6.3% of AIAN babies and 6.2% of White babies were born at a low birth weight.
A HEALTHY BODY

MATERNAL AND CHILD HEALTH

Preterm Birth (NVSS, 2011-2013)

About 10.4% of California AIAN babies were born pre-maturely under 37 weeks gestation compared to 7.6% of White babies. Most preterm births were classified as moderately premature, with 9% of AIAN births and almost 8% of White births occurring between 32 and 36 weeks gestation. Just over 1% of both AIAN and White births were classified as very premature, meaning that preterm births occurred before 32 weeks gestation.

Month Began Prenatal Care (NVSS, 2013)

Approximately 68% of non-Hispanic AIAN (AIAN) women began prenatal care in the first trimester of pregnancy compared to about 85% of non-Hispanic White (White) women. About a quarter of non-Hispanic AIAN (AIAN) women began prenatal care in the second or third trimesters of pregnancy. A total of 2% of non-Hispanic AIAN (AIAN) women received no prenatal care during pregnancy compared to less than 1% of non-Hispanic White (White) women.
In California, almost 10% of first child non-Hispanic AIAN (AIAN) births were to teenage mothers (ages 15-19 years old) compared to 2.7% of first child births being to non-Hispanic White (White) teenage mothers. Overall, the majority (about 65%) of first child non-Hispanic AIAN (AIAN) births were to mothers under 30 years old, while among non-Hispanic Whites (Whites), the majority of first child births (about 56%) were to women 30 years old and over.

**Breastfeeding Rates (IHSPM, 2013-2014)**

Breastfeeding can be beneficial for both mothers and children. Among AIAN women receiving services at reporting California IHS clinics, about 56% indicated that their babies were mostly or exclusively breastfed at 2 months of age. The national average for AIAN mothers who breastfeed 2-month-old babies was 35%.
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A Healthy Mind
A HEALTHY MIND

This section will cover Alcohol Abuse, Commercial Tobacco Use, Drug Abuse, and Mental Health. A healthy mind is integral to quality of life, as well as the quality of life for those in the community. Limiting alcohol intake, quitting smoking, and abstaining from abusing illegal and prescription drugs will promote a clean, clear, healthy mind. The cultural and traditional practices of Native people inherently promote healthy, balanced lifestyles that prevent mental health problems. Traditional healers in many Native communities successfully treat and provide counsel for those in need of spiritual and mental guidance. For Native people, all things are connected: A healthy mind, body, community and spirit are tied together.

A poor mental health status can lead to deterioration of hormonal and immune systems that ward off disease, and to behaviors that put the physical and spiritual health of the body at risk, such as substance abuse, domestic violence, and undesirable mental states of mind. Screening and seeking help for Mental Health issues will help to ensure the mind stays well. Meeting with a medicine person, spiritual leader, or psychiatrist has helped others improve their mental state. Other traditional and Western methods have shown to improve the overall health and well being for many people, such as traditional medicine, sweats, smudging, and Western medication.

Many studies have shown that AIAN use Commercial Tobacco (cigarettes and chewing tobacco) and alcohol at a higher rates than other races and ethnicities. Traditional tobacco can be enormously beneficial to the mind and to the spirit, however, commercial tobacco contains many additives that are addicting and harmful to the body and mind. Commercial tobacco use can lead to lung cancer and many other health problems. Alcohol Abuse, can lead to liver problems later in life, and is a factor in many car accidents and deaths. While AIAN have high rates of alcohol abuse, they also have the highest rate of complete abstinence from alcohol, indicating the power of the AIAN community, resources, and support systems. Quitting smoking and reducing alcohol intake (1 serving of alcohol per day for females, 2 for males) or abstaining from alcohol for those with addiction issues, can greatly improve overall health and well being. Drug Abuse, whether by using illegal substances (heroin, cocaine, methamphetamines) or prescription drugs, is harmful to the body and can lead to poor mental health.
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Depression is the most commonly experienced mental health issue. Depression is associated with more than two-thirds of suicides as well as with heart disease, diabetes, cancer, and alcohol and drug abuse.

**Depression Screening (IHSPM, 2013-2014)**

Depression is a common yet treatable mental illness, and screening for depression is an important preventative measure. Approximately 58% (n=26,112) of adult AIAN patients at reporting California IHS clinics were screened for depression compared to approximately 66% of AIAN across all IHS areas.

**Psychological Distress (CHIS, 2011-2012)**

The Kessler 6 Series is a collective measure psychological distress that rates a person’s feelings of restlessness, depression, nervousness, and worthlessness. In California, almost 10% (CI: 6.2-13.5%) of AIAN received Kessler 6 scores that indicated experiencing psychological distress during the past year compared to nearly 8% (CI: 6.9-8.2%) of non-Latino Whites (Whites).

**Prescription Medication for Mental Health Issues (CHIS, 2011-2012)**

In California, approximately 16% (CI: 10.7-21.7%) of AIAN reported taking prescription medication for a mental health issue at least two weeks during the past year whereas about 14% (CI: 13.6-15.0%) of non-Latino Whites (Whites) reported taking prescription medication at least two weeks during the past year.
Alcohol abuse can be associated with violence, teen pregnancy, sexually transmitted diseases, and/or injuries from car accidents or drowning. Alcohol abuse can also lead to heart disease, cancer, and liver disease. Because of its effect on various health factors, alcohol abuse can influence individual, family, and community well-being.

**Fetal Alcohol Syndrome Screening (IHSPM, 2013-2014)**

Screening for alcohol use has been shown to reduce the prevalence of fetal alcohol syndrome in infants. Across all IHS areas, approximately 66% of female clients aged 15 to 44 years old were screened for alcohol use, whereas nearly 55% (n=9,161) of women aged 15 to 44 years old were screened at reporting California IHS clinics.

**Binge Drinking (CHIS, 2011-2012)**

Estimates of binge drinking represent the risk of immediate alcohol related health consequences. Binge drinking is considered to be 5 or more drinks at a time for males and 4 or more drinks at a time for females. According to CHIS, 34% of AIAN (CI: 28.3-40.5%) and non-Latino Whites (CI: 32.7-35.2%) reported binge drinking in the past year (graph not shown).

**Number of Drinks Monthly (BRFSS, 2011)**

About 48% (CI: 37.2-59.0%) of AIAN reported having had no drinks in the past month compared to 34% (CI: 33.0-35.5%) of Whites. Approximately 4% (CI: 0.6-7.8%) of California AIAN reported having 50 or more drinks in the last month in comparison to almost 10% (CI: 8.7-10.3%) of Whites.
COMMERCIAL TOBACCO USE

A HEALTHY MIND

Commercial tobacco is filled with additives, is addictive, and has been linked to the development of lung cancer, chronic lung diseases, heart disease, and stroke.

Current Smoker (CHIS, 2011-2012)

Current smokers are individuals who report smoking daily and who have smoked at least 100 cigarettes in their lifetime. In California, 19% (CI: 15.2-22.8%) of AIAN reported being current smokers whereas almost 14% (CI: 12.6-14.5%) of non-Latino Whites (Whites) reported being current smokers.

Smokers Received Tobacco Cessation Intervention (IHSPM, 2013-2014)

Of AIAN commercial tobacco users served at reporting California IHS clinics, almost 39% (n=6,232) reported receiving a tobacco cessation intervention, compared to nearly 48% of AIAN across all IHS areas.

Days Breathed Secondhand Smoke in Indoor Workplace (CTBRFCS, 2012-2013)

A total of 35% of AIAN (n=304) reported breathing secondhand smoke in an indoor workplace 1 or more days during the past 7 days. Approximately 15% (n=125) of adult California AIAN reported breathing secondhand smoke in an indoor workplace for 5-7 days during the past 7 days.
Drug abuse includes abuse of both illegal substances (marijuana/hashish, cocaine, heroin, hallucinogens, inhalants) and non-medical use of prescription pills, including pain relievers, tranquilizers, stimulants, or sedatives. Drug abuse can lead to heart problems, overdoses, and death. Drug abuse can also lead to heart disease, cancer, and liver disease. Because of its effect on various health factors, drug abuse can influence individual, family, and community well-being.

Illicit Drug Use (NSDUH, 2013)

In the United States, approximately 12% of AIAN aged 12 or more years old reported using illicit drugs during the past month compared to almost 10% of non-Hispanic and non-Latino Whites (Whites).

Non-medical Use of Prescription Drugs (NSDUH, 2013)

Nationally, approximately 2% of AIAN aged 12 or more years old reported using prescription psychotherapeutic for non-medical reasons during the past month compared to almost 3% of non-Hispanic and non-Latino Whites (Whites).
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A Healthy Community
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A HEALTHY COMMUNITY

The Native community is unique, and one of the most supportive communities in the country - many AIAN people rely on their community, tribe, and culture to sustain health and wellness. This section will cover Access to Health Care, Immunizations, Elder Falls, Environmental Health, and Domestic Violence, all of which can affect the health and wellness of a community.

Often times Access to Health Care is insufficient in rural and Native communities. Transportation to and from doctor’s appointments, the availability of medicine and treatment options, having clinics open and fully staffed at all hours, and having culturally competent health care are all challenges that many Native communities face. Immunizations are an effective method to prevent disability and death from infectious diseases as well as to control the spread of diseases, yet many Native children and adults do not receive immunizations that can prevent illnesses. Unintentional injuries are the third leading cause of death for AIAN. Such injuries may be from Elder Falls. Because elders are treated exceptionally well by the community and are held in high regard for past, present and future contributions, it is important for Native families and communities to work together to prevent serious injury among Elders.

The health of the immediate Environment can be in poor condition with respect to housing facilities and water supplies. Having safe drinking water and adequate plumbing facilities are essential to a healthy community on rural and reservation/rancheria lands. Finally, Domestic Violence, whether it be by a family member or friend, continues to affect Native communities at a higher rate than other communities.
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Access to health care is necessary for preventing and treating many illnesses. Accessibility of health care varies by individual and community but it is often defined by whether or not an individual has health insurance.

Type of Medical Insurance (CHIS, 2011-2012)

About 13% (CI: 8.4-16.6%*) of AIAN in California reported having no medical insurance compared to 9% (CI: 8.4-9.6%*) of non-Latino Whites (Whites), and a total of 16% (CI: 11.1-21.0%*) of AIAN reported being enrolled in Medicaid compared to 6% (CI: 5.6-6.8%*) of non-Latino Whites.

*Data were reported prior to implementation of the Affordable Care Act in 2014.
Immunizations are an effective method to prevent disability and death from infectious diseases as well as to control the spread of diseases.

**Childhood Immunizations (IHSPM, 2013-2014)**

Immunizations for children aged 19-35 months include 4 doses of DTaP (diphtheria, tetanus, and pertussis), 3 doses of IPV (polio), 1 dose of MMR (measles, mumps and rubella), 3 doses of Hepatitis B, and 3 doses of Hib (Haemophilus influenzae type b). Approximately 58% (n=837) of children at reporting California IHS clinics received these immunizations compared to approximately 75% of children across all IHS areas. The Healthy People 2020 goal is for at least 80% of children to be fully immunized.

**Influenza Immunizations (IHSPM, 2013-2014)**

Nearly 56% (n=2,864) of patients at reporting California IHS clinics who were 65 years old and above received a flu shot, while approximately 68% of patients across all IHS areas received a flu shot. The Healthy People 2020 goal is for at least 90% of individuals 65 years old and above to receive a flu shot annually.

**Pneumococcal Immunizations (IHSPM, 2013-2014)**

In reporting California IHS clinics, approximately 77% (n=3,979) of patients who were aged 65 years old and above received the pneumococcal vaccine, which increases protection against pneumonia, bacteremia, meningitis, and other severe infections. Nearly 86% of patients received this vaccine across all IHS areas. The Healthy People 2020 goal is for at least 90% of individuals 65 years old and above to receive the pneumococcal vaccine.
Elders are the foundation of strong and healthy California Native communities. One major health concern for elders includes unintentional falls. Elder falls can lead to serious injuries and sometimes even death, but they can be prevented by individuals, families, and medical providers. Elders who are physically active; who have had home safety inspections; and who participate in ongoing medication management and regular vision exams have a reduced risk of falling.

**Elder Fell More Than Once in Past Year (CHIS, 2011-2012)**

Almost 24% (CI: 11.3-36.9%) of AIAN in California aged 65 years old and above reported accidently falling to the ground more than once during the past year, whereas approximately 13% (CI: 11.7-13.5%) of non-Latino Whites (Whites) reported falling that often.

**Elder Hospitalized Due to Falls in Past Year (CHIS, 2011-2012)**

In California, of those 65 years old and above who had fallen during the past year, fewer than 49% (CI: 29.3-68.8%*) of AIAN and 30% (CI: 24.3-36%) of non-Latino Whites (Whites) were hospitalized due to the fall.

*Includes statistically unstable data
Sanitation facilities and quality housing with safe water and sanitary waste disposal systems reduce the risk of infectious disease outbreaks and result in healthier communities. In 2007, IHS reported that approximately 11% of AIAN homes were without a safe and reliable water supply; however, the IHS goal is that at least 94% of AIAN homes have a safe water supply. As part of the Indian Health Care Improvement Act, a Sanitation Deficiency System (SDS) was established by IHS to identify deficiency levels for each home and community. Assessments are scored from Level 0 to 5 as described below, with the goal of having each home score at a Level 0 or Level 1.

- **Level 0:** No deficiencies to correct.

- **Level 1:** Sanitation system complies with all applicable water supply and pollution control laws, and deficiencies relate to routine replacement, repair, or maintenance needs. Fully adequate water supply, sewage disposal, and solid waste facilities exist for a home/community.

- **Level 2:** Sanitation system complies with all applicable water supply and pollution control laws, and deficiencies relate to capital improvements that are necessary to improve the domestic sanitation facilities. Water supply, sewage disposal, and solid waste facilities exist but water storage tank or pipes are too small or water well capacity is not adequate.

- **Level 3:** Sanitation system has inadequate or partial water supply and a sewage disposal facility does not comply with applicable water supply and pollution control laws, or has no solid waste disposal capacity. Safe water supply and sewage disposal systems exist but there are significant problems with water quantity; the sewage lagoon is overloaded/overflowing and effluent does not meet discharge standards; or there are no solid waste disposal functions.

- **Level 4:** Sanitation system lacks either a safe water supply system or a sewage disposal system.

- **Level 5:** No safe water supply and no sewage disposal system.
In California, nearly 47% (n=19,401) of the homes in the AIAN SDS system had sufficient water systems (Levels 0 to 1), but approximately 13% (n=5,029) of the homes lacked potable (drinkable) water, with deficiency Levels 4 or 5. IHS estimated that the cost of projects to correct water deficiencies in eligible AIAN homes would be $138 million.

Approximately 75% (n=30,917) of California AIAN homes in the SDS system were connected to adequate sewer systems, with a Level 0 or 1 deficiency. However, 6% (n=2,242) of homes scored at a Level 4 or 5, indicating that they did not have adequate disposal systems. IHS estimated that it would cost over $150 million to supply eligible AIAN homes with adequate sewage disposal systems.

About 92% (n=38,371) of California homes in the SDS system had sufficient solid waste disposal facilities and were rated at a Level 0 or 1 deficiency. Although none of the homes were scored as Level 4 or 5 in the SDS system, a total of 8% (n=3,042) of AIAN homes had solid waste facilities with moderate to severe deficiencies (Level 2 or 3). IHS estimated that it would cost $8 million to supply eligible homes/communities with adequate solid waste disposal systems.
Domestic violence includes abusive behaviors used by one person in a relationship to control the other person. Domestic violence can include mental, physical, emotional, and spiritual abuse, and it is often associated with alcohol and drug abuse and other risky health behaviors. Domestic violence can be disruptive to individual, family, and community functioning.

Domestic Violence Screening (IHSPM, 2013-2014)

In reporting California tribal health clinics, 56% (n=8,344) of women were screened for domestic violence compared to nearly 65% of female clients aged 15 to 40 years in all IHS areas. The IHS 2010 goal is to screen at least 40% of women aged 15 to 40 years for domestic violence.

Violence by Intimate Partner (CTBRFCS, 2012-2013)

Nearly 36% (n=329) of AIAN in California have experienced physical or sexual violence by an intimate partner.
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TECHNICAL NOTES
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NOTES ON DATA SOURCES

American Community Survey (ACS)

The American Community Survey (ACS) is conducted by the United States Bureau of the Census. The ACS includes a series of monthly samples for census tracts and block areas. These samples are then used to update the United States Census yearly. In 2010, the ACS replaced the United States Census long-form survey. The same definition of race applies for the ACS as in the United States Census. For this California AIAN Community Health Profile, CTEC used combined 2009-2013 data from those who indicated their race was AIAN alone or AIAN combined with one or more race.

Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors. BRFSS was established in 1984 by the Centers for Disease Control and Prevention (CDC); currently data is collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. More than 350,000 adults are interviewed each year, making the BRFSS the largest telephone health survey in the world. States use BRFSS data to identify emerging health problems, establish and track health objectives, and to develop and evaluate public health policies and programs. Many states also use BRFSS data to support health-related legislative efforts.

BRFSS data are self reported. The data in this report includes people who reported AIAN as their only race; therefore, it excludes people who reported identifying as more than one race. AIAN data are presented alongside individuals who reported White as their only race. BRFSS 2011 data are reported for the entire state of California and are described in a report which can be accessed on the BRFSS website: http://www.cdc.gov/BRFSS/.

California Department of Public Health (CDPH) Sexually Transmitted Disease (STD) Control Branch

California data are from the STD surveillance systems operated by state and local STD control programs. Case reports are submitted electronically to local health jurisdictions in the form of laboratory reports and Confidential Morbidity Reports (CMRs). Local health jurisdictions then submit the data to the California Department of Public Health (CDPH).
NOTES ON DATA SOURCES

Rates by county were calculated using State of California, Department of Finance, California County Population Estimates and Components of Change from 2013. The race and ethnicity reported are non-Hispanic AIAN and non-Hispanic White. *The substantial amount of missing race/ethnicity data from the laboratory reports and county medical records limits the interpretation of race/ethnicity data from surveillance data.* The majority of case reports originate from laboratories, which do not routinely collect data on race/ethnicity. Furthermore, some managed care organizations and other health care service providers do not routinely record race/ethnicity.

**California Health Interview Survey (CHIS)**

The California Health Interview Survey (CHIS) is conducted by the UCLA Center for Health Policy Research in collaboration with the California Department of Public Health, the Department of Health Care Services, and the Public Health Institute. CHIS is a telephone survey that uses a random-digit-dial (RDD) design of land lines and cellular phones for a sample that is representative of the state's population. CHIS is the nation's largest state health survey. Through 2012, it was conducted on a continual two year basis on a wide range of health topics. CHIS 2011-2012 surveyed more than 44,000 households, including more than 42,000 adults and 10,000 teens and children, with oversampling done among AIAN to give a better sample of rural and urban AIAN. The number of individually represented California counties is 41 (with the remaining smaller counties grouped into three strata). CHIS aggregates several smaller counties in sampling procedures.

There are several definitions of race that can be used in describing data in AskCHIS (CHIS currently uses the 2010 Census definition of race). Race is self-reported by the interviewee in CHIS. CTEC decided to use “any mention of American Indian or Alaska Native” when describing the AIAN population in this report, so that a large enough sample size could be obtained for health status questions in the survey. “Any mention of American Indian or Alaska Native” is assigned to respondents who reported one of the following criteria: enrolled in an AIAN tribe; single race, not Latino, and AIAN; single race or multiple race, AIAN, or most identify with AIAN. This population is compared to non-Latino Whites. California changed reporting terminology from non-Hispanic White to non-Latino White.

All data from this report comes from 2011-2012 CHIS. 95% Confidence Intervals (CIs) are reported for CHIS data, and 95% CIs are reported for all data for which there was a statistically significant difference. All data contained in this report are available at the CHIS website: http://www.chis.ucla.edu
California Tribal Behavior Risk Factor Community Survey (CTBRFCS)

California Tribal Behavior Risk Factor Community Survey (CTBRFCS) was funded by and adapted from the Centers for Disease Control (CDC) Behavioral Risk Factor Community Survey (BRFSS). BRFSS is conducted annually and nationwide by each state. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors. BRFSS was established in 1984 by the CDC; currently data is collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.

CTBRFCS was developed to ensure that the health needs of California AIAN are documented, met, and understood. The California Rural Indian Health Board (CRIHB) and CTEC use CTBRFCS data to identify emerging health problems, establish and track health objectives, and to develop and evaluate public health policies and programs. CTBRFCS data are also used to support health-related legislative efforts.

CTBRFCS was a sample of convenience. From 2012 through 2013, CTEC administered the CTBRFCS at 13 AIAN cultural events throughout California, with 975 AIAN completing the survey. Participants received a $20 gift card for completing the survey. CTBRFCS data is self-reported and the data in the profile are for people who reported AIAN as their only race; therefore, data do not include individuals who stated they identify as more than one race. Participants also had to be age 18 or older, if they were younger than 18 years of age, they were excluded. After exclusion for non-AIAN, more than one race, or under 18 years of age, the sample size was 924.
Indian Health Service Performance Measure (IHSPM)

The Indian Health Service (IHS) developed a set of performance indicators as part of the Government Performance and Results Act (GPRA). GPRA indicators are reported for AIAN Active Users. An Active User is an AIAN enrolled member or a descendant of a federally recognized tribe, who has had a reportable medical or dental visit to a clinic funded by the IHS within the last three fiscal years.

GPRA data are not available for all IHS funded health facilities. California IHS area 2014 GPRA data (July 1, 2013 to June 30, 2014) are available for approximately 87% of AIAN Active Users. There are 12 IHS Administrative Areas in the United States: Aberdeen, Alaska, Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma, Phoenix, Portland, and Tucson.

IHS Performance Measures (IHSPM) in this report include GPRA data from IHS for 33 reporting IHS Health Programs. Thus, California data in this report include information from 25 Tribal and 8 Urban Indian Health Programs. At the state level, IHSPM data were merged with data from the Indian Health Center of Santa Clara Valley; Mariposa, Amador, Calaveras, Tuolumne Health Board; Native American Health Center of Oakland and San Francisco; Redding Rancheria Tribal Health Clinic; and the United Indian Health Service, although it is important to note these health programs have their own reporting mechanisms and these data have not been validated by the IHS (see map and list of IHSPM sites). IHSPM data for California were compared to IHSPM data for all IHS areas.

California Area IHSPM data are available online at: http://www.ihs.gov/california/tasks/sites/default/assets/File/2014_California_Book.pdf
# Tribal Health Programs

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*Data have not been validated by the IHS.
NOTES ON DATA SOURCES

URBAN INDIAN HEALTH PROGRAMS

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*Data have not been validated by the IHS.

National Vital Statistics System (NVSS)

The National Vital Statistics System (NVSS) is a system that the National Center for Health Statistics (NCHS) uses for reporting deaths, births, marriages, divorces, and fetal deaths. NVSS information is reported to NCHS by contract through the jurisdiction that is legally required to report that information in each state. Data are available through tables and keyword searches. Categories and keywords were used to collect the data for this report. Some data are reported in 3 year annual averages. Information was accessed from: http://www.cdc.gov/nchs/nvss.htm.

Please Note: Race and ethnicity for infant mortality rates are based on the mother’s reported race and ethnicity. Data are reported 2010 through 2013.

National Survey on Drug Use and Health (NSDUH)

The National Survey on Drug Use and Health (NSDUH) is the primary source of information on the use of illegal drugs by the U.S. population. Each year, about 70,000 individuals aged 12 years old and above are surveyed across the 50 United States and the District of Columbia. Race and Hispanic origin were collected using the 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Data are reported as AIAN-only (Not Hispanic or Latino) in comparison to White-only (Not Hispanic or Latino). Data are not California specific and are reported for the entire United States. Data are reported for 2013. NSDUH data can be accessed at http://www.samhsa.gov/data/population-data-nsduh.
NOTES ON DATA SOURCES

Sanitation Deficiency System (SDS)

The Sanitation Deficiency System (SDS) is a web-based database used by IHS to track sanitation facilities projects and existing operation and maintenance organizations. The IHS Sanitation Facilities Construction (SFC) Program works with tribes to provide construction, development, technical assistance and continued operations of safe water, sewer, and solid waste systems. Sanitation services are provided to AIAN that are eligible to receive IHS services. Eligible AIAN include: any member of a federally recognized tribe or any descendant of an Indian who was residing in California on June 1, 1852; any Indian who holds trust interests in public domain, national forest, or Indian reservation allotments in California, or any Indian in California who is listed on the plans for distribution of the assets of California rancherias and reservations and any descendant of such an Indian. In addition, the home must be located within the sponsor tribe's Contract Health Service Delivery Area (CHSDA), be in like-new condition, and mobile homes must be skirted and on a permanent foundation.

In the California IHS Area, the California SFC service area includes 38 counties. Four counties in California have sanitation services through the Phoenix IHS Area, these include Alpine, Imperial, Inyo, and Mono, therefore data are not included in this report for these counties.

This map shows the California SFC service area. The SDS data system is one of six major data systems in the IHS Sanitation Tracking and Reporting System (STARS). SDS documents information about sanitation deficiencies related to AIAN individual homes and communities. In the SDS classification system, homes are often grouped at the community level and there is often more than one community grouped within a reservation. The California IHS Area SDS contains 160 communities.
United States Census

The United States Census is collected on a decennial schedule, and United States citizens are required by law to complete the Census survey. Data for the Census are gathered via mailed surveys to 120 million households throughout the United States. For households that did not receive a survey in the mail or for whom a survey was not returned in the mail to the government, enumerators go door-to-door to collect Census data. In 2010, the long-form survey of the United States Census was reduced to 10 questions called the American Community Survey (ACS), and it replaced the long-form Census survey.

Race is self-reported in the United States Census. In 2010, respondents were allowed to mark more than one race. In the Census survey, AIAN is defined as having descended from any of the original peoples of North and South America (including Central America) and maintain community attachment of tribal affiliation (https://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf). In this California AIAN Community Health Profile, CTEC used 2010 Census data from those who indicated that their race was “AIAN alone” or “AIAN combined with one or more race.”
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Important Terms

Race and Ethnicity Definitions

Federal Trust Responsibility

California At A Glance

Median Income
Geography: Entire State of California. AIAN alone compared to non-Hispanic White.

Below Poverty
Geography: Entire State of California. AIAN alone compared to non-Hispanic White.

Unemployment
Geography: Entire State of California. AIAN alone compared to non-Hispanic White.

Utilized Supplemental Nutrition Assistance Program
Geography: Entire State of California. AIAN alone compared to non-Hispanic White.

A Healthy Spirit

Practiced Traditional Healing in Past Year
Source: 2013 California Tribal Behavior Risk Factor Community Survey: California Tribal Epidemiology Center.
Geography: Entire state of California. AIAN only. Respondents aged 18 years old and above.

Used Tobacco for Ceremonial, Prayer, or Traditional Use
Source: 2013 California Tribal Behavior Risk Factor Community Survey: California Tribal Epidemiology Center.
Geography: Entire state of California. AIAN only. Respondents aged 18 years old and above.
A Healthy Body

Diabetes

*Ever Diagnosed with Diabetes*
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Pooled two years of data.

*Type I or Type II Diabetes*
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Pooled two years of data.

*Ever Diagnosed with Diabetes During Pregnancy*
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Results not available for multiple years.

Good Glycemic Control
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Patients with diagnosed diabetes.

Blood Pressure Control
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Patients with diagnosed diabetes.

Diabetic Assessments
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Patients with diagnosed diabetes.

Heart Disease

*Ever Diagnosed with Heart Disease*
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Pooled two years of data.
NOTES ON FIGURES

Cholesterol Level Screening
Geography: Entire state of California. Multiple racial category of AIAN only compared to White only.

Cardiovascular Disease Assessment
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. At risk patients.

Exercise, Controlling Obesity, Eating Healthy

Level of Physical Activity
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Teens. Pooled two years of data.

Proportion of Young Children with Age-Calculated BMIs At or Above the 95th Percentile
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Children aged 2-5 years old.

Daily Fruit and Vegetable Consumption (5 or more)
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Children. Pooled two years of data.

Fast Food Consumption in the Last Week
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Respondents 2 years old or above. Pooled two years of data.

Cancer

Colon Cancer Screening
Source: 2014 IHS Performance Measure
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Patients aged 50 years old and above.
Cervical Cancer Screening
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Female patients aged 24 through 64 years old with a Pap screen completed within the past 3 years and women aged 30 through 64 years old with a Pap screen and an HPV DNA completed within the past 5 years.

Breast Cancer Screening
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Female patients ages 50 to 64 years old screened within the past 2 years.

Personal Health

HIV Screening in Pregnancy
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Pregnant women.

Ever Tested for HIV
Geography: Entire state of California. Multiple racial category of AIAN only compared to White only.

Rates of Sexually Transmitted Diseases
Source: 2013 California Department of Public Health STD Control Branch: http://www.cdph.ca.gov/data/statistics/Pages/STDDataTables.aspx
Geography: Entire state of California. Native American/Alaska Native compared to non-Hispanic White.

Congenital Syphilis
Geography: Entire state of California. Native American/Alaska Native compared to non-Hispanic White.

Dental Health

Dental Visits
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas.
NOTES ON FIGURES

Topical Fluoride Treatments
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas.

Dental Sealants
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas.

Maternal and Child Health

Infant Mortality
Geography: Entire State of California. AIAN compared to White.

Low Birth Weight
Geography: Entire State of California. AIAN compared to White.

Preterm Birth
Geography: Entire State of California. AIAN compared to White.

Month Began Prenatal Care

Age of Mother at Birth of First Child

Breastfeeding Rates
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Pregnant women.
A Healthy Mind

**Mental Health**

*Depression Screening*
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Adults ages 18 years old and above.

*Psychological Distress*
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Pooled for two years of data.

*Prescription Medication for Mental Health Issues*
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Adults who received medication for emotional/mental/substance abuse problems in the past 12 months. Pooled two years of data.

**Alcohol Abuse**

*Fetal Alcohol Syndrome Screening*
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Female clients aged 15 to 44 years old.

*Binge Drinking*
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Pooled two years of data.

*Number of Drinks Monthly*
Geography: Entire state of California. Multiple racial category of AIAN only compared to White only.
NOTES ON FIGURES

Commercial Tobacco Use

Current Smoker
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget
definition of non-Latino White. Pooled two years of data.

Smokers Received a Tobacco Cessation Intervention
File/2014_California_Book.pdf
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Tobacco-
using patients.

Days Breathed Secondhand Smoke in Indoor Public Workplace
Source: 2013 California Tribal Behavior Risk Factor Community Survey: California Tribal Epidemiology Center.
Geography: Entire state of California. AIAN only. Respondents aged 18 years old and above.

Drug Abuse

Illicit Drug Use
Source: Health, United States 2002-2013, National Survey on Drug Use and Health: http://www.cdc.gov/
Nchs/data/hus/hus14.pdf#055
Geography: United States. AIAN only compared to White only.

Non-medical Use of Prescription Drugs
Source: Health, United States 2002-2013, National Survey on Drug Use and Health: http://www.cdc.gov/
Nchs/data/hus/hus14.pdf#055
Geography: United States. AIAN only compared to White only.

Access to Health Care

Type of Medical Insurance
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget
definition of non-Latino White. Pooled two years of data.
NOTES ON FIGURES

Immunizations

Childhood Immunizations
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Children aged 19-35 months old.

Influenza Immunizations
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Adults ages 65 years and above.

Pneumococcal Immunizations
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Adults aged 65 years old and above.

Elder Falls

Elder Fell More Than Once in Past Year
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Respondents 65 years old and above. Pooled two years of data.

Elder Hospitalized Due to Falls in Past Year
Geography: Entire state of California. Any mention of AIAN compared to Office of Management and Budget definition of non-Latino White. Respondents 65 years old and above who have fallen in the past 12 months. Pooled data for two years.

Environmental Health

Water Deficiency
Geography: California IHS Sanitation Facilities Construction reporting area (34 counties).

Sewer Deficiency
Geography: California IHS Sanitation Facilities Construction reporting area (34 counties).
NOTES ON FIGURES

**Solid Waste Deficiency**
Geography: California IHS Sanitation Facilities Construction reporting area (34 counties).

**Domestic Violence**

*Domestic Violence Screening*
Geography: 34 California Tribal and Urban Indian Health Programs compared to all 12 IHS areas. Female clients aged 15-40 years old.

*Violence by Intimate Partner*
Source: 2013 California Tribal Behavior Risk Factor Community Survey: California Tribal Epidemiology Center.
Geography: Entire state of California. AIAN only. Respondents aged 18 years old and above.
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## CALIFORNIA TRIBAL HEALTH PROGRAMS

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<tr>
<th>THP</th>
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<th>Active Users</th>
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<td>ANAV Tribal Health Clinic</td>
<td>Fort Jones</td>
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Active User numbers were reported by IHS in 2014.