California Tribal Epidemiology Center

Toiyabe Indian Health Project
American Indian
Community Health Profile

Issued May 2010

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Toiyabe Indian Health Project
American Indian Community Health Profile

Produced by the California Tribal Epidemiology Center

May 2010

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Attention:

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

Acknowledgements:

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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 or 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.

Dagger (†): Data source is not specific to the tribal health program area due to data being either unreliable or unavailable.

Eligibility of California Indians: California has additional, specific eligibility criteria in addition to national IHS 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 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 Indian and/or Alaska Native descent as evidenced by one or more of the following factors:

   A. Is regarded by the community in which he/she lives as an Indian or Alaska Native;

   B. Is a member, enrolled or otherwise, of an 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

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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 disease 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 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 American Indians and Alaska Natives can be classified by self-identification, tribal enrollment, Indian descendent, and many other factors. In this report, each data source defines American Indian in different ways:

Behavioral Risk Factor Surveillance System (BRFSS): Self-reported single race as AIAN

California Dept of Public Health Sexually Transmitted Diseases Control Branch: Non-Hispanic AIAN

California Health Interview Survey (CHIS): Any self-reported mention of AIAN

Indian Health Service Performance Measure (IHSPM): IHS Active Users

National Survey on Drug Use and Health (NSDUH)*:* Non-Hispanic AIAN

Sanitation Tracking and Reporting System (STARS): An AIAN enrolled member or a descendant of a federally recognized tribe

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 is not a reliable estimate due to low numbers, and should be interpreted with caution.

THP: Tribal Health Program.

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Why A Community Health Profile?

In 2005, the California Tribal Epidemiology Center was established to assist California Tribal Health Programs (THP) in their efforts to improve wellness and prevent disease in their clients. A collective California profile was created in 2009 as a resource for all Tribal programs. This Toiyabe Indian Health Project specific profile is available as a resource for your program.

What can you do with a Community Health Profile?

- Further understand how data is collected and reported for Indians living in California.
- Use as a resource for grant applications that require data, facts and figures.
- Use as a tool to help decide where your THP can focus its time, money, and efforts related to health issues.

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California Indian History

Background and Historical Context

There are currently 107 federally recognized Indian tribes, rancherias, and federations in the state of California. California is home to approximately 40 unrecognized tribes and 10 terminated tribes eligible for restoration. 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 American Indian 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, 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 first outsiders to arrive in California were the Spanish, beginning in 1769. They brought a devastating mission system, soldiers, labor camps, and destructive diseases to California. 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

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California Indian History

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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 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. 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

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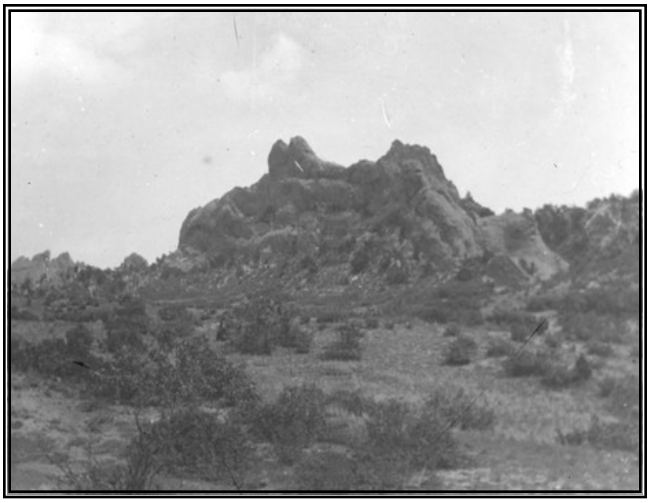

Courtesy, National Museum of the American Indian, Smithsonian Institution (L01353).

-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. The result was that the number of rancherias in California dropped 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. Much later after the Transfer Act was passed, in 1980 the Department of Health, Education and Welfare was renamed the Department of Health and Human Services (DHHS). The Indian Health Service (IHS) is currently housed within DHHS and is organized into 12

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service areas that cover the entire U.S. These service areas vary in size and American Indian/Alaska Native population. California is its own service area, though there are 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 closed federal prison building and land 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 organization were also formed during this time period, some of these organizations include, 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 the 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 the U.S. Congress. The purpose of IHCIA was to provide "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. Other laws such as the American Indian Religious Freedom Act and the Indian Child

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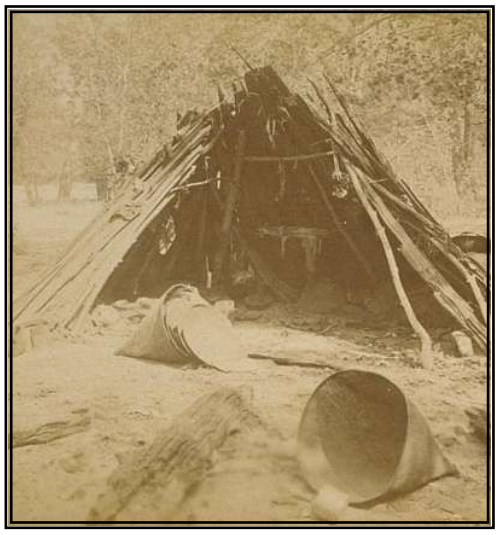
Welfare Act were also passed in the late 1970's through advocacy of strong Indian leadership. These two laws, though serving separate needs, helped to reinforce tribal rights and tribal sovereignty.

Due to the passage of the ISDEA, health care for Indian people in California has improved. There are currently 44 health programs in California that operate under contracts and compacts with the IHS. Of these, 32 are Tribal Health Programs that 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. Although there is a legal responsibility for services, the IHCIA has not been amended for improvements by the U.S. Congress since 1992.

The California IHS health care service area does not cover the entire state of California; it includes 37 of the 58 counties in the state. 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. This is partly due to the size of California in population and in land mass. The diverse tribal cultures and languages that exist throughout the state add to the 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.



California Indian History

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 founds 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—September 9, California becomes 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.

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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."

1934—President Franklin D. Roosevelt signs the Indian Reorganization Act (25 U.S.C. 461). Sixty-one California reservations totaling 7,500 acres are set aside for Indian tribes.

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.

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.

1978—American Indian Religious Freedom Act and Indian Child Welfare Act are passed.

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.

Your Community At A Glance

Toiyabe Indian Health Project service area includes the beautiful Inyo and Mono Counties in the eastern central part of California and bordering the state of Nevada. The Toiyabe Indian Health Project is governed by a consortium of tribes, which include the Big Pine Band of Owens Valley Paiute Shoshone Indians, Bridgeport Indian Colony, Death Valley Timbi-Sha Shoshone Band, Paiute Indians of the Fort Independence Reservation, Paiute Shoshone Indians of the Bishop Colony, Paiute Shoshone Indians of the Lone Pine Reservation, and Utu Utu Gwaitu Paiute Tribe of the Benton Paiute Reservation. It has a fourteen member board. The ancestral tribes of the area represented by the above mentioned tribes are the Northern Paiute, Mono, Shoshone and Timbisha.

The geography of Mono and Inyo counties highly influences tribal culture, traditions, and ceremonies. The counties stretch from the desert valleys, such as Death Valley to the high mountain terrain of the Eastern Sierra's. The climate varies, and the greatest difference between the mountain and the valley regions are the summers. The summer valley temperatures reach as high as the 120 degrees Fahrenheit. There are many lakes throughout the two counties that along with the mountains contribute to the scenic byways and national and state parks, which protect California's old growth forests. Many tribes have historically relied on the lakes and the Owens River for subsistence in the arid valleys. Traditional diet for these tribal areas includes pine nuts, ricegrass, deer, rabbits, acorns, berries, as well as various fresh water fish.

The median household income in 1999 in Mono and Inyo counties for American Indians/Alaska Natives (AIAN) was $24,322 and for non-Hispanic Whites it was $41,860. Also in 1999, almost 25% of AIAN families living in Mono and Inyo counties were living below the poverty line, compared to 6% of non-Hispanic White families. In these counties, about 10% of AIAN and 3% of non-Hispanic Whites were unemployed.

The 2000 Census reported there were 30,798 people living in Mono and Inyo counties, and the median age was 39.4 years. 2,481 people in these counties self-identified as being AIAN, reporting their race as either only AIAN or AIAN in combination with one or more other races. Of this group, 2,111 reported their race as being only AIAN, with the median age being 32.0 years, and 51% being male. All descendents of Indian ancestors residing in California from the 1852 rolls, and those of federally recognized tribes are eligible for services by Toiyabe Indian Health Project. In 2008, Toiyabe Indian Health Project had 2,681 active AIAN users, and a total active user population of 4,771 people.

Toiyabe Indian Health Project currently operates one main clinic in Bishop, California and a satellite facility in Lone Pine, California to serve the more remote locations in their service area. The clinics offer general medicine, general dental, pharmacy, dialysis, behavioral health and outreach services.

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A Healthy Spirit

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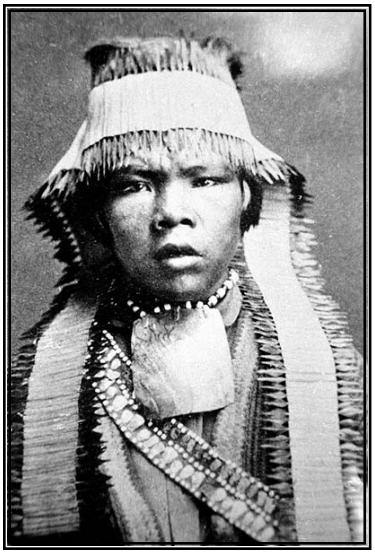
A Healthy Spirit

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 Indian 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 Indian spirituality can vary from tribal nation to tribal nation, community to community, and among individuals, common themes are evident. These common themes include creation stories, deities, ceremonies, language and traditional foods and culture among many other activities and beliefs. Traditional Indian culture encompasses many things but typically includes believing in a deity or deities who created the universe. 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 Indian 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 Indian 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 Indian people. During many of our ceremonies we eat traditional foods that provide a well balanced nutritional diet and which is much different from what is offered by mainstream America. Foods such as acorns are a significant food source for nearly all California Indian 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 Indians reveal a united worldview of the sacred and secular, of what is seen and unseen, all of which affects health and wellness. For some Indian people, a traditional spiritual way of living brings a sense of "being in a good way." For others, following another spiritual path will allow them to "get right with their Maker." There are some who combine these or other spiritual approaches into their belief system and receive healing. In the end, this view of the world, community, wellness and identity is something that strengthens us and keeps us alive as Indian people.

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A Healthy Body

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A Healthy Body

Wellness in a community is built upon a foundation of wellness among its individuals; and wellness in individuals is built on many factors - a healthy body is certainly one of them. Eating right, exercising, visiting the doctor regularly for screenings, and practicing safe behaviors will help to ensure that you, your family, and your community live balanced, healthy lives.

This section will cover the topics of Diabetes, Heart Disease, Eating, Exercise, Obesity, Cancer, Dental 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 occurs in about 5-10% of the population with diabetes and is typically evident at an early age. The remaining 90-95% of people with diabetes have Type II. Type II diabetes occurs when cells in our organs such as in our liver, brain, muscles and others are poorly responsive to insulin. That is, the insulin does not allow cells to accept the sugar that it needs for energy. The rate of diabetes is almost twice as high for American Indians/Alaska Natives than it is for the rest of the U.S. population. **Heart Disease** includes narrowed or blocked coronary arteries as a result of high cholesterol and high blood pressure. All of these conditions can lead to heart attacks (myocardial infarctions) and strokes. Managing weight, exercising, eating right, and limiting intake of cholesterol, fat and sugars can help to control or prevent heart disease and diabetes. Heart disease is the leading cause of death in American Indians/Alaska Natives. **Obesity**, or being overweight, will oftentimes contribute to the development of heart disease and diabetes. Thus, diabetes, heart disease, and obesity may be prevented by eating right: a diet low in fat and high in fruits, vegetables, and whole grains, as well as exercising every day. Eating healthy and exercise are the paths to achieving a healthy body.

Visiting the doctor regularly is important for general health - especially **Cancer** screenings. This screening involves undergoing medical tests which detect certain types of cancer before the patient has symptoms, and that are more easily cured the earlier they are found. Thus, receiving routine cancer screenings is a prevention tool that can help detect cancer before it reaches a more serious stage, or result in early death. Furthermore, having annual gynecological exams and getting tested for sexually transmitted diseases can help keep you safe. One of the most important preventative components to **Personal Health** is practicing safe sex—including consistent use of a condom. **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 6 months will promote overall wellness. Thus, practicing preventative behaviors, such as undergoing cancer screenings, wearing condoms during intercourse, and going to regular doctor and dental checkups, can help ensure a healthy body.

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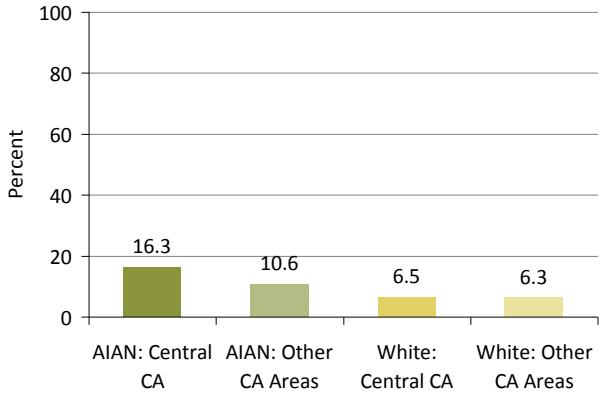
Diabetes

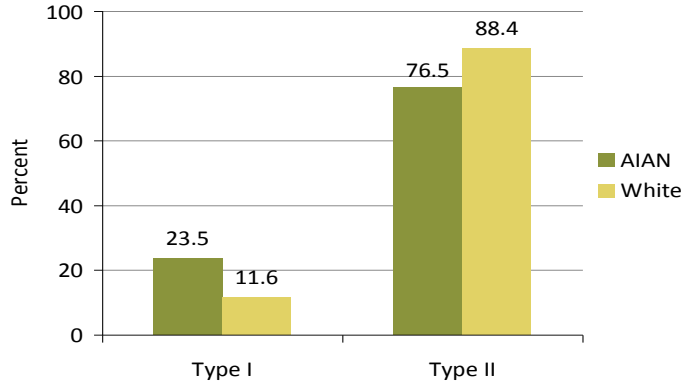
Diabetes is a chronic illness that can lead to heart disease, blindness, kidney disease, and amputations. It is the fourth leading cause of death for American Indians and Alaska Natives in the U.S. Rising rates of obesity have contributed to the growing number of people diagnosed with diabetes. Early screenings and diabetic assessments can help identify the disease and reduce associated complications.

Ever Diagnosed with Diabetes (CHIS)



Approximately 16% (CI: 10.1%-22.4%) of AIAN in central California and 11% (CI: 7.7%-13.5%) of AIAN in other areas of California reported they had been diagnosed with diabetes. This is in comparison to almost 7% (CI: 5.7%-7.3%) of non-Hispanic Whites in central California and 6% (CI: 5.9%-6.8%) in other areas of California that reported a diagnosis of diabetes.

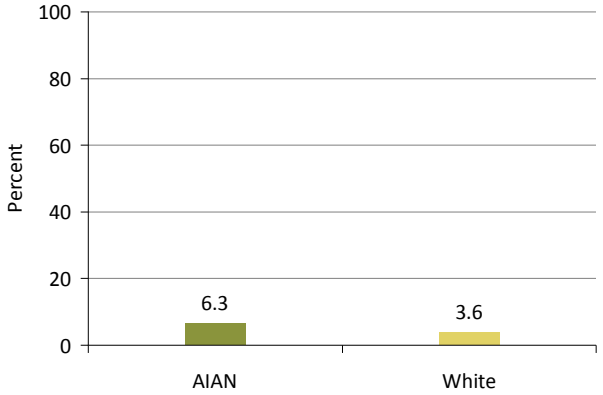
Type I or II Diabetes (CHIS)†



Of those who have been diagnosed with diabetes, about 24% (CI: 15.9%-31.2%) of California AIAN and 12% (CI: 10.2%-13.0%) of non-Hispanic Whites reported they had been diagnosed with Type I diabetes; 77% (CI: 68.8%-84.1%) of AIAN and 88% (CI: 87.0%-89.8%) of non-Hispanic Whites reported they had Type II diabetes. Type I is when the body cannot produce enough insulin to allow the body to turn sugars in food into usable energy; Type II diabetes occurs when cells in the organs are poorly responsive to insulin.

† *Data is for the entire state of California, central California data is unreliable.*

Ever Diagnosed with Diabetes During Pregnancy (CHIS)†



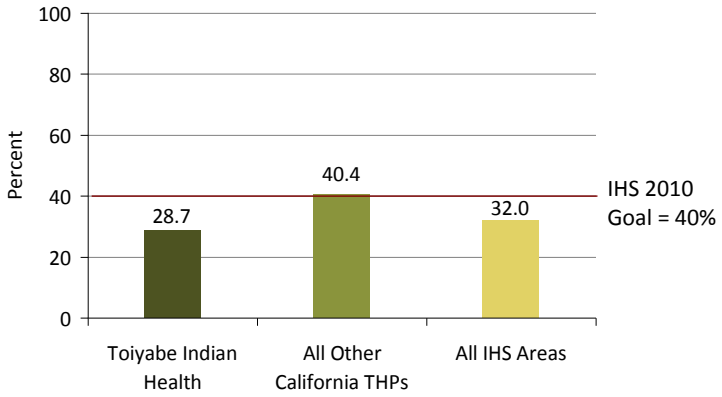
For currently non-diabetic adult women in California, 6% (CI: 3.9%-8.6%) of AIAN and almost 4% (CI: 3.1%-4.1%) of non-Hispanic Whites reported they had been diagnosed with diabetes during pregnancy. Having diabetes only while pregnant is known as gestational diabetes.

† *Data is for the entire state of California, central California data is unreliable.*

Diabetes

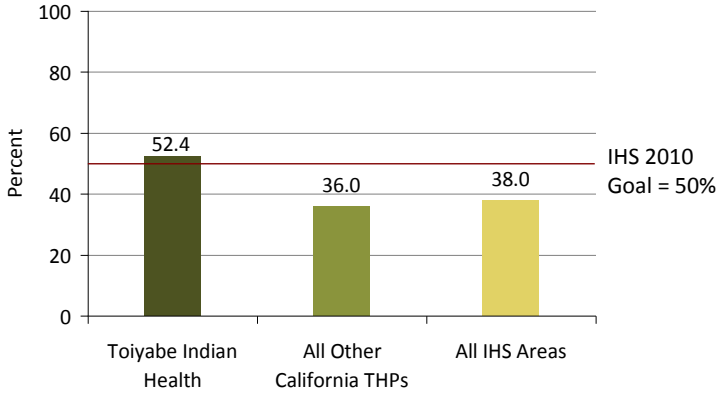
Ideal Glycemic Control (IHSPM)

Ideal glycemic control for diabetic patients is having a current hemoglobin A1c (measure of blood sugar levels) less than or equal to 7. Having a hemoglobin A1c level below 7 is essential in slowing or preventing diabetic complications of the eyes, kidneys, heart and nerves. Of diabetic patients seen at Toiyabe Indian Health, about 29% (n=73) had a measure less than 7, compared to 40% (n=1833) in other reporting California THP and approximately 32% in all IHS areas.



Blood Pressure Control (IHSPM)

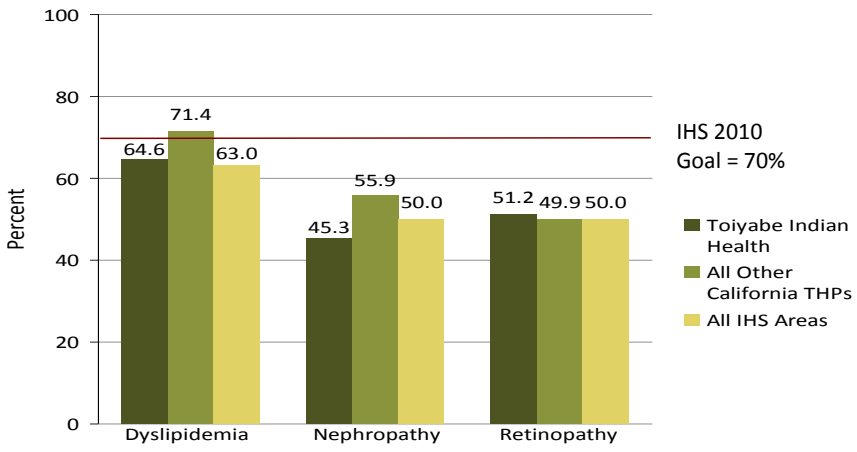
Adequate blood pressure control means achieving a pressure less than 130/80. Reaching this goal will reduce the likelihood of diabetic complications, among other adverse health outcomes. Of diabetic patients seen at Toiyabe, 52% (n=133) achieved blood pressure control, whereas 36% (n=1634) have in other reporting California THP and approximately 38% have in all IHS areas.



Diabetic Assessments: Testing Cholesterol, Kidney and Eye Complications (IHSPM)

Patients may reduce their diabetic complications by undergoing comprehensive assessments. These assessments include tests for high cholesterol, kidney disease and eye complications. The IHS goal is to have these three tests completed annually for at least 70% of all diabetic patients.

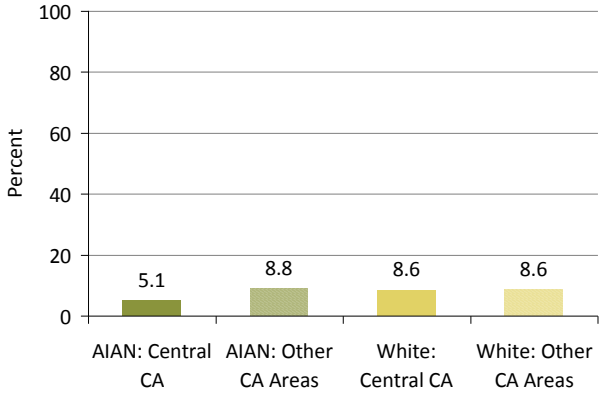
65% (n=164) of Toiyabe diabetic patients had a dyslipidemia (cholesterol) assessment, compared to 71% (n=3235) at other reporting California THP and approximately 63% in all IHS areas. At Toiyabe, 45% (n=115) of diabetic patients had a nephropathy (kidney) assessment compared to 56% (n=2532) at other THP and about 50% in all IHS areas. 51% (n=130) of diabetic patients had a proper retinal examination at Toiyabe, whereas proportions at all other California THP and all IHS areas were 50%.



Heart Disease

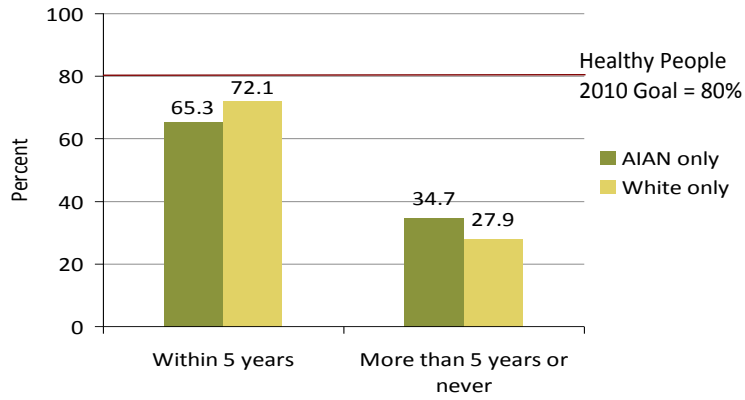
Heart disease is the leading cause of death for American Indians and Alaska Natives. High blood pressure, high cholesterol, smoking, a lack of physical activity, and obesity all contribute to the development of heart disease.

Ever Diagnosed with Heart Disease (CHIS)



For adults in central California, 5% (CI: 3.3%-6.9%) of AIAN and 9% (CI: 7.8%-9.5%) of non-Hispanic Whites reported they had been diagnosed with heart disease. Whereas, 9% (CI: 6.1%-11.6%) of AIAN and 9% (CI: 8.1%-9.2%) of non-Hispanic Whites had been diagnosed with heart disease in other California areas.

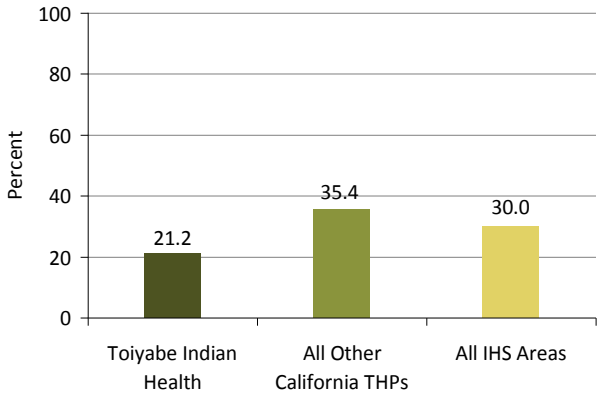
Cholesterol Level Screening (BRFSS)†



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 if medication or lifestyle changes are necessary. An ideal total cholesterol level is less than 200 mg/dL. The recommended national target for Healthy People 2010 is for at least 80% of adults to have a cholesterol screening. Almost 35% (CI: 24.3%-45.3%) of AIAN and 28% (CI: 26.2%-29.6%) of non-Hispanic Whites in California have not had a cholesterol check in past 5 years.

† *Data is for the entire state of California, central California data is unavailable.*

Cardiovascular Disease Assessment (IHSPM)



Of patients who have been diagnosed with coronary heart disease, 21% (n=14) at Toiyabe, 35% (n=464) in other included California THP and approximately 30% in all IHS areas have had a comprehensive cardiovascular disease assessment. This annual assessment includes the following tests: blood pressure, cholesterol levels, tobacco use, Body Mass Index (BMI) calculated and lifestyle counseling. BMI is an estimated measure of body fat based on height and weight.

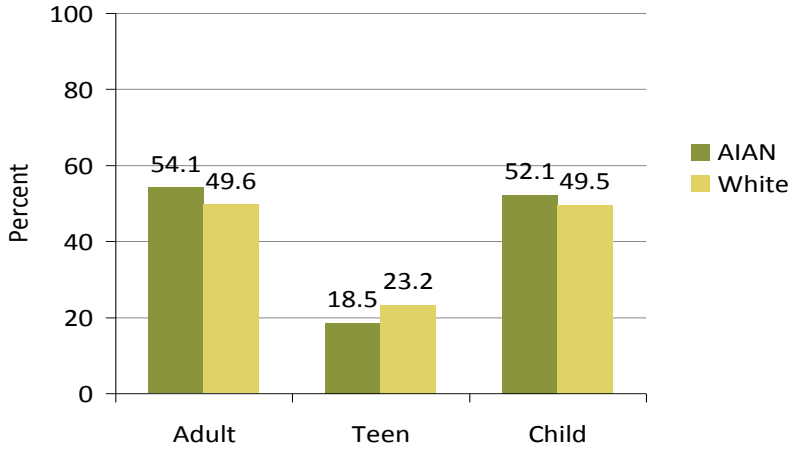
Eating Healthy, Exercise, & Controlling Obesity

Regular physical activity is important to maintain a healthy body and aids in weight control. 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 key to maintaining a healthy weight.

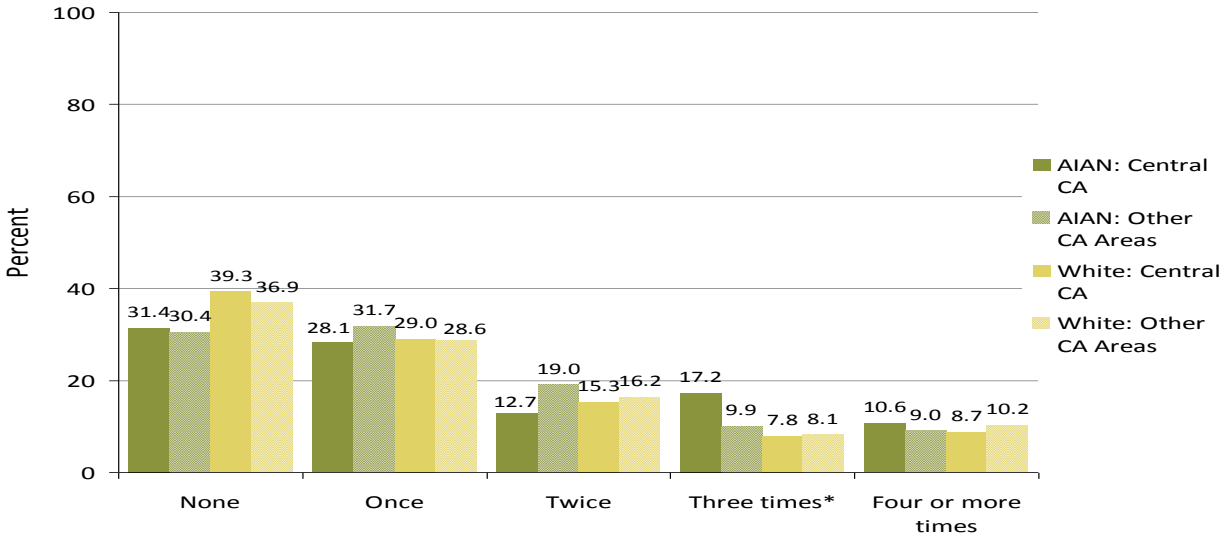
Daily Fruit and Vegetable Consumption (CHIS)†

In California, similar proportions of AIAN and non-Hispanic Whites consume five or more servings of fruit/ vegetables daily.

† *Data is for the entire state of California, central California data is unreliable.*



Fast Food Consumption in the Last Week (CHIS)



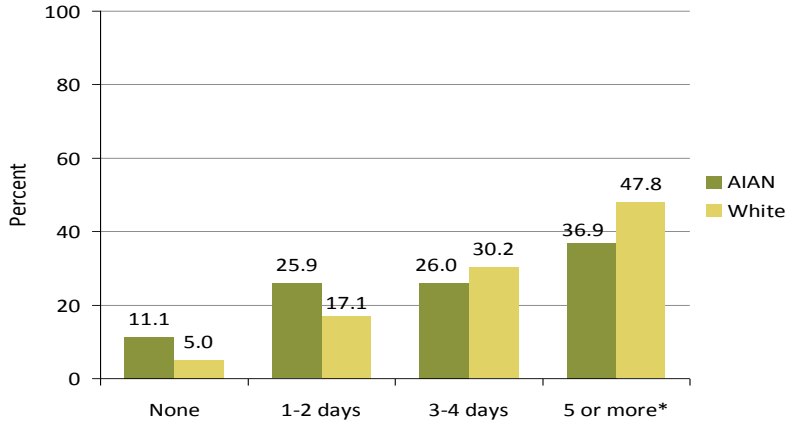
Almost 11% (CI: 5.1%-16.2%) of AIAN in central California ate fast food four or more times in the past week compared to 9% (CI: 5.6%-12.4%) of AIAN in other areas of California. Furthermore, 31% (CI: 22.5%-40.2%) of AIAN in central California did not eat fast food in the last week compared to 30% (CI: 24.6%- 36.2%) of AIAN in other areas of California.

**Includes statistically unstable data.*

In addition, fast food eaten by central California youth (aged 2 to 17 years) in past day, 56% (CI: 44.3%-67.8%) of AIAN did not eat fast food compared to 70% (CI: 66.4%-73.3%) of non-Hispanic Whites (graph not shown).

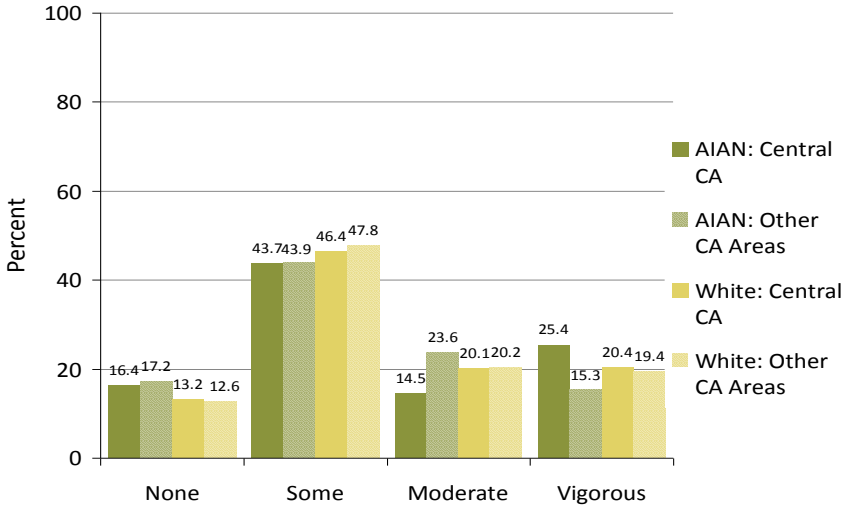
Eating Healthy, Exercise, & Controlling Obesity

Amount of Physical Activity (CHIS)†



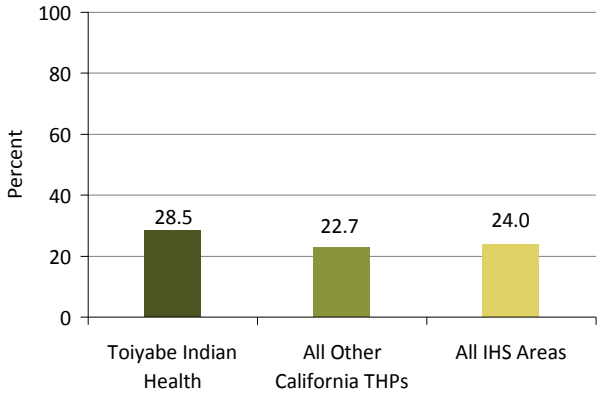
A little over 11% (CI: 5.8%-16.5%) of California AIAN reported no days of physical activity that lasted at least one hour in a typical week, compared to 5% (CI: 3.7%-6.3%) of non-Hispanic Whites.
**Includes statistically unstable data.*
† *Data is for the entire state of California, central California data is unreliable.*

Level of Physical Activity (CHIS)



When asked about physical activity in a typical week, almost 15% (CI: 8.3%-20.8%) of AIAN in central California and 24% (CI: 17.6%-29.5%) of AIAN in other areas of California reported that they had moderate physical activity. Moderate activity refers to activities that take moderate physical effort, such as 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 Obese Children (IHSPM)



The proportion of children aged 2-5 years that had a body mass index (BMI - a weight-for-height index) for age in the 95th percentile or higher was almost 29% (n=35) at Toiyabe, 23% (n=514) at other reporting California THP and 24% for all IHS areas. This means that the weight of these children was higher than 95% of other children, even after consideration of differences in their age and height. Children in the 95th percentile are considered to be obese; children between the 85th and 95th percentile are considered to be overweight or at-risk of being overweight.

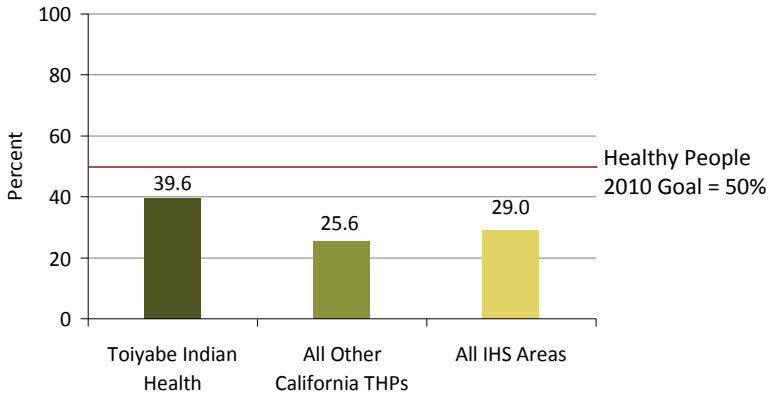
From 2003 - 2006, 17% of U.S. children aged 6-19 years had a BMI in the 95th percentile (graph not shown).

Cancer

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 cancer. Cancer is the second leading cause of death in American Indians and Alaska Natives.

Screening for Cancer of the Colon (IHSPM)

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, about 40% (n=180) were reported to have a colorectal cancer screening at Toiyabe Indian Health Project, compared to 26% (n=2193) of eligible patients in the other included California tribal health programs. The Healthy People 2010 screening goal is for at least 50% of eligible patients to have a colorectal cancer screening series.



Been Diagnosed with Cancer of the Colon (CHIS)†

Less than 1% of AIAN and non-Hispanic Whites in California reported a diagnosis of colorectal cancer (CI: 0.2%-0.7% and CI: 0.7%-0.8%, respectively).

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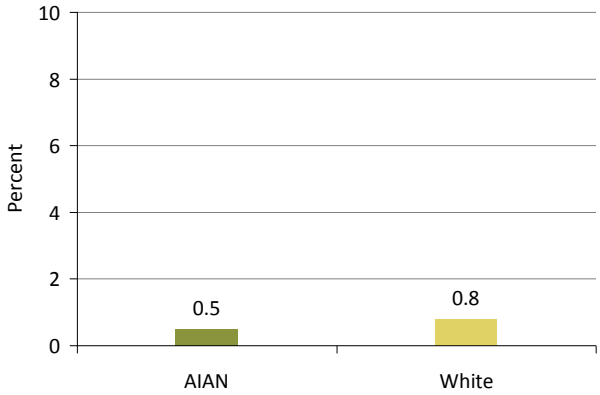
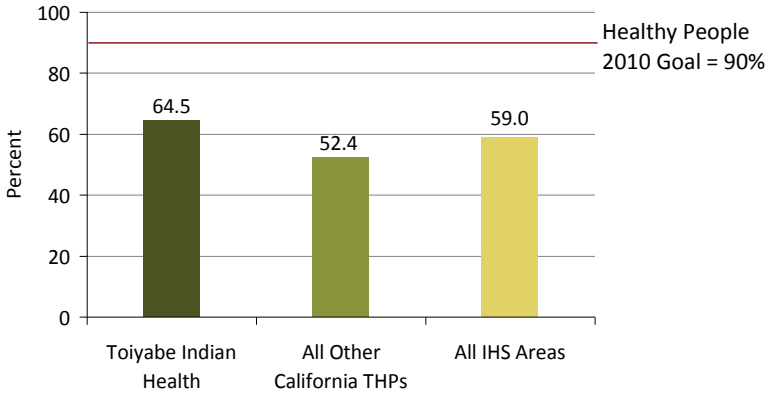


CANCER

Cervical Cancer Screening (IHSPM)

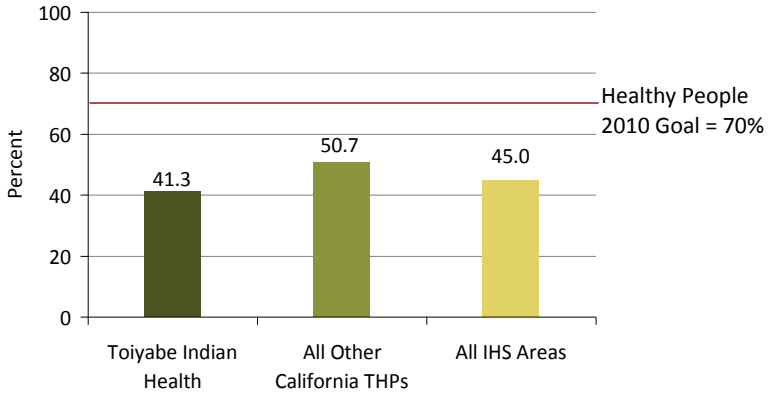
For women aged 21 to 64 years, almost 65% (n=410) of those served by Toiyabe Indian Health Project and approximately 59% by all IHS areas had a pap smear to screen for cervical cancer at least once within the last three years, whereas 52% (n=7342) of women did that were served by the other reporting California THP. The Healthy People 2010 goal is for at least 90% of women in this age range to have a pap smear to screen for cervical cancer.



Additionally, data from CHIS reports that in California, 10% (CI: 6.3%-12.7%) of AIAN and 5% (CI: 4.7%-5.9%) of non-Hispanic Whites have never had a pap smear (graph not shown).

Breast Cancer Screening (IHSPM)

Of women aged 50 through 64 years, 41% (n=66) served by Toiyabe had a mammogram within the last two years, while 51% (n=1478) of women aged 50 to 64 years did in the other reporting California THP and approximately 45% did in all IHS areas combined. The Healthy People 2010 goal is for at least 70% of women aged 50-64 to have a mammogram every two years.

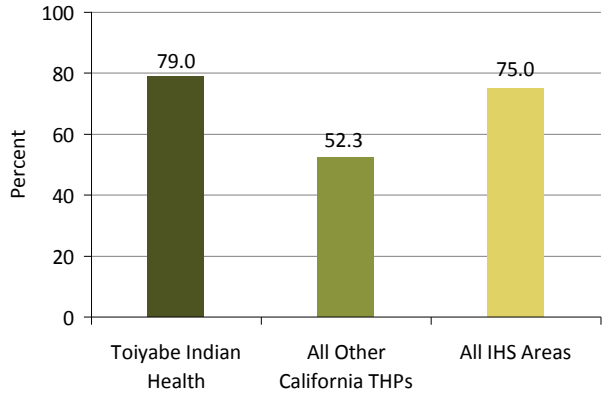


Furthermore, in central California, 26% (CI: 14.3%-37.4%) of AIAN women have never had a mammogram, compared to 18% (CI: 16.2%-20.0%) of non-Hispanic Whites (CHIS) (graph not shown).

Personal Health

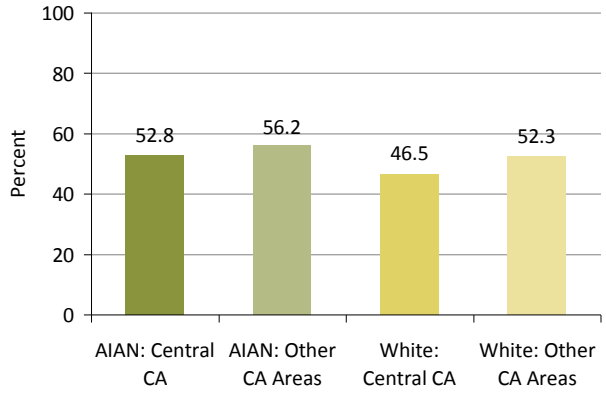
Sexually transmitted diseases (STDs) are common in the United States. Women typically suffer more serious complications from STDs than men, including pelvic inflammatory disease, ectopic pregnancy, infertility, and cervical cancer. In addition, having an STD increases the likelihood of contracting or transmitting HIV. Not knowing if 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 should be tested for STDs and HIV.

HIV Screening in Pregnancy (IHSPM)



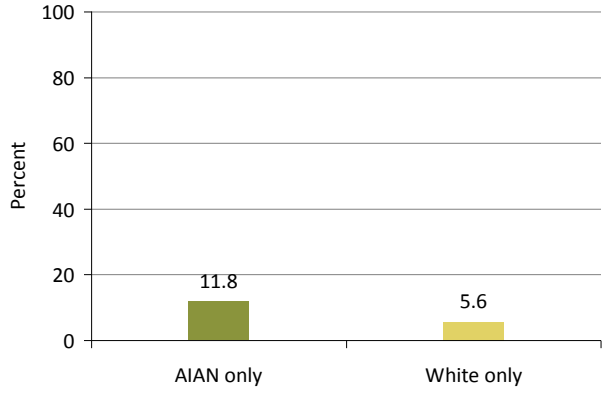
In all IHS areas combined, approximately 75% of pregnant women were screened for HIV, compared to 52% (n=532) of pregnant women being screened for HIV at other California tribal health clinics for which data is available, and 79% (n=49) were at Toiyabe Indian Health Project. Prenatal HIV screening is critical in reducing the risk of transmission from mother to child.

Ever Screened for HIV (CHIS)



In central California, 53% (CI: 45.0%-60.5%) of AIAN have been tested for HIV, whereas 47% (CI: 44.4%- 48.6%) of non-Hispanic Whites have been tested.

High Risk Behavior for HIV (BRFSS)†

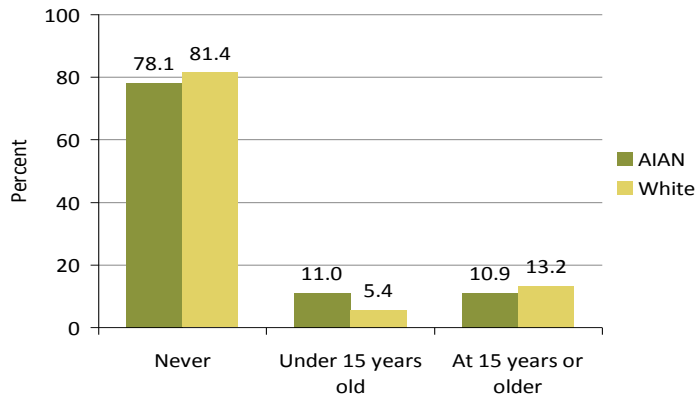


Almost 12% (CI: 2.6%-21.0%) of AIAN practice behavior that places them at a high risk for getting HIV compared to 6% (CI: 4.5%-6.6%) of Whites in California. High risk behavior includes using intravenous drugs, being treated for a STD, giving or receiving money or drugs for sex, or having anal sex without a condom in the past year.

† *Data is for the entire state of California, central California data is unavailable.*

Personal Health

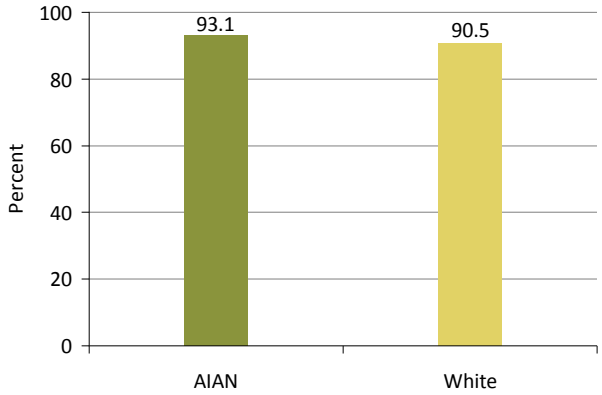
Age of Adolescents Having Sex (CHIS)†



In California, 11% (CI: 6.2%-15.8%) of AIAN adolescents (aged 12-17 years) reported having sexual intercourse before the age of 15, compared to 5% (CI: 4.1%-6.7%) of non-Hispanic Whites. The majority of AIAN and non-Hispanic White adolescents reported that they had not had sex.

† *Data is for the entire state of California, central California data is unreliable.*

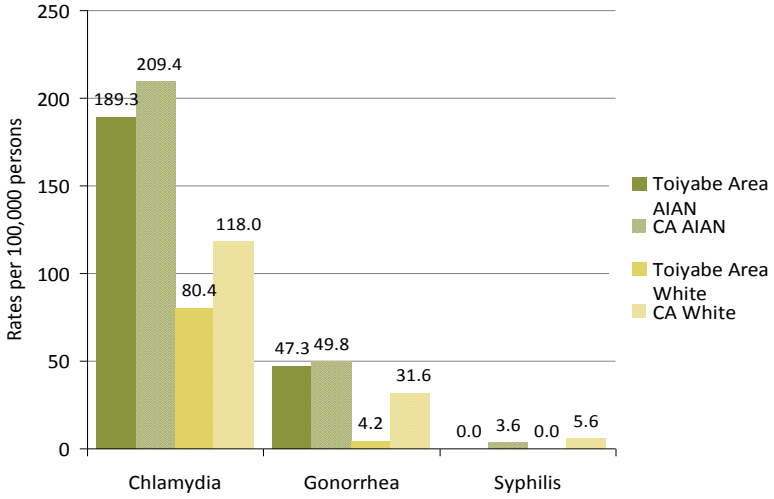
Adolescent Condom Use (CHIS)†



Condom use during sexual activities is effective in preventing pregnancy and many STDs, including HIV. A little over 93% (CI: 85.2%-100%) of AIAN adolescents in northern California aged 12 to 17 years reported using a condom during their last sexual encounter, compared to 91% (CI: 86.3%-94.8%) of non-Hispanic Whites.

† *Data is for the entire state of California, central California data is unreliable.*

Rates of Sexually Transmitted Diseases (CDPH)

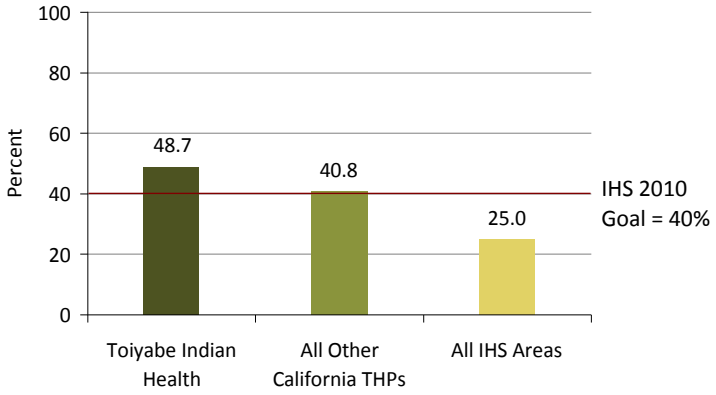


209 AIAN per 100,000 persons had Chlamydia in the entire state of California. In the Toiyabe area, 189 AIAN per 100,000 persons had Chlamydia compared to 80 Whites per 100,000 persons. For Gonorrhea in the Toiyabe area, there were 47 AIAN in comparison to 4 Whites per 100,000 persons. There were no reported cases of Syphilis in the counties served by Toiyabe Indian Health Project.

Dental Health

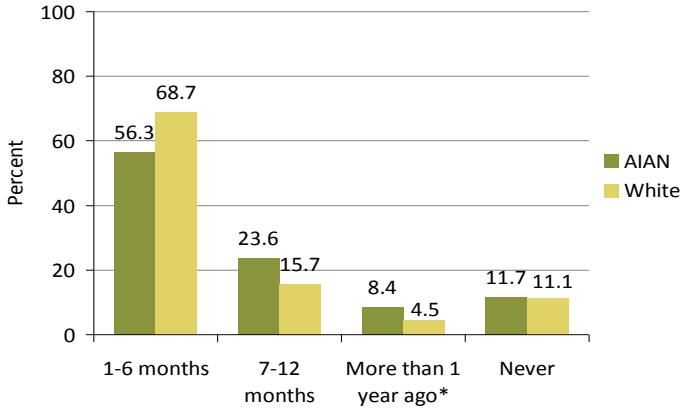
Proper dental care improves oral health and contributes to overall health. Such care is important for children as tooth decay is the most common chronic infectious disease of childhood and is also easily preventable.

Dental Visits (IHSPM)



About 49% (n=1393) of Toiyabe Indian Health Project active users have had a dental visit in the past year compared to 41% (n=28765) of other California THP active users for which data is available and approximately 25% in all IHS areas combined.

Youth Dental Visit History (CHIS)†

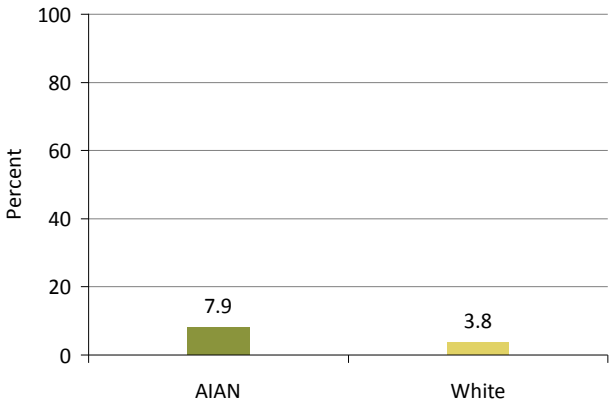


Of children aged 2 to 17 years in California, 69% (CI: 67.0%-70.4%) of non-Hispanic Whites and 56% (CI: 49.9%-62.7%) of AIAN had a dental visit in the last 6 months. Almost 24% of AIAN (CI: 17.9%-29.4%) youth had a dental visit between 7 and 12 months ago in comparison to 16% (CI: 14.3%-17.1%) of non-Hispanic Whites.

**Includes statistically unstable data*.

† *Data is for the entire state of California, central California data is unreliable.*

Unable to Afford Dental Care (CHIS)†



Almost 8% (CI: 4.4%-11.4%) of AIAN reported they could not afford needed dental care compared to 4% (CI: 2.9%-4.7%) of non-Hispanic Whites in California.

† *Data is for the entire state of California, central California data is unreliable.*

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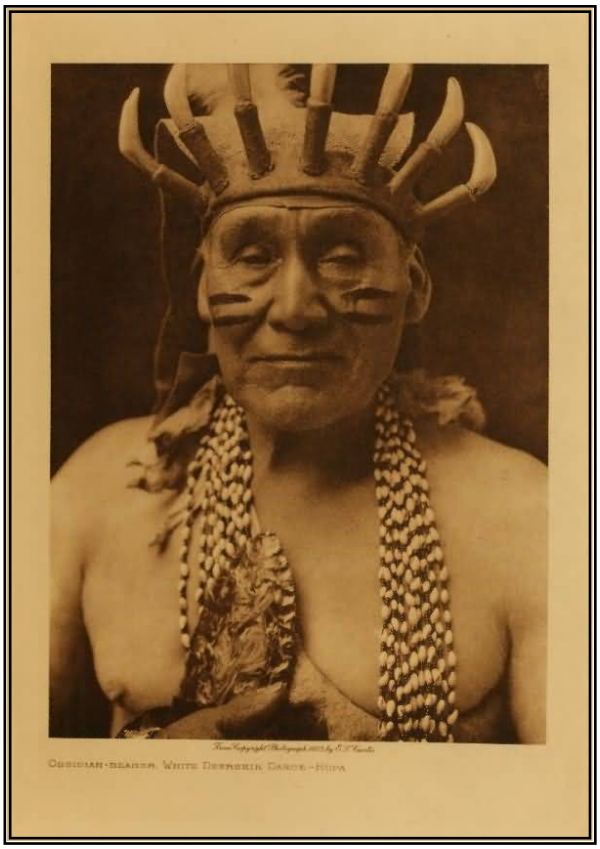
A Healthy Mind



Obsidian-Seaside. White Deerskin Dance.-Hopi.

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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 Indian 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 Indian 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 American Indians/Alaska Natives 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 American Indians/Alaska Natives have high rates of alcohol abuse, they also have the highest rate of complete abstinence from alcohol, indicating the power of the Native 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 illegal substances (heroin, cocaine, methamphetamines) or prescription drugs, is harmful to the body and can lead to poor mental health.

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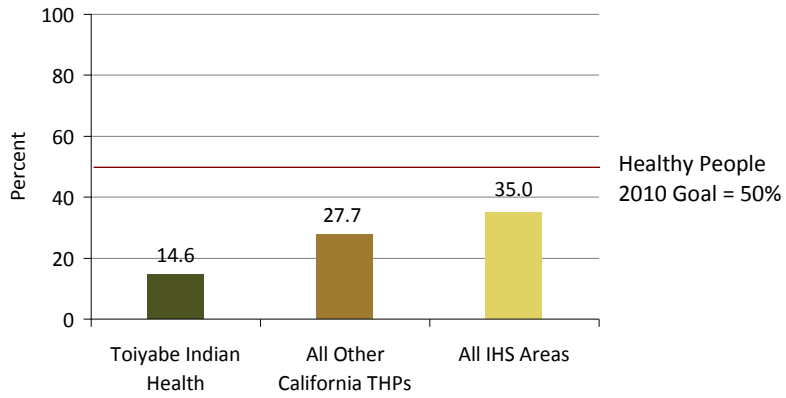
Mental Health

Depression is the most common mental health issue. Depression is associated with more than two-thirds of suicides, heart disease, diabetes, cancer, alcohol and drug abuse.

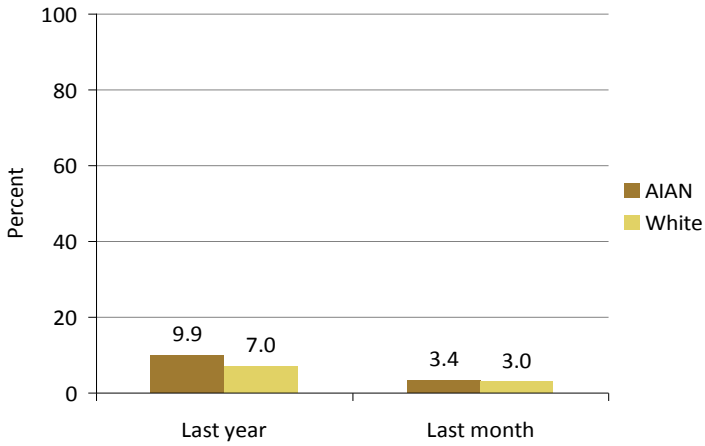
Depression Screening (IHSPM)

Depression is a common yet treatable mental illness--screening for it is an important preventative measure. About 15% (n=215) of adult patients at Toiyabe were screened for depression, compared to 28% (n=8847) in the other reporting California tribal health clinics and approximately 35% in all IHS areas. The Healthy People 2010 goal is to screen at least 50% of patients 18 years and older for depression.



Psychological Distress (CHIS)

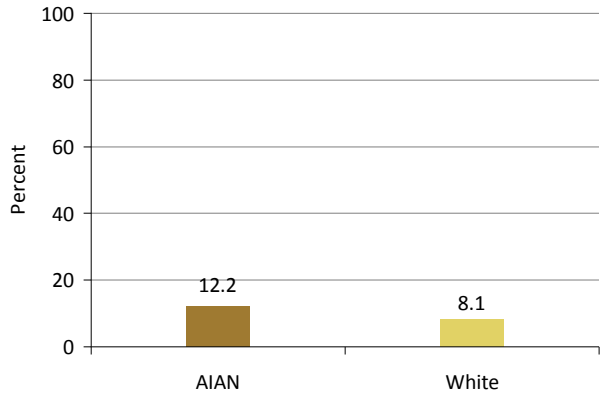
The Kessler 6 Series is often used to measure psychological distress, looking at variables such as feeling restless, depressed, nervous, and worthless. Almost 10% (CI: 5.0%-14.9%) of AIAN reported psychological distress in the past year compared to 7% (CI: 5.8%-8.1%) of non-Hispanic Whites in central California. In the past month 3% of AIAN (CI: 1.6%-5.2%) and non-Hispanic Whites (CI: 2.4%-3.7%) reported psychological distress in central California.



Difficulty Receiving or Accessing Mental Health Care (CHIS)†

In California, over 12% (CI: 9.5%-15.0%) of AIAN reported difficulty in accessing or receiving mental health care in the past year, compared to 8% (CI: 7.4%-8.7%) of non-Hispanic Whites. "Access to healthcare" includes but is not limited to: availability of health services, transportation to appointments, obtaining an appointment, and clinic availability.

† *Data is for the entire state of California, central California data is unreliable.*

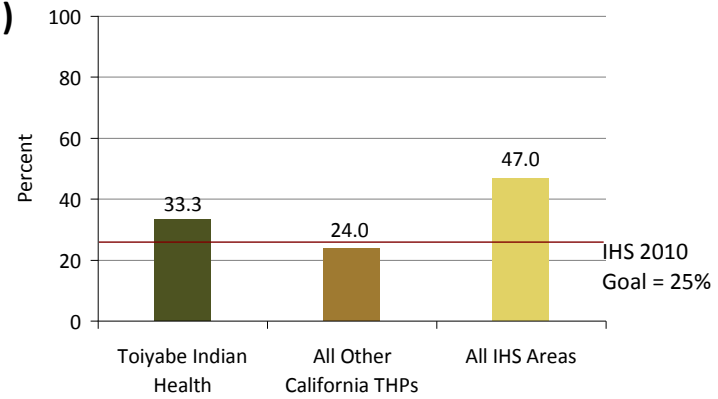


Alcohol Abuse

Alcohol abuse is associated with violence, injuries such as car wrecks and drowning, teen pregnancy and sexually transmitted diseases. It can lead to heart disease, cancer, and liver disease. Thus, it is not only personally harmful, but is a key factor in disrupting family, work, and community life.

Fetal Alcohol Syndrome Screening (IHSPM)

Screening for alcohol use has been shown to reduce fetal alcohol syndrome in infants. In all 12 IHS areas, approximately 47% of female clients aged 15 to 44 years were screened for alcohol use, whereas 33% (n=173) of women aged 15 to 44 years were screened at Toiyabe and 24% (n=2972) were screened at other included California tribal health clinics.



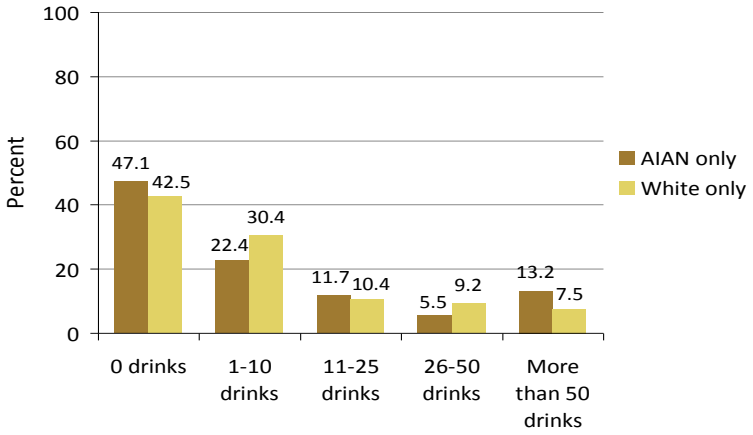
Binge Drinking (CHIS)

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. 21% (CI: 16.0%-26.8%) of AIAN reported binge drinking in the past month compared to 14% (CI: 13.0%-15.0%) of non-Hispanic Whites in central California (graph not shown).

Number of Drinks Monthly (BRFSS)†

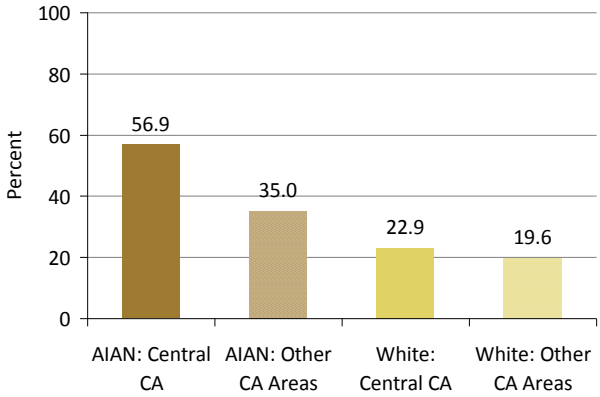
About 47% (CI: 36.5%-57.7%) of AIAN reported having had no drinks in the past month compared to 43% (CI: 40.7%-44.3%) of Whites. 13% (CI: 3.7%-22.7%) of AIAN reported having 50 or more drinks in the last month in comparison to 8% (CI: 6.5%-8.6%) of Whites in California.

† *Data is for the entire state of California, central California data is unavailable.*



Riding in a Vehicle with a Drinking Driver (CHIS)

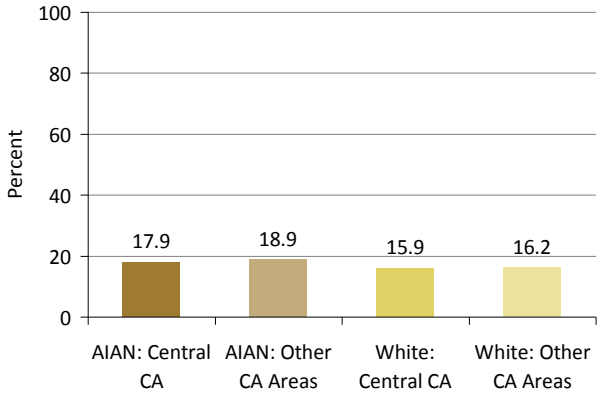
Almost 57% (CI: 34.0%-79.8%) of AIAN teens in central California reported they had ridden in a vehicle when the driver had been drinking alcohol, compared to 23% (CI: 16.2%-29.6%) of non-Hispanic White teens.



Commercial Tobacco Use

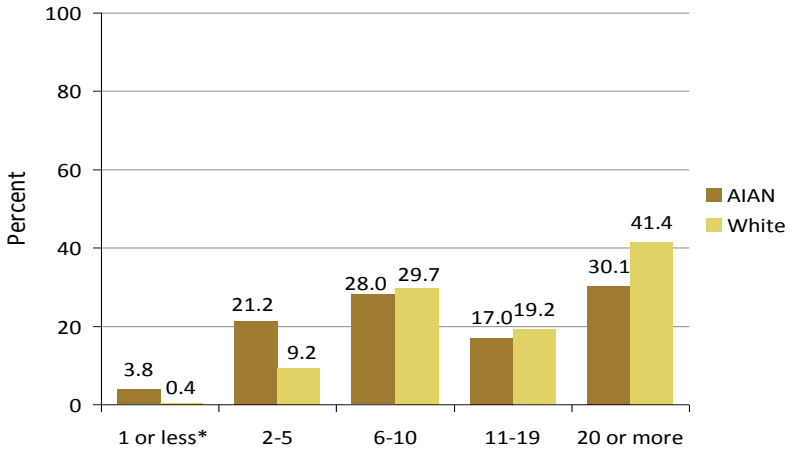
While using traditional tobacco has no health risks and is actually a plant that can improve spiritual and mental health, commercial tobacco is filled with additives, is addictive, and is the most preventable cause of disease and death in the United States. It is a major risk factor for lung cancer, chronic lung diseases, heart disease, and stroke.

Current Smoker (CHIS)



In central California, almost 18% (CI: 13.3% -22.6%) of AIAN are current smokers compared to 16% (CI: 14.4%-17.3%) of non -Hispanic Whites and 19% (CI: 15.8%-22.0%) of AIAN in other areas of California. Current smokers are those who report they smoke daily and have smoked at least 100 cigarettes in their lifetime.

Number of Cigarettes Smoked Daily by Current Smokers (CHIS)†

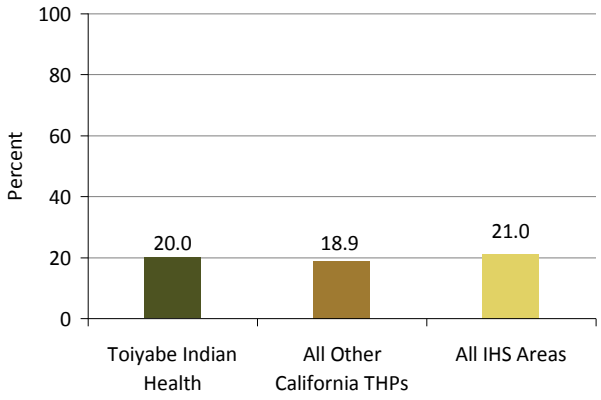


Of those who smoke, over 41% (CI: 39.4%-43.4%) of non-Hispanic Whites smoke 20 or more cigarettes per day compared to 30% (CI: 24.5%-35.6%) of AIAN in California.

**Includes statistically unstable data.*

† Data is for the entire state of California, central California data is unreliable.

Smokers Received A Tobacco Cessation Intervention (IHSPM)

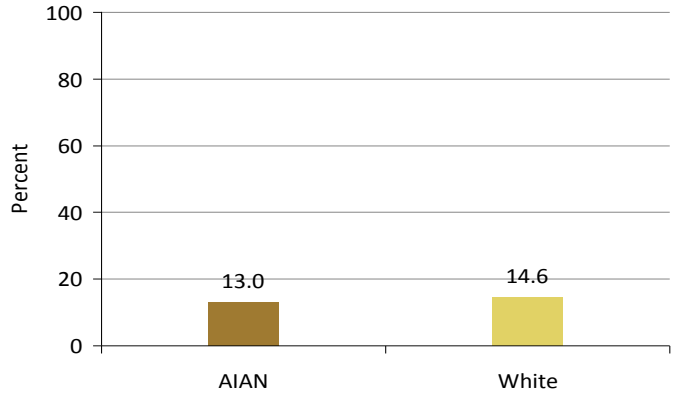


Of commercial tobacco users served at Toiyabe Indian Health Project 20% (n=87) received a tobacco cessation intervention, compared to 19% (n=2108) for all other reporting California tribal health clinics and approximately 21% at all IHS areas combined.

Drug Abuse

Drug abuse includes both illegal substances and non-medical use of prescription pills -- all of which can lead to heart problems, overdoses, and death. It is also associated with injuries such as car wrecks, violence, and sexually transmitted diseases. Drug abuse commonly disrupts family, work, and community life.

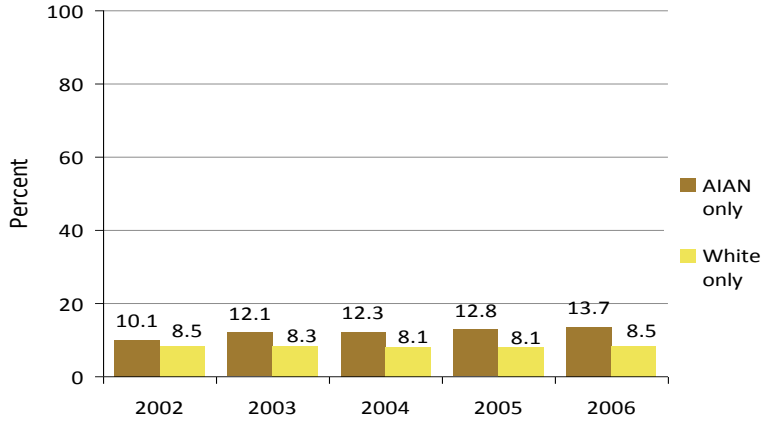
Adolescent Drug Use (CHIS)†



13% (CI: 9.0%-17.0%) of California AIAN adolescents aged 11 to 17 years have tried marijuana, cocaine, sniffing glue, or other drugs at least once, compared to 15% (CI: 12.9%-16.3%) of non-Hispanic White adolescents.

† *Data is for the entire state of California, central California data is unreliable.*

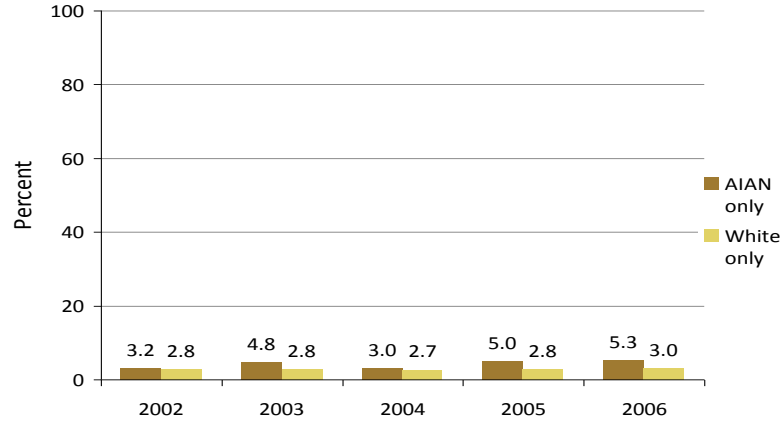
Illicit Drug Use (NSDUH)†



In the U.S., 14% of AIAN aged 12 years and older used illicit drugs in the past month, compared to 9% of Whites. Illicit drugs include marijuana/hashish, cocaine, crack, heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic drug used non-medically.

† *Data is for the entire United States, California data is unavailable.*

Nonmedical Use of Prescription Drugs (NSDUH)†



Nationally, 5% of AIAN aged 12 years and older used prescription-type psycho-therapeutic drugs in the past month for non-medical reasons, compared to 3% of Whites. This includes pain relievers, tranquilizers, stimulants, or sedatives.

† *Data is for the entire United States, California data is unavailable.*

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A Healthy Community

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A Healthy Community

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

Often times **Access to Healthcare** 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 healthcare are all challenges that many Native communities face. Furthermore, 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.

Unintentional injuries are the third leading cause of death for American Indians/Alaska Natives. Such injuries may be from car wrecks, drowning, and burns from a fire. Intentional injuries are also a concern in the community and include suicide, domestic violence, and those related to fire arms. **Domestic Violence**, whether it be by a family member or friend, continues to affect Native communities at a higher rate than other races. However, the respect and care of Native **Elders** is one of the best examples of how healthy a Native community is – Elders health is important as they give and pass down knowledge, culture, and traditional components that would be lost without their willingness to share. Elders are treated exceptionally well by the community and are held in high regard for past, present and future contributions.

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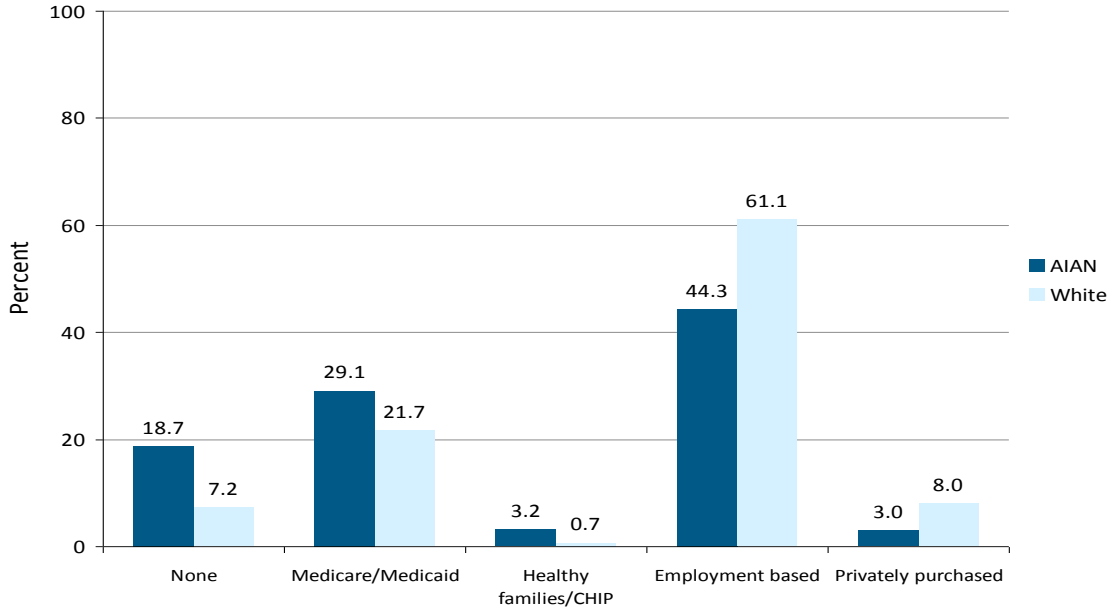
Access To Healthcare

Access to medical care helps to prevent illness and reduce the complications of many illnesses by identifying health conditions early and providing treatment. The types of healthcare access issues vary by community but are predominantly financial -- including not having health insurance, limited coverage of services, or not having enough money to cover co-payments. Structural barriers include the lack of providers or specialists and the lack of health care facilities. Personal barriers include cultural or spiritual reasons, not knowing when or how to seek care, and concerns about health information confidentiality or racial discrimination. Transportation and lack of telephone service can also be barriers, especially in rural areas and on tribal lands.

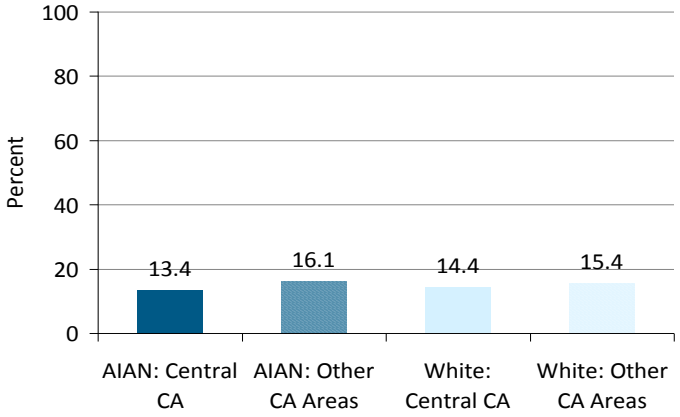
Type of Medical Insurance (CHIS)†

Health insurance facilitates access to healthcare. Almost 19% (CI: 16.6%-20.8%) of AIAN in California have no medical insurance compared to 7% (CI: 6.8%-7.5%) of non-Hispanic Whites.

† *Data is for the entire state of California, central California data is unreliable.*



Delayed or Did Not Get Care (CHIS)



During the past 12 months approximately 13% (CI: 10.0%-16.8%) of AIAN in central California and 16% (CI: 13.4%-18.8%) of AIAN in other California areas delayed or did not receive needed medical care, such as seeing a doctor, a specialist, or other health professional.

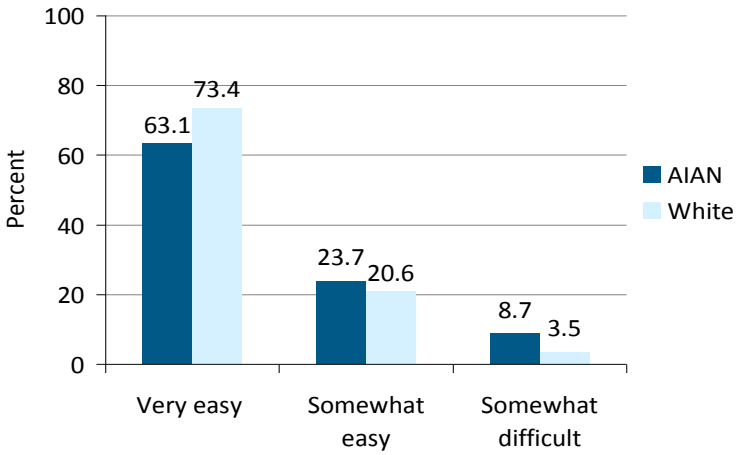
Medications

Medications are an important part of health care; they are used to treat and prevent disease and complications. The cost or availability of certain medications is often reported to be a barrier to receiving proper care and treatment. For medications to be beneficial and safe, it is important to be able to understand how and when to take them.

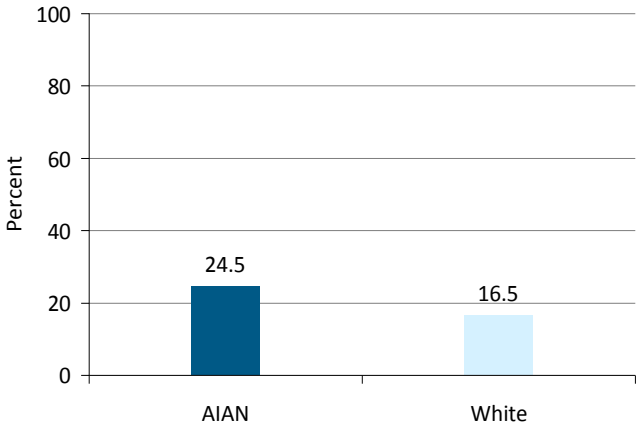
Ease of Reading Medicine Instructions (CHIS)†

A little over 63% (CI: 58.9%-67.2%) of AIAN in California thought it was very easy to read instructions on a prescription bottle compared to 73% (CI: 72.6%-74.3%) of non-Hispanic Whites. 9% (CI: 5.9%-11.5%) of AIAN and almost 4% (CI: 3.2%-3.9%) of non-Hispanic Whites reported it was somewhat difficult to read instructions on a prescription bottle.

† *Data is for the entire state of California, central California data is unreliable.*



Unable to Purchase Medication Due to Cost (CHIS)†



In California, about 25% (CI: 18.3%-30.77%) of AIAN delayed or did not obtain prescriptions because they could not afford it, compared to 17% (CI: 14.8%-18.2%) of non-Hispanic Whites.

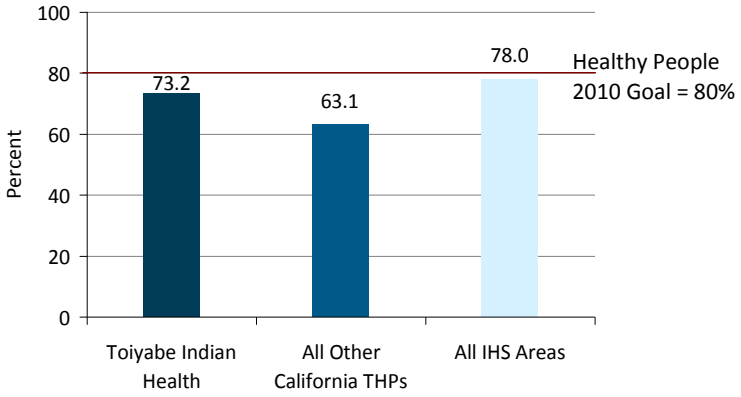
† *Data is for the entire state of California, central California data is unreliable.*

Immunizations

Immunizations are an effective method to prevent disability and death from infectious diseases, as well as controlling the spread of diseases.

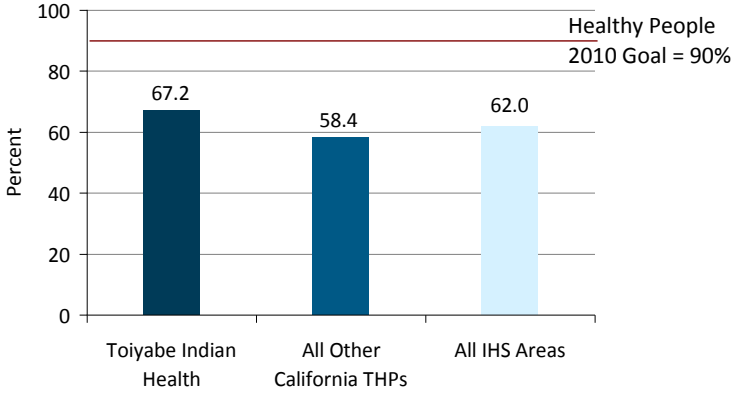
Childhood Immunizations (IHSPM)

Immunizations for children aged 19-35 months includes 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). 73% (n=41) of children at Toiyabe received this combined series, compared to 63% (n=765) of children at other reporting California THPs and approximately 78% in all IHS areas. The Healthy People 2010 goal is to have at least 80% of children fully immunized.



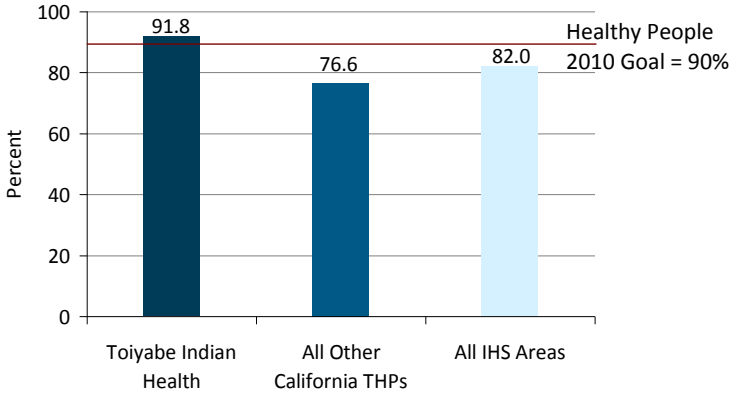
Influenza Immunizations (IHSPM)

67% (n=131) of elders aged 65 years and older served at Toiyabe received a flu shot, whereas 58% (n=1954) received the vaccine in other reporting California tribal health clinics and approximately 62% received it in all IHS areas combined for which data is available. The Healthy People 2010 goal is for at least 90% of elders 65 years and older to receive an annual flu shot.



Pneumococcal Immunizations (IHSPM)

At Toiyabe about 92% (n=179) of elders aged 65 years and older received the pneumococcal vaccine (which increases protection against pneumonia, bacteremia, meningitis, and other severe infections) whereas 77% (n=2565) received the vaccine at the other reporting California tribal health clinics and approximately 82% in all IHS areas combined. The Healthy People 2010 goal is to have at least 90% of elders 65 years and older receiving this vaccine.



ENVIRONMENTAL HEALTH

Providing sanitation facilities and better quality housing with safe water and sanitary waste disposal systems reduces the risk of infectious disease outbreaks and results in healthier communities. In 2007, IHS reported that approximately 11% of AIAN homes were without a safe and reliable water supply. The IHS goal is to have at least 94% of AIAN homes with a safe water supply by 2015. As part of the Indian Health Care Improvement Act, a **Sanitation Deficiency System (SDS)** was established to identify and prioritize projects. IHS assesses entire communities by factoring together individual deficiency levels for each home in that community. These community assessments are scored from Level 0 to 5 as described below, with the goal of having each community score at a Level 0 or Level 1.

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

- **Level 1:** An Indian tribe or community with a sanitation system which complies with all applicable water supply and pollution control laws, and in which the deficiencies relate to routine replacement, repair, or maintenance needs.

- **Level 2:** An Indian tribe or community with a sanitation system which complies with all applicable water supply and pollution control laws, and in which the deficiencies relate to capital improvements that are necessary to improve the domestic sanitation facilities.

- **Level 3:** An Indian tribe or community with a sanitation system which has an inadequate or partial water supply and a sewage disposal facility that does not comply with applicable water supply and pollution control laws, or has no solid waste disposal facility.

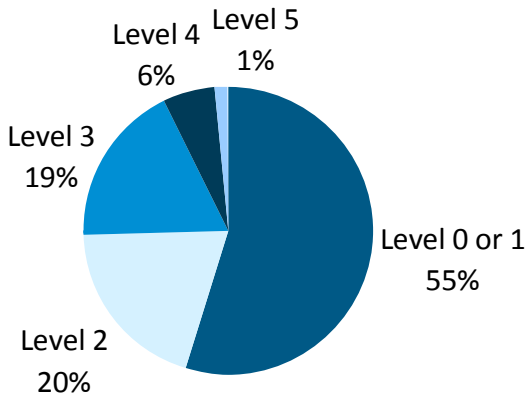
- **Level 4:** An Indian tribe or community with a sanitation system which lacks either a safe water supply system or a sewage disposal system.

- **Level 5:** An Indian tribe or community that lacks a safe water supply and a sewage disposal system.

There are 12,486 homes in the California SDS database, for which the identified deficiencies would cost more than $114 million to correct. Unfortunately, the total 2007 IHS SDS funding for all of the United States was approximately $94 million, while the estimated cost of feasible projects nationwide was $1.1 billion. None of the homes in the Toiyabe Indian Health Project service area are covered by the California SDS, the homes are served by the Phoenix area office. Therefore the data reflects the whole California SDS service area.

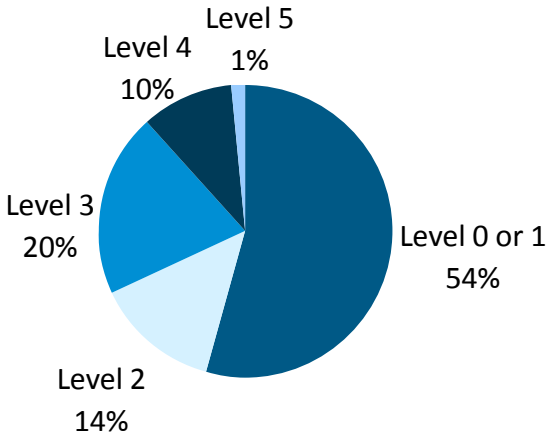
Environmental Health

Water Deficiency (SDS)



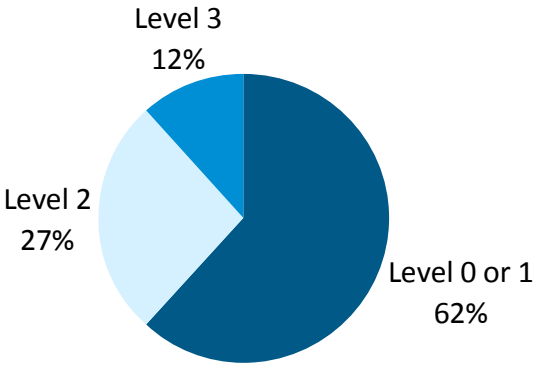
In California 55% (n=6,825) of the homes in the SDS system have sufficient water systems (Levels 0 to 1), but 7% (n=888) of the homes lack potable (drinkable) water, with deficiency Levels 4 or 5. The estimated costs of eligible projects to provide safe water are over $49 million.

Sewer Deficiency (SDS)



54% (n=6,754) of the California homes in the SDS system are connected to adequate sewer systems, with a Level 0 or 1 deficiency. However, 11% (n=1,458) of homes score at a Level 4 or 5 and do not have suitable sewer systems. IHS estimates it would cost over $54 million to supply eligible homes with adequate sewage disposal systems.

Solid Waste Deficiency (SDS)

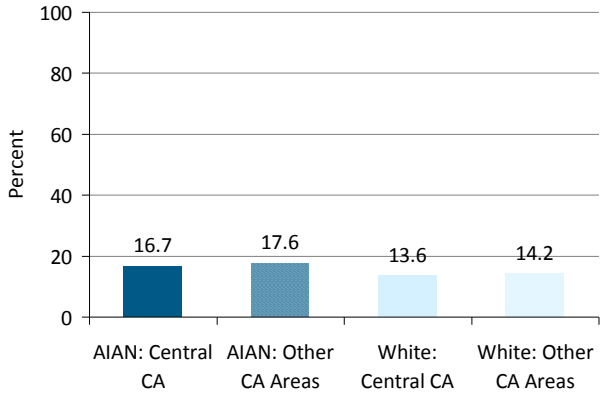


62% (n=7,695) of the California homes in the SDS system have sufficient dump sites, with a Level 0 or 1 deficiency. None of the homes are at a Level 4 or 5. IHS estimates it would cost about $10 million to supply eligible homes in California with adequate trash disposal systems.

Elder Care

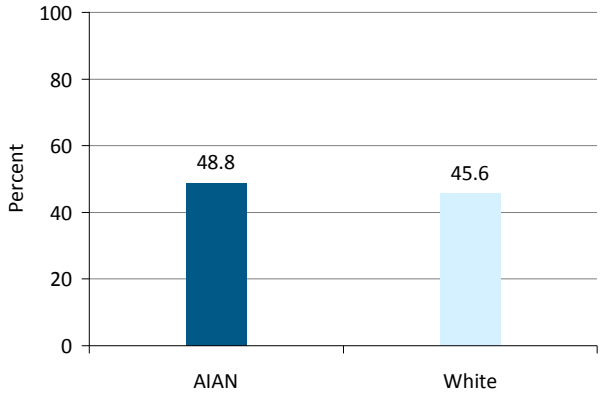
Elders are the foundation of strong and healthy California Native communities. Therefore, it is vital that special care is provided to this group who, through preserving and sharing important traditions greatly enhance the communities they live in.

Elder Fell More Than Once in Past Year (CHIS)



Almost 17% (CI: 7.5%-25.8%) of AIAN in central California aged 65 years and older accidently fell to the ground more than once in the past year, compared to 18% (CI: 10.0%-25.2%) of AIAN in other areas of California. Elder falls can be prevented through increased exercise, medication management, regular vision check ups and home safety inspections.

Elder Received Care for Falling (CHIS)†



In California, of the those over the age of 65 years and who had fallen in the past year, less than 50% of AIAN and non-Hispanic Whites received care as a result of that fall (CI: 29.1%-68.5% and CI: 42.1%-49.2%, respectively).

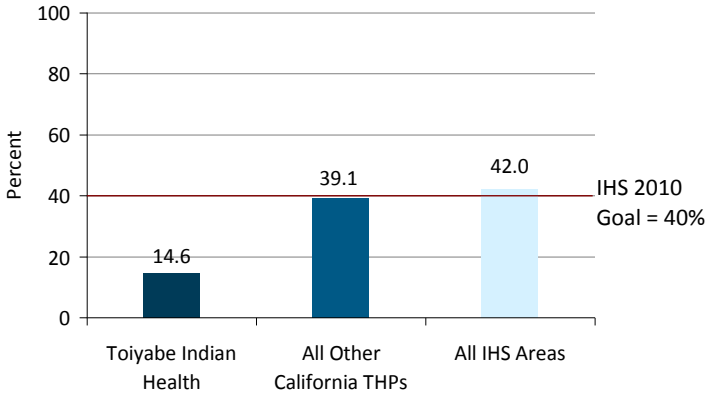
† *Data is for the entire state of California, central California data is unreliable.*

DOMESTIC VIOLENCE

Domestic violence and abuse are behaviors used by one person in a relationship to control the other. These behaviors can include mental, physical, emotional, and spiritual abuse. Domestic violence is often associated with alcohol and drug abuse, and is known to disrupt the family and community.

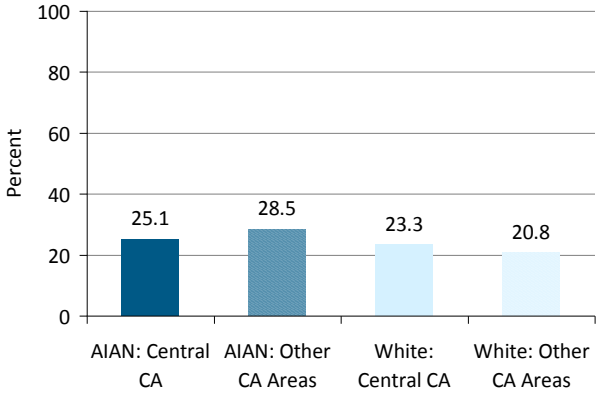
Domestic Violence Screening (IHSPM)

At Toiyabe Indian Health Project almost 15% (n=67) of women were screened for domestic violence compared to 39% (n=4285) of female clients aged 15 to 40 years in other reporting California tribal health clinics and approximately 42% at all IHS areas combined. The IHS 2010 goal is to screen at least 40% of women aged 15 to 40 years for domestic violence.



Violence by Intimate Partner (CHIS)

About 25% (CI: 14.5%-35.6%) of AIAN in central California have experienced physical or sexual violence by an intimate partner, compared to 23% (CI: 20.4%-26.3%) of non-Hispanic Whites in central California.



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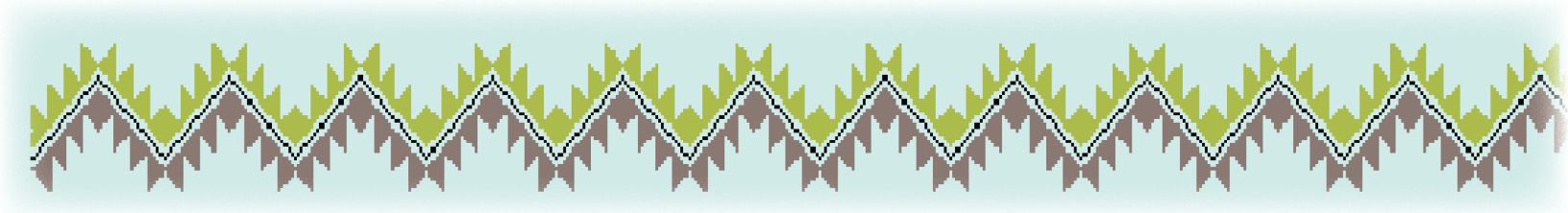
Technical Notes



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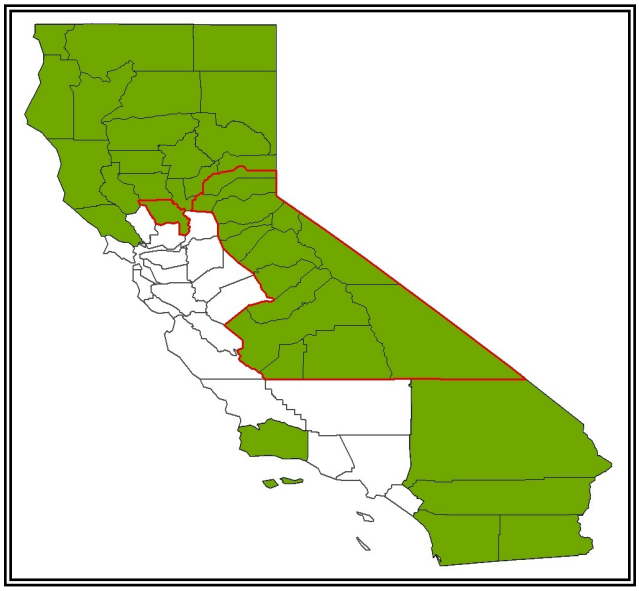
NOTES ON DATA SOURCES

California Health Interview Survey

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 for a sample that is representative of the state's population. CHIS is the nation's largest state health survey. It is conducted every two years on a wide range of health topics. CHIS 2007 surveyed more than 53,000 households including more than 51,000 adults and 13,000 teens and children, with oversampling done in Los Angeles and San Diego Counties. CHIS 2005 surveyed more than 45,000 households and expanded the number of individually represented California counties from 33 to 41 (with the remaining smaller counties grouped into three strata). CHIS aggregates several smaller counties in sampling procedures. Data is either reported for the entire state of California or comparing Central California to Other California Areas. Central California includes the counties of: Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kings, Madera, Mariposa, Mono, Placer, Nevada, Tulare, Tuolumne, and Yolo. Other California Areas includes the counties of: Butte, Colusa, Del Norte, Glenn, Humboldt, Imperial, Lake, Lassen, Mendocino, Modoc, Plumas, Riverside, San Bernardino, San Diego, Santa Barbara, Shasta, Sierra, Siskiyou, Sonoma, Sutter, Tehama, Trinity, and Yuba. Data is reported for the entire state of California when the Central California data is unreliable, shown by the dagger (†).

There are several definitions of race that can be used in describing data in AskCHIS (please visit http://www.chis.ucla.edu/pdf/race_doc_dec2008.pdf for detailed definitions of race and ethnicity in CHIS). The California EpiCenter decided to use “any mention of American Indian or Alaska Native” when describing the AIAN population, 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, Non-Latino, and American Indian/Alaska Native; single race or multiple race, American Indian/Alaska Native, or most identify with American Indian/Alaska Native. This population is compared to non-Hispanic Whites.

CHIS Central California and Other California Areas



Whenever possible, two survey years were aggregated to create a larger sample size of AIAN. 95% Confidence Intervals (CI) are reported. 95% CI’s are reported for all data that have a statistically significant difference. All data in this report are available at the CHIS website: www.chis.ucla.edu

NOTES ON DATA SOURCES

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.

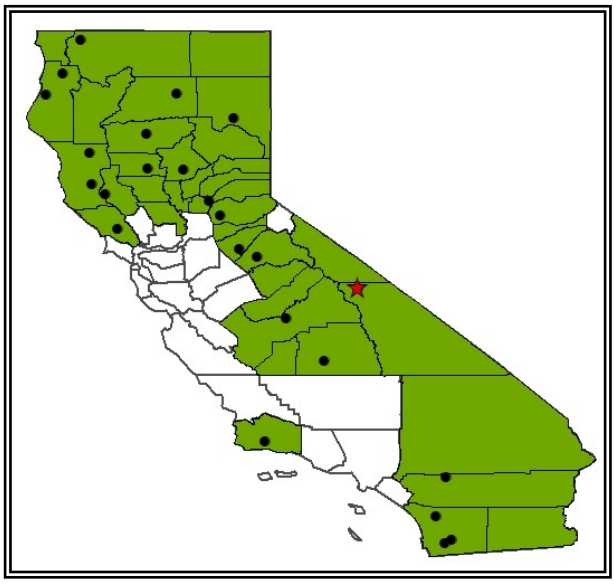
GPRA data are not available for all IHS funded health facilities. California IHS area 2008 GPRA data (July 1, 2007 to June 30, 2008) are available for approximately 87% of AIAN Active Users. There are 12 IHS Administrative Areas in the United States: Aberdeen, Alaska, Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma, Phoenix, Portland, and Tucson.

IHS Performance Measures in this report includes IHS GPRA data from 23 Tribal Health Programs in California and data from the United Indian Health Service (UIHS) which have their own reporting mechanism and their data have not been validated by the IHS. Toiyabe Indian Health Program data are compared to the data for 23 Tribal Health Programs in California (see map and list of THPs) and to all 12 IHS areas GPRA data. California data in this report does not include data for Urban Indian Health Programs.

GPRA data from IHS for the 23 Tribal Health Programs and the 12 IHS areas are available online at: www.ihs.gov/FacilitiesServices/AreaOffices/California/Universal/PageMain.cfm?p=623

As seen in the graphs, the IHSPM are compared to the IHS 2010 goals for GPRA measures, some are compared to the Healthy People 2010 goals, which are a national comprehensive set of disease prevention and health promotion objectives.

California Sites & CHSDA Counties



NOTES ON DATA SOURCES

IHSPM Tribal Health Programs	City
Central Valley Indian Health Program, Inc.	Clovis
Chapa De Indian Health Program, Inc.	Auburn
Consolidated Tribal Health Project, Inc.	Redwood Valley
Feather River Tribal Health, Inc.	Oroville
Greenville Rancheria Tribal Health Program	Greenville
Indian Health Council, Inc.	Valley Center
Karuk Tribal Health Program	Happy Camp
K'ima:w Medical Center	Hoopa
Lake County Indian Health Program, Inc.	Lakeport
MACT Health Board, Inc.	Angels Camp
Northern Valley Indian Health, Inc.	Willows
Pit River Health Services, Inc.	Burney
Riverside - San Bernardino Indian Health	Banning
Round Valley Indian Health, Inc.	Covelo
Santa Ynez Tribal Health Program	Santa Ynez
Shingle Springs Tribal Health Program	Shingle Spring
Sonoma County Indian Health Program, Inc.	Santa Rosa
Southern Indian Health Council, Inc.	Alpine
Susanville Indian Rancheria	Susanville
Sycuan Band of Mission Indians	El Cajon
Toiyabe Indian Health Project, Inc.	Bishop
Tule River Indian Health Center, Inc.	Porterville
Tuolumne Me-Wuk Indian Health Center	Tuolumne
*United Indian Health Services, Inc.	Arcata

*These data are from the tribal health program's data reporting system and have not been validated by the IHS.

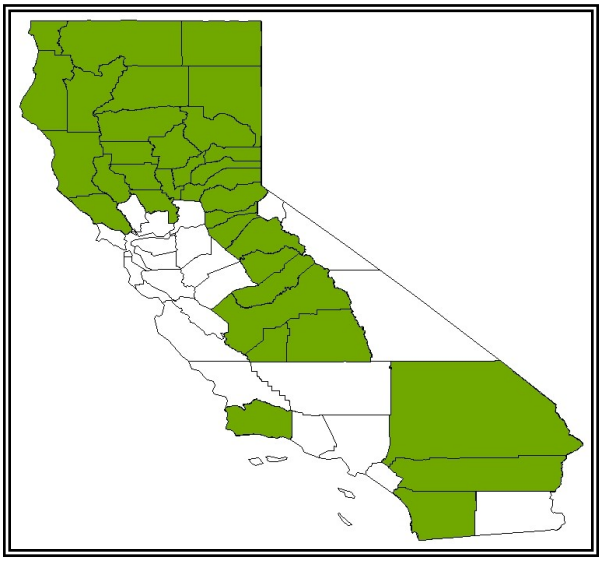
NOTES ON DATA SOURCES

Sanitation Deficiency System (SDS)

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 IHS California Area this includes 38 counties. Four counties in California that are CHSDA have sanitation services through the Phoenix Area, these include Alpine, Imperial, Inyo, and Mono, therefore data is 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):

1. CDP - the Community Deficiency Profile has information on the number and types of homes in AIAN communities;
2. **SDS – the Sanitation Deficiency System documents information about sanitation deficiencies related to AIAN individual homes and communities**;
3. PDS – the Project Data System is used to track the division of sanitation facilities construction projects;
4. HPS – the Housing Priority System is used to document, prioritize, and allocate resource needs for SFC projects for new and like-new housing;
5. OMDS – the Operation and Maintenance Data System contains information about water, wastewater and solid waste systems serving AIAN people and the organizations that operate systems;
6. HITS – the Home Inventory Tracking System is used to track applications for sanitation facilities to individuals and specific home sites.

California SFC Service Areas



The data for Toiyabe Indian Health Project are not part of the California IHS SDS database, it is served by the Phoenix IHS area. Data in this report are reported for the total California SDS.

NOTES ON DATA SOURCES

Behavioral Risk Factor Surveillance System (BRFSS)

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 is self reported and the data in the profile is for people who reported American Indian or Alaska Native as their only race and therefore excludes people who stated they are more than one race. It is compared to people who reported White as their only race. 2005 data is reported for the entire state of California. All data contained in this report is available at the BRFSS website: http://www.cdc.gov/BRFSS/.

California Department of Public Health (CDPH) STD Control Branch

California data is from the STD surveillance systems operated by state and local STD control programs. Case reports are submitted to local health jurisdictions in the form of laboratory reports and Confidential Morbidity Reports (CMRs). The local health jurisdictions then submit the data to the California Department of Public Health (CDPH). Submission of the data is electronic.

Rates by county were calculated using State of California, Department of Finance, California County Population Estimates and Components of Change by Year, July 1, 2000–2007, Sacramento, California, December 2007. Rates by age, race/ethnicity, and gender were calculated using State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050, Sacramento, California, July 2007. The race and ethnicity reported are American Indian/Alaska Native (American Indian/Alaska Native, non-Hispanic) and White (White, non-Hispanic). **The substantial amount of missing race/ethnicity data from the laboratory reports and CMRs 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. 2007 data is reported for the entire state of California in comparison to Mono and Inyo counties.

NOTES ON DATA SOURCES

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 or older are surveyed across the 50 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 is reported as American Indian or Alaskan Native only (Not Hispanic or Latino) in comparison to White only (Not Hispanic or Latino). 2002 to 2006 data is reported for the entire United States.

NOTES ON FIGURES

Important Terms

Race and Ethnicity Definitions
A Dictionary of Epidemiology. 4th Edition. Oxford University Press, 2001. Edited by John M. Last.

Federal Trust Responsibility
Roubideaux, Yvette. Perspectives on American Indian Health, 2002. American Journal of Public Health: Vol 92, No 9. Pgs 1401 - 1403.

California Community At A Glance

Source: 2000 US Census: www.census.gov
Geography: Mono and Inyo county. American Indian/Alaska Native Alone or in Combination with One or More Races. Non-Hispanic White Only.

A Healthy Body

Diabetes

Ever Diagnosed with Diabetes
Source: 2005 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Pooled two years of data.

Type I or II Diabetes
Source: 2005 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Pooled two years of data.

Ever Diagnosed with Diabetes During Pregnancy
Source: 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Results not available for multiple years.

Ideal Glycemic Control
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Patients with diagnosed diabetes.

Blood Pressure Control
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Patients with diagnosed diabetes.

NOTES ON FIGURES

Diabetic Assessments: Testing Cholesterol, Kidney and Eye Complications
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Patients with diagnosed diabetes.

Heart Disease

Ever Diagnosed with Heart Disease
Source: 2005 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Pooled two years of data.

Cholesterol Level Screening
Source: 2005 Behavioral Risk Factor Surveillance System: WEAT. http://apps.nccd.cdc.gov/s_broker/htmsql.exe/weat/index.hsql
Geography: Entire state of California. Multiple racial category of American Indian/Alaska Native only compared to White only. † Data is for the entire state of California, northern California data is unavailable.

Cardiovascular Disease Assessment
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. At risk patients.

Eating Healthy, Exercise, & Controlling Obesity

Daily Fruit and Vegetable Consumption (5 or more)
Source: 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Children. Results not available for multiple years.
Source: 2003 and 2005 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Teens. Pooled two years of data.
Source: 2005 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Adults. Results not available for multiple years.

Fast Food Consumption in the Last Week
Source: 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Respondents 2 years or older. Results not available for multiple years.

NOTES ON FIGURES

Fast Food Consumption in the Previous Day
Source: 2003 and 2005 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Children 2 years or older and adolescents. Pooled two years of data.

Amount of Physical Activity
Source: 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Results not available for multiple years. *Data of this category is statistically unstable.

Level of Physical Activity
Source: 2005 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Results not available for multiple years.

Proportion of Obese Children
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Children ages 2-5 years.

Cancer

Screening for Cancer of the Colon
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Patients ages 50 years and older.

Been Diagnosed with Cancer of the Colon
Source: 2003 and 2005 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Pooled two years of data.

Cervical Cancer Screening
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Female patients ages 21 through 64 years without a documented history of hysterectomy.

NOTES ON FIGURES

Pap Smear Screening History
Source: 2005 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Women 18 years or older who never had a hysterectomy. Pooled two years of data.

Breast Cancer Screening
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Female patients ages 50 to 64 years.

Mammogram History
Source: 2005 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Women 30 years or older. Pooled two years of data.

Personal Health

HIV Screening in Pregnancy
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Pregnant women.

Ever Screened for HIV
Source: 2005 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Adults younger than 71 and adolescents ages 11 to 17 years whose parents gave permission to discuss sexual issues. Pooled two years of data.

High Risk Behavior for HIV
Source: 2005 Behavioral Risk Factor Surveillance System: WEAT. http://apps.nccd.cdc.gov/s_broker/htmsql.exe/weat/index.hsql
Geography: Entire state of California. Multiple racial category of American Indian/Alaska Native only compared to White only.

Age of Adolescents Having Sex
Source: 2005 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Adolescents ages 14 to 17 years whose parents gave permission to discuss sexual issues. Pooled two years of data.

NOTES ON FIGURES

Adolescent Condom Use (during most recent sex)
Source: 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Adolescents ages 12 to 17 years whose parents gave permission to discuss sexual issues. Results not available for multiple years.

Rates of Sexually Transmitted Diseases
Source: 2007 California Department of Public Health STD Control Branch: http://www.cdph.ca.gov/data/statistics/Pages/STDDataTables.aspx
Geography: Mono and Inyo counties compared to the entire state of California. Native American/Alaska Native compared to White.

Dental Health

Dental Visits
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas.

Youth Dental Visit History
Source: 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Adolescents and children 2 years or older, also younger if a tooth present. Results not available for multiple years. *Data of this category is statistically unstable.

Unable to Afford Dental Care
Source: 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. All respondents older than 2, and children 1-2 if a tooth present. Results not available for multiple years.

A Healthy Mind

Mental Health

Depression Screening
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Adults ages 18 years and over.

NOTES ON FIGURES

Psychological Distress
Source: 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Results not available for multiple years.

Difficult Receiving or Accessing Mental Health Care
Source: 2001 and 2005 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Adults who needed or received help for emotional/metal/substance abuse problems in the past 12 months. Pooled two years of data.

Alcohol Abuse

Fetal Alcohol Syndrome Screening
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Female clients ages 15 to 44 years.

Binge Drinking
Source: 2001 and 2003 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Pooled two years of data.

Number of Drinks Monthly
Source: 2005 Behavioral Risk Factor Surveillance System: WEAT. http://apps.nccd.cdc.gov/s_broker/htmsql.exe/weat/index.hsql
Geography: Entire state of California. Multiple racial category of American Indian/Alaska Native only compared to White only.

Riding in a Vehicle with a Drinking Driver
Source: 2003 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Adolescents ages 12 to 17 years. Results not available for multiple years.

NOTES ON FIGURES

Commercial Tobacco Use

Current Smoker
Source: 2005 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Pooled two years of data.

Number of Cigarettes Smoked Daily by Current Smokers
Source: 2003 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Adults who smoked at least 100 cigarettes in their lifetime and who smoke daily. Pooled two years of data. *Data of this category is statistically unstable.

Smokers Received a Tobacco Cessation Intervention
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Tobacco-using patients.

Drug Abuse

Adolescent Drug Use (marijuana, cocaine, sniffing glue, other drugs)
Source: 2005 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Pooled two years of data.

Illicit Drug Use
Source: Health, United States 2008, National Survey on Drug Use and Health: http://www.cdc.gov/nchs/data/hus/hus08.pdf#066
Geography: United States. American Indian/Alaska Native only compared to White only.

Nonmedical Use of Prescription Drugs
Source: Health, United States 2008, National Survey on Drug Use and Health: http://www.cdc.gov/nchs/data/hus/hus08.pdf#066
Geography: United States. American Indian/Alaska Native only compared to White only.

NOTES ON FIGURES

A Healthy Community

Access to health care

Type of Medical Insurance
Source: 2005 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Pooled two years of data.

Delayed or Did Not Get Care
Source: 2003 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Pooled two years of data.

Medications

Ease of Reading Medicine Instructions
Source: 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Pooled two years of data.

Unable to Purchase Medication Due to Cost
Source: 2005 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Adults who delayed or did not get a prescription in the past 12 months. Results not available for multiple years.

Immunizations

Childhood Immunizations
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Children ages 19-35 months.

Influenza Immunizations
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Adults ages 65 years and older.

Pneumococcal Immunizations
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Adults ages 65 years and older.

NOTES ON FIGURES

Environmental Health

Water Deficiency
Source: 2008 IHS Sanitation Deficiency System.
Geography: California IHS Sanitation Facilities Construction reporting area.

Sewer Deficiency
Source: 2008 IHS Sanitation Deficiency System.
Geography: California IHS Sanitation Facilities Construction reporting area.

Solid Waste Deficiency
Source: 2008 IHS Sanitation Deficiency System.
Geography: California IHS Sanitation Facilities Construction reporting area.

Elder Care

Elder Fell More than Once in Past Year
Source: 2003 and 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Respondents 65 years and older. Pooled two years of data.

Elder Received Care for Falling
Source: 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Entire state of California. Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Respondents 65 years and older who have fallen in the past 12 months. Results not available for multiple years.

Domestic Violence

Domestic Violence Screening
Source: 2008 IHS Performance Measure
Geography: Toiyabe Indian Health Project compared to the other 23 reporting California Tribal Health Programs and all 12 IHS areas. Female clients aged 15 to 40 years.

Violence by Intimate Partner
Source: 2007 California Health Interview Survey: AskCHIS. www.chis.ucla.edu.
Geography: Central California compared to Other California Areas (see map on page 59). Any mention of American Indian/Alaska Native compared to OMB definition of non-Hispanic White. Respondents aged 18-65 years. Results not available for multiple years.

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California Tribal Health Programs

Tribal Health Program	City	Active Users		
		AIAN	Non-AIAN	Total
Cabazon Band of Mission Indians	Indio	9	9	18
Central Valley Indian Health Program	Clovis	6576	2949	9525
Chapa De Indian Health Program, Inc	Auburn	5248	4816	10064
Colusa Indian Health Community Council	Colusa	96	45	141
Consolidated Tribal Health Project, Inc	Redwood Valley	2571	1346	3917
Feather River Tribal Health, Inc.	Oroville	4054	3960	8014
Greenville Rancheria Tribal Health Program	Greenville	1228	6815	8043
Indian Health Council	Valley Center	4359	799	5158
Karuk Tribal Health Program	Happy Camp	1882	2962	4844
K'ima:w Medical Center	Hoopa	2873	1384	4257
Lake County Indian Health Program	Lakeport	1942	1379	3321
MACT Health Board, Inc.	Angels Camp	2175	13226	15401
Mathiesen Memorial Health Clinic	Jamestown	-	-	-
Modoc Indian Health Project	Alturas	173	38	211
Northern Valley Indian Health, Inc.	Willows	1997	7336	9333
Pit River Health Services, Inc.	Burney	926	499	1425
Quartz Valley Program	Fort Jones	144	95	239
Redding Rancheria Indian County Health Program	Redding	2677	995	3672
Riverside - San Bernardino County Indian Health	Banning	12546	2786	15332
Round Valley Indian Health	Covelo	1315	1380	2695
Santa Ynez Indian Health	Santa Ynez	925	4024	4949
Shingle Springs Tribal Health Program	Shingle Spring	951	1666	2617
Sonoma County Indian Health Program, Inc.	Santa Rosa	4829	3115	7944
Southern Indian Health Council	Alpine	2602	6688	9290
Susanville Indian Rancheria	Susanville	993	747	1740
Sycuan Band of Mission Indians	El Cajon	56	16	72
Table Mountain Medical	Friant	0	4	4
Toiyabe Indian Health Project, Inc.	Bishop	2681	2090	4771
Tule River Indian Health Center, Inc.	Porterville	2540	528	3068
Tuolumne Me-Wuk Indian Health Center	Tuolumne	94	57	151
United Indian Health Services, Inc.	Arcata	7859	1167	9026
Warner Mountain Indian Health Program	Fort Bidwell	118	1	119

Active User numbers were reported by IHS in 2008.

California Urban Indian Health Centers

Urban Indian Health Center	City	Active Users		
		AIAN	Non-AIAN	Total
American Indian Health Project Bakersfield	Bakersfield	267	17	284
Fresno American Indian Health Project	Fresno	4	0	4
Indian Health Center of Santa Clara Valley	San Jose	405	20	425
Native American Health Center	Oakland & San Francisco	1428	318	1746
Sacramento Native American Health Center	Sacramento	1121	2971	4092
San Diego American Indian Health Center	San Diego	1756	2921	4677
United American Indian Involvement	Los Angeles	253	121	374

Active User numbers were reported by IHS in 2008.