

AMERICAN INDIAN AND ALASKA NATIVE HEALTH ASSESSMENT IN CALIFORNIA



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PREFACE

In California, approximately 56% of our state's 38.2 million people are Latinos, African Americans, Asian-Pacific Islanders, and Native Americans. These ethnic groups comprise the four largest communities of color in our state. These groups also contribute extensively to California's economic and social vitality. Therefore, it is in our state's best interest to insure the health and well being of these populations.

The Ethnic Health Assessment Project seeks to clearly frame the health needs of these four population groups and makes recommendations for meeting those needs. The four companion reports generated from the Project are the result of close collaboration between academic researchers, lead ethnic organizations, and ethnic stakeholders.

The Project's leading ethnic organizations and researchers include:

- Latino Coalition for a Healthy California (LCHC) and Michael A. Rodríguez MD, MPH, David Geffen School of Medicine, University of California, Los Angeles
- California Black Health Network and Lonnie Snowden PhD, School of Public Health, University of California, Berkeley
- Asian Pacific Islander American Health Forum and Winston Tseng PhD, School of Public Health, University of California, Berkeley
- California Rural Indian Health Board (CRIHB) and Carol Korenbrot PhD, CRIHB Research Director and Rebecca Garrow MPH, CRIHB Research Associate

The unique feature of the Project was the inclusion of "stakeholders," or representatives from advocate organizations, provider networks, and consumer and community-based organizations.

The stakeholders brought their real-life experience to the discussion table, and helped frame the content and mold policy recommendations found in each of the four reports. A separate stakeholder list is presented in the beginning of each report.

The four final reports will be distributed to California's decision makers, as well as to decision makers in other states with a significant minority presence, and to national level officials who have an interest in California's racial-ethnic health care issues.

AMERICAN INDIAN ALASKAN NATIVE STAKEHOLDER LIST

Below are the names of ethnic stakeholders whose ideas and insights help frame the content found in this report.

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Matt Franklin of the Lone Band of Miwok Indians,
Michael Franks of the Toiyabe Indian Health Project, Inc.,
Britta Guerrero of the Sacramento Native American Health Center (SNAHC),
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Carrie Johnson of United American Indian Involvement (UAI),
Dawn Lulua-Claxton of the Native American Health Center (East Bay),
Helen Maldonado of the California Area Indian Health Service,
Richard Myers of the Yurok Tribe,
Nelson Pinola of the Manchester-Point Arena Band of Pomo Indians,
Joely Proudfit of the California Indian Culture and Sovereignty Center and CSU San Marcos,
David Sprenger of the California Area Indian Health Service, and
Nicky Wittig of the California Indian Manpower Consortium, Inc.

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EXECUTIVE SUMMARY

California has more American Indians/Alaskan Natives (AIAN) than any other single state. AIAN are estimated at 738,978, representing 1.9% of California's population. This low population count contributes to 'invisibility' of AIAN in state health data. Furthermore, many AIAN are of more than one race, so disease and death rates of AIAN are widely misclassified in other racial categories. A large number of AIAN reside in urban areas, such as Los Angeles (138,696), and in the five Bay Area counties of Alameda, Contra Costa, San Francisco, San Mateo, and Santa Clara (77,226). Urban AIAN are more likely to report themselves as multiracial than rural AIAN. Separate from the racial definition, is the legal definition of some AIAN who have a unique treaty-based right to health care under federal law.

Health Disparities

In California, AIAN life expectancy is shorter and AIAN death rates are higher than for Whites. The leading causes of death rates for AIAN are different than for Whites. AIAN who use Tribal Health Programs and Urban Indian Health Organizations show higher death rates than Whites from unintentional injuries, diabetes, and chronic liver disease.

Significant AIAN health problems include:

- Diabetes: AIAN in California using Tribal Health Programs showed a diabetes rate of 13% in 2006 compared to a diabetes rate of 7% for Whites in 2007.
- Obesity: Almost one quarter (23%) of AIAN children aged 2-5 years using California Tribal Health Programs had a body mass index in the 95th percentile or higher. For AIAN living in the counties surrounding Urban Indian Health Organizations in North, Central, and Southern California, 31.9%, 9.2%, and 33% respectively report that they are obese, compared to 18.5%, 8.6%, and 22.9% of the general population in those regions.
- Psychological Distress: Twice as many AIAN reported psychological distress (16%) compared to Whites (8%) in the past year.
- Injuries (national data): The prevalence rate of suicide for AIAN is 1.5 times the national rate. AIAN males ages 15 to 24 account for two-thirds of all AIAN suicides. Violent deaths (unintentional injuries, homicide, and suicide) account for 75% of all AIAN male mortality in the second decade of life.
- Dental Problems: Twice as many AIAN (8%) report they could not afford needed dental care compared to Whites (4%).

Social and Economic Elements

Lack of transportation and poverty contribute to AIAN health problems. Transportation is an important component of health care access, yet twice as many AIAN homes (14%) had no vehicle available for transportation, compared to Whites (7%). The ease of reading medication instructions is an important component in injury prevention, especially for Native elders. Fewer AIAN found it easy to read the instructions on a prescription bottle than Whites (63% compared to 73%). Income is an important component in ability to purchase medicine and purchase nutritious food. While some

tribal members saw an increase of wealth in California because of gaming, the vast majority of tribal members have not. The median family income for AIAN was less than 60% of the median family income for Whites (AIAN \$38,547 vs. White \$65,342) between 1990 and 2000. About 25% of AIAN delayed or did not get a prescribed medication because they could not afford it, compared to 17% of Whites.

Recommendations to Reduce Health Disparities

California Indians have a legally-based right to health care, which the State of California did not always fulfill. AIAN living in California who share in this right must be resolute in getting the State to honor its obligations and deliver adequate health care to all AIAN populations.

Policy recommendations include encouraging California's State Health Officials, Governor, and Legislators to:

- Establish ongoing consultations with tribes, Tribal Health Programs, and Urban Indian Health Organizations in California.
- Adequately fund the state Indian Health Program. The Indian Health Program helps to improve the health status of American Indians living in urban and rural Indian communities throughout California.
- Restore all federally reimbursable health benefits, including the Medi-Cal 'Optional' Benefits.
- Gather accurate health data. Misclassification of AIAN in other racial categories results in disease and death rates that are 30% to 70% lower than the rates in studies correcting for AIAN misclassification.
- Recognize out-of-state licensure for medical professionals in Tribal Health Programs and Urban Indian Health Organizations as authorized under the new federal health care reform. Such recognition is one way to increase the number of AIAN doctors serving AIAN patients. Less than 1% of California physicians, pharmacists, optometrists, nurse practitioners, and physician's assistants are AIAN. The population parity of AIAN physicians is just 0.6%.
- Assist Tribal Health Programs in expanding in-home health services and hospice services authorized under the new federal health care reform.

If the documented disparities in the health of California's AIAN are to be corrected before the next century, the state must change its approach to AIAN health studies, programs, and policies. Currently, AIAN are taking their own active steps to combat health problems by revitalizing and using elements in their cultural heritage, including traditional medicines, healing practices, and spiritual ceremonies. Additional State actions, such as those mentioned above, would go a long way in helping reduce AIAN health disparities.

INTRODUCTION

AIAN in California are diverse people with a range of cultures who live in a variety of environments; thus generalizations about AIAN health care needs can be difficult to make. Still, there is a narrow range of health policy and programmatic issues that grip AIAN in California today. This report considers AIAN living in California in two broad groups: AIAN who self-declare their racial ancestry to be AIAN, and those American Indians who are enrolled members or descendents of California tribes with legal and political rights, including rights to health care. The former group includes the latter group, but the majority of AIAN live in urban areas, while California tribal governments, lands, and people are primarily in rural areas.

The federal trust responsibility to AIAN, including the responsibility for AIAN health care, derives from the U.S. Constitution, including the Commerce Clause, Treaty Clause, and Supremacy Clause. The parameters of the responsibility are formed through court decisions, treaties, Congressional Actions, Executive Orders, regulations, and ongoing interaction between the federal government and tribal governments. The trust responsibility supplies the legal justification for and obligation to engage in policy-making specific to AIAN. Federal laws that provide trust or special services to AIAN have been upheld by the courts, as these laws deal with AIAN in a political rather than a racial context.

California Indians ceded land to California in exchange for smaller areas of trust land, and rights to protection, health, education and other services. California Indians received little of what was promised after their land was been relinquished. It was not until the latter decades of the twentieth century that state health officials began to work with tribal and urban Indian leaders to consider what programmatic and policy actions they should take and the state office of Indian Health, which became the state Indian Health Program, was created.

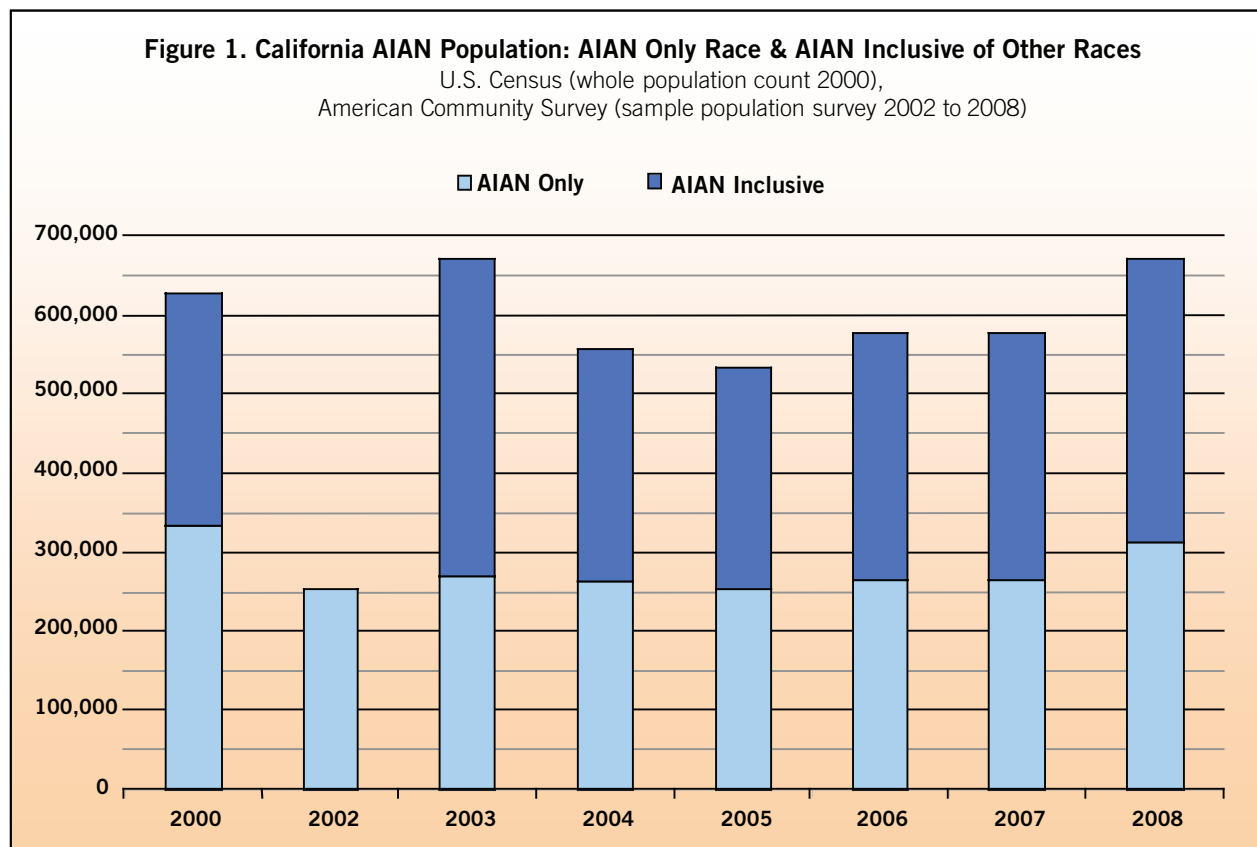
By the time the state performed its first AIAN health status study in the mid-twentieth century, health disparities for AIAN were already striking. Little had changed when a second study was done six years later. In the latest studies of state health data and health surveys of the twenty-first century, AIAN are statistically invisible. The disease and deaths of AIAN are so widely misclassified in other racial categories that reported disease and death rates are 30% to 70% lower than those in studies that correct for misclassification. The numbers of AIAN included in state health surveys are so small that rates of response to most questions cannot be reliably reported.

The report includes root causes of AIAN disparities in historical, political, social and economic contexts, as well as access to medical, dental and behavioral health services. But the report emphasizes how AIAN are developing solutions through empowerment, cultural identity, community and family life. Nonetheless, AIAN are in need of statewide support and encouragement. So long as racism, poverty, unemployment and inferior access to quality comprehensive health care persist, disparities in health will persist in AIAN communities.

I. BACKGROUND, THE PEOPLE

When policymakers speak of the four largest racial and ethnic minority groups in California, the fourth largest is that of American Indians and Alaska Natives (AIAN). The 2008 U.S. Census Population Estimates report there are 738,978 AIAN living in California¹ AIAN is the term for Native American people living in California, whether they are indigenous to California or not. The AIAN designation is based on a person's self-declared *racial* identification. Identification as AIAN indigenous to the United States or American Indians indigenous to California, however, is legally and politically defined. Federal recognition of AIAN is established through enrollment in a federally recognized tribe and the government's legal and political relationship with that tribe. The legal and political definition is a function of the U.S. Constitution, court decisions, treaties, congressional actions, executive orders, regulations and ongoing policy changes. This latter definition has special implications for the California state government and for the health care rights of AIAN living in the state. We will first provide background on AIAN according to their racial identification, and then according to their legal and political identity.

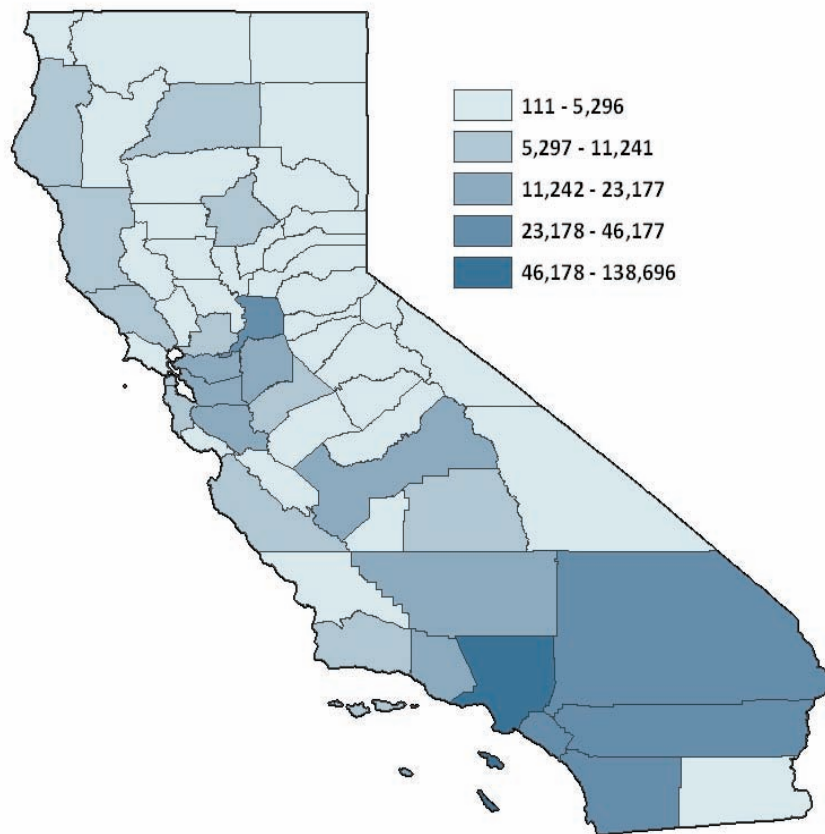
The number of AIAN in California varies according to the type of population count used (U.S. Census, American Community Survey, or the California Department of Finance Demographics Unit) and according to the inclusiveness of the racial definition of the group. Regardless of which count/definition is used, California has more AIAN than any other single state. Figure 1 shows the population count from the 2000 Census in one bar, and the population count from the 2002-2008 American Community Survey in the remaining bars.



AIAN are best enumerated through the Census and not population surveys

The American Community Survey is conducted between the ten-year U.S. Census population counts. However, this survey tends to underestimate the number of AIAN in California because it is not as accurate in rural areas. The Census provides the best estimate of AIAN. Census respondents identified as either AIAN Alone (AIAN Only Race), or AIAN as one of multiple races (AIAN Inclusive of Other Races), regardless of any Hispanic ethnic identification declared. According to the 2000 Census, the largest numbers of AIAN are in Southern California counties (Map 1).

Map 1. AIAN population by county in the 2000 Census of people who self-declared AIAN as their only race or one of their races.



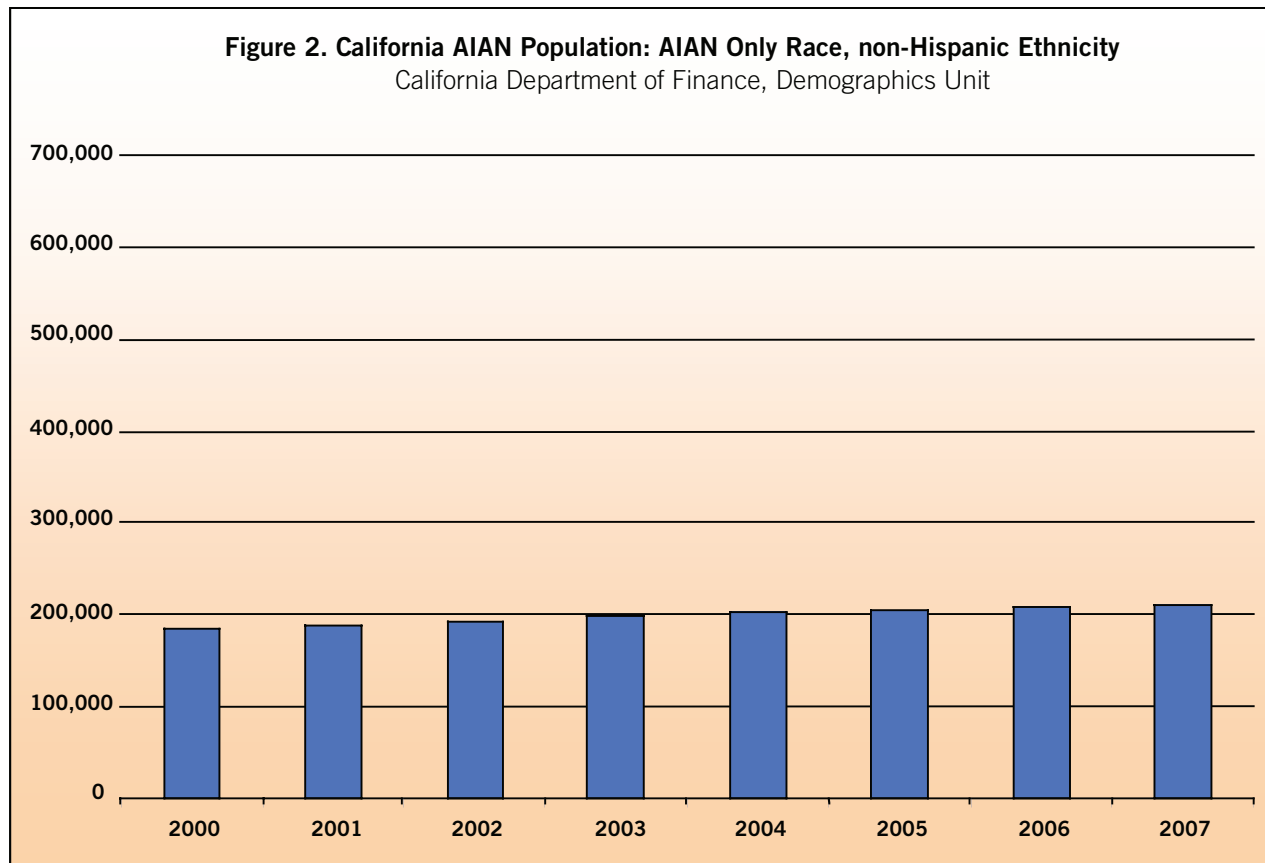
Source: 2000 U.S. Census

Many AIAN are of more than one race

More than half of the AIAN in California (53%) identified themselves only as AIAN, but the rest identified themselves as AIAN and one or more other races (Map 1).² AIAN is the most common race declared by people declaring more than one race.³ The largest group of people specifying two races nationally was 'White and AIAN' (17.3% of all mixed race people).

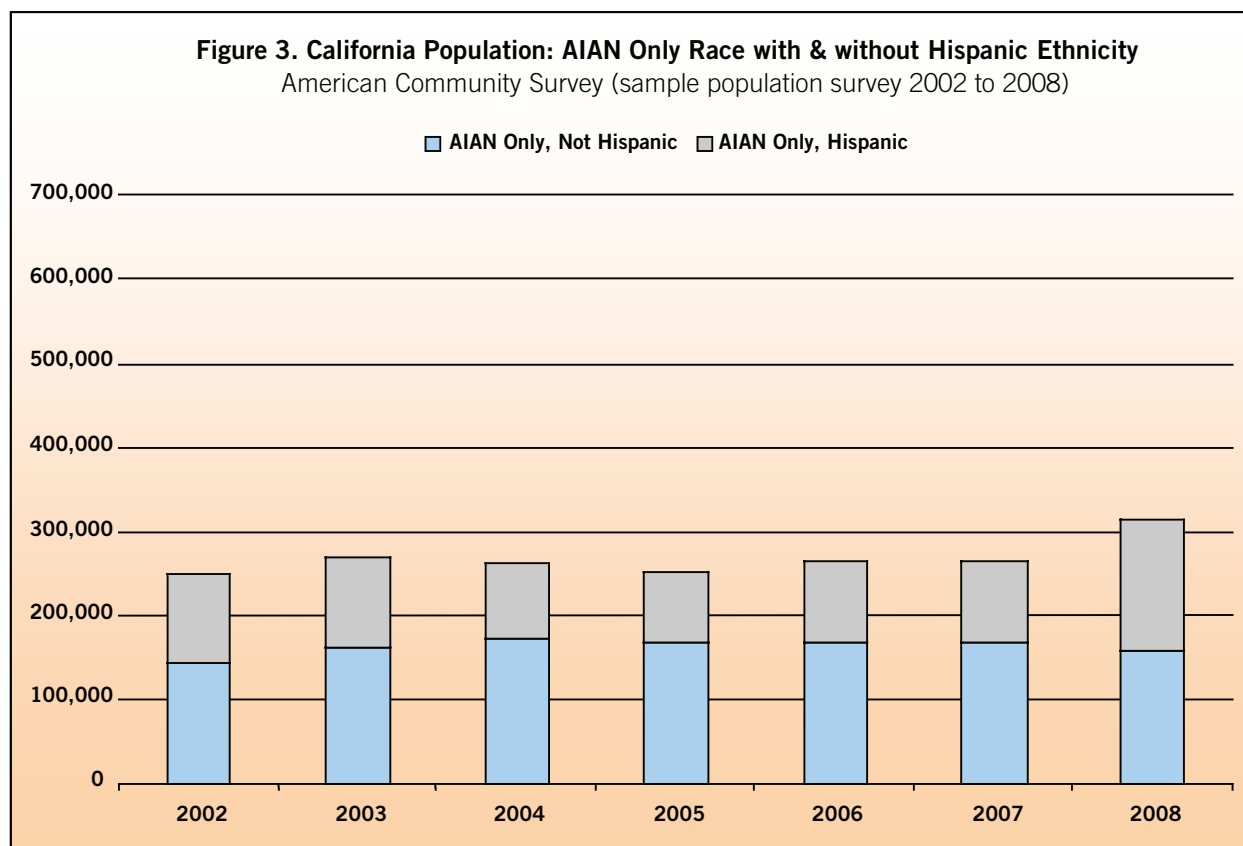
California policy planning frequently relies on the California Department of Finance Demographics Unit population figures. However, these figures also underestimate the AIAN population in California because the figures do not include AIAN who report mixed race or Hispanic ethnicity (Figure 2).⁴

In the California Department of Finance population estimates (which excludes AIAN who report another race or Hispanic ethnicity), AIAN constitute less than 0.6% of the state population.



Many AIAN are also of Hispanic ethnicity

While more than half of the AIAN in California (54%) identified themselves as non-Hispanic, the rest of the AIAN self-identified their ethnicity as Hispanic or Latino (46%).⁵ This is due in part to indigenous people of Southern California and the Southwest U.S. who have Mexican-American heritage, as well as the children born to AIAN and Hispanic parents. Furthermore, many Latin American people who have immigrated to the U.S. identify themselves as AIAN rather than White in the racial category on the Census, because they identify more with their indigenous roots than with being White. Hispanic ethnicity of AIAN in the 'AIAN Only Race' population for 2002 to 2008 is shown in Figure 3.



The majority of AIAN in California are Urban Indians

Urban Indians are individuals of AIAN ancestry who have moved to cities, either by choice - seeking employment, education and housing - or through governmental termination, assimilation and relocation policies.⁶ While there has been migration of AIAN from tribal lands around the country to California's cities throughout the history of the state, the migration increased considerably in the latter half of the twentieth century as it was formally encouraged by government policies. Federal termination of tribes, relocation and assimilation policies of the 1950s had a particularly large impact on both California tribes and California cities. A federal resolution passed in 1953 (House Concurrent Resolution 108) called for cessation of federal supervision of Indian tribes by the Bureau of Indian Affairs, and led to a series of bills designed to terminate tribes, relocate tribal Indians to cities, and facilitate assimilation of AIAN into mainstream American culture.⁷

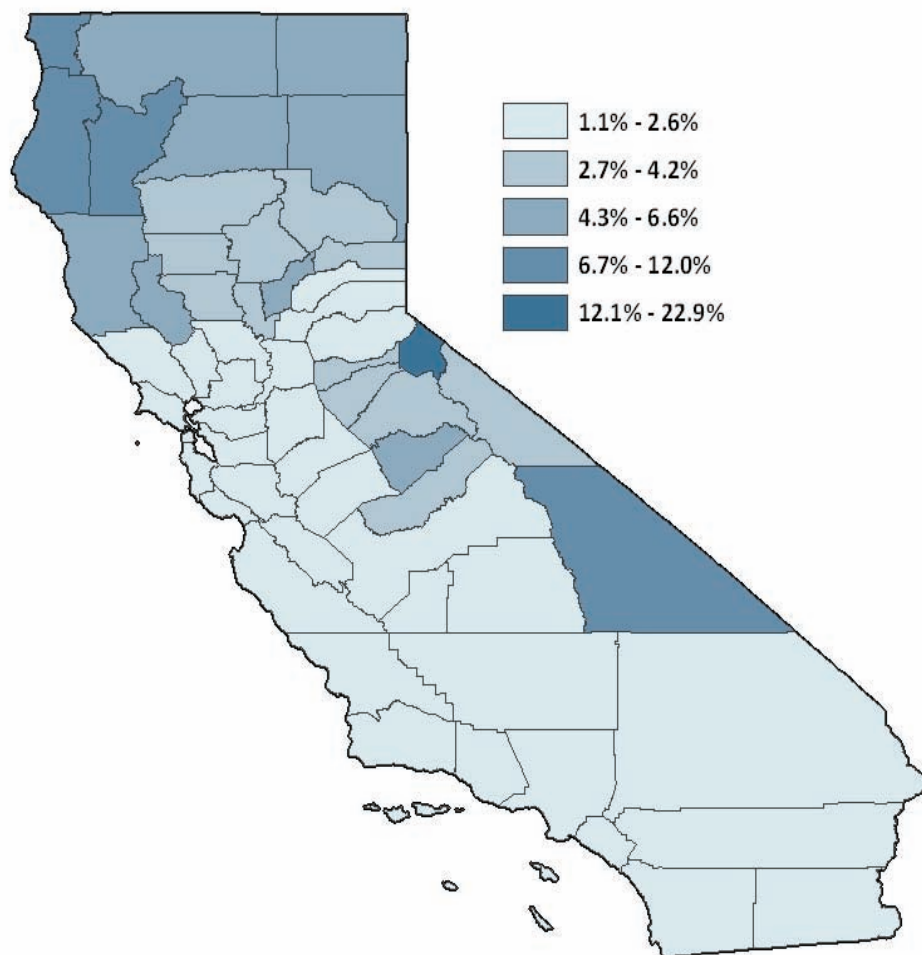
Today, a large number of AIAN reside in the county of Los Angeles (138,696 AIAN inclusive of Other Races) and in the five Bay Area counties of Alameda, Contra Costa, San Francisco, San Mateo, and Santa Clara (77,226 AIAN inclusive).⁸ The large number of AIAN in these urban areas is a result of relocation policies, employment opportunities, and rehabilitation and treatment centers in those areas.⁷ Urban Indians often come from hundreds of different tribes around the U.S.; some have lived all or most of their lives in cities, while others are relatively new arrivals. Urban Indians often maintain ties to their cultural communities; many move back and forth between the city and tribal lands.

The population of Urban AIAN in California depends on how 'Urban' is defined since there is no single definition.⁹ As many as 74% of the AIAN population in California (476,947 AIAN Inclusive of Other Races) live in metropolitan areas of California, compared to 79% of the total population.¹⁰ Urban Indians are more likely to identify themselves as multiracial than rural Indians. When this is coupled with their geographical dispersion in the city, identification with Urban Indian communities can be difficult. Urban Indian community centers seek to address the needs of the AIAN who live in California's largest urban areas.

AIAN are only 1.9% of the California Population

The 2000 U.S. Census reported that AIAN Inclusive made up almost 2% of the total California population. The low population density contributes to 'invisibility' of AIAN where numbers count in data analysis and policymaking. While the largest numbers of AIAN are in Southern California (Map 1), the largest population density for AIAN is in Northern California where county populations range from 4.3% to 22.9% AIAN (Map 2).

Map 2. AIAN Inclusive as a Percent of Total Population by County

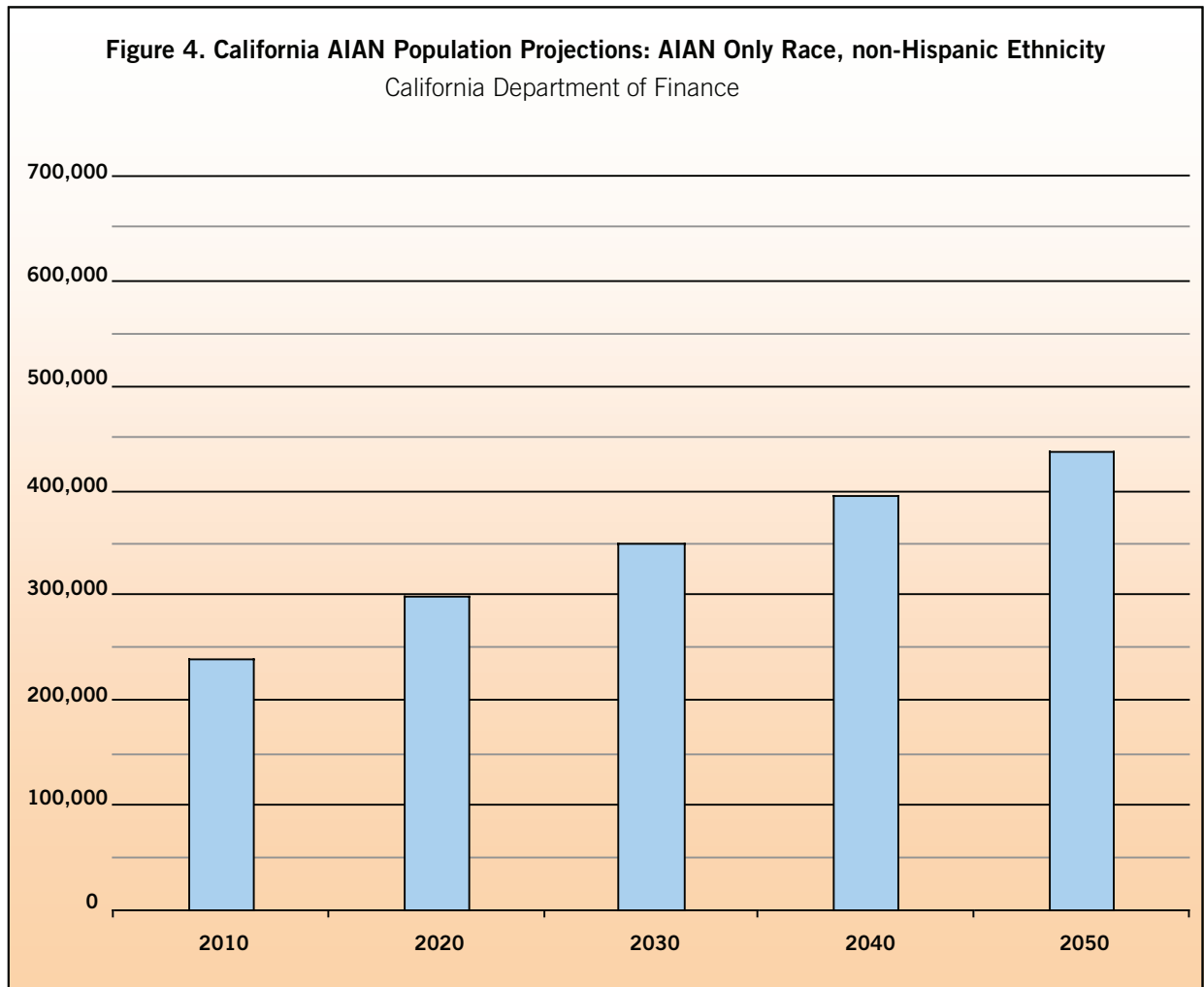


Source: 2000 U.S. Census

The number of AIAN in California continues to grow

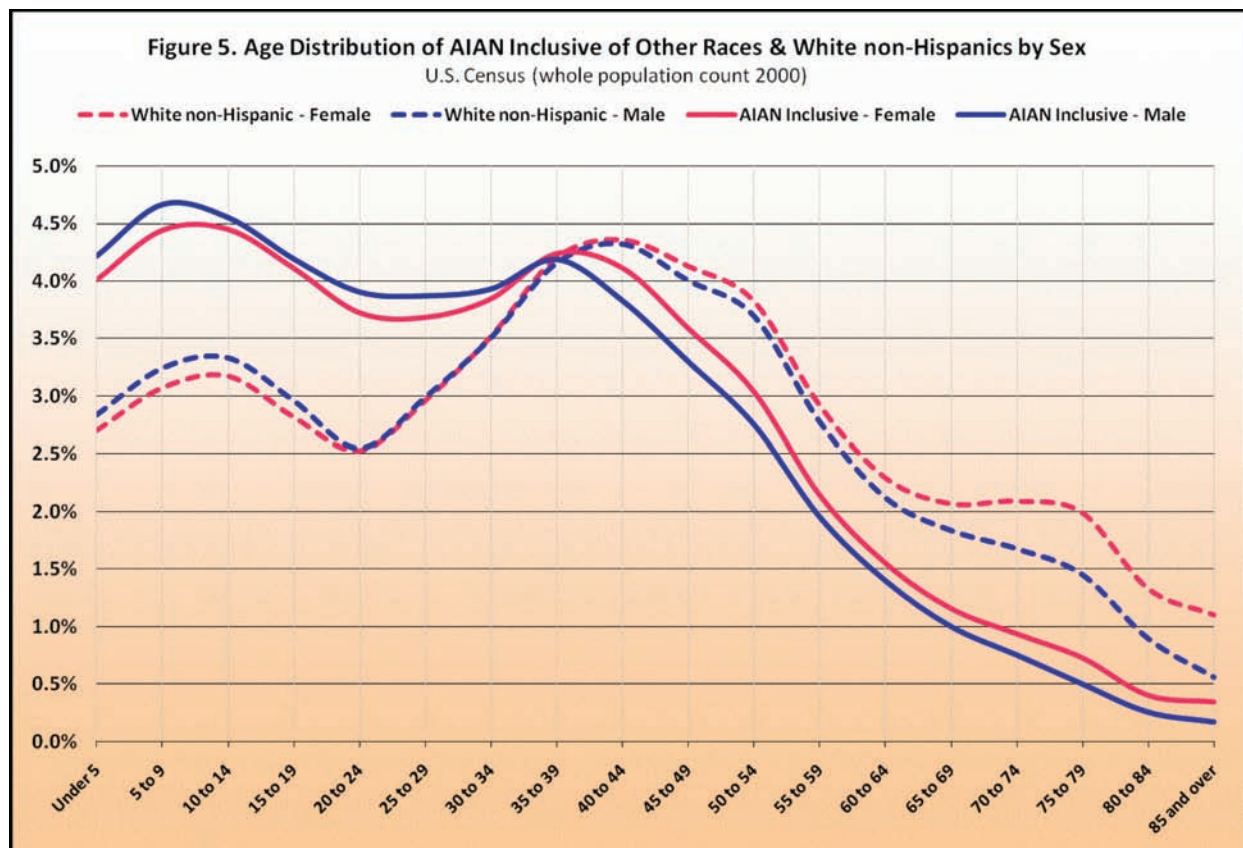
The California Department of Finance Demographics Unit estimates that the AIAN population (i.e., the non-Hispanic 'AIAN Only' population) in California is growing at one of the highest rates of any of the major racial/ethnic groups, the same rate of 1.7% per year as Asian Americans (Figure 4).¹¹

According to the department's projections, the AIAN population growth is due to a steady migration of non-Hispanic AIAN in to the state, as opposed to AIAN birth rates exceeding death rates. Again, because the California Department of Finance Demographics Unit does not use the Inclusive definition of AIAN, it is possible that these growth rates are underestimated.



AIAN populations are young

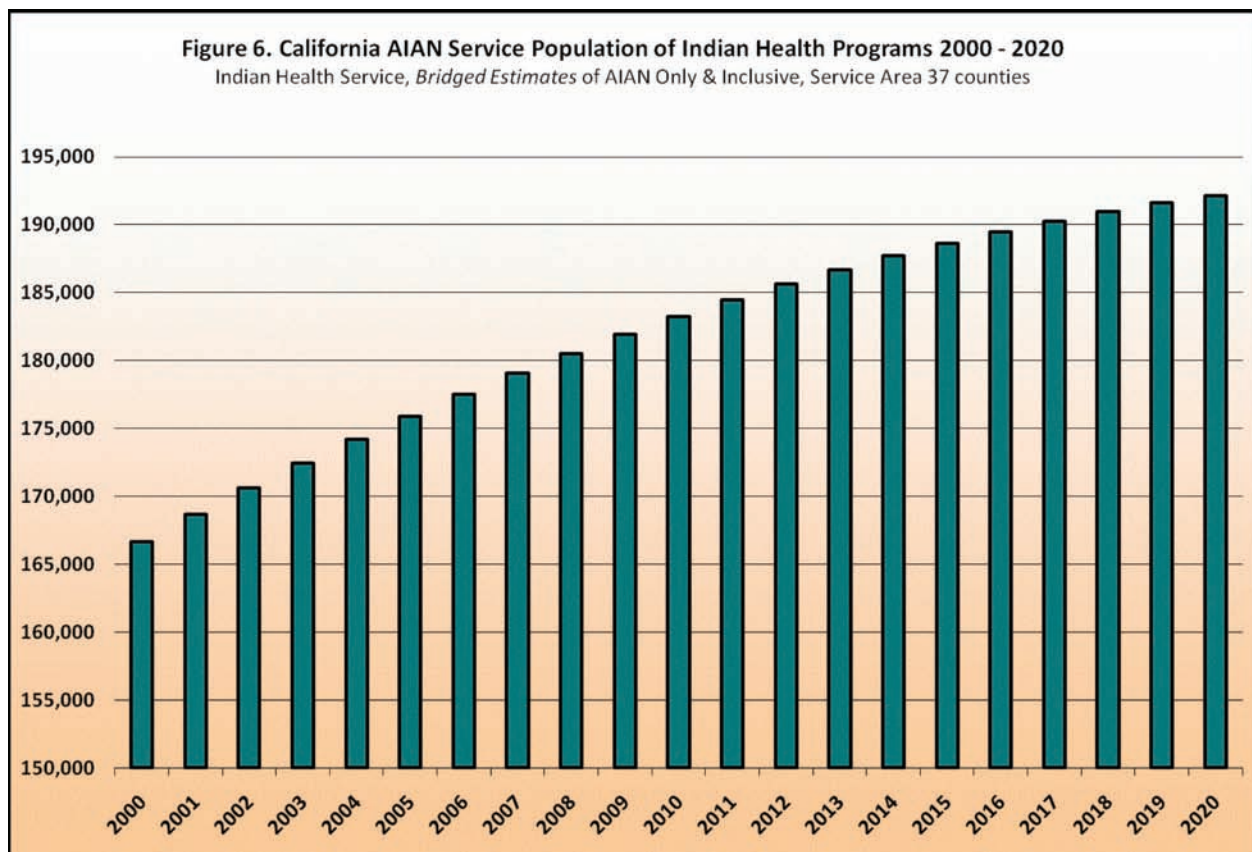
AIAN populations have more children and fewer adults than Whites. Figure 5 compares the age distribution of Whites (solid lines) to AIAN (dashed lines). More than half (57.6%) of AIAN are under age 35, while more than half (57.8%) of Whites are over age 35. There are proportionately more women than men in older AIAN age groups, as for Whites. The proportions of both men and women AIAN in the population decline steadily after age 40, whereas for Whites this starts at a later age and occurs more gradually.



American Indians indigenous to California, 'California Indians'

Within the population of self-declared AIAN are California Indians who are indigenous to the land area now called California. A person's identification as a federally recognized AIAN indigenous to the U.S. is based on the government's trust responsibility to a tribe and that person's official membership in that tribe. The federal government currently recognizes 107 California Indian tribes.¹² The number of recognized tribes changes from time to time as one of the 50 or more non-recognized tribes that are seeking recognition or reinstatement due to termination policies of the 1950's succeed at achieving recognition through the Federal Acknowledgment and Procedures program.

California tribes range in size from under 100 to over 5,000 members, although total numbers are not known because the tribes are sovereign and need not share their enrollment categories and figures. For purposes of rights to health care, there is also federal acknowledgement of a group of Indians in California who are descendants of individuals officially listed by federal agents in California as 'Indians' in 1852.¹³ One measure of the AIAN population in 37 counties of California is the estimated Service Population of the federal Indian Health Service (Figure 6). The figures are based on the 'AIAN Only' population with the addition of a calculated fraction of the mixed race AIAN developed by the National Center for Health Statistics ("Bridged Estimates").



California Indians remain tied to place

California Indian tribes are diverse in part because California is so geographically diverse. California contains mountain ranges, a multitude of rivers, lakes and streams, and an expansive coastline with a variety of beaches. The climates range from heavy snow to desert temperatures, coastal breezes to inland heat. These differences between coastal, inland, northern, central and southern locations presented different opportunities and challenges to California's Native communities. Prior to the arrival of Mexican and European people in California there were over 60 Native language groups that already encompassed a great deal of cultural diversity (Map 3).¹⁴ Separated by the Tehachapi Mountains, Southern and Northern California tribes had different experiences with colonialism that shaped the changes in their cultures. Mexican and Spanish contact dominated in the South, while American and European contact dominated in the North.

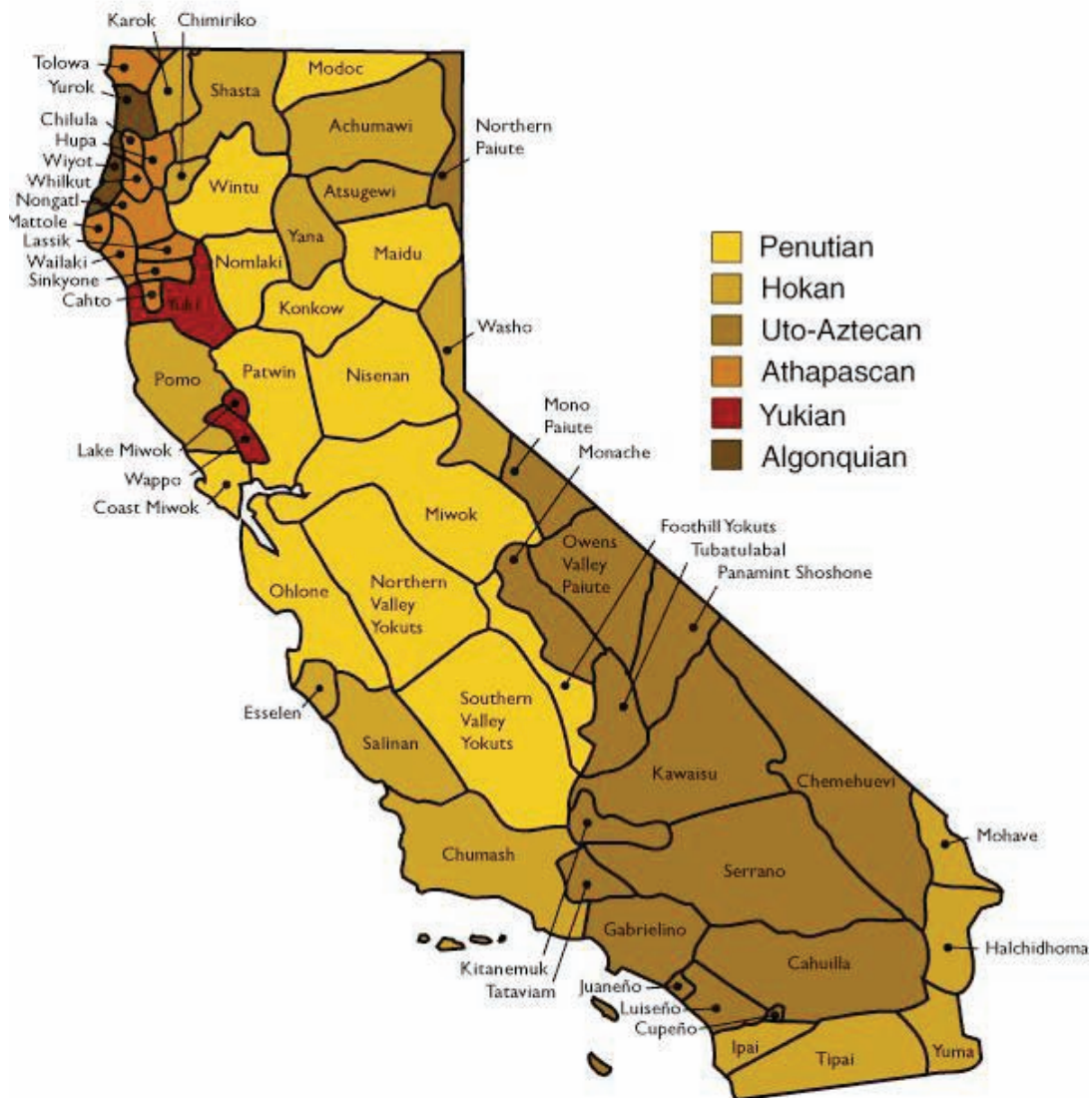
"We need community knowledge about traditional medicine. You cut your finger now, you think "where's a band aid?" Back in the day, you'd cut your finger and you'd go get a leaf from a bush and wrap it around, pinch it together. We're dependent on western medicine now, but before 1492 we took care of ourselves. Now, we can't live without all our pills."

**—AIAN Community Stakeholder,
September 2009**

Unlike other Native people across the U.S., many California Indians were not entirely uprooted or displaced from their ancestral lands. The larger Northern California tribes (such as the Yurok, Hoopa

and Karuk tribes) remain close to the Klamath River, a river which is incredibly important to the traditional food and culture of their people. In both Northern and Southern parts of California, the coastal areas remain important to tribal members who still hunt and gather traditional foods and use materials in traditional crafts and regalia. Many tribes also remain close to sacred sites; the Hoopa Reservation contains a sacred site that has been in uninterrupted use for more than five thousand years.¹⁵ Today, many California Indians draw strength from the ancestral sustenance of place.

Map 3. California Tribes and Root Languages



II. HISTORICAL FACTORS IN THE STATE'S POLICY ENVIRONMENT

California Indians have a unique state policy environment due to a history of legal and political state policy actions. The federal government has committed itself to a trust responsibility to protect California tribal communities, tribal lands, and to provide them services (including health care). This federal responsibility is at times extended to the state of California to implement.

Both the state of California and California Indian tribes have a range of common interests and a shared accountability.¹⁶ Tension between the state and tribal governments, however, is as old as the formation of the state.¹⁷ The state of California has involved itself in the U.S. trust responsibility that includes health studies and health care for California Indians, and has actively supported the self-determination of California tribes and the development of Urban Indian Organizations in owning and operating their own Tribal Health Programs and Urban Indian Health Organizations.

In the unprecedented California budget crisis of 2009, the governor and legislature removed all funding of the state Indian Health Program and ended a range of benefits that Medi-Cal could provide to AIAN at no cost to the state. In this critical time, we need to review the major historical factors that shape today's health policy environment between the state and AIAN living in California. Such a review will help develop a basis for communication on policy and programmatic actions to reduce disparities in health. We outline briefly here historic events, issues and policies between the state and AIAN in California, including health and welfare of the descendants of its original people.

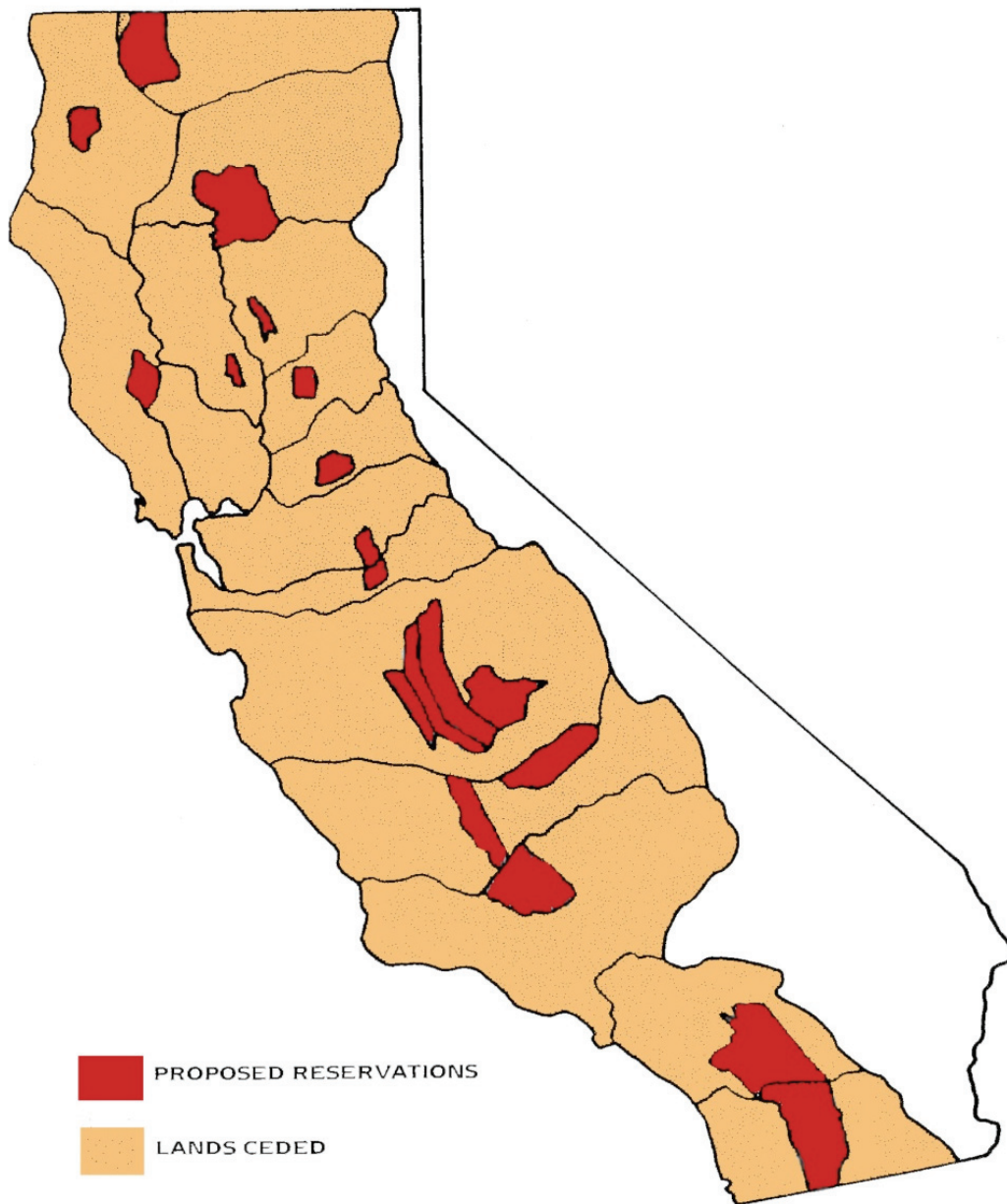
Factor 1. The Federal Trust Responsibility for California Indians was Abrogated when Treaties were Rejected at the Request of the California State Legislature

'California Indian' is a political designation distinct from any racial designation. This designation applies to indigenous people of California who were dispossessed of their rights to land, minerals and water by the federal government as part of a trust that would, in return, provide them unique rights. The federal trust responsibility to AIAN, including the responsibility for AIAN health care, derives from the U.S. Constitution, including the Indian Commerce Clause, Treaty Clause, and Supremacy Clause. The characteristics of the trust responsibility have been formed through court decisions, treaties, congressional actions, executive orders, regulations, and ongoing interaction between the federal government and tribal governments. The trust responsibility supplies the legal justification for and obligation to enact policy-making specific to AIAN. Federal laws that provide trust or special protection or services to AIAN when rationally tied to this responsibility have been upheld by the courts, as these laws deal with AIAN in a *political* rather than a *racial* context.

The federal government developed 18 treaties that were signed by tribes in 1852.¹⁹ The treaties would have reserved more than 7.5 million acres of land in 'trust' to California Indian tribes in exchange for 400 million acres of California land (Map 4). Public concern over the treaties centered on fear that the land to be set aside for Indians might contain gold. It is rumored that this public concern led California's senators in Washington D.C. to see that the treaties were not ratified.¹⁸ The signed treaties were kept secret until the 1950's, when the federal commission was sent to California

to validate land titles, and California Indians were dispossessed of all their land without the treaties. By 1854, the federal government developed reservations in the state for Indians. Because the indigenous Californians lost much of the land documented in the treaties and did not receive the 7.5 million acres of proposed reservations in return, these treaties have been involved in several lawsuits. Only a small number of California tribes were officially federally recognized for many decades as a result.

Map 4. Land areas to have been ceded by tribes through the unratified treaties of 1852, and the reservations proposed for the relocated tribes.¹⁹



In 1954, California state legislators passed a joint resolution assuming jurisdiction over California Indian lands released by federal Public Law (PL) 83-280.²⁰

The federal Bureau of Indian Affairs (BIA) had already enacted a policy of Termination to remove some Indian tribes and their lands from federal trust.

The policy affected a number of California tribes.

Around this same time, the U.S. Congress passed House Concurrent Resolution 108, which ended the status of AIAN as wards of the federal government in

several states – including California. With the passage of federal PL 280, five states (including California) were allowed both criminal and civil jurisdiction over the American Indian populations within their state boundaries (Alaska Natives came under PL 280 when Alaska became a state). These federal actions allowed California to assume jurisdiction over the California tribal lands. PL 280 is commonly misunderstood and misapplied, and is often a barrier to tribes in establishing tribal criminal justice systems. A 2007 evaluation report found that tribes in PL 280 States rated the accessibility and quality of law enforcement lower than reservations in non-PL 280 states.²¹

The state of California did not provide health care or other services to Indians from 1954 to 1969. BIA officials and their successors in the Indian Health Service (IHS) liquidated the very limited health services being provided to California Indians with the events surrounding PL 280. Two small remote hospitals and part-time health centers had served a small number of California Indians in very remote areas prior to 1954. The state assumed criminal and civil jurisdiction over California Indians but ignored health services and the other factors in the trust responsibility. Until 1969 public health and health services provided by the state were limited to occasional visits by public health nurses to some Indian tribes, or state assistance in developing water or sanitation systems on some tribal lands. **California state programs and policies need to avoid breaching the trust responsibility for health care services if disparities in health of AIAN are to be reduced.**

“[American Indians] should not need to fight, argue, or justify funding for health care. We have a treaty based right to healthcare, and there should never be an instance where we have to fight for that health care.”

**–AIAN Community Stakeholder,
September 2009**

Factor 2. The State Created its own Indian Health Program with Tribal and Urban Leaders to Address Health Disparities of AIAN in California

The origin of today's Indian Health Program dates back to 1963. In that year, a study commissioned by the California Indian Commission reported AIAN rates of diseases were higher than rates for the general population. The California State Assembly pressured for the addition of an all-Indian advisory committee to the State Advisory Commission on Indian Affairs' recommended establishment of state Indian health projects. A representative of the California Public Health Department and the Indian advisory committee to the California Indian Commission obtained federal funding to start Indian health demonstration projects. They visited the governor's office, the legislature, and the State Advisory Commission and gathered recommendations about whom to hire and where to place the projects. The newly named "California Rural Indian Health Demonstration Project" was established in the California Department of Public Health. In the summer of 1967, a group of Indian advisors from the state's seventy-eight federally recognized rural Indian groups, all advisors to the governor's

office, met to select the first project sites. They selected nine project areas: the Hoopa, Round Valley, and Tule River Reservations, Modoc County Indians, groups of Indians in Clear Lake, Tuolumne County, and Owens Valley, Soboba and Morongo Indians, and Pala and their surrounding Reservations.

In 1969, as the state Office of Indian Health started to work with tribal and urban Indian leaders to set up these local Indian health projects, another study of the California State Advisory Commission on Indian Affairs was released. The study revealed higher levels of infant mortality, tuberculosis, alcoholism, diabetes and other diseases for California Indians when

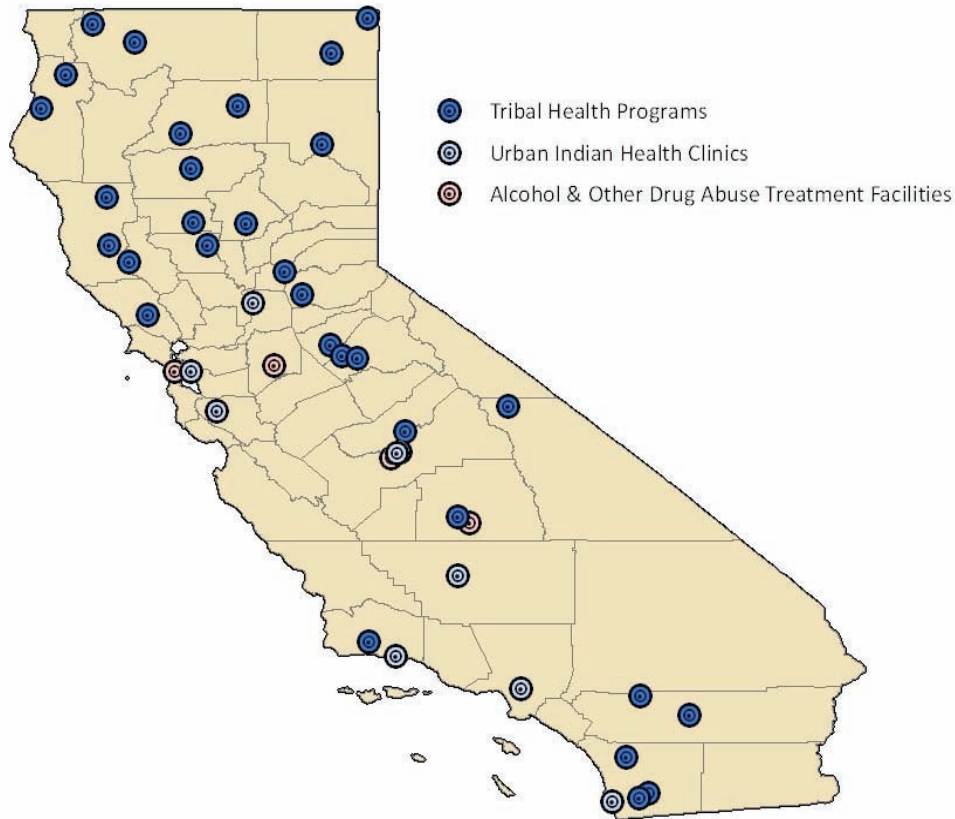
compared to the general population. The humble 'clinics' that were started eventually resulted in the extensive network of Tribal and Urban Indian Health clinics throughout the state (Map 5). Tribal and Urban Indian community health boards were functioning by 1970 to provide culturally-based input to the clinics [see photo]. In 1975, the California Legislature addressed Indian health directly. California Senate Bill (SB) 52 directed the California Department of Health Services to create an Indian health branch to conduct local health programs and provide a budget. The branch was reduced to program status in 1983 as part of the Rural Health Act (SB 1117).

The state Office of Indian Health became the state Indian Health Program, and the Indian health projects became a statewide network of local Indian Health Service (IHS) funded Tribal Health Programs and Urban Indian Health Organizations. Today, the 32 Tribal Health Programs and 8 Urban Indian Health Organizations in California operate more than 54 health facilities that provide limited public health services and a wide range of primary health care services, including medical, dental and behavioral health services.²² The facilities include full-time health clinics as well as health stations open less than 40 hours a week. Thirteen of the programs have pharmacies. Tribal Health Programs have limited amounts of IHS funds to cover specialty care and hospital care that the Tribal Health Programs are not equipped to provide (Contract Health Services and Contract Health Emergency Funds). The Tribal Health Programs and Urban Indian Health Organizations rely on private and other public sector hospital facilities to provide the specialty, hospital and emergency care their users need.

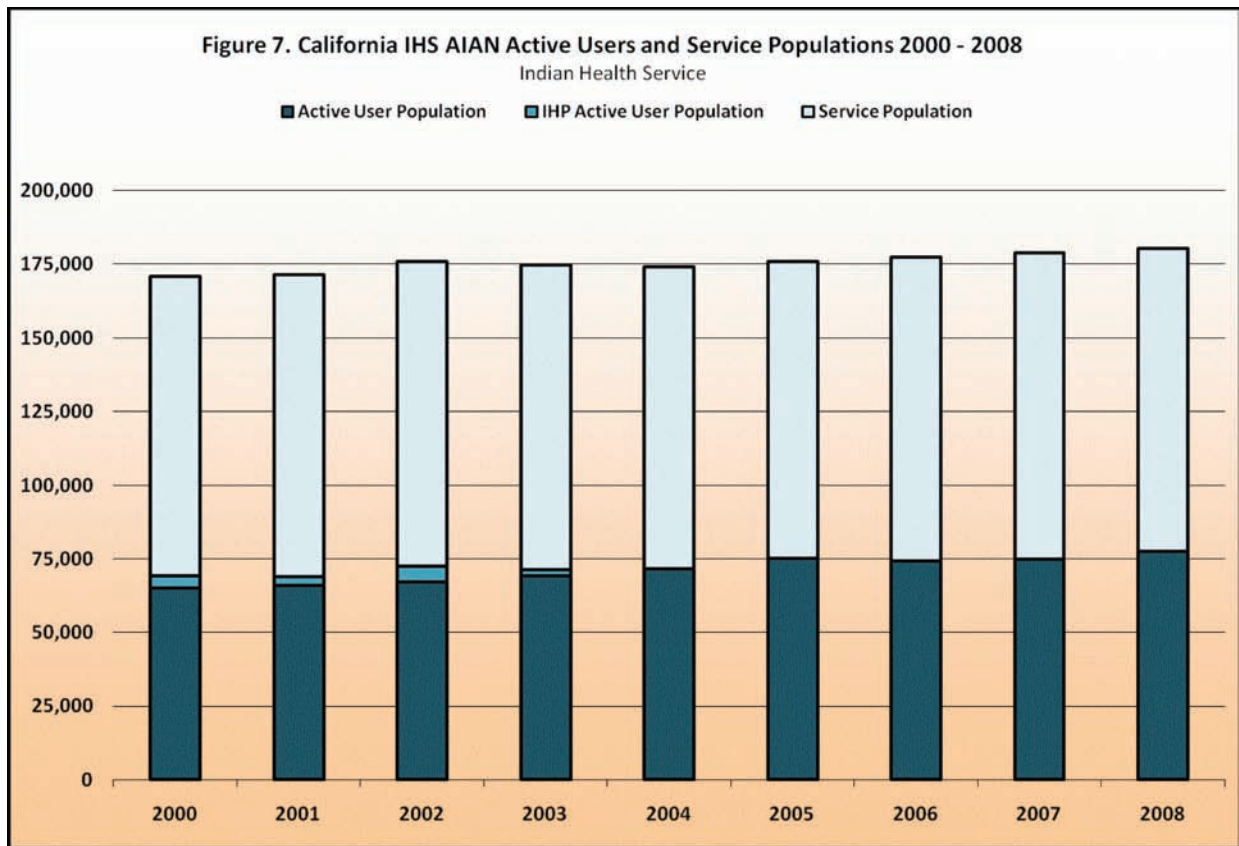


While Board members look on, Indian Health Service director Dr. Emery Johnson (right) signs a contract providing \$25,000 per month to continue the existing California Rural Indian Health Program. (Reproduced from California Health, published by the California State Department of Health, March 1970, vol. 27-9)

Map 5. Tribal Health Programs, Urban Indian Health Clinics, and Treatment Centers (2009)



The Service Area of the Tribal Health Programs is primarily that of the 37 IHS Contract Health Service Delivery Area (CHSDA) counties in California. The IHS designates CHSDA counties as those in which AIAN who use Tribal Health Programs must live to be eligible for IHS payment of specialty and hospital Contract Health Services.²³ The Service Population for these 37 (of California's 58) counties are estimated by the IHS to have grown to more than 175,000 AIAN in recent years (Figure 7). Patients who visit Tribal Health Programs or Urban Indian Health Organizations, and are provided at least one clinical service at least once every three years are known as 'Active Users' (Figure 7). In 2008, about 43% of the Service Population were Active Users. Of these documented AIAN served in rural clinics, nearly three-quarters are California Indians (71%) and more than one-quarter (29%) are AIAN members of tribes entitled to the 'Trust' from elsewhere in the U.S.²⁴ In Urban clinics, about one-third (36%) are California Indians and nearly two-thirds (64%) are AIAN from elsewhere. Many clinics also provide services to non-AIAN who have private or public insurance.



The State Indian Health Program helps serve the California AIAN community

The state's Indian Health Program is charged to improve the health status of American Indians living in urban, rural, and reservation or Rancheria communities throughout California.²⁵ The California Health and Safety Code states that the California Department of Health Care Services "... shall cooperate with local governmental agencies and contract with voluntary nonprofit organizations in connection with the development of local health programs for American Indians and their families."²⁶ The code specifies that the state Indian Health Program will distribute funds in accordance with a formula and assist programs to maximize third-party payment systems. It also encourages the Department of Health Care Services to provide sufficient funding to improve AIAN access to other service programs within the California Department of Public Health including Maternal, Child and Adolescent Health, Women, Infants, and Children (WIC) Supplemental Nutrition Program, and programs for the aging. The state Indian Health Program distributed \$6.4 million to provide specified services at 32 Tribal Health Programs and Urban Indian Health Organizations and two Traditional Indian Health education projects each fiscal year for the past ten years.²⁷ There has been no state funding for the Indian Health Program since the 2009 state budget.

California programs and policies need to respect the fundamental importance of the state Indian Health Program if disparities in AIAN health are to be reduced.

Factor 3. California Tribal and Urban Leaders Work to have the Federal Indian Health Service Address Health Needs of AIAN Eligible for their services in California

California Indians have worked relentlessly to attain their fair share of IHS federal funding for Tribal Health Programs and Urban Indian Health Organizations. The IHS, an agency in the federal Department of Health and Human Services, is a health care delivery system of health programs and facilities for federally recognized AIAN living on or near Indian reservations and in certain urban areas.²⁸ The California Indian Legal Services filed the Rincon Case in the mid-1970's to address inequities in IHS funding for AIAN health care in California. California Indians made up 10% of the U.S. Indian population, but IHS allocated at most 1.9% of its budget to the state. Furthermore, although IHS operated 51 hospitals and 99 health centers across the country, California had only one IHS-operated hospital and 2 health centers. It was eventually found that IHS had violated California Indians' constitutional rights to equal protection. IHS was ordered to adopt a program for providing health services to Indians in California comparable to those offered to Indians elsewhere. As California tribes began to succeed one-by-one with reinstatement of their federally terminated tribes, they were faced with the challenge of establishing their rights to health care funding.

Tribes in California took over the management and ownership of their own health programs as they developed in the 1970s. Nationally, Public Law (PL) 93-638, the Indian Self-Determination and Education Assistance Act, expanded the right of tribal governments to contract directly with the federal government for services and to exercise direct control over them. However, as a result of the 20 year hiatus in federal funding, and the fact that several California tribes were only reinstated in recent decades, California tribes continue to face challenges competing for equitable IHS funding.

In California, only 55% of basic health care coverage of a federally recognized AIAN is covered by IHS.²⁹ IHS is chronically underfunded and spends only 36% of what the U.S. population as a whole spends on Personal Health Care Expenditures.³⁰ In addition, California has the lowest IHS funds for specialty and hospital care (Contract Health Services funds). IHS funding of catastrophic care depends on use of those Contract Health Service funds. Only if a Tribal Health Program spends more than \$25,000 in Contract Health Services funds on a single individual's episode of care can they receive Catastrophic Health Emergency Funds to pay for further care. Since the tribes have so little Contract Health Services funds, most cannot afford to spend \$25,000 on an individual episode of care and rarely qualify for Catastrophic Health Emergency Funds.

"Tribes rely on IHS clinics and the referral system is BROKEN!"

***—AIAN Community Stakeholder,
September 2009***

The IHS health care funding deficiencies result in low levels of primary and specialty care available, which in turn has been linked to higher hospitalization rates. In one research study it was shown that the better the funding of the Tribal Health Programs in California, the lower the rates of hospitalizations of the AIAN who are admitted for conditions that are avoidable with access to effective ambulatory care.³¹

For 2010 the federal IHS is slated to receive a 13% increase in its budget, and California Indians will be advocating for their fair share of those increased funds. Even a 13% increase in Tribal Health

Program funding would be far from adequate to provide reliable access for these AIAN to equitable health care services. **California state officials will need to adopt a role in advocating for federal attention to California Indian health care needs if disparities in AIAN health are to be reduced.**

Factor 4. Urban Indian Health and Health Care Issues are Different from those of Rural AIAN

Urban Indian Health Organizations serve an important role in assuring access to primary medical care for low income Urban Indians. California's new state Office of Indian Health started to work with Urban Indian leaders as well as rural tribal leaders to set up local Indian health projects in 1969, not long after the first federal acknowledgment of the special issues of Urban Indian health.³² The first federal Indian Health Care Improvement Act of 1975 (PL 94-437) contained Title V, which established a discrete program for Urban Indians modeled after Neighborhood Health Centers. Instead of expanding the role of existing IHS services into cities, most Urban Indian health programs are owned and operated by local Indian non-profit corporations that contract with the IHS and the state. The first direct IHS funding of Urban Indian Health Organizations came in 1979 through Title V of the Indian Health Care Improvement Act. Urban Indian Health Organizations today provide IHS funded services using grants and contracts.

Urban Indians are underserved by federal Indian policies and programs, largely because federal policy tends to focus on tribal governments and their enrolled members, despite acknowledged treaty obligations to serve Indians wherever they live. Federal trust responsibility provisions to federally recognized tribal AIAN at IHS and Tribal Health Programs are not automatically extended to AIAN served by Urban Indian Health Organizations whether they are members of federally recognized tribes or not. The Medicaid and State Children's Health Insurance Program services the Urban Indian Health Organizations provide to AIAN that are paid by the state are not currently reimbursed 100% Federal matching percentage (FMAP).

The spectrum of services provided by Urban Indian Health Organizations is based on two general kinds of programs: those mainly for information, referral, and transportation based on a Minnesota Demonstration Project in 1972 (Bakersfield, Fresno and Los Angeles), and those with primary care medical, dental, behavioral health services and substance abuse counseling (Oakland, Sacramento, Santa Clara, Santa Barbara and San Diego and San Francisco) (Map 5). Urban Indians tend to live dispersed throughout metropolitan areas, but many remain connected to Indian cultural practices and services.⁷ Urban Indian Health Organizations serve a vital role in access to culturally competent primary care and preventive health services. Urban Indian Health Organizations funded through Title V have been included under the umbrella of publicly financed health programs eligible for Federally Qualified Health Center (FQHC) status. As FQHC they are eligible to receive cost-based reimbursement for Medicaid services offered. They are also eligible to be providers under the Children's Health Insurance Program (CHIP). The Urban Indian Health Organizations have diverse funding streams. While the IHS is the primary funder of most Tribal Health Programs, IHS funding does not necessarily represent the highest percentage of the annual budget of Urban Indian Health Organizations in California.³³ **California programs and policies will need to attend to Urban AIAN health programs if disparities in AIAN health are to be reduced.**

Factor 5. The Medi-Cal and Healthy Families Programs have a Unique Role in coverage of health care for AIAN that does not require state funding

State general funds do not have to pay for Medicaid services provided to IHS-eligible Indians at Tribal Health Programs. The federal Medicaid program reimburses states 100% of payments for health care that federally recognized AIAN receive through Tribal Health Programs. Thus the cost of the California state Medicaid program (Medi-Cal) for services AIAN receive through Tribal Health Programs is 0%. The state receives reimbursement for claims paid to Tribal Health Program's for services provided under an IHS 638 contract to IHS-eligible AIAN. In obtaining reimbursement for health care, Tribal Health Programs are required to seek payment first from private insurers, Medicare, and then Medi-Cal before using IHS funds. Medi-Cal plays an important role in funding care provided by Tribal Health Programs; for many of these clinics up to 40% of operating budgets can come from Medi-Cal. **California programs and policies need to expand state participation in federally paid Medicaid and CHIP programs for AIAN using Tribal Health Programs if disparities in AIAN health are to be reduced.**

State Medicaid programs are not reimbursed 100% for claims paid to Urban Indian Health Organization providers for services provided to AIAN. Health Care Reform in 2010, however, missed the opportunity to include Urban Indian Health Organizations in the 100% federal funding policy for Medicaid and CHIP. However, CHIPRA allows Urban Indian Health Organizations federal projects to assist with the Medicaid and CHIP outreach and enrollment of AIAN. ARRA waives any premiums or co-payments for IHS-eligible Indians. More ways are being sought in which the Urban Indian Health Organizations can participate in providing the AIAN they serve with benefits designed for federally recognized AIAN at IHS and Tribal Health Program facilities. **California programs and policies need to pay attention to expansion of federally paid Medicaid and CHIP programs for AIAN using Urban Indian Health Organizations if disparities in AIAN health are to be reduced.**

III. DEFINING THE POPULATION'S SOCIOECONOMIC FACTORS

AIAN face major health care access issues that adversely affect their health status. These issues include availability of providers and transportation to providers in rural areas, and coverage of care in urban areas. However, health status is not just about health care. Health status is about ensuring educational opportunities, safe communities, adequate housing, and adequate economic and employment opportunities; all these health status uses depend on socioeconomic factors. Socioeconomic indicators have been historically low for AIAN. Because tribal lands are by historical design in the state's poorest areas and because economic development on tribal lands is highly regulated, it is often difficult for tribes to generate revenues on their own.

However, tribal revenues and socioeconomic factors are changing for some California Indian members of federally recognized tribes. The re-emergence of tribal sovereignty in the last third of the twentieth century led to the development of business enterprises and employment on tribal lands. While some tribal members have had an increase of wealth in California because of gaming, the vast majority have not.

Tribal Gaming

In California, 58% of tribes operate some sort of gaming facility or bingo hall.^{34,35} There are 3 levels of Indian gaming in California – Class I: Traditional Indian gaming; Class II: Bingo, punch tabs or punch boards, non-banking card games; and Class III: all other forms of gambling. Class III games require a tribal-state government-to-government compact.³⁶ As a result of these compacts, it is estimated that California gaming tribes paid over \$35 million in to the state general fund in 2007.³⁷

When gaming profits occur they are shared in a number of ways among tribal members. According to US Code: Title 25, chapter 29, section 2710,³⁸

“Net revenues from any tribal gaming are not to be used for purposes other than –

- I. to fund tribal government operations or programs;
- II. to provide for the general welfare of the Indian tribe and its members;
- III. to promote tribal economic development;
- IV. to donate to charitable organizations; or
- V. to help fund operations for local government agencies”

Typically, promoting tribal economic development and funding operations of local government agencies take up approximately 50% of tribal gaming revenue allocation plans. Consequentially, no more than 50% of tribal gaming revenues are ever spent on per capita (i.e., providing for the general welfare of the Indian tribe and its members).

“Gaming tribes need more of an input-output relationship [with the counties]. The county gets a lot of benefits and funds programs from gaming, but what are the tribes getting in return from the county? Shame on the Indian community for never asking for anything besides more slot machines.”

**–AIAN Community Stakeholder,
September 2009**

The Indian Gaming Revenue Sharing Trust Fund in California attempts to address the economic inequalities between gaming tribes and non-gaming tribes by distributing a portion of gaming revenues to non-gaming tribes, or tribes with less than 150 slot machines. In 2007, over \$134 million dollars was paid by gaming tribes to this special distribution fund.³⁹

Income

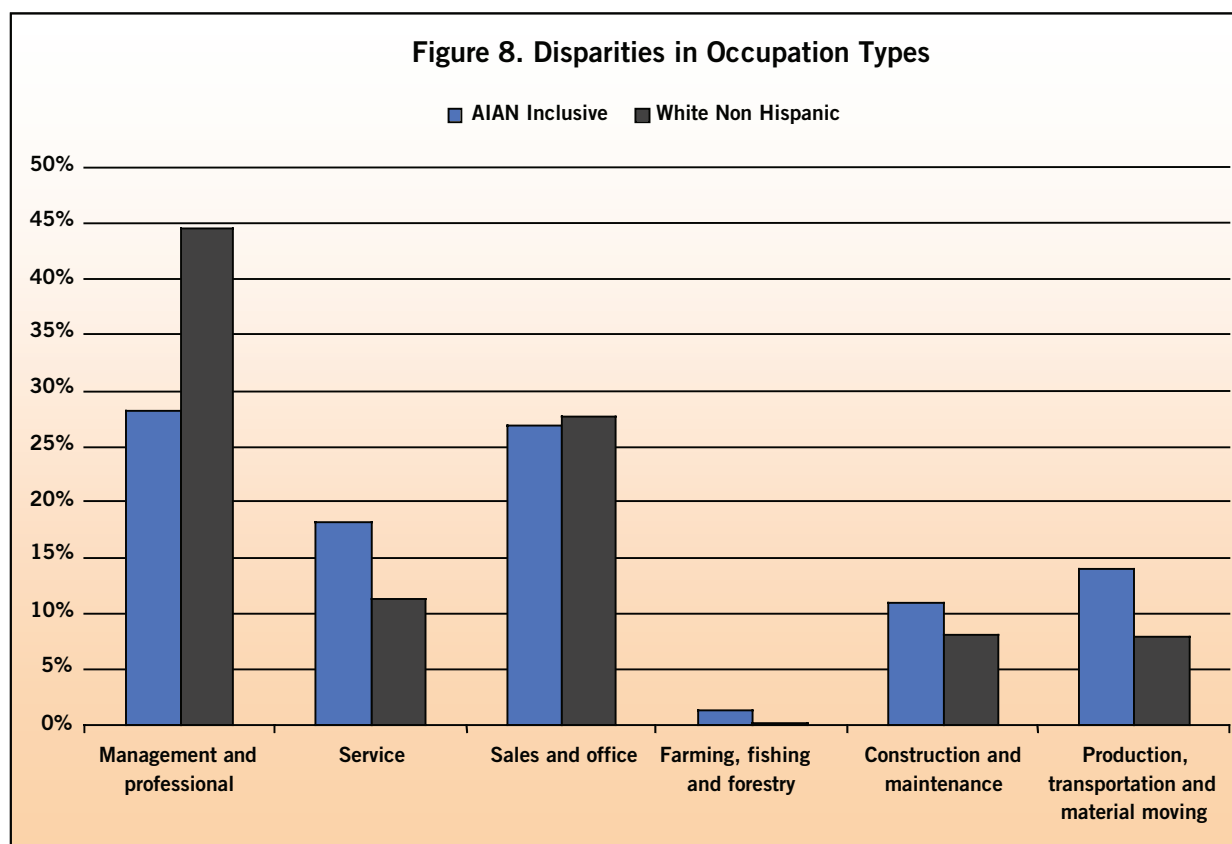
From 1990 to 2000, AIAN families located in census tracts close to gaming facilities showed a significant increase in median family income compared to families located in non-gaming census tracts (\$16,063 versus \$11,877).⁴¹ But the median family income for AIAN (\$38,547) was still less than 60% of the median family income for Whites (\$65,342) in 1999.⁴⁰ From 1990 to 2000, the average per capita income of AIAN in gaming tribes increased by 55%, compared to only 15% for non-gaming tribal members.⁴¹ Still, the average per capita (per person) income for AIAN statewide by 1999 (\$15,226) was less than half the per capita income of Whites (\$31,700). The per capita income for AIAN Inclusive was not much higher (\$16,491) than for AIAN Only (\$15,226). While income gains are expected for some AIAN since the year 2000, the disparities have not disappeared.

Poverty

The number of AIAN families living below the poverty line decreased from 35% in 1990 to 26% in 2000 for gaming tribes.⁴¹ However, these poverty rates were still over two times higher than national and state averages. Almost half (48%) of AIAN in the labor force 16 years and older lived in households with incomes below the federal poverty level compared to 15% of Whites. Of AIAN of all ages living below the poverty line, 10% were under the age of 5 compared to 5.9% of Whites. For AIAN living in the counties surrounding Urban Indian Health Organizations in the North, Central, and Southern areas of California, 15.6%, 27%, and 21.7% respectively are living in poverty, compared to 9.6%, 17.7%, and 16.7% of the general population in those counties.⁴²

Workforce

The AIAN workforce in 2000 showed an 11.1% unemployment rate, compared to the 5.0% unemployment rate for non-Hispanic Whites. There are also differences in what type of employment AIAN tend to have (Figure 8). More than a quarter of AIAN (28.3%) in the labor force are in management, professional and profession-related occupations, while almost half (44.6%) of non-Hispanic Whites are in such occupations. Compared to non-Hispanic Whites, AIAN work in lower paying employment, such as service occupations (18.2% AIAN compared to 11.3% of non-Hispanic Whites) and in production, transportation, and material moving (14.1% AIAN compared to 8.0% of non-Hispanic Whites).



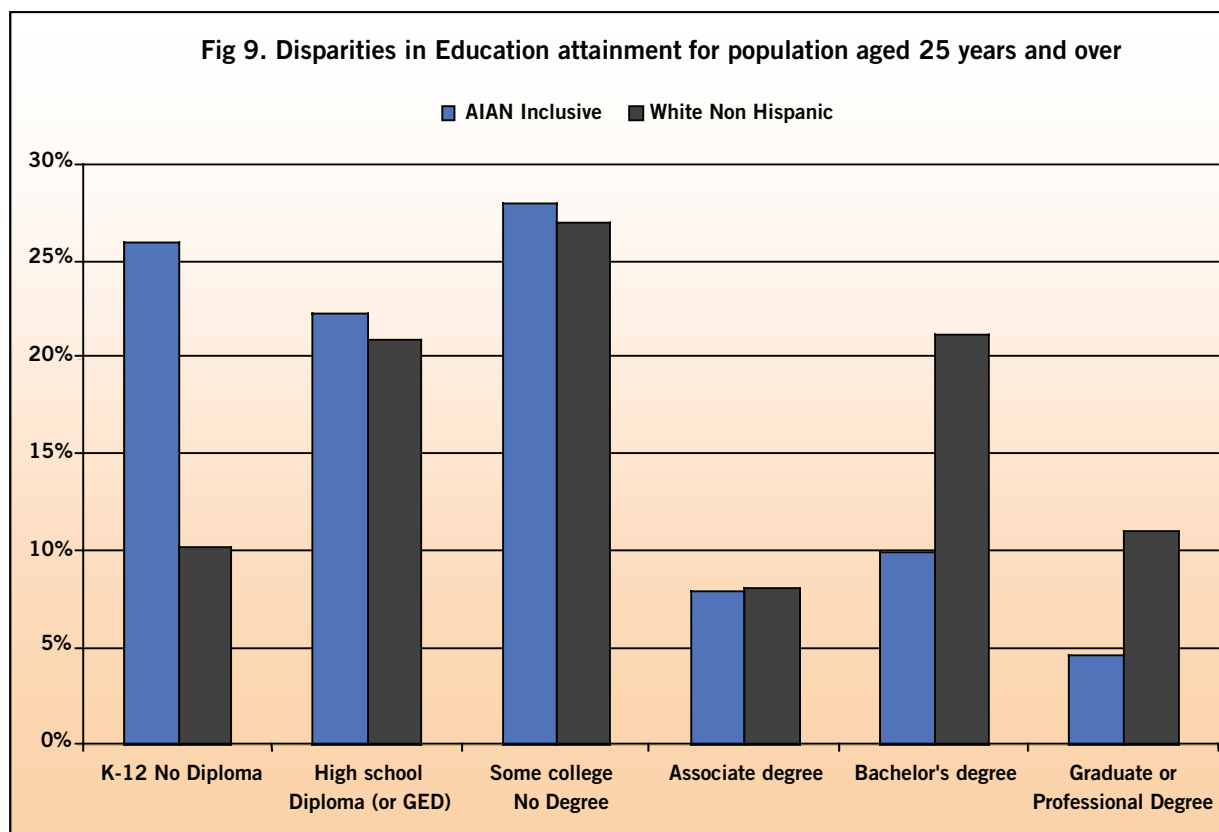
Education

Over a quarter of the AIAN adult population (26%) did not have a high school diploma compared to a tenth (10%) of non-Hispanic Whites at the time of the U.S. Census in 2000. While a sixth (16%) of AIAN had a bachelor's degree, this is less than half the proportion of Whites (34%). AIAN college enrollment rates have been rising, but the growth is from very low base levels.⁴³ Rates of college enrollment lag behind not only Whites but also other racial and ethnic groups. For

AIAN living in the counties surrounding Urban Indian Health Organizations in the North, Central, and Southern areas of California, 24.5%, 36.1%, and 37.1% respectively do not have a high school diploma, compared to 16.1%, 27.1%, and 27.2% of the general population in those counties.⁴⁴

“Our compacts direct a lot of money to the state - we need to get some of that money to go to state programs that are specific to Indians – like Indian education.”

**–AIAN Community Stakeholder,
September 2009**



Transportation

Twice as many AIAN homes (14%) had no vehicle available for transportation, compared to Whites (7%). Because transportation is an important component of access to health care, we examined the variation in this indicator for the service areas of the Tribal Health Programs with clinics. Availability of transportation varied considerably by service area. The highest proportion for AIAN homes without vehicles in a service area was 22% and the lowest was 1.4%. Of the AIAN homes that are rented (rather than owned), 20% do not have a vehicle available, compared to 13% of non-Hispanic Whites.

Telephone Service

Almost 5% of AIAN homes had no landline telephone service, compared to less than 1% of non-Hispanic Whites. In households with incomes below poverty, the proportion of no phone service was 11% for AIAN and 4% for non-Hispanic Whites. Telephone service is also important in access to health care. The highest proportion for AIAN homes without telephone service in the service areas of the Tribal Health Programs with clinics was 25% and the lowest was 1%; the disparity with Whites with respect to telephone service varied considerably by service area. AIAN homes lacked telephone service from a low of 1.3 to a high of 14.3 times as often as White homes in the same service areas.

Public Safety

Trends in public safety on tribal lands have been alarming, though the full extent of crime is not always reported. Even when criminal justice systems do exist and are capable of responding to the needs of tribal communities, tribes are hampered by limited jurisdiction, severe underfunding, and a lack of comprehensive crime prevention programs. Poverty and limited economic opportunities become the background for criminality and accidents, which are often drug-related.

IV. HEALTH STATUS

Native populations in California shoulder a large burden of health disparities. Until recently, AIAN health disparities were largely undocumented. Over the last two decades, data regarding the types of health conditions affecting AIAN living outside California show a shift from infectious diseases towards chronic and behavior-related diseases, such as diabetes, heart disease, and obesity. Unfortunately, comparable trend data for AIAN is not available in California. The state has been unable to detect or track disparities in most health indicators for AIAN, either because of misclassification of AIAN in state health administrative data, or because the AIAN population is too small a fraction of the California population to show up in health survey data. The state Center for Health Statistics in California published three landmark documents in 2003 and 2004: *Multicultural Health Disparities*, *Trends in Leading Causes of Death* and *Racial and Ethnic Disparities in Healthcare*. Again, AIAN and their health disparities were invisible in the reports because of inaccurate AIAN racial classification in administrative data, and a lack of AIAN oversampling in survey data.

The proportion of inaccuracies in the AIAN rates of death and disease stem from misclassifying AIAN in other racial groups. Misclassification occurs from 30% to 70% in state databases for deaths, hospitalizations, cancers and the like.^{45,46} In data calculations, AIAN are then undercounted in the numerators while they are accurately counted in the population denominators, which means that rates of death and disease appear much lower than they actually are.⁴⁵ Recent electronic linking of state data to federal Indian Health Service data for California is providing more accurate AIAN health data, at least for AIAN who use Tribal Health Programs. In linkage studies, the misclassification of AIAN who use Tribal Health Programs is corrected in state death certificates and hospitalizations, and thus provides more accurate rates for disparities in mortality and serious morbidity.

Disparities in Deaths

Life Expectancy of AIAN is shorter. Life expectancy for AIAN men in California who use Tribal Health Programs is 67.5 years, which is 6.5 years younger than White men (74.0 years) who live in the same counties.⁴⁶ Life expectancy for AIAN women is 75.1 years, which is 3.1 years shorter than for the White women (78.2 years).⁴⁷

Death Rates of AIAN are higher. After correcting for misclassification, the actual death rate for AIAN is 858 per 100,000, which is 65% higher than the AIAN death rate reported by the state of California and 16% higher than the AIAN death rate reported by the Indian Health Service for California.⁴⁶ The death rate for AIAN who use Tribal Health Programs is 20% higher than for Whites living in the same counties. From ages 15 to 74 years, death rates of AIAN are significantly higher than Whites. The highest disparities occur in younger age groups: death rates are more than 2.5 times as high for AIAN 15 to 34 years of age (ages 15 to 24 are 2.6 times as high, and ages 25 to 34 are 2.8 times as high) compared to Whites living in the same counties.

Leading Causes of Death of AIAN are different. As shown the table below, three out of five leading causes of death for AIAN who use Tribal Health Programs are different from the causes of death for Whites living in the same counties.⁴⁸

Table 1. Disparities with Whites in Five Leading Causes of Death⁴⁹

AIAN	Whites
1. Diseases of the Heart	1. Diseases of the Heart
2. Cancers	2. Cancers
3. Unintentional Injuries	3. Cerebrovascular Disease
4. Diabetes	4. Chronic Obstructive Pulmonary Disease
5. Chronic Liver Diseases	5. Infectious Disease

Table 2. Five Leading Causes of Death: Urban Indians⁵⁰

Northern California	Central California	Southern California
1. Heart Disease	1. Heart Disease	1. Heart Disease
2. Cancer	2. Cancer	2. Cancer
3. Lung Cancer	3. Chronic Lower Respiratory Disease	3. Cerebrovascular Disease
4. Cerebrovascular Disease	4. Cerebrovascular Disease	4. Diabetes
5. Chronic Lower Respiratory Disease	5. Unintentional Injury	5. Chronic Lower Respiratory Disease

There are substantial disparities in disease specific death rates. The three leading disparities in AIAN age-adjusted death rates with Whites are diabetes, alcohol (chronic liver disease), and unintentional injuries. Compared to Whites, the death rates due to diabetes are nearly 3.5 times higher for AIAN who use Tribal Health Programs; alcohol-related death rates are nearly 2.8 times higher; and unintentional injuries death rates are nearly 2.4 times higher. Age-adjusted death rates for AIAN users of Tribal Health Programs due to heart disease are actually significantly lower when compared to Whites, by about 12%.

Disparities in Hospitalizations

Hospitalization rates are higher. AIAN who use Tribal Health Programs are hospitalized 45% more than Whites living in the same counties.⁵¹ Specifically, AIAN men are hospitalized 40% more than White men, and AIAN women are hospitalized 43% more than White women. The California AIAN hospitalization rate from 1998 to 2002 was 25% higher than the U.S. rate for all races in 2000, and 20% higher than the U.S. rate in 2002. The disparities in hospitalization rates between AIAN and Whites could be the result of higher prevalence of disease, or similar prevalence of disease with decreased access to prevention or specialty care. In both cases AIAN would have higher levels of morbidity, but different health care and policy improvements would be indicated.

Avoidable hospitalizations are higher and depend on how well tribal clinics are funded. AIAN who use Tribal Health Programs are hospitalized for avoidable conditions at rates more than twice as high as Whites. Specifically, avoidable hospitalizations were 136% higher for AIAN men and 106% higher for AIAN women than for Whites living in the same counties of California.⁵¹ A study also showed that the avoidable hospitalization rates depended on funding provided to Tribal Health Program clinics.⁵² The higher the funding of the Tribal Health Program, the lower the avoidable

hospitalization rates for the AIAN who used them. The disparities in avoidable hospitalizations between AIAN and Whites could be the result of disparities in funding of their health care. Actuaries have determined that per capita funding for AIAN served by the IHS in California is less than 55% of what is received by federal employees with a standard benefit package. Furthermore, per capita funding is 50% that for Medicaid beneficiaries and federal prisoners, and less than 40% of the U.S. per capita amount.

Disparities Revealed by Health Survey Data

AIAN constitute an extremely low fraction of population-based survey samples. Often times, the sample size in surveys for AIAN is too small to be a statistically representative sample, and thus this population is frequently grouped with an “Other” racial classification category. In spite of these statistical limitations, valuable health information can still be extracted from population-based survey samples that include an AIAN racial category. The California Tribal Epidemiology Center at CRIHB has analyzed AIAN data from the California Health Interview Survey (CHIS) and the California State Behavioral Risk Factor Surveillance System (BRFSS) and enumerated many of its findings for AIAN.⁵³ We provide highlights of health status indicators using those survey findings here.

Diabetes. The prevalence rate of diabetes for AIAN in California who use Tribal Health Programs was 13% in 2006 (age adjusted; diagnosed diabetes among AIAN; aged 20 years or older). Twice as many AIAN report they have been diagnosed with diabetes as non-Hispanic Whites. The fraction with Type I diabetes is twice as high for AIAN; the proportion with Type II Diabetes (formerly known as Adult Onset Diabetes) is 77% of AIAN and 88% of non-Hispanic Whites.⁵⁴ For AIAN living in the counties surrounding Urban Indian Health Organizations in the North, Central and Southern areas of California, 17.4%, 9.2%, and 13.3% respectively report that they have been told by a doctor that they have diabetes, compared to 6.9%, 8.6%, and 8% of the general population in those counties.⁵⁵

Obesity, Food and Nutrition. Overweight children are of great concern to AIAN because of the high risks of Type II diabetes and other diseases. Of AIAN children aged 2-5 years who were users of California Tribal Health Programs, 23% had a body mass index in the 95th percentile or higher⁵⁶, indicating a high risk for diabetes.

Similarly, more AIAN report they eat fast food than non-Hispanic Whites.⁵⁷ For AIAN living in the counties surrounding Urban Indian Health Organizations in the North, Central and Southern areas of California, 31.9%, 9.2%, and 33.0% respectively report that they are obese, compared to 18.5%, 8.6%, and 22.9% of the general population in those counties.⁵⁵

“We need to stop embracing obesity as a badge of being Indian.”

*–AIAN Community Stakeholder,
September 2009*

Physical Activity. When asked about physical activity in a typical week, AIAN had fewer days per week with an hour of physical activity than did non-Hispanic Whites, and more AIAN reported they had only some physical activity, rather than moderate or vigorous physical activity.⁵⁸

Heart and Blood Vessel Diseases. AIAN report a prevalence of heart disease diagnoses similar to Whites (7% of AIAN and 8% of non-Hispanic Whites).⁵⁹ More AIAN than non-Hispanic Whites in California report that they have had a cholesterol check in past 5 years.⁶⁰

Dental Problems. Twice as many AIAN (8%) report they could not afford needed dental care compared to non-Hispanic Whites (4%). AIAN children aged 2 to 17 years had longer periods since their last dental visit than non-Hispanic White children.⁶¹

Psychological Distress. Twice as many AIAN report psychological distress compared to non-Hispanic Whites (in the past year 16% compared to 8%; in the past month 7% compared to 3%) (CHIS). Mental health data is limited for California AIAN, but nationally, approximately 101 AIAN mental health professionals are available per 100,000 AIAN, compared to 173 per 100,000 for Whites; in 1996 only 29 psychiatrists in the U.S. were of AIAN descent.⁶²

Injuries (National). The prevalence of suicide for AIAN is 1.5 times the national rate. AIAN males ages 15 to 24 years account for two-thirds of all AIAN suicides. Violent deaths (unintentional injuries, homicide, and suicide) account for 75% of all AIAN male mortality in the second decade of life.⁶²

Domestic Abuse. Almost 24% of AIAN in California have experienced physical or sexual violence by an intimate partner, compared to 21% of non-Hispanic Whites.⁶³

Illicit Drug Use. The levels of AIAN adolescents reporting that they have tried marijuana, cocaine, sniffing glue or other drugs at least once is similar to that of non-Hispanic Whites (13% compared to 15%).⁶⁴ Data on drug use in AIAN communities for California is very limited, but nationally, 14% of AIAN aged 12 years and older used illicit drugs in the past month compared to 9% of Whites. Additionally, 5% of AIAN aged 12 years and older used prescription medication for non-medical purposes compared to 3% of Whites.⁶⁵

Alcohol Abuse. While the proportions of AIAN who report alcohol use and binge drinking are not much higher than those for non-Hispanic Whites, nearly twice as many AIAN teens report riding in a vehicle with a drinking driver (34%) as non-Hispanic White teens (19%).⁶⁶

Tobacco Use. More AIAN smoke commercial tobacco cigarettes than non-Hispanic Whites (18% for AIAN compared to 15%).⁶⁷ For AIAN living in the counties surrounding Urban Indian Health Organizations in the North, Central and Southern areas of California, 17%, 22%, and 19% respectively report that they are current smokers, compared to 15.5%, 8.6%, and 14.8% of the general population in those counties.⁶⁸

Ease of Reading Medication Instructions. Fewer AIAN found it easy to read the instructions on a prescription bottle than non-Hispanic Whites (63% compared to 73%).⁶⁹ The ease of reading medication instructions is an important component in injury prevention, especially for Native elders.

Unaffordable Medications. About 25% of AIAN delayed or did not get a prescribed medication because they could not afford it, compared to 17% of non-Hispanic Whites.⁷⁰

“We need more culturally competent domestic violence and anger management programs for Natives. Many women do not report their domestic abusers because of the lack of cultural competency in the reporting agencies, but few tribes collect data on domestic abuse because ‘these are our families’. So many of our children grow up thinking violent behavior is ok...”

**–AIAN Community Stakeholder,
September 2009**

V. MAJOR DETERMINANTS OF AIAN HEALTH

Disparities in health among racial minorities are widely linked to historical, political, social and behavioral determinants that can be addressed through a wide range of government policies. In this section, we could review how waves of oppression, racism and attempted extermination have shaped the health of AIAN today as much as any people in history. Native Americans could easily document the devastation of generations of poverty, poor educational opportunities, and lack of employment so often cited for racial and ethnic minorities as determinants of their poor health. But AIAN instead are engaging in what has been labeled the Native Self Determination movement.⁷¹ AIAN have been seeking social and political change the past thirty years instead of assimilation, which has led to activism in policy making, progress in social and economic associations, and the expectation of health equity in urban and tribal communities.⁷² Social theories and conceptualizations of AIAN based on racial marginalization do not properly describe what contributes to disparities in the health of AIAN today. The Native Self Determination movement is about maintaining land, government, institutional relations, culture and self-sufficiency under terms compatible with indigenous cultures and beliefs.

Sovereignty and Self Determination

The empowerment embedded in tribal sovereignty and self-determination is the force behind a resurgence of hope among many AIAN in urban and tribal communities today. Federal and state government policies that lasted well into the twentieth century resulted in making California's urban and tribal AIAN in California dependent on the federal government and experiencing little, if any, control over their communal or individual lives. But in 1975, Public Law (PL) 93-638, the Indian Self Determination and Education Assistance Act, reasserted the right of tribal governments to contract and compact directly with the federal government for funding and services and to exercise direct control over the resources. Three decades of self-determination have enhanced native participation in the design and management of a number of their own programs and services – including Tribal Health Programs, Tribal Temporary Assistance to Needy Families (TANF), housing, education and Head Start programs. Tribes are investing time, talent, money and traditional wisdom. Challenged by needs for tribal leadership and solutions, many AIAN are reviving traditional practices for their own solutions.

“We need community empowerment – the ability for 1st Nation people to improve their situations”

**–AIAN Community Stakeholder,
September 2009**

Tribes have been independent nations, managing land and having autonomous political, cultural and economic institutions, for millennia. Today, tribes in California strive to maintain, recover and restore powers and institutions of government and society. Tribes pursue these goals not because they do not want to cooperate with other governments, but because they have rights to have governments cooperate with them.

Tribes are sovereign nations within the United States, and they possess rights to rule over their tribal members and tribal lands. Tribal governments are a source of services on their tribal lands. They face a broad range of governmental issues that are often the same issues faced by the state government. At the same time, the laws of the state in which a tribe operates do not necessarily apply on tribal lands. Political sovereignty has expanded tribal jurisdiction and authority over resources and decision-making and regulatory sovereignty has expanded economic ventures such as selling tobacco in smoke shops, and Indian gaming.

When the state of California wanted to apply a state tax to Indian gaming they were met with the reality of tribal self-determination and sovereignty. There was no process of communication until tribes requested the governor of the state recognize government-to-government relationships through meetings, negotiations, and compacting as policymaking. Indian gaming has arguably not meant as much about profits to California Indians, as it has meant to self-sufficiency and self-determination about what tribes choose to do. It is this government-to-government communication that recognizes the unique rights and responsibilities of tribal sovereignty that California Indians have identified as necessary from state and local governments.

Cultural Revitalization

As part of self-determination, AIAN are choosing a path to the future that is grounded in their own traditions, spirituality, religions, institutions and communities.⁷³ Today, California Indians, as well as AIAN living in California, express their rich and diverse cultures in many ways. Termination, assimilation, and relocation policies were based on the idea that assimilating AIAN into the dominant culture would reduce disparities. Non-native settlers in California developed explicit policies that suppressed the use of the more than 60 native languages by California Indians. Many AIAN lost their languages, important cultural practices and significant indigenous knowledge. In many tribes generally few, if any, elders still speak their native language. Similar policies prevented practicing native religion, drumming, songs or dancing, and placed California Indian children in Western culture boarding schools that persisted into the mid-twentieth century, where the goal was to “kill the Indian, save the child.” Assimilation policies involved banning tribal spiritual and health care (traditional health) practices as well.⁷⁴

Native ways of thinking and doing things have endured. Many AIAN view their traditions, like themselves, as survivors against all odds. As tribal communities in California reassert control over their own affairs, they invest in restoration of language, protection of ancestral and ceremonial properties, revitalization of ceremonies and crafts, and the defense of indigenous values and cultural practices. The use of traditional languages, ceremonies and other practices in California is growing again. Traditional healing, medicines, and spiritual ceremonies have not only persisted to this day, but are experiencing a rise in interest and application in a variety of ways. These cultural strengths continue to differentiate tribal communities and individuals from the other cultures of the U.S.

Access to Culturally Competent and Affordable Health Care

Medi-Cal coverage is critical to AIAN. Access to health care for AIAN is determined not only by the availability of medical, dental and behavioral services described in Section II, but by the affordability and cultural competency of these services to AIAN. The high rates of poverty among rural and urban AIAN alike make them eligible for Medi-Cal, Healthy Families, and other public insurance coverage in disproportionately high rates. In the California Health Interview Survey in 2007, 19.7% of AIAN were covered at least one month for Medi-Cal, 8.2% for Medi-Cal and Medicare combined, and 2.1% for Healthy Families. This is 3 to 4 times higher than proportions for non-Hispanic Whites: 4.7%, 2.2% and 0.7%, respectively. The proportion of uninsured AIAN were only slightly higher (9.0%) than non-Hispanic Whites (7.2%), but the proportion of those on Medi-Cal or Healthy Families was 29.0% of the AIAN surveyed population compared to 7.6% for the Whites. Half of the AIAN had private insurance (49.9%) compared to more than two-thirds of Whites (69.5%). While comparable proportions of the populations had Medicare (14.1% versus 14.5%) for AIAN, the majority were low income Medicaid enrollees in Medicare (8.2% of the 14.1%) whereas only a small fraction of Whites were Medicaid enrollees in Medicare (2.2% of the 14.5%).

Access to culturally competent care is not just a matter of having a Tribal or Urban Indian facility nearby. Access is also about having health care providers who know the history of the political environment and the determinants of health for AIAN in California. Before communication can begin about the intimate topics related to health, AIAN people want to ensure that their history and cultural traditions are deeply respected by their health care providers. Indian people want providers to understand the history of strengths and resilience are as honorable as the history of abuse and neglect are deplorable. Because family and community is so much a part of their individual identity, many AIAN only trust people who are Native or who are culturally aware of Native communities.

Health care professionals may have extensive education in health and disease in a general, medical perspective, but working in tribal communities requires training from Tribal and Urban Indian programs. There are a wide range of AIAN beliefs, languages, traditional home remedies, and health care practices that are important to the overall well-being of Native people. Many of the buildings and ceremonies of Tribal Health Programs have been built by the tribes, reflecting the re-emergence of cultural practices of California Indians. The opportunity for more culturally competent care is growing through the cultural revitalization of California Indian tribes and Urban Indian organizations in recent decades. The Tribal Health Programs and Urban Indian Health Organizations are an important resource for training and preparing culturally competent health care providers for AIAN communities.

California State Budget Cuts have been detrimental to Culturally Competent and Affordable Health Care that AIAN Depend On. The recent budget cuts experienced in California have been especially detrimental to the access to culturally competent care that AIAN have come to depend on at Tribal Health Programs and Urban Indian Health Organizations. Many programs have suffered severe losses in revenue, staff layoffs, and reductions in services offered. Outlined below are program cuts noted by four directors of Tribal and Urban Indian Health Programs.

Director – Santa Ynez Tribal Health Program

- Clinic staffing levels were reduced due to the loss of several revenue sources - the largest revenue loss was the state Indian Health Program (IHP). The total reductions equated to approximately \$500,000 out of a \$4,000,000 dollar budget. Because we used the IHP to offset salaries, we were forced to cut several staff members. In total, we reduced full time efforts of Medical Doctors by 50%, Dentists by 40%, the Psychologist by 20%, Dental Assistants by 60%, Medical Assistants by 40%, the Check-out Specialist by 40%, Alcohol and Other Drug Counselors by 20%, Community Health Representative's by 20%, and the Executive Director by 10%. We implemented salary and performance freezes.
- We did not cut departments or programs, but did reduce the level of service. In an effort to avoid further loss of morale, we made full-time reductions based on volunteers. Efforts were made to keep the lowest paid employees on staff, but did not provide cost increases in their benefits.
- All programs were impacted due to the budget cuts, and there has been a delay in accessing services for patients. This process was manageable, however, until the H1N1 situation arose. The increasing number of patients calling in or showing up because of H1N1 has amplified the stress on the overall system. Our employees are doing an excellent job in spite of the changes and understand the constraints under which we are working.
- The area most impacted by the reductions was adult dental services. We have made an effort to reach out and bring in children who qualify for Medi-Cal and Healthy Families. The money collected for children's services has helped us to offset revenue reductions from the loss of at least 1,200 dental adult visits on an annual basis (or 20% of the total number of dental patients we see). The adult dental patients who were covered under the Medi-Cal optional benefits were shifted to our sliding fee scale. A reduction in our EAPC funding by 50% forced us to move those patients to our sliding fee scale as well. Consequentially, we have seen an increase in our Accounts Receivables activity and witnessed more patients going to debt and receiving collection notices.

Director – Feather River Tribal Health Clinic

We just had a case, reported in the newspaper, where a patient who had been seeing one of our Licensed Clinical Social Workers (LCSW) for domestic violence and an abusive relationship was murdered by her husband. She had stopped coming for counseling because she had Medi-Cal as a resource, and when Medi-Cal cut optional benefits this patient could not pay for LCSW services. We could no longer see her without a payment source, and she didn't have one. Our LCSW believed that she would have eventually had the courage to leave her abuser had she been able to continue counseling.

Director – Riverside/San Bernardino County Indian Health

As a result of recent budget cuts:

- We reduced staffing along with benefits to the tune of \$814,000, which included 1 Dentist, 3 Dental Assistants, 1 Hygienist, 1 Pharmacist, 1 Psychologist, and 1 Licensed Clinical Social Worker.
- Services have also been reduced, due to the staffing cuts indicated above. Dental services, our pharmacy, and behavioral health services have been eliminated.

- The staff is more stressed than ever as they are trying hard to compensate for all the reductions. Low morale is becoming common, as a result of trying to do more without the appropriate staffing levels. Front office staffs are experiencing angrier patients due to the longer waiting periods for care.
- Patients are taking the brunt of this budget cut. Many get frustrated with having to wait so long to get access prevention/treatment services, and some just give up until it (the problem) becomes an emergency or urgent.

Director – Sacramento Native American Health Clinic

The Urban Clinics have been hit hard by recent budget cuts. The Five Top Billable Codes at our Urban Indian Health Clinic are:

- Diabetes
- Cardiovascular Diseases
- Dental Caries and Treatment
- Communicable Diseases, and
- Depression

Unfortunately, the one thing these billable codes all have in common is that they require a specialist or access to specialty care (which our clinic does not have).

VI. MAJOR ISSUES AND RECOMMENDATIONS

Issue 1. Communications with AIAN through Government-to-Government Tribal Consultations

Summary

Just as the U.S. government expands its meetings with foreign representatives and official heads of states, the U.S. government is expanding the issues about which it holds meetings with tribal representatives and officials representing tribal nations. These government-to-government Tribal Consultation meetings focus on health issues affecting tribal communities.

Recommendations

1. On-going Tribal Consultation should be established. A new state requirement established under Section 5006 (e) of the American Recovery and Reinvestment Act of 2009 directs state Medicaid agencies to establish meaningful and ongoing communications with Tribal Health Programs and Urban Indian Organizations to seek input on waiver requests, state plan amendments, demonstration projects, and the management of the Children's Health Insurance Program (CHIP). The increased involvement of Tribes in advising and participating in the decision-making process of the federal Department of Health and Human Services has resulted in stronger collaborations between the governments, and timely and important issues being brought forward for consideration by the federal government.⁷⁵

2. The State Indian Health Program should be reestablished and funded at levels that reflect the cost of providing public health and health care services in California. The major source of health care services for the AIAN is the federal Indian Health Service which helps fund Tribal Health Programs and Urban Indian Health Organizations. This system is dependent on mixed streams of funding - federal, state and private - that vary by location, but are all plagued by chronic underfunding. In response to the California state budget crisis, the long established state grant aid program operated through the Indian Health Program was defunded. The state Indian Health Program is essential to tribal and Urban Indian Health Organizations and the AIAN they serve. Owning and operating their own clinics is essential to tribal self-determination, and Indian community revitalization.

Issue 2. California can improve state implementation of federal Medicaid and CHIP with Tribal Health Programs at no cost to the State

Summary

The high rate of poverty for AIAN in California makes Indian people eligible for federal Medicaid and Child Health Insurance (CHIP) programs (Medi-Cal and Healthy Families in California) in disproportionately high numbers, but they do not enroll at high rates and their utilization of covered

services is low.⁷⁶ To improve their health status, Indian people need outreach and enrollment efforts to access health care providers where they can utilize their Medi-Cal benefits. Once outreach and enrollment efforts are successful, then not only can AIAN use Tribal Health Programs and Urban Indian Health Organizations, but referral and transportation to a medical specialist can be arranged if needed. Tribal Health Programs and Urban Indian Health Organizations are heavily dependent upon Medi-Cal, the state Indian Health Program, and Indian Health Service revenues for program operations. Medi-Cal and Healthy Families are entitlement programs, whereas the state Indian Health Program and the federal Indian Health Service healthcare delivery system rely on annual budgetary appropriations competing with all other governmental programs.

The federal Medicaid program reimburses California Medi-Cal 100% of its payments to Tribal Health Programs for medical care that IHS-eligible AIAN receive, rather than the usual 50% federal participation rate Medi-Cal receives for its payments to other Medi-Cal providers.

Recommendations

1. The Medi-Cal and Healthy Families Programmatic Outreach and Enrollment program should be enhanced for AIAN. The federal Medicaid and CHIP programs fund special outreach eligibility programs for AIAN at no cost to states.⁷⁷ The Children's Health Insurance Programs Reauthorization Act (CHIPRA, PL 111-3) and American Recovery and Reinvestment Act (ARRA, PL 111-5) amended Medicaid and CHIP statutes as they apply to AIAN to allow states to increase outreach and facilitate enrollment for eligible AIAN in Medicaid and CHIP. In addition, the legislation enables the federal Department of Health and Human Services to make grants or enter into contracts with tribes and tribal organizations for Medicaid and CHIP outreach and enrollment efforts on or near reservations and trust lands. These outreach and enrollment programs educate AIAN about the benefits of these programs, provide transportation to enrollment sites, and develop and implement methods to improve AIAN participation in the programs.

2. AIAN should have no premiums or co-pays (Share of Cost) to participate in Medi-Cal, which can be reimbursed 100% by the federal Medicaid program. AIAN paid in advance for health care rights; payment was made through land ceded to the states. Recent CHIPRA and ARRA legislation amended Medicaid and CHIP statutes so that states are required to eliminate cost sharing for eligible AIAN in those programs.

3. California should restore Medi-Cal 'Optional' Benefits that are reimbursed 100% by the federal Medicaid program. California's termination of Medi-Cal optional benefits (which included adult dental services, podiatry, and many behavioral health services) in 2009 has had a negative impact on the availability of these services for the treatment of health disparities in the AIAN population of California. These Medi-Cal optional benefits helped to address health consequences of diabetes and substance abuse, which are both significantly more prevalent in AIAN communities than the general population. These cuts in benefits have led to reduced access of low-income AIAN individuals to medical, dental, and behavioral health care, as well as reduced revenues to Tribal Health Programs and Urban Indian Health Organizations which provide these benefits in a culturally

competent environment. The development of a Tribal-specific Medi-Cal waiver request, or the exploration of new flexibility under the federal American Recovery and Reinvestment Act of 2009, could aid efforts to reestablish these benefits to California AIAN. The ability of the state to recoup 100% of the cost of Medi-Cal services provided to AIAN in Tribal facilities is the key to enabling this change in the current financial environment. The state legislature and the Medi-Cal program should continue their efforts to maximize this opportunity.

Issue 3. California can help Tribal Health Programs and Urban Indian Health Organizations Improve Health Care for AIAN

Summary

California-based Tribal Health Programs and Urban Indian Health Organizations are part of a national Indian Health Service health care delivery system focused on the provision of culturally competent care to Natives.

Recommendations

1. California should research the development of new loan and grant in aid programs to address the need for Facility Construction Funds. One critical issue reflective of the small size and distribution of the California Indian population is the persistent lack of access to facility construction funds from the federal Indian Health Service. In fact, no hospital has ever been built for a Service Unit in the Indian Health Service health care delivery system with an active user population less than 4,300, which is greater than California's average active user population of 2,270. This situation has forced California Tribal Health Programs to enter into loan arrangements to fund necessary facility construction. The impact of this strategy is that collections from Medi-Cal and Medicare and other third party payers are spent on facility costs – not the provision of additional care services. Cal Mortgage has provided access to low-cost loans to some Tribal Health Programs and should be directed to develop new approaches assisting both Tribal Health Programs and Urban Indian Health Organizations.

2. California should recognize out of state Licensure for Medical Professionals in Tribal Health Programs and Urban Indian Health Organizations. Another critical issue for Tribal Health Programs is recruiting experienced, knowledgeable and culturally competent health care professionals from out of state. Many of the Tribal Health Program clinics are exceedingly remote and have limited resources. However, a persistent barrier to successful relocation of trained and experienced health professionals is the length of time required to acquire appropriate state licensure in California. If the Tribal Health Programs in California were operated directly by the Indian Health Service, as they are in some other states, these same health professionals would not be required to acquire additional state licensure when they relocate from state to state. California should support provisional recognition of out of state licensure for health professionals who are employed in Tribal Health Programs and Urban Indian Health Organizations, as authorized under the Indian Health Care Improvement Act of the new federal health care reform. This right to practice and bill Medi-Cal should require an active

application for the appropriate state licensure, be reasonable in time, require a commitment to long term employment, and be restricted to practice in Indian Health Service-funded clinics.

3. California should promote integration of Tribal Health Programs and Urban Indian Health Organizations in local systems of Electronic Health Records and Practice Management Systems.

Tribal and Urban Indian health programs in California are largely focused on primary care, and are more dependent on federal funds to purchase services from non-Indian health care providers that the Indian Health Service cannot provide. The quality of care in clinic-based Tribal and Urban Indian health programs would be greatly improved by the ability to share patient information with their non-Indian referral partners. To facilitate communication among providers of AIAN health care, primary and specialty care, laboratory and imaging services, and hospitals should be required to include their local Tribal and Urban Indian programs in the design, governance, and operation of such data sharing systems. This raises several issues that could be addressed or mitigated by more supportive state policy. The federal American Recovery and Reinvestment Act (ARRA) of 2009 will be providing funds to support the implementation of electronic health records systems and practice management systems. Tribal Health Programs and Urban Indian Health Organizations are required to develop such systems and need to participate fully in these ARRA initiatives. Furthermore, ARRA establishes new standards for inter-operability of these systems as well as the establishment of regional information organizations to facilitate the sharing of health information.

4. Tribal Health Programs should be assisted in the development of start-up activities and programs to make in-home health services more readily available.

The aging of the AIAN population and advances in medical technology are leading to an increased need for in-home health services and hospice services. Higher rates of chronic diseases and disability contribute to the increased need for these services in the AIAN population. Furthermore, the small size and vast distribution of AIAN over large geographic areas provides additional challenges to the implementation of these services in California Indian country. These programs could be seen as expansions of the federally supported Community Health Representative program still found at many Tribal Health Programs. These professionally managed and trained community-based health paraprofessionals already provide services that are typically offered by home health agencies. With sufficient support, a consortium of Tribally Operated Health Programs might qualify for the Program of All Inclusive Care for the Elderly (PACE) funding through the federal Medicaid program. Alternatively, a new type of home health grant might assist in an expansion of a rejuvenated state Indian Health Program.

Issue 4. California can improve Public Health for AIAN and other Californians

Summary

It is only recently that issues of infectious diseases were eclipsed by chronic conditions among AIAN. Infectious diseases (as exemplified by the current H1N1 pandemic) continue to be of concern to AIAN and other Californians. Tribal Health Programs do participate in some public health reporting systems, but need to participate more fully. The utility of this participation has been grossly limited

by a lack of feedback from those public health systems to AIAN health care providers. Furthermore, this issue has been compounded by the inability of the state to provide AIAN-specific data.

Recommendations

1. The state should work with Tribal Health Programs and the California area Indian Health Service to see that Tribal Health Programs participate more fully in public health reporting systems.

2. Support programs for access to Healthy Food and Exercise. Chronic disease has taken over infectious disease as the leading cause of morbidity and death for AIAN. Access to good, nutritious food and support for individual behavior change is necessary to reduce the current epidemic of obesity. Childhood obesity carries with it lifelong risks for heart problems, diabetes, and depression. Although many tribes have used their federal housing funds to build gymnasiums and exercise centers, and a few have implemented nutrition and weight management programs, there is no consistent source of funding to provide these necessary services to the AIAN population. The state should explore the utility of creating a tribal-specific program to improve the impact of existing gymnasiums and exercise centers. Housing funds could be contracted directly to tribes or their respective Tribal Health Programs. In some tribal locations, community gardening projects have been very successful at expanding access to fresh foods, and as a teaching tool for nutrition and ecological sustainability.

3. Recognize tribal water rights for Healthy Food, Medicines, and Exercise. Water is fundamental to social and economic development. Water is also fundamental to traditional tribal foods, medicines, and physical activities like hunting, fishing and swimming. The water resources of tribal communities are a high priority issue before tribal governments. In western states, water rights are considered property rights and generally allocated according to first continuous use. The older the property rights, the more senior the claim to the waters. The precise nature of water rights, however, can be undefined. Competition for water rights is fierce in California where the rapid growth of the population and agriculture has put a large drain on the state's water resources. Negotiated water settlements and water compacts involving tribal governments, which typically include federal, state, county, municipal, and private parties, are increasingly being used to resolve questions surrounding tribal water rights. Efforts by the Department of Water Resources to conduct outreach and include Tribal Governments in water resource planning need to improve. This water rights situation is complicated by Indigenous Californians who are not currently federally recognized, so the impact of their un-acknowledged rights on both state and federal lands is unknown.

4. Recognize government-to-government programs for Mental Health services. The state implements Public Health Programs Block grants, which are granted to local governments, often bypassing tribal governments, their people, and the health systems they own and operate. California's implementation of the federal Mental Health Block Grant tends to overlook the capacity of tribal and Urban Indian behavioral health programs to provide culturally competent care to the AIAN population. Trans-generational historical trauma, social displacement, and lack of educational opportunity and attainment, and a severe lack of employment opportunities in rural California contribute to a high level of need for mental health and substance abuse treatment services.

Tribes and Tribal Health Programs did not receive the promised funds from Proposition 63 for mental health care. The legislation should be amended to direct funds to American Indian programs. A formal review of current county inclusions of AIAN provider systems in county plans would provide justification for a redirection of these funds. Redirection is critical, as decades of advocacy at the administrative level have shown negligible results.

5. Recognize Sacred Sites and Cultural Materials. For Native Californians, maintaining the integrity of sacred sites, as well as access to both sites and cultural materials, are critical to maintaining tribal identity. Legislative efforts in these areas have not been successful to date. The principal advocate on these issues is the California Indian Commission, which persistently works on site protection and repatriation of cultural materials.

6. The California Department of Justice needs to get involved in promoting public safety on California tribal lands. Public safety on some California Indian trust lands is hampered by the lack of formal arrangements with local public safety authorities, confusions over congruent jurisdictions, and a lack of funding opportunities for Tribes located in PL 83-280 states from the federal government. Tribes in non-PL 83-280 states are eligible to apply for federal funds to establish courts and tribal police officers, for example. The U.S. Attorney General started a Justice Department initiative to create better communication and coordination to fight crime and promote justice in Indian Country. The Attorney General convened a national tribal leaders' consultation and the Justice Department also held its annual tribal consultation on violence against women, as required by the Violence Against Women Act of 2005. The Department also engaged with tribal leaders on public safety in tribal communities during the White House Tribal Nations Conference in the fall of 2009. Department leadership also has conducted meetings with Indian Country experts on law enforcement and public safety efforts. In January 2010, the U.S. Attorney General announced sweeping reforms intended to improve public safety on tribal land. To address the issue of Public Safety there needs to be an increase in collaboration between the Federal Department of Justice, the Federal Department of the Interior, the State Department of Justice, and federally recognized tribes. Improved communication among these entities can help to foster improved coordination and response to issues of public safety, including drug enforcement activities, domestic violence interventions, and other crimes. Additionally, the state could address the lack of federal funding for "courts and cops" by establishing a state program to mitigate the lack of access to federal funding. The state could also explore ways to assist individual Tribes in receding from PL 83-280 and assist tribes in the acquisition of federal public service funds.

7. The California Department of Public Health needs to promote public safety programs on California tribal lands. The federal Department of Health and Human Services is integrating approaches across health and social programs, particularly programs aimed at youth. The increased willingness of government and tribal agencies to coordinate responses, to introduce traditional approaches, and to acquire health-related grant funds are beginning to suggest culturally competent ways to address public safety.

8. The California Departments of Public Health and Health Care Services need to develop accurate and complete epidemiological and vital statistics data for AIAN. The state has been unable to detect or track most health indicators for AIAN because either misclassification of AIAN in state health administrative data, or because the AIAN population is too small a fraction of the

California population in health survey data. The state continues to publish inaccurate 'multicultural' health status reports in which AIAN and their health disparities are invisible because of 1) inaccurate racial classification of AIAN in vital statistics, hospitalization or other administrative data, or 2) because there is no oversampling of AIAN in health survey data. Time trend determinations of health status and health care utilization in the state are not possible. Special attention to AIAN data issues is required if we are to have any knowledge about health conditions of AIAN living in California and California Indian populations. Such data are necessary to develop options for state policy and programmatic interventions that can guide and track a health disparity research agenda and an evidence-based policy action plan.

VII. AIAN HEALTH PROFESSIONAL WORKFORCE

Many tribal lands and rural communities in California suffer from health professional shortages and are known as medically underserved areas. Several studies have shown that increasing ethnic minority health professionals can help address the shortages in these areas; 50% - 80% of Latino, African American, and American Indian health professional graduates practice in these shortage areas.⁷⁸ Culturally competent medical professionals can help increase the quality of care on tribal lands and for Tribal Health Programs. However, the number of AIAN health professionals is exceedingly small. AIAN, including those of mixed race and Hispanic ethnicity, represent 1.9% of California's population, but account for only 0.6% of the state's physicians. Table 3 shows California data on physician race/ethnicity (Grumbach, et al, 2008).

"Workforce diversity in the health care system is needed. We need more Indian nurses, doctors, and physician assistants. We need to figure out how to train kids to aspire to these positions. We need Elders in the workforce, especially the health workforce –as they live longer, they are a cultural inspiration and can counteract myths about Elders in the workforce..."

**–AIAN Community Stakeholder,
September 2009**

Table 3 California Physician Profile by Race/Ethnicity, 2008

Group	Number	% of CA Physician %	% of CA Population 2000 Census	Proportion of Population Parity
White	45,000	61.7%	42.8%	144%
Black	2,300	3.2%	6.0%	53.3%
Asian/PI	19,300	26.4%	12.5%	211%
Amer Indian	440	0.6%	*0.5%-1.9%	**
Latino	3,800	5.2%	35.9%	14.5%
Other	2,100	2.9%		

*The 0.5% figure excludes AIAN who report another race or Hispanic ethnicity while the 1.9% figure includes AIAN who report another race or Hispanic ethnicity. About 5 of 6 respondents who identified themselves as partially American Indian were multiracial, i.e., American Indian and most often White.

**Using the 1.9% AINA population estimate, AIAN physicians are 32% of population parity.

Unfortunately, the number of Californian AIAN students accepted to U.S. medical schools has declined. As shown in Table 4 below, between 2003 and 2009 the number and percentage of AIAN Californians accepted to U.S. medical schools has varied from a total of 30 (1.5%) of all accepted Californians in 2004, to 22 (1.1%) in 2009. California Office of Statewide Health Planning and Development (OSHPD) estimated approximately 3,600 Latino, African Americans, and American Indian-Alaskan Native students enter a four-year college in California annually with the goal of becoming a physician. After three years of college, about 750 apply to medical school, and only about 350 are accepted to any U.S. medical school.⁷⁸

A leading cause for low medical school admissions among AIAN and other minorities stems from a lack of academic preparation in the sciences and mathematics. The 2010 report, “Approximate Number of Under-Represented Minority (URM) College Students in Medical School Pipeline” recommends increasing academic outreach and scholarship programs for AIAN and other minority students to increase the racial and ethnic diversity of California’s physicians.⁷⁸

Table 4. Number and Percentage of Under-Represented Minority and Total California Residents Accepted to Enter Any U.S. Medical School 2003-2009

Year	Latino		Black		American Indian		Sub	Total URM		Total CA
	#	%	#	%	#	%		#	%	
2003	187	9.3	118	5.9	11	0.5	316	15.8		2002
2004	217	10.9	97	4.9	30	1.5	344	17.3		1987
2005	212	10.4	103	5.1	30	1.5	345	17.0		2033
2006	217	10.6	105	5.1	22	1.1	344	16.9		2041
2007	224	10.8	98	4.7	26	1.2	348	16.7		2081
2008	223	10.5	104	4.9	27	1.3	354	16.7		2119
2009	203	9.8	125	6.0	22	1.1	350	16.8		2080

Source: Assn. of American Medical Colleges (AAMC)- Admission Action Summaries 2003-04 through 2009-2010

VIII. HEALTH CARE REFORM OF 2010

On March 21st as this assessment was going to press, the Patient Protection and Affordable Care Act was passed, which included a permanent reauthorization of the Indian Health Care Improvement Act (IHCIA). Originally passed in 1976, the IHCIA reauthorization will help to address, at the federal level, several of the issues outlined in this report. First and foremost, implementation of the IHCIA should help expand and improve needed health services in tribal communities.⁷⁹ The IHCIA will now include comprehensive behavioral health services aimed at decreasing disparities in suicide, substance abuse, and domestic violence in AIAN communities. The reauthorization of IHCIA should bring improvements in workforce development and recruitment of AIAN health professionals in Indian country, and improved access and modernization of health care services. Funds for facility construction and an agreement with the Departments of Defense and Veterans Affairs to share medical facilities and services will help expand Indian Health Service (IHS) services to AIAN. Other IHCIA enhancements include authorizations for hospice, assisted living, long term, and home and community based care. A newly established Community Health Representative program for Urban Indian Health Organizations will help train new medical professionals in culturally competent health care within the IHS system. The IHCIA contains a number of changes in law that will require new policies and regulations for the IHS, but also includes changes that will be implemented as soon as funding allows; thus, implementing provisions in the IHCIA will take time.

The Patient Protection and Affordable Care Act requires mandatory health insurance coverage for everyone over time, which is a potential issue for AIAN entitled to use Tribal Health Programs and Urban Indian Health Organizations at no cost. Many AIAN who rely on these Indian health programs for their health care do not have private health insurance, and do not qualify for Medi-Cal or Medicare. Fortunately, requiring such AIAN to purchase health insurance was addressed in the development of the legislation. AIAN eligible to use Tribal Health Programs and Urban Indian Health Organizations at no cost will be exempt from penalties for having insufficient health insurance coverage. Furthermore, the value of health services AIAN receive from IHS-funded Tribal Health Programs or Tribes will be excluded from their individual gross income. Instead of mandatory individual insurance, there are provisions that encourage Tribes to purchase health insurance for their members by making the insurance exempt from taxes. Additional provisions make Tribes and Tribal Organizations eligible for new and expanded Public Health Service community programs that will address obesity, commercial tobacco use, diabetes, and unplanned pregnancies.

While the Patient Protection and Affordable Care Act should improve a number of federal issues for IHS-eligible AIAN in California, there are a wide range of program and policy choices in the legislation to be made by the state of California that will affect Tribal Health Programs and Urban Indian Health Organizations. The Act will expand eligibility for Medi-Cal, which not only helps improve access to services for AIAN whether or not they use tribal health care facilities, but improves revenues for Tribal Health Programs and Urban Indian Health Organizations. By 2014, the federal Medicaid program will be expanded to cover single adults with incomes less than 133% of the federal poverty level. Because IHS is the “payer of last resort,” Tribal Health Programs and Urban Indian Health Organizations will be able to bill Medi-Cal for the services they provide to these single adults instead of using their IHS funds. The state Medi-Cal program in turn will receive 100% reimbursement from the federal Medicaid program for the claims it pays. In the legislation a number

of issues in collecting reimbursements from Medicaid, Medicare, and the Children's Health Insurance Program (CHIP) by Indian health facilities for AIAN they serve have also been updated.

The state-based health insurance exchange provided for in the Patient Protection and Affordable Care Act through which individuals and small businesses can purchase health insurance will create more affordable insurance options for AIAN, regardless of whether they use tribal healthcare facilities. However, AIAN with incomes under 300% of the federal poverty level who do use Tribal Health Programs and purchase health insurance through the exchange do not have to pay co-pays or other cost-sharing requirements of insurance companies. While the state of California has developed a number of insurance exchanges in recent decades, none of the exchanges has taken account of the special issues of AIAN who use tribal healthcare facilities. As a result of the changes in the IHS, Medicaid, and health insurance options, passage of the Patient Protection and Affordable Care Act creates a new foundation for California to address the issues and recommendations outlined in this report for the state to reduce the health disparities of AIAN.

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