# Introduction to the Indian Healthcare Delivery and Public Health Systems

CAPT THOMAS WEISER, MD, MPH

MEDICAL EPIDEMIOLOGIST,

PORTLAND AREA INDIAN HEALTH SERVICE

# Disclaimer

THE FINDINGS AND CONCLUSIONS IN THIS PRESENTATION ARE THOSE OF THE PRESENTER AND DO NOT NECESSARILY REPRESENT THE OFFICIAL POSITION OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS), THE INDIAN HEALTH SERVICE (IHS), OR ANY TRIBE.
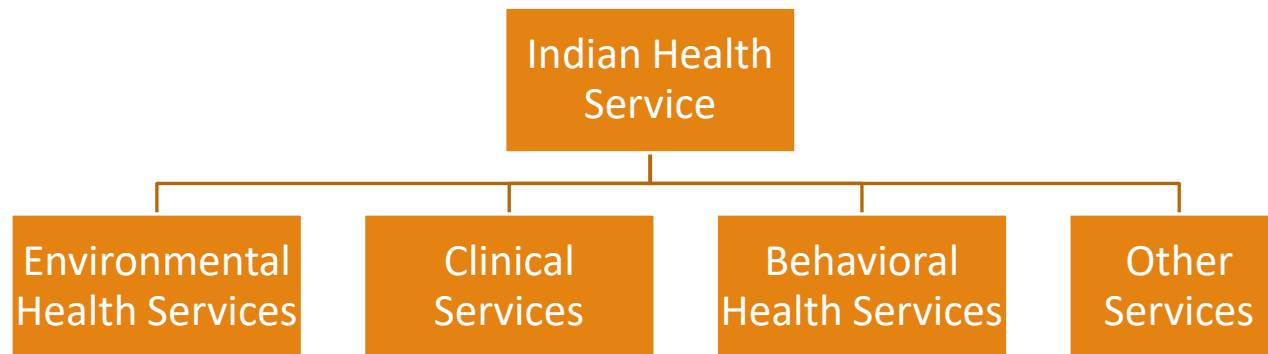
# Indian Health Service (IHS)

◦ Provides a comprehensive health service delivery system for ~2.6 million American Indian and Alaska Native (AI/AN) persons belonging to 574 federally recognized tribes in 37 states

◦ 12 area offices, each supporting a unique physical region of the United States

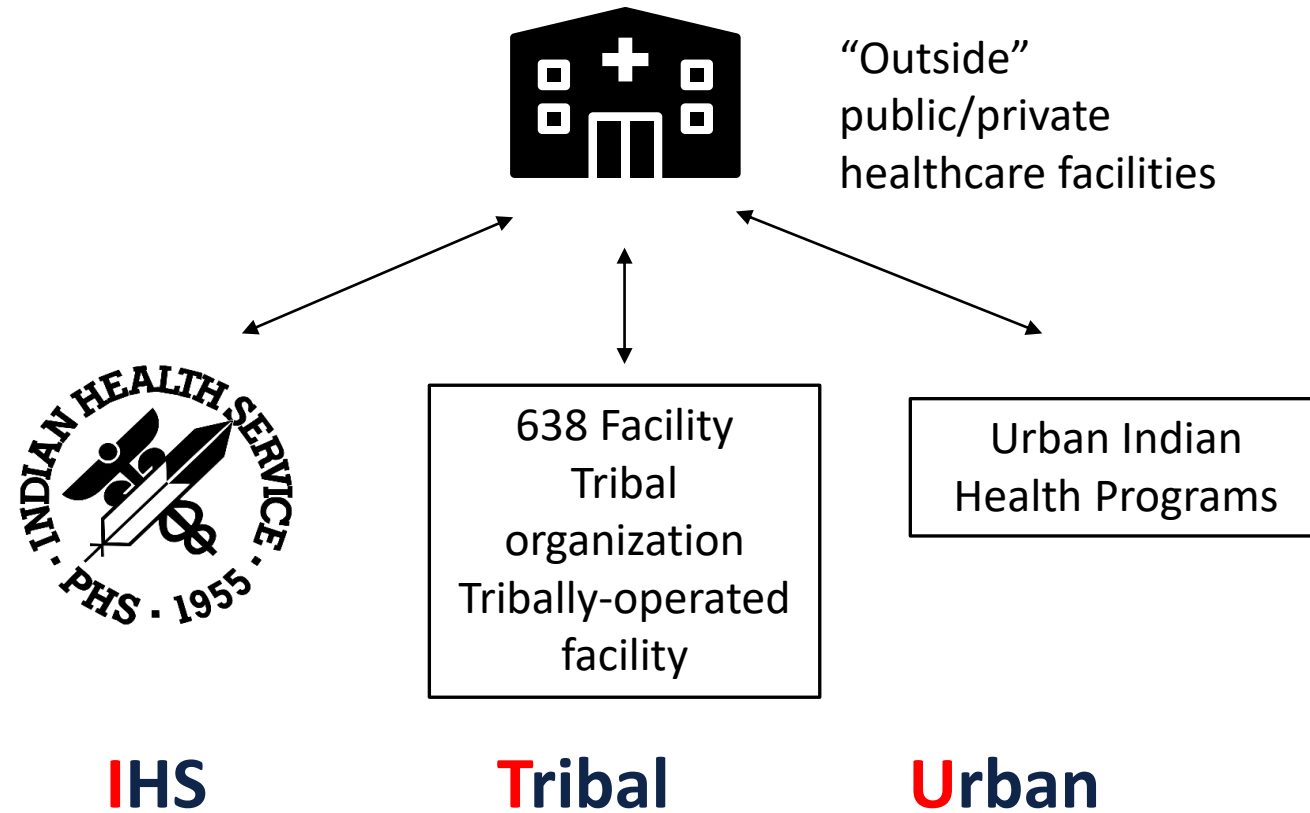◦ Non-federally recognized Tribes – may be recognized by State governments

# Indian Self-Determination and Education Assistance Act (ISDEAA) Public Law 93-638 or "638"

Gives AI/AN Tribes the authority to contract with the Federal government for the administration and operation of certain Federal programs which provide services to Tribes and their members

Indian Health Service
- Environmental Health Services
- Clinical Services
- Behavioral Health Services
- Other Services

# Indian Healthcare Delivery System & "638"



"Outside" public/private healthcare facilities

638 Facility
Tribal organization
Tribally-operated facility

Urban Indian Health Programs

**IHS**  **Tribal**  **Urban**

IHS is the "payer of last resort"

# Indian Healthcare Delivery System & "638"

Whether a clinic or program is IHS, Tribal, or Urban can impact:

◦ Electronic health record (EHR) system

◦ Governance of certain programs

◦ Other aspects of tribal health relevant to public health data or public health emergency response

◦ These can all be challenges *and* opportunities

Self-determination is vital to preserving and protecting Tribal sovereignty

# How do Tribes work with the U.S. public health system?

Federal public health

State public health

Local public health

Government-to-Government

Tribal Nation
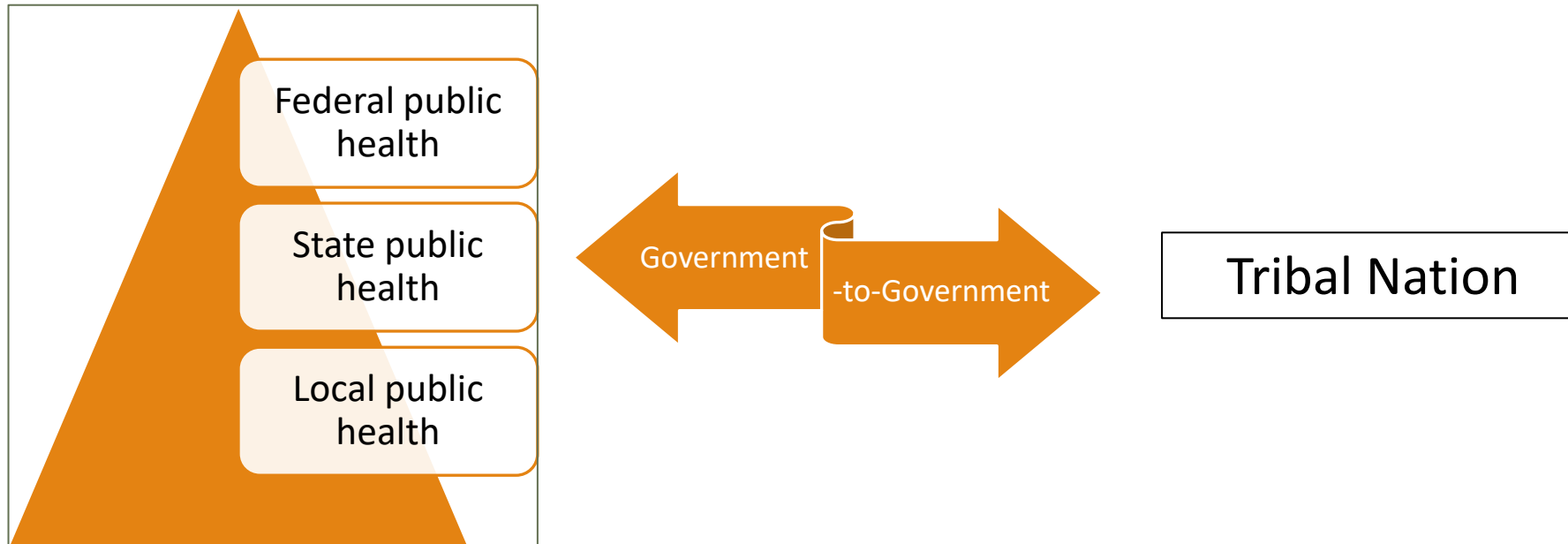
# Affordable Care Act (ACA) and Indian Healthcare Improvement Act (IHCIA)

◦ In 1992, amendments to the IHCIA authorized the establishment of tribal epidemiology centers (TECs) to serve each IHS region

◦ In 2010, the ACA permanently reauthorized the IHCIA and designated TECs as public health authorities

◦ This authorizes TECs to access data held by the U.S. Department of Health and Human Services
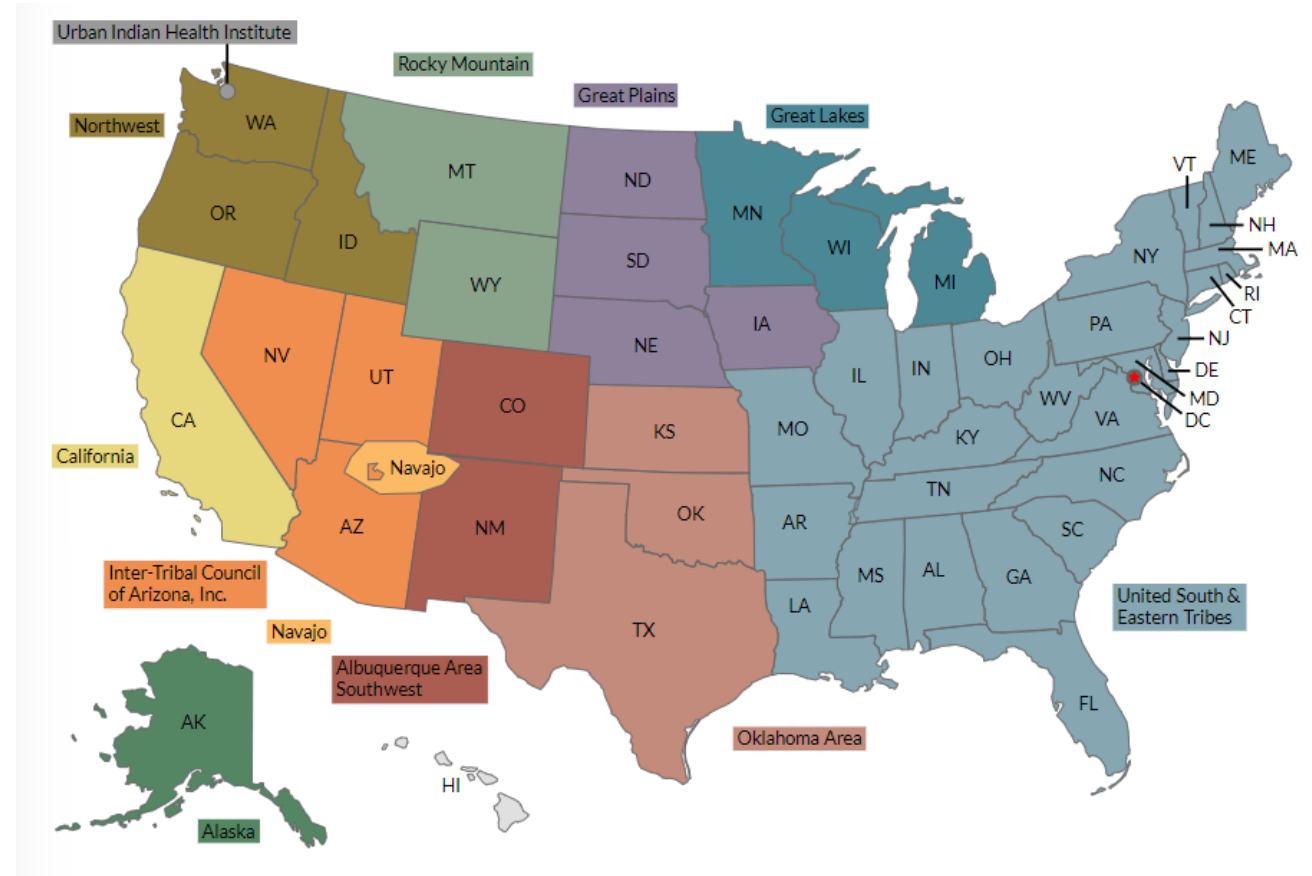
# Tribal Epidemiology Centers

# Tribal Epidemiology Centers (TEC)

◦ Indian Health Service-funded

◦ 12 TECs: 11 Tribal, 1 Urban

◦ Located within parent organizations

◦ Most serve multiple Tribes in their region

https://tribalepicenters.org/

# TEC Seven Core Functions

- Collect data and monitor progress towards meeting health status objectives
- Evaluate existing delivery and data systems that impact Indian Health
- Prioritize health status objectives based on epidemiological data
- Make recommendations for the services needed to assist communities
- Make recommendations to improve healthcare delivery systems
- Provide requested technical assistance to develop local health priorities and disease incidence and prevalence rates
- Provide disease surveillance and promote public health

Indian Health Care Improvement Act (IHCIA) amendments in 1992 mandate that TECs perform functions *"[i]n consultation with and on the request of Indian tribes, tribal organizations and urban Indian organizations"*

# Examples of NWTEC Projects

Improving Data, Enhancing Access-Northwest (IDEA-NW)
◦ Racial misclassification
◦ Data linkages with state administrative and epidemiologic datasets
◦ Community Health Profiles

Immunization program

Indian Country ECHO

Many others: Adolescent health (We R Native and other educational campaigns), cancer registry and cancer awareness/prevention work, diabetes management and capacity building, Traditional Foods and chronic disease prevention, etc.

# Data Sources Available to NWTEC

Clinical Data Sources

- IHS Epi Data Mart – extract of data from patient medical records that is shared from I/T/U facilities with IHS Division of Epidemiology and Prevention
  - Limitations: Does not contain Privacy Part 2 data on Mental Health or Substance Abuse, not systematically collected from all sites
- Patient Medical Record Data - by special arrangement from individual sites under Data Sharing Agreement
  - Limitation: Different clinics use different Electronic Health Record systems

Public Health Data Sources

- Hospital discharge (OR, WA)
- Cancer Registry/SEER (ID, OR, WA)
- Notifiable Conditions (OR)
- Trauma Registry (WA)
- Immunization Information System (OR)
- Syndromic Surveillance (ESSENCE – OR, WA)
- Other Surveillance data: PRAMS, BRFSS, YRBSS
  - Limitations: Racial misclassification, not available for every state
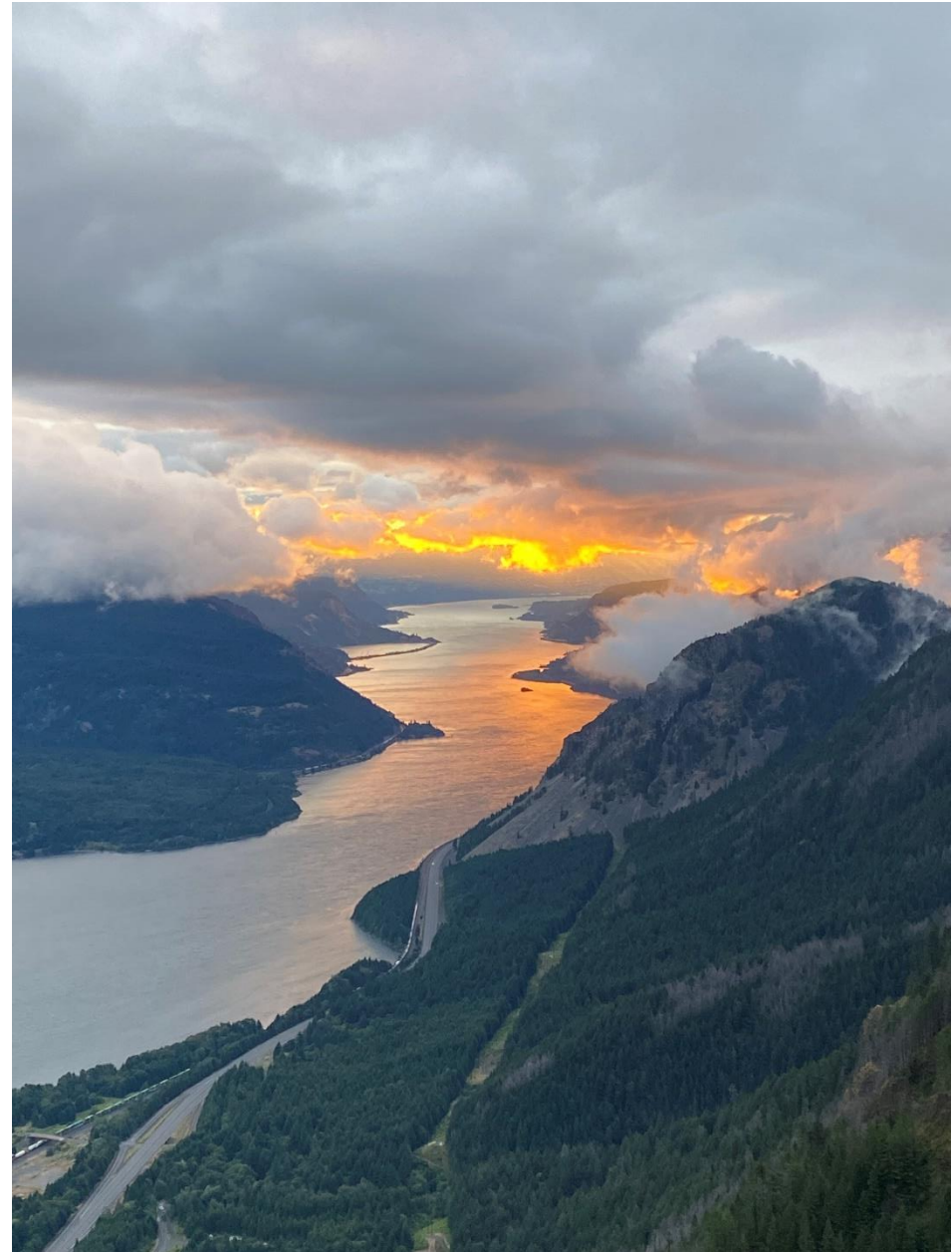
**Contact Information:**

Thomas Weiser, MD, MPH
Thomas.weiser@ihs.gov or
tweiser@npaihb.org
(503) 927-4467 cell
(503) 416-3298 office (someday!)

# THANK YOU!

# Panelists

**CAPT Thomas Weiser, MD, MPH**

Medical Epidemiologist

Indian Health Service

**German Gonzalez, MD, MPH, FACE**

Director

Great Lakes Inter-Tribal Epidemiology Center

**Jessica Leston, MPH**

Clinical Programs Director

Northwest Portland Area Indian Health Board

**CDR Mary (Molly) Evans, MD, MPH, FACP**

Medical Officer, Division of Global HIV and TB

Centers for Disease Control and Prevention

**Ronny Bell, PhD**

Professor, Social Sciences and Health Policy

Wake Forest University