AI / AN – Providing Culturally Competent Care

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- This presentation highlights my experience in the Indian Health Service. However, any and all views or opinions expressed in this presentation are solely my own are not associated nor reflect the views of the United States Government, Indian Health Service, or that of any Tribal Governments and/or organizations.

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Land Acknowledgement

We are gathered on the land of the Kalapuya, who today are represented by the Confederated Tribes of the Grand Ronde and the Confederated Tribes of Siletz Indians, whose relationship with this land continues to this day. We offer gratitude for the land itself, for those who have stewarded it for generations, and for the opportunity to study, learn, work, and be in community on this land.

Adapted from Willamette University Land Acknowledgement

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Objectives

- Appreciate the different systems of health care serving American Indians and Alaskan Natives (AI/AN)
- Identify changes you can make to provide more cultural competent care for AI/AN

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My Experience in the IHS

- Chemawa Indian Health Center in Salem, OR. Federal IHS Clinic co-located with 1 of 4 off-reservation boarding schools (ORBS) still run by the Bureau of Indian Education.

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Indian Health Service

- Serves federally recognized American Indians and Alaskan Natives (AI/AN)
- Mission: to raise the physical, mental, social, and spiritual health of AI/AN people to the highest level
- Provides
  1. Direct Care (DC)
  2. Purchased/Referred Care (PRC) (previously/AKA Contract Health Services)
- 3 settings = I/T/U = IHS/Tribal/Urban
  - Federal (Snyder Act 1921, Indian Health Transfer Act 1955)
  - Tribal (Indian Self-Determination and Education Assistance Act 1975 (ISDEEAA), PL 93-638)
  - Urban (Indian Health Care Improvement Act 1976, PL 94-437).

Rhoades ER, Rhoades DA. The public health foundation of health services for American Indians & Alaska Natives. *Am J Public Health*. 2014;104 Suppl 3(Suppl 3):S278-S285. doi:10.2105/AJPH.2013.301767

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Federal Funding

IHS Budget Appropriation	IHS Third-Party Collections *(Federal facilities only)*
FY 2016: $4.8 billion	FY 2016: $968 million
FY 2017: $5.0 billion	FY 2017: $1.02 billion
FY 2018: $5.5 billion	FY 2018: $1.09 billion
FY 2019: $5.8 billion	FY 2019: $1.14 billion
FY 2020: $6.0 billion	

Per Capita Personal Health Care Expenditures Comparison:
•FY 2019 IHS expenditure per user population: $4,078
•Total CY 2017 U.S. National Health Expenditure per person (Categories 1-4): $9,726

https://www.ihs.gov/newsroom/factsheets/ihsprofile/

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Federally Recognized

- Federally recognized Tribe
  - 574 tribes in 37 states
- Member of a Tribe
  - Each Tribe is different in terms of membership requirements (rolls, lineage, blood quantum, etc.)

www.ihs.gov/aboutihs
https://www.ihs.gov/IHM/pc/part-2/p2c1/#2-1.2 (11/1/2021)

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Purchased/Referred Care

- Health care provided away from IHS or Tribal health care facility
  - Residency
    - Purchased/Referred Care Delivery Area (PRCDA) = Reservation, trust land, bordering counties
    - School, ends 180 days after completion of studies
    - Temporary absence (e.g. travel), lapses at 180 days
  - Notification
    - Referral must be made by IHS provider to PRC OR
    - Emergency: 72 hours to notify PRC (OR 30 days for elderly and disabled)
  - Medical Priority
    1. Emergent or Acutely Urgent Care Services
    2. Preventive Care Services
    3. Primary and Secondary Care Services
    4. Chronic Tertiary Care Services
    5. Excluded Services
  - Use of alternate resources
    - “payor of last resort”

https://www.ihs.gov/prc/

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Federal

- **Funding:** Appropriated funds from the Federal Government with remainder by Third-Party Collections.
- **Population:** Provide Direct Care services to any federally recognized AI/AN patient
- **Services:** Depends on service unit. Primary care, specialty care, surgical care, emergency care, hospital care, pharmacy, laboratory, imaging, dental, optometry, mental health, ancillary care, community health, traditional health.
- **Cost:** Free
- **PRC:** For those patients that are from the service tribe living in the PRCDA
- **Examples in Oregon:** Chemawa Indian Health Center (Salem, OR). Warms Springs Service Unit (Warm Springs, OR).

https://www.ihs.gov/newsroom/factsheets/ihsprofile/

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Tribal

- Tribes can negotiate with the Federal Government a self-determination contract (Title I) or self-governance compact (Title V)) to take over some or all services provided to them by the IHS under Indian Self-Determination and Education Assistance Act 1975 (ISDEEAA)
- Over 60% of IHS appropriations are now administered by tribes
- **Funding:** Per contract or compact
- **Population:** Tribe. May also serve AI/AN with other tribal membership. May also serve non-AI/AN.
- **Services:** Per the tribe and contract/compact
- **Cost:** Per the tribe and may be different for different groups.
- **PRC:** Per the tribe
- **Examples in Oregon:** Siletz Community Health Clinic (Siletz, OR), Grand Ronde Health & Well Center (Grand Ronde, OR), and more.

https://www.ihs.gov/selfgovernance/faq/
https://www.ihs.gov/newsroom/factsheets/ihsprofile/

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Urban

- **Funding:** Contracting between IHS and Urban Indian Organizations (UIO)
- **Population:** Federally recognized AI/AN. May also serve non-AI/AN.
- **Services:** Ambulatory care, outreach, residential and outpatient substance abuse programs, and referrals.
- **Cost:** Free for AI/AN. Per UIO for other groups.
- **PRC:** Per UIO.
- **Examples in Oregon:** Native American Rehabilitation Association of the Northwest (NARA) (Portland, OR)

https://www.ihs.gov/newsroom/factsheets/ihsprofile/

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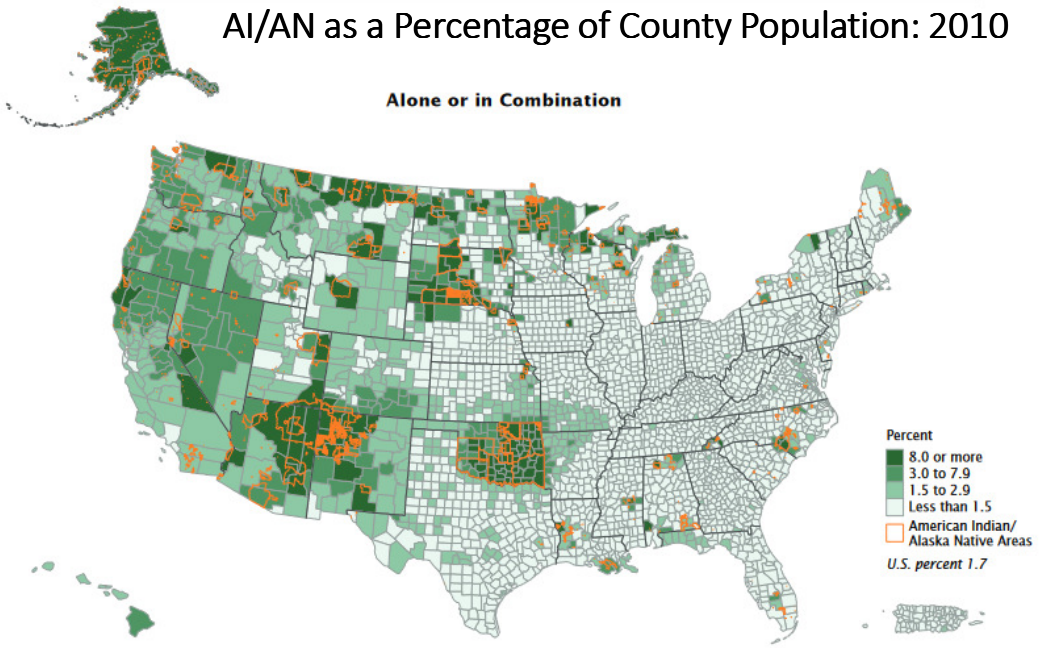
AI/AN as a Percentage of County Population: 2010



Source: U.S. Census Bureau, *2010 Census Redistricting Data (Public Law 94-171) Summary File*, Table P1.

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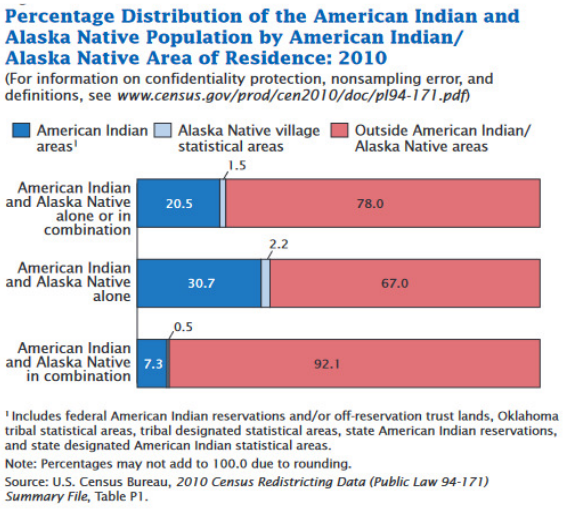
Geographic Distribution of AI/AN

- Only 8% of AI/AN were urban in 1940s, 38% in 1970 Census
- Per 2010 Census, 78% of 5.2 million AI/AN live in urban areas
- Historically, less than 1% of Federal government appropriations goes to grants/contracts for urban AI/AN.



https://www.ihs.gov/sites/urban/themes/responsive2017/display_objects/documents/IndianHealthServiceOfficeofUrbanIndianHealthProgramsStrategicPlan.pdf

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Health Insurance

- IHS is not an insurance program
- IHS' funding is congressionally appropriated and is not an entitlement (a la Social Security)
- AI/AN are not required to have health insurance under the Affordable Care Act
- AI/AN may sign up for insurance under the Marketplace at any time (always in open enrollment)

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The Importance of Stories

- A story about humility
- A story about strength
- A story about trust

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As an ally

- Trauma-Informed
  - Historical Trauma
  - Intergenerational Trauma
- Focus of strength and resilience and inform context
- Service such as volunteering, donating time or money

https://pages.nativehope.org/a-guide-to-addressing-native-american-issues-as-a-non-native-a-resource-for-allies

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As a physician

- Ask *all* your patients
  - As your physician, what would you like for me to know about any religious or cultural practices that are important to you—to help me know you and your values better?
- Offer services and coordinate with local IHS (I/T/U) service units
- Participate in Purchased/Referred Care

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As an administrator

- Inclusion in health plans and working with tribes to coordinate services
- Inclusion in pre-planning and planning for policy development and implementation and program development and implementation

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As an academic

- Mentor at all levels (pre-college, college/graduate school, residency, junior faculty, etc.)
- Consider the IHS for rotations and for trainees

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As a researcher

- Think about inclusion
- Think about attribution (misattribution)
  - What's missing in your Table 1?
- Think about data sovereignty
- Think about community-led and capacity-building
- Think about historicity of research in this group
- Think about wider context when analyzing data

Data is not neutral. It always tells a story—usually about what we think is important (and sometimes more devastatingly, what we think is not).

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Resources

- **A Guide to Addressing Native American Issues as a Non-Native: A Resource for Allies**
  - Native Hope
- **American Indian Health and Nursing**
  - Margaret P. Moss, PhD, JD, RN, FAAN

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