PUBLIC HEALTH
— IN —
INDIAN COUNTRY CAPACITY SCAN REPORT

— 2019 —

National Indian Health Board

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National Indian Health Board

MISSION STATEMENT

Established by the Tribes to advocate as the united voice of federally recognized American Indian and Alaska Native (AI/AN) Tribes, the National Indian Health Board seeks to reinforce Tribal sovereignty, strengthen Tribal health systems, secure resources, and build capacity to achieve the highest level of health and well-being for our People.

ABOUT NIHB

The National Indian Health Board (NIHB) represents Tribal governments — both those that operate their own health care delivery systems through contracting and compacting, and those receiving health care directly from the Indian Health Service (IHS).

Located in Washington, DC, NIHB, a non-profit organization, provides a variety of services to Tribes, Area Indian Health Boards, Tribal organizations, federal and state agencies, and private entities, including:

- Advocacy
- Public health policy formation and analysis
- Legislative and regulatory tracking
- Direct and timely communication and information dissemination
- Research on Indian public health issues
- Public health program development and assessment
- Public health training and technical assistance programs
- Project management

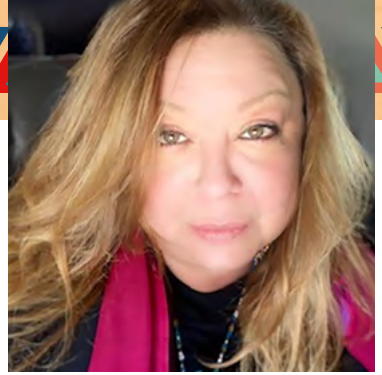
NIHB is committed to advocating on behalf of all Tribal governments and American Indian and Alaska Native peoples to promote healthy practices; prevent diseases and injuries; provide basic health resources and infrastructure to Tribes; and research and develop Tribal, local, state, and national health policy that is inclusive of Tribes and Tribal health systems. The only organization of its kind, NIHB is dedicated to strengthening health and well-being for all AI/ANs.

ABOUT THE PHICCS REPORT

Tribes and Tribal health systems have a vested interest to provide effective public health services to their communities and community members. While Tribes historically ensured their communities' health by integrating lifestyles, food systems, spirituality, and well-being, colonization decimated and continues to hinder these systems and creates pervasive, avoidable health disparities among American Indian and Alaska Native (AI/AN) populations.

The 2019 Public Health in Indian Country Capacity Scan (PHICCS) Report comes at a time when it is critical to understand the capacity and range of public health activities occurring among Tribal communities across the nation. This data-driven depiction is valuable to plan strategies and activities locally to combat public health issues and address identified gaps, inform the allocation of resources, develop policies, and educate community members and partners on the state of AI/AN health. More importantly, however, the 2019 PHICCS Report provides a vehicle for ensuring the federal trust responsibility is upheld by the federal government. This unique lever enables Tribal communities to hold the federal government accountable to strengthen Tribal public health capacity and ultimately advance health equity across Indian Country.

A LETTER FROM NIHB'S CHIEF EXECUTIVE OFFICER



Over a decade has passed since the National Indian Health Board (NIHB) published the last national, Tribal public health profile. During this time, we have seen many in Indian Country embrace and advance public health. We have seen Tribal public health departments seek and secure voluntary public health accreditation. Tribal SDPI programs (Special Diabetes Program for Indians) have won recognition and secured continued funding for their successful diabetes prevention and intervention work. Tribal leaders have successfully advocated for increased federal investment in Tribal public health, and in response, CDC has established a number of new Tribal programs — most notably the Good Health and Wellness in Indian Country Program. And these are just a few highlights from the last decade.

For our part, NIHB has been honored to stand shoulder to shoulder with the Tribes and Tribal organizations as they strengthen public health systems in Indian Country. As part of our work, we convene and facilitate an annual, national Tribal public health summit to share and celebrate Tribal public health achievements and discuss the challenges ahead. We have expanded our technical assistance and pass through funding to Tribes across Indian Country for work on a variety of public health activities, from accreditation support, to smoking cessation, to emergency preparedness, to name just a few of our programs. And of course, this year our work has taken on a greater urgency and importance as we all work together to address COVID-19.

While we celebrate the successes, we must also look for opportunities to grow and improve. As COVID-19 has reminded us, our Tribal communities continue to suffer from some of the worst health disparities in the U.S. Our people deserve nothing less than attaining the highest levels of health and wellbeing.

Advancing health equity in Indian Country is only possible by ensuring a strong Tribal public health system. Inadequate public health capacity compromises the overall health of Indian Country, and continues to widen pervasive health inequalities. Strengthening Tribal public health demands an upstream approach, one that focuses on the social, physical, economic and environmental factors in *addition* to increasing access to high quality health care in Tribal communities.

While the first national snapshot of Tribal public health was foundational in describing the important public health activities and services provided by Tribal health organizations, it is crucial to provide a more recent, comprehensive picture of the capacity of public health in Indian Country. We are pleased that this 2019 Public Health in Indian Country Capacity Scan (PHICCS) Report highlights the many strengths we see in Tribal public health, while also illuminating priority areas for growth and increased resources.

NIHB was established to serve the Tribes and strengthening Tribal public health is one of our greatest callings. We are extremely grateful to the Tribes and Tribal health organizations that responded to the PHICCS questionnaire, providing NIHB and all of Indian Country with valuable information to inform our collective work in the months and years ahead. Supporting Tribal public health requires the work of many, and we appreciate all of those at the Tribal, regional, and national level working to improve the health and wellbeing of our People. This work could not be done without you. Miigwech.

In health,

Stacy A. Bohlen
Chief Executive Officer
National Indian Health Board

A LETTER FROM CDC

Giving a standardized characterization of public health infrastructure is difficult, though having a clear picture of this infrastructure would improve how tribal, state, local, and territorial health agencies support their communities. Public health in Indian Country in the United States is very complex. Only by fully understanding the social and structural components of tribal public health systems will CDC succeed in advancing public health outcomes in Indian Country. This report is a great step toward that end.

Since 2015, the Centers for Disease Control and Prevention (CDC) has explored the idea of a tribal survey that would provide the first review of public health infrastructure of tribal public health systems and identify capacity-building needs. Like the triannual surveys provided by the Association of State and Territorial Health Officials and the National Association of County and City Health Officials, having an official report that provides specific, succinct survey information would be immensely important for advancing tribal public health priorities.

To jumpstart this task for Indian Country, CDC funded an initial project for the National Indian Health Board (NIHB) for one year to determine the feasibility of a public health capacity scan. CDC later funded NIHB for additional years to develop the scan of Indian Country, identifying its strengths and the challenges facing its communities.

Early in my medical career in Colombia, which is where I grew up and went to medical school, I learned that understanding cultural and political differences would be key to the success of any interaction. We served two indigenous groups — the Kamëntsá and the Ingas — and I used this knowledge of understanding differences to create programs that recognized the unique cultural values of each group. This methodology helped me to develop joint approaches that positively impacted their health outcomes. When I joined CDC in 2016, I wanted to apply this experience to improving public health for American Indians and Alaska Natives.

The findings from the completed 2019 scan and analysis contained in this report will be instrumental in informing CDC and its tribal public health partners about the status of public health across Indian Country. Specifically, this report will assist Tribal Health Organizations in identifying public health needs, successes, strategies, challenges, and limitations for future support in areas that include clinical care and data use and assessment for decision-making, health promotion, and workforce retention.

CDC is invested in Indian Country and is working to support the development and quality improvement of the tribal public health system. The tribal survey is just the start. It will be administered every three years and will measure how public health in Indian Country is supported, maintained, and advanced for American Indian and Alaska Native populations throughout the United States.

Sincerely,

José Montero, MD, MHCDS
Designated Federal Official, CDC/ATSDR Tribal Advisory Committee
Director, Center for State, Tribal, Local, and Territorial Support

EXECUTIVE SUMMARY

In 1972, Tribal leaders came together to create the National Indian Health Board (NIHB) to advocate on behalf of all federally recognized Tribes, to ensure the federal government upholds its trust responsibility to deliver health and public health services to the Tribes. Since that time, NIHB has worked to protect and improve health and reduce health disparities for American Indian and Alaska Native (AI/AN) people through congressional and administrative advocacy, policy research and analysis, training and technical assistance, convening and facilitation support, and outreach and real time communications.

In partnership and through support from the Centers for Disease Control and Prevention (CDC) [1], NIHB conducted a comprehensive scan, known as the Public Health in Indian Country Capacity Scan (PHICCS), to better understand the current capacity of Tribal public health. The results of this project are presented in this 2019 PHICCS Report. This report serves as a valuable tool for Indian Country to better assess needs and strengths of Tribal public health, to measure progress over time, and to allocate staff and resources where they are most needed.

METHODS

Following extensive engagement with Tribal leaders, AI/AN academics, Area Indian Health Board (AIHB) representatives, Tribal public health professionals, and federal agency representatives, NIHB finalized the PHICCS questionnaire. In November 2018, this questionnaire was sent to 291 Tribal health organizations (THOs) (including Tribal health departments, Tribal public health departments, and Tribal health consortiums) across Indian Country to gather information on the current state of Tribal public health. Data collection closed in September 2019, with responses from 134 THOs and a response rate of 46%. Half of the Indian Health Service (IHS) Areas had a response rate of 50% or higher with a range of 33% to 100%. Data was aggregated and analyzed by topic/section at a national level to capture the public health capacity of Indian Country.[2]

FINDINGS

The majority (90%) of the 134 THOs identify as representing federally recognized Tribes, with just under 9% representing Tribal health consortiums, and less than two percent self-identified as "other." The reported number of individuals who receive public health services in a calendar year was widely variable across THOs, ranging from 37 individuals to 356,000 individuals, with a median of 1,928 individuals.

Public health authority

THOs varied in the entity providing oversight and direction for their public health governance. This ranged from having no governing entity (1%) up to four governance structures in place (3%) providing public health oversight and direction. The majority (58%), however, report having just a single governance structure, with Tribal governance organization (such as a consortium) (24%) and Board of Directors (17%) the two most frequently selected single governance structures.

1 CDC Cooperative Agreement OT18-1802 (Grant #NU38OT000302), "Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health"

2 Data collection and analysis for the PHICCS project occurred prior to the 2020 COVID-19 pandemic.

While Tribes are in a unique position as sovereign nations to utilize public health law and policy to promote the health and well-being of their communities, it is evident this tool is not always utilized. Approximately 59% of THOs report the presence of any type of public health law and/or policy (as enacted by the Tribe) within their Tribal service area. Of those reporting any laws and/or policies, "policies, goals, and priorities for public health within their community" are the most common type of public health law and/or policy (84%), with public health regulations (58%) and public health codes (54%) following behind.

Public health activities

THOs play a significant role in the provision of public health activities in the Tribal communities they serve. In terms of public health activity categories, immunization, screening, and prevention and/or education activities (with the exception of a few key screening services, including hunger screening) are the most comprehensively occurring activities across THO service areas. Specifically, the following activities occur in at least 90% of THO service areas:

- Adult and child immunization services
- Alcohol and other drug screening and prevention/education
- Diabetes prevention/education
- Mental health screening
- Suicide prevention/education
- Type II diabetes screening and prevention/education
- Commercial tobacco use prevention/education

Conversely, data collection, epidemiology, and/or surveillance (DES) activities; regulation, inspection, and/or licensing (RIL) activities; and environmental health activities occur in the fewest number of THO service areas. Specifically, the following activities occur in 35% or fewer THO service areas:

- Environmental illness DES activities
- Environmental health and climate issues/climate change/environmental impact activities
- Foodborne illness DES activities
- Hunger screening
- Medical marijuana RIL
- Syndromic surveillance activities

With the exception of syndromic surveillance DES activities and various environmental health activities, THOs are the most frequently identified provider of public health activities across all categories. Other key actors in the provision of public health activities include: the IHS, other Tribal departments and organizations, local and state health departments, and private and/or non-profit health service organizations.

Assessment, performance improvement, and accreditation activities

THO engagement with the Public Health Accreditation Board's[3] (PHAB) national public health accreditation is variable, with only 29% either

3 The Public Health Accreditation Board (PHAB) is the national accrediting organization for public health departments and is dedicated to advancing the continuous quality improvement of Tribal, state, local, and territorial public health departments.

currently accredited[4] or in the process of applying for accreditation (including planning to apply for accreditation). However, a higher percentage of THOs report involvement in other assessment and performance improvement activities such as strategic planning (48%) and quality improvement activities (58%). Consequently, there is opportunity for increased involvement from THOs in all assessment, performance improvement, and public health accreditation activities.

Public health workforce

Public health employees play an integral part in delivering key public health services and activities within Tribal communities. While the public health workforce section had some notable data limitations due to overall response rate ranging between 32 respondents to 91 respondents (24% to 68%, respectively), across the occupational categories, THOs who did respond report:

- Highest average number of funded and filled full-time equivalents (FTE):
  - Behavioral health staff (average number of funded FTE = 8.7; average number of funded and filled FTE = 6.6)
  - Office and administrative support (average number of funded FTE = 5.0; average number of funded and filled FTE = 4.2)
  - Business and financial operations (average number of funded FTE = 4.6; average number of funded and filled FTE = 4.0).
- Highest average number of funded FTE vacancies and additional funded FTE needed:
  - Behavioral health staff (average number of funded FTE vacant = 1.7; average additional funded FTE needed = 1.8)
  - Community health representatives (CHRs) (average number of funded FTE vacant = 0.6; average number of additional funded FTE needed = 1.2).

4 As noted in the Limitations (Section 2.2.1), data is self-reported and was not independently verified. While seven THOs noted achieving public health accreditation, only three Tribal public health departments have achieved accreditation as of March 2020 according to PHAB. Consequently, the self-reported data may include THOs who have achieved another type of accreditation such as healthcare or behavioral health.

Public health needs and priorities

In terms of public health needs and priorities, the majority of THOs rank diabetes, substance misuse, and heart disease within the top three public health issues in their communities; data and assessment, health education and promotion are ranked by the majority of THOs in the top three organizational priorities. THOs also self-identified additional resources needed to improve public health within the Tribal communities they serve, as well as what CDC, other federal agencies, and states can do to assist Tribal organizations and entities in advancing Tribal public health. Funding support is the most identified need across all four categories. Specifically, this includes Tribally-directed monies for improving public health in Indian Country through either non-competitive grants from the CDC and other federal agencies, to Tribal set-asides from the CDC and other federal agencies akin to funding reserved for states.

SUMMARY

Advancing public health capacity in Tribal communities remains a continued priority across Indian Country. While THOs are maximizing their available resources to administer a variety of public health activities and services with the existing public health workforce, it is clear that Tribal public health is inadequately resourced. Increased, stable funding, technical assistance, and public health education is needed to ensure THOs within Indian Country have the capacity to improve the public health and well-being of Tribal communities. Furthermore, the sovereign political status of Tribal nations presents opportunities for advancing public health capacity but requires that federal agencies honor the federal trust responsibility and respect Tribal sovereignty.

APPENDICES

In addition to supplementary data tables, a supplemental report comparing data from the Association of State and Territorial Health Official's (ASTHO) and National Association of County and City Health Official's (NACCHO) most recent profile reports to the PHICCS data was compiled in a crosswalk by the National Opinion Research Center (NORC). This can be found in Appendix D.

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CONTENTS

Executive Summary 5
List of Figures 12
List of Tables 13
Acronyms 14
1.1 Introduction/Background 17
1.2.1 Historical Context of Tribal Public Health 17
1.2.2 Current State of Tribal Public Health 18
1.2.3 Public Health Profiles 19
2.1 The Public Health in Indian Country Capacity Scan (PHICCS) 21
2.2 PHICCS methods 21
2.2.1 Limitations 22
2.3 PHICCS questionnaire 23
3.1 Tribal Health Organization Characteristics 25
3.1.1 Public Health Service Population 26
3.1.2 Service Area 26
4.1 Findings 29
4.2 Public Health Authority 29
4.3 Public Health Activities 30
4.3.1 Public Health Activities Summary 30
4.3.2 Immunization Activities 33
4.3.3 Screening Activities 34
4.3.4 Prevention/Education Activities 37
4.3.5 Data Collection, Epidemiology, Surveillance (DES) Activities 41
4.3.6 Regulation, Inspection, or Licensing (RIL) Activities 44
4.3.7 Environmental Health Activities 46
4.3.8 Public Health Information 48
4.4 Assessment, Performance Improvement, and Accreditation Activities 49
4.4.1 Public Health Professional Core Competencies 50
4.4.2 Quality Improvement 50
4.4.3 Public Health Accreditation Status 51
4.5 Public Health Workforce 52
4.5.1 Overall Workforce 52
4.5.2 Occupations 52
4.5.3 Public Health Workforce Development Needs 55
4.6 Public Health Priorities and Needs 55
4.6.1 Public Health Issues and Priorities 55
4.6.2 Public Health Needs 55
5.1 Summary 59
References 60
Appendices 62
Appendix A All Public Health Activities Occurring Across THO Service Areas 62
Appendix B Provision of Public Health Activities by Category 64
Appendix C List of Public Health Needs and Priorities from PHICCS Questionnaire 69
Appendix D PHICCS Crosswalk Analysis by NORC 69

LIST OF FIGURES

Figure 1 Respondents by IHS Service Area 25

Figure 2 THOs by Organization Type 26

Figure 3 Type of Individuals Receiving Public Health Services from THOs 27

Figure 4 Number of Non-Tribal Public Health Departments in THO Service Area 27

Figure 5 Maximum Distance (in miles) to Nearest Non-Tribal Public Health Department 27

Figure 6 Number of Public Health Governance Structures 29

Figure 7 Provision of Public Health Activity Categories by Provider Type 32

Figure 8 Immunization Activities Occurring Across THO Service Areas 33

Figure 9 Immunization Activities by Provider Type 33

Figure 10 Screening Activities Occurring Across THO Service Areas 34

Figure 11 Physical Health Screening Activities by Provider Type 35

Figure 12 Social and Emotional Health Screening Activities by Provider Type 36

Figure 13 Prevention and Education Activities Occurring Across THO Service Areas 37

Figure 14 Physical Health Prevention/Education Activities by Provider Type 38

Figure 15 Social Health Prevention/Education Activities by Provider Type 39

Figure 16 Emotional Health Prevention/Education Activities by Provider Type 40

Figure 17 Data Collection, Epidemiology, and/or Surveillance (DES) Activities 41

Figure 18 Physical Health Data Collection, Epidemiology, and/or Surveillance (DES) Activities by Provider Type 42

Figure 19 Social/Emotional Health & Other Data Collection, Epidemiology, and/or Surveillance (DES) Activities by Provider Type 43

Figure 20 Regulation, Inspection, and Licensing (RIL) Activities 44

Figure 21 Regulation, Inspection, and Licensing (RIL) Activities by Provider Type 45

Figure 22 Environmental Health Activities 46

Figure 23 Environmental Health Activities by Provider Type 47

Figure 24 Public Health Information Communication 48

Figure 25 THO Assessment, Performance Improvement, and Accreditation Activity Status 49

Figure 26 THO Use of Council on Linkages Core Competencies 50

Figure 27 THO Current Quality Improvement Activities 51

Figure 28 THO Quality Improvement Plan Status 51

Figure 29 THO Engagement with PHAB's Public Health Accreditation Program 52

LIST OF TABLES

Table 1 Questionnaire Completion Rate by IHS Service Area 25

Table 2 Number of Individuals Receiving Public Health Services in a Calendar Year from a THO 26

Table 3 Public Health Governing Entities by Governance Structure.....30

Table 4 Most Often Occurring Public Health Activities Across THO Service Areas.....31

Table 5 Least Often Occurring Public Health Activities Across THO Service Areas 31

Table 6 Overview of Public Health Workforce 52

Table 7 THO Public Health Workforce by Occupation 54

Table 8 THO Public Health Needs 56

Table 9 Number and Percentage of THO Service Areas Conducting Public Health Activities 62

Table 10 Number and Percentage of THO Service Areas Conducting Immunization Activities.....64

Table 11 Number of Organizations Conducting Immunization Activities by Provider Type 64

Table 12 Number and Percentage of THO Service Areas Conducting Screening Activities.....64

Table 13 Number of Organizations Conducting Screening Activities by Provider Type.....65

Table 14 Number and Percentage of THO Service Areas Conducting Prevention/Education Activities 65

Table 15 Number of Organizations Conducting Prevention/Education Activities by Provider Type 66

Table 16 Number and Percentage of THO Service Areas Conducting Data Collection, Epidemiology, and/or Surveillance (DES) Activities.....66

Table 17 Number of Organizations Conducting Data Collection, Epidemiology, and/or Surveillance (DES) Activities by Provider Type 67

Table 18 Number and Percentage of THO Service Areas Conducting Regulation, Inspection, or Licensing (RIL) Activities.....67

Table 19 Number of Organizations Conducting Regulation, Inspection, or Licensing (RIL) Activities by Provider Type 67

Table 20 Number and Percentage of THO Service Areas Conducting Environmental Health Activities.....68

Table 21 Number of Organizations Conducting Environmental Health Activities by Provider Type 68

ACRONYMS

AI/AN	American Indian/Alaska Native
AIHB	Area Indian Health Board
ASTHO	Association of State and Territorial Health Official
BMI	Body mass index
CDC	Centers for Disease Control and Prevention
CHA	Community health aide
CHIP	Community health improvement plan
CHP	Community health practitioner
CHR	Community health representative
CSTLTS	Center for State, Tribal, Local and Territorial Support
CVD	Cardiovascular disease
DES	Data collection, epidemiology, and/or surveillance
EHR	Electronic health record
FTE	Full time employee
IHS	Indian Health Service
ISDEAA	Indian Self-determination and Education Assistance Act
LHD	Local health department
MOU	Memorandum of understanding
NACCHO	National Association of County and City Health Official
NIHB	National Indian Health Board
NORC	National Opinion Research Center
OMB	Office of Management and Budget
OSTLTS	Office for State, Tribal, Local and Territorial Support
PHAB	Public Health Accreditation Board
PHAP	Public Health Associate Program
PHICCS	Public Health in Indian Country Capacity Scan
RIL	Regulation, inspection, or licensing
SDH	Social determinants of health
STI	Sexually transmitted infection
TEC	Tribal Epidemiology Center
THO	Tribal Health Organization
UIHP	Urban Indian Health Program

1.1 INTRODUCTION/BACKGROUND

Through partnership and support from a cooperative agreement with the Centers for Disease Control and Prevention (CDC) titled, "Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health" (CDC OT18-1802, #NU38OT000302), the National Indian Health Board (NIHB) completed the Public Health in Indian Country Capacity Scan (PHICCS) to describe the current state of public health services, from a national perspective, throughout Tribal communities. The 2019 PHICCS Report serves as a valuable tool for Indian Country to identify needs and strengths of Tribal public health, to measure progress over time, to allocate staff and resources where they are most needed, and to provide data for decision making related to infrastructure, programs, and resources for the system overall.

1.2 OVERVIEW OF PUBLIC HEALTH IN INDIAN COUNTRY

American Indian and Alaska Native (AI/AN) populations suffer from some of the worst health disparities in the nation (Espey et al., 2014). Not only do AI/AN populations have a 50% higher mortality rate compared to the white population (Bauer & Plescia, 2014), they also have higher rates of other health disparities including, but not limited to: infant mortality (Wong et al, 2014), self-harm/suicide (Herne, Bartholomew & Weahkee, 2014; Murphy et al., 2014), diabetes (Cho et al, 2014), and heart disease (Veazie et al., 2014). These avoidable health disparities are exacerbated further in AI/AN communities by rural isolation, higher rates of poverty, food insecurity, and general lack of access to appropriate health care (Batliner, 2016). Adding to the issue of poor health outcomes, AI/AN populations are also less likely to participate in and have access to preventive services such as cervical pap smears, mammograms, and cholesterol screenings (Holm et al., 2010).

1.2.1 Historical Context of Tribal Public Health

Historically, Tribes ensured their communities' health by integrating systems of health and overall well-being. As with most — if not all — indigenous people, prior to European contact, Native Americans had complex traditions, cultural practices, social organizations, economies, forms of government, education, and spirituality that interrelatedly worked together to ensure the health and survival of the people. In addition to this rich background of culture and tradition, contemporary Tribal public health systems have been subsequently shaped by a history of colonialism, epidemics, government policy, and a lack of funding (Shelton, 2004; Warne & Frizzell, 2014). As a result, Tribal public health systems have evolved along a different trajectory than their local and state counterparts; consequently, they are often overlooked or underrepresented in the U.S. public health system.

America's public health system began taking its current shape in the middle of the twentieth century as responsibilities in health at the local, state, and federal levels began to increase (Institute of Medicine, 1988). With support from the federal government, state and local health departments began building a public health workforce with focused efforts on health promotion and disease prevention. However, there was no Tribal equivalent established nor was there any funding streams in place that would have supported public health infrastructure development at the Tribal level. The federal government established the Indian Health Service (IHS) in 1955 to uphold its government-to-government relationship and its statutory authority to provide health care to AI/ANs of all federally recognized Tribes (Institute of Medicine, 1988); however, the IHS's defined scope focuses the majority of its mission on treatment and direct patient care and health (Indian Health Service, n.d.). Although IHS supports limited public health activities (and limited public health-specific funding[5]) at federally operated facilities, the primary responsibility for the development of public health infrastructure and the delivery of essential public health services fall to Tribes when they become self-determined or self-governed[6].

1.2.2 Current State of Tribal Public Health

The IHS is divided into twelve physical areas of the United States[7], each with a corresponding Tribal Epidemiology Center (TEC)[8] and Area Indian Health Board (AIHB)[9]. TECs and AIHBs serve the member Tribes within their region. In addition to these regional organizations, other main players in Tribal public health include Urban Indian Health Programs (UIHPs)[10], whose main purview is AI/ANs who reside outside of IHS and Tribal service areas (or who do not meet IHS eligibility criteria), and Tribal health consortiums. The latter is primarily unique to Native communities in Alaska (but also exist in California Area) where, instead of Tribal health or public health departments, Native communities organize their health and public health service delivery through health consortiums. These Tribal health consortiums operate under the authority granted under the Indian Self-determination and Education Assistance Act (ISDEAA), or Public Law 93-638. PL93-638 which provides legal authority for Tribes to use federal funds to provide services to their own communities through contracting and compacting with federal agencies, instead of receiving direct services from those agencies (IHS, n.d.a). Members of Alaska Tribes have tasked delegates to represent their consortiums and to act on behalf of the Tribes as these delegates share the same status as a governmental entity (Alaska Native Tribal Health Consortium, n.d.). There are 31 Alaska Native health consortiums/corporations that serve on behalf of the Alaska Tribes. Members of Alaska Tribes have tasked

5 Public health specific line items represent less than 2% of the IHS FY2020 budget and include: Public Health Nursing, Health Education, and Community Health Representatives.

6 Public Law 93-638, the Indian Self-Determination and Educational Assistance Act of 1975, provided the authority for the Tribal management of federal health programs. Under PL93-638, each Tribe determines which programs it wants to administer and negotiates with the Indian Health Service to enter into contracts and compacts, which may include some or all of the health programs managed by Indian Health Service.

7 IHS regions: Alaska, Aberdeen (Great Plains), Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

8 TECs were established in 1996 under the reauthorization of the Indian Health Care Improvement Act (IHCIA). They are designated public health authorities and serve AI/AN Tribal and urban communities across the following core functions: 1) collect data, 2) evaluate data and programs, 3) identify health priorities with Tribes, 4) make recommendations for health service needs, 5) make recommendations for improving health care delivery systems, 6) provide epidemiologic technical assistance, and 7) provide disease surveillance to Tribes.

9 Area Indian Health Boards serve as Member Organizations of NIHB and are the communication link between NIHB and the Tribes.

10 UIHPs are funded through grants and contracts from the IHS, under Title V of the Indian Health Care Improvement Act, PL 94-437, as amended.

delegates to represent their consortiums and to act on behalf of the Tribes as these delegates share the same status as a governmental entity (Alaska Native Tribal Health Consortium, n.d.).

Many Tribal health systems have a public health component (and some even have a designated Tribal public health department), but they often do not operate in the same capacity as state (or even some local) public health departments. Additionally, public health accreditation (a voluntary process that seeks to advance the quality and performance of state, local, territorial and Tribal public health departments) uptake has not been as quick or as broad among Tribal health organizations. Of the more than 2,850 state, local, and integrated public health departments, approximately 283 have achieved public health accreditation, with only three Tribal health departments having achieved public health accreditation to date (Public Health Accreditation Board (PHAB), 2020). Moreover, the first health departments were awarded public health accreditation in February of 2013, more than three years before the first Tribal health department was awarded the status in August of 2016.

1.2.3 Public Health Profiles

Information on public health department infrastructure and services has been routinely collected at the state health department level and local level through the Association of State and Territorial Health Officials (ASTHO) and through the National Association of County and City Health Officials (NACCHO). However, because Tribal public health departments do not fall within ASTHO and NACCHO's domain, neither of these channels collect data on Tribal public health department infrastructure and services. As a result, neither of these two assessments provide any information on the capacity of Tribal public health department's competency to deliver essential public health services to their communities in Indian Country. As a supplement to this report, the National Opinion Research Center (NORC) compared data from ASTHO and NACCHO's most recent profile reports to the 2019 PHICCS data. This crosswalk can be found in Appendix D and analyzes comparable measures across Tribal health organizations, state/insular area health agencies, and local health departments.

In 2009, through funding from the W.K. Kellogg Foundation, NIHB conducted a similar assessment of Tribal public health. The results were released in a document the following year titled, *Tribal Public Health Profile: Exploring Public Health Capacity in Indian Country* (NIHB, 2010)[11]. This profile was an essential first step in describing the important public health activities and services provided by Tribal health organizations both in and out of Indian Country. In addition to describing Tribal public health capacity using national standards for measuring performance, it also identified areas to strengthen Tribal public health systems. While it did provide an important overview, there was a need to update that baseline in order to provide a more recent, comprehensive picture of the capacity of Tribal public health. Subsequently, this report aims to assess the current capacity of Tribal health organization's competency to deliver essential public health services to their communities. Due to differences in the questionnaire design of the 2009 profile and the 2019 PHICCS Report, data is not compared between the two.

The historical development of public health in the United States (U.S.), coupled with the current inequities faced by AI/AN people and Tribal governments, demonstrates the need for sustainable investments in Indian Country focused on the *entire* public health system, rather than simply on health care services. Furthermore, Tribal set asides for funding public health (akin to state block grants) are not always available, further limiting available Tribal public health funds. This simply widens the disparity gap that AI/ANs have been plagued with for centuries. The PHICCS project seeks to present comprehensive information on Tribal health departments and their capacity to carry out essential public health services – a pivotal first step in addressing existing funding and health disparities.

11 The 2010 Tribal Public Health Profile can be accessed at www.nihb.org/PHICCS

2.1 THE PUBLIC HEALTH IN INDIAN COUNTRY CAPACITY SCAN (PHICCS)

Through partnership and support from the CDC, NIHB established the PHICCS project as a way to increase the knowledge of Tribal and federal health leaders and stakeholders through the creation and dissemination of a comprehensive profile of the public health system and infrastructure in Indian Country. This profile was informed by a national scan of Tribal public health systems, functions, workforce, priorities, needs, strengths, and leadership.

The 2019 PHICCS Report is meant to support and guide essential public health work in Indian Country, especially in the areas of Tribal public health practice, technical support, and assessing priority areas related to improving Indian health. It also provides data for decision making at all levels in regards to Tribal public health system structure, function, and needs. Building the Tribal public health system will ultimately lead to improved health and well-being for AI/ANs. Such information directly benefits Tribes at the Tribal, regional and national levels in a number of ways, including:

- Assessing Tribal public health systems to identify needs and strengths
- Identifying Tribal priorities for development and resource allocation
- Identifying opportunities for training and technical assistance
- Establishing a baseline to measure progress over time

2.2 PHICCS METHODS

Prior to data collection, NIHB recruited[12] a work group of Tribal stakeholders and subject matter experts from Indian Country in the development of the questionnaire. This advisory committee included Tribal leaders, AI/AN academics, AIHB representatives, Tribal public health professionals, and federal agency representatives. In addition to ensuring key stakeholder involvement, the advisory committee convened between 2015 and 2016 to provide direction on the overall purpose and design of the questionnaire[13]. CDC's Center for State, Tribal, Local, and Territorial Support (CSTLTS) (formerly titled the Office for State, Tribal, Local and Territorial Support (OSTLTS)) also provided support throughout the entire development process. Following the initial draft of the questionnaire from the advisory committee, NIHB gathered feedback from Tribal leaders, AIHBs, TECs, and health directors from across Indian Country. NIHB heard their concerns, answered questions, and made substantial changes to the questionnaire based on that feedback. Furthermore, the questionnaire was pilot-tested by Tribal public health professionals to refine questions as needed, ensure accurate programming, and establish the estimated time required to complete the questionnaire. Refer to www.nihb.org/PHICCS for the final questionnaire.

12 NIHB sent out a national call for advisory committee members in fall 2015 to assist in the recruitment of Tribal stakeholders and subject matter experts.

13 Work conducted on the PHICCS project during 2015-2018 was done through the NIHB-CDC cooperative agreement OT13-1302.

Once the questionnaire was finalized, NIHB received approval from the Office of Management and Budget (OMB) (OMB No. 0920-0879) to begin data collection.

In November 2018, the PHICCS questionnaire (a web-based tool allowing respondents to complete and submit their responses electronically) was sent to 291 Tribal health organizations (THOs) (including Tribal health departments, Tribal public health departments, and Tribal health consortiums) across Indian Country. The respondent universe included Tribal health departments/entities representing 573[14] federally recognized Tribes from 35 states and 12 IHS Areas in the U.S. Only one response per THO was accepted. Due to the variation in Tribal public health leadership, the actual individuals completing the questionnaire (on behalf of the THO) included Tribal health department directors, Tribal public health department directors, and Alaska Native health consortium directors.

At the time of outreach, respondents were given multiple options for completing the questionnaire including: completing the questionnaire via the online platform, completing a hard copy version of the questionnaire (and emailing it back to NIHB), or completing the questionnaire with a NIHB staff member guiding them through it over the phone, where the NIHB staff member would enter the information into the online platform. These multiple options were offered in an effort to improve accessibility, as many Tribal communities are extremely rural and may have unreliable internet access. Two THOs completed hard copy versions of the questionnaires, which were then entered into the online survey platform by NIHB staff; no THOs completed the questionnaire over the phone.

The data collection period was open from November 2018 through September 2019, which included an initial extension provided due to the impact of a U.S. federal government shutdown and a second extension to allow ample time for completion. Following the end of the extension period, multiple attempts were made to contact THOs with unfinished questionnaires at least with at least 50% completion, encouraging them to complete and submit their questionnaires.

14 As of December 20, 2019, there are now 574 federally recognized Tribes

While the questionnaire was sent to a single organizational contact — such as the Tribal Health Director, a Tribal Public Health Director, or a Tribal Administrator—in many cases completion of the questionnaire was through a combination of these and/or other respondents. Again, only one response per THO was permissible (i.e. one respondent represents one Tribal Health Organization). Data was collected using the survey platform Qualtrics. It was then aggregated and analyzed in Microsoft Excel and Tableau (for data visualizations) by topic/section to capture the public health capacity of Indian Country, as a whole. Open ended questions were coded and categorized according to main themes. This 2019 PHICCS Report is a national level report and, at this time, does not include regional level analysis.

2.2.1 Limitations

Due to the time intensive nature of responding to the PHICCS questionnaire, respondents may have skipped some questions. Nonetheless, all returned/submitted questionnaires were used in the analysis; therefore, the number of respondents or "n" is listed for each individual question. All responses were self-reported and no attempt was made to verify information using other sources. In particular, questions on the Public Health Workforce were difficult for THOs to answer and yielded large amounts of missing data. This section had the lowest response rate across the entire scan. While justification for the low response rate in this section is outside the scope of this report, THOs may not have had this information readily available when completing the scan, particularly due to the opacity between staff working in Tribal communities who may deliver both public health and clinical health services. Consequently, the "n" is listed for each occupation, and results should be interpreted with caution.

While the initial data collection period was meant to close in the spring of 2019, the timeframe was extended following feedback from Tribal health directors on the impact of the United States federal government shutdown of 2018–2019. As a result, the data collection period remained open for almost 10 months. This means data — specifically questions asking about activities occurring within the last year — represents the timeframe from November 2017 to September 2019.

2.3 PHICCS QUESTIONNAIRE

The PHICCS questionnaire included 129 questions of various types, including: dichotomous (yes/no), multiple response, interval (rating scales), and open-ended. Questions were aimed at collecting information on the overall capacity of the public health system and infrastructure in Indian Country. They are themed and categorized according to five key areas:

- **Tribal Public Health Authority** examines who the Tribal health organization reports to and the type of activities the governing entity has control of.
- **Tribal Public Health Activities** examines the public health activities taking place in the Tribal community, such as services offered, public health communication, and accreditation status.
- **Tribal Public Health Assessment, Performance Improvement, and Accreditation Activities** examines key activities around quality improvement, performance management and public health accreditation.
- **Tribal Public Health Workforce** examines the public health workforce development needs and capacity of the workforce in the Tribal community of the Tribal health organization.
- **Tribal Public Health Priorities and Needs** examines the Tribal health organization's essential public health service priorities, asking the organization to rank their top public health issues/needs in their Tribal community.

To maintain anonymity of the Tribes, this report contains only aggregate data at the national level and does not include regional level analysis.

3.1 TRIBAL HEALTH ORGANIZATION CHARACTERISTICS

In addition to the five key areas, Tribal Health Organizations (throughout the rest of the report referred to as "THOs") were asked to provide demographic information related to the THO's public health service area at the beginning of the questionnaire. Out of the 291 THOs who received the PHICCS questionnaire, 134 respondents submitted the scan, resulting in a 46% response rate. The breakdown by IHS Service Area is captured in Figure 1 and Table 1. Half of the IHS Areas had a response rate of 50% or higher with ranges between 33% and 100%.

Figure 1 RESPONDENTS BY IHS SERVICE AREA

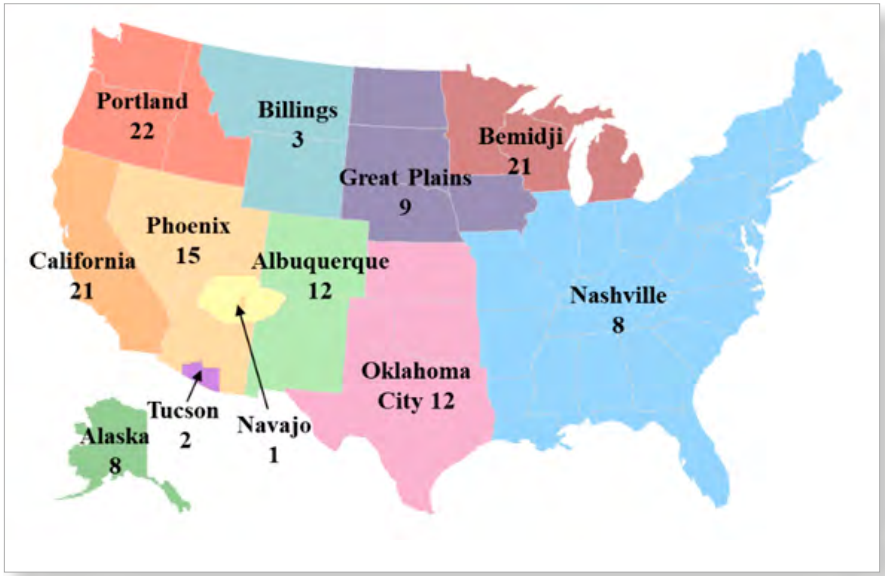


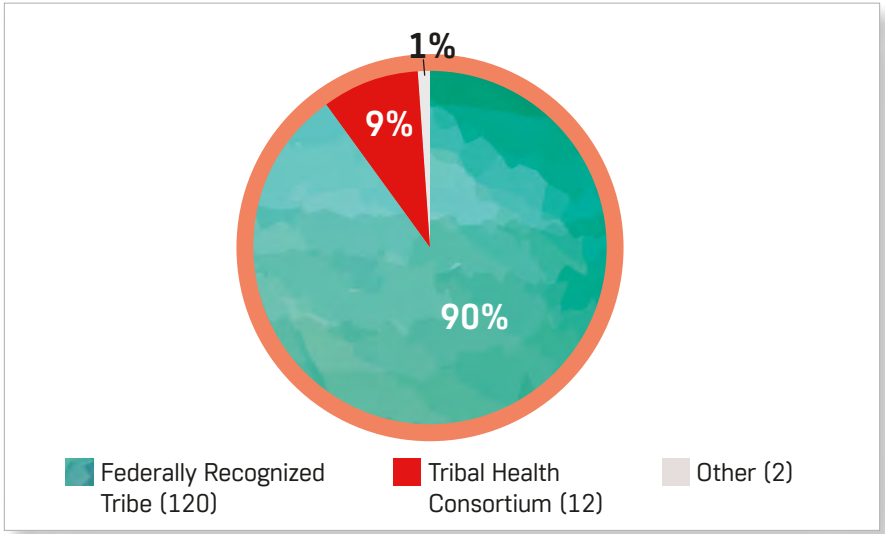
Table 1 QUESTIONNAIRE COMPLETION RATE BY IHS SERVICE AREA (N=134)

IHS Area	Total Sent Out	Total Completed	Completion Rate (%)
Alaska	18	8	44%
Albuquerque	28	12	43%
Bemidji	34	21	62%
Billings	9	3	33%
California	42	21	50%
Great Plains	18	9	50%
Nashville	21	8	38%
Navajo	2	1	50%
Oklahoma	31	12	39%
Phoenix	43	15	35%
Portland	43	22	51%
Tucson	2	2	100%
TOTAL	291	134	46%

Of the responding THOs:

- Just over half (54%) are direct service Tribes,
- The vast majority (90%) are federally recognized Tribes while 12 (9%) respondents represent a Tribal Health Consortia (Figure 2).

Figure 2 THOS BY ORGANIZATION TYPE (N=134)



3.1.1 Public Health Service Population

The number of individuals receiving public health services in a calendar year ranged widely from 37 to 356,000 with a median of 1,928 individuals. While 19% of the respondents report 10,000 or more individuals received public health services, the majority (53%) report 2,000 or less individuals receiving public health services in a calendar year (Table 2).

Table 2 NUMBER OF INDIVIDUALS RECEIVING PUBLIC HEALTH SERVICES IN A CALENDAR YEAR FROM A THO

Size of Population	Number (Percent) of THOs (n=108)
2,000 or less individuals	57 (53%)
2,001 to 9,999 individuals	30 (28%)
10,000 or more individuals	21 (19%)

A large majority of THOs provide public health services to enrolled members of a federally recognized Tribe (96%), non-enrolled members of a federally recognized Tribe (71%), and eligible non-Indians such as spouses, Tribal employees, etc. (58%) (Figure 3).

3.1.2 Service Area

THOs face varying degrees of complexity in the delivery of essential public health services within their service areas. Specifically, the delivery of services in Tribal communities may be affected by factors such as: multiple state and/or local government jurisdictions, multiple non-Tribal health departments, lower population densities, and proximity to public health services. In terms of service area and state overlap [n=130]:

- 82% (n=107) operate only in one state,
- 12% (n=15) service areas overlap two states, and
- 6% (n=8) service areas overlap three states.

74% of THOs have <6 non-Tribal public health departments in their service area while 11% report 6 or more non-Tribal health departments in their service area (Figure 4).

Figure 3 TYPE OF INDIVIDUALS RECEIVING PUBLIC HEALTH SERVICES FROM THOS (N=134)

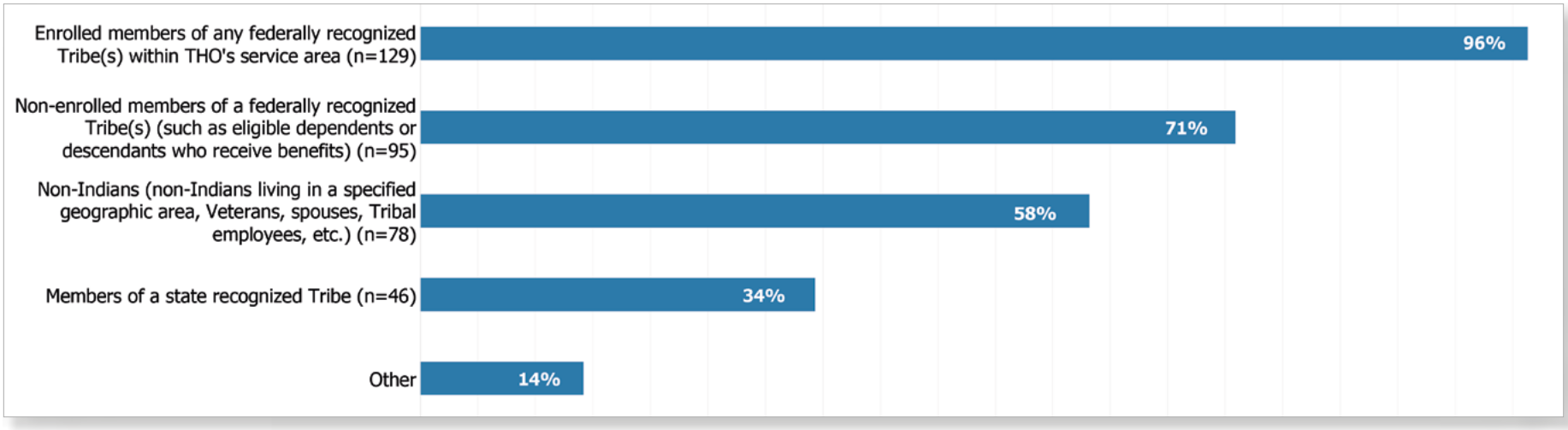
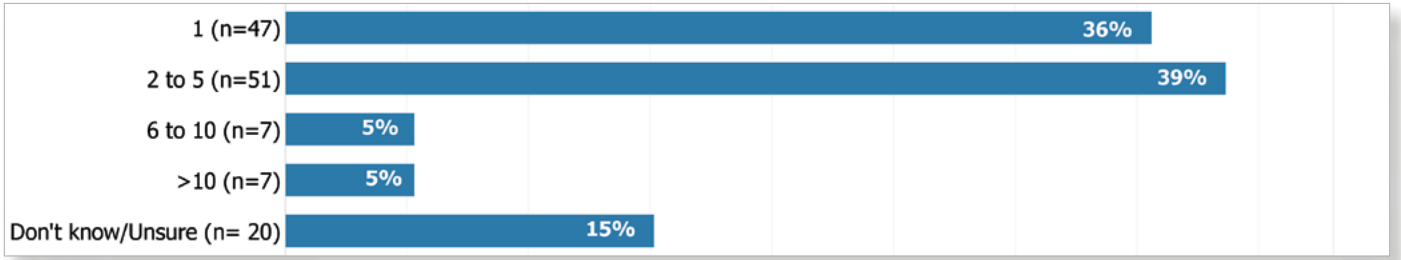
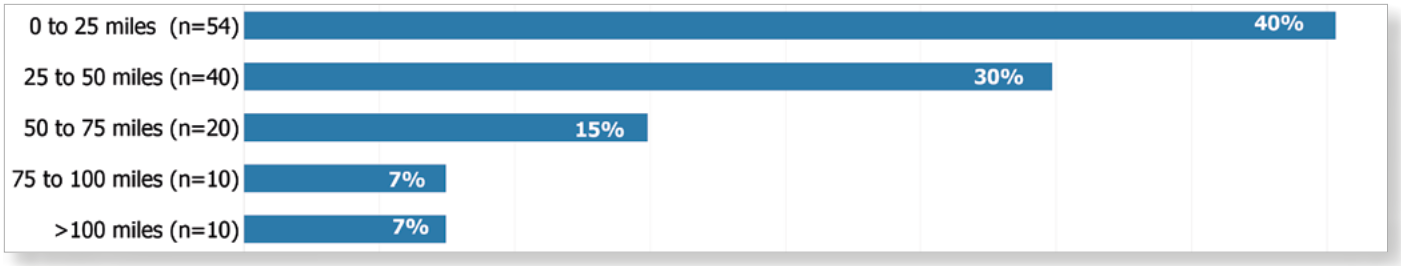


Figure 4 NUMBER OF NON-TRIBAL PUBLIC HEALTH DEPARTMENTS IN THO SERVICE AREA (N=132)



In terms of the maximum distance to the nearest non-Tribal (city, county, or state) public health department, THOs self-reports ranged from within a 0 to 25 mile range (40%) to over 100 miles (7%), demonstrating wide variance (Figure 5). This scan did not explore cross-jurisdictional sharing of services, i.e. the various means by which jurisdictions work together to provide public health services.

Figure 5 MAXIMUM DISTANCE (IN MILES) TO NEAREST NON-TRIBAL PUBLIC HEALTH DEPARTMENT (N=134)



RESTORATIVE
FORCE

4.1 FINDINGS

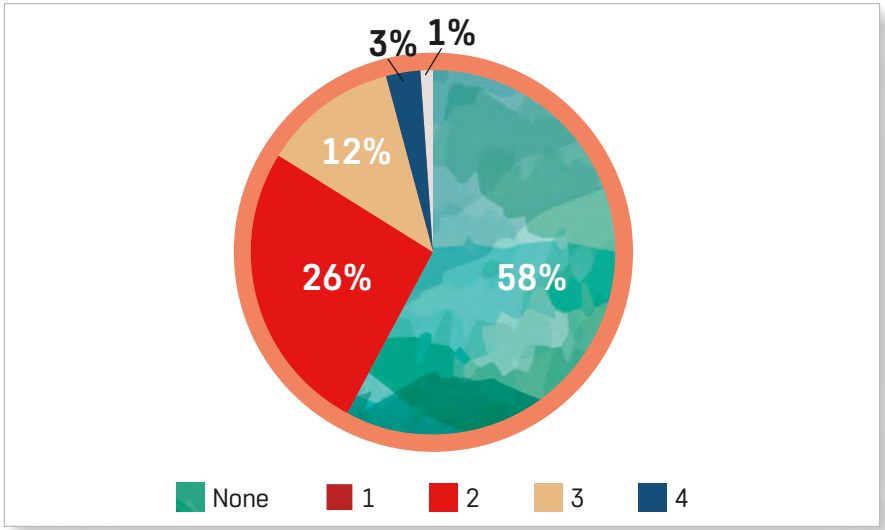
What follows is an in-depth exploration of the findings from the PHICCS questionnaire. Due to variance in response rates per IHS area and to maintain anonymity of Tribes, results are reported in aggregate at a national level only.

4.2 PUBLIC HEALTH AUTHORITY

Public health authority entails both governance (i.e. who is responsible for public health matters as part of an official mandate) as well as public health laws, policies, and regulations. Furthermore, governance structure has important implications in the delivery of essential public health services across Indian Country (e.g. roles, responsibilities, and authorities) and jurisdictional authorities are complex due to the distribution of services across various Tribal, local, state, and federal public health systems (Bryan et al., 2009).

THOs vary in the entity providing oversight and direction for their public health governance, ranging between 0-4 governance structures, (1% to 3% respectively) (Figure 6). The majority of THOs, however, report having just a single governance structure (58%).

Figure 6 **NUMBER OF PUBLIC HEALTH GOVERNANCE STRUCTURES (N=123)**



Regardless of the number of governing structures in place, Board of Health/Health Board (37%) and Tribal Chief Executive Officer/Tribal Chair (37%) are the most frequently selected governing entities (Table 3). For THOs reporting just a single governance structure, Tribal governance organization (such as a consortium) is the most frequently selected entity (24%), followed by Board of Directors (17%).

Table 3 PUBLIC HEALTH GOVERNING ENTITIES BY GOVERNANCE STRUCTURE

Governing Entity	THOs with Single Governance Structure (n=71)		THOs Overall (n=123)	
	N	%	N	%
Board of Health/Health Board	11	15%	45	37%
Board of Directors	12	17%	24	20%
Tribal Chief Executive Officer (CEO)/Tribal Chair	10	14%	45	37%
Tribal governance organization (such as consortium)	17	24%	34	28%
Tribal Council	10	14%	27	22%
Other	11	15%	21	17%
We do not have a governing entity	N/A	N/A	1	1%

Public health laws and policies are tools that can be used to promote the overall health of the public and can include statutes, rules and/or ordinances. Tribes are in a unique position as sovereign nations to utilize public health law and policy to promote the health and well-being of their communities. While approximately 59% (n=69) of THOs report having some type of public health law and/or policy in their Tribal service area, the remaining 41% (n=48) are either unsure or reported no types of public health law and/or policy in their Tribal service area, as enacted by the Tribe. Of those THOs reporting the existence of public health laws and/or policies, the specific types are:

- Policies, goals, and priorities for public health their community (84%, n=58),
- Public health regulations (58%, n=40),
- Public health codes (54%, n=37),
- Public health taxes (such as a junk food tax) (14%, n=10),
- Public health fees (9%, n=6), and
- Public health levies (1%, n=1).

4.3 PUBLIC HEALTH ACTIVITIES

The Public Health Activities section provides an in depth look at what public health activities occurred in the THO service areas during the approximate time from of 2018, as well as who provided the activities. This section also looks at THOs' communication strategies and use of public health registries. Not only is this information critical in assessing the Tribal public health system's strengths and gaps, it is also essential to prioritizing areas for public health program development.

This section is organized by activity category as follows:

- Public health activities overview
- Immunization activities
- Screening activities
- Prevention and/or education activities
- Data collection, epidemiology, and/or surveillance activities
- Regulation, inspection, or licensing activities
- Environmental health activities
- Public health information (including communication strategies and registry use)

4.3.1 Public Health Activities Summary

Public health activities in the areas of immunization, screening, and prevention and/or education are the most often occurring activities across THO service areas (Table 4); whereas the least occurring public health activities are in the areas of data collection, epidemiology, and/or surveillance (DES) activities; regulation, inspection, or licensing (RIL) activities; environmental health activities; and select screening activities (Table 5). Appendix A provides a complete list of public health activities occurring across THO service areas.

Table 4 **MOST OFTEN OCCURRING PUBLIC HEALTH ACTIVITIES ACROSS THO SERVICE AREAS**

Category/Item (number of respondents)	N	%
Prevention/education activities and services		
Diabetes (n=134)	132	99%
Alcohol and other drugs (n=134)	129	96%
Suicide (n=134)	121	90%
Cardiovascular Disease (n=132)	116	88%
Screening activities and services		
Alcohol and other drugs (n=133)	128	96%
Type II diabetes (n=132)	127	96%
Mental health (n=132)	121	92%
Suicide (n=132)	117	89%
Body mass index (BMI) (n=132)	116	88%
Immunization activities and services		
Adult (n=134)	128	96%
Child (n=133)	126	95%

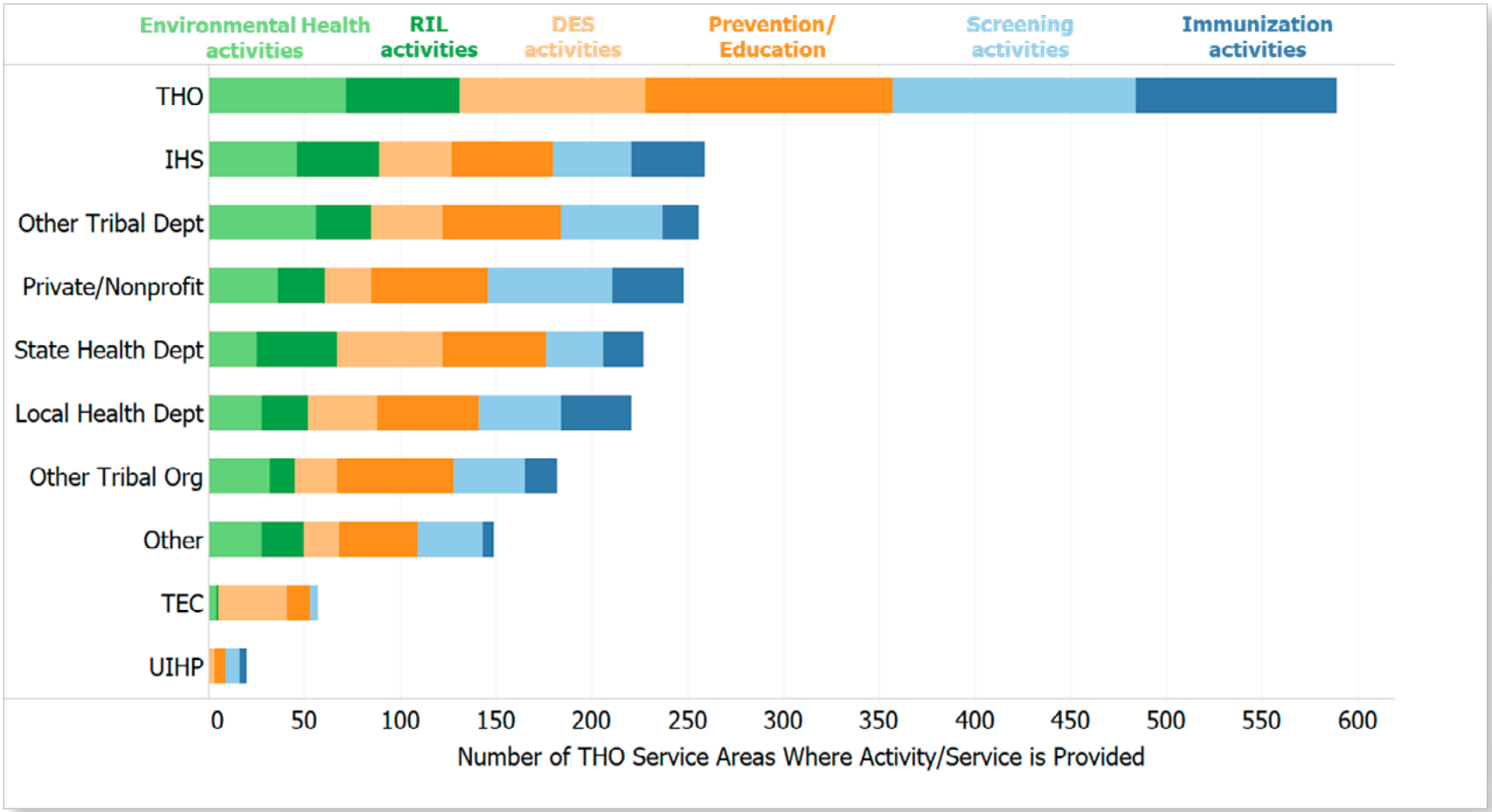
As shown in Table 5 below, it is important to highlight that homelessness and hunger screenings occur in less than 50% of THO service areas, even though these are widely known needs in Indian Country (Pindus & Hafford, 2019; Pindus et al., 2017).

Table 5 **LEAST OFTEN OCCURRING PUBLIC HEALTH ACTIVITIES ACROSS THO SERVICE AREAS**

Category / Item (number of respondents)	N	%
Regulation, inspection and/or licensing		
Medical marijuana (n=132)	**13**	10%
Environmental health (n=129)	**44**	34%
Data collection, epidemiology and/or surveillance		
Syndromic surveillance (n=132)	**32**	24%
Food borne illness (n=132)	**44**	33%
Environmental illness (n=132)	**46**	35%
Morbidity (n=130)	**53**	41%
Injury (n=132)	**55**	42%
Screening activities		
Hunger (n=133)	**44**	33%
Homelessness (n=132)	**61**	46%
Environmental health activities		
Vector control (n=128)	**47**	37%
Environmental health and climate issues/ change (n=132)	**49**	37%
Air quality monitoring (n=130)	**60**	46%

It is evident that THOs are the main provider of public health activities in Indian Country across all public health activity/service categories (Figure 7). Provision of public health activities is fairly evenly split across the other provider types, with the exception of TECs and UIHPs. However, TECs do appear to have a significant role in the provision of DES activities.

Figure 7 **PROVISION OF PUBLIC HEALTH ACTIVITY CATEGORIES BY PROVIDER TYPE**



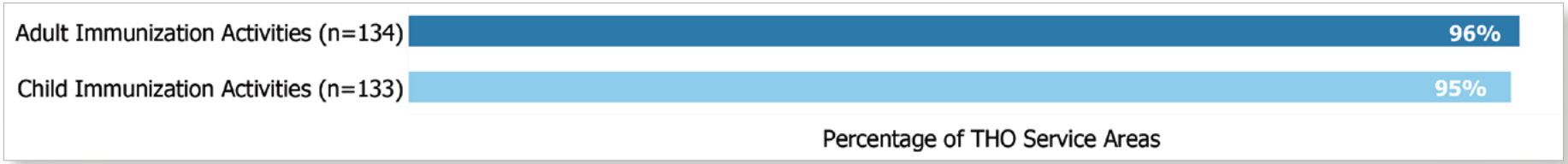
The "other" category in the following provider type figures is a compilation of other, TECs, and UHIPs due to low numbers. Additionally, "other entity/department located within the Tribe" (Other Tribal Dept.) and "other Tribal organization" (Other Tribal Org including AIHBs) have been categorized together. Response rate varied per question; consequently, the "n" range is listed for each Figure. Comprehensive data tables for each public health activity by category, including provider type, can be found in Appendix B.

Due to the large number of activities within the screening (Section 4.3.3), prevention/education (Section 4.3.4), and data collection, epidemiology, surveillance (DES) (Section 4.3.5) sections, these activities in some of the figures have been categorized further by three dimensions of wellness: social health, physical health, and emotional health.

4.3.2 Immunization Activities

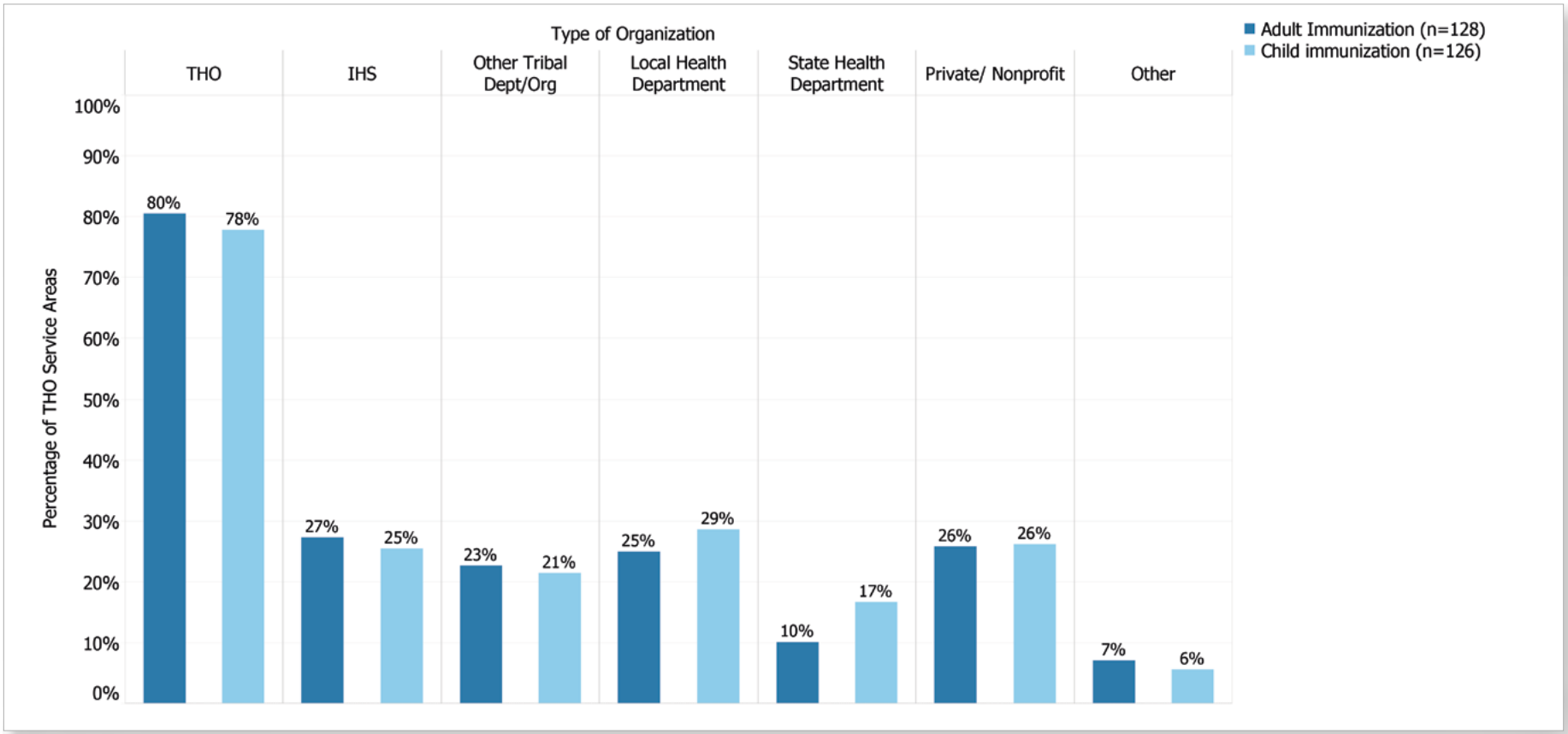
Adult and child immunization are two of the most frequently offered activities according to THOs, at 96% and 95%, respectively (Figure 8).

Figure 8 **IMMUNIZATION ACTIVITIES OCCURRING ACROSS THO SERVICE AREAS**



Of those service areas where immunization services occur, THOs are the main provider, followed by local health departments, IHS, and private/non profit health service organizations (Figure 9).

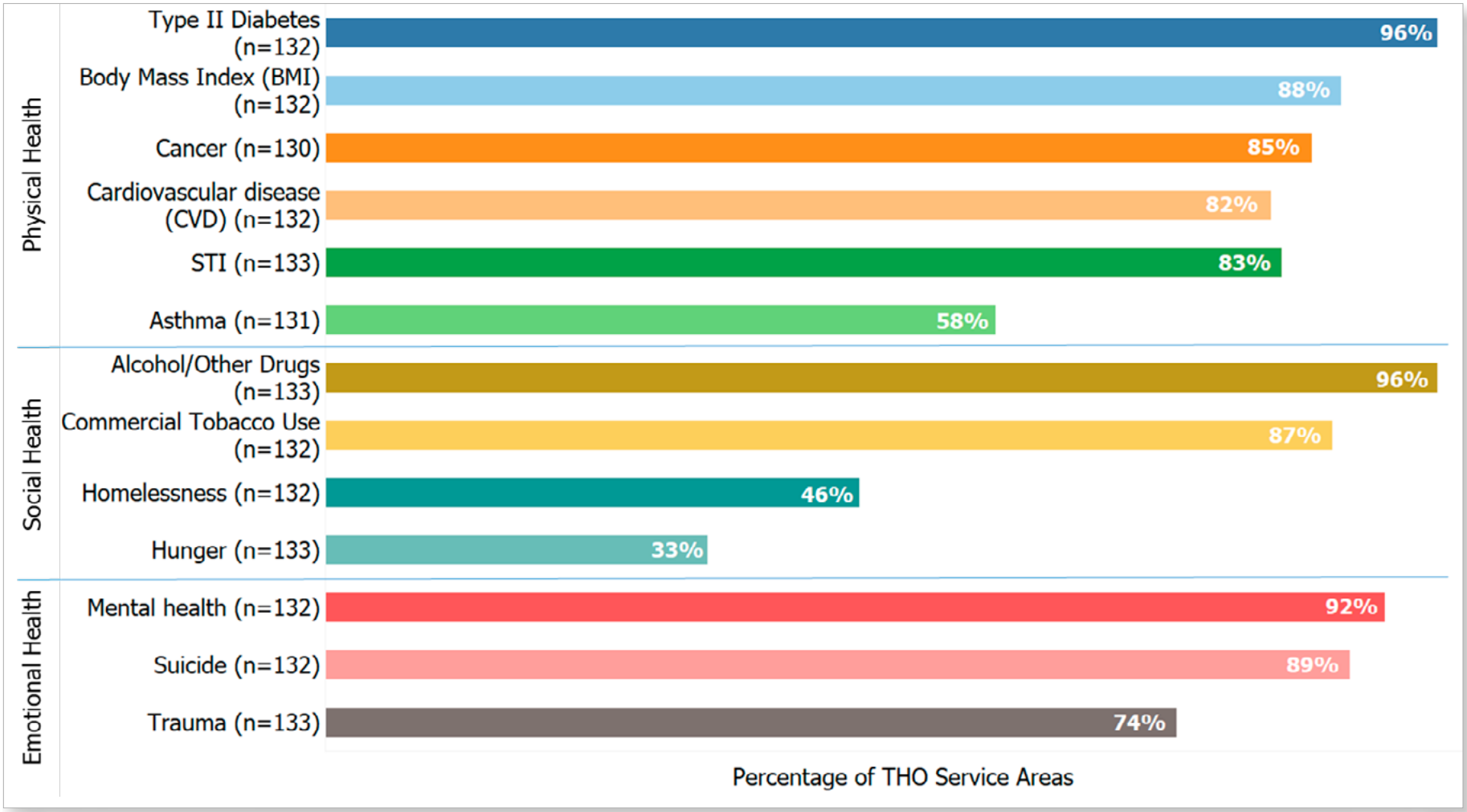
Figure 9 **IMMUNIZATION ACTIVITIES BY PROVIDER TYPE**



4.3.3 Screening Activities

THOs report offering a wide variety of screening services (Figure 10). Alcohol and other drug screening (96%) and Type II diabetes screening (96%) are the most frequently offered screening services, followed closely by mental health screening (92%). Although most of the screening activities occur in the majority of THO service areas, hunger and homelessness screening activities occur in only 33% and 46% service areas, respectively.

Figure 10 **SCREENING ACTIVITIES OCCURRING ACROSS THO SERVICE AREAS**



Of those service areas where screening activities occur, THOs are the main provider, with other Tribal departments and organizations (in particular homelessness, hunger, suicide, and trauma screenings) and private and/or nonprofit health service organizations (in particular asthma, cancer, and cardiovascular disease (CVD) screenings) being the next largest providers of screening activities (Figures 11 & 12).

Figure 11 **PHYSICAL HEALTH SCREENING ACTIVITIES BY PROVIDER TYPE**

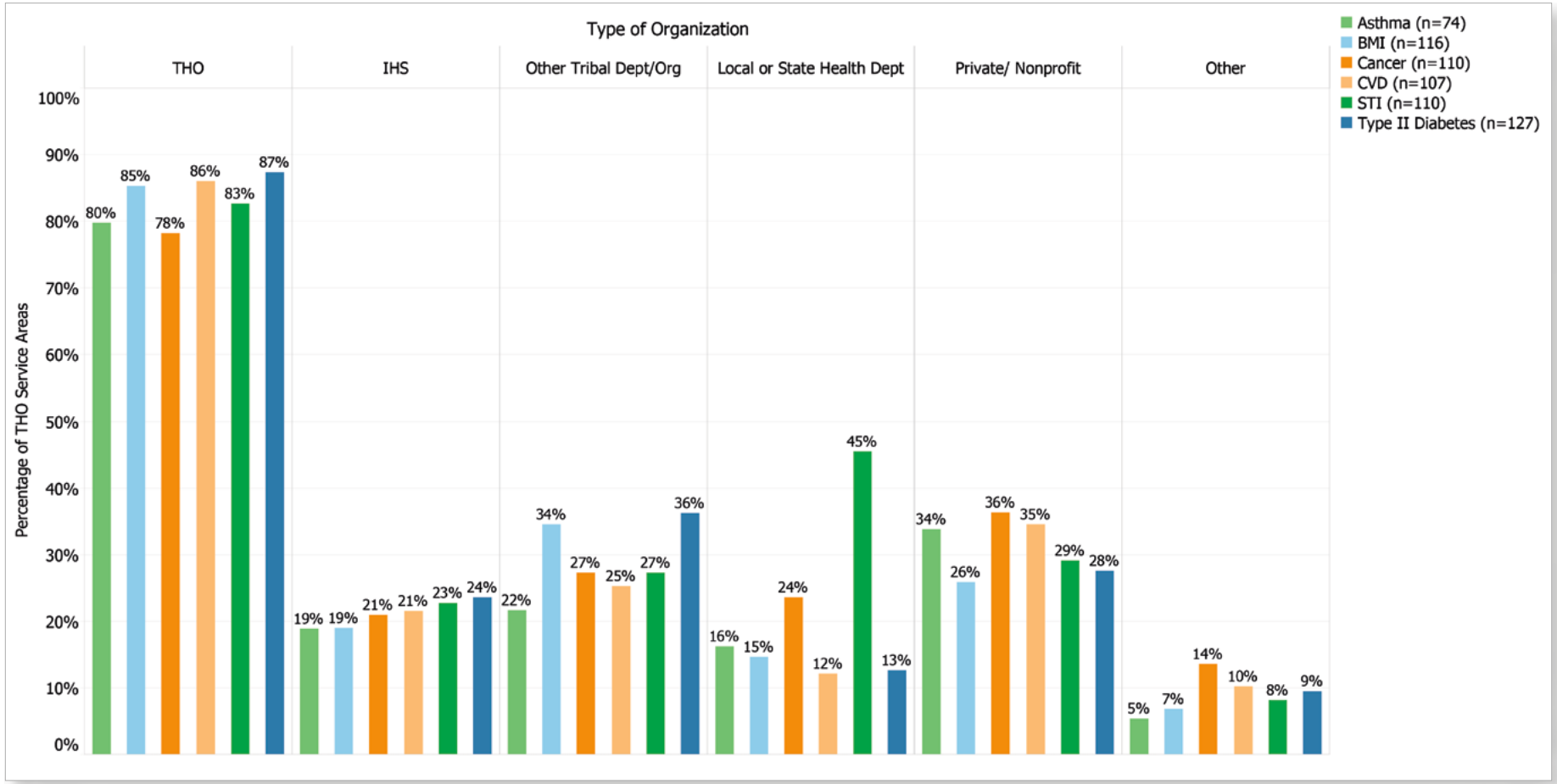
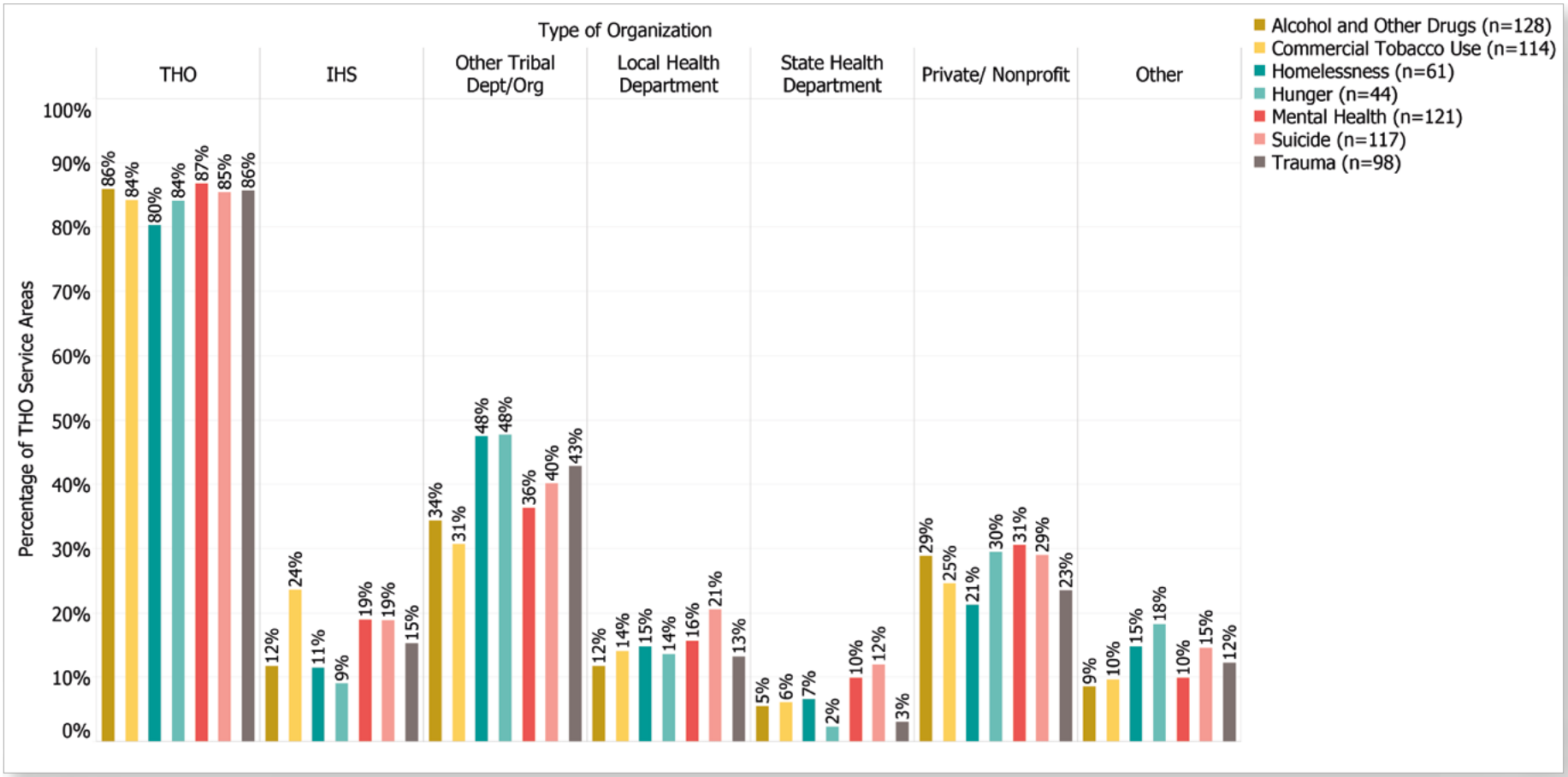


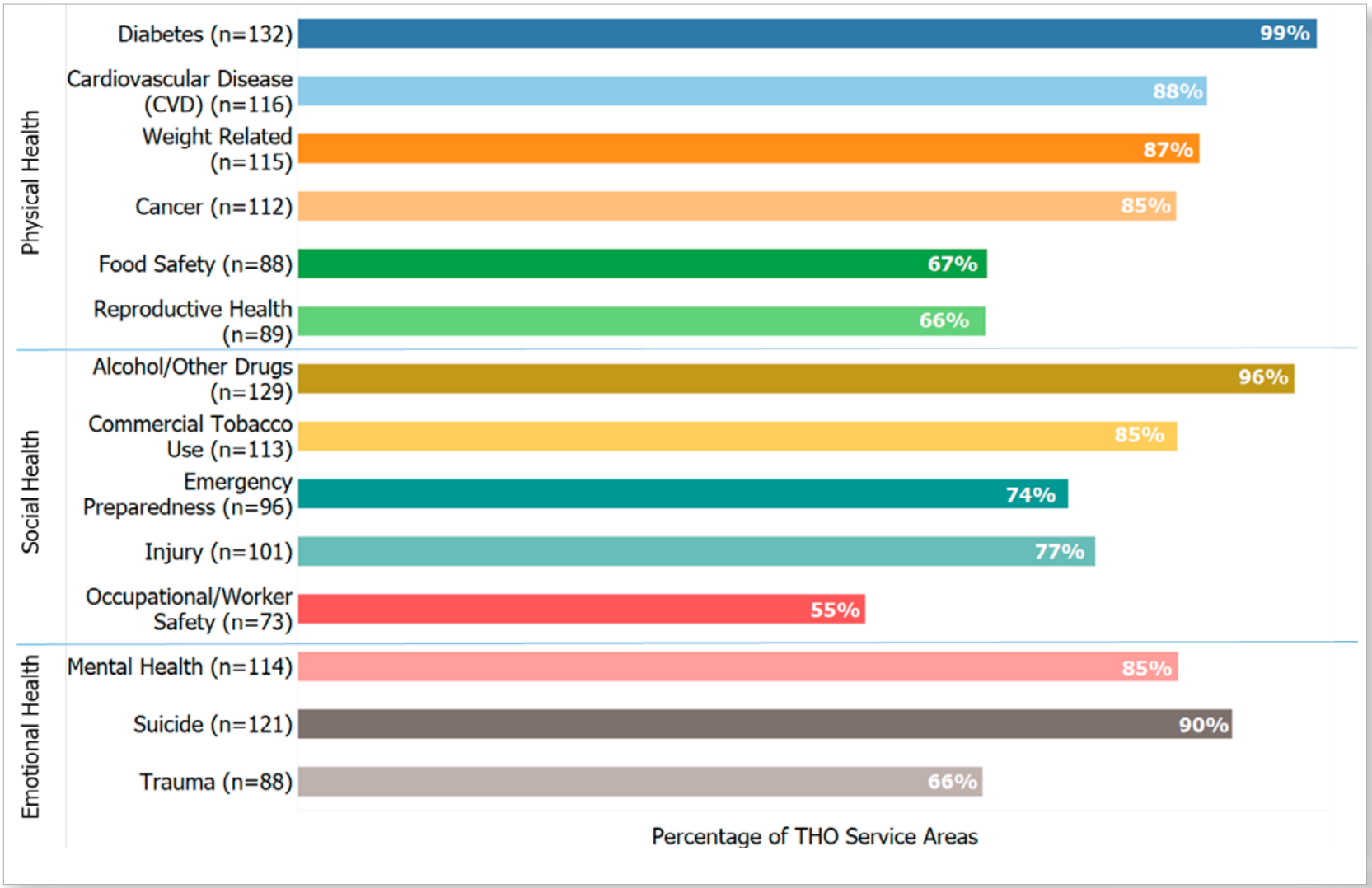
Figure 12 SOCIAL AND EMOTIONAL HEALTH SCREENING ACTIVITIES BY PROVIDER TYPE



4.3.4 Prevention/Education Activities

Over half of the THOs report providing all listed prevention and/or education activities (Figure 13). Similar to screening activities, diabetes prevention/education and alcohol and other drugs prevention/education are provided by almost all of the THOs (99% and 96%). Occupational/worker safety prevention/education activities have the smallest percentage of THOs offering the activities (55%).

Figure 13 PREVENTION AND EDUCATION ACTIVITIES OCCURRING ACROSS THO SERVICE AREAS



Among those service areas implementing prevention and/or education activities, THOs are the primary provider for the majority of activities, followed by other Tribal departments and organizations (especially emergency preparedness) (Figures 14-16).

Figure 14 PHYSICAL HEALTH PREVENTION/EDUCATION ACTIVITIES BY PROVIDER TYPE

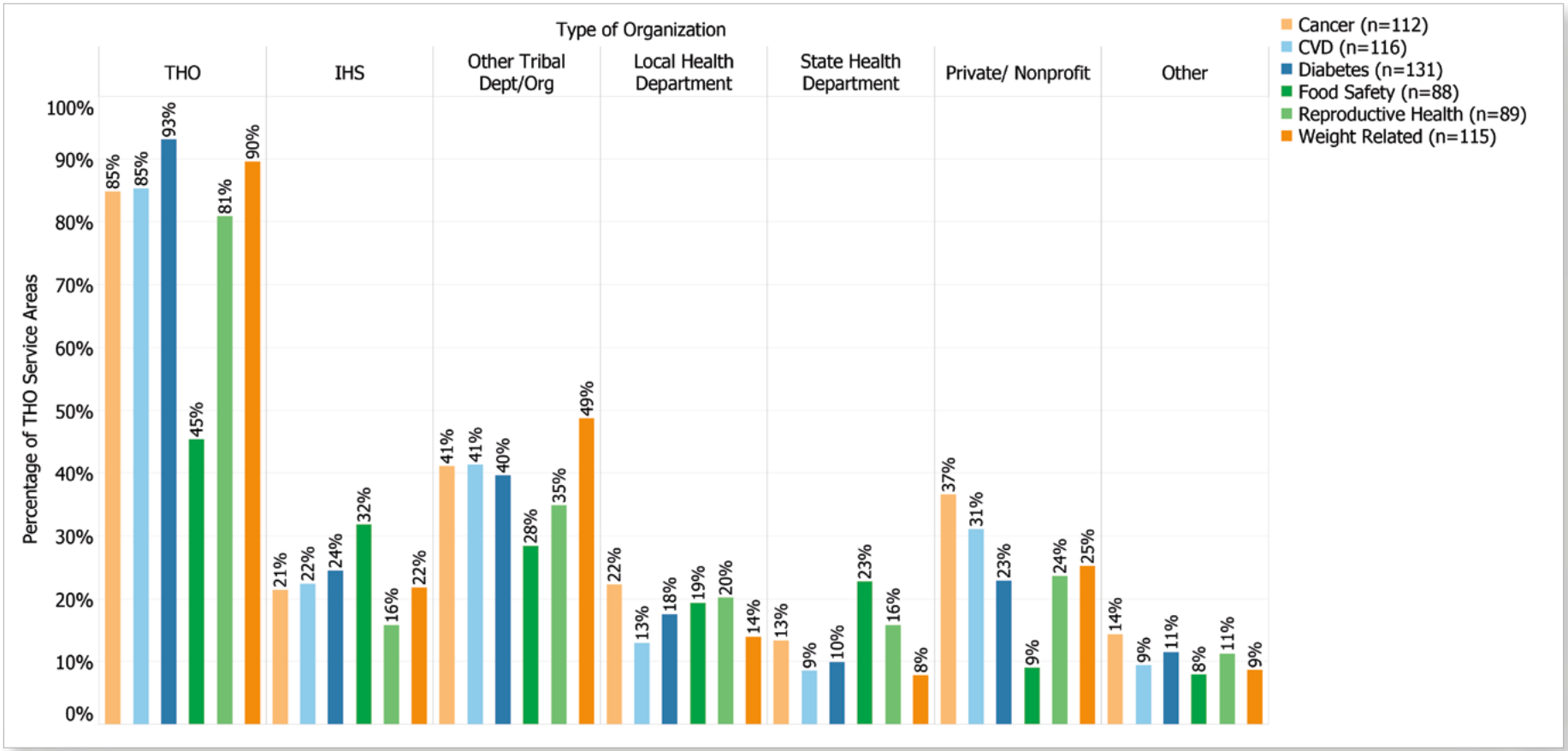


Figure 15 SOCIAL HEALTH PREVENTION/EDUCATION ACTIVITIES BY PROVIDER TYPE

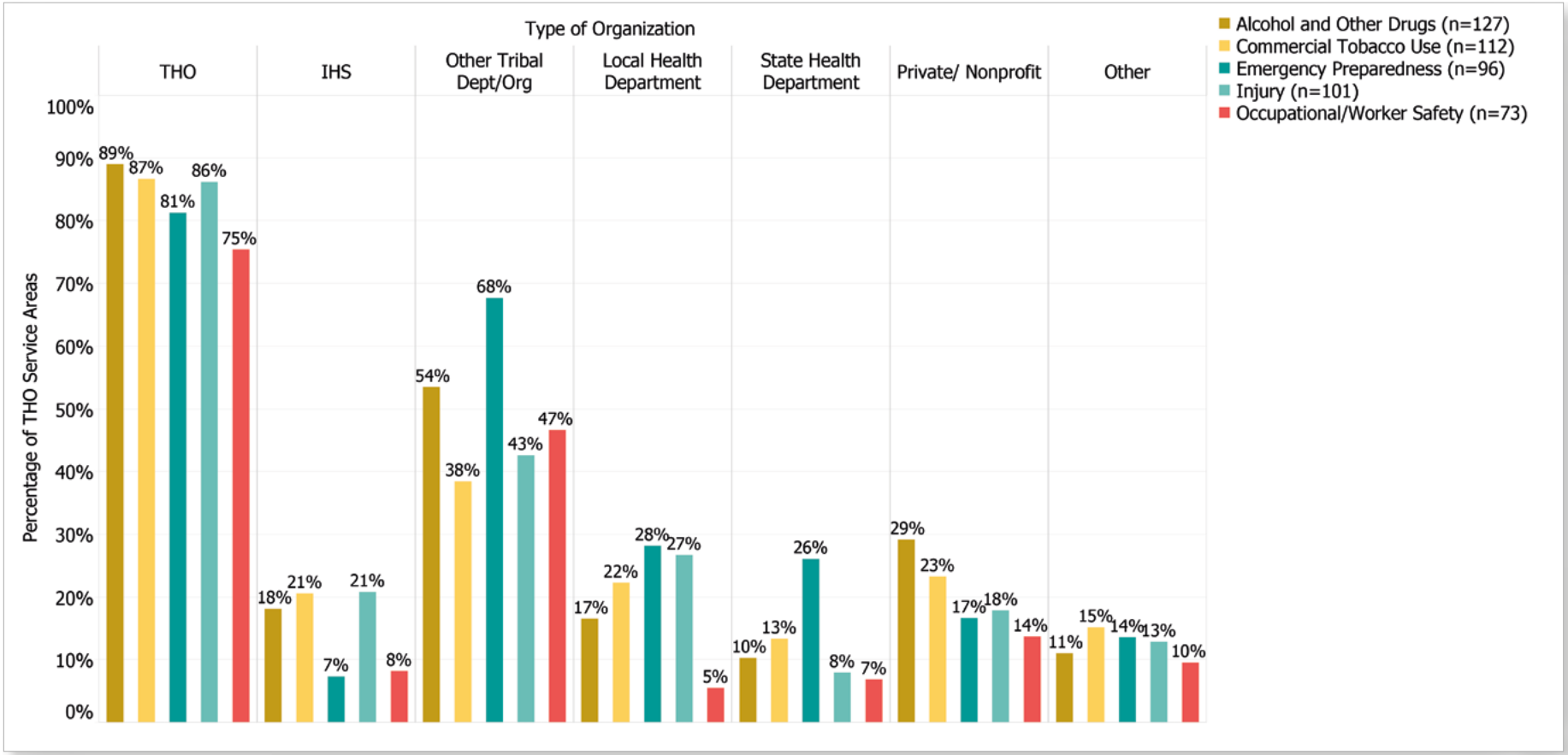
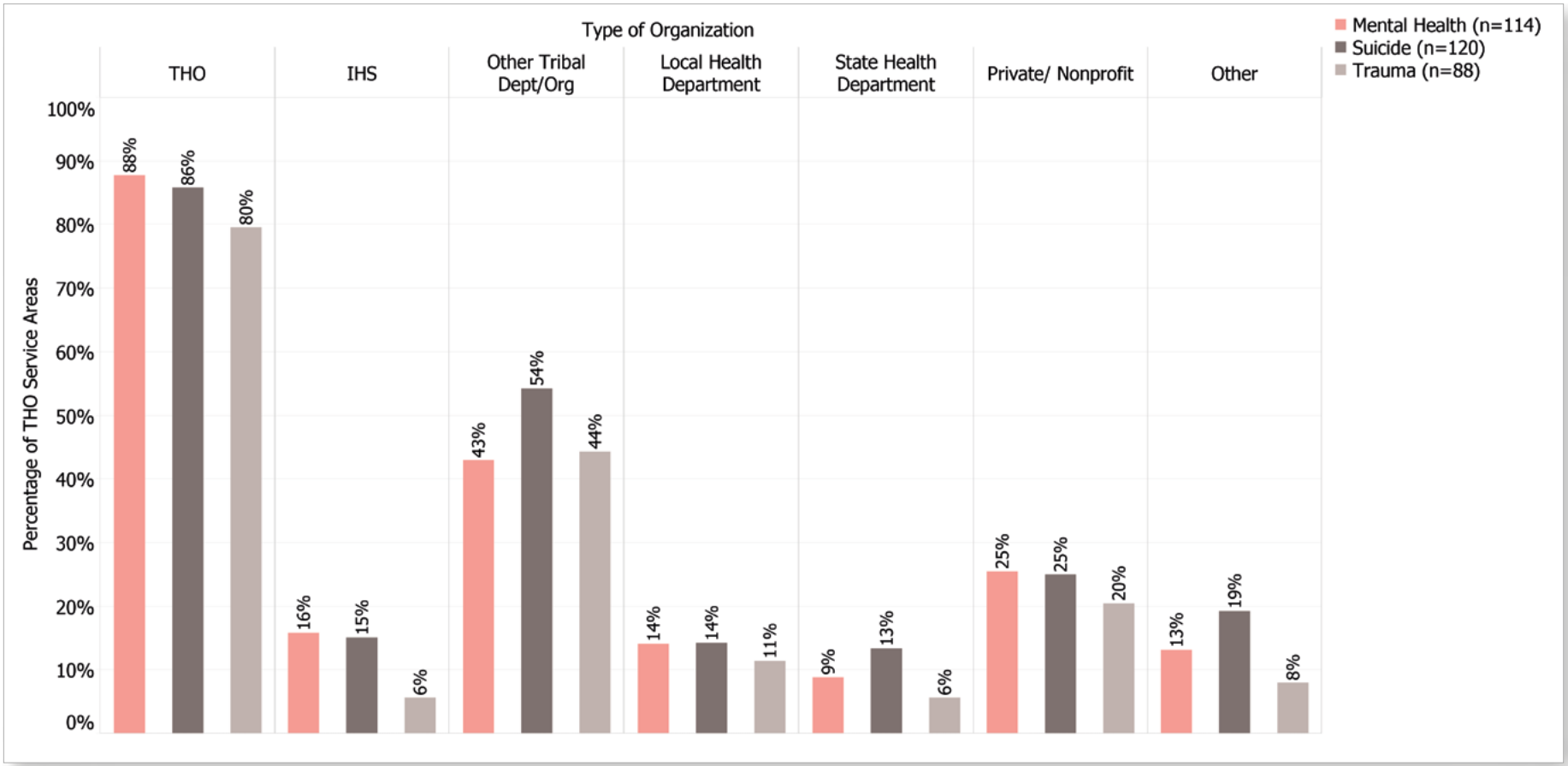


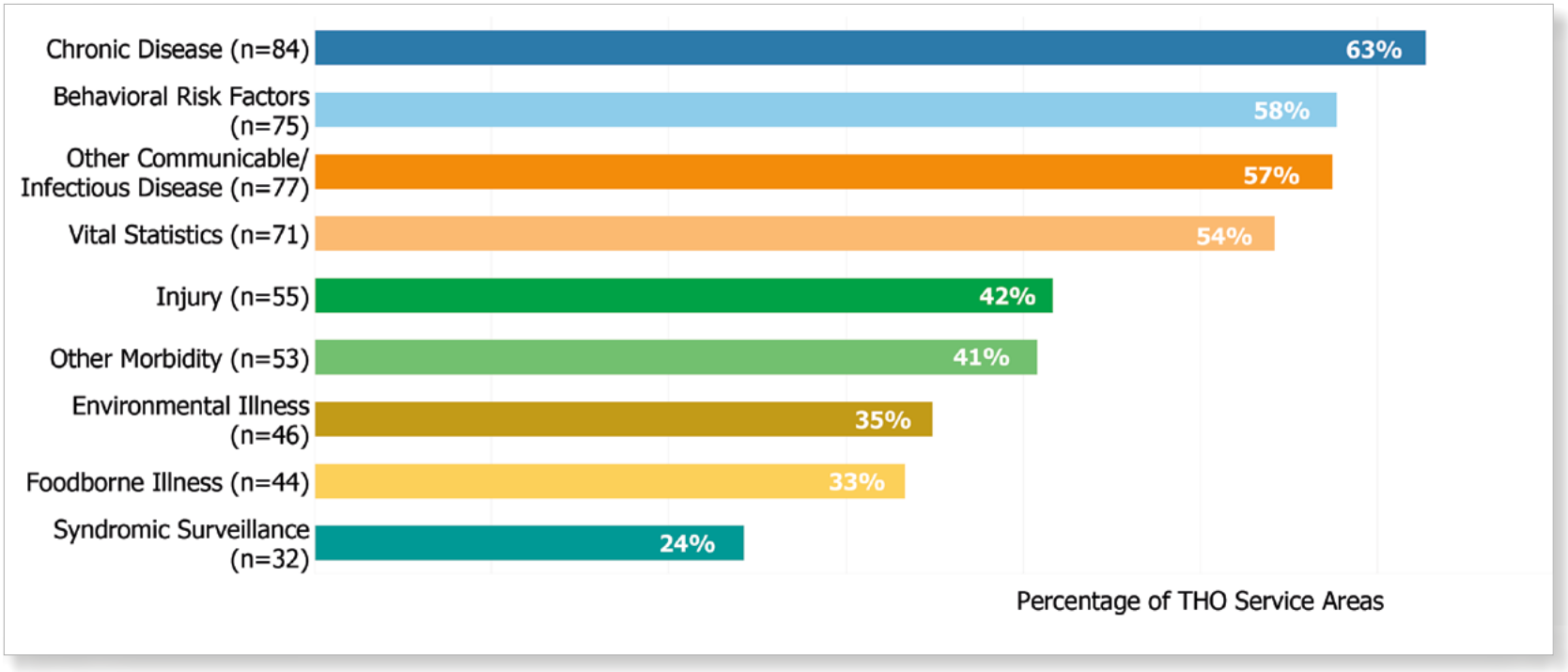
Figure 16 EMOTIONAL HEALTH PREVENTION/EDUCATION ACTIVITIES BY PROVIDER TYPE



4.3.5 Data Collection, Epidemiology, Surveillance (DES) Activities

In comparison to immunization, screening, and prevention/education activities, fewer THOs report offering DES activities within the last year (Figure 17). The most offered activity within this category is chronic disease DES activities, at 63%; syndromic surveillance — which involves continuous, systematic collection, analysis, and interpretation of health-related data — is the least offered activity at 24%.

Figure 17 **DATA COLLECTION, EPIDEMIOLOGY, AND/OR SURVEILLANCE (DES) ACTIVITIES**



THOs are the main provider of most DES activities while state health departments are significant providers of services related to other communicable/infectious disease syndromic surveillance and other communicable/infectious disease DES activities (Figures 18-19).

Figure 18 PHYSICAL HEALTH DATA COLLECTION, EPIDEMIOLOGY, AND/OR SURVEILLANCE (DES) ACTIVITIES BY PROVIDER TYPE

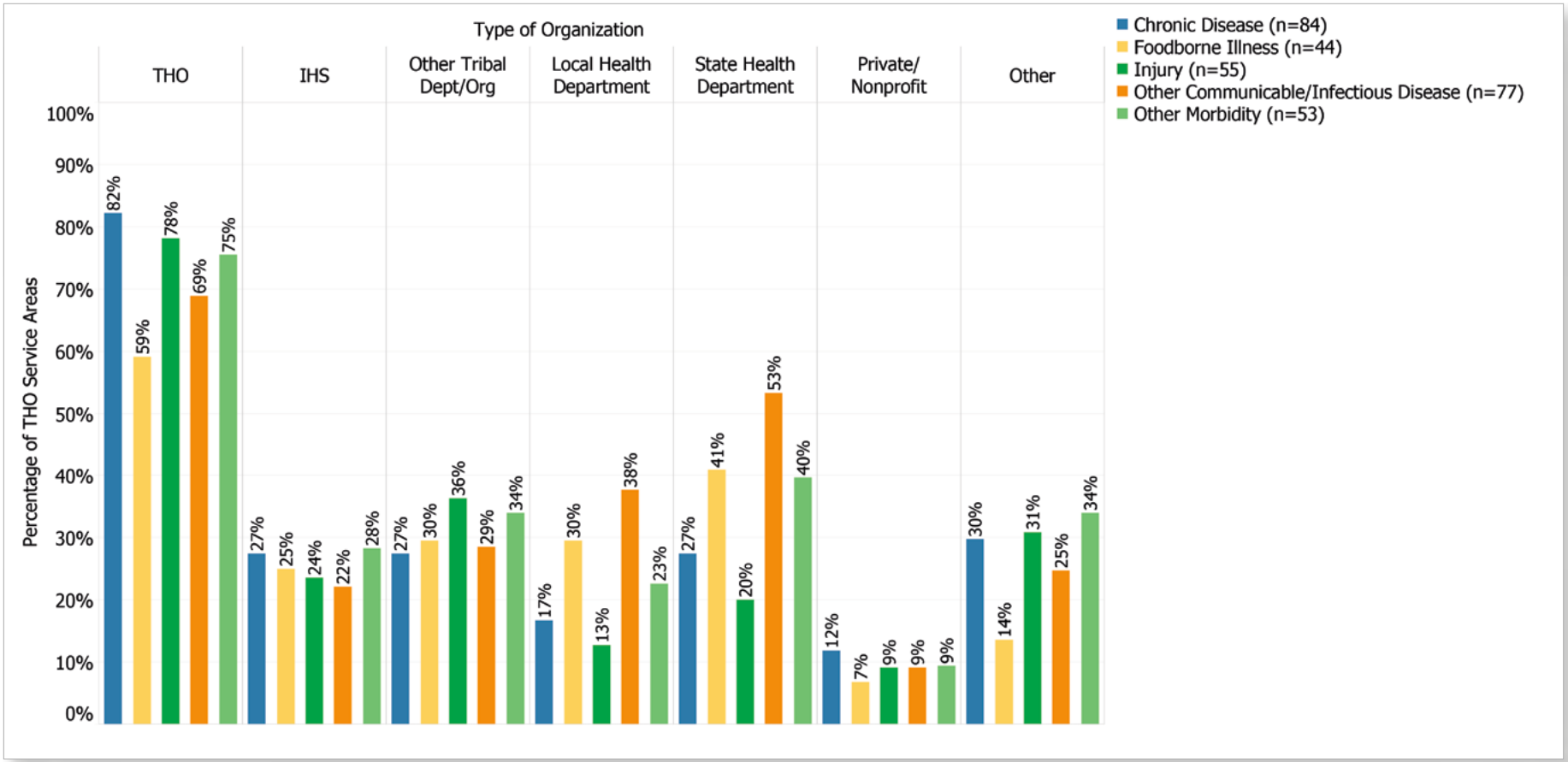
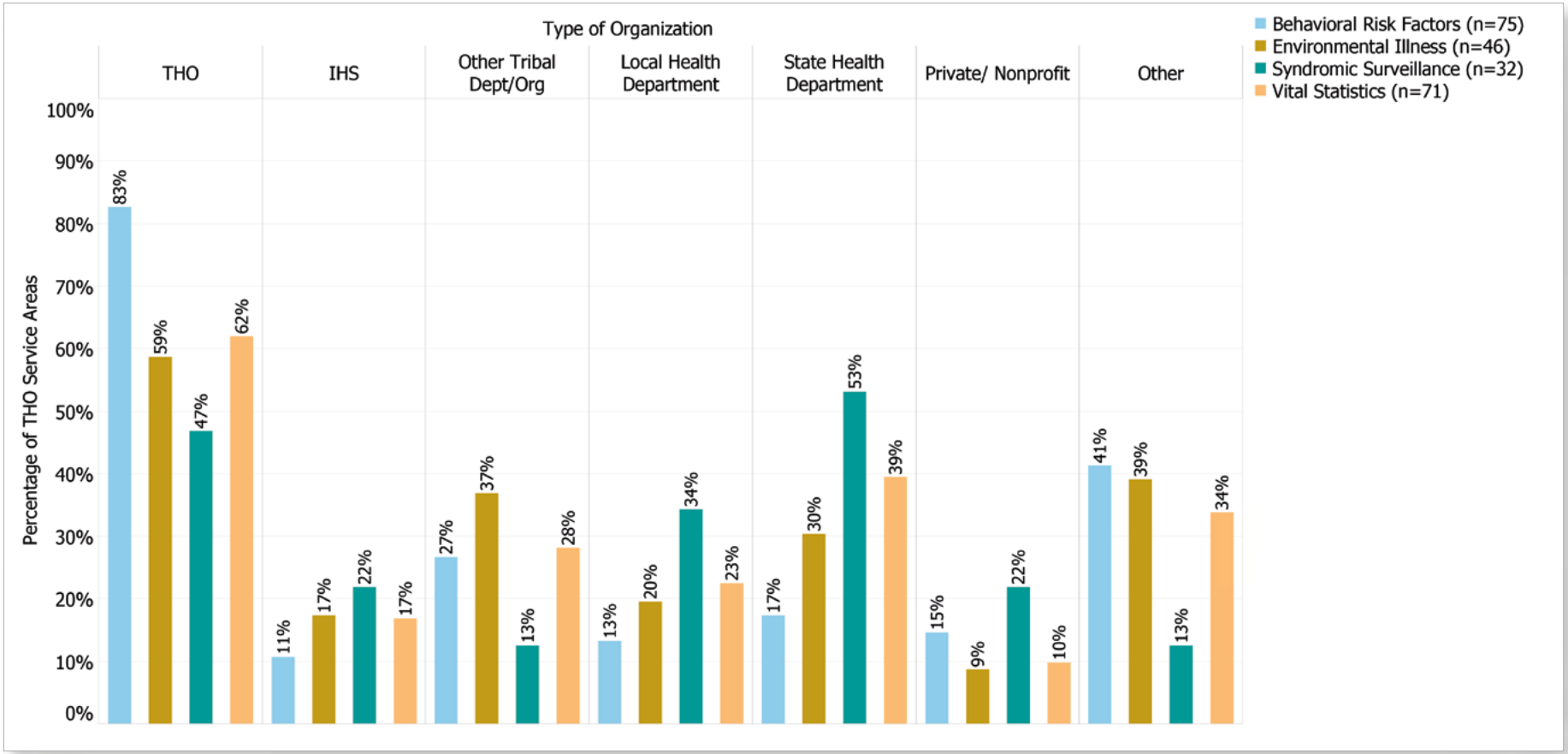


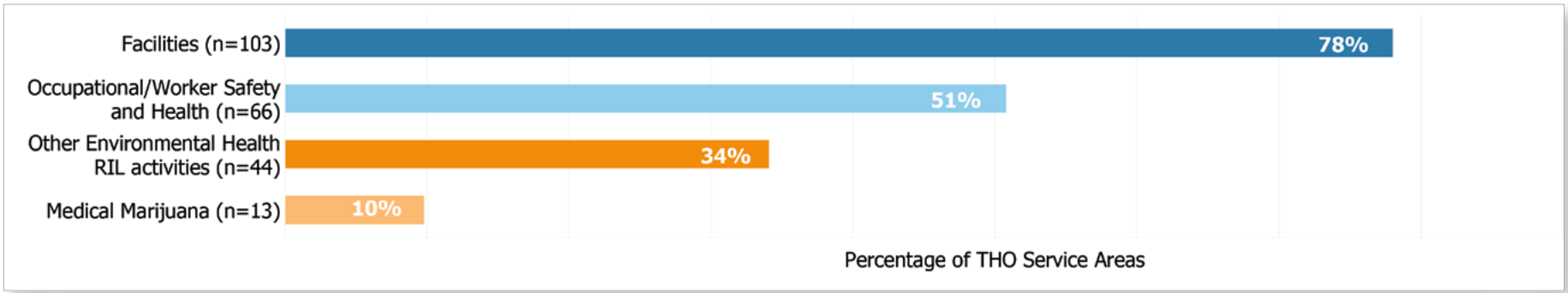
Figure 19 SOCIAL/EMOTIONAL HEALTH & OTHER DATA COLLECTION, EPIDEMIOLOGY, AND/OR SURVEILLANCE (DES) ACTIVITIES BY PROVIDER TYPE



4.3.6 Regulation, Inspection, or Licensing (RIL) Activities

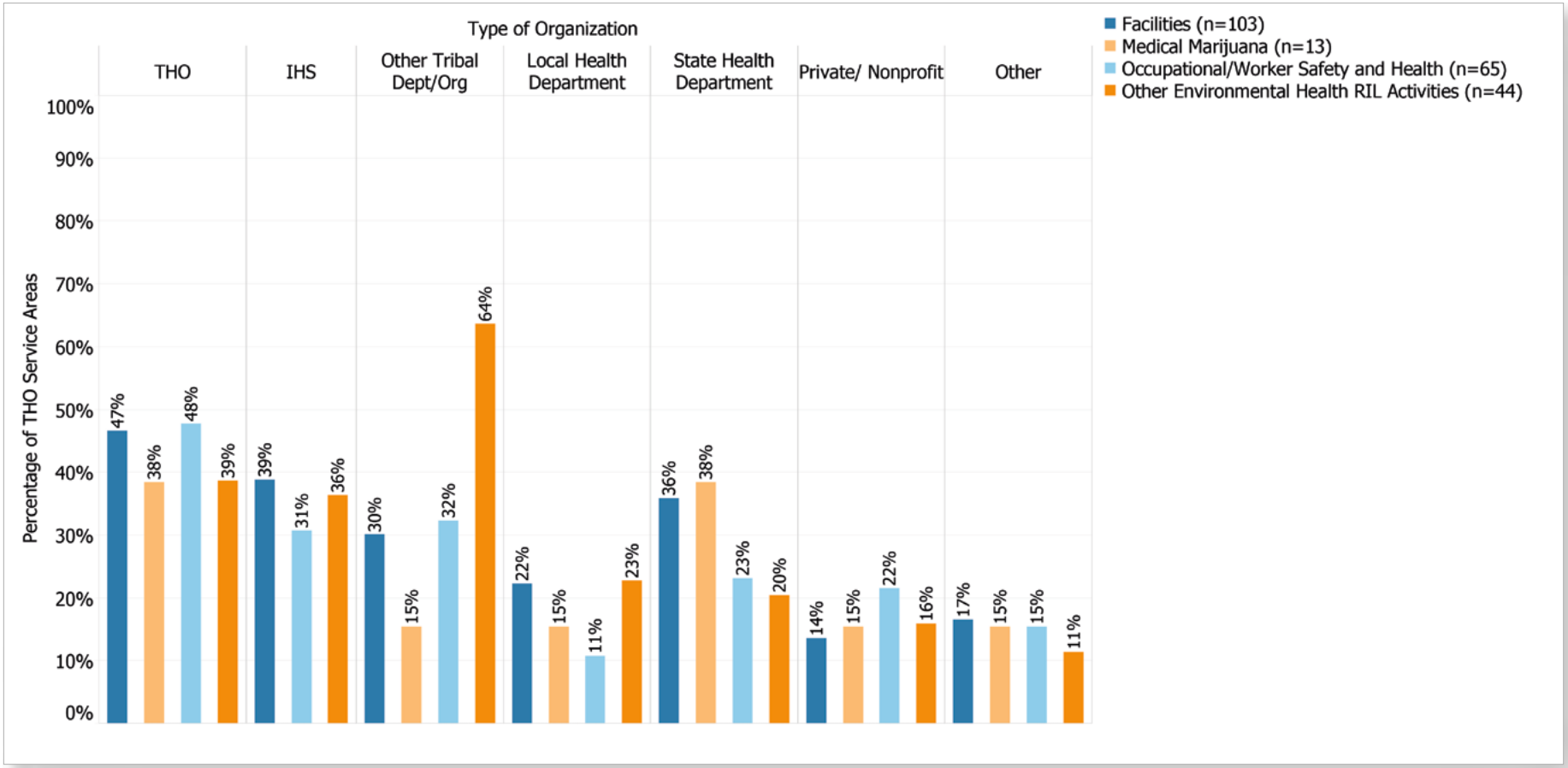
Regulation, inspection, or licensing (RIL) activities are not as comprehensively offered across the THOs (Figure 20). While facilities RIL activities are offered by 78% of THOs, only 10% of THO respondents offer medical marijuana RIL activities. Since medical marijuana is not legal across all Tribal jurisdictions, this limits the opportunity for RIL activities.

Figure 20 **REGULATION, INSPECTION, AND LICENSING (RIL) ACTIVITIES**



Among those THO service areas providing RIL services, THOs remain the main provider of most RIL activities with the exception of other environmental health RIL activities, which saw other Tribal departments and organizations as the largest provider (Figure 21). In addition to THOs, state health departments are also a main provider of medical marijuana RIL activities for the small number of THO service areas (n=13) where these activities occur.

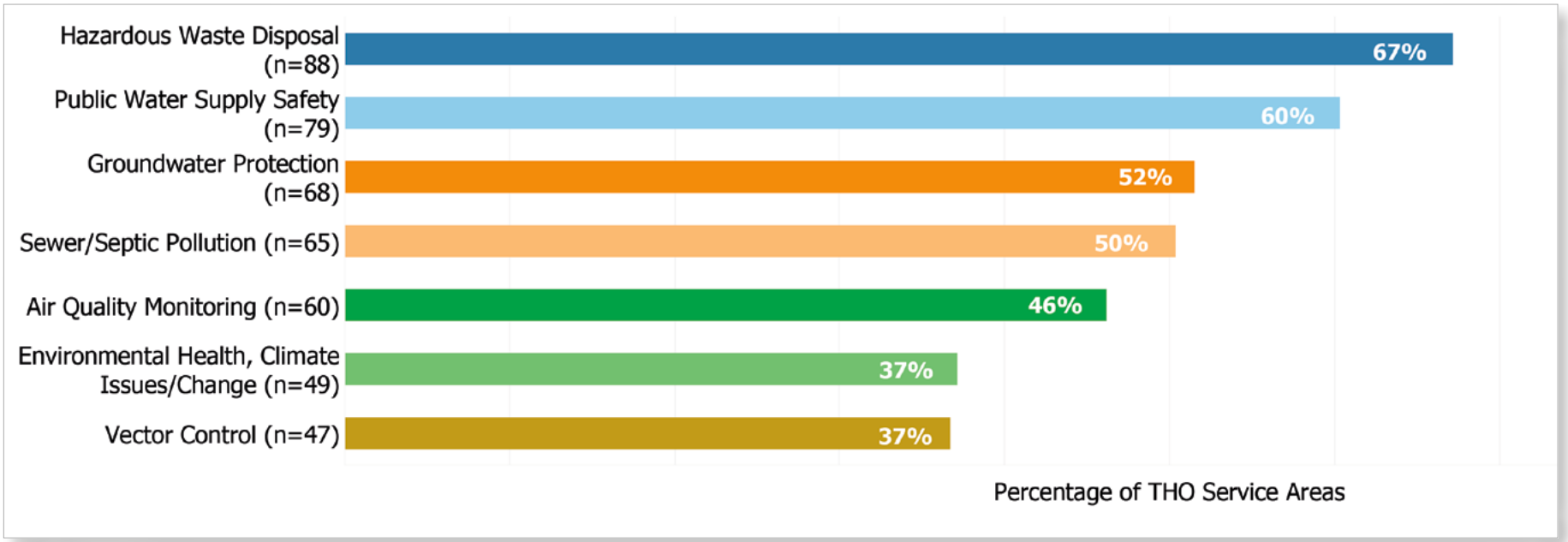
Figure 21 REGULATION, INSPECTION, AND LICENSING (RIL) ACTIVITIES BY PROVIDER TYPE



4.3.7 Environmental Health Activities

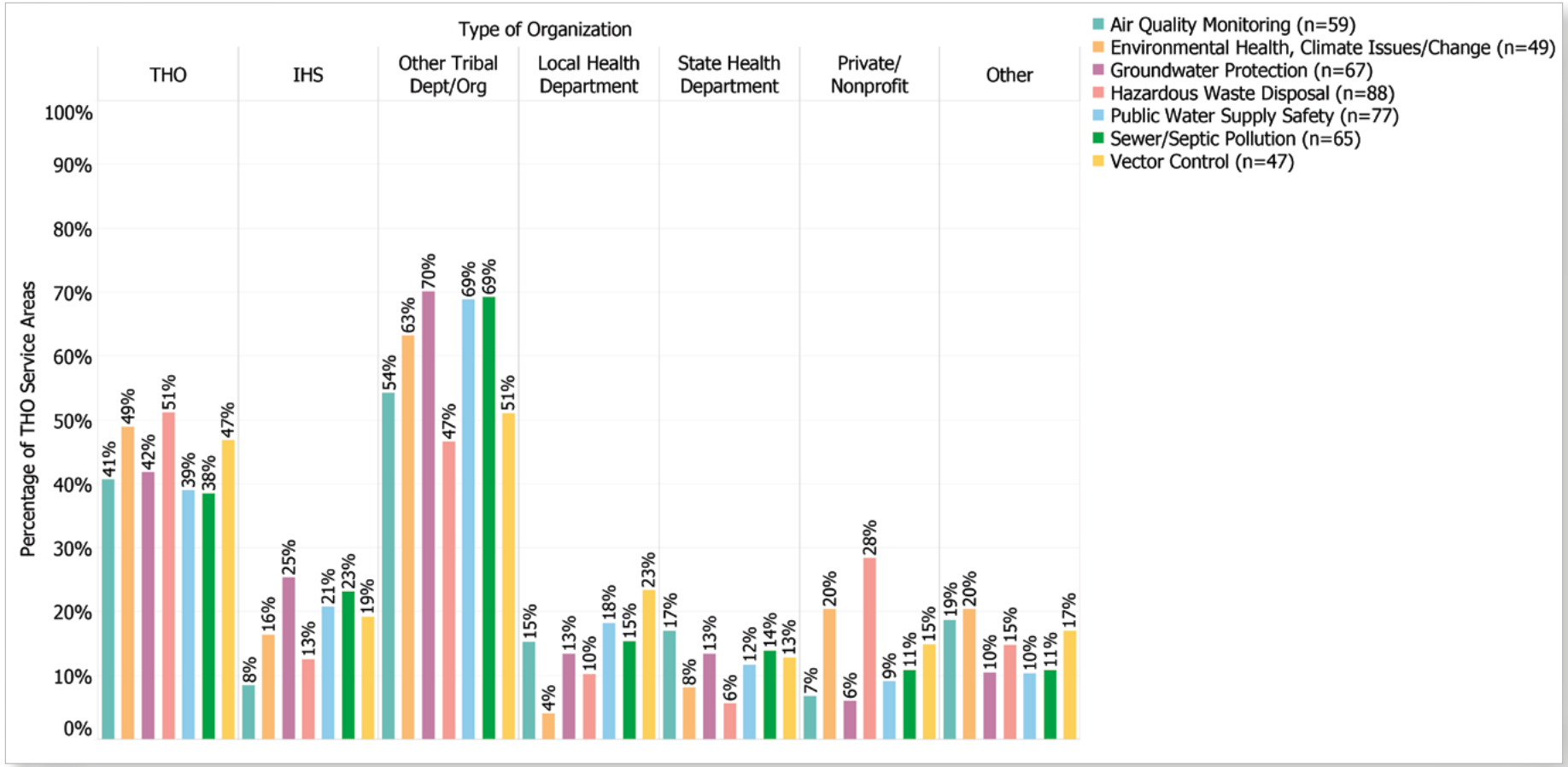
Most environmental health activities rarely occur across THO service areas (Figure 22). Hazardous waste disposal and public water supply safety are the most offered environmental health activities (67% and 60%, respectively), with the remaining activities occurring in 52% of fewer THO service areas.

Figure 22 ENVIRONMENTAL HEALTH ACTIVITIES



Unlike the previous categories, environmental health activities are not as comprehensively provided by THOs. Instead, other Tribal departments and organizations are the most frequently selected provider for the majority of environmental health activities (Figure 23). THOs, however, are still the most frequently selected provider for hazardous waste disposal.

Figure 23 ENVIRONMENTAL HEALTH ACTIVITIES BY PROVIDER TYPE

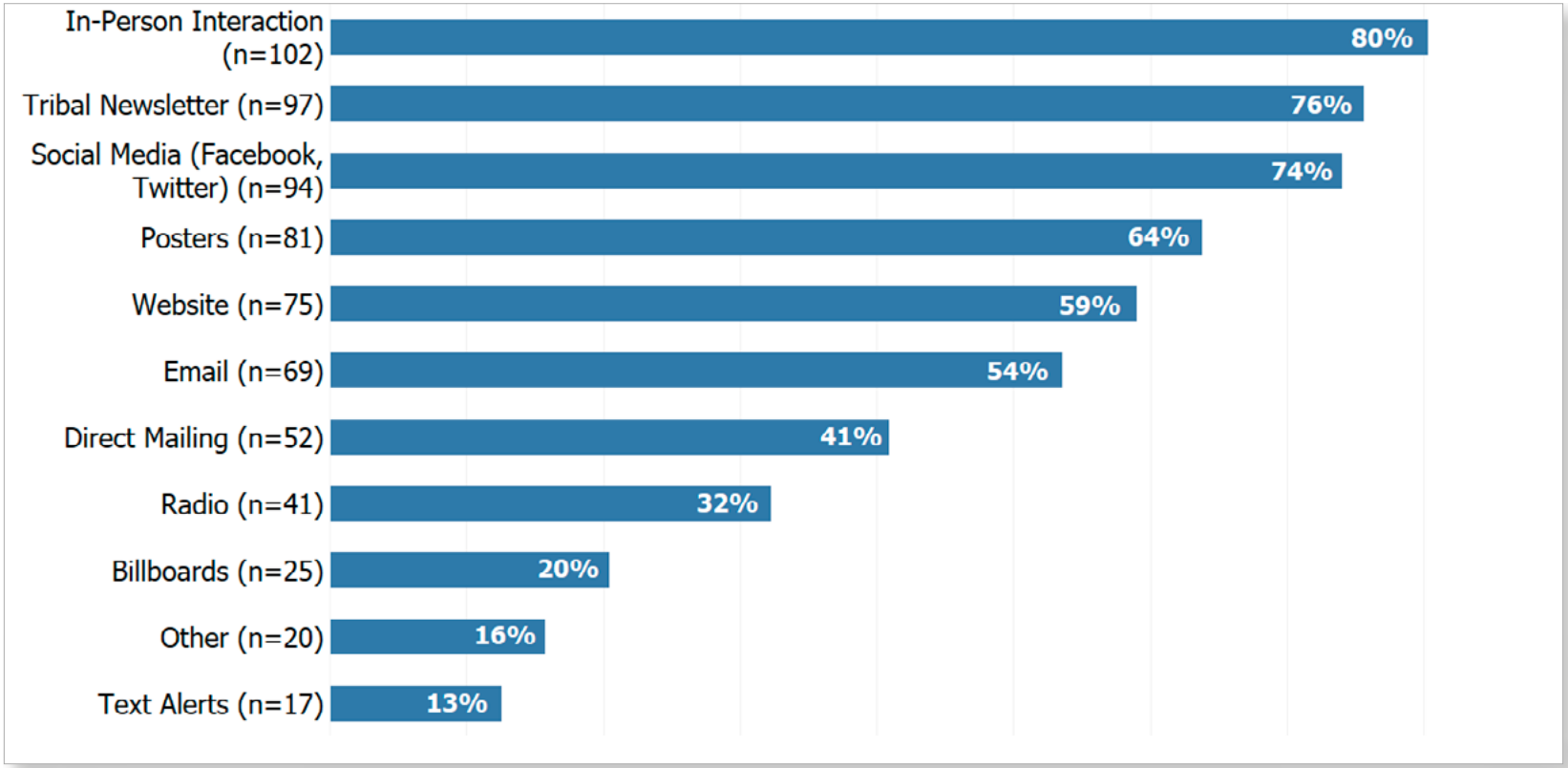


4.3.8 Public Health Information

Public health information is integral to public health systems. This includes the use of public health registries for the collection and exchange of health data as well as the communication of public health information to communities. Immunization registries are reported as the most used registries from THOs (61%, n=76). While just over half of THOs report using clinical data registries (44%, n=54), only 22% (n=27) of THOs report the use of public health registries.

The primary forms of public health information communication reported by THOs are in-person interaction (80%), Tribal newsletter (76%) and social media (74%) (Figure 24). Text alerts are reported as the least used form of public health information communication (13%).

Figure 24 PUBLIC HEALTH INFORMATION COMMUNICATION (N=127)



4.4 ASSESSMENT, PERFORMANCE IMPROVEMENT, AND ACCREDITATION ACTIVITIES

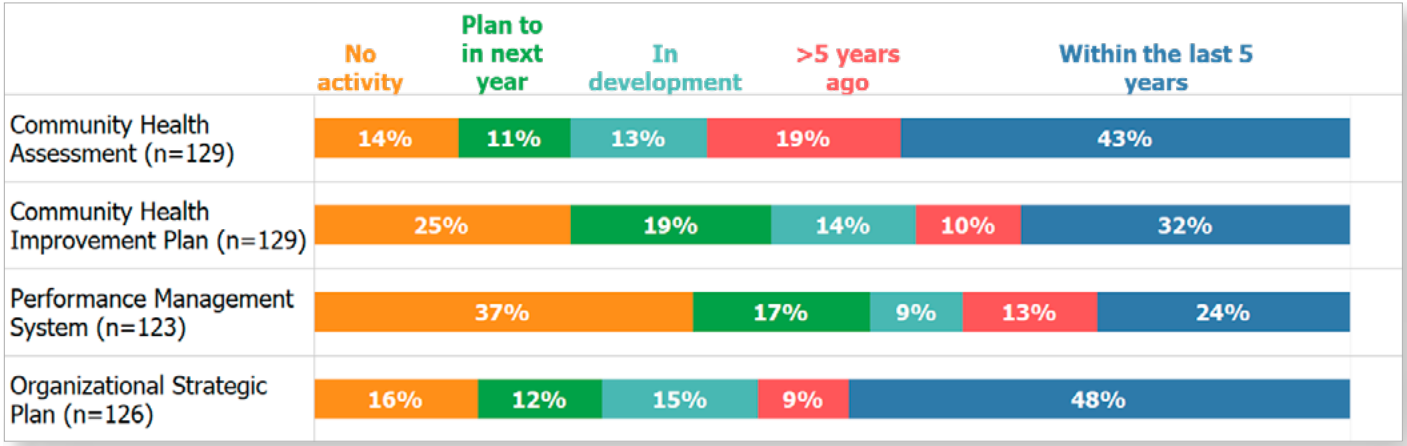
Assessment and performance improvement activities are critical to increasing the overall effectiveness of a public health system. While performance improvement focuses on internal changes to improve services, system improvement focuses on incorporating health equity and interconnection of various systems that can impact the public health of Tribal communities. THOs were subsequently asked about their organization's involvement in multiple activities related to assessment, performance and quality improvement, their use of the Council on Linkages core competencies for public health professionals, and public health accreditation activity status.

Involvement in assessment, performance improvement, and accreditation activities is variable across THOs (Figure 25).

- Less than half of THOs had conducted or created a community health assessment, community health improvement plan, performance management system, or an organizational strategic plan within the last five years.
- 24% of THOs had created a performance management system within the last five years.
- 48 % of THOs had created an organizational strategic plan within the last five years.

- *Community health assessment*– monitors the health of a community at one point in time
- *Community health improvement plan*– a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process
- *Performance management system*– a single, comprehensive approach of using objectives and measurement to evaluate performance of programs, policies, and processes, as well as achievement of outcome targets for the Tribal health department
- *Organizational strategic plan*– a strategic plan results from a deliberate decision-making process and defines the direction of an organization

Figure 25 THO ASSESSMENT, PERFORMANCE IMPROVEMENT, AND ACCREDITATION ACTIVITY STATUS (N=123-129)

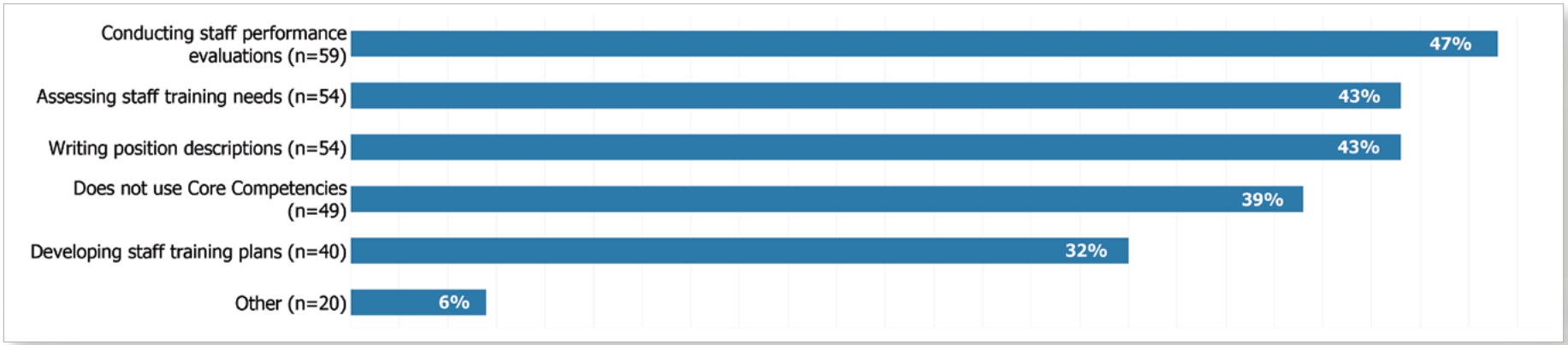


Only 61% (n=44) of THOs indicate that their community health improvement plan (CHIP) was developed using the results of a community health assessment. CHIPs are typically updated every 3 to 5 years, and 89% (n=63) of THOs indicate plans to update their CHIP in the next three years.

4.4.1 Public Health Professional Core Competencies

Developed by the Council of Linkages[15], the Core Competencies are a widely accepted set of skills for public health professionals. Similar to assessment, performance improvement, and public health accreditation activites, less than half of THOs are using any of the Core Competencies (Figure 26). The highest scoring competency across THOs is conducting performance evaluations (47%).

Figure 26 THO USE OF COUNCIL ON LINKAGES CORE COMPETENCIES (N=125)



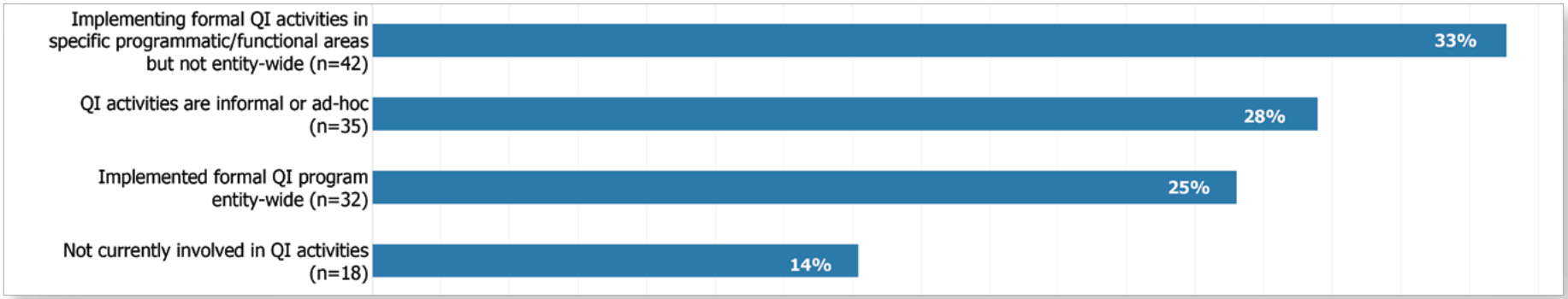
4.4.2 Quality Improvement

Quality improvement in public health is the use of a deliberate and defined improvement process, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes that achieve equity and improve the health of the community. Current quality improvement activities conducted by THOs where (Figure 27):

- 58% of THOs indicate involvement in formal quality improvement programming on an entity-wide basis or in specific programmatic or functional areas
- 14% of THOs indicate no involvement in quality improvement activities.

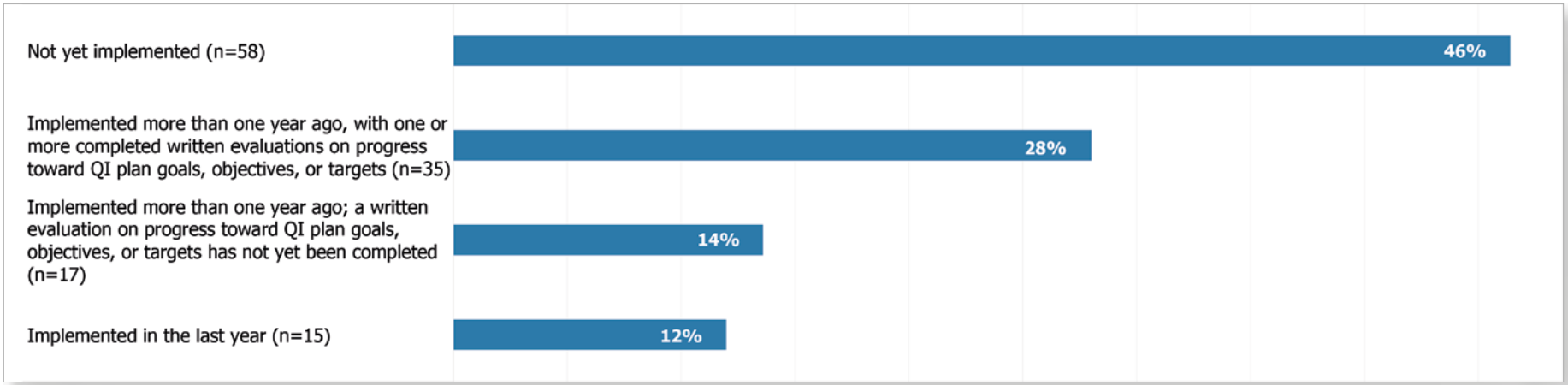
15 The Council of Linkages is a collaborative of 23 national organizations and coordinated by the Public Health Foundation.

Figure 27 **THO CURRENT QUALITY IMPROVEMENT ACTIVITIES (N=127)**



Implementation of quality improvement plans is split amongst THOs (Figure 28). However, the vast majority of THOs (88%) have not implemented a quality improvement plan within the last year.

Figure 28 **THO QUALITY IMPROVEMENT PLAN STATUS (N=125)**

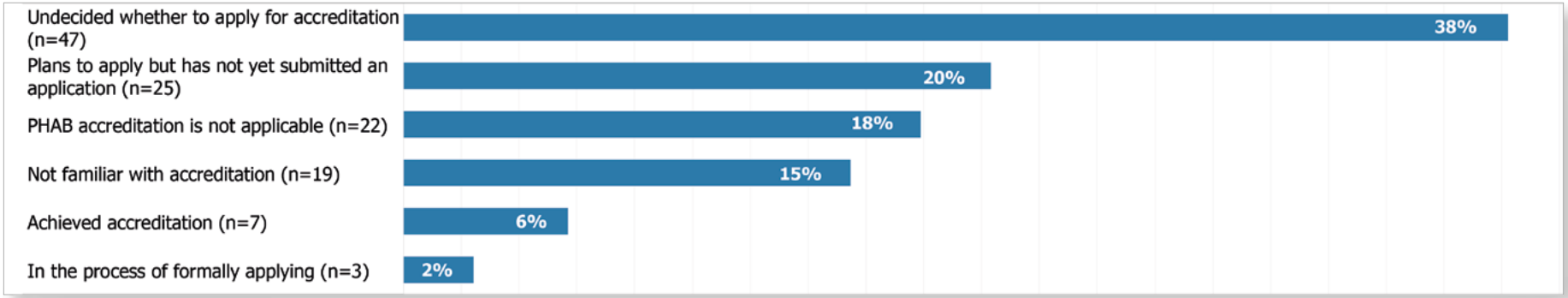


4.4.3 Public Health Accreditation Status

The Public Health Accreditation Board (PHAB) is the national accrediting organization for public health departments and is dedicated to advancing the continuous quality improvement of Tribal, state, local, and territorial public health departments. THO engagement with PHAB's national public health accreditation program is variable (Figure 29). Only 6% of THOs indicate having achieved accreditation, while just under 23% are either planning to apply (n=25) or in the process of applying (n=3) (i.e., had registered in e-PHAB and is submitting an application, uploading documentation, preparing for a site visit, etc.). The remaining THOs are either still deciding to apply (38%), unfamiliar with public health accreditation (15%) or PHAB accreditation is considered not applicable to them (18%). As noted in the Limitations (Section 2.2.1), data is self-reported and was not

independently verified. However, according to PHAB's website, only three Tribal public health departments have achieved accreditation as of March 2020 (PHAB, 2020). Consequently, the self-reported data may include THOs who report having achieved another type of accreditation such as health care accreditation or meeting other standards.

Figure 29 THO ENGAGEMENT WITH PHAB'S PUBLIC HEALTH ACCREDITATION PROGRAM (N=123)



4.5 PUBLIC HEALTH WORKFORCE

Public health employees play an integral part in delivering key public health services and activities within Tribal communities. The makeup of public health workforce in Tribal communities, however, is widely variable as Tribes do not always have designated "public health" staff, i.e. staff hired for the sole purpose of providing public health services. As a result, this section provides workforce data on all staff involved in providing public health services, but explicitly not including staff providing clinical services and treating illness after onset.

The public health workforce section has some notable data limitations. This section had the lowest response rate across the entire scan. While justification for the low response rate in this section is outside the scope of this report, THOs may not have had this information easily readable when completing the scan, particularly due to the opacity between staff working in Tribal communities who may deliver both public health and clinical health services. Consequently, the range of "n" is listed for each occupation in Table 7 (since each column was a separate question with variable response rates); results should be interpreted with caution.

4.5.1 Overall Workforce

THOs were asked to report the current number of public health staff members, including temporary and contract workers, as well as the number of full-time equivalent (FTE) public health staff members in the organization. A total of 130 THOs provided a response, with a median number of public health staff members and FTE of 5 and 4, respectively (Table 6).

Table 6 OVERVIEW OF PUBLIC HEALTH WORKFORCE

	Mean	Median	Minimum*	Maximum	N
All Public Health Staff	13.4	5	0	246	130
All Public Health FTE	14.6	4	0	266	130

**Multiple THOs noted having zero public health staff*

4.5.2 Occupations

In addition to total staffing numbers, THOs were asked to provide information on the current number of positions funded, filled, vacant, and needed in a total of 24 different occupational classifications who provide or support public health services. While total FTE positions funded were supposed to equal the sum of funded FTE positions filled and funded FTE positions vacant, these did not sum to the total number of FTE reported

overall *or* the total number of FTE reported by occupational classification. Excluding the "other" category, the occupational classifications with the highest average number of FTE funded *and* funded FTE filled are behavioral health staff (8.7/6.6), office and administrative support (5.0/4.2), and business and financial operations (4.6/4.0) (Table 7). THOs also identified behavioral health staff as having the highest average number of funded FTE vacancies (1.7) and additional funded FTE needed (1.8). Community health representatives (CHRs) (0.6) and nurse practitioners (0.6) have the next highest average number of funded FTE vacancies. CHRs (1.2) are also identified as needing additional funded FTE, followed by public health nurses (1.1).

CHRs (and their counterparts, community health aides (CHAs) and community health practitioners (CHPs)) are often integral in the delivery of both health care and public health activities in Tribal communities. Specific to the IHS, a CHR is a Tribal or Native community-based, well-trained, medically-guided, health care provider, who may include traditional Native concepts in his/her work and is funded with IHS-CHR appropriations (IHS, n.d.b). As trusted community members, CHRs are not only uniquely poised to translate information and link patients and communities to needed health and social services, they also play a public health role by creating conditions in their communities in which people can be healthy through their interconnectedness of health to social, economic, spiritual, and environmental factors.

Since an exhaustive list of occupations was not included on the questionnaire, the "other" category allowed for THOs to write in occupations not listed. This was a variable mix and did not have any significant patterning. Examples of "other" occupations written in include (but were not limited to): support staff such as health transporters and drivers (something frequently found in Tribal communities to help patients attend appointments), traditional healers, dental staff, substance abuse counselors, and diabetes educators.

Table 7 THO PUBLIC HEALTH WORKFORCE BY OCCUPATION

		TOTAL				MEAN			
Position	N	FTE Funded	Funded FTE Filled	Funded FTE Vacant	Additional Funded FTE Needed	FTE Funded	Funded FTE Filled	Funded FTE Vacant	Additional Funded FTE Needed
Agency Leadership/Upper Management	48-91	325.9	236.4	11.0	37.5	3.6	3.0	0.2	0.7
Behavioral Health Staff	41-68	640.5	429.2	77.3	77.8	8.7	6.6	1.7	1.8
Business and Financial Operations	38-59	315.1	222.1	19.0	25.3	4.6	4.0	0.5	0.6
Community Health Aides (CHAs)	47-90	78.2	73.2	5.0	26.0	1.3	1.6	0.1	0.6
Community Health Representatives (CHRs)	38-65	311.5	209.0	30.5	59.0	3.5	3.1	0.6	1.2
Environmental Health Workers	37-58	53.1	45.3	5.0	17.5	0.9	1.1	0.1	0.4
Epidemiologist/Statistician	37-54	11.0	6.0	2.0	18.0	0.2	0.2	0.1	0.4
IT	40-64	97.0	83.0	14.0	24.5	1.5	1.6	0.4	0.6
Laboratory Worker	39-60	72.3	74.3	15.0	17.5	1.2	1.6	0.4	0.4
Legal Counsel	35-53	25.1	21.1	3.0	7.8	0.5	0.5	0.1	0.2
Nurse Practitioner	43-74	97.4	76.4	24.5	27.5	1.5	1.4	0.6	0.6
Nutritionist	43-63	68.3	52.1	7.0	16.3	1.0	1.0	0.2	0.4
Occupational Therapist	41-66	32.0	6.0	1.0	7.5	0.6	0.2	0.0	0.2
Office & Administrative Support	35-52	388.7	275.7	17.0	44.0	5.0	4.2	0.4	0.9
Oral Health Professional	44-77	209.1	165.3	24.0	33.0	3.1	3.0	0.5	0.8
Physician Assistant	43-68	33.3	42.3	5.0	16.0	0.6	0.9	0.1	0.4
Preparedness Staff	38-54	63.1	44.2	5.0	21.6	1.0	0.9	0.1	0.5
Public Health Educator	39-56	69.5	47.3	5.0	37.5	1.2	1.1	0.1	0.9
Public Health Informatics Specialist	36-51	10.0	2.0	1.0	13.0	0.2	0.1	0.0	0.3
Public Health Information Specialist	38-59	8.8	6.8	1.0	11.5	0.2	0.2	0.0	0.3
Public Health Nurse	43-67	132.7	107.0	18.8	51.5	2.0	1.9	0.4	1.1
Public Health Physician	35-53	44.3	37.1	4.0	14.0	0.8	0.9	0.1	0.4
Quality Improvement Professional	36-52	38.9	29.9	7.0	19.0	0.7	0.7	0.2	0.5
Workforce Development Coordinator	37-53	21.0	16.0	0.0	11.5	0.4	0.4	0.0	0.3
Other	32-49	1102.9	934.5	73.3	227.8	22.5	24.0	2.3	6.7

4.5.3 Public Health Workforce Development Needs

Beyond public health workforce staffing numbers, THOs were asked to list up to five current public health workforce development needs including, but not limited to, training or professional development needs. The most common needs identified include:

- 60 THOs identify training, including training on technical skills (i.e. data collection and/or analysis) and general training on public health;
- 29 THOs identify professional development, including certification and licensing;
- 27 THOs identified staffing;
- 27 THOs identify needs related to assessment, performance improvement, and accreditation; and
- 23 THOs identify technical assistance, including assistance on epidemiology, data analysis, and public health informatics.

Workforce development needs around technical skills training and technical assistance are perhaps unsurprising given the overall lack of epidemiologist/statistician (0.2), public health informatics specialist (0.1), and public health information specialist (0.2) funded FTE filled positions identified by THOs in Table 7.

4.6 PUBLIC HEALTH PRIORITIES AND NEEDS

In order to assess the public health priorities in Indian Country, THOs were asked to provide information on their current public health needs and priorities. This information is critical in 1) aligning funding with public health needs and 2) providing state and federal agencies with specific strategies for advancing Tribal public health.

4.6.1 Public Health Issues and Priorities

THOs were first asked to rank public health issues and organizational priorities from pre-determined lists (Appendix C). For public health issues, THOs ranked their top five public health issues from the pre-determined list of 12 issues, with an option to write in an "other" issue as needed. Out of the 122 THOs who responded:

- Diabetes is among the top three public health issues among 84% (n=102) of respondents,
- Substance misuse was identified among the top three public health issues among 64% (n=78) of respondents,
- Heart disease is among the top three public health issues among 58% (n=71) of respondents, and
- Cancer is among the top three public health issues among 30% (n=36) of respondents.
- THOs also ranked their organizational priorities, as they relate to non-programmatic and infrastructure-building capacities and activities, from a pre-determined list of 11 priorities (ranking them all 1-11, with number 1 being the most important). Out of the 112 THOs who responded:
- Data and assessment is among the top three organizational priorities among 58% (n=65) of respondents,
- Health education and health promotion is among the top three organizational priorities among 50% (n=56) of respondents,
- Policy development is among the top three organizational priorities among 38% (n=42) of respondents, and
- Planning is among the top three organization priorities among 34% (n=38) of respondents.

4.6.2 Public Health Needs

In addition to ranking public health needs and priorities, THOs were also asked open ended questions across four categories related to improving public health within the Tribal communities they serve. The four categories included: 1) additional resources needed to improve Tribal public health, 2) what the CDC can do to assist Tribal organizations and entities in advancing Tribal public health, 3) what other federal agencies can do to assist Tribal organizations and entities in advancing Tribal public health, and 4) what states can do to assist Tribal organizations and entities in advancing Tribal public health. The responses were later coded and qualitatively analyzed using thematic coding. Across all four categories, funding is the most frequently identified need (Table 8). This includes not only funding support overall, but specifically Tribally-directed monies for improving public health in Indian Country through non-competitive

grants from the CDC and other federal agencies, to Tribal set-asides from the CDC and other federal agencies akin to funding reserved for states.

Table 8 THO PUBLIC HEALTH NEEDS

Need	Additional Resources (n=86)		CDC % (n=89)		Other Federal Agencies (n=84)		States % (n=77)		TOTAL
	N	%	N	%	N	%	N	%	N
Funding support	34	40%	36	40%	33	39%	34	44%	137
Training (including technical assistance)	7	8%	27	30%	12	14%	8	10%	54
Partnership support	3	3%	2	2%	9	11%	21	27%	35
Public health education/materials support (culturally relevant, including public health education, public health law; communication)	13	15%	14	16%	3	4%	3	4%	33
Staffing support	26	30%	2	2%	2	2%	2	3%	32
Data support	10	12%	10	11%	2	2%	8	10%	30
Honoring the federal trust responsibility through consultation and respecting Tribal sovereignty			3	3%	6	7%	5	6%	14
IT support (including equipment and telehealth)	14	16%							14
Infrastructure support	10	12%							10
Public health accreditation support	1	1%	2	2%	1	1%	3	4%	7
Transportation support	7	8%							7
Loan repayment/forgiveness			1	1%	1	1%	4	5%	6
Public Health Associate Program (PHAP, CDC-specific program) support			4	4%					4
Reimbursement for non-clinical services							4	5%	4

**This table is not an exhaustive list of all needs identified by THOs, but a summary of the most frequently identified needs across respondents.*

Additional Resources – Beyond funding support, staffing support and IT support are the most frequently identified additional resources from THOs. Staffing support includes both recruitment and retention of public health staff to Tribal communities, which often face constraints due to their remote and rural locations. Additionally, several THOs mentioned the need for more community health workers (i.e. CHRs, CHAs, CHAPs, etc.) who have the potential to serve a significant role in bridging the gap between health care, social services, and public health in a culturally relevant way. In terms of IT support, this includes clinically-focused support with electronic health record (EHR) systems, as well as necessary equipment.

CDC – Training, including technical assistance, is the second most identified need from CDC. As identified in the public health workforce section, Tribal communities often lack public health expertise around epidemiology, biostatistics, and public health informatics (which also links to data support, including data access and statistical analysis). The third most identified need from CDC is public health education and material support. THOs explicitly mentioned the need for more culturally-relevant public health materials, as well as support with public health communications within their own Tribal communities.

Other federal agencies – Similar to CDC, THOs identified the need for more training and technical assistance from other federal agencies. In addition to these requests, THOs also identified the need for partnership support, which includes increased multi-sectoral collaboration across federal agencies to avoid siloed public health work and encourage a social determinants of health (SDH) focus.

States – Partnership support is also identified as a need for what states can do to assist Tribal organizations and entities in advancing Tribal public health. In additional to multi-sectoral collaboration, this also includes improving Tribal-state relationships based on communication and respect between the governments with a focus on cross-jurisdictional sharing of services to deliver public health services. In terms of support and/or collaboration, needs identification should be Tribally-led and may vary across Tribes (even within the same state). Partnership support extends to one of the other identified needs, data support and training. Access to data *and* technical expertise to work with data are vital components of improving public health capacity in Tribal communities. Data access entails providing support for AI/AN data collection, including AIs/ANs in data gathering, and sharing data with Tribal communities. One mechanism to support Tribal/state partnerships and data sharing is through the use of memorandums of understanding (MOUs), which can clarify roles and responsibilities to enhance coordination and cooperation between Tribal governments and states.

5.1 SUMMARY

Advancing public health capacity in Tribal communities remains a continued priority across Indian Country. Results from the PHICCS project shed light on both significant opportunities and barriers to achieving this. Specifically, THOs are providing a wide range of public health activities within their Tribal communities, with particular strengths in screening and prevention/education activities. On the other hand, data collection, epidemiology, and/or surveillance (DES) activities; regulation, inspection, or licensing (RIL) activities; and environmental health activities occur less frequently in Tribal communities. Importantly, even though these activities were not as widespread, THOs are still the main provider for these types of public health activities.

The data also demonstrates there is an opportunity for THOs to be more involved in performance improvement, performance management and related-activities reflected in accreditation standards. While just over half of THOs are engaging in quality improvement activities, less than a third[16] are either currently accredited or in the process of applying for public health accreditation. Thus, it is critical to ensure THOs have sufficient resources, support, and staffing to continue and improve upon their current public health work. This includes not only funding support directly provided to Tribal communities, but also continued training, technical assistance and partnerships.

Inadequate public health capacity threatens efforts to advance health equity in Indian Country, and can be traced to Tribal communities being left behind in the development of the modern public health system. Given the unique political status of federally recognized Tribes, federal administration and congressional turnover poses a further barrier to advancing Tribal public health capacity. This demands that Tribes constantly negotiate their positions as sovereign nations to maintain legally warranted resources, leaving less for focusing on the architecture of public health.

16 National Indian Health Board (NIHB). Public Health Indian Country Capacity Scan (PHICCS) Project (Updated October 2019). Retrieved from: https://www.nihb.org/public_health/proj_phiccs.php

However, the unique political status of Tribal nations also presents opportunities for advancing public health capacity through the federal trust responsibility and Tribal sovereignty. As sovereign nations, Tribes have the authority to govern themselves and establish public health law and policy. However, just over half (59%) of THOs report the presence of any type of public health law and/or policy (as enacted by the Tribe) within their Tribal service area. While Tribes have enacted laws, policies and ordinances in the areas of environmental health, violence and injury prevention, agriculture and food safety, and emergency preparedness, continued support is needed in order for Tribes to fully utilize and enact this power.

Health disparities are a critical focus for today's public health agenda. Public health's intersectoral spread enables approaches to factor in the wider determinants of health in tackling disparities, as opposed to strictly focusing on health care access. This means that public health interventions can range from promoting individual healthy behaviors (e.g. increased consumption of fruits and vegetables and stop smoking campaigns) to social interventions such as improving housing access. In order to do this within Tribal communities, however, it is imperative that Tribal public health is adequately resourced. As this report highlights, Tribal-specific funding initiatives are critical to ensuring Tribal public health is no longer left behind in modern development.

REFERENCES

Alaska Native Tribal Health Consortium: History (n.d.). Retrieved from https://anthc.org/who-we-are/history/

Batliner, T. (2016). American Indian and Alaska Native access to oral health care: A potential solution. *Journal of Health Care for the Poor and Underserved*, 27(1), 1-10.

Bauer, U. E. and Plescia, M. (2014). Addressing disparities in the health of American Indian and Alaska Native People: The importance of improved public health data. *American Journal of Public Health*, 104(S3), S255–S257. doi: 10.2105/AJPH.2013.301602

Bryan, R.T., Schaefer, R.M., DeBruyn, L., and Stier, D.D. (2009). Public health legal preparedness in Indian Country. *American Journal of Public Health,* 99(4): 607–614.

Centers for Disease Control and Prevention (CDC). (n.d.). "National Public Health Performance Standards Program (NPHPSP): 10 Essential Public Health Services." Retrieved from http://www.cdc.gov/nphpsp/essentialservices.html_

Cho, P., Geiss, L.S., Rios-Burrows, N., Roberts, D.L., Bullock, A.K., and Toedt, ME. (2014). Diabetes-related mortality among American Indians and Alaska Natives, 1999–2009. *American Journal of Public Health*, 104(S3), S496–S503.

Espey, D.K., Jim, M.A., Cobb, N., Bartholomew, M., Becker, T., Haverkamp, D., and Plescia, M. (2014). Leading causes of death and all-cause mortality in American Indians and Alaska Natives. *American Journal of Public Health*, 104(S3), S303-S311.

Herne, M.A., Bartholomew, M.L., Weahkee, R.L. (2014). Suicide mortality among American Indians and Alaska Natives, 1999–2009. *American Journal of Public Health*, 104(S3), S336–S342.

Indian Health Service (IHS). (n.d.) About IHS. Retrieved from https://www.ihs.gov/aboutihs/

IHS. (n.d.a) Differences between Title I Contracting and Title V Compacting under the Indian Self-Determination Education Assistance Act (ISDEAA). Retrieved from https://www.ihs.gov/selfgovernance/includes/themes/newihstheme/display_objects/documents/TitleIandV.pdf

IHS. (n.d.b) Indian Health Manual. Retrieved from https://www.ihs.gov/ihm/index.cfm?module=dsp_ihm_pc_p3c16#3-16.3C

Institute of Medicine. (1988). *The Future of Public Health*. Retrieved from https://www.nap.edu/catalog/1091/the-future-of-public-health

Murphy, T.M., Pokhrel, P., Worthington, A., Billie, H., Sewell, M., and Bill, N. (2014). Unintentional injury mortality among American Indians and Alaska Natives in the United States, 1990–2009. *American Journal of Public Health*, 104(S3), S470–S480.

National Indian Health Board. (2010). 2010 Tribal Public Health Profile: Exploring Public Health Capacity in Indian Country. Retrieved from https://www.nihb.org/docs/07012010/NIHB_HealthProfile%202010.pdf

Pindus, N. and Hafford, C. (2019). Food Security and Access to Healthy Foods in Indian Country: Learning from the Food Distribution Program on Indian Reservations. Urban Institute. Retrieved from: https://www.urban.org/research/publication/food-security-and-access-healthy-foods-indian-country

Pindus, N., Kingsley, G.T., Biess, J., Levy, D., Simington, J., Hayes, C. (2017). Housing Needs of American Indians and Alaska Natives in Tribal Areas: A Report from the Assessment of American Indian, Alaska Native, and Native Hawaiian Housing Needs. U.S. Department of Housing and Urban Development Office of Policy Development and Research. Retrieved from https://www.huduser.gov/portal/sites/default/files/pdf/HousingNeedsAmerIndians-ExecSumm.pdf

Public Health Accreditation Board: Who is accredited? (2020). Retrieved from https://phaboard.org/who-is-accredited/

Shelton, B.L. (2004). Legal and Historical Roots of Health Care for American Indians and Alaska Natives in the United States. The Henry J. Kaiser Family Foundation Issue Brief. Retrieved from https://www.kff.org/wp-content/uploads/2013/01/legal-and-historical-roots-of-health-care-for-american-indians-and-alaska-natives-in-the-united-states.pdf

Veazie, M., Ayala, C., Schieb, L., Dai, S., Henderson, J. and Cho, P. (2014). Trends and disparities in heart disease mortality among American Indians and Alaska Natives, 1990–2009. *American Journal of Public Health*. 104(S3), S359–S367.

Warne, D. and Frizzell, L.B. (2014). American Indian Health Policy: Historical Trends and Contemporary Issues. *American Journal of Public Health,* 104(S3), S263–S267.

APPENDICES

APPENDIX A

ALL PUBLIC HEALTH ACTIVITIES OCCURRING ACROSS THO SERVICE AREAS

Table 9 NUMBER AND PERCENTAGE OF THO SERVICE AREAS CONDUCTING PUBLIC HEALTH ACTIVITIES

Public Health Activity	# of THO Service Areas	# of THO Respondents	% of THO Service Areas
IMMUNIZATION ACTIVITIES			
Adult immunization	128	134	96%
Child immunization	126	133	95%
SCREENING ACTIVITIES			
Alcohol and other drugs	128	133	96%
Asthma	76	131	58%
Body mass index (BMI)	116	132	88%
Cancer	111	130	85%
Cardiovascular disease (CVD)	108	132	82%
Commercial tobacco use	115	132	87%
Homelessness	61	132	46%
Hunger	44	133	33%
Mental health	121	132	92%
STI	110	133	83%
Suicide	117	132	89%
Trauma	98	133	74%
Type II diabetes	127	132	96%

Public Health Activity	# of THO Service Areas	# of THO Respondents	% of THO Service Areas
PREVENTION AND/OR EDUCATION ACTIVITIES			
Alcohol and other drugs	129	134	96%
Cancer	112	132	85%
Cardiovascular disease (CVD)	116	132	88%
Commercial tobacco use	113	133	85%
Diabetes	132	134	99%
Emergency preparedness	96	129	74%
Food safety	88	132	67%
Injury	101	131	77%
Mental health	114	134	85%
Occupational/worker safety	73	133	55%
Reproductive health	89	134	66%
Suicide	121	134	90%
Trauma	88	133	66%
Weight related health	115	132	87%
DATA COLLECTION, EPIDEMIOLOGY, AND/OR SURVEILLANCE (DES) ACTIVITIES			
Behavioral risk factors	75	130	58%
Chronic disease	84	134	63%
Environmental illness	46	132	35%
Foodborne illness	44	132	33%
Injury	55	132	42%
Other morbidity	53	130	41%
Other communicable or infectious disease	77	134	57%
Syndromic surveillance	32	132	24%
Vital statistics	71	131	54%

Public Health Activity	# of THO Service Areas	# of THO Respondents	% of THO Service Areas
REGULATION, INSPECTION, OR LICENSING (RIL) ACTIVITIES			
Facilities regulation, inspection, and/or licensing	103	132	78%
Medical marijuana regulation, inspection, and/or licensing	13	132	10%
Occupational/worker safety and health regulation, inspection, and/or licensing	66	130	51%
Environmental health regulation, inspection, or licensing activities other than those listed above	44	129	34%
ENVIRONMENTAL HEALTH ACTIVITIES			
Air quality monitoring	60	130	46%
Environmental health and climate issues/climate change/environmental impact	49	132	37%
Groundwater protection	68	132	52%
Hazardous waste disposal	88	131	67%
Public water supply safety	79	131	60%
Sewer/septic pollution	65	129	50%
Vector control	47	128	37%

APPENDIX B

PROVISION OF PUBLIC HEALTH ACTIVITIES BY CATEGORY

- Immunization Activities (p.64)
- Screening Activities (pp.64-65)
- Prevention/Education Activities (pp.65-66)
- Data Collection, Epidemiology, and/or Surveillance Activities (p.67)
- Regulation, Inspection, or Licensing Activities (p.67)
- Environmental Health Activities (p.68)

Table 10 NUMBER AND PERCENTAGE OF THO SERVICE AREAS CONDUCTING IMMUNIZATION ACTIVITIES

Immunization Activity	# of THO Service Areas	# of THO Respondents	% of THO Service Areas
Adult immunization	128	134	96%
Child immunization	126	133	95%

Table 11 NUMBER OF ORGANIZATIONS CONDUCTING IMMUNIZATION ACTIVITIES BY PROVIDER TYPE

Immunization Activity	THO	IHS	Other Tribal Dept	Other Tribal Org	Local Health Dept	State Health Dept	Private/ Nonprofit	TEC	UIHP	Other
Adult immunization (n=128)	103	35	15	14	32	13	33	0	4	5
Child immunization (n=126)	98	32	14	13	36	21	33	0	3	4

Table 12 NUMBER AND PERCENTAGE OF THO SERVICE AREAS CONDUCTING SCREENING ACTIVITIES

Screening Activity/Service	# of THO Service Areas	# of THO Respondents	% of THO Service Areas
Alcohol and other drugs	128	133	96%
Asthma	76	131	58%
Body mass index (BMI)	116	132	88%
Cancer	111	130	85%
Cardiovascular disease (CVD)	108	132	82%
Commercial tobacco use	115	132	87%
Homelessness	61	132	46%
Hunger	44	133	33%
Mental health	121	132	92%
Sexually transmitted infections (STIs)	110	133	83%
Suicide	117	132	89%
Trauma	98	133	74%
Type II diabetes	127	132	96%

Table 13 NUMBER OF ORGANIZATIONS CONDUCTING SCREENING ACTIVITIES BY PROVIDER TYPE

Screening Activity/Service	THO	IHS	Other Tribal Dept	Other Tribal Org	Local Health Dept	State Health Dept	Private/ Nonprofit	TEC	UIHP	Other
Alcohol and other drugs (n=128)	110	15	25	19	15	7	37	0	3	8
Asthma (n=74)	59	14	9	7	8	4	25	0	2	2
Body mass index (BMI) (n=116)	99	22	22	18	13	4	30	0	3	5
Cancer (n=110)	86	23	17	13	15	11	40	1	3	11
Cardiovascular disease (CVD) (n=107)	92	23	17	10	8	5	37	1	3	7
Commercial tobacco use (n=114)	96	27	20	15	16	7	28	2	4	5
Homelessness (n=61)	49	7	19	10	9	4	13	1	2	6
Hunger (n=44)	37	4	15	6	6	1	13	1	1	6
Mental health (n=121)	105	23	26	18	19	12	37	1	5	6
STI (n=110)	91	25	18	12	30	20	32	1	3	5
Suicide (n=117)	100	22	30	17	24	14	34	2	6	9
Trauma (n=98)	84	15	26	16	13	3	23	1	4	7
Type II diabetes (n=127)	111	30	27	19	12	4	35	1	4	7

Table 14 NUMBER AND PERCENTAGE OF THO SERVICE AREAS CONDUCTING PREVENTION/EDUCATION ACTIVITIES

Prevention/Education Activity	# of THO Service Areas	# of THO Respondents	% of THO Service Areas
Alcohol and other drugs	129	134	96%
Cancer	112	132	85%
Cardiovascular disease (CVD)	116	132	88%
Commercial tobacco use	113	133	85%
Diabetes	132	134	99%
Emergency preparedness	96	129	74%
Food safety	88	132	67%
Injury	101	131	77%
Mental health	114	134	85%
Occupational/worker safety	73	133	55%
Reproductive health	89	134	66%
Suicide	121	134	90%
Trauma	88	133	66%
Weight related health	115	132	87%

Table 15 NUMBER OF ORGANIZATIONS CONDUCTING PREVENTION/EDUCATION ACTIVITIES BY PROVIDER TYPE

Prevention/Education Activity	THO	IHS	Other Tribal Dept	Other Tribal Org	Local Health Dept	State Health Dept	Private/ Nonprofit	TEC	UIHP	Other
Alcohol and other drugs (n=127)	113	23	36	32	21	13	37	0	3	11
Cancer (n=112)	95	24	29	17	25	15	41	5	2	9
Commercial tobacco use (n=112)	97	23	29	14	25	15	26	8	2	7
Cardiovascular disease (CVD) (n=116)	99	26	28	20	15	10	36	4	4	3
Type II diabetes (n=131)	122	32	28	24	23	13	30	5	4	6
Emergency preparedness (n=96)	78	7	41	24	27	25	16	1	1	11
Food safety (n=88)	40	28	15	10	17	20	8	0	0	7
Injury (n=101)	87	21	26	17	27	8	18	2	3	8
Mental health (n=114)	100	18	33	16	16	10	29	2	2	11
Occupational/worker safety (n=73)	55	6	24	10	4	5	10	0	0	7
Reproductive health (n=89)	72	14	21	10	18	14	21	2	1	7
Suicide (n=120)	103	18	38	27	17	16	30	5	5	13
Trauma (n=88)	70	5	23	16	10	5	18	1	0	6
Weight related health (n=115)	103	25	31	25	16	9	29	0	3	7

Table 16 NUMBER AND PERCENTAGE OF THO SERVICE AREAS CONDUCTING DATA COLLECTION, EPIDEMIOLOGY, AND/OR SURVEILLANCE (DES) ACTIVITIES

DES Activity	# of THO Service Areas	# of THO Respondents	% of THO Service Areas
Behavioral risk factors	75	130	58%
Chronic disease	84	134	63%
Environmental illness	46	132	35%
Foodborne illness	44	132	33%
Injury	55	132	42%
Morbidity	53	130	41%
Other communicable/infectious disease	77	134	57%
Syndromic surveillance	32	132	24%
Vital statistics	71	131	54%

Table 17 NUMBER OF ORGANIZATIONS CONDUCTING DATA COLLECTION, EPIDEMIOLOGY, AND/OR SURVEILLANCE (DES) ACTIVITIES BY PROVIDER TYPE

DES Activity	THO	IHS	Other Tribal Dept	Other Tribal Org	Local Health Dept	State Health Dept	Private/ Nonprofit	TEC	UIHP	Other
Behavioral risk Factors (n=75)	62	8	13	7	10	13	11	19	1	11
Chronic disease (n=84)	69	23	15	8	14	23	10	20	1	4
Environmental illness (n=46)	27	8	12	5	9	14	4	11	0	7
Foodborne illness (n=44)	26	11	10	3	13	18	3	5		1
Injury (n=55)	43	13	13	7	7	11	5	13	0	4
Syndromic surveillance (n=32)	15	7	3	1	11	17	7	3	1	0
Vital statistics (n=71)	44	12	11	9	16	28	7	20	1	3
Other communicable/ infectious disease (n=77)	53	17	15	7	29	41	7	13	1	5
Other morbidity (n=53)	40	15	12	6	12	21	5	16	1	1

Table 18 NUMBER AND PERCENTAGE OF THO SERVICE AREAS CONDUCTING REGULATION, INSPECTION, OR LICENSING (RIL) ACTIVITIES

Regulation, Inspection, or Licensing Activity	# of THO Service Areas	# of THO Respondents	% of THO Service Areas
Facilities	103	132	78%
Medical marijuana	13	132	10%
Occupational/worker safety and health	66	130	51%
Other environmental health RIL activities	44	129	34%

Table 19 NUMBER OF ORGANIZATIONS CONDUCTING REGULATION, INSPECTION, OR LICENSING (RIL) ACTIVITIES BY PROVIDER TYPE

RIL Activity	THO	IHS	Other Tribal Dept	Other Tribal Org	Local Health Dept	State Health Dept	Private/ Nonprofit	TEC	UIHP	Other
Facilities (n=103)	48	40	21	10	23	37	14	1	0	16
Medical marijuana (n=13)	5	0	1	1	2	5	2	0	0	2
Occupational/worker safety and health (n=65)	31	20	15	6	7	15	14	0	0	10
Other environmental health RIL activities (n=44)	17	16	16	12	10	9	7	0	0	5

Table 20 NUMBER AND PERCENTAGE OF THO SERVICE AREAS CONDUCTING ENVIRONMENTAL HEALTH ACTIVITIES

Environmental Health Activity	# of THO Service Areas	# of THO Respondents	% of THO Service Areas
Air quality monitoring	60	130	46%
Environmental health and climate issues/ climate change/environmental impact	49	132	37%
Groundwater protection	68	132	52%
Hazardous waste disposal	88	131	67%
Public water supply safety	79	131	60%
Sewer/septic pollution	65	129	50%
Vector control	47	128	37%

Table 21 NUMBER OF ORGANIZATIONS CONDUCTING ENVIRONMENTAL HEALTH ACTIVITIES BY PROVIDER TYPE

Environmental Health Activity	THO	IHS	Other Tribal Dept	Other Tribal Org	Local Health Dept	State Health Dept	Private/ Nonprofit	TEC	UIHP	Other
Air quality monitoring (n=59)	24	5	19	13	9	10	4	1	0	10
Environmental health and climate issues/ climate change/environmental impact (n=49	24	8	21	10	2	4	10	2	0	8
Groundwater protection (n=67)	28	17	29	18	9	9	4	0	0	7
Hazardous waste disposal (n=88)	45	11	26	15	9	5	25	0	0	13
Public water supply safety (n=77)	30	16	31	22	14	9	7	0	0	8
Sewer/septic pollution (n=65)	25	15	27	18	10	9	7	0	0	7
Vector control (n=47)	22	9	16	8	11	6	7	1	0	7

APPENDIX C

LIST OF PUBLIC HEALTH NEEDS AND PRIORITIES FROM PHICCS QUESTIONNAIRE

Public health issues

- Accidents or unintentional injuries
- Cancer
- Diabetes
- Heart disease
- Infectious disease (not including Influenza)
- Influenza and pneumonia
- Kidney disease
- Liver disease
- Respiratory disease
- Stroke
- Substance misuse
- Suicide

Public health priorities (as they relate to non-programmatic and infrastructure-building capacities and activities)

- Data and assessment
- Enforcement
- Evaluation
- Health education and health promotion
- Partnership development
- Planning
- Policy development
- Quality improvement and performance management
- Research
- Surveillance and investigation
- Workforce development

APPENDIX D

PHICCS CROSSWALK ANALYSIS BY NORC

Public Health in Indian Country Capacity Scan (PHICCS) Crosswalk Analysis

Presented To: National Indian Health Board (NIHB)
Presented By: NORC at the University of Chicago
4350 East-West Highway, Suite 800
Bethesda, Maryland 20814
Date: June 24, 2020

Introduction

The National Indian Health Board (NIHB) conducted the 2019 Public Health in Indian Country Capacity Scan (PHICCS) to assess the public health activities and services provided across Indian Country.[17] At the national level, the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO) routinely field surveys designed to assess the activities, services, and capacity of state and insular area (U.S. territories and freely associated states) and local (city and county) health departments, respectively. To determine alignment between the 2019 PHICCS instrument, the 2016 ASTHO Profile Survey Questionnaire for States[18] ("ASTHO Profile"), and the 2016 NACCHO Profile Questionnaire for Local Health Departments[19] ("NACCHO Profile"), NIHB contracted with NORC at the University of Chicago to develop a crosswalk, conduct a targeted analysis of PHICCS data, and compare responses to comparable measures

17 National Indian Health Board (NIHB). *Public Health Indian Country Capacity Scan (PHICCS) Project (Updated October 2019)*. Retrieved from: https://www.nihb.org/public_health/proj_phiccs.php https://www.nihb.org/docs/10162018/NIHB_Copy%20of%20PHICCS%20Instrument_Oct%202018.pdf

18 ASTHO. *2016 ASTHO Profile Survey*. Retrieved from: https://www.astho.org/Profile/Volume-Four/2016-ASTHO-Profile-Survey-Questionnaire-State/

19 National Profile of Local Health Departments. *2016 NACCHO Profile Questionnaire for Local Health Departments*. Retrieved from: http://nacchoprofilestudy.org/data-requests/

across tribal health organizations, state/insular area health agencies, and local health departments. This brief report describes the project methods, including crosswalk development; findings from the crosswalk analysis; and conclusions.

Methods

Crosswalk Development. To identify alignment across the 2019 PHICCS instrument, 2016 ASTHO Profile, and 2016 NACCHO profile, NORC obtained a copy of each instrument and compared their content to identify similar or identical measures. The PHICCS instrument consisted of 129 questions organized into the following sections: Demographic/Background Information, Public Health Activities, Public Health Workforce, Public Health Needs and Priorities, Public Health Authority, and Additional Comments. To develop the crosswalk, the questions within the PHICCS instrument were reviewed and compared to questions in the ASTHO Profile and NACCHO Profile instruments to determine whether the wording or content of the questions were identical, similarly worded, or did not match. Identical and similar questions in all three instruments were included in the crosswalk. Similar measures identified across two of the three instruments were excluded from the crosswalk. Questions with similar wording but slight differences in phrasing, which resulted in major differences in question meaning, were also excluded from the crosswalk.

The crosswalk identified 43 measures that were either identical of similarly worded across the PHICSS, ASTHO Profile, and NACCHO Profile survey instruments within three domains: public health activities, including direct service provision, epidemiology and data collection, and surveillance (21 measures); assessment, quality improvement, and accreditation (6 measures); and public health workforce (16 measures). The final crosswalk is available in Appendix A.

Data Analysis. In December 2019, NORC obtained the de-identified PHICCS dataset from NIHB through an approved data use agreement. NORC calculated summary statistics (e.g., frequency, percentage, mean, and median) and obtained comparable summary data from the publicly available ASTHO and NACCHO Profile reports.[20],[21],[22] For PHICCS data on public health activities (direct service provision, epidemiology and data collection, and surveillance), we reported the percentage of respondents that indicated that Tribal Health Organizations (THOs) provided the service. Therefore, the public health activities data excludes information on other entities that may provide the service within the THO's service area. Analysis was limited to the measures within the crosswalk, the publicly available data from ASTHO and NACCHO, and the data provided by NIHB.

Limitations. There are several limitations of the PHICCS data. Primarily, the overall response rate to the PHICCS survey (46 percent) was lower than the overall response rate to the ASTHO Profile (97 percent among all states, DC, territories, and freely associated states)[4] and to the NACCHO Profile (76 percent).[5] The lower response rate may point to differences between PHICCS respondents and non-respondents and may limit the generalizability of findings to all tribal entities. There was also variable response between PHICCS questions. In particular, the public health workforce measures had lower response rates compared to other measures (as low as 27 percent), which may further reduce the generalizability of those data for all tribal entities. Additional information regarding these limitations is available in the *Public Health Workforce* findings. Additionally, since we did not conduct inferential statistics for the analysis of survey data, the results are not generalizable to all tribal entities. There were also analysis limitations due to the types of data available. While individual responses to PHICCS measures were available, the ASTHO and NACCHO data were reported as summary statistics calculated by their respective organizations. As such, the comparative analyses of the PHICCS data were mirrored to the parameters of the

20 ASTHO. *ASTHO Profile of State and Territorial Public Health, Volume Four*. (2017). Retrieved from: https://www.astho.org/Profile/Volume-Four/2016-ASTHO-Profile-of-State-and-Territorial-Public-Health/

21 NACCHO. *2016 National Profile of Local Health Departments: Main Report*. (2017). Retrieved from: http://nacchoprofilestudy.org/wp-content/uploads/2017/10/ProfileReport_Aug2017_final.pdf

22 NACCHO. *2016 National Profile of Local Health Departments: Highlights Report*. (2017). Retrieved from: http://nacchoprofilestudy.org/wp-content/uploads/2017/10/Summary_Report_Oct2017_Final.pdf

ASTHO and NACCHO analyses. Additionally, while the sample size for each PHICCS question is known, ASTHO and NACCHO reported a range of sample sizes for measures with a variety of response options (e.g., a measure about immunization administration featured two response options — one specific to childhood immunizations and one specific to adult immunizations), so the response rate for each possible answer is unknown.

FINDINGS

The crosswalk analysis addressed the following topics: public health activities; assessment, quality improvement, and accreditation; and the public health workforce. For each topic, we compared responses from tribal, state, insular area, and local health departments for the identified measures in the crosswalk.

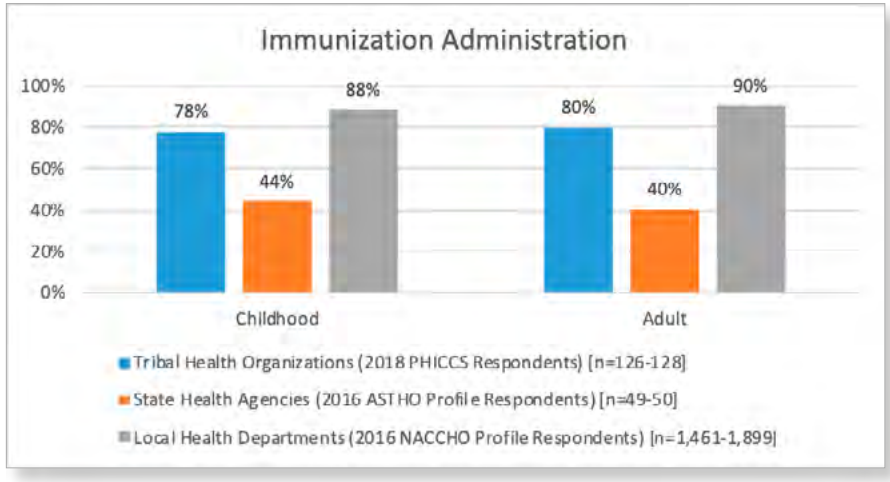
PUBLIC HEALTH ACTIVITIES

The crosswalk identified 21 similar measures across four public health activities: immunizations, screenings for diseases and conditions, population-based primary prevention activities, and activities related to data collection, epidemiology, and surveillance. For tribal responses, we reported the percentage of respondents who indicated that their own organization, the "Tribal Health Organization-Respondent," (THO) provided the activity or service directly. For state and local responses, we reported the percentage of state health agencies (SHAs) and local health departments (LHDs), respectively, that performed the service or activity directly. Data from insular area health agencies were not available.

(1) Immunizations

Exhibit 1 presents the proportion of health departments that directly administered immunizations. Over three quarters of THOs and LHDs directly administered vaccinations, and less than half of SHAs provided this service directly. Fewer THOs provided both childhood and adult immunizations than LHDs.

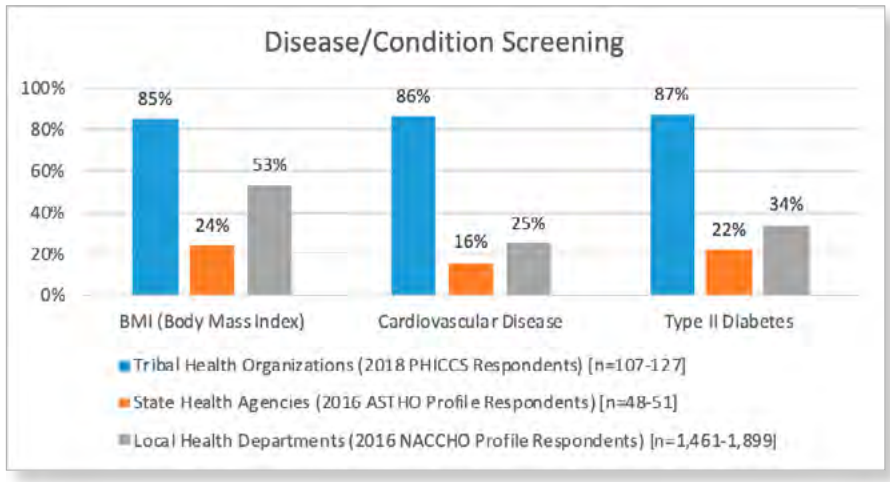
Exhibit 1 PROPORTION OF AGENCIES THAT DIRECTLY ADMINISTERED IMMUNIZATIONS



(2) Screening for Diseases and Conditions

More than 85 percent of THOs provided screenings for selected chronic conditions, including body mass index (BMI), cardiovascular disease, and type II diabetes, compared to less than half of LHDs and less than a quarter of SHAs (Exhibit 2). A greater proportion of LHDs provided each screening activity than SHAs.

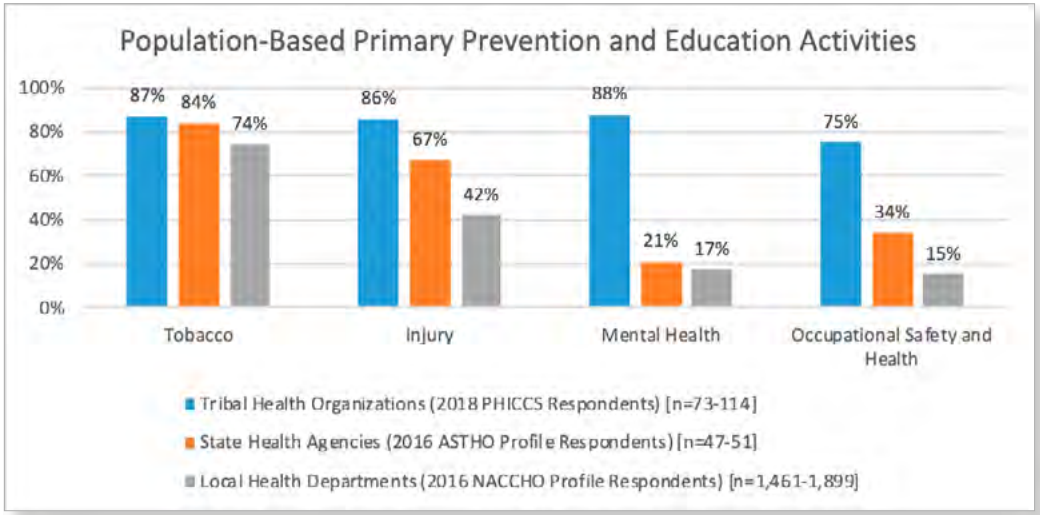
Exhibit 2 PROPORTION OF AGENCIES THAT DIRECTLY PROVIDED DISEASE/CONDITION SCREENING



(3) Population-Based Primary Prevention Activities

Overall, a greater proportion of THOs conducted the population-based primary prevention and education activities in the crosswalk, compared to the same prevention services provided by SHAs and LHDs (see Exhibit 3). Over three quarters of THOs conducted primary prevention and education activities for commercial tobacco use, injury, mental health, and occupational safety and health. A substantially larger proportion of THOs provided mental health education services as well as occupational safety education services compared to SHAs and LHDs.

Exhibit 3 PROPORTION OF AGENCIES THAT ENGAGED IN POPULATION-BASED PRIMARY PREVENTION AND EDUCATION ACTIVITIES

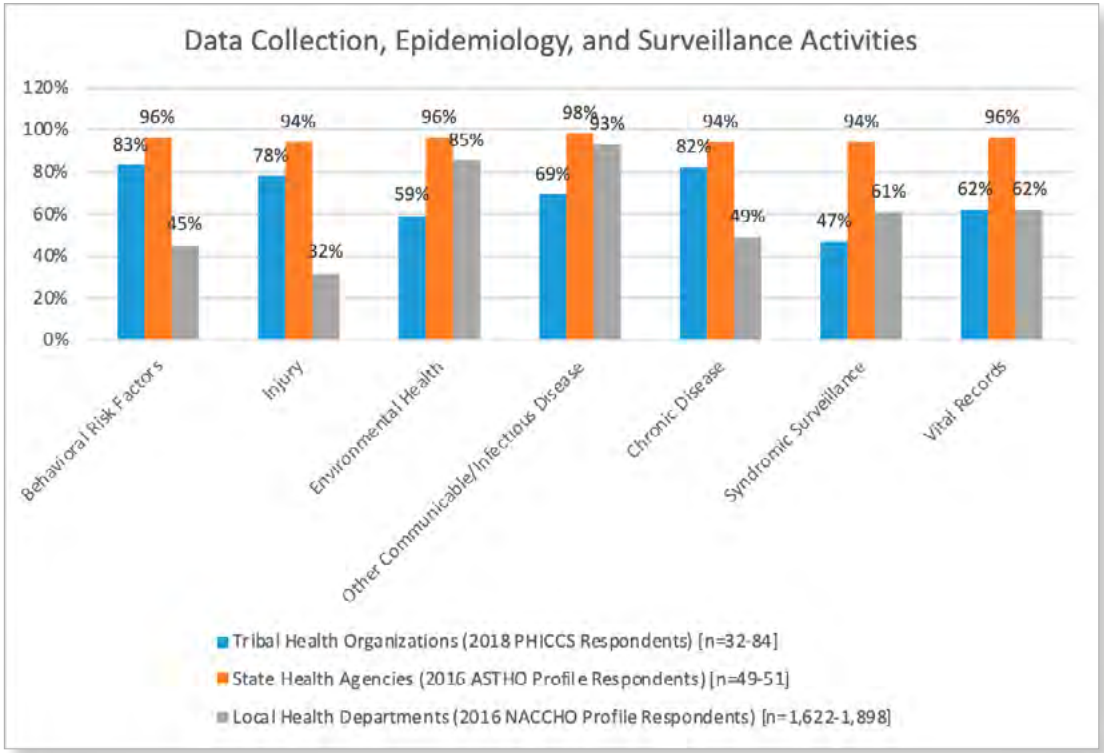


(4) Data Collection, Epidemiology, and Surveillance Activities

There was substantial variation in measure-specific sample sizes among PHICCS questions about data collection, epidemiology, and surveillance activities. More than 80 entities responded to the chronic disease measure, while approximately 30 responded to the measure about syndromic surveillance and data collection. The variation in sample sizes may result in an underestimation of the proportion of THOs that conducted the activities and the sample may not be representative of all THOs. These limitations should be considered when interpreting the comparisons below.

Exhibit 4 presents the proportion of agencies that engaged in data collection, epidemiology, and surveillance activities. Approximately 60 percent or more of THOs that responded to these questions conducted data collection, epidemiology, and surveillance activities, with the exception of just under half that managed vital records. Nearly all SHAs conducted these activities, while data and surveillance activities varied among LHDs. Activities related to other communicable/infectious diseases were provided by nearly 70 percent of THOs and 90 percent or more of SHAs and LHDs. While the lowest proportion of LHDs conducted surveillance and data collection activities related to injury, behavioral risk factors, and chronic disease, the highest proportion of THOs conducted these activities.

Exhibit 4 PROPORTION OF AGENCIES THAT ENGAGED IN DATA COLLECTION, EPIDEMIOLOGY, AND SURVEILLANCE ACTIVITIES



ASSESSMENT, QUALITY IMPROVEMENT, AND ACCREDITATION

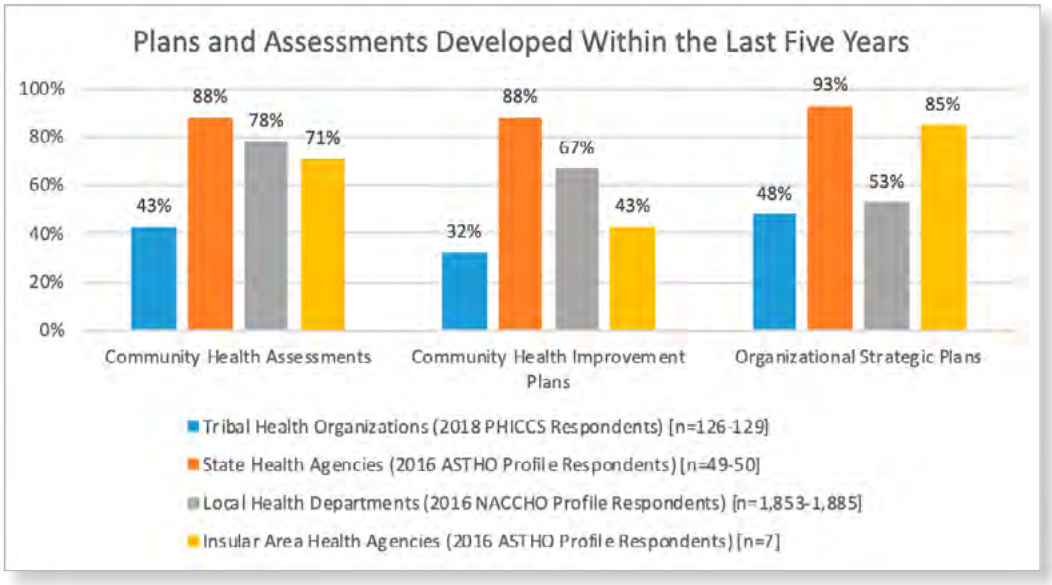
The crosswalk identified seven identical and similarly worded questions related to assessment, quality improvement, and accreditation across the three instruments. For each item below we compared tribal, state, insular area, and local health department responses to their respective surveys.

(5) Assessment and Planning

The crosswalk shows variation in the wording of questions regarding community health assessments (CHAs), community health improvement plans (CHIPs), and organizational strategic plans. PHICCS respondents could indicate that an assessment or plan was developed in the last five years, more than five years ago, or is currently in development. ASTHO and NACCHO respondents could indicate that an assessment or plan was developed in the last three years, more than three years but less than five years, or five or more years ago.

Exhibit 5 presents the proportion of agencies that developed a CHA, a CHIP, and an organizational strategic plan within the last five years. Less than one half of THOs had developed a CHA or organizational strategic plan in the past five years (as of 2019), and less than one third had created a CHIP in that timeframe. In contrast, the majority of state and insular area health agencies and LHDs had developed a CHA, CHIP, and organizational strategic plan within the last five years (as of 2016). The proportion of SHAs that developed these plans and assessments is more than double that of THOs.

Exhibit 5 PROPORTION OF AGENCIES THAT DEVELOPED ASSESSMENTS AND PLANS WITHIN THE LAST FIVE YEARS*

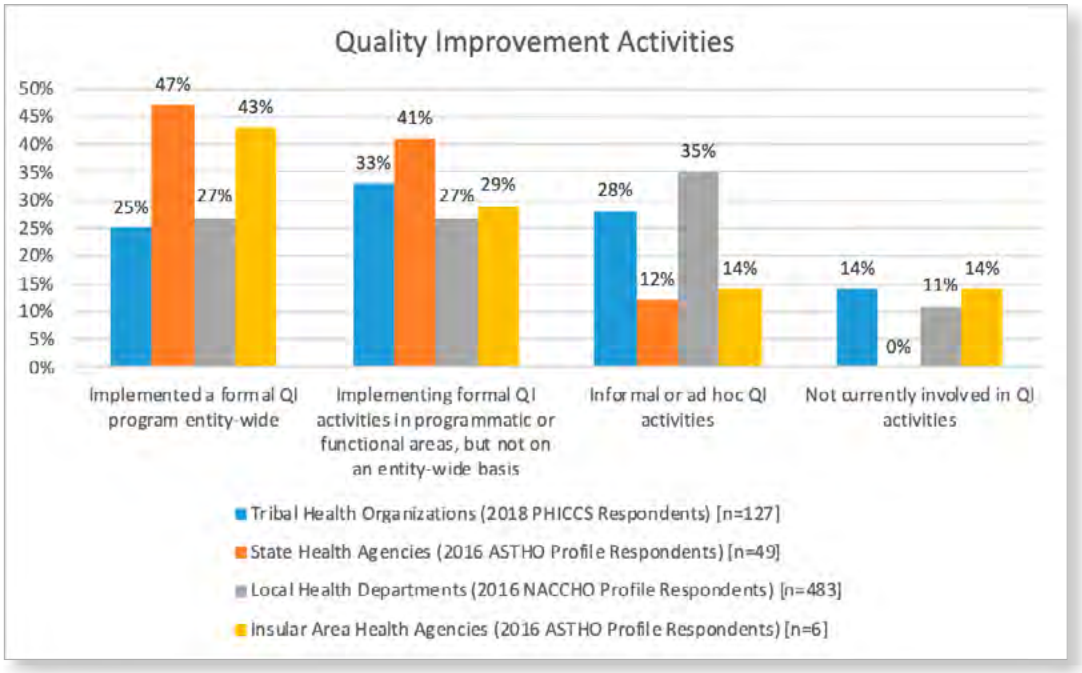


**Given the differences in measures between the survey instruments, the percentages of THOs reflect those that selected "in the last five years" for each question, whereas the percentages of state and insular area health agencies and LHDs reflect a combination of those that selected "within the last three years" and "more than three but less than five years ago" for each question.*

(6) Quality Improvement

Exhibit 6 presents the proportion of agencies that engaged in quality improvement (QI) activities. For each item, approximately one-quarter of THOs and LHDs selecting each response option regarding their agency's QI activities. By comparison, a majority of SHAs had implemented formal QI activities on either an agency-wide basis or within program areas. Among LHDs, this measure had a much smaller response rate (n=483) than other measures in the entire crosswalk.

Exhibit 6 PROPORTION OF AGENCIES THAT ENGAGED IN QUALITY IMPROVEMENT (QI) ACTIVITIES

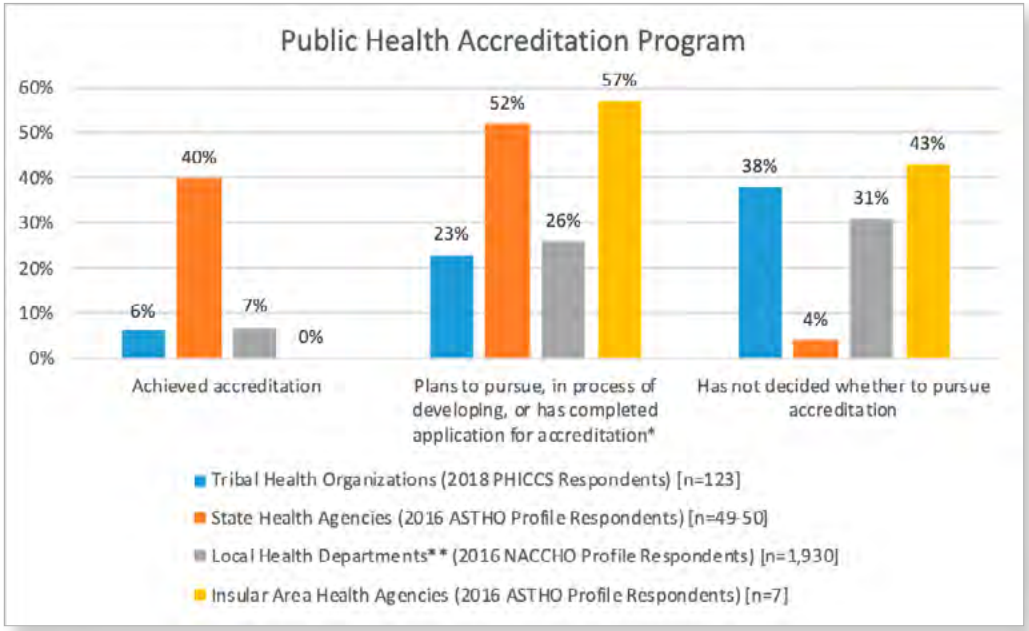


(7) Public Health Accreditation

Exhibit 7 presents the proportion of agencies engaged in the Public Health Accreditation Board (PHAB) public health department accreditation program. The majority (38 percent) of THOs had not made a decision about whether to pursue accreditation and about one-quarter (23 percent) planned to apply, were in the process of applying, or had applied for accreditation. This was comparable to LHD responses. Among SHAs, 40 percent were accredited and over half were in the process of pursuing accreditation.

Specific to THOs, 15 percent were not familiar with public health accreditation and 18 percent indicated that the program was not applicable to their entities. With regard to non-tribal entities, four percent of SHAs decided to not apply for the program; no insular area health agencies had made the decision to not pursue accreditation. In contrast, one in five (20%) LHDs decided to not apply. Five percent of LHDs did not know their organization's status regarding accreditation.

Exhibit 7 **PROPORTION OF AGENCIES ENGAGED IN THE PUBLIC HEALTH ACCREDITATION PROGRAM**



**Consolidates state, insular area, and local measures that track application status beyond not having registered in e-PHAB (e.g., has registered in e-PHAB; has submitted an application for accreditation), excluding having achieved accreditation.*
***Includes independent LHDs part of an integrated system. The data made publicly available do not sum to 100 percent.*

PUBLIC HEALTH WORKFORCE

The crosswalk identified 16 identical or similar questions related to public health workforce. The PHICCS workforce measures yielded substantially smaller response rates than the other measures in the crosswalk. These data were analyzed as reported by NIHB although several discrepancies were identified. For some responses, the reported number of FTEs per occupational classification did not sum to the reported total number of FTEs. We were also unable to confirm whether a blank response should indicate zero FTEs and conversely whether a response of zero may indicate a skip. Because data cleaning and validation were beyond the scope of this study, we did not verify or correct responses that appeared to be errors. These limitations should be considered when interpreting the comparisons below.

Total Staff and Full-Time Equivalents. PHICCS respondents were asked to report the current number of public health staff members, including temporary and contract workers; ASTHO respondents were asked to report the current number of staff members working in the agency, including temporary and contract workers; and NACCHO respondents were asked to report how many individuals currently work for the LHD, including regular full-time, part-time, and contractual employees. Overall, the total staff and FTEs across all THOs was substantially smaller than the total staff and FTEs across all SHAs and LHDs (see Exhibit 8).

Exhibit 8 TOTAL STAFF MEMBERS AND FTES REPORTED

	THOs (n=130)	SHAs (n=49)	Insular Area Health Agencies (n=6-7)	LHDs (n=1,828-1,743)
Total Staff Members	1,739	101,009	6,527	147,000
Total FTEs	1,904	96,902	6,523	133,000

Occupational Classifications. Exhibit 9 summarizes the FTEs reported by tribal, state, and local health departments for each occupational classification. We report mean, median, and total FTEs for THOs; mean and median FTEs for state and insular area health agencies; and total FTEs for LHDs. These data reflect the summary statistics available in the ASTHO and NACCHO Profile reports.

Exhibit 9 MEAN, MEDIAN, AND TOTAL FTES BY OCCUPATIONAL CLASSIFICATION*

	THOs (n=30-79)			SHAs (n=34-46)			Insular Area Health Agencies (n=6-7)			LHDs (n=1,611-1,828)		
	Mean	Median	Total	Mean	Median	Total	Mean	Median	Total	Mean	Median	Total (est.)
Agency leadership	3.0	2.0	236	43.3	18.5	—	42.0	7.0	—	—	—	7,000
Business and financial operations staff	4.0	2.0	222	276.7	90.6	—	43.0	15.0	—	—	—	6,000
Preparedness staff	0.9	0.8	44	20.1	18.0	—	20.0	7.0	—	—	—	2,100
Environmental health worker	1.1	0.0	45	143.3	61.0	—	38.0	11.0	—	—	—	13,000
Epidemiologist/ Statistician	0.2	0.0	6	63.5	46.0	—	14.0	2.0	—	—	—	1,600
Laboratory worker	1.6	1.0	74	83.0	58.0	—	21.0	6.0	—	—	—	1,600
Behavioral health staff	6.6	3.0	429	230.9	0.0	—	150.0	17.0	—	—	—	3,200
Nutritionist	1.0	0.8	52	49.3	17.0	—	34.0	7.0	—	—	—	4,900
Office and administrative support	4.2	2.0	276	310.2	160.0	—	164.0	19.0	—	—	—	23,700
Oral health professional	3.0	2.0	165	13.9	3.0	—	8.0	5.0	—	—	—	1,800
Health educator	1.1	1.0	47	51.6	27.0	—	19.0	8.0	—	—	—	5,700
Public health physician	0.9	0.0	37	15.4	4.0	—	9.0	6.0	—	—	—	1,400
Public information specialist	0.2	0.0	7	5.8	4.0	—	1.0	1.0	—	—	—	540

**Mean and median numbers are rounded to one decimal point.*

Among THOs, the occupational classification with the largest median FTE was behavioral health staff (3 FTE). Other occupational classifications with one or more median FTE included agency leadership, business and financial operations staff, laboratory workers, office and administrative support, oral health professionals, health educators, and public health nurses. Among SHAs, over half of median FTEs were dedicated to office and administrative support and business and financial operations. In contrast, just over one third of median FTEs and just over one quarter of median FTEs among THOs and insular area health agencies, respectively, reflected these roles. Other occupational classifications with a large number of median FTEs among SHAs included environmental health workers, laboratory workers, public health nurses, and epidemiologists or statisticians. The occupational classification with the greatest median FTEs among insular area health agencies were public health nurses, followed by office and administrative support, behavioral health staff, business and finance operations, and environmental health workers. LHDs dedicated the greatest number of FTEs to office

and administrative support, public health nurses, and environmental health workers

.

CONCLUSION

The PHICCS crosswalk revealed moderate alignment across the existing tribal, state/ insular area, and local health department survey instruments designed to assess and describe the activities, services, and capacity of health departments. Approximately one-third of tribal measures aligned with the state/insular area and local health department measures (43 of 129 measures in PHICCS were identical or similar to measures in the ASTHO and NACCHO Profile surveys). Alignment was identified in several topic areas – public health activities (21 measures); assessment, quality improvement, and accreditation (6 measures); and public health workforce (16 measures).

The crosswalk analysis provided insights into the comparability of services, activities, and capacities of tribal, state/insular area, and local health departments. With regard to public health activities, it appeared that a larger proportion of THOs engaged in direct service provision than SHAs and LHDs, specifically screening for select chronic conditions and primary prevention activities for mental health and occupational health and safety. One possible explanation for these differences is that other agencies may be responsible for providing these activities within a given jurisdiction or service area. The majority of THOs and SHAs engaged in most of the data collection and surveillance activities in the crosswalk; in contrast, LHDs inconsistently engaged in these activities. While most SHAs conducted QI activities on an agency-wide or programmatic basis, and most insular areas had informal or ad hoc activities, both THOs and LHDs had a more even spread across varies levels of QI engagement, including formal, entity-wide QI programs, formal QI activities, and informal or ad hoc activities. THOs and LHDs also reported similar levels of engagement with accreditation — spread across various stages of participation, with most tribes unsure whether to pursue accreditation — whereas most SHAs were engaged with the program and the majority of insular area health agencies were in the process of applying. With regard to public health workforce, SHAs dedicated a larger proportion of their workforce to leadership and business or administrative operations compared to THOs, insular area health agencies, or LHDs. In contrast, these health departments typically reported a larger proportion of staff in the field, such as behavioral health workers, public health nurses, and oral health professionals.

Various aspects of the available data present limitations to our analyses. As discussed, the relatively low overall response rate to the PHICCS, and particularly the variability of response rates between measures, inhibited the representativeness of the data across all tribal organizations. Further, we did not clean or validate the PHICCS data, but rather analyzed the data as provided by NIHB. Further data verification may be beneficial for future analyses, particularly for the workforce data. Beyond data quality considerations, the available data reflect only the services provided and workforce employed directly by each individual health department that responded to the survey; therefore, the data are not reflective of all services provided within a given jurisdiction or service area. In particular, the tribal public health activities data reflects the services provided by THOs directly, and excludes data on the percentage of other entities that provide the service within the jurisdiction. While alignment across survey instruments is beneficial for comparing the services and activities of tribal, state/insular area, and local health departments, not all measures may be appropriate for all health departments, given that agencies may differ by governance structure, capacity, authority, and other characteristics. Continued alignment of measures will facilitate future comparisons, but all comparisons drawn from the available data must account for data quality and the role of each type of health department.

Appendix A: Crosswalk

The 2019 Public Health in Indian Country Capacity Scan (PHICCS) compared to the 2016 Association of State and Territorial Health Officials (ASTHO) and 2016 National Association of County and City Health Officials (NACCHO) Profile Surveys.

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
Public Health Activities		Activities		Activities	
The following set of questions asks about both immunization and screening services offered in the Tribal Organization/Entity's service area.		**Immunizations — administration of vaccine to population. (For EACH cell, select Yes or No)**		**Immunization** **6. For each activity, check whether and how your LHD and other organizations provided that activity or service in your jurisdiction during the past year. (For each row, select all that apply)**	
Who provided the child immunization services or activities in the Tribal Organization/Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Childhood immunizations	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Childhood immunizations	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
Who provided the adult immunization services or activities in the Tribal Organization/Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Adult immunizations	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Adult immunizations	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
		Screening for diseases/conditions. (For EACH cell, select Yes or No)		**Screening for Diseases/Conditions** **7. For each activity, check whether and how your LHD and other organizations provided that activity or service in your jurisdiction during the past year. (For each row, select all that apply)**	

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
Who provided the body mass index (BMI) screening services or activities in the Tribal Organization/Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Body Mass Index (Obesity)	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	BMI (Body Mass Index)	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
Who provided the cardiovascular disease screening services or activities in the Tribal Organization/Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Cardiovascular disease	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Cardiovascular disease	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
Who provided the type II diabetes screening services or activities in the Tribal Organization/Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Diabetes	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Diabetes	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
The following questions ask about prevention and/or education activities offered in the Tribal Organization/Entity's service area.		**Population-based primary prevention services. (For EACH cell, select Yes or No)**		**Population-based Primary Prevention Activities** **12. For each activity, check whether and how your LHD and other organizations provided that activity or service in your jurisdiction during the past year. (For each row, select all that apply)**	
Who provided the commercial tobacco use prevention and/or education activities in the Tribal Organization/ Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Tobacco	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Tobacco	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
Who provided the injury prevention and/ or education activities in the Tribal Organization/ Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Injury	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Injury	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
Who provided the mental health education activities in the Tribal Organization/ Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Mental health education and prevention services	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Mental illness	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
Who provided the occupational/worker safety education activities in the Tribal Organization/ Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Occupational safety and health services	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Occupational safety and health	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
The following questions ask about data collection, epidemiology, and/or surveillance activities offered in the Tribal Organization/ Entity's service area.		**Data collection, epidemiology and surveillance activities. (For EACH cell, select Yes or No)**		**Epidemiology and Surveillance Activities 11. For each activity, check whether and how your LHD and other organizations provided that activity or service in your jurisdiction during the past year. (For each row, select all that apply)**	
Who provided the behavioral risk factors data collection, epidemiology, and/or surveillance activities in the Tribal Organization/ Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Behavioral risk factors	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Behavioral risk factors	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
Who provided the injury data collection, epidemiology, and/or surveillance activities in the Tribal Organization/ Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Injury	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Injury	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
Who provided the environmental illness data collection, epidemiology, and/or surveillance activities in the Tribal Organization/Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Environmental health	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Environmental health	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
Who provided the data collection, epidemiology, and/or surveillance activities for other communicable or infectious diseases in the Tribal Organization/Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Communicable/ infectious diseases	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Communicable/ infectious disease	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
Who provided the chronic disease data collection, epidemiology, and/or surveillance activities in the Tribal Organization/Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Chronic diseases	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Chronic disease	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
Who provided the syndromic surveillance data collection, epidemiology, and/or surveillance activities in the Tribal Organization/ Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Syndromic surveillance	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Syndromic surveillance	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
Who provided the vital statistics data collection, epidemiology, and/or surveillance activities in the Tribal Organization/ Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Vital statistics	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Vital records	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
The following questions ask about specific and particular environmental health services or activities offered in the Tribal Organization/Entity's service area		**Other environmental health activities. (For EACH cell, select Yes or No)**		**Other Environmental Health Activities 14. For each activity, check whether and how your LHD and other organizations provided that activity or service in your jurisdiction during the past year. (For each row, select all that apply)**	
Who provided the food safety training/education services or activities in the Tribal Organization/ Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Food safety training/education	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Food safety education	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
Who provided the groundwater protection services or activities in the Tribal Organization/ Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Groundwater protection	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Groundwater protection	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
Who provided the hazardous waste disposal services or activities in the Tribal Organization/ Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Hazardous waste disposal	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Hazardous waste disposal	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
Who provided the air quality monitoring services or activities in the Tribal Organization/Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Indoor air quality	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Indoor air quality	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
Who provided the vector control services or activities in the Tribal Organization/Entity's service area in the past year? (Choose all that apply.)	• ${Q1/ChoiceTextEntryValue/10} • Entity/Department other than ${Q1/ChoiceTextEntryValue/10} located within the Tribe • Tribal organization • Tribal epidemiology center • Urban Indian health program • Indian Health Service • Local health department • State health department • Private and/or non-profit health service organization • Other	Vector control	• Performed by state public health agency directly - Yes/No • Contracted out by state public health agency - Yes/No	Vector control	• Performed by LHD directly • Contracted out by LHD • Provided by others in community independent of LHD funding • Not available in community • Don't Know
The following questions ask about assessment, performance improvement, and accreditation activities offered in the Tribal Organization/Entity's service area.		**Planning and Quality Improvement**		**Community Health Assessment and Planning**	
Has Tribal Organization/Entity developed a community health assessment? By "health assessment" we mean the systematic collection and analysis of data and information for use in educating and mobilizing communities, developing priorities, garnering resources or using resources in different ways, adopting or revising policies, and planning actions to improve the population's health.	• Yes, within the last 5 years • Yes, but more than 5 years ago • Yes, currently in development • No, but plan to in the next year • No	Has your state public health agency developed a state health assessment? By "health assessment" we mean the systematic collection and analysis of data and information for use in educating and mobilizing communities, developing priorities, garnering resources or using resources in different ways, adopting or revising policies, and planning actions to improve the population's health.	• Yes, within the last three years • Yes, more than three but less than five years ago • Yes, five or more years ago • No, but plan to in the next year • No	Has a community health assessment been completed for your LHD's jurisdiction?	• Yes, within the last three years • Yes, more than three but less than five years ago • Yes, five or more years ago • No, but plan to in the next year • No

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
Has Tribal Organization/ Entity developed or participated in developing a community health improvement plan for your community? A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process.	• Yes, within the last 5 years • Yes, but more than 5 years ago • Yes, currently in development • No, but plan to in the next year • No	Has your state public health agency developed or participated in developing a health improvement plan for your state? By "health improvement plan" we mean a series of timely and meaningful action steps that define and direct the distribution of services, programs, and resources to improve your state's health, or definite strategic action steps to improve health status in the state.	• Yes, within the last three years • Yes, more than three but less than five years ago • Yes, five or more years ago • No, but plan to in the next year • No	Has your LHD participated in developing a health improvement plan for your community? (Select only one)	• Yes, within the last three years • Yes, more than three but less than five years ago • Yes, five or more years ago • No, but plan to in the next year • No
Do you have a community health improvement plan that was developed using the results of a community health assessment?	• Yes • No	Do you have a health improvement plan that was developed using the results of a state health assessment?	• Yes • No	Was the community health improvement plan developed using the results of a community health assessment?	• Yes • No
Has Tribal Organization/ Entity developed an organizational strategic plan?	• Yes, within the last 5 years • Yes, but more than 5 years ago • Yes, currently in development • No, but plan to in the next year • No	Has your state public health agency developed an agency-wide strategic plan?	• Yes, within the last three years • Yes, more than three but less than five years ago • Yes, five or more years ago • No, but plan to in the next year • No	Has your LHD developed a comprehensive, agency-wide strategic plan?	• Yes, within the last three years • Yes, more than three but less than five years ago • Yes, five or more years ago • No, but plan to in the next year • No

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
Which of the following statements best characterizes your Tribal Organization/ Entity's current quality improvement activities? (Select only one.)	• We have implemented a formal quality improvement program entity-wide. • We are implementing formal quality improvement activities in specific programmatic or functional areas of the entity, but not on an entity-wide basis. • Our quality improvement activities are informal or ad-hoc in nature. • We are not currently involved in quality improvement activities.	Which of the following statements best characterizes your state public health agency's current quality improvement activities?	• State public health agency has implemented a formal quality improvement program agency-wide • Formal quality improvement activities are being implemented in specific programmatic or functional areas of the state public health agency, but not on an agency-wide basis • State public health agency's quality improvement activities are informal or ad hoc in nature • State public health agency is not currently involved in quality improvement activities	Which of the following statements best characterizes your LHD's current quality improvement activities? (Select only one)	• LHD has implemented a formal quality improvement program agency-wide • Formal quality improvement activities are being implemented in specific programmatic or functional areas of the LHD, but not on an agency-wide basis • LHD's quality improvement activities are informal or ad hoc in nature • LHD is not currently involved in quality improvement activities. → (If checked, skip questions 66–68)

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
Which of the following best describes Tribal Organization/Entity with respect to engagement in the Public Health Accreditation Board's (PHAB's) national public health accreditation program?	• Tribal Organization/Entity has achieved accreditation. • Tribal Organization/Entity is in the process of formally applying (i.e., has registered in e-PHAB and is submitting an application, uploading documentation, preparing for a site visit, etc.). • Tribal Organization/Entity plans to apply but has not yet submitted an application. • Tribal Organization/Entity has not decided whether to apply for accreditation. • Tribal Organization/Entity is not familiar with accreditation. • PHAB accreditation is not applicable.	Which of the following best describes your state public health agency with respect to participation in the Public Health Accreditation Board's accreditation program?	• My state public health agency has achieved accreditation • My state public health agency has submitted an application for accreditation • My state public health agency has registered in e-PHAB in order to pursue accreditation • My state public health agency plans to apply for accreditation, but has not yet registered in e-PHAB • My state public health agency has not decided whether to apply for accreditation • My state public health agency has decided NOT to apply for accreditation	Which of the following best describes your LHD's participation in the Public Health Accreditation Board's (PHAB's) national accreditation program for LHDs? (Select only one) Please report on PHAB accreditation only; do NOT report on state-based accreditation programs or accreditation for specific programs (e.g., Joint Commission or JCAHO).	• My LHD has been accredited by PHAB • My LHD is part of a PHAB-accredited centralized state integrated local public health department system • My LHD has submitted an application for PHAB accreditation • My LHD has registered in e-PHAB in order to pursue accreditation • The state health agency has registered in e-PHAB in order to pursue accreditation as an integrated system that includes my LHD • My LHD plans to apply for PHAB accreditation, but has not yet registered in e-PHAB • The state health agency plans to apply for PHAB accreditation as an integrated system that includes my LHD, but has not yet registered in e-PHAB • My LHD has not decided whether to apply for PHAB accreditation • My LHD has decided NOT to apply for PHAB accreditation • Do not know

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
Public Health Workforce		Workforce		Workforce	
Please indicate the current number of public health staff members (for example, staff providing public health services such as prevention, rather than staff providing clinical services and treating illness after onset). Please include temporary and contract workers.		**Please indicate the current number of staff members (include temporary and contract workers) and FTEs working in your state public health agency.**			
Number of staff members:	[Number]	Number of staff members:	[Number]	41. How many individuals currently work for your LHD? • Please include all regular full-time, part-time, and contractual employees.	[Number]
Number of full-time equivalents (FTEs):	[Number]	Number of full-time equivalents (FTEs):	[Number]	What is the total Full-time Equivalents (FTEs) workforce at your LHD? • Please include all regular full-time, part-time, and contractual employees.	[Number]

PHICCS (Tribal)		ASTHO Profile (State)		NACCHO Profile Survey (Local)	
In the below table, please indicate Tribal Organization/ Entity's current number of positions funded in each occupational classification listed. Employees who provide or support public health services in each of these classifications should be listed in full-time equivalent (FTE) units.		**For each occupational classification listed in the following table, please provide the total current FTE count and the annual salary range for staff working in your state public health agency. Please use the "other" rows to add additional classifications.**		**Indicate which of the following categories of public health workers are currently employed by your LHD. Categorize staff according to their primary job responsibilities or function, not by their degree or education.**	
Agency Leadership / Upper management	[Number of Funded FTE Positions Filled]	Agency leadership	[Total current FTE count]	Agency leadership	[Number of FTEs currently Employed]
Business and Financial Operations Staff	[Number of Funded FTE Positions Filled]	Business and financial operations staff	[Total current FTE count]	Business and financial operations staff	[Number of FTEs currently Employed]
Preparedness Staff	[Number of Funded FTE Positions Filled]	Preparedness staff	[Total current FTE count]	Preparedness staff	[Number of FTEs currently Employed]
Environmental Health Worker	[Number of Funded FTE Positions Filled]	Environmental health worker	[Total current FTE count]	Environmental health worker	[Number of FTEs currently Employed]
Epidemiologist/ Statistician	[Number of Funded FTE Positions Filled]	Epidemiologist/ Statistician	[Total current FTE count]	Epidemiologist/ Statistician	[Number of FTEs currently Employed]
Laboratory Worker	[Number of Funded FTE Positions Filled]	Laboratory worker	[Total current FTE count]	Laboratory worker	[Number of FTEs currently Employed]
Behavioral Health Staff	[Number of Funded FTE Positions Filled]	Behavioral health staff	[Total current FTE count]	Behavioral health staff	[Number of FTEs currently Employed]
Nutritionist	[Number of Funded FTE Positions Filled]	Nutritionist	[Total current FTE count]	Nutritionist	[Number of FTEs currently Employed]
Office and Administrative Support	[Number of Funded FTE Positions Filled]	Office and administrative support	[Total current FTE count]	Office and administrative support staff	[Number of FTEs currently Employed]
Oral Health Professional	[Number of Funded FTE Positions Filled]	Oral health professional	[Total current FTE count]	Oral health care professional	[Number of FTEs currently Employed]
Public Health Educator	[Number of Funded FTE Positions Filled]	Health educator	[Total current FTE count]	Health educator	[Number of FTEs currently Employed]
Public Health Physician	[Number of Funded FTE Positions Filled]	Public health physician	[Total current FTE count]	Public health physician	[Number of FTEs currently Employed]
Public Information Specialist	[Number of Funded FTE Positions Filled]	Public information specialist	[Total current FTE count]	Public information professional	[Number of FTEs currently Employed]

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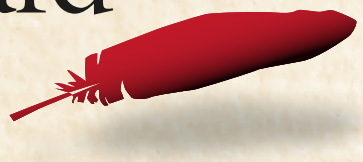
National Indian
Health Board



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