



National Indian
Health Board



2010 Tribal Public Health Profile

Exploring Public Health Capacity
in Indian Country

National Indian Health Board



The Red Feather Of Hope And Healing

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Our Vision

The National Indian Health Board advocates on behalf of all Tribal Governments, American Indians and Alaska Natives in their efforts to provide quality health care for ALL Indian People!

About NIHB

The National Health Board (NIHB) is a non-profit, charitable organization that provides health care advocacy services, facilitates tribal budget consultation and provides timely information and other services to all tribal governments. Whether Tribes operate their own health care delivery systems through contracting and compacting or receive health care directly from the Indian Health Services (IHS), NIHB is their advocate. NIHB also conducts research, policy analysis, program assessment and development, national and regional meeting planning, training, technical assistance programs and project management. These services are provided to Tribes, Area Indian Health Boards, Tribal organizations, federal agencies, and private foundations. The NIHB represents the tribal perspective while monitoring, reporting on and responding to federal legislation and regulations. It also serves as conduit to open opportunities for the advancement of American Indian and Alaska Native health care with other national and international organizations, foundations, corporations and others in its quest to build support for, and advance, Indian health care issues.

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Pilot Sites

NIHB acknowledges the eleven Tribal Health Organizations that dedicated time and participated in the questionnaire pilot test. Pilot test sites represented the Aberdeen, Bemidji, California, Navajo, Phoenix, Portland and Tucson Service Areas.

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NIHB staff, Aimee Centivany, MPH, and Red Star Innovations, LLC, led by Aleena M. Hernandez, MPH, Principal Investigator, Christina Ore de Boehm, MPH, who assisted with questionnaire development and data analysis; Nicolette Teufel-Shone, PhD, who served as an academic advisor providing technical review on all aspects of the project; and Theresa M. Carino, MEd, who assisted with outreach to tribal health directors and officials.

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Letter from NIHB Chairman and Executive Director

In this new era of permanent Reauthorization of the Indian Health Care Improvement Act and the achievement of Health Care Reform, there is a great deal of optimism and momentum toward improving the health status of American Indians and Alaska Natives. The movement toward disease prevention, health promotion and wellness represented in these new laws reflects long-embraced Native values and centuries of traditional community-based health practices.

Now more than ever, focused efforts are needed to create a tribal public health system that is functioning proactively, rather than reactively, to address the health needs of our communities. As Tribes move toward greater self determination, providing quality healthcare in our tribal communities is becoming increasingly complex and involves many stakeholders. Although the definition of public health in Indian Country includes many different activities and services that vary by tribe and region, public health is ultimately the work that is done to promote, improve and maintain the health and wellness of our tribal communities. Therefore, it is increasingly important to understand the range of public health activities occurring among tribal public health departments and Indian health organizations across the nation.

We are pleased to present the 2010 Tribal Public Health Capacity Report, the first national snapshot of our tribal public health systems to be made publically available. The results found in this report highlight the good work that is occurring across Indian Country and will provide support to our Tribal Leadership to:

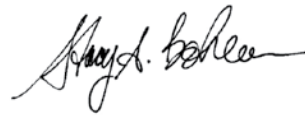
- Measure growth and change in tribal public health capacity
- Prioritize areas for development and resource allocation
- Advocate for resources and policy on behalf of Tribes and public health
- Assess readiness for tribal public health accreditation
- Identify technical assistance and quality improvement needs

On behalf of the NIHB Governing Board and staff, we express our gratitude to all tribal health departments/ organizations and staff for the work that is being done across the nation to improve the health of American Indians and Alaska Natives. We greatly appreciate those who participated in the 2010 NIHB Tribal Public Health Profile. Your contributions will assist our continued efforts to monitor the progress and improvement in tribal public health capacity across Indian Country.

Respectfully,



Reno Keoni Franklin
Chairman



Stacy Bohlen
Executive Director

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Executive Summary

Nationally, a great deal of work has been done to assess the capacity and performance of local and state public health systems, but little is known about tribal public health capacity. Given the history and complexity of tribal public health systems, it is important to explore the role these systems may play in improving health status and reducing health disparities. The 2010 NIHB Tribal Public Health Profile describes the important public health activities and services provided by tribal health organizations. It was designed to describe tribal public health capacity using national standards for measuring performance, including key areas specific to tribal health. The results are a valuable tool for describing public health activities and services, identifying areas to strengthen tribal public health systems and addressing health disparities.

The 2010 NIHB Tribal Public Health Profile serves as an important foundation to inform strategies and strengthen efforts to address health disparities and improve health status among American Indians/Alaska Natives.

The 2010 NIHB Tribal Public Health Profile includes important data about tribal capacity and performance to inform strategies and strengthen efforts to address health disparities and improve health status among American Indians/Alaska Natives. The results of this report help demonstrate the connections between the daily operations of individual tribal health organizations and the collective efforts to improve health status taking place nationally. Such information will benefit Tribes in a number of ways, including but not limited to:

- Provide a baseline to measure growth and change in tribal public health capacity
- Prioritize areas for development and resource allocation
- Advocate for resources and policy on behalf of Tribes and public health
- Assess readiness for tribal public health accreditation
- Identify technical assistance and quality improvement needs

DESIGN

The questionnaire used in the 2010 NIHB Tribal Public Health Profile was modeled after existing public health performance assessment instruments, including those used by organizations and associations serving local, state and territorial health departments. National models were used to ensure that future work describing public health structure and function in the nation can include the harmonization of data from tribal, local and state health departments. Similar to other public health performance assessment instruments, the questionnaire was organized around the Three Core Functions of Public Health and the Ten Essential Public Health Services¹. Adaptations were made to the questionnaire to include key areas specific to tribal public health, such as tribal compacting or contracting of Indian Health Services; the presence and role of tribal Health Committees or Boards; and the use of traditional healers and culturally relevant prevention.

RESULTS AND HIGHLIGHTS

The 2010 NIHB Tribal Public Health Profile questionnaire was administered using a web-based format that was sent by email to 376 directors and administrators of Tribal Health Organizations, including Tribal Health Departments, Indian Health Service (IHS) Facilities, Area Indian Health Boards, and Urban Indian Health Centers. A total 346 questionnaires were successfully delivered. Of the 346 questionnaires delivered, 145 (42 percent) responses were received. 112 (77 percent) questionnaires were complete and 33 (23 percent) were partially complete. All 145 responses were used in the analysis; therefore, the response rate was variable for individual questions.

The 2010 NIHB Tribal Public Health Profile serves as an important baseline of information to measure growth and change in tribal public health capacity over time. Highlights from the 2010 Tribal Profile are organized by the Three Core Functions of Public Health: Assessment, Assurance and Policy Development:

¹ <http://www.Cdc.Gov/Od/Ocphp/Nphpsp/Essentialphservices.htm>

Assessment

The majority of TRIBAL HEALTH Organizations conduct data collection, monitoring, surveillance and evaluation activities. Nearly half of Tribal Health Organizations, 44 percent, had conducted a community health assessment in the past 3 years, and 77 percent plan to conduct one within the next three years. Chronic disease, communicable/infectious disease and behavioral risk factors are among the top epidemiologic and surveillance activities conducted by Tribal Health Organizations. 47 percent of Tribal Health Departments and 46 percent of IHS Facilities, 60 percent of Area Indian Health Boards and 74 percent of Urban Indian Health Centers have data sharing agreements with state health departments. Although more Tribal Health Organizations reported having data sharing agreements with state health departments, Tribal Health Departments report that local non-tribal conduct prevention activities in tribal communities more frequently than do state health departments. The majority, 66 percent, of Tribal Health Organizations evaluate public health activities and/or services.

Assurance

More than half, 59 percent, of Tribal Health Organizations serve populations that travel 50 miles or more to access their services. The average distance traveled is 123 miles, one way. The majority, 83 percent, of Tribal Health Organizations have either an initiative or mechanism in place to enroll eligible individuals into public benefit programs, such as Medicaid/Medicare. Tribal Health Organizations employ a variety of public health occupations. Health occupations most employed are administrators, primary health care

providers, and behavioral health professionals. 54 percent of Tribal Health Organizations have less than 50 employees and 10 percent have more than 200. The average number of Tribal Health Organization employees is 64. The average percentage of employees that are members of federally recognized tribes is 57. Tribal Health Organizations ranked their collaborative relationships with other Tribal Health Organizations most frequently as effective or highly effective.

Policy Development

A quarter of Tribal Health Organizations have adopted a new local public health policy, ordinance or regulation in the past 2 years. Among these Tribal Health Organizations, the majority of their new policies pertain to emergency preparedness and planning, and tobacco prevention and control. Regulatory activities are provided primarily by the Tribal Health Departments or IHS in tribal communities. Less than 40 percent of Tribal Health Organizations indicate that they receive funding from their state health agency/department through the CDC public health preparedness cooperative agreement. Over 40 percent of Tribal Health Organizations have a research policy or ordinance that outlines protocols for reviewing and participating in health research. Tribal Health Organizations report using a multi-step process in reviewing and approving research that includes multiple stakeholders, including Tribal Councils, Health Boards/Committees, Institutional Review Boards (IHS and university), and Tribal Health Organization staff.

FUTURE DIRECTIONS

Tribal Health Organizations and other agencies and entities that make up tribal public health systems are engaged in a broad range of public health activities within a system that is severely underfunded². In the era of Healthcare Reform and the permanent Reauthorization of the Indian Healthcare Improvement Act, there is a great deal of optimism and momentum towards improving the health status of American Indians and Alaska Natives. The 2010 NIHB Tribal Public Health Profile provides an

important foundation of data and information on which to build. Key recommendations and areas identified for further exploration are highlighted below:

Development and resource allocation

- Tribal Health Organizations conduct many of the same public health activities which may indicate that service duplication or overlap is occurring, there is greater tribal readiness to 638 contract services, and/

² U.S. Commission on Civil Rights. (2003). A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country.

or there are opportunities to collaborate at the local level.

- Tribal Health Organizations provide a wide range of public health activities. Further investigation is needed to determine the level at which these services are provided.
- Opportunities exist for developing and expanding relationships with colleges and universities in the areas of workforce development, public health interventions, and research.
- Overall, Tribal Health Organizations differed in their perception and awareness about which organizations conduct which public health services in tribal communities. Collaborative efforts to address these differences in perception are critical to effectively provide public health services.

Advocate for resources and policy on behalf of Tribes and public health

- Many tribes provide public health services in their communities in partnership with local and state health departments. Further investigation is needed to understand and strengthen the nature and quality of relationships among Tribal Health Organizations with state and local health departments and agencies.
- Federal funding needs to be provided directly to the tribes rather than as pass through grants from the states.
- Access to care is a significant issue, especially for small, rural tribal communities. Greater advocacy for funding and resources are needed to address related barriers.

Assess readiness for tribal public health accreditation

- Tribal Health Departments are engaged in a multitude of public health activities across the 10 Essential Public Health Services, including governance and administration, which are the basis for the accreditation standards and measures. Self-assessments are an important first step to determining at what level individual Tribal Health Departments are providing these services and their readiness for accreditation.
- Many Tribal Health Departments conduct

community health assessments, a key component of accreditation. Further study is needed to determine whether community health assessment data are used in community health improvement plans.

- Tribal Health Organizations are engaged in quality improvement activities, which can increase readiness for accreditation.

Identify technical assistance and quality improvement needs

- Tribal Health Organizations are increasingly interested in data based decision making, an important factor in strategic planning, community health improvement planning, and quality improvement. Data use and interpretation is a critical area for technical assistance and training, and is directly tied to the need for a skilled public health workforce.
- Resources, staff and training are needed to support Tribal Health Organizations in conducting community health assessments and community health improvement planning.
- Training in quality improvement is needed to build tribal infrastructure and improve performance.

The 2010 NIH Tribal Public Health Profile is the first publically available snapshot of the national tribal public health systems. Focused efforts are needed to create a tribal public health system that is functioning proactively, rather than reactively, to address the needs of tribal communities. Assessing tribal public health capacity is time consuming and complex; however, it is an important means to describe the processes by which Tribal Health Organizations identify, address and prioritize community health needs. Tribal Health Organizations can use the resulting data to make informed decisions, take strategic action and measure impact over time.

Introduction

With funding from W.K. Kellogg Foundation, the National Indian Health Board (NIHB) completed a Tribal Public Health Profile to provide relevant and valuable information about the current capacities of American Indian/Alaska Native (AI/AN) public health systems. As sovereign nations, Tribes are increasingly involved in public health activities, regulation and service delivery, alone and in partnership with others. As a result, Tribal Public Health Systems are made up of a variety of stakeholders and partners that are engaged in public health activities in tribal communities, such as tribal health departments, the Indian Health Service (IHS), Area Indian health boards, urban Indian health centers, local and state health departments, and other private and public agencies.

Nationally, a great deal of work has been done to assess the capacity and performance of local and state public health systems, but little is known about tribal public health capacity. The 2010 NIHB Tribal Public Health Profile presents important data that can be used to inform strategies and strengthen efforts to address health disparities and improve health status among American Indians/Alaska Natives (AI/AN). These results provide preliminary information about tribal readiness to participate in national initiatives, such as electronic health records and voluntary public health accreditation, which is scheduled to launch in 2011.

Tribal public health includes a complex set of services and activities that vary by tribe and region. Established in 1955, the Indian Health Service, an agency within the Department of Health and Human Services, has delivered healthcare to American Indians and Alaska Natives through a comprehensive, primary care health system of hospitals and clinics located on or near Indian reservations. The provision of healthcare services to the AI/AN population is based on treaties signed by tribal nations and the federal government in which the tribes exchanged vast amounts of land and natural resources for services, including housing, education and healthcare. As a result, the federal government has a trust responsibility to provide healthcare and other services to enrolled members of federally recognized tribes.

Tribal nations are responsible for the overall health

and well-being of their members along with the land and environment of their tribe. As a result, tribes have increasingly opted to enter into contracts or compacts with the federal government to administer the health programs in their community that were previously managed by the Indian Health Service. Public Law 93-638, the Indian Self-Determination and Educational Assistance Act of 1975, provided the authority for this transition to tribal management of federal health programs. 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. Many tribes have also established health departments and supplement contract services with public health programs and services.

Tribal Public Health Systems are made up of a diverse set of stakeholders and partners engaged in public health activities in tribal communities.

Given the history and complexity of tribal public health systems, exploring the role tribal systems play in improving health status and reducing health disparities is critical to plan future directions. The 2010 NIHB Tribal Public Health Profile was designed to assess tribal public health capacity based on national standards for measuring performance, including key areas specific to tribal health. The results are a valuable tool for describing tribal public health activities and services, identifying areas to strengthen tribal public health systems and addressing health disparities.

Background

The term public health capacity is often used to describe the ability of a public health system to improve community health status. A nationally accepted framework for measuring performance³ was adapted for the 2010 NIHB Public Health Profile to explore the capacity of tribal public health systems.

The framework includes 5 main components: Context, Public Health System Mission and Goals, Structural Capacity, Processes and Outcomes. The table below outlines some, not all, considerations made for each component from a tribal systems perspective.

Framework (Handler, Turnock, 2001)	Tribal Systems Perspective
<p>Context: Social, political, and economic forces operating in the overall society; level of demand and need for public health services within the population; social values and preferences for products; external pressures (technology, healthcare system, governmental relationships)</p>	<p>The sovereign status of Tribes; tribal economic development and self-determination; significant health disparities; the unique culture, language, history and traditions of each tribe; federal trust responsibility as provided through the Indian Health Service; underfunded health services; government- to-government relationship.</p>
<p>Public Health System Mission and Goals: Overall purpose and goals and how they are carried out through the core public health functions of assessment, policy development and assurance.</p>	<p>Local diversity within the tribal public health system; mission and goals as determined by each Tribe's leadership; overarching mission to improve health, wellness and quality of life among AI/AN; and reduce health disparities among AI/AN.</p>
<p>Structural Capacity: Resources and relationships needed to implement public health processes, including informational, organizational, physical, human, and fiscal resources.</p>	<p>Tribal governance; relationship with IHS (direct service or contracting and compacting of health services); data sharing, workforce, revenue generating activities, such as third party billing; other important resources and relationships specific to tribes needed to carry out public health activities to improve AI/AN health status.</p>
<p>Processes: The 10 Essential Public Health Services, which are considered the key process through which public health professionals seek to identify, address and prioritize community health needs.</p>	<p>Tribes determine the process with which they identify, address and prioritize community health needs, which are influenced by self-governance, traditional/cultural values, and relationships with federal, state, and local agencies.</p>
<p>Outcomes: Intended improvements in health status. Outcomes can be used to provide information about system performance.</p>	<p>System change, including improvements within health department operations that lead to short and long-term improvements in health status experienced by AI/AN individuals, families, tribal communities.</p>

³ Handler, A. Issel, M, and Turnock, B. A Conceptual Framework to Measure Performance of the Public Health System. American Journal Public Health, 2001.

10 Essential Public Health Services

The 10 Essential Public Health Services support the three core functions of public health (assessment, policy development and assurance) as identified in the Institutes of Medicine Report: *The Future of Public Health*⁴. The 10 Essential Services are used as a framework to guide the responsibilities and activities

of tribal, local, and state public health systems. The results of this report help demonstrate the connections between the daily operations of individual tribal health organizations and the collective efforts to improve health status of all American Indians and Alaska Natives taking place nationally.

10 Essential Public Health Services

- Monitor health status to identify and solve community health problems.
- Diagnose and investigate health problems and health hazards in the community.
- Inform, educate and empower people about health issues.
- Mobilize community partnerships and action to identify and solve health problems.
- Develop public health policies and plans that support individual and community health efforts.
- Enforce laws and regulations that protect and ensure safety.
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
- Assure competent public and personal health care workforce.
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
- Research for new insights and innovation solutions to health problems.

Tribal Public Health Profile Process

The 2010 NIHB Tribal Public Health Profile was administered using a web-based questionnaire sent by email. The questionnaire included 50 questions and was modeled after existing public health performance assessment instruments, including National Association of City and County Health Officials (NACCHO), the National Profile of Local Public Health Departments survey⁵, the National Public Health Performance Standards Program⁶, (a collaborative project sponsored by the Center for Disease Control and Prevention (CDC) and NACCHO) and the Association of State and Territorial Health Officials' Baseline Survey of State

Health Departments⁷. Adaptations were made to the questionnaire to include key areas specific to tribal public health, including, but not limited to: 1) Tribal compacting or contracting of Indian Health Services; 2) Diverse public health partnerships that exist within the tribal context; 3) Presence and role of tribal Health Committees or Boards; 4) Research review

and approval policies and processes; 5) Presence of traditional healers and culturally relevant prevention programs; and 6) Representation of tribal members within the public health workforce. National models were used to ensure that future work describing public health structure and function in the nation can include the harmonization of data about tribal, local and state health departments.

Tribal Health Departments/Organizations (Tribal Health Organizations) identified to participate include Tribal Health Departments, Indian Health Service Units, Area Indian Health Boards or Intertribal Councils, specifically those with Epidemiology Centers, and Urban Indian Health Centers. Prior to sending the questionnaire, calls were made to individual Tribal Health Organizations to identify the appropriate person and email address to ensure accurate responses. On October 16, 2009, a total of 376 NIHB Tribal Public Health Capacity electronic questionnaires were emailed to Tribal Health Organization directors and administrators; however,

⁴ Institutes of Medicine Report (U.S.). Committee for the Study of the Future of Public Health, Division of Health Care Services. *The Future of Public Health*. National Academy Press, Washington, D.C., 1988. <http://www.nap.edu/openbook.php?isbn=0309038308>.

⁵ National Association of City and County Health Officials. The 2008 National Profile of Local Health Departments Study Questionnaire. www.naccho.org/topics/infrastructure/profile/upload/Profile08CoreplusModules.pdf.

⁶ Centers for Disease Control and Prevention. Office of the Director, Office of the Chief of Public Health Practice, National Public Health Performance Standards Program. <http://www.cdc.gov/od/ocphp/nphsp/TheInstruments.htm>.

⁷ Association of State and Territorial Health Officials. Profile of State Public Health, Volume 1. <http://www.astho.org/Research/Major-Publications/Profile-of-State-Public-Health-Vol-1/>.

30 were returned as undeliverable due to firewalls or invalid emails. Tribal Health Organization directors and administrators, or designee, were given 45 days to complete the electronic questionnaire. Follow up calls and emails were sent to those who had not responded by the initial deadline to ensure all Tribal Health Organizations had the opportunity to participate.

Questionnaire

Of the 346 Tribal Health Organization directors and administrators who received the 2010 NIH Tribal Public Health Profile questionnaire, 145 responded, 112 completed and 33 partially completed the questionnaire, for an overall response rate of 42 percent. Of the 346 who received the questionnaire, 80 of 197 Tribal Health Department Directors (44 percent) responded, 38 of 102 IHS Administrators (37 percent), 7 of 10 Area Indian Health Board Directors (70 percent), and 20 of 39 Urban Indian Health Center Directors (51 percent). All 145 returned questionnaires were used in the analysis; therefore, the response rate was variable for individual questions.

According to the Division of Instructional Innovation and Assessment, University of Texas at Austin, Instructional Assessment Resources (2007), acceptable rates for online surveys is 30%⁸. While the overall response rate to the questionnaire is acceptable by national standards, there may have been a number of impeding factors such as competing demands, a need for greater clarity of the intent of the assessment, a respondent's uncertainty about the value of his/her response, and/or the respondent's comfort with completing an online survey. All responses were self reports and no attempt was made to verify information using other sources.

⁸<http://www.utexas.edu/academic/diia/assessment/iar/teaching/gather/method/survey-Response.php?task=research>

Tribal Health Organization Characteristics

Highlights

- A total of 145 Tribal Health Organizations participated in the assessment.
- 20 percent serve a population over 20,000, with the largest reported population reaching 736,688.
- 60 percent of Tribal Health Departments contract one or more IHS service; 30 percent compact all services.

Tribal Public Health Systems are composed of a diverse set of stakeholders and partners engaged in public health activities in tribal communities. To capture the capacity performance of the primary stakeholders within tribal systems, the following Tribal Health Organizations were invited to participate in the Tribal Public Health Profile:

Tribal Health Department: a health department, corporation or organization operated under the jurisdiction of a federally recognized tribe, or association of federally recognized tribes, which is funded by the tribe(s) and/or contract service(s) from the Indian Health Service.

IHS Facility: a local administrative unit of the Indian Health Service that provides contract health services on or near an Indian reservation.

Area Indian Health Board or Inter Tribal Council: a non-profit organization with a governing board that is made up of the highest ranking official or appointee of federally recognized tribes within a designated geographic area and operates a Tribal Epidemiology Center through funding from the Centers for Disease Control and IHS.

Urban Indian Health Center: a non-profit organization that receives funding from IHS under Title V of the Indian Health Care Improvement Act to provide public health services to American Indian/Alaska Natives living in urban areas, or a member of the National Council of Urban Indian Health.

Participants

A total of 145 Tribal Health Organization executive directors/administrators or appointees participated in the 2010 NIHB Tribal Public Health Profile. Among participating Tribal Health Organizations, 55 percent self-identified as representing a Tribal Health Department, 26 percent an IHS Facility, 6 percent an Area Indian Health Board or Inter Tribal Council, and 14 percent an Urban Indian Health Center. Among those that self-identified as a Tribal Health Department, 78 percent represented a single tribal nation and 22 percent represented multiple tribes through tribal associations/consortia.

Chart 1. Participating THD/Os

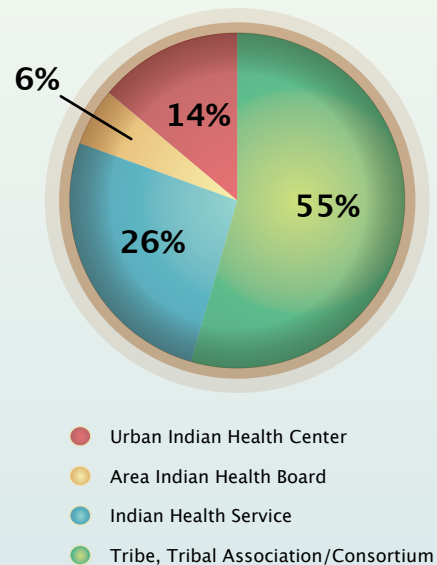
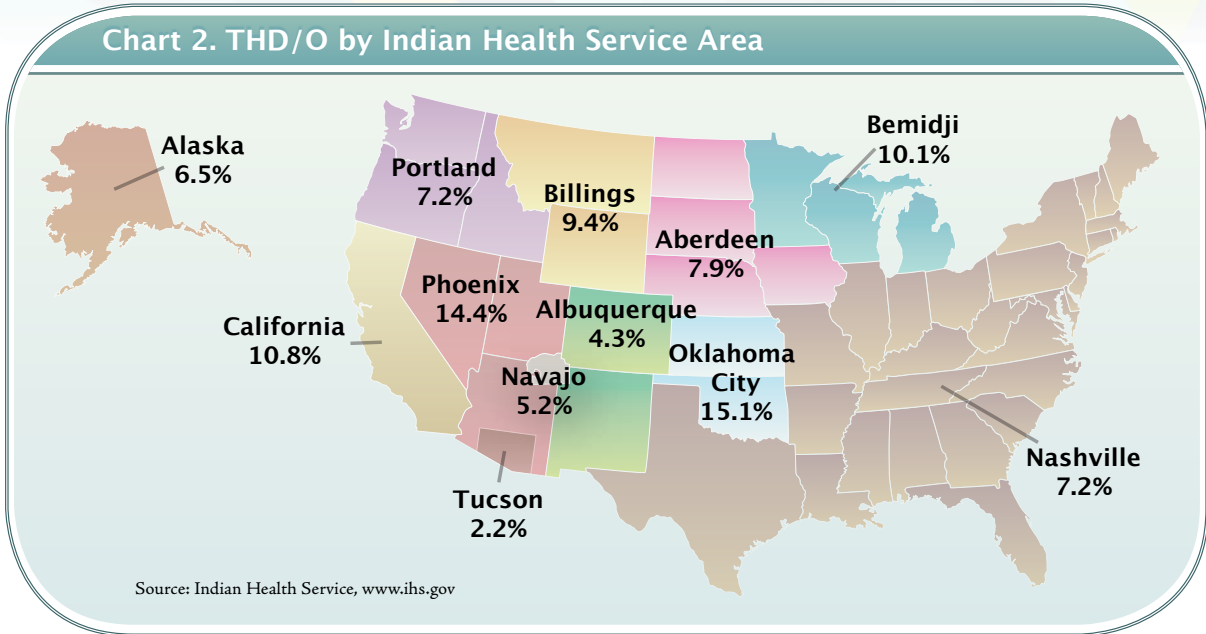


Chart 2. THD/O by Indian Health Service Area



Tribal Health Organization participants were fairly well distributed throughout Indian Health Service Areas.

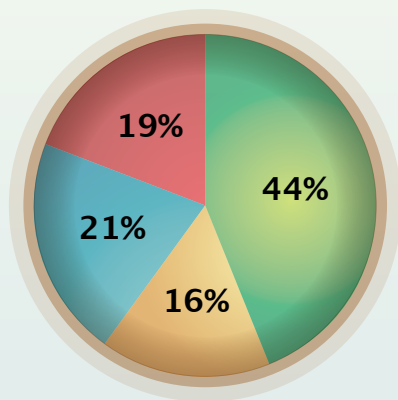
Population Size

Nearly half of the participating Tribal Health Organizations serve a population of less than 5000. About 20 percent serve a population over 20,000 with the largest reported population reaching 736,688.

Operational Resources And Budgets

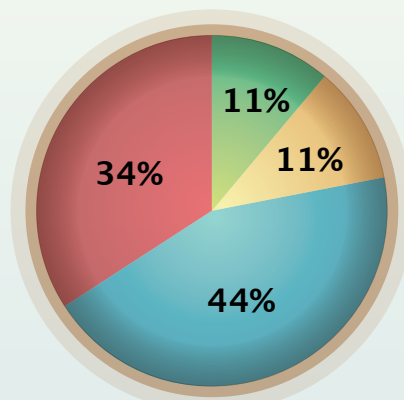
Participants were asked to report the Tribal Health Organization’s total budget for the most recent fiscal year. Nearly half, 44 percent reported a total budget between \$1 and \$5 million and 34 percent reported a total budget of over \$5 million.

Chart 3. Population Size Served by THD/Os



- More than 20,000
- 10,001 - 20,000
- 5,001 - 10,000
- 0 - 5,000

Chart 4. THD/O Total Budget for Most Recent Fiscal Year, 2009



- More than \$5,000,000
- \$1,000,001 - \$5,000,000
- \$501,000 - \$1,000,000
- \$1 - \$500,000

Funding for tribal public health systems comes from a variety of sources, including IHS, federal grants other than IHS, tribes and other governmental and private grants. Chart 5 represents the number of Tribal Health Organization that reported receiving funding from sources listed.

Funding sources and amounts vary by type of Tribal Health Organization. Table 1 illustrates the percent of Tribal Health Organizations by type that receive funds from a tribe, Indian Health Service, federal agency other than IHS, state, county, and private grants, in-kind donations and other sources. In most cases, state funding reported supported Women, Infant and Children (WIC), Medicaid, Medicare, and other third party billing sources. Non-IHS federal funding sources include Center for Disease Prevention and Control (CDC), Health Resources and Services Administration (HRSA) and Substance Abuse and Mental Health Services Administration (SAMSHA).

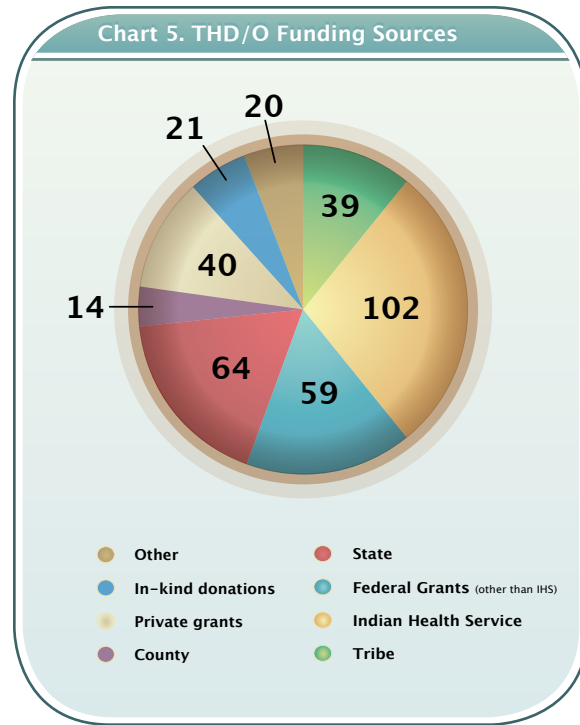


Table 1. Funding Sources by Tribal Health Organization Type

Funding Source	Tribal Health Organization Type			
	Tribe	IHS	Health Board/Epi Center	Urban Center
Tribe	43%	3%	50%	5%
Indian Health Service	79%	64%	67%	68%
Federal Grants	50%	25%	67%	37%
State	52%	19%	67%	63%
County	10%	3%	-	26%
Private Grants	33%	6%	67%	42%
In Kind Donations	9%	8%	33%	47%
Other	14%	8%	16%	26%

Most Tribal Health Departments reported receiving funds from the Indian Health Service, tribe(s), state and federal grants. Indian Health Service units reported receiving other funds from federal and state

grants. Area Indian Health Boards and Urban Indian Health Centers reported greater diversity in funding sources, including IHS, private, state grants and in-kind donations.

Tribal Health Departments

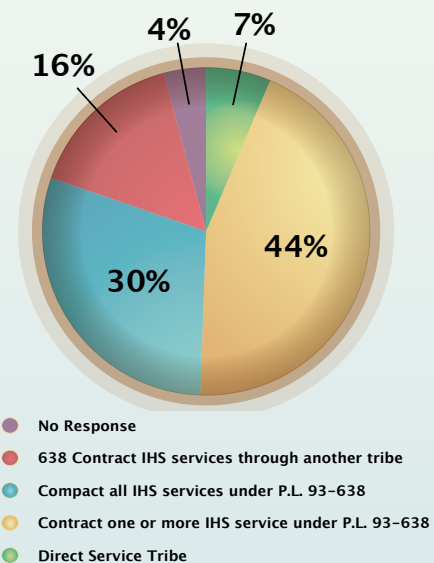
Since 1955 healthcare has been delivered to American Indians and Alaska Natives through the Indian Health Service (IHS), an agency within the Department of Health and Human Services. The introduction of Public Law 93-638, the Indian Self-Determination and Educational Assistance Act of 1975, changed how health care services were provided by authorizing the transition of federal health programs to tribal management. Under Public Law 93-638 a tribe can contract with Indian Health Service to take over the management of specific programs. Tribes may seek eligibility to compact health services provided by the Indian Health Services. A compact is more like a block grant than a contract giving a tribe greater management and administrative authority to administer health services⁹. Over time, tribes have increasingly opted to enter into contracts or compacts with the federal government to administer the health programs that were previously managed by the IHS.

The chart below illustrates the percent of Tribal Health Departments that self-identified as direct service tribes or that contract or compact health services from IHS. Only 7 percent of tribes self-identified as direct service, while 89 percent indicate they contract one or more IHS services, compact all services, or contract or compact services through another tribe.

Overlapping Jurisdictions

Tribal lands and jurisdictions may overlap multiple local and state jurisdictions. Tribal relations with local and state health departments can impact the level, quality, and consistency of public health activities occurring in the community, such as law enforcement, outbreak investigation and service provision. County overlap with tribal jurisdictions ranges from 1 to 18 counties with an average overlap of 3. State overlap with tribal jurisdictions ranges from 1 to 4; however, most Tribal Health Organizations reported that their jurisdictions were not overlapped by more than 1 state.

Chart 6. Percent of Tribal Health Departments that Contract IHS Services



⁹ Dixon M, Roubideaux Y, eds. Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century. Washington, DC: American Public Health Association; 2001.

Community Health Assessments And Planning

ESSENTIAL SERVICES I: MONITOR HEALTH STATUS TO IDENTIFY COMMUNITY HEALTH PROMOTION

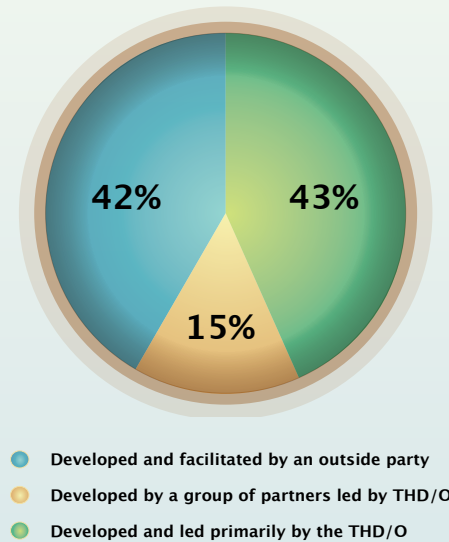
Highlights

- 44 percent of Tribal Health Organizations have conducted a community health assessment in the past 3 years.
- Lack of staff and resources and the need for training were identified as the top 3 barriers to conducting community health assessments.
- 100 percent of participating Area Indian Health Boards indicated that they have a data sharing agreement with local tribe(s).

Community health assessments monitor the health status of a community at one point in time. Several models and processes can be used, such as Mobilizing for Action through Planning and Partnerships (MAPP), Assessment Protocol for Excellence in Public Health (APEXPH), and National Public Health Performance Standards Program, among others¹⁰. Conducted regularly over consistent periods of time with the same population, they can yield health status trends, reveal change and be used in Community Health Improvement Planning. Conducting a community health assessment will be important for tribes seeking voluntary public health accreditation in the future.

“We [plan to seek] public health accreditation and will most likely need an updated [community health] assessment within the next 3 years”

Chart 7. THD/Os Who Conducted Community Health Assessment in the Past 3 Years



Less than half of the Tribal Health Organizations, 44 percent, conducted a community health assessment in the past 3 years, and 77 percent plan to conduct one within the next three years. Among those Tribal Health Organizations that conducted a community health assessment within the past three years, a variety of approaches were used as illustrated in Chart 7. Community health assessments were equally developed and led by the Tribal Health Organizations or in partnership with an outside party. About 15 percent of community assessments were conducted by a coalition or group of partners.

¹⁰ For more information: <http://www.naccho.org/topics/infrastructure/>.

Health indicators measure and track the health status of a defined population or community. The table below highlights different types and examples of health indicators used in community health assessments.

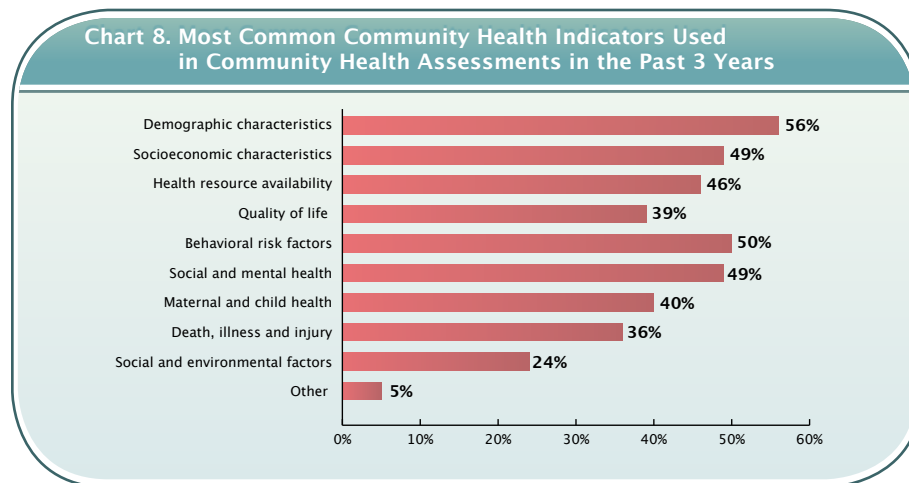
Indicators used by Tribal Health Organizations include demographic and socioeconomic characteristics (95 and 83 percent respectively), behavioral risk factors (85 percent), and social and mental health indicators (83 percent). Social and environmental factors were the least used indicators by Tribal Health Organizations (41 percent).

Indicators	Examples
Demographic Characteristics	Age, gender, tribal affiliation
Behavioral Risk Factors	Physical activity, tobacco use, substance abuse
Socio-Economic Characteristics	Income, education, household size, employment
Social and Mental Health	Substance abuse, depression, mental health disorders and treatment
Health Resource Availability	Health insurance, access to care and services, transportation
Quality Of Life	Overall physical and emotional health and wellness
Maternal and Child Health	Prenatal care, childhood immunizations, child well checks
Death, Illness and Injury	Mortality, disease specific data, accidents
Social and Environmental	Safe roads, hazardous materials, land use

Community Health Improvement Planning

A community health improvement plan can be defined as a long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process¹¹. This plan is used by health and other education and human service departments and/or agencies, in collaboration with community partners, to set priorities and target resources.

A follow-up survey was sent to Profile participants to determine how many Tribal Health Organizations have developed a Community Health Improvement Plan using results from a community health assessment. Of the 52 responses received, 50 percent did develop a Community Health Improvement Plan within the last three years.

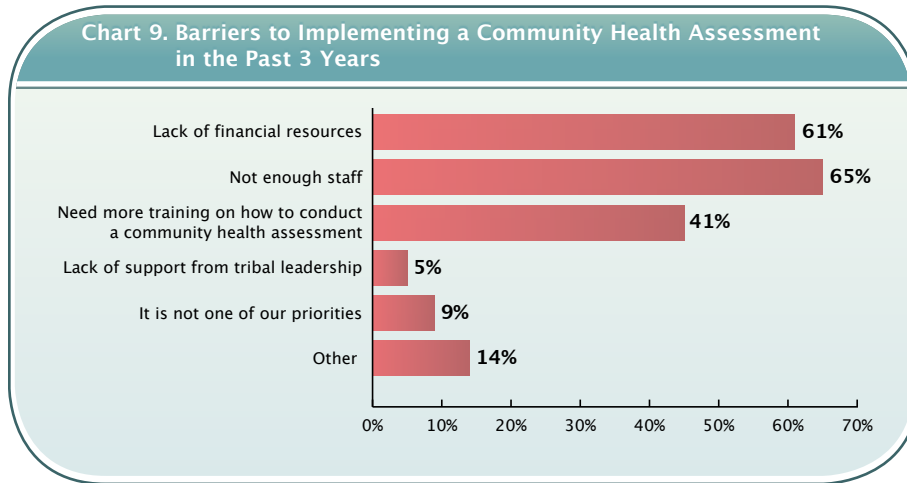


¹¹ Public Health Accreditation Board. Acronyms and Glossary Terms. July 15, 2009. www.phaboard.org/assets/documents/Glossary-07-15-2009.doc

Barriers To Implementing Community Health Assessments

Tribal Health Organizations were asked to identify the most significant barriers to completing community health assessments in their area. Most identified not

enough staff, lack of financial resources, and need more training as the primary barriers to completing a community health assessment.



Data Sharing

Health statistics and data measure a wide range of health indicators for a community. Health data can establish a baseline to measure change over time, prioritize resource allocation, identify community health needs and patterns of disease or illness, and evaluate program effectiveness. Data sharing agreements are one way public health systems can collaborate and partner to promote wellness and prevent disease.

The majority of Tribal Health Organizations manage data from shared databases, such as the IHS Resource Patient Management Service. Less frequently used formats include paper spreadsheets, such as Microsoft Excel, and local relational databases, such as Microsoft Access or SPSS. Of the 54 percent of Tribal Health Organizations that have staff dedicated to data management only 26 percent are full time positions; 46 percent of Tribal Health Organizations indicate that they do not have any staff dedicated to data management.

Tribal Health Organizations enter into data sharing agreements with a variety of agencies. Table 2 shows the percent of Tribal Health Organizations by type that report data sharing agreements with partner agencies. Area Indian Health Boards have Tribal Epidemiology Centers through funding from Indian Health Service and Centers for Disease Control and Prevention. Tribal Epidemiology Centers provide technical assistance and data monitoring for the tribes and Indian health programs within their region. It is of no surprise that all (100 percent) participating Area Indian Health Boards have a data sharing agreement with one or more of the local tribe within their Service Area. A greater percentage of Tribal Health Departments have agreements with Area Indian Health Boards than any other agency. Urban Indian Health Centers are more likely to have data sharing agreements with local and state health departments than are other Tribal Health Organizations. Tribal Health Departments and IHS reported having more data sharing agreements with states than with local health departments.

Tribal Health Organizations identified other organizations, (such as universities) and federal agencies, (such as CDC, HRSA and SAMSHA), with which they share data. When asked about the nature

of the data sharing agreements, 34 percent reported formal written agreements and 37 percent reported a combination of formal and informal agreements.

Table 2. Data Sharing Agreements by Tribal Health Organization

Partner Agency	Tribal Health Organization Type			
	Tribe	IHS	Health Board/Epi Center	Urban Center
Local Tribe(s)	27%	58%	100%	16%
Indian Health Service	68%		60%	79%
Area Indian Health Boards (Tribal Epi Centers)	81%	27%		37%
Federal agency other than IHS	16%	15%	20%	32%
Local/County Health Departments	37%	37%	-	63%
State Health Department	47%	46%	60%	74%
Private or non-governmental health care facility	8%	3%	-	16%
Other Agency	12%	3%	40%	21%
Do not have any data sharing agreements with other agencies	10%	12%	-	11%

Public Health Activities And Services

ESSENTIAL SERVICE II: DIAGNOSE AND INVESTIGATE HEALTH PROBLEMS

Highlights

- Population primary prevention activities for chronic disease and tobacco are provided by a higher percent of Tribal Health Organizations than other activities.
- Screening activities for high blood pressure and diabetes are provided by a higher percentage of Tribal Health Organizations than other screening activities.
- The most common surveillance activity of Urban Indian Health Centers is chronic disease, followed by communicable disease and behavioral risk factors.
- Tribal Health Departments report that local health departments provide more public health activities in their communities than state health departments.

The 2010 NIH Tribal Public Health Profile asked participants to provide information relative to a list of public health related activities and services. For each activity, participants identified the organization that provides the activity or services within their community. Overall, Tribal Health Organizations differed in their perception and awareness about which organizations conduct which public health services in tribal communities. Understanding these differences in perception are critical to collaborative efforts designed to provide public health services.

Tables 3-10 show the percent of Tribal Health Organizations that offer each listed activity or service internally. Only the Tribal Health Department response to whether state and/or local (city, county or other non-tribal municipality) health departments provide each public health activity or service is included in the tables.

Epidemiology And Surveillance

Epidemiology is the study of the amount and distribution of disease within a community by person, place and time and surveillance refers to the monitoring of data trends over time. Epidemiology and surveillance activities provide the necessary health status information for setting priorities in health promotion and monitoring disease and potential outbreaks. The following section describes how Tribal Health Organizations diagnose and investigate

Understanding differences in perception about which organizations conduct which public health services in tribal communities is key to developing collaborative public health efforts.

health problems, the number of staff dedicated to data management, epidemiology and surveillance activities, and the formats used for data management of key public health activities.

More than 80 percent of IHS Facilities report being engaged in the epidemiology and surveillance activities listed; 93 percent conduct chronic disease surveillance. The most common surveillance activities of Tribal Health Departments, Area Indian Health Boards and Urban Indian Health Centers are chronic disease, followed by communicable/infectious disease and behavioral risk factors. Tribal Health Departments report that more state health departments engage in the epidemiology and surveillance activities in tribal communities than local health departments; the one exception is environmental health.

Table 3. Epidemiology and Surveillance Activities As Reported by Tribal Health Organizations

Activity or Service	Epidemiology/Surveillance Service Provider				Tribal Health Department Response	
	Tribe	IHS	Health Board/Epi Center	Urban Center	State Health Dept.	Local Health Dept.
Communicable/ Infectious Disease	63%	86%	50%	83%	51%	48%
Chronic Disease	67%	93%	50%	89%	16%	14%
Injury	60%	86%	33%	44%	10%	10%
Behavioral Risk Factors	70%	86%	50%	78%	22%	19%
Environmental Health	59%	82%	33%	22%	19%	21%
Sentinel Event Surveillance	33%	82%	33%	22%	11%	10%

ESSENTIAL SERVICE III: INFORM, EDUCATE, AND EMPOWER PEOPLE ABOUT HEALTH ISSUES

Prevention

Disease prevention and wellness promotion are key components of public health. Prevention activities include information about disease risk and transmission, strategies for health behavior change and screening services and recommendations designed to promote health and prevent disease. The 2010 NIHB Tribal Public Health Profile focused on

the following prevention activities: immunizations, screening, maternal and child health, and general health care. Tribal Health Departments reported that local health departments conduct prevention activities in tribal communities more frequently than do state health departments.

A higher percent of IHS Facilities, followed by Urban Indian Health Centers and Tribal Health Departments, provide child and adult immunizations in their respective communities. Area Indian Health Boards do not provide immunization services. Tribal Health Departments indicated that local health departments more frequently provide child immunizations and state health departments more frequently provide adult immunizations in their communities.

Table 4. Child and Adult Immunization Activities As Reported by Tribal Health

Activity or Service	Child/Adult Immunization Service Providers				Tribal Health Department Response	
	Tribe	IHS	Health Board/ Epi Center	Urban Center	State Health Dept.	Local Health Dept.
Child Immunizations	84%	96%		89%	32%	41%
Adult Immunizations	83%	93%		88%	36%	4%

Screening activities for cardiovascular disease, high blood pressure, diabetes and HIV/AIDS are frequently provided by IHS Facilities. Tribal Health Departments and Urban Indian Health Centers were more likely to provide diabetes, high blood pressure and STD screenings than for other health conditions. Tribal

Health Departments reported that state and/or local health departments are more likely to provide screening services for HIV/AIDS, STDs and tuberculosis than for cancer and cardiovascular related screenings.

Table 5. Screening for Health Conditions As Reported by Tribal Health Organizations

Activity or Service	Epidemiology/Surveillance Service Provider				Tribal Health Department Response	
	Tribe	IHS	Health Board/ Epi Center	Urban Center	State Health Dept.	Local Health Dept.
HIV/AIDS	74%	93%	33%	83%	28%	33%
Other STDs	78%	89%	33%	89%	30%	35%
Tuberculosis	74%	89%	17%	78%	26%	30%
Cancer	72%	89%	33%	72%	13%	14%
Cardiovascular Disease	77%	93%	33%	83%	9%	18%
Diabetes	89%	93%	33%	94%	6%	16%
High Blood Pressure	82%	93%	16%	89%	9%	20%

A larger percent of Tribal Health Departments, 59 percent, report providing WIC services. 89 and 85 percent of IHS Facilities report providing prenatal care and well child clinics, respectively. More than three quarters of Urban Indian Health Centers provide family planning and 67 percent provide well

child clinics. More than a third of Tribal Health Departments indicated that local health departments provide family planning and well child clinics in their community.

Table 6. Maternal and Child Health Care As Reported by Tribal Health Organizations

Activity or Service	Epidemiology/Surveillance Service Provider				Tribal Health Department Response	
	Tribe	IHS	Health Board/ Epi Center	Urban Center	State Health Dept.	Local Health Dept.
Family Planning	68%	78%	17%	78%	13%	36%
Prenatal Care	59%	89%	17%	39%	13%	26%
Women Infant and Children (WIC)	59%	26%	-	28%	14%	29%
Well Child Clinic	78%	85%	-	67%	12%	30%

Table 7. Other Health Services As Reported by Tribal Health Organizations

Activity or Service	Other Health Services and Provider				Tribal Health Department Response	
	Tribe	IHS	Health Board/ Epi Center	Urban Center	State Health Dept.	Local Health Dept.
Comprehensive Primary Care	78%	88%	-	78%	1%	15%
Home Health Care	50%	19%	-	22%	9%	19%
Oral Health	68%	92%	17%	56%	1%	10%
Behavioral Health	84%	81%	-	89%	7%	25%
Substance Abuse Services	90%	58%	17%	83%	7%	19%

Comprehensive primary care, oral health, behavioral health and substance abuse services are provided by more than three quarters of Tribal Health Departments. Comprehensive primary care, oral health services and behavioral health are provided by more 80 percent of participating IHS Facilities and just over half provide substance abuse services. More Tribal Health Departments provide home health care. More than three quarters of Urban Indian Health Centers provide behavioral health, substance abuse services and comprehensive primary care.

Population-based primary prevention activities for chronic disease and tobacco are provided by more Tribal Health Organizations than the other activities listed. A greater percent of Urban Indian Health Centers and Tribal Health Departments reported providing culturally based programs than did other Tribal Health Organizations. More Area Indian Health Boards conduct primary prevention activities for unintentional injury and tobacco, than other primary prevention activities.

Table 8. Primary Prevention Activities As Reported by Tribal Health Organizations

Activity or Service	Epidemiology/Surveillance Service Provider				Tribal Health Department Response	
	Tribe	IHS	Health Board/ Epi Center	Urban Center	State Health Dept.	Local Health Dept.
Unintentional Injury	76%	89%	50%	56%	18%	19%
Unintended Pregnancy	60%	79%	-	56%	12%	34%
Chronic Disease	96%	100%	33%	89%	10%	18%
Violence	79%	86%	33%	56%	12%	24%
Tobacco	82%	89%	50%	89%	18%	22%
Culturally Based Prevention Programs	85%	71%	33%	89%	0%	0%
Asthma	68%	86%	16%	61%	9%	16%

Environmental Health

Nearly three quarters of Tribal Health Departments conduct land surface and ground water protection and hazardous waste disposal. IHS Facilities report that they provide more than 50 percent of the listed environmental services. Urban Indian Health Center engagement in environmental health activities is limited, with food safety education being the most common. None of the participating Area Indian Health Boards engage in the activities listed below. Tribal Health Departments indicate that local health departments more frequently conduct environmental health activities than do state health departments, especially in the areas of hazardous materials and waste disposal. State health departments are more likely to conduct air pollution, radiation control and indoor air quality activities.

“We have high rates of asthma on our reservation. There aren’t enough [resources available to adequately] address this problem.”

Table 9. Environmental Health Activities As Reported by Tribal Health Organizations

Activity or Service	Epidemiology/Surveillance Service Provider				Tribal Health Department Response	
	Tribe	IHS	Health Board/ Epi Center	Urban Center	State Health Dept.	Local Health Dept.
Indoor Air Quality	48%	57%		11%	11%	9%
Food Safety Education	54%	61%		28%	9%	14%
Radiation Control	26%	50%		11%	9%	3%
Vector Control	42%	64%		6%	12%	17%
Land Use Planning	63%	21%		6%	8%	14%
Groundwater Protection	68%	57%		-	14%	20%
Surface Water Protection	71%	61%		-	14%	18%
Hazmat Response	49%	64%		-	22%	29%
Hazardous Waste Disposal	68%	71%		-	15%	25%
Air Pollution	32%	32%		-	22%	14%

Other Public Health Activities

Other public health activities explored within tribal public health systems include emergency medical services, animal control, occupational safety and

health, laboratory services, outreach and enrollment for Medicaid/Medicare, school-based clinics, and vital records.

Table 10. Other Activities As Reported by Tribal Health Organizations

Activity or Service	Other Activities Providers				Tribal Health Department Response	
	Tribe	IHS	Health Board/ Epi Center	Urban Center	State Health Dept.	Local Health Dept.
Emergency Medical Services	50%	46%		11%	6%	37%
Animal Control	44%	18%		0%	6%	34%
Occupational Safety and Health	50%	71%		11%	12%	24%
Laboratory Services	62%	93%		50%	13%	19%
Outreach and Enrollment for Medicaid/Medicare	81%	93%		56%	16%	22%
School Based Clinics	25%	50%		11%	12%	26%
Tribal Correctional Health	25%	36%		0%	1%	6%
Vital Records	35%	57%		6%	38%	24%

Collaboration

ESSENTIAL SERVICE IV: MOBILIZE COMMUNITY PARTNERSHIPS TO IDENTIFY AND SOLVE HEALTH PROBLEMS

Community partnerships among multiple stakeholders are important to identify and address health concerns within tribal public health systems. Tribal Health Organizations were asked to rate the effectiveness of their collaboration with specific organizational partners on a scale of highly effective, effective, neutral, could be more effective, or not effective. Collaboration with neighboring tribe(s), Area Indian Health Boards, Indian Health Service, hospitals, Tribal Epi Centers and state and local

governments were rated most frequently as effective or highly effective. The majority of participants did not rate the effectiveness of the collaboration with Tribal College/University and College/School of Public Health and indicated that it does not apply.

Table 11. Effectiveness Ratings for Tribal Health Organization Collaboration with Specified Partners

Organizational Partners	Highly Effective	Effective	Neutral	Could Be More Effective	Not Effective	Does Not Apply
Neighboring Tribes	21%	31%	10%	29%	3%	6%
Area Indian Health Board	12%	29%	16%	25%	6%	11%
Indian Health Service	23%	33%	16%	21%	3%	5%
Bureau of Indian Affairs	3%	12%	30%	22%	11%	22%
Hospital	12%	40%	17%	22%	3%	5%
Tribal Epi Center	10%	28%	19%	15%	4%	23%
Tribal College/University	3%	19%	12%	12%	5%	49%
Other College/University	6%	23%	19%	20%	5%	27%
College/School of Public Health	7%	18%	18%	19%	4%	33%
State Government	8%	35%	17%	25%	10%	5%
Local County/City Government	9%	39%	13%	25%	10%	5%

Administration and Governance

ESSENTIAL SERVICE V: DEVELOP POLICIES AND PLANS THAT SUPPORT INDIVIDUAL AND COMMUNITY HEALTH EFFORTS

Highlights

- 85 percent of Tribal Health Organizations have a Tribal Health Committee, Board or Group.
- Over half of Tribal Health Committees, Boards, or Groups are composed of elected Tribal Council Members.
- Nearly 60 percent report policy planning and development as a primary responsibility of the Tribal Health Committee, Board or Group.

Governance

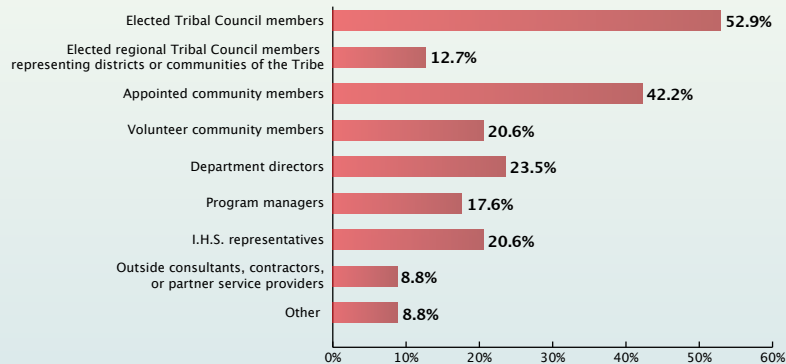
As sovereign nations, Tribes have an inherent right to protect and ensure the safety of its citizenry and one of the ways in which that occurs is through governance. Governance, in terms of public health performance, usually refers to the local governing body, such as boards, councils, commissions or other body with legal authority over a public health agency¹². Governance is also an important mechanism for community engagement. To understand governance in tribal public health systems, the 2010 NIHB Tribal Public Health Profile explored whether Tribal Health Organizations have a health committee, board or other group that meets regularly to provide oversight, make recommendations and/or approve major decisions, and if so, membership characteristics and primary function.

“Our health board has 9 members appointed by Tribal Council to oversee the Executive Director”

Health Committee, Board Or Group

85 percent of Tribal Health Organizations have a Tribal Health Committee, Board or Group (THC) that meets regularly to provide oversight, approve major decisions and/or makes recommendations to their respective Tribal Health Organization. Among Tribal Health Organizations that have a THC, over half of THCs are composed of elected Tribal Council Members and appointed community members. Participation by department directors, volunteer community members and IHS representatives are similarly distributed in these THCs.

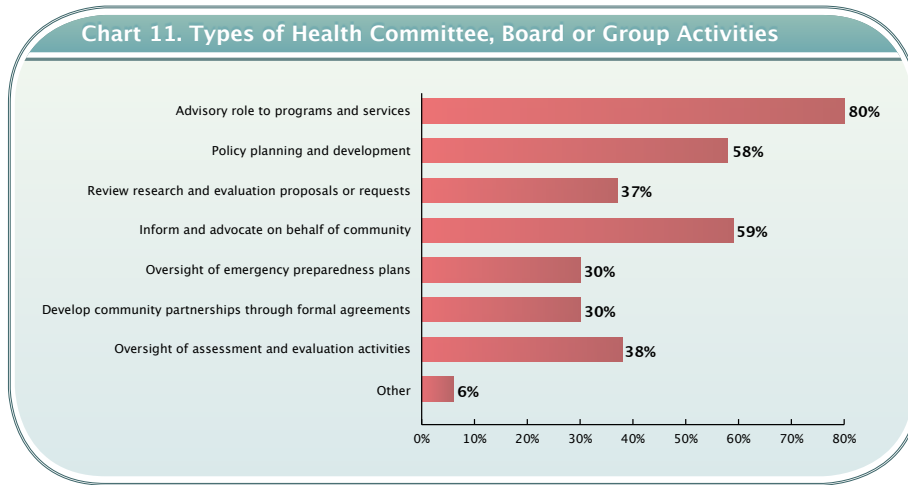
Chart 10. Composition of Tribal Health Committees, Boards or Groups



¹² Centers for Disease Control and Prevention. Office of the Director, Office of the Chief of Public Health Practice, National Public Health Performance Standards Program. Local Public Health Governance Performance Assessment Instrument. http://www.cdc.gov/od/ocphp/nphpsp/documents/07_110300%20Gov%20Booklet.pdf

THCs primarily serve in an advisory role to programs and services. Secondary activities include informing and advocating on behalf of community and policy planning and development. A little over a third of THC activities relate to oversight of assessment

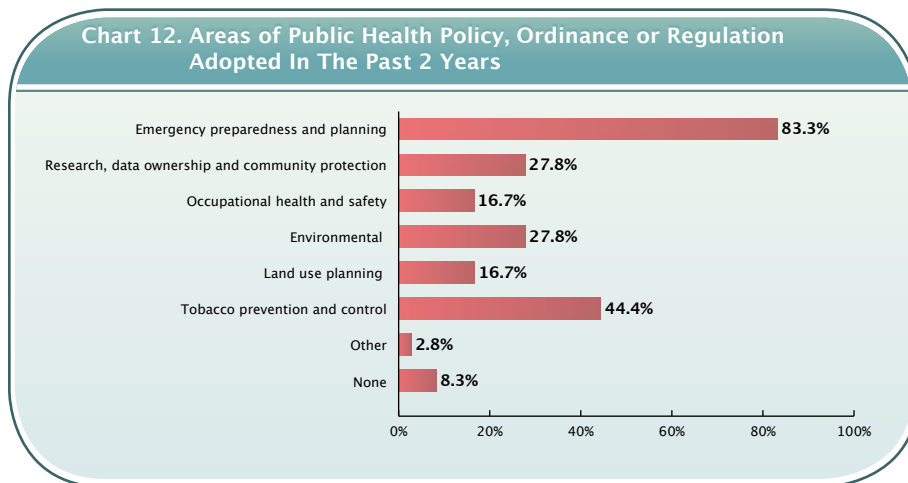
and evaluation activities and review of research and evaluation proposals. Less than a third of THCs provide oversight of emergency preparedness plans and formal partnership agreements.



Adoption Of New Local Public Health Policy, Ordinance Or Regulation

Nearly a third of Tribal Health Organizations adopted a new local public health policy, ordinance or regulation in the past 2 years. Among these Tribal Health Organizations, the majority of policies pertained to emergency preparedness and planning, and tobacco prevention and control. Approximately

a third of Tribal Health Organizations indicated that new policies were developed in the areas of research, including data ownership and community protections, and the environmental quality, setting indoor air, water, and soil standards.



Ensuring Safety and Regulation

ESSENTIAL SERVICE VI: ENFORCE LAWS AND REGULATIONS THAT PROTECT HEALTH AND ENSURE SAFETY

Highlights

- Less than 40 percent of Tribal Health Organizations receive funds from their state health agency/department through the CDC public health preparedness cooperative agreement.
- Emergency activities most identified by Tribal Health Organizations were pandemic flu, natural disasters and severe weather, and infectious disease.

Communities are not always aware of the influence of public health regulations on their environment. Regulations ensure safe drinking water, clean air, and sanitary conditions at restaurants, Head Start Program safety, and safe food storage, preparation and service. Other important public health activities that are regulated, licensed, and monitored include emergency preparedness, pandemic flu, infectious disease, and hazardous materials containment.

State Distributed CDC Public Health Preparedness Funding

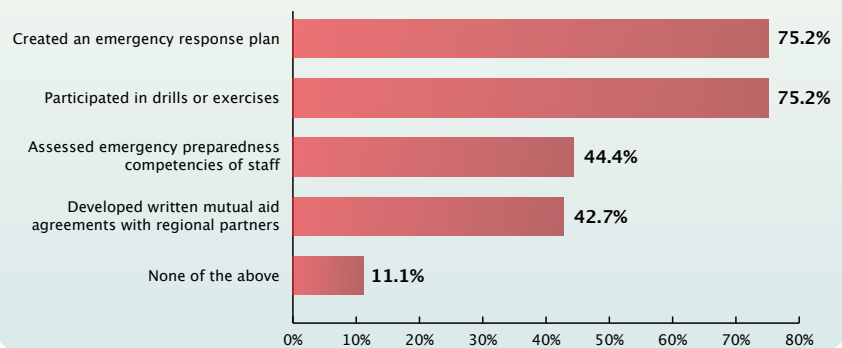
The federal government sometimes transfers its responsibility and funding for public health functions to the states, as with public health preparedness funding and block grants. Such transfers fail to recognize tribal sovereignty and impede self-determination. Many tribes provide public health services in their communities in partnership with state health departments; however, tribal consultation at the state level is not routinely accomplished. Presidential Executive Order 13175 Consultation and Coordination with Indian Tribal Governments requires regular and meaningful consultation and collaboration with tribal officials on significant policy and funding decisions that have tribal implications. The extent to which tribal consultation, partnerships and relationships occur varies by tribe, state and type of service.

“Funding for emergency preparedness needs to come directly to the tribes and not through the state.”

Less than 40 percent of Tribal Health Organizations receive funds from their state health agency/department through the CDC Public Health Preparedness Cooperative Agreement. Among Tribal Health Organizations that do receive CDC public health preparedness funds, only 33 percent receive funds for full and part time staff. 77 percent of Tribal Health Organizations that do not receive funds from their state health agency/department through the CDC Public Health Preparedness Cooperative Agreement participate in a task force or coalition of community partners that is led by another agency to develop and maintain local and/or regional emergency preparedness and response plans.

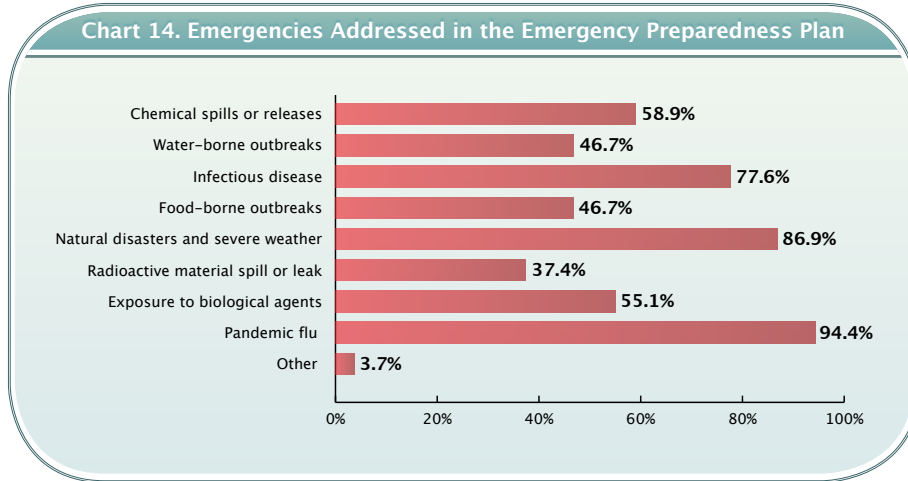
The majority of Emergency Preparedness (EP) plans provide for pandemic flu (H1N1), natural disasters and infectious diseases. A little over half of the EP plans provide for chemical spills and exposure to biological agents (anthrax). Less than half of the EP plans provide for water and food borne outbreaks.

Chart 13. Emergency Preparedness Activities Led By THD/Os in Past 2 Years



The majority of Tribal Health Organizations engaged in emergency preparedness activities participated in drills or exercises and created an emergency preparedness (EP) response plan. Fewer Tribal Health Organizations assessed emergency preparedness competencies of staff based on the nine core EP competencies or developed written mutual

aid agreement with neighboring or regional local health department or IHS. Emergency activities most included by Tribal Health Organizations in EP plans were pandemic flu, such as H1N1 and avian flu, natural disasters and severe weather, and infectious disease, such as hepatitis and tuberculosis.



Regulation, Inspection And Licensing

Regulatory activities are provided primarily by the Tribal Health Departments or IHS in tribal communities. Areas under regulation, inspection and licensing included are mobile homes, solid waste disposal sites, solid waste haulers, septic systems, hotels/motels, schools/daycare/Head Start, swimming pools, tobacco retailers, smoke free ordinances, and lead/asbestos inspection.

For Tribes, Tribal Associations/Consortia, these regulatory activities may be supervised by tribal departments other than the health department. Area Indian Health Boards and Urban Indian Health Centers do not engage in regulatory activities, with the exception of health facilities where four Urban Indian Health Centers regulate and/or inspect such facilities. A small percent of Tribal Health Departments indicate that state and local health departments engage in regulatory activities within their communities.

Table 12. Regulation, Inspection and Licensing Activities by Tribal Health Organization Type

Activity or Service	Epidemiology/Surveillance Service Provider				Tribal Health Department Response	
	Tribe	IHS	Health Board/ Epi Center	Urban Center	State Health Dept.	Local Health Dept.
Mobile Homes	30%	12%			6%	8%
Solid Waste Disposal Sites	39%	27%			9%	20%
Solid Waste Haulers	25%	27%			8%	13%
Septic Systems	44%	50%			6%	11%
Hotels/Motels	16%	12%			8%	16%
Schools/Daycare/Head Start	44%	35%		6%	22%	20%
Swimming Pools	25%	23%			9%	19%
Tobacco Retailers (smoke shops)	33%	8%			9%	8%
Smoke-Free Ordinances	47%	23%		11%	16%	11%
Lead/Asbestos Inspection	34%	42%			16%	14%
Public/Private Drinking Water	63%	50%			22%	17%
Food Service Establishments (including casinos)	47%	38%			14%	14%
Health Facilities	61%	69%		22%	20%	20%
Housing Inspections	64%	35%			9%	11%

Access

ESSENTIAL SERVICE VII: LINK PEOPLE TO NEEDED PERSONAL HEALTH SERVICES AND ASSURE THE PROVISION OF HEALTH CARE WHEN OTHERWISE UNAVAILABLE

Highlights

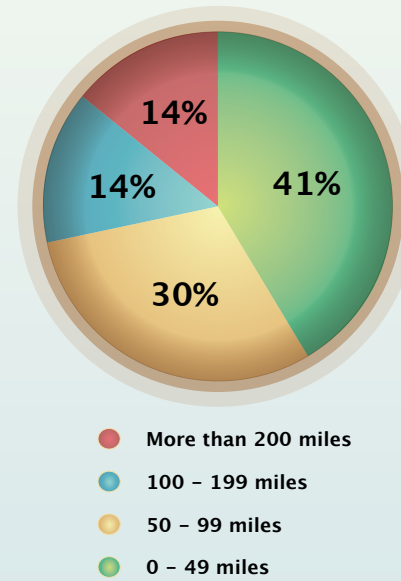
- 59 percent of Tribal Health Organizations serve populations that travel 50 miles or greater to access their services.
- Tribal Health Departments are more likely to provide services for persons with disabilities, recently released from incarceration, and those with addictions than do other Tribal Health Organization.
- 83 percent of Tribal Health Organizations have either an initiative or mechanism in place to enroll eligible individuals into public benefit programs, such as Medicaid/Medicare.

Assuring access to care and health promotion services is an important function of public health. American Indian/Alaska Native communities experience a number of barriers in accessing services. Some barriers are historical and cultural, such as distrust of providers, cultural incompetence and disrespect for traditional practices and beliefs, and discrimination^{13,14}. Other barriers are more physical, such as lack of transportation, distance between home and services, wait times for services, lack of insurance and low availability of specialty services from contract providers. Many of these barriers manifest differently in rural and urban communities. The Profile is limited to distance travelled, services available for vulnerable populations, and Medicaid/Medicare programs.

Distance

When asked for the furthest distance (in miles) the user population has to travel to obtain primary health care in their community, more than half, 59 percent, of Tribal Health Organizations reported a distance of 50 miles or greater to access their services. The average distance reported is 123 miles, one way.

Chart 15. Distance Traveled by Populations Served As Reported by THD/Os



¹³ Call, KT, McAlpine, DD, et al. barriers to care among American Indians in public health care programs. *Medical Care*. June 2006; 44:6, pp 595-600

¹⁴ Lillie-Blanton, M, Roubideaux, Y. Understanding and addressing the health care needs of American Indians and Alaska Natives. *American Journal of Public Health*. 2005; 95:5, pp 1-3.

Vulnerable Populations

Almost all Tribal Health Departments and IHS Facilities provide services for persons 65 years of age and older. Tribal Health Departments are more likely to provide services to those with disabilities, recently released from incarceration, and with addictions than other Tribal Health Organizations. More IHS Facilities provide services for lesbian, gay,

bisexual and transgendered individuals than other Tribal Health Organizations. More Urban Indian Health Centers provide services for persons 65 years of age and older, with addictions, and with physical disabilities than other services listed. The majority of Area Indian Health Boards do not provide these types of services.

Table 13. Services For Vulnerable Population By Tribal Health Organization Type

Activity or Service	Tribe	IHS	Health Board/Epi Center	Urban Center
Persons 65 Years of Age and Older	97%	93%	20%	89%
Persons with Physical Disabilities	78%	70%	20%	67%
Persons with Mental Illness	83%	85%	20%	61%
Persons Recently Released from Incarceration	62%	37%	-	56%
Lesbian, Gay, Bisexual and Transgendered Individuals	48%	63%	20%	61%
Persons with Addictions	87%	78%	20%	78%

Medicaid/Medicare Programs

Medicaid and Medicare are governmental programs that provide medical and health related services to individuals who qualify. Medicaid is a medical services program for low income individuals and families. Medicare is a federal health insurance program that pays for hospital and medical care for elderly and certain disabled Americans. Many

American Indians and Alaska Natives who meet the eligibility requirements for Medicaid and Medicare are not enrolled. The majority, 83 percent, of Tribal Health Organizations have either an initiative or mechanism in place to enroll eligible individuals into public benefit programs, such as Medicaid/Medicare.

Workforce

ESSENTIAL SERVICE VIII: ASSURE A COMPETENT PUBLIC AND PERSONAL HEALTH CARE WORKFORCE

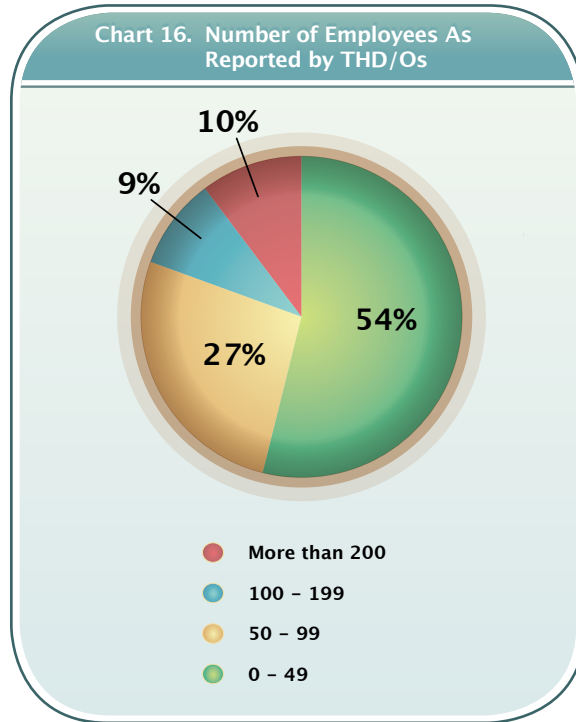
Highlights

- The average percentage of employees that are members of federally recognized tribes is 57.
- More than half of Tribal Health Organizations have less than 50 employees.
- 14 percent of Tribal Health Organization report having a traditional healer on staff.

Tribal Health Organization employees are an important component of the overall tribal public health system. Tribal and/or Indian Preference in hiring is common practice as a means for strengthening tribal self-determination. Title VII of the Civil Rights Act of 1964 and the Self-Determination Act include exemptions that allow tribes to implement Tribal and/or Indian Preference hiring practices under certain conditions. The average percentage of employees that are members of federally recognized tribes is 57.

As seen in Chart 16, more than half of Tribal Health Organizations have less than 50 employees and 10 percent have more than 200. The average number employees for responding Tribal Health Organizations is 64.

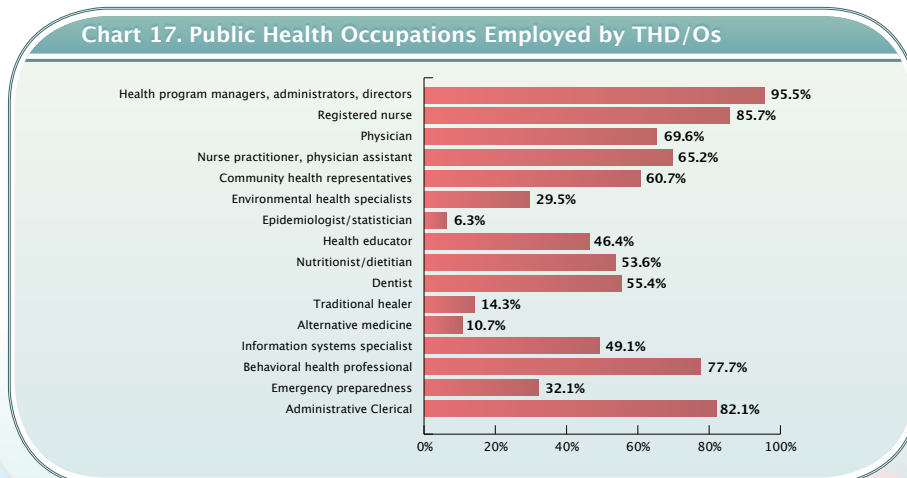
Chart 16. Number of Employees As Reported by THD/Os



Tribal Health Organizations employ a variety of public health occupations. Prevention care is most frequently provided by community health representatives (CHRs), nutritionist/dietician, health educators and community health nurses. CHRs are lay health care workers and work closely with the registered nurses. Many health program managers are responsible for coordinating prevention health programs.

Public health occupations most frequently employed are administrators and primary health care providers, including physicians, registered nurses and nurse practitioners, and behavioral health professionals. Only 6 percent of Tribal Health Organizations report having an epidemiologist or statistician on staff.

Chart 17. Public Health Occupations Employed by THD/Os



Evaluation

ESSENTIAL SERVICE IX: EVALUATE EFFECTIVENESS, ACCESSIBILITY AND QUALITY OF PERSONAL AND POPULATION-BASED SERVICES

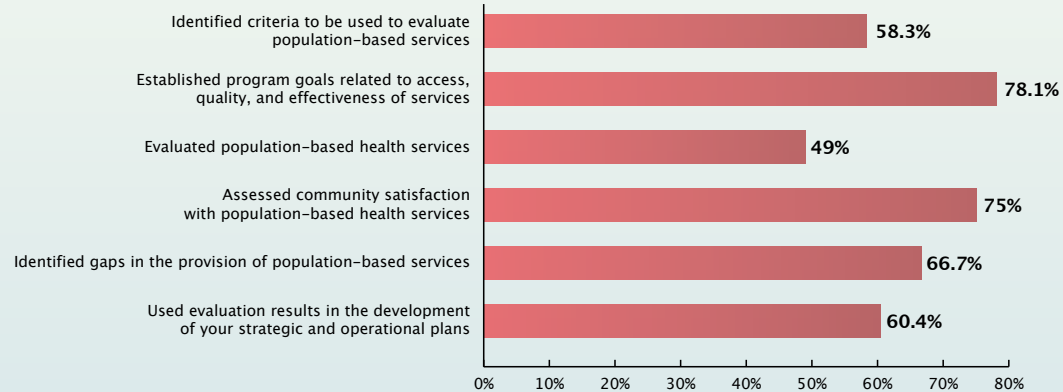
Highlights

- 66 percent of Tribal Health Organizations evaluate public health activities and/or services.

Evaluation helps public health professionals continually strengthen and improve programs and services. The process of evaluation helps Tribal Health Organizations and their collaborators determine the success of community health initiatives. Ongoing evaluation of health programs based on analysis of health status and service utilization data can be used to inform Community Health Improvement Plans, assess program effectiveness and provide information necessary to make informed decisions about allocating resources and modifying programs.

Among respondents, 66 percent of Tribal Health Organizations evaluate public health activities and/or services. The top three population-based services evaluation activities of Tribal Health Organizations in the past three years, in descending order, are 1) Established program goals related to access, quality and effectiveness, 2) Assessed community satisfaction with population based health services, and 3) Identified gaps in the provision of population based services. To a lesser degree, Tribal Health Organizations use evaluation results to develop strategic and operational plans and, establish criteria to assess and evaluate population-based health services.

Chart 18. Evaluation Activities Of Population Based Health Services, In The Past Three Years



Participation In Health Research

ESSENTIAL SERVICE X: RESEARCH FOR NEW INSIGHT AND INNOVATIVE SOLUTIONS TO HEALTH PROBLEMS

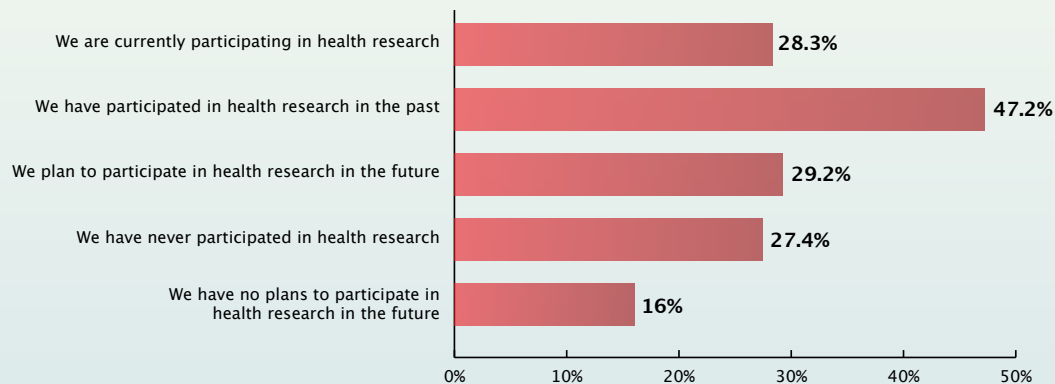
Highlights

- Nearly 30 percent of Tribal Health Organizations are currently participating in health research and plan to participate in the research in the future.
- Over 40 percent of Tribal Health Organizations have a research policy or ordinance that outlines protocols for reviewing and participating in health research.

Nearly 30 percent of Tribal Health Organizations are currently participating in health research and plan to participate in the research in the future. Approximately half, 47 percent, of Tribal Health Organizations have participated in health research in the past and 28 percent have never participated. 16 percent have no plans to participate in health research in the future.

Tribal Health Organizations are increasingly engaged in health research; however, historically and even recently, research has brought harm and stigmatization to American Indian/Alaska Native communities. Such events have created barriers related to mistrust, confidentiality, and community protections. Tribal Leaders and Tribal Health Organizations are faced with the responsibility of balancing the potential benefits (such as increased knowledge about the cause or treatment of disease, identification of effective prevention strategies, and community education) and ensuring appropriate policies and protocols are established and enforced to address potential barriers.

Chart 19. THD/O Participation In Health Research



Research Review And Approval

Over 40 percent of Tribal Health Organizations have a research policy or ordinance that outlines protocols for reviewing and participating in health research. Research review and approval protocols include research review committees or boards to serve in that capacity. Tribal Health Organization research review and approval process descriptions fell into four primary categories:

- 1) Health Board/Committee (17 percent)
Authority is given to a Health Board/Committee to review and approve research on behalf of the tribe, tribal association/consortium.
- 2) Health Board/Committee and Tribal Council (9 percent)
The Department Head/Administrator is responsible for reviewing and preparing the proposal for review by a Health Board/Committee, Advisory Board, or other group, that provides recommendations for approval to Tribal Council. Process may include a Tribe's legal counsel. Tribal Council is responsible for the final review and approval decision.
- 3) Tribal Council only (17 percent)
Tribal Council is the sole body to review and approve research. Process usually includes a Tribe's legal counsel.
- 4) Institutional Review Board (IRB) (52 percent)
IRBs, also known as an independent ethics committee, are a committee that is formally designated to approve, monitor and review biomedical and behavioral research involving human subjects with the aim to protect the rights and welfare of the research subjects. IRBs are governed by federal regulations, Title 45 CFR Part 46. (<http://ohsr.od.nih.gov/guidelines/45cfr46.html>)

The majority of Tribal Health Organizations require approval from an IRB, whether tribal, IHS, or university. Most other approval processes involve a health board/committee and/or Tribal Council. Although IRB approval of research involving human subjects is legally required, most Tribal Health Departments did not identify it in the Tribe's review and approval process. IHS Facilities and Area Indian Health Boards most commonly identified a process that includes staff review, IHS IRB approval within the formal IHS Research Guidelines, and Tribal Council approval by participating tribes. Most Urban Indian Health Centers described processes that include staff review and formal IRB approval, either through IHS or a university.

What Is Working In Tribal Health Organizations

Tribal Health Organizations conduct a wide array of public health activities in the communities they serve. The unique and successful activities designed to improve health services identified by Tribal Health Organizations fell in three primary areas: Partnerships, Targeted Services/Programs, and Quality Improvement.

Partnerships. Tribal Health Organizations form partnerships with multiple tribal, local and state agencies, universities, and community organizations to plan, coordinate and provide public health services in their communities. Cross cutting themes among successful partnership descriptions include formal agreements, such as intergovernmental agreements and memoranda of understanding, support from leadership, and multi-disciplinary advisory and coordinating teams, committees or other groups.

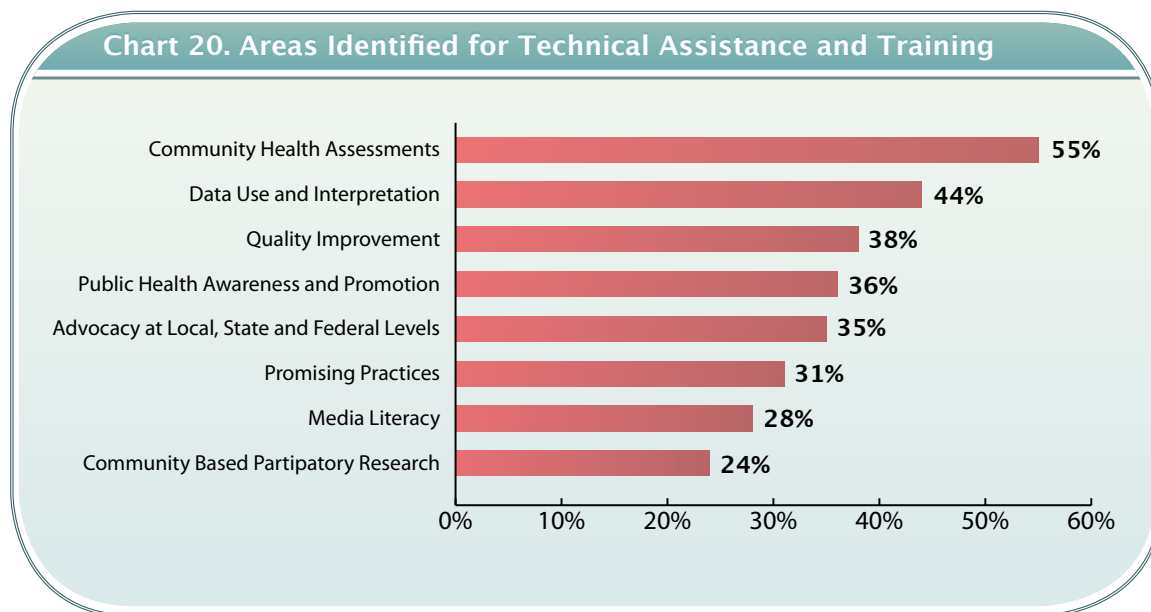
Targeted Services. Partnerships formed around targeted services, such as oral health, family centered wellness, HIV/AIDS education, and elder care, are having a positive impact. Cross training among partnering agencies provide greater understanding of agency roles and responsibilities, increased communication, and strengthen coordination.

Quality Improvement. Tribal Health Organizations are increasingly engaged in quality improvement activities to improve service delivery and performance to better serve communities. Quality improvement activities include monthly review of ongoing Plan-Do-Check-Act improvement processes, participation in Innovations in Planned Care, and strategic planning with quality improvement goals.

Technical Assistance And Training

Tribal Health Organizations were asked to identify areas for technical assistance and/or training needs that would be of greatest benefit to their organization. The areas identified most commonly

for technical assistance are highlighted in the table below. Community health assessments, data use and interpretation and quality improvement are the top three areas for technical assistance.



Future Directions

Tribal Health Organizations and other agencies and entities that make up tribal public health systems are engaged in a broad range of public health activities within a system that is severely underfunded. In the era of Healthcare Reform and the permanent reauthorization of the Indian Healthcare Improvement Act, there is a great deal of optimism and momentum towards improving the health status of American Indians and Alaska Natives. There is a great deal of work that remains to be done to create a tribal public health system that is functioning proactively, rather than reactively, to address the needs of the community. The 2010 NIH Tribal Public Health Profile provides important data and information to describe tribal public health systems. Important areas identified for further investigation include, but are not limited to, the following:

Development and resource allocation

- Tribal Health Organizations conduct many of the same public health activities which may indicate that service duplication or overlap is occurring, there is greater tribal readiness to 638 contract services, and/or there are opportunities to collaborate at the local level.
- Tribal Health Organizations provide a wide range of public health activities. Further investigation is needed to determine the level at which these services are provided.
- Opportunities exist for developing and expanding relationships with colleges and universities in the areas of workforce development, public health interventions, and research.
 - There is a significant need for qualified public health professionals (epidemiologists, statisticians, environmental health professionals, etc.); and identification of workforce training and education needs.
 - Develop public health interventions that are effective in American Indian and Alaska Native communities.
 - Strengthen partnerships to conduct tribally driven and culturally appropriate research to improve health outcomes
- Overall, Tribal Health Organizations differed

in their perception and awareness about which organizations conduct which public health services in tribal communities. Collaborative efforts to address these differences in perception are critical to effectively provide public health services.

Advocate for resources and policy on behalf of Tribes and public health

- Many tribes provide public health services in their communities in partnership with local and state health departments. The extent of tribal partnerships and relationships with these other public health entities varies by tribe, state, and type of service. Further investigation is needed to understand and strengthen the nature and quality of relationships among Tribal Health Organizations with state and local health departments and agencies.
 - More Tribal Health Organizations reported having agreements with state health departments than local health Departments. Conversely, more local health departments conduct prevention activities in tribal communities than state health departments.
 - Less than percent of tribes reported receiving funds from their state health agency/ department through the CDC Public Health Preparedness Cooperative Agreement.
 - More data sharing agreements are needed among Tribal Health Organizations, state and local health departments to better serve communities at the local level.
- Federal funding needs to be provided directly to the tribes rather than as pass through grants from the states.
 - Access to federal funding that is passed through the states is limiting Tribal Health Organizations' ability to address community needs, as occurred with H1N1 among other health concerns.
- Access to care is a significant issue, especially for small, rural tribal communities. Greater advocacy for funding and resources are needed to address related barriers.

Assess readiness for tribal public health accreditation

- Tribal Health Departments are engaged in a multitude of public health activities across the 10 Essential Public Health Services, including governance and administration, which are the basis for the accreditation standards and measures. Self-assessments are an important first step to determining at what level individual Tribal Health Departments are providing these services and their readiness for accreditation.
- Many Tribal Health Departments conduct community health assessments, a key component of accreditation. Further study is needed to determine whether community health assessment data are used in community health improvement plans.
- Tribal Health Organizations are engaged in quality improvement activities, which can increase readiness for accreditation.

Identify technical assistance and quality improvement needs

- Tribal Health Organizations are increasingly interested in data based decision making, an important factor in strategic planning, community health improvement planning, and quality improvement. Data use and interpretation is a critical area for technical assistance and training, and is directly tied to the need for a skilled public health workforce.
- Resources, staff and training are needed to support Tribal Health Organizations in conducting community health assessments and community health improvement planning.
- More training in quality improvement is needed to build tribal infrastructure and improve performance.

The 2010 NIHB Tribal Public Health Profile is the first publically available snapshot of the national tribal public health systems. Focused efforts are needed to create a tribal public health system that is functioning proactively, rather than reactively, to address the needs of tribal communities. Assessing tribal public health capacity is time consuming and complex; however, it is an important means to describe the processes by which Tribal Health Organizations identify, address and prioritize community health needs. Tribal Health Organizations can use the resulting data to make informed decisions, take strategic action and measure impact over time.

Tribal Public Health Accreditation

The Public Health Accreditation Board (PHAB) and The National Indian Health Board (NIHB) have partnered in a national effort to improve public health practice in Indian Country. PHAB is developing a national voluntary public health accreditation program for state, territorial, tribal, and local health departments. Public health accreditation is a process that will measure the degree to which a public health department meets nationally recognized standards. The national voluntary public health accreditation program will launch in 2011. PHAB is working with NIHB to ensure that accreditation standards address the specific needs and challenges of the tribal public health programs. As the national public health accrediting body, PHAB recognizes the unique and critical role that tribal governments have in developing the accreditation program. As PHAB tests the accreditation standards, measures and procedures through the upcoming beta test, tribal health programs will have an opportunity to provide important feedback on the accreditation program prior to its national launch in 2011.

What public health accreditation means for Indian Country

The goal of the accreditation program is to improve and protect the health of AI/ANs by advancing the quality of public health services. Through work with NIHB, PHAB understands that enhancing public health in Indian Country means addressing a complex set of services that are often provided by a diverse group of partners and stakeholders. Tribal leaders and health officials are giving valuable input into the creation of the accreditation standards and the process of becoming accredited, and therefore are taking an active role in ensuring that Native communities are safe, healthy places to live.

Why accreditation matters to tribal public health

The expectation is that accreditation will strengthen all public health departments and the services they provide, which will contribute to improved community health. Accreditation can benefit Native communities in various ways, including:

- Responsibility and visibility. Implementing accreditation standards can support tribal governments in their efforts to improve their community's health.

- Performance feedback and quality improvement. The accreditation assessment process provides valuable, measurable feedback to public health programs on their strengths and areas for improvement.
- Valuable partnerships. The accreditation process encourages strong, active partnerships between public health practitioners, stakeholders and community members in Indian Country.
- Reducing health disparities. The accreditation process promotes building and enhancing public health services so that the same level of high quality public health services is available to everyone.

Learn more

Efforts are already underway to help tribal health providers prepare for accreditation. Tribal health officials, health department staff, local partners, non-profits and other stakeholders who are interested in an accountable and effective public health system are encouraged to contact NIHB (www.nihb.org, 202-507-4070) or PHAB (www.phaboard.org 703-778-4549) for more information.

“NIHB and PHAB share a commitment to building strong, thriving Tribal communities. Accreditation is an opportunity to strengthen public health in Indian Country, address the unique needs of the Tribes, and create healthier environments for Our People.”

*- H. Sally Smith, PHAB Board Member
and NIHB Board Member*

Glossary and Acronyms

1. AI/AN – American Indians and Alaska Natives
2. Area Indian Health Board or Inter Tribal Council – a non-profit organization with a governing board that is made up of the highest ranking official or appointee of federally recognized tribes within a designated geographic area and has a Tribal Epidemiology Center through funding from the Centers for Disease Control and Indian Health Service.
3. Community Health Assessment* – a call for regularly and systematically collecting, analyzing, and making available information on the health of a community, including statistics on health status, health needs, epidemiologic and other studies of health problems.
4. Community Health Improvement Plan* – a long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process.
5. Compact Services (638)** – Under Public Law 93-638 a tribe may seek eligibility to compact health services provided by the Indian Health Services. A compact is more like a block grant than a contract giving a tribe greater management and administrative authority to administer health services.
6. Contract Services (638)** – Under Public Law 93-638 a tribe can contract with Indian Health Service to take over the management of specific programs.
7. Direct Service Tribe** – a tribe that receives their health care through the Indian Health service is considered a direct service tribe.
8. Epidemiology – the study of the amount and distribution of disease within a community by person, place and time.
9. EP – Emergency Preparedness
10. Health Indicators – data used to measure and track the health status of a defined population or community.
11. IHS – Indian Health Service
12. Indian Health Service Facility – a local administrative unit of the Indian Health Service that provides contract health services on or near an Indian reservation.
13. IHS Resource Patient Management Service (RPMS) – the data management system used by IHS for clinical business and administrative information.
14. Presidential Executive Order 13175 Consultation and Coordination with Indian Tribal Governments** – requires federal agencies to consult with tribes in the development of budgets and policies that affect them.
15. Public Health Accreditation* The development of a set of standards, a process to measure health department performance against those standards, and some form of reward or recognition for those agencies meeting the standards.
16. Public Health Accreditation Board* – the accrediting body for national public health accreditation.
17. Public Health Capacity – describes the ability of a public health system to improve community health status.
18. Public Law 93-638, Indian Self-Determination and Educational Assistance Act of 1975** – directs the Secretary of the Department of the Interior and the Secretary of the Department of Health and Human Services, to enter into self-determination contracts upon the request of any tribe. These “638” contracts may be for planning, conducting and administering programs that are provided by the federal government for the benefit of American Indians/Alaska Natives.

19. Surveillance – refers to the monitoring of data trends over time.
20. Quality Improvement* – is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization. The intent is to improve the level of performance of key processes and outcomes within an organization.
21. THC – Tribal Health Committee, Board or Group that meets regularly to provide oversight, approve major decisions and/or makes recommendations to their respective Tribal Health Organization.
22. Tribal Health Organization – for purposes of the Profile, Tribal Health Organizations is the term used to describe the entities that participated in the profile. These entities include Tribal Health Departments, Indian Health Service Units, Area Indian Health Boards and Urban Indian Health Centers.
23. Title V of the Indian Health Care Improvement Act** – contains an array of provisions designed to increase the quality of Indian health services and to improve tribal participation in planning and providing services. It includes the consolidation and authorization of funding for existing Indian Health Service programs, facilities construction, health and medical services for urban Indians, and scholarships for American Indian/Alaska Native health professionals to work in Indian communities, among other programs.
24. Tribal Epidemiology (Epi) Center** – funded by Indian Health Service and Centers for Disease Control and Prevention to provide technical assistance and data monitoring for the tribes and Indian health programs within their region.
25. Tribal Health Department – a health department, corporation or organization operated under the jurisdiction of a federally recognized tribe, or association of federally recognized tribes, and is funded by the tribe(s) and/or contract service(s) from IHS.
26. Tribal Public Health Systems – the diverse set of stakeholders and partners engaged in public health activities in tribal communities.
27. Trust Responsibility – the provision of healthcare services to the American Indian and Alaska Native population as established by treaties, legislation and court decisions.
28. Urban Indian Health Center – a non-profit organization that receives funding to provide public health services to American Indian/Alaska Natives living in urban areas from IHS under Title V of the Indian Health Care Improvement Act, or is a member of the National Council of Urban Indian Health.

* Public Health Accreditation Board. Acronyms and Glossary Terms. July 15, 2009.
www.phaboard.org/assets/documents/Glossary-07-15-2009.doc

** Dixon M, Roubideaux Y, eds. Promises to Keep: Public Health Policy for American Indians and Alaska Natives in the 21st Century. Washington, DC: American Public Health Association; 2001.



Notes

National Indian Health Board



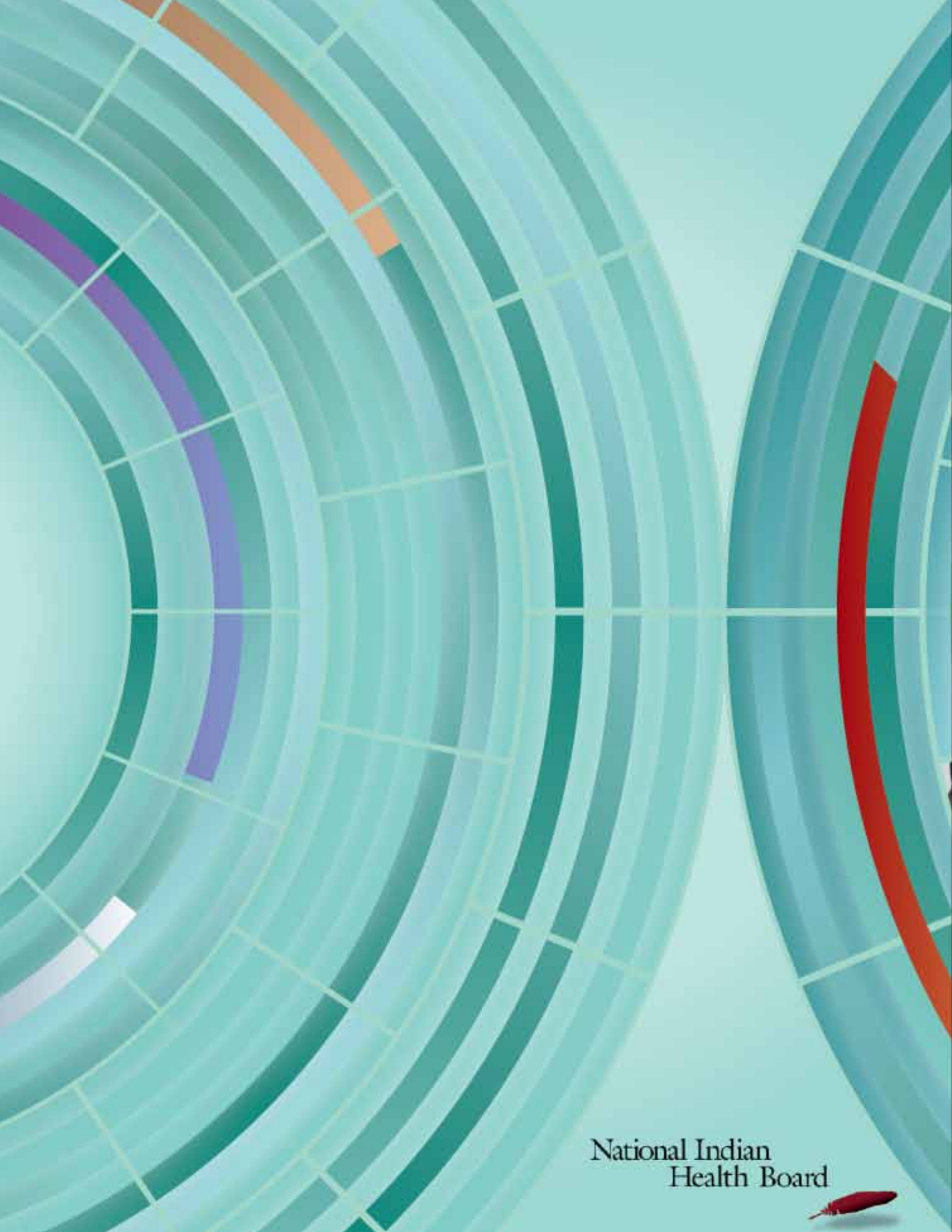
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