PHICCS II

PUBLIC HEALTH IN INDIAN COUNTRY CAPACITY SCAN

National
Indian Health
Board

A. Contact Information

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B. NIHB Mission Statement

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

C. About the PHICCS Report

The 2023 Public Health in Indian Country Capacity Scan (PHICCS) II Report remains a valuable scan of the Tribal public health systems in Tribal communities during the COVID-19 pandemic. The scan provides insight into Tribal capacity in public health and health service delivery and the spectrum of Tribal health systems in Indian Country. The purpose of the 2023 PHICCS Report is a second comprehensive scan similar to the 2019 PHICCS Report to assess the needs and strengths of Tribal public health.

D. Suggested citation:

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E. Funding

A Letter from NIHB's Interim Chief Executive Officer:

Since 2019, the National Indian Health Board (NIHB) has been committed to developing a reliable, Tribally focused resource to enhance our understanding of public health capacity in Tribal communities. Our goal has always been to improve access to relevant and secure data, which in turn informs initiatives, policies, and resources that impact Tribal health. The Public Health in Indian Country Capacity Scan (PHICCS) serves as an innovative tool that provides a snapshot of Tribal public health capacity across Indian Country. It addresses existing resource gaps and considers the structures of Tribal governance and the specific factors that influence Tribal public health services.

With the introduction of PHICCS II, we build upon our initial findings and expand our focus to include aspects related to the COVID-19 pandemic, which has profoundly affected Tribal communities and families. The lessons learned from the pandemic have shaped our approach to promoting public health for our people. The resilience and commitment displayed by Tribal Health Organizations (THOs) and their dedicated staff are now central to our mission of fostering optimal health in our communities. Our responsibility is to ensure that they have the necessary tools, resources, and infrastructure to succeed.

The PHICCS II report exemplifies how NIHB prioritizes Tribal perspectives and evidence-based practices in our efforts to support and enhance the capacity of the Tribes we serve. Access to culturally relevant resources like PHICCS is essential for improving and developing effective Tribal public health services while respecting Tribal sovereignty in Indian Country. This project identifies areas for collaboration to address gaps and strengthen the readiness of Tribes to respond to current, emerging, and future public health challenges.

This effort has not been undertaken in isolation; it is inspired by the partnerships and public health networks we have formed with Tribes, Area Indian Health Boards, subject matter experts, Tribal Epidemiology Centers, and many others. We sincerely appreciate the time and effort you have contributed to this initiative, which has been vital to its success.

As we look to the future of Tribal health and our capacity to serve our communities while honoring our cultures and traditions, we hope that the continued evolution of PHICCS will further enhance NIHB's ability to serve Indian Country. We aim to ensure that THOs are equipped, trained, and prepared to meet the needs of their Tribal members. We look forward to the ongoing and expanded partnerships that make projects like PHICCS meaningful.

Yours in health,

A.C. Locklear, JD (Lumbee Nation)
Interim CEO, National Indian Health Board
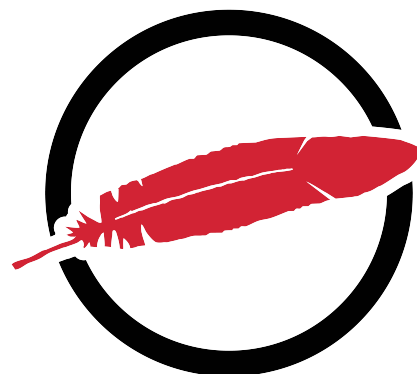
1   Executive Summary

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

In partnership and through support from the Centers for Disease Control and Prevention (CDC)[1], NIHB conducted the second comprehensive scan, known as the Public Health in Indian Country Capacity Scan (PHICCS), to better understand the current capacity of Tribal public health. The results of this project are in this 2023 PHICCS Report. This report serves as a valuable tool for Indian Country to assess better the needs and strengths of Tribal public health systems.

1.1 Methods

The PHICCS II survey was comprised of 68 questions aimed at understanding Tribal Health Organization (THO) capacity across core areas. Between August 10, 2022, and February 17, 2023, the PHICCS survey was sent to the 282 THOs identified by NIHB as serving the 574 federally recognized Tribal nations. There were 135 responses collected, with a response rate of 48%.

133 responses were included in the final analysis. Descriptive statistics were conducted for quantitative questions, while qualitative data was analyzed using a content analysis approach. Regional analysis was conducted using the CDC Cancer Regions to prevent respondents from being identifiable while providing regional-level data.

The survey did have limitations due to the response rate. However, despite high turnover in THO leadership, conflicting priorities, and the length of the survey, the response rate remained stable from PHICCS I. This data should be viewed as a "snapshot" of the capacity of THOs, and likely cannot be inferred to generalize public health capacity across all THOs. However, this remains one of the most comprehensive surveys of Tribal public health capacity to date.

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

1.2 **Findings**

1.2.1 Public Health Authority

How Tribes choose to exercise their inherent right to provide public health services for their Tribal citizens varies. While a majority (69%) of THOs reported governance through a Tribal Council, there is often oversight provided through additional and complimentary organizational structures commonly including Boards of Health (29%) and Tribal Chief or a designated Chairperson (29%). Most THOs reported receiving oversight for public health related delegations through multiple entities.

Tribal public health authority is often coupled with formal agreements of partnership across various sectors to strengthen subject matter expertise, resources, and services that are pertinent to the delivery of efficient public health services. Examples of these partnerships commonly include engagement with Tribal government (67%), schools (65%), and external governments (63%). These collaborative efforts aid in the development of responsive public health laws and regulations that speak to the needs of Tribal communities most often in preparation for response to public health emergencies (70%) and public health policies and priorities (60%).

1.2.2 Public Health Workforce

Tribal public health workforce includes both internal and external staffing that carry out efforts and activities for health promotion within Tribal communities. Despite the reported need for additional staffing across each staffing type, internal Tribal workforce continues to reflect the highest number of funded and filled full-time staffing among:

- Leadership/Upper management
- Office & Administrative positions
- Community Health Representatives
- Behavioral Health Staff

Among all survey respondents, an additional 1,238 new roles need to be filled to operate at full workforce capacity. Opportunities for recruitment among technical roles remain consistent with the highest average number of funded full-time employee (FTE) vacancies and additional funded FTE needed reflected among:

- Grant Writing
- Epidemiology/Statisticians
- Public Health Communications

Participating THOs also noted the need for training and professional development to retain and ensure their workforce is competent and able to deliver care.

Community involvement and volunteerism continue to play a role in the capacity of Tribes to provide essential public health service delivery. A reported 11% of THOs relied on volunteers for assistance with immunization services and emergency preparedness.

1.2.3   Assessment, Planning, and Performance Management

The continuous improvement of quality and informed decision-making for Tribal public health services is supported through development of essential plans including the community health needs assessments and insight from formal or informal evaluations. A majority of THOs (72%) are in the process of completing or have in place a comprehensive community health needs assessment that can provide base-line evidence to support public health efforts. At least 83% reported the conduction of formal or informal evaluation of their public health activities.

1.2.4   Public Health Activities

Understanding the scope of public health activities offered in a service area is critical for understanding a current system's strengths and gaps in addressing public health challenges. Public health activities generally include population health services, screenings, education, data collection and disease surveillance, emergency activities, regulations, inspections and licensing, and health communications. Most PHICCS respondents stated that, in the past year, immunization activities, direct population services, screenings and education on chronic disease and behavioral health, and COVID-19 service occurred in their service areas, while services related to public health data collection, emergency response, and regulatory activities were offered in few services areas. Direct population services were often provided by the THO either on their own or alongside partners. However, emergency response and regulatory activities, when offered, were often provided by an organization other than the THO.

1.2.5   Public Health Priorities and Needs

Public health priorities and needs may vary across jurisdictions, but often drive the actions of a THO. PHICCS respondents identified their top priorities as:

- Data assessment
- Workforce development
- Emergency preparedness
- Health education and promotion
- Planning and priority setting
- Tribal public health governance

The specific health problems that THOs were focused on include chronic disease (diabetes, heart disease, and cancer) and behavioral health problems including substance misuse and suicide. To address these priorities, THOs emphasized their top needs were for staffing and funding for the public health systems. Respondents shared their significant challenges recruiting and retaining staff due to inflation and increases in professional wages while budgets

have stagnated. Many respondents also highlighted the need for non-competitive funding for THOs, particularly for infrastructure purposes.

1.3 **Summary**

With the addition of considerations related to the COVID-19 pandemic, the newest rendition of the PHICCS report builds on existing findings and previously highlighted priorities. Several mentions from PHICCS I remain consistent and new emerging areas were identified. Demonstrated resilience continues to be reflected by the ability of Tribal communities to carry out public health services despite multifaceted challenges and chronic limitations in resources. Continued support in the areas of funding, training, partnership, and data remain top priorities for advancement of public health capacity building in Indian Country.

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Acronyms

AI/AN   American Indian/Alaska Native

AIHB   Area Indian Health Board

BMI   Body mass index

CDC   Centers for Disease Control and Prevention

CHA   Community health assessment

CHIP   Community health improvement plan

CHR   Community health representative

COVID-19   Coronavirus Disease 2019

FTE   Full time employee

HIPAA   Health Insurance Portability and Accountability Act

IDH   Indigenous Determinants of Health

IHS   Indian Health Service

ISDEAA   Indian Self-determination and Education Assistance Act

NIHB   National Indian Health Board

PHAB   Public Health Accreditation Board

PHAP   Public Health Associate Program

PHICCS   Public Health in Indian Country Capacity Scan

RIL   Regulation, inspection, or licensing

STI   Sexually transmitted infection

TEC   Tribal Epidemiology Center

THO   Tribal Health Organization

2   Introduction/Background

2.1 Overview of Public Health in Indian Country

American Indian and Alaska Native (AI/AN) people have practiced public health since time immemorial. Like many Indigenous Peoples, AI/AN people historically viewed health differently than non-Indigenous communities. While significant cultural differences exist across AI/AN Nations, commonly held beliefs include the idea of health across mind, body, spirit, and the connection of the People to the land.

Unfortunately, due to the impact of colonization and the disruption of traditional systems of wellness, AI/AN people now face some of the worst outcomes and health disparities of any population in the United States. AI/AN people suffer from higher rates of many chronic, behavioral, and infectious diseases compared to their non-Indigenous counterparts. The COVID-19 pandemic widened the gap in health outcomes- multiple studies showed higher COVID-19 mortality risks for AI/AN people compared to the general population. While life expectancy dropped during the pandemic across all racial and ethnic groups, life expectancy for AI/AN people fell the most drastically. Currently, AI/AN people have an average life expectancy of only 67.9 years: the lowest of all racial and ethnic groups[2].

However, the pandemic also led to many changes in Tribal public health. There has been a renewed focus on public health self-governance, leading to system-level changes. There is also a renewed understanding of the importance of public health among both Tribal leadership and the citizens of Tribal Nations.

2.2 Historical Context of Tribal Public Health

Historically, Tribes ensured their communities' health by integrating systems of health and overall well-being. As with most — if not all — Indigenous people, prior to European contact, Native Americans had complex traditions, cultural practices, social organizations, economies, forms of government, education, and spirituality that interrelatedly worked together to ensure the health and survival of the people.

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[2] Arias, E, Kochanek, M.A., Xu, J., Tejada-Vera, B.. (2023, November). Provisional Life Expectancy Estimates for 2022. National Vital Statistics System Vital Statistic Rapid Release. 31. Retrieved 12/5/2024 from https://www.cdc.gov/nchs/data/vsrr/vsrr031.pdf.

European colonization of the Americas changed the trajectory of Indigenous health. The disruption of family life, forcible relocations, epidemics, the loss of languages and traditions through forced assimilation and indoctrination, the destruction of land, violence, and government policies aimed at weakening Tribal sovereignty contributed the deterioration of historical Indigenous systems of wellness.

Tribal Nations are recognized by the U.S. Constitution as the oldest governments in North America, with sovereign powers that predate the US. or its predecessors. In recognition of this, the U.S. entered into treaties with Tribal Nations in which the provision of health services was exchanged for Tribal land. These treaties constitute the basis for the Federal Trust Responsibility- the obligation for the federal government to provide certain benefits to AI/AN people, including the provision of health services. This responsibility has been reinforced in various court cases including the Marshall Trilogy, the Snyder Act of 1921, and the permanent reauthorization of the Indian Health Care Improvement Act in 2010. Additionally, the Indian Self Determination and Education Assistance Act (ISDEAA) of 1975 transitioned Tribes into a period of self-governance by allowing Tribes to take control over their own health systems through contracts and compacts with the federal government, particularly IHS to administer these services.[3]

Unfortunately, many of the policies of the U.S. government led to poorer health outcomes for AI/AN people when compared to the general population. Periods of removal from ancestral lands and forced assimilation led to disparate outcomes for AI/AN people. These factors can best be understood through the Indigenous Determinants of Health (IDH) Model, which outlines the specific determinants that most closely impact Indigenous people, and how colonization led to inequities and disconnection from many of these determinants.[4]

These disparities are further compounded by the differences in the development of public health systems in state and local jurisdictions when compared to Tribal jurisdictions. The first public health services offered to AI/AN people by the federal government came in response to infectious diseases, such as the smallpox immunization campaigns of the early 1800's. These public health services tended to be heavily integrated into healthcare and were primarily offered first by the Bureau of Indian Affairs, and later following the Transfer Act of 1954, the Indian Health Service (IHS). While Tribes continued to receive minimal public health services,

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[3] Indian Health Service. (2015, January). Basis for health services. IHS Newsroom Fact Sheets. Retrieved 4/13/2024 from https://www.ihs.gov/newsroom/factsheets/basisforhealthservices/,

[4] Permanent Forum on Indigenous Issues (2023, January 31). Indigenous Determinants of Health in the 2030 Agenda for Sustainable Development. United Nations Social and Economic Council. E/C.19/2023/5.

the current public health system began to develop at the state and local levels, with support from the federal government. These systems looked very different, with health promotion and disease prevention- not clinical services- as the focus. While state and local jurisdictions received funding and investment into these systems, Tribes were left out of the funding streams needed to develop their own public health systems. Today, in the spirit of Tribal sovereignty and self-governance, Tribes are clear public health authorities with the rights and responsibilities to carry out public health activities. Tribal health departments are developing, both within and separately from Tribal self-governance healthcare clinics. However, due to their continued exclusion from public health system-building at the foundational level, Tribes are often an afterthought, and remain under-resourced, understaffed, and face unprecedented challenges in accessing the data needed to protect the health and well-being of their people.

2.3 Current State of Tribal Public Health

Tribal public health systems are less cohesive than their state and local counterparts, and public health services are provided through a patchwork of services provided by a variety of public health and healthcare authorities, including Tribal governments, IHS, the Centers for Disease Control and Prevention (CDC), Area Indian Health Boards (AIHBs), Tribal Epidemiology Center (TECs), state health departments, and local health departments. AI/AN people are citizens of their Tribe, their state, and the United States concurrently, and may receive services from all three jurisdictions.

The IHS is the primary federal agency providing direct health services to Tribes, although all federal agencies are held by the Federal Trust Responsibility. IHS administers services through 12 Area offices across the U.S. While IHS does have some public health services, the main scope of the agency is to provide direct patient care.

Across the IHS Areas, there are 11 Tribally serving AIHB and corresponding Tribal Epidemiology Centers that serve the member Tribes within their region. The Phoenix and Tucson Areas are served by a single AIHB/ TEC. The AIHBs are member organizations of the National Indian Health Board (NIHB), which represents the 574 federally recognized Tribes. TEC specifically are granted public health authority status by the Affordable Care Act (2010) for the purposes of Health Insurance Portability and Accountability Act (HIPAA) data.[5]

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[5] Hoss, A., Ransom, M., Penn, M.P. (2015, April 16). Tribal Epidemiology Centers Designated as Public Health Authorities Under Health Insurance Portability and Accountability Act. Public Health Law. Office for State, Tribal, Local, and Territorial Support, CDC. Retrieved 4/13/2024 from https://www.cdc.gov/phlp/docs/tec-issuebrief.pdf.

Figure 1. 12 IHS Service Areas[6]

Tribes, as sovereigns, are inherent public health authorities.[7] Some Tribes receive services from IHS (direct service Tribes), although as outlined, public health activities are limited, and it often falls on the Tribe to implement public health programs and policies. Many Tribes, therefore, may, under the authority of the ISDEAA/Public Law 93-638, choose to exercise self-governance and contract or compact some or all of their health systems and administer health services in their own community using federal funds. Tribes may also choose to form Tribal consortiums and designate these consortiums the authority to act on behalf of the member Tribes. These consortiums are considered governmental entities and have public health authority. These consortiums are most common in California and Alaska, and generally will provide public health services instead of the individual Tribes and/or Alaska Native villages.

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[6] Indian Health Service. (N.D.). Locations. IHS. Retrieved 4/13/2024 from https://www.ihs.gov/locations/.

[7] Hoss, A. (2021, January 12). Tribes are Public Health Authorities: Protecting Tribal Sovereignty in Times of Public Health Crisis. Available on SSRN. DOI: https://dx.doi.org/10.2139/ssrn.3759311.

Tribal public health systems often do not resemble their state and local counterparts. While many Tribal health systems have public health components, some Tribes may have formal public health departments, while others may operate public health services through integrated public-health/healthcare systems, and others may have divisions that implement some aspects of public health but may not implement all of the 10 Essential Public Health Services[8] directly through the Tribe.

2.4 Tribal Public Health Barriers

Funding, data access, misunderstandings of Tribal legal status, understaffing, and a lack of formal Tribal consultation remain some of the most significant structural barriers to building strong public health systems. Federal actions have been undertaken to address these barriers. President Joe Biden's December 2023 Executive Order 14112 directs federal agencies to administer funding in a way that better supports Tribal sovereignty and self-determination, reduces administrative burdens, and improves Tribal autonomy.[9] A number of executive orders and memorandums have sought to improve Tribal consultation practices, including November 2000 Executive Order 13175 which directs federal agencies to engage in regular, meaningful, and robust Tribal consultation; January 2021 Presidential Memorandum (Tribal Consultation and Strengthening the Nation-to-Nation Relationship) which requires all federal agencies to submit action plans to implement consultation; and most recently November 2023 Presidential Memorandum on Uniform Standards for Tribal Consultation, which stresses the importance of striving for consensus with Tribes and seeking to further improve consultation through standardizing processes[10]. The Government Accountability Office has addressed the significant barriers faced by Tribal Epidemiology Centers in accessing public health data, and made clear recommendations that HHS agencies, including CDC and IHS improve guidance and procedures for Tribal Epidemiology Centers to receive the public health data that is required by federal

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[8] Centers for Disease Control and Prevention. (2023, September 18). 10 Essential Public Health Services. Retrieved 4/13/2024 from https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html.

[9] Biden, J. (2023, December 6). Reforming Federal Funding and Support for Tribal Nations To Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination. Federal Register. Retrieved 4/13/2024 from https://www.federalregister.gov/documents/2023/12/11/2023-27318/reforming-federal-funding-and-support-for-Tribal-nations-to-better-embrace-our-trust.

[10] Biden, J. (2022, November 20). Memorandum on Uniform Standards for Tribal Consultation. WH.GOV. Retrieved 4/13/2024 from https://www.whitehouse.gov/briefing-room/presidential-actions/2022/11/30/memorandum-on-uniform-standards-for-Tribal-consultation/.

law.[11] Unfortunately, despite federal agency efforts to improve in these areas, Tribal leaders have shared that the systems in place to address these requirements and recommendations remain inadequate in addressing Tribal and Tribal Epidemiology Centers' needs.

The PHICCS report was created with the intent of providing information that can be used by Tribes, Tribal organizations, federal, state, and local partners, and others in addressing these barriers. This report intends to shine light on the current practices, capacities, and challenges faced by THOs. This information can be used to understand what resources are needed to continue to support public health capacity building and Tribal Sovereignty across Indian Country.

2.5 The Public Health in Indian Country Capacity Scan (PHICCS)

The Public Health in Indian Country Capacity Scan (PHICCS) is a priority project for NIHB, Tribes, and funders. PHICCS is the only major survey of Tribal public health capacity administered to Tribes nationwide that we are aware of and attempts to capture a snapshot of current Tribal public health infrastructure. The purpose of PHICCS is to assess the capacity of Tribal health and Tribal public health organizations for delivering public health services. This important effort helps Tribes, Tribal organizations, partners, and policymakers better understand Tribal public health infrastructure and plan for future improvements.

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[11] United States Government Accountability Office. (2022, March). Tribal Epidemiology Centers: HHS Actions Needed to Enhance Data Access. GAO. Retrieved 2/23/2023 from https://www.gao.gov/assets/gao-22-104698.pdf.

3   PHICCS Methods

3.1   **Survey Design**

A terminology note: we use the terms "scan," "survey," and "instrument" interchangeably. These refer to both the hard copy documents and online survey forms.

3.1.1   PHICCS I (2019) Initial Survey Background

The PHICCS II survey was adapted from a prior iteration of PHICCS, PHICCS I, which was published by NIHB in 2019. PHICCS I followed a census data collection method. The survey was completed by 134 THOs of the survey population of 291. These THOs represented the 573 (at the time) federally recognized Tribes across 35 states and 12 IHS Areas. This was a 46% response rate.

This survey was comprised of 129 questions and was conducted to understand THO capacity in five key areas:

1) Public Health Authority
2) Public Health Activities
3) Assessment, Performance Improvement, and Accreditation Activities
4) Public Health Workforce
5) Public Health Needs and Priorities

3.1.2   PHICCS II Survey Design:

The survey used for PHICCS I was adapted and streamlined for the 2023 PHICCS II Report. The goal of the PHICCS II survey was to have continuity of data collection with PHICCS I, while decreasing the survey length to improve the response rate and improving the questions to collect more valid and reliable data on Tribal public health capacity. In Fall 2021, NIHB contracted with the Johns Hopkins University (JHU) Center for American Indian Health to provide support for the re-design of the initial PHICCS survey and to develop PHICCS II. Between November 2021 and March 2022, JHU participated in weekly PHICCS team meetings and provided edits to enhance the survey while reducing the length. Questions that did not yield informative data during PHICCS I were removed or modified. Several questions were also removed when other sources of collecting this data were identified. JHU also assisted in adding COVID-19 questions to address major changes in health department services related to the pandemic.

Following these initial edits, NIHB formed a PHICCS Stakeholder group comprised of AIHB and TEC directors and their staff. This group met four times: March, May, August, and November 2021. Participants provided feedback on the PHICCS survey. NIHB edited the survey to reflect this feedback. The Stakeholder group also shared some hesitancy from Areas regarding the scan, outreach, and engagement with PHICCS II and NIHB.

NIHB piloted the PHICCS II survey to garner feedback and make final edits. Pilot participants were volunteers from 3 THOs with significant experience working with NIHB on performance and system improvement initiatives. In May 2022, NIHB released the PHICCS II pilot surveys. Based on feedback, changes were not made to the survey following the pilot, and the pilot participants' responses were recorded in the final PHICCS data analysis.

The final PHICCS II survey was comprised of 68 questions and was conducted to understand THO capacity in five key areas:

1. Public Health Authority
2. Public Health Workforce
3. Assessment, Planning, and Performance Management
4. Public Health Activities
5. Public Health Priorities and Needs

The final survey was created using the Qualtrics survey software and could be completed by participants online. Paper and PDF copies were also developed for those who could not use Qualtrics software. NIHB informed THOs that they could also complete the survey over the phone with assistance from a NIHB staff member.

3.2 Study Population and Sampling Method:

The population study of the PHICCS II survey included all THOs serving the 574 Tribal Nations that are currently federally recognized.

The PHICCS II survey followed a census method for data collection. 282 THOs were identified. All 282 THOs were contacted and asked to complete the survey.

NIHB developed a database of all Tribal health departments, Tribal public health departments, Tribal 638 clinics providing public health services, and Tribal health consortiums from 12 Indian Health Service (IHS) regions including:

- Alaska
- Aberdeen (Great Plains)
- Albuquerque
- Bemidji
- Billings
- California

- Nashville
- Navajo
- Oklahoma City
- Phoenix
- Portland
- Tucson

This database was cross-referenced with Tribal health department lists from each IHS region. Prior to the start of the survey, NIHB staff made over 400 calls during this project to update the contact information for the THOs in order to send the survey links to the right individuals. Throughout the survey period, NIHB continued to maintain and update this database.

3.3 Data Collection:

The PHICCS II survey was sent through Qualtrics to 282 THOs by email on August 10, 2022, with an anticipated survey close date of December 9, 2022. NIHB was not able to identify email addresses for 9 THOs.

Following the initial launch, NIHB identified 39 THOs that did not receive the initial survey email due to staffing changes and contacted these THOs for updated contact information. These THOs received an initial survey email on September 20, 2022. All THOs received 7 email reminders from Qualtrics to complete the survey. NIHB also sent paper copies by mail to 282 THOs for whom an address was available on October 17, 2022.

Starting December 2022, NIHB staff called all THOs that had not completed the survey to remind them of the closing date and to address any questions and concerns. Those who were not reachable by phone received a personalized email. At least 200 THOs received at least 2 calls or personalized email, and all communication from NIHB included an offer to complete the survey by phone with assistance from a NIHB staff member. Over 400 calls were made during the survey period.

In addition to direct communication with THOs, NIHB advertised the survey widely- NIHB staff included information about PHICCS at all meetings via flyers and presentation slides. NIHB contacted all AIHBs and requested assistance in sharing information about PHICCS. Staff and NIHB Board Members presented at the Great Plains AIHB monthly meeting and Alaska Area meeting. Other AIHBs sent information to their members regarding PHICCS. NIHB also posted 11 times on social media regarding the PHICCS survey. NIHB also offered a raffle of 20 $200 gift cards to those who completed the survey.

As of December 9, 2022, 38 responses were received. Due to low response rates, the survey deadline was initially extended to January 6, 2023, then later extended to February 17, 2023.

Surveys were collected from 135 THOs with a response rate of 48%. Two respondents from inter-Tribal councils were excluded, as these organizations did not meet the criteria as a governmental THO. Therefore, 133 THOs were included in the analysis. It should be noted that the response rate does not reflect the actual percentage of the population served, as some respondents represented multiple Tribal governments (Tribal consortiums), while others represented only one individual Tribal nation, and respondents ranged in size of population

served. Therefore, the response rate should be interpreted only as the percentage of organizations that responded.

3.4 Data Analysis

All data analysis was conducted in SAS 9.4 and charts and tables were created in Microsoft Excel. Descriptive statistics were conducted for all quantitative survey questions. For multiple choice and "check all" questions in which a sample size could be determined, it is listed in the text. For grouped questions, such as public health workforce, the sample size reflects the total number that responded to that question block. For check-all questions in which a true response rate could not be determined, the full sample size is used as a denominator. Qualitative data was analyzed with a content analysis approach. The written survey responses were reviewed, and relevant categories were determined, then responses were reviewed and allocated into one or more categories for quantitative analysis.

We defined the regions in this report as:

- Pacific Coast & Alaska (Alaska, California, Idaho, Oregon, and Washington)
- Southwest (Arizona, Colorado, Nevada, New Mexico, and Utah)
- Northern Plains (Indiana, Iowa, Michigan, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wisconsin, and Wyoming)
- Southern Plains (Kansas, Oklahoma, and Texas)
- East (Alabama, Connecticut, Florida, Louisiana, Massachusetts, Maine, Mississippi, New York, North Carolina, Rhode Island, South Carolina, and Virginia)

These regions were chosen to align with the regions used in CDC's Cancer in American Indians and Alaska Natives in the United States study. NIHB used these regions for several reasons. The most commonly used regions for AI/AN data are the IHS service Areas- however, using IHS Areas would have allowed for some respondents to potentially be identifiable in the data. CDC has previously combined these Areas into larger regions, which would improve the confidentiality of the data. While there is, of course, significant variation within each region as far as culture, traditions, history, resources, and public health capacity, regions were chosen to align Tribes that may have similar history or cultural backgrounds due to geographic proximity.

Since the data from Alaska was limited, Alaska and the Pacific Coast were combined to ensure data would not be identifiable and due to geographic proximity. States without federally recognized Tribes were not included in this report.

3.5 **Limitations**

The response rate (133 out of a sample of 282) fell short of the sample size calculations needed to make inferences at the population level for a 95% confidence level with a 5% margin of error. Sample size calculations suggest 163 responses out of a population size of 282 would be necessary.

However, a high sample size would not have removed the inherent bias of our sampling method (voluntary census with non-random sampling). Due to the sampling method, and the voluntary nature of this survey, the results should not be viewed as generalizable to Indian Country. Those who chose to complete the survey likely differ from those who chose not to complete the survey, leading to significant response bias. We suggest viewing the PHICCS report as a "snapshot" of the capacity of THOs that completed this survey, which represent approximately half of the Tribes providing public health services. Data likely cannot be inferred to measure the public health capacity of THOs that did not participate in PHICCS II. However, despite high turnover in THO leadership, conflicting priorities, and the length of the survey, the response rate remained stable from PHICCS I. This remains one of the most comprehensive surveys of Tribal public health capacity to date.

While the initial data collection period was meant to close at the end of 2022, the timeframe was extended due to low response rates. As a result, the data collection period remained open for almost seven months. Respondents were asked to identify services in the year prior to completing the survey. This means data — specifically questions asking about activities occurring within the last year — represent a timeframe of 1.5 years, from August 2022 to February 2023, with 84% of surveys completed between December 2022 and February 2023. There may be differences based on the timeframe in which the survey was completed, and responses may not be comparable across the THOs since services may have changed within the survey-time period for some respondents.

Given the extensive length of the survey, many respondents skipped some questions. Respondents who returned surveys after February 2nd were told to focus on completing sections 3-5 (Public Health Workforce, Public Health Priorities and Needs, and Public Health Authority), increasing the likelihood of partial survey completion. These specific sections were selected as they contained priority information when understanding key capacity needs for Tribes.

All responses are self-reported, and no attempt was made to verify information using other sources. Some sections of this report, particularly **Section 6.4: Public Health Activities** rely extensively on THO's second-hand reports of the activities of external organizations. In this section of the survey, Tribal organizations can list the activities of other entities only to the extent to which they are aware of those activities. The accuracy of this second-hand data is

dependent on both the strength of the relationships between Tribes and state, local, private, and other entities, and the degree to which the services, screenings and education conducted by other organizations accessible in the service area are known by and accessible to Tribal communities. This likely has led to significant information bias and may not accurately represent the true percentage of service areas in which each of the activities occurred.

THOs have significant leadership staff turnover, and this impacted NIHB's ability to identify contacts for all THOs. Approximately 70 THOs updated their contact information during the survey period due to leadership staff turnover. Those who had turnover may have had less time to complete the survey and may have responded differently due to the limited time to complete the survey. Additionally, those with a high turnover or newer staff may have had less information about the capacity of their THO, leading to information bias. Those who had turnover also might have had lower capacity compared to those with staffing stability. In general, staffing turnover was likely associated with both NIHB's ability to contact and receive a response from a THO and the THO's public health capacity, leading to response bias.

4 | **Characteristics of Survey Respondents**

American Indian and Alaska Native (AI/AN) people receive public health and health services through the Tribal government or other government and non-government entities such as the Indian Health Service (IHS). The health delivery system landscape for Tribal nations varies and differs from state jurisdictions. These distinctions are recognized and acknowledged, but for the purposes of this report, the respondents to the PHICCS II Report are referred to as Tribal health organizations (THOs) throughout the report.

Please note that due to rounding, the percentages in figures and graphs may not add to 100%.

In **Figure 2**, individuals from THOs who were included in the final analysis of the survey were mostly from federally recognized Tribes (116 respondents, 87%) and a few from Tribal Health Consortiums (14 respondents, 11%). Tribal Health Consortiums in this survey were from a federally recognized Tribe. There were 133 respondents included in the final analysis of the survey. Three THOs did not specify the type of organization.

Figure 2. Number of THOs by Type (n= 133)

There are 574 federally recognized American Indian Tribes and Alaska Native entities in the US. The Tribal enrollment process is at the discretion of each Tribe while examining the shared customs, traditions, language, and Tribal blood. In **Figure 3**, there were 113 THOs that reported Tribal enrollment members. Forty-four percent represented Tribes with enrollment between with less than 2,000 members. Forty-four percent of THOs also reported an enrollment of 2,000 up to 9,999. Seventeen percent of THOs reported enrollment of more than 10,000 members. The range of Tribal enrollment signifies population size differences and variability in public health needs.

Figure 3. Ranges of Tribal enrollment members by Percent of THOs (n= 113)
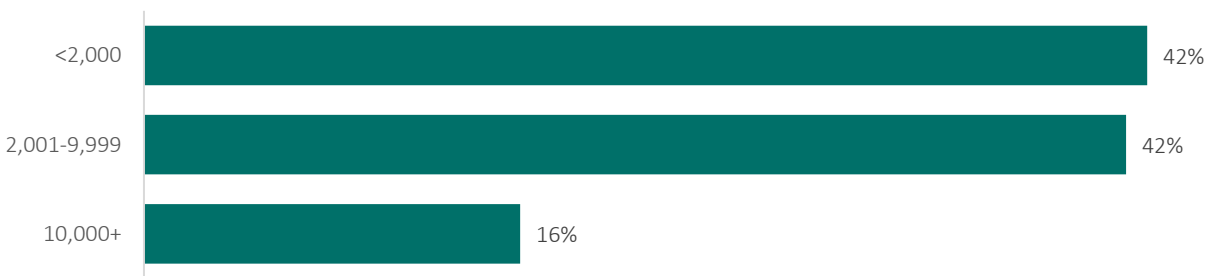
A public health system includes public, private, and voluntary organizations that contribute to the delivery of essential public health services within a jurisdiction.[12] Within Tribal communities, public health services are offered through Tribes as sovereign nations with the power and duty to safeguard their citizens' health.

4.1 Geographic Representation in PHICCS

THOs in this report consisted of American Indian and Alaska Native Tribes across the United States. Nationally, of the 574 federally recognized Tribes, 227 are located in Alaska, and the remaining 347 are located in the lower 48 states. In this report, 35% percent of respondents of THOs were based in the Pacific Coast & Alaska, 26% in the Southwest, 22% in the Northern Plains, 10% in the Southern Plains, and 7% in the East **(Figure 4)**.

Figure 4. Percent and Number of THOs responding by region out of Total Respondents (n=133)

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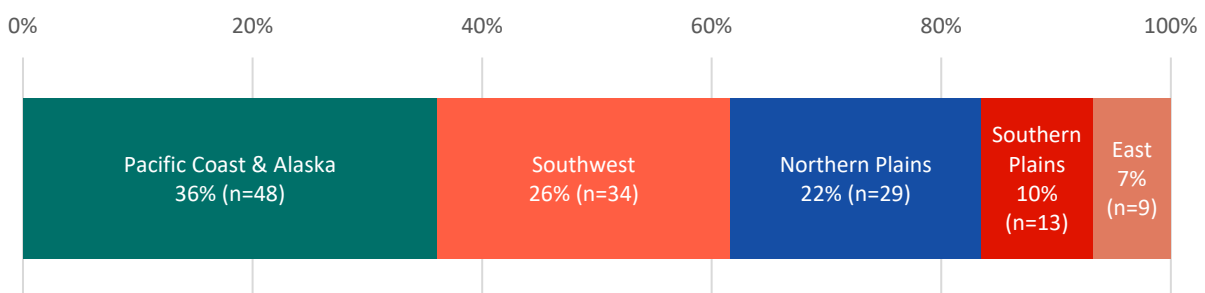
[12] Centers for Disease Control and Prevention (2024, May 16). 10 Essential Public Health Services. Public Health Professionals Gateway. Retrieved 12/5/2024 from https://www.cdc.gov/public-health-gateway/php/about/index.html.

4.2 Service Population Characteristics

Among the 128 THOs responding to the question of who received public health services within their jurisdiction, there was variability in who received public health services from their organization. In **Figure 5**, nearly all THOs (98%) served enrolled members of any federally recognized Tribe. Non-enrolled members of federally recognized Tribes were able to access services through 72% of the Tribal health organizations. Sixty-one percent of THOs served non-Indians (also referred to as Non-AI/ANs) living in a specified geographic area, for example, Veterans, spouses, or Tribal employees. Thirty-one percent of THOs reported providing services for members of a state-recognized Tribe, and 12% reported that additional unspecified populations were served by the organization.

Figure 5. Percentage of THOs who Provide Public Health Services to Certain Individuals (n=128)
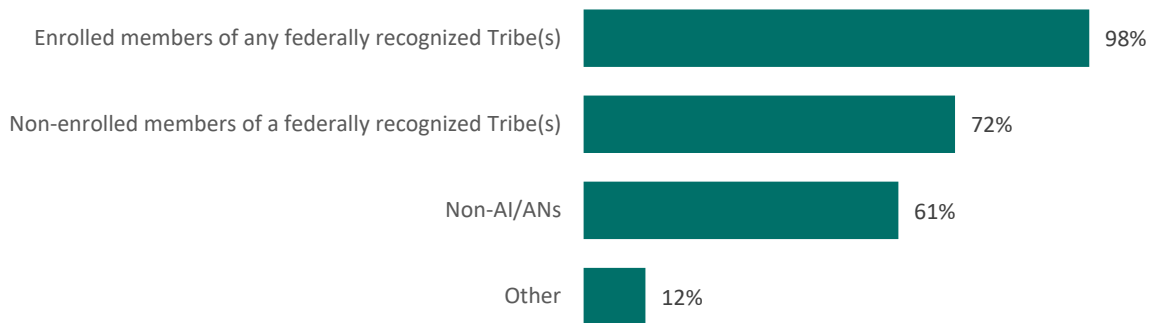
In **Figure 6**, 34% of the THOs (n=113) reported less than 2,500 persons were eligible for public health services, 33% reported that 2,500-9,999 persons were eligible for services, and 33% of THOs indicated 10,000 or more persons eligible for services.

Figure 6. Range of Individuals Eligible for Public Health Services by Percent of THOs **(n=113)**
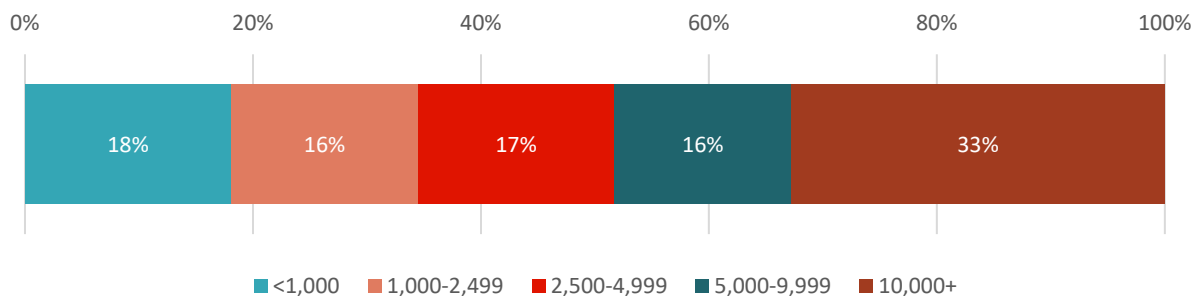
In **Figure 7**, nearly one-half (48%) of the THOs (n=106) reported providing public health services to less than 2,500 persons. Thirty-six percent of the THOs served between 2,500 and 9,999 individuals each year, while 17% of the THOs had 10,000 or more persons eligible for services.

Figure 7. Range of Individuals who Received Public Health Services from THOs in the Past Year by Percent of THOs (n=106)

| <1,000 | 1,000-2,499 | 2,500-4,999 | 5,000-9,999 | 10,000+ |
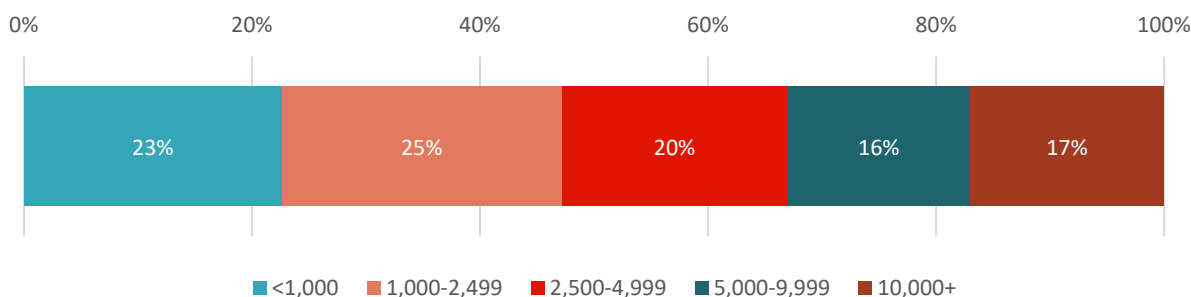
4.3 Role of Non-Tribal Public Health Jurisdictions

Tribal public health systems collaborate with local, state, and federal public health departments to provide essential public health services. American Indian and Alaska Native persons are citizens of their Tribe, state, and the United States. This dynamic status could interfere with effective public health services to reduce health disparities. The majority (85%) of the THOs service area (n=132) overlapped with one state, while 15% overlapped with two or more states.

The amount of non-Tribal (city, county, and state) public health departments within the THOs service area varied there were at least 13% of THOs reported no other public health departments in their service area, and 38% reported one public health department and 50% reported two (2) or more public health departments (**Figure 8**).

Figure 8. Range of Non-Tribal Public Health Departments Located within Service Area by Percent of THOs (n=131)
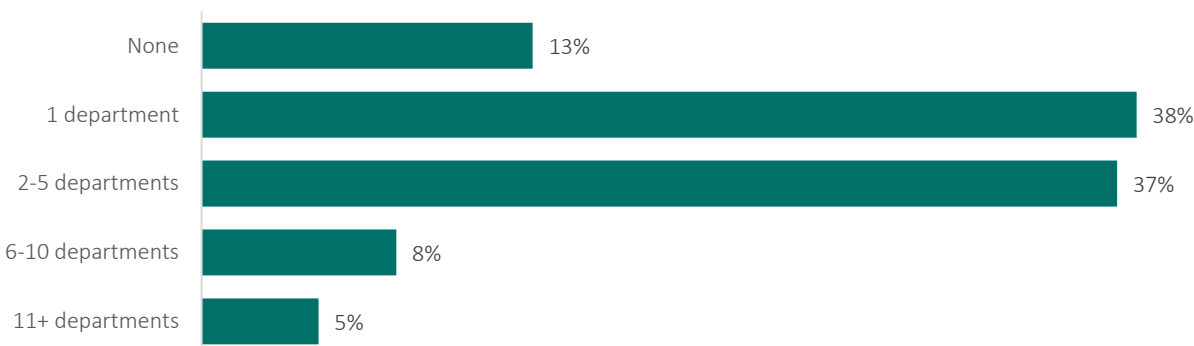
The distance of individuals in the service area to <u>any</u> public health department plays a role in access to public health services. Public departments external to the Tribal government are located in county and state jurisdictions. In **Figure 9**, 42% of THOs reported that individuals in

31

their service area could access a non-Tribal public health department less than 25 miles away, whereas 32% of THOs reported individuals 25-49 miles away. Tribal lands are often in rural areas with varying terrain and, in many cases, unpaved roads, contributing to more travel time. One-quarter (25%) of THOs reported 50 miles or more to the nearest non-Tribal public health department, which may easily translate to more than one hour of travel time.

Figure 9. Maximum Distance an Individual would have to Travel to Access the Nearest Non-Tribal Public Health Department by Percent of THOs (n=129)
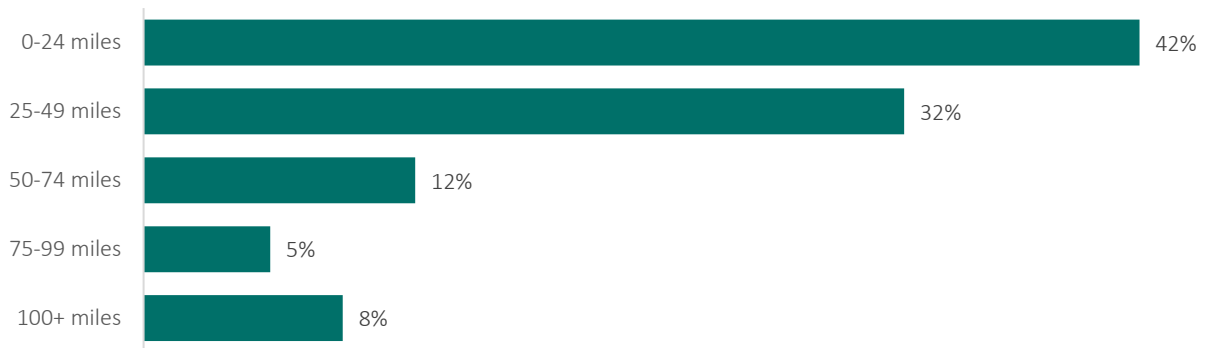
5 Overall Findings

5.1 Public Health Authority

> **Key Findings**
>
> - **All Tribal nations inherently possess public health authority but vary greatly in how they choose to exercise this authority.**
> - **A majority of THOs are governed by a Tribal Council but may receive direction and oversight from additional entities.**
> - **Use of law and policy for public health has increased among Tribes but both remain underutilized tools.**
> - **While THO partnerships most frequently include Tribal governments, schools, and Tribal Councils, THOs report the closest collaboration with Tribal emergency services, Tribal governments, and transportation services.**
> - **Major challenges related to exercising Tribal public health authority include insufficient public health infrastructure; need for clarifying Tribal public health codes, policies, and intragovernmental coordination; need for increased recognition of Tribal sovereignty and public health authority from federal, state, and local government entities; and barriers to data access.**

Public Health Authority Overview

Tribal nations' inherent sovereignty is the legal basis for the status of Tribes as public health authorities. Public health authority refers to the legal authority of a sovereign government to engage in public health activities as part of its official duties, to protect and promote the health of the people within its jurisdiction. Tribal sovereignty — the inherent right or power of Tribes to govern themselves — has been repeatedly affirmed by the U.S. Supreme Court, the U.S. Constitution, and hundreds of Indian treaties and federal statutes. Like all sovereigns, Tribes maintain authority to execute public health functions to protect the health of their citizens. This can include activities like collecting and analyzing data about the population's health; crafting, supporting, and implementing health-supporting laws and regulations; conducting food and water inspections; declaring public health emergencies and coordinating emergency response; identifying public health priorities; and designing and implementing community interventions to address priority health concerns.

5.1.1   Tribal Governance

Tribal government structures can vary greatly across Tribes. Tribes may operate their own traditional government systems and, at times, incorporate Western models similar to the three branches of U.S. federal government – legislative, executive, and judicial. How and to what extent a Tribe chooses to exercise its public health authority is decided by each Tribal government. Governance structures and public health systems vary widely across Tribes. Public health activities may be carried out by multiple entities and may or may not be delegated to a designated public health department.

Figure 10 demonstrates how Tribal Health Organizations (THOs) vary in their governance structure. The majority of THOs reported receiving oversight and direction from multiple entities, most commonly Tribal Council (69%), followed by Board of Health (29%), Tribal Chief or Chairperson (29%), or Tribal Chief Executive Officer (23%). Eight percent of THOs received oversight from less common entities such as Executive Directors, Tribal Chief Medical Officers, Indian Health Service, health committees, school boards, and other branches of Tribal government.

Figure 10. Governance Structure of THOS by Percent of THO (n=130)
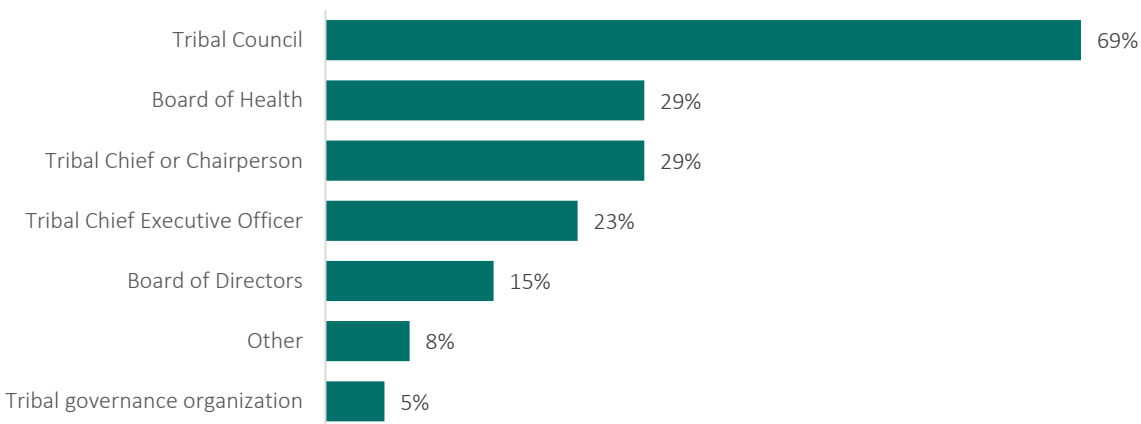
5.1.2   Public Health Laws & Policies

Public health laws and policies are not only essential components of public health infrastructure, but they can also be used as tools to carry out certain public health interventions to protect and promote health. As sovereign nations, Tribes enact their own laws and policies to promote the health and well-being of their communities.

THOs were asked if certain legal levers were used by the Tribe(s) within their service area to support public health. Most reported enacting public health emergency declarations (70%) and public health policies, goals, and priorities (60%). About half had enacted public health codes or

regulations. Fewer reported use of legal tools like fees collected for services (such as inspection fees), public health fines for regulation violations, excise taxes to discourage unhealthy choices (such as a junk food tax), or levies to specifically fund public health services.

Likely due to the need for public health emergency declarations during the height of the COVID-19 pandemic, the proportion of THOs reporting use of public health laws and policies in their jurisdictions significantly increased since the 2019 PHICCS Report. However, nearly half of the THOs in the most recent survey responded "Don't Know" about the use of at least one of the listed public health legal tools.

Figure 11. Use of Public Health Law/Policy Tools in THO's Jurisdiction by Percent of THOs
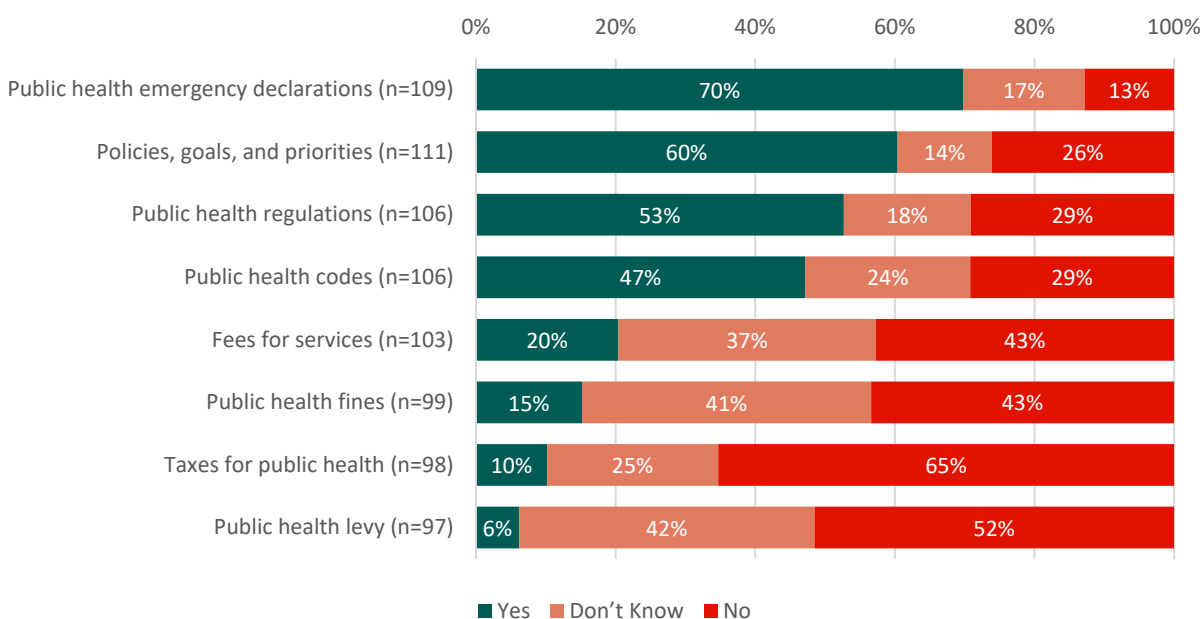
5.1.3 Partnerships

THOs frequently depend on partnerships with other organizations or governmental bodies to stretch limited resources, extend the reach of services, and address important social, structural, and Indigenous determinants of health. During the past year across 129 THOs, **Figure 12** shows that more than half of the THOs partnered with Tribal governments (67%), schools (65%), Tribal councils (64%), external governments (state, local, federal; 63%), social services (61%) and/or law enforcement (61%). Other external partnerships included spiritual or religious entities, TECs, IHS, universities, local non-profits, fire departments, consulting groups, and other private businesses.

Figure 12. Types of THO External Partnerships by Percent of THO (n=129)

Partner	Percent
Tribal government	67%
Schools	65%
Tribal council	64%
External governments	63%
Social services	61%
Law enforcement/public safety	61%
Tribal emergency services	55%
Communications/Media	43%
Tribally owned businesses	42%
Transportation services	40%
Culture or language entities	37%
Environmental services	37%
Spiritual/Faith based organizations	24%
Other external partnerships	22%

THOs were asked to rate their level of engagement with external partners, ranging from conversation/communication (lowest level of engagement) to cooperation/collaboration (highest level of engagement).

Figure 13. Level of Engagement with Community Partners by Percent of THOs per Partner

Partner	Cooperation/Collaboration	Coordination	Conversation/Communication	n
Tribal emergency services	87%	9%	4%	n=71
Tribal governments	79%	13%	8%	n=86
Transportation services	75%	15%	10%	n=52
Tribal council	72%	15%	14%	n=81
Social services	70%	13%	18%	n=79
Law enforcement/public safety	70%	22%	9%	n=79
Other external partnerships	69%	10%	21%	n=29
Comminications/Media	64%	20%	16%	n=56
External governments	59%	28%	12%	n=81
Schools	56%	20%	24%	n=84
Tribally owned businesses	54%	22%	24%	n=54
Environmental entities	53%	28%	19%	n=47
Culture or language entities	52%	17%	31%	n=48
Spiritual/faith-based organizations	43%	27%	30%	n=30

■ Cooperation/Collaboration ■ Coordination ■ Conversation/Communication

Note: Five categories were collapsed into three categories (conversation/communication, coordination, and cooperation/collaboration).

Certain partnerships benefit from formal mechanisms to solidify roles and responsibilities of partnering organizations. In **Figure 14**, THOs were asked about their formal mechanisms to define relationships regarding public health functions. Of the 108 THOs that responded, about half reported using memorandums of understanding (62%) or contracts (56%). A few THOs (11%) reported other legally binding agreements, such as resolutions and mandates, declarations of public health authority, intergovernmental service agreements, regional membership agreements, and specific contracts with federal services (e.g., Veterans Affairs, Medicaid).

Figure 14. Formal Mechanisms Used to Define Relationships Related to Public Health Functions by Percent of THOs (n=108)
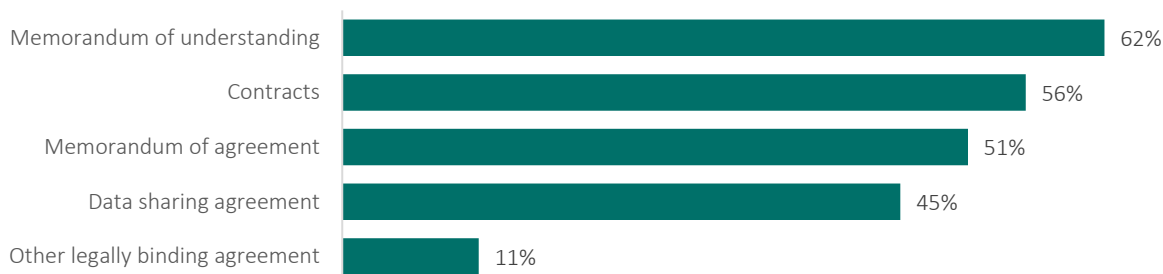
5.1.4   Challenges in Exercising Public Health Authority

Tribes and Tribal health organizations exercise public health authority in their jurisdiction based on the community's public health needs and according to their government structures. As an example, during the COVID-19 pandemic, many Tribes used their public health authority to access and analyze data, conduct contact tracing, implement vaccination mandates, enforce COVID precautions, and apply shutdowns.

THOs described a variety of barriers when asked about challenges they face in exercising their public health authority. Among 75 THOs who wrote in open-ended responses about challenges, 21% of THOs stated they faced no challenges to exercising public health authority. Some described their success working with local health departments and with full support from their Tribal leadership.

However, many other respondents described significant and varied challenges to exercising Tribal public health authority. In some cases, the THO responding to the survey was not the designated public health authority for the Tribe, reflecting the complexity of Tribal public health systems. In other cases, enforcement was cited as a challenge to exercising public health authority. As one commenter stated,

*"The codes are written and approved but are **not easily enforced**."*

One of the strongest themes to emerge centered on the need for stronger Tribal public health infrastructure. Staffing shortages were frequently cited as a challenge to exercising public health authority; without sufficient staff capacity, Tribes cannot implement or enforce decisions made through their public health authority. A few commenters mentioned the need for more stable funding or less complicated grant requirements to support their public health capacity. In addition, some respondents described a need for clearer policies, Tribal public health codes, and training on policies or public health codes. Others cited a need for improved internal coordination across Tribal governmental entities or more clarity on where public health authority is vested within the Tribe and the roles and responsibilities of public health. For example, one respondent described the challenge as a "lack of enumerated powers from the Tribe to public health." For many Tribes, exercising their public health authority through distinct public health departments, laws, policies, and initiatives is still relatively new, and that newness itself can present a challenge.

Other frequently reported challenges had to do with intergovernmental issues that arise at the sometimes-complex intersections of Tribal, federal, state, and local jurisdictions. One commenter succinctly summarized a range of these intergovernmental challenges as:

*"1. Receiving data; 2. Having public health authority **acknowledged and respected externally**; 3. **Lack of recognition** of Tribal sovereignty by other governmental entities."*

Many THOs discussed challenges in accessing state or federal data sources and systems, sometimes because Tribal public health authority was challenged, sometimes for unclear reasons, and sometimes due to frustrating reasons like:

"The entities such as I.H.S. lose our paperwork we submit to them."

Other intergovernmental challenges included state health department staff not being aware of Tribal/state agreements and trying to conduct inappropriate data collection; differing guidelines given by CDC, county, and state authorities; "lack of knowledge of working with Tribes from the local, state, and federal government"; and general intergovernmental coordination. One respondent summarized the challenge as,

*"Keeping the **balance** of sovereignty and compliance with local or state authority."*

Some comments offered insight into how emerging public health priorities created awareness and made space for public health related activities:

*"Transitioning the teams **from crisis response to a wellness model** is difficult, since the Public Health department did not exist prior to COVID-19."*

Several respondents referenced challenges stemming from the COVID-19 pandemic, whether because of the disruption from their previous work in the community, difficulty transitioning from emergency-response to a wellness model, loss of COVID funding critical to functioning, or

backlash and mistrust from the community after the use of public health authority to implement restrictions during the pandemic. Others cited the challenge in exercising public health authority as rooted in mistrust from misinformation, beliefs, lack of education in the community, or politics. A few responses mentioned a need for improved community engagement while others provided insight on unique challenges that Tribes face when operating in their authority:

"An interpretation of who or what program/agency is our public health authority is not clearly defined."

*"Lack of recognition by some Federal Agencies as **not being "real" public health authorities**."*

*"Timely communication and **understanding the unique county/state/Tribal health relationships**."*

5.2 Public Health Workforce

> **Key Findings:**
>
> - **Public health staffing within THOs is mostly filled by a staff of 1 to 4 full-time employees, contractors, and temporary staffing. However, the majority of THOs utilized and experienced complications securing external staffing as a solution for the conduction of public health services.**
> - **Volunteers represent the majority of THO staffing capacity related to COVID-19 services and education, immunization, and emergency preparedness.**
> - **A 21.5% increase in new Tribal public health positions is needed for THOs to operate at full workforce capacity.**
> - **Additional staffing with subject matter expertise in technical fields such as epidemiology and data analytics are among the most needed for THOs to operate at full capacity.**
> - **Key areas for priority public health staffing needs included:**
>   - **Epidemiology/Statistics**
>   - **Data Analytics**
>   - **Grant Writing**
>   - **Public Health Communications**
>   - **Community Health Aid**
>   - **Occupational Health**
> - **Challenges related to training included 69% of THOs noting the need for workforce development and 30% needing leadership development to retain staff and operate at full capacity.**

Public Health Workforce Overview

The Tribal public health workforce encompasses the personnel with a range of subject matter expertise that play an integral part in the delivery of key public health services and activities for and within Tribal communities. The foundation of a public health workforce in Tribal communities widely varies due to resource allocations. As a result, this section provides workforce data on all staff involved in providing public health services but explicitly does not include staff providing medical services.

5.2.1 Overall Workforce

Current Public Health Staffing Status

Across all THO survey respondents, there were a total of 2,394 full-time public health employees and a total of 338 part-time employees (including contractors and temporary workers). The

median number of full-time public health employees across THOs was four, while the median number of part-time employees was zero. The number of employees per THO ranged from a minimum of zero and a maximum of 400 full-time employees and a minimum of zero and a maximum of 150 part-time employees.

In **Figure 15**, THOs were asked about the number of full and part-time public health staff members they employee. The majority of THOs (75%) of THOs had at least one full-time employee; however, only 32% of THOs had at least one part-time employee.

Figure 15. Full-time and Part-time Public Health Staff Members by Percent of THOs
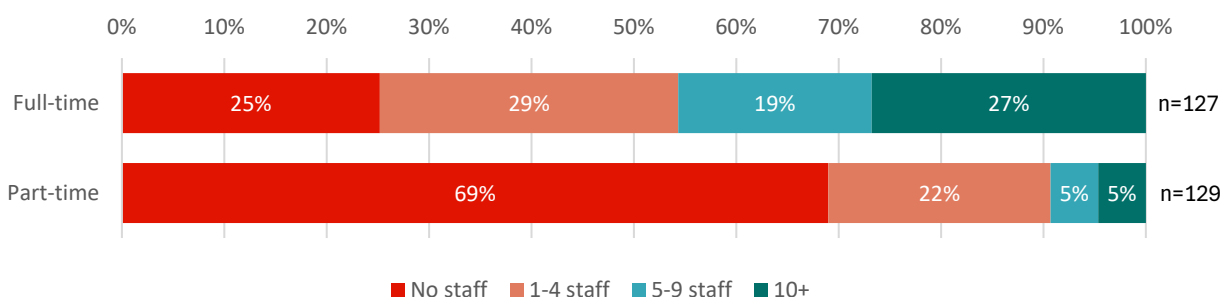
Volunteer Workforce

The Tribal public health workforce often may rely on volunteers. Not only do volunteers help fill gaps in personnel, but volunteers are essential to improving patient experience. In the past year, 11% of THOs (n=131) relied on volunteers to provide public health services, and 12% were unsure whether volunteers provided services. COVID-19 related services or education were the most commonly provided services by volunteers in addition to immunization services and emergency preparedness.

5.2.2 Occupations

To assess organizational capacity across Tribal public health systems, THOs were asked to identify their current workforce and if additional staff were needed. The overall workforce capacity is dependent on recognizing current positions that are filled and unfilled. THOs identified full-time (FT) and part-time (PT) staff performing public health activities, including vacant but budgeted positions and new positions needed but unfunded. Although organizations allocate funding for positions, there may be circumstances that impact a THO's ability to fill openings (e.g. delayed posting of vacancies, development and approval of job descriptions, and adequate time needed to gather applications).

THOs were asked to list the number of current full-time and part-time staff presently employed, in addition to the number of currently vacant roles (FT or PT). Respondents were then asked to estimate the number of additional funded positions needed to operate at full capacity. The sum

of FT, PT, vacant, and needed (unfunded) positions represents the public health staffing levels necessary for Tribal organizations to operate at full capacity. Throughout this section, we reported each category as a percentage of the full capacity staffing level to best describe how current staffing levels meet the needs of Tribal organizations and the Tribal populations they serve. It is important to note that due to missing data, the number of Tribal organizations represented in each job category ranges from 97 to 111 organizations. The total number of responses for each occupational grouping is listed in the text of each section.

Leadership & Administrative Roles

In **Figure 16**, there were 2467 positions needed across 104 THOs to achieve full workforce capacity for leadership and administrative roles. Overall, 84% of these positions were filled, 5% were vacant, and 10% were new positions needed.

The majority of full-time leadership and administration positions needed for full workforce capacity included business & financial operations (867 positions; 35% of total positions needed), leadership/upper management (624 positions; 25% of total positions needed), and office and administrative (603 positions; 24% of positions needed).

Critical workforce gaps included grant writer (46% of positions are either vacant or unfunded), workforce development (42% of positions are either vacant or unfunded), and legal counsel positions (25% of positions are either vacant or unfunded).

Figure 16. Current Status of THO Leadership and Administration Positions Needed for Full Workforce Capacity across 104 THOs by Percent of Positions
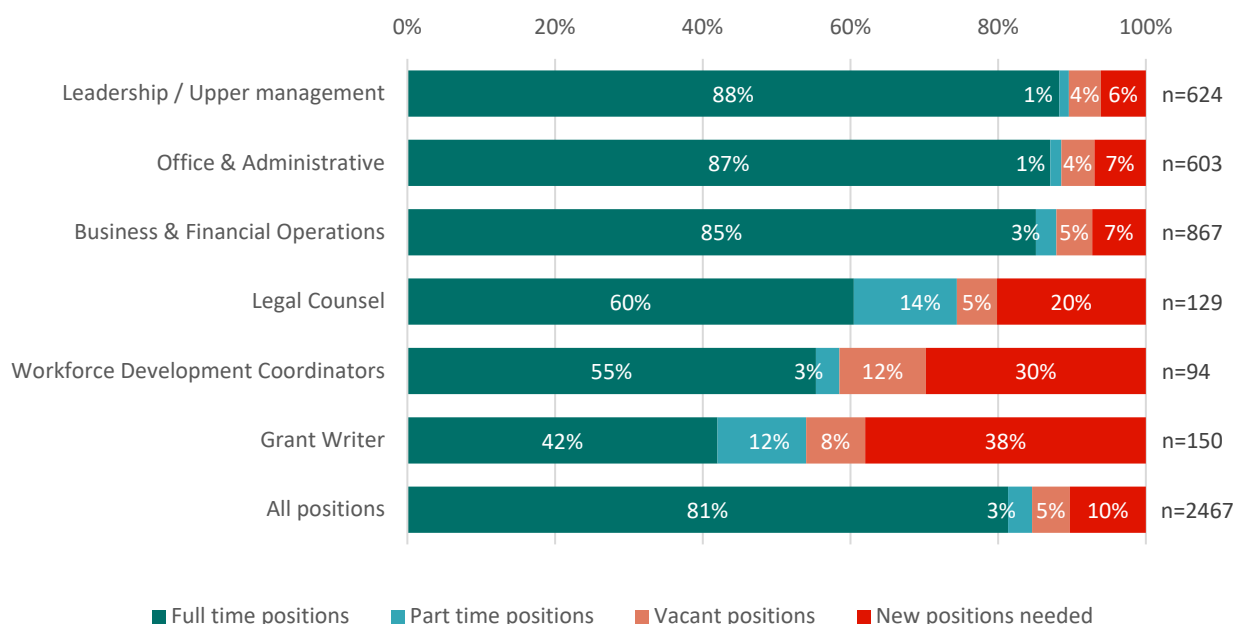
Analytics and Information Technology Public Health Roles

Epidemiologists, statisticians, and information specialists have important roles in gathering, analyzing, and reporting public health data to conduct proper surveillance and monitoring of diseases and public health interventions. In **Figure 17**, there were 221 positions needed across 97 THOs to achieve full workforce capacity for analytic and information technology public health roles. Overall, 43% of these positions were filled, 10% were vacant, and 47% were new positions needed. As over half of all these positions are currently either vacant or unfunded, there is a need for greater investment in Tribal analytic and information technology roles.

Figure 17. Current Status of THO Analytic Public Health Positions Needed for Full Workforce Capacity across 97 THOs by Percent of Positions
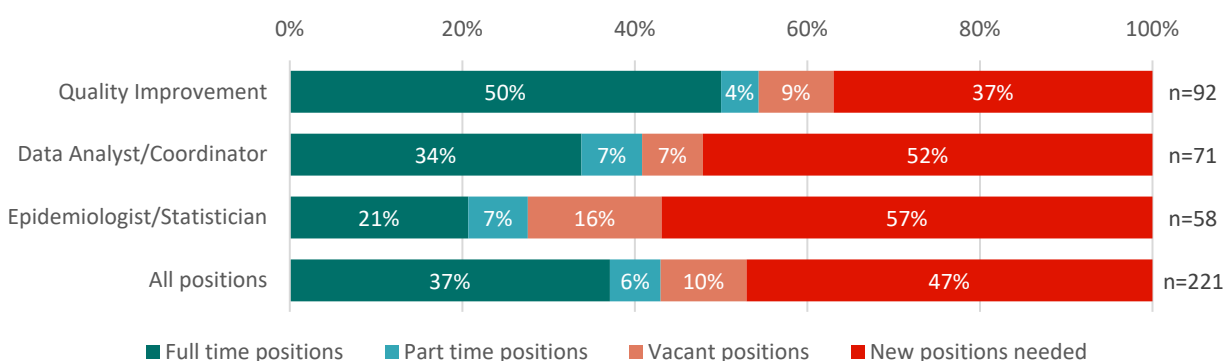
Public Health Practitioner Roles

Public health practitioners provide services in the community and, at times, through care coordination with clinicians to conduct follow-up care at home. While some practitioners manage programs, others provide general health education on environmental health and emergency preparedness, as well communication of public health to the public.

In **Figure 18**, there were 221 positions needed across 111 THOs to achieve full workforce capacity for public health practitioner roles. Overall, 61% of these positions were filled, 11% were vacant, and 28% were new positions needed.

Community Health Representatives (CHRs) are the most-needed position (556 positions; 37% of positions needed) in Tribal public health systems; however, 35% of these positions remain vacant or unfunded.

Public health communicator positions face a critical gap with 65% of positions either vacant or unfunded, although the full number of positions needed to fill this gap is lower than other categories (n=51). Community Health Aids also face large gaps, with 71% of positions either vacant or unfunded and with a larger overall number of vacancies (n=122).

Figure 18. Current Status of Public Health Practitioner Positions Needed for Full Workforce Capacity across 111 THOs by Percent of Positions

	Full time positions	Part time positions	Vacant positions	New positions needed	
Environmental Health	63%	4%	7%	26%	n=106
Project/Program Coordinator	61%	6%	11%	22%	n=138
Community Health Representatives	64%	1%	14%	21%	n=566
Public Health Nurse	60%	5%	15%	21%	n=280
Preparedness Staff	51%	14%	5%	30%	n=123
Public Health Educator	55%	2%	5%	38%	n=130
Public Health Communications	27%	8%	4%	61%	n=51
Community Health Aides	27%	2%	8%	63%	n=122
All positions	57%	4%	11%	28%	n=1516

■ Full time positions ■ Part time positions ■ Vacant positions ■ New positions needed

Healthcare Roles

Healthcare providers working at Tribally operated and/or federal healthcare facilities such as IHS are essential to providing public health services to AI/AN patients. Due to the unique Indian healthcare delivery system, public health services and healthcare services are often integrated. Healthcare providers are, therefore, important contributors to the public health workforce for AI/AN people.

In **Figure 19**, there were 2306 positions needed across 103 THOs to achieve full workforce capacity for healthcare. Overall, 71% of these positions were filled, 14% were vacant, and 15% were new positions needed.

Behavioral health staff are the most-needed positions (1282 positions; 56% of positions needed) in Tribal public health systems; however, 27% of these positions remain vacant or unfunded.

Figure 19. Current Status of Healthcare Positions Needed for Full Workforce Capacity across 103 THOs by Percent of Positions
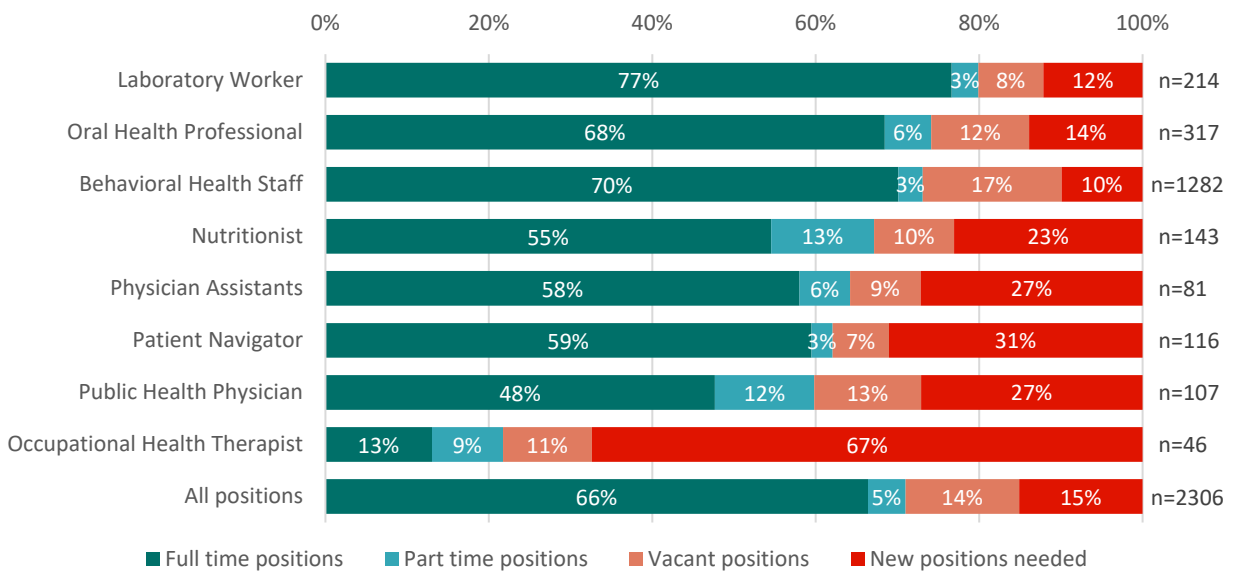
Other Public Health Roles

In **Figure 20**, there were 481 positions needed across 95 THOs to achieve full workforce capacity for additional public health positions. Overall, 70% of these positions were filled, 8% were vacant, and 21% were new positions needed.

Figure 20. Current Status of Additional Public Health Positions Needed for Full Workforce Capacity across 95 THOs by Percent of Positions
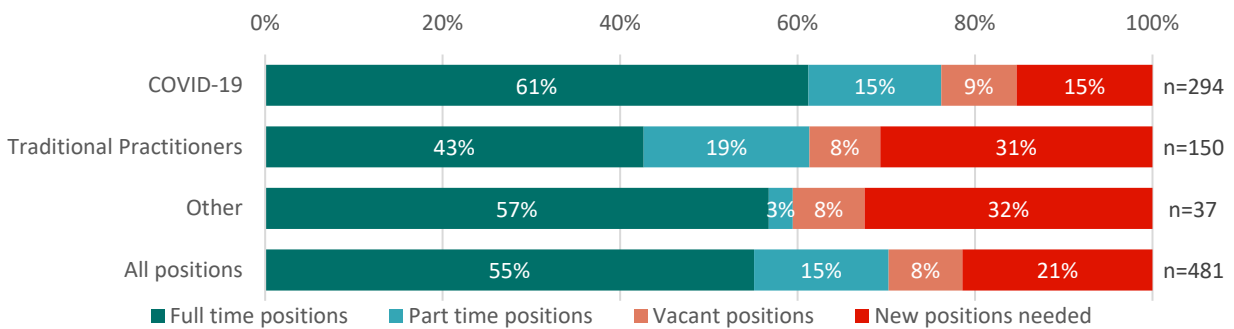
External Staffing Support

While many organizations rely on internal staff to conduct public health activities, in some cases, Tribal public health systems may seek additional workforce from external organizations to access skillsets outside of their organization. Despite these efforts, accessing external staffing support with the skills needed posed substantial challenges. Only a small percentage of THOs (12%)

indicated that it was "very easy" or "easy" to access the staff they needed on a day-to-day basis. Two-thirds of THOs stated that it was somewhat difficult (37%) or very difficult (30%) to access needed staff outside their organization.

Figure 21. Difficulty Accessing Staff with Needed Skills Outside Organization by Percent of THOs (n=115)

Legend: ■ Very easy ■ Somewhat easy ■ Neither easy nor difficult ■ Somewhat difficult ■ Very difficult
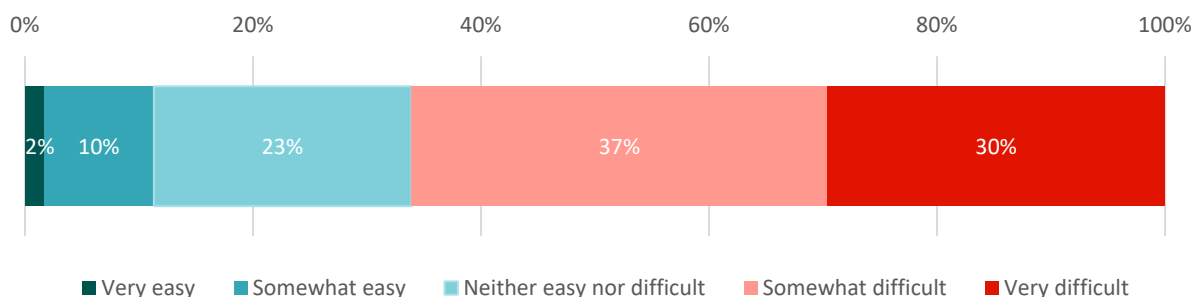
In **Figure 22**, the difficulty of accessing staff outside an organization also highlighted the long delays in accessing the staff. On a day-to-day basis, 17% of THOs reported their organization did not have to wait to access needed staff, while 24 percent reported waiting 1-3 days. Nearly half of THOs reported longer wait times, with 19% waiting 2-4 weeks and 19% waiting one month or more.

Figure 22. Wait Time to Access Outside Staff with Needed Skills by Percent of THOs (n=108)

Legend: ■ No wait ■ Several hours ■ 1-3 days ■ 1 week ■ 2-4 weeks ■ More than 1 month
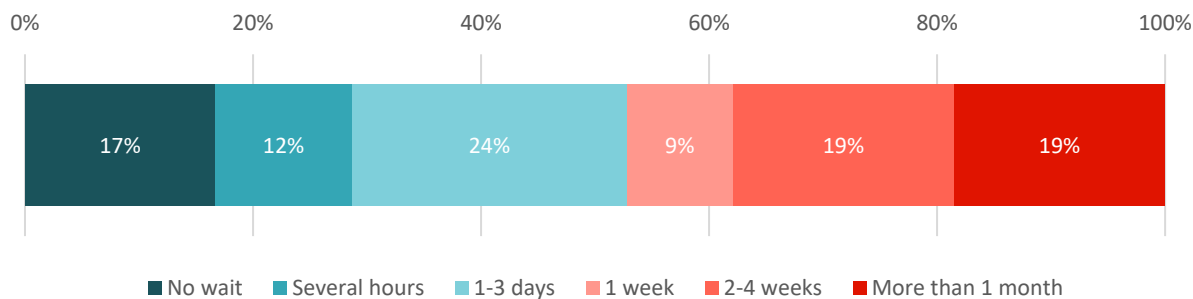
5.2.3   Overall Staffing Gaps and Needs

Across the THOs that reported staffing levels, approximately 6991 total positions are needed for Tribal organizations to operate at full capacity. At the time of the survey, these THOs employed 5,079 full and part-time staff and had 674 positions that were created but vacant. An additional 1,238 new roles must be created and funded for THOs to operate at full capacity. To meet the needs of the THOs surveyed, a 21.5% increase in funded positions will be necessary to reach full workforce capacity, in addition to filling vacant roles.

5.2.4 Core Competencies for Public Health & Essential Public Health Services Framework

More than two decades ago, the *10 Essential Public Health Services* were established and have since become widely accepted and pivotal in shaping the understanding of the role of public health.[13] Since then, the existing framework has been modified to be inclusive of equity in public health practice and to achieve good health and well-being for all citizens (**Figure 23**). The framework is used to strengthen public health systems universally; however, these core functions may vary as Tribal public health systems differ across communities.

In addition to the services highlighted through the *10 Essential Public Health Services*, relevant skills and knowledge for a competent workforce to implement those services are included in the *Core Competencies for Public Health Professionals*.[14] This framework offers a consensus of skills and knowledge across relevant public health areas and is foundational to understanding various aspects of the public health workforce including existing needs and potential areas of improvement. The *Core Competencies for Public Health Professionals* works in alignment with the *10 Essential Public Health Services* and is often adapted to fit organizational needs for recruitment and training of the public health workforce.

The *10 Essential Public Health Services* define the core competencies of the public health workforce. Among 115 THOs, fifty-seven percent did not use the *Core Competencies for Public Health Professionals* in any capacity (**Figure 24**).

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[13] Centers for Disease Control and Prevention. (2024, May 16). 10 Essential Public Health Services. Public Health Professionals Gateway. Retrieved 8/6/2024 from https://www.cdc.gov/public-health-gateway/php/about/index.html.

[14] Centers for Disease Control and Prevention. (2024, May 16). Competencies for Public Health Professionals. Public Health Professionals Gateway. Retrieved 8/6/2024 from https://www.cdc.gov/public-health-gateway/php/our-work/public-health-professionals-competencies.html.

Figure 23. The 10 Essential Public Health Services[15]
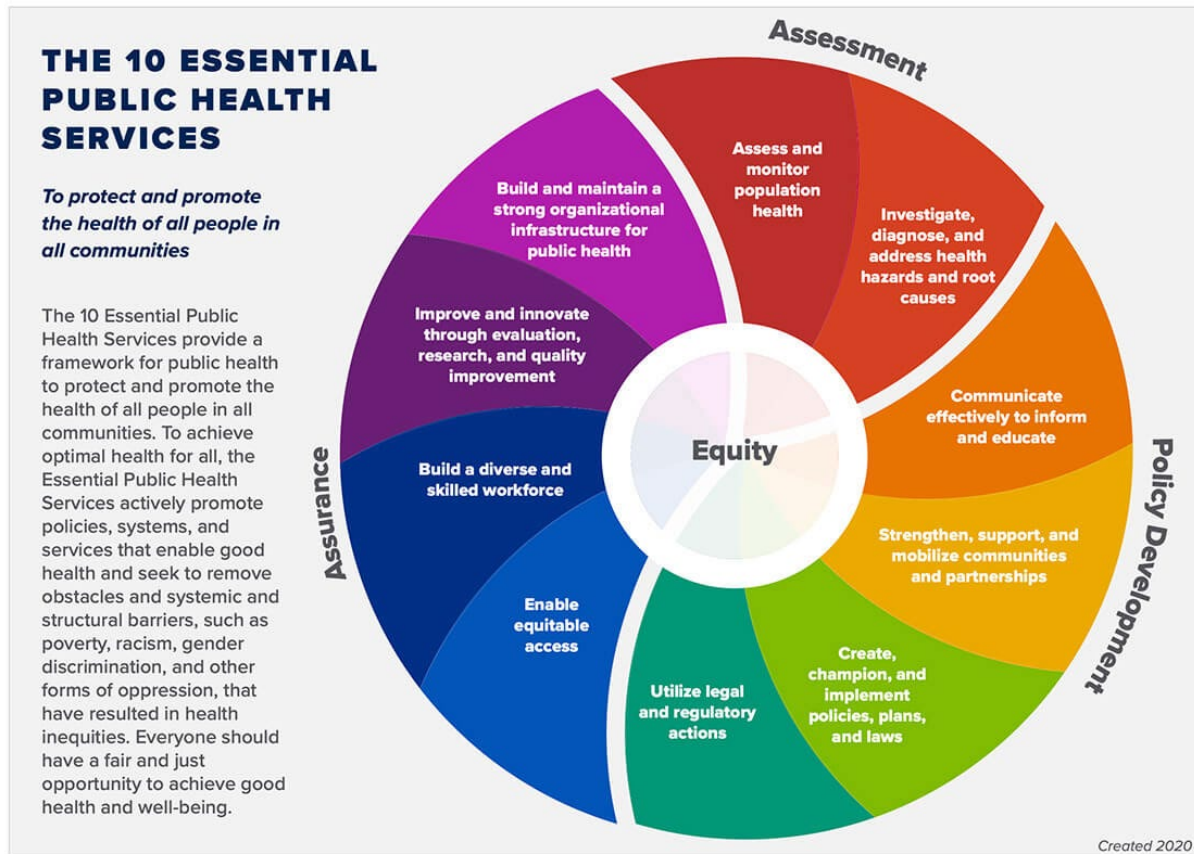
Figure 24. Percent of THOs Using the Core Competencies for Public Health Professionals for Various Purposes (n=115)
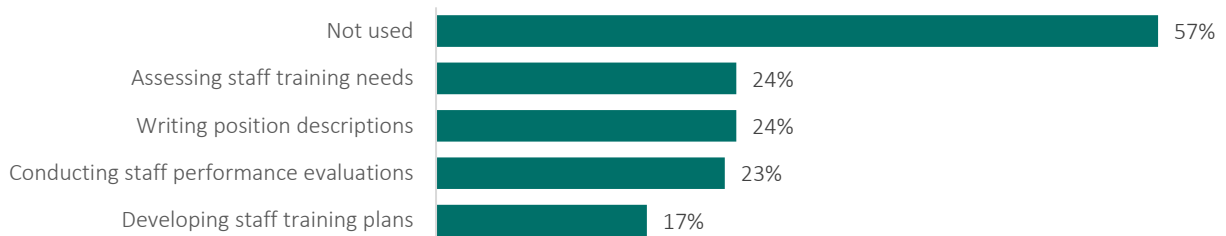
Category	Percent
Not used	57%
Assessing staff training needs	24%
Writing position descriptions	24%
Conducting staff performance evaluations	23%
Developing staff training plans	17%

[15] Centers for Disease Control and Prevention. (2024, May 16). 10 Essential Public Health Services. Public Health Professionals Gateway. Retrieved 8/6/2024 from https://www.cdc.gov/public-health-gateway/php/about/index.html.

5.2.5 Public Health Workforce Development Needs

While the public health workforce could differ across Tribal public health systems, we asked THOs to describe their top three public health workforce development needs in their own words. Sixty-nine percent of THOs (n=110) identified training opportunities such as public health and community leadership. Nearly one-half (45%) of THOs stated staffing needs to either fill vacant positions or retain staff. There was a demand for public health nurses, community health workers, educators, case managers, and coordinators. Thirty percent of THOs indicated further professional development needs in core competency training and continuing education activities. One THO highlighted the need to "grow our own medical professionals."

Twenty-five percent identified policy and procedure development in their top three needs, particularly around strategic planning, personnel management, financial management, and emergency preparedness. THOs also stated a need to improve their public health infrastructure through the expansion of their physical buildings, such as larger offices, employee housing, and new specialized centers, indicated the need to address their technical infrastructure, such as electronic health records, needs assessments, and data analytics to support data-driven decision-making, and mentioned funding primarily focused on filling needed positions, recruitment, or providing competitive wages.

Twenty-six percent of other needs identified by THOs consisted of communication items such as customer service and social media. In addition, THOs expressed the need for community engagement (outreach for adults and in schools) and cultural competency. Grant writing and report writing were also identified as workforce development needs. Some THOs stated the need for specific services or education around topics including social determinants of health, COVID-19, diabetes, gun violence, and fall prevention.

The Tribal public health workforce is complexly shaped by unique characteristics and challenges that may vary across each Tribe. Respondents identified the need for not only more staff but also relevant training as the most common workforce development needs. While there are identifiable gaps in Tribal public health workforce staffing, it is also important to highlight opportunities to adapt and leverage existing framework that can aid in the effort to recruit, retain, and train competent staff with the skills and knowledge needed to complete the necessary work. Forty-nine percent of respondents reported not utilizing the core competencies in any capacity to support training, recruitment, or evaluation. The adoption of these practices, as each Tribe deems fit, can contribute to the other identified needs related to grant writing, funding, and policy.

5.3 Assessment, Planning, and Performance Management

Key Findings:

- **The majority of THOs (72%) had at least begun the process of developing a community health assessment (CHA). 43% had developed a CHA within the last five years.**
- **The majority of THOs (57%) reported having at least begun the process of developing a community health improvement plan (CHIP). 31% had developed a CHIP within the last five years.**
- **The majority of THOs (83%) reported having procedures in place to support the improvement of ongoing public health efforts, whether through formal quality improvement activities (60%), or informally (23%).**

Assessment, Planning, and Performance Management Overview

It is considered a best practice for effective public health systems to utilize public health assessments, planning, and performance improvement activities as foundational tools to strengthen public health capacity. Community health assessments (CHAs) play a significant role in identifying community health needs, issues, and priorities. These assessments also lay the foundation for developing community health improvement plans (CHIPs), which address the health concerns identified. Once the CHIP is developed, a performance management system can be used to measure the effectiveness and outcomes of implementing the CHIP at an organizational or departmental level. Together, these tools are systematic and evidence-based methods of achieving high levels of performance and improving community health outcomes.

5.3.1 Community Health Assessment

A CHA (also referred to as Tribal health assessment or THA) is the systematic collection and analysis of data and information for use in public health interventions, developing priorities, resource allocation, policy development, and planning actions to improve the population's health. The majority of THOs (59%) had already developed a CHA, with an additional 13% in the process of developing a CHA and 8% planning to develop a CHA within one year. The Public Health Accreditation Board, the organization that sets national standards for public health departments in the United States, requires that accredited health departments develop a new CHA every five years[16]; 43% of THOs met reported meeting these criteria (**Figure 25**).

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[16] Public Health Accreditation Board. (2022, February). Standards & Measures for Initial Accreditation Version 2022. Retrieved 12/5/2024 from https://phaboard.org/accreditation-recognition/version-2022/.

Figure 25. Status of Community Health Assessment by Percent of THOs (n=122)

| 16% | 43% | 13% | 8% | 12% | 8% |

■ >5 years ago ■ Within past 5 years ■ In development ■ Planning in <1 year ■ No □ Don't Know
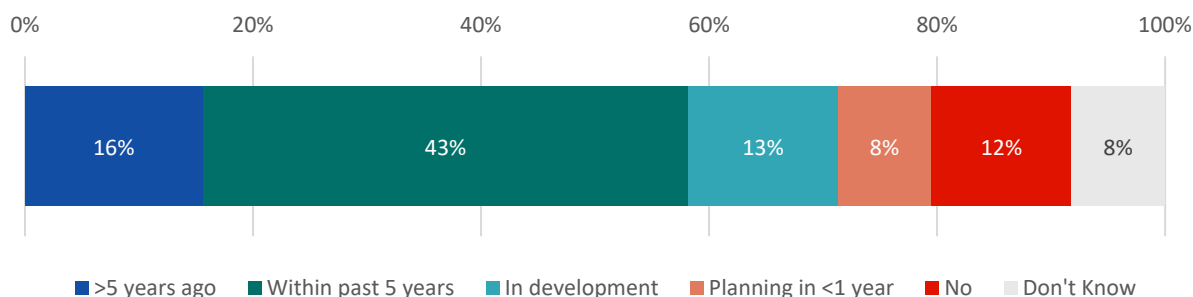
5.3.2 Community Health Improvement Plans

A CHIP (also referred to as a Tribal health improvement plan or THIP) is a long term, systematic effort to address public health problems. It is best practice to base this plan on the results of a CHA. Nearly half of THOs (45%) reported developing or participating in the development of a CHIP, with an additional 12% in the process of developing a CHIP and 12% planning to develop a CHIP within one year. The Public Health Accreditation Board requires that accredited health departments develop a new CHIP every five years[17]; 31% of THOs met reported meeting these criteria (Figure 26).

Figure 26. Status of Community Health Improvement Plan by Percent of THOs (n=122)

| 14% | 31% | 12% | 12% | 16% | 14% |

■ >5 years ago ■ Within past 5 years ■ In development ■ Planning in <1 year ■ No □ Don't Know
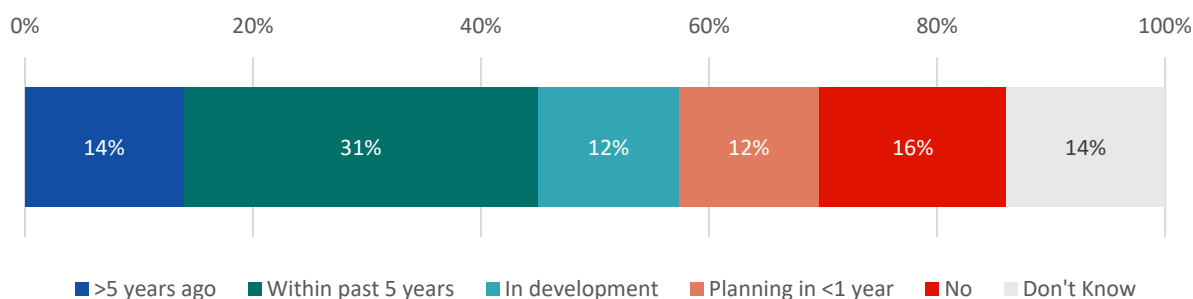
5.3.3 Organizational Strategic Plan and Performance Management

The development of organizational strategic plans consists of defining the organization's roles, priorities, and direction. The plan serves to guide the allocation of resources for the organization. Nearly half of THOs (49%) reported developing an organizational strategic plan, with an additional 17% in the process of developing a strategic plan and 8% planning to develop a strategic plan within one year. The Public Health Accreditation Board requires that accredited

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[17] Ibid.

health departments develop a new organizational strategic plan every five years[18]; 42% of THOs met reported meeting these criteria.

The establishment and continuance of a performance management system assists in obtaining the organizational or department goals and evaluating ongoing improvements to accomplish healthy outcomes. Only 31% of THOs reported establishing a performance management system, with an additional 9% in the process of establishing a performance management system and 7% planning to establish a performance management system within one year. The Public Health Accreditation Board requires that accredited health departments update the performance management system every five years to align with the strategic plan and other organizational goals[19]; less than a quarter (22%) of THOs met reported meeting these criteria.

Figure 27. Status of Organizational Strategic Plan and Performance Management System by Percent of THOs (n=120)
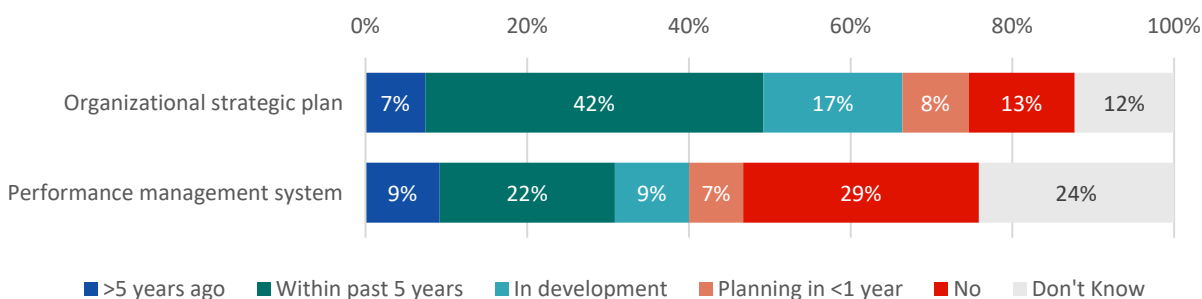
Quality improvement practices are critical aspects of a performance management system. An organization's ongoing monitoring and evaluation of strategies and plans reflects continuous improvements to support a culture of quality among employees.

The implementation of quality improvement activities can demonstrate the effectiveness of a performance management system. In **Figure 28**, 83% of THOs reported conducting some level of quality improvement activities. Sixty percent of THOs reported that these evaluations occurred through formal quality improvement activities, whether in specific areas (30%) or organization wide (30%). An additional 23% engaged in quality improvement efforts informally.

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[18] Ibid.

[19] Ibid.

Figure 28. Implementation of Quality Improvement Activities by Percent of THOs (n=120)

Activity	Percent
Formal quality improvement activities entity-wide	30%
Formal quality improvement activities in specific areas	30%
Informal or ad-hoc quality improvement	23%
No quality improvement activities	6%
Don't know	12%
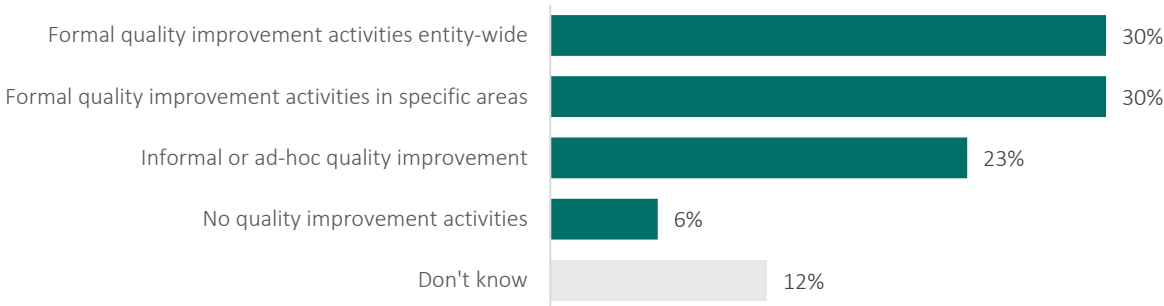
5.4 Public Health Activities

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Key Findings:

The most common public health activities offered in 85% or more of respondent THO service areas include:

- **Immunization (including COVID-19)**
- **Direct population services (e.g., home health visits and telehealth)**
- **Screenings and education on:**
    - **Type II diabetes, Nutrition, and Physical Activity**
    - **Alcohol and Drug Use, Depression, General Mental Health, and Suicide**
- **COVID-19 Testing**

The least occurring public health activities offered in 50% or less of respondent THO service areas include:

- **Collection of certain public health data, including injury and accident, environmental illness, foodborne illness, and syndromic surveillance data.**
- **Emergency response capacities or functions including contact tracing, laboratory, and epidemiological data capacity.**
- **Regulation, inspections, and licensing activities around a variety of environmental concerns, such as water supply safety, occupational health, and air quality monitoring.**

THOs were equally or more likely to provide services related to immunization, screenings, education, and direct population services compared to other organizations in the THOs service area. The majority of THOs were also involved in some public health data related activities over the past year. THOs were similarly or slightly less likely to provide emergency response capacities or functions in their service area over the past year compared to other organizations. THOs were also less likely to provide regulation, inspection, and licensing activities in their service area compared to other organizations.

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Public Health Activities Overview

The Public Health Activities section provides an in-depth look at what public health activities occurred in the THO service areas in the past calendar year, as well as what type of entity provided the activities. Not only is this information critical in assessing a Tribal public health system's strengths and gaps, but it is also essential to prioritize areas for public health program development and data-driven resource allocation.

This section includes data on population services, screenings, and education activities; the use of public health data including for disease surveillance, emergency operations capacities and functions; public health regulation, inspection, and licensing activities; and health communication. In addition to discussing services related to a variety of public health topics including chronic disease, behavioral health, and mental health, this section also includes data specific to COVID-19 services and education.

Tribal public health services are often offered by various entities. Therefore, respondents were asked which entities provided public health services within their area to better understand which services are provided by THOs, other Tribal governmental departments, state and local partners, Tribal organizations such as AIHBs and TECs, nonprofits, federal agencies such as CDC and IHS, and other key providers of health services. A comprehensive list of other organizations can be found in **APPENDIX II: List of All "Other Organizations" Providing Public Health Activities**.

5.4.1 Population Services, Screenings, and Education Activities

Population Services and/or Education Activities

General Population Services and/or Education Activities

In **Table 1**, THOs were asked to identify if the following services and/or education on these services were provided in their area. Over 80% of THOs reported that immunization services and services related to telehealth and home visiting were provided in their area during the last year.

Table 1. Percentage of Public Health Population Services and/or Education Activities Occurring in THO Service Area in Past Year

Activity	%
Immunization Services and/or Education	
Adult Immunization **(n=129)**	92%
Child Immunization **(n=129)**	89%
Patient Services and/or Education	
Telehealth (Public Health) **(n=129)**	89%
Home Visiting (Public Health) **(n=129)**	87%
Workplace Safety Education **(n=123)**	60%
Unintentional Injury Prevention Education **(n=123)**	54%

In **Figure 29** and **Figure 30**, a majority of THOs reported that the THO was <u>a provider </u>for each public health population service and/or education activity occurring in the THO's service area, either alone or in conjunction with another entity. However, most respondents reported that the THO was not the <u>only provider</u> of each activity within the THO's service area.

Figure 29. Entities Providing Population Services (n=129)
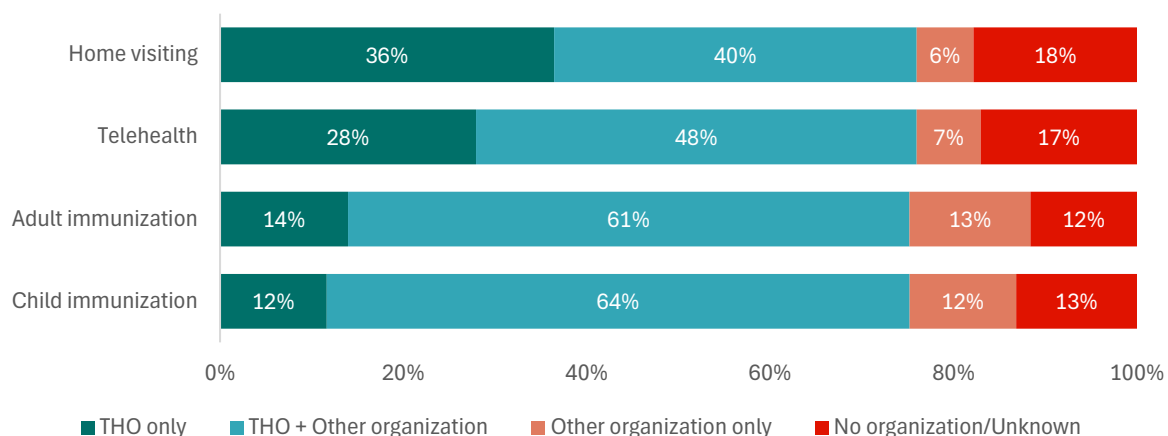
Figure 30. Entities Providing Population Education (n=129)
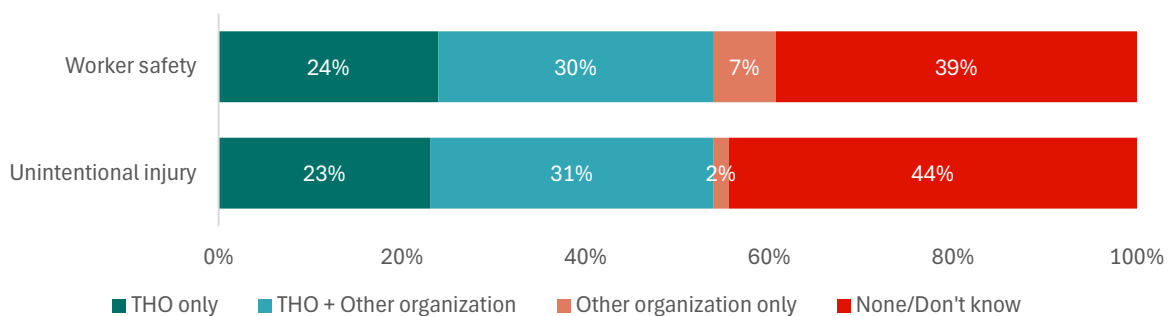
COVID-19 Related Population Services and/or Education Activities

In 2020, THOs faced an unprecedented challenge in responding to the COVID-19 pandemic. A survey conducted by NIHB in March 2020 found that while most Tribal respondents had COVID-19 diagnostic capability, only 24% of respondents had the capacity to isolate ill patients. Respondents indicated challenges including obtaining personal protective equipment, low staffing capacity, and the need for additional access to resources related to COVID-19.[20] With an understanding that many Tribes implemented new public health services because of the

[20] National Indian Health Board. (2020, March 17). Summary of COVID-19 Survey Responses. Retrieved 4/15/2024 from https://www.nihb.org/docs/03172020/NIHB%20COVID%20data%20summary_3.17.2020.pdf.

need to respond to COVID-19, the PHICCS survey asked several questions related to COVID-19 services and education.

In **Table 2**, THOs were asked to identify if any COVID-19-related services and education were provided in their service area in the past year. Most respondents stated that each COVID-19 service was available in their area, with over 90% of respondents offering COVID-19 vaccination and testing.

Table 2. Percentage of COVID-19-Related Services and Education Available in the THO Service Area in Past Year (n=129)

Activity	%
COVID-19 testing	96%
COVID-19 vaccination	95%
COVID-19 contact tracing	80%
COVID-19 home visits	73%

Organization(s) Providing Population Services

Over half of THOs reported that they provided COVID-19 testing, vaccination, and contact tracing services in conjunction with another entity (**Figure 31**). THOs were more likely (36%) than other organizations to be the sole provider for home visiting services. About one-quarter of COVID-19 contact tracing and home visiting services were either unknown by respondents or not provided.

The breakdown of which organization provided population services versus education on these services can be found in **APPENDIX III: Supplement to Activities Section: Organizations Providing Services versus Education on Services**.

Figure 31. Entities Providing COVID-19 Services (n=129)

	THO only	THO + Other organization	Other organization only	No organization/Unknown
COVID-19 testing	12%	71%	9%	8%
COVID-19 vaccination	13%	66%	12%	9%
COVID-19 contact tracing	12%	53%	10%	25%
COVID-19 home visiting	36%	29%	5%	29%
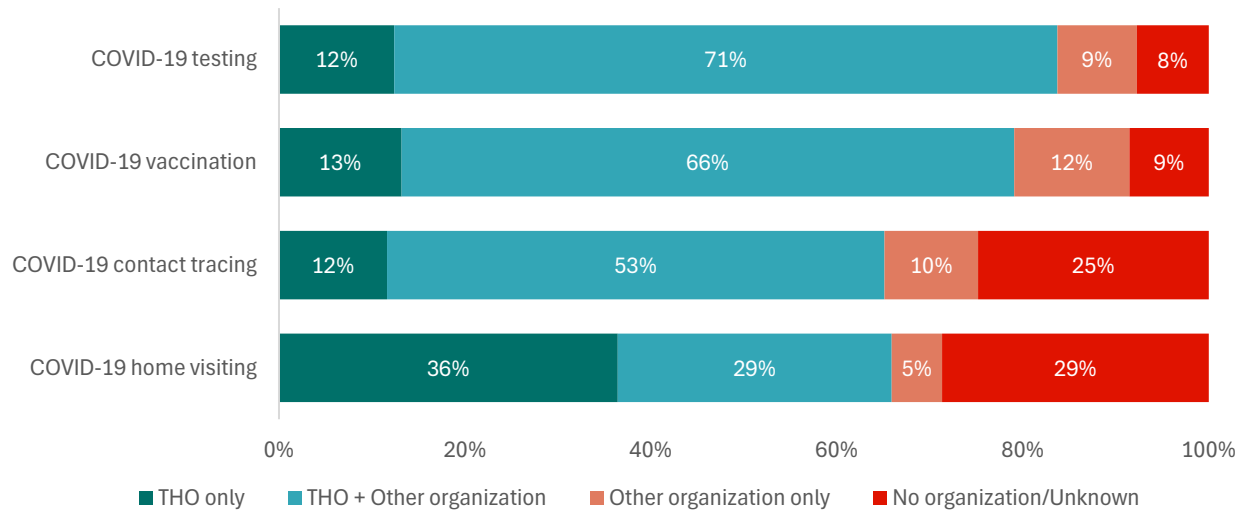
Public Health Screenings and/or Education Activities

In **Table 3**, THOs were asked to identify if the following screenings and/or education on these screenings were provided in their area. Over 80% of respondents identified that screenings for Type II Diabetes, Nutrition, Alcohol and other drugs, physical activity, commercial tobacco use, sexually transmitted infections, depression, general mental health, suicide, and essential supplies and resources took place in their area during the last year.

Organization(s) Providing Public Health Screenings

When a screening was offered, the majority of THOs reported that they provided each screening type in conjunction with another entity. However, when there was a sole provider of a screening, THOs were generally more likely to be the sole provider of a screening type compared to other organizations only (**Figure 32 A-D**).

The breakdown of which organization provided screenings versus education on these screenings can be found in **APPENDIX III: Supplement to Activities Section: Organizations Providing Services versus Education on Services**.

Table 3. Percentage of Public Health Screenings and/or Education Activities Occurring in THO Service Area in Past Year

Activity	%
Chronic Disease Screenings and/or Education (n=132)	
Type II Diabetes	91%
Nutrition	86%
Body mass index (BMI)	80%
Cardiovascular disease	77%
Cancer	73%
Asthma	71%
Social and Behavioral Health Screenings and/or Education (n=130)	
Alcohol and other drug use	95%
Physical activity	91%
Commercial tobacco use	84%
Sexually transmitted infections	82%
Reproductive Health	69%
Mental Health Screenings and/or Education (n=130)	
Depression	94%
General mental health	91%
Suicide	89%
Trauma	79%
Dementia	57%
Other	9%
Social Services Screenings and/or Education (n=129)	
Essential supplies and resources	85%
Social determinants of health	75%
Homelessness	64%
Hunger	63%

Figure 32. Entities Providing Public Health Screenings by Topic

32.A Chronic Disease Screenings (n=126)

	THO only	THO + Other organization	Other organization only	No organization/Unknown
BMI	29%	44%	9%	18%
Type II diabetes	28%	55%	10%	8%
Asthma	28%	35%	10%	27%
Cardiovascular disease	27%	41%	10%	22%
Nutrition	23%	54%	10%	13%
Cancer	23%	42%	9%	26%
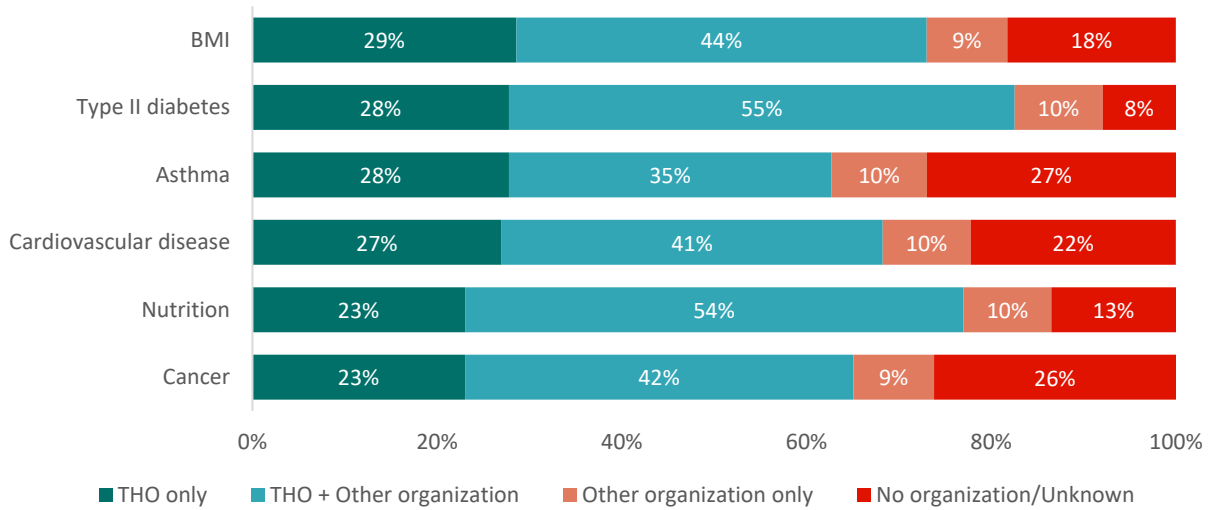
32.B Social and Behavioral Screenings (n=126)

	THO Only	THO & Other organization	Other organization only	No organization/Unknown
Physical activity	35%	46%	6%	13%
Commercial tobacco use	27%	40%	10%	23%
Sexually transmitted diseases	23%	48%	10%	19%
Alcohol and other drug	21%	61%	12%	6%
Reproductive health	20%	37%	11%	33%
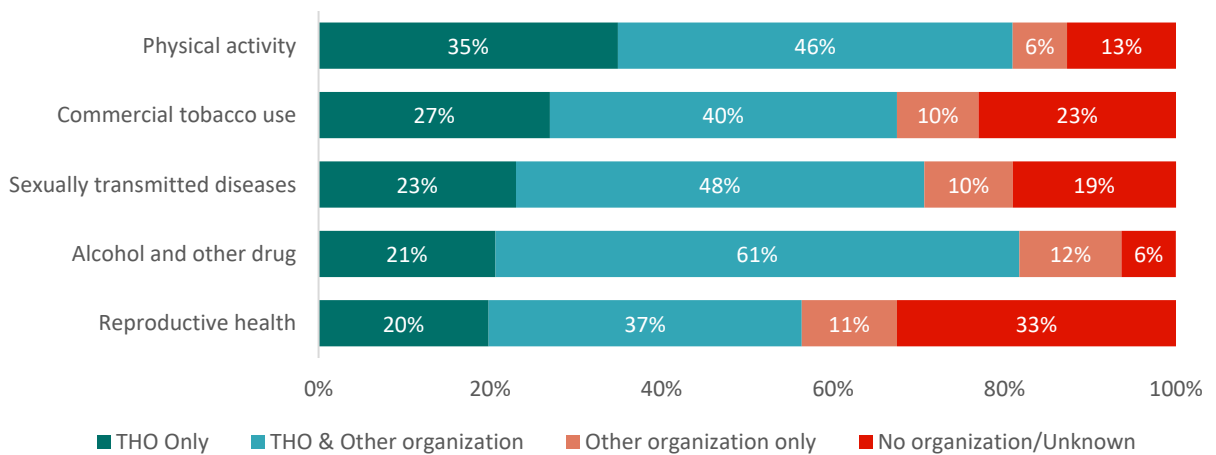
32.C Mental Health Screenings (n=126)

Category	THO Only	THO & Other organization	Other organization only	No organization/Unknown
Depression	26%	59%	8%	7%
Suicide	20%	61%	9%	10%
General mental health	25%	56%	9%	10%
Trauma	26%	42%	8%	24%
Dementia	21%	26%	8%	44%

■ THO Only ■ THO & Other organization ■ Other organization only ■ No organization/Unknown
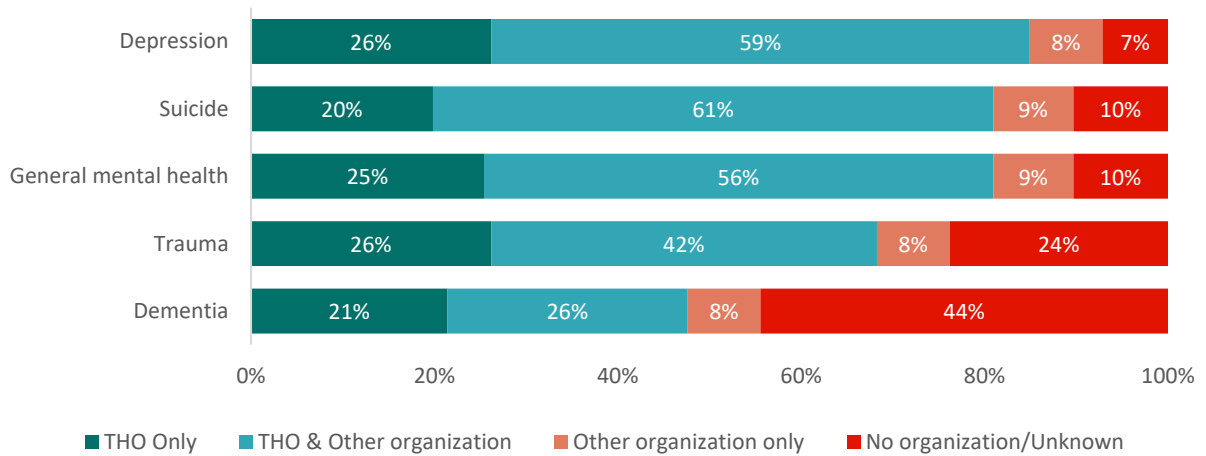
32.D Social Services Screenings (n=123)

Category	THO only	THO + Other organization	Other organization only	No organization/Unknown
Hunger	14%	38%	7%	41%
Homelessness	15%	35%	8%	41%
Social determinants of health	22%	45%	5%	28%
Essential supplies and resources	21%	54%	7%	17%

■ THO only ■ THO + Other organization ■ Other organization only ■ No organization/Unknown
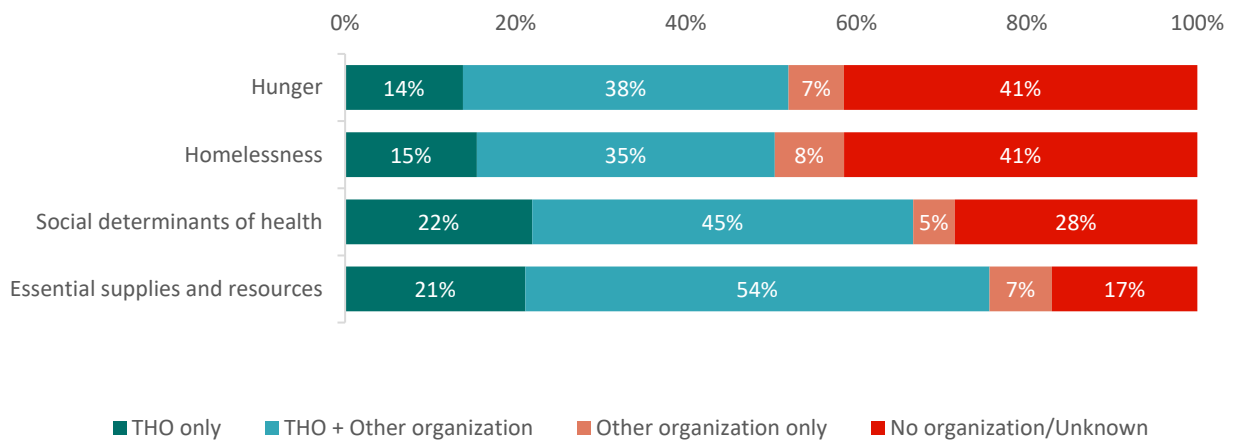
5.4.2   Data Collection, Epidemiology, and/or Surveillance for Public Health Data

Tribes are public health authorities, with the legal right to access public health data for the purposes of monitoring, preventing and controlling diseases. However, Tribes are often denied access to core public health data needed to monitor health and make public health decisions. To better understand the current capacity of Tribes in relation to public health data, several questions were asked on the current role of THOs in collecting, storing, and analyzing public health data.

THO Role in Data-Related Public Health Services

In **Table 4**, THOs were asked to identify if their organization participated in data-related services in their organization's area. The majority of respondents did participate in data-related services.

Table 4. Percentage of THOs that had a Role in Data Collection, Epidemiology, and/or Surveillance for Public Health Data in the Past Year

Activity	%
Data Management Storage and Security (n=124)	71%
Conducting Analysis of Data (general, epidemiologic, and/or surveillance data) (n=124)	60%
Health Program Evaluation (n=124)	52%

Data Collected in Service Area

Data on a variety of public health topics were collected within each THO's service area (**Figure 33**). The majority of THOs reported that data was collected or reported in the service area related to COVID-19, health behaviors, chronic disease, mental health, and infectious disease. Data on environmental illness (20%) and foodborne illness (18%) were least likely to be collected by any entity operating within the THO's service area.

Most respondents reported that, when data on a topic was collected or reported, the THO was involved whether alone or in conjunction with another organization. 10% or less of THOs reported another organization being the sole collector or reporter of data within the THO service area for each topic.

Figure 33. Public Health Data Collected or Reported in the Service Area in the Past Year (n = 124)
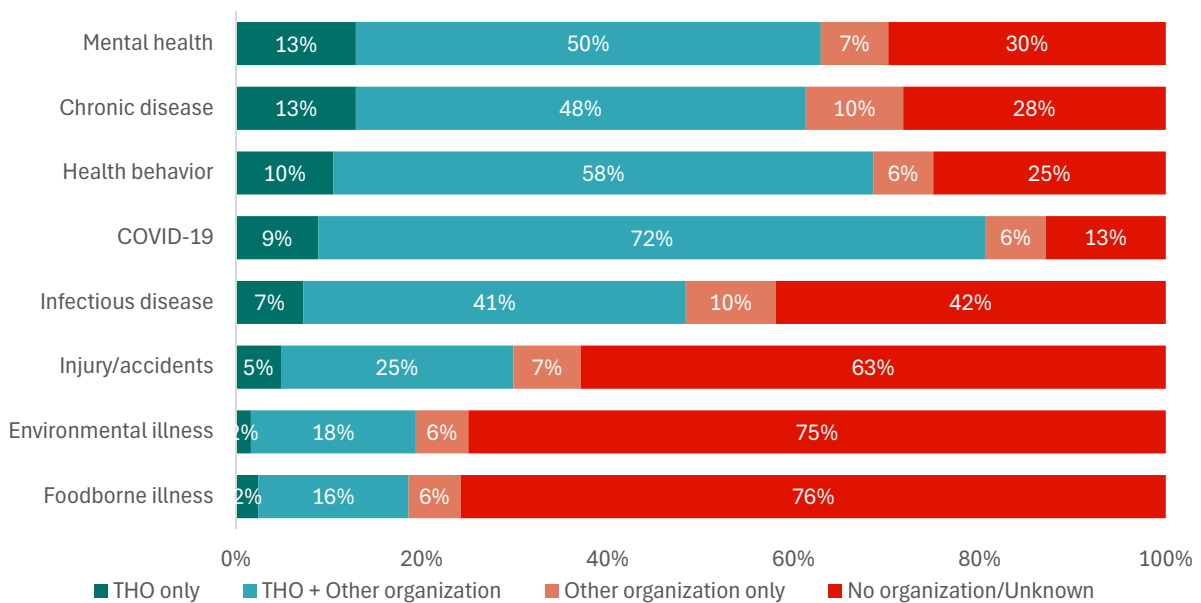
Syndromic Surveillance and Other Morbidity Data

Syndromic surveillance refers to a system that detects outbreaks early through coordination with health facilities, health departments and federal agencies. It has been identified as a method of applying public health data to detecting and preventing diseases. Only 38 organizations (31%) reported that syndromic surveillance data was collected or reported in their service area. Thirty-five percent of respondents said no syndromic surveillance data was reported and collected and an additional 34% did not know is syndromic surveillance data was reported and collected.

Forty nine percent of THOs reported that morbidity data was collected in their service area. Twenty-three percent said it was not collected and 27% did not know.

Figure 34. Syndromic Surveillance and Morbidity Data Collected or Reported in the Service Area in the Past Year
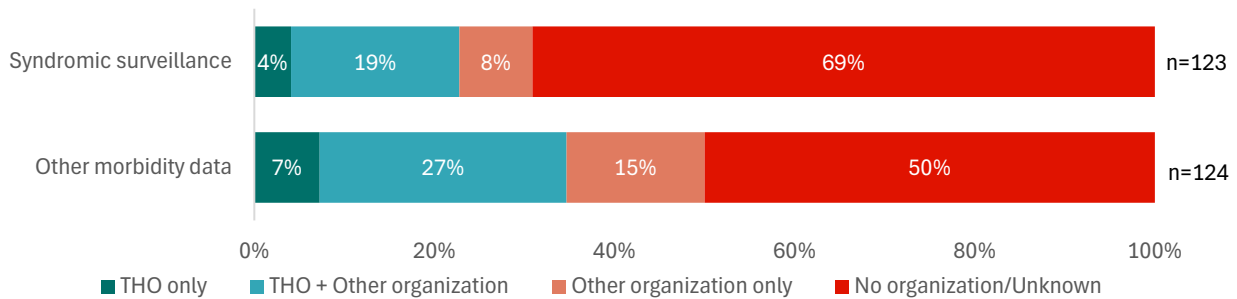
Vital Statistics

Vital statistics, including birth and death records, can be used by public health entities to better understand their service population. Vital statistics were collected or reported in the service areas of 55% of 123 THOs that responded to this question. Only 41% of 127 Tribal organizations reported receiving this data from external entities.

5.4.3   Emergency Operations and Response Activities

Emergency operations activities are preparedness efforts that ensure a public health entity can quickly respond to emergencies within their area. To understand capacity for emergency response, THOs were asked to report on their capacity within various areas of emergency operations and response (**Table 5**; **Figure 35**).

Table 5. Percentage of Response Capacity or Function Provided in THO Service Area in the Past Year (n=129)

Activity	%
Policies and protocols	75%
A Tribal emergency operation plan	67%
Emergency preparedness education	64%
A named Public Health Official	61%
Communications capacity	61%
Investigations/contact tracing capacity	50%
Laboratory capacity	39%
Epidemiological/data capacity	31%
Other	9%

Figure 35. Emergency Response Capacities or Functions Conducted in the Service Area in the Past Year
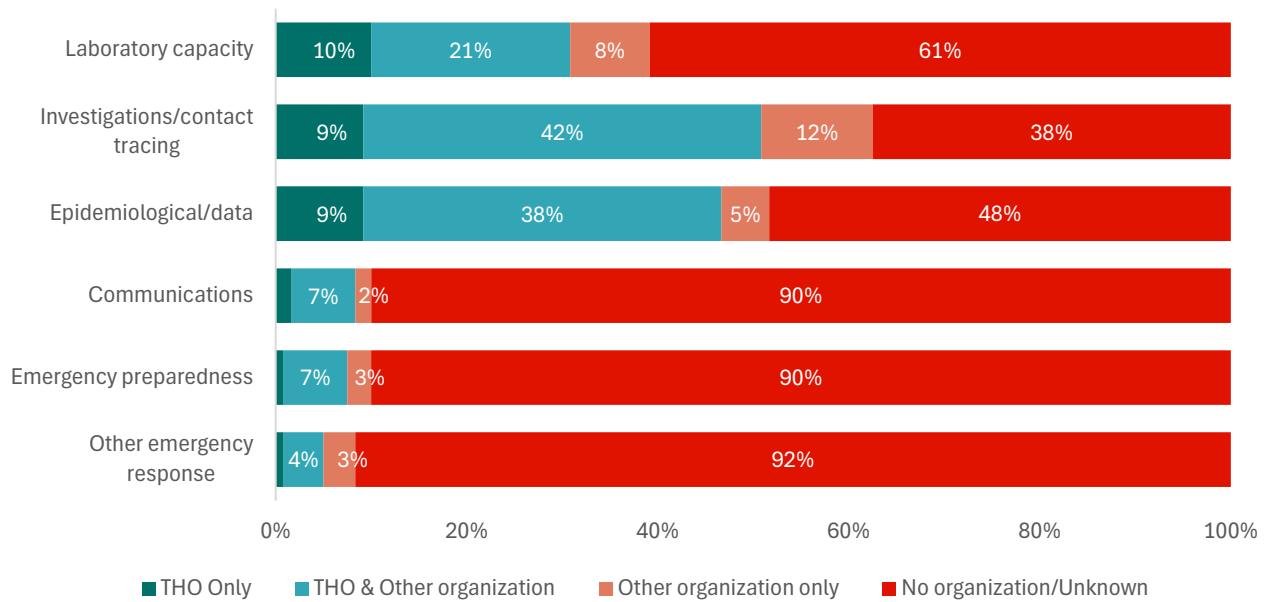
5.4.4   Regulations, Inspections, and Licensing Activities

Environmental regulation, inspection, and licensing (RIL) activities are vital for maintaining safety of food, water, waste, and other environmental systems that impact population health. As public health authorities, THOs can provide these services, or may receive them from other organizations. Half or more of respondents reported that inspection of facilities (62%), food safety training and education (57%), and public water supply safety (50%) were provided in their service area.

Table 6. Percentage of RIL Activities Available in the THO Service Area in the Past Year (n=124)

Activity	%
Inspection of facilities (food, nursing home, hotel, childcare facilities)	62%
Food safety training and education	57%
Public water supply safety	50%
Hazardous waste disposal	45%
Sewer/Septic Pollution	42%
Groundwater Protection	40%
Air quality monitoring	39%
Occupational/Worker safety and health	39%
Climate issues	24%
Vector control	23%
Medical marijuana	9%
Other environmental health RIL activities	39%

THOs were asked who provides each activity within their service area. The type of organization providing each activity varied by activity, however, for all activities except food safety training and health behavior, the majority of THOs stated that either no one provided RIL activities, or they did not know if RIL activities were offered (**Figure 36**).

Figure 36. Environmental RIL activities conducted in the service area in the past year (n=116)

	THO Only	THO & Other organization	Other organization only	No organization/Unknown
Food safety training	13%	26%	22%	39%
Hazardous waste disposal	13%	16%	18%	53%
Air quality monitoring	12%	11%	18%	59%
Public water supply safety	9%	20%	25%	47%
Other	9%	12%	19%	60%
Groundwater protection	9%	11%	22%	58%
Sewer/septic pollution	7%	15%	23%	55%
Climate issues	6%	11%	9%	74%
Vector control	3%	9%	12%	75%

■ THO Only ■ THO & Other organization ■ Other organization only ■ No organization/Unknown

Figure 37. General RIL Activities Conducted in the Service Area in the Past Year (n=124)

	THO only	THO + Other organization	Other organization only	No organization/Unknown
Injury/accidents	10%	18%	10%	62%
Health behavior	14%	32%	22%	32%
Mental health			7%	91%

■ THO only ■ THO + Other organization ■ Other organization only ■ No organization/Unknown
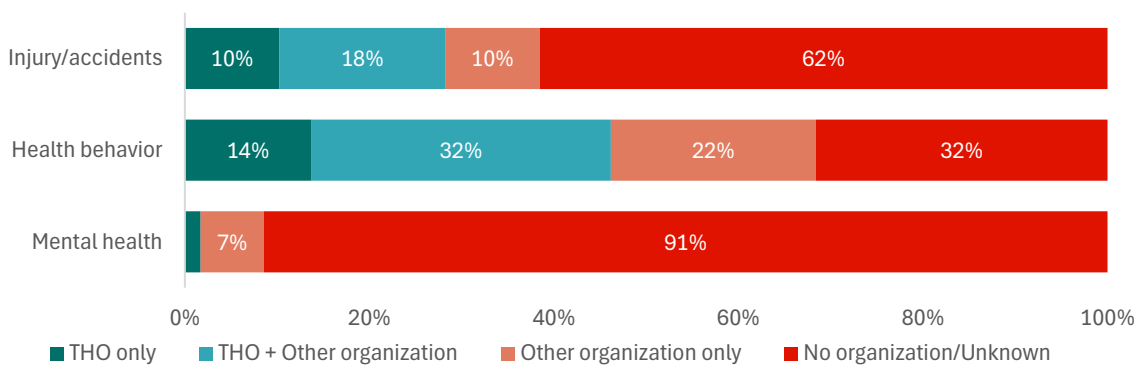
5.4.5   Public Health Communication

Public health communication is vital in developing and disseminating intentional information that contributes to Tribal communities' health. These efforts contribute not only to providing public health alerts and updates, but effective communication can influence culture and

decision-making and advocate across many subject matters. Strategic implementation of public health communication is carried out through various outlets, some of which may include physical, virtual, and audio outlets based on how to most appropriately reach the intended audience. THOs shared which communications outlets they used in **Figure 38**.

Figure 38. Public Health Communication Outlets Used by Tribal Organizations (n=129)
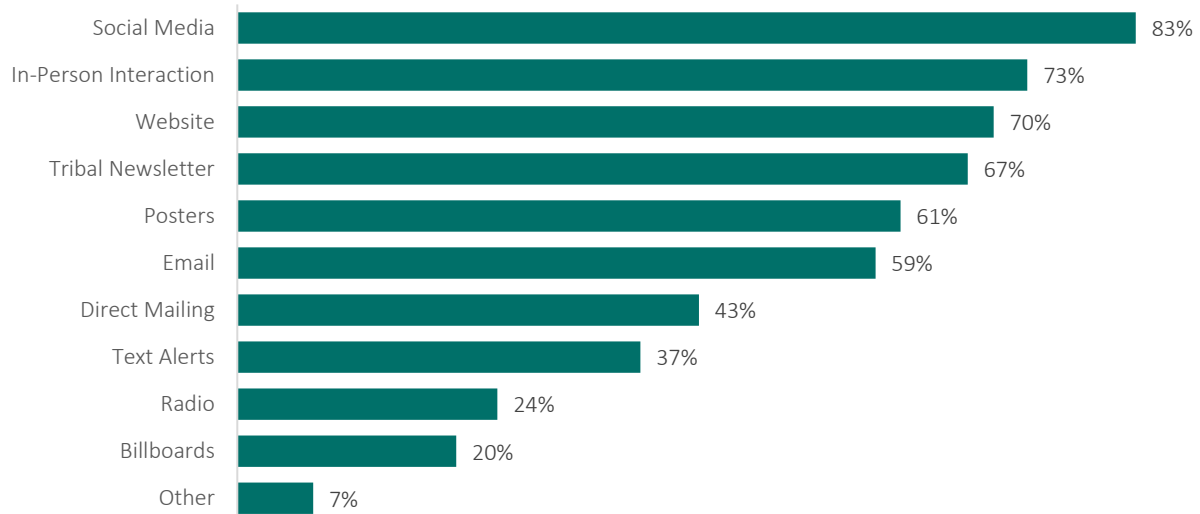
5.5 Public Health Priorities and Needs

> **Key Findings:**
>
> **The top five public health issues for respondents were:**
>
> 1. **Diabetes**
> 2. **Substance use disorders/misuse**
> 3. **Heart disease**
> 4. **Cancer**
> 5. **Suicide**
>
> **The top public health priorities were:**
>
> - **Data assessment**
> - **Workforce development**
> - **Emergency preparedness**
> - **Health education and promotion**
> - **Planning and priority setting**
> - **Tribal public health governance**
>
> **The top public health needs were:**
>
> - **Staffing**
> - **Funding**

Public Health Priorities and Needs Overview

The Public Health Priorities and Needs section provides a summary of respondents' topical and infrastructure-related priorities and needs for public health improvement. In addition to identifying key areas of focus and need, this section includes qualitative information on public health infrastructure changes, needed resources, and how partners including federal agencies and states can support the advancement of Tribal public health.

5.5.1 Public Health Priorities

THOs (n=119) were asked to rank their top five public health issues, from critical to least critical (**APPENDIX IV: List of Public Health Issues and Priorities Options from PHICCS Questionnaire**). Priorities not in the top five were not ranked. Diabetes and substance use/misuse were ranked the highest and in the top five for roughly 90% of THOs. Heart disease and suicide were also highly ranked, but heart disease was more consistently in the top five public health priorities (68%) than

suicide (32%). Other self-reported public health priorities not ranked within the top five were mental health, suicide, behavioral health, and obesity.

The following are the top five public health priorities reported by THOs:

1. Diabetes
2. Substance use disorders/misuse
3. Heart disease
4. Cancer
5. Suicide

THOs (n=119) were then asked to rank their priorities as they relate to 13 non-programmatic and infrastructure-building capacities and activities, from highest priority to the least priority (**APPENDIX IV: List of Public Health Issues and Priorities Options from PHICCS Questionnaire**). All priorities were ranked. The highest median ranked priorities were data assessment and workforce development, followed by emergency preparedness, health education and promotion, planning and priority setting (including strategic planning, quality improvement and performance management, and Tribal public health governance.

Figure 39. Median Rank of Non-Programmatic and Infrastructure-Building Public Health Priorities (n=119)
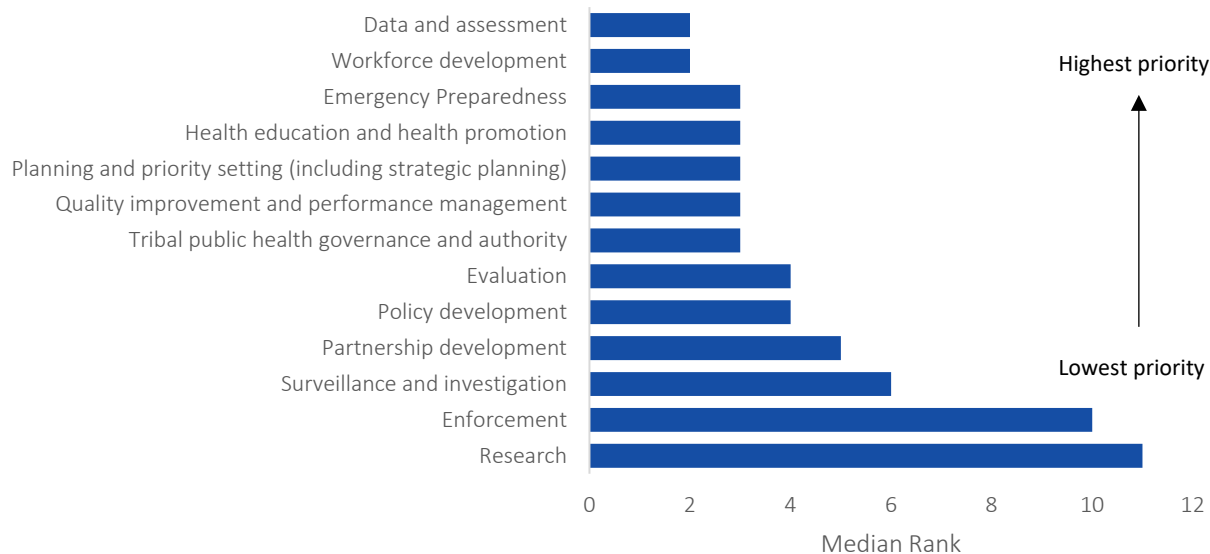
5.5.2 Public Health Needs

Survey respondents were asked to describe the resources their Tribal health organization needed to serve the Tribal communities they serve, in addition to how federal and state governments

and organizations can best assist in advancing Tribal public health. After reviewing written responses, qualitative data was categorized into 22 categories, in which one response may be associated with multiple categories. As an example, a response highlighting the need for "Additional funding for behavioral health positions" would be tallied into columns for (1) funding, (2) staffing and (3) behavioral health. The categorization matrix is in **APPENDIX V: Public Health Categorization Matrix on Public Health Needs**.

Resources Needed to Improve Tribal Public Health

In **Figure 40**, 48% of THOs mentioned staffing as a resource needed to improve Tribal public health. Responses that mentioned staffing often also mentioned funding, public health infrastructure and health care services. Recruiting and retaining local staff to provide in-person care was a major challenge for Tribal organizations. Respondents noted that inflation and increases in professional wages have posed challenges for fixed budgets.

"Community health staff. Years ago, Tribes had a Public Health Nurse, Nutritionist and Environmental Health person on staff. We no longer [do] because of funding and the need for clinic staff."

"Staffing. Far too many vacancies and insufficient funding to fill vacancies. There is little housing to offer in the community, both for professional and non-professional persons. We have homeless persons working for our organization as there is nowhere to live."

Overall, 42% of responses mentioned funding, with respondents highlighting the need for Tribe-specific non-competitive funding, particularly for public health infrastructure broadly and building physical infrastructure. Nine percent of respondents mentioned the need for physical infrastructure (e.g., facilities, buildings). Twenty-two percent of responses discussed public health infrastructure and the need to build up public health departments with sufficient knowledge, staff, and programming. Multiple respondents needed support in building Public Health Departments that currently do not exist or were only recently established.

"Non-Competitive Funding specific to Tribal nations to build the Public Health Infrastructure and the knowledge of Public Health among their associates across the entire Tribal organization."

"Funding and staffing. We can come up with a collective vision for the state, but without increased funding and a pipeline of workers, we cannot implement the vision."

"Additional funds are needed for infrastructure development to establish a viable Public Health agency independent of healthcare. Funding for Public Health facilities, operational budget, public health trained personnel are needed."

In addition, 17% of respondents described the need for more resources for staff, particularly educational and training resources on topics including best practices, strategic planning, and community development. Access to data was mentioned in 14% of responses, often in

combination with the need for technical infrastructure and resources for staff. Reliable Tribal data, analytic public health staff and access to data analysis software were highlighted. Community health services were mentioned in 12% of responses, with a particular focus on the need for more community health staff. More community outreach (12%) was needed, particularly to provide more Zoom meetings, public health materials, and resources for community members outside of the clinic.

> *"Training and education for workforce regarding best practices for community development, mental health first aid education and techniques, and emergency management resources."*

> *"Data access; on site epidemiologist; well-funded and trained workforce; money to create programs and systems that will aid the community in disease prevention, age-related programming, and emergency preparedness."*

Nine percent of respondents cited the need for more policy and procedure support and physical infrastructure. Six percent require more behavioral health services and staff. Details on the resources needed to improve Tribal public health are presented in **Figure 40**. Categories mentioned in less than five responses are not represented but include housing support, partnerships, transportation, culturally relevant resources, local activities, and Tribal consultation/participation.

Figure 40. Resources Needed by Tribal Organizations to Advance Tribal Public Health by Percent of THOs (n=99)

Staffing — 48%
Funding — 42%
Public health infrastructure — 22%
Resources — 17%
Data — 14%
Community outreach — 12%
Community health services — 12%
Technical infrastructure — 11%
Health care services — 11%
Policy support — 9%
Physical infrastructure — 9%
Behavioral health services — 6%
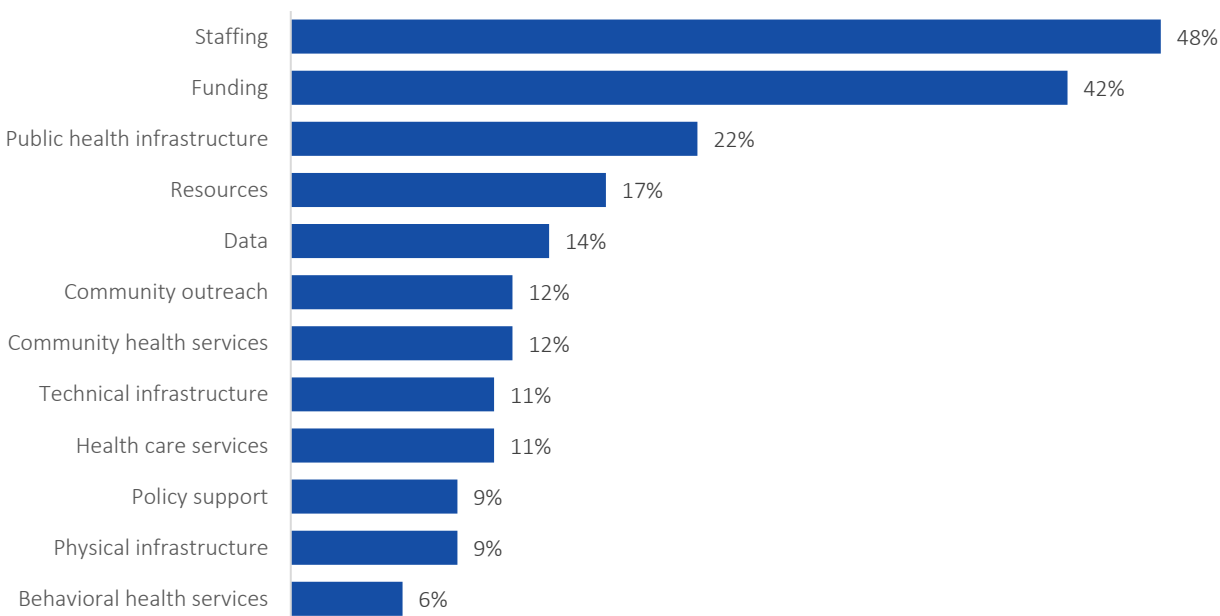
Support from the Centers for Disease Control and Prevention

In **Figure 41**, 49% of THOs reported that additional resources (e.g. education, training) for staff were needed from the CDC. Resources were often mentioned in combination with partnerships, particularly around providing educational training to staff on topics such as data analysis, disease prevention, preparedness, and rural public health. One respondent requested a Tribally led page on the CDC website to share information and tools among Tribal public health professionals working in rural and underfunded communities.

The need for resources was also often mentioned alongside the need for consistent guidance and better coordination with other federal and state partners as lack of coordination drastically increases the amount of work for Tribal organizations. Eleven percent of all responses discussed the need for improved communication and coordination from CDC.

"Consistent messaging with practical applications for Tribal facilities with limited resources. Improved communication with all other federal/state/local facilities instead of having us small clinics communicate the same data to 4-6 different organizations because those organizations either cannot or will not talk to each other."

Thirty-eight percent of organizations needed more funding from CDC, with many respondents citing the need for consistent funding that enables organizations to build up and maintain public health infrastructure. Non-competitive funding and allocation of Public Health Association Program (PHAP) placements was highlighted. Overall, CDC support for Tribal public health infrastructure was mentioned by 18% of respondents.

"Culturally appropriate programs. Funding to improve collaboration for public and private partnerships…. Non-competitive grant funding that has no restrictive use, limitations or burdensome reporting requirements."

"The competitiveness puts Tribes in adversarial positions to compete for funding."

Additionally, 23% of Tribal organizations surveyed wanted stronger partnerships with the CDC, particularly around building public health infrastructure. Tribal organizations needed more support from CDC in staffing (16%), with many respondents asking the CDC to work directly with Tribal organizations to fund, recruit, train and retain staffing in hard to fill public health positions. Multiple respondents explicitly asked for guidance or advice from the CDC to support public health advancements. Nine percent mentioned in-person activities, with multiple Tribal organizations inviting the CDC to send public health professionals.

"Fund Tribal specific grants to build infrastructure and provide additional information on how to build that infrastructure."

*"It would be very good if CDC can **develop a program to fund students who have interest in public health positions** or help identify programs that can **help develop health professionals**."*

*"**Come on site, observe what we have in place and make recommendations** to support public health advancement. Offer grants from CDC to support this work."*

*"**Designated deployments** to live and work in an area for multiple years."*

Ten percent of Tribal organizations highlighted the need for better Tribal data and improved technical infrastructure. Another 10% mentioned additional support and professional development for Tribal public health professionals.

*"Allowing Tribal organizations to **create a program and evaluation framework that suites the unique needs of their community**."*

Details on the resources needed from CDC to improve Tribal public health are presented in **Figure 41** below. Categories that were mentioned in less than five responses are not represented, but are: healthcare services, culturally competent resources, policy support, community health services, behavioral health services, housing and transportation support, Tribal consultation, and Tribal sovereignty.

Figure 41. Resources Needed from the CDC to Advance Tribal Public Health by Percent of THOs (n= 89)
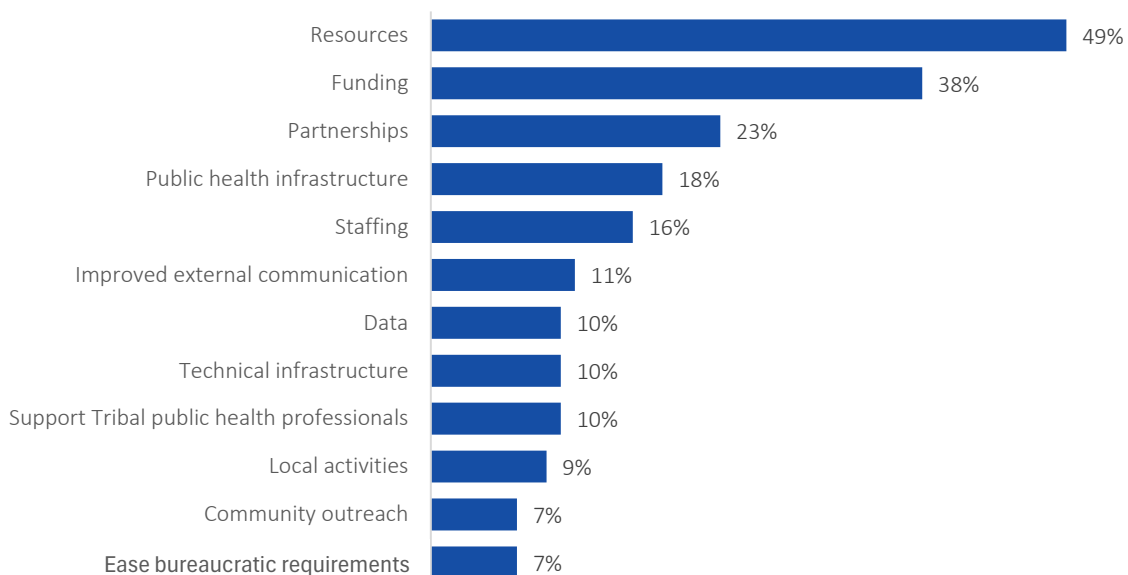
Support from Federal Agencies

In **Figure 42**, 53% of THOs highlighted the need for additional funding from the federal government. Respondents reported that the funding allocated to Tribal organizations is insufficient to meet public health goals and targets. The need for consistent and non-competitive funding specifically for Tribes and Tribal organizations was raised in many responses, with 10% calling for reduced administrative work. Funding was most often mentioned in connection with resources and public health infrastructure.

"Create and set GPRA measures/goals that support improved health outcomes, and advocate for funding that supports EBIs to meet the goals and measures… The Federal government is underfunding and underestimating the capabilities of IHS clinic staff, and the AI/AN population's will to live."

Funding challenges were commonly mentioned in combination with staffing concerns and the need for easing bureaucratic requirements. Tribal organizations cited challenges utilizing funding to meet the needs of their communities. Often the administrative needs for applying and reporting on grants can greatly strain small organizations. Calls for support in staffing (11%) focused on healthcare providers, public health professionals and human resources in rural areas. Six percent of THOs needed support in providing healthcare services.

"Grants do not allow us to do what our need is. They tie our hands because they are specific for services that may not fit our needs. Reporting is burdensome. Make more funding available that can be used and designed for our needs."

"…Recognize eligible provider types (all licensed and certified rural healthcare providers) and require payers to reimburse for services. Promote synergy and alignment between reporting initiatives, such as GPRA, MIPS, HEDIS, and UDS across HHS agencies. Provide funding through IHS for long-term care services for our Elders including residential care services, home and community-based services, caregiver services, case management and hospice care."

Thirty percent of respondents needed more resources from federal agencies, including access to culturally competent curriculum for staff, and local, affordable training. Respondents asked for directories to be created that list federal agencies that support Tribal public health. Administrative resources are needed for Tribal organizations to better understand what services can be offered to Tribal members within and outside their service areas.

"Provide training which is inexpensive and within our service area. Too often, trainings are held too far in high end resort type facilities that does not allow some Tribes to participate. Training locations should be taken into consideration, as well as the cost. Especially the cost for Zoom training are still expensive."

Federal support for public health infrastructure was mentioned by 18% of Tribal organizations. Many respondents mentioned public health infrastructure resources. Without sufficient funding, Tribal organizations cannot build the infrastructure needed to become accredited and run public health departments. Tribal organizations needed organizational and technical support in building public health departments and tools to best utilize their workforce capacity to offer more services.

"Provide Tribal public health departments the same access, resources, systems, and support as county and local health departments; recognition as public health authority on Tribal lands."

"Develop public health personnel on-site support programs similar to CDC PHAP to assist Tribes with all aspects of public health planning and infrastructure development."

Eighteen percent of responses called for greater partnership and collaboration between federal agencies and Tribal organizations. Respondents primarily seek guidance and resources in how to build public health infrastructure and collaboration in tackling Tribal public health emergencies. Seven percent of responses raised the need for more Tribal consultation. Relationship building was a key element, with respondents calling for stronger one-to-one relationships with federal agencies to provide feedback, partner on projects and stay engaged in the needs of Tribal communities.

"Have [federal agencies] check up on the Tribes and see how they are doing."

Staffing was mentioned in 11% of responses, particularly funding for staff, recruitment, and the need for public health professionals to be deployed to Tribal organizations. Overall local activities and easing administrative burdens were mentioned in 9% of all responses. Data was mentioned by 7% of THOs and technical support was mentioned in 6%. Tribal organizations need Tribe-specific AI/AN data, support in conducting assessments and reliable broadband internet. Six percent of THOs mentioned the need for more support to Tribal public health professionals, particularly in professional development and employee health programs.

"Increase rural community access to high quality internet for social media platforms to be used in outreach efforts. So many people are homebound and do not have the ability to always come in for educational events put on by public health programs."

Resources needed from federal agencies to improve Tribal public health are detailed in **Figure 42**. Categories that were mentioned in less than five responses are not represented, but include healthcare services, improved external communication, community outreach, Tribal sovereignty. culturally competent resources, community health services, behavioral health services, housing support and physical infrastructure.

Figure 42. Resources Needed from Federal Agencies to Advance Tribal Public Health by Percent of THOs (n=83)
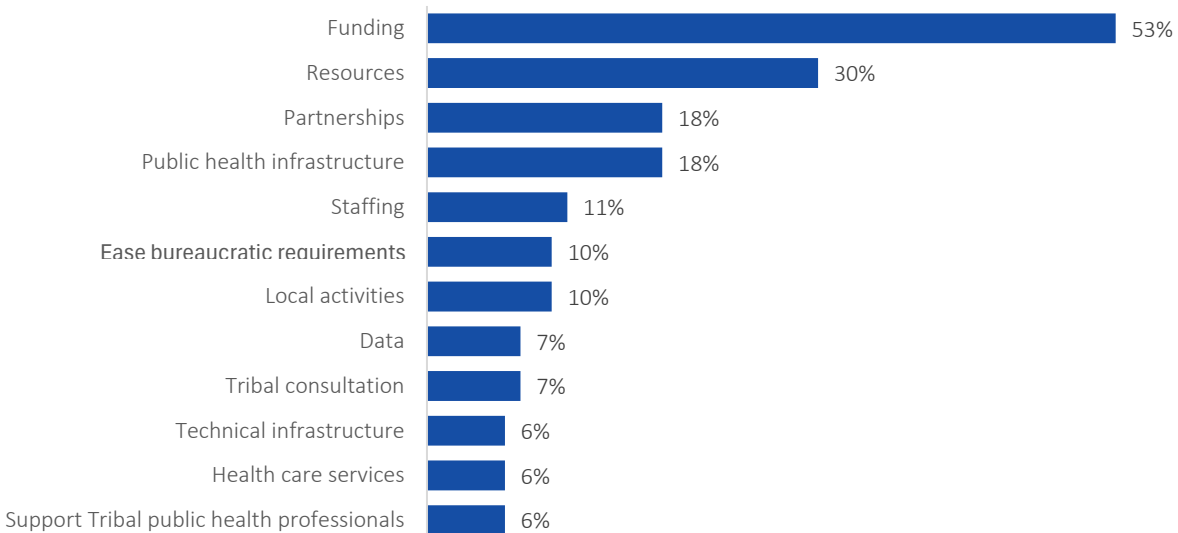
Support from State Agencies

In **Figure 43**, funding from state agencies was mentioned by 41% of THOs, particularly the funding of resources, staffing and data. Tribal organizations need funding to build public health infrastructure and perform necessary public health functions. As mentioned above, there is a need for reduced administrative requirements so that Tribal organizations can use funds to meet the needs of their communities. Overall, 11% of Tribal organizations mentioned state support for public health infrastructure.

"Funding to help with disease prevention, suicide awareness, and drug prevention. Workforce development and training programs for Tribal communities. Improve the quality of surveillance data. Funding to improve collaboration, infrastructure, and retention of talent. Funding for all Tribal communities to have the best and most efficient EHR [electronic health record] system that aids with collaboration with other healthcare systems for a more concerted flow for healthcare support and data linkage. Funding from the state to improve Tribal infrastructure and land to aid with improving environmental public health."

Thirty-three percent of responses called for stronger partnerships with state agencies, particularly around increased Tribal consultation, participation and allocating funding and resources. Tribes want increased communication with state agencies and to be included in conversations earlier in the decision-making process. Partnerships are needed to assess, fund, and meet the public health needs in their service areas. Respect for Tribal sovereignty and Tribal data sovereignty was highlighted as key to state-Tribal partnerships. Twelve percent called for

more Tribal consultation. It is important to note that multiple respondents used this section to call attention to strong, positive working relationships with their state, highlighting the important work of Tribal liaisons and the collaborative efforts to tackle the COVID-19 pandemic.

*"To begin **visiting their constituent communities**. A lot of our state folks do not equally make time to visit Tribes or to gain any insight of what is going on within a Tribal community. **Tribal Consultations may happen, but often are not followed through on a Tribe's needs**."*

*"Collaborate and partner with Tribe on Public Health Initiatives, **respecting Tribal [sovereignty]**."*

Twenty-four percent of respondents mentioned the need for additional resources, particularly on-site training and professional development for public health nurses. Multiple respondents called for state directories of resources and agencies that can assist Tribal organizations and provide administrative resources in and around their service area. Responses mentioning the need for improved communication (8%) centered on providing Tribes with the administrative information they need and working in collaboration instead of duplicating efforts.

*"**Provide local training**. More of our staff are not able to travel long distances for training so **if we could have local trainings, we could get more of our public health staff the training they need** to keep up to date on the current topics related to public health issues."*

*"**Develop a list of resources for Tribes to have available to connect Tribal members with the support they need**. Work with Tribes to **develop emergency plans, develop and conduct regional exercises**."*

Data was a key resource mentioned by 17% of respondents, particularly around the data sovereignty rights of Tribes to control and maintain data on their citizens. Despite acting as public health authorities, many Tribal organizations do not have as much access to state data and data systems as county and local health departments. Many respondents expressed that they do not have the level of access to state data systems needed to serve their patients and community. While Tribe-specific data is essential to Tribal public health goals, some respondents reported difficulty even accessing AI/AN-specific data that has not been re-categorized into "Other". Technical infrastructure was mentioned in 8% of respondents, particularly the need for technical assistance, electronic record management and reporting.

*"**Work in collaboration** on public health issues and **not duplicate services** in the boundaries of the Tribal organization. Attempt to obtain **better AI/AN specific data**."*

Eleven percent of responses called for states to recognize Tribal sovereignty and Tribal public health authority. This is essential to ensuring that Tribes can provide public health services and is a critical element to developing lasting government-to-government partnerships. Local activities (8%) were encouraged to reduce barriers for staff and provide more opportunities for networking and collaboration between Tribal and state partners.

"Recognize the inherent public health authority that Tribes possess. This is necessary for the Tribes to respond in real-time to public health issues."

A need for support in providing healthcare services came up in 8% of responses, with a focus on Medicaid expansion, expanding reimbursable services and increasing reimbursements. Seven percent of responses mentioned the need for state support in staffing, particularly around healthcare provider roles and administrative support. An additional 7% of responses mentioned the barriers posed by high administrative burdens, with Tribal organizations citing the need to use funds outside of delegated restrictions, from billing for case management to providing food during public health events. These responses highlight the difficulties that Tribal organizations face in acquiring and utilizing grant funding to best meet the needs of their diverse communities.

"Become educated that most Tribal organizations have different systems and priorities, so there isn't a one-size approach."

Resources needed from state agencies to improve Tribal public health are detailed in **Figure 43**. Categories that were mentioned in less than five responses are not represented, but include supporting Tribal public health staff, community outreach, physical infrastructure, behavioral health services, culturally competent resources, housing, and transportation support.

Figure 43. Resources Needed from States and State Agencies to Advance Tribal Public Health by Percent of THOs (n= 86)

Category	Percent
Funding	40%
Partnerships	33%
Resources	24%
Data	17%
Tribal consultation	12%
Public health infrastructure	11%
Tribal soveriegnty	11%
Technical infrastructure	9%
Health care services	8%
Improved external communication	8%
Local activities	8%
Staffing	7%
Ease bureaucratic requirements	7%
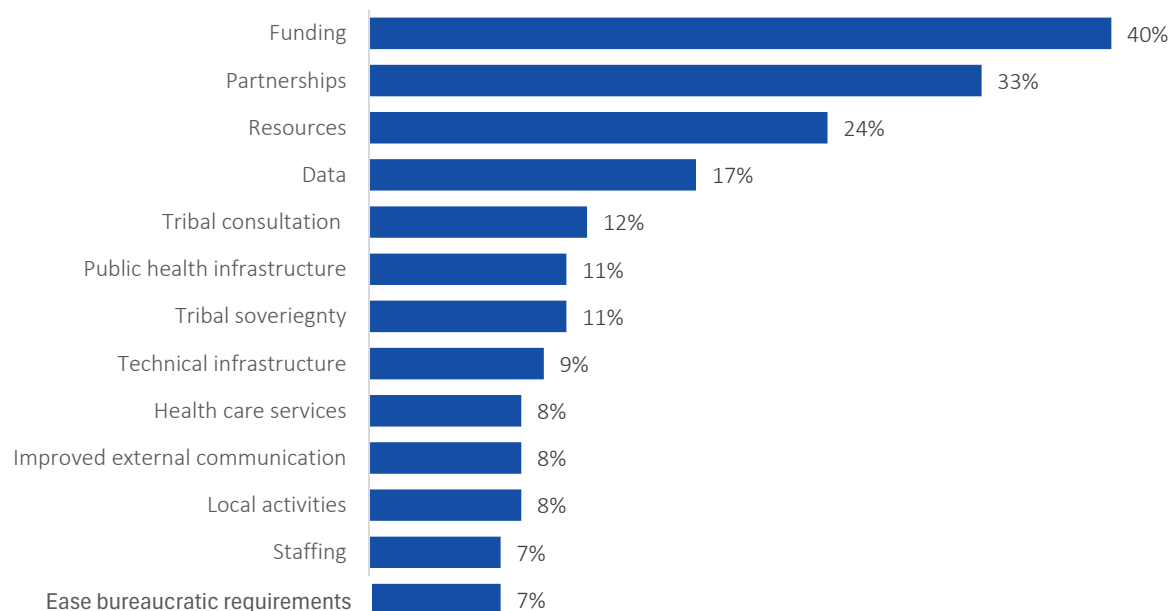
6   Regional Findings

Key Findings:

- **Tribal Councils were the most frequently used public health governance structure within each of the regions.**
- **Funding, partnership, and resources were consistently reported in all regions as priority opportunities and needs for support to advance Tribal public health both in general and from external entities including state and federal partners.**
- **The vast majority of THOs across each region had assessment and planning activities in place, but did not use performance management systems.**
- **Training was a priority workforce development need shared across regions. However, workforce development tools like the Core Competencies for Public Health Professionals were mostly not used among responding THOs.**
- **While public health issues varied by region, diabetes and substance use and/or misuse were shared among each region as top five public health issues.**
- **Health education and promotion was consistently shared as a non-programmatic and infrastructure-building public health priority among each of the regions.**

Regional Analysis Overview

Tribal public health capacity and priorities can vary by region due to a variety of factors including, but not limited to geographic, environmental, historical, cultural, economic, political, and social reasons. Due to a history of forced removal and relocation, the population of AI/AN citizens and the corresponding number of Tribes differs by region, with Tribal Nations more concentrated in certain areas of the United States, and specific needs and challenges based on these geographic locations.

The overall PHICCS data is valuable in providing a snapshot of the biggest successes, challenges, and resource needs in Indian Country. However, these successes, challenges, and needs are subject to the high variation in the number of respondents by region. Therefore, this section will discuss key data by region and highlight regional variance across the five PHICCS capacity areas.

This regional analysis is meant to provide more granular level data to better understand how priorities may differ in THOs across the country. However, each region contains a multitude of Tribes with varying history, traditions, cultures, governing structures, and practices. This

regional analysis does not erase the need to understand variance within each region that was included within the PHICCS survey.

Limitations

The number of respondents differed significantly by region. Caution should be used when interpreting the results due both to this variation and the overall low response rate. Certain regions are represented less in the data compared to regions with a larger percentage of responses. As with other components of PHICCS, we recommend viewing the results as a snapshot of those who responded to PHICCS.

6.1 Characteristics of Survey Respondents

6.1.1 Respondents by Region

The number of respondents varies by region, with the highest percentage of respondents from the Pacific Coast & Alaska (36%), and a lower percentage of respondents in the Southern Plains (10%) and East (7%) (**Figure 44**). This response rate reflects the higher concentration of Tribes within the Pacific Coast & Alaska Region (although many THOs operate in consortiums in Athis region, making the number of THOs lower than the total number of federally recognized Tribes), and the lower concentration in the Southern Plains (10%) and East (7%).

Figure 44. Number and Percent of THO Respondents by Region (n=133)
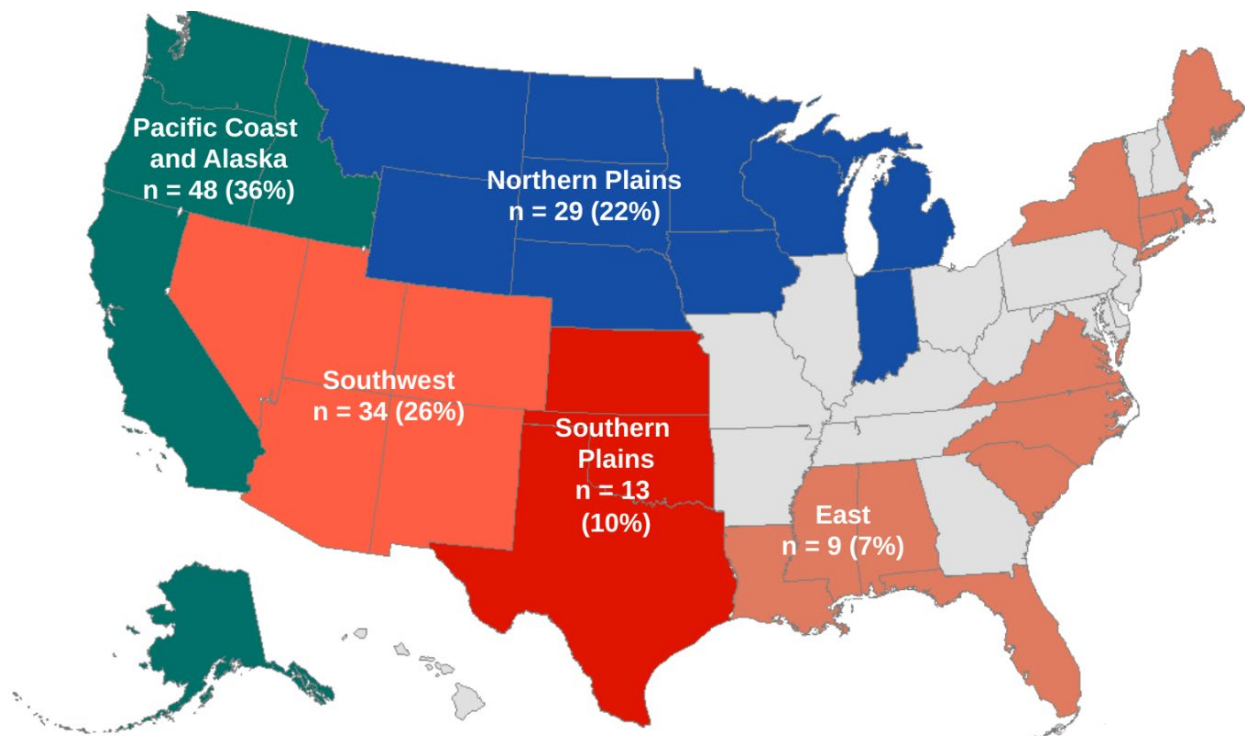
While there may be similarities and overlaps in Tribal service areas, THO service populations vary by Tribe and are determined by each Tribe/THO. Assessing how service populations differ by region highlights important variability in who is eligible for and receives THO services. Regional findings provide context regarding the eligibility for services by non-AI/AN employees and family members, as well as members of state recognized Tribes. They also provide context regarding the ability of the service population to access and receive care within each region.

In **Figure 45** respondents were asked to identify which populations had received the public health services offered by the THO. Most THOs across all regions reported that THO services were received by enrolled members of <u>any</u> federally recognized Tribe, with 100% of the THOs in the Southwest, Northern Plains, and Southern Plains, 98% of THOs Pacific Coast & Alaska Region, and 88% of THOs in the East offering services to this population.

THOs were less likely to offer services to other populations. A smaller majority of Tribes offered services to non-enrolled members of federally recognized Tribes (such as eligible dependents and descendants), with the East (88%) and Pacific Coast & Alaska (83%) being more likely to offer services to this population. Similarly, the East (75%) and the Pacific Coast & Alaska (74%) regions were most likely to offer services to non-AI/ANs. Around a quarter of respondents across the majority of region served state recognized Tribal members, with the Pacific Coast & Alaska respondents being more likely (39%) to serve this population than their counterparts in other regions, and the Southern Plains region being the least likely (13%).

Figure 45. Individuals who Received Services by the THO (% of Regional Respondents)
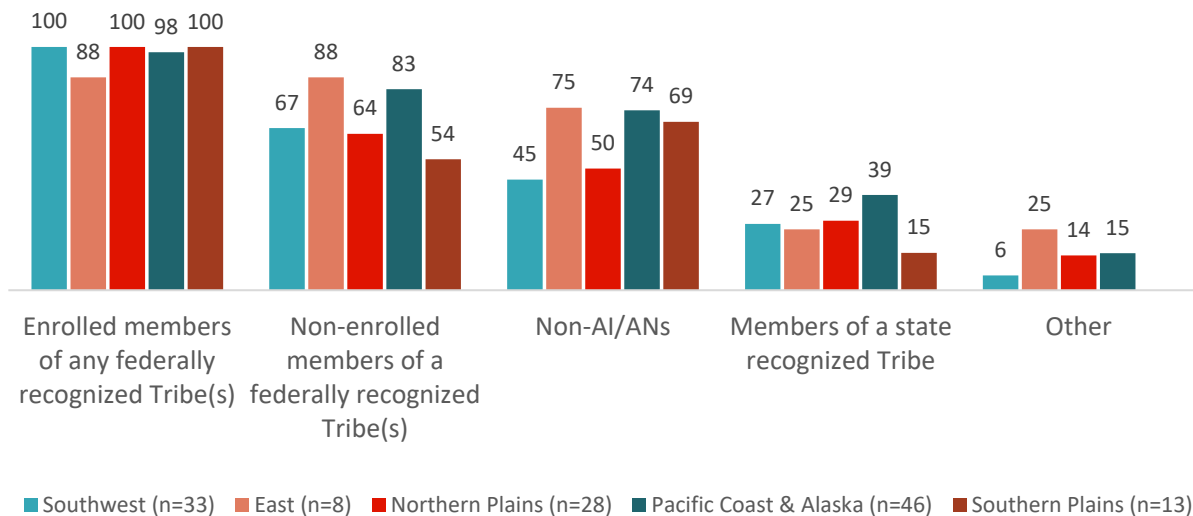
6.2 Public Health Authority

6.2.1 Tribal Governance

Figure 46 highlights the diversity of governance structures by region. Overall, THOs were governed by multiple types of governance structures with Tribal Councils being the most commonly used structure in all regions when compared to the other governance structures used within the corresponding region.

Governance structure is determined by each individual Tribe as a core practice of Tribal Sovereignty, and each THO may engage with more than one governance structure. Therefore, there are some notable differences observed by region. While all Tribes in the Eastern region utilized Tribal Councils, only 76% of Tribes in the Southwest region, 75% in the Northern Plains, and 63% in the Pacific & Alaska Coast used Tribal Councils to govern their public health activities. Tribal Council governance was the least common in the Southern Plains compared to the other regions, with only 46% of Tribes in this region using this structure. Instead, THOs in the Southern Plains utilized a combination of Boards of Health (38%) and Tribal Chief or Chairpersons (23%). Other notable differences include regional use of Tribal Chiefs or a Chairperson for Tribal governance among 75% of Tribes in the Eastern region.

Figure 46. Governance Structure of THOs by Region (% of Regional Respondents)

Legend: ■ Southwest (n=33) ■ East (n=8) ■ Northern Plains (n=28) ■ Pacific Coast & Alaska (n=48) ■ Southern Plains (n=13)
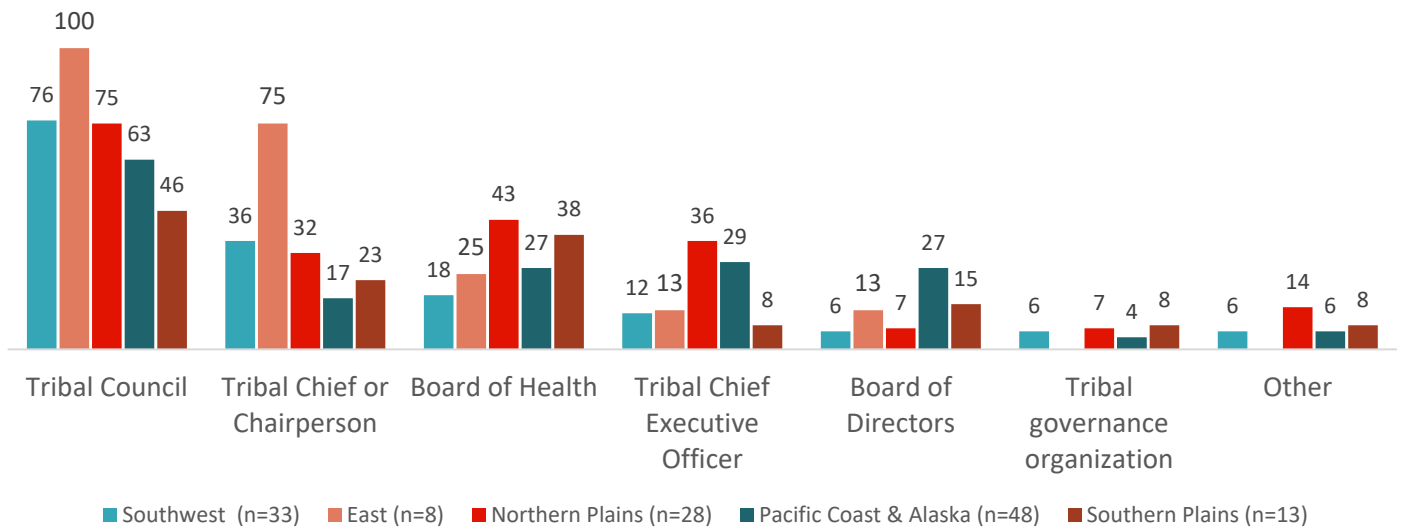
6.2.2 Partnership

Partnership, and the corresponding complex networks of skills and subject matter expertise, are integral to not only conducting public health activities, but also to accessing tools and resources to ensure efficient public health services. Collaborative efforts between Tribes and

external agencies or entities are often formalized through mechanisms that ensure mutually beneficial engagement. Understanding what mechanisms Tribes are familiar with and most often use within each region can aid in the navigation of partnership and relationship building efforts that support public health services and activities. In **Figure 47** THOs were asked what type of formal mechanisms were used to define their relationship and engagements. Responses among each of the regions were consistent apart from the Eastern region where all the responding THOs utilized contracts and memorandums of understanding. Data sharing was a point of interest, as there was relatively low utilization of this mechanism with less than half of each region using data sharing agreements apart from the Eastern region where 67% of respondents had these in place.

Figure 47. Formal Mechanisms Used to Define Relationships by THOs (% of Regional Respondents)

Legend: Southwest (n=28), East (n=6), Northern Plains (n=23), Pacific Coast & Alaska (n=40), Southern Plains (n=11)
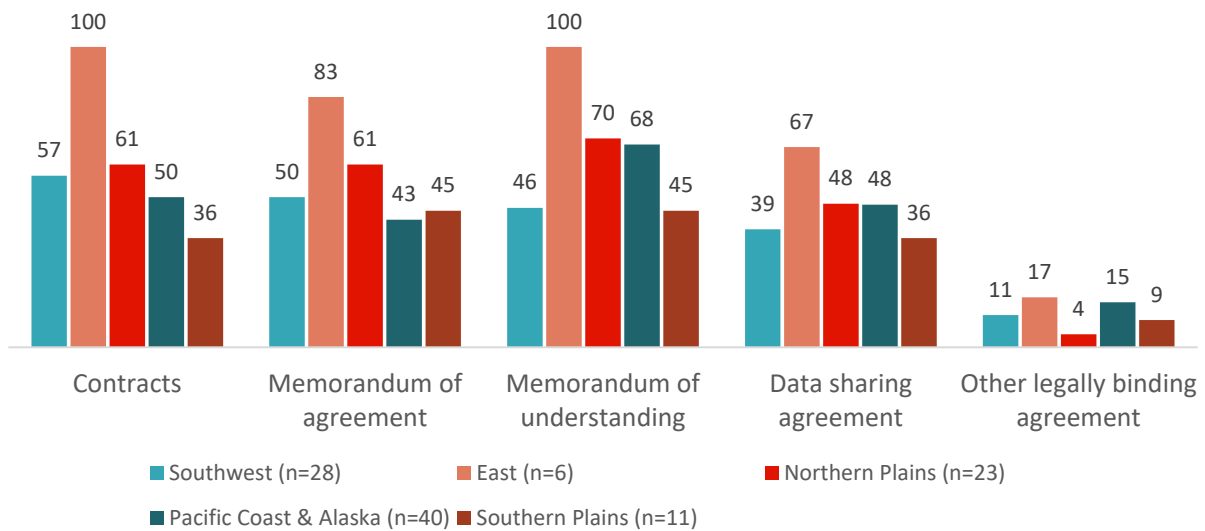
6.3 **Workforce**

6.3.1 **Public Health Workforce Needs by Region**

Regional analysis of Tribal public health workforce can aid in the ability to understand opportunities and gaps that impact public health capacity. This understanding can facilitate targeted resources for supporting recruitment and training activities. Regionally, public health workforce capacity, priorities, and needs related to supporting an efficient workforce differed. When asked to identify top public health workforce development needs, training was identified as the primary workforce development need across all regions. Staffing was highlighted as the secondary workforce development need among four regions (Southwest, East, Pacific Coast & Alaska, and Southern Plains), with approximately half of respondents in each region reporting staffing as a top need. The Northern Plains region, however, reported professional development and "other" as their tied secondary workforce development needs.

While funding was among the most requested sources of support among capacity needs overall, workforce specific funding was among the less suggested needs for Tribal workforce development, with Southern Plains having the most respondents identify this as a need (33%). Additionally, while approximately a quarter of respondents in most regions identified a need for policy and procedure development, this was not a need among any respondents in the East region (**Figure 48**).

Figure 48. Top Public Health Workforce Development Needs for THOs (% of Regional Respondents)
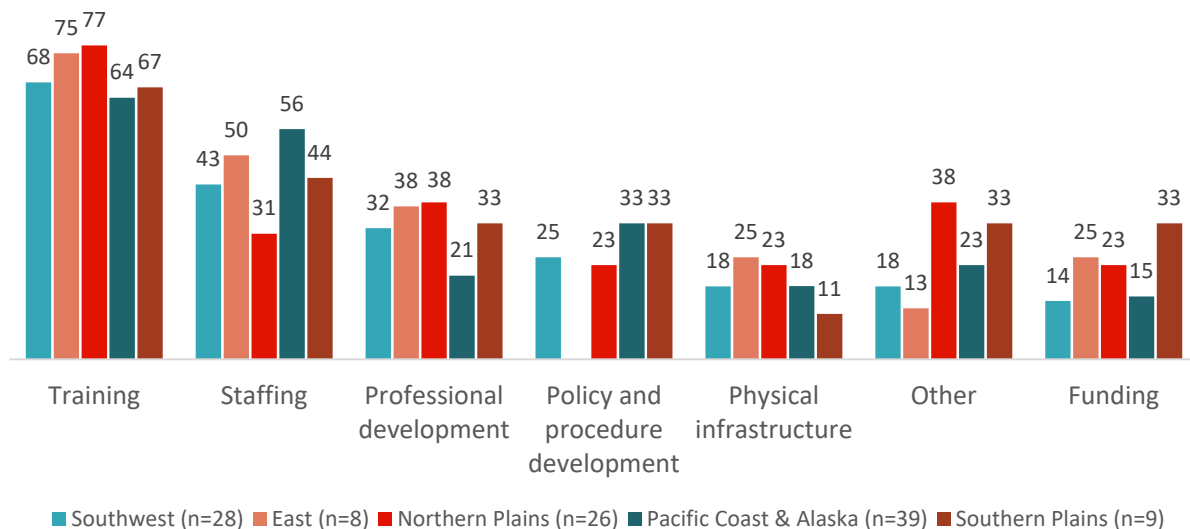
6.3.2 Usage of *Core Competencies for Public Health Professionals* by Region

Tools like the *Core Competencies for Public Health Professionals* can contribute to addressing Tribal workforce development needs. While there was some organizational use of the *Core Competencies*, in **Figure 49** most THOs did not utilize this resource to advance their workforce capacity. At least 50% of THOs in each region did not utilize this resource in any capacity. Additionally, the number of THOs that used *Core Competencies* to improve their training, performance evaluations, and the development of job descriptions was limited to no more than 32% of THOs.

Figure 49. Organizations Using the Core Competencies (% of Regional Respondents)

■ Southwest (n=31) ■ East (n=9) ■ Northern Plains (n=22) ■ Pacific Coast & Alaska (n=42) ■ Southern Plains (n=11)
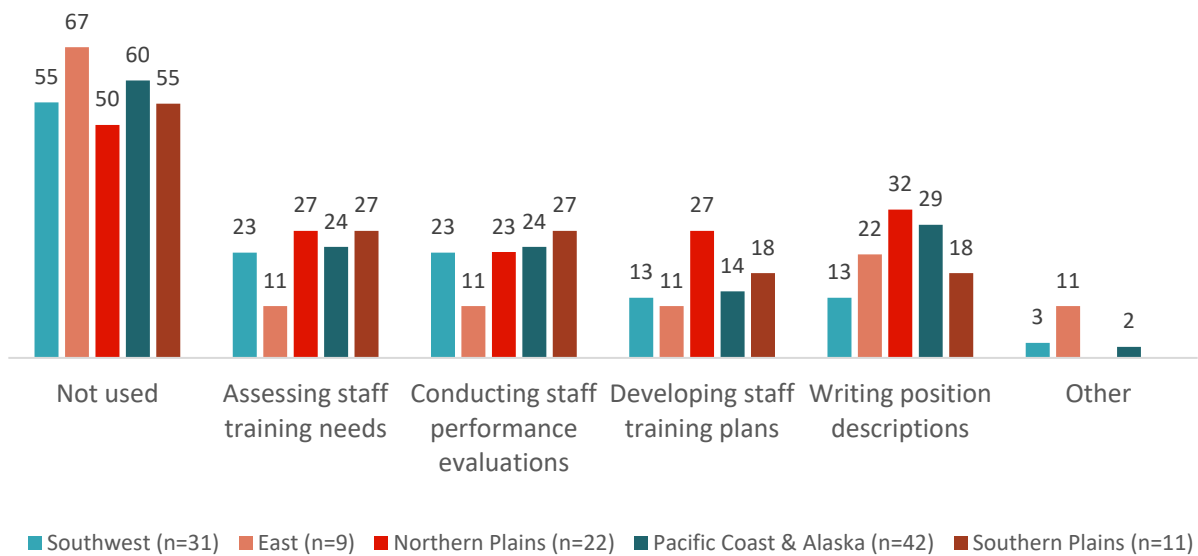
6.4 Assessment, Planning, and Performance Management

The regional analysis of assessment planning and performance management analyzed the regional variation in the development and use of community health assessments (CHAs), improvement and strategic plans, as well as intentional evaluation of quality. These efforts demonstrate THO capacity to access and/or collect data and use evidence-based approaches to guide THO programs and the continuous effort to ensure efficiency of THO offerings.

6.4.1 Community Health Assessments by Region

Regionally, there was a large amount of variability in the completion of CHAs by the respondents (**Figure 50**). Overall, the majority of THOs in each region already had or planned to complete a CHA, although at least 10% of THOs reported their CHA as being completed more than five years ago and beyond the allowable timeframe for activities related to achieving public health accreditation. This trend is especially evident within the Eastern region where 63% of THOs had developed their CHAs beyond the 5-year time frame. Strategic placement of regional or individual of resources and tools to support the capacity needed to initiate and complete CHA activities may be among the Tribes that do not have this document in place, are still in the planning phase, or are unaware of CHA related activities. As much as 27% of THOs in the Southern Plains and as low as 12% of THOs in the Northern Plains did not have a CHA in place and had no plans to implement one over the next year.

Figure 50. Status of THO Community Health Assessment Engagement by Percent of THOs per Region (n=122)
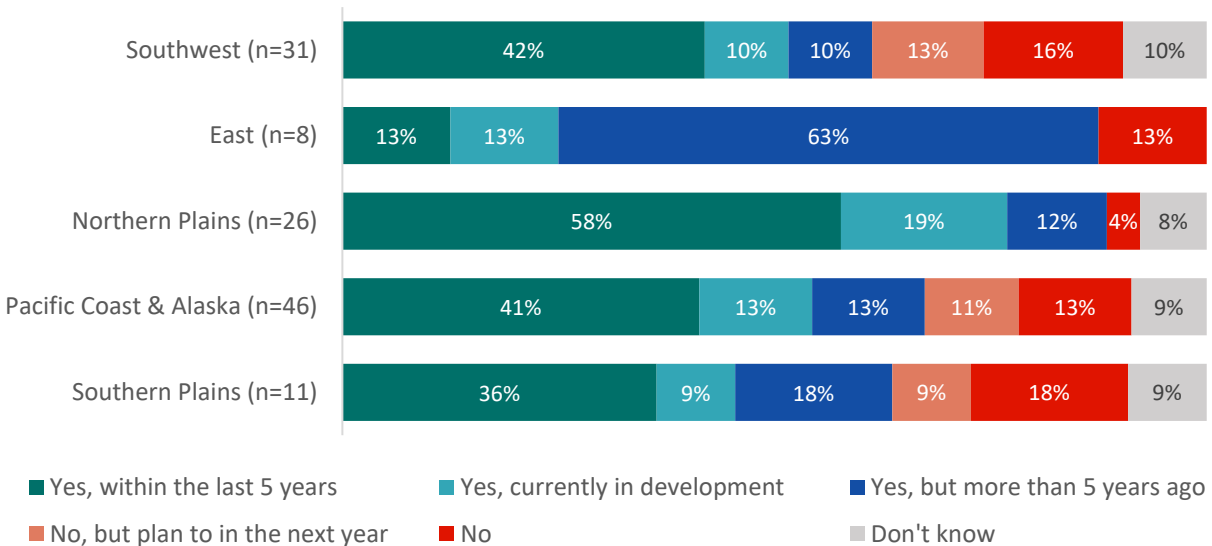
6.4.2 Community Health Improvement Plan by Region

Engagement related to the development of Community Health Improvement Plans (CHIP) varied greatly across regions (**Figure 51**). Overall, most THOs had at least begun developing a CHIP or had plans to initiate development activities within the next year. The greatest number of CHIP related activities were among THOs that had developed this plan within the last 5 years. This includes 58% of Tribes in the Northern Plains, 42% in the Southern region, 41% in the Pacific & Alaska region, and 36% in the Southern Plains. Only 13% of THOs in the Eastern region had a CHIP that was developed within the last 5 years. Instead, the majority of THO's in the Eastern region had a CHIP that was developed more than 5 years ago, while 18% or less of THOs from the other regions fit this category. Key points for strategically building awareness and capacity related to CHIP development may be among THOs that have no plans or do not know if they will develop this resource. The number of THOs that fall into these categories varies by region, with the highest percentage of respondents from the Southern Plains (27%), and the lower percentage of respondents in the Northern Plains (12%).

Figure 51. Percentage of THOs Developing Community Health Improvement Plans by Percent of THOs per Region (n=122)
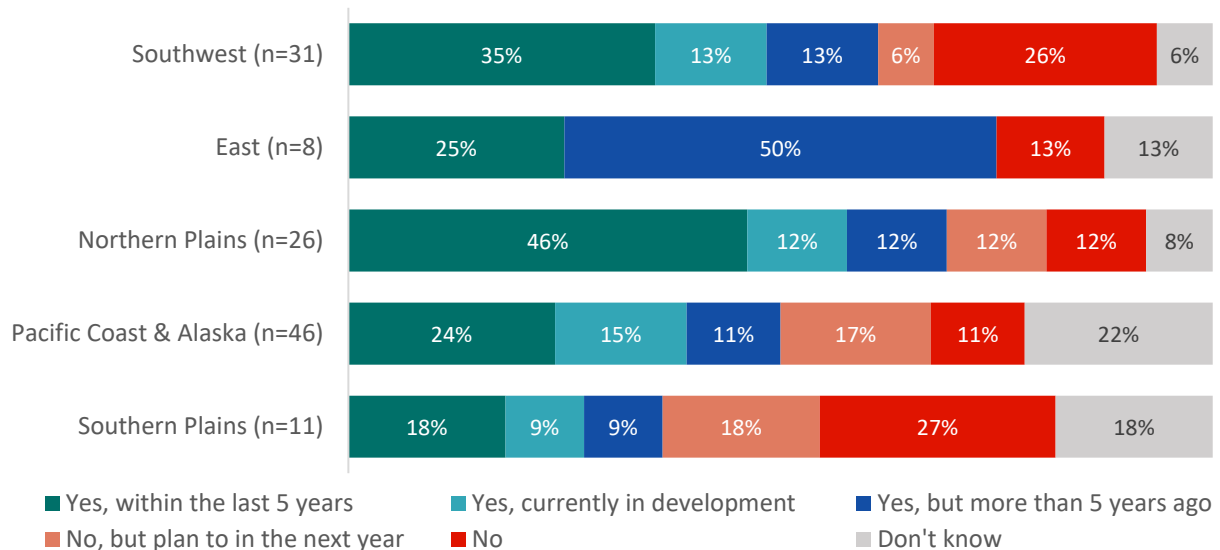
6.4.3 Strategic Planning by Region

Strategic planning was commonly implemented across most THOs (**Figure 52**). Most of these activities were among THOs that had developed these plans within the last 5 years. Fifty-four percent of Tribes in the Northern Plains, 48% in the Pacific Coast & Alaska, 32% in the Southwest, 27% in the Southern Plains, and 25% of THOs in the Eastern region each had Strategic Plans that were put in place within the last 5 years. Many THOs had no plan or were

unaware if there were plans in place for strategic planning. The number of THOs that fall into the categories of "No" or "Don't know" varies by region, with the highest percentage of respondents from the Southern Plains (27%), and the lower percentage of respondents in the Pacific Coast & Alaska region (11%). Capacity building surrounding this topic could be a valuable opportunity for development.

Figure 52. Percentage of THOs with Organizational Strategic Plans by Percent of THOs per Region (n=122)

Legend:
- ■ Yes, within the last 5 years
- ■ Yes, currently in development
- ■ Yes, but more than 5 years ago
- ■ No, but plan to in the next year
- ■ No
- ■ Don't know
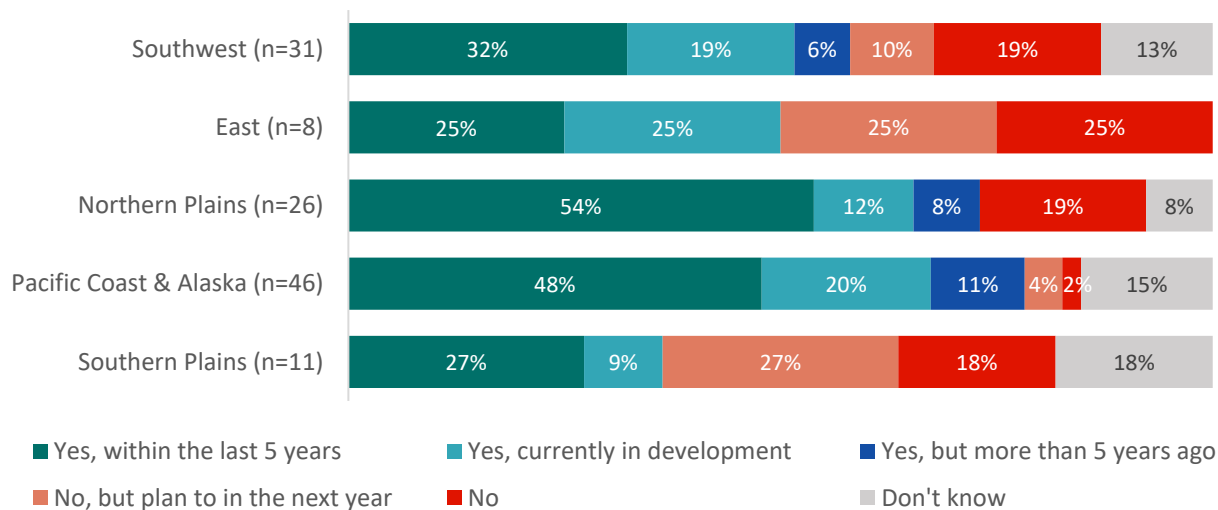
6.4.4   Usage of Performance Management Systems by Region

The use of performance management systems was relatively lower among each of the Tribal regions in comparison to other major plans that contribute to programmatic efficiency (**Figure 53**). Between 20% and 40% of THOs did not have a performance management system in place. The number of THOs that were unaware of performance management activities further exacerbates challenges related to absence of public health program management capacity. As many as 50% of THOs in the Southern Plains were unaware of performance management were in place to support their public health activities.

Figure 53. Percentage of THOs with Performance Management Systems by Percent of THOs per Region (n=120)

Legend:
- Yes, within the last five years
- Yes, currently in development
- Yes, but more than five years ago
- No, but plan to in the next year
- No
- Don't know

Region	Yes, within last 5 years	Yes, currently in development	Yes, but more than 5 years ago	No, but plan to next year	No	Don't know
Southwest (n=30)	13%	13%	10%	3%	40%	20%
East (n=8)	13%			38%	38%	13%
Northern Plains (n=26)	23%	4%	12%	8%	31%	23%
Pacific Coast & Alaska (n=46)	26%	13%	11%	4%	22%	24%
Southern Plains (n=10)	30%				20%	50%

6.4.5 Quality Improvement Activities by Region

Figure 54 highlights the THOs that participated in quality improvement activities to enhance their public health offerings. Most THOs utilized both formal and informal quality improvement activities, with formal activities being the most common. The Southern Plains only utilized formal quality improvement activities, and all THOs in the Pacific Coast & Alaska region had some form of quality improvement in place. Less than 20% of THOs had no awareness of quality improvement related activities and all responding THOs in the Eastern region were aware of the conduction, or lack thereof, of quality improvement activities that were underway.

Figure 54. Percentage of THOs with Quality Improvement Activities (n=120)

Legend:
- Formal quality improvement activities entity-wide
- Formal quality improvement activities in specific areas
- Informal or ad-hoc quality improvement
- No quality improvement activities
- Don't know

Region	Formal entity-wide	Formal specific areas	Informal or ad-hoc	No QI activities	Don't know
Southwest (n=30)	17%	33%	30%	3%	17%
East (n=8)	25%	13%	25%	38%	
Northern Plains (n=26)	42%	27%	15%	8%	8%
Pacific Coast & Alaska (n=46)	33%	30%	26%		11%
Southern Plains (n=10)	30%	40%		10%	20%

6.5 Public Health Activities

6.5.1 Population Services and Education Activities

The regional analysis of population services and educational activities highlights the types of programs and activities that are offered to Tribal citizens by THOs across each region, and how these overlap or differ. These activities are often developed and prioritized based on needs identified during community needs assessments such as CHAs but can also reflect emerging and critical public health topics as seen during recent response efforts related to COVID-19. In **Figure 55**, THOs were asked to identify which COVID-19 related population services and/or educational activities were offered within their service area. Close to all THOs in each region provided each of the COVID-19 related services and education, with no less than 75% of THOs in each region offering each COVID-19 related service and/or education.

Figure 55. Entities Providing Immunization, Home Visiting, and COVID Related Services and/or Education (% of Regional Respondents)
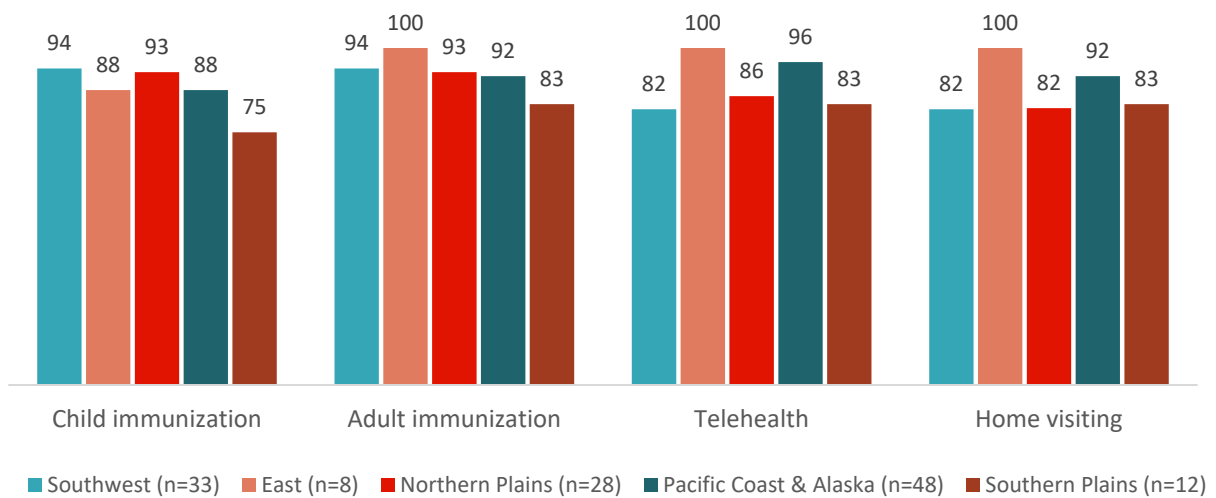
In **Figure 56,** THOs were asked to identify which, if any, COVID-19 immunization related services and education were provided in their service area. Testing and vaccination were offered in nearly all THOs across all regions. Contract tracing and home visits were more variable- while fewer THOs in all regions offered these services compared to testing and vaccination, the Southern Plains region THOs were less likely to offer these services than their counterparts in other regions.

90

Figure 56. Entities Providing COVID-19 Services (% of Regional Respondents)

COVID-19 testing: Southwest 94, East 100, Northern Plains 96, Pacific Coast & Alaska 98, Southern Plains 92
COVID-19 vaccination: Southwest 94, East 100, Northern Plains 100, Pacific Coast & Alaska 94, Southern Plains 92
COVID-19 contact tracing: Southwest 88, East 88, Northern Plains 82, Pacific Coast & Alaska 79, Southern Plains 50
COVID-19 home visits: Southwest 76, East 88, Northern Plains 79, Pacific Coast & Alaska 71, Southern Plains 50

Legend: Southwest (n=33), East (n=8), Northern Plains (n=28), Pacific Coast & Alaska (n=48), Southern Plains (n=12)

6.5.2 Population Screening and Education Activities

In **Figure 57**, chronic disease screenings were widely offered across each of the regions. Diabetes was the most common chronic disease screening and/ or education service offered in all regions. Overall, there is some minor regional variation in the screenings and/or education activities offered, however diabetes, nutrition, and BMI were the most highly implemented services in most regions. Cardiovascular disease, cancer, and asthma screenings and/or education activities were slightly less likely to be undertaken by THOs, with the Pacific Coast & Alaska region THOs reporting the highest percent of THOs offering these activities and the Southern Plains region reporting the lowest.

Figure 57. Chronic Disease Screenings and/or Education (% of Regional Respondents)

Type II Diabetes: Southwest 88, East 89, Northern Plains 97, Pacific Coast & Alaska 94, Southern Plains 77
Nutrition: Southwest 82, East 89, Northern Plains 86, Pacific Coast & Alaska 94, Southern Plains 69
Body mass index (BMI): Southwest 76, East 89, Northern Plains 83, Pacific Coast & Alaska 83, Southern Plains 62
Cardiovascular disease: Southwest 73, East 78, Northern Plains 79, Pacific Coast & Alaska 85, Southern Plains 54
Cancer: Southwest 67, East 67, Northern Plains 76, Pacific Coast & Alaska 83, Southern Plains 46
Asthma: Southwest 61, East 78, Northern Plains 76, Pacific Coast & Alaska 79, Southern Plains 46

Legend: Southwest (n=33), East (n=9), Northern Plains (n=29), Pacific Coast & Alaska (n=48), Southern Plains (n=13)

Similarly, in **Figure 58**, behavioral health screenings and/or education activities were high across most regions, with alcohol and other drug screenings and physical activity uniformly being undertaken by a high percentage of THOs. Screenings and/or education activities related to commercial tobacco use were more likely to be undertaken by THOs from the Pacific Coast & Alaska (96%) and Southern Plains regions (85%), while STI screenings and/or education activities were more reported in the East (89%), Northern Plains (93%), and Pacific Coast & Alaska regions (87%). Reproductive health was the least reported screening and/or education activity across all regions, but varied, with the highest percentage of THOs reporting conducting this activity in the Pacific Coast & Alaska (81%) and the lowest in the Southern Plains (38%).

Figure 58. Social and Behavioral Screenings and/or Education (% of Regional Respondents)
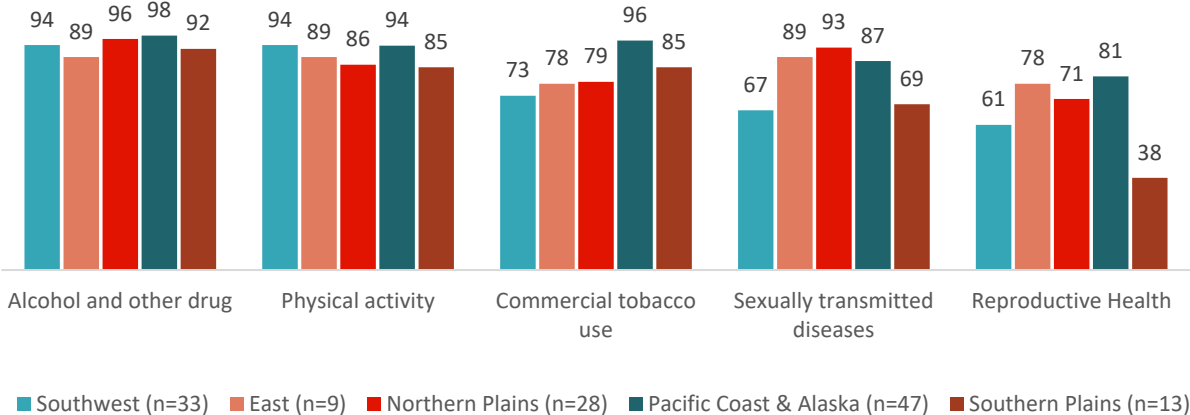
THOs were asked about services related to mental health screening and/or education in **Figure 59**. Depression, general mental health, and suicide screenings and/or education were among the highest offered in each region, while dementia screenings and/or education were the lowest, with the East region being the most likely (67%) and the Southwest region being least likely (45%) to offer Dementia screening and/or education. 8% of THOs in the Southern Plains did report not participating in any of the listed services.

Figure 59. Mental Health Screenings and/or Education (% of Regional Respondents)

Figure 59 bar chart data:

Category	Southwest (n=33)	East (n=9)	Northern Plains (n=28)	Pacific Coast & Alaska (n=47)	Southern Plains (n=13)
Depression	94	89	96	98	77
General mental health	88	89	96	94	77
Suicide	88	89	93	91	69
Trauma	76	78	82	87	54
Dementia	45	67	57	64	54
Other	12	11	11	6	8
None of the above					8
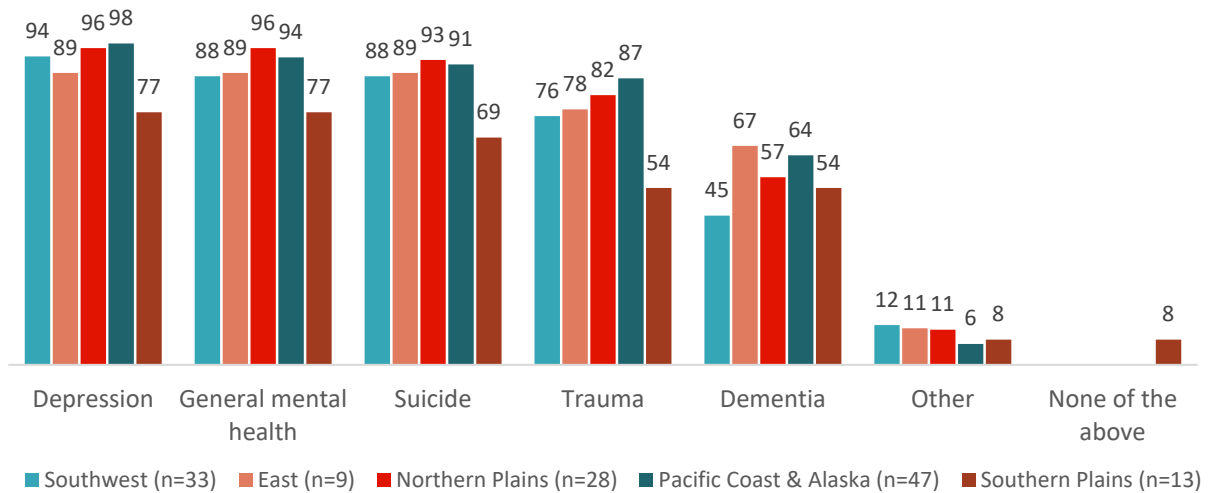
Figure 60 demonstrates the percentage of regional respondents that conducted social service screenings. Screenings for essential supplies and resources were the most common social services screening across each of the regions. Homelessness and hunger screenings varied more, with the Southwest region being the least likely to offer either.

Figure 60. Social Services Screenings and/or Education (% of Regional Respondents)

Figure 60 bar chart data:

Category	Southwest (n=33)	East (n=9)	Northern Plains (n=29)	Pacific Coast & Alaska (n=45)	Southern Plains (n=13)
Essential supplies and resources	91	89	86	84	69
Social determinants of health	70	89	79	73	77
Homelessness	45	78	69	71	62
Hunger	45	78	66	73	54
None of the above	3		3	2	
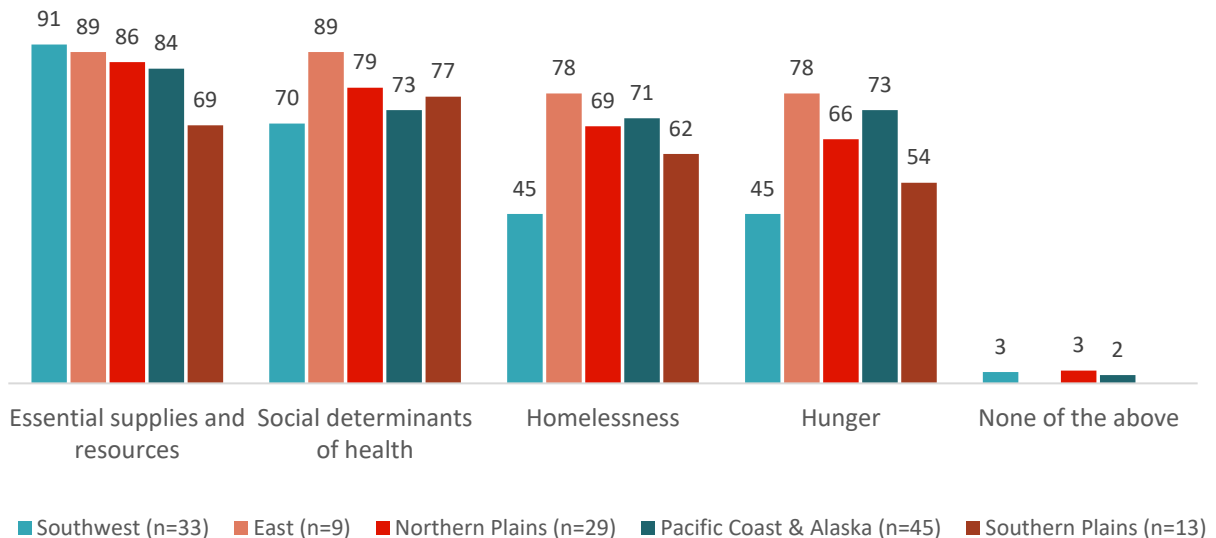
6.5.3 THO Role in Data-Related Public Health Services

Over the last year, each of the regions experienced gaps in syndromic surveillance data collection. In the Southwest, Northern Plains, and Pacific Coast & Alaska regions, very few THOs had the capacity to carry out these services by themselves. In several regions, THOs that carried out these collection activities were more likely to do so in partnership with other organizations than alone. The Northern Plains had the highest engagement with syndromic surveillance with 43% of THOs conducting these activities either alone (11%) or in partnership with another organization (32%). The Pacific Coast & Alaska and the Southwest also reported leaning heavily on other organizations to conduct these activities *in addition* to the THO, with 22% and 10% of syndromic surveillance activities being conducted by both the THO and another organization respectively. There was also regional representation among respondents that mostly outsourced these data collection activities through other organizations. Twenty-five percent of the respondents in the East region outsourced these activities. However, overall half or more of the respondents across all regions had either no organizational capacity or no awareness of syndromic data collection activities (**Figure 61**).

Figure 61. Percentage of THOs Collecting or Reporting Syndromic Surveillance Data in the Past Year by Percent of THOs per Region (n=123)
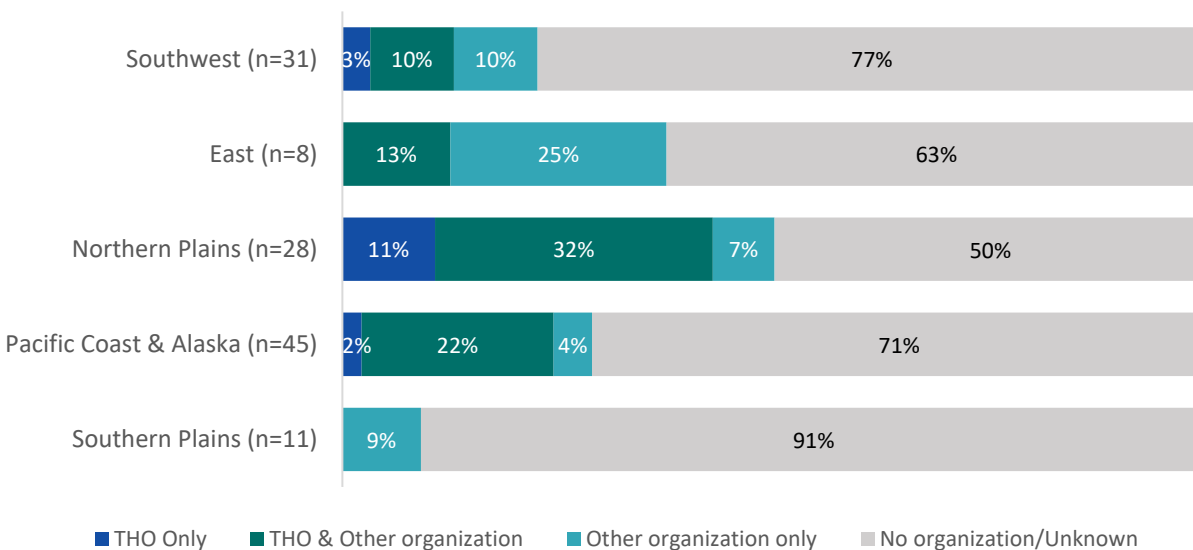
Findings from **Figure 62** demonstrated a low engagement in the collection and reporting of morbidity data in THO service areas. The East region reported the highest level of engagement, with 75% of THOs reporting these services occurring within their service area. In all other regions, around half of THOs reported these activities were occurring with variation in who was providing the services.

Figure 62. Percentage of THOs Collecting or Reporting Other Morbidity Data in the Past Year by Percent of THOs per Region (n=124)
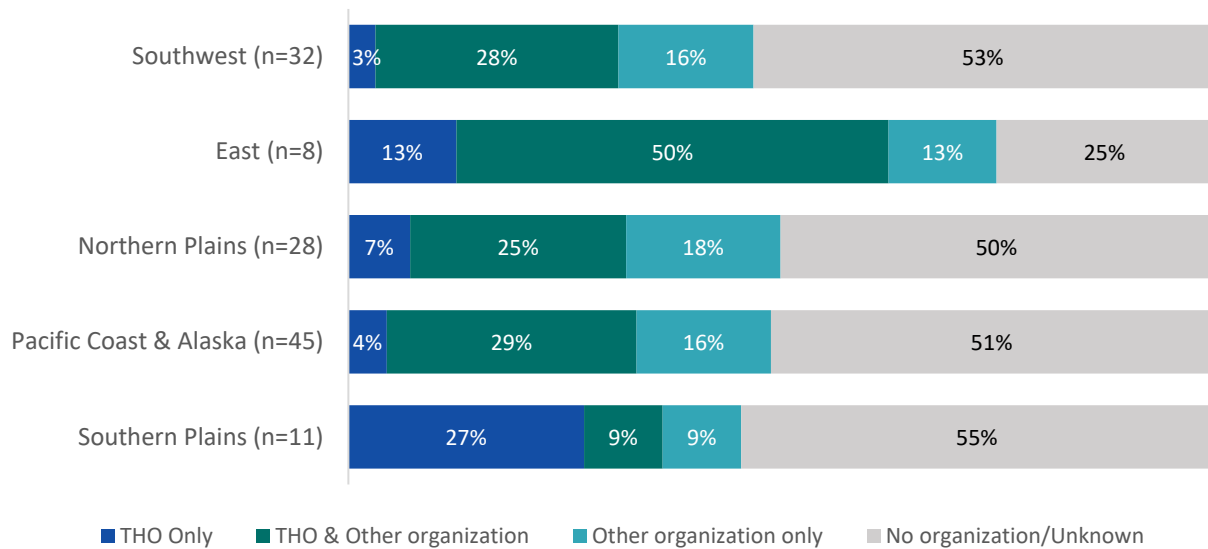
6.5.4 Emergency Operations and Response Activities

Tribal public health emergency related operations and response are often related to resources, interests, and needs in each of those respective areas. In some instances, the lack of regional activity conduction may not reflect a gap, but the current environment for need regarding that topic area.

The Northern Plains region had some of the highest engagement with response capacity or functions, with 82% of respondents having policies and protocols for emergency operations, 82% having a Tribal emergency operation plan, and 82% having a named Public Health Official.

Areas with the greatest opportunity to build emergency response capacity were reflected in the topic areas where Tribes have limited or no existing immediate access. Some regions had a small portion of Tribes reported having no access to any of the response capacity activities, including Southern Plains at 23%, Northern Plains at 4%, and Southwest at 3%. Another major gap was data capacity and laboratory capacity, both of which less than 50% of THOs reported capacity in four of the five regions.

Table 7. Response Capacity or Function Provided in THO Service Area in the Past Year by Percent of THOs per Region

Activity	Southwest	East	Northern Plains	Pacific Coast & Alaska	Southern Plains
Emergency preparedness education	66%	67%	64%	68%	38%
Policies and protocols for emergency operations	63%	67%	82%	87%	54%
A Tribal emergency operation plan	63%	78%	82%	68%	38%
Communications capacity	59%	67%	61%	68%	31%
A named Public Health Official	56%	56%	82%	60%	31%
Investigations/contact tracing capacity	53%	56%	54%	51%	23%
Epidemiological/Data capacity	34%	67%	43%	21%	8%
Laboratory capacity	25%	44%	54%	45%	15%
Other	9%	22%	7%	9%	8%
None of the above	3%	0%	4%	0%	23%

6.6 Public Health Priorities and Needs

Table 8 highlights the top five public health issues in each region, ranked by mean. While each of the regions exhibited varying priorities, there was an overlap among some topic areas. All regions listed diabetes, heart disease, and substance use disorder/misuse among their top five issues. Diabetes was the top issue for the Southwest, Pacific Coast & Alaska, and Southern Plains, and the secondary issue for the East and Northern Plains. Substance use disorders/ misuse was the top issue for the East and Northern Plains, and the secondary issue for the Southwest and Pacific Coast & Alaska (see **APPENDIX V: Top Five Tribal Public Health Issues by Region** for list of top public health issues).

Table 8. Top Five Public Health Issues in Each Region, Ranked by Weighted Mean

	Southwest	East	Northern Plains	Pacific Coast & Alaska	Southern Plains
Cancer	5	4	5		4
COVID-19			4	5	
Dementia					
Diabetes	1	2	2	1	1
Heart Disease	3	3	3	3	2
Infectious Disease					
Influenza and Pneumonia					
Kidney Disease					5
Liver Disease					
Respiratory Disease				4	
Stroke					
Substance use disorders/misuse	2	1	1	2	3
Suicide	4	5			

Table 9 lists the top five non-programmatic and infrastructure-building public health priorities in each region, ranked by mean. Health education and health promotion were the only shared priorities noted across each of the regions. Planning and priority setting, policy development, quality improvement and performance management, and workforce development were all priorities in four out of five regions. There was little overlap in top priorities across the regions (see **APPENDIX V: Top Five Non-Programmatic and Infrastructure-Building Public Health Priorities by Region** for list of top public health priorities by region).

Table 9. Top Five Non-Programmatic and Infrastructure-Building Public Health Priorities in Each Region, Ranked by Weighted Mean

	Southwest	East	Northern Plains	Pacific Coast & Alaska	Southern Plains
Data and assessment	1				4
Emergency Preparedness	5	4			
Enforcement					
Evaluation					
Health education and health promotion	4	1	3	5	1
Partnership development					
Planning and priority setting (including strategic planning)		5	1	4	2
Policy development		3	4	3	5
Quality improvement and performance management	3		2	2	3
Research					
Surveillance and investigation					
Tribal public health governance and authority					
Workforce development	2	2	5	1	

6.6.1 Public Health Opportunities and Needs for Support

General Resource Needs

Figure 63 reports on resources needed by Tribal organizations to advance Tribal public health generally. Among each of the regions, staffing and funding were the two highest needs for advancing Tribal public health. Other priorities with at least a quarter of regional respondents selecting the need included public health infrastructure for the Pacific Coast & Alaska region (32%), data for the Northern Plains region (29%), and public health infrastructure (25%), community outreach (25%), physical infrastructure (25%), and community health services (25%) for the East region.

Figure 63. Resources Needed by Tribal Organizations to Advance Tribal Public Health (% of Regional Respondents)

Resource	Southwest (n=21)	East (n=8)	Northern Plains (n=24)	Pacific Coast & Alaska (n=37)	Southern Plains (n=9)
Staffing	62	50	38	49	33
Funding	48	38	38	41	56
Public health infrastructure	14	25	13	32	22
Resources	24		13	19	22
Data	10	13	29	11	
Community outreach		25	17	11	22
Health care services	10	8		16	11
Technical infrastructure	5	13	17	11	11
Policy support	5	13	8		22
Physical infrastructure		25	4	14	11
Community health services	14	25		8	
Behavioral health services	5	13	4	8	
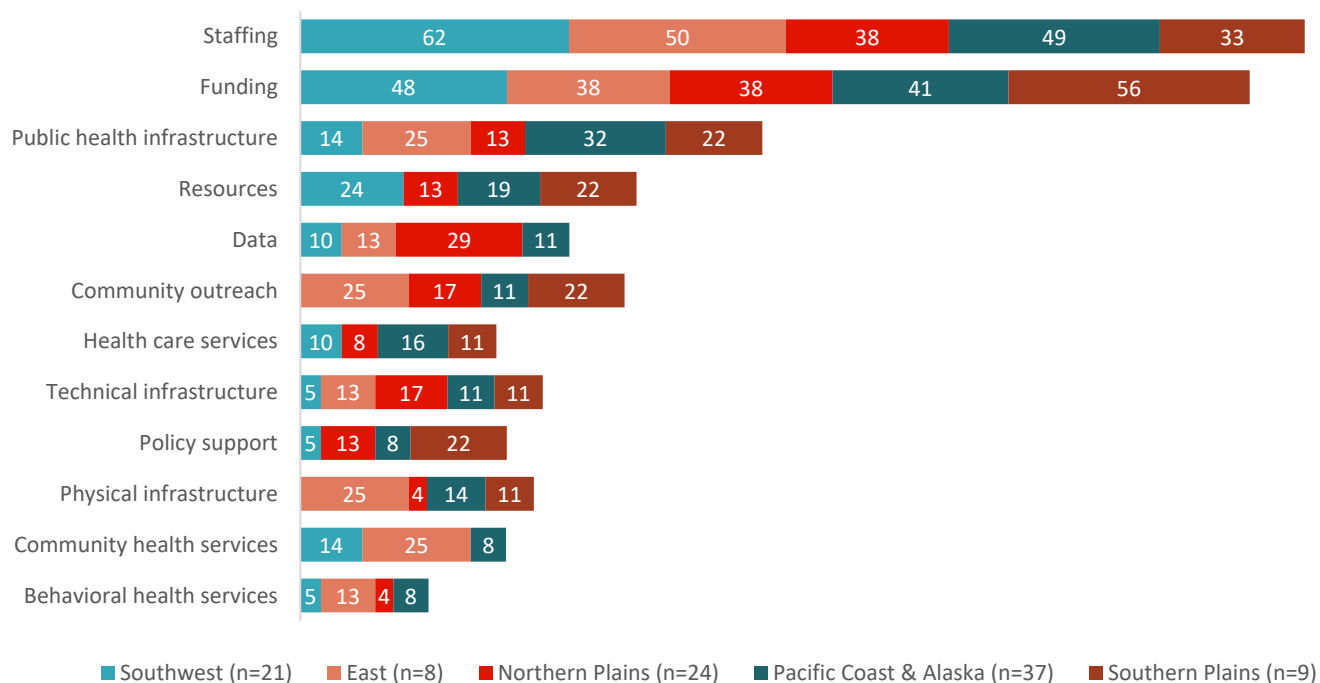
Challenges in Exercising Public Health Authority

Figure 64 demonstrates various challenges that were reported related to Tribal capacity to exercise public health authority and carry out Tribal public health activities.

In the Southwest region, lack of Tribal buy-in was the leading challenge shared related to exercising public health authority. There were no staffing or funding challenges shared relative to this topic.

The most frequent challenge reported in the East region was community outreach, education and enforcement (40%). Other more frequently reported challenges at 20% of respondents included coordination and communication, staffing, healthcare emergencies, or no existing public health authority being established. Twenty percent of respondents in this region also reported no challenges.

The Northern Plains region experienced no challenges in authority among 22% of respondents. The highest reported challenges, at 17% of respondents, were related to recognition of authority by external entities and no authority being clearly defined.

Within the Pacific Coast & Alaska region, 23% of respondents experienced no challenges in public health authority. The highest reported challenges, at 19% of respondents, were related to staffing and coordination and communication.

The highest reported challenges in the Southern Plains region (25%) included community outreach, healthcare emergencies, and infrastructure. Another quarter of the respondents reported not experiencing public health authority-related challenges.

Figure 64. Challenges Faced by THOs in exercising Public Health Authority (% of Regional Respondents)

Legend: ■ Southwest (n=18) ■ East (n=5) ■ Northern Plains (n=18) ■ Pacific Coast & Alaska (n=26) ■ Southern Plains (n=8)
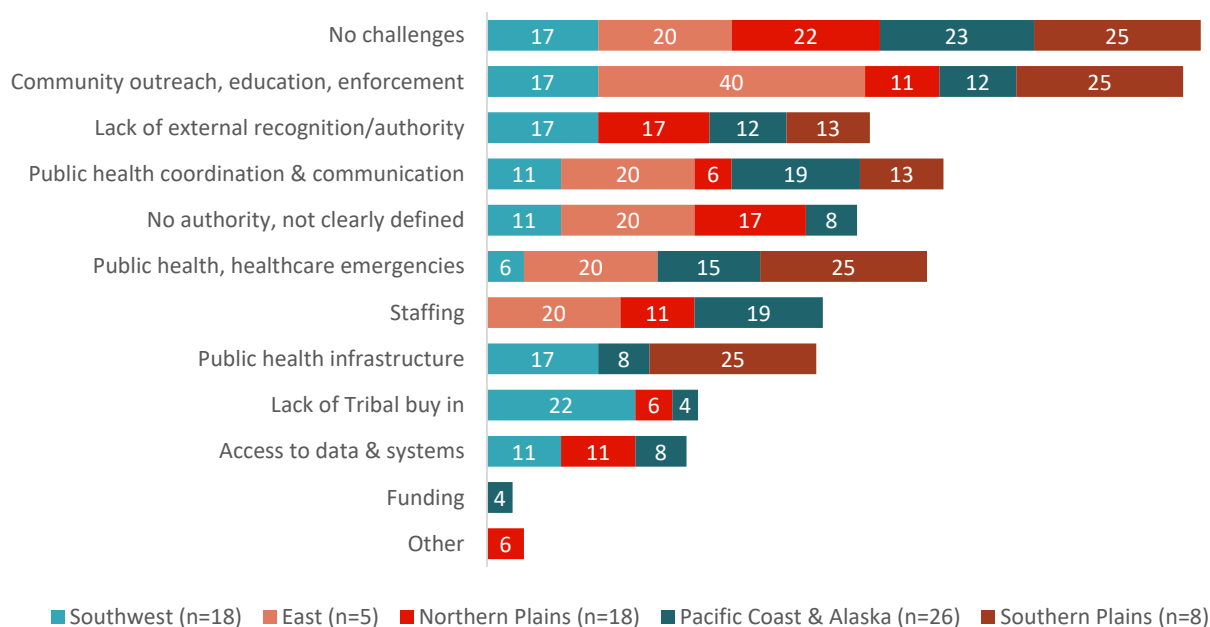
Resources Needed from States and State Agency Partners

Figure 65 reports on the resources THOs need from their state partners. Partnership and funding were identified as the highest two needs across all regions, with the Southwest (37%), Northern Plains (35%), and Pacific Coast & Alaska (48%) reported as the most frequent need, and the East (57%) and Southern Plains (43%) reporting partnerships as the most frequent need. Other needs varied by region. Other priorities, with at least a quarter of regional respondents selecting the need included data (27%) in the Pacific Coast & Alaska region, Tribal consultation (29%), public health infrastructure (29%), and health care services (29%) in the East region, resources (29%) and local activities (20%) in the Southern Plains region, and staffing (26%) in the Southwest Region.

Figure 65. Resources Needed from States and State Agencies to Advance Tribal Public Health (% of Regional Respondents)

Category	Southwest (n=19)	East (n=7)	Northern Plains (n=20)	Pacific Coast & Alaska (n=33)	Southern Plains (n=7)
Funding	37	29	35	48	29
Partnerships	32	57	25	30	43
Resources	26	14	20	27	29
Data		5	20	27	14
Tribal consultation	16	29	5	9	14
Public health infrastructure	11	29		5	12
Tribal sovereignty	11		15	12	
Technical infrastructure	5		15	12	
Improved external communication	11	5		9	14
Local activities	11	5	6		29
Health care services	11	29		5	6
Staffing	26			14	
Ease bureaucratic requirements		14	10	9	
Support tribal public health professionals	11	5	3	14	

Legend: ■ Southwest (n=19) ■ East (n=7) ■ Northern Plains (n=20) ■ Pacific Coast & Alaska (n=33) ■ Southern Plains (n=7)

Resources Needed from Federal Partners

Figure 66 reports on the most frequently shared federal assistance THOs need to advance Tribal public health. Funding was highest across all regions, with resources as the second highest (and tied for highest at 44% in the Southern Plains region). Other priorities with at least a quarter of regional respondents selecting the need included for the Southwest region, partnerships (26%), and staffing (26%), and for the East, public health infrastructure (43%), and Tribal consultation (29%).

Figure 66. Resources Needed from Federal Agencies to Advance Tribal Public Health (% of Regional Respondents)

	Southwest (n=19)	East (n=7)	Northern Plains (n=16)	Pacific Coast & Alaska (n=32)	Southern Plains (n=9)
Funding	47	57	38	66	44
Resources	26	29	25	31	44
Partnerships	26	14	13	22	
Public health infrastructure	16	43	6	22	11
Staffing	26	14	6	6	
Local activities	16	14	6	3	22
Ease bureaucratic requirements		14	6	19	
Data			5	13	11
Tribal consultation		29	6	6	11
Technical infrastructure	11		13	3	
Health care services	11			9	
Support tribal public health professionals	11	14	3	11	
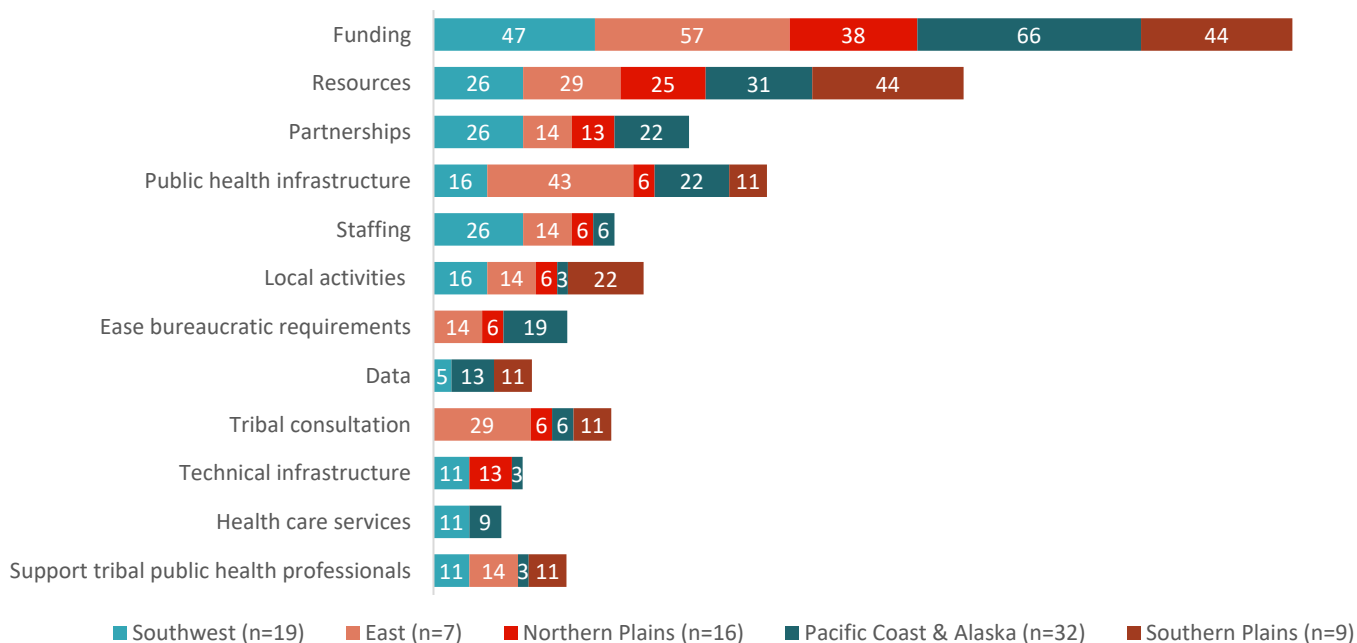
Resources Needed from CDC

In **Figure 67**, respondents shared how the CDC can assist Tribal organizations and entities in advancing Tribal public health. Across all regions, resources were the highest reported need. The Southern Plains region had a high percentage of respondents that chose this as a priority need (75%). Other high priorities across several regions were funding and partnerships. However, results varied by region. In the Southwest region, the primary need for CDC assistance was funding with 50% of respondents sharing this response. The region also expressed the need for resources with 40% of respondents, and staffing with 25% of respondents. The East region shared resources and partnerships as a primary need among 43% of their respondents. This was followed by public health infrastructure and funding. Fifty-five percent of Northern Plains respondents shared the need for access to CDC resources in addition to 43% needing partnerships. This region tied the need for funding and public health infrastructure among 29% of respondents. The Pacific Coast had a primary need for CDC support related to funding, resources, and public health infrastructure. The Southern Plains also shared resources as a primary need for CDC support followed by improved external communication.

The least reported needs across the regions were related to easing bureaucratic requirements where only 9% of Northern Plains respondents and 13% of Pacific Coast & Alaska respondents shared the need for CDC assistance. There were also lower reported needs for assistance with community outreach. This may indicate that there is an existing and sufficient partnership with

CDC to cover these topic areas or there may be less of a need or awareness of CDC-related support or technical assistance available on these topics.

Figure 67. Resources Needed from the CDC to Advance Tribal Public Health (% of Regional Respondents)

Legend: Southwest (n=20), East (n=7), Northern Plains (n=22), Pacific Coast & Alaska (n=32), Southern Plains (n=8)
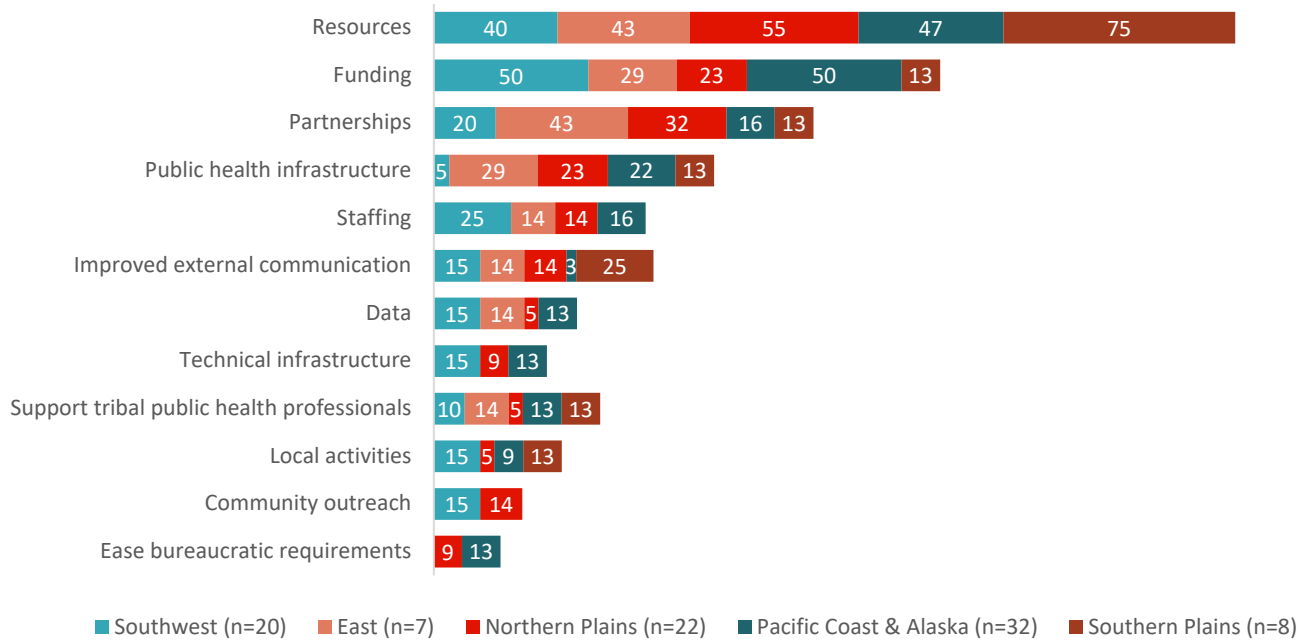
7   **Discussion**

The PHICCS II survey illustrates the hands-on public health services provided by Tribal organizations and the degree to which those services would not be accessible to Tribal members without THOs. THOs consistently provided chronic disease, mental health, physical health services and education at higher levels than other organizations in their service areas. The most notable engagement by THOs was seen in hands-on community health services such as telehealth, general home visiting, and COVID home visiting, which THOs performed at levels 20-30% higher than other organizations in their service areas. While reports on other organizations' activities are secondhand, Tribal members are less likely to be widely referred to external services if THOs are unaware of them, and as such, this data is likely a good indication that THOs are the primary provider of these services. Furthermore, even in cases where public health services and education are available through other organizations besides the THO, these organizations may not be geographically accessible to Tribal members. Nearly two-thirds of THOs reported that their members would have to travel 25 or more miles to the next public health access point, and over a quarter of THOs reported that their members would need to travel more than 50 miles.

THOs provided extensive healthcare and public health services despite significant gaps in staffing. Achieving full operational capacity would require THOs to increase their current healthcare provider workforce by 41%, their public health professional workforce by 64% and their analytic public health workforce by 131%. Shortfalls in staffing can be largely attributed to insufficient funding levels, with two-thirds of the needed roles lacking designated funding. Support in staffing was in the top five resources requested from the CDC and state and federal agencies, with THOs suggesting that these organizations develop programs to better support Tribal public health staff. THOs emphasized that non-competitive funding, specifically allocated to Tribes and Tribal organizations, is needed to build up the public health workforce. The current competitive funding mechanisms, with high bureaucratic requirements, place THOs in competition with each other and pose compounded challenges to THOs with severe staffing shortages, as grant writing and administration positions are currently staffed at only 54% of their needed capacity.

Achieving sufficient staffing levels is just one piece of the puzzle needed to maintain a sustainable Tribal public health landscape. Many THOs do not have the underlying technical infrastructure needed to monitor the changing public health needs of Tribal communities. While one half of THOs reported that vital statistic and morbidity data was collected and reported in their area, more than a quarter of THOs did not know whether this data was collected. This suggests large gaps in communication and access between state and local data collection entities and THOs. Accordingly, access to data was highlighted as a key barrier to exercising public health authority, with many THOs reporting that they were denied access to state and county data systems. When data is available to THOs, insufficient AI/AN data, lack of Tribal-specific data, and lack of cultural

relevancy limit the usefulness for public health planning. THOs must rely on their own data collection to drive public health decision making, which requires not only funding but also data and analytics staff with access to epidemiology training, software, and technical infrastructure. This high barrier to entry limits the feasibility of large data collection efforts for smaller THOs. At the time of survey, less than half of THOs had data from a community health assessment conducted in the past five years and one-third had a recent community health improvement plan. Federal, state and local partners must support THOs by both collecting and sharing high quality data and by providing the training and technical support necessary for THOs to collect and analyze their own data.

THOs emphasized that partnership with the CDC, federal, state and local partners are essential to reach full public health operating capacity. Many THOs are building up their public health departments and need broad support from established public health networks. This begins with respecting Tribal sovereignty, recognizing THOs as public health authorities, and granting them the appropriate level of access and support. External partners need to build trust and strengthen relationships with individual THOs by including them at earlier stages of public health initiatives, increasing consultation and communication, and visiting Tribal communities. THOs want the CDC to develop Tribal-specific programs that bring on-site personnel and skills to Tribes for public health development and *build stronger* public health networks. Resource sharing was listed as the primary way that the CDC can provide administrative support to THOs. THOs emphasized that they need more guidance and training from the CDC and other partners, particularly on topics like strategic and emergency planning, workforce development, and program development. In addition to programmatic training, THOs need access to affordable, local, and culturally competent training for public health staff. By building lasting relationships with THOs, sharing institutional knowledge, and respecting Tribal sovereignty, the CDC and other agencies will more effectively support THOs efforts to advance the public health needs of the communities they serve.

8   Appendices

8.1   APPENDIX I: About NIHB

About NIHB

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

Located in Washington, District of Columbia on Capitol Hill, the NIHB, a non-profit organization, provides a variety of services to Tribes, Area Indian Health Boards, Tribal organizations, federal agencies, and private foundations, including:

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

NIHB continually presents the Tribal perspective while monitoring federal legislation and opening opportunities to network with other national health care organizations to engage their support on Indian health care issues.

Raising Awareness

Elevating the visibility of Indian health care issues has been a struggle shared by Tribal governments, the federal government, and private agencies. NIHB consistently plays a major role in focusing attention on Indian health care needs, resulting in progress for Tribes.

 NIHB advocates for the rights of all federally recognized American Indian/Alaska Native (AI/AN) Tribes through the fulfillment of the trust responsibility to deliver health and public health services. Since 1972, NIHB has advised the United States Congress, IHS federal agencies, and private foundations on health care issues of AI/ANs.

NIHB staff maintains communication with Area Indian Health Boards, national Indian organizations, Tribes, and AI/AN people. NIHB gives voice to AI/AN health policy concerns through participation in national organizations ranging from the Association of State Medicaid Directors to the IHS Leadership Council.

<u>A Shared Goal – Quality Health Care</u>

The future of health care for AI/ANs is intertwined with policy decisions at the federal level and changes in mainstream health care management. NIHB brings Tribal governments timely information to help them effectively make sound health care policy decisions. NIHB provides a vehicle to keep the flow of health care information in front of policymakers and Tribal governments manifesting progress in health care and strengthening Tribal sovereignty.

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

8.2 APPENDIX II: List of All "Other Organizations" Providing Public Health Activities

The following list of entities that could be selected as providing service in a THO's service area was included in the PHICCS II survey. Respondents could select all that applied.

- Your organization
- Entity/Department other than your organization located within the Tribe
- Tribal organization
- Tribal Epidemiology Center
- Urban Indian Health Program
- Indian Health Service
- Other federal agency or office (e.g., Department of Veteran's Affairs, Federal Emergency Management Agency)
- Local health department
- State health department
- Private and/or non-profit health service organization
- Academic institution (e.g., Tribal college, university)
- Other (please specify)

8.3 APPENDIX III: Supplement to Activities Section: Organizations Providing Services versus Education on Services

In **Public Health Activities**, **Organization(s) Providing Population Services** data regarding whether an organization provided a service or education on a service was combined, or in some cases where relevant, only data on services were provided. In this appendix, we provide the full data breaking down the percentage of respondents that provide a service compared to the percentage of respondents providing education on a service.

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Figure 68. Percentage of Public Health Population Services Compared to Education Activities Occurring in THO Service Area in Past Year, Including COVID 19 Services and Education (n=129)
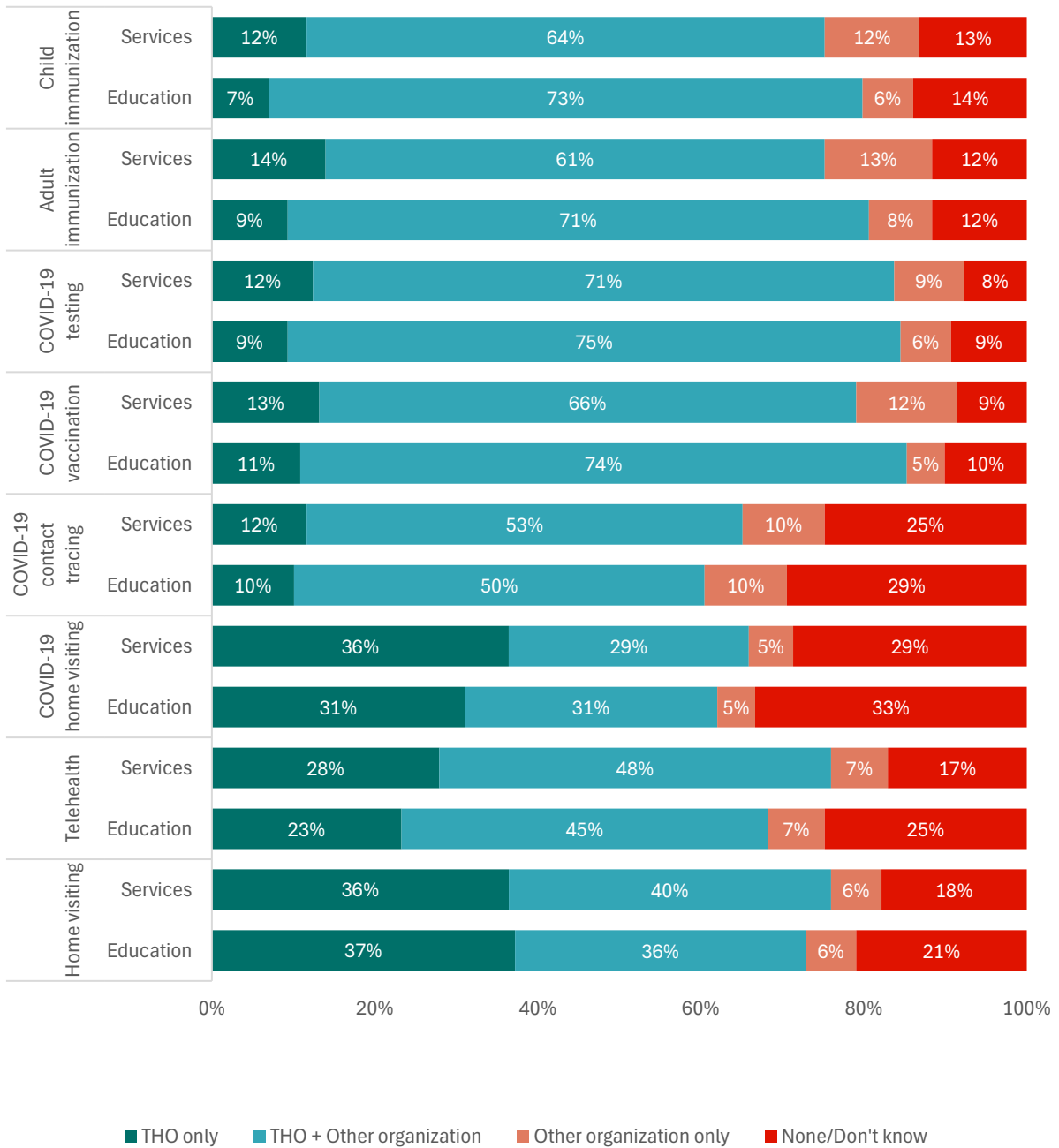
Figure 69. Percentage of Public Health Screenings Compared to Related Education Activities Occurring in THO Service Area in Past Year (n=126)
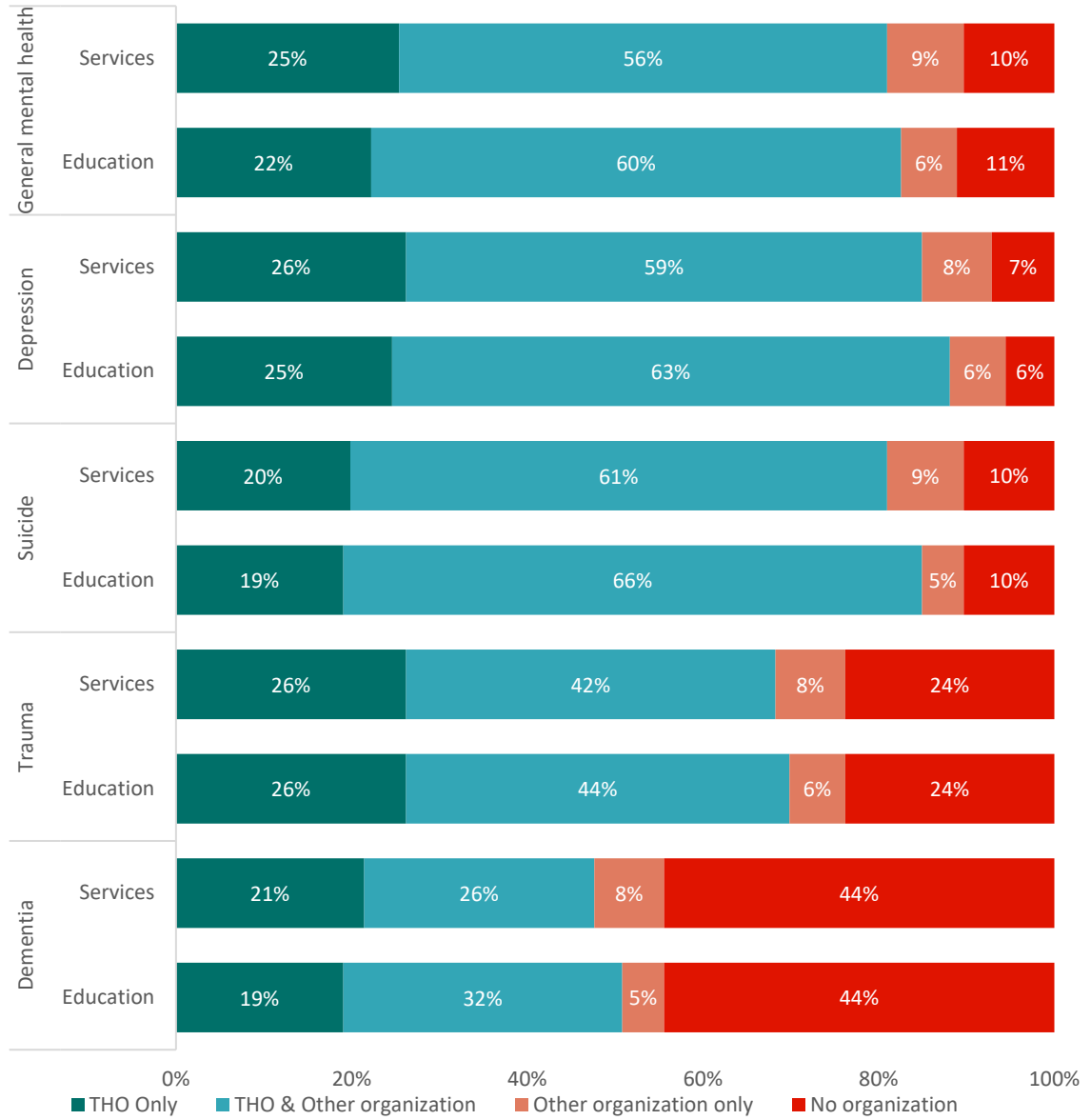
Figure 70. Percentage of Social and Behavioral Health Screenings (Services) Compared to Related Education Activities Occurring in THO Service Area in Past Year by Percent of THOs (n=126)

		THO Only	THO & Other organization	Other organization only	No organization
Alcohol and other drug	Services	21%	61%	12%	6%
	Education	17%	71%	6%	6%
Commercial tobacco use	Services	27%	40%	10%	23%
	Education	24%	52%	6%	17%
Sexually transmitted diseases	Services	23%	48%	10%	19%
	Education	17%	55%	9%	19%
Reproductive health	Services	20%	37%	11%	33%
	Education	17%	41%	8%	34%
Physical activity	Services	35%	46%	6%	13%
	Education	28%	59%	4%	10%

112
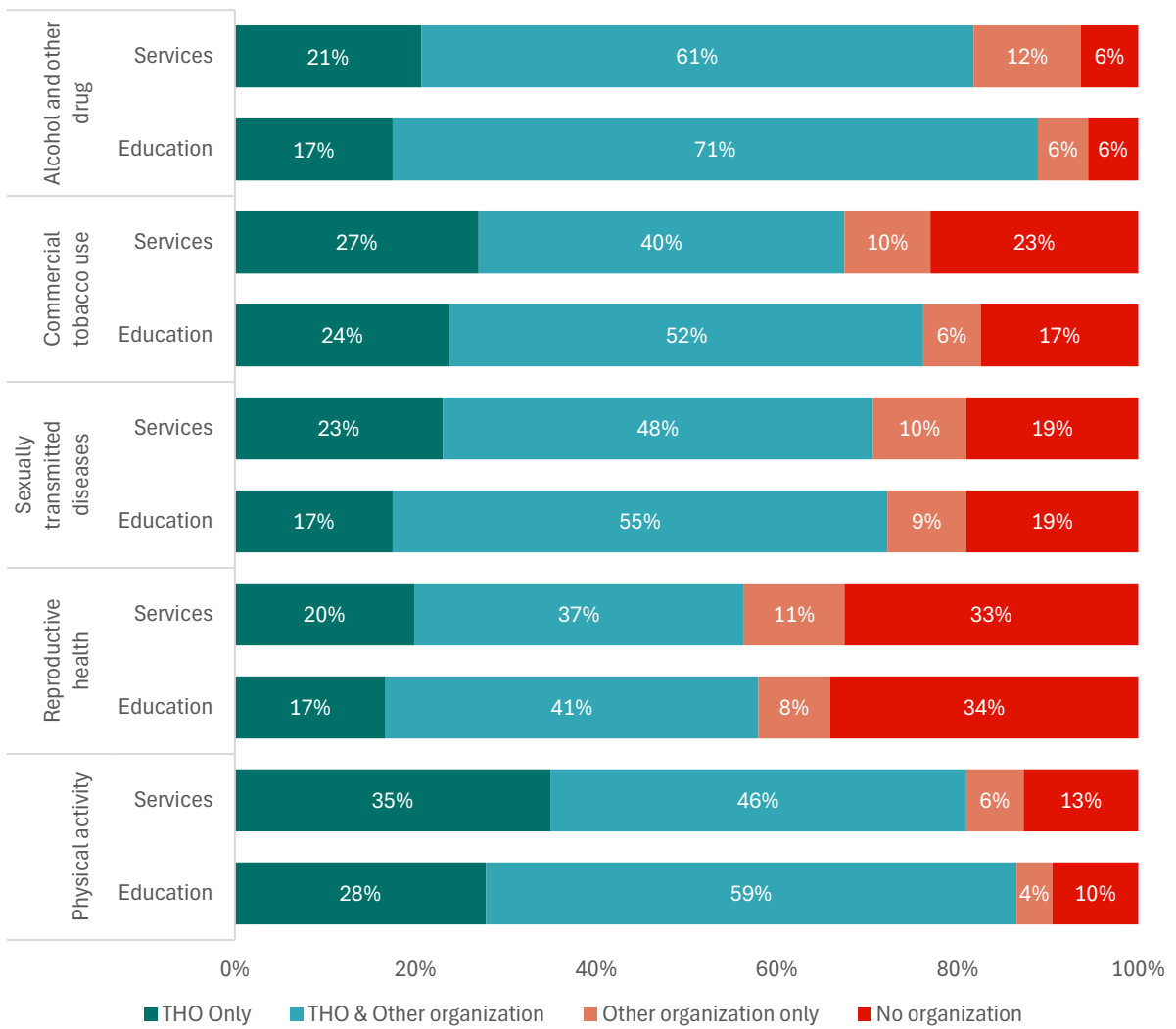
Figure 71. Percentage of Chronic Disease Screenings (Services) Compared to Related Education Activities Occurring in THO Service Area in Past Year by Percent of THOs (n=126)

		THO only	THO + Other organization	Other organization only	No organization/Unknown
Asthma	Services	28%	35%	10%	27%
	Education	25%	40%	8%	28%
BMI	Services	29%	44%	9%	18%
	Education	29%	47%	6%	19%
Nutrition	Services	23%	54%	10%	13%
	Education	25%	59%	6%	11%
Cancer	Services	23%	42%	9%	26%
	Education	21%	47%	6%	27%
Cardiovascular disease	Services	27%	41%	10%	22%
	Education	28%	46%	5%	21%
Type II diabetes	Services	28%	55%	10%	8%
	Education	25%	63%	5%	6%
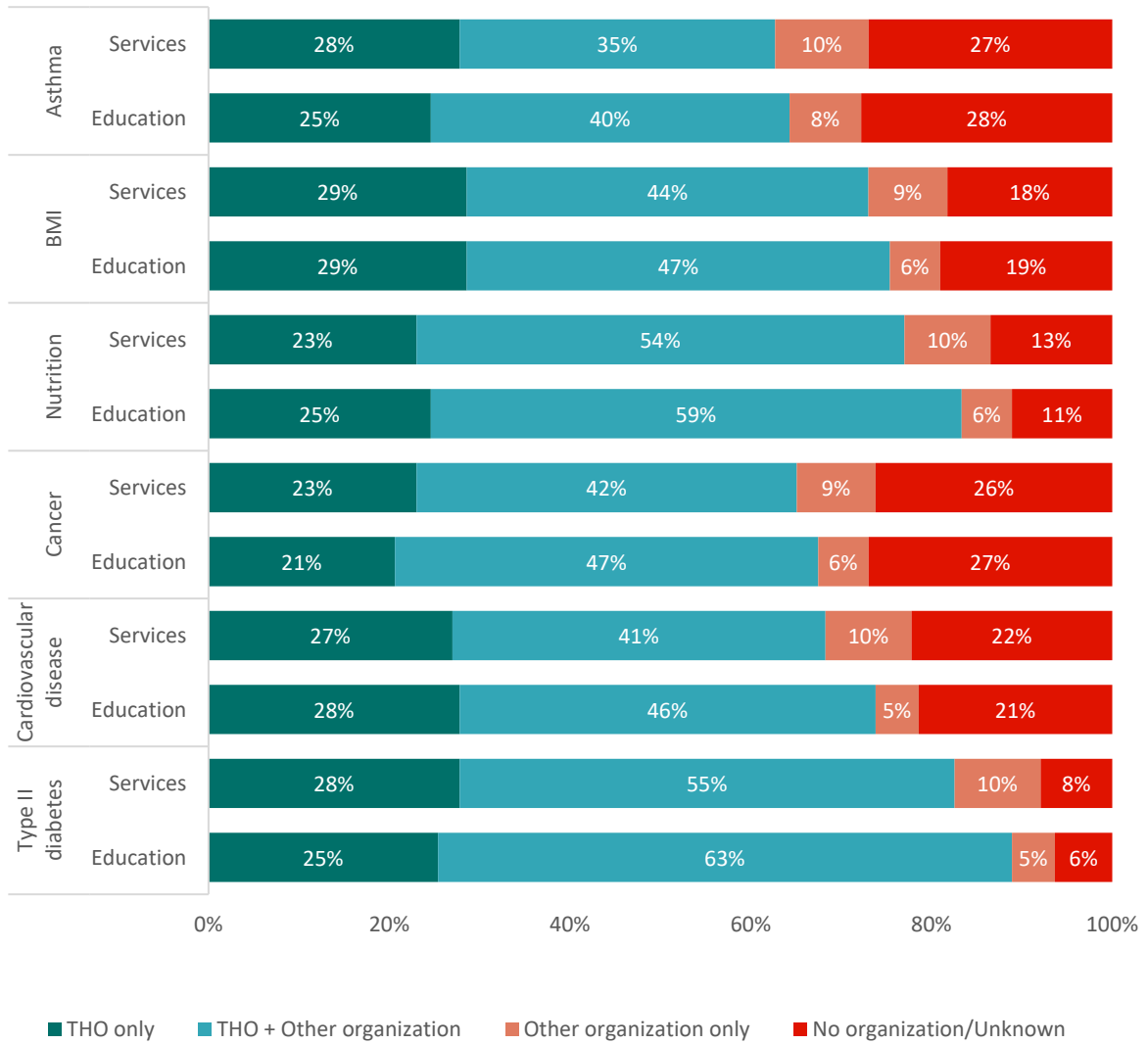
8.4 APPENDIX IV: List of Public Health Issues and Priorities Options from PHICCS Questionnaire

8.4.1 Respondents ranked their top five public health issues based on the list below:

- Accidents/ Unintentional Injuries
- Cancer
- COVID-19
- Dementia (including Alzheimer's)
- Diabetes
- Heart Disease
- Infectious Disease (not including Influenza or COVID-19)
- Influenza and pneumonia
- Kidney Disease
- Liver Disease
- Respiratory Disease
- Stroke
- Substance use and/or misuse
- Suicide
- Violence prevention (including domestic or intimate partner violence)
- Other (please specify)

8.4.2 Respondents ranked their organization's priorities as they related to non-programmatic and infrastructure building capacities and activities based on the list below

- Data and assessment
- Emergency Preparedness
- Enforcement
- Evaluation
- Health education and health promotion
- Partnership development
- Planning and priority setting (including strategic planning)
- Policy development
- Quality improvement and performance management
- Research
- Surveillance and investigation
- Tribal public health governance and authority
- Workforce development

8.5 APPENDIX V: Public Health Categorization Matrix on Public Health Needs

Table 10. Description of Qualitative Methods used to Categorize Public Health Needs.

	Category	Topics included
Broad categories	Funding	Any mention of funding or money, including grant funding or a call for non-competitive funding.
	Staffing	Any mention of hiring, recruiting, retaining or a specific role is needed.
	Data	Any mention of data or analysis, including needed health assessments and surveys.
	Partnership	Any mention of collaboration, guidance, or support, including language such as "work together" or "send people."
	Resources	Any mention of resources for staff including education, training, materials, or best practices.
	Community outreach	Any mention of outreach activities, resources, or pamphlets to distribute to the community.
	Public health infrastructure	Any mention of building up a public health department including public health staff, programming, or setting priorities
	Technical infrastructure	Any mention of information technology or analysis support, including access to data systems.
	Physical infrastructure	Any mention of buildings, physical space, or expansion.
	Community health services	Any mention of community health services, programs, or community health roles.
	Behavioral health services	Any mention of behavioral health services, programs, or behavioral health roles.
	Health services	Any mention of health services, programs, or health provider roles.
	Support Tribal health professionals	Any mention of existing or suggested programs to directly support or recruit Tribal health staff.
Narrow categories	Tribal sovereignty	Direct mention of Tribal sovereignty or Tribal data sovereignty.
	Tribal consultation	Direct mention of the need for Tribal consultation or greater Tribal participation.
	Improved external communication	Any mention of communication between an external agency with the Tribal organization or inter-agency communication.
	Policy support	Direct mention of policy support.
	Housing support	Direct mention of housing as a need or barrier.
	Transportation support	Direct mention of transportation as a need or barrier.

	Culturally relevant resources	Direct mention of culturally relevant care, interventions, or resources, including educational and training materials.
	Ease bureaucratic requirements	Direct mention of reporting requirements or other difficulties.
	Local activities	Direct mention of a need for local or in-person activities, including in-person training and the provision of local services.

8.6 APPENDIX V: Top Five Tribal Public Health Issues by Region

Southwest

1. Diabetes
2. Substance use and/or misuse
3. Dementia (including Alzheimer's)
4. Cancer
5. Infectious Disease (not including Influenza or COVID-19)

East

1. Substance use and/or misuse
2. Diabetes
3. Suicide
4. Cancer
5. Heart Disease

Northern Plains

1. Substance use and/or misuse
2. Diabetes
3. COVID-19
4. Suicide
5. Stroke

Pacific Coast & Alaska

1. Diabetes
2. Substance use and/or misuse
3. Infectious Disease (not including Influenza or COVID-19)
4. Heart Disease
5. COVID-19

Southern Plains

1. Heart Disease
2. Diabetes
3. Cancer
4. Substance use and/or misuse
5. Liver Disease; Suicide; Respiratory Disease; Influenza and pneumonia; Dementia (including Alzheimer's)

8.7 APPENDIX V: Top Five Non-Programmatic and Infrastructure-Building Public Health Priorities by Region

Southwest

1. Emergency preparedness
2. Data and assessment
3. Health education and promotion
4. Tribal public health governance and authority
5. Quality improvement and performance management

East

1. Health education and health promotion
2. Workforce development
3. Emergency preparedness; Quality improvement and performance management
4. Evaluation
5. Enforcement; Surveillance and investigation

Northern Plains

1. Health education and health promotion
2. Workforce development
3. Planning and priority setting (including strategic planning)
4. Quality improvement and performance management
5. Data and assessment

Pacific Coast & Alaska

1. Workforce development
2. Data and assessment
3. Health education and health promotion
4. Tribal public health governance and authority
5. Quality improvement and performance management

Southern Plains

1. Tribal public health governance and authority
2. Health education and health promotion
3. Planning and priority setting (including strategic planning)
4. Quality improvement and performance management
5. Policy development

SOVERIGNTY. STRENGTH. EQUITY

National Indian Health Board