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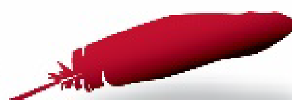


Understanding Tribal Performance and System Improvement in the Context of the COVID-19 Pandemic

October 2022

This paper was supported through funding by the Centers for Disease Control and Prevention (CDC), Center for State, Tribal, Local, and Territorial Support (CSTLTS), as part of the "Strong Systems, Stronger Communities" project. The contents are those of the authors and do not necessarily represent the views of the CDC.

INTRODUCTION

In December of 2019, people across the world began to learn about an outbreak of pneumonia in Wuhan, China, with an unknown cause. By early January 2020, there was concern as the disease began to spread internationally; by January 20, the Centers for Disease Control and Prevention (CDC) confirmed the first United States (U.S.) case of SARS-COV-2 in Washington State and began to take action to prevent the spread of this emerging disease. By mid-March, the U.S. began to implement shutdowns to prevent the spread of the newly named COVID-19 pandemic[i,ii,iii].

Tribal Nations have been disproportionately impacted by COVID-19. Many American Indians and Alaska Natives (AI/AN) are more susceptible due to existing health disparities. Due to a history of colonialism, which led to the removal of traditional food sources, loss of culture, loss of environment, poverty, and chronic stress, AI/AN people are more likely to have pre-existing conditions, including diabetes[iv], obesity, and heart disease[v], that put them at risk of severe COVID-19 outcomes.

In August 2020, the CDC published data from 23 states indicating that the COVID-19 incidence rate for AI/AN people was estimated to be 3.5 times the rate compared to white populations- an estimated 594 cases per 100,000 AI/AN population compared to 169 cases per 100,000 white population[vi]. In December 2020, the CDC published additional data indicating that the cumulative age-adjusted COVID-19 mortality rate among AI/AN people in 14 states was estimated to be 1.8 times the rate among white people[vii]. Unfortunately, accurate data on the burden of COVID-19 on Tribes is challenging to report due to misclassification and underrepresentation in national data collection efforts[viii]. The Urban Indian Health Institute estimated 474,782 cases in AI/AN communities as of October 3, 2022[ix]. The National Indian Health Board (NIHB) estimated 11,017 deaths between February 2021 and April 27, 2022, using CDC provisional AI/AN data[x].

Tribal public health systems have been tremendously impacted by COVID-19. Already underfunded[xi] and facing staffing shortages[xii], many Tribes faced challenges adding intensive COVID-19-related services on top of their existing work. However, COVID-19 also served as an opportunity for many Tribes to bring awareness – and subsequent funding – to public health. Strong Tribal health and public health systems are key to protecting AI/AN people from this disease and future pandemics.

This paper will discuss the changes to Tribal health systems' capacity to engage in performance and system improvement (PI/SI) work due to COVID-19. We will also discuss how Tribes leveraged prior PI/SI efforts to respond effectively to the COVID-19 pandemic. Our observations are qualitative and/or anecdotal and are based on the NIHB's reflections on the work of Tribal partners engaged in processes to strengthen their public health systems. Specifically, we will focus on Tribal health agencies engaging in the joint NIHB-CDC project, Strong Systems, Stronger Communities (SSSC). This paper will explore the challenges Tribes faced due to the COVID-19 pandemic, the new efforts to address these challenges, and the potential future of public health systems in Indian Country.

WHAT IS STRONG SYSTEMS, STRONGER COMMUNITIES?

Since 2014, NIHB, with support from the CDC Center for State, Tribal, Local and Territorial Support (CSTLTS), has supported Tribes to strengthen their public health systems based on national standards. Between 2014-2018, NIHB focused on working with Tribal health agencies pursuing public health

accreditation through the Tribal Accreditation Support Initiative (ASI). Public health accreditation is defined as:

- "The measurement of health department performance against a set of nationally recognized, practice-focused, and evidenced-based standards.
- The issuance of recognition of the achievement of accreditation within a specified time frame by a nationally recognized entity.
- The continual development, revision, and distribution of public health standards.[xiii]"

Twenty (20) Tribal agencies worked with NIHB on various one-year projects, with each grant cycle starting in early fall and ending in the summer. These Tribes engaged in performance improvement tasks aimed at increasing the capacity of their public health system to meet the national set of standards defined by the Public Health Accreditation Board (PHAB). It is expected that health departments that meet these standards will be able to provide the 10 Essential Public Health Services to their communities[xiv]. Many of the funded sites used support for efforts related to meeting specific national standards, such as conducting a comprehensive Tribal community health assessment, developing a strategic plan, or undertaking quality improvement activities.

In 2018, CDC created the Strong Systems, Stronger Communities (SSSC) program, and funded NIHB to implement this new initiative as a continuation of these efforts. SSSC expands on ASI and offers support for PI/SI, efforts to meet national public health accreditation standards, and increased system interconnection with the goal of improving population health and addressing social determinants of health.

Both SSSC and its predecessor ASI focus on public health efforts specifically. Public health services, as defined by the PHAB Standards and Measures, focus on preventing disease before it occurs and promoting overall population health. Healthcare services focused on the care, diagnosis, and treatment of individuals are not included in this project. However, many Tribal public health systems are unique, as Tribal public health departments are often more integrated into Tribal healthcare systems compared to state and local models.

SHIFTING PRIORITIES FOR TRIBAL HEALTH SYSTEMS

SSSC Grantees FY 2019-2020

Tribes in this cohort began their grants in Fall 2019, several months before the start of the COVID-19 pandemic. For Tribes already engaged in PI/SI work, COVID-19 was an unexpected challenge to existing plans for improvement. However, COVID-19 was also a chance for Tribes to test their emergency preparedness plans and capacity to respond to public health threats.

Background on PI/SI and Accreditation Readiness Model

COVID-19 was a significant challenge to many Tribes on their performance improvement journey. NIHB monitors Tribal health agencies' progress on readiness to engage in system-wide improvement and/or pursue public health accreditation. This is monitored using adapted evaluations following the guidelines of the Community Readiness Model. This model operates under the assumptions that 1) readiness is measurable, 2) readiness is multi-dimensional and can vary from dimension to dimension, 3) action to increase readiness or address a communal concern must be aligned to a community's level of readiness,

and that such action can be equally multi-faceted. The use of the model is a systematic way for an organization to track its ability to make changes and the underlying dynamics for these changes[xv].

The Accreditation Readiness Model (previously described in detail [xvi]) and PI/SI Readiness Models were created by NIHB to understand how Tribes increased their underlying capacity for meeting national standards regarding public health services. Factors include community and leadership support, staff buy-in, knowledge of the efforts being undertaken, resources secured, and activities conducted towards goals. The tool was beneficial for Tribes to track their progress and for NIHB to learn more about the internal factors needed to successfully improve health systems across Indian Country.

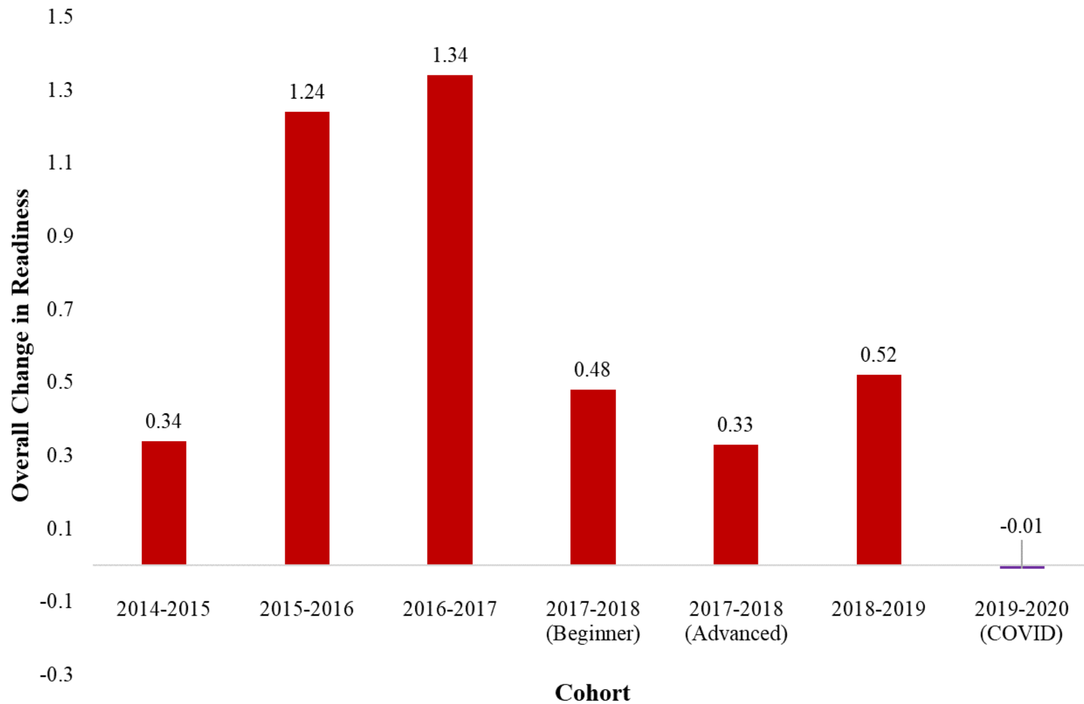
Based on data collected from 2014-2018, NIHB staff saw moderate improvements in each area measured through the assessment during each ASI/ SSSC grant cycle. In general, the greatest advancements were seen in increased PI/SI activities, increased staff knowledge of improvement activities, improved leadership support, and increased community knowledge of public health systems. In 2018-2019 NIHB also saw improvements in all areas except for resources related to accreditation and performance improvement, which decreased slightly among the awardees. Overall readiness increased across the cohorts each year by an average of 0.7 points on a 9-point scale. It should be noted that a more drastic increase was seen in earlier years of the grant. As continuing awardees entered with progressively higher scores, the annual difference between the pre- and post-assessment was reduced **(Table 1)**.

Challenges to Tribal Readiness for 2019-2020

NIHB did see a change during the 2019-2020 grant cycle that can likely be attributed to the impact of the COVID-19 pandemic. Several areas that generally experience the greatest improvement instead demonstrated reduced capacity over the course of the grant year. This included leadership support for PI/SI and accreditation activities, an overall less supportive climate for improvement, reduced community knowledge of accreditation efforts, and fewer resources related to PI/SI and/or accreditation. This reflected a larger trend seen across the public health field – attention and priorities were shifted due to the need to focus on responding to the pandemic.

Overall readiness decreased by 0.01 points over the 2019-2020 cycle **(Table 1)**. While this reduction in capacity is small, it does seem to suggest that, at minimum, grantees were not able to make progress towards improving their readiness and suggests that overall support for accreditation and performance improvement activities decreased in the face of priorities related to COVID-19. Three (3) awardees were also unable to complete several major grant activities, further suggesting a significantly diminished capacity to engage in this work. In their final reports, these grantees noted that successful Tribal public health efforts required connecting with the community, including elders, and acknowledging appropriate rites and ceremonies. With COVID-19, they were not able to engage in the planned activities safely or appropriately. In addition to the Tribes that could not complete their project, several Tribal agencies changed their work plan activities to reallocate resources towards COVID-19 related capacity building or to delay in-person events to a later date, interrupting their original plans.

TABLE 1



Tribal partners elaborated on the challenges they faced in conversation with NIHB and through final reports for SSSC. Overall, they indicated an inability to join virtual trainings in real-time due to conflicting priorities, a prioritization of staff towards COVID-19 efforts, a reduction in staffing, the inability to hold committee, coalition and workgroup meetings given increased safety requirements, the necessity to adapt to rapid policy changes, the loss of financial resources, and the shortage of needed materials to run programs safely. There was a shift away from allocating resources towards public health accreditation specifically, although many of these resources were still used to support Tribal capacity for public health activities, specifically those related to COVID-19. As highlighted earlier, there were also unexpected challenges and adaptations needed to conduct in-person aspects of health system strengthening. As community buy-in and involvement are key for successful performance improvement, many Tribes needed to delay planned activities.

Benefits of Prior PI/SI Work on COVID -19 Response for 2019-2020 Grantees

Several Tribal partners who had more experience in the PI/SI process as of the 2019-2020 cycle highlighted how their prior work prepared them to respond more effectively to the pandemic. They noted that existing policies, such as Emergency Operation Plans, allowed them to respond efficiently and effectively. They noted that years of improvement in these areas allowed for successful COVID-19 responses.

Additionally, more funding became available in important areas of capacity related to emergency response efforts. Tribes with experience in PI/SI were able to apply for this additional funding and use existing

PI/SI and accreditation-related funding to respond to the COVID-19 pandemic. By building resilient systems, these Tribes were able to leverage their prior work to improve their response.

Tribes also discussed how existing partnerships with outside agencies such as county and state health departments and Tribal Epidemiology Centers assisted in the responses and were strengthened by joint efforts to combat COVID-19. New partnerships were also formed using established PI/SI methods to strengthen relationships between various social sectors to provide better resources for communities in consideration of COVID-19.

Changes in Priorities for SSSC Applications 2020-2021

Tribes applying to SSSC for the 2020-2021 grant cycle shaped their plans around the new need to tackle COVID-19 through their public health systems. Several new applicants indicated they were looking to strengthen their public health systems due to a lack of preparedness for the COVID-19 pandemic. In fact, some did not have a public health department and were looking to bolster their understanding of public health services and lay the foundation for increased public health efforts. While NIHB was not able to collect data on this, anecdotal evidence seemed to suggest a greater understanding of the difference between public health and healthcare, something which had been a challenge for public health efforts in Indian Country in the past. Going forward, collecting data on if this shift in understanding resulted in increased funding allocated towards public health (as opposed to healthcare) at the Tribal level would clarify if this potential shift in knowledge translated to a shift in practice.

Other Tribal agencies who applied to SSSC with established public health systems looked to prioritize funds to engage in system-strengthening activities specifically targeted towards combating the complex public health challenges surrounding COVID-19. This included performing quality improvement on COVID-19 response activities and doing a gap assessment to determine where services were lacking in relation to COVID-19.

For the remaining Tribes, while COVID-19 was not the focus of their plans, there were needed adaptations to conduct activities related to PI/SI. This included managing staff time and adapting to virtual activities.

OVERALL RESPONSES TO COVID-19

Anecdotal Data from Across Indian Country

Between 2020 and 2022, NIHB gathered anecdotal information from partners engaged in PI/SI across Indian Country to better understand their early COVID responses, challenges, and needs.

Early in the pandemic many Tribes reviewed and updated their emergency response systems, particularly out-of-date policies and plans. They also prioritized essential services during the pandemic, which for some organizations differed from the nationally defined 10 Essential Public Health Services they would normally strive to offer. Many of the efforts undertaken were pursued using systems that had already been developed through PI/SI work, including efforts to pursue accreditation, although some staff noted that, out of the necessity to respond quickly, they were using less-formal processes for improvement compared to their efforts in a non-emergency setting.

Tribal health agencies indicated several significant challenges during their early response efforts. One issue was the necessity to reallocate and downsize staff. This was compounded by the issues faced by a

lack of Personal Protective Equipment (PPE) available for staff to wear. Some Tribes also did not have the capacity to deliver public health services from remote-work settings.

Another major challenge was accessing financial resources, in part due to an influx of funding opportunities with rapid turnaround time and short-term funding periods. While funding was widely available, Tribes shared that they struggled to meet the application requirements and felt many opportunities were not conducive to sustaining long-term recovery plans.

Tribal COVID-19 Response Case Studies

Between August 2020 and June 2021, NIHB sent out a call for stories to Tribal health departments engaged in PI/SI or public health accreditation process to better understand how prior efforts prepared them for COVID-19 and how COVID-19 impacted their continued efforts to strengthen their health systems. Two Tribal public health agencies provided details regarding their experience with the pandemic.

Case Study: Winnebago Tribe of Nebraska

The Winnebago Tribe of Nebraska had been working towards public health accreditation for three (3) years when the COVID-19 pandemic began. Prior work included developing and implementing quality improvement and performance management plans. COVID-19 posed a major challenge, and the Tribe was forced to redirect some resources and effort initially allocated towards PI/SI and accreditation efforts to the COVID-19 response. However, the robust system the Tribe had established allowed the Winnebago Tribal health system to respond effectively to the pandemic, particularly through the Emergency Operations Plan. They stated, "I think COVID helped us to make effective changes within our programs in order to rise to the challenge for the programs. We were able to be responsive to the needs of the community because we had such a robust public health program."

The Winnebago Tribal health system cited the separation of public health and healthcare as an important component of their response. Because of this, the public health department was able to operate independently from the hospital system and they were more efficient.

Case Study: Anonymous Tribal Health Agency

A Tribal health agency, unnamed by request, serving a Tribal population of less than 3,000 citizens in the mid-west, and with experience conducting PI/SI activities, shared challenges faced during their response. COVID-19 had a significant impact on their ability to provide services. Most staff were laid off or furloughed during the early pandemic, and the staff that remained were not well utilized in their role as a public health department for emergency response activities. Additionally, most PI/SI work was halted as it was not considered a priority. However, the health department did leverage existing connections with the nearby county to work together toward contact tracing and vaccine distribution. Formal relationships were particularly helpful in ensuring the various jurisdictions were able to work efficiently together in all aspects of the response. The Tribe also recognized that many grants secured for PI/SI work were flexible and allowed the Tribe to use the funding to create links with the community to discuss COVID-19 related programs. Despite the benefits of having a strong existing public health system, the Tribe is still struggling to re-prioritize working on PI/SI, as staffing remains a challenge.

CONCLUSION

Reviewing the available data on COVID-19 and Tribal health systems makes two (2) competing ideas apparent. 1) Tribes who had done prior work to strengthen their public health systems felt this benefited their pandemic response efforts, and 2) at least in the short-term, the COVID-19 pandemic has disrupted Tribes' effort to prioritize and fund health system strengthening initiatives.

The majority of information NIHB was able to gather regarding COVID-19 and Tribal health systems was anecdotal. However, this information highlights that several Tribal health agencies perceived their prior efforts to strengthen health systems as beneficial to allowing them to respond to the pandemic. Tribes who are newer to defining public health services as a separate entity from healthcare may benefit from leveraging their experience during the pandemic towards building public health capacity. In particular, strong Emergency Operations Plans, Quality Improvement Plans, and formal partnerships or experience in these areas, seemed beneficial for Tribal health system responses.

COVID-19 was and continues to be extremely disruptive to Tribal public health systems. Efforts to rebuild staffing capacity and re-secure leadership support for PI/SI work may be necessary. National support could include minimizing grant application requirements for COVID-19-related funding and offering longer-term resources for Tribes applying for this funding. Additionally, partners of Tribal health agencies should continue to offer flexibility as Tribes prioritize their COVID-19 efforts. Non-Tribal partners should remember that Tribes have been disproportionately burdened by this disease and may need additional time and resources to conduct recovery efforts.

However, the pandemic has also spurred a renewed interest in public health activities. To date, only six (6) Tribes have achieved Public Heath Accreditation, as opposed to 40 state and 310 local health organizations[xvii]. As the pandemic slows, more Tribes may pursue formal PI/SI and accreditation-related processes, and some may even develop their newly formed public health systems around these national standards. As both PHAB and NIHB have reported, the accreditation process is highly beneficial for communities served by the health agency[xviii,xix]. While more data is needed to gain a greater understanding of the long-term impact of COVID-19, it is clear that many Tribes may use this pandemic to emerge as stronger health systems, more capable of serving their community. However, recovery remains a priority to Tribal agencies, and PI/SI work may continue to face challenges for several years in many Tribal organizations.

ACKNOWLEDGEMENTS

Thank you to those Tribal agencies who shared information regarding their COVID-19 response efforts, including our current and former Tribal ASI/SSSC awardees. Your partnership is invaluable.

NIHB would also like to specifically acknowledge the work and support of the following NIHB staff members in developing this report:

- Nina Martin, Public Health Project Manager
- Sarah Price, Public Health Project Coordinator
- Jessica Dean, Public Health Project Coordinator

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