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National Indian Health Board

A Profile of Tribal Health Departments

Alana Knudson, PhD, Aleena Hernandez, MPH, Jessica Kronstadt, MPP, Paul Allis, BSW, MEd, Michael Meit, MA, MPH, Shena Popat, BA, BS, Marilyn G. Klug, PhD and Chris Francis, BA

Tribal health departments play an important role in improving health status and reducing health disparities among American Indian/Alaska Native people. Past research has explored the link between highly functioning health departments and improved health outcomes and revealed challenges stemming from misalignment between assigned state and local public health department functions and allocated resources. Yet this research has not focused on Tribal health departments serving American Indians/Alaska Natives (AI/ANs). Establishing a baseline understanding of how Tribal health departments are structured and the services they provide is important for identifying ways that Tribal public health can be enhanced.

In 2009, the National Indian Health Board (NIHB) conducted a national Tribal Public Health Capacity Assessment (TPHCA) based on similar assessments conducted by the National Association of County and City Health Officials (NACCHO) and the Association of State and Territorial Health Officials (ASTHO). The result of the assessment was the *2010 NIHB Tribal Public Health Profile*, the first national snapshot of Tribal public health to be made publically available.

This brief summarizes additional analysis of data from this first ever profile of Tribal health departments, as well as a synthesis of information collected through focus groups. The current project explored the services that are conducted by Tribal health departments (THDs), as well as how those services compare to local health departments (LHDs) of a similar size and geographic location. It also focused on Tribal health departments' engagement in community health assessments, one of the prerequisites to the recently launched national public health accreditation program. Recognizing the importance of systematic data collection to build understanding about Tribal health departments, the research team also explored opportunities for enhancing the survey instrument and solicited recommendations for administering a similar survey in the future.

Methodology

This study entailed several data collection and analysis tasks. First, additional analysis was conducted on the data collected from the

KEY FINDINGS

- The size of the population served and geographic location influence the types of services provided by health departments. The services provided by Tribal health departments (THDs) and local health departments (LHDs) are very similar when THDs and LHDs are matched based on population size and geographic location.
  - THDs provide more health screenings and behavioral health services than their LHD counterparts. THDs are often more integrated with the health care delivery system than LHDs.
  - Although LHDs provide more environmental health and regulatory functions than THDs, these functions are often provided in Tribal communities by other partners, such as Indian Health Service or other governmental public health agencies.
- Fewer THDs conducted a community health assessment in the past three years than LHDs matched by size and geographic location (36% versus 51%).
- THDs identified needs for technical assistance and training, particularly for preparation for public health accreditation.

TPHCA, including more detailed analysis of the data on the 79 Tribal health departments that responded to the survey, a comparison of their data to data from NACCHO's 2008 National Profile of Local Health Departments, and an analysis of free-text responses to the TPHCA. Second, the research team collected qualitative data from two focus groups to gather additional feedback to supplement and add nuance to the information available in the TPHCA. Third, the team developed a revised survey instrument and recommendations for deploying the survey in the future, based on a review of the first TPHCA as well as conversations with two advisory groups. To guide the research team throughout the study, a nine-member Advisory Committee representing tribal and non-tribal public health practice, as well as public health researchers, was convened.

Qualitative Findings

The study included two focus groups, which discussed the significance of the TPHCA, the topics of greatest interest in TPHCA, and the Public Health Accreditation Board prerequisites. Key findings include:

Perceived Significance and Value of the TPHCA. When asked about their primary motivation for completing the survey, most focus group participants felt that it was important to contribute and share the work they are doing at their respective THD and that there is not enough information about Tribal public health services nationally. Focus group participants who had not completed the survey indicated that time and competing priorities were the most significant barriers.

Topics of Greatest Interest in TPHCA. Focus group participants were especially interested in information about access to care, partnerships, and surveillance.

Perspectives on the Three Public Health Accreditation Prerequisites. Participants agreed that community health assessments are not just an outcome, but a process that should include the community, specifically in identifying data indicators. With regard to the community health improvement plan, participants shared that health should be broadly defined to include social and human services. They also shared that planning should include formal and informal assessment information. Participants noted that the strategic plan is often shared externally with the community rather than being an internal document. All participants found the prerequisites to be valuable, but explained that the components of each need to be clearly defined.

Free-text responses to the TPHCA regarding reactions to the survey instrument and areas for technical assistance or training were reviewed. Key findings follow.

General Reactions to Survey. Given the time required to complete the survey and the limited staff resources at THDs, thirteen respondents commented on the length of the survey; most of whom felt that the survey was too long and needed to be shortened. Others did not have adequate information required to complete the survey. Aside from length of the survey, most comments regarding the survey were positive.

Technical Assistance. One free response question called upon respondents to identify areas where technical assistance and/or training would be beneficial to their organization. Fifty-one THD respondents described technical assistance and training needs. Community assessment, advocacy, quality improvement, data use and interpretation, media literacy and public promotion, best practices and promising public health practices, and community-based participatory research were the most common areas for which technical assistance and training would be beneficial.

Quantitative Findings

A descriptive analysis of the THD and LHD survey respondents was conducted to ascertain baseline information. A total of 79 THDs responded to the 2010 TPHCA (40% response rate) and a total of 2,332 LHDs responded to the NACCHO 2008 National Profile of Local Health Departments (83% response rate). Because there were great differences in the size of the populations served by the THDs and LHDs, and THDs were not located in every state, a "case-control" method to match THDs with like LHDs was used. THDs were divided into four distinct regions—North, West, Southwest, and South/East—using Indian Health Service (IHS) area classifications. States were matched to the regions where the THDs were located. Two LHDs from each state in each region were identified and matched to each THD based on size of population served. A LHD could match with only one Tribe.

Top Nine THD Public Health Activities. The top nine public health activities reported by THDs include: diabetes screening, chronic disease prevention, substance abuse services, blood pressure screening, behavioral health, childhood immunizations, adult immunizations, tobacco prevention programs, and cardiovascular disease (CVD) screening. LHDs (matched LHDs and other LHDs located in the same state) were significantly less likely to provide health screenings and mental health/behavioral health services than their THD counterparts ($p < 0.05$). For example, 82.9% of THDs reported providing diabetes screening while 31.6% of matched LHDs and 38.9% of LHDs in the same state provided these activities. The greatest difference between THDs and other LHDs located in their same states was the provision of behavioral health services. Three-fourths of THDs (75.0%) provide behavioral health services whereas only 2.6% of matched LHDs and 10.3% of other LHDs in the same state provide these services (Table 1).

Top Nine LHD Public Health Activities. The top nine services reported by LHDs in the NACCHO survey include: adult immunizations, communicable/infectious disease surveillance, childhood immunizations, tuberculosis screening, food service establishment inspection, environmental health surveillance, food safety education, tobacco use prevention, and school/daycare center inspection. Overall, THDs are below the national NACCHO average for indicating that these activities are available in the jurisdiction ($p < 0.001$), and have higher missing or unreported values ($p < 0.001$). The missing or unreported THD respondent values for these activities range from 15.2% to 34.2%.

When looking at the services provided directly by THDs and matched LHDs, THDs were significantly less likely to provide communicable disease/infectious disease activities than the matched LHDs (60.5% versus 75.0%) ($p < 0.05$); there were no other statistical differences found between the services provided by the THDs and matched LHDs. However, there were some significant differences at the regional level. Overall, THDs were significantly less likely to provide public health activities for eight of the nine public health activities than the other LHDs (non-matched) located in the same states ($p < 0.05$). There was no statistical difference in the level of tobacco use prevention programs provided by THDs, matched LHDs, and all LHDs in the same states (Table 2).

Community Health Assessment. Sixty-five THDs (87%) reported that they had ever conducted a community health assessment. Over one-third of THDs (36%) reported they had conducted a community health assessment in the past three years, while half of the matched LHDs (51%) conducted a community health assessment in the past three years. There are no statistically significant differences between THDs that had conducted a community health assessment in the past three years and those that had not with regards to various characteristics, including population served by the THD, geographic region, type of IHS funding, type of Tribal organization (single Tribe or consortium), budget size category, and funding source.

Discussion

THDs provide a broad array of public health services in their communities. Although some of the most common THD public health services differ from the services most frequently delivered by LHDs, there are more commonalities than differences. For example, adult and child immunizations and tobacco use prevention programs are frequently performed by both THDs and LHDs. In addition, when matching THDs and LHDs based on population size and geographic location, the services the health departments provide are very similar. This suggests that these factors—population size and geographic location—influence the types of services provided by health departments.

At the same time, this study revealed several differences in the types of public health services delivered by THDs and LHDs. THDs provide more health screenings and behavioral health services than their LHD counterparts, whereas LHDs provide more environmental health and regulatory functions (e.g., food service establishment inspections). These differences may be attributable to the complexities of Tribal public health systems, the role of IHS and other key stakeholders, and jurisdictional authority. IHS and/or local and state health departments often carry out environmental health and regulatory functions in partnership with the Tribe. Jurisdictional authority may also have a role in determining whether a Tribal, local, or state health department provides regulatory

Table 1. Comparison of Public Health Activities Performed by THDs to Matched LHDs and LHDs in Same States for Top Nine Tribal Public Health Activities

	THDs		Matched LHDs		LHDs in Same State as THDs	
	Number (n)	Percentage (%)	Number (n)	Percentage (%)	Number (n)	Percentage (%)
Diabetes Screening	63	82.89	48	*31.58	584	*38.91
Chronic Disease Prevention	63	82.89	63	*41.45	727	*48.43
Substance Abuse Services	61	80.26	33	*21.71	310	*20.65
Blood Pressure Screening	59	77.63	90	*59.21	921	*61.36
Behavioral Health	57	75.00	4	*2.63	155	*10.33
Childhood Immunizations	57	75.00	118	77.63	1,225	81.61
Adult Immunizations	56	73.68	119	78.29	1.254	83.54
Tobacco Prevention	55	72.37	104	68.42	988	66.49
CVD Screening	55	72.37	28	*18.42	427	*28.45

*$p < 0.05$

Table 2. Comparison of Public Health Activities Performed by THDs to Matched LHDs and LHDs in Same States for Top Nine NACCHO Public Health Activities

	THDs		Matched LHDs		LHDs in Same State as THDs	
	Number (n)	Percentage (%)	Number (n)	Percentage (%)	Number (n)	Percentage (%)
Adult Immunizations	56	73.68	119	78.29	1,254	*83.54
Communicable/Infectious Diseases	46	60.53	114	*75.00	1,251	*83.34
Childhood Immunizations	57	75.00	118	77.63	1,225	81.61
TB Screening	49	64.47	104	68.42	1,162	*77.42
Food Service Inspections	30	39.47	79	51.97	1,003	*66.82
Environmental Health	42	55.26	78	51.32	1,033	*68.62
Food Safety	35	46.05	77	50.66	1,004	*66.89
Tobacco Prevention	55	72.37	104	68.42	998	66.49
School Inspections	28	36.84	70	46.05	899	*59.89

*$p < 0.05$

activities in a Tribal community. Other factors may include the organization of the Tribal health department, access to health care providers, health insurance rates, and the unique needs of the community. THDs are often more integrated with the health care delivery system than LHDs. In addition, THD respondents may view public health in a more holistic manner than LHDs because many public health and health care services are co-provided on reservations or in Tribal communities.

Limitations

The analyses presented in this study have a number of limitations. First, the data in the TPHCA and NACCHO profiles are self-reported and are not independently verified. Second, because of the response rate for the TPHCA (40%), there may be constraints in the ability to provide an accurate representation of THDs. NIHB conducted an analysis of one potential source of nonresponse bias in the TPHCA using data from IHS. This analysis showed that survey respondents are similar to all THDs with regard to their status as direct service Tribes or Tribes that contract or compact services from IHS. Third, not all TPHCA respondents answered all questions in the survey. To address this issue, further analysis showed that nonresponse to those questions cannot be solely attributed to survey fatigue. The focus groups provided important perspectives to supplement the data in the TPHCA. However, a small number of individuals participated in those discussions and their views may not be representative of the general population of Tribal public health stakeholders. All the same, efforts were made to recruit participants representing geographic diversity. In addition, the comments made by focus group participants often mirrored information gleaned through the survey.

Recommendations

With input from advisory groups, the following recommendations for future iterations of data collection were identified:

- Ensure the data needs of THDs continue to be the primary driver for the TPHCA
- Consolidate THD surveys, where possible, to decrease the burden on respondents
- Harmonize the TPHCA questions with the ASTHO and NACCHO profiles, where possible
- Consider alternate mechanisms for administering the survey (e.g., paper- or phone-based)
- Provide incentives for THDs and education about the benefits of completing to the TPHCA
- Implement a technical assistance strategy to support the THDs in completing the TPHCA (e.g., webinars, training at NIHB meetings, and phone/email contact)
- Develop a TPHCA communication plan to raise awareness about the assessment, its purpose, and use

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