FINAL REPORT

A Profile of Tribal Health Departments

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PRESENTED TO:
The Robert Wood Johnson Foundation
P.O. Box 2316
Princeton, NJ 08543
(877) 843- 7953

PRESENTED BY:
NORC at the University of Chicago
Public Health Research
Alana Knudson
4350 East-West Highway
Suite 800
Bethesda, MD 20814
(301) 634-9300
(301) 634-9301

NORC at the UNIVERSITY of CHICAGO

National Indian Health Board

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Authors who contributed to this study:
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
Chris Francis, BA

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Alana Knudson, PhD
The Walsh Center for Rural Health Analysis
NORC at the University of Chicago
4350 East West Highway, Suite 800
Bethesda, Maryland 20814
301-634-9324
301-634-9301 (fax)
HTTP://WALSHCENTER.NORC.ORG

Table of Contents

List of Tables

List of Figures

Executive Summary

In order to explore how Tribal health departments may play a role in improving health status and reducing health disparities, this study includes an analysis of data collected as part of the Tribal Public Health Capacity Assessment (TPHCA), which was conducted by the National Indian Health Board (NIHB) in 2009. This report describes the services that are conducted by Tribal health departments (THD) and provides an overview of how those services compare to local health departments (LHD) of a similar size and geographic location. It also focuses on Tribal health departments' engagement in community health assessments, one of the prerequisites to the recently launched national public health accreditation program. Through new qualitative data collection, the research team gathered information on Tribal public health stakeholders' technical assistance needs, their perceptions of the accreditation prerequisites, and their 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 TPHCA data, 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 that survey. 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.

Findings. Qualitative analysis of the focus group discussions and the free-response questions in the TPHCA yielded the following findings:

Feedback of the TPHCA. Respondents viewed the assessment positively and believed it would provide valuable information. Focus group participants were especially interested in information about access to care, partnerships, and surveillances. While survey respondents felt the assessment was useful, many indicated that the instrument was too long.

Perspectives on the Public Health Accreditation Prerequisites. All focus group participants found the three Public Health Accreditation Board prerequisites—a community health assessment, a community health improvement plan, and a strategic plan—to be valuable.

However, they commented that the components of each need to be clearly defined and that the development of Tribal models and templates would be helpful in preparing for accreditation.

Technical Assistance. Among THD respondents to the TPHCA, the following topics were most commonly cited as areas of need for technical assistance: 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.

In addition to gathering and analyzing qualitative data, the research team also conducted analyses comparing data from THD respondents to the TPHCA to LHD respondents from the NACCHO profile that were matched according to the size of the population served and geographic location. THDs were significantly less likely to provide communicable disease/infectious disease activities than the matched LHDs. At the same time, THDs were significantly more likely to provide health screenings and mental health/behavioral health services than their LHD counterparts.

TPHCA data related to community health assessments were also analyzed. Of the 74 THD respondents, 65 THDs (87%) reported 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. 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 childhood 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 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.

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.
- Harmonize the TPHCA questions with the ASTHO and NACCHO profiles, where possible.
- Consolidate THD surveys, where possible, to decrease the burden on respondents.
- 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.
- Develop a TPHCA communication plan to raise awareness about the assessment, its purpose, and use.

Introduction

It is critical to explore how Tribal health departments may play an important role in improving health status and reducing health disparities. 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.[1,2,3] Yet this research has not focused on Tribal health departments serving American Indians/ Alaska Natives (AI/ANs). Research that provides a baseline understanding of how Tribal health departments are structured and the services they provide will serve as an important foundation for investigating ways that Tribal public health can be enhanced.

To better understand the nature of Tribal public health, the National Indian Health Board (NIHB) conducted a national Tribal Public Health Capacity Assessment (TPHCA) in 2009 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 assessment was conducted using a web-based survey that collected information on the provision of public health services by Tribes, IHS, and other stakeholders; community involvement; Tribal health policy and regulation; program evaluation and quality improvement; and partnerships among local, state, federal, and Tribal entities. The result of the assessment was the 2010 NIHB Tribal Public Health Profile, which was the first national snapshot of Tribal public health to be made publically available.

This study provides additional analysis of data from this first ever profile of Tribal health departments (THD), as well as a synthesis of information collected through focus groups. It explores the services that are conducted by THDs, as well as an overview of how those services compare to local health departments (LHD) of a similar size. It also focuses 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 the understanding about the Tribal health departments, the research team also explored opportunities for enhancing the survey instrument used in this first profile and solicited recommendations for administering a similar survey in the future.

[1] Derose, S. F., Schuster, M. A., Fielding, J. E., & Asch, S. M. (2002). Public health quality measurement: concepts and challenges. *Annual Reviews of Public Health, 23*, 1-21.
[2] Ford, E. W., W. J. Duncan, and P. M. Ginter (2003). The structure of state health agencies: A strategic analysis. *Medical Care Research and Review 60*(1): 31-57.
[3] Beitsch, L. M., R. G. Brooks, N. Menachemi, and P. M. Libbey (2006). Public health at center stage: New roles, old props. *Health affairs 25*(4): 911-922.

As sovereign nations, Tribes are responsible for the overall health and well-being of their members. Tribes have a vested interest in providing valuable public health services to the communities they serve. To enhance those public health services, THDs may engage in quality improvement initiatives and efforts to prepare for voluntary public health accreditation, which could lead to overall improvements in health status in AI/AN communities. Findings from this study may help identify areas where technical assistance (TA) may be most valuable to help Tribal health departments increase their capacity.

This report begins with background information about the Tribal health system, health disparities, and the public health accreditation system, in order to provide context for the remainder of the report. Next we provide an overview of the methodology employed in this study, which includes analysis of data from the TPHCA and the NACCHO profile, two focus groups, and a structured review process for developing recommendations for revisions to the survey instrument. We then share the key findings from the study, highlighting both quantitative analyses of TPHCA and NACCHO data and themes that emerged through qualitative data collection. We conclude with a discussion that features recommendations for continued collection of information about Tribal health departments.

Background

Tribal Health System

There are 565 federally recognized Tribes in the United States, each with a distinct language, culture, and governance structure. Native American Tribes are sovereign and maintain a unique government-to-government relationship with the federal government, as established historically and legally by the U.S. Constitution, Supreme Court decisions, treaties, and legislation. Treaties signed by Tribes and the federal government established a *trust responsibility* in which Tribes ceded land and natural resources in exchange for education, health care, and other services.

Public health services are delivered by a diverse and varied set of stakeholders and partners in AI/AN communities. Since 1955, health care and public health services have been delivered to American Indians and Alaska Natives through the Indian Health Service (IHS), an agency within the Department of Health and Human Services (HHS). IHS has specified 10 service areas (Figure 1). A function of the federal trust responsibility, IHS is a comprehensive, primary health care system for approximately 1.6 million of the nation's estimated 2.6 million AI/AN population.[4] IHS is the only agency within HHS that provides direct patient care; service delivery includes some public health services. Services are provided in direct care hospitals and clinics (service units), located on or near Indian reservations, which are operated and managed by the federal government or by Tribes that have assumed the management of their local facilities.

[4] U.S. Department of Health and Human Services, Indian Health Service. *Trends in Indian Health*. Washington, DC: Indian Health Service; 2002-2003.

Figure 1. IHS Service Area Map

Source: Indian Health Service. IHS Regional Map. Available at: http://www.ihs.gov/PublicAffairs/IHSBrochure/map.asp

Insufficient IHS funding has been an ongoing challenge resulting in difficult choices determining how limited funds are allocated. IHS spends less per capita on health care services than any other agency of the U.S. government—$1,914 per patient per year. IHS spends less than half in patient care than the Federal Bureau of Prisons spends each year on prisoners.[5] This lack of health care spending is of particular concern given that the AI/AN population is younger and expanding with birth rates exceeding those of the overall U.S. population.[6]

Tribes are increasingly involved in public health activities, regulation, and service delivery, alone and in partnership with others. In 1975, Public Law 93-638, the Indian Self-Determination and Educational

[5] US Commission on Civil Rights (2004). A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country. http://www.usccr.gov/pubs/na0703.pdf.
[6] U.S. Census Bureau (2007). We the People: American Indians and Alaska Natives in the United States. http://www.census.gov/Press-Release/ch96-182.html

Assistance Act, provided the authority to Tribes to enter into contracts or compacts with the federal government to administer the health programs previously managed by IHS. Tribes with larger populations and/or those with adequate resources to contract or compact health programs tend to be involved in more public health activities, such as disease prevention and health promotion, than smaller Tribes with fewer resources.

Tribal public health systems are complex and involve a diverse set of partners and stakeholders. Tribes may provide public health services in their communities in partnership with federal agencies, local and state health departments, and other private or public third parties. Regional Tribal Epidemiology Centers, which are IHS-funded entities, also have a role in managing public health information systems and disease prevention and control programs in partnership with Tribal communities and urban AI/AN communities. The nature and extent to which Tribes partner and coordinate services with other public health entities varies by Tribe, region, and type of service.

In addition to understanding the governance and organizational context, when studying Tribal public health, it is also imperative to understand that some aspects of AI/AN culture may bolster the health of communities, including strong communal ties. Many AI/AN people are committed to nurturing traditional health practices, including an emphasis on traditional medicine, natural foods, healing, and appropriate physical activities and rest.

Disparities

The context in which AI/AN communities operate health services, including disease prevention and health promotion, can be greatly influenced by the significant disparities that are experienced by AI/AN populations. AI/AN populations face a shorter life expectancy than the U.S. population as a whole and higher mortality rates for such conditions as alcoholism, diabetes, unintentional injuries, and suicide.[7] Understanding Tribal public health systems will provide valuable insights in addressing these disparities.

For the purpose of clarity, we shall refer to the Health Resources and Services Administration (HRSA) Workgroup for the Elimination of Health Disparities definition of health disparities, which is a "population-specific difference in the presence of disease, health outcomes or access to health care."[8] Giger and Davidhizer have defined the sociological perspective of health disparities as a chain of events

[7] Indian Health Service (2011). Indian Health Disparities. The Indian Health Service Fact Sheets. http://info.ihs.gov/Disparities.asp

[8] Health Resources and Services Administration Workgroup for the Elimination of Health Disparities. US Department of Health and Human Services, Washington, DC. www.hrsa.gov/OMH/disparities/pages09-14.pdf

signified by a difference in (1) environment; (2) access to, utilization of, and quality of care; (3) health status; and (4) health outcome.[9]

AI/ANs have long experienced health disparities due to socioeconomic and cultural factors, as well as access to health care. AI/ANs have the shortest life expectancies of any population in the United States.[10] Within the AI/AN populations the vast majority of disparities occur within preventable diseases.[11] According to the IHS, AI/AN babies born today have a life expectancy 4.6 years less than the overall U.S. population. Further, the age-adjusted death rate for adult AI/ANs is 40% higher than that of the general population.[12] While the overall health status of AI/ANs has improved over the last century, significant disparities still exist in the quality of and access to health care, social services, behavioral health, and community health.

Public Health Accreditation

The Public Health Accreditation Board (PHAB) has developed a national voluntary public health accreditation program for state, territorial, Tribal, and local health departments. The accreditation process will measure the degree to which a health department meets nationally recognized standards and seeks to advance the quality of public health services. Implementing accreditation standards can support Tribal governments in efforts to improve AI/AN community health. The accreditation assessment process can provide valuable, measurable feedback to public health programs on their strengths and areas for improvement and encourage strong, active partnerships between public health stakeholders and AI/AN community members. The process can also assist in reducing AI/AN health disparities by strengthening and enhancing public health services so that the same level of high quality public health services is available to everyone.

This analysis provides insights on one component of accreditation. It includes an analysis of the extent to which Tribal health departments have conducted community health assessments—one of the prerequisites for national accreditation—as well as an exploration of the factors that are associated with increased likelihood of having developed a community health assessment.

[9] Giger JN, Davidhizer R. (2007). Eliminating Health Disparities Understanding this Important Phenomenon. *The Health Care Manager. 26* (3).
[10] Indian Health Service (2011). Indian Health Disparities. The Indian Health Service Fact Sheets. http://info.ihs.gov/Disparities.asp
[11] Warne, D. (2006). Research and Educational Approaches to Reducing Health Disparities Among American Indians and Alaska Natives. *Journal of Transcultural Nursing. 17* (3).
[12] Sarche M, Spicer P. (2008). Poverty and Health Disparities for American Indian and Alaska Native Children Current Knowledge and Future Prospects. *Annals of the New Academy of Science. 1136*: 126-136.

Methodology

This study entailed several data-collection and analysis tasks. First, additional analysis was conducted on the data from the first TPHCA. This included more detailed analysis of the data on the 79 Tribal health departments that responded to the survey, a comparison of their data to NACCHO profile data, 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. These tasks were reviewed by the NORC Institutional Review Board. The methods are described in greater detail below.

To guide the research team throughout the study, we convened an Advisory Committee. The individuals who served on the Committee were selected to represent Tribal and non-Tribal public health practice, as well as public health researchers. The Committee met two times via conference call. Table 1 lists the individuals who participated as Advisory Committee members.

Table 1. Advisory Committee Members

Advisory Committee Members
Cathy Abramson NIHB Treasurer, Board Member Sault Ste. Marie Tribe of Chippewa Indians
Leslie Beitsch, MD, JD Associate Dean for Health Affairs, University of Florida College of Medicine
Kaye Bender, RN, PhD, FAAN President and CEO, Public Health Accreditation Board
Ron Bialek, MPP President, Public Health Foundation
Stacy Bohlen Executive Director, NIHB
Joe Finkbonner, RPh, MHA, NIHB Board Member Executive Director, Northwest Portland Area Indian Health Board
Trina Pyron, MA Public Health Advisor, Centers for Disease Control and Prevention

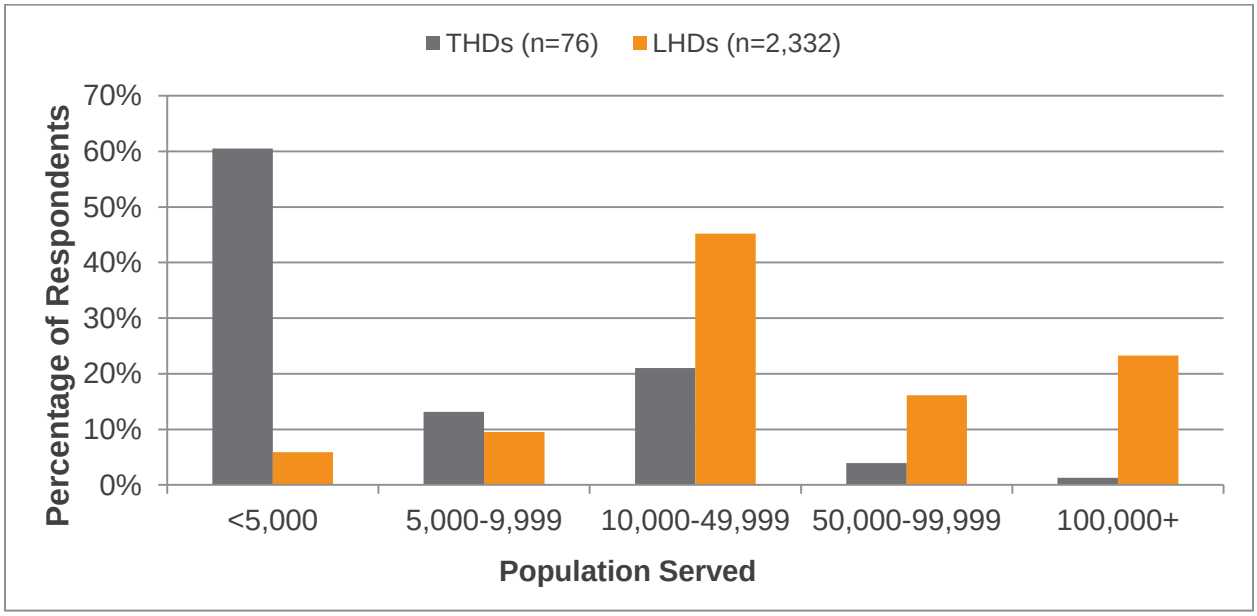
Advisory Committee Members
H. Sally Smith Chairman of the Board, Bristol Bay Area Health Corporation
Roslyn Tso Acting Director, Office of Direct Service and Contracting Tribes, Indian Health Service

Quantitative Analysis

Analysis of TPHCA and NACCHO Profile Data

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[13] (40% response rate) and a total of 2,332 LHDs responded to the 2008 NACCHO profile[14] (83% response rate). The distribution of the THD and LHD respondents by size of population served is illustrated in Figure 2.

Figure 2. Distribution of THDs and LHDs by Total Population Served



[13] Other types of Tribal organizations (e.g., Indian Health Service, Area Indian Health Boards, and Urban Indian Health Centers) completed the TPHCA. However those types of organizations are excluded from this analysis in order to focus on Tribes and Tribal consortia—the entities that are more comparable to LHDs and are eligible for PHAB accreditation.

[14] National Association of County and City Health Officials – NACCHO (2008). *National Profile of Local Health Departments Survey, (2008): Core and Modules* [Data file]. Obtained (May 2011) from NACCHO.

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, we used a "case-control" method to match THDs with like LHDs. First, we divided the THDs into four distinct regions—North, West, Southwest, and South/East—using the Indian Health Service area classifications. We then matched states to the regions where the THDs were located. See regional definitions below (Table 2).

Table 2. Regional Definitions

Region	Tribes (Number of TPHCA respondents)	Matching States (Number of NACCHO respondents)
North	Aberdeen (4), Bemidji (9), Billings (3) (16 THDs)	ND, SD, NE, IA, MN, IN, WI, MT, WY (480 LHDs)
West	Alaska (9), Portland (5), California (10) (24 THDs)	AK, OR, WA, ID, CA (125 LHDs)
Southwest	Albuquerque (1), Phoenix (13), Tucson (1), Navajo (2) (17 THDs)	NM, CO, TX, AZ, NV, UT (166 LHDs)
South/East^	Nashville (8), Oklahoma (13) (21 THDs)	OK, KS, TX, AL, CT, FL, LA, ME, MA, MS, NY, NC, RI, SC (797 LHDs)
Total	**79 THDs**	**1,501 LHDs in designated states***

^ Note: 2 THDs in this region did not report population served
* Note: TX is in two regions so total LHDs is lower

The next step was to identify two LHDs from each state in each region and match to each THD based on population served. Matches were identified by searching LHDs in the region whose population value was at least 200 lower than the THD or the next highest value. Many THDs served small populations (under 1,000 people) so most matches were higher than the THDs but as close as possible. A LHD could match with only one Tribe.

Table 3. Population Served by THDs in TPCHA and Matched NACCHO Profile LHDs

	Number (n)	Minimum	Median	Maximum	Mean
Total					
Tribe*	76	200	3650	135000	10228
NACCHO	152	100	7722	139096	15608
North					
Tribe	16	794	4479	14281	5501
NACCHO	32	750	4446	14000	5403
West					
Tribe	24	200	4250	135000	15187
NACCHO	48	100	22339	139096	31246
Southwest					
Tribe	17	200	2000	17500	4248
NACCHO	34	575	5989	17435	6959
South/East					

Tribe	19	320	5000	69000	12112
NACCHO	38	310	4904	69495	12106

* Of the 79 THD respondents, only 76 provided information about the size of the jurisdiction they serve and/or their geographic location.

Once the data were matched and stratified, we analyzed the data using SAS v9.3. Tests for differences in proportions using normal approximations were used to compare prevalences. Linear regression, one-way ANOVAs, and independent t-tests were used to compare prevalences across the survey.

Qualitative Analysis

Analysis of Free-Response Questions in TPHCA

Throughout the TPHCA, respondents were given the opportunity to provide additional information in free text comment boxes after most questions. At the end of the survey, respondents were able to provide general comments about the survey and their experience completing it, including the ease of answering survey questions. Respondents were also asked what areas of technical assistance and/or training would be most beneficial to their organization. The research team analyzed responses to these questions to identify common themes.

Focus Groups

Two semi-structured focus groups lasting no more than 90 minutes were conducted and facilitated by NIHB in September and December 2010. The two main topics explored in the focus groups include:

- Perceived significance and value of the TPHCA
- Tribal perspectives on the three prerequisites for national public health accreditation, which include a community health assessment, community health improvement plan, and strategic plan.

Focus Group 1. Participants were recruited using the TPHCA respondent list, which was compared with the NIHB Annual Consumer Conference attendee list. All TPHCA respondents who were attending the conference were invited to participate. Participants were selected based on who responded first to the invitation and on geographic diversity using the Indian Health Service Area representation to ensure geographically diverse representation designations. There were a total of five participants representing Tribal health departments located in five of the IHS Service Areas, including Aberdeen, Bemidji, California, Oklahoma, and Tucson.

Focus Group 2. Participants were members of the NIHB Tribal Public Health Accreditation Advisory Board, which includes Tribal public health leaders and administrators nominated by Tribes and Tribal

Area Health Boards to represent Tribes located within their IHS Service Area. A total of 12 members participated representing 10 Tribal health departments or organizations in nine IHS Service Areas. IHS Service Areas represented include Alaska, Albuquerque, Bemidji, California, Navajo, Phoenix, Portland, Oklahoma, and Tucson.

Invitations to potential participants were sent in advance of the focus groups informing them of the purpose of the group and that an incentive of a $25 gift certificate would be given to compensate them for their time. Prior to the consenting process, a brief 15-minute presentation on the development and implementation of the TPHCA was provided to introduce the focus group and to familiarize and remind participants of the project. A moderator guided the focus group discussions so that topics relevant to the TPHCA and Tribal public health activities could be explored in depth.

Instrument Revisions

In order to develop recommendations for proposed revisions to the instrument as well as strategies for administering a future Tribal public health profile, the research team engaged in the following activities:

1. **Reviewed Responses to the TPHCA.** We looked at responses to the TPHCA to identify instances where the questions may not have been clear. Respondents were given the opportunity to provide free-text comments on every screen of the online survey. Those comments occasionally indicated questions where respondents were uncertain about how to interpret the question. We used this information to propose potential revisions to the questions.

2. **Reviewed Questions from the ASTHO and NACCHO Profiles.** We looked at the instruments used for the ASTHO and NACCHO profiles to identify instances where those profiles asked questions that were similar in content to the TPHCA questions. In order to better harmonize data across the profile instruments, we proposed making some adjustments to the TPHCA questions so that the same wording was used to ask the same questions. For example, we propose adjusting the wording of questions related to the number of employees working in the health department, so those questions are more similar across the three profiles. However, we were sensitive to the fact that there might be reasons to maintain differences in the wording. For example, as part of a question about the types of professionals employed by the health department, we maintained additional options in the TPHCA for traditional healer and alternative medicine.

3. **Received Guidance from Experts.** NIHB shared their perspectives about the types of information that are important to capture in the TPHCA. Based on their input and the first two steps described above, we developed a draft of the revised instrument. Then we convened the project Advisory Committee and shared with them this revised instrument. In addition to

soliciting general feedback about the revised questionnaire, we asked several targeted questions. For example, given the Committee's familiarity with national accreditation, we asked for suggestions about revisions to those questions. We also convened the NIHB Tribal Public Health Accreditation Advisory Board for a second conversation. They provided valuable feedback on a number of questions. For example, they helped the research team determine the most appropriate way to ask whether Tribal health departments are direct service Tribes or if they contract/compact some or all services from IHS.

Findings

Qualitative Findings

Focus Groups

Data collected from two focus groups were compiled in order to provide a comprehensive analysis of findings and identify emerging themes. Areas of analysis included the perceived significance and value of the TPHCA; the topics of most importance covered in the survey; and perspectives on the value and relevance of the three public health accreditation prerequisites.

Perceived Significance and Value of the TPHCA. Focus group participants who had completed the TPHCA were asked about their primary motivation for completing the survey. The most common responses were that it was important to contribute and share the work they are doing at their respective Tribal health departments/organizations 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. Most surveys were completed by the director of each entity in consultation with other staff, such as deputy directors and public health nurses. All participants agreed that the *2010 Tribal Public Health Profile* is useful—primarily for raising awareness and as an educational tool, but also for providing data and information for grant writing and advocacy.

Significant Topics. Tribal health departments often engage with multiple partners to provide both public health and health care services. Service coordination is critical to address issues related to accessing care, monitoring health status, and advancing health improvement efforts.

- **Access to care.** Participants noted the data collected regarding the significant distances many community members must travel to access health care or public health services are very important. Distances of 50 miles or more may be a barrier to obtaining screenings, preventative care, education and information. It may also increase the chance of motor vehicle accidents. (American Indians have high mortality rates due to motor vehicle accidents.[15])
- **Partnerships.** Focus group participants were interested in learning about partnerships and what services are available and who are providing these services. That information raised questions about service duplication and about various issues related to data sharing.
- **Surveillance.** Multiple stakeholders, including the Tribe, Tribal Epidemiology Centers (Tribal EpiCenters) located in Area Health Boards or Inter Tribal Councils, and IHS often conduct data

[15] Pollack KM, Frattaroli S, Young JL, Dana-Sacco G, Gielen AC. Motor vehicle deaths among American Indian and Alaska Native Populations. *Epidemiologic Reviews.* 2010;34(1):73-88.

surveillance. Surveillance topics of greatest interest included data sources, collection and usage, and challenges related to data access.

When participants were asked if they had any questions or additional comments, the need to centralize data collection efforts for national surveys was raised. There are other efforts to survey Tribes and to describe the various aspects of their programs and services. As a result, there is confusion surrounding the differences between surveys and survey sponsors, as well as how information will be reported back to the Tribes.

Perspectives on the Three Public Health Accreditation Prerequisites. After the discussion about the TPHCA, the moderator defined the three accreditation prerequisites using definitions from the Public Health Accreditation Board. Focus group participants were then asked to share any changes or additions to the definitions, to describe the perceived value of the prerequisites, and to identify technical assistance needs, if any, in preparing these prerequisites.

- **Community Health Assessment.** Participants agreed that community health assessments are not just an outcome, but a process. The process should include the community, specifically in identifying data indicators. Tribes use a number of data sources when conducting assessments. Those cited most frequently include Tribal EpiCenter data, state data, Resource and Patient Management System (RPMS) (an electronic health record system used by IHS providers), and U.S. Census data.
- **Community Health Improvement Plan.** Participants shared that health should be broadly defined to include social and human services. This emphasis on broader services may be related to the fact that such services often fall within the scope of THDs. They also shared that planning should include formal and informal assessment information.
- **Strategic Plan.** Participants recommended that the required components of the plan be identified and communicated. A strategic plan is not just an internal document, but is often shared externally with the community.

All found the prerequisites to be valuable, but that the components of each need to be clearly defined. In order to develop these documents, focus group participants identified several technical assistance needs, including the development of Tribal models and templates, as well as training.

Free-Response Questions in TPHCA

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. Ten respondents felt that the survey was too long and needed to be shortened. One respondent commented that he/she did not have sufficient time to provide thorough responses to the survey questions. Another respondent was only able to provide

estimates and did not have the time to gather exact numbers. Three respondents did not have the information required to complete the survey. (The lack of staff time to devote to the survey may reflect overall constraints facing THDs. Throughout the survey, many respondents commented that a lack of resources and personnel was a barrier to conducting public health activities.)

There were few comments about the survey content as a whole. Four respondents commented that some public health questions do not accurately reflect how their THDs operate, specifically urban centers and freestanding IHS clinics. Others provided feedback on the way the survey was administered. One THD requested a hard copy of the survey to complete, as that individual found the tables in the online study to be difficult to follow. Another respondent would have liked to know how long the survey would take prior to completing it.

Aside from length of the survey, most comments were positive. Ten respondents provided positive feedback to the survey. Six of these respondents specifically asked to see the results of the survey.

Technical Assistance. One free response question called upon respondents to identify areas where technical assistance and/or training would be beneficial to their organization. The survey listed the following as potential areas to consider: data use and interpretation, community assessment, quality improvement, promising public health practices, community based participatory research, media literacy and public promotion, and advocacy at local, state, and federal levels. However respondents were also instructed that they could provide feedback on other topics as well. Fifty-one THD respondents described needed technical assistance and training.

Community assessment was identified as the area with the greatest need for technical assistance and training. Twenty-nine THDs stated that assistance in conducting a community assessment would be beneficial. One of these respondents specifically noted the need for assistance with community health assessment for the purpose of seeking public health accreditation.

Advocacy was also a common need for technical assistance and training. Twenty-four respondents would like assistance on advocacy at the local, state, and/or federal levels. Three THDs responded that they would benefit from assistance in seeking funding. One of these respondents specifically noted a need for identifying funding opportunities to conduct a community assessment. Two THDs commented on the need for technical assistance and training around grant writing, including gathering data for the grant-writing process.

Twenty-four respondents would like technical assistance and training for quality improvement. One respondent commented that, given limited resources, THD staff would benefit from outlining a complete

program and how it functions, including defining goals, implementing the program, and measuring outcomes.

Twenty respondents commented that they would benefit from technical assistance in data use and interpretation. Specifically, two respondents requested assistance related to Institutional Review Boards and the use of records databases.

Media literacy and public promotion was another area which THDs would benefit from technical assistance and training, with 19 respondents commenting on this area. Enhancing community participation was a common area in which additional support was requested.

Technical assistance and training for specific public health activities would also be beneficial to THDs. Seventeen respondents identified best practices and promising public health practices as an area of need. Another two respondents specifically highlighted assistance in the area of emergency preparedness. One respondent said that they would benefit from assistance with updating policies and procedures.

Sixteen THDs identified the need for technical assistance surrounding community-based participatory research. One respondent would like assistance with developing surveys, analyzing survey results, and using electronic tools, such as Epi Info and SurveyMonkey, in order to support community-based participatory research.

Survey respondents also highlighted areas within the provision of health services that would benefit from technical assistance and training. Three respondents commented that they would benefit from technical assistance and staff training with electronic health records. One respondent specifically noted continued assistance for Resource and Patient Management System (RPMS) implementation. Another respondent said that patient data input, retrieval, and assessment is an area of need. Another respondent wrote that they need telehealth assistance, including equipment installation and improving systems. One respondent stated a need for technical assistance to become accredited through the Accreditation Association for Ambulatory Health Care.

Quantitative Findings

Public Health Services

To examine similarities and differences in the provision of public health services among THDs and LHDs, we examined the nine most frequently provided services for both THDs and LHDs.

Table 4 shows the number and percentage of TPHCA and NACCHO respondents who reported that the specified service was available in their jurisdiction. The public health services in this table represent the top nine services reported by LHDs in the NACCHO survey including: 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. The table includes detail regarding what entity is providing the service, if it is available. In the TPHCA, these entities include Tribal Health Departments (THD), Indian Health Service (IHS), Area Indian Health Boards (AIHB) and Tribal Epi Centers (EPI), State Health Departments (SHD), Local Health Departments (LHD), other, not available in service area (N/A), and missing. The "total" row for each activity represents the number and percentage of health departments that responded to each question and did not report that the service is not available in their jurisdiction—in other words, the number of health departments that reported the service is available in their jurisdiction. 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%. Please see Appendix A for a more detailed assessment of these missing values.

Table 4. Comparison of Tribal Health Departments (THDs) and Local Health Departments (LHDs) Performing NACCHO's Top Nine Public Health Activities

	79 THDs		2,332 LHDs	
	Number (n)	**Percentage of Total (%)**	**Number (n)**	**Percentage of Total (%)**
Adult Immunization				
Total	**66**	****83.54**	**2,287**	**98.07**
Tribe	56	70.89		
IHS	26	32.91		
AIHB / EPI	5	6.33		
SHD	18	*22.78	81	3.47
LHD	25	**31.65	2,047	87.78
Other	5	6.33		
N/A	1	1.27	18	0.77
Missing	12	*15.19	23	0.99
Communicable/Infectious Disease Surveillance				
Total	**66**	****83.54**	**2,276**	**97.60**
Tribe	46	58.23		
IHS	37	46.84		
AIHB / EPI	31	39.24		
SHD	37	46.84	780	33.45
LHD	35	**44.30	2,028	86.96

	79 THDs		2,332 LHDs	
	Number (n)	Percentage of Total (%)	Number (n)	Percentage of Total (%)
Other	2	2.53		
N/A	0	0	10	0.43
Missing	13	*16.46	45	1.93
Childhood Immunizations				
Total	**67**	****84.81**	**2,260**	**96.91**
Tribe	57	72.15		
IHS	27	34.18		
AIHB / EPI	16	20.25		
SHD	22	*27.85	74	3.17
LHD	28	**35.44	2,006	86.02
Other	6	7.59		
N/A	0	0	30	1.29
Missing	12	*15.19	38	1.63
Tuberculosis Screening				
Total	**65**	****82.28**	**2,239**	**96.01**
Tribe	49	62.03		
IHS	27	34.18		
AIHB / EPI	7	8.86		
SHD	18	*22.78	175	7.50
LHD	21	**26.58	1,880	80.62
Other	7	8.86		
N/A	1	1.27	39	1.67
Missing	13	*16.46	44	1.89
Food Service Establishment Inspection				
Total	**50**	****63.29**	**2,298**	**98.54**
Tribe	30	37.97		
IHS	24	30.38		
AIHB / EPI	1	1.27		
SHD	9	11.39	499	21.40
LHD	9	**11.39	1,797	77.06
Other	4	5.06		
N/A	3	*3.80	2	0.09
Missing	26	32.91	32	1.37
Environmental Health Surveillance				
Total	**60**	****75.95**	**2,224**	**95.37**
Tribe	42	53.16		
IHS	37	46.84		
AIHB / EPI	13	16.46		
SHD	14	17.72	810	34.73
LHD	15	**18.99	1,750	75.04
Other	5	6.33		

	79 THDs		2,332 LHDs	
	Number (n)	Percentage of Total (%)	Number (n)	Percentage of Total (%)
N/A	1	1.27	35	1.50
Missing	18	*22.78	66	2.83
Food Safety Education				
Total	**56**	****70.89**	**2,214**	**94.94**
Tribe	35	44.30		
IHS	26	32.91		
AIHB / EPI	2	2.53		
SHD	6	7.59	546	23.41
LHD	9	**11.39	1,732	74.27
Other	6	7.59		
N/A	0	0	35	1.50
Missing	23	*29.11	80	3.43
Tobacco Use prevention				
Total	**64**	****81.01**	**2,201**	**94.38**
Tribe	55	69.92		
IHS	19	24.05		
AIHB / EPI	6	7.59		
SHD	12	15.19	622	26.67
LHD	15	**18.99	1,610	69.04
Other	14	17.72		
N/A	1	1.27	45	1.93
Missing	14	*17.72	85	3.64
School/Daycare Center Inspection				
Total	**49**	****62.03**	**2,238**	**95.97**
Tribe	28	35.44		
IHS	17	21.52		
AIHB / EPI	1	1.27		
SHD	13	16.46	815	34.95
LHD	12	**15.19	1,582	67.84
Other	8	10.13		
N/A	3	3.80	14	0.60
Missing	27	*34.18	77	3.30

*p < 0.05
**p < 0.01
^Area Indian Health Board (AIHB) and Tribal Epi Center (EPI) were combined for this analysis.

Two LHDs were matched to each THD based on state location and the size of the population served. Using these match criteria, we examined the same nine NACCHO public health activities to compare provision by the THDs, the matched LHDs, and all other LHDs located in the states where THDs are located. (This analysis is only comparing the services provided by either the THD or the LHD. These public health services may be provided by another public health system stakeholder.) Table 5 shows that

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 between the THDs and matched LHDs. Six of the public health activities were more likely to be provided by the matched LHDs in the West region than their THD counterparts. The matched LHDs also provided more food service inspections in the South/East region than the THDs (84.2% versus 52.6%), yet the THDs provided more childhood immunizations than the matched LHDs (79.0% versus 39.5%) in that region. 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 5. 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**
North	11	68.75	29	90.63	441	*91.88
West	19	79.17	46	*95.83	122	*97.60
Southwest	11	64.71	28	82.35	128	76.65
South/East	14	73.68	16	42.11	605	75.91
Communicable/ Infectious Diseases	**46**	**60.53**	**114**	***75.00**	**1,251**	***83.34**
North	10	62.50	21	65.63	402	*83.75
West	15	62.50	47	*97.92	123	*98.40
Southwest	12	70.59	27	79.41	127	76.05
South/East	9	47.37	19	50.00	640	*80.30
Childhood Immunizations	**57**	**75.00**	**118**	**77.63**	**1,225**	**81.61**
North	13	81.25	30	93.75	455	94.79
West	17	70.83	46	*95.83	120	*96.00
Southwest	11	64.71	27	79.41	129	77.25
South/East	15	78.95	15	*39.47	565	70.89
TB Screening	**49**	**64.47**	**104**	**68.42**	**1,162**	***77.42**
North	8	50.00	22	68.75	393	81.88
West	18	75.00	46	*95.83	122	*97.60
Southwest	10	58.82	22	64.71	116	69.46
South/East	12	63.16	14	36.84	569	71.39
Food Service	**30**	**39.47**	**79**	**51.97**	**1,003**	***66.82**

Inspections						
North	7	43.75	5	15.63	241	50.21
West	7	29.17	35	*72.92	94	*75.20
Southwest	6	35.29	7	20.59	106	63.47
South/East	10	52.63	32	*84.21	612	*76.79
Environmental Health	**42**	**55.26**	**78**	**51.32**	**1,033**	***68.62**
North	11	68.75	12	37.50	324	67.50
West	14	58.33	38	79.17	101	*80.80
Southwest	9	52.94	12	35.29	102	61.08
South/East	8	42.11	16	42.11	548	*68.76
Food Safety	**35**	**46.05**	**77**	**50.66**	**1,004**	***66.89**
North	7	43.75	9	28.13	291	60.63
West	10	41.67	42	*87.50	104	*83.20
Southwest	5	29.41	8	23.53	96	57.49
South/East	12	63.16	18	47.37	555	69.64
Tobacco Prevention	**55**	**72.37**	**104**	**68.42**	**998**	**66.49**
North	12	75.00	24	75.00	329	68.45
West	18	75.00	40	83.33	112	89.60
Southwest	11	64.71	25	73.53	90	53.89
South/East	13	68.42	15	39.47	480	60.23
School Inspections	**28**	**36.84**	**70**	**46.05**	**899**	***59.89**
North	8	50.00	10	31.25	189	39.38
West	7	29.17	24	50.00	69	55.20
Southwest	5	29.41	11	32.35	98	*58.68
South/East	7	36.84	25	65.79	585	*73.40

*$p < 0.05$

We also examined the top nine public health activities provided by THDs. These public health activities included: diabetes screening, chronic disease prevention, substance abuse services, blood pressure screenings, behavioral health, childhood immunizations, adult immunizations, tobacco prevention programs, and cardiovascular disease (CVD) screening. Table 6 illustrates that 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 38.91% of LHDs in the same state provided these services. The greatest difference between THD 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. In addition, at the regional level there were significant differences detected in the level of public health activities provided by the THDs, matched LHDs, and other LHDs from the

same states. Overall, THDs are engaged in providing more health screening and behavioral health services than LHDs, regardless of the size of health department or geographic location.

Table 6. 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**
North	13	81.25	18	*56.25	173	*36.04
West	19	79.17	7	*14.58	33	*26.40
Southwest	14	82.35	14	*41.18	63	*37.72
South/East	16	84.21	9	*23.68	337	*42.28
Chronic Disease Prevention	**63**	**82.89**	**63**	***41.45**	**727**	***48.43**
North	13	81.25	14	*43.75	260	*54.17
West	18	75.00	25	*52.08	76	60.80
Southwest	15	88.24	16	*47.06	62	*37.13
South/East	16	84.21	8	*21.05	341	*42.79
Substance Abuse Services	**61**	**80.26**	**33**	***21.71**	**310**	***20.65**
North	13	81.25	3	*9.38	133	*27.71
West	17	70.83	9	*18.75	34	*27.20
Southwest	14	82.35	14	*41.18	28	*16.77
South/East	16	84.21	7	*18.42	118	*14.81
Blood Pressure Screening	**59**	**77.63**	**90**	***59.21**	**921**	***61.36**
North	12	75.00	27	84.38	339	70.63
West	19	79.17	25	*52.08	54	*43.20
Southwest	12	70.59	24	70.59	90	53.89
South/East	15	78.95	14	*36.84	468	*58.72
Behavioral Health	**57**	**75.00**	**4**	***2.63**	**155**	***10.33**
North	12	75.00	0	*0	40	*8.33
West	16	66.67	3	*6.25	20	*16.00
Southwest	13	76.47	0	*0	6	*3.59
South/East	15	78.95	1	*2.63	90	*11.29
Childhood Immunizations	**57**	**75.00**	**118**	**77.63**	**1,225**	**81.61**
North	13	81.25	30	93.75	455	94.79
West	17	70.83	46	*95.83	120	*96.00
Southwest	11	64.71	27	79.41	129	77.25
South/East	15	78.95	15	*39.47	565	70.89
Adult Immunizations	**56**	**73.68**	**119**	**78.29**	**1.254**	**83.54**

North	11	68.75	29	90.63	441	*91.88
West	19	79.17	46	*95.83	122	*97.60
Southwest	11	64.71	28	82.35	128	76.65
South/East	14	73.68	16	42.11	605	75.91
Tobacco Prevention	**55**	**72.37**	**104**	**68.42**	**988**	**66.49**
North	12	75.00	24	75.00	329	68.45
West	18	75.00	40	83.33	112	89.60
Southwest	11	64.71	25	73.53	90	53.89
South/East	13	68.42	15	39.47	480	60.23
CVD Screening	**55**	**72.37**	**28**	***18.42**	**427**	***28.45**
North	11	68.75	6	*18.75	131	*27.29
West	18	75.00	8	*16.67	30	*24.00
Southwest	11	64.71	11	32.35	49	*29.34
South/East	14	73.68	3	*7.89	229	*28.73

*$p < 0.05$

Community Health Assessment

Community health assessments, as defined by the Public Health Accreditation Board, involve "collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve the public's health."[16] Community health assessments include, but are not limited to, models such as MAPP, APEX, and the National Public Health Performance Standards (NPHPS). A total of 74 THDs responded to the question asking whether the THD had conducted a community health assessment. A total of 65 THD respondents (87.8%) reported they had ever conducted a community health assessment.

The NACCHO Profile asks if community health assessments had been completed in the past three years. When looking at that three-year time period, over one-third of THDs (36.5%) reported they had conducted a community health assessment in the past three years, while half of the matched LHDs (51.1%) conducted a community health assessment in the past three years. This represents a statistically significant difference in the percentage of THDs and LHDs conducting community health assessments ($p < 0.05$).

Table 7 below shows the number and percentage of THDs that did and did not conduct a community health assessment in the past three years by various characteristics, including geographic region, type of IHS funding, type of Tribe (single/consortium), budget size category, and funding source. There were no significant differences in the characteristics explored in Table 7.

[16] Public Health Accreditation Board. Getting Started. Available at http://www.phaboard.org/accreditation-overview/getting-started/

Table 7. Did your THD conduct a community health assessment in the past three years?

	Conducted a Community Health Assessment in the past 3 years		Did Not Conduct a Community Health Assessment in the past 3 years	
	Number (n)	Percentage (%)	Number (n)	Percentage (%)
All				
All THDs	27	36.49	47	63.51
Geographic Region				
North	8	50.00	8	50.00
West	8	34.78	15	65.22
Southwest	5	29.41	12	70.59
South/East	6	33.33	12	66.67
IHS Funding				
Direct Service	1	20.00	4	80.00
IHS 1 +	10	30.30	23	69.70
IHS All	9	45.00	11	55.00
IHS Other	5	41.67	7	58.33
Tribe Type				
Single	19	32.20	40	67.80
Consortium	6	42.86	8	57.14
Budget				
< $1 Million	5	41.67	7	58.33
$1-5 Million	12	30.77	27	69.23
> $5 Million	8	40.00	12	60.00
Funding Source: Tribe/IHS/Other				
Yes	25	39.68	38	60.32
No	1	100	0	0
Funding Source: Federal Grants/State/County/Private Grants				
Yes	22	40.00	33	60.00
No	4	44.44	55	55.56

The average population served by health departments that conducted a community health assessment was 11,245.3 (sd = 17,496.1). For those THDs that did not conduct a community health assessment, the average population served was 6,472.6 (sd = 12,696.6). There was no significant difference between the average populations served by THDs that did and did not conduct a community health assessment.

Discussion

The data collected as part of this study, as well as the more detailed analysis of TPHCA data, yielded important insights related to: 1) comparison of public health services delivery in THDs and LHDs; 2) technical assistance needs of Tribal study participants; and 3) feedback on data collection strategies.

We describe each of these topics below and then conclude this section with an overview of some of the study's limitations and recommendations for future data collection.

Comparison of public health services delivery. 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 childhood immunizations and tobacco 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. It also speaks to the importance of identifying appropriate comparison groups when analyzing data from the TPHCA. After reviewing the information about the size of the population served by THD respondents, the research team determined it was more appropriate to compare Tribal data with information about small LHDs in the same states, rather than with all LHDs, or with state health agencies.

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 jurisdiction. 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 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.

Technical assistance needs. As part of the survey, THD respondents were given the opportunity to identify areas in which technical assistance and/or training would be beneficial. The most common response was related to community assessment. More than half of the respondents who identified a need for technical assistance, described community assessment as a potentially beneficial topic for additional support. In one case, the respondent specified that the interest in community health assessment TA was tied to interest in pursuing accreditation. Focus group participants also talked about the need for resources related to the accreditation prerequisites. In particular, they noted that the components of each prerequisite need to be clearly defined. Tribal models and templates would also be helpful in preparing THDs to apply for accreditation.

One of the other areas commonly cited for technical assistance is quality improvement. Quality improvement initiatives provide the potential for THDs to enhance the effectiveness and efficiency of their services and operations. This is especially critical given the fact that many survey respondents referred to lack of resources and personnel as a barrier for conducting public health activities. Engaging in such initiatives may also help health departments prepare for accreditation, as one of the domains on which applicants are assessed focuses on "evaluating and continuously improving health department processes, programs, and interventions."

Feedback on data collection strategies. Survey respondents and focus group participants also weighed in on the TPHCA instrument. Overall, they viewed the assessment positively and believed it would provide valuable information, particularly for raising awareness about Tribal public health and providing information for grant writing and advocacy. The most common concern from survey respondents was the perception that the instrument is too long. Indeed, some respondents did not answer all of the survey questions. In the recommendations section below, we outline some suggestions that emerged from the survey responses and focus group discussions about ways to strengthen future data collection.

Limitations. The quantitative 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 the universe of 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. Further analysis (Appendix A) shows that a disproportionately large number of respondents failed to answer a particular subset of questions—suggesting 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. However, 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

The study consisted of quantitative analyses of THD and LHD data, as well as qualitative analyses from survey comments and focus groups. These analyses led to a greater understanding of Tribal public health and needs for future data collection activities. With input from the Advisory Committee, a revised TPHCA instrument was developed (Appendix C) and key recommendations for future iterations of data collection were identified:

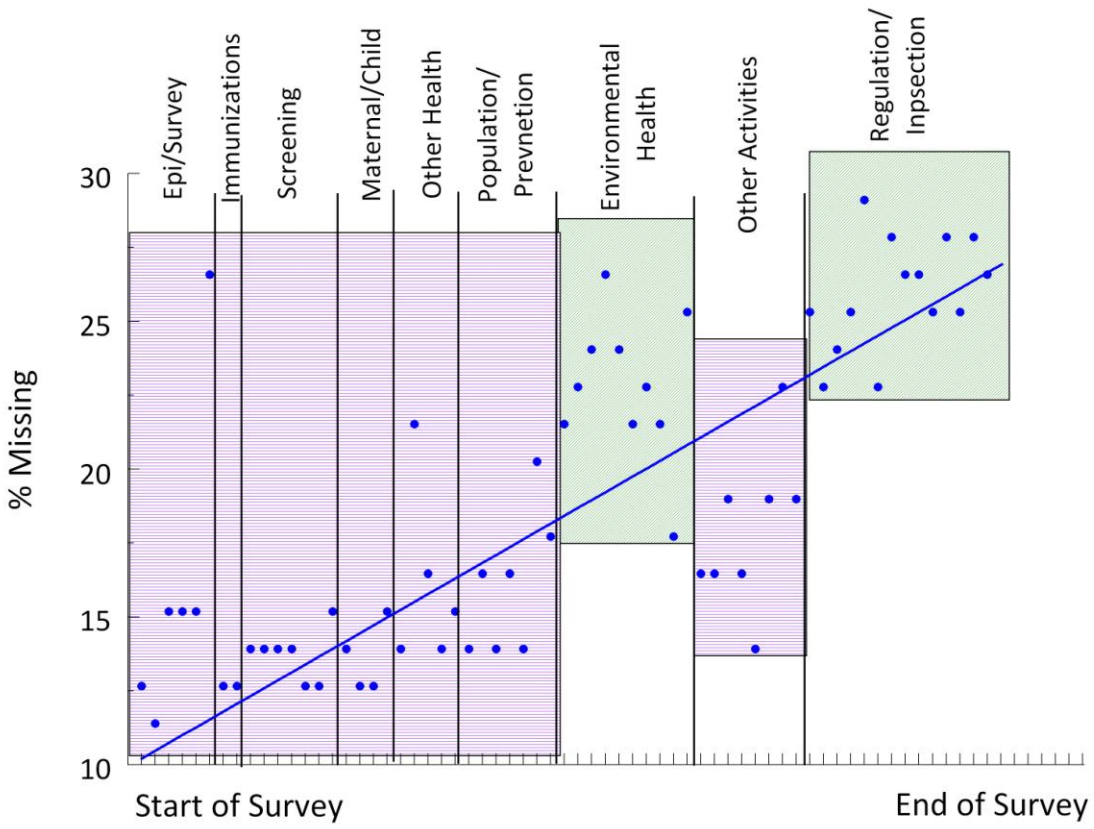
- **Ensure the data needs of THDs continue to be the primary driver for the TPHCA.** In discussions with focus groups and the advisory committee, it was important that the data collected be applicable and useful to Tribes.
- **Harmonize the TPHCA questions with the ASTHO and NACCHO profiles, where possible.** While the needs of THDs should be the primary driver of data collection efforts, harmonization with data collected by ASTHO and NACCHO for any possible data points is essential for more comparable analyses.
- **Consolidate THD surveys, where possible, to decrease the burden on respondents.** Focus group participants expressed confusion between the many surveys collecting data on the various services provided by THDs. To reduce the burden on THDs with limited resources, consolidation of surveys would eliminate duplication of data collected and enhance the quality of data.
- **Consider alternate mechanisms for administering the survey.** In order to bolster response rates, it may be appropriate to offer respondents the option of completing the survey on paper or over the phone.
- **Provide incentives for THDs and education about the benefits of completing to the TPHCA.** Education and incentives may be used to improve response rates for future surveys, as well as increase use of survey findings by THDs.
- **Implement a technical assistance strategy to support the THDs in completing the TPHCA.** Technical assistance regarding survey format and content, such as clarifying definitions, will help to ensure consistent and complete reporting across THDs. Technical assistance activities may include webinars, trainings at NIHB meetings, and one-on-one technical assistance by phone and email.

- **Develop a TPHCA communication plan.** A communication plan should raise awareness about the assessment, its purpose, and use. It should clearly articulate who is collecting the data, how the data will be reported and shared with the Tribes, and if there will be any other ways the data will be shared and protected, if applicable.

Appendix A. Length of Survey: Missing Values

To ascertain if the high level of missing data was due to survey fatigue, the amount of missing answers was studied across the survey from the first question to the last question. Figure 3 shows the scatter plot of the prevalence of missing answers for each question. A regression line was fitted and found that the prevalence of missing answers did increase through the survey (Missing = 0.221*Time + 11.95, t=9.36, p < 0.001).

Figure 3. Prevalence of Missing Answers

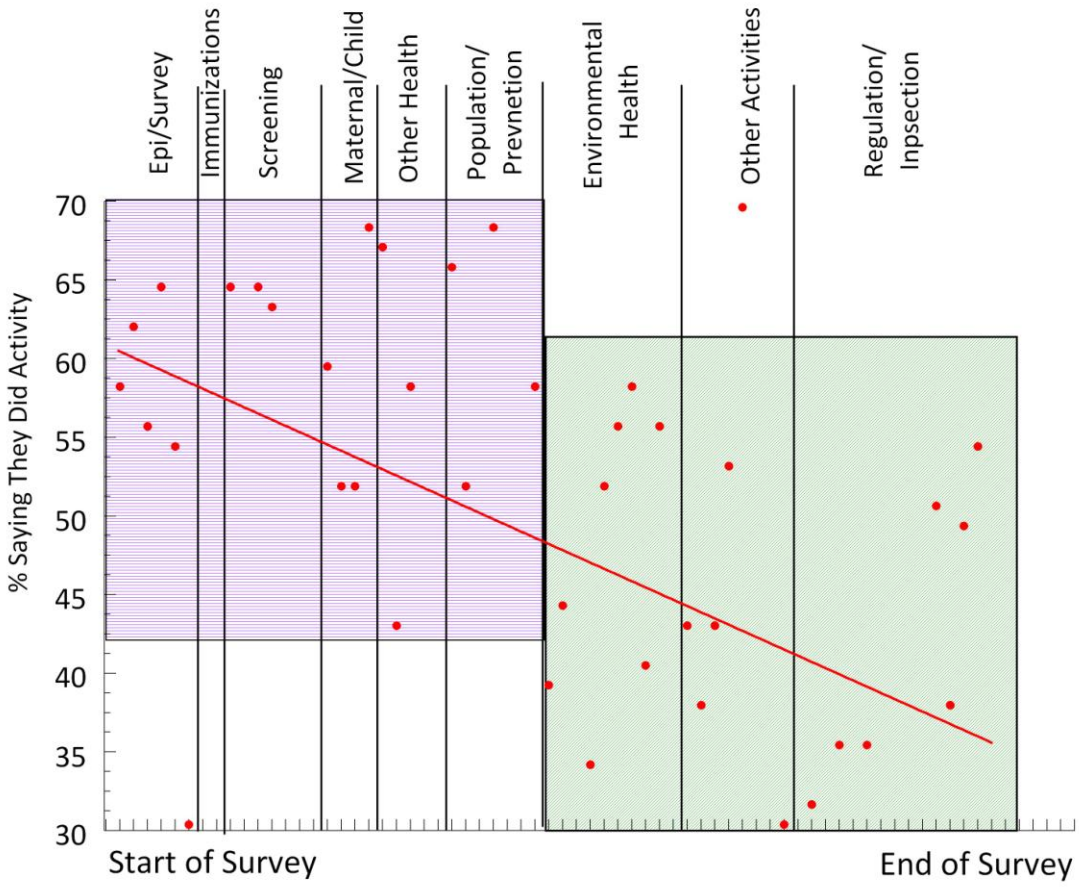


A one-way ANOVA was conducted by grouping the question into categories and comparing the average percent of missing answers between the nine categories. The average percent of missing answers was only significant between the categories Environmental Health and Regulation/Inspection (Table 8, combined mean 24.63% missing) with all the other categories (combined mean 15.61% missing, F = 24.3, p <

0.001). An independent t-test verified this grouping. This finding suggests that the increase in missing answers was not due to length of the survey, but to certain categories creating more missing answers.

It was further hypothesized that the amount of activities that THD respondents reported was related to the length of the survey. Figure 4 shows the scatter plot of the prevalence of activities by questions from first to last. Again a regression equation was fitted and it was significant showing the amount of activities declined as the survey continues (Missing = -0.656*Time + 71.3, t=-6.50, p < 0.001).

Figure 4. Prevalence of Activities



A one-way ANOVA was conducted and we found that categories again made a difference in which activities were performed. THD respondents tended not to report activities in the categories of Environmental Health, Other Activities, and Regulation/Inspection (Table 8, F = 1.11, p < 0.001). Though these activities were at the end of the survey, they were clearly separate in average prevalence of activity performance (Epidemiology/Survey to Population/Prevention mean = 64.03, Environmental Health to Regulation/Inspection mean = 36.91, t = -8.14, p < 0.001).

Table 8. Average Prevalence of Missing Values and Activity Performance by 63 THDs over Survey Duration

Activity	Prevalence Missing			Prevalence Performed	
	n	Mean	St. D.	Mean	St. D.
Activity Categories					
1) Epi/Survey	6	16.033	5.409	54.222	12.285
2) Immunizations	2	12.660	0	72.785	0.898
3) Screening	7	13.741	0.872	70.526	6.999
4) Maternal/Child Health	4	13.607	1.211	57.910	7.826
5) Other Health	5	16.202	3.154	63.546	13.438
6) Population/Prevention	7	16.093	2.393	67.270	9.979
7) Environmental Health	10	22.784	2.460	42.786	12.755
8) Other Activities	8	17.881	2.658	40.031	16.251
9) Regulation/Inspection	14	25.949	1.908	30.921	14.180
Activity Category Groupings					
1 – 6, 8	39	15.612	3.173		
7, 9	24	24.630	2.639		
1 – 6	32			36.907	14.867
7 - 9	31			64.027	11.259

Appendix B. Tribal Public Health Capacity Assessment

Instructions

Thank you for participating in the NIHB Tribal Public Health Capacity Assessment. There are a total of 54 questions about the types of public health activities occurring within the community you serve. You may enter and exit the survey as often as necessary to complete the questionnaire accurately. The estimated time to complete the survey is less than one hour.

We have included a text box after each question(as seen below) where you can enter comments and additional information. Given the diversity and uniqueness across tribal settings, some of the questions may not be worded in a manner that reflects the work that is occurring at your site. If this is the case, please feel free to use the text box to provide relevant information related to the question.

At the end of the questionnaire, there is an opportunity to provide general feedback to NIHB. Your feedback is encouraged as it will improve the assessment process.

PLEASE COMPLETE AND SUBMIT ALL OF YOUR RESPONSES BY DECEMBER 11, 2009.

Thank you for participating in the National Indian Health Board Tribal Public Health Capacity Assessment.

Comment (optional):

Tribal Public Health Department/Organization Characteristics

For purposes of this survey, a Tribal Health Department/Organization (THD/O) is defined as a health department, center or other provider of public health services operated by a tribe, tribal association or consortium of tribes; an Indian Health Service facility; an Area Indian health board/inter tribal council/Tribal EpiCenter; or an urban Indian health center.

Questions 1 through 9 ask for general information about the characteristics of your Tribal Health Department/Organization (THD/O).

1. Which of the following best describes your THD/O?

- Tribe, tribal association, tribal consortium
- Indian Health Service – service unit, hospital, clinic, satellite, center
- Area Indian Health Board, including agencies with a Tribal Epi Centers
- Urban Indian Health Center
- None of the above (please specify)

Tribe Specific

1. Which of the following best describes my THD/O as it relates to IHS funding:

- Direct Service Tribe
- Contract one or more IHS service under P.L. 93-638
- Compact all IHS services under P.L. 93-638
- 638 Contract or compact IHS services through another tribe
- Don’t know/Unsure

Comment (optional):

2. To describe your THD/O, you selected Tribe, tribal association, tribal consortium. Please specify below:

   - Single tribe/nation
   - Tribal Association or Consortium (representing multiple tribes)

   If tribal association or consortium, please enter the number of tribes that make up the association/consortium:

3. How many county(ies) and/or state(s) overlap with your tribal lands? Your best estimate is fine (enter number):

   County(ies) (enter number):

   State(s) (enter number):

   Comment (optional):

1. Are you the Executive Director/Administrator for your THD/O?

   - Yes
   - No

   If no, provide your title and briefly describe your responsibilities

2. What is the total population your THD/O serves? (regardless of whether they access services)

   Your best estimate is fine (enter number):

   Comment (optional):

3. In which Indian Health Service Area is your THD located? Please choose one.

   - Aberdeen
   - Alaska
   - Albuquerque
   - Billings
   - Bemidji
   - California
   - Nashville
   - Navajo
   - Oklahoma
   - Phoenix
   - Tucson
   - Portland

   Comment (optional):

4. What was your THD/O department's total budget for the most recent fiscal year? Please choose one.

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

   Comment (optional):

5. We receive funding and/or grants from the following sources (Please mark yes or no next to each source. If yes, indicate the approximate funding percentage of the total budget):

	Yes	No	0-25%	26-50%	51-75%	76-100%
Tribe						
Indian Health Service						
Federal Grants other than IHS (such as NIH, CDC, SAMSHA, HRSA)						
State						
County						
Private Grants						
In-Kind Donations						
Other						

Comment (optional):

ESSENTIAL SERVICE #1: Monitor Health Status to Identify Community Health P...

The next 5 questions focus on Essential Service #1, which includes accurate, periodic assessment of the community's health status, including health risks, determinants of health, vital statistics, health disparities, and community assets.

1. Have you conducted a community health assessment within the last 3 years? (Choose the best response)

Community assessments includes, but is not limited to, such models such as MAPP, APEX, and the National Public Health Performance Standards (NPHPS).

- Yes, developed and led primarily by the THD/O
- Yes, developed by a coalition (group of partners) with our THD/O as the lead
- Yes, developed and facilitated by an outside party, such as a contractor/consultant, university, local/state health department or other source
- No, it has been more than 3 years
- No, we have never conducted a community health assessment

Comment (optional):

1. Which of the following types of data were included in your most recent community health assessment? (Select all that apply)

    - Demographic characteristics (such as, age, gender, tribal affiliation)
    - Socioeconomic characteristics (such as, education, employment, income)
    - Health resource availability (such as, health insurance, access to health care services, transportation)
    - Quality of Life (such as data related to overall physical and emotional health and wellness)
    - Behavioral risk factors (such as, physical activity, tobacco use, substance use)
    - Social and mental health (such as, substance abuse, mental health disorders, treatment)
    - Maternal and child health (such as, prenatal care, childhood immunizations, well child checks)
    - Death, illness and injury (such as, mortality rates, disease-specific data, accidents)
    - Social and Environmental factors (such as, safe roads, hazardous materials, land use)
    - Other (please specify below)

    Comment (optional):

1. If you have NOT conducted a community health assessment within the last 3 years, what were the most significant barriers? (Check all that apply)

    - Lack of financial resources
    - Not enough staff
    - Need more training on how to conduct a community health assessment
    - Lack of support from tribal leadership
    - It is not one of our priorities
    - Other (please specify below)
    - DOES NOT APPLY

    Comment (optional):

2. Do you plan to conduct a community health assessment within the next 3 years?

    - Yes
    - No

    Comment (optional):

3. Data are often shared among multiple agencies through data sharing agreements.

    Examples of shared data include epidemiology or surveillance (such as, immunization, tobacco use, diabetes prevalence, vital statistics, infectious disease incidences), emergency preparedness, inspections, clinical services, administrative services and other public health services.

    Indicate which of the following agencies have a data sharing agreement with your THD/O: (Check all that apply)

    - Local Tribe(s)
    - Indian Health Service
    - Area Health Board, including inter tribal councils
    - Tribal EpiCenters
    - Federal agency other than IHS (please specify)
    - Local/County Health Department
    - State Health Department
    - Private or non-governmental health care facility
    - Other (please specify below)
    - We do not have a data sharing agreement with another agency

    Comment (optional):

4. Which of the following best describes the nature of the data sharing agreement? (Select only one)

- Formal written agreement
- Informal agreements
- Some formal and some informal
- Does not apply

Comment (optional):

ESSENTIAL SERVICE #2 : Diagnose and Investigate Health Problems and Health...

The next 3 questions focus on Essential Service #2, which includes epidemiological investigations of disease outbreaks and patterns of infectious and chronic diseases and injuries, environmental hazards and other health threats.

1. Do you have staff dedicated to data management (such as, collecting, analyzing, and monitoring data)?

- Yes, part-time
- Yes, full-time
- No, we do not have staff dedicated to data management

Comment (optional):

2. EPIDEMIOLOGY AND SURVEILLANCE ACTIVITIES

For each public health activity in the following charts, check all activities that are currently conducted for your community and by which public health entity.

- If the activity was provided by more than one entity, then select all entities that provided that service to your service population.

	Tribe or Tribal Association/ Consortium	IHS	Area Indian Health Board	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Done by Someone Else	Not Available in Service Area	Unknown
Communicable/Infectious disease										
Chronic disease										
Injury										
Behavioral risk factors										
Environmental health										
Sentinel Event surveillance										

Comment (optional):

3. For each of the following activity or service that is conducted by your THD/O and please share how the records are kept. (Check all that apply)

	Paper Spreadsheet (MS Excel)	Local Relational Database (MS Access, SPSS)	Shared Database (web based or special server, RPMS)	DOES NOT APPLY
Childhood Immunization				
Reportable Diseases				
Vital Records				
Laboratory Reporting				
Outbreak Management				

Comment (optional):

ESSENTIAL SERVICE #3: Inform, Educate and Empower People about Health Issues

The next 7 questions focus on what health activities are conducted in your community and by who. Such activities include health information, health education and health promotion activities designed to reduce health risk and promote better health.

1. IMMUNIZATIONS

For each public health activity in the following charts, check all activities that are currently conducted for your community and by which public health entity, including your own.

- If the activity was provided by more than one entity, then select all entities that provided that service to your service population.

Check all that apply.

	Tribe or Tribal Association/ Consortium	IHS	Area Indian Health Board	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Done by Someone Else	Not Available in Service Area	Unknown
Childhood Immunizations										
Adult Immunizations										

Comment (optional):

2. SCREENING FOR DISEASES/CONDITIONS

For each public health activity in the following charts, check all activities that are currently conducted for your community and by which public health entity, including your own.

- If the activity was provided by more than one entity, then select all entities that provided that service to your service population.

Check all that apply.

	Tribe or Tribal Association/ Consortium	IHS	Area Indian Health Board	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Done by Someone Else	Not Available in Service Area	Unknown
HIV/AIDS										
Other STDs										
Tuberculosis										
Cancer										
Cardiovascular disease										
Diabetes										
High Blood Pressure										

Comment (optional):

3. MATERNAL AND CHILD HEALTH

For each public health activity in the following charts, check all activities that are currently conducted for your community and by which public health entity, including your own.

- If the activity was provided by more than one entity, then select all entities that provided that service to your service population.

Check all that apply.

	Tribe or Tribal Association/ Consortium	IHS	Area Indian Health Board	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Done by Someone Else	Not Available in Service Area	Unknown
Family Planning										
Prenatal Care										
WIC										
Well Child Care										

Comment (optional):

4. OTHER HEALTH SERVICES

For each public health activity in the following charts, check all activities that are currently conducted for your community and by which public health entity, including your own.

- If the activity was provided by more than one entity, then select all entities that provided that service to your service population.

Check all that apply.

	Tribe or Tribal Association/ Consortium	IHS	Area Indian Health Board	Epi Center	Urban Health Center	State	Local City/ County	Done by Someone Else	Not Available in Service Area	Unknown
Comprehensive Primary Care										
Home health care (e.g., disabled, elder care)										
Oral Health										
Behavioral health										
Substance abuse services										

Comment (optional):

5. POPULATION-BASED PRIMARY PREVENTION ACTIVITIES

Population-based primary prevention activities include health education, outreach, and information sharing activities that your THD/O does to promote healthy behaviors in your community.

For each health prevention activity in the following charts, check all activities that are currently conducted for your service community and by which public health entity, including your own.

- If the activity was provided by more than one entity, then select all entities that provided that service to your service population.

Check all that apply.

	Tribe or Tribal Association/ Consortium	IHS	Area Indian Health Board	Epi Center	Urban Health Center	State	Local City/ County	Done by Someone Else	Not Available in Service Area	Unknown
Unintentional Injury (including child safety, seat belt use)										
Unintended pregnancy (family planning)										
Chronic disease program (including diabetes, obesity, cardiovascular)										
Violence (including domestic violence, relationship violence, bullying)										
Tobacco										
Culturally based prevention programs										
Asthma										

Comment (optional):

6. ENVIRONMENTAL HEALTH ACTIVITIES

For each public health activity in the following charts, check all activities that are currently conducted for your community and by which public health entity, including your own.

- If the activity was provided by more than one entity, then select all entities that provided that service to your service population.

Check all that apply.

	Tribe or Tribal Association/ Consortium	IHS	Area Indian Health Board	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Done by Someone Else	Not Available in Service Area	Unknown
Indoor air quality										
Food safety education										
Radiation control										
Vector control										
Land use planning										
Groundwater protection										
Surface water protection										
Hazmat response										
Hazardous waste disposal										
Air pollution										

Comment (optional):

7. OTHER ACTIVITIES

For each public health activity in the following charts, check all activities that are currently conducted for your service community and by which public health entity.

- If the activity was provided by more than one entity, then select all entities that provided that service to your service population.

Check all that apply.

	Tribe or Tribal Association/ Consortium	IHS	Area Indian Health Board	Epi Center	Urban Health Center	Local City/ County Health Dept	Done by Someone Else	Not Available in Service Area	Unknown
Emergency medical services									
Animal control									
Occupational safety and health									
Laboratory services									
Outreach and enrollment for Medicaid/Medicare									
School-based clinics									
Tribal correctional health									
Vital records									

Comment (optional):

ESSENTIAL SERVICE #4: Community Engagement: Mobilize Community Partnerships

ESSENTIAL SERVICE #4: Community Engagement: Mobilize Community Partnerships to Identify and Solve Health Problems includes identifying potential stakeholders who contribute to or benefit from public health and increase their awareness of the value of public health. It also includes building partnerships to engage in health improvement activities.

1. How effective would you rate your collaboration with the following organizational partners to improve the health status of your community?

	Highly Effecti ve	Effective	Neutral	Could Be More Effective	Not Effective	Does Not Apply
Neighboring Tribe (s)						
Area Health Board						
Indian Health Service						
Bureau of Indian Affairs (BIA)						
Hospital						
Tribal Epi Center						
Tribal College/University						
Other College/University						
College/School of Public Health						
State Government						
Local County/City Government						
Other (please specify)						

Comment: optional

ESSENTIAL SERVICE #5: Develop Policies and Plans

The next 8 questions focus on ESSENTIAL SERVICE #5, which is to develop policies and plans that support individual and community health efforts. This includes effective governmental presence at the tribal level, development of policy to protect the health of the public and guide the practice of public health, systematic community level planning for health improvement and public health emergency response.

1. Is there a Health Committee, Board, or other group that meets regularly to provide oversight, advise, and/or approve major decisions and/or makes recommendations to your THD/O?

- Yes
- No

If yes, briefly describe:

Health Committees/Boards

1. 1. Which of the following describes the membership of your Health Committee, Board or Group? (Check all that apply)

    - Elected tribal council members
    - Elected regional tribal council members representing districts or communities of the tribe
    - Appointed community members
    - Volunteer community members
    - Department directors
    - Program managers
    - I.H.S. representatives
    - Outside consultants, contractors, or partner service providers
    - Other

    Comment (optional):

2. Which of the following best describes the activities of the Health Committee, Board, or Group:

    - Advisory role to programs and services
    - Policy planning and development
    - Review research and evaluation proposals or requests
    - Inform and advocate on behalf of community (community engagement)
    - Oversight of emergency preparedness plans
    - Develop community partnerships through formal agreements (such as inter-governmental agreements, Memorandum of Understanding, contracts)
    - Oversight of assessment and evaluation activities (such as health status, workforce, technology)
    - Other

    Comment: Optional

Emergency Preparedness

1. Does your THD/O receive any funding from your state health agency through the CDC public health preparedness cooperative agreement?

    - Yes
    - No

    Comment (optional):

1. Are any of your staff (regular or contract staff) supported using funds through any of the CDC public health emergency preparedness cooperative agreement?

    - No staff are supported by this funding source
    - Yes, Full time staff supported by this funding source
    - Yes, part time staff supported by this funding source

    Comment (optional):

Emergency Preparedness and Response Plans

1. Which of the following emergency preparedness activities has YOUR THD/O led in the past 2 years? (Check all that apply)

    - Created an emergency response plan
    - Participated in drills or exercises
    - Assessed emergency preparedness competencies of staff based on the nine core Emergency Preparedness Competencies and the THD/O all hazards response plan
    - Developed written mutual aid agreements with neighboring or regional local health departments, I.H.S., other
    - None of the above

    Comment (optional):

2. Do you participate in a task force or coalition of community partners that is LED BY ANOTHER AGENCY to develop and maintain local and/or regional emergency preparedness and response plans?

    - Yes
    - No

    Comment (optional):

3. Which of the following emergencies are provided for in the preparedness plan, whether it's led by your THD/O or other agency? (Check all that apply)

    - Chemical spills or releases
    - Water-borne outbreaks
    - Infectious disease(such as Hepatitis outbreak, TB outbreak)
    - Food-Borne outbreaks
    - Natural disasters and severe weather
    - Radioactive material spill or leak
    - Exposure to biological agents (such as anthrax, plague)
    - Pandemic Flu (H1N1 (swine flu), avian flu)
    - Other (please specify below)

    Comment (optional):

ESSENTIAL SERVICE #6: Enforce Laws and Regulations that Protect Health and ...

The next 3 questions focus on the review, evaluation and revision of laws, regulations and ordinances designed to protect health and safety; education of persons and entitles obligated to obey and to enforce laws, regulations and ordinances in order to encourage compliance; and enforcement activities of public health concern.

1. Has a new local public health policy, ordinance or regulation been adopted by your THD/O in the past 2 years?

    - Yes
    - No

    Comment (optional):

1. Please indicate each area in which a new local public health ordinance or regulation was adopted in the past 2 years. (Select all that apply)

    - Emergency Preparedness and Planning
    - Research , Data ownership and Community protection
    - Occupational Health and Safety
    - Environmental (such as indoor air, water, soil quality)
    - Land use planning (such as natural resources, transportation, parks)
    - Tobacco prevention and control
    - Some other (please specify in the comment box below)
    - None

    Comment (optional):

Regulation, Inspection and/or Licensing Activities

1. REGULATION, INSPECTION AND/OR LICENSING ACTIVITIES

For each public health activity in the following charts, check all activities that are currently conducted for your service community and by which public health entity, including your own.

- If the activity was provided by more than one entity, then select all entities that provided that service to your service population.

Check all that apply.

	Tribe or Tribal Association/ Consortium	IHS	Area Indian Health Board	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Done by Someone Else	Not Available in Service Area	Unknown
Mobile Homes										
Solid waste disposal sites										
Solid waste haulers										
Septic systems										
Hotels/motels										
Schools/daycare/Head Start										
Swimming pools										
Tobacco Retailers (smokeshops)										
Smoke-free ordinances										
Lead/Asbestos inspection										
Public/private drinking water										
Food service establishments (casinos)										
Health-related facilities										
Housing (inspections)										

Comment (optional):

ESSENTIAL SERVICE #7: Outreach, Referral or Services: Link People to Needed...

A THD/O supports and coordinates partnerships and referral mechanisms among the community's public health, primary care, oral health, social service, and mental health systems to increase access to needed health services. The next 3 questions focus on Essential Service #7.

1. What is the furthest distance (in miles) that your user population has to travel to obtain primary health care in your community (if applicable)?

   Please enter your best estimate.

   Comment (optional):

2. VULNERABLE POPULATIONS

   For each vulnerable population listed in the following chart, indicate who currently provides services within your community, including your own THD/O.

   - If the activity was provided by more than one entity, then select all entities that provide that service to your service population.

   Check all that apply.

	Tribe or Tribal Association/ Consortium	IHS	Area Indian Health Board/Tribal Council/Epi Center	Urban Health Center	Done by Someone Else	Not Available in Service Area	Unknown
Persons 65 years of age and older							
Persons with physical disabilities							
Persons with mental illness							
Persons recently released from incarceration							
Lesbian, gay,bisexual, and trans-gendered individuals							
Persons with addictions							

   Comment (optional):

3. Does your THD/O have initiatives or mechanisms in place to enroll eligible individuals in public benefit programs, such as Medicaid/Medicare programs?

   - Yes
   - No

   If yes, please describe. (Other comment optional)

ESSENTIAL SERVICE #8: Assure a Competent Public and Personal Health Care Workforce

The next 3 questions ask for general characteristics about the public health workforce at your THD/O.

1. How many individuals currently work for your THD/O in the following categories? (Please enter number)

   Regular full-time (40 hours per week)

   Part-time (less than 40 hours per week)

   Contractual employees

   Comment (optional):

2. How many of the staff working at your THD/O are members of federally recognized tribes?

   Enter number:

   Comment (optional):

3. OCCUPATIONS EMPLOYED

   Indicate which of the following categories of health workers are currently employed by your THD/O.

   - Health program managers, administrators, health service directors
   - Registered nurse (including public health nurse, school nurse, community health nurse, LPNs)
   - Nurse practitioner, physician assistant
   - Physician
   - Community Health Representatives
   - Environmental health specialists
   - Epidemiologist/Statistician
   - Health Educator
   - Nutritionist/dietitian
   - Dentist
   - Traditional Healer
   - Alternative Medicine
   - Information systems specialist
   - Behavioral health professional (counsel worker, case manager, intake specialist
   - Emergency preparedness
   - Administrative Clerical

   Comment (optional)

ESSENTIAL SERVICE #9: Evaluate Effectiveness, Accessibility and Quality of...

This service encompasses the quantitative and qualitative assessment of the impact of health services. Activities include but are not limited to measuring change in clinical and health outcomes such as blood pressure, lipid levels, weight, fitness performance, dental caries, and/or response on a behavioral questionnaire.

1. In the past 3 years, has your THD/O participated in any of the following evaluation activities of your population-based health services?

   Examples of population-based health services include outreach, education, other services that aim to promote wellness and prevent disease, such as physical activity promotion, overweight and obesity prevention, tobacco use prevention, substance abuse prevention, injury prevention, and STD prevention.

   - Identified criteria to be used to evaluate population-based services
   - Established program goals related to access, quality, and effectiveness of services
   - Evaluated population-based health services
   - Assessed community satisfaction with population-based health services
   - Identify gaps in the provision of population-based services
   - Use evaluation results in the development of your strategic and operational plans

ESSENTIAL SERVICE #10: Research for New Insights and Innovative Solutions t...

The next 3 questions explore research activities to inform public health strategies and guide intervention activities.

1. Which of the best describes your THD/O's experience with health research? (Check all that apply)

    - We are currently participating in health research
    - We have participated in health research in the past
    - We plan to participate in health research in the future
    - We have never participated in health research
    - We have no plans to participate in health research in the future

    Comment (optional):

2. Does your THD/O have a policy or ordinance that outlines protocols for reviewing and participating in health research?

    - Yes
    - No

    If yes, please describe (comment optional):

3. Do you have a formal research review committee or board?

    - Yes
    - No

    Comment (optional):

4. Please provide a brief description of your research review and approval process:

    Some examples include a formal IRB that follows federal guidelines; a Health Board/Committee that reviews and approves research and then recommends to Tribal Council or Governing Board; or all research reviewed approved by Tribal Council only.

    - Open-ended response

Concluding Questions

1. What areas of technical assistance and/or training do you think would be of greatest benefit to your THD/O?

    Areas to consider include, but are not limited to, data use and interpretation, community assessment, quality improvement, promising public health practices, community based participatory research, media literacy and public promotion, and advocacy at local, state, and federal level.

    - Open-ended response

2. What work are you doing to improve health services at your THD/O that is unique and successful and can be shared with other THD/O's? Consider unique partnerships, agreements, services, policies, or other areas that have had significant impact in the work that you are doing to serve your community.

    - Open-ended response

3. Please rate ease/difficulty in completing the questionnaire:

   - Very simple
   - Simple
   - Not simple, not difficult
   - Difficult
   - Very difficult

   Comment (optional)

3. Please rate ease/difficulty in completing the questionnaire:

   - Very simple
   - Simple
   - Not simple, not difficult
   - Difficult
   - Very difficult

   Comment (optional)

4. What is the approximate amount of time that it took to complete the assessment?

   - Open-ended response

5. 5. Please provide any feedback or additional comments related to the assessment.

   - Open-ended response

1. Thank you for participating in the NIHB Tribal Public Health Capacity Assessment PILOT TEST. Please provide contact information below in case any follow-up is needed.

   Name:

   Email Address:

   Phone Number:

Appendix C. Revised Tribal Public Health Capacity Assessment

Instructions

Thank you for participating in the NIHB Tribal Public Health Capacity Assessment. There are a total of 56 questions about the types of public health activities occurring within the community you serve. You may enter and exit the survey as often as necessary to complete the questionnaire accurately. The estimated time to complete the survey is less than one hour.

We have included a text box after each question (as seen below) where you can enter comments and additional information. Given the diversity and uniqueness across tribal settings, some of the questions may not be worded in a manner that reflects the work that is occurring at your site. If this is the case, please feel free to use the text box to provide relevant information related to the question.

At the end of the questionnaire, there is an opportunity to provide general feedback to NIHB. Your feedback is encouraged as it will improve the assessment process.

PLEASE COMPLETE AND SUBMIT ALL OF YOUR RESPONSES BY [DATE].

Thank you for participating in the National Indian Health Board Tribal Public Health Capacity Assessment.

1. Comment (optional):

2. For purposes of this survey, a Tribal Health Department is the governmental department or division responsible for serving the jurisdiction and members of a federally recognized Tribe. This includes Tribal governments, Tribal organizations or inter-Tribal consortia, as defined in the Indian Self-Determination and Education Assistance Act, as amended. Such departments have the jurisdictional authority to provide public health (community and/or population-based) services to promote and protect the Tribe's overall health, wellness and safety; prevent disease; and respond to issues and events.

   Which of the following best describes your THD?

   - Tribal consortium (primarily in California)
   - Tribal IRA (Indian Reorganization Act) (primarily in Alaska)
   - Tribe
   - None of the above (please specify)

Tribal Public Health Department Characteristics

3. Which of the following describes your THD as it relates to IHS funding? (Terms are defined below.) (Select all that apply)

   - Direct Service Tribe
   - Contract one or more IHS service under P.L. 93-638
   - Compact all IHS services under P.L. 93-638
   - 638 Contract IHS services through another tribe
   - Compact IHS services through another tribe
   - Don't know/Unsure

   Comment (optional):

   Please refer to the following definitions:

   - Direct Service Tribe – A tribe that receives their health care through the Indian Health Service is considered a direct service tribe.
   - Contract Services – Under Public Law 93-638, a tribe can contract with Indian Health Service to take over the management of specific programs.
   - Compact Services – Under Public Law 93-638, a tribe may seek eligibility to compact health services provided by the Indian Health Service. A compact is more like a block grant than a contract, giving a tribe greater management and administrative authority to administer health services.

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

4. What your title or role with regard to the tribal health department?

   - Tribal Leader, Tribal Council, Chief
   - Head of the THD
   - Other

   Please provide your title:

5. What is the total population your THD serves? (regardless of whether they access services)

   - Your best estimate is fine (enter number):

   Comment (optional):

6. In which Indian Health Service Area is your THD located? Please choose one.

   - Aberdeen
   - Alaska
   - Albuquerque
   - Billings
   - Bemidji
   - California
   - Nashville
   - Navajo
   - Oklahoma
   - Phoenix
   - Tucson
   - Portland

   Comment (optional):

7. a. What was your THD department's total budget for the most recent fiscal year? Please choose one.

- $1-$500,000
- $501,000 -$1,000,000
- $1,000,001 - $2,500,000
- $2,500,001 - $5,000,000
- $5,000,001 - $7,500,000
- $7,500,001 - $10,000,000
- $10,000,001 - $15,000,000
- More than $15,000,000

Comment (optional):

b. What percentage is for clinical care?

Enter number between 0 and 100:

8. What percentage, if any, of your total budget is from funding and/or grants from the following sources: (Please select one option in each row)

	We receive no funding or grants from this source	1-25%	26-50%	51-75%	76-100%	We receive funding from this source, but I do not know the percentage
Tribe						
Indian Health Service (compact/contract services)						
Federal Grants other than IHS (such as NIH, CDC, SAMSHA, HRSA)						
State (do NOT include Medicaid)						
County						
Third party collections (Medicaid, Medicare, private insurance, or other)						
Private Grants						
In-Kind Donations						
Other						

Comment (optional):

ESSENTIAL SERVICE #1: Monitor Health Status to Identify Community Health P...

9. Has a community health assessment been completed within your community? (Choose the best response)

Community health assessment can be defined as regularly and systematically collecting, analyzing, and making available information on the health of a community, including statistics on health status, community health needs, epidemiologic and other studies of health problems, and an analysis of community strengths and resources. Community health assessments can be conducted using such models such as MAPP, APEX, the National Public Health Performance Standards Program (NPHPSP), or other models.

- Yes, within the last three years
- Yes, more than three but less than five years ago
- Yes, five or more years ago
- No, but plan to in the next year
- No

Comment (optional):

10. [If response to prior question is Yes (options a-c) ask the following questions]

a. Which of the following best describes the role of the THD in developing the community health assessment?

- The THD developed and primarily led the community health assessment
- The THD led a coalition (group of partners) in developing the community health assessment
- The THD participated in a process that was led by another entity
- The THD was not involved in the development of the community health assessment

Comment (optional):

b. What other organizations played a leading role in the development of the community health assessment? (Select all that apply)

- Non-profit hospital
- For-profit hospital
- Tribal Epi Center
- Local city/county health department
- State health department
- IHS
- Universities or colleges
- Nonprofit health organizations
- Schools
- Other: please specify

Comment (optional):

11. [Add skip logic so this question is not asked of respondents who did not complete a Community Health Assessment]

Which of the following types of data were included in your most recent community health assessment? (Select all that apply)

- Demographic characteristics (such as, age, gender, tribal affiliation, language spoken)
- Socioeconomic characteristics (such as, education, employment, income)
- Health resource availability (such as, health insurance, access to health care services, transportation)
- Quality of Life (such as, data related to overall physical and emotional health and wellness)
- Behavioral risk factors (such as, physical activity, tobacco use, substance use)
- Mental health (such as, substance abuse, mental health disorders, treatment)
- Maternal and child health (such as, prenatal care, childhood immunizations, well child checks)
- Death, illness and injury (such as, mortality rates, disease-specific data, accidents)
- Environmental factors (such as, safe roads, hazardous materials, land use)
- Other (please specify below)
- None of the above

Comment (optional):

12. [Add skip logic so only asked of health departments that said they have not conducted a CHA]

If there is not a community health assessment for your community, what were the most significant barriers? (Select all that apply)

- Lack of financial resources
- Not enough staff
- Need more training on how to conduct a community health assessment
- Lack of support from tribal leadership
- It is not one of our priorities
- Other (please specify below)
- None of the above

Comment (optional):

13. When do you next plan to conduct a community health assessment?

- In the next 1-2 years
- In 3-5 years
- In more than 5 years
- We do not intend to conduct a community health assessment in the future

Comment (optional):

14. Data are often shared among multiple agencies through data sharing agreements.

    Indicate which of the following organizations have a data sharing agreement with your THD: (Check all that apply)

    - Local Tribe(s)
    - Indian Health Service
    - Area Health Board, including inter tribal councils
    - Tribal EpiCenters
    - Federal agency other than IHS (please specify)
    - Local/County Health Department
    - State Health Department
    - Private or non-governmental health care facility
    - Universities or colleges
    - Other (please specify below)
    - We do not have a data sharing agreement with another organization

    Comment (optional):

15. Which of the following best describes agreements that your THD has with other organizations with whom it shares data:

    - Formal written agreements with every organization with whom we share data
    - Formal written agreements with some organizations with whom we share data
    - Informal agreements with all organizations with whom we share data
    - Informal agreements with some organizations with whom we share data
    - No agreements

    Comment (optional):

16. To be eligible for public health accreditation, a Tribal Health Department must have the authority to provide public health services to the community, as evidenced by the Tribe's constitution, Tribal Council resolution, executive order, or other legal means.

    By which of the following has the Tribal Council granted authority to the Tribal Health Department to provide health services to the community (mark all that apply):

    - Constitution
    - Tribal Resolution
    - Public health and safety code or ordinance
    - Executive Order
    - Other legal means (please specify): _____
    - The Tribal Health Department does not have a code, policy or other legal document granting authority to provide health services to the community

    Comment (optional):

ESSENTIAL SERVICE #2 : Diagnose and Investigate Health Problems and Health ...

17. Do you have staff dedicated to data management (such as, collecting, analyzing, and monitoring data)?

    - Yes, part-time
    - Yes, full-time
    - No, we do not have staff dedicated to data management

    Comment (optional):

18. EPIDEMIOLOGY AND SURVEILLANCE ACTIVITIES

For each public health activity in the following charts, check all activities that are currently conducted for your community and by which public health entity. Indicate which one is the primary provider.

- If the activity is provided by more than one entity, then select all entities that provided that service to your service population.

-If an entity provides technical assistance or other support to help you provide the services, please place a check in the appropriate column.

	Tribe or Tribal Association/Consortium*	IHS	Area Indian Health Board/Inter Tribal Council	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Other federal agency	Done by Someone Else	Not Available in Service Area	Unknown
Communicable/ Infectious disease											
Chronic disease											
Injury											
Behavioral risk factors											
Environmental health											
Sentinel Event surveillance											

Comment (optional):

*If the specified service is carried out by any agency within your Tribe, please place a check in this column.

19. For each of the following activities or services that is conducted by your THD, please share how the records are kept. (Check all that apply)

	Paper Spreadsheet (MS Excel)	Local Relational Database (MS Access, SPSS)	Shared Database (web based or special server, RPMS)	DOES NOT APPLY
Newborn Screening				
Childhood Immunizations				
Reportable Diseases				
Vital Records (i.e., birth and death records)				
Laboratory Reporting				
Outbreak Management				

Comment (optional):

ESSENTIAL SERVICE #3: Inform, Educate and Empower People about Health Issues

20. Immunizations

	Tribe or Tribal Association/Consortium*	IHS	Area Indian Health Board/Inter Tribal Council	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Other federal agency	Done by Someone Else	Not Available in Service Area	Unknown
Childhood immunizations											
Adult immunizations											

Comment (optional):

21. Screening for Diseases and Conditions

	Tribe or Tribal Association/Consortium*	IHS	Area Indian Health Board/Inter Tribal Council	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Other federal agency	Done by Someone Else	Not Available in Service Area	Unknown
HIV/AIDS											
Other STDs											
Tuberculosis											
Cancer											
Cardiovascular disease											
Diabetes											
High blood pressure											

Comment (optional):

22. Maternal and Child Health

	Tribe or Tribal Association/Consortium*	IHS	Area Indian Health Board/Inter Tribal Council	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Other federal agency	Done by Someone Else	Not Available in Service Area	Unknown
Family Planning											
Prenatal Care											
WIC											
Well Child Clinic											

Comment (optional):

23. Other Health Services

	Tribe or Tribal Association/Consortium*	IHS	Area Indian Health Board/Inter Tribal Council	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Other federal agency	Done by Someone Else	Not Available in Service Area	Unknown
Comprehensive primary care											
Home health care (e.g., disabled, elder care)											
Oral health											
Behavioral health											
Substance abuse services											

Comment (optional):

24. Population Based-Primary Prevention Activities

	Tribe or Tribal Association/Consortium*	IHS	Area Indian Health Board/Inter Tribal Council	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Other federal agency	Done by Someone Else	Not Available in Service Area	Unknown
Unintentional Injury (including child safety, seat belt use)											
Unintended pregnancy (family planning)											
Chronic disease program (including diabetes, obesity, cardiovascular)											
Violence (including domestic violence, relationship violence, bullying)											
Tobacco											
Culturally based prevention programs											
Asthma											

Comment (optional):

25. Environmental Health Activities

	Tribe or Tribal Association/Consortium*	IHS	Area Indian Health Board/Inter Tribal Council	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Other federal agency	Done by Someone Else	Not Available in Service Area	Unknown
Indoor air quality											
Food safety education											
Radiation control											
Vector control											
Land use planning											
Groundwater protection											
Surface water protection											
Hazmat response											
Hazardous waste disposal											
Air pollution											

Comment (optional):

26. Other Activities

	Tribe or Tribal Association/Consortium*	IHS	Area Indian Health Board/Inter Tribal Council	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Other federal agency	Done by Someone Else	Not Available in Service Area	Unknown
Emergency medical services											
Animal control											
Occupational safety and health											
Laboratory services											
Outreach and enrollment for Medicaid/Medicare											
School-based clinics											
Health care in Tribal correctional facilities											
Vital records (i.e., birth and death records)											

Comment (optional):

ESSENTIAL SERVICE #4: Community Engagement: Mobilize Community Partnerships

27. How effective would you rate your collaboration with the following organizational partners to improve the health status of your community?

	Highly Effective	Effective	Neutral	Could Be More Effective	Not Effective	Does Not Apply
Neighboring Tribe (s)						
Area Health Board/Inter Tribal Council						
Indian Health Service						
Bureau of Indian Affairs (BIA)						
Hospital						
Tribal Epi Center						
Tribal College/University						
Other College/University						
College/School of Public Health						
State Government						
Local County/City Government						
Other (please specify)						

Comment (optional):

ESSENTIAL SERVICE #5: Develop Policies and Plans

28. a. Has your THD participated in developing a health improvement plan for your community?

A **community health improvement plan** can be defined as a long-term, systematic effort to address health problems. This plan is used by health and other government education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources.

- Yes, within the last three years
- Yes, more than three but less than five years ago
- Yes, five or more years ago
- No, but plan to in the next year
- No

Comment (optional):

[if answer a-c]

b. Was the health improvement plan developed using data from the community health assessment?

- Yes
- No
- I don't know

29. a. Has your LHD developed a comprehensive, agency-wide strategic plan?

- Yes, within the last three years
- Yes, more than three but less than five years ago
- Yes, five or more years ago
- No
- No, but plan to in the next year

Comment (optional):

[if answer a-c]

b. What is the status of your agency's implementation of its strategic plan?

- Not yet implemented
- Implemented in the past year
- Implemented more than one year ago; a written evaluation on progress toward strategic plan goals, objectives, or targets has not yet been conducted
- Implemented more than one year ago
- I don't know

30. Is there a Health Committee, Health Board, or other advisory health group that provides oversight, advises, and/or approves major decisions and/or makes recommendations to your THD?

- Yes
- No

Comment (optional):

Health Committees/Boards

31. [add skip logic here, so only asked of respondents that report having a health/committee, etc]

Which of the following describes the membership of your Health Committee, Health Board or other advisory health group? (Check all that apply)

- Elected tribal council members
- Elected regional tribal council members representing districts or communities of the tribe
- Appointed community members
- Volunteer community members
- Department directors
- Program managers
- IHS representatives
- Outside consultants, contractors, or partner service providers
- None of the above
- Other

Comment (optional):

32. Which of the following describe the activities of the Health Committee, Health Board, or other advisory health group: (Select all that apply)

- Lead and/or engage in policy planning and development (e.g., public health regulations)
- Serve in an advisory role to programs and services
- Review research and evaluation proposals or requests that involve outside entities
- Inform and advocate on behalf of community (community engagement)
- Provide oversight of emergency preparedness plans
- Develop community partnerships through formal agreements (such as inter-governmental agreements, Memoranda of Understanding, contracts)
- Review health budget
- Advise Tribal health department or Tribal council (i.e., elected officials) on policies, programs, and budgets
- Set policies, goals, and priorities that guide the THD
- None of the above
- Other

Comment (optional):

Emergency Preparedness

33. Does your THD receive any funding from your state health agency through the CDC public health preparedness cooperative agreement?

- Yes
- No
- I don't know

Comment (optional):

34. Are any of your staff (regular or contract staff) supported using funds through the CDC public health emergency preparedness cooperative agreement?

- No staff are supported by this funding source
- Yes, at least one full-time staff member is supported by this funding source
- Yes, at least one part-time staff member is supported by this funding source
- I don't know

Comment (optional):

Emergency Preparedness and Response Plans

35. Which of the following emergency preparedness activities has YOUR THD led in the past 2 years? (Check all that apply)

- Created an emergency response plan
- Conducted drills or exercises
- Assessed emergency preparedness competencies of staff based on the nine core Emergency Preparedness Competencies and the THD all hazards response plan
- Developed written mutual aid agreements with neighboring or regional local health departments, IHS, other
- None of the above
- I don't know
- Other (please specify)

Comment (optional):

36. Do you participate in a task force or coalition of community partners to develop and maintain local and/or regional emergency preparedness and response plans?

- Yes, led the task force or coalition
- Yes, participated in task force or coalition led by another agency
- No

Comment (optional):

37. Which of the following emergencies are provided for in the preparedness plan, whether it is led by your THD or other agency? (Check all that apply)

- Chemical spills or releases
- Water-borne outbreaks
- Infectious disease (such as Hepatitis outbreak, TB outbreak)
- Food-Borne outbreaks
- Natural disasters and severe weather
- Radioactive material spill or leak
- Exposure to biological agents (such as anthrax, plague)
- Pandemic Flu (H1N1 (swine flu), avian flu)
- All hazards
- There is no preparedness plan
- I don't know
- Other (please specify below)

Comment (optional):

ESSENTIAL SERVICE #6: Enforce Laws and Regulations that Protect Health and ...

38. Has a new local public health policy, ordinance or regulation been adopted by your THD in the past 2 years?

- Yes
- No
- I don't know

Comment (optional):

39. [skip question if response to above is b-c]

Please indicate each area in which a new local public health ordinance or regulation was adopted in the past 2 years. (Select all that apply)

- Health and safety code or public health code
- Emergency preparedness and planning
- Research , data ownership and community protection
- Occupational health and safety
- Environmental (such as indoor air, water, soil quality)
- Land use planning (such as natural resources, transportation, parks)
- Tobacco prevention and control
- Nutrition or physical activity
- Some other (please specify in the comment box below)
- None
- I don't know

Comment (optional):

Regulation, Inspection and/or Licensing Activities

40. Regulation, Inspection and/or Licensing Activities

	Tribe or Tribal Association/Consortium*	IHS	Area Indian Health Board/Inter Tribal Council	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Other federal agency	Done by Someone Else	Not Available in Service Area	Unknown
Mobile homes											
Solid waste disposal sites											
Solid waste haulers											
Septic systems											
Hotels/motels											
Schools/daycare/ Head Start											
Swimming pools											
Tobacco Retailers (smokeshops)											
Smoke-free ordinances											
Lead/Asbestos inspection											
Public/private drinking water											
Food service establishments (casinos)											
Health-related facilities											
Housing (inspections)											

Comment (optional):

ESSENTIAL SERVICE #7: Outreach, Referral or Services: Link People to Needed...

41. What is the furthest distance (in miles) that your user population has to travel one way to obtain primary health care in your community (if applicable)?

    Please enter your best estimate:

    Comment (optional):

42. Vulnerable Populations

    For each vulnerable population listed in the following chart, indicate who currently provides services within your community, including your own THD.

	Tribe or Tribal Association/Consortium*	IHS	Area Indian Health Board/Inter Tribal Council	Epi Center	Urban Health Center	State Health Dept	Local City/ County Health Dept	Other federal agency	Done by Someone Else	Not Available in Service Area	Unknown
Persons 65 years of age and older											
Persons with physical disabilities											
Persons with mental illness											
Persons recently released from incarceration											
Lesbian, gay, bisexual, and trans-gendered individuals											
Persons with addictions											

    Comment (optional):

43. Does your THD have initiatives or mechanisms in place to enroll eligible individuals in public benefit programs, such as Medicaid/Medicare programs?

    - Yes
    - No

    If yes, please describe. (Other comment optional):

ESSENTIAL SERVICE #8: Assure a Competent Public and Personal Health Care Workforce

44. a. What is the number of individuals working in your THD? (Must be whole number)

- Open-ended response

b. What is the total Full-time Equivalents (FTEs) workforce at your THD?

- Please include ALL regular full-time, part-time, and contractual employees

- To calculate FTEs, count a full-time employee as 1 FTE, a half-time employee as a 0.5 FTE, etc.

- Open-ended response

45. a. What is the number of staff members working at your THD who are enrolled members of federally recognized tribes?

- Enter number:

Comment (optional):

b. OCCUPATIONS EMPLOYED

Indicate which of the following categories of health workers are currently employed by your THD. (Check all that apply)

- Health program managers, administrators, health service directors
- Nurse (including public health nurse, school nurse, community health nurse, RN, LPN)
- Midlevel provider (nurse practitioner, physician assistant)
- Physician
- Community health representatives
- Environmental health specialists
- Epidemiologist/statistician
- Health educator
- Nutritionist/dietitian
- Dentist
- Traditional healer
- Alternative medicine
- Information systems specialist
- Behavioral health professional (counselor, social worker, case manager, intake specialist)
- Emergency preparedness
- Administrative or clerical personnel

Comment (optional):

ESSENTIAL SERVICE #9: Evaluate Effectiveness, Accessibility and Quality of ...

46. In the past 3 years, has your THD participated in any of the following evaluation activities of your population-based health services? (Check all that apply)

Examples of population-based health services include outreach, education, other services that aim to promote wellness and prevent disease, such as physical activity promotion, overweight and obesity prevention, tobacco use prevention, substance abuse prevention, injury prevention, and STD prevention.

- Identified criteria to be used to evaluate population-based services
- Established program goals related to access, quality, and effectiveness of services
- Evaluated population-based health services
- Assessed community satisfaction with population-based health services
- Identified gaps in the provision of population-based services
- Used evaluation results in the development of your strategic and operational plans
- None of the above
- I don't know

Comment (optional):

ESSENTIAL SERVICE #10: Research for New Insights and Innovative Solutions t...

47. Which of the following statements describe your THD's experience with health research? (Check all that apply)

- We are currently participating in health research
- We have participated in health research in the past
- We plan to participate in health research in the future
- We have never participated in health research
- We have no plans to participate in health research in the future

Comment (optional):

48. [add skip logic so only respondents who select a-c above are asked this and the remaining questions in this section]

Does your THD have a policy or ordinance that outlines protocols for reviewing and participating in health research?

- Yes
- No

If yes, please describe (comment optional):

49. Do you have a formal research review committee or board?

- Yes
- No

Comment (optional):

50. Please provide a brief description of your research review and approval process:

- Open-ended response

Some examples include a formal IRB that follows federal guidelines; a Health Board/Committee that reviews and approves research and then recommends to Tribal Council or Governing Board; or all research reviewed approved by Tribal Council only.

Concluding Questions

51. Please rate your level of agreement with the following statements.

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
Our THD intends to apply for accreditation by the Public Health Accreditation Board.					
Our THD intends to apply for accreditation by the Public Health Accreditation Board by **September 2013.**					

Comment (optional):

52. What areas of technical assistance and/or training do you think would be of greatest benefit to your THD?

- Open-ended response

Areas to consider include, but are not limited to, data use and interpretation, community assessment, quality improvement, promising public health practices, community based participatory research, media literacy and public promotion, and advocacy at local, state, and federal level.

53. What work are you doing to improve population health services at your THD that is unique and successful and can be shared with other THDs? Consider unique partnerships, agreements, services, policies, or other areas that have had significant impact in the work that you are doing to serve your community.

- Open-ended response

54. Please rate ease/difficulty in completing the questionnaire:

- Very simple
- Simple
- Not simple, not difficult
- Difficult
- Very difficult

Comment (optional):

55. Please provide an estimate of the total amount of staff time that your THD devoted to completing the Profile questionnaire.

- Number of hours:

56. Please provide any feedback or additional comments related to the assessment.

- Open-ended response