

# **Public Health in Indian Country Capacity Scan Assessment**

OSTLTS Generic Information Collection Request  
OMB No. 0920-0879

## **Supporting Statement – Section A**

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**Purpose of the collection:** The purpose of this data collection is to assess the capacity and infrastructure of tribal public health departments to provide essential public health services and activities to their communities.

**Intended use of the resulting data:** The information collected from the scan will be used to develop a report that will support and guide Tribal essential public health service work in the areas of public health practice, technical support, and assessing issues related to improving Indian health.

**Methods to be used to collect:** The PHICCS data collection will be done primarily using a web-based data collection instrument. In the event that the web-based instrument cannot be accessed, participants can request a hard copy version or work with an NIHB staff person to complete the assessment over the phone. There will be no sampling; all Tribal health departments, Tribal public health departments, and, in the case of Alaska, Tribal health consortiums, will be invited to participate.

**The subpopulation to be studied:** 261 Tribal health departments, Tribal public health departments, Alaska Native health consortiums/organizations from 12 IHS regions including: Alaska, Aberdeen (Great Plains), Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma City, Phoenix, Portland, and Tucson.

**How data will be analyzed:** NIHB will use descriptive statistics to analyze data collected from all participating Tribal health departments/consortiums looking at response frequencies, and narrative responses will be summarized. Depending on the response distribution, frequencies may be cross-tabulated to identify response similarities and differences among sub-groups of respondents, such as by IHS region.

## **Section A – Justification**

### **1. Circumstances Making the Collection of Information Necessary**

#### **Background**

This information collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. The respondent universe for this information collection aligns with that of the O2C2. Data will be collected from up to 261 Tribal health directors from Tribal health departments/entities representing 573 federally recognized Tribes from 35 states and 12 Indian Health Service

Areas in the United States (see **Attachment A – Respondent Breakdown**). Due to the variation in Tribal public health leadership, respondents include Tribal health department directors, Tribal public health department directors, and Alaska Native health consortium directors. The latter group of respondents is unique to Native communities in Alaska where, instead of Tribal health or public health departments, Native communities organize their health and public health service delivery through health consortiums, operating under authority granted under Public Law 93-638. The *Indian Self-determination and Education Assistance Act (ISDEAA)*, or Public Law 93-638, provides legal authority for Tribes to use federal funds to provide services to their own communities through contracting and compacting with federal agencies, instead of receiving direct services from those agencies.<sup>1</sup> Members of Alaska tribes have tasked delegates to represent their consortiums and to act on behalf of the tribes as these delegates share the same status as a governmental entity.<sup>2</sup> There are 31 Alaska Native health consortiums/corporations that serve on behalf of the Alaska tribes.

This information collection is authorized by Section 301 of the Public Health Service Act (42 U.S.C. 241). This information collection falls under the essential public health service(s) of:

- 1. Monitoring health status to identify community health problems
- 2. Diagnosing and investigating health problems and health hazards in the community
- 3. Informing, educating, and empowering people about health issues
- 4. Mobilizing community partnerships to identify and solve health problems
- 5. Development of policies and plans that support individual and community health efforts
- 6. Enforcement of laws and regulations that protect health and ensure safety
- 7. Linking people to needed personal health services and assure the provision of health care when otherwise unavailable
- 8. Assuring a competent public health and personal health care workforce
- 9. Evaluating effectiveness, accessibility, and quality of personal and population-based health services
- 10. Research for new insights and innovative solutions to health problems<sup>2</sup>

America's public health system began taking its current shape in the middle of the twentieth century. With support of the federal government, state and local health departments began building a public health workforce with focused efforts on health promotion and disease prevention.<sup>3</sup> At this time, however, there was no Tribal equivalent established, nor was there any funding streams in place that would have supported that development at the Tribal level. The federal government established the Indian Health Service (IHS) in 1955 to uphold its government-to-government relationship and its

statutory authority to provide health care to American Indians and Alaska Natives (AI/ANs) of all federally recognized Tribes.<sup>4</sup> IHS's defined scope focuses the majority of its mission on treatment and direct patient care and health.<sup>5</sup> While IHS has a significant role in public health activities at federally operated facilities, Tribes are responsible for public health infrastructure development when they become self-determined or self-governed. While many Tribal health departments have a public health component, few provide the comprehensive public health activities of state or local public health departments. This is evidenced by the small number of Tribes awarded public health accreditation (PHAB, a voluntary process that seeks to advance the quality and performance of state, local, territorial and Tribal public health departments). Although over 175 state, local, and integrated public health departments have received accreditation, only one Tribal health department has achieved accreditation to date. Moreover, the first health departments were awarded accreditation in February of 2013, more than three years before the first Tribal health department, which was awarded the status in August of 2016 (Public Health Accreditation Board, 2017).<sup>6</sup>

The history of public health in America coupled with the current inequities faced by AI/AN people and Tribal governments demonstrates the need for sustainable investments in Indian Country, focused on the entire public health system, rather than simply on health care. AI/AN Tribes must compete amongst one another, as well as better resourced state and local health departments for limited public health funds. This simply widens the disparity gap that AI/ANs have been plagued with for centuries. Addressing the problem requires data on the existing capacity of Tribal health departments to carry out essential public health services<sup>7</sup>, which will be addressed in the Public Health in Indian Country Capacity Scan (PHICCS).

The Strengthening AI/AN Public Health Infrastructure through Local Capacity Building and National Visibility cooperative agreement (CDC OT13-1302) provides funding to create a comprehensive picture of Tribal public health amongst AI/AN people. A significant component of the work plan is to create a comprehensive profile of the current public health capacity in Indian Country using an informational tool known as the Public Health in Indian Country Capacity Scan or PHICCS. This profile will examine the public health activities, workforce, systems, and infrastructure that exists among AI/AN Tribes to address health disparities and provide public health services. The end result will be a comprehensive picture of the landscape, areas of collective strengths, and weaknesses. This document will be a tool for Tribal leaders, CDC leadership, and other federal entities as they create programmatic opportunities for Indian Country. It will also be used by Tribes and AI/AN-serving organizations as they seek to undergo Tribal health planning and

sustainability planning. To achieve this, the CDC has partnered with the National Indian Health Board (the only organization serving all 573 federally recognized Tribes in the health and public health realm) to complete this work.<sup>8</sup>

In 2009, the National Indian Health Board (NIHB) conducted a similar assessment of Tribal public health capacity released in a document titled, *2010 Tribal Public Health Profile: Exploring Public Health Capacity in Indian Country* (see **Attachment B – 2010 NIHB Tribal Public Health Profile**). While this report provided an important foundation, there is a need to expand and build upon this baseline in order to provide a more recent, comprehensive picture of the capacity of public health in Indian Country. Therefore, the purpose of this data collection request is to assess the capacity of Tribal health department's competency to deliver essential public health services to their communities. The end result will be a national scan of Tribal public health systems, functions, workforce, priorities, needs, strengths, and leadership.

The information collected from the scan will be used to develop a report that will support and guide Tribal public health advocacy work in the areas of public health practice, technical support, and research on issues related to improving Indian health. Wide participation of Tribal health departments, Tribal public health departments (where they exist), and Alaska Native health consortiums in this capacity scan is critical to put forth a comprehensive picture of public health in Indian Country.

### **Overview of the Information Collection System**

Data will be collected from 261 Tribal health directors via the PHICCS assessment scan, which is a web-based tool allowing respondents to complete and submit their responses electronically (see **Attachment C – PHICCS Instrument (Web version)** and **Attachment D – PHICCS Instrument (Word version)**). If the respondent would rather not fill the assessment out in the online platform, respondents can request a hard copy version of the tool, which will be returned to NIHB via mail. Per request, respondents will also be allowed to complete the tool with an NIHB staff member guiding them through the tool over the phone (see **Attachment E – PHICCS Phone Administration of Instrument: Introductory Language**), where the NIHB staff member will enter the information in to the online platform. The reason that we will be offering other options besides the online instrument is to improve accessibility, as many Tribal communities are extremely rural and may have unreliable internet access. The information collection instrument was pilot tested by six public health professionals. Feedback from this group was used to refine questions as needed, ensure accurate programming, and establish the estimated time required to complete the information collection instrument.

## Items of Information to be Collected

The online data collection instrument consists of up to 129 questions of various types, including: dichotomous (yes/no), multiple response, interval (rating scales), and open-ended. An effort was made to limit questions requiring narrative responses from respondents whenever possible. This data collection will collect information on the overall capacity of the Public Health System and Infrastructure in Indian Country. To do this we will collect information on 4 key areas related to public health capacity in Indian Country. The instrument will collect information on the following:

- **Tribal Public Health Activities** area examines the public health activities such as services offered, public health communication, and accreditation status taking place in the Tribal community. The instrument includes up to 109 questions related to this area, including questions on: public health service provision in the community (e.g. who is providing services such as screenings, immunizations, or environmental services), public health communication, and public health accreditation.
- **Tribal Public Health Workforce** area is examining the public health workforce development needs and capacity of the workforce in the Tribal community. There are three questions in the public health workforce section focused on assessing the capacity of the public health workforce in the Tribal entity's community including workforce development and position status of key public health occupations (i.e. whether the position is filled or vacant).
- **Tribal Public Health Priorities and Needs** area has six questions and covers the Tribal public health organization's essential public health service priorities, and asks the organization to rank their top 5 public health issues/needs in their Tribal community. There are five questions in the public health priorities and needs area. These questions are designed to ask about the Tribal entity's specific health priorities and needs, including what support they might need from state or federal agencies to advance Tribal public health.
- **Tribal Public Health Authority** examines who the Tribal health organization reports to and the type of activities the governing entity has control of. The two questions in this section ask what type of governing authority the Tribal entity reports to and what public health governing activities occur within the community.

## 2. Purpose and use of the Information Collection

The purpose of this data collection is to assess the capacity and infrastructure of tribal public health departments to provide essential public health services and activities to their communities.

The information collected from the scan will be used to develop a report that will support and guide Tribal essential public health service work in the areas of public health practice, technical support, and assessing issues related to improving Indian health.

### **3. Use of Improved Information Technology and Burden Reduction**

Data will be collected via a web-based questionnaire allowing respondents to complete and submit their responses electronically. This method was chosen to reduce the overall burden on respondents. The information collection instrument was designed to collect the minimum information necessary for the purposes of this project (i.e., limited to 129 questions).

While the online platform will be the primary method of data collection, per request, respondents will have the option of completing the scan via hard copy or with an NIHB staff member guiding them through the tool over the phone. Data gathered from paper scans that are mailed to NIHB will be entered into the web-based platform by an NIHB staff member. The justification of these methods are based on access for respondents who are either not technologically proficient or live in areas with unreliable internet access.

### **4. Efforts to Identify Duplication and Use of Similar Information**

Information on public health department infrastructure and services has been collected at the state health department level and local level through the Association of State and Territorial Health Officials (ASTHO) (**see Attachment F – ASTHO Profile Volume Three**) and through the National Association of County and City Health Officials' (NACCHO) (**see Attachment G – NACCHO 2016 Report**). However, neither of these channels collected data on the Tribal public health department infrastructure and services. Because neither of these two assessments collect information from Tribal entities, they do not provide any information on the capacity of Tribal public health department's competency to deliver essential public health services to their communities in Indian Country.

It is important to collect information on Tribal public health systems to understand how they may improve the health status and combat health disparities among tribal populations. The last time data specific to Tribal public health was collected was in 2009 and disseminated in 2010 (**see Attachment B – 2010 NIHB Tribal Public Health Profile**). The profile set out to describe Tribal public health activities and services, identify areas for improvement, and address health disparities. The questionnaire collected information on the three core functions of public health (Assessment, Assurance and Policy Development) as well as information specific to Tribal public health such as the Tribal compacting or



contracting of the Indian Health Services (IHS) and the presence and role of Tribal health committees and boards. The 2010 profile provided a baseline of comparison for the public health capacity of the Tribes with state and local health departments as well as future assessments like the PHICCS tool. There is a need to expand and build upon this baseline, especially in the fields of key public health activities (e.g. prevention, surveillance, screenings, and environmental health services), public health workforce, and public health accreditation, in order to provide a more recent, more comprehensive picture of the capacity of public health in Indian Country.

Collaboration and consultation with Indian Country was sought in the preparation of this collection. NIHB obtained from IHS a distribution list of IHS and tribal health departments for participants. The information gathered through this genIC is not available from IHS. IHS is involved in the provision of public health services (e.g., public health nursing, community health workers, environmental health), but has not focused on collecting data on public health infrastructure, services, or capacity. Thus, this scan is not duplicative of past or planned IHS efforts (see **Attachment H: IHS Letter of Support**).

#### **5. Impact on Small Businesses or Other Small Entities**

No small businesses will be involved in this information collection.

#### **6. Consequences of Collecting the Information Less Frequently**

This request is for a one time information collection. There are no legal obstacles to reduce the burden. If no data are collected, CDC will be unable to:

- Determine current Tribal community priorities as they relate to Tribal public health.
- Determine the workforce deficiencies that exist in Tribal public health.
- Determine opportunities for technical assistance to improve Tribal public health.
- Examine the gaps in public health services provided to Tribal members.

#### **7. Special Circumstances Relating to the Guidelines of 5 CFR 1320.5**

There are no special circumstances with this information collection package. This request fully complies with the regulation 5 CFR 1320.5 and will be voluntary.

#### **8. Comments in Response to the Federal Register Notice and Efforts to Consult Outside the Agency**

This data collection is being conducted using the Generic Information Collection mechanism of the OSTLTS OMB Clearance Center (O2C2) – OMB No. 0920-0879. A 60-day Federal Register Notice was published in the Federal Register on April 27, 2017, Vol. 82,

No. 80, pp 19371-19373. One non-substantive comment was received. CDC sent forward the standard CDC response.

CDC partners with professional STLT organizations, such as the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and the National Association of Local Boards of Health (NALBOH) along with the National Center for Health Statistics (NCHS) to ensure that the collection requests under individual ICs are not in conflict with collections they have or will have in the field within the same timeframe.

### **9. Explanation of Any Payment or Gift to Respondents**

CDC will not provide payments or gifts to respondents.

### **10. Protection of the Privacy and Confidentiality of Information Provided by Respondents**

The Privacy Act does not apply to this information collection. STLT governmental staff and delegates will be speaking from their official roles.

This information collection is not research involving human subjects.

### **11. Institutional Review Board (IRB) and Justification for Sensitive Questions**

No information will be collected that are of sensitive nature.

### **12. Estimates of Annualized Burden Hours and Costs**

The estimate for burden hours is based on a pilot test of the information collection instrument by six public health professionals. In the pilot test, the average time to complete the instrument including time for reviewing instructions, gathering needed information and completing the instrument across all three modes of collection (i.e., online, hard copy and phone administration of the online assessment), and), was 60 minutes (range: 45 to 60 minutes). For the purposes of estimating burden hours, the upper limit of this range (i.e., [60] minutes) is used. There is no difference in time estimates across the three modes of administration.

Estimates for the average hourly wage for respondents are based on the Department of Labor (DOL) Bureau of Labor Statistics for occupational employment for Medical and Health Services Manager [http://www.bls.gov/oes/current/oes\\_nat.htm](http://www.bls.gov/oes/current/oes_nat.htm). Based on DOL

data, an average hourly wage of \$46.41 is estimated for all 261 respondents. Table A-12 shows estimated burden and cost information.

**Table A-12:** Estimated Annualized Burden Hours and Costs to Respondents

Information collection Instrument: Form Name	Type of Respondent	No. of Respondents	No. of Responses per Respondent	Average Burden per Response (in hours)	Total Burden Hours	Hourly Wage Rate	Total Respondent Costs
PHICCS Instrument	Tribal Health Directors	261	1	60/60	261	\$46.41	\$12,113
	<b>TOTALS</b>	261	1		261		\$12,113

### 13. Estimates of Other Total Annual Cost Burden to Respondents or Record Keepers

There will be no direct costs to the respondents other than their time to participate in each information collection.

### 14. Annualized Cost to the Government

There are no equipment or overhead costs. Contractors, however, are being used to support development of the assessment tool, data collection, and data analysis. The only cost to the federal government would be the salary of CDC staff and contractors. The total estimated cost to the federal government is \$51,320.75. Table A-14 describes how this cost estimate was calculated.

**Table A-14:** Estimated Annualized Cost to the Federal Government

Staff (FTE)	Average Hours per Collection	Average Hourly Rate	Average Cost
CDC Project Officer, GS-13	45	\$36.24	\$1630.80
CDC Project Officer, GS-11	45	\$29.35	\$1320.75
Contractor – NIHB (3 staff)			\$50,000
<b>Estimated Total Cost of Information Collection</b>			<b>\$52,951.55</b>

### 15. Explanation for Program Changes or Adjustments

This is a new information collection.

## 16. Plans for Tabulation and Publication and Project Time Schedule

All data will be stored on password protected computers on secured servers within the NIHB. Data will be aggregated and analyzed by topic/section to capture the public health capacity of Indian Country, as a whole. The findings will be compiled into an Indian Country-wide report and disseminated to Tribal Leaders, Tribal health departments, federal entities, and national partners.

Additionally, each Tribal health entity will have access to their own data. This will allow individual Tribes to compare their results to a national aggregate. Tribes will receive this information in a spreadsheet format.

### Project Time Schedule

- ✓ Design instrument ..... (COMPLETE)
- ✓ Develop protocol, instructions, and analysis plan ..... (COMPLETE)
- ✓ Pilot test instrument ..... (COMPLETE)
- ✓ Prepare OMB package ..... (COMPLETE)
- ✓ Submit OMB package ..... (COMPLETE)
- OMB approval ..... (TBD)
- Conduct data collection ..... (Assessment Open 3 months)
- Code data, conduct quality control, and analyze data..... (2 months)
- Prepare report(s) ..... (4 months)
- Disseminate results/reports ..... (4 months)

## 17. Reason(s) Display of OMB Expiration Date is Inappropriate

We are requesting no exemption.

## 18. Exceptions to Certification for Paperwork Reduction Act Submissions

There are no exceptions to the certification. These activities comply with the requirements in 5 CFR 1320.9.

### **LIST OF ATTACHMENTS – Section A**

- A. Attachment A: Respondent Breakdown
- B. Attachment B: 2010 NIHB Tribal Public Health Profile
- C. Attachment C: PHICCS Instrument (Web version)
- D. Attachment D: PHICCS Instrument (Word version)
- E. Attachment E: PHICCS Phone Administration of Instrument: Introductory Language
- F. Attachment F: ASTHO Profile Volume Three
- G. Attachment G: NACCHO 2016 Report
- H. Attachment H: IHS Letter of Support

## REFERENCE LIST

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