

Assessing Tribal Health Organization (THO) Role in Data-Related Public Health Services through the 2023 Public Health in Indian Country Capacity Scan (PHICCS)

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Abstract

Tribes are public health authorities, with the legal right to access public health data for the purposes of monitoring, preventing and controlling diseases. However, Tribes are often denied access to core public health data needed to monitor health and make public health decisions. To better understand the current capacity of Tribes in relation to public health data, several questions were asked in the 2023 Public Health in Indian Country Capacity Scan (PHICCS) on the current role of Tribal Health Organizations (THOs) in collecting, storing, and analyzing public health data. Results demonstrated that 10% or less of THOs were sole collectors or reporters of data within the THO service areas. Furthermore, 35% of respondents had no syndromic surveillance data reported and collected and an additional 34% did not know if syndromic surveillance data was reported and collected. Data collection related to vital statistics were collected or reported in the service areas of 55% of 123 THOs that responded to this question and 41% of 127 Tribal organizations reported receiving this data from external entities. Recognition and honoring of Tribal sovereignty and authority complicated Tribal access and use of relevant data. These findings highlight the need for investments and strategic approaches to assess and strengthen Tribal capacity to internally provide data services and activities as well as the importance of improving awareness and partnerships among Tribal public health data networks.

Introduction

PHICCS is a national scan conducted by the National Indian Health Board (NIHB) every three years to assess the capacity of Tribal health and Tribal public health organizations to deliver public health services. PHICCS helps Tribes, Tribal organizations, partners, and policy makers better understand Tribal public health infrastructure and plan for future improvements.

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PHICCS provides an in-depth look at what public health activities related to data occurred in the THO service areas over a one-year period, and what type of entity provided these activities during this time-frame. Due to the often patchwork network of public health agencies that provide services in Indian Country, those that provided services could include the THOs, other Tribal governmental departments, state and local partners, Tribal organizations such as Area Indian Health Boards and Tribal Epidemiology Centers (TECs), nonprofits, federal agencies, and other key providers of health services.

The information collected through PHICCS can be used to better understand how resources related to public health data vary by region, and to identify both strengths and gaps in the ability of THOs to assure services related to public health data are provided to their population (whether through a THO or another entity).



Methodology

Procedure: The PHICCS II survey was comprised of 68 questions aimed at understanding Tribal Health Organization (THO) capacity across core areas. Between August 10, 2022, and February 17, 2023, the PHICCS survey was sent to the 282 THOs identified by NIHB as serving the 574 federally recognized Tribal nations. There were 135 responses collected, with a response rate of 48%. 133 responses were included in the final analysis. Descriptive statistics were conducted for quantitative questions, while qualitative data was analyzed using a content analysis approach. Regional analysis was conducted using the CDC Cancer Regions to prevent respondents from being identifiable while providing regional-level data. The final survey was created using the Qualtrics survey software and could be completed by participants online. Paper and PDF copies were also developed for those who could not use Qualtrics software. NIHB informed THOs that they could also complete the survey over the phone with assistance from a NIHB staff member.

Participants: Surveys were collected from 135 THOs with a response rate of 48%. Two respondents from inter-Tribal councils were excluded, as these organizations did not meet the criteria as a governmental THO. Therefore, 133 THOs were included in the analysis.

Limitations:

- This data should be viewed as a “snapshot” of the capacity of THOs, and likely cannot be inferred to generalize public health capacity across all THO’s.
- The response rate fell short of sample size calculations needed to make inferences with a 95% confidence level with a 5% margin of error. There was a suggested sample size of 163 responses out of 282 would be necessary in comparison to the 133 collected.

Figure 1. Number of THOs by Type (n=133)

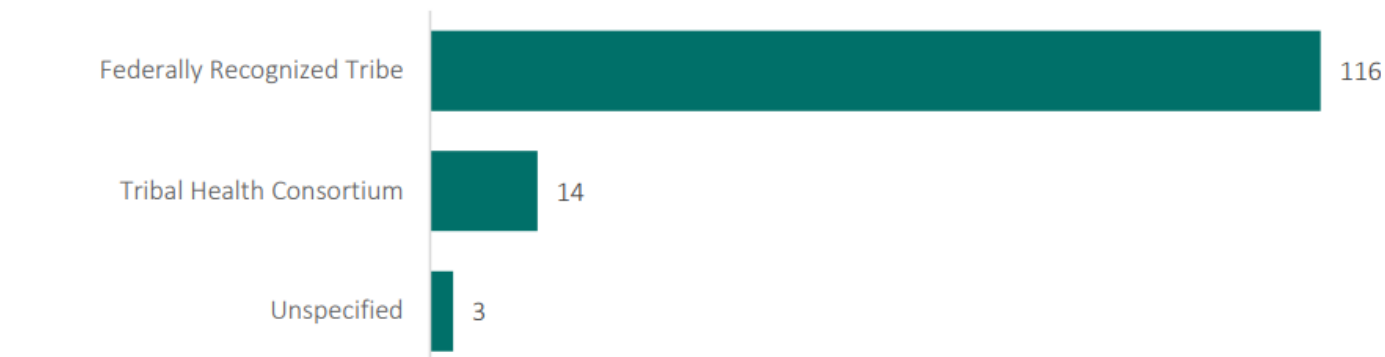
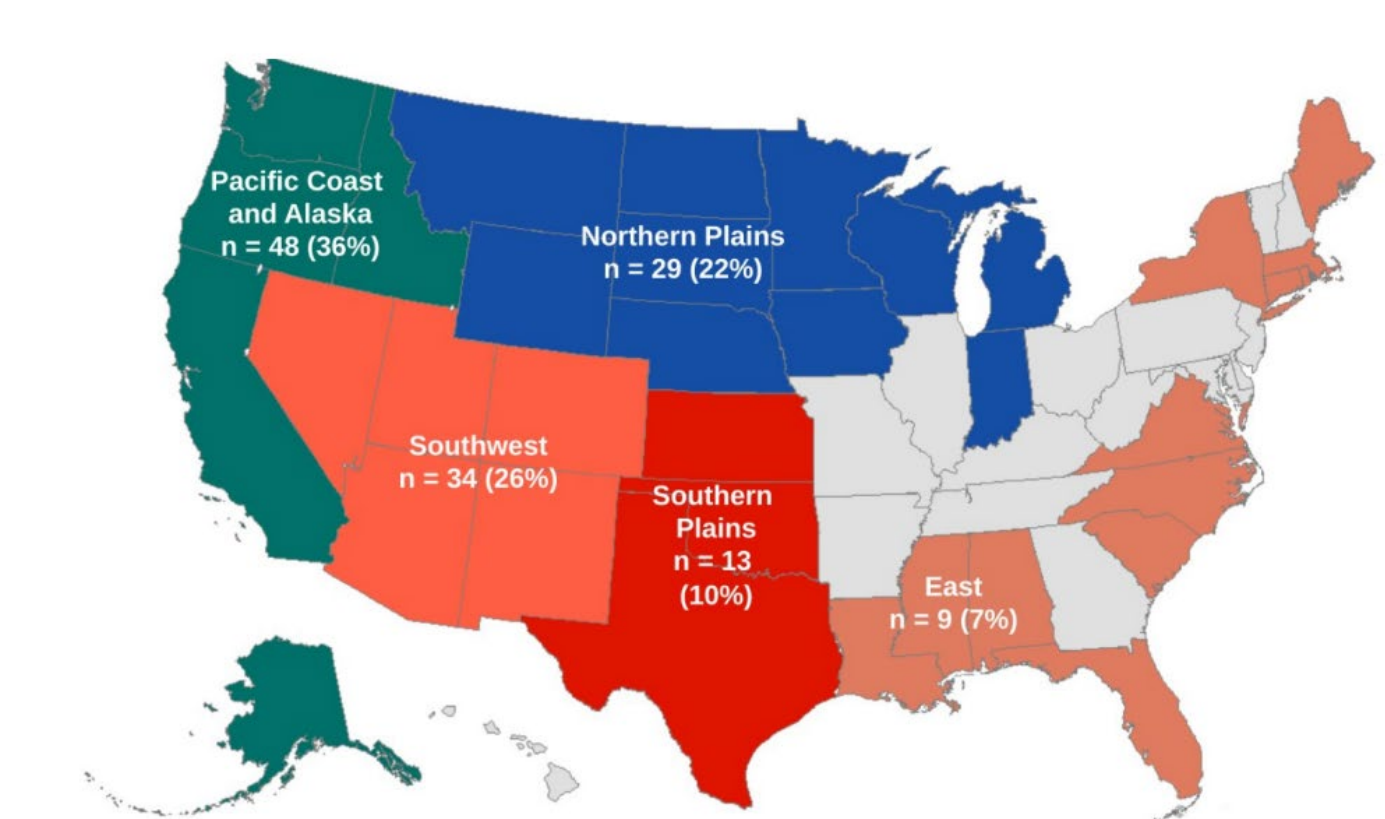


Figure 2. Number and Percentage of THO Respondents by Region (n=133)



Results

Figure 3. Public Health Data Collected or Reported in the Service Area in the Past Year (n=124)

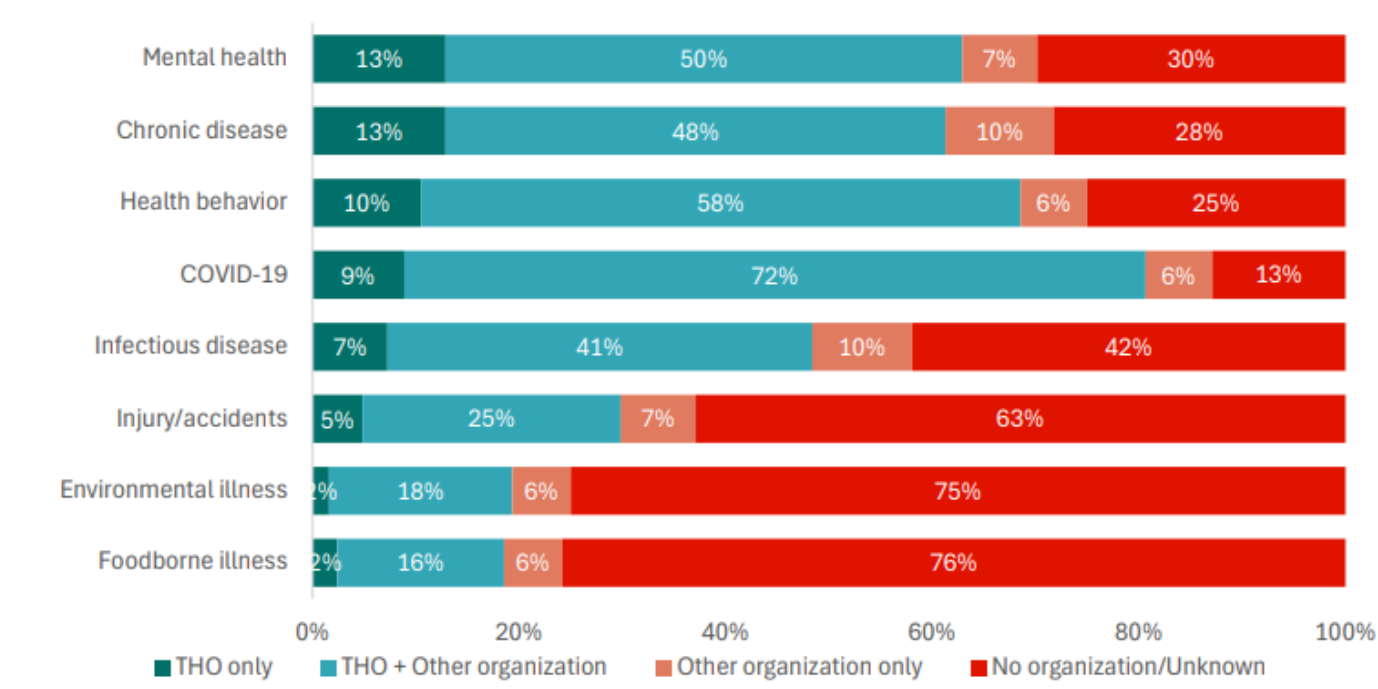


Figure 4. Percentage of THOs that had a Role in Data Collection, Epidemiology, and/or Surveillance for Public Health Data in the Past Year

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

Figure 5. Emergency Response Capacities or Functions Conducted in Service Areas in the Past Year

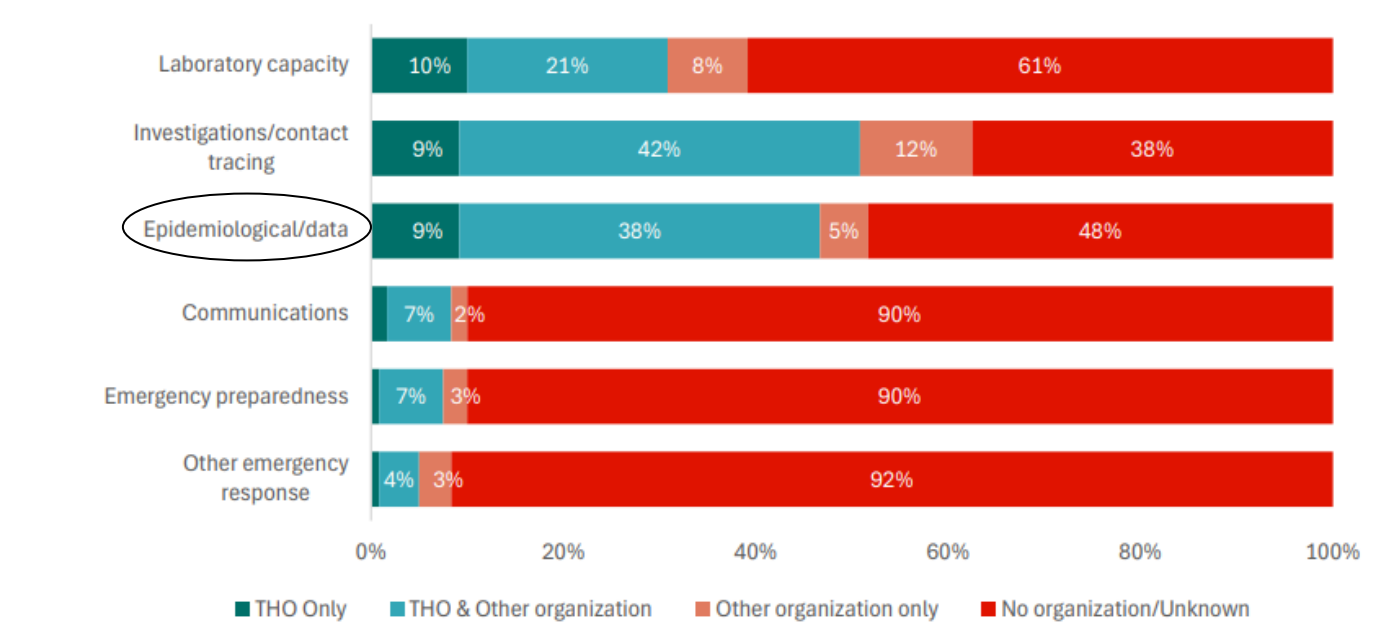
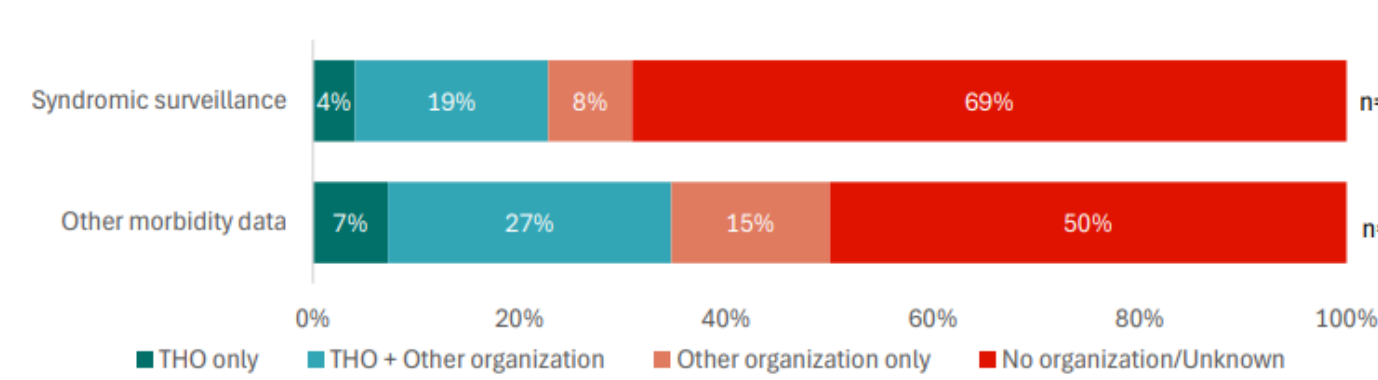


Fig 6. Syndromic Surveillance and Morbidity Data Collected or Reported in the Service Area in the Past Year



Qualitative Feedback:

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

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

Regional Analysis

Figure 7. Percentage of THOs Collecting or Reporting Syndromic Surveillance Data in the Past Year by Percent of THOs per Region (n=123)

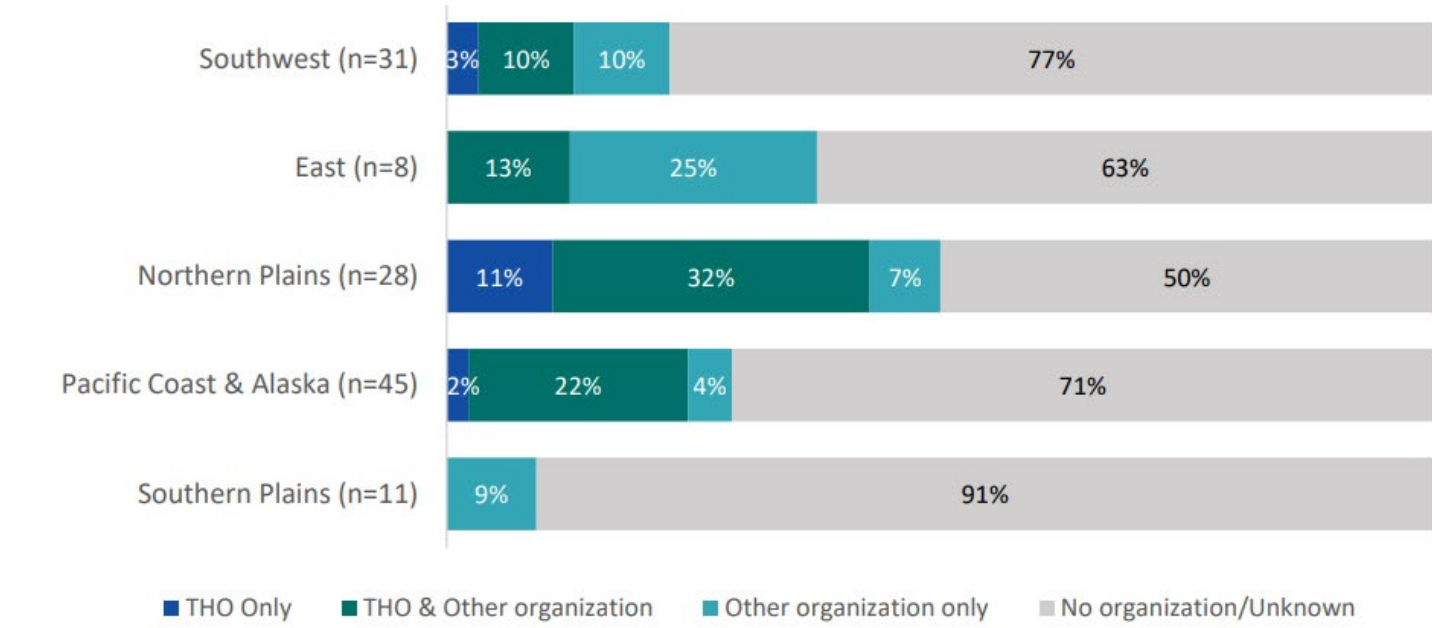
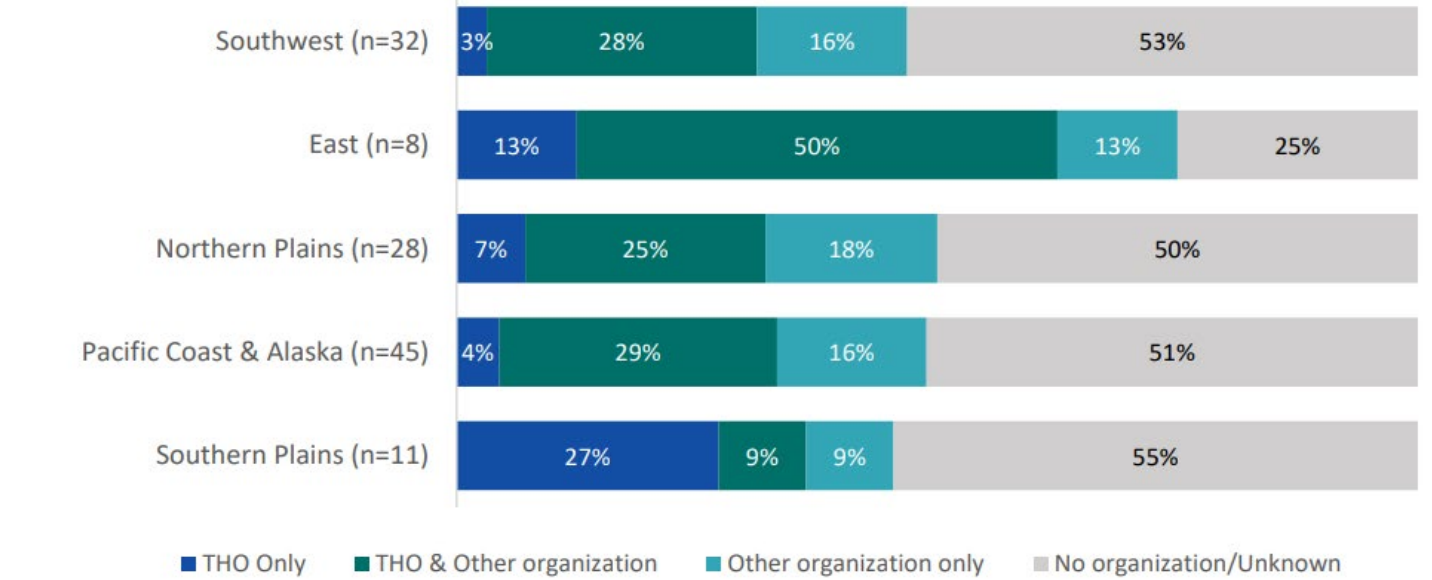


Figure 8. Percentage of THOs Collecting or Reporting Other Morbidity Data in the Past Year (n=124)



Conclusion/Discussion

Key takeaways related to Tribal public health data:

- There is a need for technical infrastructure to monitor the changing public health needs of Tribal communities.
- While half of THOs collected vital statistics and morbidity data, more than a quarter did not know whether this data was collected. This suggests gaps in communication and access between external data collection entities and THOs.
- Access to data was highlighted as a key barrier to exercising public health authority, with many THOs being denied access to state and county systems.
- Insufficient AI/AN data, lack of Tribal-specific data, and lack of cultural relevancy limits the usefulness for public health planning.

Implications for building Tribal capacity related to data:

- THOs must rely on their own data collection to drive public health decision making, which requires not only funding but also data and analytics staff with access to epidemiology training, software, and technical infrastructure.
- Improved awareness and relations among external data collecting entities must be prioritized.

Acknowledgements

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