Bridging Health and Health Care

Cross Jurisdictional Sharing Between Tribes and Counties for Emergency Management

Research In Progress Webinar
Thursday, April 21, 2016 1:00-2:00pm ET/ 10:00-11:00am PT

Funded by the Robert Wood Johnson Foundation
Agenda

Welcome: Rick Ingram, DrPH, RWJF Systems for Action National Coordinating Center, and Assistant Professor, University of Kentucky College of Public Health

Cross Jurisdictional Sharing Between Tribes and Counties for Emergency Management

Presenter: Maureen A. Wimsatt, PhD, MSW, Director, California Tribal Epidemiology Center and Manager of Epidemiology, California Rural Indian Health Board Maureen.Wimsatt@CRIHB.ORG

Commentary: Michael Mudgett, MPH, Epidemiologist, California Tribal Epidemiology Center Michael.Mudgett@CRIHB.ORG and Charles Magruder, MD, Chief Medical Officer, Indian Health Service California Area Office Charles.Magruder@IHS.GOV

Questions and Discussion
Maureen A. Wimsatt, PhD, MSW
Director, California Tribal Epidemiology Center
Manager of Epidemiology, California Rural Indian Health Board

Maureen.Wimsatt@CRIHB.ORG
Research-In-Progress Webinar: Cross-Jurisdictional Sharing Between Tribes and Counties for Emergency Management

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California Rural Indian Health Board
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Support for this presentation was provided by the Robert Wood Johnson Foundation through the National Coordinating Center for Public Health Services and Systems Research (Project ID: 72458).
Project Overview

- Project aims to study and promote cross-jurisdictional sharing (CJS) of emergency management (i.e., preparedness, mitigation, response, and recovery) services between tribes and counties in California.
- Project provides tribal and county representatives an opportunity to share views about CJS and make recommendations for successful government-to-government CJS arrangements.
- Recommendations will guide content of a CJS toolkit.
- In the long term, project could help tribes and counties establish CJS arrangements so both jurisdictions can access adequate funding before, during, and after emergencies.
Tribe-County CJS Context

- Each American Indian tribe is unique in governance, legal processes, culture, tradition, economic and social resources, and relationships with local governments.
- Many tribes at unique risk for emergencies due to their location in remote and rural areas.
  - Far from major hospitals and county resources
  - Varied capacity to address natural and non-natural emergencies
- Despite benefits of sharing services for emergency management between tribes and counties, only a tribe as a sovereign governing body can choose to enter into a CJS relationship with a county.
- Due to uniqueness of each tribe, CJS arrangements between tribes and counties are expected to vary.
  - 111 tribes in California
Originally Proposed Research Questions and Methods

RQ1. Current prevalence and scope of CJS between tribal and county governments? Survey, at least 83 tribes and corresponding counties

RQ2. How valuable are CJS arrangements with county governments and how do tribes determine this value? Stakeholder interviews, at least 21 tribes and corresponding counties

RQ3. What factors influence the implementation, effectiveness, and value of CJS agreements? In-depth survey, at least 21 tribes and corresponding counties

RQ4. What CJS characteristics are associated with achieving benchmarks in public health emergency preparedness measures? In-depth survey, from subset of the 21 tribes (no counties): 1) tribes in high value CJS agreements; 2) tribal governments who have met pre-defined emergency preparedness benchmarks
Focus of Today’s Presentation

RQ1. Current prevalence and scope of CJS between tribal and county governments? Survey, at least 83 tribes and corresponding counties
Study Procedure

• Tribal and county leaders approached and asked to select representative to participate in project.
• Institutional Review Board-approved questionnaire administered to tribal and county representatives.
  • Adapted from Center for Sharing Public Health Services “Existing CJS Arrangement” survey (CSPHS, 2014)
  • Items about jurisdictional information, current CJS arrangements, accreditation
  • Honored tribal requests for verbal and face-to-face participation
Response and Participation Rates

- Tribe response rate = 87%
  - Formal participation from 83 of 111 tribes (75%)
  - Response indicating reason for declining participation from 14 of 111 tribes (12%)
- Corresponding county response/participation rate = 100%
  - Formal participation from all 29 counties associated with the 83 tribes who participated
Number of Participants

Tribe (n=83)
- Elected Leader or Tribal Staff: 36
- Emergency Manager/Staff: 31
- Environmental Manager/Staff: 14
- Tribal Health Clinic Staff: 2

County (n=29)
- Office of Emergency Services Staff: 25
- Health Department Staff: 3
- Administrator: 1
Jurisdictional Information

- **Population size**
  - Tribes: 0 to 84,000 people ($M = 1,651$)
  - Counties: 9,500 to 3.2 million people ($M = 468,191$)

- **Geographic size**
  - Tribes: 0 to 547 square miles ($M = 16.77$)
  - Counties: 612 to 22,000 square miles ($M = 3,794$)

- **Total Number of Tribes in County** (CA Gov. Office of the Tribal Advisor, 2015)
  - 1 to 18 ($M = 7$ tribes)
Prevalence and Scope of CJS

• Coded tribe and county questionnaire responses, and supported with open-ended responses; 4 researcher agreement.
• 5 Categories for CJS from Center for Sharing Public Health Services ($1 = \text{yes}$, $0 = \text{no}$)
  • Formal arrangements
  • Informal or customary arrangements ("handshake arrangement," verbal arrangements)
  • Service-related arrangements (as-needed contracts or consultations before, during, or after emergency)
  • Shared functions with joint oversight arrangements
  • Regionalization arrangements (tribe and county become one department to serve both jurisdictions)
• 37 tribes (45%) and 5 counties (17%) reported no CJS arrangements

• Among the 46 tribes and 22 counties with any CJS arrangements (see Graph), tribes ranged between having 1-3 arrangements, and counties ranged between having 1-4 arrangements.
### Prevalence and Scope of CJS (Cont.)

#### Tribe CJS Arrangement Inter-Correlations

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<thead>
<tr>
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<th>Formal</th>
<th>Informal</th>
<th>Service-Related</th>
<th>Shared Functions</th>
<th>Regionalization</th>
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#### County CJS Arrangements Inter-Correlations

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*p < .05, **p < .01, ***p < .001
Associations Between Measures

- Statistical analyses tested relations between jurisdictional and CJS measures for tribes and counties.

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<thead>
<tr>
<th>Jurisdictional Measures</th>
<th>CJS Measures</th>
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<tr>
<td>• Population size</td>
<td>• Sum of CJS arrangements (0-5)</td>
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<tr>
<td>• Geographic size</td>
<td>• Each type of CJS arrangement (formal, informal or customary, service-related, shared functions with joint oversight, and regionalization)</td>
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<tr>
<td>• Total number of tribes in county</td>
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<td>• Proportions: Total number of tribes in county to county population and geographic size</td>
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- 4 significant findings for tribes:

  - Negative association between number of CJS arrangements and proportion of total tribes to county population size \( (t = -2.12, p = .04) \).
    - Tribes with a higher number of CJS arrangements were in counties with fewer tribes to overall county population size.

  - Positive associations between: Formal arrangements and population size \( (r = .24, p = .03) \); shared functions with joint oversight arrangements and population size \( (r = .25, p = .02) \); and shared functions with joint oversight arrangements and geographic size \( (r = .24, p = .03) \).
Statistical analyses tested relations between jurisdictional and CJS measures for tribes and counties.

1 significant finding for counties:

- Positive association between informal or customary CJS arrangements and total number of tribes in county \((r = .43, p = .02)\).
Tribe-County CJS Agreement

- Determined whether tribes and counties agreed about having no (0) or any (1-5) CJS arrangements (1 = agree, 0 = disagree).

  - 46 of 83 tribe-county dyads (55%) agreed about having no or any CJS arrangements.
    - 11 of 83 agreed about having no CJS arrangements
    - 35 of 83 agreed about having CJS arrangements
  
  - 37 of 83 of tribe-county dyads (45%) disagreed about having no or any CJS arrangements.
    - 26 of 83 county reported CJS but tribe did not
    - 11 of 83 tribe reported CJS but county did not
**Associations Between Measures**

- Statistical analyses tested relations between tribe-county CJS agreement and CJS measures.

<table>
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<tr>
<th>Tribe-County CJS Agreement Measure</th>
<th>CJS Measures</th>
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<tr>
<td>• Tribe-county dyad in agreement about having no or any CJS</td>
<td>• Each type of CJS arrangement (formal, informal, service-related, shared functions w joint oversight, and regionalization)</td>
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- Statistically significant associations between tribe-county CJS agreement and *tribe*-reported formal arrangements ($\chi^2(1) = 4.42, p = .04$), informal or customary arrangements ($\chi^2(1) = 7.64, p = .01$), and shared functions with joint oversight arrangements ($\chi^2(1) = 7.42, p = .01$).
  - Post hoc analyses: Positive associations.

- No significant relations between tribe-county CJS agreement and county-reported CJS arrangements.
Accreditation

- 3 of 83 tribes and 2 of 29 counties reported that current tribe-county CJS efforts were to meet national accreditation standards in emergency management.
  - Accreditation Association for Ambulatory Health Care, Inc.
  - National Emergency Response Framework
Summary and Discussion

- Tribal representatives were often elected officials or emergency staff, not health clinic staff.
  - Tribal leaders or designated tribal emergency or environmental staff should be involved in developing and sustaining tribe-county CJS arrangements.
- CJS arrangements, including formal CJS arrangements, were associated with tribe-specific population sizes and how many total tribes were in the county jurisdiction.
  - Consider informal tribe-county arrangements as step toward formal or other CJS arrangements.
  - Reach out to smaller tribes, especially in counties with a greater number of tribal jurisdictions.
Summary and Discussion (Cont.)

- Tribe-county CJS agreement was associated with tribes’ report of CJS arrangements.
  - Important to engage in cross-jurisdictional communication.
- Accreditation-related CJS arrangements were limited.
  - Consider accreditation as an avenue for improving population and community health.
Next Steps: Dissemination

- Advisory groups
- Other meetings of Tribal Leaders
- National conferences (American Public Health Association, National Indian Health Board)
- Regional roundtables in Northern, Central, and Southern California
- Reports and manuscripts
Next Steps: Research

- Address additional research questions.
  - Interview at least 21 tribe-county pairs.
    - Agree do not have CJS arrangements (6 pairs)
    - Agree have CJS arrangements (6 pairs)
    - Disagree about having CJS arrangements - county reports CJS but tribe does not (6 pairs)
    - Disagree about having CJS arrangements – tribe reports CJS but county does not (6 pairs)
  - Assess value placed on current CJS arrangements.
  - Assess historical or other factors influencing current CJS arrangements.
Project Information & Updates

go to: http://www.publichealthsystems.org/cross-jurisdictional-sharing-arrangements-between-tribes-and-counties-emergency-preparedness
Commentary

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Questions and Discussion
## Upcoming Webinars

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<tr>
<th>Date</th>
<th>Time</th>
<th>Title</th>
<th>Speaker(s)</th>
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<tr>
<td>May 4, 2016</td>
<td>12-1p ET/ 10-11a MT</td>
<td><strong>Hospital Investment and Interaction in Public Health Systems</strong></td>
<td>Danielle Varda, PhD, University of Colorado, and Lisa VanRaemdonck, MPH, MSW, Colorado Association of Local Public Health Officials</td>
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<td>May 19, 2016</td>
<td>1-2p ET/ 10-11a PT</td>
<td><strong>Are We Measuring Up? Exploring Public Health Performance and Health Equity in the United States and Canada</strong></td>
<td>Phuc Dang, MA, University of Victoria, British Columbia and University of Kentucky College of Public Health</td>
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<td>June 23, 2016</td>
<td>12-1p ET/ 11-12a CT</td>
<td><strong>Improving the Efficiency of Newborn Screening from Collection to Test Results</strong></td>
<td>Beth Tarini, MD, MS, University of Iowa College of Medicine, formerly at University of Michigan Medical School</td>
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Thank you for participating in today’s webinar!

For more information about the webinars, contact:
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Speaker Bios

Maureen Wimsatt, PhD, MSW is Director, California Tribal Epidemiology Center and Manager of Epidemiology at the California Rural Indian Health Board. She has thirteen years of public health research and program evaluation experience, including a research history with the University of Maryland, Washington State University, and University of Michigan, and several independent consulting firms. Dr. Wimsatt completed a PhD in Human Development at the University of Maryland, where she conducted research on health, social relationships, and culture with the Center for Children, Relationships, and Culture. Dr. Wimsatt previously worked for an Indian-owned, small business federal contractor in Washington state, where she helped evaluate health and education programs in American Indian and Alaska Native communities. Dr. Wimsatt earned a Master of Social Work degree with emphasis in rural social work practice and mental health counseling from Eastern Washington University. Maureen.Wimsatt@CRIHB.ORG

Michael Mudgett, MPH is an enrolled member of the Spirit Lake Nation in North Dakota and an Epidemiologist for the California Tribal Epidemiology Center housed within the California Rural Indian Health Board. Mr. Mudgett obtained a Master of Public Health from the University of North Dakota, and previously worked with the National Resource Center on Native American Aging and the Urban Indian Health Institute. Michael.Mudgett@CRIHB.ORG

Charles Magruder, MD is the Chief Medical Officer for the Indian Health Service California Area Office. Dr. Magruder is a graduate of University of Kansas School of Medicine. He completed residencies in Preventive Medicine, and Psychiatry from Walter Reed Army Institute of Research and a Masters’ of Public Health from Harvard University School of Public Health. Dr. Magruder has extensive experience in public health, medical epidemiology, primary care and medical administration. He is a military veteran and has worked as a county health officer and for government agencies such as the U.S. Army, the U.S. Air Force, and the Centers for Disease Control and Prevention. Charles.Magruder@IHS.GOV