2025 Tribal Foundational Public Health Services Implementation Report

2024–2025 Evaluation Report

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Introduction

Foundational public health services are the basic capabilities and programs that must be present in every community to protect the safety and health of all citizens. They are key components of effective governance. As sovereign nations, Tribes must have the resources and partnerships needed to support a robust system of self-determined, foundational public health services (Kauffman and Associates, Inc., 2021).

The American Indian Health Commission (AIHC) is a Tribally-driven nonprofit organization operated by the 29 federally recognized Tribes and two Urban Indian Health Programs (UIHPs) in Washington State, carrying out the priorities set by the Tribes and UIHPs (Washington State Legislature - a, n.d.). AIHC provides a forum for addressing Tribal-state health issues through collaboration with the Washington State agencies that are party to the Governor's Indian Health Advisory Council (GIHAC), including the Washington State Department of Health (WA DOH) (Washington State Legislature-b, n.d.). Through this Tribal-state collaboration, these systems are being strengthened within each Tribal nation to improve the health status of American Indians/Alaska Natives (AI/AN) across the state.

Most recently, funding was provided through an appropriation by the legislature to build a more equitable public health system across the state, inclusive of the 29 federally recognized Tribes and two UIHPs, who are recognized as part of the state's governmental public health system in RCW 43.70.515. Each Tribal nation is working to build public health infrastructure in their jurisdiction, including hiring staff and designing projects to strengthen their public health programs and bolster Washington's governmental public health system.

The goal of this evaluation is to: (1) provide formative data to support the process; (2) gauge progress toward each program's goals; (3) facilitate collaborative learning to accelerate capacity building; and (4) document the essential elements of this Tribal-state, cross-jurisdictional relationship.

From December 2024 through June 2025, the AIHC, in partnership with Kauffman and Associates, Inc., (KAI) conducted an evaluation of the implementation of Tribal Foundational Public Health Services (TFPHS) to:

- Examine how TFPHS resources supported community-driven health projects
- Explore key indicators of project initiation and ongoing sustainability

The evaluation included both quantitative and qualitative components. All Tribes and UIHPs were invited to complete a survey assessing their jurisdiction's current FPHS capacity and expertise. The results were compared to the 2020 baseline assessment survey when possible. Findings from the evaluation survey were used to illustrate Tribes' and UIHPs' progress toward implementing their TFPHS project, identify key elements of their work, and determine remaining support needs. In addition, two focus groups were convened to gather qualitative information on

the same topics and to supplement the quantitative findings. This report documents the results and findings from the survey and qualitative information from the focus groups.

Background

While there are many different conceptualizations of public health, the CDC Foundation offers the following succinct yet broadly encompassing definition: "*Public health is the science of protecting and improving the health of people and their communities*" (CDC Foundation, 2023). In the United States, the responsibility to uphold and promote the health of the public is a core function at all levels of government (federal, Tribal, state, and local) (Institute of Medicine, 2002). As domestic sovereign nations, Tribes have a unique political and legal status, allowing them to exercise legal authority over their jurisdictions, including in the area of public health (Public Health Law Center, 2020). While the Snyder Act of 1924 defined the obligation of the U.S. government to provide essential public health services to Tribes (Snyder Act of 1924), it was not until later legislation—including the Indian Health Care Improvement Act (Patient Protection and Affordable Care Act, 2010) and the Indian Self-Determination and Education Assistance Act (Indian Self-Determination and Education Assistance Act, 1975)— that Tribes' authority to oversee public health functions for their people as they see fit was recognized. It is through their authority as sovereign nations that Tribes determine, establish, control, operate, deliver, and evaluate public health services for their citizens.

As sovereign nations, Tribes are Tribal Health Jurisdictions. In the context of public health, Tribes have inherent authority as sovereign nations to protect and promote the health and welfare of their citizens, using the methods they deem most relevant for their communities (United States v. Wheeler, 1978). Tribal inherent authority is a "plenary and exclusive power over their members and their territory, subject only to limitations imposed by federal law," and includes the power to determine the form of Tribal government and the power to legislate and tax, among others (Newton et al, 2012). Given the complex nature of Tribal jurisdictions, this exercise of authority is often performed within and beside overlapping federal, state, and local jurisdictions. At the state level, Washington state's public health system has four main components: the DOH (state), State Board of Health (SBOH), Local Health Jurisdictions (LHJs) (local), and sovereign Tribal nations and Indian health programs (Washington State Legislature – c, n.d.). With their commitment to the transformation and modernization of public health to ensure the health and safety of their Tribal communities, Tribes are an essential component of the Washington state public health system.

Washington state has been working to modernize and adequately fund its public health system. Washington state established three goals:

- Adopt a limited, statewide set of core FPHS;
- Fund FPHS through state funds, providing local revenue-generating options and allowing local communities to address local public health priorities; and
- Deliver FPHS services in ways that maximize efficiency and effectiveness and are evaluated over time.

In 2015, the state's Foundational Public Health Policy Workgroup recommended that Tribal public health jurisdictions, with support from the DOH, undertake a process to analyze how the state's FPHS funding and delivery framework relates to Tribal public health and determine how Tribal public health, DOH, and LHJs can best work together to serve all people in Washington state.

In 2015, the AIHC convened a TFPHS technical workgroup on behalf of the 29 Tribes and two UIHPs. The workgroup included representatives from Tribal programs, Tribal councils, and Tribal organizations; AIHC staff; and liaisons from the Washington State Association of Local Public Health Officials. The workgroup was tasked with:

- Facilitating a process for Tribes to document and define TFPHS;
- Identifying TFPHS gaps in Tribal communities; and
- Estimating resources needed and costs of filling the identified gaps.

In 2018, the AIHC's executive director and executive committee members joined the state's FPHS steering committee and contributed to drafting the Foundational Public Health Policy Act of 2019. This act recognized Washington state Tribes and UIHPs as one of four components of the state's public health system, along with the DOH, SBOH, and LHJs. The bill's budget package included $1.2 million for Tribes to develop a set of definitions for TFPHS and a plan to fund the work of strengthening Tribes and UIHPs' FPHS programs and capabilities. The funds were also targeted at supporting the efforts of Tribal organizations.

Through the work of the FPHS steering committee, a request to fully fund FPHS across all sectors of Washington state's public health system was made to the Washington State Legislature. During the 2021 legislative session, the legislature committed to sustainably fund FPHS at a level not seen before. For the 2021–2023 biennium, this increase was nearly $147 million. While some funding was originally intended to complete projects interrupted by the COVID-19 pandemic, Tribes could still use these funds to improve their communities' health. AIHC delegates met on March 8, 2023, in a special delegates meeting and voted that the remaining funding should be split between the Tribes contracted to do FPHS work.

For the 2023–2025 biennium, the increase will be just over $324,230,000, with $109 million distributed in FY2023–2024. Additionally, sovereign Tribal nations and UIHPs received a set-aside of approximately five percent each biennium from these funds for their work. This funding is essential for Tribes and UIHPs to build their FPHS capacity, implement service-delivery models that allow for system stabilization and transformation, and strengthen the ability of all four of Washington state's public health system sectors to work together.

In 2019, DOH contracted KAI to work with the AIHC to facilitate a process for Tribes and UIHPs to develop a set of common TFPHS definitions. The TFPHS technical workgroup defined Tribal foundational capabilities as "the knowledge, skills, or abilities necessary to carry out public health activities and programs." They then identified six TFPHS capabilities:

- Assessment and epidemiology;
- Emergency preparedness and response;
- Communications;

- Policy and planning;
- Community and partnership development; and
- Leadership and organizational competencies.

In addition, the TFPHS technical workgroup defined Tribal foundational programs as “programs that are necessary to assess, protect, and improve public health.” They then identified five TFPHS foundational programs:

- Communicable disease control;
- Prevention and health promotion;
- Environmental public health;
- Clinical and preventive services; and
- Maternal, child, and infant health.

Additionally, AIHC and KAI created a matrix to document which partners (Tribes, Tribal epidemiology centers, Washington state, and LHJs) perform FPHS functions and definitions of those functions. This matrix demonstrated that there are shared responsibilities across most FPHS areas.

In 2020, AIHC and KAI implemented a survey aimed at understanding how the TFPHS funding was being used by Tribes and UIHPs to support public health functions in their communities. The survey was open to all 29 Tribes and the two UIHPs in Washington state. To expand on and further clarify the data collected through the survey, the AIHC and KAI facilitated five regional focus groups to collect qualitative data on Tribes’ and UIHPs’ (1) TFPHS provision, (2) experiences responding to the COVID-19 pandemic, and (3) funding needed to strengthen the Tribal public health system.

Throughout the past six years, KAI has continued to implement the evaluation of TFPHS projects by Tribes and UIHPs. In 2022 through 2023, KAI evaluated 10 funded TFPHS projects, comprising nine Tribes and one UIHP. The evaluation was designed to build on the previous self-assessment survey. Currently, from 2023 through 2025, KAI is again undertaking an evaluation, this time of all TFPHS projects and their process, progress, and goals. At the time of this report, 28 Tribes and one UIHP completed the contracting process for the 2023-2025 biennium.

Evaluation Approach

The evaluation uses a mixed-methods design to collect summative data that will address the evaluation questions aligned with the goals and objectives of the program. The evaluation plan is guided by two key objectives:

I. Examine how TFPHS resources supported community-driven health projects
II. Explore key indicators of project initiation and ongoing sustainability

To do so in a manner that is culturally appropriate and attuned to the needs of the Tribal constituents, an evaluation plan based on the principles of the Indigenous Evaluation Framework (IEF) was developed (LaFrance & Nichols, 2009; LaFrance, Nichols, and Kirkhart, 2012). The full evaluation plan is available in **Appendix A: WA DOH TFPHS Comprehensive Evaluation Plan.**

The evaluation criteria are based on these same principles and seek to answer the following questions:

- Cultural Relevance
  - How do TFPHS projects align with Tribal community cultural values and traditional practices?
  - How do community members perceive the projects?
- Community Engagement
  - How were community needs considered in the TFPHS projects?
- Usability
  - No questions were developed under this criterion, but it was used to guide the evaluation summary and recommendations.
- Effectiveness
  - To what extent have the TFPHS initiatives achieved their stated goals and objectives?
- Sustainability
  - What factors contribute to the sustainability of the TFPHS initiatives in their communities?
  - What resources or support systems are necessary to ensure the ongoing success of the public health infrastructure developed through this initiative?

The comprehensive evaluation plan will guide the process for gathering the information needed to address each question. In addition, the plan outlines related sub-questions, data sources, timing, and analytical methods.

Methodology

The TFPHS 2025 evaluation plan consists of two main sources of data: (1) an assessment that evaluates Tribes/UIHPs based on their capacity and expertise in the six foundational public health capacities, five foundational public health services, and (2) two focus group discussions that provided qualitative data**.**

Tribes/UIHPs were organized into one of two groups: a pre-post assessment group consisting of those who had completed an assessment during the first round of evaluation in 2020 and also completed an assessment in 2025, and a comprehensive group that includes all Tribes that submitted an assessment in 2025. This approach provides both a view of how things have changed for the pre-post group and the current state of TFPHS as the 2023-2025 cycle comes to an end. For confidentiality, this document does not identify which Tribes/UIHPs were assigned to each group.

For the focus groups, the audience was the same, and both groups received the same questions. The findings represent an aggregate view of each question across both focus groups.

Quantitative

Each of the two groups received the same assessment instrument, available in **Appendix B: Assessment Instrument**. For Tribes that had completed an assessment in 2024, their previous capacity and expertise scores were attached so that they could easily assess any change year-to-year. However, these scores were not used in analysis and were provided only to facilitate a more accurate self-assessment of capacity and expertise.

Data collection was conducted between January 31 and March 31, 2025, and was entirely electronic; the assessment was hosted on SurveyMonkey. Distribution occurred via email through SurveyMonkey, with regular bi-weekly reminders sent to participants who had not yet completed the assessment. Supplementary follow-up was conducted via the Tribal FPHS Workgroups hosted by AIHC and through personal email follow-up to those participants who either requested support or were identified as needing further support. This comprehensive outreach strategy was developed to maximize the number of complete assessment responses. Nevertheless, because the total sample size is limited (maximum = 31), no statistical comparisons were made between groups.

Assessment

The self-assessment was adapted from BERK Consulting's framework used in the *State of Oregon Tribal Public Health Modernization Assessment Process Summary* (July 2018). The tool includes two scales:

- **Capacity –** The degree to which the organization currently has the staffing and resources necessary to carry out the activity.
- **Expertise –** The degree to which the organization possesses the appropriate knowledge, training, and education to carry out the activity.

For each public health activity under foundational capabilities and foundational programs, Tribal representatives were asked to score their Tribe on a scale from one to five, as shown in Figure 1. The scores represent each respondent's best judgement of the degree to which their Tribe has the capacity and expertise required to carry out each public health activity. Unlike a Likert scale, which is symmetrical around a neutral midpoint, this sliding scale was considered a better fit for this assessment. Each increasing numerical value represents a subjective perception of an increase in the degree to which the organization has the capacity or expertise to carry out each function.

Score	1	2	3	4	5
Capacity	Not currently provided	→	Able to provide the basics at a lower level of service	→	Fully meets requirements

Expertise	Not currently provided	→	There is a meaningful gap in skills or knowledge	→	Fully meets requirements

Figure 1: Capacity and Expertise Scale

Assessments were first administered between June and August 2020. These are considered "pre" assessments for the purpose of this analysis. For this evaluation, the updated assessment was distributed to all Tribes and UIHPs in Washington state.

Participants were asked to score their current capacity and expertise for each of the foundational capabilities or foundational programs that they had selected as a focus area in their project scope of work. An aggregate analysis comparing the pre-assessment scores (2020) to the post-assessment scores (2025) was then performed by each capability or program area. Similarly, descriptive analysis of all the 2025 scores was also performed and presented on an aggregate level.

Qualitative

Two 60-minute focus groups ("roundtable discussions") were held to gather qualitative information unavailable during the last evaluation or from other data sources. The focus group guide can be found in **Appendix C: Focus Group Guide.** Each discussion group was limited to 5-10 participants and included an experienced facilitator.

AIHC facilitates monthly 2-hour technical-advisory workgroup sessions for tribes and UIHPs; these meetings provided an ideal venue for the focus groups. AIHC outreach alerted participants to the opportunity and encouraged attendance. Both focus groups took place on March 26, 2025.

Sessions were recorded and transcribed using Rev.com. Analysis consisted of thematic coding, based on pre-set codes based on the evaluation plan questions, conducted in NVivo Version 15 software. A descriptive qualitative analysis summary was produced for each question and associated code.

Findings

Participation

Overall, 19 Tribes and two UIHPs participated in the 2025 TFPHS evaluation, comprising a 67.7% response rate across all eligible participants.

For the focus groups, 13 total participants represented 9 Tribes and one UIHP. While there were other participants from AIHC and DOH who joined to listen or assist, they are not counted in this participant list and responses are not included in the analysis.

For the assessment, 16 complete assessments and two partially completed assessments were received from 16 Tribes and both UIHPs. The 16 completed assessments were analyzed in their entirety; the two partially completed assessments were only included in the analysis of the open-

ended questions. Of the 16 completed assessments, six Tribes had previously completed a baseline assessment in 2020, and thus comprised the pre-post assessment group.

Assessment of Capacity and Expertise

An assessment of Tribal and UIHPs responses was performed to evaluate levels of public health capacity and expertise across each foundational capability and program area. Individual responses were aggregated and presented as averages. For respondents that completed the 2020 pre-assessment, the results were compared to examine change between funding biennia. Aggregate findings are presented first, followed by pre-post results.

Aggregate Findings

Table 1 shows the scoring chart that displays the level of implementation for each foundational program and capability across all Tribes/UIHPs. It was adapted from the Public Health Accreditation Board's Assessment of Public Health Systems tool (Public Health Accreditation Board, 2023). As described in the Methodology section, participants were asked to score their capacity and expertise in each area according to a five-point scale. Average scores were calculated by averaging capacity and expertise scores across all functions within each area. Scores are presented for the 2025 aggregate and pre-post assessment groups, along with aggregate averages, allowing comparison within the sample and insight into the overall state of TFPHS in 2025.

Table 1: Level of Implementation Scoring Chart

Level of Implementation				
Not implemented	Limited	Partial	Significant	Fully Implemented

Table 2: Level of Implementation for TFPHS

	Aggregate	Pre-post	2025
Assessment and Epidemiology	3.3	3.3	3.2
Emergency Preparedness and Response	3.4	3.4	3.3
Policy and Planning	3.5	3.6	3.5
Communications	3.6	3.9	3.2
Community Partnership Development	3.8	4.0	3.7
Leadership Competencies	3.8	3.9	3.7
Communicable Disease Control	3.9	4.1	3.6
Prevention and Health Promotion	3.9	3.9	3.8
Environmental Public Health	2.7	2.8	2.7
Clinical Preventive Services	3.8	3.9	3.6
Maternal and Child Health	3.5	3.5	3.5

Table 2 displays the level of implementation for each of the TFPHS capabilities and programs on an aggregate level. According to this matrix, the lowest level of implementation was observed in the Environmenta Public Health capability (2.7) while the highest level of implementation was observed in the Communicable Disease Control program and Prevention and Health Promotion program (3.9). For almost all areas, the pre-post group's average scores were higher than the baseline group's, with the exception being Maternal and Child Health, where the scores were even. No area met the level of full implementation; likewise, no area fell below the standard of partial implementation.

Assessment and Epidemiology

Figure 2 includes a breakdown of the average 2025 aggregate scores for the Assessment and Epidemiology foundational capability, with each of the three functions separated by capacity and expertise. For the first function, "collect sufficient data and develop and maintain electronic information systems to guide public health planning and decision making," the average scores for capacity and expertise were 3.0 and 3.4, respectively. For the second function, "access, analyze, use and interpret data," capacity was scored 3.1, while expertise also scored at 3.4. The third function "Conduct a comprehensive community assessment…" had even scores of 3.3 across both capacity and expertise.

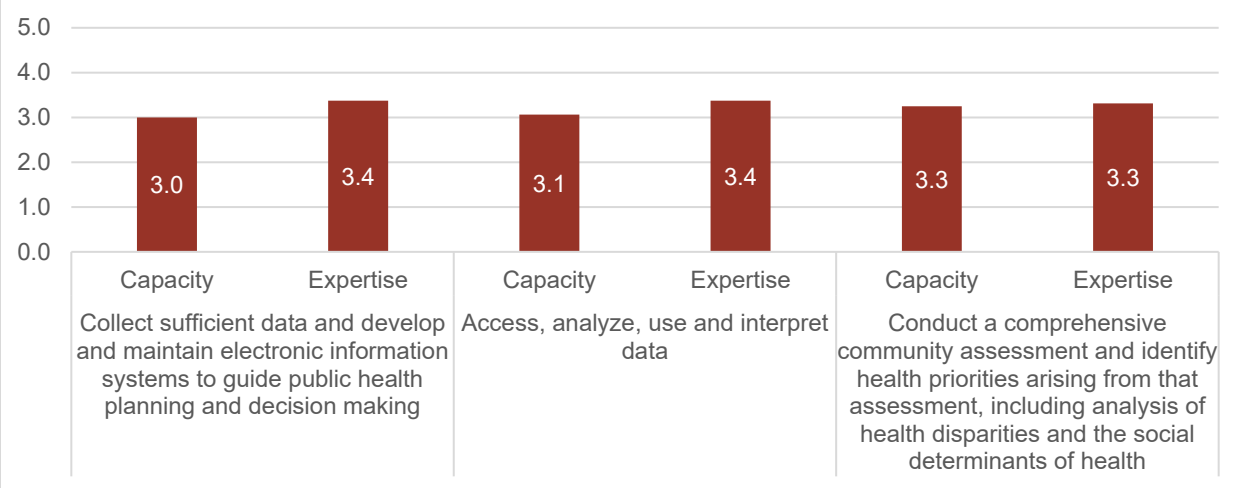

Figure 2: Assessment and Epidemiology–2025 Aggregate Analysis (n= 16)

Figure 3 displays the pre-post comparison of capacity and expertise for the assessment and epidemiology foundational capability. Overall, both capacity and expertise scores increased or stayed the same between 2020 and 2025 for most functions, with the exception of expertise for the third function. For the first function, capacity increased from 2.4 to 3.2, while expertise increased from 2.7 to 3.7. For the second function, capacity remained the same, 3.0, while expertise increased from 3.3 to 3.7. For the third function, capacity increased from 2.6 to 3.3, while expertise decreased to 3.0 from 3.3 in 2020.

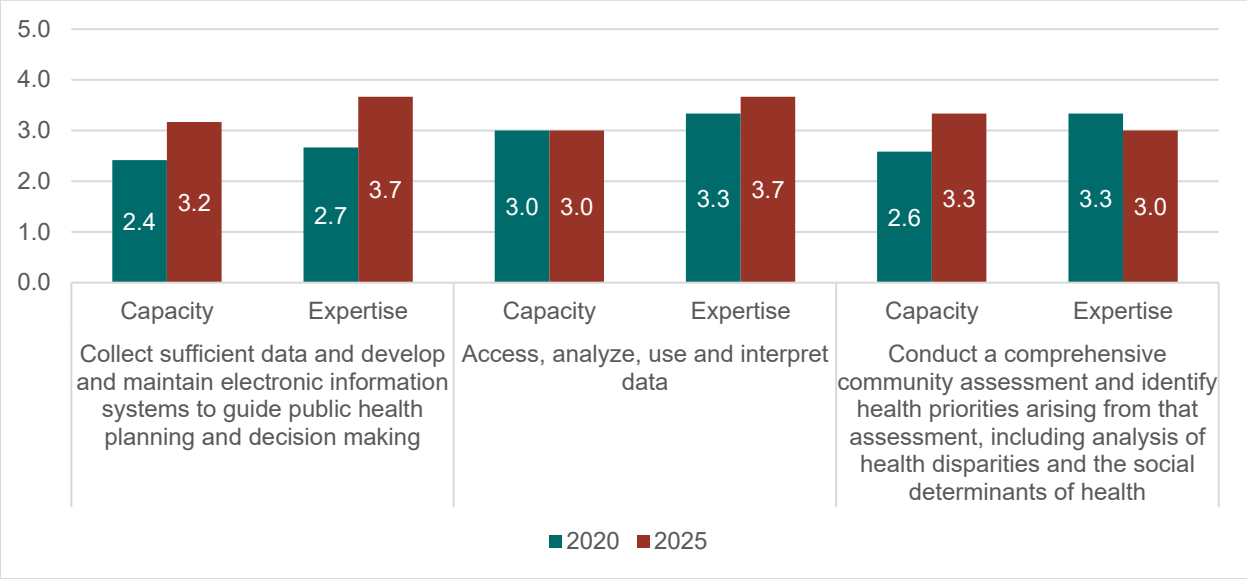

Figure 3: Assessment and Epidemiology–Pre-post Analysis (n=6)

Emergency Preparedness and Response

Figure 4 provides an overview of the average 2025 aggregate scores for capacity and expertise of the Emergency Preparedness and Response foundational capability by each of the four functions. For the first function, capacity was rated at 3.4, while expertise was 3.7— the highest score across each of the four functions. The second function “Lead the Emergency Support Function 8…” had a score of 2.8 for capacity and 3.1 for expertise— the lowest of any of the four functions. The third function “Activate and mobilize public health personnel and response teams…” had a capacity score of 3.0 and expertise score of 3.4. Finally, scores were even at 3.6 for capacity and expertise for the fourth function ”Communicate with diverse communities….”

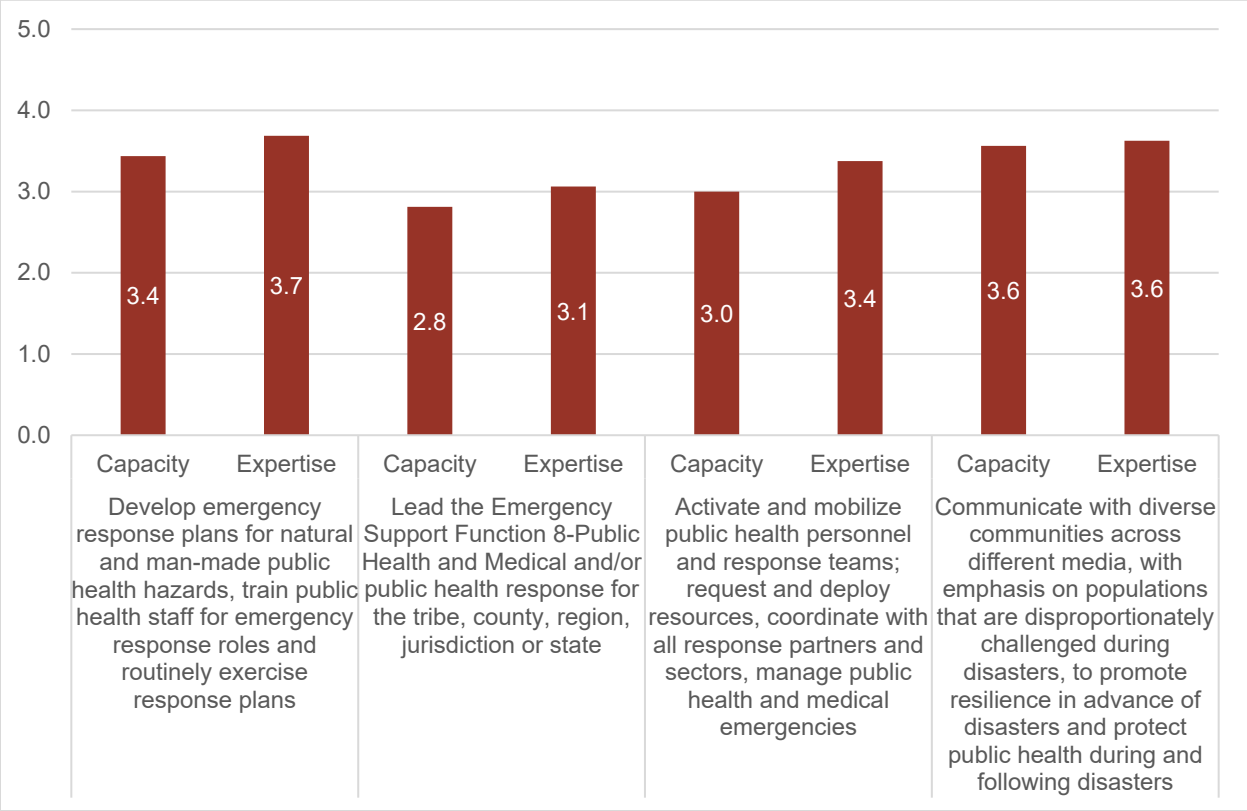

Figure 4: Emergency Preparedness and Response—2025 Aggregate Analysis (n= 16)

Figure 5 displays the pre-post scores for capacity and expertise of the Emergency Preparedness and Response foundational capability by each of the four functions. Across all functions, expertise was scored higher than capacity, with the highest expertise score (4.0) in the fourth function. Positive change was observed for all functions. For the first function, “Develop emergency response plans…,” capacity improved from 2.2 in 2020 to 3.5 in 2025, while expertise improved from 2.2 to 3.7 over the same time period. For the second function, “Lead the Emergency Support Function 8…”, capacity improved from 2.1 to 2.7, while expertise improved from 2.0 to 2.8.

The third function, “Activate and mobilize public health personnel and response teams…,” had a capacity score of 3.0 in 2020 and 3.2 in 2025, while the expertise score was 2.6 in 2020 and 3.5 in 2025. Finally, scores for the fourth function, “Communicate with diverse communities…,” increased from 2.8 to 3.8 for capacity and from 3.1 to 4.0 for expertise.

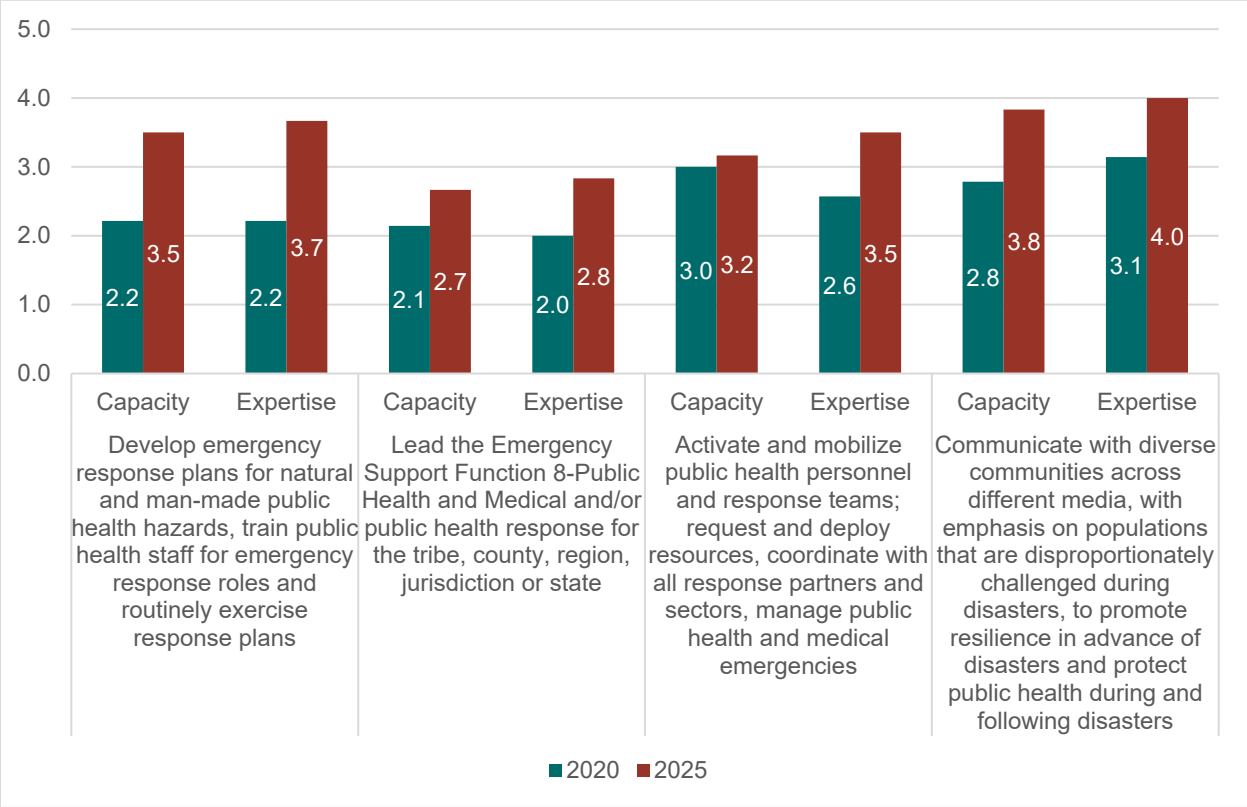

Figure 5: Emergency Preparedness and Response–Pre-post Analysis (n=6)

Policy and Planning

Figure 6 displays the summary of the Policy and Planning foundational capability by capacity and expertise for the three functions for the 2025 aggregate analysis. The first function, “Develop basic public health policy recommendations…,” was scored at 3.4 for both capacity and expertise. For the second function, “Work with partners and policy makers…,” the capacity score was 3.4, while the expertise was slightly higher at 3.6. Similar scores for capacity (3.4) and expertise (3.6) were observed for the final function, “ability to utilize cost-benefit information..”.

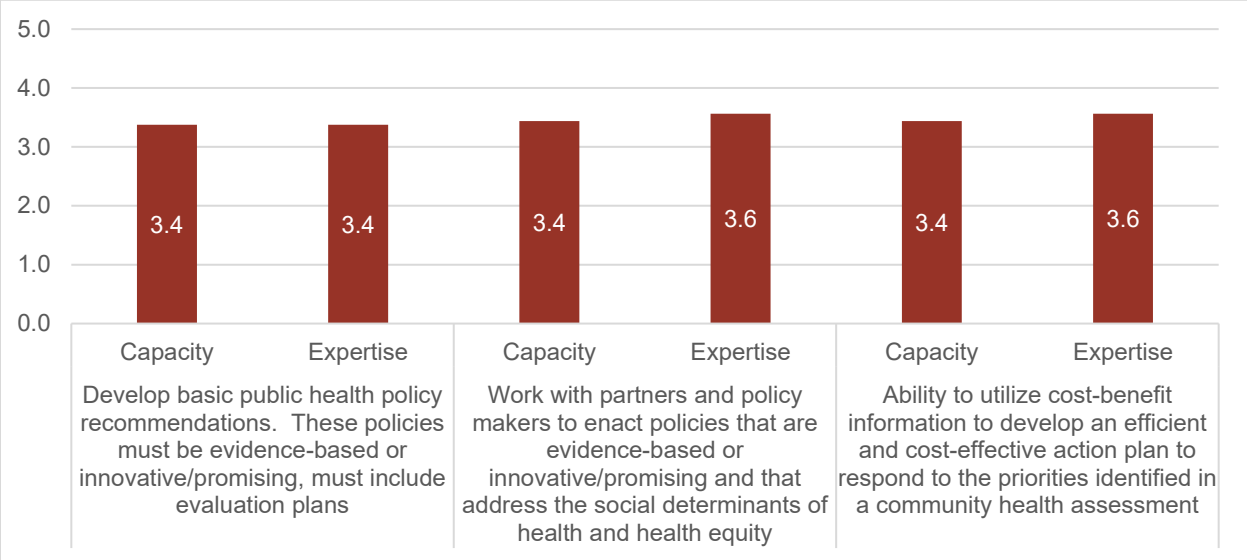

Figure 6: Policy and Planning–2025 Aggregate Analysis (n= 16)

Figure 7 displays the pre-post comparison of capacity and expertise for the Policy and Planning foundational capability. Between 2020 and 2025, capacity for the first function increased from 3.1 to 3.5, while expertise increased from 3.4 to 3.5. For the second function, capacity increased from 3.4 to 3.5, while expertise remained stable at 3.7. For the third function, capacity increased from 2.8 to 3.7while expertise increased from 3.3 to 3.7.

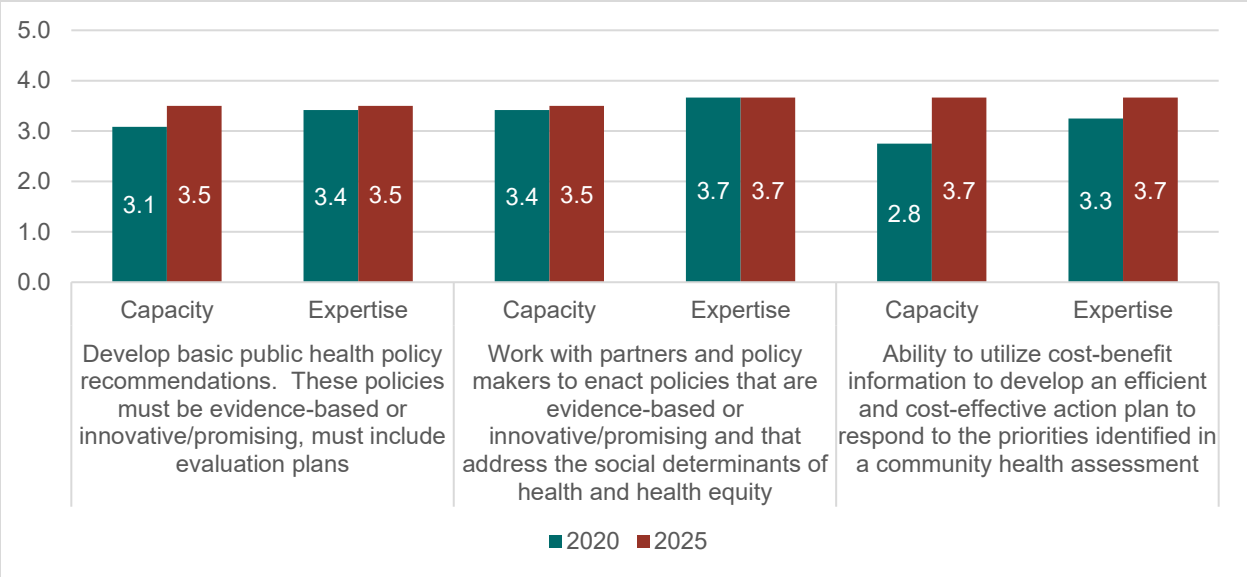

Figure 7: Policy and Planning–Pre-post Analysis (n=6)

Communications

Figure 8 outlines the average 2025 aggregate scores for the Communications foundational capability by capacity and expertise across its two functions. For the first function, “Engage and maintain ongoing relations with local and statewide media,” scores of 3.2 for capacity and 3.4 for expertise were observed. For the second function, “Develop and implement a communication strategy…,” capacity was scored at a 3.1, while expertise was scored at 3.3.

Figure 8: Communications–2025 Aggregate Analysis (n= 16)

Figure 9 displays the pre-post comparison of capacity and expertise for the Communications foundational capability. Overall, capacity and expertise either increased or stayed the same across each of the functions. For the first function, capacity stayed stable at 3.5 between 2020 and 2025, while expertise increased from 3.4 to 3.8. For the second function, both capacity and expertise increased: capacity increased from 2.9 in 2020 to 4.0 in 2025, while expertise increased from 3.3 in 2020 to 4.2 in 2025.

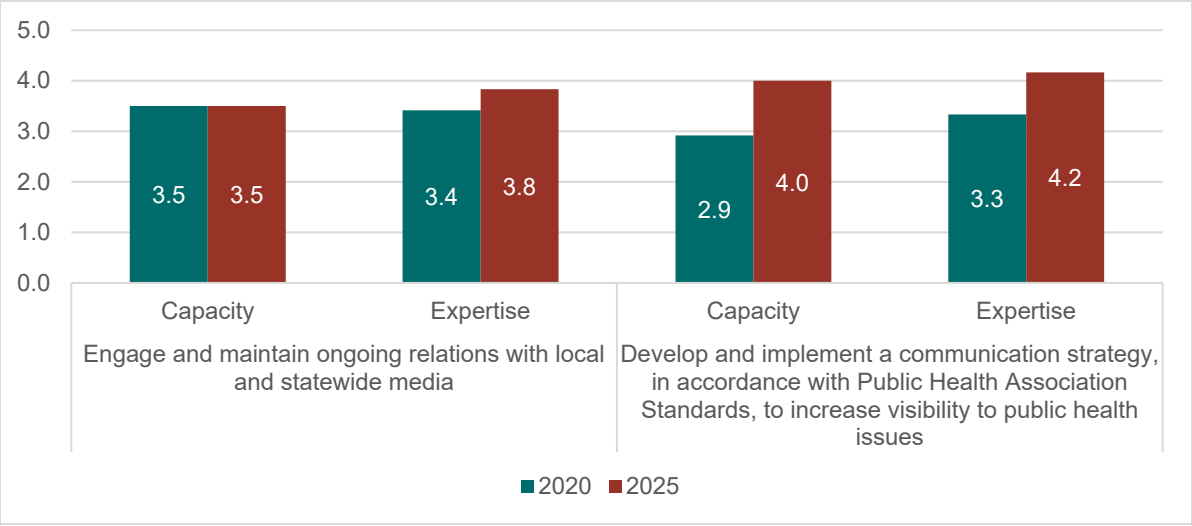

Figure 9: Communications–Pre-post Analysis (n=6)

Community Partnership Development

Figure 10 depicts the 2025 aggregate findings for the Community Partnership Development foundational capability by capacity and expertise for its two functions. The average scores for the first function, "Create and maintain relationships with diverse partners…," were 3.8 for capacity and 4.0 for expertise. For the second function, "Select and articulate governmental public health roles…," capacity was scored at a 3.5, while expertise was scored at 3.6.

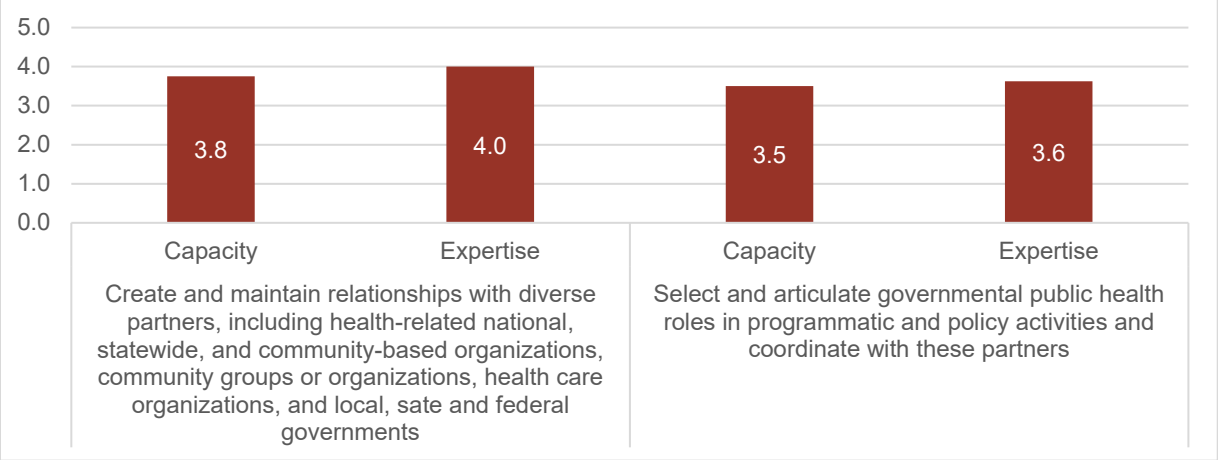

Figure 10: Community Partnership Development–2025 Aggregate Analysis (n= 16)

Figure 11 displays the pre-post comparison of capacity and expertise for the Community Partnership Development foundational capability. For the first function, capacity increased from 3.5 in 2020 to 3.8 in 2025, while expertise increased from 3.8 to 4.2 over the same period. For the second function, capacity increased from 2.8 to 3.8 between 2020 and 2025, while expertise increased from 2.8 to 4.0.

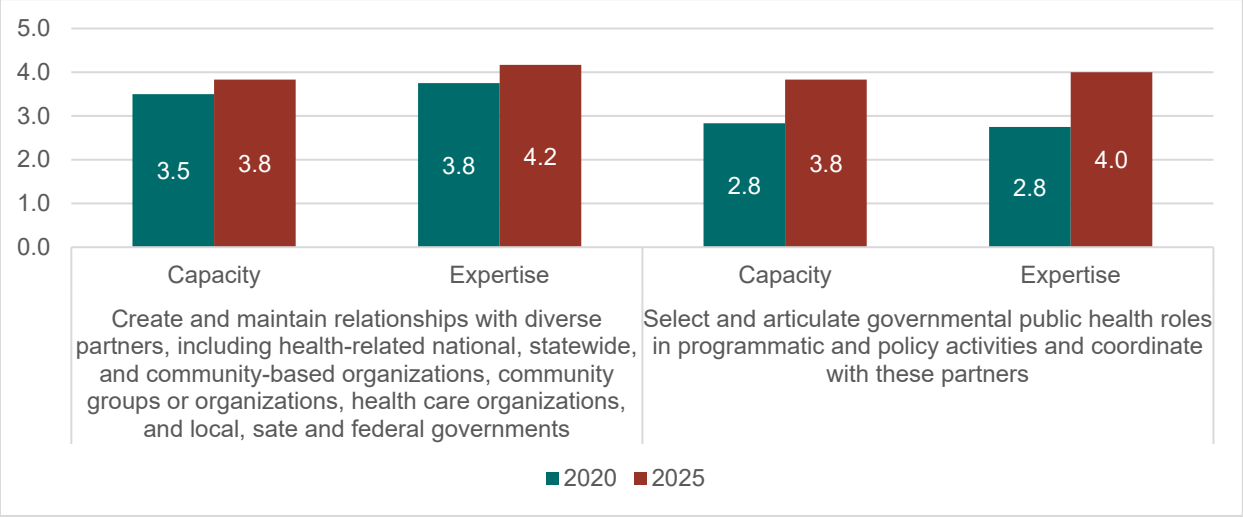

Figure 11: Community Partnership Development–Pre-post Analysis (n=6)

Leadership Competencies

Figure 12 displays average 2025 aggregate capacity and expertise scores for the Leadership Competencies foundational capability across eight functions. For the first function, “Lead internal and external partners to consensus…,” capacity was scored at 3.6, while expertise was scored at 3.8. The second function, “Uphold business standards and accountability,” had a capacity score of 3.6 and expertise score of 3.4. For the third function, “Evaluate programs and continuously improve processes,” capacity was scored at 3.4 while expertise was scored at 3.5. Capacity was 3.4 with expertise at 3.5 for function four “Develop, maintain and access electronic health information….” The fifth function, “Develop, maintain a competent workforce…” was scored at 3.1 for capacity and 3.2 for expertise. Capacity and expertise were highest (4.3) for the sixth function of “Fiscal Management….” Capacity and expertise scores were even at 4.1 for the seventh function of “Procure, maintain and manage safe facilities….” For the last function, “Access and appropriately use legal services…” capacity was scored at 4.0 while expertise was slightly higher at 4.1.

Figure 13 and Figure 14 display the pre-post comparison of capacity and expertise for the Leadership Competencies foundational capability. For the first function, capacity increased from 3.0 in 2020 to 3.8 in 2025, while expertise increased even more, from 2.5 to 4.2. For the second function, capacity increased from 3.4 to 3.8; however, expertise declined slightly from 3.4 to 3.2 over the same period. For the third function, capacity increased to 3.5 in 2025 from 3.3 in 2020, while expertise also increased to 3.7 from 3.2. Capacity increased to 4.0 from 2.8 for the fourth function while expertise also increased to 3.8 from 2.9.

Interestingly, capacity and expertise both decreased for the fifth function: from 3.4 to 3.2 (capacity) and from 3.3 to 3.2 (expertise). Increases were again observed for the sixth function, with capacity increasing from 4.3 to 4.7 and expertise increasing from 4.1 to 4.5. For the seventh function, capacity increased from 3.5 to 4.3, while expertise increased from 3.6 to 4.2. For the eighth function, capacity increased from 3.9 to 4.2; however, expertise decreased slightly from 4.3 to 4.2.

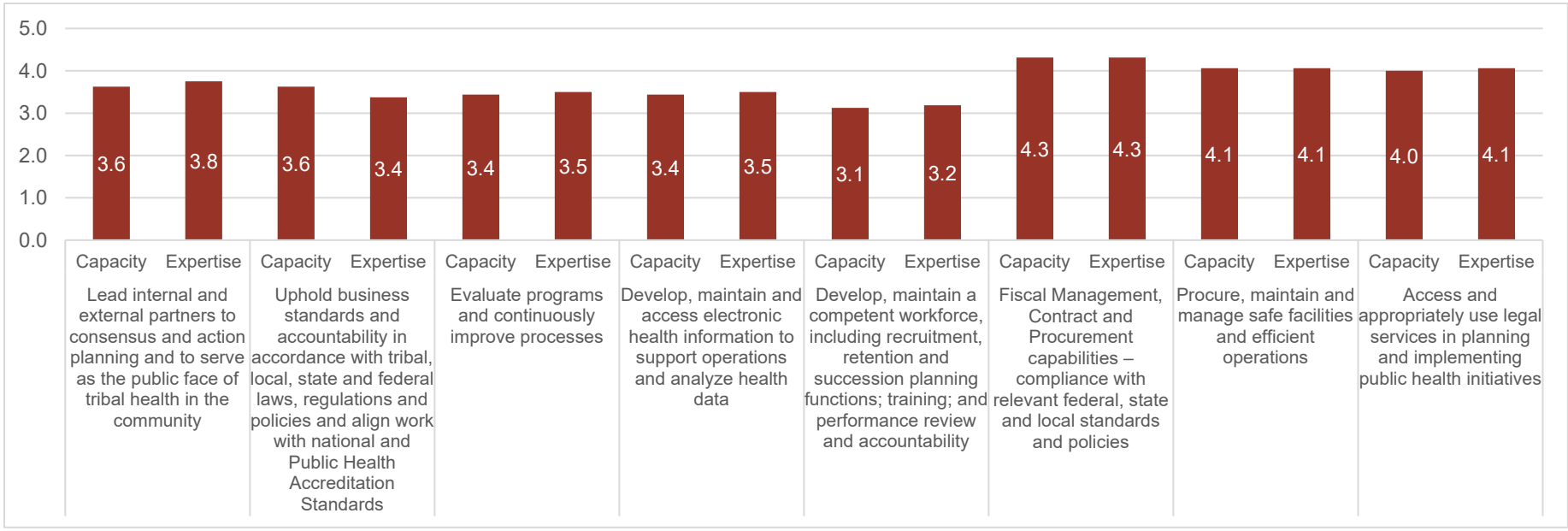

Figure 12: Leadership Competencies–2025 Aggregate Analysis (n=16)

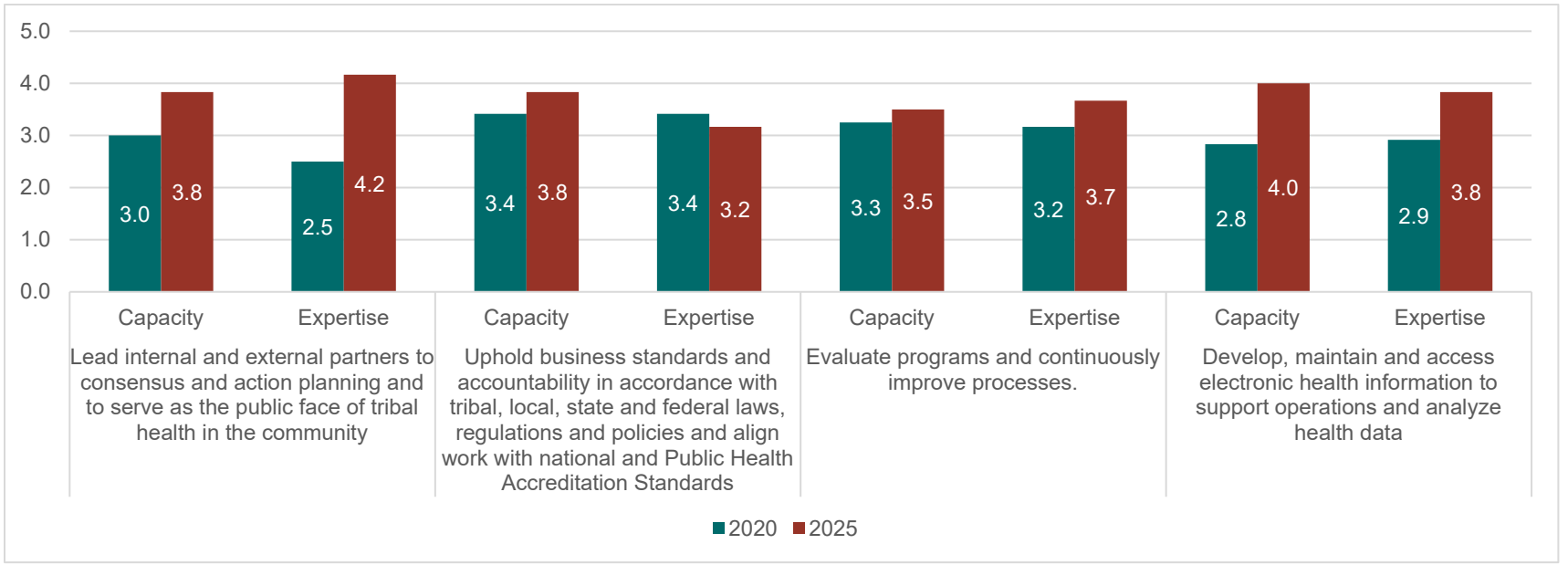

Figure 13: First Four Functions of Leadership Competencies–Pre-post Analysis (n=6)

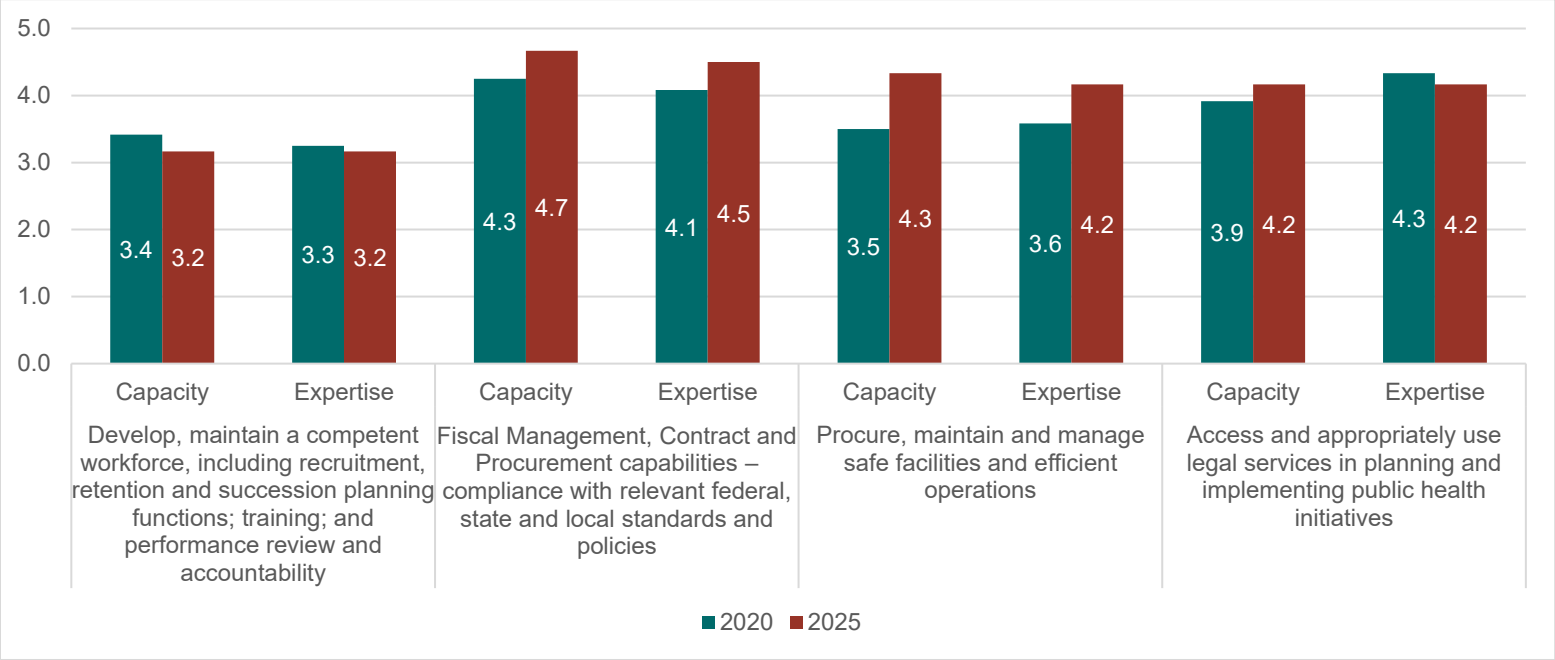

Figure 14: Last Four Functions of Leadership Competencies - Pre-post Analysis (n=6)

Communicable Disease Control

Figure 15 displays findings from the 2025 aggregate analysis for the Communicable Disease Control foundational program across four functions. For the first function, “Provide timely and accurate information…,” capacity was scored at 3.6, while expertise was scored at 3.9. For the second function, “Identify community assets…,” capacity was scored at 3.4 and expertise was 3.8. Scores were even at 3.6 for capacity and expertise for the third function, “Provide immunization and use….” For the fourth function, “Ensure disease surveillance…,” capacity was scored at 3.5 and expertise was scored at 3.6.

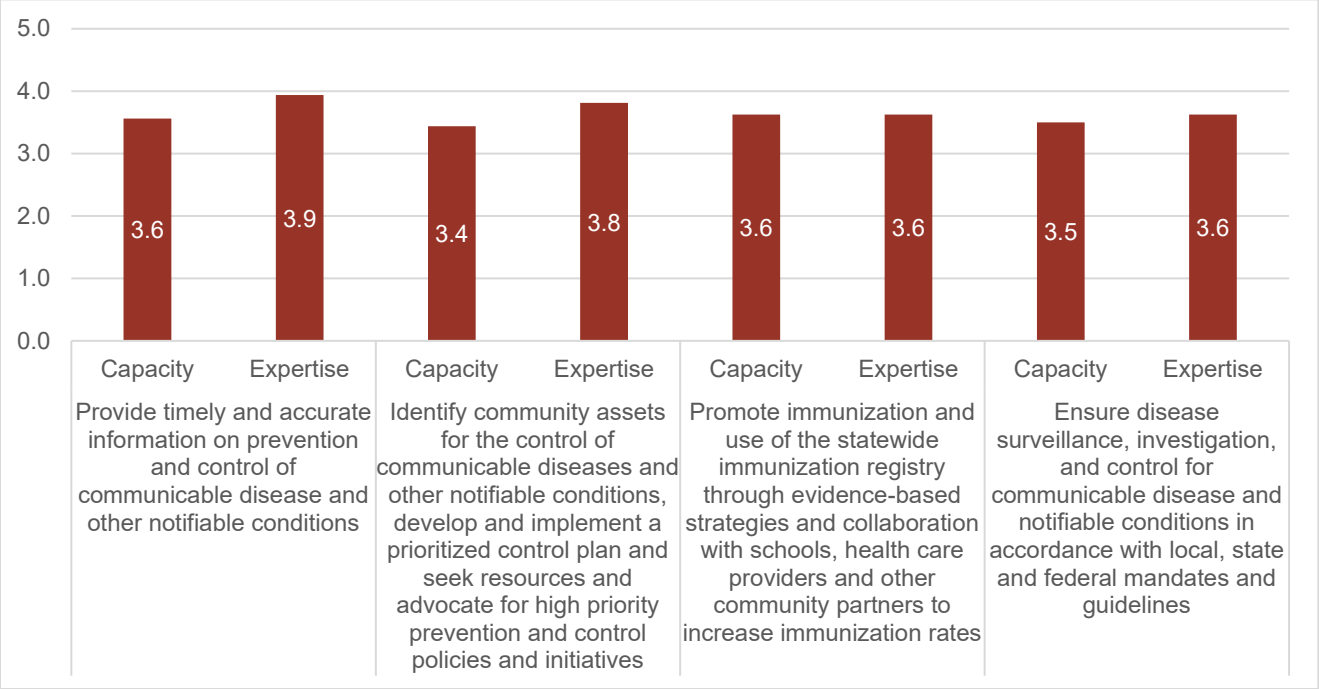

Figure 15: Communicable Disease Control–2025 Aggregate Analysis (n= 16)

Figure 16 displays the pre-post comparison of capacity and expertise for the Communicable Disease Control foundational program. Between 2020 and 2025, capacity and expertise increased for all functions except the first. For that function, capacity decreased from 3.8 to 3.3, while expertise remained the same at 4.0. For the second function, capacity increased from 3.3 to 4.0 and expertise also increased from 3.7 to 4.0. Capacity and expertise increased slightly for the third function, from 4.1 to 4.3 for capacity and from 4.0 to 4.2 for expertise. For the fourth function, both capacity and expertise increased from 3.8 to 4.3.

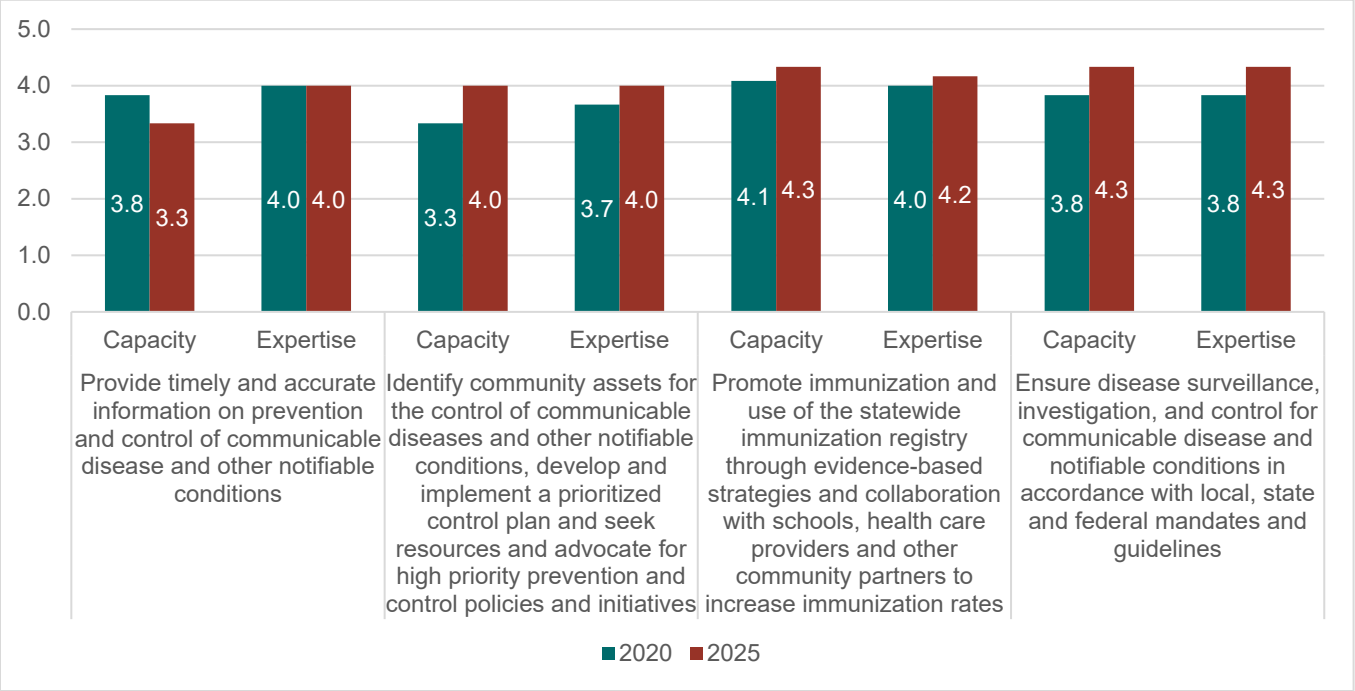

Figure 16: Communicable Disease Control–Pre-post Analysis (n=6)

Prevention and Health Promotion

Figure 17 illustrates 2025 aggregate findings for the Prevention and Health Promotion foundational program. For the first function, "Provide timely, relevant and accurate information…," capacity was scored at 3.5 and expertise at 4.0. For the second function, "Identify chronic disease…," capacity was scored at 3.8, while expertise was scored at 4.2. The third function, "Develop and implement a prioritized prevention plan…," had a capacity score of 3.5 and expertise score of 3.9.

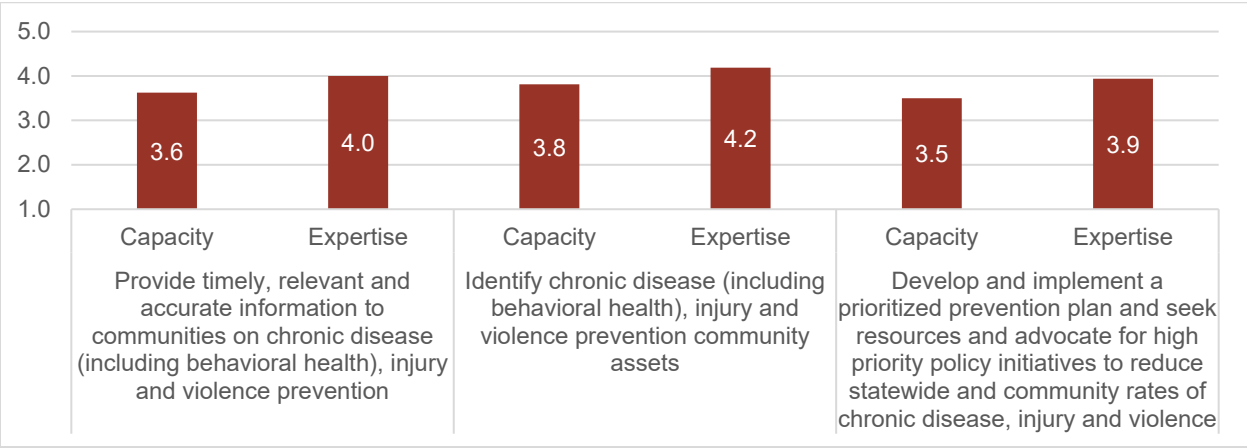

Figure 17: Prevention and Health Promotion–2025 Aggregate Analysis (n= 16)

Figure 18 displays the pre-post comparison of capacity and expertise for the Prevention and Health Promotion foundational program. Between 2020 and 2025, capacity increased from 3.4 to 3.7 for the first function, while expertise increased from 3.8 to 4.0. Over the same period, capacity increased from 3.1 to 4.0 and expertise increased from 3.3 to 4.3 for the second function. For the third function, capacity increased from 3.1 to 3.5 and expertise increased from 3.3 to 4.0.

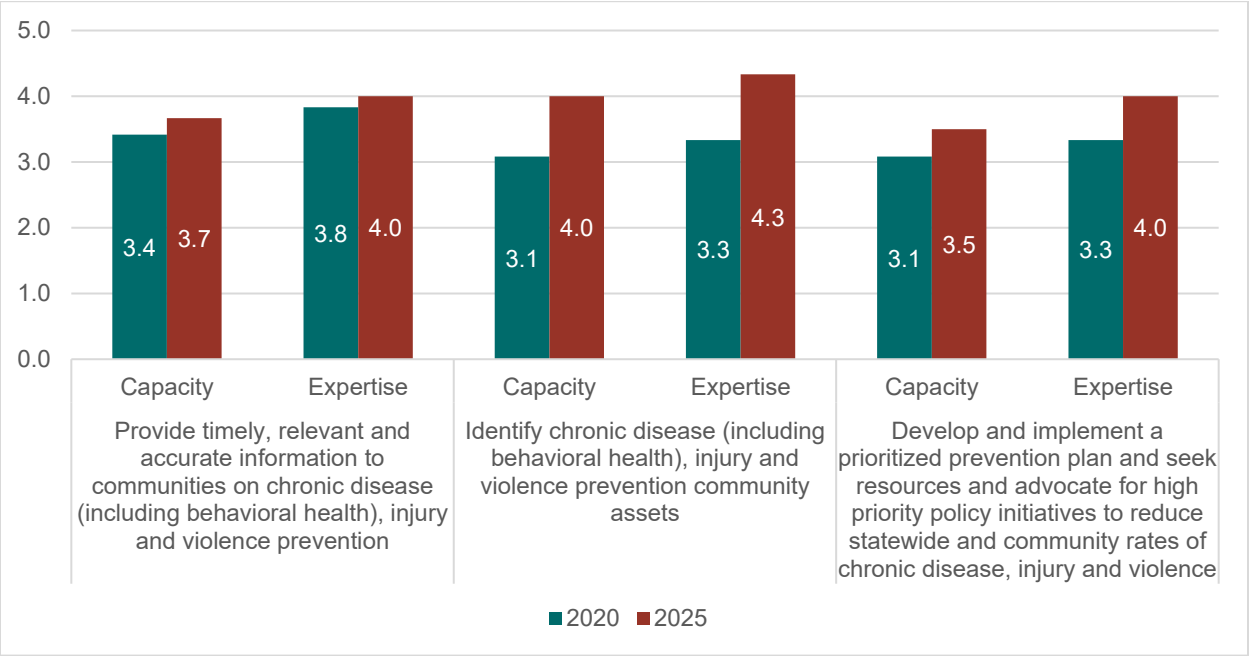

Figure 18: Prevention and Health Promotion–Pre-post Analysis (n=6)

Environmental Public Health

Figure 19 represents the average scores for the Environmental Public Health foundational program by capacity and expertise across six functions. The first function, “Provide timely, relevant, and accurate information on environmental public health issues,” had scores of 2.3 for capacity and 2.8 for expertise. Both the second function, “Identify environmental public health assets…,” and third function, “Conduct public health investigations…”, had capacity scores of 2.6 and expertise scores of 2.9. Capacity and expertise were scored at 2.3 and 2.6, respectively, for the fourth function, “Identify and address priority notifiable zoonotic conditions…”. For the fifth function, “Protect the population…”, capacity was scored at 2.4 and expertise at 2.7. Finally, the sixth function, “Participate in broad land use planning..”, had the highest capacity and expertise scores, 2.9 and 3.0.

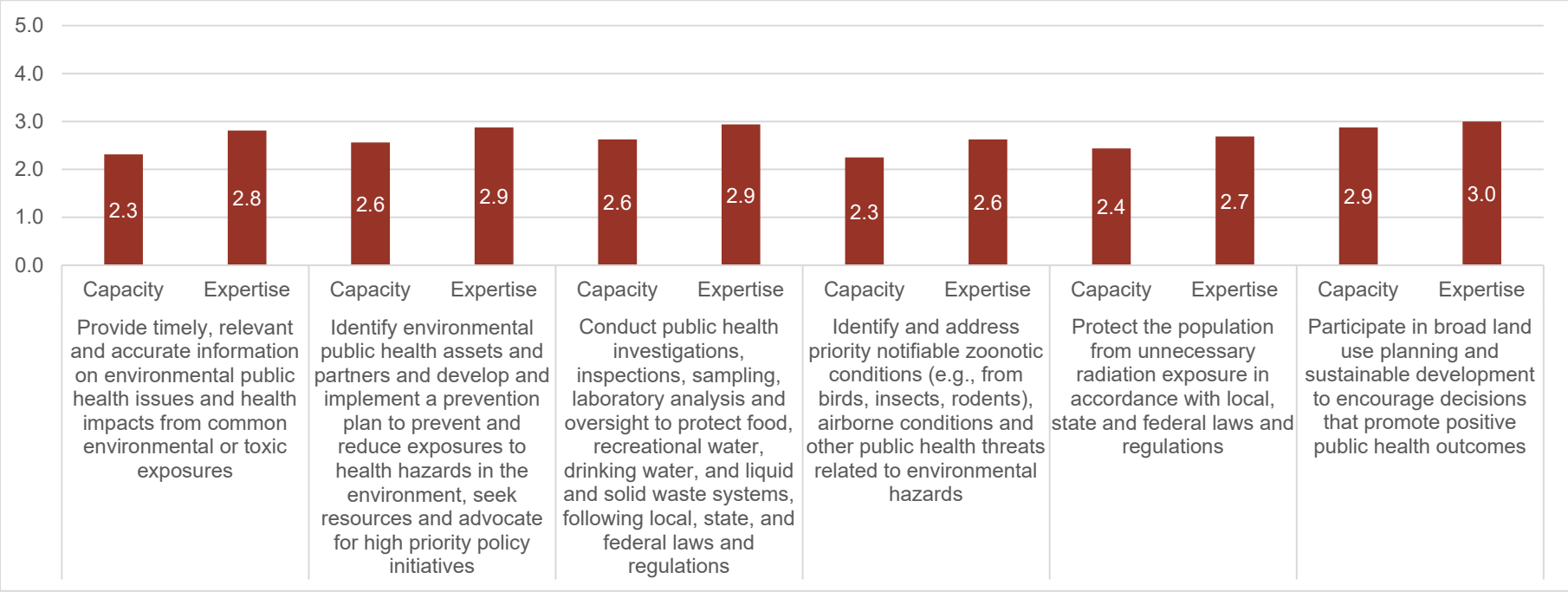

Figure 19: Environmental Public Health–2025 Aggregate Analysis (n=16)

Figure 20 displays the pre-post analysis of capacity and expertise for the Environmental Public Health foundational program. For the first function, capacity increased from 2.3 to 2.8, while expertise increased from 2.8 to 3.2. For the second function, capacity increased from 2.5 to 2.7, while expertise increased from 2.7 to 3.0. Capacity rose from 2.3 to 3.0 for the third function, with expertise similarly increasing from 2.5 to 3.0. For the fourth function, capacity increased from 2.3 to 2.7 and expertise increased from 2.5 to 2.7. The lowest scores were observed for the fifth function, although both capacity and expertise increased–from 1.8 to 2.5 for capacity and from 2.0 to 2.5 for expertise. For the sixth function, capacity increased only slightly, from 2.7 to 2.8, while expertise remained the same at 2.8.

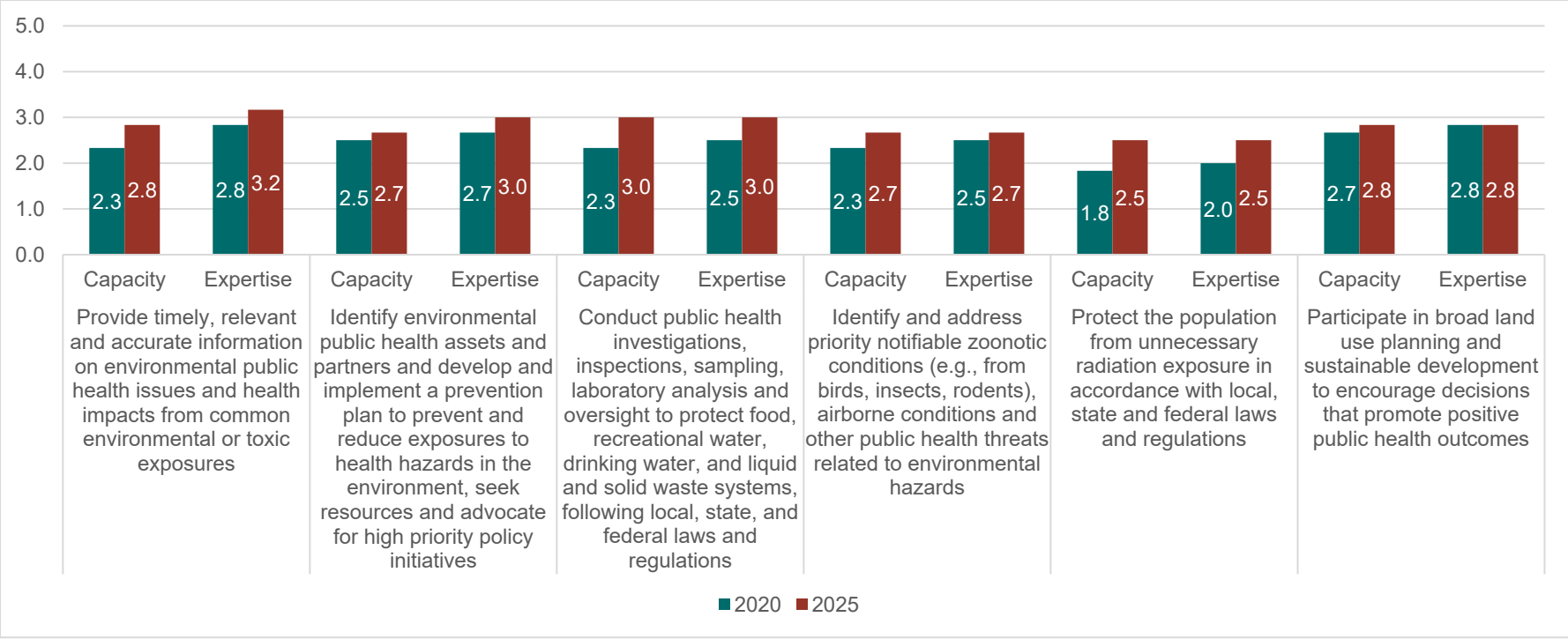

Figure 20: Environmental Public Health–Pre-post Analysis (n=6)

Clinical Preventive Services

Figure 21 provides an overview of the 2025 aggregate Clinical Preventive Services foundational program area capacity and expertise scores. For the first function, “Provide accurate, timely, Tribal, statewide, and locally relevant information…”, capacity and expertise were both scored at 3.8. The second function “Participate actively in local, regional, and state level collaborative efforts…”, was scored at 3.3 for capacity and 3.6 for expertise. The third function, “Improve patient safety…”, had a capacity score of 3.5 and expertise score of 3.6. Finally, the fourth function, “When additional important services are delivered…”, had a capacity score of 3.4 and expertise score of 4.0.

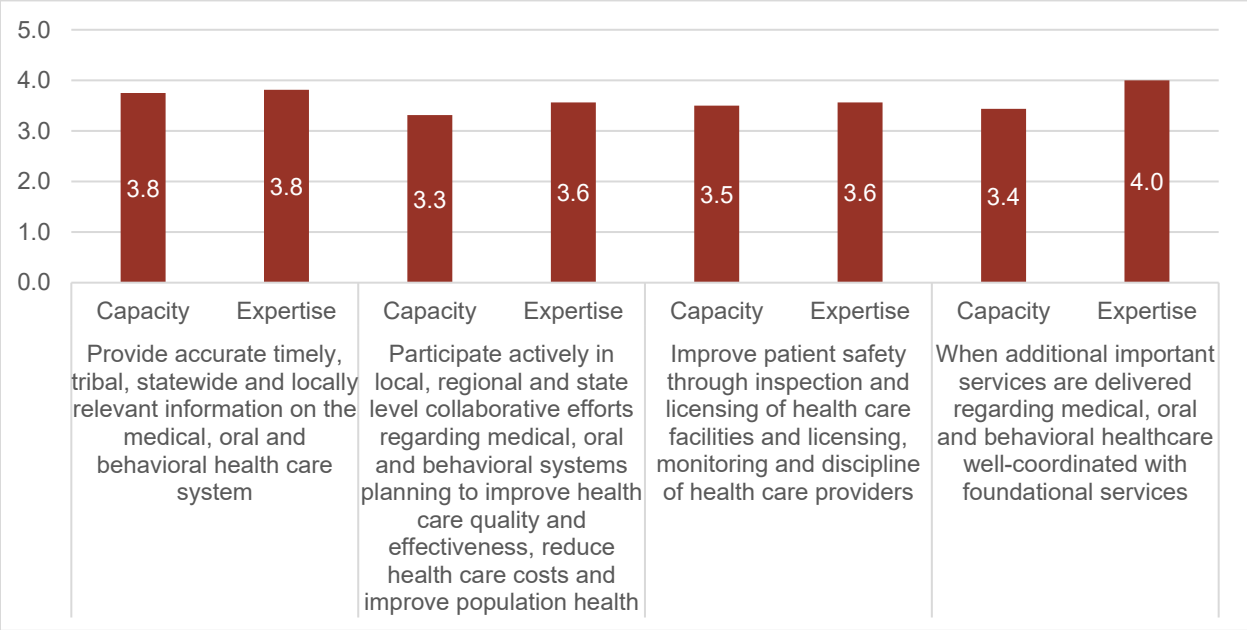

Figure 21: Clinical Preventive Services–2025 Aggregate Analysis (n= 16)

Figure 22 displays the pre-post analysis comparison of capacity and expertise scores in the Clinical Preventive Services foundational program area. Between 2020 and 2025, capacity increased from 3.8 to 4.0 for the first function, while expertise decreased from 4.3 to 4.0. Both capacity and expertise decreased for the second function, from 3.7 to 3.3 for capacity and from 4.0 to 3.8 for expertise. For the third function, capacity increased substantially from 2.5 to 3.7 while expertise also increased substantially from 2.7 to 3.7. Finally, both capacity and expertise increased for the fourth function: capacity increased from 3.8 to 4.3 and expertise increased from 4.3 to 4.5.

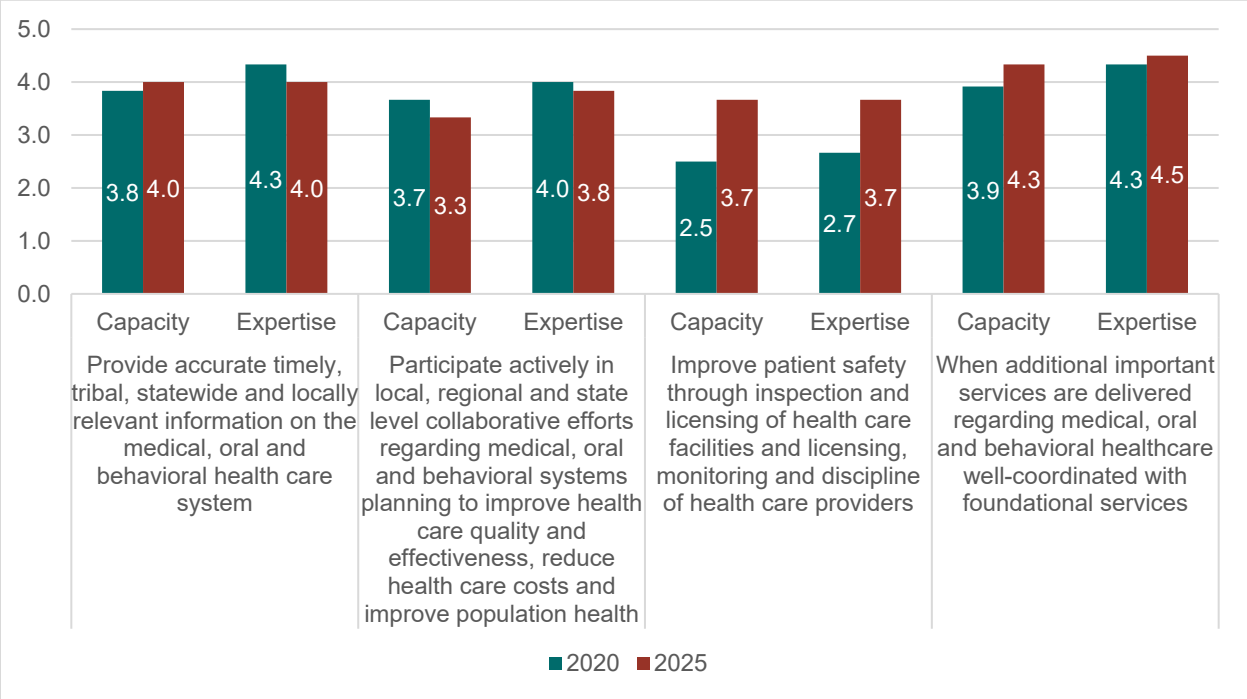

Figure 22: Clinical Preventive Services–Pre-post Analysis (n=6)

Maternal, Child, and Infant Health

Figure 23 displays the 2025 aggregate findings for the Maternal, Child, and Infant Health foundational program by capacity and expertise across the two functions. Both functions had the same scores for capacity and expertise, with the average capacity score being 3.4 while the expertise score was 3.6.

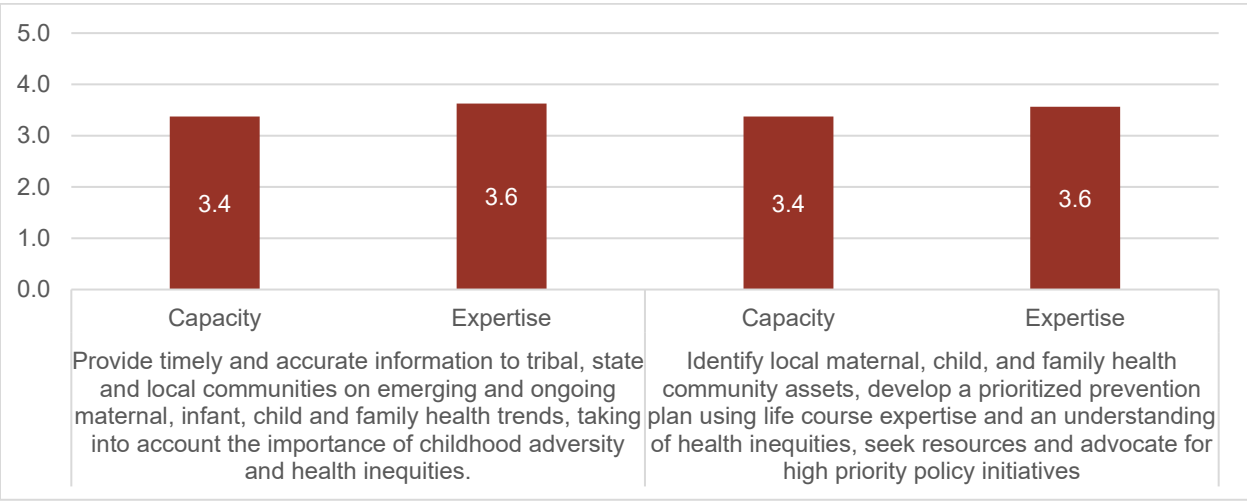

Figure 23: Maternal, Child, and Infant Health–2025 Aggregate Analysis (n= 16)

Figure 24 displays the pre-post comparison of capacity and expertise for the Maternal, Child, and Infant Health foundational program. Between 2020 and 2025, capacity increased slightly for both functions while expertise decreased slightly. For the first function, capacity increased from 3.5 to 3.7 while expertise decreased from 4.2 to 3.8. For the second function, capacity increased to 3.3 from 3.1, while expertise decreased to 3.3 in 2025 from 3.5 in 2020.

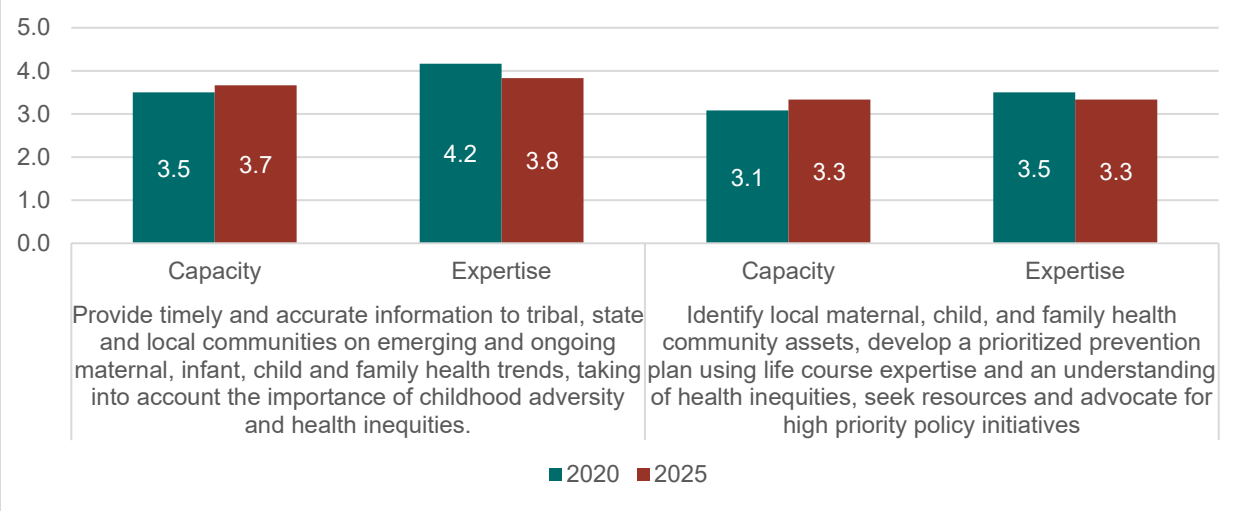

Figure 24: Maternal, Child, and Infant Health–Pre-post Analysis (n=6)

Quantitative Findings

What essential documents and key processes have been developed and implemented to effectively accomplish and sustain the project work?

Figure 25 displays the percentage of Tribes who have developed or implemented essential documents or key processes by type. Of the 18 Tribes who completed the question, eight (44.4%) responded that they had created policies and procedures. This was the most frequently selected choice, followed closely by implementation plans or roadmaps (n=7, 38.9%). 16.7% of Tribes (n=3) responded that they had created data sharing or data use agreements or memorandums of understanding or agreement (MOUs/MOAs). 11.1% of respondents (n=2) had created logic models/theory of change models or public health codes.

Finally, 22.2% of respondents (n=4) reported that they had created other documents or key processes. Examples included a Drug Task Force Strategic Plan to address community drug harms, a public health strategy to combat drug use and STIs, and program designs.

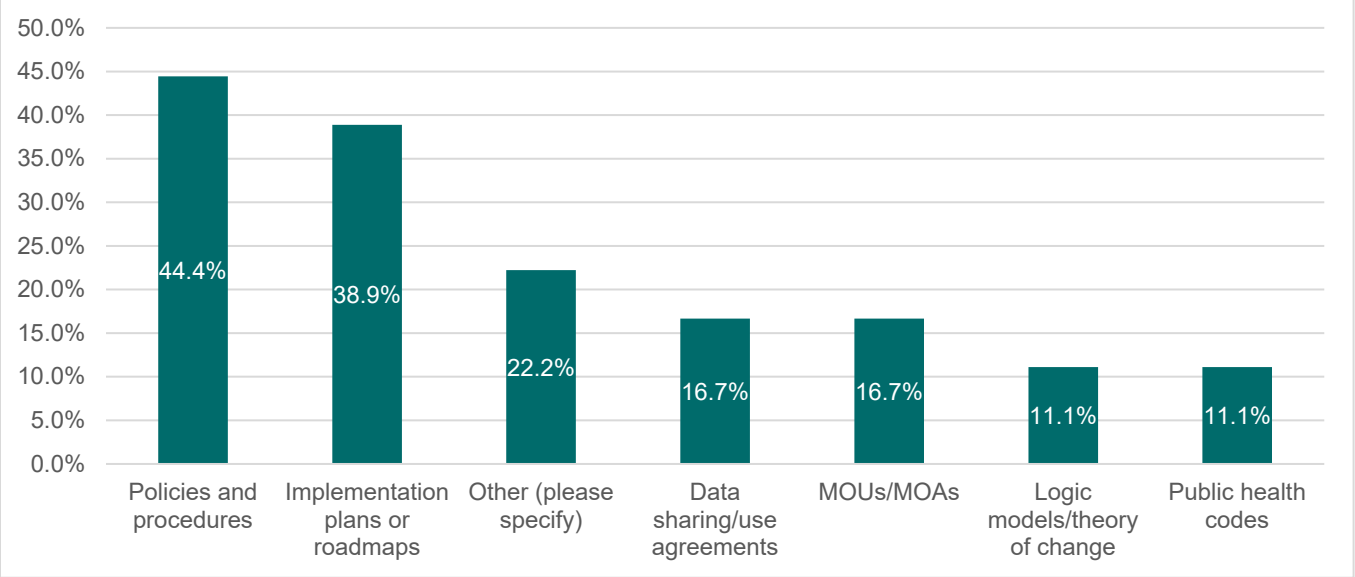

Figure 25: Percentage of Essential Documents Created by Type (n=18)

Has your Tribe or Tribal organization formed partnerships with any of the following jurisdictions, Tribal organizations, or constituent groups?

Participants were asked to select which other jurisdictions and constituent groups they had formed key partnerships with, if they had the opportunity to do so. As with the previous question, participants could select as many options as applied, even if that was all options. Therefore, the totals displayed are out of the total number of participants (18).

Figure 26 displays the percentage of participants who formed partnerships by the type of partner. About two-thirds of participants (66.7%, n=12) reported that they had formed partnerships with community members and stakeholders. Another half of participants (n=9) formed a partnership with the Washington State DOH. 38.9% of participants (n=7) formed a partnership with LHJs, while 33.3% (n=6) had partnered with other Tribes or UIHPs. 22.2% of participants (n=4) partnered with local nonprofit health organizations.

16.7% of participants (n=3) reported that they had formed other partnerships not already listed. Of these, partnerships included those with Northwest Portland Area Indian Health Board (NPAIHB) and the NPAIHB ECHO Team, AIHC, and local schools.

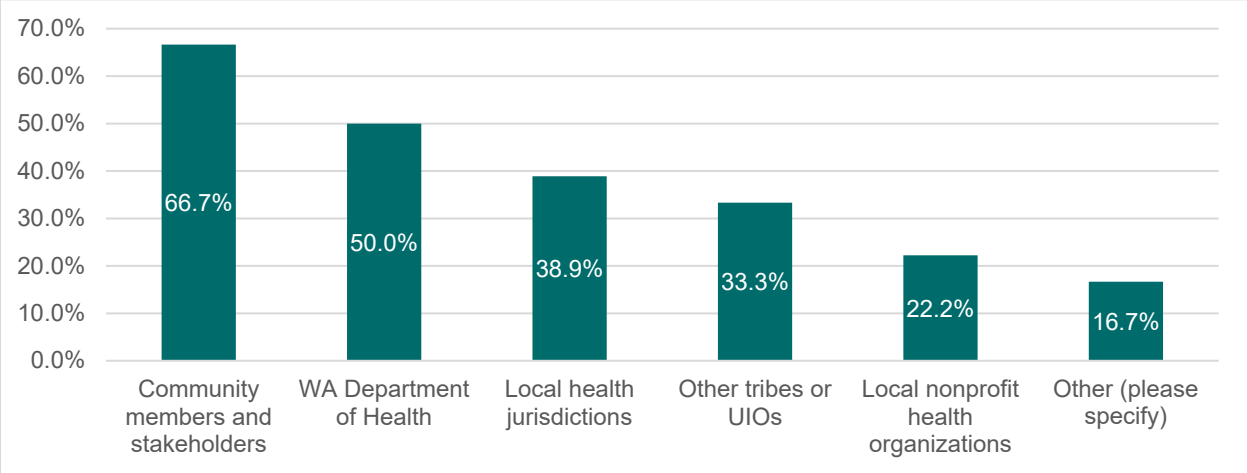

Figure 26: Percentage of Key Partnerships by Type (n=18)

Assessment responses demonstrate that Tribal health organizations have established a broad and impactful range of partnerships—both external and internal—that have significantly enhanced their capacity to deliver integrated public health services. External collaborations include partnerships with organizations such as the American Indian Cancer Foundation (AICAF), NPAIHB, Fred Hutch Cancer Center, and NARA NW, all of which have contributed valuable educational resources, cancer screening event support, and culturally relevant materials. Additionally, connections with agencies like Adult Protective Services, local food and housing programs, and public health departments have facilitated the delivery of holistic services, including patient referrals and support for social determinants of health. These partnerships have enabled the development of cancer provider education, expansion of substance use disorder training, and increased outreach to underserved populations.

Tribes have also built strong local and intertribal collaborations to address pressing health challenges such as the opioid epidemic and youth behavioral health. Notably, Lummi Nation partnered with local law enforcement and national experts to address substance use among homeless individuals and youth, and they established relationships with international tribes to learn effective prevention strategies. Collaborations with entities like the North Sound ACH, Planet Youth, AIHC, and King County Public Health have supported programs ranging from food access and car seat safety to sports, mental health, and policy development. Monthly meetings with county and Tribal health departments have also helped build sustained

collaboration on health promotion initiatives. These partnerships, often supported by TFPHS funds, have led to the creation of key public health roles and strategic training events that continue to strengthen Tribal health systems and community wellness.

Qualitative Findings

Implementation of TFPHS Plan

This section describes the different focus areas for each Tribe's TFPHS projects, how they determined the focus, any essential or needed resources to complete their project, and their perspectives on the TFPHS process and achieving a successful project.

TFPHS Project Focus and Determination of Focus

Tribes focused on a variety of different topics for their TFPHS plans. One Tribe is working on revising and revamping their public health code to be more inclusive of foundational public health services and epidemiological capacity. Another Tribal participant shared that they were working on developing policies and procedures for the program and felt that this was paramount to establishing a working public health program for their community, as it provides a strong foundation for moving forward with public health in the Tribe.

Several Tribes were working on building out public health departments or programs. One mentioned they established a public health work group—consisting of staff from many different departments—to help guide their work. Two Tribes shared that they were developing a public health program within their health clinic or health and wellness center, with a focus on infection and communicable disease control, prevention and health promotion, and emergency preparedness.

At least one Tribe was implementing a community health assessment, while another previously completed such an assessment and is now addressing those findings. For the latter, they created a patient resource guide, added a chronic care nurse, introduced optometry services, and hired a Tribal member as a trainee.

Participants shared that they used several methods to determine the appropriate focus of their projects. For some, historical knowledge, lived experience, and expertise guided them. For example, working on the COVID-19 response raised awareness of the need to revamp public health codes and prepare emergency preparedness plans. Often, Tribes were conducting or analyzing community health needs assessments to determine the project focus. They emphasized the need to hear from community to understand their needs and concerns:

> *"I did a year of just qualitative data collection and analysis from the community for them to determine what would that public health and wellness program look like."*

Overall, most projects targeted building foundational services and revamping public health services within their communities in accordance with identified needs.

Essential Resources

A variety of resources were mentioned, but overall, consensus was that AIHC was a significant resource. Participants noted that the Data Users Group hosted by AIHC was extremely helpful as a resource because it provides an opportunity for Tribes to learn about data-related topics together. AIHC also provided Tribally specific support in developing documents such as policies or public health codes, and it holds regular meetings to keep Tribes involved in TFPHS grounded in the work and stay on track for upcoming needs or deadlines.

Other resources mentioned specifically were trainings that Tribes were able to fund with TFPHS dollars. One participant mentioned that they seldom have funding to send staff to trainings and appreciated the flexibility of this funding as it enabled them to do so.

> *AIHC has been helpful with me in developing some policy. They're not easy to find or access because every Tribe is different. Our needs are different; our resources are different. Our outlook is different in a sense.*

Additional Needed Resources

Through assessment and focus group feedback, Tribal partners articulated a clear and strategic vision for the resources required to advance their TFPHS work. Respondents identified three primary areas of need: targeted workforce development, sustainable and equitable funding, and intentional infrastructure for collaboration and knowledge exchange. A critical gap identified was the need for comprehensive and ongoing training, particularly for new staff and those new to the TFPHS framework. Requests for specialized training on foundational public health services, policy development, and culturally responsive strategies for supporting unhoused individuals were made. Even seasoned public health professionals noted a lack of orientation resources specific to TFPHS, underscoring the necessity for tailored onboarding materials and structured mentorship opportunities. Establishing systematic onboarding would not only accelerate staff integration but strengthen institutional knowledge and program continuity.

Participants emphasized the importance of sustainable funding streams to support long-term public health capacity. There was a particular call for equitable funding allocation between Tribes and UIHPs to ensure all Indigenous communities are resourced to address their unique health challenges. It was highlighted that dedicated funding to support specialized roles, such as Public Health Cultural Specialists is essential for offering public health services that integrate cultural knowledge and practices.

Finally, respondents expressed a desire for mechanisms for inter-Tribal collaboration and peer learning. Suggestions included the formation of a cohort of Tribal agencies focused on public health accreditation from a distinct Tribal perspective, as well as the establishment of regular, in-person gatherings supported by TFPHS. These forums would provide critical opportunities for sharing best practices, leveraging collective expertise, and advancing shared priorities in a culturally grounded manner.

Tribal partners are drawn to a holistic approach for resource development. Addressing the call for an approach that invests in people, ensures equitable and sustained funding, and creates strong networks for shared learning and connection builds resilient and self-determined Tribal public health systems.

TFPHS Project Process

Respondents consistently reported that the TFPHS contracting process was smooth, straightforward, and easy to complete. Many emphasized that the TFPHS funding mechanism was flexible and allowed Tribes to truly exercise sovereignty and determine their own project priorities and design projects that align with their values and community needs. The contract structure and reporting requirements were described as simple and manageable, allowing Tribal staff to focus more on understanding and addressing local health priorities rather than being burdened by administrative tasks. In addition, the reporting requirements are simple and are not overly restrictive or arduous. One respondent noted that this allows them time to understand what their Tribe needs instead of spending a significant amount of their time completing reporting requirements. Another respondent described the TFPHS funding as the easiest contract they have ever completed. Finally, another respondent shared that they actually use TFPHS funding as a model for how funding for other departments at the state and federal level should work.

However, some respondents noted the importance of effectively writing for the TFPHS funds to ensure the contract allows for maximal flexibility. Several respondents had come onto contracts that were written for very specific purposes (e.g., emergency preparedness), and when they identified other needs, it was difficult to pivot because the funding was targeted for only that specific purpose. One respondent suggested that it would be helpful to hold a training session on how to write goals and develop contract scopes that are written broadly so Tribes can work on other needs throughout the life of the contract. This experience underscored the value of writing broad, adaptable contract goals from the outset.

Overall, these insights reinforce the importance of flexible, streamlined funding processes that respect Tribal sovereignty, reduce administrative burden, and enable Tribes to respond effectively to their communities.

> *I often use FPHS as a model for funding for other departments at the state and at the federal level. And I really think it's a good model on how we need to, or how agencies should interact with Tribes, and trust that Tribes can do the work that they describe that they want to do and make the best determination for their own Tribe what to do with the money without having to do a lot of reporting and jumping through a lot of hoops.*

Definition of Success

When asked to define success, respondents emphasized the role of community engagement and satisfaction in their vision of effective public health initiatives. Success was described not simply in terms of project completion, but by the extent to which Tribal members actively participated in and felt ownership of the process. For example, one respondent noted that the success of their community health assessment would be by robust Tribal members participation, with Tribal members openly sharing their priorities and goals. This level of engagement would ensure that resulting goals and strategies are genuinely actionable.

Another respondent highlighted the importance of ongoing evaluation, expressing anticipation for repeating their community health assessment in the following year. Their intent is to measure whether new services have improved satisfaction and met the need previously identified. This approach reflects a commitment to continuous improvement and accountability, ensuring that public health efforts remain responsive to evolving Tribal community priorities.

Overall, these definitions of success underscore the importance of culturally grounded, participatory approaches that honor Tribal sovereignty, elevate community voices, and foster lasting improvements in health and well-being.

Other examples of success included gaining approval from Tribal council, which indicates alignment with leadership expectations and establishing foundational elements for a public health program, such as job descriptions, policies, and procedures.

> *"I think for me success will be when we're able to get some really helpful information from the community we serve and then how we can best go about to meet those expectations in the future."*

FPHS Effect on Public Health Capacity and Expertise

Experiences of Exercising Sovereignty and Self-Determination

Overall, there was consensus that the TFPHS funding mechanism provided the needed flexibility for the Tribes to exercise true sovereignty and self-determination in developing and implementing their public health projects. Respondents appreciated that the funding allowed them to engage with community members to understand needs, determine goals to address unaddressed issues, and ensure the project is aligned with—and supported by—Tribal leadership.

> *"I think that was the best part about working with this contract, because we decide what we need for our community, and those desires came from the community members themselves….to have them endorse that I think just reinforces our sovereignty and self-determination."*

At the same time, some respondents mentioned that when they started their roles on TFPHS projects, the contracts had already been approved. Some of these already approved contracts had narrowly defined funding purposes, thus restricting their ability to pivot to other needed services. One example was a contract focused on policies, procedures, and communications, while membership desired more emergency management preparation. Respondents expressed frustration that they were limited in exercising sovereignty due to this barrier; however, they also felt it was a temporary setback they could work around.

Improvements to Public Health Capacity and Expertise

Respondents mentioned many improvements to both capacity and expertise, including hiring for new positions or expanding full-time employees (FTEs) using TFPHS funds. Specifically, respondents mentioned hiring the following positions:

- Public health managers
- Epidemiologist
- Chronic care nurse

The additional funding allowed service expansion and strengthened coordination between departments. For example, the chronic care nurse coordinated with diabetes coordinators and prevention specialists at the elders program, enhancing the services offered to the community. In addition, one Tribe mentioned that they had been able to hire a Tribal member to train in their newly added optometry services, improving the sustainability of the local workforce.

Alongside workforce development, Tribes also built partnerships with other Tribes and organizations. One example is a pilot project with three counties and seven Tribes that offers mutual assistance and collaboration, made possible through the TFPHS funds.

Other Benefits to Public Health

Tribal responses highlighted how TFPHS funding fosters deeper cultural and community connections within their communities. Many Tribes emphasized that the program's flexibility and support allows them to integrate Tribal values, traditional practices, and cultural protocols—such as prayers, drumming, traditional medicine, and the involvement of traditional healers—into public health work.

The program also encouraged cross-generational partnerships by bringing together elders, youth, and families in culturally rooted activities that promote wellness and unity. Some Tribes structured entire TFPHS work plans around cultural values, aligning strategic planning and policy development with traditional practices that honor traditional ways of life. Tribes and UIHPs emphasized the importance of being able to exercise sovereignty in incorporating cultural values and priorities into their work, thus ensuring the work they perform is reflective of the community itself.

Lessons Learned/Challenges Faced

Challenges and Barriers

Respondents in the focus groups mentioned several different challenges and barriers to achieving the goals of their TFPHS projects. These included accessing necessary data, building community engagement, and working across departments and levels of leadership. In addition, a common theme across Tribes was that TFPHS staff often perform many roles, limiting their ability to concentrate on the TFPHS project specifically.

- **Accessing data:** Many Tribes reported difficulty getting the data they need about their own members, even though they have a sovereign right to this information. Others added that even when data is available, staff may not have the training or resources to analyze and use it effectively. One participant shared that they were not fully aware of what data is available to them for their Tribe or whether it is detailed enough to help with issues like tracking emerging infectious diseases.
- **Community Engagement:** Gathering input from the community is essential but many Tribes shared that their members are tired of being asked to fill out surveys or participate in interviews, noting that communities are "surveyed out." At least two Tribes expressed their desire to conduct a community health assessment but felt the community was unwilling to participate in any more data gathering activities like surveys. In addition, Tribes in rural or remote areas may find it even more difficult to reach people and encourage survey and focus group participation.
- **Bureaucracy:** One respondent shared that they must pass projects through many committees, but the committees often only meet once a month. This slows down progress and can put project success at risk. Others shared that not all Tribal leaders or decision-makers are familiar with public health work, which can make it harder to get support for new projects or ideas.
- **Staffing:** A common theme was that TFPHS staff are balancing multiple roles and responsibilities. This can limit the time and energy they have to focus on TFPHS projects. High turnover among staff and leaders can also disrupt progress and reduce the Tribe's ability to carry out long-term public health work.

By sharing these challenges openly, Tribal partners directly shape future improvements to TFPHS efforts. Recognizing and addressing these barriers across TFPHS efforts builds a stronger, more effective public health that meets the needs of Tribal communities.

Success Stories and Lessons Learned

Focus group participants were asked to share any success stories about their TFPHS projects or lessons learned. These success stories underscore the impact of TFPHS funding in empowering Tribal communities to address their unique public health priorities.

By supporting innovative programs such as a colorectal cancer health promotion program, opioid epidemic response, and youth wellness initiatives, Tribes have been able to implement culturally relevant solutions and build sustainable public health capacity with TFPHS funds. The direct hiring of Tribal members and the strengthening of partnerships with local agencies further

demonstrate that TFPHS has a role in fostering Tribal self-determination and workforce development. The ability to engage Tribal leadership and council members in these projects ensures that public health strategies are guided by Tribal community values. These achievements demonstrate the immediate benefits realized by participating Tribes, but also the long-term potential for continued collaboration.

As the TFPHS work continues, these lessons and successes will serve future efforts and further advance the health and well-being of Tribal nations.

Summary

This evaluation examined the impact of TFPHS on Tribal/UIHP public health capacity and expertise. It focused on how TFPHS resources enable community-driven health projects and assessed key indicators of project initiation and sustainability. Using a mixed-methods approach, including an assessment to measure quantitative changes in capacity and expertise, and focus groups to qualitative community perspectives, the evaluation addressed cultural relevance, community engagement, effectiveness, and sustainability. The findings clearly demonstrate that TFPHS funding strengthens Tribal and UIHP public health systems, supports culturally relevant programming, and enhances long-term project sustainability. Key results are summarized below.

Cultural Relevance

How do TFPHS projects align with Tribal community cultural values and traditional practices?

TFPHS projects are intentionally designed to reflect and honor Tribal community cultural values and traditional practices. Staff engage directly with community members, Tribal departments, and leadership to ensure that project work is rooted in community priorities. Responses emphasized that the flexible nature of TFPHS funding has been essential, enabling them to integrate traditional practices. This flexibility also supports the creation and sustainability of culturally specific roles, such as an Indian Child Welfare Registered Nurse, further ensuring that TFPHS remains relevant and respectful of Tribal needs.

RECOMMENDATION: Preserve, and where possible, enhance the flexibility of TFPHS funding. Consider increasing funding to allow Tribes to expand culturally specific positions and further integrate traditional practices into public health programming.

How do community members perceive the projects?

While comprehensive feedback from community members is still being gathered, initial responses have been positive. For example, one Tribe reported that community members expressed appreciation of the new health promotion and prevention programs. Another Tribe highlighted the success of youth engagement initiatives, which were well-received over the years. However, most Tribes shared their projects are still in early stages, making it difficult to

collect extensive community feedback on completed activities. As projects progress and community input is gathered, it is anticipated that perceptions will become clearer and likely remain positive.

RECOMMENDATION: Strengthen ongoing engagement with community members by actively seeking their perspectives as projects develop and conclude. Incorporate community voices into future TFPHS evaluation efforts through storytelling, testimonials, or other culturally relevant media to ensure authentic representation of community experiences and perceptions.

Community Engagement

How were community needs considered in the TFPHS projects?

Community needs were considered throughout the lifecycle of TFPHS projects, but particularly in the initiation stages when Tribes were developing the focus and priorities of their projects. Tribes reported prioritizing community engagement throughout their TFPHS projects to ensure initiatives were responsive to local needs. The most common approach was conducting community health assessments, which often included both quantitative assessments and qualitative methods such as focus groups and interviews. Many Tribes used the results from previous assessments to inform the direction and priorities of their TFPHS projects, while others were actively gathering and analyzing new community input. Across all projects, there was a strong emphasis on listening to community members and incorporating their feedback, ensuring that project activities reflected the unique needs and priorities identified by the community itself.

RECOMMENDATION: Continue and expand support for Tribes to engage their communities in meaningful ways. This can include providing resources and technical assistance for all stages of community health assessments such as planning, data collection, analysis, and using results to guide project design. Training and capacity building for staff will help Tribes align their TPFHS projects to community-identified needs.

Usability

While the evaluation was grounded in principles of the IEF and designed to prioritize Tribal relevance and contextual application, usability was not formally measured as part of the evaluation. This is an opportunity to extend the impact of this work by facilitating the dissemination of findings and assessing their usability within all participating Tribes and their communities. Ensuring the findings are not only shared, but also understood, applied, and valued by Tribal partners is essential to the long-term success of the TFPHS. In addition, it may be useful to produce individual reports or brief summaries of the TFPHS work being done by each Tribe to garner support and awareness among their communities. A broader picture of TFPHS accomplishments may be less applicable to individual community members than a concise report tailored to their Tribe.

RECOMMENDATION: TFPHS can facilitate a brief post-evaluation usability assessment. Example questions might include:

- Were the findings shared in a format that worked well for your community?

- Will you use any of the results in planning, reporting, or community engagement?
- What aspects of the evaluation findings were most useful to you?

RECOMMENDATION: Work with Tribes/UIHPs to develop brief descriptions—such as one-pagers or short videos—showing what TFPHS funding is doing for their community.

Effectiveness

To what extent have the TFPHS initiatives achieved their stated goals and objectives?

By allowing flexibility in TFPHS funding, Tribes are empowered to exercise sovereignty and self-determination in setting their own goals and defining measures of success for their TFPHS projects. As a result, there is no single quantitative measure that can be used to assess the extent to which these initiatives have achieved their stated goals and objectives. During the focus groups, Tribes shared how they defined a successful project and their current progress toward that achievement. Some Tribes measured success through community engagement and reported that their projects were successful because there was ample participation in their community health assessments or public health programming. Others shared that success was achieved through successfully engaging with and getting approval from Tribal leadership. In addition, Tribes shared in the open-ended questions included in the assessment about the partnerships they had formed, how TFPHS benefited their communities, and the specific work they were able to accomplish with this funding, thus also providing an illustration of success. Overall, respondents across both data collection methods spoke positively of the work they were able to accomplish through TFPHS funding and were actively engaged in preparing to sustain that success by strategizing how to continue their TFPHS work into the future.

RECOMMENDATION: Quantifying success in a sovereignty-centered context can support future funding applications or for engaging Tribal leadership. Each Tribe may consider defining their own success indicators, then translating those into measurable outcomes. Additionally, Tribes may consider applying the constructs measured in this evaluation and considering which are most relevant to their project (e.g. community engagement, access to care, capacity building). Tribes can also apply goal attainment scaling (GAS) to their own measures of success. For example, if the goal is to expand culturally responsive health education, the quantitative measurement can rely on rating level of goal attainment.

In what ways is the project enhancing public health capacity and expertise for Tribes and UIHPs?

Overall, it is clear from the capacity and expertise assessment that Tribes have improved their capacity and expertise across TFPHS capabilities and programs between 2020 and 2025. In addition, results from the 2025 aggregate analysis show that for almost all TFPHS areas, at least a partial level of implementation had been achieved. The only area where partial implementation was not achieved was Environmental Public Health. The areas where the highest level of implementation was observed, across both the pre-post and 2025 aggregate

assessment groups, were Communicable Disease Control and Prevention and Health Promotion.

Respondents in the focus groups also noted that they hired several critical public health positions, as well as expanded full-time staffing for existing positions. New partnerships were formed, and existing partnerships were strengthened and contributed to an increase in the level and specificity of expertise available. In addition, respondents mentioned that they were able to utilize the TFPHS funding to support necessary trainings for their staff, further enhancing expertise.

RECOMMENDATION: Provide resources including training or workforce support to Improve capacity and expertise across the Environmental Public Health program.

RECOMMENDATION: Consider designing and piloting a scale that provides a more measured method of evaluating progress or improvements to capacity and expertise. The current scale is limited in its validity, as it relies on subjective assessments.

Sustainability

What factors contribute to the sustainability of the TFPHS initiatives in their communities?

Factors that support the sustainability of TFPHS initiatives include maintaining adequate staffing, providing training or continuing education to existing staff, hiring Tribal members to support the project, and consistently engaging with the community to ensure perspectives and project goals are aligned. Overall, the dedication and determination of TFPHS project staff, in partnership with AIHC and Washington State DOH, ultimately contribute to sustaining TFPHS initiatives.

RECOMMENDATION: Provide supports to new and existing TFPHS program staff, such as an orientation program for new staff and spaces for engagement with other TFPHS program staff.

What resources or support systems are necessary to ensure the ongoing success of the public health infrastructure developed through this initiative?

Respondents shared that the additional resources they needed were primarily more training, increased funding, and more avenues for engagement with other Tribes/UIHPs. Specific training needs were identified for the TFPHS program overall, data access and use, and public health policy development. Funding is an ongoing need that should orient towards being equitable across communities. Many participants appreciated the work groups facilitated by AIHC and requested more in-person work groups or a conference. Finally, capacity and expertise scores for the Environmental Public Health program indicate that more resources would benefit that particular TFPHS area. Given that scores were low for both capacity and expertise in this area, both financial resources to support expanded workforce capacity and training resources to support enhanced expertise of staff would be appropriate.

RECOMMENDATION: Develop or identify training in public health policy and procedure writing for TFPHS professionals.

RECOMMENDATION: Facilitate an in-person gathering for TFPHS professionals and related public health staff to collaborate.

RECOMMENDATION: Expand resources targeted at Environmental Public Health, including increased funding and training for Tribal Environmental Public Health professionals.

Conclusion

This report provides a robust assessment of the TFPHS funding program, the projects it supported, and its impact on Tribes/UIHPs and their communities. The findings are derived from a combination of data collection efforts, including a quantitative assessment instrument and focus group discussion with participating Tribes and UIHPs. Out of the 29 Tribes and two UIHPs located in Washington State, 19 Tribes and both UIHPs participated in one or both of the evaluation's data collection opportunities. With this wide-ranging response rate, this report is able to provide a meaningful snapshot of TFPHS project experiences and outcomes since the inception of the funding, particularly through the inclusion of a pre-post assessment group of six Tribes with baseline data from 2020.

At the same time, the findings should be considered in light of several limitations. While the sample size was considerably larger than in past years, not all Tribes/UIHPs were able to participate in the entire evaluation, and thus it may not fully represent the diversity of experiences across all TFPHS recipients. In addition, the absence of baseline data for many participants limits the ability to understand trends or impacts of TFPHS across the entire funding period. Finaly, the reasons for lack of participation are unknown, and could be a source of bias. For example, it is possible that those Tribes/UIHPs who did not participate in the evaluation were more under resourced than those who did participate, thus leading to an overestimation of TFPHS project success.

However, despite these constraints, the evaluation results offer valuable, community-driven insights that can guide future improvements in TFPHS, ultimately benefiting the Tribes/UIHPs for which this funding is intended. Efforts to increase participation in the evaluation through understanding and overcoming barriers to participation will enhance data completeness and further strengthen the evidence base for effective Tribal public health practice in Washington.

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Appendix A: WA DOH TFPHS Comprehensive Evaluation Plan

The comprehensive evaluation plan outlines each overarching evaluation question, related sub-questions, data sources, timing, and analytical methods.

Introduction

Along with the Washington State Department of Health (WA DOH), and the American Indian Health Commission for Washington State (AIHC), Kauffman and Associates, Inc., (KAI) will build this year's evaluation plan based on prior evaluation efforts while introducing important revisions based on feedback from TFPHS awardees. Last year, many participants expressed that while the surveys and roundtables were useful, the depth of their work and the cultural significance of their early efforts was not fully captured. Specifically, it was shared that the standard reporting framework did not adequately reflect the community impacts of their initiatives.

In response, this revised plan aims to amplify the community-centered impact of these projects by capturing a more holistic view of Tribe and UIHP efforts. By balancing the previously used reporting metrics with the unique ways in which communities measure success and change, this plan will capture a more complete understanding of the contributions made by these projects.

To support this effort, the previous evaluation report has been included in the appendix for reference. This evaluation plan builds on that foundation, intentionally integrating community-defined outcomes and cultural perspectives to reflect the different ways Tribes and UIHPs measure success across different contexts.

Evaluation Team Members

Table 3: Evaluation Team Members

Role on Project	Staff
Evaluator	Jaime Begay, MPH
Data Collection and Analyst Lead	Emily Bear, MPH
Project Director	Emily Bear, MPH

Corporate Monitor **Subject Matter Expert - Evaluation**	 Chesleigh Keene, PhD, MA

Objectives

III. Examine how TFPHS resources supported community-driven health projects
    a. Objectives
        i. Explore how effectively the health projects strengthened foundational public health capacity in ways that are meaningful to the community
        ii. Assess the alignment of the health projects with the expressed needs, priorities, and cultural values of the communities served
        iii. Determine the significance of the funded projects in addressing foundational public health challenges, as defined by the communities involved

I. Explore key indicators of project initiation and ongoing sustainability
    b. Objectives
        i. Identify community-defined indicators that signify the successful initiation of a project
        ii. Assess the markers of sustained activity, considering the community's perspectives and ongoing engagement
        iii. Evaluate the sustainability of the project, including:
            1. A review of the project's statement of work through a cultural and community lens
            2. Understanding what sustainability means to the community as they build public health programs
            3. Investigate any changes made during implementation and whether these adjustments align with the community's long-term goals for sustainability

Evaluation Context

This evaluation aims to align with the principles of the Indigenous Evaluation Framework (LaFrance & Nichols, 2010; LaFrance, Nichols, and Kirkhart, 2012) to provide actionable insights and recommendations for supporting TFPHS. The evaluation context is framed by a commitment to building a more equitable public health system of foundational public health services that are Tribally-driven. The initiative empowers Tribal nations to develop public health infrastructure tailored to the needs of their members and territories. This evaluation plan acknowledges feedback from awardees regarding their desire to offer more depth and context to their projects. This year's plan seeks to consider community-defined outcomes and cultural perspectives, ensuring that the evaluation reflects the unique contexts of the TFPHS awardees. By incorporating both quantitative

and qualitative data collection tools, including interview guides and facilitation protocols designed by the evaluation team, information will be collected that supports the 2025 Washington State Health Report; while honoring the meaningful impact these projects have on their communities and offer dissemination that can inform Tribal leaders and Tribal communities.

The cumulative products produced from this evaluation will include a final report, community impact stories and a video compilation of prioritized stories, Tribal leadership briefs and project highlights. These products offer tailored data summaries focused on clear communication and usability for each Tribe, UIHP, and their communities.

Who is the Community?

This evaluation plan identifies the community as encompassing multiple interconnected groups, each playing a vital role in the TFPHS initiative's success. At the state level, representatives of WA DOH are deeply committed to the success and sustainability of the TFPHS initiative. Their dedication extends beyond simply providing oversight; they are passionate advocates for the projects and the communities involved. Their commitment is reflected in their active efforts to engage all Washington Tribes, ensuring widespread participation and fostering collaboration. Recognizing the value of the work being done, they have identified an additional funding opportunity to expand dissemination efforts, which enables wider sharing of the impact of the TFPHS projects. AIHC is central to the work, from their initial outreach and engagement of Washington Tribes to participate in the definition and funding request of TFPHS, to the ongoing advocacy for a sustainably funded TFPHS that is Tribally focused. Additionally, the TFPHS programs and staff are vital to the work, driving the projects while placing their communities' unique needs and cultural contexts at the forefront of their efforts. As researchers, the team holds a community role, working in collaboration with these groups to ensure evaluation not only meets reporting needs, but also respects and integrates the values and priorities of all Tribes and UIHPs involved.

Evaluation Scope

The scope of this evaluation will include:

- Evaluation of the implementation of TFPHS services in line with the previous year's evaluation (Appendix B: 2023-24 Year 2 Evaluation Plan), to provide a longitudinal update on projects
- Design and use of culturally responsive data collection tools, including an impact interview to feature one Tribe's TFPHS journey and roundtable discussion protocols for facilitation and questions
- Explore and disseminate the data to gather insights and feedback on the relevance and impact of all TFPHS efforts on Tribal communities
- Explore the collaborative learning among communities to support capacity building to understand and report on the impact of the TFPHS workgroup

Explore and document the essential elements of the relationship between state funding and community-led efforts, highlighting collaborative strategies and shared goals

Evaluation Criteria and Questions

The evaluation criteria are based on the principles of the Indigenous Evaluation Framework and include:

- Cultural Relevance
    a. How do TFPHS projects align with Tribal community cultural values and traditional practices?
    b. How do community members perceive the projects?
- Community Engagement
    a. Making sure community voices are heard and valued by including them in the impact video.
    b. How were community needs considered in the TFPHS projects?
- Usability
    a. The findings and recommendations from the evaluation will be accessible and useful to WA DOH, AIHC, TFPHS, and Tribal communities.
    b. Dissemination products will represent the multiple levels of community represented in this initiative.
- Effectiveness
    a. To what extent have the TFPHS initiatives achieved their stated goals and objectives?
- Sustainability
    a. What factors contribute to the sustainability of the TFPHS initiatives in their communities?
    b. What resources or support systems are necessary to ensure the ongoing success of the public health infrastructure developed through this initiative?

Outreach, Recruitment, and Engagement

By leveraging a range of communication channels and carefully planning data collection activities, KAI seeks to foster productive, collaborative relationships that will drive positive outcomes for all communities involved in this project. The primary goal is to engage effectively with TFPHS representatives and Tribal members with voices and perspectives on the TFPHS initiative and ensure all are heard and valued. KAI understands that the process of engagement is as important as the content received.

KAI, WA DOH, and AIHC will work with TFPHS to ensure high levels of participation from TFPHS representatives and Tribes across Washington. Workgroup feedback indicated there are areas for improvement in recruitment efforts and identifying the best point of contact for participation data collection. Recommended promotional strategies will provide advance notice and information for each engagement opportunity. KAI recommends broad and focused eblasts, posts to listservs, and

sending survey links directly to individual emails. Personal, one-on-one emails were requested by TFPHS workgroup members; this request will be accommodated.

Data Collection Methods

Data Sources and Tools

Quantitative Data Collection

1. Administer the survey (Appendix A: 2024-2025 Survey) used in the previous evaluation to ensure consistency in measuring progress in capacity and expertise, and to allow for comparative analysis across evaluation periods.
    a. Two additional qualitative questions were added:
        i. In what ways does the TFPHS funding mechanism support the development of a sustainable local public health workforce?
        How has the TFPHS program fostered existing cultural or community connections within your Tribe or urban Indian community? Please describe. [Open Text Box]
2. Perform quantitative data collection as outlined in the previous evaluation plan:
    a. Review project reports and documentation
    b. Analyze health outcome data and performance metrics related to each project
    c. Review project timelines
    d. Analyze funding disbursement records and expenditure reports
    e. Review service capacity and use data before and after the funding period
    f. Examine staffing records—hiring can be used as evidence of increased expertise, new skills

Qualitative Data Collection

1. Roundtable Discussions
    a. Four Roundtable Discussions (Up to 10 participants per Roundtable)
        i. No more than 60 minutes per session
        ii. Facilitator will guide the discussion
        iii. Notetaker will document key points and observations
    b. All sessions will be recorded and transcribed for analysis
    c. Scheduling
        i. Roundtables will take place during an already scheduled TFPHS Workgroup meeting
        ii. Coordinate with AIHC to confirm focus group dates and times
        iii. Facilitation plan and interview questions will be available in advance
    d. Participants

i. All contracted Tribes and Urban Indian Health Centers

2. TFPHS Impact Video
    a. Video A:
        i. Purpose: Feature one Tribe's TFPHS journey (Target time: 2:30)
        ii. Identify Featured Tribe
            1. Ensure alignment with key evaluation goals
        iii. Story Mapping
            1. Develop a narrative that connects the Tribe's TFPHS work with specific outcomes
            2. Perform key information gathering to craft a comprehensive overview of the Tribe's TFPHS story, in line with the following components:
                a. Theme
                b. Who/what/where/when/why/how
                c. Understanding the importance of TFPHS
                d. Alignment with FPHS objectives
                e. Tribal sovereignty
                f. How TFPHS improves outcomes for communities
                    i. What was the result and impact on people and community
                g. Demonstrate funding impact, project impact
            3. Example questions to support story expansion
                a. What Tribal values should be considered in TFPHS?
                b. What obstacles or challenges have been identified in TFPHS for your Tribal nation?
                c. What resources are needed to sustain the TFPHS initiatives in place now?
                d. What's needed to support Tribes in their TFPS development visions and plans?
                e. What community needs guided your TFPHS work?
        iv. Identify Filming Location
            1. Identify an appropriate, relevant location where the story unfolds
                a. Certain locations are better than others
                    i. Clinics, hospitals, mobile units offer visual storytelling
        v. Story Script
            1. Create a clear script that outlines the Tribe's TFPHS journey, the challenges faces, the impact achieved
        vi. Team Involvement
            1. Identify any team members who will participate in the video
        vii. Scheduling

1. Coordinate with time for the Tribe and videographer to align schedules for a one-day shoot

viii. Videography Plan

1. Videographer will ensure a smooth filming and editing process

b. Video B: Overall TFPHS Results (Target time: 0:30 minutes of animated content)

i. Purpose: Provide a high-level summary of the overall evaluation results

1. Coordinate with WA DOH and AIHC to align on the most impactful findings of the evaluation to be included in the video
2. Develop a brief and compelling script summarizing key evaluation outcomes

3. Synthesize the two parts of the impact video into a cohesive narrative that will effectively communicate both the featured Tribe's impact and the overall evaluation findings
   a. KAI will synthesize the knowledge gained through all story information collected and identify the connection to the work of WA DOH and AIHC
   b. WA DOH and AIHC will provide guidance on the video style and focus of information captured
      i. WA DOH and AIHC will have one review of the generated video
      ii. WA DOH has identified their TFPHS website and AIHC (if it can support the upload) website as primary hosts for the video

Data Collection and Reporting Timeline

- Period of performance: June 30, 2024, to July 1, 2025
- Data for the evaluation will be collected January 16–April 23, 2025

Table 4: Tentative Evaluation Timeline

Tentative Evaluation Timeline	
Planning Phase	July 30–November 15, 2024
Data Collection Phase -Survey (Quantitative) -Roundtable Discussions (Qualitative) -TFPHS Impact Video	January 16–April 23, 2025
Analysis Phase	April 1–May 23, 2025
Reporting Phase/Video Generation Phase	March 17–May 30, 2025
KAI Quality Control of Final Report and Video	May 19–May 22, 2025

Tentative Evaluation Timeline	
AIHC/ WA DOH Review of Report and Video	May 26–May 30, 2025
KAI Integration of AIHC/WA DOH Feedback	May 30–June 6, 2025
AIHC/WA DOH Final Review of Report and Video	June 6–June 13, 2025
KAI Final Edits/KAI QC	June 13–June 19, 2025
KAI Final Submission to AIHC/WA DOH	June 20, 2025
FPHS Dissemination Presentation/ Video Upload	TBD

Appendix B: Assessment Instrument

Introduction

Assessment Framework

This Tribal foundational public health services (TFPHS) assessment follows the Washington State model for local public health jurisdictions. This framework consists of five foundational public health programs and six public health capabilities, with respective definitions. This assessment aims to determine Tribal capacity and expertise in each program and capacity area. Additional questions provide insight into your Tribal organization's FPHS project and its progress, supporting a broader TFPHS evaluation.

Benefits of Completing an Assessment

Completing this assessment supports local planning by enabling service evaluation, resource allocation, and quality improvement activities. Additionally, it can aid in securing federal and state funding to support FPHS. This assessment promotes public health system awareness of the FPHS model and highlights Tribes' significant role in protecting the health and safety of Tribal and surrounding communities. As a result, Tribal and public health partners can identify and collaborate to address financial and human resource gaps in the statewide FPHS system.

Assessment

PROJECT PROGRESS AND SUSTAINABILITY

1. Is your Tribe or Tribal organization currently contracted to receive FPHS funding for the 2023-2025 cycle?
    a. Yes
    b. No
    c. Unsure
2. [**IF NO**]: Please describe any barriers or challenges to contracting your Tribe or Tribal organization may have experienced.
3. Have any of the following essential documents been developed to effectively accomplish and sustain the project work? Please select all that apply.
    a. Implementation plans or roadmaps
    b. Logic model/Theory of change
    c. Public health codes
    d. Policies and procedures
    e. Data sharing and/or data use agreements
    f. Memorandums of understanding/agreements (MOUs/MOAs)
    g. Other (please specify)
4. Has your Tribe or Tribal organization formed partnerships with any of the following jurisdictions, Tribal organizations, or constituent groups? Select all that apply.
    a. Community members and stakeholders
    b. Local health jurisdictions
    c. Washington State Department of Health

d. Other Tribes or UIOs
e. Local nonprofit health organizations
f. Other (please specify)

5. Please describe the partnerships formed, including resources or opportunities they provided.
6. Are there any additional resources or training opportunities that are needed to support your TFPHS work? Please describe.
7. In what ways does the TFPHS funding mechanism support the development of a sustainable local public health workforce?
8. How has the TFPHS program fostered existing cultural or community connections within your Tribe or urban Indian community? Please describe.

SELF-ASSESSMENT INSTRUCTIONS

This self-assessment supports Tribes in assessing their current capacity and expertise to meet the foundational capabilities and programs defined within the public health framework. This assessment is designed to Tribes in identifying public health modernization activities and the expertise with which they are providing these activities.

The assessment uses two measurements:

- **Capacity**: The degree to which the organization has the **staffing** and **resources** necessary to provide each activity.
- **Expertise**: The degree to which the organization's current capacity aligns with the **appropriate knowledge** to implement the activities.

For each public health modernization activity under Foundational Capabilities and Foundational Programs in the following tables below, identify a score on a scale from one to five, as illustrated below, that represents your best judgement of the degree to which the Tribal organization that you represent has the capacity and expertise required to implement it. If you have completed a prior assessment, your baseline scores will also be provided to you. Please keep these scores in mind when you assess whether your Tribal organization's capacity and expertise has changed in relation to the previous scores.

SCORING TABLE

Score	1	2	3	4	5
CAPACITY	Not currently provided	→	Able to provide the basics at a lower level of service	→	Fully meets requirements
EXPERTISE	Not currently provided	→	There is a meaningful gap in skills or knowledge	→	Fully meets requirements

FOUNDATIONAL CAPABILITIES	Capacity	Expertise
1. Assessment and Epidemiology		
a. Collect sufficient data and develop and maintain electronic information systems to guide public health planning and decision making.		
b. Access, analyze, use, and interpret data.		
c. Conduct a comprehensive community assessment and identify health priorities arising from that assessment, including analysis of health disparities and the social determinants of health.		
2. Emergency Preparedness and Response		
a. Develop emergency response plans for natural and man-made public health hazards, train public health staff for emergency response roles and routinely exercise response plans.		
b. Lead the Emergency Support Function #8-Public Health and Medical Services and or public health response for the Tribe, county, region, jurisdiction, or state.		
c. Activate and mobilize public health personnel and response teams; request and deploy resources, coordinate with all response partners and sectors, and manage public health and medical emergencies.		
d. Communicate with diverse communities across different media, with emphasis on populations that are disproportionately challenged during disasters, to promote resilience in advance of disasters and protect public health during and following disasters.		
3. Policy and Planning		
a. Develop basic public health policy recommendations. These policies must be evidence-based or innovative/promising and must include evaluation plans.		
b. Work with partners and policymakers to enact policies that are evidence-based or innovative/promising and that address the social determinants of health and health equity.		
c. Ability to use cost-benefit information to develop an efficient and cost-effective action plan to respond to the priorities identified in a community health assessment.		

4. Communications		
a. Engage and maintain ongoing relations with local and statewide media.		
b. Develop and implement a communication strategy, in accordance with Public Health Association Standards, to increase visibility of public health issues.		
5. Community Partnership Development		
a. Create and maintain relationships with diverse partners, including health-related national, statewide, community-based organizations, community groups or organizations, health care organizations, and local, state and federal governments.		
b. Select and articulate governmental public health roles in programmatic and policy activities, and coordinate with these partners.		
6. Leadership Competencies		
a. Lead internal and external partners to consensus and action planning and serve as the public face of Tribal health in the community.		
b. Uphold business standards and accountability in accordance with Tribal, local, state and federal laws, regulations and policies and align work with national and Public Health Accreditation Standards.		
c. Evaluate programs and continuously improve processes.		
d. Develop, maintain, and access electronic health information to support operations and analyze health data.		
e. Develop and maintain a competent workforce, including recruitment, retention and succession planning functions, training, and performance review and accountability.		
f. Fiscal management, contract and procurement capabilities—maintain compliance with relevant federal, state and local standards and policies.		
g. Procure, maintain, and manage safe facilities and efficient operations.		
h. Access and appropriately use legal services in planning and implementing public health initiatives.		

FOUNDATIONAL PROGRAMS	Capacity	Expertise
1. Communicable Disease Control		
a. Provide timely and accurate information on prevention and control of communicable disease and other notifiable conditions.		
b. Identify community assets for the control of communicable diseases and other notifiable conditions, develop and implement a prioritized control plan addressing communicable diseases and other notifiable conditions, seek resources and advocate for high priority prevention and control policies, and initiatives regarding communicable diseases and other notifiable conditions.		
c. Promote immunization and use of the statewide immunization registry through evidence-based strategies and collaboration with schools, health care providers, and other community partners to increase immunization rates.		
d. Ensure disease surveillance, investigation, and control for communicable disease and notifiable conditions in accordance with local, state, and federal mandates and guidelines.		
2. Prevention and Health Promotion		
a. Provide timely, relevant and accurate information to communities on chronic disease (including behavioral health), injury, and violence prevention.		
b. Identify chronic disease (including behavioral health), injury, and violence prevention community assets.		
c. Develop and implement a prioritized prevention plan and seek resources and advocate for high priority policy initiatives to reduce statewide and community rates of chronic disease, injury, and violence.		
3. Environmental Public Health		
a. Provide timely, relevant and accurate information on environmental public health issues and health impacts from common environmental or toxic exposures.		
b. Identify environmental public health assets and partners and develop and implement a prioritized prevention plan to protect the public's health by preventing and reducing exposures to health hazards in the environment; seek resources and advocate for high priority policy initiatives.		
c. Conduct environmental public health investigations, inspections, sampling, laboratory analysis and oversight to protect food, recreational water, drinking water, and liquid and solid waste systems in accordance with local, state, and federal laws and regulations.		

d. Identify and address priority notifiable zoonotic conditions (e.g. those transmitted by birds, insects, rodents, etc.), airborne conditions, and other public health threats related to environmental hazards.		
e. Protect the population from unnecessary radiation exposure in accordance with local, state, and federal laws and regulations.		
f. Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes.		

4. Clinical Preventative Services		
a. Provide accurate timely, Tribal, statewide and locally relevant information on the medical, oral and behavioral health care system.		
b. Participate actively in local, regional, and state level collaborative efforts regarding medical, oral, and behavioral systems planning to improve health care quality and effectiveness, reduce health care costs, and improve population health.		
c. Improve patient safety through inspection and licensing of health care facilities and licensing, monitoring and discipline of health care providers. (Centralized activity currently provided by DOH.)[1]		
d. When additional important services are delivered regarding medical, oral and behavioral health, assure that they are well coordinated with foundational services.		
5. Maternal and Child Health		
a. Provide timely and accurate information to Tribal, state, and local communities on emerging and ongoing maternal, infant, child and family health trends, taking into account the importance of childhood adversity and health inequities.		
b. Identify local maternal, child, and family health community assets, develop a prioritized prevention plan using life course expertise and an understanding of health inequities; seek resources and advocate for high priority policy initiatives.		

[1] Tribes have the sovereign authority to do this, but in practice look to the state to enforce licensing laws.

Appendix C: Focus Group Guide

Interviewee Name/Title: Tribal FPHS Work Group
Interviewed by:
Date:

Introduction:

Hello, my name is (name). I am (position/title) with Kauffman and Associates, Inc. (KAI), a Native American, woman-owned small business based in Spokane, Washington. In partnership with WA DOH and AIHC, KAI has been conducting an annual evaluation of the tribal foundational public health services program funding (TFPHS) since 2019.

Thank you for agreeing to talk with us today. The purpose of our discussion is to understand your experiences with the tribal foundational public health services program funding (TFPHS) provided by the Washington State Legislature through contract with the Washington State Department of Health (DOH). We hope today's conversation will help us better understand your tribes' or urban Indian organizations' public health needs, the goals for your TFPHS projects, and any lessons learned or challenges you've encountered while designing and implementing your projects. What we learn today will inform our evaluation of the TFPHS program, as well as the greater FPHS program at the state level. It will also be used to guide future fiscal priorities.

I'm going to ask you some questions which you can answer in any way you wish. Please raise your hand, or add a question or comment to the chat, and we will call on you. Feel free to elaborate on any of your points. If a question is unclear, stop me at any time and ask me to explain. You may also choose to skip any question or end your participation in the focus group whenever you wish. Participation is completely voluntary. Information and feedback from these discussions will be used in this year's evaluation of the TFPHS program. All audio recordings will be deleted after they are transcribed. All information from our discussion will be kept private and confidential, and names will not be used in the final evaluation. In addition, it will be presented as an aggregate, so no identifiable information will be used.

For today's discussion, I would like to record the interview. Is it OK if I record our discussion? (Moderator requires oral consent from each participant to record before proceeding).

Implementation of FPHS Plan (20 mins)

1. First, please introduce yourselves, your role and your experience with TFPHS. *[Moderator goes around the room, inviting each person to introduce themselves]*
2. What is the focus of your public health project? (e.g., public health plans and codes, environmental health, emergency preparedness)
    a. How was the project's focus determined?
3. How did you find the process for undertaking a TFPHS project with WA DOH? For example, was it smooth, confusing, too long?

   a. If you did not complete the contract, why? Were there barriers to completing it, such as staff turnover, platform issues with Adobe or DocuSign?
   b. If you did complete the contract, do you have any suggestions for improvements to the contracting process?
4. What resources (e.g., partnerships, trainings, funding) were essential for the success of your project?
5. Are there any additional resources or training opportunities you need to support your TFPHS work? Please describe.
6. What does a successful project look like for you and your community?
   a. How do you define or measure success for your project?

FPHS Effect on Public Health Capacity and Expertise (15 mins)

7. How would you describe your experiences with exercising sovereignty and self-determination in public health during the FPHS project?
8. How has public health capacity and expertise in your tribe or community been enhanced due to the FPHS program?
9. Besides capacity and expertise, are there other ways in which the FPHS program directly benefited public health for your tribe or community? (e.g., fostering internal community connections or connections with other tribes)

Lessons Learned/Challenges Faced (15 mins)

10. What is a success story or lesson learned while doing this work so far?
11. What challenges and barriers have you encountered during your TFPHS work? How did they affect the success of your project?
    a. How did you mitigate any challenges or barriers you encountered?
12. Do these questions help tell the complete story of the work that has been done with the TFPHS funds?
13. Are there any additional comments anyone in the group would like to make?

Those are all the questions I have for you today. Thank you for sharing your time and knowledge with us. We appreciate the chance to learn about your work with the TFPHS program and look forward to sharing the results of this evaluation with you after it has been completed.

Time Ended: _____