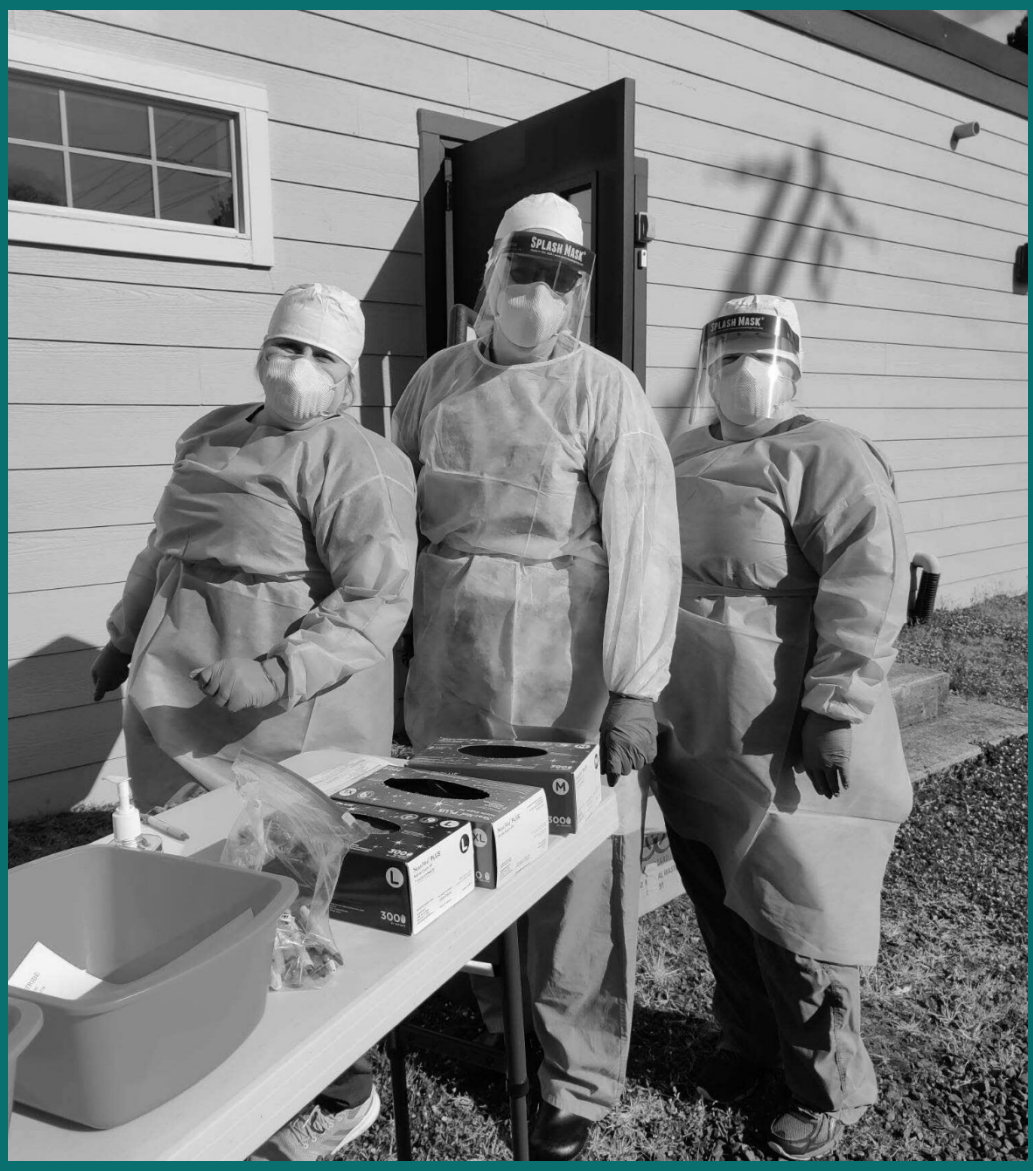
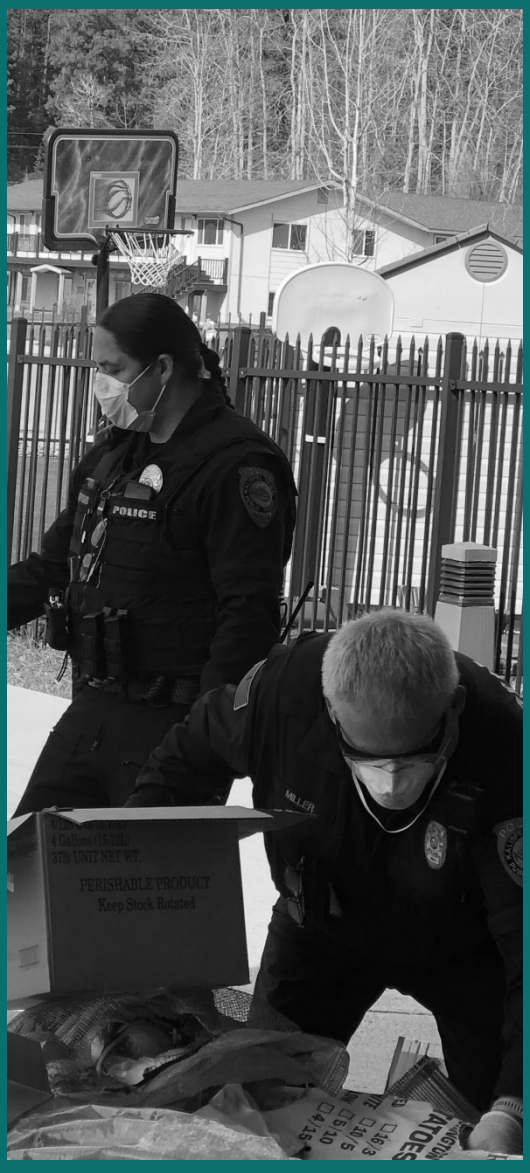
American Indian Health Commission

TRIBAL COVID-19 PANDEMIC AFTER ACTION REPORT

Tribal Health Jurisdictions and
Urban Indian Health Programs
in Washington State

Feb. 2020-March. 2023





Vicki Lowe, Executive Director
American Indian Health Commission

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AMERICAN INDIAN HEALTH COMMISSION FOR WASHINGTON STATE

About The

American Indian Health Commission

The American Indian Health Commission was created in 1994 by Washington's federally recognized Tribes, urban Indian health programs, and other Indian organizations to improve the health status of American Indian and Alaska Native people through intergovernmental collaboration on health policies and programs. The Commission's work is directed by the Tribes and urban Indian health programs in Washington. Delegates are officially appointed by Tribal councils and urban Indian health program boards to represent each individual Tribe and urban Indian health program.

AMERICAN INDIAN HEALTH COMMISSION DELEGATES

Tribal Nations

Chehalis
Confederated Tribes of Colville
Cowlitz
Jamestown S'Klallam Kalispel
Lower Elwha Klallam
Lummi Nation
Makah Nation
Muckleshoot
Nisqually
Nooksack
Port Gamble S'Klallam
Puyallup
Quileute
Quinault
Samish
Sauk-Suiattle
Shoalwater Bay
Skokomish
Snoqualmie
Spokane
Squaxin Island
Stillaguamish
Suquamish
Swinomish
Tulalip
Upper Skagit
Yakama Nation

Urban Indian Health Programs

Native Project of Spokane Seattle Indian Health Board

Tribal Organizations

American Indian Community Center

Acknowledgments

The American Indian Health Commission (Commission) wishes to acknowledge and thank the Tribes and urban Indian health programs in Washington State without whom this report would not be possible. Their generosity in contributing their time and knowledge and sharing their experiences is greatly appreciated.

We would like to dedicate this report to Lou Schmitz. For almost 30 years, Lou has worked tirelessly on Commission efforts to support the safety and wellbeing of American Indians and Alaska Natives (AI/AN) in Washington State. Lou has been a driving force in advocating for the inclusion of Tribal health jurisdictions and urban Indian health programs in all aspects of Washington's emergency response cycle. Her tenacious, yet gracious personality continues to inspire us every day.

American Indian Health Commission
Executive Director
Vicki Lowe

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EXECUTIVE SUMMARY

The COVID-19 pandemic illustrated a long-held principle in pandemic preparedness: communicable diseases do not stop at jurisdictional boundaries. The inclusion of Tribal health jurisdictions is not only imperative for strengthening Tribal sovereignty but is vital for the leveraging of critical resources across all neighboring federal, Tribal, state, and local jurisdictions. Throughout the pandemic, Tribes in Washington served as a national model for cross-jurisdictional collaboration with state and local jurisdictions. Tribal health jurisdictions and urban Indian health programs vaccinated over 250,000 Washingtonians and lent staffing resources and equipment to multiple local health jurisdictions. Many Tribal and local health jurisdictions supported each other through the sharing of personnel, vaccine, personal protective equipment, and technical assistance.

These accomplishments were built upon a long history of Tribal efforts to make institutional and structural changes that respect and honor the sovereignty of Tribal nations to serve their people during pandemics. A critical component of the State's success was adopting and implementing a policy that protected the sovereign right of Tribes to vaccinate their community. The Centers for Disease Control and Prevention would later adopt this policy at the national level. As a result of federal and state governments respecting the right of Tribes to vaccinate their people in accordance with their governmental protocols, Tribal health jurisdictions throughout our nation served a seminal role in getting shots in the arms of not only their own citizens, but of those in their surrounding communities.

While Tribal health jurisdictions and urban Indian health programs saved the lives of countless community members, they faced numerous challenges in responding to the pandemic. These challenges often stemmed from historic inequities in funding for Tribal public health infrastructure compared to local health jurisdictions. Other challenges resulted from the lack of understanding and respect for a Tribe's sovereign authority to exercise public health powers and the failure to recognize and acknowledge the expertise of Indian health care providers in responding to their communities in ways that no other entities could. Toni Lodge, Director for the Native Project, shared that respecting the expertise and knowledge of Tribes and urban Indian health programs means that "Next time we have a pandemic, ***don't tell us what to do, ask us how we should do it***."

To develop this report, the American Indian Health Commission held a series of webinar style hotwashes and after action reports with individual Tribes and urban Indian health programs for a total of 45 meetings, each two hours in length, from November 2021 to March 2023. Tribal and urban Indian health program representatives identified more than 70 recommendations for improving coordination and collaboration with Tribes and UIHPs in pandemic preparedness and response. Four key insights emerged from the gathering of comprehensive feedback from Tribes and urban Indian health programs:

1. **Federal and State Requirements Regarding a Tribe's Sovereign Right to Choose Their Priority Groups and Service Populations Played a Key Role in Vaccinating Thousands of Washingtonians.** Tribes reported that the new policy of recognizing the sovereign right of Tribes to receive vaccine and determine their own service and priority populations was the strongest factor for Tribes' success in conducting widespread vaccination efforts. This policy benefited not only Tribal nations but their surrounding communities as well. While the vaccine distribution was largely successful, issues arose regarding federal and state agencies adhering to federal and state policy that only Tribes determine their service populations and priority groups.
2. **Tribal Health Jurisdiction and Urban Indian Health Program Set Asides for Vaccine and Personal Protective Equipment (PPE) Are Critical to Ensuring Equitable Access**. In general, most Tribal health jurisdictions and Indian health care providers reported that the State was quicker and more responsive in sending the amount of vaccine requested than the Indian Health Service. The State set aside of 5% of vaccine allocation was key in ensuring access. State plans, in consultation with Tribes and confer with urban Indian health programs, should be updated to include a minimum of 5% medical countermeasures and PPE allocation.
3. **Lack of Equitable Funding for Public Health Staffing for Tribal Health Jurisdictions and UIHPs Remains a Significant Barrier to Pandemic Response.** Tribal health jurisdictions operated throughout the pandemic with no dedicated federal or state funding to employ public health staff. As a result, many Tribal health jurisdictions and urban Indian health programs used critical health care staff to perform public health functions such as mass testing and vaccinations, case and contact investigations, isolation and quarantine, and PPE acquisition and storage. For Tribal health jurisdictions and urban Indian health programs to sustain this level of service, funding for public health staff is imperative. Tribal health jurisdictions are a vital component of Washington's governmental public health system and should be funded as such. Federal and state agencies must prioritize funding to Tribal health jurisdictions and urban Indian health programs for at least 1.0 FTE public health staff position for each Tribal health jurisdiction and urban Indian health program.
4. **Maintaining Cross-Jurisdictional Collaboration Efforts is Essential for Future Preparedness Efforts.** The weekly American Indian Health Commission facilitated calls with the Indian Health Service, the State Department of Health, Tribal health jurisdictions, and urban Indian health programs were key in providing up-to-date information in an easy to access and reliable format. These calls, which allowed Tribal health jurisdictions and urban Indian health programs to receive and request resources and information directly from Tribal, federal, and state governments, should be stood up in future public health emergencies. Additionally, the American Indian Health Commission Tribal Liaison position within the Department of Health Incident Management Team served a crucial role in facilitating cross-jurisdictional collaboration between Tribes and the State. The State should formally add this position to emergency response plans.

All levels of government, upon reviewing and reflecting on this report, must work to ensure Tribal nations have equitable access to resources that other local and state governments have had for decades. The key insights and recommendations detailed in this report are the result of Tribes and urban Indian health programs volunteering their time to provide constructive feedback for federal, state, and local agencies. We hope the State of Washington honors their knowledge and expertise through actions that are consistent with the right and power of a Tribe to self-govern and fulfill their governmental duties to protect the health and safety of their people.

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INTRODUCTION

Report Framework

This report follows the applicable Centers for Disease Control and Prevention's Public Health Emergency Preparedness and Response capabilities. The definitions for each capability are presented in their respective sections.

To collect the recommendations presented in this report, the American Indian Health Commission (Commission) conducted 45 webinar-style hotwashes and after action reviews with individual Tribes and urban Indian health programs (UIHPs) between November 2021 to March 2023. Tribal and UIHP staff with various roles, ranging from human resource and emergency response staff to clinic directors, were among the participants. The Commission asked key questions in alignment with the applicable Centers for Disease Control and Preventions (CDC) Public Health Emergency Preparedness capabilities and the central topic of cross-jurisdictional collaboration (See Appendix B).

Hotwash and After Action Review Meeting Overview

Meeting Type	Time Frame	Participants	Jurisdictions/Entities Represented
23 Hotwashes	Spring 2021 Fall 2021 Fall 2022	Tribal council leaders, UIHP directors and staff, Tribal and local public health officers, local health jurisdiction staff, Tribal and local emergency management, Tribal law enforcement, Tribal health	**Washington State Public Health Regions 1-9** Tribes, UIHPs, local health jurisdictions
22 After Action Reviews	Fall 2022 Winter 2022 Winter 2023 Spring 2023	Tribal council leaders, UIHP directors and staff, Tribal health clinic providers, Tribal behavioral health providers, Tribal law enforcement, IT, human resources, casino staff, planning, emergency management, Tribal public health officers	Tribes and UIHPs

State Tribal Consultation and Government-to-Government Requirements

As the State moves forward with implementing after action report recommendations, updating comprehensive emergency management plans, and amending state laws, regulations and policies, it must ensure compliance with state policies and laws regarding Tribal consultation. RCW 43.376.020 requires state agencies to "make reasonable efforts to collaborate with Indian tribes in the development of policies, agreements, and program implementation that directly affect Indian tribes." In addition, the State of Washington is bound by the Centennial Accord of 1989 between the State of Washington and the Tribes where each party "respects the sovereign status of the parties, enhances and improves communications between them, and facilitates the resolution of issues." To comply with the spirit and

intent of the Centennial Accord, the State of Washington must regard Tribal nations as Tribal health jurisdictions with all the attending powers and duties of any other state or local health jurisdiction.

Understanding Tribal Health Jurisdiction Authority and Powers

Recognizing the public health powers of Tribal health jurisdictions is critical to properly addressing recommendations made in the after action report. Tribal nations possess the inherent power to self-govern.[1] This power includes the essential role of protecting the safety and general welfare of their community members and promoting public health. Tribal health jurisdictions have a wide range of governmental responsibilities to fulfill, including the following functions:

Marilyn Scott, Chairwoman for the Upper Skagit Tribe

1. **Legislative and Regulatory Authority:** Enact tribal public health laws and regulations. Exercise legal authority as applicable and understand the roles, responsibilities, obligations and functions of the governing body, health officer, and Tribal staff (e.g., declare emergencies, close reservation borders during public health emergencies, issue isolation and quarantine orders).
2. **Policy Development:** Develop and implement policies that protect, promote, and improve public health while ensuring that these policies are consistent with the laws, rules, and cultural values of the Tribe.
3. **Resource Assessment and Acquisition:** Assure the availability of adequate resources (legal, financial, human, technological and material) to perform essential public health services.
4. **Community Engagement:** Build and strengthen engagement of community members in promoting and protecting the community's health.
5. **Continuous Improvement:** Routinely evaluate, monitor, and set measurable outcomes for improving community health status and the Tribal health jurisdiction's ability to meet its responsibilities.

[1] For an overview of Tribal public health jurisdiction, see Aila Hoss, Toward Tribal Health Sovereignty, 419 U. Wis. L. Rev. 2022 (2022).

TRIBAL AND URBAN INDIAN HEALTH PROGRAM COVID-19 PANDEMIC RESPONSE SUMMARY

The public health achievements of Tribal health jurisdictions and urban Indian health programs (UIHPs) during the pandemic were nothing short of astounding. As of the date of this report, almost every Tribe and UIHP within Washington has developed significant capacity and capability in core public health response areas. And yet, many who did not understand the knowledge and expertise of Tribal health jurisdictions and UIHPs were often surprised or in disbelief of their success. To strengthen future pandemic response, federal, state, and local agencies must carefully learn from these successes and reflect on why Tribal health jurisdiction and UIHPs had been overlooked, underestimated, and underfunded in public health emergency response.

In contrast to local health jurisdictions, most Tribal health jurisdictions did not have a public health officer or resources to build systems for contact tracing, testing, and conducting mass vaccinations. A few Tribes already had a dedicated public health staff person, but those Tribes were the exception. Tribal health jurisdictions reported during the after action reviews and hotwashes that historically they received little to no funding at the federal and state levels despite their governmental responsibility to protect the health and safety of their people who are also Washington state citizens. As a result, many Tribal health jurisdictions and UIHPs had to utilize their clinic staff to serve dual roles as both health care providers and public health responders.

As one Tribal representative pointed out, Tribes may not have had a public health department, but they had a great number of skilled people. Tribes pulled together clinic staff, Tribal law enforcement, IT departments, elder services, and other departments to build an army of public health responders. The ingenuity, depth of experience, and most importantly the trust and knowledge of their community members led to model responses that neighboring jurisdictions greatly benefited from. Several local health jurisdictions (LHJs) reported they learned invaluable strategies from Tribes and UIHPs and expressed their gratitude for the resources shared by Tribal health jurisdictions and UIHPs with LHJs and surrounding organizations. One LHJ observed their admiration of their neighboring Tribal health jurisdiction's ability to develop and implement testing, vaccine management, and isolation and quarantine in such a short period of time, noting their "system was being built as the plane was flying." Another LHJ observed the impressive ability of a Tribe in covering a jurisdiction that stretched over a very large land mass when providing pandemic response services to their people.

Despite the tremendous challenges, Tribal nations and UIHPs saved an untold number of lives. Their determination, historical knowledge, and culture contributed to their tremendous success in serving their people and surrounding communities. As Cheryl Kinley, retired nurse and former Lummi Tribal Councilwoman shared, "I believe our ancestors prepared us. It's not the first time a pandemic has been

in our community. We are so resilient. I really believe in our DNA."

The sections outlined below provide an overview of the demonstrated strengths of Tribal health jurisdictions and UIHPs in executing public health emergency response.

Vaccination. Perhaps one of the greatest success stories for Tribal health jurisdictions and UIHPs was the hundreds of thousands of Tribal members and surrounding community members they vaccinated. Tribal health jurisdictions and UIHPs worked with numerous agencies to coordinate the delivery of COVID-19 vaccines. They organized and operated mass vaccination sites at Tribal casinos, created pop-up events in their clinic parking lots, and conducted drive-thru clinics. Multiple Tribal health jurisdictions and UIHPs reported vaccinating between 600-1000 people in a single day.

As a result of the expertise and capacity of Tribal health jurisdictions to conduct their own vaccinations, most Tribal communities had significantly higher vaccination rates than their surrounding communities. One LHJ representative asked during a regional hotwash, "What can we learn from Tribes in their vaccination efforts?" The LHJ representative pointed out that their neighboring Tribal health jurisdiction had a community vaccination rate of 81% while their LHJ had a rate of 61%.

> **"When I got my idea around that we have to save our own lives and use our cultural humility it was lifesaving."**
>
> -Indian health care provider

Underlying Tribal health jurisdictions' and UIHPs' successes in vaccination are their expertise and knowledge of the communities they serve. They understood all too well that federal and state jurisdictions often lacked this expertise and knowledge when establishing priority groups. For example, the CDC initially set priority populations at ages 65 and above without consideration of certain populations. Tribal health jurisdictions and UIHPs knew this approach would result in a dangerous risk of life to their people given that American Indian/Alaska Natives (AI/AN) experience the highest health disparities and lowest life expectancies of any other population.[2] Early on, Tribal health jurisdictions and UIHPs developed and implemented vaccination strategies specifically

[2] According to the Indian Health Service, "American Indians and Alaska Natives born today have a life expectancy that is 5.5 years less than the U.S. all races population (73.0 years to 78.5 years, respectively). American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases." See https://www.ihs.gov/newsroom/factsheets/disparities.

tailored to their communities including culturally appropriate vaccine promotional materials and employee vaccine incentive programs. As one Indian health care provider stated, "When I got my idea around that we have to save our own lives and use our cultural humility it was lifesaving."

> **"I was blown away by the Jamestown Tribe drive-thru clinic…They let us watch their drive thru vaccination clinics which helped us set up our own."**
>
> -Local health jurisdiction staff member

Tribal health jurisdictions also administered thousands of vaccines to essential workers such as teachers and first responders in surrounding communities. The efforts of Tribal health jurisdictions and UIHPs significantly reduced the burden on the State and LHJs in getting shots in arms and served as models to surrounding LHJs. One LHJ representative shared, "I was blown away by the Tribe's drive-thru clinic. They let us watch their drive thru vaccination clinics which helped us set up our own." One Tribal health jurisdiction alone vaccinated approximately 30,000 Tribal members and surrounding community members. UIHPs also went above and beyond serving their patients and extended their expertise to serving other underserved communities. One UIHP held vaccine clinics for local Hispanic communities and other communities of color who did not feel comfortable attending mass vaccination events administered by U.S. military personnel.

Public Health Emergency Response Plans and Policies. Unlike local and state governments, Tribes and UIHPs have had few resources to develop public health emergency response plans, policies, and procedures. During the pandemic, Tribes shared with each other through weekly American Indian Health Commission meetings their various plans, policies, and procedures for issues such as isolation and quarantine, vaccine prioritization, masking, and employee vaccine mandates.

Emergency Operation Center Activation. Several Tribes reported that activating their Emergency Operations Center (EOC) and employing an incident commander were critical to their pandemic response. As part of this process, many Tribes brought together their public health response team (most commonly Tribal health clinic staff) with the Tribe's EOC. As a result of staff at Tribes and UIHPs wearing several hats during the pandemic, their incident command system (ICS) was more flexible and allowed for the right leadership and staff to serve various roles in pandemic response including representing the Tribe at various federal, state, and local meetings.

Communication. Tribes and UIHPs were the primary source of pandemic information for their community members. Both reported that regular and consistent communication with their community members was key to successful pandemic response along with developing evolving strategies for community outreach. One Tribe reported success with holding question and answer evening sessions

with their Tribal members. Other Tribes published monthly newsletters (digital and paper) and regular updates via social media.

Testing. Several Tribal health jurisdictions and UIHPs highlighted their ability to stand-up robust testing programs quickly, despite erratic access to supplies. Tribes contracted with labs and delivered their tests to the labs to ensure community members received results quickly. Later in the pandemic, Tribes and UIHPs had access to point-of-care tests and home tests. The acquisition of these tests was game changing for protecting their communities and maintaining continuity of operations. One Indian health care provider created a system to send rapid tests home with a sticker that contained Tribal health clinic contact information for patients to call for resources and follow-up in the event of a positive test. These wraparound services were extremely helpful in working towards the best health outcomes for positive community members. One Indian health care provider reported testing 300 people in an hour during their drive-thru testing event. Knowing their community members and being consistent in their testing procedures was key.

Isolation and Quarantine. Several Tribal health jurisdictions operated their own quarantine sites and/or operated isolation programs. They provided wraparound services including food, shelter, and cultural resources for people needing to isolate or quarantine. These wraparound services varied by jurisdiction, but meal/grocery delivery was reported among most Tribal health jurisdictions. Often, Tribal health jurisdictions coordinated isolation and quarantine facilities and staff with neighboring LHJs.

Case and Contact Tracing. Tribal health jurisdictions shared their practices for conducting effective case and contact tracing programs. Tribal public health staff noted their success in case and contact tracing largely resulted from knowing the addresses and names of all their community members and being a trusted and familiar face. Many Tribes that intended to coordinate case and contact tracing with LHJs eventually conducted investigations themselves as they were more effective at reaching their own community members.

ISSUES AND RECOMMENDATIONS FOR STATE, FEDERAL, AND LOCAL JURISDICTIONS

This section documents strengths and challenges of federal, state, and local governments in coordinating and collaborating with Tribal health jurisdictions and urban Indian health programs (UIHPs). Recommendations provided in this section should be incorporated into applicable federal, state, and local comprehensive emergency management plans, laws, and policies (See Appendix A for a summary of recommendations).

Capability 1: Community Recovery

Community recovery is the ability to identify vital assets within public health and other sectors that can guide and prioritize recovery operations. This involves collaboration with other jurisdictions and partners to return to at least pre-incident day-to-day levels of functioning.

Issues

1. **Tribal Expertise Needs to Be Considered in State and Local Community Recovery and Emergency Planning**

   Federal, state, and local governments do not always understand the value of supporting Tribes in serving their own people. Tribal leader after action participants stressed the need to have their own public health officers and emergency managers to rely on during emergencies. Not only do they have the expertise to best respond to an emergency in their community, but the community is more likely to trust them and listen. In referring to their Tribal public health officer and Tribal emergency manager, a Tribal leader stated, “Being a Tribal community, we understand the process of protecting each other. The Tribe does a good job of complying because they want to and not because they have to. It works because our Tribal public health officer and emergency manager have been here for a long time and because we trust what they say when they are saying it.”

   After action participants described balancing safety recommendations and their sense of culture and community, which is also protective of the community’s health. “We were very consistent in following the science, DOH, and our local health officer. But they don’t keep consistent with cultural needs. So, we focused on keeping our community alive. We have to account for our cultural needs that keep us alive. We were falling into the more communal approach instead of individual needs and wants. We looked at our elders with their individual needs and people with addictions, mental health issues, and homelessness.”

   Tribal health jurisdictions understand the importance of maintaining cultural resources unique to their community. For example, Tribes provided language classes, drumming, and other cultural practices through virtual platforms. According to one Tribal representative, “Lack of being able to gather was where we suffered the most. We made sure to have song and dance so we could share with the community. We relied a long on our cultural leaders to keep the community connected culturally.” Another Tribal representative shared, “We made sure our seafood was distributed to our membership to have our souls fed.”

2. **Mental Health Support for Tribal Staff**

   Tribes and UIHPs reported a need to provide mental health support to their staff who have been on the front lines. Many Tribal representatives reported that staff are leaving their fields entirely. “Once the community feels secure in something that feels so scary, they are not going to let go of you. We felt the strain of the long response with lack of staffing. It did take a toll after so many years of working under that strain.”

   During after action meetings, participants expressed a variety of emotions. Some were moved to tears reflecting on the hard work their team has done over the last several years while others felt they needed to cleanse (smudge) those years away after discussing them.

Recommendations

1. **Support for Tribal Health Jurisdictions and UIHPs to Lead Community Recovery.** Since community members look to Tribes and their UIHPs as the most trusted source for how to keep safe during an emergency, state and local governments should provide technical support and resources for Tribal health jurisdictions and UIHPs to lead and conduct their own emergency response and recovery.

2. **Resources for Tribal Health Jurisdictions and UIHPs to Provide Mental Health Support to Staff.** The State of Washington should provide resources for Tribal health jurisdictions and UIHPs to conduct or outsource mental health support to staff who responded during the pandemic. This support could include resources to conduct debriefing exercises.

Capability 2: Emergency Operations Coordination

Emergency operations coordination refers to the ability to coordinate with emergency management and to direct and support an incident with health implications by creating a scalable response structure capable of providing oversite, organization, and supervision that is consistent with a jurisdiction’s standards and practice. In the context of the COVID-19 pandemic, this meant creating a state response structure that was collaborative with local health jurisdictions (LHJs) and Tribal health jurisdictions.

Issues

1. **Local Emergency Management Inclusion of Tribal Health Jurisdictions**

   Several counties and Tribes agreed to have a Tribal representative within the county’s incident command structure. Both Tribes and counties reported that this practice was highly beneficial to both governments. This inclusion resulted in strong relationships that helped jurisdictions leverage resources, reduce duplicative efforts, and receive up-to-date information. Tribes were able to be part of regular discussions with other key community partners including hospitals.

   This level of inclusion and coordination did not happen statewide, however. Some counties did not invite neighboring Tribes to serve on their incident command teams. Several Tribes stated they would like to see improvement in counties including Tribal health jurisdictions in their incident command structures.

2. **Washington State Department of Health Incident Management Team Inclusion of Tribal Health Jurisdictions**

   During the COVID-19 pandemic, the Washington State Department of Health (DOH) included an American Indian Health Commission (AIHC) Tribal liaison position on the DOH incident management team. As a result of this position, the AIHC Tribal liaison was able to regularly report to DOH concerns, requests, and recommendations provided by Tribal health jurisdictions and UIHPs based on the weekly AIHC public health emergency preparedness calls and daily communications. As one Tribal emergency manager shared, the AIHC Tribal liaison was able to do what their Tribal staff did not have the time do by, "telling them what she was hearing and getting the changes and what we needed." These changes included processes for how to order and distribute vaccine to Tribes.

   This position has yet to be reflected in the state's comprehensive emergency management plan, the Emergency Support Function 8: Public Health, Medical, and Mortuary Services (ESF8)-specific plan, or within the DOH incident management team organization chart.

3. **Inclusion of Tribal Public Health Officers in State, Regional, and Local Public Health Officer Meetings**

   Most Tribes appointed Tribal public health officers either through Tribal public health codes or Tribal resolutions. These Tribal public health officers coordinated and engaged with state and LHJ public health officers including attending statewide and regional meetings. This cross-jurisdictional collaboration was vital for sharing resources and up-to-date information in a manner that was more consistent across jurisdictions.

4. **Supporting Tribal Emergency Management Infrastructure**

   For many Tribes, only a small group of staff provided emergency management. Most of these staff members wore multiple hats for their Tribe resulting in significant burn-out and a reduction in critical services. These Tribes reported that more equitable funding is needed to support Tribal jurisdictional emergency response. One Tribal emergency manager shared they felt that the State of Washington's emergency management program grant is very disproportionate with $8.5 million going from the federal government to the State of Washington and Tribes receiving only 2% of that for all twenty-nine tribes.

Recommendations

1. **Inclusion of Tribes in Local Government Incident Command Structures.** LHJs and county emergency management should update their comprehensive emergency management plans and incident command structures to include a role for Tribes should Tribes choose to coordinate response with them.

2. **Inclusion of American Indian Health Commission (AIHC) Tribal Liaison Position in Emergency Management and Incident Command Structures.**

   (a) The State Emergency Management Division (EMD) should add the AIHC Tribal liaison position to the state comprehensive emergency management plan and the ESF 8-specific plan.

(b) DOH should permanently establish the AIHC Tribal Liaison position within their agency's incident management team in the following manner:

(1) include language with the DOH emergency response plan that the purpose of the AIHC Tribal Liaison is to ensure that (a) all Tribal health jurisdictions are included in state decision making; and (b) critical information is going back to Tribal health jurisdictions;

(2) add the AIHC Tribal Liaison to the incident management team organization chart; and

(3) include language within the DOH emergency response plans that requires the incident management team to deploy the AIHC Tribal Liaison during emergencies.

3. **Coordination and Collaboration with Tribal Public Health Officers.** State and local agencies should update comprehensive emergency management plans to include a requirement for public health officers to coordinate with and include Tribal public health officers by adding them to public health officer contact lists, meetings, and email distribution lists. Agencies should extend the same invitation for Tribal representation if the Tribe does not currently have a public health officer.

Capability 3: Emergency Public Information and Warning

Emergency public information and warning is the ability to develop, coordinate, and disseminate information, alerts, warnings, and notifications to the public and incident management responders.

Issues

1. **Reducing Delays in Receiving Critical Information**

   Tribal health jurisdictions experienced delays in getting information from reliable sources in a timely manner. Oftentimes, updates regarding the pandemic would be in the news before the State or Tribes would hear about them from the federal government. Getting information in a timely manner during a pandemic is critical, and crisis and emergency risk communication principles were hard to follow when unreliable media sources were first to share information. Information changes rapidly during emergency response, and transparency about what is known is preferred over holding information back until the state or locals hear more.

2. **Improving Access to Culturally Appropriate Communication Materials**

   Tribal health jurisdictions reported a lack of culturally appropriate/relevant communication materials. State agencies created many communication materials, such as flyers, fact sheets, etc. However, some Tribal representatives reported that they were not relatable within their communities.

3. **Increasing Tribal Health Jurisdiction Capacity to Conduct Emergency Public Information and Warning**

   Several Tribal health jurisdictions reported that electronic health record (EHR) platforms such as

EPIC were extremely effective in sending out mass communications to patients concerning COVID-19 masking, quarantine, and business closure guidance and updates.

Recommendations

1. **Establish a Clear and Reliable Communication Pathway with Tribes.** The State should ensure clear communication pathways leading back to Tribes in emergency response plans. State agencies can accomplish this by inviting Tribal representation to local emergency management meetings and creating a permanent AIHC Tribal Liaison position on the DOH IMT.

2. **Resources for Tribal Health Jurisdictions and UIHPs to Develop/Acquire Culturally Relevant Community Messaging.** Provide Tribes, UIHPs, and Tribal organizations resources so that they can create their own culturally relevant and appropriate communication resources, such as flyers and posters.

3. **Funding for Tribal Health Jurisdiction to Implement Electronic Health Record Systems.** Provide Tribal health jurisdictions with funding necessary to implement Electronic Health Records (EHRs) such as EPIC with the capability to send emergency information and warnings to community members via texts, etc.

4. **Improve Clarity and Consistency Among Federal, State, and Local Guidance Documents.** Federal, state, and LHJ emergency improvement plans should include strategies to ensure that public information and guidance is:

   (a) Succinct, clearly written, and internally consistent; and

   (b) Where possible, consistent with information and guidance from other jurisdictions.

Capability 4: Information Sharing

Information sharing is the ability of Tribal, federal, state, and local governments to exchange information and situational awareness data in preparation for, and response to, a public health emergency.

Issues

1. **Government-to-Government Public Health Emergency Meetings**

   In the very beginning of the pandemic, Governor Inslee met with Tribal leaders on a regular basis to discuss pandemic response and coordinate with Tribal governments on state and Tribal mandates for business closures. During the hotwashes and after action report meetings, many Tribal and UIHP representatives applauded the Governor for holding these meetings. While there was not always agreement in these meetings, according to one Tribal council leader, Governor Inslee was “clearly recognizing each Tribal government's right to make decisions for our own populations.” Our experience has been very positive in that there has been the Centennial Accord.” However, these meetings are not institutionalized for all state emergency response efforts.

2. Inadequate, Confusing, and Changing Guidance

Tribal health jurisdictions and UIHPs experienced a significant administrative burden of staying up to date with constant information they received from the federal, state, and local levels. During hotwash meetings, both Tribal health jurisdictions and LHJs expressed frustration that federal and state guidance was often internally inconsistent, in conflict with other jurisdictions, and constantly in flux. More specifically, CDC guidelines frequently changed, and not knowing what the guidelines were or not having the same guidelines between the CDC and the State created challenges for Tribal health jurisdictions when messaging to their communities and creating their own jurisdictional guidance. A Tribal representative shared that regarding the information sharing capability, "It was trying to keep up to date and not act on old information and trying to integrate new information. Just about the time we thought we had it down, they changed it." In addition, Tribal and UIHPs reported that written information was at times confusing and lacked clarity.

3. Lack of Broadband Access and Communications for Tribes

For several Tribes located in rural locations, information sharing is complicated by the ongoing lack of broadband access in Washington state. Cable and cellular companies for many years have provided little to no service on many Tribal reservations despite extensive efforts by Tribal leadership to build adequate communications infrastructure. Many Tribes reported they cannot use Comcast or Wave on their reservations. This is due in part to frequent power outages. Lack of broadband access made it challenging, if not impossible, for these Tribes to provide medical and behavioral health services through telehealth and/or to exchange emergency information with federal, state, and local governments.

Several Tribes reported their appreciation for federal funds to support improving their broadband infrastructure. At the state level, Washington State Department of Commerce, Office of Broadband, pulled together funding and partners to address lack of broadband in Indian country. For example, they coordinated with a Tribe, the American Indian Health Commission, and the Department of Natural Resources to use an existing cell tower on Department of Natural Resources land to send the signal that brought broadband to a Tribe's reservation for the first time ever. They also helped coordinate "hotspot" trucks to reservations.

Another Tribe utilized federal funding to significantly improve their radio towers. These improvements allowed the surrounding counties' law enforcement and fire departments to use the signal as well. According to this Tribe's representative, because of these efforts, "Agencies came to the table to discuss partnership and working together. That was something really good that came out of the pandemic."

4. Maintaining and Accessing Public Health Contacts

Tribal health jurisdictions reported that maintaining up to-date contact information for other Tribal, federal, state, and local health jurisdictions has been a challenge. Both Tribal health jurisdictions and LHJs reported during the hot washes that they do not always know who to contact at another jurisdiction, and most Tribal health jurisdictions were not aware of a central location for key public health contacts.

5. **Reducing the Administrative Burden of Meeting Attendance**

   Tribes had meetings with multiple federal, state, and local agencies including Governor Inslee, the White House, FEMA, Indian Health Service (IHS), the State, and LHJs. While Tribes appreciated the opportunity to attend these meetings and acquire important information, many Tribal and UIHP representatives reported that the sheer number of meetings to attend significantly impacted the staffs' ability to perform their day-to-day and emergency response functions. According to one Tribal representative, "It was a bit overwhelming because there were so many meetings. It was a challenge to keep up with everything and track everything**."**

6. **Providing Easily Accessible Information and Materials**

   Tribal health jurisdictions shared that it was difficult to find federal and state guidance information online. Some Tribes reported difficulty in finding Tribal specific resources such as sample orders, policies, codes, etc. One Tribe reported that while they appreciated all the material the American Indian Health Commission provided, it was difficult to navigate their website.

Recommendations

1. **Add Statutory Requirement for Governor to Meet Regularly with Tribal Leaders During Emergencies.** The State should amend RCW 43.376.050 to include a requirement for the Governor's Office to meet regularly with Tribal government leaders during a state declared emergency.

2. **Resources for Tribal Health Jurisdictions to Develop/Improve Broadband Infrastructure.** The State through their various agencies, including the Department of Commerce and the Department of Natural Resources, should provide continued planning and support to Tribal governments for the development of broadband infrastructure in rural areas to ensure that Tribal health jurisdictions can effectively communicate with their community members, provide critical services, and coordinate with federal, state, and local governments during the next pandemic.

3. **Update and Maintain an Online Contact List.** The Washington State Department of Health should create and maintain an online database for all Tribal and local health jurisdictions to access up-to-date contact information. Tribal health jurisdictions should have a choice as to whether to opt-in to the database and share their contact information with other Tribal and local health jurisdictions.

4. **Consolidate and Reduce the Number of Meetings.** Federal and state agencies should coordinate amongst jurisdictions and partners to streamline the volume of meetings. For example, federal and state agencies should appear together at American Indian Health Commission meetings so that Tribal health jurisdictions and UIHPs can come to one meeting to get the most up-to-date information from their federal and state partners.

5. **Improve Website Organization and Access to Important Information.** Federal, state, local agencies and public health organizations should ensure their websites provide properly dated guidance and resources and post them online in a manner that is easily searchable and easy to locate.

Capability 5: Vaccines and Antivirals Acquisition and Dispensing

Vaccines and antivirals acquisition and dispensing refers to the ability to:

- acquire, manage, transport, track vaccines and antivirals during a public health emergency; and
- provide vaccine and antivirals to prevent, mitigate, or treat the public to ensure improved health outcomes during the pandemic.

Issues

1. **Improving Implementation of Federal and State Policy on Tribal health jurisdictions' Authority to Determine their Service and Priority Populations**

   The Washington State Medical Countermeasures Plan, Annex 9 (see Appendix D) and the COVID-19 Vaccination Program Interim Playbook for Jurisdictions Operations Annex (see Appendix B) provide the following requirements for federal, state, and local health jurisdictions in distributing vaccine to Tribal health jurisdictions:

   > Each Tribal nation has the sovereign authority to provide for the welfare of its people and, therefore, has the authority to:
   >
   > - Choose among the jurisdiction or Indian Health Service (IHS) options for accessing vaccine;
   > - Determine the population(s) it chooses to serve;
   > - Choose how vaccines are distributed to its community; and
   > - Establish priority groups when there is a limited supply of COVID-19 vaccine or other accompanying resources.

   This policy is a result of the hard work of Tribal leadership demanding recognition of the sovereign right of Tribes to determine their priority groups and services populations. The impetus for seeking this policy change was a devastating experience in the H1N1 pandemic in which some LHJs withheld pandemic influenza vaccine. Eleven years after H1N1, many Tribes credited the above-referenced federal and state policy for dramatically improving their access to vaccine. One Tribal leader attributed this success to the work of Secretary Weisman and his recognition of Tribal governments as being sovereign and to "All the work we have done to recognize what Tribes have the power to do."

   Most Tribes reported that the new policy of recognizing the sovereign right of Tribes to receive vaccine and determine their own service and priority populations was the strongest factor for Tribes getting shots in arms. This policy benefited not only Tribal nations but also their surrounding communities. One Tribe, despite limited resources and capacity, vaccinated almost 30,000 people in their rural location within a short period of time.

   While the vaccine distribution was largely successful, issues arose in consistently following the federal and state policy that Tribes determine their service populations and priority groups. In March 2021, several Tribes reported a significant decrease in the number of vaccines received from the Washington State Department of Health (DOH). The reduction in vaccines appeared to stem from DOH stating they would determine which Tribes have received doses equivalent to

100% of their priority population. Through Tribal consultation, DOH recognized, consistent with their state medical countermeasures plan, that only an individual Tribe can determine whether they have received enough doses to vaccinate their priority groups and how far along they are in vaccinating their service population.

In addition, there were reports that LHJs were concerned that Tribal health jurisdictions were vaccinating surrounding communities while other LHJs praised Tribal health jurisdictions for vaccinating essential workers in their communities. One Tribe for example provided one thousand vaccinations to teachers and staff at their neighboring school district. The criticism Tribes faced seemed contrary to the goal of vaccinating as many individuals as quickly as possible. In addition, prior to the above policy changes, the LHJs, for decades, received Tribal health jurisdiction's share of vaccine without this same criticism. In the future, state and local health jurisdictions should shift from this disparate view to one that seeks the goal of mass vaccination.

Recognizing and honoring the strength of Tribal health jurisdictions to act as public health authorities also respects the right of Tribes to exercise their cultural values. One Tribal public health officer stated that Tribes vaccinating the local schoolteachers was "an expression of their values in caring for their Tribe and others around their community. In a time of scare resources and competing interests, Tribes cared for others."

Tribes also reported frustration with Indian Health Service (IHS) not complying with federal policy that Tribes determine their priority groups, not IHS. Tribes were instructed to complete certain information for IHS so that IHS could make distributions according to IHS priority groups determinations. These actions by IHS and the "IHS COVID-19 Pandemic Vaccine Plan" are inconsistent with CDC policy that states only Tribes may determine their priority populations (see Appendix C). As one Indian health care provider noted, "IHS is not familiar with our community, so it was beneficial to get our own protocols in place." Tribes advocated for IHS to correct their policy at the June 15, 2021, U.S. Department of Health and Human Services Tribal Consultation, but IHS has yet to amend their policy.

2. Improving Coordination in Vaccine Ordering and Dispensing

Effective coordination between the Tribal health jurisdictions, UIHPs, Washington Department of Health, Indian Health Service, and the American Indian Health Commission (AIHC) IMT Tribal liaison was critical to ensuring Tribes and UIHPs received these resources in accordance with the above state and federal policy. The AIHC IMT Tribal liaison worked daily with administration and staff from the Washington Department of Health (DOH) to plan for and distribute thousands of COVID-19 vaccines to over twenty Tribes and both UIHPs. When barriers arose for Tribes and UIHPs in receiving the appropriate number of vaccines, the AIHC reported these concerns and worked with DOH to identify a resolution. The AIHC utilized surveys and weekly meetings to document these barriers.

One challenge with DOH was not knowing when a Tribe was receiving vaccine or how much. As a result, some Tribes reported having to cancel vaccination events because the Tribe was not told when they would be receiving the vaccine. It was challenging to cancel appointments for mass vaccination events with over a one thousand people already scheduled.

Other Tribes reported that DOH micromanaged vaccine providers when supply was greater than

demand. For example, under the state guidelines, providers could only vaccinate one person in a romantic couple if the other was not over 65. This was very inefficient in terms of vaccinating people quickly. In addition, these State requirements were inflexible (e.g., the "90% burn rate" requirement that required 90% of vaccine to be used within one week under penalty of being denied future shipments). While Tribes determine their priority groups and service populations, the State's micromanagement still impacted those Tribes who were trying to be consistent with state guidelines. As a result, vaccine efforts stalled, and the vaccine demand went down. Tribes reported front office staff and some staff members resigned because of the stress of denying patients vaccination.

3. **Vaccine Allocation for Tribal Health Jurisdictions**

   Throughout the vaccine response, there was a disparity in how much vaccine and vaccine readiness resources Tribes received through IHS compared to those who received these resources through the State. According to one Indian health care provider, when ordering through IHS, "we were limited to one hundred vaccines, while other Tribes had more. People who went through the State got vaccine faster." In general, most Tribes and Indian health care providers reported that the State was quicker and more responsive in sending the amount of vaccine requested than IHS. IHS was not consistently attending the weekly meetings and supplies seemed to lag behind the state efforts. The state set aside of 5% of vaccine allocation was key in ensuring access.

   In conducting mass vaccinations for Tribal communities and the communities at large, Tribes and UIHPs were integral to the success of statewide vaccination efforts. However, this role was marred by public records requests that made it appear as though Tribes and UIHPs received more vaccine than other groups when, in reality, they were vaccinating the community at large in addition to Tribal communities.

4. **Vaccine Dispensing Support for Tribal Health Jurisdictions**

   Tribal health jurisdictions that utilized the Washington State Department of Health's (DOH) mobile nurse teams and mobile vaccine services referred to as "the Care-a-Van" reported that those resources were helpful. As noted by one Tribal public health officer, "In the second year as we were resuming staffing, it became challenging to do vaccinations. Thankfully, we used the DOH Care-a-Van to help. The Care-A-Van helped us expand our services at the clinic. Without that support, we would have been in a really tough spot. Having state mobile vaccine clinics has been really critical."

Recommendations

1. **In Coordination with the American Indian Health Commission, Train and Educate Staff Regarding a Tribe's Sovereign Right to Choose Their Priority Groups and Service Populations.** DOH, in coordination with the American Indian Health Commission, should regularly review and train staff on implementing Washington State Medical Countermeasures Plan, Annex 9 (see Appendix D) to ensure understanding and compliance with federal and state policies which include the right of Tribal health jurisdictions to choose their own priority groups and determine their service populations.

2. **Correct Indian Health Service Vaccine Plans to be Consistent with CDC Policy.** Indian Health Service (IHS) must amend the IHS COVID-19 Pandemic Vaccine Plan to be consistent with the CDC's COVID-19 Vaccination Program Interim Playbook for Jurisdictions Operations 2.0 (See Appendix C) which provides that Tribes shall determine their priority groups, not IHS.

3. **Ensure Tribal Access to Both IHS and State Vaccines Supplies.** Federal and state governments should improve health inequities by ensuring that Tribes, who serve populations with high health disparities, can access vaccine from both IHS and the State. Federal and state agencies should refrain from requiring Tribes to choose one or the other.

4. **Improve Vaccine Distribution Communication.** DOH should create a consistent and timely communication pathway to let Tribal health jurisdictions know how much vaccine they can expect to receive and when, so they can plan their vaccination activities accordingly.

5. **Increase Flexibility in Vaccine Prioritization Criteria.** While Tribal health jurisdictions use state prioritization as guidance only, state and federal governments should develop broadly supported prioritization criteria for future vaccines, antivirals, and medical countermeasures in advance (rather than emergency decrees by a single elected official) to better balance the public health benefit with equity considerations.

6. **IHS Regular Participation at Tribal Emergency Coordination Meetings.** IHS should ensure they are present and available at government-to-government coordination meetings.

7. **Support for American Indian Health Commission Tribal-Federal-State Facilitation.** DOH should continue to support and enhance the role of the American Indian Health Commission in facilitating cross-jurisdictional meetings for Tribes and UIHPs in Tribal vaccine readiness planning and pandemic response.

8. **Improve Volume and Speed of IHS Vaccine Distribution to Tribes.** Federal agencies must ensure that IHS receives an adequate supply of vaccine to distribute to Tribes, and IHS must develop strategies to ensure quicker distribution of vaccine and improve the ability to fulfill the amounts of vaccine Tribes are requesting.

9. **Establish in State Plans a Tribal 5% Set Aside for Medical Countermeasures.** The State should put a 5% Tribal set aside of medical countermeasures in Annex 9 (see Appendix D), the plan specific to distribution of medical countermeasures. This set aside should apply to anti-viral access as well, since it is a type of medical countermeasure.

10. **Amend Washington State Public Records Act to Exempt Disclosure of Tribal Data.** The State should add an exemption to the public records act for information related to Tribes.

11. **Expand Mobile Nurse Teams and Care-A-Van.** Expand resources such as the mobile nurse teams and the Care-A-Van to include multiple types of vaccinations, and update DOH's written pandemic and outbreak response plans to include these resources.

Capability 6: Medical Materiel Management and Distribution

Management and distribution of medical material is the ability to acquire, manage, transport, and track

medical materiel during a public health emergency as well as the ability to recover excess materiel following the response.

Issues

1. **Logistics and Supply Chain Management**

   Most Tribes and UIHPs reported difficulties in acquiring medical materiel, such as personal protective equipment (PPE), syringes, HVAC equipment, and cleaning supplies early in the pandemic. According to one Indian health care provider, "There were a number of weeks where we would not get enough supplies to be able to work." Tribal dental clinics were particularly impacted with dentists having to change gloves multiple times a day, wear specific masks, and install expensive HVAC systems and other types of equipment for infection control.

   Tribes and UIHPs reported accessing PPE from the Indian Health Service (IHS), Washington State Department of Health, the American Indian Health Commission (Commission), other Tribal organizations, charities, and private vendors. Many Tribes reported that ordering supplies from IHS was mostly a positive experience. Other Tribes and Indian health care providers reported that IHS failed to deliver or send needed PPE. IHS seemed to be a preferred resource for PPE over the State and local health jurisdictions but that was not a universal finding. Other Tribes preferred coordinating with DOH because IHS did not have electronic ordering and used outdated paper ordering. Almost all Tribes and UIHPs reported that the weekly Commission-IHS-DOH calls were critical for knowing where to access hard to find supplies and to share supplies with each other.

   Common logistics and supply chain issues reported by Tribes and UIHPs included:

   - Needing drive-thru vaccination clinic trays sooner. Many of the supplies needed for drive-thru vaccine and testing were on back order;
   - Needing a state-held reserve of Tribal and UIHP PPE supply so that Tribes and UIHPs could coordinate delivery of PPE and share resources;
   - Receiving supplies from the Strategic National Stockpile, IHS, DOH, and nonprofits that were expired, not needed or requested, too large to receive or store, or of poor quality. This included goggles leftover from the Vietnam war, hospital beds, construction masks, excess and/or defunct vaccine ancillary supplies, and gallon-sized industrial hand sanitizer. As one Tribal representative stated, "We had huge pallets showing up with things we needed and other times not;" and
   - Needing software to help track inventory.

Recommendations

1. **Establish Policy for Direct Access of PPE for Tribal Health Jurisdictions.** Update State Emergency Management Department and Department of Health (DOH) plans to include language that Tribal health jurisdictions can access personal protective equipment (PPE) directly from state stockpiles.

2. **Establish in State Plans a 5% Tribal Set Aside for PPE and Maintain a Tribal Stockpile**. The State should put a 5% Tribal set aside of PPE in state plans specific to distribution of PPE. DOH should also maintain and establish a Tribal stockpile to ensure Tribes and UIHPs have access to PPE and medical supplies that are likely to be impacted by supply chain issues.
3. **Ensure Appropriate Staff Attend American Indian Health Commission Tribal-IHS-DOH Public Health Emergency Response Meetings.** IHS and DOH should provide regular and ongoing technical assistance to Tribes and UIHPs for acquiring PPE at the American Indian Health Commission Tribal-IHS-DOH public health emergency response meetings.
4. **Strengthen Protocols for Reducing Distribution of Expired PPE.** DOH and IHS planning efforts should include protocols for ensuring that expired PPE are not distributed.
5. **Develop Procedures for Distribution of PPE to Tribes and UIHPs.** Federal and state agencies should update comprehensive emergency plans to include procedures for coordinating the delivery of PPE to Tribes and UIHPs. These plans should include:
    (a) requirements for agencies to confirm with recipients prior to delivering PPE the following:
        (1) what items are needed;
        (2) what quantities are needed; and
        (3) whether the recipient has the necessary equipment (e.g., pallet jack) and infrastructure to receive the PPE.
    (b) processes for ensuring direct distribution of PPE to Tribes and UIHPs.
6. **Develop PPE Resource Exchange Site.** Create a resource coordination process where facilities can submit a query for any PPE to share and/or sell.
7. **Expand Access to Inventory Tracking Software.** Provide funding and resources to Tribes and UIHPs to purchase/obtain inventory tracking software.
8. **Develop Capacity to Manufacture PPE Domestically.** Federal and state governments should develop or increase the capacity to make essential PPE and testing supplies domestically to prepare for future supply chain disruptions.

Capability 7: Medical Surge

Medical surge is the ability to provide adequate medical evaluation and care during events that exceed limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive hazard impact and maintain or rapidly recover operations that were compromised. This includes behavioral health care.

Issues

1. **Lack of Funding for Tribal Public Health Staff**

    Perhaps one of the greatest challenges was continuity of operations. Prior to the pandemic, Tribes and UIHPs experienced barriers to recruiting and maintaining clinical staff. The pandemic exacerbated these staffing issues with entire clinics switching from treating patients to

responding to COVID. Tribes and UIHPs reported that health clinic staff had to transition quickly to taking part in vaccination clinics. As a result of wearing multiple hats, taking on newly assigned duties, and working longer hours, Tribal staff experienced significant exhaustion and burn out. Most Tribal Public Health Officers faced the enormous task of simultaneously continuing their role as Tribal health clinic director. Tribes and UIHPs shared that they are continuing to catch up on clinic duties that are not directly COVID-19 related.

While LHJs also faced severe staffing shortages and burnout, Tribal health jurisdictions are still operating without any dedicated federal or state funding to employ public health staff. Looming in the background for Tribal health jurisdictions and UIHPs is the impending reduction or loss of funding to continue their public health operations. Tribal health jurisdictions and UIHPs served thousands of Washington state citizens by providing vaccinations, case and contact investigations, isolation and quarantine facilities, and PPE supplies. For Tribal health jurisdictions and UIHPs to sustain this level of service, funding for public health staff is imperative. Tribal health jurisdictions are a vital component of Washington's overall public health system and should be funded as such.

2. Recovering Critical Medical and Behavioral Health Services

Several Tribes and Indian health care providers stated that reimbursement for telehealth was critical in being able to continue and maintain medical and behavioral health services for their patients and community members. In addition to reimbursement for services, the Health Care Authority deployed laptops and cell phones which enabled patients to have telehealth visits with their Indian health care providers.

However, for some Indian health care providers telehealth was not a panacea. This became a challenge in providing behavioral health. Many faced challenges with broadband infrastructure necessary to implement telehealth. Others felt that telehealth did not work well in their communities where face-to-face was essential. According to one Indian health care provider, "Going remote didn't work for us. Behavioral health issues don't just stop, but they were asking us to stop. That was a huge challenge. What were we going to do to help people?"

Despite the huge gains of having telehealth, the backlog of services continues to build. According to one Indian health care provider, "Substance use disorders increased because there was nothing better to do. We know there's people who need help, and we're not getting to them." In addition, many Indian health care providers reported they may never get fully caught up on dental services. Some Indian health care providers reported having to use temporary agencies to provide health care services. Others shared that they are competing with county facilities who are recruiting Tribal public health and medical staff away.

3. Hospital Capacity

Several Tribes reported serious concerns regarding the lack of hospital capacity throughout the state. A Tribal public health officer shared, "We only have one hospital in our community and our people aren't at the top of their list. A paramedic told an elder that 'if you don't go in an ambulance, you will be stuck there for hours.'" Tribes also reported their concern that hospital beds are empty and that hospitals are not being held accountable for failing to hire enough nurses to staff those beds.

Recommendations

1. **Fund Tribal and UIHP Public Health Staff.** The State should prioritize funding for at least 1.0 FTE public health staff position for each Tribal health jurisdiction and UIHP.

2. **Include Distribution of Laptops and Cell Phones in Emergency Planning.** The State should include in future planning the distribution of laptops and cell phones for Indian health care providers to be able to maintain medical and behavioral health services.

3. **Ensure Hazard Pay and Responder Benefits.** State and Federal agencies should ensure medical and behavioral health staff receive hazard pay and responder benefits during pandemics.

4. **Expand and Make Permanent Telehealth.** Federal and state agencies should expand and permanently fund telehealth as one tool for mitigating workforce shortages.

5. **Conduct Analysis on Hospital Bed Utilization and Shortages.** The State, particularly the Governor's Office, should conduct analysis to understand why hospital beds are empty in some hospitals while others are over capacity. In addition, the Governor's Office should implement strategies for requiring and/or incentivizing hospitals to maximize bed capacities.

Capability 8: Nonpharmaceutical Interventions

Nonpharmaceutical interventions are actions that people and communities can take to help slow the spread of illness or to reduce the adverse impact of public health emergencies. Contextual examples include isolation and quarantine, social distancing, and masking.

Issues

1. **Improving Isolation and Quarantine Protocols**

   Several Tribes coordinated with LHJs to locate county sites for isolation and/or quarantine of their community members. These regions reported a positive relationship between Tribal health jurisdictions and LHJs in that they could leverage each other's resources especially when quarantine sites and the resources necessary to maintain those sites were severely limited. Some Tribes provided facilities that both Tribal health jurisdictions and LHJs could share. Other Tribes provided staffing for LHJ isolation and quarantine facilities. Another effective coordination strategy was the sharing of expertise among the jurisdictions. For example, one LHJ noted their neighboring Tribe, "had good ideas on isolation and quarantine and helped us get up and running faster."

   Several Tribes also reported issues with Tribal members having access to transportation to and from isolation and quarantine facilities. Lack of support around isolation and quarantine may have contributed to individuals not taking it seriously and not isolating after exposure.

2. **Continuing Investment in Tribes' Infection Control Measures**

   Tribes and UIHPs swiftly utilized federal funds to build critical infrastructure for the protection of their community members, patients, and staff. These funds helped build environmental

modifications including HVAC systems, heating systems with UV lighting, plexiglass, and negative pressure rooms. Tribes and UIHPs reported that these much-needed updates improved their ability to continue providing services.

Recommendations

1. **Consider High Needs Populations in Isolation and Quarantine Facility Planning.** Future planning for isolation and quarantine facilities should include considerations for serving high needs populations such as individuals with behavioral health issues and transportation challenges.

2. **Increase Cross-Jurisdictional Collaboration in Planning for Isolation and Quarantine Facilities.** Tribal health jurisdiction and local health jurisdiction planning for standing up and operating isolation and quarantine facilities should consider leveraging resources between jurisdictions such as shared facility sites and staffing.

3. **Provide funding for Physical Infection Control Measures.** Federal and state governments should ensure that future planning includes funding for clinics to install physical infection control measures such as HVAC systems, heating systems with UV lighting, plexiglass, and negative pressure rooms.

Capability 9: Testing

Public health laboratory testing is the ability to detect, characterize, and confirm public health threats. It also includes the ability to provide surveillance and report timely data, provide investigative support, and use partnerships to address exposure to public health threats and emergencies.

Issues

1. **Strengthening Infrastructure for Mass Testing**

   Cross jurisdictional collaboration contributed to strengthening mass testing across the state. Several counties and Tribal health jurisdictions conducted joint testing drives which were reported as extremely successful and resulted in a significant increase in testing in their communities.

   A significant barrier to sustaining mass testing during a pandemic is staffing capacity. Many Tribal health jurisdictions reported issues in staff retention throughout the pandemic. While this was not specific to testing, it did limit the ability of many Tribal health jurisdictions and UIHPs to conduct mass testing efforts.

2. **Increasing Access to Testing Supplies**

   Many Tribal health jurisdictions reported that getting testing supplies was difficult, and in several instances, they received expired products from IHS and DOH. “We had DOH send expired testing media. That pushed us into panic mode. Two out of three times, DOH sent expired tests to our Tribe and to county.” There were also reports that some labs would not accept certain materials. One Tribe reported that Quest Diagnostics would not accept IHS swabs. Indian health care providers also reported that ancillary kits included missing or unusable

needles/syringes. Tribal health jurisdictions reported that once they had in-house PCR testing capability and home tests became accessible, testing improved drastically along with advising community members on isolation and quarantine.

Several Tribal health jurisdictions reported that testing was the most effective tool in pandemic response. One Tribal public health officer shared that future planning to increase rapid testing with appropriate isolation and contact testing will allow Tribes to keep schools and businesses open, prevent case surges that overwhelm health care facilities, and allow early use of antiviral medications to limit severity of illness.

3. **Improving Public Laboratory Testing**

   Public health labs and private labs were overrun with COVID tests. This resulted in backlogs which, in some cases, took as long as fifteen days for results. Performing contact tracing with a fifteen-day lag time was not the most effective use of limited staff time. In addition, some Indian health care providers reported difficulty in transporting tests to public health labs such as the University of Washington. Travel time was considerably long, and health care staff had to conduct a delivery every single day at certain times during the pandemic.

4. **Accessing Test Results for Contact Tracing**

   Tribal health jurisdictions reported frustration in not having access to Washington's Disease Reporting System. As the only public health authority on their respective reservations that can court order quarantine, access to test results for Tribes is vital. Many Tribes and UIHPs conducted their own contact tracing and were better suited to conduct these investigations than LHJs who are not as familiar with Tribal communities.

Recommendations

1. **Update Plans to Include Cross Jurisdictional Collaboration for Mass Testing.** State and local health jurisdictions (LHJ) should coordinate with Tribal health jurisdictions to update state and LHJ plans to include processes for coordinating mass testing with Tribal health jurisdictions.

2. **Fund Tribal and UIHP Public Health Staff.** The State should prioritize funding to Tribal health jurisdictions and UIHPs for at least 1.0 FTE public health staff position.

3. **Establish in State Plans a 5% Tribal Set Aside for Testing Supplies.** The State should hold a 5% set aside of any future testing supplies in public health emergencies for Tribes and UIHPs.

4. **Invest in Expanding Public Health Lab Capacity and Tribal Health Jurisdiction Lab Infrastructure Development.** Federal and state agencies should invest in significant efforts to increase public health lab capacity including support for Tribal public health lab capacity and capabilities through technical assistance and funding. The State should also develop/plan for a courier system for the transportation of laboratory tests to avoid the use of limited health care staff for transporting tests.

5. **Strengthen Protocols for Reducing Distribution of Expired Tests.** DOH and IHS planning efforts should include protocols for ensuring that expired tests are not distributed.

6. **Plan for the Expansive Deployment of Rapid Testing.** Future planning efforts should focus on quickly deploying rapid testing instead of reliance on lab-based PCR testing which is slower. This will take an ongoing commitment to manufacture and provide low cost or no cost testing for the foreseeable future.

7. **Increase Tribal Health Jurisdiction Access to WDRS.** DOH should ensure that all Tribal health jurisdictions have access to the Washington Disease Reporting System (WDRS) to review the test results of their residents and coordinate follow up.

Capability 10: Public Health Surveillance and Epidemiological Investigation

Public health surveillance and epidemiological investigation is the ability to detect and investigate incidents of public health significance.

Issues

1. **Increasing Access to Data for Tribal Health Jurisdictions**

   Access to data remains a critical issue according to Tribal leaders. As sovereign nations, Tribal health jurisdictions need access to Tribal data to fulfil their responsibilities as public health authorities. According to Marilyn Scott, Vice Chairwoman for the Upper Skagit Tribe, "Tribes having direct access to their own data is critical for Tribal governments to make decisions for the protection of our citizens within our jurisdictions." Likewise, Steve Kutz, former Tribal leader and Tribal health clinic director, shared that "Keeping track of data locally at the Tribal level is a foundational part of public health."

   Despite the critical need for public health data, a number of Tribal health jurisdictions reported that, "data is not bidirectional." Tribes spent a lot of time providing data to state and local governments and were not receiving data in return. Tribes also shared that limited access to state databases created a significant administrative burden: "Reporting was a huge burden. I really appreciated [the eventual] access to WDRS but it was read only. I was having to hand write all our reports."

   Indian health care providers also reported that the Indian Health Service data system, RPMS, remains extremely outdated and unable to interface well with any systems, including those used for deliverable reporting and vaccine administration reporting. Other EHR systems allow queries for specific patient information that could be useful to Tribal health jurisdictions in responding in outbreak and pandemic scenarios.

2. **Inclusion of Tribal Health Jurisdictions for Notifiable Conditions**

   Chapter 246-100 WAC contains important requirements for laboratories, health providers, the Washington State Department of Health and other state agencies in providing notice and documentation of notifiable conditions to LHJs. A significant gap in these regulations is a requirement to cooperate and provide notification to Tribal health jurisdictions. While recent revisions were made to Chapter 246-101 in 2021 to include Tribes in the definition of "public health authority," additional revisions are necessary to effectively include Tribes in the state's public health system. For example, the current WAC requires health care providers to submit

reports of cases involving notifiable conditions to LHJs but not to Tribal health jurisdictions.

3. Improving Accuracy and Quality of AI/AN Data

Tribes and UIHPs identified early that initial state reports did not include American Indian and Alaska Native (AI/AN) data. According to one AAR participant, "We knew it was having a greater impact on people of color and AI/AN and data wasn't showing it. It was very discouraging to not have access and that it was incomplete." Another participant shared the critical need for stronger data surveillance systems and methods of identifying Tribal people. One Tribal health jurisdiction reported they hired their own epidemiologist which was very helpful to understanding COVID-19's impact within their community.

At the federal level, Tribal after action review (AAR) participants reported that CDC needs to consult with Tribes and confer with UIHPs regarding their forms that request race information. According to one AAR participant, "You're only allowed to put one race when people reported five races. There needs to be a better way to get people's races. When people were Hispanic, they didn't know what to put. It was very confusing." Only allowing people to identify one race or ethnicity is an equity issue that prevents many individuals from being represented in the data.

Another challenge reported by Tribal public health officers was that federal agencies were not aware early on of the AI/AN disparities regarding COVID-19 rates. The Tribal public health officers applauded Northwest Tribal Epidemiology Center's study showing high numbers of morbidity and mortality which was critical in elevating the importance of getting vaccine to the Tribes.

AAR participants also reported that data collection regarding AI/AN was done by some LHJs without consulting Tribes or Tribal Epidemiology Centers.

4. Case and Contact Tracing

While many Tribes coordinated case and contract tracing with neighboring LHJs, several Tribal health jurisdictions conducted their own case and contact investigations. Some Tribal health jurisdictions shared that their initial plan was to have the LHJs conduct case and contact investigations. These Tribal health jurisdictions observed they could complete these investigations more rapidly and effectively since they were intimately familiar with members of their community and their community members were more likely to speak with them. Tribal health jurisdictions also reported that LHJs were often too overwhelmed to conduct case and contact investigations: "We did all of our own contact tracing. We really preferred to do our own contact tracing. The county was really happy that we were willing to take that over."

Lack of understanding and respect for Tribal health jurisdiction and UIHP expertise and knowledge of their communities was a barrier in some regions. One Indian health care provider reported that their neighboring county allocated some of their resources to hire "native navigators" without coordinating with the Indian health care provider who already had staff with the expertise and trusted relationships to conduct contact tracing more effectively. In addition, such resources such as funding for staff should have been directed to Indian health care providers and Tribal health jurisdictions who already directly serve native communities. In the words of Esther Lucero, President and CEO of Seattle Indian Health Board: "Equity is the

transfer of power and resources. The right thing is to give the resources and get out the way."

During the regional hotwashes, one LHJ shared that they developed protocols for coordinating case and contact investigations with the neighboring Tribal health jurisdictions. These protocols were based on best practices between the LHJs and Tribal health jurisdictions for determining which jurisdiction would handle which case as well as communication procedures. The LHJ reported that lack of Tribal access to the Washington Disease Reporting System (WDRS) hampered cross-jurisdictional coordination.

An Indian health care provider reported that contact tracing forms were not fillable online through DOH resulting in having to print and hand write forms. This made an already labor and resource intensive task, more so.

Tribal health jurisdictions also reported that clinic staff were conducting case and contact investigations. Most Tribal health jurisdictions lack dedicated public health staff.

Recommendations

1. **Increase Equitable Access to State Disease Data by Tribal Health Jurisdiction.** Washington State Department of Health data sharing agreements with Tribal health jurisdictions should include the access to state disease data that is at least equal to access granted to LHJs including both read and write access to the Washington Disease Reporting System (WDRS).

2. **Invest in Data Systems with Cross-Jurisdictional Sharing Capabilities.** Federal and state agencies should make investments in data systems a high priority and ensure these systems are better able to share more accurate information with Tribal health jurisdictions.

3. **Provide Equitable Notice to Tribal Health Jurisdictions of Communicable Diseases.** DOH should work to amend Chapter 246-100 WAC to include the following:

    (a) requirements to notify Tribal health jurisdictions of any exposure or potential exposures of a notifiable condition of their community members. Listed entities should notify Tribal health jurisdictions in the same manner that LHJs are notified; and

    (b) recognition of the sovereign authority of Tribal governments to act as public health jurisdictions.

4. **Coordinate with Tribal health jurisdictions and UIHPs on Improving Tribal Data Accuracy.** To ensure accurate AI/AN reporting, the State should work with Tribal health jurisdictions and UIHPs to address data quality issues upstream in the data collection process.

5. **Include Tribal Data Disclaimer in State Data Reports.** In reports discussing American Indian and Alaska Native (AI/AN) data, DOH should include the following disclaimer: “Due to significant racial misclassification of AI/AN in state databases and the lack of inclusion of data from Tribal, urban Indian and other AI/AN data sources, DOH makes no representation or warranty of any kind, express or implied, regarding the accuracy, adequacy, validity, reliability, availability, or completeness of this information.”

6. **Fund Tribal and UIHP Public Health Staff.** The State should prioritize funding to Tribal health jurisdictions and UIHPs for a 1.0 FTE public health staff position so that Tribal health jurisdictions may hire Tribal public health officers, public health nurses, and/or epidemiologists to support emergency preparedness. Tribal health jurisdictions provide public health services to Washington state citizens, including surveillance, and are a part of the Washington state public health system. Such efforts to strengthen all of Washington's public health system will reduce the burden on LHJs in conducting surveillance activities such as case and contact investigations.

7. **Increase and Support Cross-Jurisdictional Case and Contact Investigations.** In coordination with Tribal health jurisdictions, LHJs should add protocols for coordinating case and contact investigations with Tribal health jurisdictions.

8. **Rely on and Defer to the Expertise of UIHPs and Tribal Health Jurisdictions for Working with Native Populations.** LHJs should refrain from hiring "native navigators," or other staff intended to work with AI/AN populations without proper engagement and input from neighboring Tribal health jurisdictions and UIHPs.

9. **Establish Equitable Access for Tribal health Jurisdiction Access to State Data.** DOH should ensure Tribal health jurisdictions have access to the Washington Disease Reporting System in the same manner LHJs do, so they can perform their governmental duties as public health jurisdictions.

10. **Create Electronic Reporting for Case and Contact Investigation.** DOH should develop and maintain an electronic mechanism for submitting case and contact tracing forms to the State.

Capability 11: Cross-Jurisdictional Collaboration

Cross-jurisdictional collaboration is the ability of a government and its partners to work across traditional boundaries to prepare for, respond, and mitigate a public health emergency. Cross-jurisdictional collaboration is about (1) increasing a government's capacity to respond to a public health emergency; (2) reducing the cost of public health response; (3) preserving and improving local decision-making and public health response to community members; and (4) improving the overall effectiveness and efficiency of public health response.

Issues

1. **Recognizing Tribes as Public Health Jurisdictions**

   Understanding and recognizing Tribal governance in public health is critical to avoiding unnecessary barriers such as inequitable access to public health data, medical countermeasures, governmental funding, and incident command teams, etc. Tribal nations possess the inherent power to self-govern. This power includes the essential role of protecting the safety and general welfare of their people and their lands and promoting public health.

2. **Reducing and Simplifying Reporting Requirements and Funding Restrictions**

   Tribal health jurisdictions and UIHPs shared that tracking and reporting for federal and state funds was tremendously burdensome upon their staff, many of whom were also on the front

lines of the pandemic or performing other essential functions for their Tribal government. According to one Tribal staff member, "We had to bring in a staff person just for reporting because it was so time consuming. The staff person was here some nights until 8 p.m. just doing the reporting." Another Tribal staff member shared that CDC was challenging to communicate with regarding grant reporting mainly because of CDC staff turnover. Tribal staff would have to explain issues repeatedly to a revolving door of CDC grant managers. One Tribal leader requested that federal agencies work to streamline funding and provide a more organized response and designation of how Tribes are accounting for additional resources. Another Indian health care provider suggested that "there needs to be systems in place to track all these funds from the beginning. There are some better ways we could have done it. We would like some best practices, not just staff, but systems."

Indian health care providers stressed the importance of categorical funding being more flexible during an emergency response. For example, many Indian health care providers and Tribal councils often provided lunch to their staff who were on the front lines of the pandemic and did not have time to bring or buy lunch. Such activities were not allowable with federal funding.

3. **Improving and Maintaining Cross-Jurisdictional Collaborations with State, Regional, and Local Health Jurisdictions**

A commonly cited issue by both Tribal health jurisdictions and LHJs during regional hotwashes was the importance of maintaining relationships with other jurisdictions. As one Tribal Public Health Officer stated when it comes Tribal health jurisdiction and LHJ coordination, "you should not be meeting them at a table during the pandemic. You need to have that relationship beforehand and know your strength and weaknesses." Most Tribal health jurisdictions reported having positive partnerships with LHJs throughout the pandemic, particularly in the rural areas: "We did a lot to engage in coordinating with other Tribes, state, feds, and locals. It was mostly participating in meetings and having a voice and saying where we were at. I do feel like for us, we were recognized as a jurisdiction." For some Tribal health jurisdictions, new and stronger relationships were formed that had either been non-existent or fractured because of the longstanding history between the Tribe and the counties. Several Tribal health jurisdictions and LHJs stressed the need to maintain relationships by continuing to hold regular regional meetings. Having a mutual aid agreement in place was helpful in establishing relationships and understanding sovereignty.

However, challenges remain for a small number of LHJs and their surrounding Tribal health jurisdictions and UIHPs. One of the state's largest LHJs continues to need improvement in coordinating with their Tribal and UIHP partners. Tribal health jurisdictions and UIHPs reported that this specific county had tremendous resources but did not communicate those resources to Tribes or UIHPs. In addition, this county offered resources that were not needed and duplicative of what Tribes and UIHPs offered and were already experts at or would pass on resources that came with a heavy reporting burden. According to one AAR participant, LHJs should "think ahead and give us the resources we need."

An important mechanism for increasing collaboration between Tribes and counties is the recent passage of ESSB 1152 requiring counties to include Tribal representation on their local health boards. One Tribal public health officer expressed concerned that it has been incredibly challenging to recruit Tribal representation to serve: "Much of the authority is at the county

level and that's been a weakness especially for those Tribes who don't have a good relationship with counties. That would be my biggest hope for the future. The opportunity is there, but it's not happening, and I don't understand why."

Several Indian health care providers reported that having a direct line to the Governor's office to report on issues was very beneficial including one Tribal leader who shared, "Having access to Governor's Office and legislators made a huge difference for us." AAR participants noted that the Governor's Special Assistant to the Chief of Staff and Senior Policy Advisor Behavioral Health, Aging and Disability were particularly responsive to the needs of Tribes and UIHPs.

4. Federal-State-Tribal Model of Collaboration

Since the first year of the pandemic, the American Indian Health Commission (Commission) has facilitated a weekly Public Health Updates meeting with DOH and Indian Health Service. The purpose of the weekly meeting is to create a forum for government-to-government engagement in which Tribes and UIHPs can:

1) Receive updates from federal and state governments;
2) Make requests to federal and state governments for information and resources; and
3) Share ideas and resources with other Tribal governments/UIHPs.

Numerous Tribal health jurisdictions shared that the Commission's (referred to as AIHC below) Weekly Public Health Updates with the DOH and the Indian Health Service were a vital component of their emergency public health response. Here is some of their feedback:

- "*The role of AIHC in our response is understated. There was a tremendous coordination and sharing of each Tribe's experience, and I think those opportunities afforded to Tribes was a very important addition that made the States' effort much more effective.*"
- "*The most valuable thing for us was participating in the AIHC conference call. It was short and sweet. Any other information was too much.*"
- *"The meetings were a great opportunity to hear from other Tribes and their creative ideas for pandemic response and stretched the brain power out."*
- *"It was beneficial to work together for hard-to-get resources."*
- *"Really finding that information from other Tribes and agencies and what they were doing and how they were approaching the pandemic was really helpful."*
- *"You feel like you're not alone when we have the weekly calls."*
- *"The forum was just as beneficial as the access. Sometimes we would literally get the answer from DOH and IHS, and we were not left having to chase all that information."*
- *"Participating in AIHC weekly pandemic updates was very helpful because there were people from various positions/jurisdictions and the resources were explained in a Tribal-*

centric framework."

- *"The meetings helped inform the Chairman's newsletter."*
- *"It was nice to have Tribes pick each other's brains. Sometimes Tribes don't want state and federal partners on the call."*
- *"The weekly forum by AIHC became invaluable. Not only were there resources that helped give us a kickstart, but also guidelines that helped us with planning. We had to deal the challenge of how to prioritize vaccine distribution. That framework provided by AIHC was hugely successful."*
- *"The one common denominator was our weekly call. People didn't have time to listen to all those meetings. We would not be where we are today without those. We didn't have the time. It's one of the strengths that happened out of this."*

5. The Role of the Tribal Casino in Tribal Governance and Pandemic Response

Tribal enterprises and casinos play an essential role in Tribal governance and the Washington state economy. According to the Washington Indian Gaming Association:

- The total effect of Tribal government and enterprise spending within Washington exceeded $6.6 billion. And that sum yielded $1.2 billion in state and local taxes in Washington.
- The economic activity of the Washington Tribes created 54,000 jobs.
- 100% of Tribal net income translates into Tribal government efforts to build more vibrant households; ample housing; better schooling; healthier, safer communities; cleaner environments and other public goods, services, and amenities in the state of Washington.
- Before the disruptions of COVID-19, more than three-quarters of Tribal budgets originated from Tribal sovereignty. Even during COVID-19, most Tribal funding came from Tribal governments and businesses.

As a result of the significant funding that Tribal casinos provide for essential government services, Tribal leaders were faced with extraordinarily difficult decisions to close casinos. They met regularly to discuss the various considerations for when to close and when to reopen. Many Tribal jurisdictions closed their casinos for months at a time. According to one Tribal leader, "the biggest challenge was coming to grips with having to close the casino. There was a lot of angst and struggle with that. Casino funds most of the Tribe's activities." Tribal public health officers who also served as clinicians in the Tribal health clinics often advised Tribal council on the issue of reopening. A Tribal public health officer shared that, "Our council was very open to what the clinicians were saying. That was a big issue. The Tribe had courage to do that. We might have been one of the early ones to close."

Some Tribal leaders reported that they did not feel that Governor Inslee and other governmental officials understood what casino closures meant to Tribal communities. Here is one Tribal council leader's experience:

> "We have the community. They worried about our casino. And then you have the employees worried about 'what's going to happen to my job.' Balancing that was tough. Governor Inslee basically told us they were opening up Boeing, but he wanted Tribes to shut casinos down. You are opening Boeing, but he called up very mad at our Tribe. Casinos are not your corner bar. We did more than Boeing. You need to come here. Have you ever set foot in a Tribal casino?"

Casinos are an essential part of Tribal communities and are not viewed simply as sources of income. In addition, Tribal casinos played a key role in the public health response. Casinos provided large spaces to conduct mass vaccination and testing events which were utilized by both Tribal and local health jurisdictions. Tribes reported vaccinating as many as 800 people in one day and conducting daily vaccinations of 200 per day for weeks at a time within their casions. Casinos also serve as quarantine facilities, locations for incident command, storage for personal protective equipment, and a meeting place for community members to receive other resources, such as food, during the pandemic.

Upon reopening, Tribal casinos took extensive measures to protect the public including installing HVAC systems, spreading machines apart, reducing capacity, installing temperature check stations, mandating masks, and requiring identification in order to conduct case and contact investigations if necessary.

6. **Respecting Tribal Culture and Considerations for AI/AN People in Federal, State, and Local Emergency Planning**

Several Tribes reported on the role culture played in their response and the lack of understanding federal, state, and local jurisdictions had regarding its importance in pandemic response. Many Tribes faced criticism for vaccinating their surrounding community members including teachers, restaurant workers, and youth sports teams. Tribes reported that vaccinating their surrounding community members was part of their cultural obligation to care for others and a critical tool in protecting their Tribal members. According to one Tribal leader, "The way our Tribe responded is we did what we always do. We did what came natural to us. Be good hosts and be generous hosts. We were given the sacred duty to steward the land and that includes people too." The scrutiny Tribes faced over vaccinating other communities stemmed from both a failure to respect the sovereign rights of Tribes to determine their priority and service populations and a failure to understand many Tribes' cultural obligations to protect their people and care for others.

In addition to vaccination protocols, the State's protocols were not always consistent with Tribal protocols for funerals and stay-at-home orders. One former Tribal leader reported that "funeral policies went against our protocols. We were burying loved ones you couldn't touch. You couldn't be there. That's part of the wounds we have to take care of. Governor Inslee's protocols didn't take that into account."

Others also shared that state protocols did not have appropriate considerations for homeless populations. One Indian health care provider shared that Governor Inslee's request for elders to stay at home did not account for the needs of homeless populations they serve, and as a result, they had to create different protocols.

Recommendations

1. **Use "Tribal Health Jurisdiction" Reference Throughout DOH Documents.** DOH should revise DOH regional maps and regional planning/information documents to properly include Tribal health jurisdictions to help other jurisdictions understand and recognize Tribe's governmental public health powers.

2. **Minimize and Streamline Federal Reporting Requirements.** Federal agencies must streamline and minimize the reporting requirements around essential public health services and develop best practices and a model system for less intensive tracking and reporting.

3. **Increase Flexibility in Emergency Funding.** State and federal agencies must allow for more flexible funding to buy items such as food and support items for community members.

4. **Support American Indian Health Commission Weekly Cross-Jurisdictional Public Health Meetings.** DOH should continue to support the American Indian Health Commission's (AIHC) facilitation of weekly AIHC-DOH-IHS weekly updates as part of public health emergency preparedness work. Meetings should continue to provide a forum for (1) receiving updates from federal and state agencies; (2) making requests to federal and state agencies for information and resources; and (3) sharing ideas and resources with other Tribal governments/UIHOs. Meetings should also include opportunities for Tribal and UIHP meetings to share information with each other without the presence of state and federal partners.

5. **Support American Indian Health Commission Regional Cross-Jurisdictional Public Health Meetings.** DOH should continue to support the American Indian Health Commission's facilitation of regional cross-jurisdictional meetings between Tribal health jurisdictions, UIHPs, and local health jurisdictions as part of public health emergency preparedness work. Meetings should continue to provide a forum for (1) sharing of best cross-jurisdictional practices among Tribal and local health jurisdictions; and (2) conducting table-top exercises. Per the request of Tribal and local health jurisdictions, meetings should be hybrid with the opportunity to attend in person and online and to participate in breakout rooms.

6. **Maintain State DOH and American Indian Health Commission Collaboration and Coordination.** DOH should add to the DOH Vaccine Tribal Liaison position description a requirement to coordinate and collaborate on at least a weekly basis with the American Indian Health Commission (AIHC) Incident Management Team Tribal Liaison during an active response and at least once a month when not in an active response. Coordination and collaboration should include, but not be limited to, preparing for and attending AIHC's weekly cross-jurisdictional public health meetings as well as regional meetings.

7. **Update Policies and Plans to Include Cross-Jurisdictional Collaboration and Coordination.** LHJs should update their policies and plans to reflect current and best practices for collaboration and coordination with Tribal health jurisdictions and UIHPs.

8. **Expand WALSPHO Membership to Tribal Health Jurisdictions.** The Washington State Association of Local Public Health Officials (WALSPHO) should extend membership to Tribal public health officers and include Tribal public health officers in statewide meetings.

9. **Include Tribal Public Health Officers in a State Regional Structure.** The State should maintain a regional structure with public health officers including Tribal public health officers to support morale building during times of stress. This would also promote regional resource sharing in emergencies.

10. **Update the Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State.** The State should support the American Indian Health Commission in updating the Mutual Aid Agreement for Tribes and local health jurisdictions in Washington State (MAA), and hold regular MAA exercises to help build, strengthen, and maintain Tribe/county relationships.

11. **Update State Tabletop Exercises to Include Jurisdictional Challenges.** Future tabletop exercises should include injects that involve jurisdictional challenges (e.g., how is information timely shared between jurisdictions when communicable diseases cross jurisdictional boundaries).

12. **Fund Tribal Emergency Preparedness Training.** Federal and state governments must make funding commitments for ongoing Tribal emergency preparedness training to improve the future pandemic response.

13. **Establish Governor's Office Tribal Liaisons in Public Health Emergency Response.** The Governor's Office should update their emergency plans to include the Special Assistant to the Chief of Staff and Senior Policy Advisor for Behavioral Health, Aging and Disability as Tribal liaisons to Tribes and UIHPs during public health emergencies.

14. **Support the American Indian Health Commission in Providing Technical Assistance to Tribes.** DOH should continue to support American Indian Health Commission's (AIHC) role in providing emergency preparedness and response technical assistance to Tribes and UIHPs including, but not limited to, facilitating government-to-government meetings, drafting emergency model orders, laws, and policies, staffing the AIHC Tribal Liaison to the DOH Incident Management Team, and coordinating the delivery of emergency resources to Tribes.

15. **In Coordination with the American Indian Health Commission, Provide Training and Education to State Staff on the Role of Tribal Casinos.** State and local governmental leaders must gain knowledge and understanding of the vital role that Tribal casinos serve in supporting essential governmental functions such as Tribal law enforcement, Tribal school, Tribal administration, Tribal courts, Tribal health care, and cultural events. Such knowledge and understanding are critical for respectful government-to-government discussions regarding closure of businesses.

16. **In Coordination with the American Indian Health Commission, Provide Training and Education on Tribal Jurisdiction and Sovereignty.** Require all federal, state, and local officials and staff receive training on Tribal jurisdiction including the state and federal policy recognizing the sovereign authority of Tribe's to establish their own priority groups and determine their service populations (see Appendices A and B).

17. **Consult with Tribes on Funeral Protocols.** Consult with Tribal nations prior to the next pandemic on updating funeral protocols during a pandemic emergency. While state protocols do not apply on Tribal land, they significantly impact Tribal communities utilizing funeral services off Tribal land.

18. **Increase Understanding of Impacts of State Emergency Orders on Homeless Populations.** The State should consider the unique challenges for homeless populations in its plans for emergency response orders.

CONCLUSION

In Washington, Tribes and urban Indian health programs led the way in saving lives and protecting the health and cultural well-being of their communities. They conducted mass testing and vaccination to hundreds of thousands of Tribal members and Washington state citizens and provided culturally competent care and access for those belonging to other under-resourced populations. Key successes at the state level included the adopting policies that reenforce a Tribes' sovereign right to determine their own priority groups for vaccination and the creation of a state set-aside for Tribal access to vaccine. In addition, state and local governments made significant improvements in strengthening cross-jurisdictional collaboration. However, many challenges remain in ensuring equitable access to public health resources. Despite Tribes' well-established legal authorities and public health powers, Tribal health jurisdictions receive far fewer resources than local health jurisdictions. To strengthen future pandemic response, the State of Washington and federal agencies must strive to ensure that Tribal governments are properly coordinated with and have equitable access to all resources necessary to fulfill their governmental duties to protect the health and welfare of their people.

APPENDIX A: TRIBAL COVID-19 PANDEMIC AFTER ACTION REPORT RECOMMENDATIONS SUMMARY

APPENDIX A: TRIBAL COVID-19 PANDEMIC AFTER ACTION REPORT RECOMMENDATIONS SUMMARY

This summary includes recommendations for federal, state, and local health jurisdictions to improve collaboration and coordination with Tribal health jurisdictions and urban Indian health programs (UIHPs) in pandemic planning and response. These recommendations were provided by Tribal nations and UIHPs during the American Indian Health Commission After Action Report meetings. Federal, state, and local governments should incorporate these recommendations into applicable federal, state, and local policies, laws, and comprehensive emergency management plans.

Capability 1: Community Recovery

1. **Support for Tribal Health Jurisdictions and UIHPs to Lead Community Recovery.** State and local governments should provide technical support and resources for Tribal health jurisdictions and UIHPs to lead and conduct their own emergency response and recovery since community members look to Tribes and their UIHPs as the most trusted source for how to keep safe during an emergency.
2. **Resources for Tribal Health Jurisdictions and UIHPs to Provide Mental Health Support to Staff.** The State of Washington should provide resources for Tribal health jurisdictions and UIHPs to conduct or outsource mental health support to staff who responded during the pandemic. This support could include resources to conduct debriefing exercises.

Capability 2: Emergency Operations Coordination

3. **Inclusion of Tribes in Local Government Incident Command Structures.** Local health jurisdictions and county emergency management should update their comprehensive emergency management plans and incident command structures to include a role for Tribes should Tribes choose to coordinate response with them.
4. **Inclusion of American Indian Health Commission (AIHC) Tribal Liaison Position in Emergency Management and Incident Command Structures.**
    (a) EMD should add the AIHC Tribal liaison position to the state comprehensive emergency management plan and the ESF 8-specific plan.
    (b) DOH should permanently establish the AIHC Tribal Liaison position to their agency's incident management team in the following manner:
        (1) include language with the DOH emergency response plan that the purpose of the AIHC Tribal Liaison is to ensure that (a) all Tribal health jurisdictions are included in state decision making; and (b) critical information is going back to Tribal health jurisdictions;
        (2) add the AIHC Tribal Liaison to the incident management team organization chart; and
        (3) include language within the DOH emergency response plans that requires the incident management team to deploy the AIHC Tribal Liaison during emergencies.
5. **Coordination and Collaboration with Tribal Public Health Officers.** State and local agencies should update comprehensive emergency management plans to include a requirement for public health officers to coordinate with and include Tribal public health officers by adding them to public health officer contact lists, meetings, and email distribution lists. Agencies should extend the same invitation for Tribal representation if

the Tribe does not currently have a public health officer.

6. **Tribal Consultation on Distribution of FEMA Funds.** DOH should conduct Tribal consultation to provide transparent information on the amount of FEMA funds sent to the State and to seek Tribal input on how those funds should be allocated to Tribal nations serving Washington residents.

Capability 3: Emergency Public Information and Warning

7. **Establish a Clear and Reliable Communication Pathway with Tribes.** The State should ensure clear communication pathways leading back to Tribal health jurisdictions in emergency response plans. State agencies can accomplish this by inviting Tribal representation to local emergency management meetings and creating a permanent AIHC Tribal Liaison position on the DOH IMT.
8. **Resources for Tribal Health Jurisdictions and UIHPs to Develop/Acquire Culturally Relevant Community Messaging.** Provide Tribes, UIHPs, and Tribal organizations resources so that they can create their own culturally relevant and appropriate communication resources, such as flyers and posters.
9. **Funding for Tribal Health Jurisdiction to Implement Electronic Health Record Systems.** Provide Tribal health jurisdictions with funding necessary to implement Electronic Health Records (EHRs) such as EPIC with the capability to send emergency information and warnings to community members via texts, etc.
10. **Improve Clarity and Consistency Among Federal, State, and Local Guidance Documents.** Federal, state, and local health jurisdiction emergency improvement plans should include strategies to ensure that public information and guidance is:

    (a) Succinct, clearly written, and internally consistent; and

    (b) Where possible, consistent with information and guidance from other jurisdictions.

Capability 4: Information Sharing

11. **Add Statutory Requirement for Governor to Meet Regularly with Tribal Leaders During Emergencies.** The State should amend RCW 43.376.050 to include a requirement for the Governor's Office to meet regularly with Tribal government leaders during a state declared emergency.
12. **Resources for Tribal Health Jurisdictions to Develop/Improve Broadband Infrastructure.** The State through their various agencies, including the Department of Commerce and the Department of Natural Resources, should provide continued planning and support to Tribal governments for the development of broadband infrastructure in rural areas to ensure that Tribal health jurisdictions can effectively communicate with their community members, provide critical services, and coordinate with federal, state, and local governments during the next pandemic.
13. **Update and Maintain an Online Contact List**. The Washington State Department of Health should create and maintain an online database for all Tribal and local health jurisdictions to access up-to-date contact information. Tribal health jurisdictions should have a choice as to whether to opt-in to the database and share their contact information with other Tribal and local health jurisdictions.
14. **Consolidate and Reduce the Number of Meetings**. Federal and state agencies should coordinate amongst jurisdictions and partners to streamline the volume of meetings. For example, federal and state agencies should appear together at American Indian Health Commission meetings so that Tribal health jurisdictions and UIHPs can come to one meeting to get the most up-to-date information from their federal and state partners.

15. **Improve Website Organization and Access to Important Information.** Federal, state, local agencies and public health organizations should ensure their websites provide properly dated guidance and resources and post them online in a manner that is easily searchable and easy to locate.

Capability 5: Vaccines and Antivirals Acquisition and Dispensing

16. **In Coordination with American Indian Health Commission, Train and Educate Staff Regarding Tribe's Sovereign Right to Choose Their Priority Groups and Service Populations.** DOH, in coordination with the American Indian Health Commission, should regularly review and train staff on implementing Washington State Medical Countermeasures Plan, Annex 9 (see Appendix D) to ensure understanding and compliance with federal and state policies which include the right of Tribal health jurisdictions to choose their own priority groups and determine their service populations.
17. **Correct Indian Health Service Vaccine Plans to be Consistent with CDC Policy.** Indian Health Service (IHS) must amend the IHS COVID-19 Pandemic Vaccine Plan to be consistent with the CDC's COVID-19 Vaccination Program Interim Playbook for Jurisdictions Operations 2.0 (See Appendix C) which provides that Tribes shall determine their priority groups, not IHS.
18. **Ensure Tribal Access to Both IHS and State Vaccines Supplies.** Federal and state governments should improve health inequities by ensuring that Tribes, who serve populations with high health disparities, can access vaccine from both IHS and the State. Federal and state agencies should refrain from requiring Tribes to choose one or the other.
19. **Improve Vaccine Distribution Communication.** DOH should create a consistent and timely communication pathway to let Tribal health jurisdictions know how much vaccine they can expect to receive and when, so they can plan their vaccination activities accordingly.
20. **Increase Flexibility in Vaccine Prioritization Criteria**. While Tribal health jurisdictions use state prioritization as guidance only, state and federal governments should develop broadly supported prioritization criteria for future vaccines, antivirals, and medical countermeasures in advance (rather than emergency decrees by a single elected official) to better balance the public health benefit with equity considerations.
21. **IHS Regular Participation at Tribal Emergency Coordination Meetings.** IHS should ensure they are present and available at government-to-government coordination meetings.
22. **Support for American Indian Health Commission Tribal-Federal-State Facilitation.** DOH should continue to support and enhance the role of the American Indian Health Commission in facilitating cross-jurisdictional meetings for Tribes and UIHPs in Tribal vaccine readiness planning and pandemic.
23. **Improve Volume and Speed of IHS Vaccine Distribution to Tribes.** Federal agencies must ensure that IHS receives an adequate supply of vaccine to distribute to Tribes, and IHS must develop strategies to ensure quicker distribution of vaccine and improve the ability to fulfill the amounts of vaccine Tribes are requesting.
24. **Establish in State Plans a Tribal 5% Set Aside for Medical Countermeasures.** The State should put a 5% Tribal set aside of medical countermeasures in Annex 9 (see Appendix D), the plan specific to distribution of medical countermeasures. This set aside should apply to anti-viral access as well, since it is a type of medical countermeasure.
25. **Amend Washington State Public Records Act to Exempt Disclosure of Tribal Data.** The State should add an exemption to the public records act for information related to Tribes.
26. **Expand Mobile Nurse Teams and Care-A-Van.** Expand resources such as the mobile nurse teams and the Care-A-Van to include multiple types of vaccinations, and update DOH's written pandemic and outbreak

response plans to include these resources.

Capability 6: Medical Materiel Management and Distribution

27. **Establish Policy for Direct Access of PPE for Tribal Health Jurisdictions.** Update State Emergency Management Department and Department of Health (DOH) plans to include language that Tribal health jurisdictions can access personal protective equipment (PPE) directly from state stockpiles.

28. **Establish in State Plans a 5% Tribal Set Aside for PPE and Maintain a Tribal Stockpile**. The State should put a 5% Tribal set aside of PPE in state plans specific to distribution of PPE. DOH should also maintain and establish a Tribal stockpile to ensure Tribes and UIHPs have access to PPE and medical supplies that are likely to be impacted by supply chain issues.

29. **Ensure Appropriate Staff Attend American Indian Health Commission Tribal-IHS-DOH Public Health Emergency Response Meetings.** IHS and DOH should provide regular and ongoing technical assistance to Tribes and UIHPs for acquiring PPE at the American Indian Health Commission Tribal-IHS-DOH public health emergency response meetings.

30. **Strengthen Protocols for Reducing Distribution of Expired PPE.** DOH and IHS planning efforts should include protocols for ensuring that expired PPE are not distributed.

31. **Develop Procedures for Distribution of PPE to Tribes and UIHPs.** Federal and state agencies should update comprehensive emergency plans to include procedures for coordinating the delivery of PPE to Tribes and UIHPs. These plans should include:

    (a) requirements for agencies to confirm with recipients prior to delivering PPE the following:

        (1) what items are needed;

        (2) what quantities are needed; and

        (3) whether the recipient has the necessary equipment (e.g., pallet jack) and infrastructure to receive the PPE.

    (b) processes for ensuring direct distribution of PPE to Tribes and UIHPs.

32. **Develop PPE Resource Exchange Site.** Create a resource coordination process where facilities can submit a query for any PPE to share and/or sell.

33. **Expand Access to Inventory Tracking Software.** Provide funding and resources to Tribes and UIHPs to purchase/obtain inventory tracking software.

34. **Develop Capacity to Manufacture PPE Domestically.** Federal and state governments should develop or increase the capacity to make essential PPE and testing supplies domestically to prepare for future supply chain disruptions.

Capability 7: Medical Surge

35. **Fund Tribal and UIHP Public Health Staff.** The State should prioritize funding for at least 1.0 FTE public health staff position for each Tribal health jurisdiction and UIHP.

36. **Include Distribution of Laptops and Cell Phones in Emergency Planning.** The State should include in future planning the distribution of laptops and cell phones for Indian health care providers to be able to maintain medical and behavioral health services.

37. **Ensure Hazard Pay and Responder Benefits**. State and Federal agencies should ensure medical and behavioral health staff receive hazard pay and responder benefits during pandemics.

38. **Expand and Make Permanent Telehealth.** Federal and state agencies should expand and permanently fund telehealth as one tool for mitigating workforce shortages.

39. **Conduct Analysis on Hospital Bed Utilization and Shortages.** The State, particularly the Governor's Office, should conduct analysis to understand why hospital beds are empty in some hospitals while others are over capacity. In addition, the Governor's Office should implement strategies for requiring and/or incentivizing hospitals to maximize bed capacities.

Capability 8: Nonpharmaceutical Interventions

40. **Consider High Needs Populations in Isolation and Quarantine Facility Planning.** Future planning for isolation and quarantine facilities should include considerations for serving high needs populations such as individuals with behavioral health issues and transportation challenges.

41. **Increase Cross-Jurisdictional Collaboration in Planning for Isolation and Quarantine Facilities.** Tribal health jurisdiction and local health jurisdiction planning for standing up and operating isolation and quarantine facilities should consider leveraging resources between jurisdictions such as shared facility sites and staffing.

42. **Provide funding for Physical Infection Control Measures.** Federal and state governments should ensure that future planning includes funding for clinics to install physical infection control measures such as HVAC systems, heating systems with UV lighting, plexiglass, and negative pressure rooms.

Capability 9: Testing

43. **Update Plans to Include Cross Jurisdictional Collaboration for Mass Testing.** State and local health jurisdictions (LHJ) should coordinate with Tribal health jurisdictions to update state and LHJ plans to include processes for coordinating mass testing with Tribal health jurisdictions.

44. **Fund Tribal and UIHP Public Health Staff.** The State should prioritize funding to Tribal health jurisdictions and UIHPs for at least 1.0 FTE public health staff position.

45. **Establish in State Plans a 5% Tribal Set Aside for Testing Supplies**. The State should hold a 5% set aside of any future testing supplies in public health emergencies for Tribes and UIHPs.

46. **Invest in Expanding Public Health Lab Capacity and Tribal Health Jurisdiction Lab Infrastructure Development.** Federal and state agencies should invest in significant efforts to increase public health lab capacity including support for Tribal public health lab capacity and capabilities through technical assistance and funding. The State should also develop/plan for a courier system for the transportation of laboratory tests to avoid the use of limited health care staff for transporting tests.

47. **Strengthen Protocols for Reducing Distribution of Expired Tests.** DOH and IHS planning efforts should include protocols for ensuring that expired tests are not distributed.

48. **Plan for the Expansive Deployment of Rapid Testing.** Future planning efforts should focus on quickly deploying rapid testing instead of reliance on lab-based PCR testing which is slower. This will take an ongoing commitment to manufacture and provide low cost or no cost testing for the foreseeable.

49. **Increase Tribal Health Jurisdiction Access to WDRS.** DOH should ensure that all Tribal health jurisdictions have access to the Washington Disease Reporting System (WDRS) to review the test results of their residents

and coordinate follow up.

Capability 10: Public Health Surveillance and Epidemiological Investigation

50. **Increase Equitable Access to State Disease Data by Tribal Health Jurisdiction.** Washington State Department of Health data sharing agreements with Tribal health jurisdictions should include the access to state disease data that is at least equal to access granted to local health jurisdictions including both read and write access to the Washington Disease Reporting System (WDRS).

51. **Invest in Data Systems with Cross-Jurisdictional Sharing Capabilities.** Federal and state agencies should make investments in data systems a high priority and ensure these systems are better able to share more accurate information with Tribal health jurisdictions.

52. **Provide Equitable Notice to Tribal Health Jurisdictions of Communicable Diseases.** DOH should work to amend Chapter 246-100 WAC to include the following:

    (a) requirements to notify Tribal health jurisdictions of any exposure or potential exposures of a notifiable condition of their community members. Listed entities should notify Tribal health jurisdictions in the same manner that local health jurisdictions are notified; and

    (b) recognition of the sovereign authority of Tribal governments to act as public health jurisdictions.

53. **Coordinate with Tribal Health Jurisdictions and UIHPs on Improving Tribal Data Accuracy.** To ensure accurate AI/AN reporting, the State should work with Tribal health jurisdictions and UIHPs to address data quality issues upstream in the data collection process.

54. **Include Tribal Data Disclaimer in State Data Reports.** In reports discussing American Indian and Alaska Native (AI/AN) data, DOH should include the following disclaimer: "Due to significant racial misclassification of AI/AN in state databases and the lack of inclusion of data from Tribal, urban Indian and other AI/AN data sources, DOH makes no representation or warranty of any kind, express or implied, regarding the accuracy, adequacy, validity, reliability, availability, or completeness of this information."

55. **Fund Tribal and UIHP Public Health Staff.** The State should prioritize funding to Tribal health jurisdictions and UIHPs for a 1.0 FTE public health staff position so that Tribal health jurisdictions may hire Tribal public health officers, public health nurses, and/or epidemiologists to support emergency preparedness. Tribal health jurisdictions provide public health services to Washington state citizens, including surveillance, and are a part of the Washington state public health system. Such efforts to strengthen all of Washington's public health system will reduce the burden on local health jurisdictions in conducting surveillance activities such as case and contact investigations.

56. **Increase and Support Cross-Jurisdictional Case and Contact Investigations.** In coordination with Tribal health jurisdictions, local health jurisdictions should add protocols for coordinating case and contact investigations with Tribal health jurisdictions.

57. **Rely on and Defer to the Expertise of UIHPs and Tribal Health Jurisdictions for Working with Native Populations.** Local health jurisdictions should refrain from hiring "native navigators," or other staff intended to work with AI/AN populations without proper engagement and input from neighboring Tribal health jurisdictions and UIHPs.

58. **Establish Equitable Access for Tribal Health Jurisdiction Access to State Data.** DOH should ensure Tribes have access to Washington Disease Reporting System (WDRS) in the same manner local health jurisdictions do, so they can perform their governmental duties as public health jurisdictions.

59. **Create Electronic Reporting for Case and Contact Investigation.** DOH should develop and maintain an electronic mechanism for submitting case and contact tracing forms to the State.

Capability 11: Cross-Jurisdictional Collaboration

60. **Use "Tribal Health Jurisdiction" Reference Throughout DOH Documents.** DOH should revise DOH regional maps and regional planning/information documents to properly include Tribal health jurisdictions to help other jurisdictions understand and recognize Tribe's governmental public health powers.

61. **Minimize and Streamline Federal Reporting Requirements.** Federal agencies must streamline and minimize the reporting requirements around essential public health services and develop best practices and a model system for less intensive tracking and reporting.

62. **Increase Flexibility in Emergency Funding.** State and federal agencies must allow for more flexible funding to buy items such as food and support items for community members.

63. **Support American Indian Health Commission Weekly Cross-Jurisdictional Public Health Meetings.** Washington State Department of Health should continue to support the American Indian Health Commission's (AIHC) facilitation of weekly AIHC-DOH-IHS weekly updates as part of public health emergency preparedness work. Meetings should continue to provide a forum for (1) receiving updates from federal and state agencies; (2) making requests to federal and state agencies for information and resources; and (3) sharing ideas and resources with other Tribal governments/UIHOs. Meetings should also include opportunities for Tribal and UIHP meetings to share information with each other without the presence of state and federal partners.

64. **Support American Indian Health Commission Regional Cross-Jurisdictional Public Health Meetings.** Washington State Department of Health should continue to support the American Indian Health Commission's facilitation of regional cross-jurisdictional meetings between Tribal health jurisdictions, UIHPs, and local health jurisdictions as part of public health emergency preparedness work. Meetings should continue to provide a forum for (1) sharing of best cross-jurisdictional practices among Tribal and local health jurisdictions; and (2) conducting table-top exercises. Per the request of Tribal and local health jurisdictions, meetings should be hybrid with the opportunity to attend in person and online and to participate in breakout rooms**.**

65. **Maintain State DOH and American Indian Health Commission Collaboration and Coordination.** Washington State Department of Health (DOH) should add to the DOH Vaccine Tribal Liaison position description a requirement to coordinate and collaborate on at least a weekly basis with the American Indian Health Commission (AIHC) Incident Management Team Tribal Liaison during an active response and at least once a month when not in an active response. Coordination and collaboration should include, but not be limited to, preparing for and attending AIHC's weekly cross-jurisdictional public health meetings as well as regional meetings.

66. **Update Policies and Plans to Include Cross-Jurisdictional Collaboration and Coordination.** Local health jurisdictions should update their policies and plans to reflect current and best practices for collaboration and coordination with Tribes and UIHPs.

67. **Expand WALSPHO Membership to Tribal Health Jurisdictions.** The Washington State Association of Local Public Health Officials (WALSPHO) should extend membership to Tribal public health officers and include Tribal public health officers in statewide meetings.

68. **Include Tribal Public Health Officers in a State Regional Structure.** The State should maintain a regional structure with public health officers including Tribal public health officers in order to support morale building during times of stress. This would also promote regional resource sharing in emergencies.

69. **Update the Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State.** The State should support the American Indian Health Commission in updating the Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State (MAA), and hold regular MAA exercises to help build, strengthen, and maintain Tribe/county relationships.

70. **Update State Tabletop Exercises to Include Jurisdictional Challenges.** Future tabletop exercises should include injects that involve jurisdictional challenges (e.g., how is information timely shared between jurisdictions when communicable diseases cross jurisdictional boundaries).

71. **Fund Tribal Emergency Preparedness Training.** Federal and state governments must make funding commitments for ongoing Tribal emergency preparedness training to improve the future pandemic response.

72. **Establish Governor's Office Tribal Liaisons in Public Health Emergency Response.** The Governor's Office should update their emergency plans to include the Special Assistant to the Chief of Staff and Senior Policy Advisor for Behavioral Health, Aging and Disability as Tribal liaisons to Tribes and UIHPs during public health emergencies.

73. **Support the American Indian Health Commission in Providing Technical Assistance to Tribes.** Washington State Department of Health should continue to support American Indian Health Commission's (Commission) role in providing emergency preparedness and response technical assistance to Tribes and UIHPs including, but not limited to, facilitating government-to-government meetings, drafting emergency model orders, laws, and policies, staffing the American Indian Health Commission Tribal Liaison to the DOH Incident Management Team, and coordinating the delivery of emergency resources to Tribes.

74. **In Coordination with the American Indian Health Commission, Provide Training and Education to State Staff on the Role of Tribal Casinos.** State and local governmental leaders must gain knowledge and understanding of the vital role that Tribal casinos serve in supporting essential governmental functions such as Tribal law enforcement, Tribal school, Tribal administration, Tribal courts, Tribal health care, and cultural events. Such knowledge and understanding are critical for respectful government-to-government discussions regarding closure of businesses.

75. **In Coordination with the American Indian Health Commission, Provide Training and Education on Tribal Jurisdiction and Sovereignty.** Require all federal, state, and local officials and staff receive training on Tribal jurisdiction including the state and federal policy recognizing the sovereign authority of Tribe's to establish their own priority groups and determine their service populations (see Appendices A and B).

76. **Consult with Tribes on Funeral Protocols.** Consult with Tribal nations prior to the next pandemic on updating funeral protocols during a pandemic emergency. While state protocols do not apply on Tribal land, they do significantly impact Tribal communities utilizing funeral services off Tribal land.

77. **Increase Understanding of Impacts of State Emergency Orders on Homeless Populations.** The State should consider the unique challenges for homeless populations in its plans for emergency response orders.

APPENDIX B: AAR PLANNING QUESTIONS

APPENDIX B: AAR PLANNING QUESTIONS

1. **Community Preparedness**

In what ways was your Tribe/UIHP prepared to learn about, understand, and respond to the pandemic?

What challenges did you face?

What changes or actions will help your Tribe/UIHP be better prepared to learn about, understand and respond to the next emergency?

2. **Community Recovery**

In what ways was your Tribe/UIHP able to restore and maintain a day-to-day level of functioning comparable to pre-incident levels and to improved levels, where possible?

What challenges did you face?

What changes or actions will help strengthen this ability in future emergencies?

3. **Emergency Operations Coordination**

In what ways was your Tribe/UIHP able to establish a system of leadership (e.g., Emergency Operations Center, Incident Command, etc.) to direct response activities such as needs assessments, response planning, response actions, etc.?

What challenges did you face?

What changes or actions will help strengthen this ability in future emergencies?

4. **Emergency Public Information and Warning**

In what ways was your Tribe/UIHP able to develop, coordinate, and disseminate information, alerts, warnings, and notifications to your community members and response staff?

What challenges did you face?

What changes or actions will help strengthen this ability in future emergencies?

5. **Information Sharing**

In what ways was your Tribe/UIHP able to exchange information and situational awareness data with federal, state, and local governments and other response partners?

What challenges did you face?

What changes or actions will help strengthen this ability in future emergencies?

6. **Medical Countermeasures Dispensing and Administration**

In what ways was your Tribe/UIHP able to dispense and administer medical countermeasures, such as vaccines, antiviral drugs, etc.?

What challenges did you face?

What changes or actions will help strengthen this ability in future emergencies?

7. **Medical Materiel Management and Distribution**

In what ways was your Tribe/UIHP able to acquire, manage, transport, and track medical materiel, such as gloves, masks, testing supplies, etc.?

What challenges did you face?

What changes or actions will help strengthen this ability in future emergencies?

8. **Medical Surge**

In what ways was your Tribe/UIHP able to provide medical care, despite the risks, staffing challenges, supply chain shortages, hospital over-capacity, etc.?

What challenges did you face?

What changes or actions will help strengthen this ability in future emergencies?

9. **Nonpharmaceutical Interventions**

In what ways was your Tribe/UIHP able to take actions to help slow the spread of illness or reduce the adverse impacts of the pandemic to your community (e.g., isolation and quarantine, masking requirements, reservation lockdowns, etc.)?

What challenges did you face?

What changes or actions will help strengthen this ability in future emergencies?

10. **Public Health Laboratory Testing**

In what ways was your Tribe/UIHP able to maintain access to laboratory testing services, supplies, results, etc.?

What challenges did you face?

What changes or actions will help strengthen this ability in future emergencies?

11. **Responder Safety and Health**

In what ways was your Tribe/UIHP able to protect public health and other emergency response staff while they carried out their response duties?

What challenges did you face?

What changes or actions will help strengthen this ability in future emergencies?

12. **Volunteer Management**

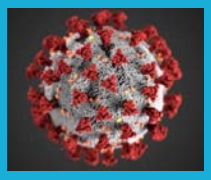
In what ways was your Tribe/UIHP able to coordinate with emergency management and partner agencies to identify, recruit, register, verify, train, and engage volunteers to support your efforts (e.g., Medical Reserve Corps volunteers, Red Cross, DOH Mobile Nurse Teams, Washington National Guard, etc.)?

13. **Cross-Jurisdictional Collaboration**

What activities did you engage in to coordinate with other Tribes, local health jurisdictions and/or Washington State?

APPENDIX C: FEDERAL POLICY ON TRIBAL VACCINATION

CDC COVID-19 Vaccination Program Interim Playbook for Jurisdiction Operations, Version 2.0, p. 9



Tribal Nations and Tribal Communities

While engaging with tribal leaders, jurisdictional[2] immunization programs must remember each tribal nation has the sovereign authority to provide for the welfare of its people and, therefore, has the authority to:

- Choose among the jurisdiction or Indian Health Service (IHS) options for accessing vaccine.
- Determine the population(s) it chooses to serve.
- Choose how vaccines are distributed to its community.
- Establish priority groups when there is a limited supply of COVID-19 vaccine or other accompanying resources.

For the COVID-19 Vaccination Program, tribal nations have two options for receiving vaccine:

1. Through the jurisdiction's allocation and distribution mechanism
2. Through the IHS allocation and distribution mechanism

State and local jurisdictions do not possess legal authority over tribal nations directly providing vaccine to their service populations. However, if a tribal nation or any of the health facilities serving that tribal nation receive vaccine from the jurisdiction's allocation, they are responsible for adhering to vaccine storage, handling, distribution, and reporting requirements outlined in the *CDC COVID-19 Vaccination Program Provider Agreement.*

Jurisdictions should reach out to tribal nations within their respective areas for involvement in planning efforts. Jurisdictions must include each tribe's preference for COVID-19 vaccine distribution to ensure vaccine is effectively delivered to tribal nations and their communities. State and local jurisdictions should also engage with Urban Indian Health Centers (UIHCs). IHS may be able to support distribution to UIHCs and is planning to formally confer with UHICs to solicit their feedback. Additionally, awardee jurisdictions should reach out to UIHCs as part of the planning process to determine their preference for vaccine access. Details of engagement with tribal nations and other tribal entities should be included in jurisdiction COVID-19 vaccination plans.

The jurisdictional planning process should include state-recognized tribes, unrecognized tribes, and American Indian/Alaska Native individuals who are included in state-recognized tribes because the option to access COVID-19 vaccine through IHS may not be possible for these communities.

COVID-19 Vaccination Program Implementation Committee (Internal and External)

Reaching intended vaccine recipients is essential to achieving desired levels of COVID-19 vaccination coverage. To ensure equitable access to vaccinations, information about populations within a jurisdiction and the logistical requirements for providing them access to COVID-19 vaccination services will require collaboration with external entities and community partners who are familiar with how they obtain healthcare and other essential services. Jurisdictions should establish a COVID-19 Vaccination Program implementation committee to enhance development of plans, reach of activities, and risk/crisis response communication messaging and delivery. Committee membership should include leadership from the jurisdiction's COVID-19 planning and coordination team as well as representatives from key COVID-19 vaccination providers for critical population groups

[2] "Jurisdiction/jurisdictional," as used in this document, refers to the federal immunization funding awardees described in the Executive Summary and their state public health emergency preparedness counterparts who are tasked with developing COVID-19 vaccination plans for submission to CDC.

APPENDIX D: WASHINGTON STATE POLICY ON TRIBAL VACCINATION

(1) Washington State Department of Health Emergency Response Plan
Annex 9: Medical Countermeasures

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47890 • Olympia, Washington 98504-7890
Tel: 360-236-4030 • 711 Washington State Relay

September 3, 2020

Steve Kutz, Chairman
American Indian Health Commission
808 North 5th Avenue
Sequim, Washington 98382

Dear Chairman Kutz:

SUBJECT: Medical Countermeasures Tribal-State-LHJ Coordination Plan

On August 12, 2020, the Department of Health (DOH) hosted a consultation with the AIHC, tribal nations, and other Indian health organizations to be prepared for the eventual distribution of medical countermeasures related to the COVID-19 pandemic. The recommendations were shared with consultation partners and a comment period was held open on them through August 31, 2020. During that period, there was a single comment submitted to DOH from AIHC. It was incorporated into the final actions I have now approved, which are as follows:

1. Starting September 1, 2020, DOH staff from both the Emergency Preparedness and Response Division and the Prevention and Community Health Division/Office of Immunization and Child Profile will work together with tribal and local health jurisdiction (LHJ) leaders and representatives to support successful tribal-state-local health partnerships for the distribution of medical countermeasures, including vaccines.

2. By October 1, 2020, the Tribal-State-LHJ Medical Countermeasures Guide will be finalized to include this language on page 1, paragraph 2, under the Tribal Sovereign Authority Regarding Medical Countermeasures: **For each incident, the Tribe, not the local health jurisdiction or Washington State, shall determine the Tribe's service population. Each Tribe will coordinate with the State on the specific allocation of MCM to be distributed to the Tribe.**

3. By October 1, 2020, DOH will incorporate the following language into Annex 9, page 6, first item under the Tribal Sovereign Authority Regarding Medical Countermeasures: **For each incident, the Tribe, not the local health jurisdiction nor Washington State, shall determine the population the Tribe will serve to provide MCM, and each Tribe will coordinate with the State on the specific allocation of MCM to be distributed to the tribe.**

4. By November 2, 2020, the DOH Emergency Preparedness and Response team will begin training for tribal-state-LHJ partners on the revised Annex 9.

Chairman Kutz, we thank your Executive Committee for their leadership and your staff for their work on these important issues. We appreciate the strong and positive public health partnership we have to do this work together—work that supports the health of all Washingtonians.

Respectfully,

John Wiesman, DrPH, MPH
Secretary of Health

cc: Tamara Fife, Department of Health
Erika Henry, Department of Health

ANNEX 9: MEDICAL COUNTERMEASURES

INTRODUCTION
I.

A. Purpose
The purpose of this annex is to define Washington State Department of Health's (DOH) Medical Countermeasures (MCM) capacity to support local health jurisdictions (LHJs), military installations, and tribal governments and describe the Washington State Secretary of Health's decision making around the use of MCM modality in Washington State.

B. Scope
The scope of this plan is large scale, multi-jurisdictional and tribal MCM dispensing.

C. Policies
The Secretary of Health, the Executive Team, and any other advisors the Secretary deems necessary, will determine the involvement of DOH and state resources to support the dispensing of MCM. Additionally, if specific countermeasures are in short supply the Secretary of Health will determine the specific allocations and the need for requesting federal resources.

Any activation of the MCM Strike Team or the Receiving, Staging, and Storage (RSS) Task Force will be at the direction of the DOH Incident Management Team (IMT) on behalf of the Secretary of Health.

II. SITUATION AND ASSUMPTIONS

A. Situation
This plan applies to an event that requires extensive emergency MCM distribution to the public in order to control disease. The incident could range from an isolated incident managed by a single local or tribal jurisdiction, to a large-scale incident affecting multiple jurisdictions. DOH becomes involved in these events when the scope and magnitude of the incident exceeds the resources of the local jurisdictions, military installations, or Tribes.

B. Planning Assumptions

- One or more local jurisdiction, tribal government, or military installation has requested MCM or medical resource support for their response to a public health emergency or disaster.
- **Responsibility for Distributing and Dispensing Medical Countermeasures to Tribes.** The state and local health jurisdictions are responsible for distributing and dispensing MCM to tribal nations in accordance with the National Response Framework and Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness

Version 11.

- **MCM Distribution Options for Tribal Governments**. Tribal governments may choose to receive MCM directly from the state in which they are located, or a local jurisdiction. In some circumstances, a Tribe may choose to receive MCM directly from a federal agency. In most emergencies, the federal government will delegate responsibility of MCM distribution to the state in which the tribal nation is located. Attachment 3 provides detailed steps for coordination of MCM distribution among tribal, state, and local health jurisdictions (LHJs).

III. CONCEPT OF OPERATIONS

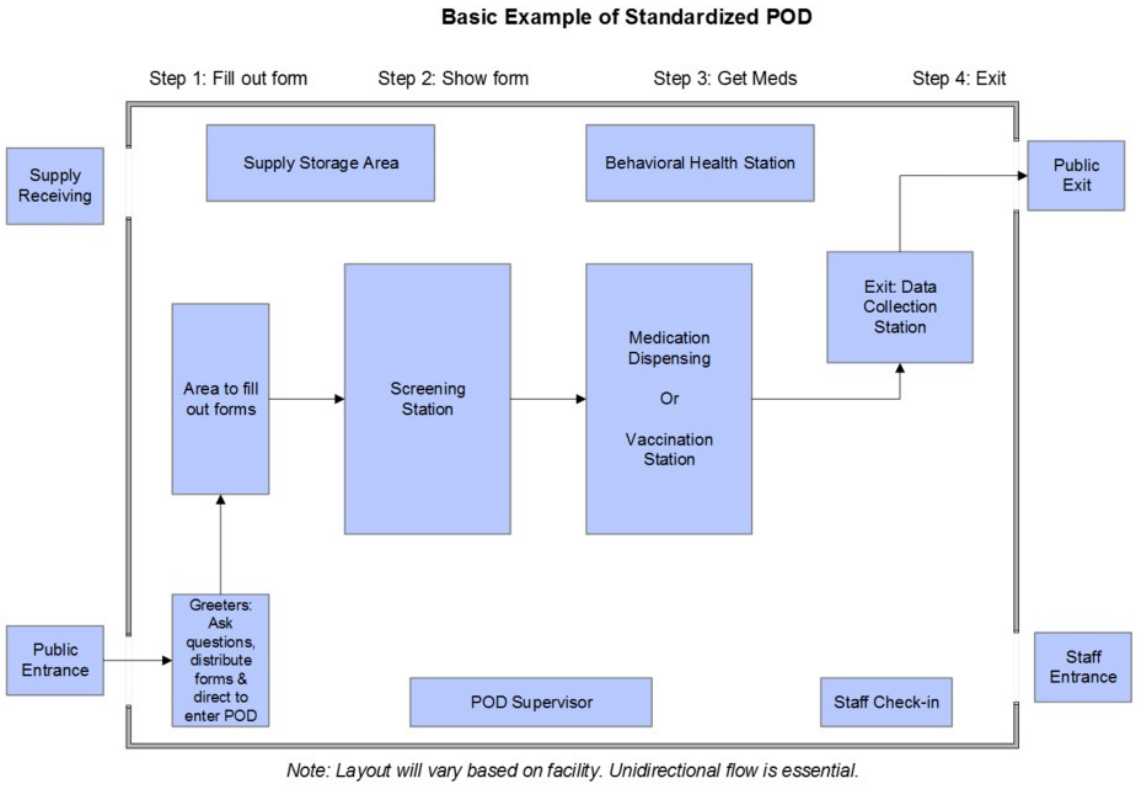
A. General

The responsibility for dispensing MCM requires a Whole Community approach. This approach includes pharmacies, healthcare organizations, closed PODs, and PODs open to the public. Using state resources, DOH will support LHJ and tribal government requests for assistance.

B. Tribal Coordination

To ensure that citizens living on tribal lands will receive MCM, it is vital that state and local jurisdictions coordinate with Tribes. This is done through joint planning efforts, engaging Tribes in exercises to test plans, mutual aid agreements (MAAs), memorandums of agreement (MOAs), memorandums of understanding (MOUs), and other efforts that strengthen all jurisdictions' capabilities and clarify roles, responsibilities and authorities.

Fig. 1 POD Diagram



Note: Layout will vary based on facility. Unidirectional flow is essential.

C. Organization and Assignment of Responsibilities

1. Executive Team

The DOH Executive Team is comprised of the Secretary of Health, Chief of Staff, Center for Public Affairs Director, Policy & Legislative Relations Director, Executive Assistant, and State Health/Chief Science Officer. The Secretary of Health may call upon the Executive Team to collaborate on decisions regarding activation of the IMT, allocation of scarce resources, and the need for requesting federal resources.

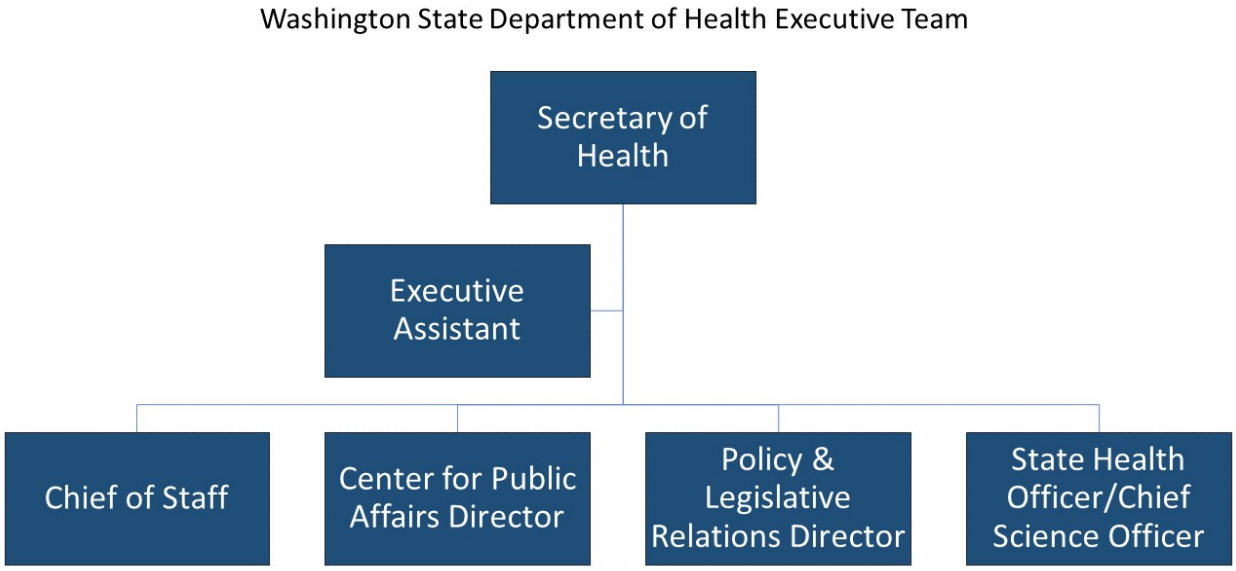


Fig. 2 Executive Team

2. MCM Strike Team

DOH maintains a team that can provide technical support to LHJs, military installations, and tribal governments to support MCM operations.

The staffing of this team includes six members, with three full teams for backup and 24-hour operations. The MCM Strike Team may be supplemented by private agencies through a contract or MOU.

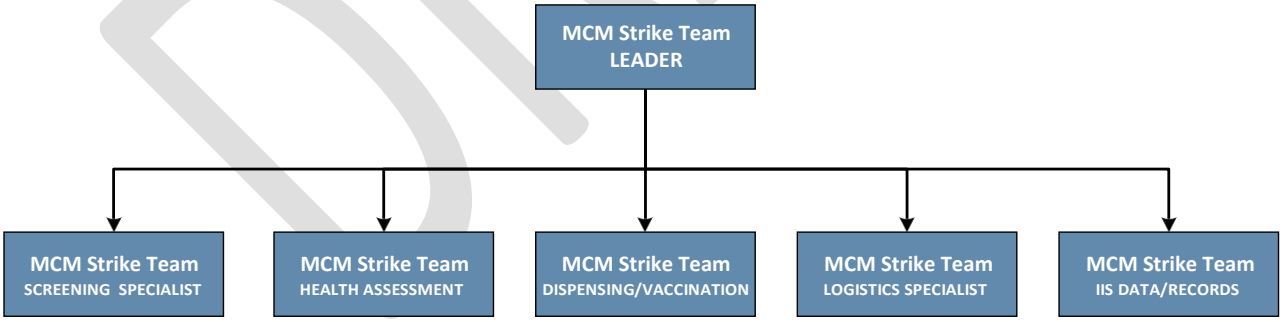


Fig. 3 MCM Strike Team

3. Response Team Activation and Deployment

The DOH IMT will activate the MCM Strike Team or RSS Task Force as necessary to support MCM missions.

Tribal Medical Countermeasure Activation and Distribution Options:

In the State of Washington, Tribes have four primary options for the delivery of medical countermeasures to their tribal nations:

- Option #1: The Tribe can choose to coordinate with the Washington State Department of Health (DOH) and have tribal representatives travel to DOH's distribution hub and pick up the Tribe's supply of medical countermeasures.
- Option #2: The Tribe can choose to coordinate with the Washington State Department of Health and have DOH deliver medical countermeasures directly to the Tribe.
- Option #3: The Tribe can choose to have the Washington State Department of Health deliver the Tribe's allocation of medical countermeasures to a local health jurisdiction. The Tribe will then coordinate with the local health jurisdiction for the delivery of medical countermeasures to the Tribe.
- Option #4: The Tribe can choose to coordinate with the federal Strategic National Stockpile for the distribution of medical countermeasures to the Tribe.

Tribal Considerations for LHJs:

- Recognition of Tribal Sovereignty. Local health jurisdictions (LHJs) recognize the sovereignty of Tribes. This plan does not supplant Tribes' emergency plans and processes for distributing and dispensing emergency medications and vaccines to their Tribal members, employees, and others.
- Responsibility for Distribution and Dispensing of Tribal Medical Countermeasures. The State and local health jurisdictions are responsible for distributing and dispensing MCM to tribal nations in accordance with the National Response Framework and Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness Version 11.

4. Authorities and Limitations

The State and local health jurisdictions do not possess legal authority over how a Tribe receives MCM or dispenses MCM.

Tribal Sovereign Authority Regarding Medical Countermeasures. Each tribal nation has the sovereign authority to provide for the welfare of its people and, therefore, has the authority to:

- Determine the population it chooses to serve. For each incident, the Tribe, not the local health jurisdiction nor the State, shall determine the population the Tribe will serve to provide MCM, and each Tribe will coordinate with the State on the specific allocation of MCM to be distributed to the Tribe;
- Choose how medical countermeasures are distributed to its community; and
- Establish priority groups when there are not enough resources to provide mass dispensing to 100% of the tribal nation's service population. State and local jurisdictions do not possess legal authority over tribal nations directly dispensing MCM to their service populations. Issues regarding a tribal nation dispensing MCM shall be addressed by the tribal nation and the federal agency responsible for the MCM.

All response requires both the responsibility to act and the authority to act. The key state authorities that govern public health emergency response are summarized in the ESF 8 Annex and are cited in the DOH Basic Plan.

D. Information Collection, Analysis, and Dissemination

Successful operations depend on information to ensure that appropriate resources are delivered to the requesting state agencies, LHJs, military installations, and Tribes in a timely manner.

E. Whole Community Involvement and Non-Discrimination

This plan is committed to communicating with the Whole Community as needed during emergency response and disaster recovery operations. The Whole Community includes populations with Limited English Proficiency (LEP), individuals with disabilities, and Access and Functional Needs (AFN). Any agency or organization that receives federal funding is required to have a plan or policy for addressing the needs of individuals with LEP, pursuant to title VI, the Civil Rights Act. The Washington State Department of Health expects all entities to comply with federal law. For more information on how each entity complies with federal law, please contact the individual entity.

IV. PLAN DEVELOPMENT AND MAINTENANCE

A. Training

All DOH planning documents will be introduced to appropriate DOH response teams, partnering agencies, LHJs and Tribes through seminars. DOH staff required to complete this training consists of emergency response team members and DOH Leadership. Training regarding this Emergency Response Plan and implementing documents will be performed with these response staff.

B. Drills and Exercises

This plan and its components will be tested using a progressive exercise cycle. The content and timing of the exercise will be based on improvement plans from previous exercises and real incidents. All public health related exercises conducted at DOH will conform to the Homeland Security Exercise Evaluation Program (HSEEP) guidelines.

C. Periodic Reviews and Updates

This plan will be reviewed and updated based on peer-reviewed literature, after action improvement items, and improvements identified through the corrective action program as needed and at least every five years. The Office of Emergency Preparedness and Response will notify all partners of any significant updates in writing.

D. Plan Approval

The DOH Chief of Emergency Preparedness and Response approves this annex and attachments for DOH use in responding to public health and all-hazards emergencies that affect public health. This annex and its attachments are vetted with response partners representing local public health, Tribes, the Washington Society for Independent Living, other state agencies, and healthcare sector partners. The review process includes input from all DOH Assistant Secretaries and key executive staff.

Figures

Figure 1 – POD Diagram
Figure 2 – Executive Team Organizational Chart Figure 3 – MCM Strike Team Organizational Chart

Attachments

Attachment 1 – Medical Countermeasures (MCM) Operating Procedures (TBD)
Attachment 2 – Medical Countermeasures (MCM) Field Operations Guide (FOG) (TBD)
Attachment 3 – Tribal-State-LHJ Medical Countermeasures (MCM) Coordination Guide

Tribal-State-LHJ Medical Countermeasures Coordination Guide

Planning Assumptions

Responsibility for Distribution and Dispensing of Tribal Medical Countermeasures: The State and Local Health Jurisdictions are responsible for distributing and dispensing MCM to tribal nations in accordance with the National Response Framework and Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness Version 11.

Tribal Sovereign Authority Regarding Medical Countermeasures: Each tribal nation has the sovereign authority to provide for the welfare of its people and, therefore, has the authority to (1) determine the population it chooses to serve; (2) choose how medical countermeasures are distributed to its community; and (3) establish priority groups when there are not enough resources to provide mass dispensing to 100% of the tribal nation's service population. State and local jurisdictions do not possess legal authority over tribal nations directly dispensing MCM to their service populations. For each incident, the Tribe, not the local health jurisdiction or Washington State, shall determine the Tribe's service population. Each Tribe will coordinate with the State on the specific allocation of MCM to be distributed to the Tribe. Issues regarding a tribal nation's dispensing of MCM shall be addressed by the tribal nation and the federal agency responsible for the MCM.

Tribal Medical Countermeasures Distribution Options

DISTRIBUTION OPTION	TRIBE	STATE	LHJ
1. TRIBE ⟺ STATE COORDINATION **Tribe picks up MCM from State** Tribal representatives travel to the State's Receive, Stage and Store (RSS) location and pick up the Tribe's supply of MCM	• Tribe contacts DOH to request MCM • Tribe provides DOH information on the Tribe's service population and other relevant community-specific data • Tribe sends tribal representatives to RSS location	• State reports to Tribe the amount and type of MCM available • State provides instructions to Tribe on requesting MCM • State provides Tribe vehicle and transporting requirements • State provides Tribe regular updates regarding MCM availability timelines • State provides Tribe information regarding documentation, dispensing, return of non-consumable materials, etc. • State releases MCM to Tribe	
2. TRIBE ⟺ STATE COORDINATION **DOH delivers directly to Tribe** Tribe coordinates with DOH to have DOH deliver MCM directly to a location identified by the Tribe	• Tribe contacts DOH to request MCM • Tribe provides DOH information on the Tribe's service population and other relevant community-specific data • Tribe provides DOH information on the desired MCM delivery location	• State reports to Tribe the amount and type of MCM available • State provides instructions to Tribe on requesting MCM • State provides Tribe information regarding delivery location requirements • State provides Tribe regular updates regarding MCM availability timelines • State provides Tribe information regarding documentation, dispensing, return of non-consumable materials, etc. • State releases MCM to Tribe	

DISTRIBUTION OPTION	Tribe	State	LHJ
3. TRIBE ⇔ LHJ ⇔ STATE COORDINATION **Tribe Coordinates with Local Health Jurisdiction (LHJ)** Tribe requests DOH to deliver Tribe's MCM allocation to a LHJ Tribe coordinates with LHJ to arrange delivery or pickup of MCM	• Tribe engages with LHJ in pre-incident planning on how they will coordinate efforts during a response • Tribe contacts LHJ to confirm and coordinate process for delivery or pickup of MCM • Tribe contacts DOH to request MCM • Tribe provides DOH information on the Tribe's service population and other relevant community-specific data • Tribe provides DOH information on the desired MCM delivery location (Actual process may vary, depending on the incident)	• State reports to Tribe the amount and type of MCM available • State provides instructions to Tribe on requesting MCM • State provides Tribe information regarding delivery location requirements • State provides Tribe regular updates regarding MCM availability timelines • State provides Tribe information regarding documentation, dispensing, return of non-consumable materials, etc. • State delivers Tribe's MCM to LHJ at requested location	• LHJ engages with Tribe in pre-incident planning on how they will coordinate efforts during a response • LHJ distributes and releases the Tribe's MCM allocation based on the Tribe's requested approach which could include: the LHJ delivering the MCM to a tribal location, the Tribe picking up the MCM from the LHJ's location, the Tribe and LHJ managing a joint point of dispensing (POD), or other tribally-determined process
4. TRIBE ⇔ FEDERAL COORDINATION **Tribe Coordinates with Federal Government**	• Tribe contacts federal government (CDC and/or ASPR)	• State may be called upon by the federal government to assist, depending on the facts and circumstances of the incident	

Tribal Medical Countermeasures Dispensing Options

Each tribal nation has the sovereign authority to provide for the welfare of its people and, therefore, has the authority to choose among various options to dispense MCM and to establish priority groups when there are not enough resources to provide mass dispensing to 100% of the tribal nation's service population. Issues regarding a tribal nation's dispensing of MCM shall be addressed by the tribal nation and the federal agency responsible for the MCM. State and local jurisdictions do not possess legal authority over tribal nations' direct dispensing MCM to their service population. Notwithstanding this paragraph, state and local jurisdictions are responsible for dispensing MCM to a tribal nation's community members if requested by the tribe.

EXAMPLE 1: Tribe Activates and Operates a Tribal Medication Dispensing Center (POD)

EXAMPLE 2: Tribe Operates a Joint Medication Dispensing Center (POD) with a LHJ

EXAMPLE 3: Tribe Coordinates with LHJ for LHJ to Manage a Medication Dispensing Center (POD) for the Tribe