



## American Indian Health Commission for Washington State



Region 8 Tabletop Exercise

6/30/2018

Medical Countermeasures Preparedness  
Cross-Jurisdictional Collaboration Project

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**American Indian Health Commission  
for Washington State**



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# American Indian Health Commission for Washington State

## MEDICAL COUNTERMEASURES PREPAREDNESS CROSS-JURISDICTIONAL COLLABORATION PROJECT

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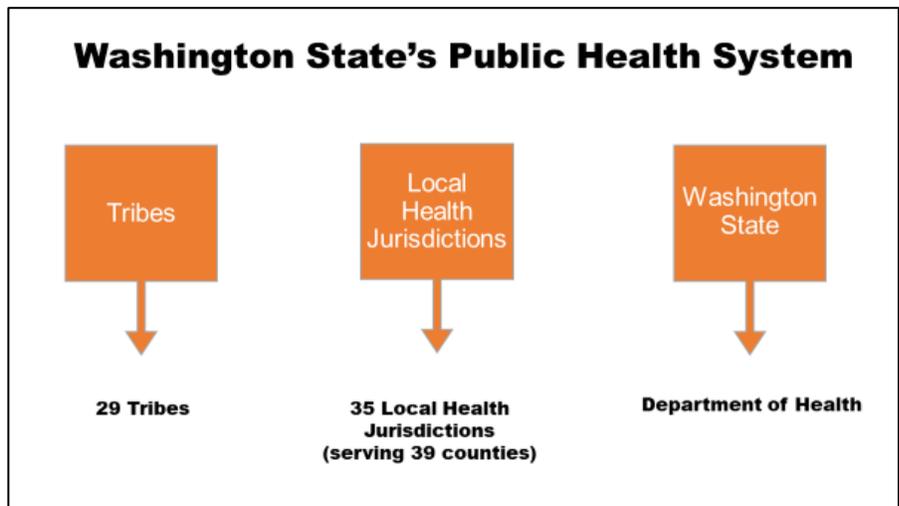
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## II. TRIBES AND MEDICAL COUNTERMEASURES OVERVIEW

The Centers for Disease Control and Prevention (CDC)'s Strategic National Stockpile (SNS) holds large quantities of life-saving pharmaceuticals and medical supplies to protect the public when local resources cannot meet the needs of a public health emergency. Each time a public health event requires these medical countermeasures (MCM), every federally-recognized tribe has the sovereign authority to choose how the medical countermeasures are distributed to its community.

### State and Local Health Jurisdiction Role in Distribution of Medical Countermeasures to Tribes

Collaboration among the twenty-nine (29) tribes, thirty-five (35) local health jurisdictions, and Washington State is vital to the effective distribution of medical countermeasures to tribes. The CDC's publication *"Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11"* (commonly referred to as "Version 11") provides limited guidance on the responsibility of state and local governments to



ensure effective delivery of medical countermeasures to the tribes within their regions: "the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident."<sup>1</sup> Furthermore, Version 11 states that "Jurisdictions should coordinate and collaborate with American Indian and Alaska Native (AI/AN) tribes through a memorandum of agreement (MOA) or memorandum of understanding (MOU) that ensures those living on tribal lands will receive MCMs."

### Summary of Four Options for Distribution of Medical Countermeasures to Tribal Nations

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

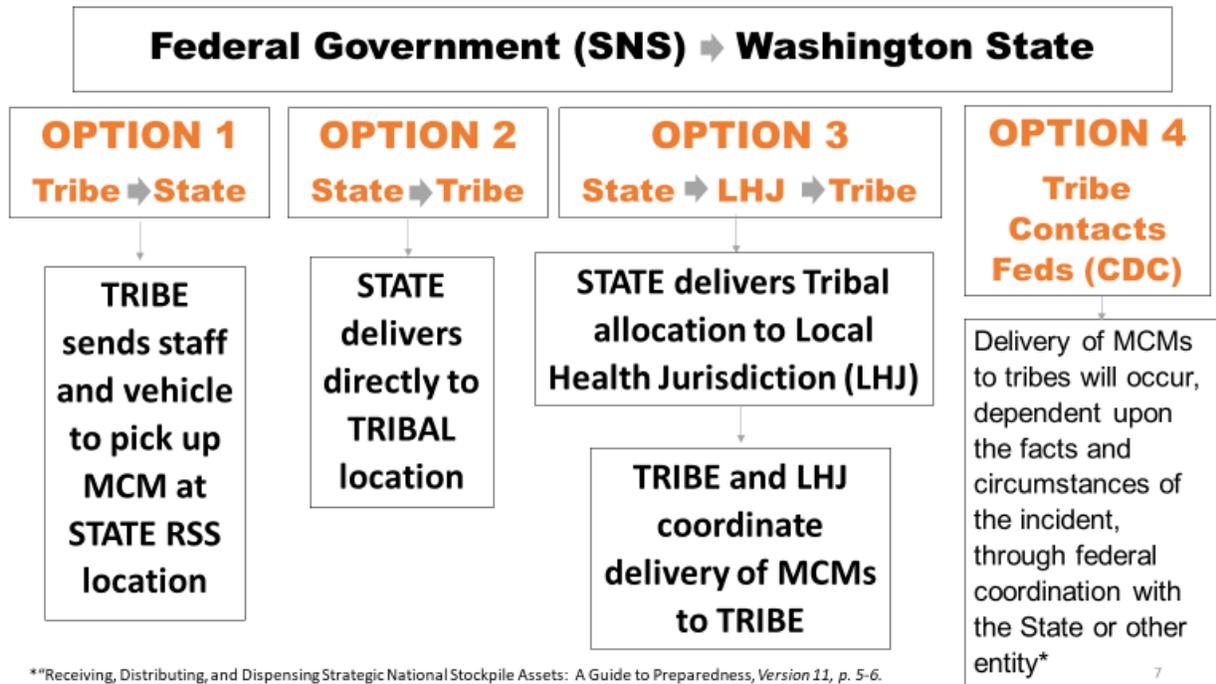
**Option #1:** The tribe can choose to coordinate with the Washington State Department of Health (DOH) to have tribal representatives travel to Washington State's distribution hub (the Receive, Stage and Store (RSS) warehouse in Tumwater) and pick up the tribe's allocation of medical countermeasures.

<sup>1</sup> "Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5-6 (electronic version), p. 1-2 (print copy).

**Option #2:** The tribe can choose to coordinate with the Washington State Department of Health (DOH) and have DOH deliver the tribe’s allocation of medical countermeasures directly to the tribe.

**Option #3:** The tribe can choose to have the Washington State Department of Health (DOH) deliver the tribe’s allocation of medical countermeasures to a local health jurisdiction (LHJ) in its Public Health Emergency Planning Region. The tribe can then coordinate with the local health jurisdiction to pick up the tribe’s medical countermeasures or have the LHJ deliver to the tribe.

**Option #4:** The tribe can choose to coordinate with Centers for Disease Control (CDC) and/or the Office of the Assistant Secretary for Preparedness and Response (ASPR) for the distribution of medical countermeasures to the tribe. Delivery of medical countermeasures to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with Washington State or other entity/ies. (Refer to “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11,” p. 5-6, for more information.)



**2009 - 2010 H1N1 Influenza Pandemic & the Failure to Deliver Medical Countermeasures to Some Washington Tribes**

The Centers for Disease Control (CDC) has neglected to provide clear and sufficient guidance to tribes, states, and local health jurisdictions regarding the distribution of medical countermeasures (MCM) to tribes. This lack of detailed guidance and clarity about the roles of local health jurisdictions (LHJs) and state governments in the distribution of MCM to tribes has resulted in failed distribution and coordination between local health jurisdictions and tribes in certain regions of Washington State.

During the 2009 - 2010 H1N1 influenza pandemic, Washington State's model for distributing MCM to the twenty-nine (29) tribal nations consisted of sending the tribes' allocations to the LHJs bordering the tribes. The intent was for the LHJs to deliver the tribes' allocations to the tribal nations. As is customary, CDC published recommendations regarding priority populations for receiving the H1N1 vaccine. A small number of Washington tribes made plans to administer vaccine to elders before children. Tribal governments based these plans on cultural considerations and analysis of morbidity and mortality within their communities. Some LHJs responsible for coordinating delivery of vaccines and antivirals to these tribes argued this approach would conflict with CDC guidelines. On that basis, those LHJs did not distribute MCMs to tribes.

Shortly after this occurred, CDC Director Thomas Frieden issued a letter informing state health officers that, based on morbidity and mortality data, American Indians and Alaska Natives should receive the vaccine on a priority basis (regardless of age). By the time the letter was issued, the problem had already become too entrenched and many tribes never received their allocations of vaccines from the neighboring LHJs.

To prevent future failures to deliver medical countermeasures to tribal nations and potentially catastrophic consequences, every federal agency, state government and local health jurisdiction must collaborate to assure that tribal nations receive appropriate amount and sufficient medical countermeasures in a timely manner during public health emergencies.

### III. 2018 AMERICAN INDIAN HEALTH COMMISSION (AIHC) MEDICAL COUNTERMEASURES PREPAREDNESS CROSS-JURISDICTIONAL COLLABORATION PROJECT

In fall of 2017, The American Indian Health Commission (Commission) applied for and obtained funding from the Washington State Department of Health (DOH) to provide technical assistance to the twenty-nine (29) tribes, the State of Washington Department of Health, and the thirty-five (35) local health jurisdictions on planning and coordinating for the distribution of medical countermeasures to tribes during public health incidents. The goal



**Region 6 Tabletop Exercise**

of this project was to assure that tribes, Washington State, and local health jurisdictions work together effectively so the appropriate amount and type of medical countermeasures and materiel reach every Washington tribe quickly during public health emergencies

#### **A. PROJECT OBJECTIVES**

1. Strengthen collaboration and mutual aid between tribes and non-tribal partners;
2. Enhance each of the state's nine (9) public health emergency preparedness planning region's ability to manage and distribute medical countermeasures and materiel; and
3. Prevent problems in the distribution of medical countermeasures to tribes like those experienced during the 2009 - 2010 H1N1 response

#### **B. PROJECT ACTIVITIES**

1. **Outreach and Engagement.** The Commission reached out to key contacts at every jurisdiction via phone and email to announce the project and invite their participation in the project. The outreach was designed to maximize inclusion, asking the key contacts to participate in the project activities and to invite others in their jurisdiction who should also be included. Key contacts who were invited to participate and maintain informed included but were not limited to:
  - a. **Tribes.** Tribal Chairs, American Indian Health Commission Delegates, Health Directors, Health Officers, Medical Directors, Clinic Managers, Public Health Emergency Coordinators, Emergency Managers

**b. Local Health Jurisdictions.** Public Health Officers; Health Department Administrators/Directors, Local Emergency Response Coordinators, Healthcare Coalition Coordinators, County Emergency Managers

2. **CDC Webinar.** On March 15, 2018, the American Indian Health Commission (AIHC) facilitated a webinar with participation of key representatives from the tribes, the Centers for Disease Control and Prevention (CDC), and Washington State Department of Health (DOH). One local health jurisdiction's Emergency Response Coordinator participated in the webinar to describe their LHJ's process for coordinating with tribes to assure quick delivery of the region's tribes' medical countermeasures. The primary purpose for the webinar was to request CDC to provide clear guidance on the process for tribes to request medical countermeasures directly from the federal government. The CDC relied on their "Version 11" guidance to state that, in most instances when a tribe requests MCM directly from the federal government, the CDC will coordinate the distribution of medical countermeasures to the tribe with the state in which the tribe is located. Tribes requested the CDC to provide written guidance that clearly: 1) outlines the process for tribes to request medical countermeasures from the federal government, and 2) specifies to LHJs and state governments that federal, state, and local governments do not have authority over tribal governments' determinations of priority populations in dispensing medical countermeasures and handling of the MCM. The CDC promised to provide a "White Paper" to address these key issues. To date, the CDC has not published this document. See Appendix C.
3. **9 Regional Planning Meetings.** The Commission organized and facilitated a total of nine (9) regional planning meetings with the tribes and local health jurisdictions in each of the public health emergency planning regions in Washington. The purpose of these meetings was to increase partners' understanding of each jurisdiction's organization, capacity and resources, and to a plan tabletop exercise. See Appendix D.

4. **9 Tabletop Exercises.** The Commission planned and facilitated nine (9) regional tabletop exercises to test each region's ability to effectively distribute medical countermeasures to tribes. Each meeting



**Region 4 Tabletop Exercise**

was approximately six (6) hours long and included an introduction, the tabletop exercise, and a hotwash (debrief and discussion of strengths and areas for improvement). See Appendix E, F, and G.

5. **Draft Guidance Documents and Forms.** Through this project, the Commission developed the following documents and forms: draft "DOH Tribal Countermeasures Guidance", Partner Profile Template, CDC March 15 Webinar PowerPoint, Planning Meeting Project Overview PowerPoint, Western Washington Regions Tabletop Exercise PowerPoint, Eastern Washington Regions Tabletop Exercise PowerPoint. See Appendix A, B C, D, E, F, and G.

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## C. PARTICIPATION BY REGION

### 1. Region 1

Counties: Island, Skagit, Snohomish, Whatcom (18 participants)

Tribes: Nooksack, Samish, Sauk-Suiattle, Stillaguamish, Swinomish, Tulalip, Upper Skagit (17 participants)

Washington State Department of Health (DOH): (2 participants)

Northwest Washington Indian Health Board (NWIHB): (3 participants)

### 2. Region 2

Counties: Clallam, Jefferson, Kitsap (9 participants)

Tribes: Lower Elwha, Jamestown S’Klallam, Makah, Port Gamble S’Klallam, Suquamish (23 participants)

Washington State Department of Health (DOH): (3 participants)

### 3. Region 3

Counties: Grays Harbor, Lewis, Mason, Pacific, Thurston (12 participants)

Tribes: Nisqually, Quinault, Shoalwater Bay, Skokomish, Squaxin Island (14 participants)

Washington State Department of Health (DOH): (2 participants)

### 4. Region 4

Counties: Clark, Cowlitz (10 participants)

Tribe: Cowlitz (7 participants)

Washington State Department of Health (DOH): (3 participants)

### 5. Region 5

County: Pierce -- Tacoma-Pierce County Health Department (6 participants)

Tribe: Puyallup (8 participants)

Washington State Department of Health (DOH): (5 participants)

### 6. Region 6

County: King -- Seattle-King County Public Health (4 participants)

Tribes: Muckleshoot, Snoqualmie (8 participants)

Northwest Healthcare Response Network (NHRN): (2 participants)

Washington State Department of Health (DOH): (4 participants)

### 7. Region 7

County: Chelan, Douglas (2 participants)

Tribe: Colville (4 participants)

Indian Health Service (IHS): (4 participants)

Washington State Department of Health (DOH): (2 participants)

### 8. Region 8

Counties: Yakima (2 participants)

Tribe: Yakama (7 participants)

Indian Health Service (IHS): (3 participants)

Hospitals: Astria Health (2 participants), Virginia Mason Memorial Hospital (1 participant)

White Swan Ambulance: (1 participant)

Toppenish School District: (1 participant)

Washington State Department of Health (DOH): (2 participants)

### 9. Region 9

County: Ferry, Pend Oreille, Spokane, Stevens, Whitman (6 participants)

Tribe: Colville, Kalispel (5 participants)

Washington State Department of Health (DOH): (3 participants)

## IV. KEY FINDINGS

This project provided opportunities for many new relationships to develop between individuals and entities that will need to work closely during public health incidents. The project established an important framework for strengthening collaboration and coordination between tribal, state, and local health jurisdiction partners in the distribution of medical countermeasures.

The following are key findings from the project:

1. Participants from the various jurisdictions (tribal, state, local) greatly value meeting in person to learn about each jurisdiction, strengthen relationships, and clarify strategies for collaboration during responses; these opportunities should continue to be made available;
2. The failure of the federal government (CDC/ASPR) to provide clear guidance to states, local health jurisdictions and tribes regarding the distribution of medical countermeasures to tribes has created a dangerous situation which resulted in some tribes not receiving their allocations of medical countermeasures during the 2009 - 2010 H1N1 pandemic; the United States government must develop clear and complete guidance to prevent catastrophic consequences during future responses;
3. Most local health jurisdictions understand their role regarding the distribution of medical countermeasures to tribes is limited to transporting and/or handing over the tribes' allocations; however, there remain a small number of local health officers who mistakenly believe their jurisdiction has authority over a tribe's handling or dispensing; every effort must be made to identify these local health jurisdictions, compel their understanding and acknowledgement, and assure tribes that may be affected by these LHJs' misinterpretation are informed and can adequately adjust their medical countermeasures plans;
4. Most local health jurisdictions' medical countermeasures planning documents do not address processes for distribution of medical countermeasures to tribes; all LHJs should edit their plans to address these gaps;
5. Eight (8) of the state's nine (9) public health emergency preparedness planning regions raised concerns about not having strategies in place to include tribes in communication, decision-making, public information messaging and coordination of response actions during a public



**Region 8 Tabletop Exercise**

health incident; every region should engage tribal and local health jurisdiction partners in developing plans that clearly outline processes for assuring that tribes can participate as equal partners in these key functions;

6. Most tribes do not have written medical countermeasures plans in place; opportunities should be made available to tribes to access technical assistance to develop and adopt written medical countermeasures plans;
7. Most tribal clinics do not have Continuity of Operations Plans or Crisis Standards of Care to clearly guide their operations during a public health incident; opportunities should be made available to tribes to access technical assistance to develop and adopt written Continuity of Operations Plans and Crisis Standards of Care;
8. Access to current and accurate contact information for the individuals with key roles during responses is a challenge all nine (9) regions identified; strategies to publish and maintain these contact lists current and accessible should be developed, preferably identifying a single official point of access for the information that is restricted to authorized users; and
9. Tribes that operate pharmacies are interested in receiving additional information regarding the statewide Pharmacy Memorandum of Understanding; DOH should provide additional information regarding the Pharmacy Memorandum of Understanding to tribes.

## V. RECOMMENDATIONS

The following outlines recommendations based on this project's key findings.

### **Centers for Disease Control and Prevention (CDC)/Office of the Assistant Secretary for Preparedness and Response (ASPR)**

1. The United States federal government should draft clear guidance outlining the roles and responsibilities of the federal government, state government, local government and tribal government in the distribution of medical countermeasures to tribes.
2. The United States federal government should draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government.
3. The United States federal government should conduct an agency consultation with tribes on these guidelines and processes.

### **Washington State Department of Health (DOH)**

1. DOH should continue to support opportunities for DOH Office of Emergency Preparedness and Response staff, local health jurisdictions, tribes, healthcare coalitions and other key preparedness partners to meet in person.
2. DOH should continue to request clear guidance from CDC/ASPR regarding distribution of medical countermeasures to tribes.
3. DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. See Appendix A.
4. DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes.
5. DOH should collaborate with the Commission to develop a solution that provides tribes and local health jurisdictions with current and accurate contact information for individuals with key roles during responses. A single, official point of access restricted to authorized users is preferred.
6. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
7. DOH should provide additional information to tribes regarding the Pharmacy Memorandum of Understanding.

## Local Health Jurisdictions (LHJs)

1. LHJs should continue to reach out to tribes and participate in opportunities to coordinate with tribes on public health matters.
2. LHJs should acknowledge their role regarding the distribution of medical countermeasures to tribes is limited to transporting and/or handing over the tribes' allocations.
3. LHJs should engage in planning with tribes and amend their medical countermeasures planning documents to address processes for distribution of medical countermeasures to tribes.
4. LHJs should collaborate with the tribes and other partners in their region to develop plans that clearly outline processes for including tribes in communication, decision-making, and coordination of response actions during responses.
5. LHJs should collaborate with the tribes and other partners in their region to develop plans that clearly outline processes for coordinating unified public messaging.

## Tribes

1. Tribes should continue to reach out to LHJs and participate in opportunities to coordinate with LHJs on public health matters.
2. Tribes should engage in planning with LHJs, in developing processes for distribution of medical countermeasures to tribes.
3. Tribes should collaborate with the LHJs and other partners in their region to develop plans that clearly outline processes for including tribes in communication, decision-making, and coordination of response actions during responses.
4. Tribes should develop medical countermeasures plans that include processes to request, receive, and dispense medical countermeasures.
5. Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patient population during most public health incidents and to guide their operations during these events.
6. Tribes should collaborate with the LHJs and other partners in their region to develop plans that clearly outline processes for coordinating unified public messaging.



Region 2 Tabletop Exercise

## **VI. NEXT STEPS – AMERICAN INDIAN HEALTH COMMISSION**

The following outlines next steps for the Commission, based on this project's key findings:

- 1.** The Commission will continue to support and facilitate opportunities for tribes and LHJs to collaborate on medical countermeasures responses and other public health matters.
- 2.** The Commission will seek funding to develop draft language for federal government guidance regarding medical countermeasures distribution to tribes, and will continue to advocate for clear guidance and agency consultation with tribes.
- 3.** The Commission will seek funding to assist local health jurisdictions in amending their plans to clearly address processes for distribution of medical countermeasures to tribes in their medical countermeasures planning documents.
- 4.** The Commission will seek funding to assist the nine (9) public health emergency planning regions in engaging tribes and LHJs to develop plans that clearly outline processes for including tribes in communication, decision-making, public information messaging, and coordination of response actions during responses.
- 5.** The Commission will seek funding to assist tribes in developing written medical countermeasures plans.
- 6.** The Commission will seek funding to assist tribal clinics in developing Continuity of Operations Plans and Crisis Standards of Care to clearly guide their operations during a public health incident.
- 7.** The Commission will collaborate with DOH to develop a solution to provide tribes and local health jurisdictions with current and accurate contact information for individuals with key roles during responses.
- 8.** The Commission will continue to coordinate with DOH to: 1) gather jurisdictions' information regarding medical countermeasures distribution using the MCM Partner Profile, including whether the LHJ has the capacity to deliver directly to the tribe, and 2) assure that tribes and LHJs have access to a current copy of their neighboring jurisdictions' partner profiles.
- 9.** The Commission will seek funding to reach out to the tribes and counties that were unable to participate in this project and provide information and technical assistance, as needed, to strengthen medical countermeasure preparedness.

**APPENDIX A: D R A F T WASHINGTON DEPARTMENT OF HEALTH  
TRIBAL MEDICAL COUNTERMEASURES DISTRIBUTION  
GUIDANCE**

# Washington Department of Health

## Tribal Medical Countermeasures Distribution Guidance

### Overview of Tribal Medical Countermeasures Distribution Options

The Centers for Disease Control and Prevention (CDC)'s Strategic National Stockpile (SNS) holds large quantities of potentially life-saving pharmaceuticals and medical supplies (medical countermeasures – MCM) to protect the public when local supplies cannot meet the immediate needs of a public health emergency. Each time a public health incident requires these medical countermeasures, a Tribe has the sovereign authority to choose how those medical countermeasures are distributed to their community. The purpose of this guidance is to provide Tribes with detailed information needed to assess which option(s) for distribution will be best for ensuring the fastest response and protecting each tribal community during an incident.

### Summary of Four Options for Distribution of Medical Countermeasures to Tribal Nations

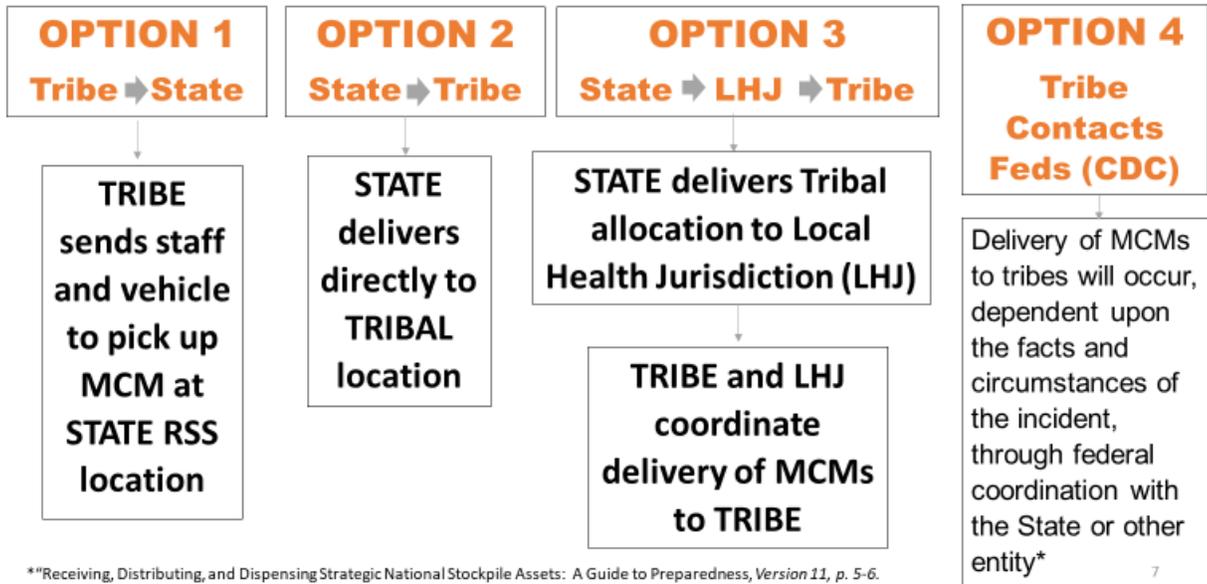
**Option #1:** The tribe can choose to coordinate with the Washington State Department of Health (DOH) to have Tribal representatives travel to Washington State's distribution hub (the Receive, State and Store (RSS) warehouse in Tumwater) and pick up the Tribe's allocation of medical countermeasures.

**Option #2:** The tribe can choose to coordinate with the Washington State Department of Health (DOH) and have DOH deliver the tribe's allocation of medical countermeasures directly to the tribe.

**Option #3:** The tribe can choose to have the Washington State Department of Health (DOH) deliver the tribe's allocation of medical countermeasures to its local health jurisdiction (LHJ). The Tribe will then coordinate with the local health jurisdiction to pick up the tribe's medical countermeasures or have the LHJ deliver to the tribe.

**Option #4:** The tribe can choose to coordinate with Center for Disease Control and/or the Office of the Assistant Secretary for Preparedness and Response (ASPR) for the distribution of medical countermeasures to the tribe. Delivery of medical countermeasures to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with Washington State or other entity/ies. Refer to "Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, *Version 11*," p. 5-6, for more information.

**Federal Government (SNS) → Washington State**



\*"Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5-6.

DRAFT

## Medical Countermeasures Distribution Process to Tribal Nations

### OPTION 1: Tribe Coordinates with DOH to Pick-Up MCM from Washington State RSS

This outline illustrates the process for a tribe to access medical countermeasures (MCM) directly from the Washington State Department of Health (DOH) by sending authorized tribal representatives to a designated state hub site to pick up MCM and transport to the tribe's designated location.

1. At the time an incident response that requires MCM begins, the tribe will contact the DOH to request MCM and provide the tribe's service population numbers specific to the response, and other community and incident-specific data. The Tribe will contact DOH by calling \_\_\_\_\_ or emailing to \_\_\_\_\_.
2. DOH will report to the tribe the amount and type of MCM available and provide additional instructions to the tribe on requesting MCM.
3. DOH will provide the tribe information regarding vehicle and transporting requirements for pickup.
4. DOH will provide the tribe regular updates regarding MCM availability timelines.
5. DOH will provide the tribe information regarding documentation, dispensing, return of non-consumable materials, etc.

### OPTION 2: Tribe Coordinates with DOH to Deliver MCM to Tribe

This outline illustrates the process for a tribe to access medical countermeasures (MCM) directly from the Washington State Department of Health (DOH) by having DOH deliver MCM to a location identified by the tribe.

1. At the time an incident response that requires MCM begins, the tribe will contact the DOH to request MCM and provide the tribe's service population numbers specific to the response, and other community and incident-specific data. The Tribe will contact DOH by calling \_\_\_\_\_ or emailing to \_\_\_\_\_.
2. DOH will report to the tribe the amount and type of MCM available and provide additional instructions to the Tribe on requesting MCM.
3. DOH will provide the tribe information regarding requirements for the delivery location. (For example, is there a requirement for a loading dock? Does the delivery vehicle have access limitations?)
4. DOH will provide regular updates regarding MCM delivery timelines.
5. DOH will provide information regarding documentation, dispensing, return of non-consumable materials, etc.

### OPTION 3: Tribe Coordinates with Its Local Health Jurisdiction (LHJ)

This outline provides an example of the process for tribes to access MCM during public health emergencies by coordinating with their local health jurisdiction (LHJ). The actual process may vary depending on the nature of the incident and the local health jurisdiction.

1. At the time an incident response that requires MCM begins, the tribe will contact the DOH to request MCM and provide the tribe's service population numbers specific to the response, and other community and incident-specific data. The Tribe will contact DOH by calling \_\_\_\_\_ or emailing to \_\_\_\_\_.
2. DOH will report to the tribe the amount and type of MCM available and provide additional instructions to the Tribe on requesting MCM.
3. DOH will provide the tribe information regarding requirements for the delivery location. (For example, is there a requirement for a loading dock? Does the delivery vehicle have access limitations?)
4. The Tribe will contact the LHJ and coordinate a process for pickup or delivery of the MCMs to the tribe.
5. The Tribe will confirm with DOH that the tribe's allocation of MCM should be delivered to the LHJ location.
6. The DOH will deliver the tribe's allocation to the LHJ location.
7. The LHJ will distribute 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. ***The role of the LHJ is simply to hand over the tribe's allocation. The LHJ has no authority or responsibility over how the tribe manages or dispenses the MCM.***

### OPTION 4: Tribe Coordinates with Federal Government-CDC (ASPR, effective \_\_\_\_\_)

The tribe can choose to coordinate with Center for Disease Control and/or the Office of the Assistant Secretary for Preparedness and Response (ASPR) for the distribution of medical countermeasures to the tribe. Delivery of medical countermeasures to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with Washington State or other entity/ies. Refer to "Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, *Version 11*," p. 5-6, for more information.

**APPENDIX B: PARTNER PROFILE TEMPLATE**

## Medical Countermeasures Partner Profile Template

What is the name of your jurisdiction? (e.g., Lummi Nation; Tacoma-Pierce County Health District)	
Is your jurisdiction a Tribe, County or Region?	
If a Tribe, what is the most likely distribution option you will choose? (a. Tribe picks up in Olympia area, b. DOH delivers to tribal location, c. DOH delivers to LHI-Tribe coordinates with LHI, d. Tribe contacts CDC-federal)	
Do you have a plan in place for managing and receiving medical countermeasures?	
Do you have a plan in place for dispensing medical countermeasures?	
What is the name of the location or building/structure where you would like to receive medical countermeasures?	
What is the street address of the location or building/structure where you would like to receive medical countermeasures?	
Does this location or building/structure have a loading dock?	
Does your jurisdiction have a forklift?	
Does your jurisdiction have at least two individuals with forklift certification?	
Does your jurisdiction have a pallet jack?	
Can you provide a "campus map" of the location or structure and surrounding buildings?	
Service Population - In the event of an emergency that calls for dispensing medical countermeasures, how many individuals will you need to serve?	
Do you have a mutual aid agreement(s) (MAAs) in place with other public health jurisdictions in your region?	
Do you have a memorandum(s) of understanding (MOUs) in place with other public health jurisdictions in your region?	
Do you have a list of clinicians (RNs, LPNs, Pharmacists, MDs, PA-Cs, ARNPs) and other staff (and/or volunteers) identified and trained to carry out your mass vaccination efforts?	

## Medical Countermeasures Partner Profile Template

Would you like assistance in determining the size (number of individuals) and composition (clinicians versus non-clinicians) of the team you should identify and train for a mass vaccination event?	
Do you have a list of clinicians (RNs, LPNs, Mas, Pharmacists, MDs, DOs, PA-Cs, ARNPs), and others identified and trained to carry out your mass dispensing efforts?	
Would you like assistance in determining the size (number of individuals) and composition (clinicians versus non-clinicians) of the team you should identify and train for a mass dispensing event?	
Do you have a vehicle(s) and adequate staff to pick up medical countermeasures in the Olympia area?	
What is the NAME of the PRIMARY CONTACT at your jurisdiction during a medical countermeasures (MCM) response?	
What is the OFFICE PHONE NUMBER of the PRIMARY CONTACT at your jurisdiction during a medical countermeasures (MCM) response?	
What is the CELL PHONE NUMBER of the PRIMARY CONTACT at your jurisdiction during a medical countermeasures (MCM) response?	
What is the EMAIL ADDRESS of the PRIMARY CONTACT at your jurisdiction during a medical countermeasures (MCM) response?	
What is the NAME of the SECONDARY CONTACT at your jurisdiction during a medical countermeasures (MCM) response?	
What is the OFFICE PHONE NUMBER of the SECONDARY CONTACT at your jurisdiction during a medical countermeasures (MCM) response?	
What is the CELL PHONE NUMBER of the SECONDARY CONTACT at your jurisdiction during a medical countermeasures (MCM) response?	
What is the EMAIL ADDRESS of the SECONDARY CONTACT at your jurisdiction during a medical countermeasures (MCM) response?	
Is your jurisdiction interested in receiving training on obtaining and/or distributing medical countermeasures?	
Is your jurisdiction interested in receiving training on dispensing medical countermeasures?	
If you are a local health jurisdiction, do you have the ability to deliver MCM to the tribe(s) in your region?	

## **APPENDIX C: CDC MARCH 15 WEBINAR POWERPOINT**

# AMERICAN INDIAN HEALTH COMMISSION FOR WASHINGTON STATE



## Tribal Options for Receiving Medical Countermeasures

### Facilitators:

Lou Schmitz, AIHC Consultant, [lou.Schmitz.aihc@outlook.com](mailto:lou.Schmitz.aihc@outlook.com)

Heather Erb, AIHC Legal Consultant, [heather@erblawfirm.com](mailto:heather@erblawfirm.com)

March 15, 2018



American Indian Health Commission  
for Washington State

# About Us

## **Pulling Together for Wellness**

We are a Tribally-driven, non-profit organization providing a forum for the twenty-nine tribal governments and two urban Indian health programs in Washington State to work together to improve health outcomes for American Indians and Alaska Natives.



# Today's Objective



Provide clear information to tribes regarding the existing options for tribes to access distribution of MCM so they can make an informed decision for choosing a default (placeholder) option

**NOTE: Tribes as sovereign nations are not required to select any option at all. The purpose of this webinar is only to provide technical assistance by providing information regarding these options. Selecting a default option will likely expedite response time during an event.**



American Indian Health Commission  
for Washington State

# Today's Presentation Overview

- Part 1:** Understanding Medical Countermeasures and Medical Materiel
- Part 2:** AIHC Project Overview
- Part 3:** Overview of MCM Access Options for Tribes
- Part 4:** Open Dialogue
- Part 5:** Next Steps





# Part 1

## UNDERSTANDING MEDICAL COUNTERMEASURES AND MEDICAL MATERIEL



# Public Health Threats

*Chemical  
Biological  
Radiological  
Nuclear*



*Pandemic  
Influenza*



*Emerging  
Diseases*

**EMERGING & RE-EMERGING  
INFECTIOUS DISEASES**



# Medical Countermeasures

Medical treatments or prophylaxes for public health threats



# Medical Materiel

Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



Why is collaboration between Tribes, Local Governments, and the State **vital** to accessing Medical Countermeasures?



# **Tribal References within CDC’s “Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11”**

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”



# Tribal References within CDC's "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11"

## Distribution

- "Jurisdictions should coordinate and collaborate with American Indian and Alaska Native (AI/AN) tribes through a memorandum of agreement (MOA) or memorandum of understanding (MOU) that ensures those living on tribal lands will receive MCMs."
- "the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident."

## Dispensing

"AI/AN tribal members may receive MCMs through a local health department point of dispensing (POD); hosting their own PODs on tribal lands; or arranging with the Indian Health Service to provide MCMs."





# Part 2

## AIHC PROJECT OVERVIEW



# 2009 H1N1 Influenza Outbreak & the Failure to Deliver Medical Countermeasures to Some WA Tribes

A small number of Washington tribes made plans to administer vaccine to elders before children. Some local health jurisdictions (LHJs) responsible for coordinating delivery of vaccines and antivirals to tribes argued this approach would be in conflict with CDC guidelines. On that basis, those LHJs did not distribute MCMs to tribes.

Shortly after this occurred, CDC Director Thomas Frieden issued a letter informing state health officers that American Indians and Alaskan Natives should receive the vaccine on a priority basis (regardless of age). By the time the letter was issued, the problem had already become too entrenched and many tribes never received the vaccines from their neighboring LHJs.



# Project Goal



Assure that tribes, Washington State, and local health jurisdictions work together effectively so the appropriate amount and type of medical countermeasures and materiel reach every Washington tribe quickly during public health emergencies



# Project Objectives

- Strengthen collaboration and mutual aid between Tribes and non-Tribal partners
- Enhance each region's ability to manage and distribute medical countermeasures and materiel
- ***Prevent problems like those experienced during 2009-2010 H1N1 response***



# Project Products

- Partner MCM distribution profiles
- 29 tribes select default access option
- Tabletop exercise scenarios
- After-Action Reports (9)
- Final project report
- Recommendations on how to address Tribal issues in Washington's 2019 statewide full-scale exercise



# Meeting 1 – Desired Outcomes

- Increase partners' understanding of each others' capacity, organization, resources, etc.
- Plan a tabletop exercise



# Meeting 2 – Desired Outcomes

- Test each region’s ability to effectively distribute medical countermeasures and materiel across Tribal and non-Tribal jurisdictions
- Identify potential legal issues/challenges
- Document and provide actionable insight on strengths and areas for improvement
- Test and compare performance in partners who are signatories to Mutual Aid Agreements versus partners who are not





## Part 2

# OVERVIEW OF MCM ACCESS OPTIONS FOR TRIBES

# Tribal Sovereignty and MCMs

- Tribes have the sovereign authority to choose which partners (federal, state, local) they work with in receiving distribution of MCMs
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
Tribe → State

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
State → Tribe

**STATE**  
delivers  
directly to  
TRIBAL  
location

**OPTION 3**  
State → LHJ → Tribe

**STATE** delivers Tribal  
allocation to LHJ

**TRIBE** and LHJ  
coordinate  
conveyance of  
MCMs to TRIBE

**OPTION 4**  
Fed → Tribe

**?**

\*LHJ = Local Health Jurisdiction



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# Option 4

FEDERAL GOVERNMENT TO TRIBE



# Tribal Access to MCM: The CDC Perspective



- As sovereign nations, tribes can request MCM directly from the Strategic National Stockpile
  - CDC would engage all relevant partners to approve best approach
  - Criteria to ensure appropriate and timely distribution and dispensing of MCM must be followed
- CDC shares the goal of tribal, state, and local partners to get MCM to the right people at the right time
  - Whichever strategy is used, coordinating with state HD is essential
  - Roles, responsibilities, and authority must be clearly understood
  - Logistics from federal, state, local, and tribal partners must be considered
    - CDC's goal is to decide what is easiest, fastest, most cost effective, and best meets the need
- In a declared emergency, work with FEMA; in isolated cases, call CDC Emergency Operations Center at 770-488-7100

**Presenter:**

Mark A. Davis  
Chief, Program Services Branch

**Contact:**

Gregory A. Smith  
Tribal Liaison Officer  
Program Services Branch  
Division of State and Local  
Readiness  
Office of Public Health  
Preparedness and Response  
[GQS0@cdc.gov](mailto:GQS0@cdc.gov)

# Federal Government

There is a need for federal guidance that states the following:

- Tribes have the sovereign authority to choose which partners (federal, state, local) they work with in receiving distribution of MCMs
- LHJs/states should CONVEY MCMs only and NOT oversee or assert authority over the dispensing of MCMs.



# Federal Government

What relief is available for tribes if an issue arises regarding distribution of MCMs between a tribe and state or local government?





# Option 1

TRIBE PICKS UP MCM FROM STATE RSS

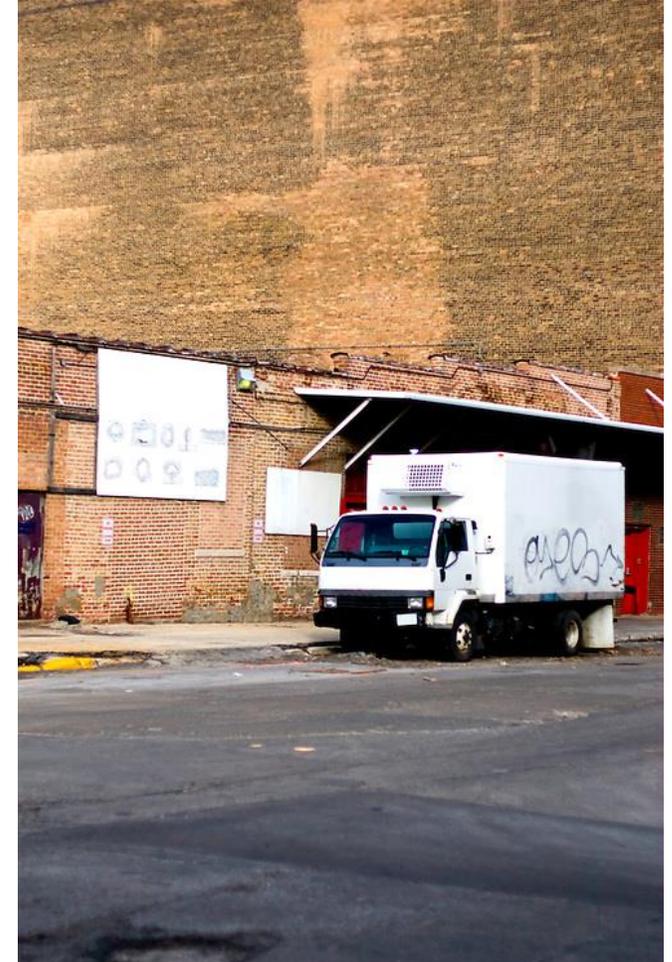
# Distribution

## Option 1, Pickup at the RSS

- Pick-up at the Receive, Stage, Store (RSS) warehouse
  - DSNS delivers MCM to the state RSS
  - DOH operates the RSS
  - Tribal Government operates vehicle to pickup MCM
  - Tribal Government manages the MCM dispensing to members

### **Presenter and Contact:**

David H. Owens  
Emergency Preparedness Specialist  
Emergency Preparedness and Response  
Washington State Department of Health  
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# Option 2

STATE DELIVERS MCM TO TRIBAL LOCATION

# Distribution

## Option 2, RSS direct delivery to Tribe

- Direct delivery to the Tribe:
  - DSNS delivers MCM to the state RSS
  - DOH operates the RSS
  - DOH work with DES to schedule delivery to LHJ Hub and Tribal order/allocation
  - Delivery vehicles drive directly to the Tribal MCM dispensing clinic
  - Tribal staff dispense MCM to members.



### **Presenter and Contact:**

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# Option 3

STATE DELIVERS TRIBAL ALLOCATION OF MCM TO LHJ -  
TRIBE AND LHJ COORDINATE CONVEYANCE OF MCM TO TRIBE

# Distribution Option 3, Pick up at Local Health Jurisdiction Hub

- Pick-up MCM at the LHJ Hub
  - DSNS delivers MCM to the state RSS
  - DOH operates the RSS
  - DOH work with DES to schedule delivery to LHJ Hub and Tribal order/allocation
  - Truck driver signs for load and drives directly to the LHJ Hub
    - Unload MCM completes chain of custody forms
  - Tribal vehicle picks up at LHJ Hub
    - Load MCM complete chain of custody forms
  - Vehicle drives directly to Tribal dispensing site to deliver MCM
  - Tribal staff dispense MCM

**Presenters:**

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Emergency Preparedness Specialist  
Sue Poyner  
Emergency Response Manager  
Thurston County Public Health and Social Services

**Contact:**

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Washington State Department of Health  
[david.owens@doh.wa.gov](mailto:david.owens@doh.wa.gov)



# Part 4

## OPEN DIALOGUE



# Part 5

## NEXT STEPS



# Next Steps

All regions complete Meeting 1

All regions complete Tabletop Exercise

All tribes select default/“placeholder” option

CDC finalize draft guidance and distribute for review



**Thank you!**



**APPENDIX D: PLANNING MEETING PROJECT OVERVIEW**



# Cross Jurisdictional Collaboration Project

## Distributing Medical Countermeasures Across Tribal and Non-Tribal Jurisdictions

January 2018 – June 2018

Lou Schmitz, Consultant

Heather Erb, Legal Consultant



American Indian Health Commission  
for Washington State

# About Us

## **Pulling Together for Wellness**

We are a Tribally-driven, non-profit organization providing a forum for the twenty-nine tribal governments and two urban Indian health programs in Washington State to work together to improve health outcomes for American Indians and Alaska Natives.



# Today's Presentation

**PART 1:** Understanding Medical Countermeasures and Medical Materiel

**PART 2:** Protecting Your Community through Cross-Jurisdictional Collaboration

**PART 3:** Overview of 2017-2018 Cross-Jurisdictional Collaboration Project



American Indian Health Commission  
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# Part 1

## UNDERSTANDING MEDICAL COUNTERMEASURES AND MEDICAL MATERIEL



# Public Health Threats

*Chemical  
Biological  
Radiological  
Nuclear*



*Pandemic  
Influenza*



*Emerging  
Diseases*

**EMERGING & RE-EMERGING  
INFECTIOUS DISEASES**



# Medical Countermeasures

Medical treatments or prophylaxes for public health threats



# Medical Materiel

Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



**2009 H1N1  
Influenza  
Outbreak & the  
Failure to Deliver  
Medical  
Countermeasures  
to Some WA  
Tribes**

A small number of Washington tribes made plans to administer vaccine to elders before children. Some local health jurisdictions (LHJs) responsible for coordinating delivery of vaccines and antivirals to tribes argued this approach would be in conflict with CDC guidelines. On that basis, those LHJs did not distribute the tribes' allocated MCMs to the tribes.



# Our Mission

We must assure that Tribes and all Washington communities receive appropriate and sufficient medical countermeasures and materiel in a timely manner during public health emergencies



# Part 2

## PROTECTING YOUR COMMUNITY THROUGH CROSS-JURISDICTIONAL COLLABORATION



Why is collaboration between Tribes, Local Governments, and the State **vital** to community health and safety?



Every emergency and public health incident is experienced first and is responded to first by local, tribal, and state personnel.

See Homeland Security and Emergency Management, Abbott and Hetzel, p. 5





Public health issues,  
emergencies and  
disasters know **no**  
**boundaries**



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## **Capacity**

No federal, state, local, or tribal government has the capacity to respond to every public health incident or emergency that may occur within its jurisdiction without assistance



## **Cascadia Rising Exercise 2016**

During a catastrophic event, some areas of Washington State may have to wait up to 21 days for state and/or federal assistance





A Local Health Officer has  
**NO JURISDICTION**  
on Tribal lands



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# Collaboration and Preparedness

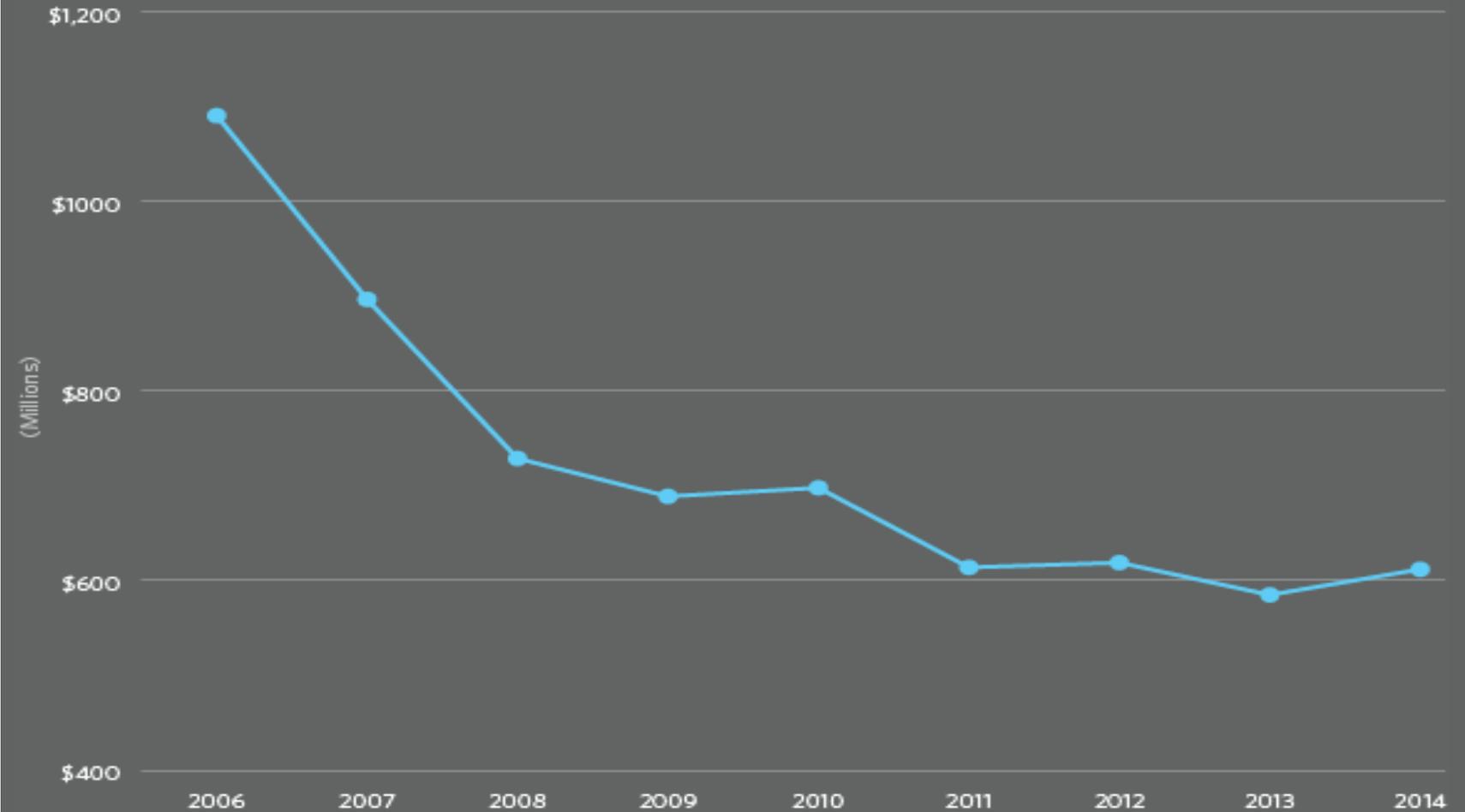
The unfolding of a catastrophic event is a poor time to begin learning how to collaborate with neighboring jurisdictions and knowing their capabilities and available resources



# Diminishing Federal Funding

## Public Health Emergency Preparedness Funding (2006-2014) in Millions

Federal funding to states for infectious disease outbreaks and other public health emergencies has dropped 44 percent since 2006.



Source: U.S. Centers for Disease Control and Prevention

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# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE** and LHJ  
coordinate hand-  
over of MCMs to  
**TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

# **Tribal References within CDC’s “Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11”**

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”



# **Tribal References within CDC’s “Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11”**

## **Distribution**

- “Jurisdictions should coordinate and collaborate with American Indian and Alaska Native (AI/AN) tribes through a memorandum of agreement (MOA) or memorandum of understanding (MOU) that ensures those living on tribal lands will receive MCMs.”
- “the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.”





# Part 3

## OVERVIEW OF 2017-2018 AIHC CROSS-JURISDICTIONAL COLLABORATION PROJECT





## Project Goal

Assure the appropriate amount and type of medical countermeasures and materiel reach every Tribe **quickly** during public health emergencies

# Project Objectives

- Provide clearer guidance to tribes and LHJs on Tribal MCM distribution
- Strengthen collaboration and mutual aid between Tribes and non-Tribal partners
- Enhance each region's ability to manage and distribute medical countermeasures and materiel
- ***Prevent problems like those experienced during 2009-2010 H1N1 response***



# Meeting 1 – Desired Outcomes

- Review options for Tribal MCM distribution
- Increase partners' understanding of each others' capacity, organization, resources, etc.
- Plan a tabletop exercise



# Meeting 2 – Desired Outcomes

- Test each region’s ability to effectively distribute medical countermeasures and materiel across Tribal and non-Tribal jurisdictions
- Identify potential legal issues/challenges
- Document and provide actionable insight on strengths and areas for improvement
- Test and compare performance in partners who are signatories to Mutual Aid Agreements versus partners who are not



# Project Products

- Tribal MCM Distribution Guidance
- Partner profiles
- Tabletop exercise scenario
- After-Action Reports
- Final project report
- Recommendations



# DOH Tribal Medical Countermeasures Distribution Guidance

The purpose of this document is to:

- (1) Provide guidance to tribes and local health jurisdictions on distribution of medical countermeasures to tribes in collaboration with federal, state, and local governments.
- (2) provide tribes with detailed information on the **four options** for distribution of MCMs to their community; and





## **APPENDIX E: WESTERN WASHINGTON TRIBES POWERPOINT**

# **Cross-Jurisdictional Collaboration Project Medical Countermeasures**

---

## **Tabletop Exercise**

**Region 5**

**June 13, 2018**



**American Indian Health Commission**  
for Washington State

# Agenda



**Introductions and Overview**



**Unfolding Situation → Decisions and Responses**



**Break**



**Later Developments → Decisions and Responses**



**Break and Photos**



**Hotwash, Findings and Self-Evaluation**



**Next Steps**

# **Introductions and Overview**





# **Introductions**

- **What is your job title?**
- **How long have you worked in your current position?**
- **What responsibilities do you have related to community emergency preparedness?**

# What are Medical Countermeasures (MCM)?

- Medical treatments or prophylaxes for public health threats
- Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



# Medical Countermeasures and Tribes

- Each time an incident occurs, a tribe has the sovereign authority to choose how medical countermeasures are distributed to their community by federal, state, and or local governments
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for each incident, ensuring the fastest response and protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE and LHJ**  
coordinate  
conveyance of  
MCMs to **TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

## Option 4 → Tribe Contacts Federal Government

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity; **\*SEE FEDERAL REFERENCES BELOW.**

### \*Version 11

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”

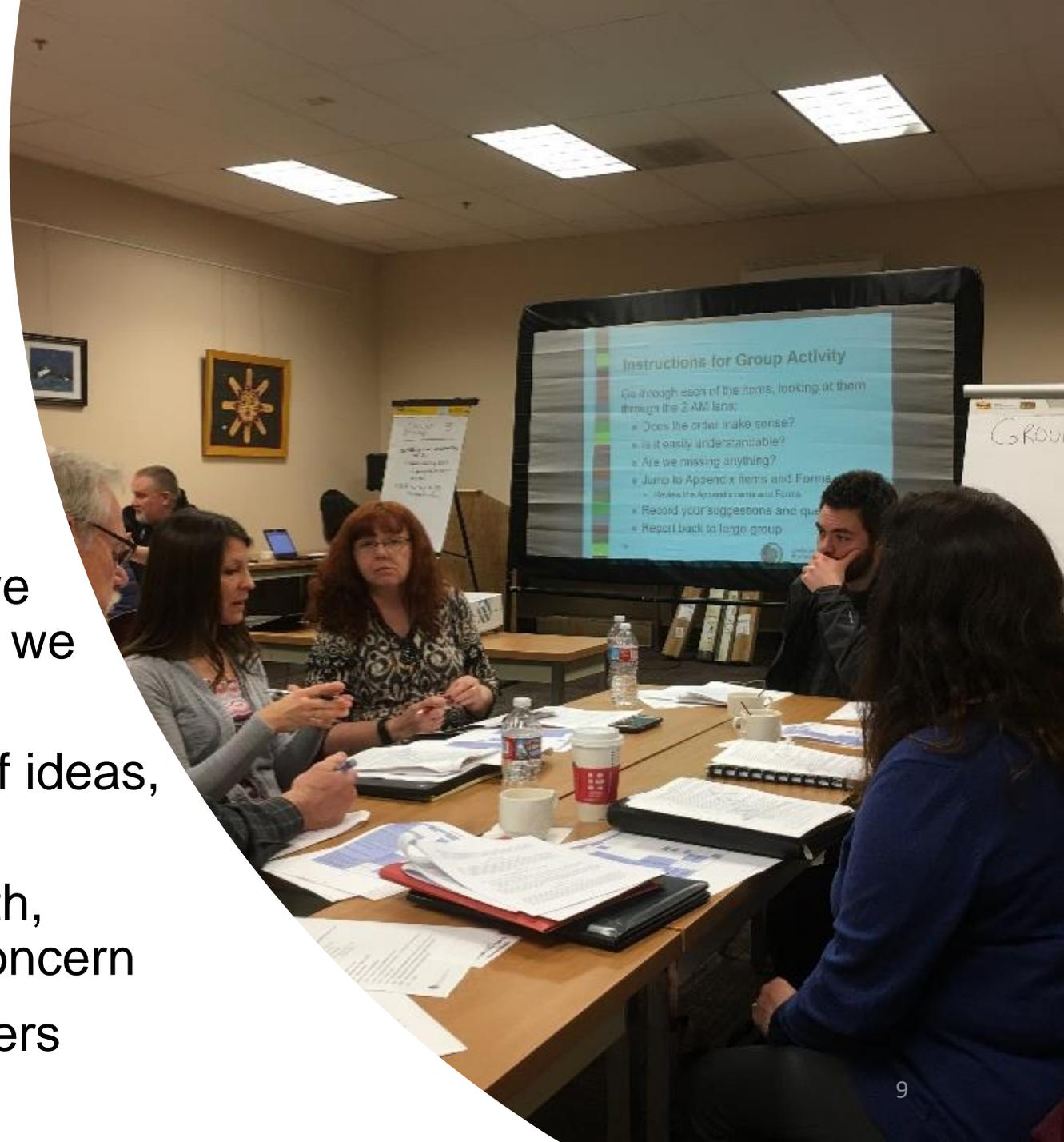
See CDC’s “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5.

“the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.” Version 11, p. 6

**Regardless of the dispensing option chosen, MCMs will be distributed through the system developed by the state health department once an emergency is declared** and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the community has access to MCMs. Version 11, p. 6. *Emphasis added.*

# What is a Tabletop Exercise?

- An informal discussion using a scripted scenario as a catalyst
- Identifies gaps in our plans, issues we have not yet thought about, changes we should make to our plans
- Promotes free and open exchange of ideas, no time pressures
- Opportunity to discuss issues in depth, collaboratively examining areas of concern
- There are no “right” or “wrong” answers



# Purpose of the Tabletop Exercise

Testing communication and MCM distribution processes through a tabletop exercise will increase:

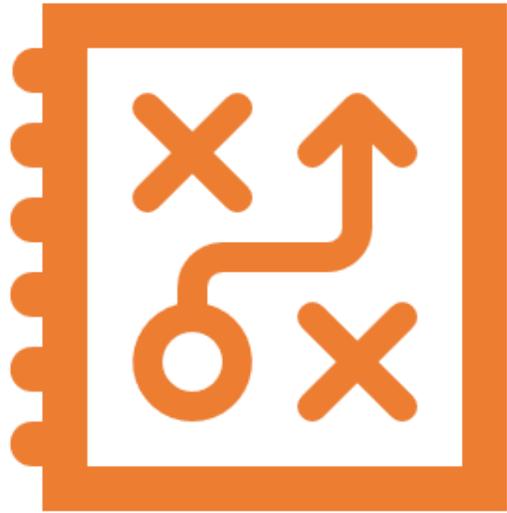
- tribes' understanding of how the different options will work for their communities and strengthen their decision-making at the time of an incident
- tribal, local, and state partners' understanding of how they will interact during MCM distribution



# Specific Objectives

1. Provide an opportunity for the Puyallup Tribe, Pierce County, Tacoma-Pierce County Health Department and WA Department of Health to discuss emergency response coordination ahead of Canoe Journey 2018 hosting
2. Test the region's ability to effectively coordinate distribution of MCM across tribal and nontribal jurisdictions
3. Identify strengths and areas for improvement
4. Identify potential legal issues
5. Test resource- and information-sharing between tribal and non-tribal jurisdictions
6. Have the Tribe make an informed analysis of what will be the most likely option for MCM distribution to its jurisdiction





# Tabletop Scenario



# Assumptions

- The purpose of this exercise is to identify gaps and vulnerabilities
- No jurisdiction is fully prepared for this type of public health emergency
- Open, honest and respectful dialogue and feedback are expected and valued throughout the exercise
- Today's exercise, discussions, and findings will inform future preparedness planning and actions

# Assumptions

- If a tribe requests medical countermeasures directly from the federal government, the federal government will deliver medical countermeasures to one site for the entire State of Washington - the Washington State Receive Stage and Store (RSS) warehouse

(Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives)



# Assumptions



- The Puyallup Tribe will be hosting a large number (as many as 10,000) of Native and non-Native visitors on its lands as part of the Annual Canoe Journey events, mostly between July 28, 2018 and August 4, 2018

# Late July 2018

- There have been no major public health emergencies in your region
- The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations
- The annual tribal canoe journey has brought together participants from around the state and other countries between starting in mid-July, for events along the route
- As many as 10,000 Native and non-Native individuals are expected to participate in the many canoe journey events



## **Day One – July 30, 2018**

A local hospital has admitted two non-Native patients (34 year old female, 19 year old male) with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# Day One Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 1, 2018 Morning**

The hospital has made the diagnosis of pneumonic plague for both non-tribal patients who presented on day one



# Pneumonic plague

Pneumonic plague is a severe lung infection caused by the bacterium *Yersinia pestis*. Symptoms include fever, headache, shortness of breath, chest pain, and cough. They typically start about one to seven days after exposure. It is one of three forms of plague, the other two being septicemic plague and bubonic plague.

Pneumonic plague can be caused in two ways: primary, which results from the inhalation of aerosolized plague bacteria, or secondary, when septicemic plague spreads into lung tissue from the bloodstream. Pneumonic plague is not exclusively vector-borne like bubonic plague; instead it can be spread from person to person.

Pneumonic plague symptoms often include fever, weakness, and headache as well as rapidly developing pneumonia with shortness of breath, cough, and chest pain.

<https://emergency.cdc.gov/agent/plague/factsheet.asp>

<https://www.cdc.gov/plague/faq/index.html>



# **Day Three Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 1, 2018 Afternoon**

The Puyallup Tribe's medical clinic has had two patients (58 year old female, 66 year old male) present with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# **Day Three Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?

# Day Four – August 2, 2018 Morning

- The Puyallup Tribe's medical clinic has had three more patients (female 59, male 64, male 72) present with similar symptoms
- We know one of these 3 Native patients participated in Canoe Journey events (the other 2 we don't know)
- Both tribal patients who presented on Day Three are critically ill
- All 5 tribal patients that have presented with symptoms are ages 55 and older
- One of the non-Native patients that presented at the hospital on Day One participated in Canoe Journey events





# **Day Four Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Four – August 2, 2018 Afternoon**

- Rumors are spreading through social media and in-person
- People are starting to panic
- Traffic problems are happening throughout the region



# **Day Four Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 3, 2018**

- Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington
- Washington State Emergency Management Division (EMD) is now activated – Mission Number has been issued
- DOH Incident Management Team (IMT) is now activated

# Day Five – August 3, 2018



- Three local health jurisdiction employees have called in sick and have been referred to the hospital for care
- Two nurses from the hospital have become ill with the same symptoms
- The two initial tribal clinic patients were diagnosed with pneumonic plague
- Both initial tribal clinic patients attended Canoe Journey events
- Centers for Disease Control and Prevention (CDC) Director publishes a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment; the initial shipment to Washington State will not be sufficient to administer prophylaxis to the entire target population; more will be available in 10-14 days
- Tribal and nontribal health jurisdictions need to request medical countermeasures



# Day Five Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



**Centers for Disease Control (CDC)  
Strategic National Stockpile  
"Push Pack"**

## **Day Six – August 4, 2018**

The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse



# Day Six Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



# Hotwash, Findings and Self-Evaluation

# Next Steps



- AIHC will provide each jurisdiction with their compiled notes and after-action report (AAR)
- Tribe and LHJ complete the Partner Profile Form and return to AIHC ASAP
- Schedule follow-up meeting
- Other?

## **APPENDIX F: EASTERN WASHINGTON TRIBES POWERPOINT**

# **Cross-Jurisdictional Collaboration Project Medical Countermeasures**

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## **Tabletop Exercise**

**May 2018**



**American Indian Health Commission**  
for Washington State

# Agenda



**Introductions and Overview**



**Unfolding Situation → Decisions and Responses**



**Break**



**Later Developments → Decisions and Responses**



**Break and Photos**



**Hotwash, Findings and Self-Evaluation**



**Next Steps**

# **Introductions and Overview**





# **Introductions**

- **What is your job title?**
- **How long have you worked in your current position?**
- **What responsibilities do you have related to community emergency preparedness?**

# What are Medical Countermeasures (MCM)?

- Medical treatments or prophylaxes for public health threats
- Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



# Medical Countermeasures and Tribes

- Each time an incident occurs, a tribe has the sovereign authority to choose how medical countermeasures are distributed to their community by federal, state, and or local governments
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for each incident, ensuring the fastest response and protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE and LHJ**  
coordinate  
conveyance of  
MCMs to **TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

## Option 4 → Tribe Contacts Federal Government

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity; **\*SEE FEDERAL REFERENCES BELOW.**

### \*Version 11

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”

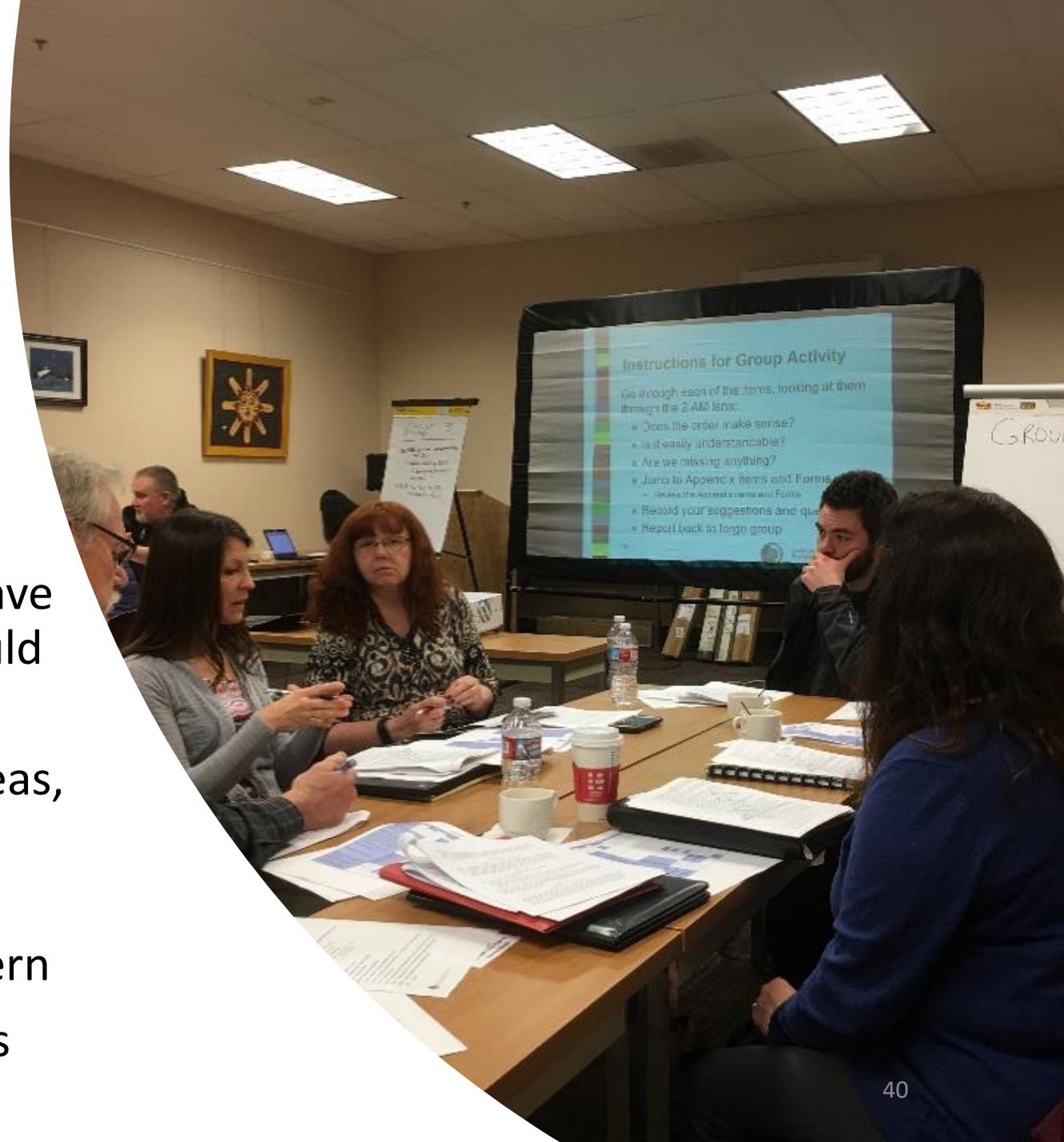
See CDC’s “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, *Version 11, p. 5.*”

“the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.” *Version 11, p. 6*

**Regardless of the dispensing option chosen, MCMs will be distributed through the system developed by the state health department once an emergency is declared** and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the community has access to MCMs. *Version 11, p. 6. Emphasis added.*

# What is a Tabletop Exercise?

- An informal discussion using a scripted scenario as a catalyst
- Identifies gaps in our plans, issues we have not yet thought about, changes we should make to our plans
- Promotes free and open exchange of ideas, no time pressures
- Opportunity to discuss issues in depth, collaboratively examining areas of concern
- There are no “right” or “wrong” answers



# Purpose of the Tabletop Exercise

Testing communication and MCM distribution processes through a tabletop exercise will increase:

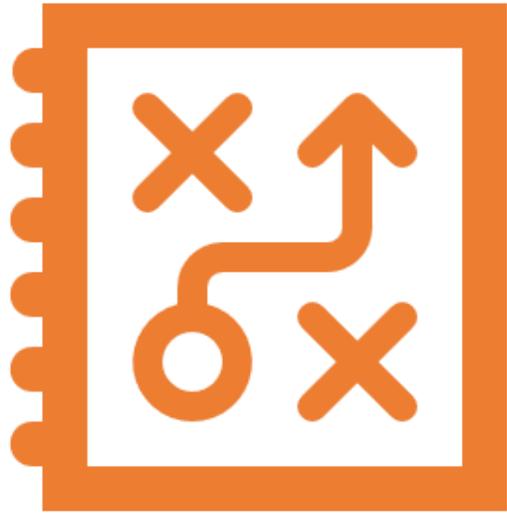
- tribes' understanding of how the different options will work for their communities and strengthen their decision-making at the time of an incident
- tribal, local, and state partners' understanding of how they will interact during MCM distribution



# Specific Objectives

1. Test the region's ability to effectively coordinate distribution of MCM across tribal and nontribal jurisdictions
2. Identify strengths and areas for improvement
3. Identify potential legal issues
4. Test resource- and information-sharing between tribal and non-tribal jurisdictions
5. Have each tribe make an informed analysis of what will be the most likely option for MCM distribution to its jurisdiction





# Tabletop Scenario



# Assumptions

- The purpose of this exercise is to identify gaps and vulnerabilities
- No jurisdiction is fully prepared for this type of public health emergency
- Open, honest and respectful dialogue and feedback are expected and valued throughout the exercise
- Today's exercise, discussions, and findings will inform future preparedness planning and actions

# Assumptions

- If a tribe requests medical countermeasures directly from the federal government, the federal government will deliver medical countermeasures to one site for the entire State of Washington - the Washington State Receive Stage and Store (RSS) warehouse

(Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives)





# Early August 2018

- There have been no major public health emergencies in your region
- The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations
- The annual Omak Stampede has brought together participants from around the state from August 9 to August 12
- Over 8500 Native and non-Native individuals participated in the many Omak Stampede events from across Washington, Idaho, Oregon and Canada



## **Day One – August 16, 2018**

The local hospital has admitted two non-Native patients (34 year old female, 19 year old male) with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# Day One Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 18, 2018 Morning**

The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one



# Pneumonic plague

Pneumonic plague is a severe lung infection caused by the bacterium *Yersinia pestis*. Symptoms include fever, headache, shortness of breath, chest pain, and cough. They typically start about three to seven days after exposure. It is one of three forms of plague, the other two being septicemic plague and bubonic plague.

Pneumonic plague can be caused in two ways: primary, which results from the inhalation of aerosolized plague bacteria, or secondary, when septicemic plague spreads into lung tissue from the bloodstream. Pneumonic plague is not exclusively vector-borne like bubonic plague; instead it can be spread from person to person.

Pneumonic plague symptoms often include fever, weakness, and headache as well as rapidly developing pneumonia with shortness of breath, cough, and chest pain.

<https://emergency.cdc.gov/agent/plague/factsheet.asp>

<https://www.cdc.gov/plague/faq/index.html>



# **Day Three Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 18, 2018 Afternoon**

A tribal clinic has had two patients (58 year old female, 66 year old male) present with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# **Day Three Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?

# Day Four – August 19, 2018

- A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of:
  - high fever
  - severe weakness
  - bloody sputum
  - shortness of breath
  - possible pneumonia
- One of the patients participated in the Stampede
- Both tribal patients who presented on Day Three are critically ill
- All 5 tribal patients that have presented with symptoms are ages 55 and older





# Day Four Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Morning**

- Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington
- Washington State Emergency Management Division (EMD) is now activated – Mission Number has been issued
- DOH Incident Management Team (IMT) is now activated

# Day Five – August 20, 2018

## Morning

- Three local health jurisdiction employees have called in sick and have been referred to the hospital for care
- Two nurses from the hospital have become ill with the same symptoms
- The two initial tribal clinic patients were diagnosed with pneumonic plague
- Both initial tribal patients attended the Stampede
- Centers for Disease Control and Prevention (CDC) Director publishes a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment; the initial shipment to Washington State will be sufficient to administer prophylaxis to 80% of the 25 and younger population in Washington; more will be available in 10-14 days
- Tribal and nontribal health jurisdictions need to request medical countermeasures





# **Day Five Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Afternoon**

- A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS
- A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle



# Day Five Afternoon Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Afternoon**

- A local health jurisdiction needs to request use of tribal staff to dispense medical countermeasures
- A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Six – August 21, 2018**

The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse



# Day Six Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



# **Hotwash, Findings and Self-Evaluation**

# Next Steps



- AIHC will provide each jurisdiction with their compiled notes and after-action report (AAR)
- Tribes and LHJs complete the Partner Profile Form and return to AIHC ASAP
- Other?

## **APPENDIX G: AFTER ACTION REPORTS**



# 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise

After Action Report and Improvement Plan

## Region 1



**American Indian Health Commission  
for Washington State**

*In partnership with*



## Acronyms

Acronym	Definition
AAR	After Action Report
ASPR	Office of the Assistant Secretary for Preparedness and Response
CDC	Center for Disease Control
COOP	Continuity of Operations Plan
DOH	Washington State Department of Health
LHJ	Local Health Jurisdiction
MCM	Medical Countermeasures
POD	Point of Dispensing
PPE	Personal Protective Equipment
RSS	Receive, Stage and Store Warehouse

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## PREFACE

An After Action Report and Improvement Plan (AAR/IP) provide actionable insights for building community preparedness by documenting strengths and areas for improvement that participants identify during a simulated response to an emergency.

This report is tangible evidence of the valuable partnerships that exist between tribes, local governments and Washington State to improve public health preparedness in our communities. It serves as a collection of lessons learned, outlines recommended actions, and provides the basis for planning future exercises. This AAR/IP will contribute to improving future incident responses, training, exercises, equipment prioritization, plan effectiveness and overall preparedness.

The tabletop exercise this AAR documents was part of the American Indian Health Commission's Cross-Jurisdictional Collaboration Project of 2018. The project was facilitated by the American Indian Health Commission for Washington State (AIHC) with funding from the Washington State Department of Health (DOH).

"I have very much appreciated the opportunity to talk, compare, and plan with colleagues at 'neighbor' clinics and to meet and exchange phone numbers with my county LHJ folks."

Stillaguamish Tribe Participant

"This tabletop has opened my eyes on what needs to be done within our county. Meeting people from the tribes has been especially beneficial. We plan to continue to meet and build relationships."

Skagit County Department of Emergency  
Management Participant

The American Indian Health Commission for Washington State wishes to express gratitude and appreciation for the many tribal, local and state partners that participated in this project and invested significant time and effort in support of our shared commitment to protecting the lives of all Washington State citizens.

## SECTION 1: EXERCISE OVERVIEW

Exercise Name	2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise
Exercise Dates	May 24, 2018
Scope	This exercise was a discussion-based tabletop exercise for Region 1, to address coordination and collaboration between the 7 tribes and 5 local health jurisdictions regarding the distribution of medical countermeasures.
Mission Area(s)	Response
Core Capabilities	PHEP Capability 06: Information Sharing PHEP Capability 09: Medical Materiel Management and Distribution
Overarching Objectives	<p>PHEP Capability 06 Information Sharing: Test the ability of federal, state, local, and tribal governments to exchange information and situational awareness data in preparation for, and response to, a plague outbreak.</p> <p>PHEP Capability 09 Medical Materiel Management and Distribution: Test the ability to coordinate logistical operations and medical material requests among federal, state, local, and tribal jurisdictions.</p>
Threat or Hazard	Pneumonic plague
Scenario	<p>The exercise scenario included an outbreak of plague shortly after the annual tribal canoe journey that draws the participation of thousands of Natives and non-Natives from Washington, Idaho, Oregon, Canada and other countries visiting various locations along the Pacific coast of Washington and Puget Sound.</p> <p>A total of 35 individuals participated in the exercise.</p>
Participating Organizations	<p>Nooksack Tribe, Samish Tribe, Stillaguamish Tribe, Swinomish Tribe, Tulalip Tribes, Upper Skagit Tribe</p> <p>Skagit County Public Health Department, Whatcom County Public Health Department, Island County Public Health Department, Snohomish Health District</p> <p>Washington State Department of Health</p>
Point of Contact	Lou Schmitz, Consultant for American Indian Health Commission, <a href="mailto:lou.schmitz.aihc@outlook.com">lou.schmitz.aihc@outlook.com</a>

## SECTION 2: EXERCISE DESIGN AND SCENARIO SUMMARY

### Exercise Purpose and Design

On May 24, 2018, the American Indian Health Commission for Washington State (Commission) in partnership with the Washington State Department of Health (DOH) conducted a public health tabletop exercise where the DOH's Incident Management Team (IMT) was activated, and tribes, DOH, and LHJs coordinated on the distribution of medical countermeasures to tribes.

The exercise was conducted to strengthen the response capabilities of tribal, state, and local governments and to assure the appropriate amount and type of medical countermeasures and materiel reach every tribe quickly during public health emergencies. This exercise was developed and conducted by the Commission, in cooperation with representatives from DOH and various tribal and local governments and organizations.

The exercise was designed to test tribal, state, and local health jurisdiction plans, policies and procedures and provide an opportunity to evaluate current operations concepts, plans, and capabilities in response to a public health incident. The exercise was developed and evaluated utilizing objectives that were identified by tribal, state, and local government representatives.



### Exercise Planning Process

The Commission facilitated a planning meeting at each of the nine public health emergency planning regions for representatives from DOH, tribes and local health jurisdictions. The purpose of the planning meetings was for each region to: (1) increase partners' understanding of the various jurisdictions' capacity, organization, resources, etc; and (2) plan a tabletop exercise. Participants' suggestions were incorporated into the exercise design. The Commission designed the exercise, with technical assistance from DOH on epidemiological and logistical details.

## Exercise Objectives

### Objective 1: PHEP Capability 09 Medical Materiel Management and Distribution

Test the state and region’s ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### Objective 2: PHEP Capability 06 Information Sharing

Test resource and information-sharing between tribal and non-tribal jurisdictions

## Scenario Summary

The scenario for this exercise utilizes a public health incident that involves a population exposure to pneumonic plague. Cascading events require the incident managers and responders to take steps to identify, mitigate the effects of, protect the community from, and respond to the hazard and to acquire prophylaxis through the state medical countermeasures distribution system.

## Assumptions

If a tribe requests medical countermeasures directly from the federal government, the federal government will coordinate with the State and deliver medical countermeasures the Washington State Receive Stage and Store (RSS) warehouse in Tumwater.<sup>1</sup>

## Major and Detailed Events

- **Early August 2018:** There have been no major public health emergencies in the region. The mild winter and the hot and dry summer have caused many of Washington’s regions to experience flea infestations. The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route. Over 2500 Native and non-Native individuals participated in the many canoe journey events.
- **Day One August 6, 2018.** The local hospital has admitted two non-Native patients (34-year-old female, 19-year-old male) with symptoms of: (1) high fever; (2) severe weakness;

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<sup>1</sup> Based on CDC’s guidance “Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11” and discussion with CDC representatives on a March 15, 2018 webinar.

(3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.

- **Day Three August 8, 2018 Morning.** The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one.
- **Day Three August 8, 2018 Afternoon.** A tribal clinic has had two patients (58-year-old female, 66-year-old male) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.
- **Day Four August 9, 2018.** A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia. One of the patients participated in the annual canoe journey. Both tribal patients who presented on Day Three are critically ill. All 5 tribal patients that have presented with symptoms are ages 55 and older.
- **Day Five – August 10, 2018 Morning.** Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington. Washington State Emergency Management Division (EMD) is now activated and a Mission Number has been issued. DOH Incident Management Team (IMT) is now activated.
- **Day Five – August 10, 2018 Morning.** Three local health jurisdiction employees have called in sick and have been referred to the hospital for care. Two nurses from the hospital have become ill with the same symptoms. The two initial tribal clinic patients were diagnosed with pneumonic plague. Both initial tribal patients attended the canoe journey. Centers for Disease Control and Prevention (CDC) Director published a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment. The initial shipment to Washington State will be insufficient to administer prophylaxis to the entire target population. More supplies will be available in 10-14 days. Tribal and nontribal health jurisdictions need to request medical countermeasures.



- **Day Five-August 10, 2018 Afternoon.** A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS. A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle.
- **Day Five-August 10, 2018 Afternoon.** A local health jurisdiction has requested use of tribal staff to dispense medical countermeasures. A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts.
- **Day Six-August 11, 2018.** The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse.

## SECTION 3: KEY FINDINGS

The 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise was developed to assess the capability of tribes, the Washington State Department of Health (DOH), and the local health jurisdictions (LHJs) to coordinate distribution of medical countermeasures to tribal nations during a public health incident. A tabletop exercise was held in each of Washington State's nine (9) public health emergency preparedness regions.

The following objectives that were exercised align with the Centers for Disease Control (CDC) Public Health Emergency Preparedness Capabilities (PHEP):

<b>Exercise Objective</b>	<b>Objective Description</b>	<b>Related PHEP Capability Number/Description</b>
Objective 1	Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.	C09 Medical Materiel Management and Distribution
Objective 2	Test resource and information-sharing between tribal and non-tribal jurisdictions	C06 Information Sharing

This section of the After Action Report (AAR) presents strategic findings as they relate to the tabletop objectives and key issues that were identified as a result of the exercise.

## **MEDICAL MATERIEL MANAGEMENT AND DISTRIBUTION (RELATES TO PHEP CAPABILITY 09).**

Objective 1 of this tabletop exercise tested the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### **Major Strengths**

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** The DOH and almost all LHJs recognized the sovereign authority of tribes to determine who their priority populations are in the dispensing of medical countermeasures, even if that determination may conflict with CDC guidelines. As a result, the DOH and most LHJs stated they will distribute medical countermeasures to the tribe regardless of the tribes' internal decisions regarding priority populations.
- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Most LHJs stated they have the capacity to deliver medical countermeasures to tribes.

### **Primary Areas for Improvement**

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** Not all LHJ representatives understand that their role is limited to transporting and/or handing over tribes' medical countermeasures allocations, unless a tribe specifically requests additional coordination or assistance. Some LHJ participants believe they have legal obligations to ensure that tribes follow CDC recommendations. This lack of understanding resulted in some tribes in Washington State not receiving vaccine and antivirals during the 2009 - 2010 H1N1 pandemic response and can produce catastrophic consequences during future public health incidents, unless corrected.



**2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Some LHJs stated they may not have the capacity to deliver medical countermeasures directly to tribes.

**3. Identification of Tribal Service Population.** Tribal service population numbers can vary greatly from one public health incident to another, due to large events like the annual Canoe Journey, Omak Stampede, pow wows, concerts, tourism, etc. Some LHJs noted the need for a system to inform the LHJs, during a response, specifically which population the tribe will be serving to avoid duplication or gaps.



**4. Medical Countermeasures Plans.** Most local health jurisdictions' medical countermeasures planning documents do not address processes for distribution of medical countermeasures to tribes. Most tribes need to develop and adopt medical countermeasures plans, including a clear process for making decisions during public health incidents regarding how they want their medical countermeasures delivered.

**5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.** There is no clearly documented system in place for including tribes in communication, decision-making, and coordination of efforts during public health incidents and responses.

## Recommendations

### 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.

- a) DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing.
- b) The United States federal government should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the

distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an agency consultation with tribes on these guidelines.

- c) DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government.
- d) DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes.

**2. LHI Capacity to Deliver Medical Countermeasures to Tribes.** The Partner Profile form should be amended to collect from each LHI confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHI. This is key information for the tribe to make plans to pick up the MCM from the LHI, or to choose an alternate option for delivery.

**3. Identification of Tribal Service Population.** DOH should develop and document a streamlined process for tribes to inform DOH of the population they will serve for each specific public health incident.

**4. Medical Countermeasures Plans.** Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.

**5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.**

- a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
- b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.
- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
- d. DOH and the Commission should continue to work with tribes to sign on to the "Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State"

so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.

- e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.

**6. Pharmacy Memorandum of Understanding.** DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU). This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.

**7. Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State.** DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.

**8. Ability to Receive, Manage and Store Medical Countermeasures.** Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.

**9. Staff Training.** Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.



**INFORMATION SHARING BETWEEN JURISDICTIONS (RELATES PHEP CAPABILITY 06).** Objective 2 of this tabletop exercise tested resource and information-sharing between tribal and non-tribal jurisdictions.

### Major Strengths

- 1. Reporting Public Health Incidents to State.** Once the LHJs received notice from the hospitals and/or clinics, all LHJs immediately contacted DOH during the exercise. DOH immediately began coordinating with the LHJs, the hospitals, and the tribes to begin an investigation to share information, determine where the disease originated and initiate response actions.
- 2. Reporting Public Health Incidents to Indian Health Care Providers.** Many LHJs maintain healthcare provider notification systems that include Indian health care providers and other tribal representatives. Tribal partners are eligible to register for the Washington State Department of Health's (DOH's) SECURES health alert system and receive notifications.

### Primary Areas for Improvement

- 1. Reporting Public Health Incident to Indian Health Care Providers.** Not all LHJs have a system in place to ensure all Indian health care providers and other tribal contacts are notified of a public health incident. Also, not every tribe is registered on the Washington State Department of Health's (DOH's) SECURES health alert system.
- 2. Accuracy and Maintenance of Contact List.** There is no system in place for maintaining accurate and current partner contact lists for individuals with key roles during responses. DOH's "Yellow Book" and "Red Book" are published in paper format, and thus not updated in real time. DOH has plans to convert the books to an online system, to be updated quarterly.

### Recommendations

- 1. Reporting Public Health Incidents to Indian Health Care Providers.**
  - a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
  - b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the correct tribal contacts are registered and kept current.

- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
  - d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 2. Accuracy and Maintenance of Contact List.** DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.

## **EMERGENCY PUBLIC INFORMATION AND WARNING (RELATES TO PHEP CAPABILITY 04):**

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.

### **Major Strengths**

- 1. LHJ Public Information Officers.** Some LHJs have public information officers who can quickly manage public information dissemination and provide technical assistance to other jurisdictions in the region that do not have this capability.
- 2. DOH Public Information Resources.** DOH has resources to provide technical assistance to LHJs and tribes regarding public information sharing and messaging.
- 3. Tribes' Knowledge Access to Communicating With Tribal Community Members and Expertise.** Tribes have comprehensive systems in place to communicate with their community members. They also have the knowledge to develop messaging that is respectful of culture and history, and appropriate for their community members.

### **Primary Areas for Improvement**

- 1. Inclusion of Tribes in State and Local Public Information Sharing.** There is no clearly documented system in place for coordination and collaboration on public information and messaging for the tribal communities. It is imperative for LHJs to coordinate with tribes on messaging, to assure respect for culture and history and assure message efficacy. Many tribal community members will disregard or distrust public health messages that do not originate from tribal council or other tribal officials. Health literacy is a critical factor to consider in ensuring community members understand alerts and notices. A strong understanding of the community's culture and historical context are also key. Messages should provide tribal community members with clear guidance on reasonable action steps they can take to protect themselves and others.



2. **Controlling Spread of Misinformation within Tribal Communities.** Tribes voiced concern about controlling information to the public in small communities where information spreads quickly and inaccurately through word of mouth and on social media. This spread of misinformation could result in tribal clinics being overwhelmed. Tribes expressed interest in receiving technical assistance in this area.

## Recommendations

1. **Inclusion of Tribes in State and Local Public Information Sharing.**
  - a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses.
  - b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.
2. **Controlling Spread of Misinformation within Tribal Communities.** The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.

**PUBLIC HEALTH SURVEILLANCE AND EPIDEMIOLOGICAL INVESTIGATION (RELATES TO CAPABILITY 13):** Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

### Major Strengths

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** All LHJs coordinate on some level with tribes when they must go on tribal lands to conduct epidemiological investigations that involve tribal community members. One LHJ partners with a tribe on conducting communicable disease investigations by including a tribal employee to serve as a community liaison. Several participants recognized the importance of having a tribal community liaison available during investigations, since tribal members may be hesitant to communicate with non-tribal members. The tribal community liaison can also be an especially valuable asset, given their knowledge of the community.



### Recommendations

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.

**RESPONDER SAFETY AND HEALTH (RELATES TO PHEP CAPABILITY 14):** The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

### Major Strengths

- 1. Access to Training and Personal Protective Equipment (PPE).** Many tribes and LHJs have access to training and personal protective equipment (PPE) necessary to safely respond to a public health incident.
- 2. Notification of Risk of Exposure to EMS Personnel.** Many tribes and LHJs have a system in place to notify emergency medical services (EMS) personnel before they transport a patient that can expose them to a communicable disease or other potential risk.

### Primary Areas for Improvement

- 1. Access to Training and Personal Protective Equipment (PPE).** Some tribes stated their law enforcement staff (and other potential responders) do not have access to PPE and training on PPE and other precautions needed to safely respond to incidents that may expose them to communicable diseases or other risks.
- 2. Notification of Risk of Exposure to EMS Personnel.** Some tribes and LHJs need to develop and implement standard operating procedures to ensure that EMS and other emergency responders are not exposed to communicable diseases or other potential risks.

### Recommendations

- 1. Access to Training and Personal Protective Equipment (PPE).**
  - a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.
  - b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.
- 2. Notification of Risk of Exposure to EMS Personnel.** All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other

emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.

**MEDICAL SURGE (RELATES TO PHEP CAPABILITY 10):** 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.

### Major Strengths

- 1. Tribal Clinic Capacity and Expertise.** Many tribal clinics are well equipped and staffed to respond to a public health incident, and plan to continue serving their patient population for the duration of most public health incidents.



### Areas for Improvement

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Most tribal clinics do not have Continuity of Operations (COOP) Plans or Crisis Standards of Care to clearly guide their operations during a public health incident.

### Recommendations

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.

## Appendix A: IMPROVEMENT PLAN

The Improvement Plan (IP) specifically details what actions will be taken to address each recommendation presented in the After Action Report (AAR), who or what entity will be responsible for taking the action, and the timeline for completion.

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Medical Materiel Management and Distribution</b> (Relates to PHEP Capability 9)	1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes	a. DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing	a. DOH	10/30/19
		b. The United States federal government (CDC/ASPR) should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an	b. CDC and ASPR	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>agency consultation with tribes on these guidelines.</p> <p>c. DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government</p> <p>d. DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes</p>	<p>c. DOH and Commission</p> <p>d. DOH and Commission</p>	<p>10/30/19</p> <p>12/30/19</p>
	2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.	The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.	DOH and Commission	10/30/19
	3. Identification of Tribal Service Population.	DOH should develop and document a streamlined process for tribes to inform DOH	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		of the population they will serve for each specific public health incident.		
	4. Medical Countermeasures Plans.	Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.	LHJs and Tribes	04/30/19
	5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.	<ul style="list-style-type: none"> <li>a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.</li> <li>b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.</li> <li>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g.</li> </ul>	<ul style="list-style-type: none"> <li>LHJs and Tribes</li> <li>LHJs and Tribes</li> <li>DOH</li> </ul>	<ul style="list-style-type: none"> <li>04/30/19</li> <li>04/30/19</li> <li>06/30/19</li> </ul>

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH and the Commission should continue to work with tribes to sign on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.</p> <p>e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH and Commission</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	6. Pharmacy Memorandum of Understanding	DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU).	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.		
	7 Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State	DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.	DOH and Commission	06/30/19
	8. Ability to Receive, Manage and Store Medical Countermeasures	Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.	Tribes and LHJs	04/30/19
	9. Staff Training	Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.	Tribes and LHJs	04/30/19
Information Sharing between Jurisdictions (Relates to PHEP Capability 6)	1. Reporting Public Health Incidents to Indian Health Care Providers	a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.	Tribes and LHJs	04/30/19
		b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>correct tribal contacts are registered and kept current.</p> <p>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	2. Accuracy and Maintenance of Contact List	DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Emergency Public Information and Warning</b> (Relates to PHEP Capability 4)	1. Inclusion of Tribes in State and Local Public Information Sharing	a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses. .	LHJs and Tribes	04/30/19
		b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.	DOH and Commission	06/30/19
	2. Controlling Spread of Misinformation Within Tribal Communities	The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.	DOH and Commission	6/30/19
<b>Public Health Surveillance and Epidemiological Investigation</b> (Relates to PHEP capability 13)	LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.	LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.	LHJs and Tribes	6/30/19
<b>Responder Safety and Health</b> (Relates to PHEP capability 14)	1. Access to Training and Personal Protective Equipment	a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and	LHJs and Tribes	6/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.</p> <p>b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.</p>	DOH and Commission	06/30/19
	2. Notification of Risk of Exposure to EMS Personnel.	All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.	LHJs and Tribes	6/30/19
<b>Medical Surge</b> (Relates to PHEP capability 10)	Continuity of Operations (COOP) Plans and Crisis Standards of Care	Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.	Tribes	4/30/19

## Appendix B: TABLETOP EXERCISE SLIDES

# **Cross-Jurisdictional Collaboration Project Medical Countermeasures**

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## **Tabletop Exercise**

**May 2018**



**American Indian Health Commission**  
for Washington State

# Agenda



**Introductions and Overview**



**Unfolding Situation → Decisions and Responses**



**Break**



**Later Developments → Decisions and Responses**



**Break and Photos**



**Hotwash, Findings and Self-Evaluation**



**Next Steps**

# **Introductions and Overview**





# **Introductions**

- **What is your job title?**
- **How long have you worked in your current position?**
- **What responsibilities do you have related to community emergency preparedness?**

# What are Medical Countermeasures (MCM)?

- Medical treatments or prophylaxes for public health threats
- Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



# Medical Countermeasures and Tribes

- Each time an incident occurs, a tribe has the sovereign authority to choose how medical countermeasures are distributed to their community by federal, state, and or local governments
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for each incident, ensuring the fastest response and protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE and LHJ**  
coordinate  
conveyance of  
MCMs to **TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

## Option 4 → Tribe Contacts Federal Government

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity; **\*SEE FEDERAL REFERENCES BELOW.**

### \*Version 11

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”

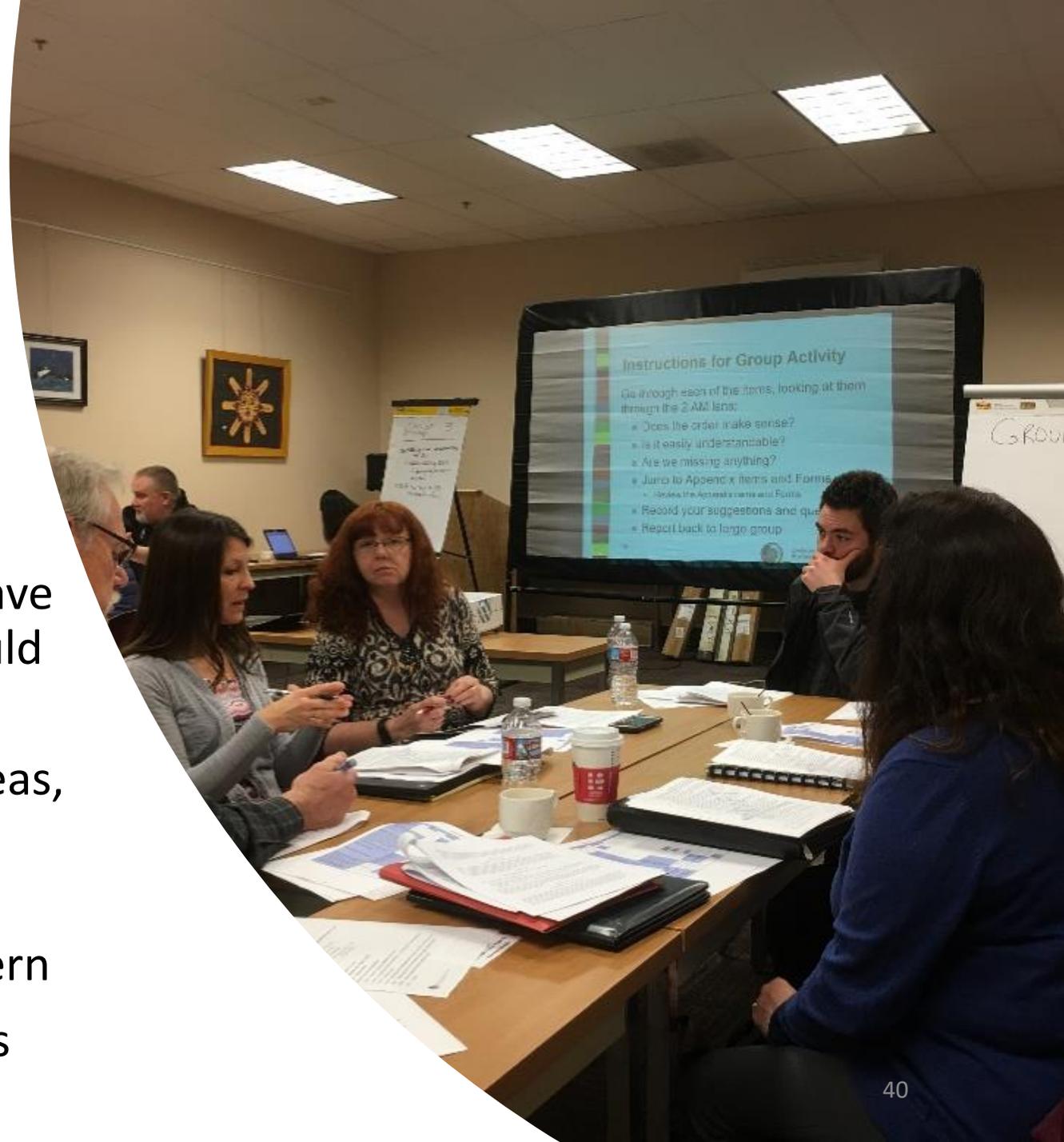
See CDC’s “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5.

“the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.” Version 11, p. 6

**Regardless of the dispensing option chosen, MCMs will be distributed through the system developed by the state health department once an emergency is declared** and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the community has access to MCMs. Version 11, p. 6. *Emphasis added.*

# What is a Tabletop Exercise?

- An informal discussion using a scripted scenario as a catalyst
- Identifies gaps in our plans, issues we have not yet thought about, changes we should make to our plans
- Promotes free and open exchange of ideas, no time pressures
- Opportunity to discuss issues in depth, collaboratively examining areas of concern
- There are no “right” or “wrong” answers



# Purpose of the Tabletop Exercise

Testing communication and MCM distribution processes through a tabletop exercise will increase:

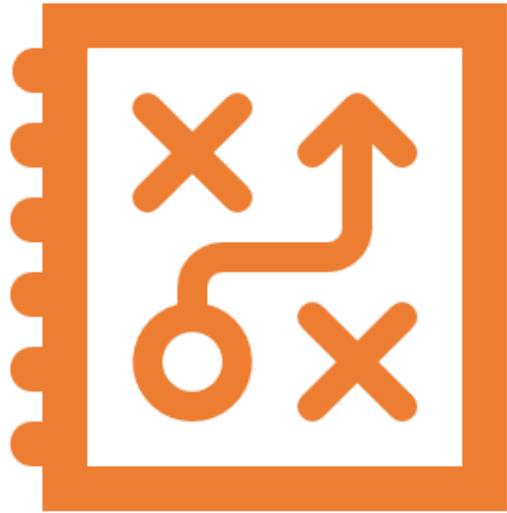
- tribes' understanding of how the different options will work for their communities and strengthen their decision-making at the time of an incident
- tribal, local, and state partners' understanding of how they will interact during MCM distribution



# Specific Objectives

1. Test the region's ability to effectively coordinate distribution of MCM across tribal and nontribal jurisdictions
2. Identify strengths and areas for improvement
3. Identify potential legal issues
4. Test resource- and information-sharing between tribal and non-tribal jurisdictions
5. Have each tribe make an informed analysis of what will be the most likely option for MCM distribution to its jurisdiction





# Tabletop Scenario



# Assumptions

- The purpose of this exercise is to identify gaps and vulnerabilities
- No jurisdiction is fully prepared for this type of public health emergency
- Open, honest and respectful dialogue and feedback are expected and valued throughout the exercise
- Today's exercise, discussions, and findings will inform future preparedness planning and actions

# Assumptions

- If a tribe requests medical countermeasures directly from the federal government, the federal government will deliver medical countermeasures to one site for the entire State of Washington - the Washington State Receive Stage and Store (RSS) warehouse

(Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives)





# Early August 2018

- There have been no major public health emergencies in your region
- The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations
- The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route
- Over 7500 Native and non-Native individuals participated in the many canoe journey events



## **Day One – August 6, 2018**

The local hospital has admitted two non-Native patients (34 year old female, 19 year old male) with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# Day One Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Morning**

The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one



# Pneumonic plague

Pneumonic plague is a severe lung infection caused by the bacterium *Yersinia pestis*. Symptoms include fever, headache, shortness of breath, chest pain, and cough. They typically start about three to seven days after exposure. It is one of three forms of plague, the other two being septicemic plague and bubonic plague.

Pneumonic plague can be caused in two ways: primary, which results from the inhalation of aerosolized plague bacteria, or secondary, when septicemic plague spreads into lung tissue from the bloodstream. Pneumonic plague is not exclusively vector-borne like bubonic plague; instead it can be spread from person to person.

Pneumonic plague symptoms often include fever, weakness, and headache as well as rapidly developing pneumonia with shortness of breath, cough, and chest pain.

<https://emergency.cdc.gov/agent/plague/factsheet.asp>

<https://www.cdc.gov/plague/faq/index.html>



# **Day Three Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Afternoon**

A tribal clinic has had two patients (58 year old female, 66 year old male) present with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



## **Day Three Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?

# Day Four – August 9, 2018

- A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of:
  - high fever
  - severe weakness
  - bloody sputum
  - shortness of breath
  - possible pneumonia
- One of the patients participated in the annual canoe journey
- Both tribal patients who presented on Day Three are critically ill
- All 5 tribal patients that have presented with symptoms are ages 55 and older





# Day Four Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Morning**

- Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington
- Washington State Emergency Management Division (EMD) is now activated – Mission Number has been issued
- DOH Incident Management Team (IMT) is now activated

# Day Five – August 10, 2018

## Morning

- Three local health jurisdiction employees have called in sick and have been referred to the hospital for care
- Two nurses from the hospital have become ill with the same symptoms
- The two initial tribal clinic patients were diagnosed with pneumonic plague
- Both initial tribal patients attended the canoe journey
- Centers for Disease Control and Prevention (CDC) Director publishes a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment; the initial shipment to Washington State will be sufficient to administer prophylaxis to 80% of the 25 and younger population in Washington; more will be available in 10-14 days
- Tribal and nontribal health jurisdictions need to request medical countermeasures





# **Day Five Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS
- A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A local health jurisdiction needs to request use of tribal staff to dispense medical countermeasures
- A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Six – August 11, 2018**

The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse



# Day Six Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



# Hotwash, Findings and Self-Evaluation

# Next Steps

- AIHC will provide each jurisdiction with their compiled notes and after-action report (AAR)
- Tribes and LHJs complete the Partner Profile Form and return to AIHC ASAP
- Other?



## Appendix C: TABLETOP SIGN-IN SHEET



American Indian Health Commission  
For Washington State

## REGION 1

### Cross-Jurisdictional Collaboration Project

#### TABLETOP EXERCISE

May 24, 2018  
SIGN-IN SHEET



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REGION 1

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 24, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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REGION 1

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 24, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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REGION 1

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 24, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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American Indian Health Commission  
For Washington State

# REGION 1

## Cross-Jurisdictional Collaboration Project

### TABLETOP EXERCISE

May 24, 2018  
SIGN-IN SHEET



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# 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise

After Action Report and Improvement Plan

**Region 2**



**American Indian Health Commission  
for Washington State**

*In partnership with*



## Acronyms

Acronym	Definition
AAR	After Action Report
ASPR	Office of the Assistant Secretary for Preparedness and Response
CDC	Center for Disease Control
COOP	Continuity of Operations Plan
DOH	Washington State Department of Health
LHJ	Local Health Jurisdiction
MCM	Medical Countermeasures
POD	Point of Dispensing
PPE	Personal Protective Equipment
RSS	Receive, Stage and Store Warehouse

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## PREFACE

An After Action Report and Improvement Plan (AAR/IP) provide actionable insights for building community preparedness by documenting strengths and areas for improvement that participants identify during a simulated response to an emergency.

This report is tangible evidence of the valuable partnerships that exist between tribes, local governments and Washington State to improve public health preparedness in our communities. It serves as a collection of lessons learned, outlines recommended actions, and provides the basis for planning future exercises. This AAR/IP will contribute to improving future incident responses, training, exercises, equipment prioritization, plan effectiveness and overall preparedness.

The tabletop exercise this AAR documents was part of the American Indian Health Commission's Cross-Jurisdictional Collaboration Project of 2018. The project was facilitated by the American Indian Health Commission for Washington State (AIHC) with funding from the Washington State Department of Health (DOH).

### STRENGTHS

“County leadership supports providing aid to tribal partners during an emergency.”

Clallam County Health Department Participant

“Relationships are already established between tribal public health and emergency preparedness staff with local health jurisdiction personnel.”

Makah Nation Participant

### AREAS FOR IMPROVEMENT

“I love how AIHC redid our Mutual Aid Operational Plan; I wish we had a training webinar for our staff on the Plan.”

Kitsap County Health District Participant

“It would be useful to hold regular exercises and regularly review the Mutual Aid Agreement with regional partners and Tribal Council.”

Port Gamble S’Klallam Tribe Participant

The American Indian Health Commission for Washington State wishes to express gratitude and appreciation for the many tribal, local and state partners that participated in this project and invested significant time and effort in support of our shared commitment to protecting the lives of all Washington State citizens.

## SECTION 1: EXERCISE OVERVIEW

Exercise Name	2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise
Exercise Dates	May 1, 2018
Scope	This exercise was a discussion-based tabletop exercise for Region 2, to address coordination and collaboration between the 8 tribes and 3 local health jurisdictions regarding the distribution of medical countermeasures.
Mission Area(s)	Response
Core Capabilities	PHEP Capability 06: Information Sharing PHEP Capability 09: Medical Materiel Management and Distribution
Overarching Objectives	<p>PHEP Capability 06 Information Sharing: Test the ability of federal, state, local, and tribal governments to exchange information and situational awareness data in preparation for, and response to, a plague outbreak.</p> <p>PHEP Capability 09 Medical Materiel Management and Distribution: Test the ability to coordinate logistical operations and medical material requests among federal, state, local, and tribal jurisdictions.</p>
Threat or Hazard	Pneumonic plague
Scenario	<p>The exercise scenario included an outbreak of plague shortly after the annual tribal canoe journey that draws the participation of thousands of Natives and non-Natives from Washington, Idaho, Oregon, Canada and other countries visiting various locations along the Pacific coast of Washington and Puget Sound.</p> <p>A total of 27 individuals participated in the exercise.</p>
Participating Organizations	Jamestown S’Klallam Tribe, Lower Elwha Klallam Tribe, Makah Nation, Port Gamble S’Klallam Tribe, Suquamish Tribe Clallam County Public Health Department, Jefferson County Public Health Department, Kitsap County Health District Washington State Department of Health
Point of Contact	Lou Schmitz, Consultant for American Indian Health Commission, <a href="mailto:lou.schmitz.aihc@outlook.com">lou.schmitz.aihc@outlook.com</a>

## SECTION 2: EXERCISE DESIGN AND SCENARIO SUMMARY

### Exercise Purpose and Design

On May 1, 2018, the American Indian Health Commission for Washington State (Commission) in partnership with the Washington State Department of Health (DOH) conducted a public health tabletop exercise where the DOH's Incident Management Team (IMT) was activated, and tribes, DOH, and LHJs coordinated on the distribution of medical countermeasures to tribes.

The exercise was conducted to strengthen the response capabilities of tribal, state, and local governments and to assure the appropriate amount and type of medical countermeasures and materiel reach every tribe quickly during public health emergencies. This exercise was developed and conducted by the Commission, in cooperation with representatives from DOH and various tribal and local governments and organizations.

The exercise was designed to test tribal, state, and local health jurisdiction plans, policies and procedures and provide an opportunity to evaluate current operations concepts, plans, and capabilities in response to a public health incident. The exercise was developed and evaluated utilizing objectives that were identified by tribal, state, and local government representatives.



### Exercise Planning Process

The Commission facilitated a planning meeting at each of the nine public health emergency planning regions for representatives from DOH, tribes and local health jurisdictions. The purpose of the planning meetings was for each region to: (1) increase partners' understanding of the various jurisdictions' capacity, organization, resources, etc; and (2) plan a tabletop exercise. Participants' suggestions were incorporated into the exercise design. The Commission designed the exercise, with technical assistance from DOH on epidemiological and logistical details.

## Exercise Objectives

### Objective 1: PHEP Capability 09 Medical Materiel Management and Distribution

Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### Objective 2: PHEP Capability 06 Information Sharing

Test resource and information-sharing between tribal and non-tribal jurisdictions

## Scenario Summary

The scenario for this exercise utilizes a public health incident that involves a population exposure to pneumonic plague. Cascading events require the incident managers and responders to take steps to identify, mitigate the effects of, protect the community from, and respond to the hazard and to acquire prophylaxis through the state medical countermeasures distribution system.

## Assumptions

If a tribe requests medical countermeasures directly from the federal government, the federal government will coordinate with the State and deliver medical countermeasures the Washington State Receive Stage and Store (RSS) warehouse in Tumwater.<sup>1</sup>

## Major and Detailed Events

- **Early August 2018:** There have been no major public health emergencies in the region. The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations. The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route. Over 2500 Native and non-Native individuals participated in the many canoe journey events.
- **Day One August 6, 2018.** The local hospital has admitted two non-Native patients (34-year-old female, 19-year-old male) with symptoms of: (1) high fever; (2) severe weakness;

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<sup>1</sup> Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives on a March 15, 2018 webinar.

(3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.

- **Day Three August 8, 2018 Morning.** The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one.
- **Day Three August 8, 2018 Afternoon.** A tribal clinic has had two patients (58-year-old female, 66-year-old male) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.
- **Day Four August 9, 2018.** A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia. One of the patients participated in the annual canoe journey. Both tribal patients who presented on Day Three are critically ill. All 5 tribal patients that have presented with symptoms are ages 55 and older.
- **Day Five – August 10, 2018 Morning.** Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington. Washington State Emergency Management Division (EMD) is now activated and a Mission Number has been issued. DOH Incident Management Team (IMT) is now activated.
- **Day Five – August 10, 2018 Morning.** Three local health jurisdiction employees have called in sick and have been referred to the hospital for care. Two nurses from the hospital have become ill with the same symptoms. The two initial tribal clinic patients were diagnosed with pneumonic plague. Both initial tribal patients attended the canoe journey. Centers for Disease Control and Prevention (CDC) Director published a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment. The initial shipment to Washington State will be insufficient to administer prophylaxis to the entire target population. More supplies will be available in 10-14 days. Tribal and nontribal health jurisdictions need to request medical countermeasures.



- **Day Five-August 10, 2018 Afternoon.** A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS. A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle.
- **Day Five-August 10, 2018 Afternoon.** A local health jurisdiction has requested use of tribal staff to dispense medical countermeasures. A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts.
- **Day Six-August 11, 2018.** The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse.

## SECTION 3: KEY FINDINGS

The 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise was developed to assess the capability of tribes, the Washington State Department of Health (DOH), and the local health jurisdictions (LHJs) to coordinate distribution of medical countermeasures to tribal nations during a public health incident. A tabletop exercise was held in each of Washington State's nine (9) public health emergency preparedness regions.

The following objectives that were exercised align with the Centers for Disease Control (CDC) Public Health Emergency Preparedness Capabilities (PHEP):

<b>Exercise Objective</b>	<b>Objective Description</b>	<b>Related PHEP Capability Number/Description</b>
Objective 1	Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.	C09 Medical Materiel Management and Distribution
Objective 2	Test resource and information-sharing between tribal and non-tribal jurisdictions	C06 Information Sharing

This section of the After Action Report (AAR) presents strategic findings as they relate to the tabletop objectives and key issues that were identified as a result of the exercise.

## **MEDICAL MATERIEL MANAGEMENT AND DISTRIBUTION (RELATES TO PHEP CAPABILITY 09).**

Objective 1 of this tabletop exercise tested the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### **Major Strengths**

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** The DOH and almost all LHJs recognized the sovereign authority of tribes to determine who their priority populations are in the dispensing of medical countermeasures, even if that determination may conflict with CDC guidelines. As a result, the DOH and most LHJs stated they will distribute medical countermeasures to the tribe regardless of the tribes' internal decisions regarding priority populations.
- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Most LHJs stated they have the capacity to deliver medical countermeasures to tribes.

### **Primary Areas for Improvement**

#### **1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.**

Not all LHJ representatives understand that their role is limited to transporting and/or handing over tribes' medical countermeasures allocations, unless a tribe specifically requests additional coordination or assistance. Some LHJ participants believe they have legal obligations to ensure that tribes follow CDC recommendations. This lack of understanding resulted in some tribes in Washington State not receiving vaccine and antivirals during the 2009 - 2010 H1N1 pandemic response and can produce catastrophic consequences during future public health incidents, unless corrected.



- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Some LHJs stated they may not have the capacity to deliver medical countermeasures directly to tribes.

**3. Identification of Tribal Service Population.** Tribal service population numbers can vary greatly from one public health incident to another, due to large events like the annual Canoe Journey, Omak Stampede, pow wows, concerts, tourism, etc. Some LHJs noted the need for a system to inform the LHJs, during a response, specifically which population the tribe will be serving to avoid duplication or gaps.



**4. Medical Countermeasures Plans.** Most local health jurisdictions' medical countermeasures planning documents do not address processes for distribution of medical countermeasures to tribes. Most tribes need to develop and adopt medical countermeasures plans, including a clear process for making decisions during public health incidents regarding how they want their medical countermeasures delivered.

**5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.** There is no clearly documented system in place for including tribes in communication, decision-making, and coordination of efforts during public health incidents and responses.

## Recommendations

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.**
  - a) DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing.
  - b) The United States federal government should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a

process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an agency consultation with tribes on these guidelines.

- c) DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government.
- d) DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes.

**2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.

**3. Identification of Tribal Service Population.** DOH should develop and document a streamlined process for tribes to inform DOH of the population they will serve for each specific public health incident.

**4. Medical Countermeasures Plans.** Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.

**5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.**

- a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
- b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.
- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
- d. DOH and the Commission should continue to work with tribes to sign on to the "Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State" so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.

- e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 6. Pharmacy Memorandum of Understanding.** DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU). This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.
- 7. Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State.** DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.
- 8. Ability to Receive, Manage and Store Medical Countermeasures.** Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.
- 9. Staff Training.** Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.



**INFORMATION SHARING BETWEEN JURISDICTIONS (RELATES PHEP CAPABILITY 06).** Objective 2 of this tabletop exercise tested resource and information-sharing between tribal and non-tribal jurisdictions.

### Major Strengths

- 1. Reporting Public Health Incidents to State.** Once the LHJs received notice from the hospitals and/or clinics, all LHJs immediately contacted DOH during the exercise. DOH immediately began coordinating with the LHJs, the hospitals, and the tribes to begin an investigation to share information, determine where the disease originated and initiate response actions.
- 2. Reporting Public Health Incidents to Indian Health Care Providers.** Many LHJs maintain healthcare provider notification systems that include Indian health care providers and other tribal representatives. Tribal partners are eligible to register for the Washington State Department of Health's (DOH's) SECURES health alert system and receive notifications.

### Primary Areas for Improvement

- 1. Reporting Public Health Incident to Indian Health Care Providers.** Not all LHJs have a system in place to ensure all Indian health care providers and other tribal contacts are notified of a public health incident. Also, not every tribe is registered on the Washington State Department of Health's (DOH's) SECURES health alert system.
- 2. Accuracy and Maintenance of Contact List.** There is no system in place for maintaining accurate and current partner contact lists for individuals with key roles during responses. DOH's "Yellow Book" and "Red Book" are published in paper format, and thus not updated in real time. DOH has plans to convert the books to an online system, to be updated quarterly.

### Recommendations

- 1. Reporting Public Health Incidents to Indian Health Care Providers.**
  - a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
  - b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the correct tribal contacts are registered and kept current.

- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
  - d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 2. Accuracy and Maintenance of Contact List.** DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.

## **EMERGENCY PUBLIC INFORMATION AND WARNING (RELATES TO PHEP CAPABILITY 04):**

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.

### **Major Strengths**

- 1. LHJ Public Information Officers.** Some LHJs have public information officers who can quickly manage public information dissemination and provide technical assistance to other jurisdictions in the region that do not have this capability.
- 2. DOH Public Information Resources.** DOH has resources to provide technical assistance to LHJs and tribes regarding public information sharing and messaging.
- 3. Tribes' Knowledge Access to Communicating With Tribal Community Members and Expertise.** Tribes have comprehensive systems in place to communicate with their community members. They also have the knowledge to develop messaging that is respectful of culture and history, and appropriate for their community members.

### **Primary Areas for Improvement**

- 1. Inclusion of Tribes in State and Local Public Information Sharing.** There is no clearly documented system in place for coordination and collaboration on public information and messaging for the tribal communities. It is imperative for LHJs to coordinate with tribes on messaging, to assure respect for culture and history and assure message efficacy. Many tribal community members will disregard or distrust public health messages that do not originate from tribal council or other tribal officials. Health literacy is a critical factor to consider in ensuring community members understand alerts and notices. A strong understanding of the community's culture and historical context are also key. Messages should provide tribal community members with clear guidance on reasonable action steps they can take to protect themselves and others.



2. **Controlling Spread of Misinformation within Tribal Communities.** Tribes voiced concern about controlling information to the public in small communities where information spreads quickly and inaccurately through word of mouth and on social media. This spread of misinformation could result in tribal clinics being overwhelmed. Tribes expressed interest in receiving technical assistance in this area.

## Recommendations

1. **Inclusion of Tribes in State and Local Public Information Sharing.**
  - a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses.
  - b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.
2. **Controlling Spread of Misinformation within Tribal Communities.** The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.

**PUBLIC HEALTH SURVEILLANCE AND EPIDEMIOLOGICAL INVESTIGATION (RELATES TO CAPABILITY 13):** Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

### Major Strengths

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** All LHJs coordinate on some level with tribes when they must go on tribal lands to conduct epidemiological investigations that involve tribal community members. One LHJ partners with a tribe on conducting communicable disease investigations by including a tribal employee to serve as a community liaison. Several participants recognized the importance of having a tribal community liaison available during investigations, since tribal members may be hesitant to communicate with non-tribal members. The tribal community liaison can also be an especially valuable asset, given their knowledge of the community.

### Recommendations

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.



**RESPONDER SAFETY AND HEALTH (RELATES TO PHEP CAPABILITY 14):** The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

### Major Strengths

- 1. Access to Training and Personal Protective Equipment (PPE).** Many tribes and LHJs have access to training and personal protective equipment (PPE) necessary to safely respond to a public health incident.
- 2. Notification of Risk of Exposure to EMS Personnel.** Many tribes and LHJs have a system in place to notify emergency medical services (EMS) personnel before they transport a patient that can expose them to a communicable disease or other potential risk.

### Primary Areas for Improvement

- 1. Access to Training and Personal Protective Equipment (PPE).** Some tribes stated their law enforcement staff (and other potential responders) do not have access to PPE and training on PPE and other precautions needed to safely respond to incidents that may expose them to communicable diseases or other risks.
- 2. Notification of Risk of Exposure to EMS Personnel.** Some tribes and LHJs need to develop and implement standard operating procedures to ensure that EMS and other emergency responders are not exposed to communicable diseases or other potential risks.

### Recommendations

- 1. Access to Training and Personal Protective Equipment (PPE).**
  - a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.
  - b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.
- 2. Notification of Risk of Exposure to EMS Personnel.** All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other

emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.

**MEDICAL SURGE (RELATES TO PHEP CAPABILITY 10):** 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.

### Major Strengths

- 1. Tribal Clinic Capacity and Expertise.** Many tribal clinics are well equipped and staffed to respond to a public health incident, and plan to continue serving their patient population for the duration of most public health incidents.



### Areas for Improvement

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Most tribal clinics do not have Continuity of Operations (COOP) Plans or Crisis Standards of Care to clearly guide their operations during a public health incident.

### Recommendations

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.

## Appendix A: IMPROVEMENT PLAN

The Improvement Plan (IP) specifically details what actions will be taken to address each recommendation presented in the After Action Report (AAR), who or what entity will be responsible for taking the action, and the timeline for completion.

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Medical Materiel Management and Distribution</b> (Relates to PHEP Capability 9)	1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes	a. DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing	a. DOH	10/30/19
		b. The United States federal government (CDC/ASPR) should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an	b. CDC and ASPR	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>agency consultation with tribes on these guidelines.</p> <p>c. DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government</p> <p>d. DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes</p>	<p>c. DOH and Commission</p> <p>d. DOH and Commission</p>	<p>10/30/19</p> <p>12/30/19</p>
	2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.	The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.	DOH and Commission	10/30/19
	3. Identification of Tribal Service Population.	DOH should develop and document a streamlined process for tribes to inform DOH	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		of the population they will serve for each specific public health incident.		
	4. Medical Countermeasures Plans.	Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.	LHJs and Tribes	04/30/19
	5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.	<ul style="list-style-type: none"> <li>a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.</li> <li>b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.</li> <li>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g.</li> </ul>	<ul style="list-style-type: none"> <li>LHJs and Tribes</li> <li>LHJs and Tribes</li> <li>DOH</li> </ul>	<ul style="list-style-type: none"> <li>04/30/19</li> <li>04/30/19</li> <li>06/30/19</li> </ul>

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH and the Commission should continue to work with tribes to sign on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.</p> <p>e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH and Commission</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	6. Pharmacy Memorandum of Understanding	DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU).	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.		
	7 Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State	DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.	DOH and Commission	06/30/19
	8. Ability to Receive, Manage and Store Medical Countermeasures	Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.	Tribes and LHJs	04/30/19
	9. Staff Training	Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.	Tribes and LHJs	04/30/19
Information Sharing between Jurisdictions (Relates to PHEP Capability 6)	1. Reporting Public Health Incidents to Indian Health Care Providers	a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.	Tribes and LHJs	04/30/19
		b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>correct tribal contacts are registered and kept current.</p> <p>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	2. Accuracy and Maintenance of Contact List	DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Emergency Public Information and Warning</b> (Relates to PHEP Capability 4)	1. Inclusion of Tribes in State and Local Public Information Sharing	a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses. .	LHJs and Tribes	04/30/19
		b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.	DOH and Commission	06/30/19
	2. Controlling Spread of Misinformation Within Tribal Communities	The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.	DOH and Commission	6/30/19
<b>Public Health Surveillance and Epidemiological Investigation</b> (Relates to PHEP capability 13)	LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.	LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.	LHJs and Tribes	6/30/19
<b>Responder Safety and Health</b> (Relates to PHEP capability 14)	1. Access to Training and Personal Protective Equipment	a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and	LHJs and Tribes	6/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.</p> <p>b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.</p>	DOH and Commission	06/30/19
	2. Notification of Risk of Exposure to EMS Personnel.	All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.	LHJs and Tribes	6/30/19
<b>Medical Surge</b> (Relates to PHEP capability 10)	Continuity of Operations (COOP) Plans and Crisis Standards of Care	Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.	Tribes	4/30/19

Appendix B: TABLETOP EXERCISE SLIDES

# **Cross-Jurisdictional Collaboration Project Medical Countermeasures**

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## **Tabletop Exercise**

**May 2018**



**American Indian Health Commission**  
for Washington State

# Agenda



**Introductions and Overview**



**Unfolding Situation → Decisions and Responses**



**Break**



**Later Developments → Decisions and Responses**



**Break and Photos**



**Hotwash, Findings and Self-Evaluation**



**Next Steps**

# **Introductions and Overview**





# **Introductions**

- **What is your job title?**
- **How long have you worked in your current position?**
- **What responsibilities do you have related to community emergency preparedness?**

# What are Medical Countermeasures (MCM)?

- Medical treatments or prophylaxes for public health threats
- Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



# Medical Countermeasures and Tribes

- Each time an incident occurs, a tribe has the sovereign authority to choose how medical countermeasures are distributed to their community by federal, state, and or local governments
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for each incident, ensuring the fastest response and protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE and LHJ**  
coordinate  
conveyance of  
MCMs to **TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

## Option 4 → Tribe Contacts Federal Government

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity; **\*SEE FEDERAL REFERENCES BELOW.**

### \*Version 11

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”

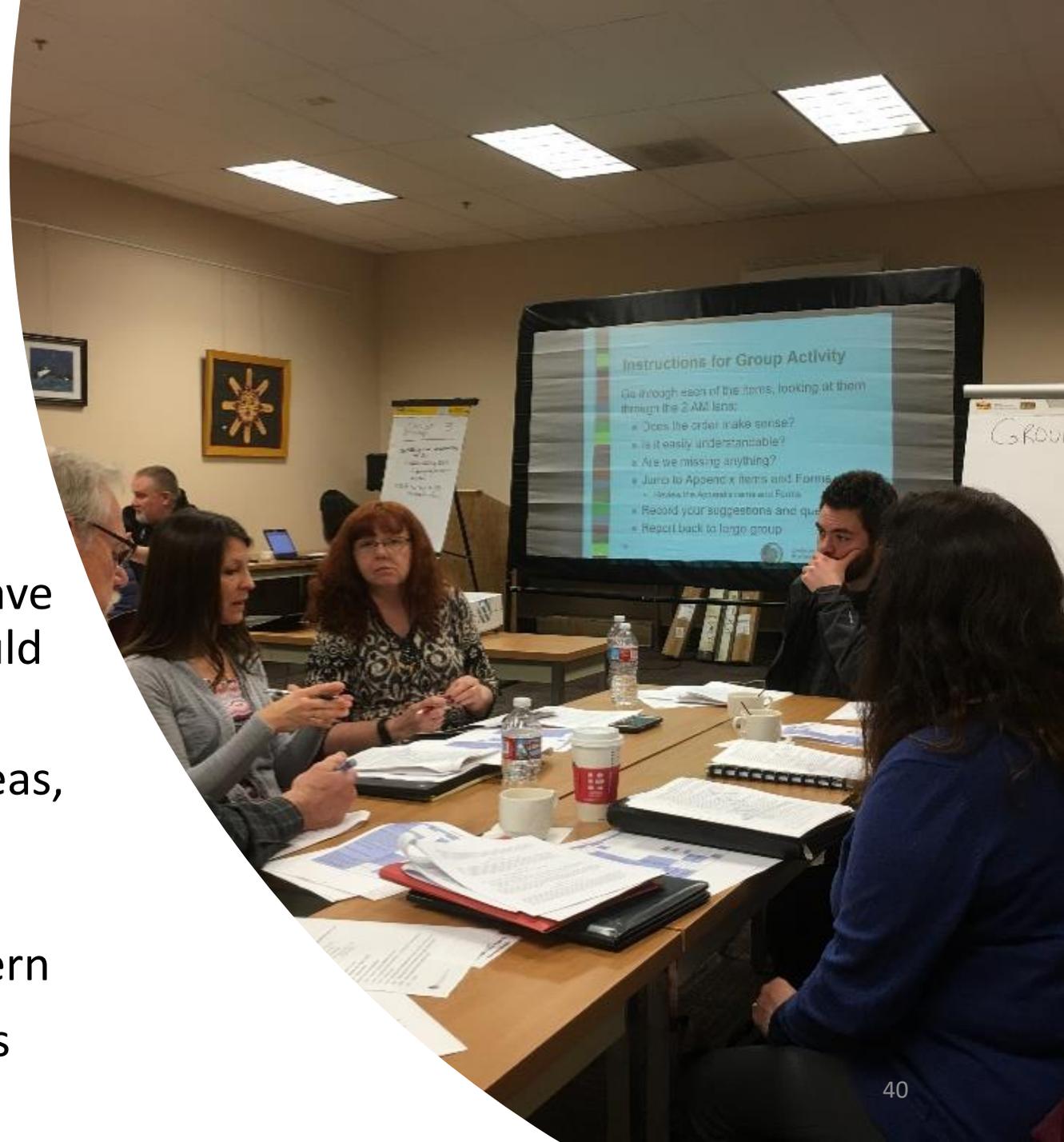
See CDC’s “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5.

“the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.” Version 11, p. 6

**Regardless of the dispensing option chosen, MCMs will be distributed through the system developed by the state health department once an emergency is declared** and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the community has access to MCMs. Version 11, p. 6. *Emphasis added.*

# What is a Tabletop Exercise?

- An informal discussion using a scripted scenario as a catalyst
- Identifies gaps in our plans, issues we have not yet thought about, changes we should make to our plans
- Promotes free and open exchange of ideas, no time pressures
- Opportunity to discuss issues in depth, collaboratively examining areas of concern
- There are no “right” or “wrong” answers



# Purpose of the Tabletop Exercise

Testing communication and MCM distribution processes through a tabletop exercise will increase:

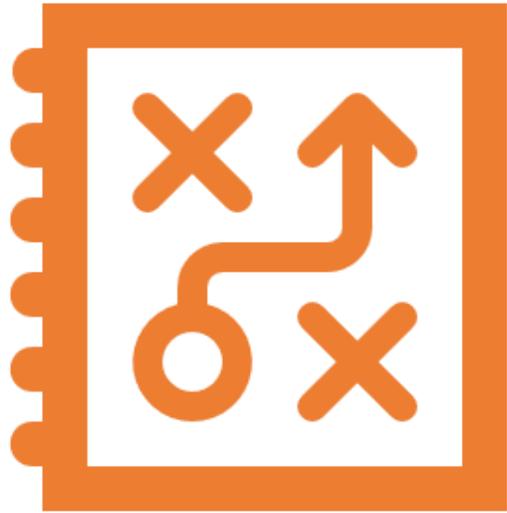
- tribes' understanding of how the different options will work for their communities and strengthen their decision-making at the time of an incident
- tribal, local, and state partners' understanding of how they will interact during MCM distribution



# Specific Objectives

1. Test the region's ability to effectively coordinate distribution of MCM across tribal and nontribal jurisdictions
2. Identify strengths and areas for improvement
3. Identify potential legal issues
4. Test resource- and information-sharing between tribal and non-tribal jurisdictions
5. Have each tribe make an informed analysis of what will be the most likely option for MCM distribution to its jurisdiction





# Tabletop Scenario



# Assumptions

- The purpose of this exercise is to identify gaps and vulnerabilities
- No jurisdiction is fully prepared for this type of public health emergency
- Open, honest and respectful dialogue and feedback are expected and valued throughout the exercise
- Today's exercise, discussions, and findings will inform future preparedness planning and actions

# Assumptions

- If a tribe requests medical countermeasures directly from the federal government, the federal government will deliver medical countermeasures to one site for the entire State of Washington - the Washington State Receive Stage and Store (RSS) warehouse

(Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives)





# Early August 2018

- There have been no major public health emergencies in your region
- The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations
- The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route
- Over 7500 Native and non-Native individuals participated in the many canoe journey events



## **Day One – August 6, 2018**

The local hospital has admitted two non-Native patients (34 year old female, 19 year old male) with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# Day One Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Morning**

The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one



# Pneumonic plague

Pneumonic plague is a severe lung infection caused by the bacterium *Yersinia pestis*. Symptoms include fever, headache, shortness of breath, chest pain, and cough. They typically start about three to seven days after exposure. It is one of three forms of plague, the other two being septicemic plague and bubonic plague.

Pneumonic plague can be caused in two ways: primary, which results from the inhalation of aerosolized plague bacteria, or secondary, when septicemic plague spreads into lung tissue from the bloodstream. Pneumonic plague is not exclusively vector-borne like bubonic plague; instead it can be spread from person to person.

Pneumonic plague symptoms often include fever, weakness, and headache as well as rapidly developing pneumonia with shortness of breath, cough, and chest pain.

<https://emergency.cdc.gov/agent/plague/factsheet.asp>

<https://www.cdc.gov/plague/faq/index.html>



# **Day Three Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Afternoon**

A tribal clinic has had two patients (58 year old female, 66 year old male) present with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



## **Day Three Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?

# Day Four – August 9, 2018

- A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of:
  - high fever
  - severe weakness
  - bloody sputum
  - shortness of breath
  - possible pneumonia
- One of the patients participated in the annual canoe journey
- Both tribal patients who presented on Day Three are critically ill
- All 5 tribal patients that have presented with symptoms are ages 55 and older





# Day Four Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Morning**

- Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington
- Washington State Emergency Management Division (EMD) is now activated – Mission Number has been issued
- DOH Incident Management Team (IMT) is now activated

# Day Five – August 10, 2018

## Morning

- Three local health jurisdiction employees have called in sick and have been referred to the hospital for care
- Two nurses from the hospital have become ill with the same symptoms
- The two initial tribal clinic patients were diagnosed with pneumonic plague
- Both initial tribal patients attended the canoe journey
- Centers for Disease Control and Prevention (CDC) Director publishes a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment; the initial shipment to Washington State will be sufficient to administer prophylaxis to 80% of the 25 and younger population in Washington; more will be available in 10-14 days
- Tribal and nontribal health jurisdictions need to request medical countermeasures





# **Day Five Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS
- A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A local health jurisdiction needs to request use of tribal staff to dispense medical countermeasures
- A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Six – August 11, 2018**

The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse



# Day Six Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



# **Hotwash, Findings and Self-Evaluation**

# Next Steps

- AIHC will provide each jurisdiction with their compiled notes and after-action report (AAR)
- Tribes and LHJs complete the Partner Profile Form and return to AIHC ASAP
- Other?



## Appendix C: TABLETOP SIGN-IN SHEET

REGION 2

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 1, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
Misty Eves	HR Representative Neo-Kayet Development Corp.	mives@pgst.nsn.us
Kim Wiewolf	Special Projects & Grants Coord PGST Health Services	kfwiewolf@pgst.nsn.us
Adele Stokes	Health prevention specialist PGST Health Services	adeles@pgst.nsn.us
Kerstin Powell	Health SVCS Mgr	kerstin@pgst.nsn.us
John J Folz	Facilities Manager	john@Neo-Kayet.com
SAM WHITE	PGST-CHIEF OF POLICE	SWHITE@PGST.NSN.US
Renee Veregge	Special Projects/SEA Coordinator & Tribal Council	reneev@pgst.nsn.us
STAR HAMON	PGST BCSP DATA SPECIALIST	starla@PgSt.nsn.us
Julia Danskin	Jefferson County Local emergency Response Coordinator	jdanskin@co.jefferson.wa.us



American Indian Health Commission  
For Washington State

REGION 2

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 1, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
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Kelly Sullivan	Exec Director PGST	sullyk@pgst.nsn.us
Jessica Guidry	Public Health Emergency Prep & Response Program Manager <sup>Kitap PH</sup>	jessica.guidry@kitsappublichealth.org
Amy Anderson	Training & Exercise Specialist - PHEPR KPHD	amy.anderson@kitsappublichealth.org
Susan Turner MD	Health Officer	susanturner@ " "
Cherrie May	Emerg. mgmt. Coordinator	cmay@Squamish.nsn.us
Jen Garcelon	Clallam Local Emerg. Resp. Coordinator	jgarcelon@co.clallam.wa.us
Janyce Wisecup	Emergency Mgt. Program Coordinator	jwisecup@co.clallam.wa.us



American Indian Health Commission  
For Washington State

REGION 2

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 1, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
CHRIS FRANK	Health officer	cfrank@co.clallam.wa.us
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# 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise

After Action Report and Improvement Plan

**Region 3**



**American Indian Health Commission  
for Washington State**

*In partnership with*



## Acronyms

Acronym	Definition
AAR	After Action Report
ASPR	Office of the Assistant Secretary for Preparedness and Response
CDC	Center for Disease Control
COOP	Continuity of Operations Plan
DOH	Washington State Department of Health
LHJ	Local Health Jurisdiction
MCM	Medical Countermeasures
POD	Point of Dispensing
PPE	Personal Protective Equipment
RSS	Receive, Stage and Store Warehouse

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## PREFACE

An After Action Report and Improvement Plan (AAR/IP) provide actionable insights for building community preparedness by documenting strengths and areas for improvement that participants identify during a simulated response to an emergency.

This report is tangible evidence of the valuable partnerships that exist between tribes, local governments and Washington State to improve public health preparedness in our communities. It serves as a collection of lessons learned, outlines recommended actions, and provides the basis for planning future exercises. This AAR/IP will contribute to improving future incident responses, training, exercises, equipment prioritization, plan effectiveness and overall preparedness.

The tabletop exercise this AAR documents was part of the American Indian Health Commission's Cross-Jurisdictional Collaboration Project of 2018. The project was facilitated by the American Indian Health Commission for Washington State (AIHC) with funding from the Washington State Department of Health (DOH).

## AREAS FOR IMPROVEMENT

“The tribes should be part of cobbling together the communications message.”

Lewis County Health Department Participant

“We need to work more with neighboring jurisdictions on exercises.”

Shoalwater Bay Tribe Participant

## STRENGTHS

“Participating in these meetings with other Region 3 partners helps us all become more familiar with the others' operations and circumstances.”

Chehalis Tribe Participant

“We are committed to respecting the autonomy and authority of other Nations and jurisdictions and will actively collaborate or assist as best we can.”

Grays Harbor Public Health Department Participant

The American Indian Health Commission for Washington State wishes to express gratitude and appreciation for the many tribal, local and state partners that participated in this project and invested significant time and effort in support of our shared commitment to protecting the lives of all Washington State citizens.

## SECTION 1: EXERCISE OVERVIEW

Exercise Name	2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise
Exercise Dates	May 8, 2018
Scope	This exercise was a discussion-based tabletop exercise for Region 3, to address coordination and collaboration between the 6 tribes and 5 local health jurisdictions regarding the distribution of medical countermeasures.
Mission Area(s)	Response
Core Capabilities	PHEP Capability 06: Information Sharing PHEP Capability 09: Medical Materiel Management and Distribution
Overarching Objectives	PHEP Capability 06 Information Sharing: Test the ability of federal, state, local, and tribal governments to exchange information and situational awareness data in preparation for, and response to, a plague outbreak.  PHEP Capability 09 Medical Materiel Management and Distribution: Test the ability to coordinate logistical operations and medical material requests among federal, state, local, and tribal jurisdictions.
Threat or Hazard	Pneumonic plague
Scenario	The exercise scenario included an outbreak of plague shortly after the annual tribal canoe journey that draws the participation of thousands of Natives and non-Natives from Washington, Idaho, Oregon, Canada and other countries visiting various locations along the Pacific coast of Washington and Puget Sound.
Participating Organizations	A total of 22 individuals participated in the exercise. Chehalis Tribe, Nisqually Tribe, Quinault Tribe, Shoalwater Bay Tribe Grays Harbor County Public Health Department, Lewis County Public Health Department, Pacific County Public Health Department, Thurston County Health Department Washington State Department of Health
Point of Contact	Lou Schmitz, Consultant for American Indian Health Commission, <a href="mailto:lou.schmitz.aihc@outlook.com">lou.schmitz.aihc@outlook.com</a>

## SECTION 2: EXERCISE DESIGN AND SCENARIO SUMMARY

### Exercise Purpose and Design

On May 8, 2018, the American Indian Health Commission for Washington State (Commission) in partnership with the Washington State Department of Health (DOH) conducted a public health tabletop exercise where the DOH's Incident Management Team (IMT) was activated, and tribes, DOH, and LHJs coordinated on the distribution of medical countermeasures to tribes.

The exercise was conducted to strengthen the response capabilities of tribal, state, and local governments and to assure the appropriate amount and type of medical countermeasures and materiel reach every tribe quickly during public health emergencies. This exercise was developed and conducted by the Commission, in cooperation with representatives from DOH and various tribal and local governments and organizations.

The exercise was designed to test tribal, state, and local health jurisdiction plans, policies and procedures and provide an opportunity to evaluate current operations concepts, plans, and capabilities in response to a public health incident. The exercise was developed and evaluated utilizing objectives that were identified by tribal, state, and local government representatives.



### **Exercise Planning Process**

The Commission facilitated a planning meeting at each of the nine public health emergency planning regions for representatives from DOH, tribes and local health jurisdictions. The purpose of the planning meetings was for each region to: (1) increase partners' understanding of the various jurisdictions' capacity, organization, resources, etc; and (2) plan a tabletop exercise. Participants' suggestions were incorporated into the exercise design. The Commission designed the exercise, with technical assistance from DOH on epidemiological and logistical details.

## Exercise Objectives

### Objective 1: PHEP Capability 09 Medical Materiel Management and Distribution

Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### Objective 2: PHEP Capability 06 Information Sharing

Test resource and information-sharing between tribal and non-tribal jurisdictions

## Scenario Summary

The scenario for this exercise utilizes a public health incident that involves a population exposure to pneumonic plague. Cascading events require the incident managers and responders to take steps to identify, mitigate the effects of, protect the community from, and respond to the hazard and to acquire prophylaxis through the state medical countermeasures distribution system.

## Assumptions

If a tribe requests medical countermeasures directly from the federal government, the federal government will coordinate with the State and deliver medical countermeasures the Washington State Receive Stage and Store (RSS) warehouse in Tumwater.<sup>1</sup>

## Major and Detailed Events

- **Early August 2018:** There have been no major public health emergencies in the region. The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations. The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route. Over 2500 Native and non-Native individuals participated in the many canoe journey events.
- **Day One August 6, 2018.** The local hospital has admitted two non-Native patients (34-year-old female, 19-year-old male) with symptoms of: (1) high fever; (2) severe weakness;

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<sup>1</sup> Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives on a March 15, 2018 webinar.

(3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.

- **Day Three August 8, 2018 Morning.** The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one.
- **Day Three August 8, 2018 Afternoon.** A tribal clinic has had two patients (58-year-old female, 66-year-old male) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.
- **Day Four August 9, 2018.** A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia. One of the patients participated in the annual canoe journey. Both tribal patients who presented on Day Three are critically ill. All 5 tribal patients that have presented with symptoms are ages 55 and older.
- **Day Five – August 10, 2018 Morning.** Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington. Washington State Emergency Management Division (EMD) is now activated and a Mission Number has been issued. DOH Incident Management Team (IMT) is now activated.
- **Day Five – August 10, 2018 Morning.** Three local health jurisdiction employees have called in sick and have been referred to the hospital for care. Two nurses from the hospital have become ill with the same symptoms. The two initial tribal clinic patients were diagnosed with pneumonic plague. Both initial tribal patients attended the canoe journey. Centers for Disease Control and Prevention (CDC) Director published a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment. The initial shipment to Washington State will be insufficient to administer prophylaxis to the entire target population. More supplies will be available in 10-14 days. Tribal and nontribal health jurisdictions need to request medical countermeasures.



- **Day Five-August 10, 2018 Afternoon.** A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS. A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle.
- **Day Five-August 10, 2018 Afternoon.** A local health jurisdiction has requested use of tribal staff to dispense medical countermeasures. A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts.
- **Day Six-August 11, 2018.** The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse.

## SECTION 3: KEY FINDINGS

The 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise was developed to assess the capability of tribes, the Washington State Department of Health (DOH), and the local health jurisdictions (LHJs) to coordinate distribution of medical countermeasures to tribal nations during a public health incident. A tabletop exercise was held in each of Washington State's nine (9) public health emergency preparedness regions.

The following objectives that were exercised align with the Centers for Disease Control (CDC) Public Health Emergency Preparedness Capabilities (PHEP):

<b>Exercise Objective</b>	<b>Objective Description</b>	<b>Related PHEP Capability Number/Description</b>
Objective 1	Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.	C09 Medical Materiel Management and Distribution
Objective 2	Test resource and information-sharing between tribal and non-tribal jurisdictions	C06 Information Sharing

This section of the After Action Report (AAR) presents strategic findings as they relate to the tabletop objectives and key issues that were identified as a result of the exercise.

## **MEDICAL MATERIEL MANAGEMENT AND DISTRIBUTION (RELATES TO PHEP CAPABILITY 09).**

Objective 1 of this tabletop exercise tested the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### **Major Strengths**

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** The DOH and almost all LHJs recognized the sovereign authority of tribes to determine who their priority populations are in the dispensing of medical countermeasures, even if that determination may conflict with CDC guidelines. As a result, the DOH and most LHJs stated they will distribute medical countermeasures to the tribe regardless of the tribes' internal decisions regarding priority populations.
- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Most LHJs stated they have the capacity to deliver medical countermeasures to tribes.

### **Primary Areas for Improvement**

#### **1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.**

Not all LHJ representatives understand that their role is limited to transporting and/or handing over tribes' medical countermeasures allocations, unless a tribe specifically requests additional coordination or assistance. Some LHJ participants believe they have legal obligations to ensure that tribes follow CDC recommendations. This lack of understanding resulted in some tribes in Washington State not receiving vaccine and antivirals during the 2009 - 2010 H1N1 pandemic response and can produce catastrophic consequences during future public health incidents, unless corrected.



- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Some LHJs stated they may not have the capacity to deliver medical countermeasures directly to tribes.

3. **Identification of Tribal Service Population.** Tribal service population numbers can vary greatly from one public health incident to another, due to large events like the annual Canoe Journey, Omak Stampede, pow wows, concerts, tourism, etc. Some LHJs noted the need for a system to inform the LHJs, during a response, specifically which population the tribe will be serving to avoid duplication or gaps.
4. **Medical Countermeasures Plans.** Most local health jurisdictions' medical countermeasures planning documents do not address processes for distribution of medical countermeasures to tribes. Most tribes need to develop and adopt medical countermeasures plans, including a clear process for making decisions during public health incidents regarding how they want their medical countermeasures delivered.
5. **Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.** There is no clearly documented system in place for including tribes in communication, decision-making, and coordination of efforts during public health incidents and responses.

## Recommendations

### 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.

- a) DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing.
- b) The United States federal government should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the



distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an agency consultation with tribes on these guidelines.

- c) DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government.
- d) DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes.

**2. LHI Capacity to Deliver Medical Countermeasures to Tribes.** The Partner Profile form should be amended to collect from each LHI confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHI. This is key information for the tribe to make plans to pick up the MCM from the LHI, or to choose an alternate option for delivery.

**3. Identification of Tribal Service Population.** DOH should develop and document a streamlined process for tribes to inform DOH of the population they will serve for each specific public health incident.

**4. Medical Countermeasures Plans.** Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.

**5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.**

- a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
- b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.
- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
- d. DOH and the Commission should continue to work with tribes to sign on to the "Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State"

so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.

- e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.

**6. Pharmacy Memorandum of Understanding.** DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU). This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.

**7. Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State.** DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.

**8. Ability to Receive, Manage and Store Medical Countermeasures.** Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.

**9. Staff Training.** Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.



**INFORMATION SHARING BETWEEN JURISDICTIONS (RELATES PHEP CAPABILITY 06).** Objective 2 of this tabletop exercise tested resource and information-sharing between tribal and non-tribal jurisdictions.

### Major Strengths

- 1. Reporting Public Health Incidents to State.** Once the LHJs received notice from the hospitals and/or clinics, all LHJs immediately contacted DOH during the exercise. DOH immediately began coordinating with the LHJs, the hospitals, and the tribes to begin an investigation to share information, determine where the disease originated and initiate response actions.
- 2. Reporting Public Health Incidents to Indian Health Care Providers.** Many LHJs maintain healthcare provider notification systems that include Indian health care providers and other tribal representatives. Tribal partners are eligible to register for the Washington State Department of Health's (DOH's) SECURES health alert system and receive notifications.

### Primary Areas for Improvement

- 1. Reporting Public Health Incident to Indian Health Care Providers.** Not all LHJs have a system in place to ensure all Indian health care providers and other tribal contacts are notified of a public health incident. Also, not every tribe is registered on the Washington State Department of Health's (DOH's) SECURES health alert system.
- 2. Accuracy and Maintenance of Contact List.** There is no system in place for maintaining accurate and current partner contact lists for individuals with key roles during responses. DOH's "Yellow Book" and "Red Book" are published in paper format, and thus not updated in real time. DOH has plans to convert the books to an online system, to be updated quarterly.

### Recommendations

- 1. Reporting Public Health Incidents to Indian Health Care Providers.**
  - a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
  - b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the correct tribal contacts are registered and kept current.

- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
  - d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 2. Accuracy and Maintenance of Contact List.** DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.

## **EMERGENCY PUBLIC INFORMATION AND WARNING (RELATES TO PHEP CAPABILITY 04):**

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.

### **Major Strengths**

- 1. LHJ Public Information Officers.** Some LHJs have public information officers who can quickly manage public information dissemination and provide technical assistance to other jurisdictions in the region that do not have this capability.
- 2. DOH Public Information Resources.** DOH has resources to provide technical assistance to LHJs and tribes regarding public information sharing and messaging.
- 3. Tribes' Knowledge Access to Communicating With Tribal Community Members and Expertise.** Tribes have comprehensive systems in place to communicate with their community members. They also have the knowledge to develop messaging that is respectful of culture and history, and appropriate for their community members.

### **Primary Areas for Improvement**

- 1. Inclusion of Tribes in State and Local Public Information Sharing.** There is no clearly documented system in place for coordination and collaboration on public information and messaging for the tribal communities. It is imperative for LHJs to coordinate with tribes on messaging, to assure respect for culture and history and assure message efficacy. Many tribal community members will disregard or distrust public health messages that do not originate from tribal council or other tribal officials. Health literacy is a critical factor to consider in ensuring community members understand alerts and notices. A strong understanding of the community's culture and historical context are also key. Messages should provide tribal community members with clear guidance on reasonable action steps they can take to protect themselves and others.



2. **Controlling Spread of Misinformation within Tribal Communities.** Tribes voiced concern about controlling information to the public in small communities where information spreads quickly and inaccurately through word of mouth and on social media. This spread of misinformation could result in tribal clinics being overwhelmed. Tribes expressed interest in receiving technical assistance in this area.

## Recommendations

1. **Inclusion of Tribes in State and Local Public Information Sharing.**
  - a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses.
  - b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.
2. **Controlling Spread of Misinformation within Tribal Communities.** The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.

**PUBLIC HEALTH SURVEILLANCE AND EPIDEMIOLOGICAL INVESTIGATION (RELATES TO CAPABILITY 13):** Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

### Major Strengths

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** All LHJs coordinate on some level with tribes when they must go on tribal lands to conduct epidemiological investigations that involve tribal community members. One LHJ partners with a tribe on conducting communicable disease investigations by including a tribal employee to serve as a community liaison. Several participants recognized the importance of having a tribal community liaison available during investigations, since tribal members may be hesitant to communicate with non-tribal members. The tribal community liaison can also be an especially valuable asset, given their knowledge of the community.

### Recommendations

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.



**RESPONDER SAFETY AND HEALTH (RELATES TO PHEP CAPABILITY 14):** The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

### Major Strengths

- 1. Access to Training and Personal Protective Equipment (PPE).** Many tribes and LHJs have access to training and personal protective equipment (PPE) necessary to safely respond to a public health incident.
- 2. Notification of Risk of Exposure to EMS Personnel.** Many tribes and LHJs have a system in place to notify emergency medical services (EMS) personnel before they transport a patient that can expose them to a communicable disease or other potential risk.

### Primary Areas for Improvement

- 1. Access to Training and Personal Protective Equipment (PPE).** Some tribes stated their law enforcement staff (and other potential responders) do not have access to PPE and training on PPE and other precautions needed to safely respond to incidents that may expose them to communicable diseases or other risks.
- 2. Notification of Risk of Exposure to EMS Personnel.** Some tribes and LHJs need to develop and implement standard operating procedures to ensure that EMS and other emergency responders are not exposed to communicable diseases or other potential risks.

### Recommendations

- 1. Access to Training and Personal Protective Equipment (PPE).**
  - a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.
  - b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.
- 2. Notification of Risk of Exposure to EMS Personnel.** All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other

emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.

**MEDICAL SURGE (RELATES TO PHEP CAPABILITY 10):** 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.

### Major Strengths

- 1. Tribal Clinic Capacity and Expertise.** Many tribal clinics are well equipped and staffed to respond to a public health incident, and plan to continue serving their patient population for the duration of most public health incidents.



### Areas for Improvement

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Most tribal clinics do not have Continuity of Operations (COOP) Plans or Crisis Standards of Care to clearly guide their operations during a public health incident.

### Recommendations

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.

## Appendix A: IMPROVEMENT PLAN

The Improvement Plan (IP) specifically details what actions will be taken to address each recommendation presented in the After Action Report (AAR), who or what entity will be responsible for taking the action, and the timeline for completion.

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Medical Materiel Management and Distribution</b> (Relates to PHEP Capability 9)	1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes	a. DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing	a. DOH	10/30/19
		b. The United States federal government (CDC/ASPR) should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an	b. CDC and ASPR	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>agency consultation with tribes on these guidelines.</p> <p>c. DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government</p> <p>d. DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes</p>	<p>c. DOH and Commission</p> <p>d. DOH and Commission</p>	<p>10/30/19</p> <p>12/30/19</p>
	2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.	The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.	DOH and Commission	10/30/19
	3. Identification of Tribal Service Population.	DOH should develop and document a streamlined process for tribes to inform DOH	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		of the population they will serve for each specific public health incident.		
	4. Medical Countermeasures Plans.	Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.	LHJs and Tribes	04/30/19
	5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.	<p>a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.</p> <p>b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.</p> <p>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g.</p>	LHJs and Tribes	04/30/19
			LHJs and Tribes	04/30/19
			DOH	06/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH and the Commission should continue to work with tribes to sign on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.</p> <p>e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH and Commission</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	6. Pharmacy Memorandum of Understanding	DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU).	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.		
	7 Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State	DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.	DOH and Commission	06/30/19
	8. Ability to Receive, Manage and Store Medical Countermeasures	Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.	Tribes and LHJs	04/30/19
	9. Staff Training	Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.	Tribes and LHJs	04/30/19
Information Sharing between Jurisdictions (Relates to PHEP Capability 6)	1. Reporting Public Health Incidents to Indian Health Care Providers	a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.	Tribes and LHJs	04/30/19
		b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>correct tribal contacts are registered and kept current.</p> <p>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	2. Accuracy and Maintenance of Contact List	DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Emergency Public Information and Warning</b> (Relates to PHEP Capability 4)	1. Inclusion of Tribes in State and Local Public Information Sharing	a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses. .	LHJs and Tribes	04/30/19
		b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.	DOH and Commission	06/30/19
	2. Controlling Spread of Misinformation Within Tribal Communities	The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.	DOH and Commission	6/30/19
<b>Public Health Surveillance and Epidemiological Investigation</b> (Relates to PHEP capability 13)	LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.	LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.	LHJs and Tribes	6/30/19
<b>Responder Safety and Health</b> (Relates to PHEP capability 14)	1. Access to Training and Personal Protective Equipment	a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and	LHJs and Tribes	6/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.</p> <p>b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.</p>	DOH and Commission	06/30/19
	2. Notification of Risk of Exposure to EMS Personnel.	All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.	LHJs and Tribes	6/30/19
<b>Medical Surge</b> (Relates to PHEP capability 10)	Continuity of Operations (COOP) Plans and Crisis Standards of Care	Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.	Tribes	4/30/19

## Appendix B: TABLETOP EXERCISE SLIDES

# **Cross-Jurisdictional Collaboration Project Medical Countermeasures**

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## **Tabletop Exercise**

**May 2018**



**American Indian Health Commission**  
for Washington State

# Agenda



**Introductions and Overview**



**Unfolding Situation → Decisions and Responses**



**Break**



**Later Developments → Decisions and Responses**



**Break and Photos**



**Hotwash, Findings and Self-Evaluation**



**Next Steps**

# **Introductions and Overview**





# **Introductions**

- **What is your job title?**
- **How long have you worked in your current position?**
- **What responsibilities do you have related to community emergency preparedness?**

# What are Medical Countermeasures (MCM)?

- Medical treatments or prophylaxes for public health threats
- Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



# Medical Countermeasures and Tribes

- Each time an incident occurs, a tribe has the sovereign authority to choose how medical countermeasures are distributed to their community by federal, state, and or local governments
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for each incident, ensuring the fastest response and protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE and LHJ**  
coordinate  
conveyance of  
MCMs to **TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

## Option 4 → Tribe Contacts Federal Government

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity; **\*SEE FEDERAL REFERENCES BELOW.**

### \*Version 11

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”

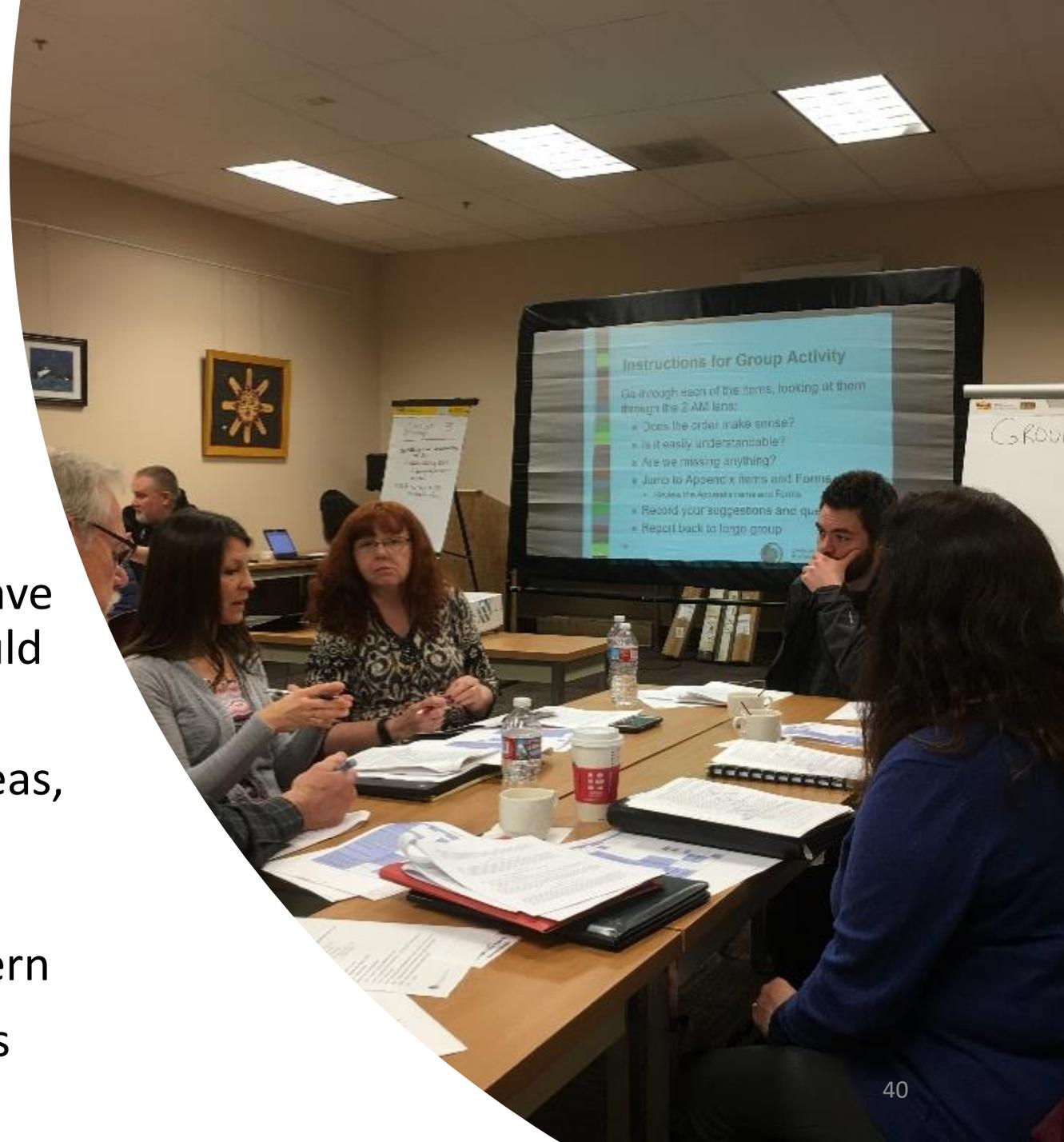
See CDC’s “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5.

“the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.” Version 11, p. 6

**Regardless of the dispensing option chosen, MCMs will be distributed through the system developed by the state health department once an emergency is declared** and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the community has access to MCMs. Version 11, p. 6. *Emphasis added.*

# What is a Tabletop Exercise?

- An informal discussion using a scripted scenario as a catalyst
- Identifies gaps in our plans, issues we have not yet thought about, changes we should make to our plans
- Promotes free and open exchange of ideas, no time pressures
- Opportunity to discuss issues in depth, collaboratively examining areas of concern
- There are no “right” or “wrong” answers



# Purpose of the Tabletop Exercise

Testing communication and MCM distribution processes through a tabletop exercise will increase:

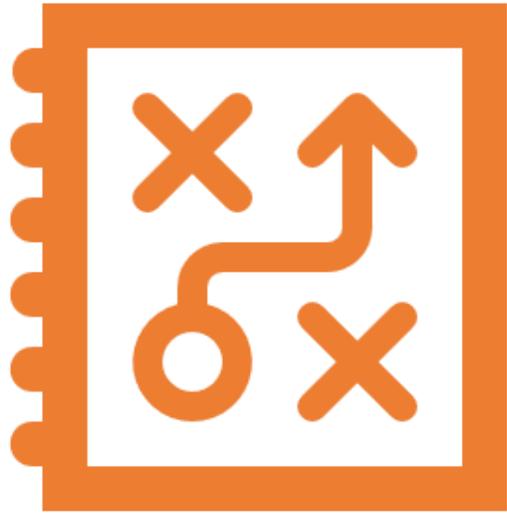
- tribes' understanding of how the different options will work for their communities and strengthen their decision-making at the time of an incident
- tribal, local, and state partners' understanding of how they will interact during MCM distribution



# Specific Objectives

1. Test the region's ability to effectively coordinate distribution of MCM across tribal and nontribal jurisdictions
2. Identify strengths and areas for improvement
3. Identify potential legal issues
4. Test resource- and information-sharing between tribal and non-tribal jurisdictions
5. Have each tribe make an informed analysis of what will be the most likely option for MCM distribution to its jurisdiction





# Tabletop Scenario



# Assumptions

- The purpose of this exercise is to identify gaps and vulnerabilities
- No jurisdiction is fully prepared for this type of public health emergency
- Open, honest and respectful dialogue and feedback are expected and valued throughout the exercise
- Today's exercise, discussions, and findings will inform future preparedness planning and actions

# Assumptions

- If a tribe requests medical countermeasures directly from the federal government, the federal government will deliver medical countermeasures to one site for the entire State of Washington - the Washington State Receive Stage and Store (RSS) warehouse

(Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives)





# Early August 2018

- There have been no major public health emergencies in your region
- The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations
- The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route
- Over 7500 Native and non-Native individuals participated in the many canoe journey events



## **Day One – August 6, 2018**

The local hospital has admitted two non-Native patients (34 year old female, 19 year old male) with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# Day One Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Morning**

The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one



# Pneumonic plague

Pneumonic plague is a severe lung infection caused by the bacterium *Yersinia pestis*. Symptoms include fever, headache, shortness of breath, chest pain, and cough. They typically start about three to seven days after exposure. It is one of three forms of plague, the other two being septicemic plague and bubonic plague.

Pneumonic plague can be caused in two ways: primary, which results from the inhalation of aerosolized plague bacteria, or secondary, when septicemic plague spreads into lung tissue from the bloodstream. Pneumonic plague is not exclusively vector-borne like bubonic plague; instead it can be spread from person to person.

Pneumonic plague symptoms often include fever, weakness, and headache as well as rapidly developing pneumonia with shortness of breath, cough, and chest pain.

<https://emergency.cdc.gov/agent/plague/factsheet.asp>

<https://www.cdc.gov/plague/faq/index.html>



# **Day Three Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Afternoon**

A tribal clinic has had two patients (58 year old female, 66 year old male) present with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



## **Day Three Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?

## Day Four – August 9, 2018

- A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of:
  - high fever
  - severe weakness
  - bloody sputum
  - shortness of breath
  - possible pneumonia
- One of the patients participated in the annual canoe journey
- Both tribal patients who presented on Day Three are critically ill
- All 5 tribal patients that have presented with symptoms are ages 55 and older





# Day Four Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Morning**

- Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington
- Washington State Emergency Management Division (EMD) is now activated – Mission Number has been issued
- DOH Incident Management Team (IMT) is now activated

# Day Five – August 10, 2018

## Morning

- Three local health jurisdiction employees have called in sick and have been referred to the hospital for care
- Two nurses from the hospital have become ill with the same symptoms
- The two initial tribal clinic patients were diagnosed with pneumonic plague
- Both initial tribal patients attended the canoe journey
- Centers for Disease Control and Prevention (CDC) Director publishes a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment; the initial shipment to Washington State will be sufficient to administer prophylaxis to 80% of the 25 and younger population in Washington; more will be available in 10-14 days
- Tribal and nontribal health jurisdictions need to request medical countermeasures





# **Day Five Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS
- A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A local health jurisdiction needs to request use of tribal staff to dispense medical countermeasures
- A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Six – August 11, 2018**

The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse



# Day Six Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



# Hotwash, Findings and Self-Evaluation

# Next Steps

- AIHC will provide each jurisdiction with their compiled notes and after-action report (AAR)
- Tribes and LHJs complete the Partner Profile Form and return to AIHC ASAP
- Other?



## Appendix C: TABLETOP SIGN-IN SHEET



American Indian Health Commission  
For Washington State

### REGION 3

## Cross-Jurisdictional Collaboration Project

### TABLETOP EXERCISE

May 8, 2018

SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Carrie Corder	Emergency Specialist WA. DOH	Carrie.corder@doh.wa.gov
Ted Fischer	Emergency Specialist WA DOH OEPK	ted.fischer@doh.wa.gov
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Brianne Probasco	Public Health Educator	bprobasco@co.grays-harbor.wa.us
Beth Mizushima	Deputy Director	bmizushima@co.grays-harbor.wa.us
Karolyn Holden	Director	kholden@co.grays-harbor.wa.us
John McGee	various (safety officer) CTWC	jmcgee@chehalistribe.org
Denise Walker	Health Director CTWC	dwalker@chehalistribe.org



American Indian Health Commission  
For Washington State

### REGION 3

## Cross-Jurisdictional Collaboration Project

### TABLETOP EXERCISE

May 8, 2018

SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Jennifer Dixon	Emergency Prep Thurston Co. PH	dixonjm@co.thurston.wa.us
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James Edstam	Pacific Co Health Officer	jedstam@co.pacific.wa.us
Rachel Wood	Lewis & Thurston Counties Health Officer	woodr@Thurston.wa.us Rachel.Wood@lewiscountypu .gov
Ed Mund	Lewis County Public Health Emergency Preparedness Coord.	ed.mund@lewiscountypu.gov

REGION 3

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 8, 2018

SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
CAL BRAY	EMERGENCY MGMT. COORDINATOR	CBRAY@CHEHALIS TRIBE.ORG
Christina Breault	Environ. Health Spec.	cbreault@quinault.org
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Kim Thompson	Health Director	Kzillyett@shoalwaterbay-nsn.gov
Robin Souvenir	Chief of Police	rsouvenir@shoalwaterbay-nsn.gov



# 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise

After Action Report and Improvement Plan

**Region 4**



**American Indian Health Commission  
for Washington State**

*In partnership with*



## Acronyms

Acronym	Definition
AAR	After Action Report
ASPR	Office of the Assistant Secretary for Preparedness and Response
CDC	Center for Disease Control
COOP	Continuity of Operations Plan
DOH	Washington State Department of Health
LHJ	Local Health Jurisdiction
MCM	Medical Countermeasures
POD	Point of Dispensing
PPE	Personal Protective Equipment
RSS	Receive, Stage and Store Warehouse

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## PREFACE

An After Action Report and Improvement Plan (AAR/IP) provide actionable insights for building community preparedness by documenting strengths and areas for improvement that participants identify during a simulated response to an emergency.

This report is tangible evidence of the valuable partnerships that exist between tribes, local governments and Washington State to improve public health preparedness in our communities. It serves as a collection of lessons learned, outlines recommended actions, and provides the basis for planning future exercises. This AAR/IP will contribute to improving future incident responses, training, exercises, equipment prioritization, plan effectiveness and overall preparedness.

The tabletop exercise this AAR documents was part of the American Indian Health Commission's Cross-Jurisdictional Collaboration Project of 2018. The project was facilitated by the American Indian Health Commission for Washington State (AIHC) with funding from the Washington State Department of Health (DOH).

### STRENGTHS

All participants (Tribe and Counties) identified the region's Public Health Governing Council as a key asset that has instituted collaboration and coordination between the Counties and the Tribe in Region 4.

### AREAS FOR IMPROVEMENT

Priority areas for future work, identified by participants from the Tribe and the Counties in Region 4, include:

- Signing the Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State
- Developing a regional Joint Information System

The American Indian Health Commission for Washington State wishes to express gratitude and appreciation for the many tribal, local and state partners that participated in this project and invested significant time and effort in support of our shared commitment to protecting the lives of all Washington State citizens.

## SECTION 1: EXERCISE OVERVIEW

Exercise Name	2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise
Exercise Dates	May 7, 2018
Scope	This exercise was a discussion-based tabletop exercise for Region 4, to address coordination and collaboration between the 1 tribe and 4 local health jurisdictions regarding the distribution of medical countermeasures.
Mission Area(s)	Response
Core Capabilities	PHEP Capability 06: Information Sharing PHEP Capability 09: Medical Materiel Management and Distribution
Overarching Objectives	<p>PHEP Capability 06 Information Sharing: Test the ability of federal, state, local, and tribal governments to exchange information and situational awareness data in preparation for, and response to, a plague outbreak.</p> <p>PHEP Capability 09 Medical Materiel Management and Distribution: Test the ability to coordinate logistical operations and medical material requests among federal, state, local, and tribal jurisdictions.</p>
Threat or Hazard	Pneumonic plague
Scenario	The exercise scenario included an outbreak of plague shortly after the annual tribal canoe journey that draws the participation of thousands of Natives and non-Natives from Washington, Idaho, Oregon, Canada and other countries visiting various locations along the Pacific coast of Washington and Puget Sound.
Participating Organizations	A total of 16 individuals participated in the exercise. Cowlitz Tribe Clark County Public Health Department, Cowlitz County Health and Human Services Washington State Department of Health
Point of Contact	Lou Schmitz, Consultant for American Indian Health Commission, <a href="mailto:lou.schmitz.aihc@outlook.com">lou.schmitz.aihc@outlook.com</a>

## SECTION 2: EXERCISE DESIGN AND SCENARIO SUMMARY

### Exercise Purpose and Design

On May 7, 2018, the American Indian Health Commission for Washington State (Commission) in partnership with the Washington State Department of Health (DOH) conducted a public health tabletop exercise where the DOH's Incident Management Team (IMT) was activated, and tribes, DOH, and LHJs coordinated on the distribution of medical countermeasures to tribes.

The exercise was conducted to strengthen the response capabilities of tribal, state, and local governments and to assure the appropriate amount and type of medical countermeasures and materiel reach every tribe quickly during public health emergencies. This exercise was developed and conducted by the Commission, in cooperation with representatives from DOH and various tribal and local governments and organizations.

The exercise was designed to test tribal, state, and local health jurisdiction plans, policies and procedures and provide an opportunity to evaluate current operations concepts, plans, and capabilities in response to a public health incident. The exercise was developed and evaluated utilizing objectives that were identified by tribal, state, and local government representatives.



### Exercise Planning Process

The Commission facilitated a planning meeting at each of the nine public health emergency planning regions for representatives from DOH, tribes and local health jurisdictions. The purpose of the planning meetings was for each region to: (1) increase partners' understanding of the various jurisdictions' capacity, organization, resources, etc; and (2) plan a tabletop exercise. Participants' suggestions were incorporated into the exercise design. The Commission designed the exercise, with technical assistance from DOH on epidemiological and logistical details.

## Exercise Objectives

### Objective 1: PHEP Capability 09 Medical Materiel Management and Distribution

Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### Objective 2: PHEP Capability 06 Information Sharing

Test resource and information-sharing between tribal and non-tribal jurisdictions

## Scenario Summary

The scenario for this exercise utilizes a public health incident that involves a population exposure to pneumonic plague. Cascading events require the incident managers and responders to take steps to identify, mitigate the effects of, protect the community from, and respond to the hazard and to acquire prophylaxis through the state medical countermeasures distribution system.

## Assumptions

If a tribe requests medical countermeasures directly from the federal government, the federal government will coordinate with the State and deliver medical countermeasures the Washington State Receive Stage and Store (RSS) warehouse in Tumwater.<sup>1</sup>

## Major and Detailed Events

- **Early August 2018:** There have been no major public health emergencies in the region. The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations. The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route. Over 2500 Native and non-Native individuals participated in the many canoe journey events.
- **Day One August 6, 2018.** The local hospital has admitted two non-Native patients (34-year-old female, 19-year-old male) with symptoms of: (1) high fever; (2) severe weakness;

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<sup>1</sup> Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives on a March 15, 2018 webinar.

(3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.

- **Day Three August 8, 2018 Morning.** The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one.
- **Day Three August 8, 2018 Afternoon.** A tribal clinic has had two patients (58-year-old female, 66-year-old male) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.
- **Day Four August 9, 2018.** A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia. One of the patients participated in the annual canoe journey. Both tribal patients who presented on Day Three are critically ill. All 5 tribal patients that have presented with symptoms are ages 55 and older.
- **Day Five – August 10, 2018 Morning.** Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington. Washington State Emergency Management Division (EMD) is now activated and a Mission Number has been issued. DOH Incident Management Team (IMT) is now activated.
- **Day Five – August 10, 2018 Morning.** Three local health jurisdiction employees have called in sick and have been referred to the hospital for care. Two nurses from the hospital have become ill with the same symptoms. The two initial tribal clinic patients were diagnosed with pneumonic plague. Both initial tribal patients attended the canoe journey. Centers for Disease Control and Prevention (CDC) Director published a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment. The initial shipment to Washington State will be insufficient to administer prophylaxis to the entire target population. More supplies will be available in 10-14 days. Tribal and nontribal health jurisdictions need to request medical countermeasures.



- **Day Five-August 10, 2018 Afternoon.** A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS. A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle.
- **Day Five-August 10, 2018 Afternoon.** A local health jurisdiction has requested use of tribal staff to dispense medical countermeasures. A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts.
- **Day Six-August 11, 2018.** The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse.

## SECTION 3: KEY FINDINGS

The 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise was developed to assess the capability of tribes, the Washington State Department of Health (DOH), and the local health jurisdictions (LHJs) to coordinate distribution of medical countermeasures to tribal nations during a public health incident. A tabletop exercise was held in each of Washington State's nine (9) public health emergency preparedness regions.

The following objectives that were exercised align with the Centers for Disease Control (CDC) Public Health Emergency Preparedness Capabilities (PHEP):

<b>Exercise Objective</b>	<b>Objective Description</b>	<b>Related PHEP Capability Number/Description</b>
Objective 1	Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.	C09 Medical Materiel Management and Distribution
Objective 2	Test resource and information-sharing between tribal and non-tribal jurisdictions	C06 Information Sharing

This section of the After Action Report (AAR) presents strategic findings as they relate to the tabletop objectives and key issues that were identified as a result of the exercise.

## MEDICAL MATERIEL MANAGEMENT AND DISTRIBUTION (RELATES TO PHEP CAPABILITY 09).

Objective 1 of this tabletop exercise tested the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### Major Strengths

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** The DOH and almost all LHJs recognized the sovereign authority of tribes to determine who their priority populations are in the dispensing of medical countermeasures, even if that determination may conflict with CDC guidelines. As a result, the DOH and most LHJs stated they will distribute medical countermeasures to the tribe regardless of the tribes' internal decisions regarding priority populations.
- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Most LHJs stated they have the capacity to deliver medical countermeasures to tribes.

### Primary Areas for Improvement

#### 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.

Not all LHJ representatives understand that their role is limited to transporting and/or handing over tribes' medical countermeasures allocations, unless a tribe specifically requests additional coordination or assistance. Some LHJ participants believe they have legal obligations to ensure that tribes follow CDC recommendations. This lack of understanding resulted in some tribes in Washington State not receiving vaccine and antivirals during the 2009 - 2010 H1N1 pandemic response and can produce catastrophic consequences during future public health incidents, unless corrected.



- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Some LHJs stated they may not have the capacity to deliver medical countermeasures directly to tribes.

- 3. Identification of Tribal Service Population.** Tribal service population numbers can vary greatly from one public health incident to another, due to large events like the annual Canoe Journey, Omak Stampede, pow wows, concerts, tourism, etc. Some LHJs noted the need for a system to inform the LHJs, during a response, specifically which population the tribe will be serving to avoid duplication or gaps.
- 4. Medical Countermeasures Plans.** Most local health jurisdictions' medical countermeasures planning documents do not address processes for distribution of medical countermeasures to tribes. Most tribes need to develop and adopt medical countermeasures plans, including a clear process for making decisions during public health incidents regarding how they want their medical countermeasures delivered.
- 5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.** There is no clearly documented system in place for including tribes in communication, decision-making, and coordination of efforts during public health incidents and responses.

## Recommendations

### 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.

- a) DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing.
- b) The United States federal government should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an agency consultation with tribes on these guidelines.
- c) DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government.
- d) DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes.

- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.



- 3. Identification of Tribal Service Population.** DOH should develop and document a streamlined process for tribes to inform DOH of the population they will serve for each specific public health incident.
- 4. Medical Countermeasures Plans.** Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.
- 5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.**
- Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
  - Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.
  - DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
  - DOH and the Commission should continue to work with tribes to sign on to the "Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State" so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.
  - DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver

directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.

- 6. Pharmacy Memorandum of Understanding.** DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU). This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.
- 7. Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State.** DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.
- 8. Ability to Receive, Manage and Store Medical Countermeasures.** Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.
- 9. Staff Training.** Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.



**INFORMATION SHARING BETWEEN JURISDICTIONS (RELATES PHEP CAPABILITY 06).** Objective 2 of this tabletop exercise tested resource and information-sharing between tribal and non-tribal jurisdictions.

### Major Strengths

- 1. Reporting Public Health Incidents to State.** Once the LHJs received notice from the hospitals and/or clinics, all LHJs immediately contacted DOH during the exercise. DOH immediately began coordinating with the LHJs, the hospitals, and the tribes to begin an investigation to share information, determine where the disease originated and initiate response actions.
- 2. Reporting Public Health Incidents to Indian Health Care Providers.** Many LHJs maintain healthcare provider notification systems that include Indian health care providers and other tribal representatives. Tribal partners are eligible to register for the Washington State Department of Health's (DOH's) SECURES health alert system and receive notifications.

### Primary Areas for Improvement

- 1. Reporting Public Health Incident to Indian Health Care Providers.** Not all LHJs have a system in place to ensure all Indian health care providers and other tribal contacts are notified of a public health incident. Also, not every tribe is registered on the Washington State Department of Health's (DOH's) SECURES health alert system.
- 2. Accuracy and Maintenance of Contact List.** There is no system in place for maintaining accurate and current partner contact lists for individuals with key roles during responses. DOH's "Yellow Book" and "Red Book" are published in paper format, and thus not updated in real time. DOH has plans to convert the books to an online system, to be updated quarterly.

### Recommendations

- 1. Reporting Public Health Incidents to Indian Health Care Providers.**
  - a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
  - b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the correct tribal contacts are registered and kept current.

- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
  - d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 2. Accuracy and Maintenance of Contact List.** DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.

## **EMERGENCY PUBLIC INFORMATION AND WARNING (RELATES TO PHEP CAPABILITY 04):**

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.

### **Major Strengths**

- 1. LHJ Public Information Officers.** Some LHJs have public information officers who can quickly manage public information dissemination and provide technical assistance to other jurisdictions in the region that do not have this capability.
- 2. DOH Public Information Resources.** DOH has resources to provide technical assistance to LHJs and tribes regarding public information sharing and messaging.
- 3. Tribes' Knowledge Access to Communicating With Tribal Community Members and Expertise.** Tribes have comprehensive systems in place to communicate with their community members. They also have the knowledge to develop messaging that is respectful of culture and history, and appropriate for their community members.

### **Primary Areas for Improvement**

- 1. Inclusion of Tribes in State and Local Public Information Sharing.** There is no clearly documented system in place for coordination and collaboration on public information and messaging for the tribal communities. It is imperative for LHJs to coordinate with tribes on messaging, to assure respect for culture and history and assure message efficacy. Many tribal community members will disregard or distrust public health messages that do not originate from tribal council or other tribal officials. Health literacy is a critical factor to consider in ensuring community members understand alerts and notices. A strong understanding of the community's culture and historical context are also key. Messages should provide tribal community members with clear guidance on reasonable action steps they can take to protect themselves and others.



2. **Controlling Spread of Misinformation within Tribal Communities.** Tribes voiced concern about controlling information to the public in small communities where information spreads quickly and inaccurately through word of mouth and on social media. This spread of misinformation could result in tribal clinics being overwhelmed. Tribes expressed interest in receiving technical assistance in this area.

## Recommendations

1. **Inclusion of Tribes in State and Local Public Information Sharing.**
  - a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses.
  - b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.
2. **Controlling Spread of Misinformation within Tribal Communities.** The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.

**PUBLIC HEALTH SURVEILLANCE AND EPIDEMIOLOGICAL INVESTIGATION (RELATES TO CAPABILITY 13):** Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

### Major Strengths

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** All LHJs coordinate on some level with tribes when they must go on tribal lands to conduct epidemiological investigations that involve tribal community members. One LHJ partners with a tribe on conducting communicable disease investigations by including a tribal employee to serve as a community liaison. Several participants recognized the importance of having a tribal community liaison available during investigations, since tribal members may be hesitant to communicate with non-tribal members. The tribal community liaison can also be an especially valuable asset, given their knowledge of the community.

### Recommendations

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.

**RESPONDER SAFETY AND HEALTH (RELATES TO PHEP CAPABILITY 14):** The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

### Major Strengths

- 1. Access to Training and Personal Protective Equipment (PPE).** Many tribes and LHJs have access to training and personal protective equipment (PPE) necessary to safely respond to a public health incident.
- 2. Notification of Risk of Exposure to EMS Personnel.** Many tribes and LHJs have a system in place to notify emergency medical services (EMS) personnel before they transport a patient that can expose them to a communicable disease or other potential risk.

### Primary Areas for Improvement

- 1. Access to Training and Personal Protective Equipment (PPE).** Some tribes stated their law enforcement staff (and other potential responders) do not have access to PPE and training on PPE and other precautions needed to safely respond to incidents that may expose them to communicable diseases or other risks.
- 2. Notification of Risk of Exposure to EMS Personnel.** Some tribes and LHJs need to develop and implement standard operating procedures to ensure that EMS and other emergency responders are not exposed to communicable diseases or other potential risks.



## Recommendations

### 1. Access to Training and Personal Protective Equipment (PPE).

- a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.
- b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.

### 2. Notification of Risk of Exposure to EMS Personnel.

All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.

**MEDICAL SURGE (RELATES TO PHEP CAPABILITY 10):** 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.

### Major Strengths

- 1. Tribal Clinic Capacity and Expertise.** Many tribal clinics are well equipped and staffed to respond to a public health incident, and plan to continue serving their patient population for the duration of most public health incidents.



### Areas for Improvement

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Most tribal clinics do not have Continuity of Operations (COOP) Plans or Crisis Standards of Care to clearly guide their operations during a public health incident.

### Recommendations

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.

## Appendix A: IMPROVEMENT PLAN

The Improvement Plan (IP) specifically details what actions will be taken to address each recommendation presented in the After Action Report (AAR), who or what entity will be responsible for taking the action, and the timeline for completion.

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Medical Materiel Management and Distribution</b> (Relates to PHEP Capability 9)	1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes	a. DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing	a. DOH	10/30/19
		b. The United States federal government (CDC/ASPR) should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an	b. CDC and ASPR	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>agency consultation with tribes on these guidelines.</p> <p>c. DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government</p> <p>d. DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes</p>	<p>c. DOH and Commission</p> <p>d. DOH and Commission</p>	<p>10/30/19</p> <p>12/30/19</p>
	2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.	The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.	DOH and Commission	10/30/19
	3. Identification of Tribal Service Population.	DOH should develop and document a streamlined process for tribes to inform DOH	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		of the population they will serve for each specific public health incident.		
	4. Medical Countermeasures Plans.	Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.	LHJs and Tribes	04/30/19
	5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.	<ul style="list-style-type: none"> <li>a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.</li> <li>b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.</li> <li>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g.</li> </ul>	<ul style="list-style-type: none"> <li>LHJs and Tribes</li> <li>LHJs and Tribes</li> <li>DOH</li> </ul>	<ul style="list-style-type: none"> <li>04/30/19</li> <li>04/30/19</li> <li>06/30/19</li> </ul>

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH and the Commission should continue to work with tribes to sign on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.</p> <p>e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH and Commission</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	6. Pharmacy Memorandum of Understanding	DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU).	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.		
	7 Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State	DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.	DOH and Commission	06/30/19
	8. Ability to Receive, Manage and Store Medical Countermeasures	Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.	Tribes and LHJs	04/30/19
	9. Staff Training	Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.	Tribes and LHJs	04/30/19
Information Sharing between Jurisdictions (Relates to PHEP Capability 6)	1. Reporting Public Health Incidents to Indian Health Care Providers	a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.	Tribes and LHJs	04/30/19
		b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>correct tribal contacts are registered and kept current.</p> <p>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	2. Accuracy and Maintenance of Contact List	DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Emergency Public Information and Warning</b> (Relates to PHEP Capability 4)	1. Inclusion of Tribes in State and Local Public Information Sharing	a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses. .	LHJs and Tribes	04/30/19
		b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.	DOH and Commission	06/30/19
	2. Controlling Spread of Misinformation Within Tribal Communities	The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.	DOH and Commission	6/30/19
<b>Public Health Surveillance and Epidemiological Investigation</b> (Relates to PHEP capability 13)	LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.	LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.	LHJs and Tribes	6/30/19
<b>Responder Safety and Health</b> (Relates to PHEP capability 14)	1. Access to Training and Personal Protective Equipment	a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and	LHJs and Tribes	6/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.</p> <p>b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.</p>	DOH and Commission	06/30/19
	2. Notification of Risk of Exposure to EMS Personnel.	All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.	LHJs and Tribes	6/30/19
<b>Medical Surge</b> (Relates to PHEP capability 10)	Continuity of Operations (COOP) Plans and Crisis Standards of Care	Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.	Tribes	4/30/19

Appendix B: TABLETOP EXERCISE SLIDES

# **Cross-Jurisdictional Collaboration Project Medical Countermeasures**

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## **Tabletop Exercise**

**May 2018**



**American Indian Health Commission**  
for Washington State

# Agenda



**Introductions and Overview**



**Unfolding Situation → Decisions and Responses**



**Break**



**Later Developments → Decisions and Responses**



**Break and Photos**



**Hotwash, Findings and Self-Evaluation**



**Next Steps**

# **Introductions and Overview**





# **Introductions**

- **What is your job title?**
- **How long have you worked in your current position?**
- **What responsibilities do you have related to community emergency preparedness?**

# What are Medical Countermeasures (MCM)?

- Medical treatments or prophylaxes for public health threats
- Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



# Medical Countermeasures and Tribes

- Each time an incident occurs, a tribe has the sovereign authority to choose how medical countermeasures are distributed to their community by federal, state, and or local governments
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for each incident, ensuring the fastest response and protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE and LHJ**  
coordinate  
conveyance of  
MCMs to **TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

## Option 4 → Tribe Contacts Federal Government

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity; **\*SEE FEDERAL REFERENCES BELOW.**

### \*Version 11

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”

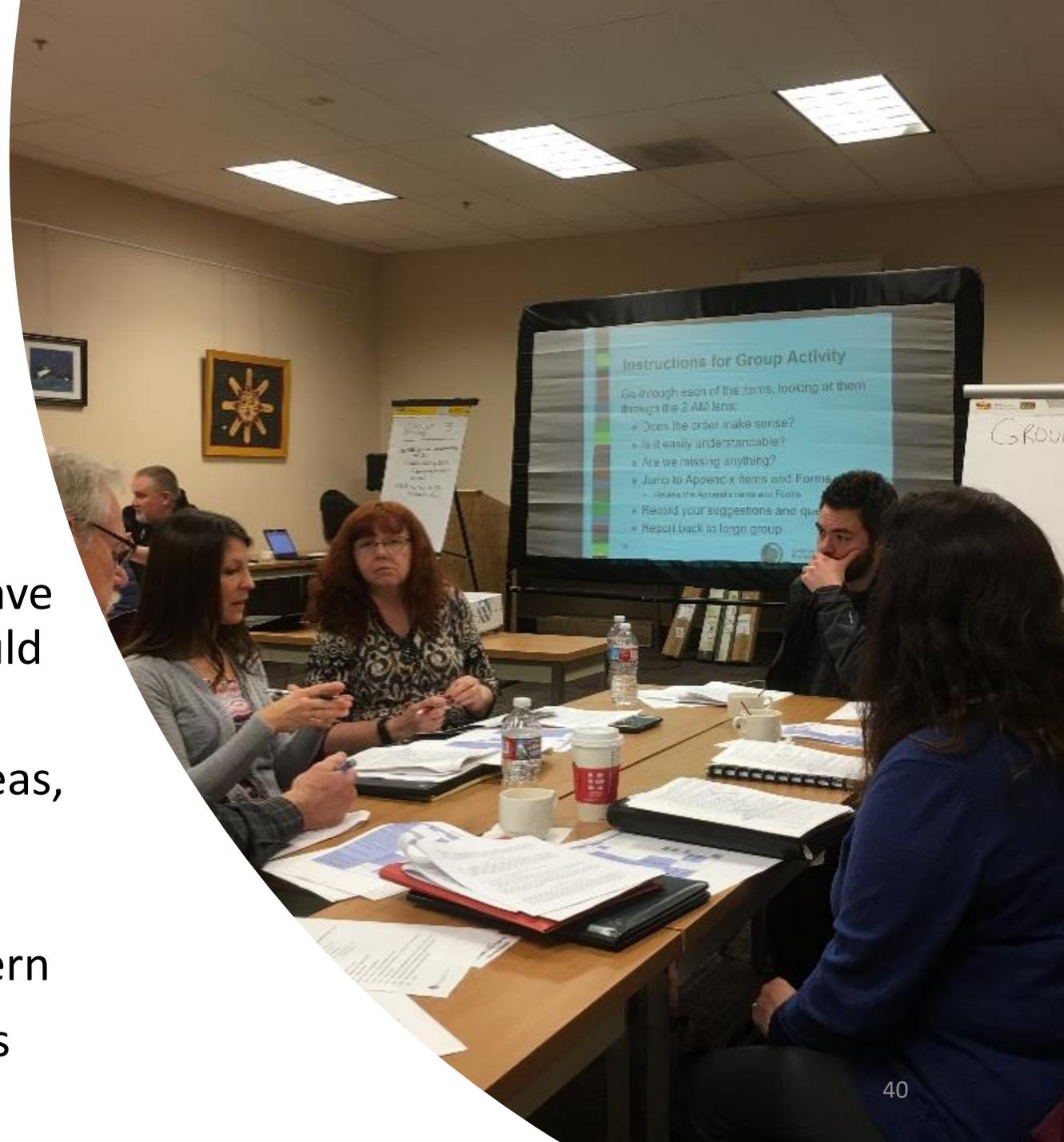
See CDC’s “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5.

“the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.” Version 11, p. 6

**Regardless of the dispensing option chosen, MCMs will be distributed through the system developed by the state health department once an emergency is declared** and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the community has access to MCMs. Version 11, p. 6. *Emphasis added.*

# What is a Tabletop Exercise?

- An informal discussion using a scripted scenario as a catalyst
- Identifies gaps in our plans, issues we have not yet thought about, changes we should make to our plans
- Promotes free and open exchange of ideas, no time pressures
- Opportunity to discuss issues in depth, collaboratively examining areas of concern
- There are no “right” or “wrong” answers



# Purpose of the Tabletop Exercise

Testing communication and MCM distribution processes through a tabletop exercise will increase:

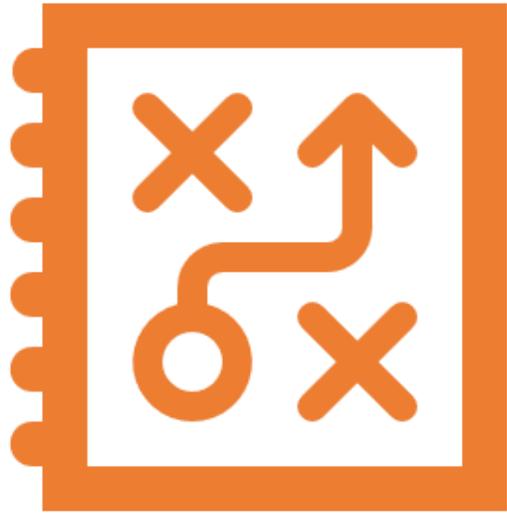
- tribes' understanding of how the different options will work for their communities and strengthen their decision-making at the time of an incident
- tribal, local, and state partners' understanding of how they will interact during MCM distribution



# Specific Objectives

1. Test the region's ability to effectively coordinate distribution of MCM across tribal and nontribal jurisdictions
2. Identify strengths and areas for improvement
3. Identify potential legal issues
4. Test resource- and information-sharing between tribal and non-tribal jurisdictions
5. Have each tribe make an informed analysis of what will be the most likely option for MCM distribution to its jurisdiction





# Tabletop Scenario



# Assumptions

- The purpose of this exercise is to identify gaps and vulnerabilities
- No jurisdiction is fully prepared for this type of public health emergency
- Open, honest and respectful dialogue and feedback are expected and valued throughout the exercise
- Today's exercise, discussions, and findings will inform future preparedness planning and actions

# Assumptions

- If a tribe requests medical countermeasures directly from the federal government, the federal government will deliver medical countermeasures to one site for the entire State of Washington - the Washington State Receive Stage and Store (RSS) warehouse

(Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives)





# Early August 2018

- There have been no major public health emergencies in your region
- The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations
- The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route
- Over 7500 Native and non-Native individuals participated in the many canoe journey events



## **Day One – August 6, 2018**

The local hospital has admitted two non-Native patients (34 year old female, 19 year old male) with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# Day One Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Morning**

The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one



# Pneumonic plague

Pneumonic plague is a severe lung infection caused by the bacterium *Yersinia pestis*. Symptoms include fever, headache, shortness of breath, chest pain, and cough. They typically start about three to seven days after exposure. It is one of three forms of plague, the other two being septicemic plague and bubonic plague.

Pneumonic plague can be caused in two ways: primary, which results from the inhalation of aerosolized plague bacteria, or secondary, when septicemic plague spreads into lung tissue from the bloodstream. Pneumonic plague is not exclusively vector-borne like bubonic plague; instead it can be spread from person to person.

Pneumonic plague symptoms often include fever, weakness, and headache as well as rapidly developing pneumonia with shortness of breath, cough, and chest pain.

<https://emergency.cdc.gov/agent/plague/factsheet.asp>

<https://www.cdc.gov/plague/faq/index.html>



# **Day Three Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Afternoon**

A tribal clinic has had two patients (58 year old female, 66 year old male) present with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



## **Day Three Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?

# Day Four – August 9, 2018

- A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of:
  - high fever
  - severe weakness
  - bloody sputum
  - shortness of breath
  - possible pneumonia
- One of the patients participated in the annual canoe journey
- Both tribal patients who presented on Day Three are critically ill
- All 5 tribal patients that have presented with symptoms are ages 55 and older





# Day Four Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Morning**

- Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington
- Washington State Emergency Management Division (EMD) is now activated – Mission Number has been issued
- DOH Incident Management Team (IMT) is now activated

# Day Five – August 10, 2018

## Morning

- Three local health jurisdiction employees have called in sick and have been referred to the hospital for care
- Two nurses from the hospital have become ill with the same symptoms
- The two initial tribal clinic patients were diagnosed with pneumonic plague
- Both initial tribal patients attended the canoe journey
- Centers for Disease Control and Prevention (CDC) Director publishes a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment; the initial shipment to Washington State will be sufficient to administer prophylaxis to 80% of the 25 and younger population in Washington; more will be available in 10-14 days
- Tribal and nontribal health jurisdictions need to request medical countermeasures





# **Day Five Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS
- A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A local health jurisdiction needs to request use of tribal staff to dispense medical countermeasures
- A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



**Centers for Disease Control (CDC)  
Strategic National Stockpile  
"Push Pack"**

## **Day Six – August 11, 2018**

The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse



# Day Six Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



# Hotwash, Findings and Self-Evaluation

# Next Steps

- AIHC will provide each jurisdiction with their compiled notes and after-action report (AAR)
- Tribes and LHJs complete the Partner Profile Form and return to AIHC ASAP
- Other?



## Appendix C: TABLETOP SIGN-IN SHEET



American Indian Health Commission  
For Washington State

## REGION 4

### Cross-Jurisdictional Collaboration Project

#### TABLETOP EXERCISE

May 7, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
ALAN MELNICK	PUBLIC HEALTH DIRECTOR / HEALTH OFFICER (CLARK COUNTY)  HEALTH OFFICER SKAMANIA	alan.melnick@clack.wa.gov
Tippy Hartford	Office Assistant III Clark County Public Health / RIV	tippy.hartford@clark.wa.gov
Robin Albrandt	Regional E.R. Coordinator Clark County PH/RIV	robin.albrandt@clack.wa.gov
RICH KONRAD	EM. PREPAREDNESS COORDINATOR CLARK / RIV PUBLIC HEALTH	richard.konrad@clark.wa.gov
Lianne Martinez	Emerg Prep Coord Region IV PH	Lianne.Martinez@clark.wa.gov
Stephen Kutz	Exec. Dir. HHS Cowlitz Tribe	skutz@cowlitz.org
William Elliott	Emergency Management Coordinator, Cowlitz Tribe	belliot@cowlitz.org
Alyssa Fine	Diabetes Educator / RN PHS officer Cowlitz Tribe	afine@cowlitz.org



American Indian Health Commission  
For Washington State

REGION 4

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 7, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Jim Sherrill	Retired	
Ted Fischer	E.P.R.S. DoH OEPR	Ted.fischer@doh.wa.gov
Cory Portner	DoH EPR	cory.portner@doh.wa.gov
ERNIE SCHNABLER	DEM Director / Cowlitz Sheriff's Office	schnablere@co.cowlitz.wa.us
Michelle Ashby	Community Health Manager @ cowlitz HHS	ashbym@co.cowlitz.wa.us
Carole Harrison	Deputy Director Cowlitz County HHS	harrisonc@co.cowlitz.wa.us
Arcen Workman	Cowlitz Tribe Tribal Administration Manager	arcenw@cowlitz.org
Kay Culbertson	Cowlitz Tribal Health Director	Kculbertson@ cowlitz.org



**The Puyallup Tribe of Indians**



# 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise

## After Action Report and Improvement Plan

### Region 5



**American Indian Health Commission  
for Washington State**

*In partnership with*



## Acronyms

Acronym	Definition
AAR	After Action Report
ASPR	Office of the Assistant Secretary for Preparedness and Response
CDC	Center for Disease Control
COOP	Continuity of Operations Plan
DOH	Washington State Department of Health
LHJ	Local Health Jurisdiction
MCM	Medical Countermeasures
POD	Point of Dispensing
PPE	Personal Protective Equipment
RSS	Receive, Stage and Store Warehouse

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## PREFACE

An After Action Report and Improvement Plan (AAR/IP) provide actionable insights for building community preparedness by documenting strengths and areas for improvement that participants identify during a simulated response to an emergency.

This report is tangible evidence of the valuable partnerships that exist between tribes, local governments and Washington State to improve public health preparedness in our communities. It serves as a collection of lessons learned, outlines recommended actions, and provides the basis for planning future exercises. This AAR/IP will contribute to improving future incident responses, training, exercises, equipment prioritization, plan effectiveness and overall preparedness.

The tabletop exercise this AAR documents was part of the American Indian Health Commission's Cross-Jurisdictional Collaboration Project of 2018. The project was facilitated by the American Indian Health Commission for Washington State (AIHC) with funding from the Washington State Department of Health (DOH).

## AREAS FOR IMPROVEMENT

Areas for improvement identified by participants from the Puyallup Tribe, Tacoma-Pierce County Health Department and Pierce County Emergency Management include:

- Increasing coordination between Puyallup Tribal Health Authority, Puyallup Tribe Emergency Management, Tacoma-Pierce County Health District and Pierce County Emergency Management
- Increasing opportunities for the Tribe and the County to exercise together

## STRENGTHS

Strengths identified by participants from the Puyallup Tribe, Tacoma-Pierce County Health Department and Pierce County Emergency Management include:

- Strong, established relationship between Puyallup Tribe Emergency Management and Pierce County Emergency Management
- Strong, established relationship between Puyallup Tribal Health Authority and Tacoma-Pierce County Health Department on disease control

The American Indian Health Commission for Washington State wishes to express gratitude and appreciation for the many tribal, local and state partners that participated in this project and invested significant time and effort in support of our shared commitment to protecting the lives of all Washington State citizens.

## SECTION 1: EXERCISE OVERVIEW

Exercise Name	2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise
Exercise Dates	June 13, 2018
Scope	This exercise was a discussion-based tabletop exercise for Region 5, to address coordination and collaboration between the 1 tribe and 1 local health jurisdiction regarding the distribution of medical countermeasures.
Mission Area(s)	Response
Core Capabilities	PHEP Capability 06: Information Sharing PHEP Capability 09: Medical Materiel Management and Distribution
Overarching Objectives	<p>PHEP Capability 06 Information Sharing: Test the ability of federal, state, local, and tribal governments to exchange information and situational awareness data in preparation for, and response to, a plague outbreak.</p> <p>PHEP Capability 09 Medical Materiel Management and Distribution: Test the ability to coordinate logistical operations and medical material requests among federal, state, local, and tribal jurisdictions.</p>
Threat or Hazard	Pneumonic plague
Scenario	The exercise scenario included an outbreak of plague shortly after the annual tribal canoe journey that draws the participation of thousands of Natives and non-Natives from Washington, Idaho, Oregon, Canada and other countries visiting various locations along the Pacific coast of Washington and Puget Sound.
Participating Organizations	A total of 16 individuals participated in the exercise. Puyallup Tribe Pierce County Emergency Management Tacoma-Pierce County Health Department Washington State Department of Health
Point of Contact	Lou Schmitz, Consultant for American Indian Health Commission, <a href="mailto:lou.schmitz.aihc@outlook.com">lou.schmitz.aihc@outlook.com</a>

## SECTION 2: EXERCISE DESIGN AND SCENARIO SUMMARY

### Exercise Purpose and Design

On June 13, 2018, the American Indian Health Commission for Washington State (Commission) in partnership with the Washington State Department of Health (DOH) conducted a public health tabletop exercise where the DOH's Incident Management Team (IMT) was activated, and tribes, DOH, and LHJs coordinated on the distribution of medical countermeasures to tribes.

The exercise was conducted to strengthen the response capabilities of tribal, state, and local governments and to assure the appropriate amount and type of medical countermeasures and materiel reach every tribe quickly during public health emergencies. This exercise was developed and conducted by the Commission, in cooperation with representatives from DOH and various tribal and local governments and organizations.

The exercise was designed to test tribal, state, and local health jurisdiction plans, policies and procedures and provide an opportunity to evaluate current operations concepts, plans, and capabilities in response to a public health incident. The exercise was developed and evaluated utilizing objectives that were identified by tribal, state, and local government representatives.



### Exercise Planning Process

The Commission facilitated a planning meeting at each of the nine public health emergency planning regions for representatives from DOH, tribes and local health jurisdictions. The purpose of the planning meetings was for each region to: (1) increase partners' understanding of the various jurisdictions' capacity, organization, resources, etc; and (2) plan a tabletop exercise. Participants' suggestions were incorporated into the exercise design. The Commission designed the exercise, with technical assistance from DOH on epidemiological and logistical details.

## Exercise Objectives

### Objective 1: PHEP Capability 09 Medical Materiel Management and Distribution

Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### Objective 2: PHEP Capability 06 Information Sharing

Test resource and information-sharing between tribal and non-tribal jurisdictions

## Scenario Summary

The scenario for this exercise utilizes a public health incident that involves a population exposure to pneumonic plague. Cascading events require the incident managers and responders to take steps to identify, mitigate the effects of, protect the community from, and respond to the hazard and to acquire prophylaxis through the state medical countermeasures distribution system.

## Assumptions

If a tribe requests medical countermeasures directly from the federal government, the federal government will coordinate with the State and deliver medical countermeasures the Washington State Receive Stage and Store (RSS) warehouse in Tumwater.<sup>1</sup>

## Major and Detailed Events

- **Early August 2018:** There have been no major public health emergencies in the region. The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations. The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route. Over 2500 Native and non-Native individuals participated in the many canoe journey events.
- **Day One August 6, 2018.** The local hospital has admitted two non-Native patients (34-year-old female, 19-year-old male) with symptoms of: (1) high fever; (2) severe weakness;

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<sup>1</sup> Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives on a March 15, 2018 webinar.

(3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.

- **Day Three August 8, 2018 Morning.** The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one.
- **Day Three August 8, 2018 Afternoon.** A tribal clinic has had two patients (58-year-old female, 66-year-old male) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.
- **Day Four August 9, 2018.** A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia. One of the patients participated in the annual canoe journey. Both tribal patients who presented on Day Three are critically ill. All 5 tribal patients that have presented with symptoms are ages 55 and older.
- **Day Five – August 10, 2018 Morning.** Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington. Washington State Emergency Management Division (EMD) is now activated and a Mission Number has been issued. DOH Incident Management Team (IMT) is now activated.
- **Day Five – August 10, 2018 Morning.** Three local health jurisdiction employees have called in sick and have been referred to the hospital for care. Two nurses from the hospital have become ill with the same symptoms. The two initial tribal clinic patients were diagnosed with pneumonic plague. Both initial tribal patients attended the canoe journey. Centers for Disease Control and Prevention (CDC) Director published a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment. The initial shipment to Washington State will be insufficient to administer prophylaxis to the entire target population. More supplies will be available in 10-14 days. Tribal and nontribal health jurisdictions need to request medical countermeasures.



- **Day Five-August 10, 2018 Afternoon.** A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS. A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle.
- **Day Five-August 10, 2018 Afternoon.** A local health jurisdiction has requested use of tribal staff to dispense medical countermeasures. A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts.
- **Day Six-August 11, 2018.** The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse.

## SECTION 3: KEY FINDINGS

The 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise was developed to assess the capability of tribes, the Washington State Department of Health (DOH), and the local health jurisdictions (LHJs) to coordinate distribution of medical countermeasures to tribal nations during a public health incident. A tabletop exercise was held in each of Washington State's nine (9) public health emergency preparedness regions.

The following objectives that were exercised align with the Centers for Disease Control (CDC) Public Health Emergency Preparedness Capabilities (PHEP):

<b>Exercise Objective</b>	<b>Objective Description</b>	<b>Related PHEP Capability Number/Description</b>
Objective 1	Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.	C09 Medical Materiel Management and Distribution
Objective 2	Test resource and information-sharing between tribal and non-tribal jurisdictions	C06 Information Sharing

This section of the After Action Report (AAR) presents strategic findings as they relate to the tabletop objectives and key issues that were identified as a result of the exercise.

## **MEDICAL MATERIEL MANAGEMENT AND DISTRIBUTION (RELATES TO PHEP CAPABILITY 09).**

Objective 1 of this tabletop exercise tested the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### **Major Strengths**

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** The DOH and almost all LHJs recognized the sovereign authority of tribes to determine who their priority populations are in the dispensing of medical countermeasures, even if that determination may conflict with CDC guidelines. As a result, the DOH and most LHJs stated they will distribute medical countermeasures to the tribe regardless of the tribes' internal decisions regarding priority populations.
- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Most LHJs stated they have the capacity to deliver medical countermeasures to tribes.

### **Primary Areas for Improvement**

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** Not all LHJ representatives understand that their role is limited to transporting and/or handing over tribes' medical countermeasures allocations, unless a tribe specifically requests additional coordination or assistance. Some LHJ participants believe they have legal obligations to ensure that tribes follow CDC recommendations. This lack of understanding resulted in some tribes in Washington State not receiving vaccine and antivirals during the 2009 - 2010 H1N1 pandemic response and can produce catastrophic consequences during future public health incidents, unless corrected.



- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Some LHJs stated they may not have the capacity to deliver medical countermeasures directly to tribes.

- 3. Identification of Tribal Service Population.** Tribal service population numbers can vary greatly from one public health incident to another, due to large events like the annual Canoe Journey, Omak Stampede, pow wows, concerts, tourism, etc. Some LHJs noted the need for a system to inform the LHJs, during a response, specifically which population the tribe will be serving to avoid duplication or gaps.
- 4. Medical Countermeasures Plans.** Most local health jurisdictions' medical countermeasures planning documents do not address processes for distribution of medical countermeasures to tribes. Most tribes need to develop and adopt medical countermeasures plans, including a clear process for making decisions during public health incidents regarding how they want their medical countermeasures delivered.
- 5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.** There is no clearly documented system in place for including tribes in communication, decision-making, and coordination of efforts during public health incidents and responses.

## Recommendations

### 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.

- a) DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing.
- b) The United States federal government should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an agency consultation with tribes on these guidelines.
- c) DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government.
- d) DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes.

**2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** The Partner Profile form should

be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to



the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.

**3. Identification of Tribal Service Population.** DOH should develop and document a streamlined process for tribes to inform DOH of the population they will serve for each specific public health incident.

**4. Medical Countermeasures Plans.** Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.

**5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.**

- a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
- b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.
- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
- d. DOH and the Commission should continue to work with tribes to sign on to the "Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State" so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.

- e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 6. Pharmacy Memorandum of Understanding.** DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU). This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.
- 7. Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State.** DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.
- 8. Ability to Receive, Manage and Store Medical Countermeasures.** Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.
- 9. Staff Training.** Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.



**INFORMATION SHARING BETWEEN JURISDICTIONS (RELATES PHEP CAPABILITY 06).** Objective 2 of this tabletop exercise tested resource and information-sharing between tribal and non-tribal jurisdictions.

### Major Strengths

- 1. Reporting Public Health Incidents to State.** Once the LHJs received notice from the hospitals and/or clinics, all LHJs immediately contacted DOH during the exercise. DOH immediately began coordinating with the LHJs, the hospitals, and the tribes to begin an investigation to share information, determine where the disease originated and initiate response actions.
- 2. Reporting Public Health Incidents to Indian Health Care Providers.** Many LHJs maintain healthcare provider notification systems that include Indian health care providers and other tribal representatives. Tribal partners are eligible to register for the Washington State Department of Health's (DOH's) SECURES health alert system and receive notifications.

### Primary Areas for Improvement

- 1. Reporting Public Health Incident to Indian Health Care Providers.** Not all LHJs have a system in place to ensure all Indian health care providers and other tribal contacts are notified of a public health incident. Also, not every tribe is registered on the Washington State Department of Health's (DOH's) SECURES health alert system.
- 2. Accuracy and Maintenance of Contact List.** There is no system in place for maintaining accurate and current partner contact lists for individuals with key roles during responses. DOH's "Yellow Book" and "Red Book" are published in paper format, and thus not updated in real time. DOH has plans to convert the books to an online system, to be updated quarterly.

### Recommendations

- 1. Reporting Public Health Incidents to Indian Health Care Providers.**
  - a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
  - b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the correct tribal contacts are registered and kept current.

- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
  - d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 2. Accuracy and Maintenance of Contact List.** DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.

## **EMERGENCY PUBLIC INFORMATION AND WARNING (RELATES TO PHEP CAPABILITY 04):**

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.

### **Major Strengths**

- 1. LHJ Public Information Officers.** Some LHJs have public information officers who can quickly manage public information dissemination and provide technical assistance to other jurisdictions in the region that do not have this capability.
- 2. DOH Public Information Resources.** DOH has resources to provide technical assistance to LHJs and tribes regarding public information sharing and messaging.
- 3. Tribes' Knowledge Access to Communicating With Tribal Community Members and Expertise.** Tribes have comprehensive systems in place to communicate with their community members. They also have the knowledge to develop messaging that is respectful of culture and history, and appropriate for their community members.

### **Primary Areas for Improvement**

- 1. Inclusion of Tribes in State and Local Public Information Sharing.** There is no clearly documented system in place for coordination and collaboration on public information and messaging for the tribal communities. It is imperative for LHJs to coordinate with tribes on messaging, to assure respect for culture and history and assure message efficacy. Many tribal community members will disregard or distrust public health messages that do not originate from tribal council or other tribal officials. Health literacy is a critical factor to consider in ensuring community members understand alerts and notices. A strong understanding of the community's culture and historical context are also key. Messages should provide tribal community members with clear guidance on reasonable action steps they can take to protect themselves and others.



2. **Controlling Spread of Misinformation within Tribal Communities.** Tribes voiced concern about controlling information to the public in small communities where information spreads quickly and inaccurately through word of mouth and on social media. This spread of misinformation could result in tribal clinics being overwhelmed. Tribes expressed interest in receiving technical assistance in this area.

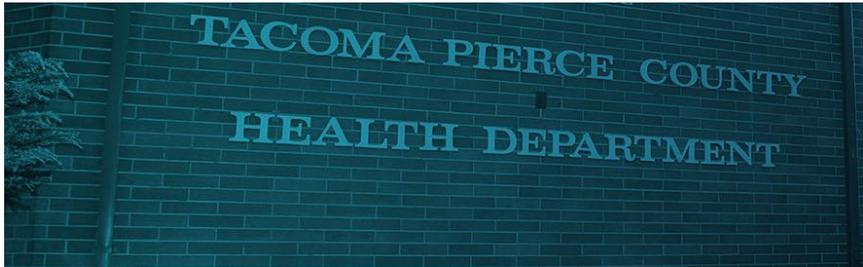
## Recommendations

1. **Inclusion of Tribes in State and Local Public Information Sharing.**
  - a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses.
  - b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.
2. **Controlling Spread of Misinformation within Tribal Communities.** The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.

**PUBLIC HEALTH SURVEILLANCE AND EPIDEMIOLOGICAL INVESTIGATION (RELATES TO CAPABILITY 13):** Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

### Major Strengths

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** All LHJs coordinate on some level with tribes when they must go on tribal lands to conduct epidemiological investigations that involve tribal community members. One LHJ partners with a tribe on conducting communicable disease investigations by including a tribal employee to serve as a community liaison. Several participants recognized the importance of having a tribal community liaison available during investigations, since tribal members may be hesitant to communicate with non-tribal members. The tribal community liaison can also be an especially valuable asset, given their knowledge of the community.



### Recommendations

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.

**RESPONDER SAFETY AND HEALTH (RELATES TO PHEP CAPABILITY 14):** The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

### Major Strengths

- 1. Access to Training and Personal Protective Equipment (PPE).** Many tribes and LHJs have access to training and personal protective equipment (PPE) necessary to safely respond to a public health incident.
- 2. Notification of Risk of Exposure to EMS Personnel.** Many tribes and LHJs have a system in place to notify emergency medical services (EMS) personnel before they transport a patient that can expose them to a communicable disease or other potential risk.

### Primary Areas for Improvement

- 1. Access to Training and Personal Protective Equipment (PPE).** Some tribes stated their law enforcement staff (and other potential responders) do not have access to PPE and training on PPE and other precautions needed to safely respond to incidents that may expose them to communicable diseases or other risks.
- 2. Notification of Risk of Exposure to EMS Personnel.** Some tribes and LHJs need to develop and implement standard operating procedures to ensure that EMS and other emergency responders are not exposed to communicable diseases or other potential risks.

### Recommendations

- 1. Access to Training and Personal Protective Equipment (PPE).**
  - a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.
  - b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.
- 2. Notification of Risk of Exposure to EMS Personnel.** All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other

emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.

**MEDICAL SURGE (RELATES TO PHEP CAPABILITY 10):** 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.

### Major Strengths

- 1. Tribal Clinic Capacity and Expertise.** Many tribal clinics are well equipped and staffed to respond to a public health incident, and plan to continue serving their patient population for the duration of most public health incidents.



### Areas for Improvement

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Most tribal clinics do not have Continuity of Operations (COOP) Plans or Crisis Standards of Care to clearly guide their operations during a public health incident.

### Recommendations

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.

## Appendix A: IMPROVEMENT PLAN

The Improvement Plan (IP) specifically details what actions will be taken to address each recommendation presented in the After Action Report (AAR), who or what entity will be responsible for taking the action, and the timeline for completion.

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Medical Materiel Management and Distribution</b> (Relates to PHEP Capability 9)	1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes	a. DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing	a. DOH	10/30/19
		b. The United States federal government (CDC/ASPR) should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an	b. CDC and ASPR	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>agency consultation with tribes on these guidelines.</p> <p>c. DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government</p> <p>d. DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes</p>	<p>c. DOH and Commission</p> <p>d. DOH and Commission</p>	<p>10/30/19</p> <p>12/30/19</p>
	2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.	The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.	DOH and Commission	10/30/19
	3. Identification of Tribal Service Population.	DOH should develop and document a streamlined process for tribes to inform DOH	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		of the population they will serve for each specific public health incident.		
	4. Medical Countermeasures Plans.	Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.	LHJs and Tribes	04/30/19
	5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.	<ul style="list-style-type: none"> <li>a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.</li> <li>b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.</li> <li>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g.</li> </ul>	<ul style="list-style-type: none"> <li>LHJs and Tribes</li> <li>LHJs and Tribes</li> <li>DOH</li> </ul>	<ul style="list-style-type: none"> <li>04/30/19</li> <li>04/30/19</li> <li>06/30/19</li> </ul>

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH and the Commission should continue to work with tribes to sign on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.</p> <p>e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH and Commission</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	6. Pharmacy Memorandum of Understanding	DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU).	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.		
	7 Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State	DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.	DOH and Commission	06/30/19
	8. Ability to Receive, Manage and Store Medical Countermeasures	Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.	Tribes and LHJs	04/30/19
	9. Staff Training	Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.	Tribes and LHJs	04/30/19
Information Sharing between Jurisdictions (Relates to PHEP Capability 6)	1. Reporting Public Health Incidents to Indian Health Care Providers	a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.	Tribes and LHJs	04/30/19
		b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>correct tribal contacts are registered and kept current.</p> <p>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	2. Accuracy and Maintenance of Contact List	DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Emergency Public Information and Warning</b> (Relates to PHEP Capability 4)	1. Inclusion of Tribes in State and Local Public Information Sharing	a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses. .	LHJs and Tribes	04/30/19
		b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.	DOH and Commission	06/30/19
	2. Controlling Spread of Misinformation Within Tribal Communities	The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.	DOH and Commission	6/30/19
<b>Public Health Surveillance and Epidemiological Investigation</b> (Relates to PHEP capability 13)	LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.	LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.	LHJs and Tribes	6/30/19
<b>Responder Safety and Health</b> (Relates to PHEP capability 14)	1. Access to Training and Personal Protective Equipment	a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and	LHJs and Tribes	6/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.</p> <p>b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.</p>	DOH and Commission	06/30/19
	2. Notification of Risk of Exposure to EMS Personnel.	All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.	LHJs and Tribes	6/30/19
<b>Medical Surge</b> (Relates to PHEP capability 10)	Continuity of Operations (COOP) Plans and Crisis Standards of Care	Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.	Tribes	4/30/19

## Appendix B: TABLETOP EXERCISE SLIDES

# **Cross-Jurisdictional Collaboration Project Medical Countermeasures**

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## **Tabletop Exercise**

**May 2018**



**American Indian Health Commission**  
for Washington State

# Agenda



**Introductions and Overview**



**Unfolding Situation → Decisions and Responses**



**Break**



**Later Developments → Decisions and Responses**



**Break and Photos**



**Hotwash, Findings and Self-Evaluation**



**Next Steps**

# **Introductions and Overview**





# **Introductions**

- **What is your job title?**
- **How long have you worked in your current position?**
- **What responsibilities do you have related to community emergency preparedness?**

# What are Medical Countermeasures (MCM)?

- Medical treatments or prophylaxes for public health threats
- Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



# Medical Countermeasures and Tribes

- Each time an incident occurs, a tribe has the sovereign authority to choose how medical countermeasures are distributed to their community by federal, state, and or local governments
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for each incident, ensuring the fastest response and protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE and LHJ**  
coordinate  
conveyance of  
MCMs to **TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

\*"Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5-6.

## Option 4 → Tribe Contacts Federal Government

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity; **\*SEE FEDERAL REFERENCES BELOW.**

### \*Version 11

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”

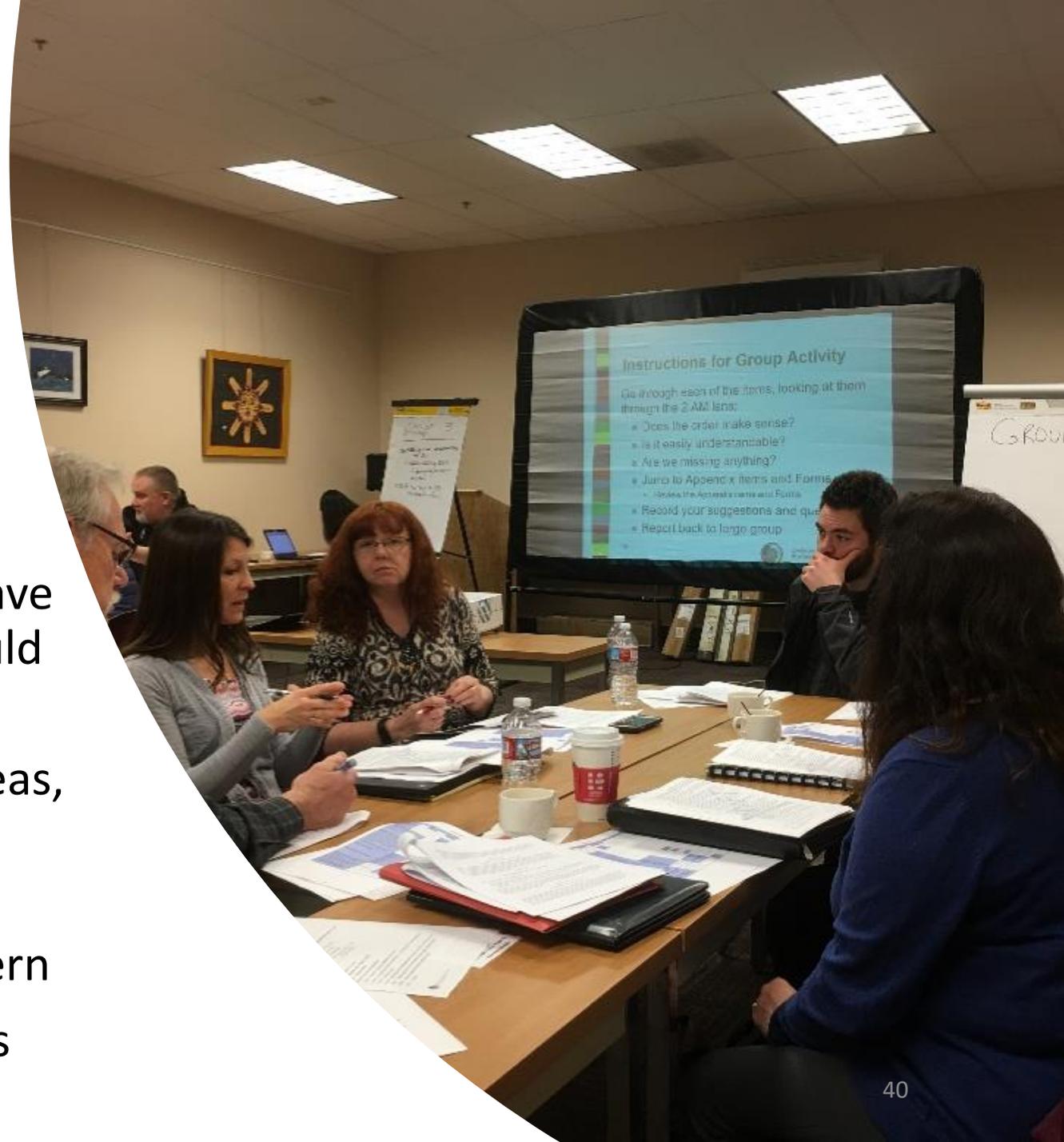
See CDC’s “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5.

“the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.” Version 11, p. 6

**Regardless of the dispensing option chosen, MCMs will be distributed through the system developed by the state health department once an emergency is declared** and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the community has access to MCMs. Version 11, p. 6. *Emphasis added.*

# What is a Tabletop Exercise?

- An informal discussion using a scripted scenario as a catalyst
- Identifies gaps in our plans, issues we have not yet thought about, changes we should make to our plans
- Promotes free and open exchange of ideas, no time pressures
- Opportunity to discuss issues in depth, collaboratively examining areas of concern
- There are no “right” or “wrong” answers



# Purpose of the Tabletop Exercise

Testing communication and MCM distribution processes through a tabletop exercise will increase:

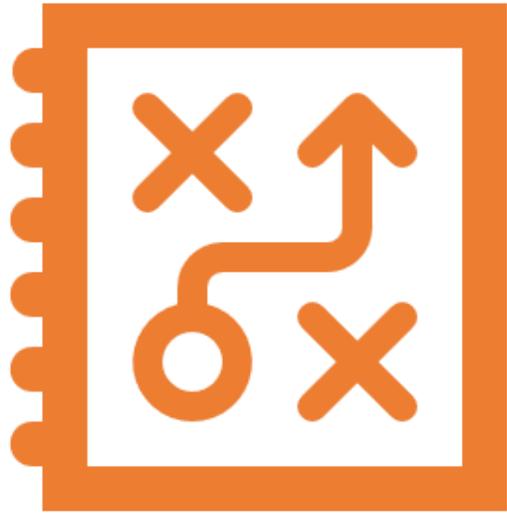
- tribes' understanding of how the different options will work for their communities and strengthen their decision-making at the time of an incident
- tribal, local, and state partners' understanding of how they will interact during MCM distribution



# Specific Objectives

1. Test the region's ability to effectively coordinate distribution of MCM across tribal and nontribal jurisdictions
2. Identify strengths and areas for improvement
3. Identify potential legal issues
4. Test resource- and information-sharing between tribal and non-tribal jurisdictions
5. Have each tribe make an informed analysis of what will be the most likely option for MCM distribution to its jurisdiction





# Tabletop Scenario



# Assumptions

- The purpose of this exercise is to identify gaps and vulnerabilities
- No jurisdiction is fully prepared for this type of public health emergency
- Open, honest and respectful dialogue and feedback are expected and valued throughout the exercise
- Today's exercise, discussions, and findings will inform future preparedness planning and actions

# Assumptions

- If a tribe requests medical countermeasures directly from the federal government, the federal government will deliver medical countermeasures to one site for the entire State of Washington - the Washington State Receive Stage and Store (RSS) warehouse

(Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives)





# Early August 2018

- There have been no major public health emergencies in your region
- The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations
- The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route
- Over 7500 Native and non-Native individuals participated in the many canoe journey events



## **Day One – August 6, 2018**

The local hospital has admitted two non-Native patients (34 year old female, 19 year old male) with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# Day One Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Morning**

The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one



# Pneumonic plague

Pneumonic plague is a severe lung infection caused by the bacterium *Yersinia pestis*. Symptoms include fever, headache, shortness of breath, chest pain, and cough. They typically start about three to seven days after exposure. It is one of three forms of plague, the other two being septicemic plague and bubonic plague.

Pneumonic plague can be caused in two ways: primary, which results from the inhalation of aerosolized plague bacteria, or secondary, when septicemic plague spreads into lung tissue from the bloodstream. Pneumonic plague is not exclusively vector-borne like bubonic plague; instead it can be spread from person to person.

Pneumonic plague symptoms often include fever, weakness, and headache as well as rapidly developing pneumonia with shortness of breath, cough, and chest pain.

<https://emergency.cdc.gov/agent/plague/factsheet.asp>

<https://www.cdc.gov/plague/faq/index.html>



# **Day Three Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Afternoon**

A tribal clinic has had two patients (58 year old female, 66 year old male) present with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



## **Day Three Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?

# Day Four – August 9, 2018

- A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of:
  - high fever
  - severe weakness
  - bloody sputum
  - shortness of breath
  - possible pneumonia
- One of the patients participated in the annual canoe journey
- Both tribal patients who presented on Day Three are critically ill
- All 5 tribal patients that have presented with symptoms are ages 55 and older





# Day Four Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Morning**

- Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington
- Washington State Emergency Management Division (EMD) is now activated – Mission Number has been issued
- DOH Incident Management Team (IMT) is now activated

# Day Five – August 10, 2018

## Morning

- Three local health jurisdiction employees have called in sick and have been referred to the hospital for care
- Two nurses from the hospital have become ill with the same symptoms
- The two initial tribal clinic patients were diagnosed with pneumonic plague
- Both initial tribal patients attended the canoe journey
- Centers for Disease Control and Prevention (CDC) Director publishes a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment; the initial shipment to Washington State will be sufficient to administer prophylaxis to 80% of the 25 and younger population in Washington; more will be available in 10-14 days
- Tribal and nontribal health jurisdictions need to request medical countermeasures





# **Day Five Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS
- A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A local health jurisdiction needs to request use of tribal staff to dispense medical countermeasures
- A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



**Centers for Disease Control (CDC)  
Strategic National Stockpile  
"Push Pack"**

## **Day Six – August 11, 2018**

The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse



# Day Six Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



# Hotwash, Findings and Self-Evaluation

# Next Steps

- AIHC will provide each jurisdiction with their compiled notes and after-action report (AAR)
- Tribes and LHJs complete the Partner Profile Form and return to AIHC ASAP
- Other?



## Appendix C: TABLETOP SIGN-IN SHEET



American Indian Health Commission  
For Washington State

REGION 5

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

June 13, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Carrie Corder	Specialist - Emergency Preparedness	carrie.corder@doh.wa.gov
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Nigel Turner	DIVISION DIRECTOR	nturner@tpchd.org
Cindy Miron	Program Manager - PITEP	cmiron@tpchd.org
Rebecca Baron	Training & Exercise Coordinator	rbaron@tpchd.org
TERESA Mathews	Puyallup Tribe EMERGENCY Management	Teresa.l.mathews@PuyallupTribe.com
JASON Dillon	Puyallup Tribe EMERGENCY MANAGEMENT COOR.	JASON.Dillon@puyallupTribe.com



American Indian Health Commission  
For Washington State

## REGION 5

### Cross-Jurisdictional Collaboration Project

#### TABLETOP EXERCISE

June 13, 2018  
SIGN-IN SHEET



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**Public Health**  
Seattle & King County



# 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise

After Action Report and Improvement Plan

**Region 6**



**American Indian Health Commission  
for Washington State**

*In partnership with*



## Acronyms

Acronym	Definition
AAR	After Action Report
ASPR	Office of the Assistant Secretary for Preparedness and Response
CDC	Center for Disease Control
COOP	Continuity of Operations Plan
DOH	Washington State Department of Health
LHJ	Local Health Jurisdiction
MCM	Medical Countermeasures
POD	Point of Dispensing
PPE	Personal Protective Equipment
RSS	Receive, Stage and Store Warehouse

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## PREFACE

An After Action Report and Improvement Plan (AAR/IP) provide actionable insights for building community preparedness by documenting strengths and areas for improvement that participants identify during a simulated response to an emergency.

This report is tangible evidence of the valuable partnerships that exist between tribes, local governments and Washington State to improve public health preparedness in our communities. It serves as a collection of lessons learned, outlines recommended actions, and provides the basis for planning future exercises. This AAR/IP will contribute to improving future incident responses, training, exercises, equipment prioritization, plan effectiveness and overall preparedness.

The tabletop exercise this AAR documents was part of the American Indian Health Commission's Cross-Jurisdictional Collaboration Project of 2018. The project was facilitated by the American Indian Health Commission for Washington State (AIHC) with funding from the Washington State Department of Health (DOH).

## AREAS FOR IMPROVEMENT

Areas for improvement identified by participants from the Muckleshoot Tribe, Public Health Seattle-King County and Northwest Healthcare Response Network include:

- Increasing coordination between Muckleshoot Tribe, Snoqualmie Tribe, Public Health Seattle-King County and Northwest Healthcare Response Network
- Increasing opportunities for Muckleshoot Tribe, Snoqualmie Tribe, King County and NWHRN to exercise together

## STRENGTHS

Strengths identified by participants from the Muckleshoot Tribe, Public Health Seattle-King County and Northwest Healthcare Response Network include:

- Existing relationships between Muckleshoot Tribe and Public Health Seattle King County through programs like Communicable Disease-Epidemiology and Immunizations
- Strong commitment by all jurisdictions to work together

The American Indian Health Commission for Washington State wishes to express gratitude and appreciation for the many tribal, local and state partners that participated in this project and invested significant time and effort in support of our shared commitment to protecting the lives of all Washington State citizens.

## SECTION 1: EXERCISE OVERVIEW

Exercise Name	2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise
Exercise Dates	June 1, 2018
Scope	This exercise was a discussion-based tabletop exercise for Region 6, to address coordination and collaboration between the 2 tribes and 1 local health jurisdiction regarding the distribution of medical countermeasures.
Mission Area(s)	Response
Core Capabilities	PHEP Capability 06: Information Sharing PHEP Capability 09: Medical Materiel Management and Distribution
Overarching Objectives	<p>PHEP Capability 06 Information Sharing: Test the ability of federal, state, local, and tribal governments to exchange information and situational awareness data in preparation for, and response to, a plague outbreak.</p> <p>PHEP Capability 09 Medical Materiel Management and Distribution: Test the ability to coordinate logistical operations and medical material requests among federal, state, local, and tribal jurisdictions.</p>
Threat or Hazard	Pneumonic plague
Scenario	The exercise scenario included an outbreak of plague shortly after the annual tribal canoe journey that draws the participation of thousands of Natives and non-Natives from Washington, Idaho, Oregon, Canada and other countries visiting various locations along the Pacific coast of Washington and Puget Sound.
Participating Organizations	A total of 12 individuals participated in the exercise. Muckleshoot Tribe Seattle-King County Public Health Washington State Department of Health
Point of Contact	Lou Schmitz, Consultant for American Indian Health Commission, <a href="mailto:lou.schmitz.aihc@outlook.com">lou.schmitz.aihc@outlook.com</a>

## SECTION 2: EXERCISE DESIGN AND SCENARIO SUMMARY

### Exercise Purpose and Design

On June 1, 2018, the American Indian Health Commission for Washington State (Commission) in partnership with the Washington State Department of Health (DOH) conducted a public health tabletop exercise where the DOH's Incident Management Team (IMT) was activated, and tribes, DOH, and LHJs coordinated on the distribution of medical countermeasures to tribes.

The exercise was conducted to strengthen the response capabilities of tribal, state, and local governments and to assure the appropriate amount and type of medical countermeasures and materiel reach every tribe quickly during public health emergencies. This exercise was developed and conducted by the Commission, in cooperation with representatives from DOH and various tribal and local governments and organizations.

The exercise was designed to test tribal, state, and local health jurisdiction plans, policies and procedures and provide an opportunity to evaluate current operations concepts, plans, and capabilities in response to a public health incident. The exercise was developed and evaluated utilizing objectives that were identified by tribal, state, and local government representatives.



### Exercise Planning Process

The Commission facilitated a planning meeting at each of the nine public health emergency planning regions for representatives from DOH, tribes and local health jurisdictions. The purpose of the planning meetings was for each region to: (1) increase partners' understanding of the various jurisdictions' capacity, organization, resources, etc; and (2) plan a tabletop exercise. Participants' suggestions were incorporated into the exercise design. The Commission designed the exercise, with technical assistance from DOH on epidemiological and logistical details.

## Exercise Objectives

### **Objective 1: PHEP Capability 09 Medical Materiel Management and Distribution**

Test the state and region’s ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### **Objective 2: PHEP Capability 06 Information Sharing**

Test resource and information-sharing between tribal and non-tribal jurisdictions

## Scenario Summary

The scenario for this exercise utilizes a public health incident that involves a population exposure to pneumonic plague. Cascading events require the incident managers and responders to take steps to identify, mitigate the effects of, protect the community from, and respond to the hazard and to acquire prophylaxis through the state medical countermeasures distribution system.

## Assumptions

If a tribe requests medical countermeasures directly from the federal government, the federal government will coordinate with the State and deliver medical countermeasures the Washington State Receive Stage and Store (RSS) warehouse in Tumwater.<sup>1</sup>

## Major and Detailed Events

- **Early August 2018:** There have been no major public health emergencies in the region. The mild winter and the hot and dry summer have caused many of Washington’s regions to experience flea infestations. The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route. Over 2500 Native and non-Native individuals participated in the many canoe journey events.
- **Day One August 6, 2018.** The local hospital has admitted two non-Native patients (34-year-old female, 19-year-old male) with symptoms of: (1) high fever; (2) severe weakness;

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<sup>1</sup> Based on CDC’s guidance “Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11” and discussion with CDC representatives on a March 15, 2018 webinar.

(3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.

- **Day Three August 8, 2018 Morning.** The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one.
- **Day Three August 8, 2018 Afternoon.** A tribal clinic has had two patients (58-year-old female, 66-year-old male) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.
- **Day Four August 9, 2018.** A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia. One of the patients participated in the annual canoe journey. Both tribal patients who presented on Day Three are critically ill. All 5 tribal patients that have presented with symptoms are ages 55 and older.
- **Day Five – August 10, 2018 Morning.** Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington. Washington State Emergency Management Division (EMD) is now activated and a Mission Number has been issued. DOH Incident Management Team (IMT) is now activated.
- **Day Five – August 10, 2018 Morning.** Three local health jurisdiction employees have called in sick and have been referred to the hospital for care. Two nurses from the hospital have become ill with the same symptoms. The two initial tribal clinic patients were diagnosed with pneumonic plague. Both initial tribal patients attended the canoe journey. Centers for Disease Control and Prevention (CDC) Director published a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment. The initial shipment to Washington State will be insufficient to administer prophylaxis to the entire target population. More supplies will be available in 10-14 days. Tribal and nontribal health jurisdictions need to request medical countermeasures.



- **Day Five-August 10, 2018 Afternoon.** A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS. A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle.
- **Day Five-August 10, 2018 Afternoon.** A local health jurisdiction has requested use of tribal staff to dispense medical countermeasures. A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts.
- **Day Six-August 11, 2018.** The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse.

## SECTION 3: KEY FINDINGS

The 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise was developed to assess the capability of tribes, the Washington State Department of Health (DOH), and the local health jurisdictions (LHJs) to coordinate distribution of medical countermeasures to tribal nations during a public health incident. A tabletop exercise was held in each of Washington State's nine (9) public health emergency preparedness regions.

The following objectives that were exercised align with the Centers for Disease Control (CDC) Public Health Emergency Preparedness Capabilities (PHEP):

<b>Exercise Objective</b>	<b>Objective Description</b>	<b>Related PHEP Capability Number/Description</b>
Objective 1	Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.	C09 Medical Materiel Management and Distribution
Objective 2	Test resource and information-sharing between tribal and non-tribal jurisdictions	C06 Information Sharing

This section of the After Action Report (AAR) presents strategic findings as they relate to the tabletop objectives and key issues that were identified as a result of the exercise.

## MEDICAL MATERIEL MANAGEMENT AND DISTRIBUTION (RELATES TO PHEP CAPABILITY 09).

Objective 1 of this tabletop exercise tested the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### Major Strengths

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** The DOH and almost all LHJs recognized the sovereign authority of tribes to determine who their priority populations are in the dispensing of medical countermeasures, even if that determination may conflict with CDC guidelines. As a result, the DOH and most LHJs stated they will distribute medical countermeasures to the tribe regardless of the tribes' internal decisions regarding priority populations.
- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Most LHJs stated they have the capacity to deliver medical countermeasures to tribes.

### Primary Areas for Improvement

#### 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.

Not all LHJ representatives understand that their role is limited to transporting and/or handing over tribes' medical countermeasures allocations, unless a tribe specifically requests additional coordination or assistance. Some LHJ participants believe they have legal obligations to ensure that tribes follow CDC recommendations. This lack of understanding resulted in some tribes in Washington State not receiving vaccine and antivirals during the 2009 - 2010 H1N1 pandemic response and can produce catastrophic consequences during future public health incidents, unless corrected.



- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Some LHJs stated they may not have the capacity to deliver medical countermeasures directly to tribes.

- 3. Identification of Tribal Service Population.** Tribal service population numbers can vary greatly from one public health incident to another, due to large events like the annual Canoe Journey, Omak Stampede, pow wows, concerts, tourism, etc. Some LHJs noted the need for a system to inform the LHJs, during a response, specifically which population the tribe will be serving to avoid duplication or gaps.
- 4. Medical Countermeasures Plans.** Most local health jurisdictions' medical countermeasures planning documents do not address processes for distribution of medical countermeasures to tribes. Most tribes need to develop and adopt medical countermeasures plans, including a clear process for making decisions during public health incidents regarding how they want their medical countermeasures delivered.
- 5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.** There is no clearly documented system in place for including tribes in communication, decision-making, and coordination of efforts during public health incidents and responses.

## Recommendations

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.**
  - a) DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing.
  - b) The United States federal government should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an agency consultation with tribes on these guidelines.
  - c) DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government.
  - d) DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes.

**2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.**

The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.



**3. Identification of Tribal Service Population.** DOH should develop and document a streamlined process for tribes to inform DOH of the population they will serve for each specific public health incident.

**4. Medical Countermeasures Plans.** Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.

**5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.**

- a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
- b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.
- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
- d. DOH and the Commission should continue to work with tribes to sign on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.
- e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the

MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.

- 6. Pharmacy Memorandum of Understanding.** DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU). This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.
- 7. Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State.** DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.
- 8. Ability to Receive, Manage and Store Medical Countermeasures.** Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.
- 9. Staff Training.** Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.



**INFORMATION SHARING BETWEEN JURISDICTIONS (RELATES PHEP CAPABILITY 06).** Objective 2 of this tabletop exercise tested resource and information-sharing between tribal and non-tribal jurisdictions.

### Major Strengths

- 1. Reporting Public Health Incidents to State.** Once the LHJs received notice from the hospitals and/or clinics, all LHJs immediately contacted DOH during the exercise. DOH immediately began coordinating with the LHJs, the hospitals, and the tribes to begin an investigation to share information, determine where the disease originated and initiate response actions.
- 2. Reporting Public Health Incidents to Indian Health Care Providers.** Many LHJs maintain healthcare provider notification systems that include Indian health care providers and other tribal representatives. Tribal partners are eligible to register for the Washington State Department of Health's (DOH's) SECURES health alert system and receive notifications.

### Primary Areas for Improvement

- 1. Reporting Public Health Incident to Indian Health Care Providers.** Not all LHJs have a system in place to ensure all Indian health care providers and other tribal contacts are notified of a public health incident. Also, not every tribe is registered on the Washington State Department of Health's (DOH's) SECURES health alert system.
- 2. Accuracy and Maintenance of Contact List.** There is no system in place for maintaining accurate and current partner contact lists for individuals with key roles during responses. DOH's "Yellow Book" and "Red Book" are published in paper format, and thus not updated in real time. DOH has plans to convert the books to an online system, to be updated quarterly.

### Recommendations

- 1. Reporting Public Health Incidents to Indian Health Care Providers.**
  - a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
  - b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the correct tribal contacts are registered and kept current.

- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
  - d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 2. Accuracy and Maintenance of Contact List.** DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.

## **EMERGENCY PUBLIC INFORMATION AND WARNING (RELATES TO PHEP CAPABILITY 04):**

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.

### **Major Strengths**

- 1. LHJ Public Information Officers.** Some LHJs have public information officers who can quickly manage public information dissemination and provide technical assistance to other jurisdictions in the region that do not have this capability.
- 2. DOH Public Information Resources.** DOH has resources to provide technical assistance to LHJs and tribes regarding public information sharing and messaging.
- 3. Tribes' Knowledge Access to Communicating With Tribal Community Members and Expertise.** Tribes have comprehensive systems in place to communicate with their community members. They also have the knowledge to develop messaging that is respectful of culture and history, and appropriate for their community members.

### **Primary Areas for Improvement**

- 1. Inclusion of Tribes in State and Local Public Information Sharing.** There is no clearly documented system in place for coordination and collaboration on public information and messaging for the tribal communities. It is imperative for LHJs to coordinate with tribes on messaging, to assure respect for culture and history and assure message efficacy. Many tribal community members will disregard or distrust public health messages that do not originate from tribal council or other tribal officials. Health literacy is a critical factor to consider in ensuring community members understand alerts and notices. A strong understanding of the community's culture and historical context are also key. Messages should provide tribal community members with clear guidance on reasonable action steps they can take to protect themselves and others.



2. **Controlling Spread of Misinformation within Tribal Communities.** Tribes voiced concern about controlling information to the public in small communities where information spreads quickly and inaccurately through word of mouth and on social media. This spread of misinformation could result in tribal clinics being overwhelmed. Tribes expressed interest in receiving technical assistance in this area.

## Recommendations

1. **Inclusion of Tribes in State and Local Public Information Sharing.**
  - a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses.
  - b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.
2. **Controlling Spread of Misinformation within Tribal Communities.** The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.

**PUBLIC HEALTH SURVEILLANCE AND EPIDEMIOLOGICAL INVESTIGATION (RELATES TO CAPABILITY 13):** Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

### Major Strengths

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** All LHJs coordinate on some level with tribes when they must go on tribal lands to conduct epidemiological investigations that involve tribal community members. One LHJ partners with a tribe on conducting communicable disease investigations by including a tribal employee to serve as a community liaison. Several participants recognized the importance of having a tribal community liaison available during investigations, since tribal members may be hesitant to communicate with non-tribal members. The tribal community liaison can also be an especially valuable asset, given their knowledge of the community.



### Recommendations

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.

**RESPONDER SAFETY AND HEALTH (RELATES TO PHEP CAPABILITY 14):** The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

### Major Strengths

- 1. Access to Training and Personal Protective Equipment (PPE).** Many tribes and LHJs have access to training and personal protective equipment (PPE) necessary to safely respond to a public health incident.
- 2. Notification of Risk of Exposure to EMS Personnel.** Many tribes and LHJs have a system in place to notify emergency medical services (EMS) personnel before they transport a patient that can expose them to a communicable disease or other potential risk.

### Primary Areas for Improvement

- 1. Access to Training and Personal Protective Equipment (PPE).** Some tribes stated their law enforcement staff (and other potential responders) do not have access to PPE and training on PPE and other precautions needed to safely respond to incidents that may expose them to communicable diseases or other risks.
- 2. Notification of Risk of Exposure to EMS Personnel.** Some tribes and LHJs need to develop and implement standard operating procedures to ensure that EMS and other emergency responders are not exposed to communicable diseases or other potential risks.

### Recommendations

- 1. Access to Training and Personal Protective Equipment (PPE).**
  - a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.
  - b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.
- 2. Notification of Risk of Exposure to EMS Personnel.** All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other

emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.

**MEDICAL SURGE (RELATES TO PHEP CAPABILITY 10):** 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.

### Major Strengths

- 1. Tribal Clinic Capacity and Expertise.** Many tribal clinics are well equipped and staffed to respond to a public health incident, and plan to continue serving their patient population for the duration of most public health incidents.



### Areas for Improvement

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Most tribal clinics do not have Continuity of Operations (COOP) Plans or Crisis Standards of Care to clearly guide their operations during a public health incident.

### Recommendations

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.

## Appendix A: IMPROVEMENT PLAN

The Improvement Plan (IP) specifically details what actions will be taken to address each recommendation presented in the After Action Report (AAR), who or what entity will be responsible for taking the action, and the timeline for completion.

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Medical Materiel Management and Distribution</b> (Relates to PHEP Capability 9)	1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes	a. DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing	a. DOH	10/30/19
		b. The United States federal government (CDC/ASPR) should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an	b. CDC and ASPR	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>agency consultation with tribes on these guidelines.</p> <p>c. DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government</p> <p>d. DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes</p>	<p>c. DOH and Commission</p> <p>d. DOH and Commission</p>	<p>10/30/19</p> <p>12/30/19</p>
	2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.	The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.	DOH and Commission	10/30/19
	3. Identification of Tribal Service Population.	DOH should develop and document a streamlined process for tribes to inform DOH	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		of the population they will serve for each specific public health incident.		
	4. Medical Countermeasures Plans.	Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.	LHJs and Tribes	04/30/19
	5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.	<ul style="list-style-type: none"> <li>a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.</li> <li>b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.</li> <li>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g.</li> </ul>	<ul style="list-style-type: none"> <li>LHJs and Tribes</li> <li>LHJs and Tribes</li> <li>DOH</li> </ul>	<ul style="list-style-type: none"> <li>04/30/19</li> <li>04/30/19</li> <li>06/30/19</li> </ul>



Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.		
	7 Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State	DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.	DOH and Commission	06/30/19
	8. Ability to Receive, Manage and Store Medical Countermeasures	Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.	Tribes and LHJs	04/30/19
	9. Staff Training	Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.	Tribes and LHJs	04/30/19
Information Sharing between Jurisdictions (Relates to PHEP Capability 6)	1. Reporting Public Health Incidents to Indian Health Care Providers	a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.	Tribes and LHJs	04/30/19
		b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>correct tribal contacts are registered and kept current.</p> <p>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	2. Accuracy and Maintenance of Contact List	DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Emergency Public Information and Warning</b> (Relates to PHEP Capability 4)	1. Inclusion of Tribes in State and Local Public Information Sharing	a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses. .	LHJs and Tribes	04/30/19
		b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.	DOH and Commission	06/30/19
	2. Controlling Spread of Misinformation Within Tribal Communities	The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.	DOH and Commission	6/30/19
<b>Public Health Surveillance and Epidemiological Investigation</b> (Relates to PHEP capability 13)	LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.	LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.	LHJs and Tribes	6/30/19
<b>Responder Safety and Health</b> (Relates to PHEP capability 14)	1. Access to Training and Personal Protective Equipment	a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and	LHJs and Tribes	6/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.</p> <p>b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.</p>	DOH and Commission	06/30/19
	2. Notification of Risk of Exposure to EMS Personnel.	All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.	LHJs and Tribes	6/30/19
<b>Medical Surge</b> (Relates to PHEP capability 10)	Continuity of Operations (COOP) Plans and Crisis Standards of Care	Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.	Tribes	4/30/19

Appendix B: TABLETOP EXERCISE SLIDES

# **Cross-Jurisdictional Collaboration Project Medical Countermeasures**

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## **Tabletop Exercise**

**May 2018**



**American Indian Health Commission**  
for Washington State

# Agenda



**Introductions and Overview**



**Unfolding Situation → Decisions and Responses**



**Break**



**Later Developments → Decisions and Responses**



**Break and Photos**



**Hotwash, Findings and Self-Evaluation**



**Next Steps**

# **Introductions and Overview**





# **Introductions**

- **What is your job title?**
- **How long have you worked in your current position?**
- **What responsibilities do you have related to community emergency preparedness?**

# What are Medical Countermeasures (MCM)?

- Medical treatments or prophylaxes for public health threats
- Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



# Medical Countermeasures and Tribes

- Each time an incident occurs, a tribe has the sovereign authority to choose how medical countermeasures are distributed to their community by federal, state, and or local governments
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for each incident, ensuring the fastest response and protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE and LHJ**  
coordinate  
conveyance of  
MCMs to **TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

\*"Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5-6.

## Option 4 → Tribe Contacts Federal Government

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity; **\*SEE FEDERAL REFERENCES BELOW.**

### \*Version 11

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”

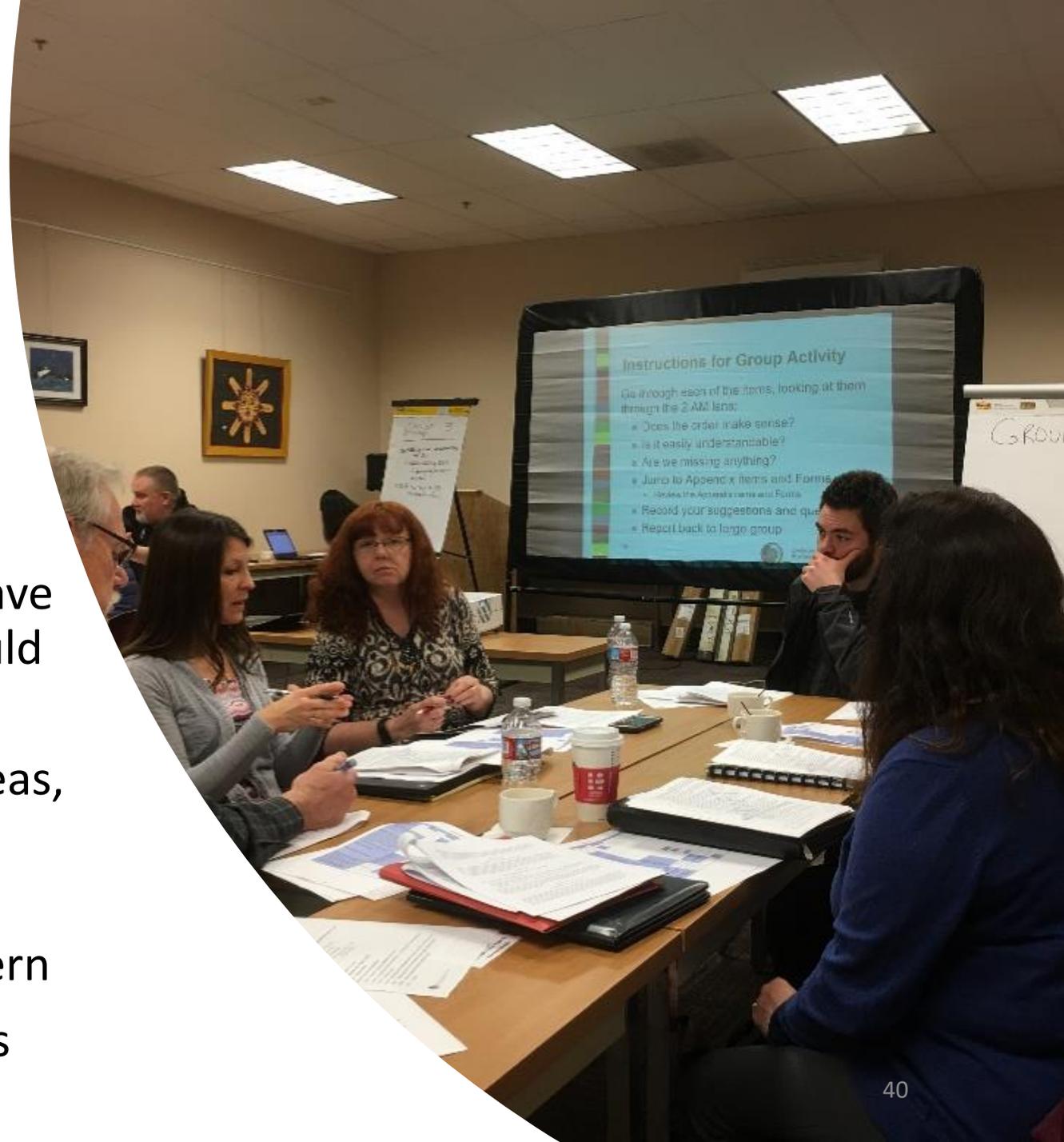
See CDC’s “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5.

“the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.” Version 11, p. 6

**Regardless of the dispensing option chosen, MCMs will be distributed through the system developed by the state health department once an emergency is declared** and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the community has access to MCMs. Version 11, p. 6. *Emphasis added.*

# What is a Tabletop Exercise?

- An informal discussion using a scripted scenario as a catalyst
- Identifies gaps in our plans, issues we have not yet thought about, changes we should make to our plans
- Promotes free and open exchange of ideas, no time pressures
- Opportunity to discuss issues in depth, collaboratively examining areas of concern
- There are no “right” or “wrong” answers



# Purpose of the Tabletop Exercise

Testing communication and MCM distribution processes through a tabletop exercise will increase:

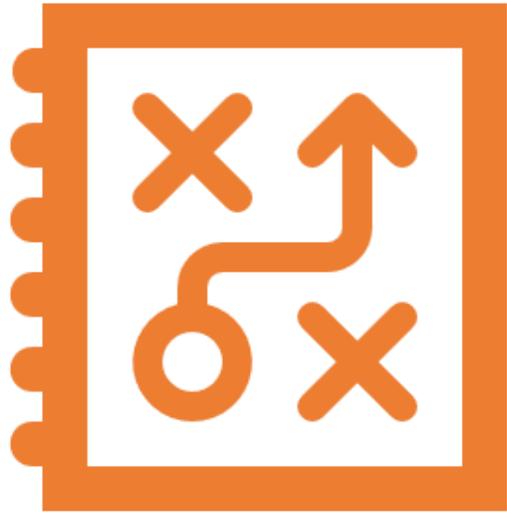
- tribes' understanding of how the different options will work for their communities and strengthen their decision-making at the time of an incident
- tribal, local, and state partners' understanding of how they will interact during MCM distribution



# Specific Objectives

1. Test the region's ability to effectively coordinate distribution of MCM across tribal and nontribal jurisdictions
2. Identify strengths and areas for improvement
3. Identify potential legal issues
4. Test resource- and information-sharing between tribal and non-tribal jurisdictions
5. Have each tribe make an informed analysis of what will be the most likely option for MCM distribution to its jurisdiction





# Tabletop Scenario



# Assumptions

- The purpose of this exercise is to identify gaps and vulnerabilities
- No jurisdiction is fully prepared for this type of public health emergency
- Open, honest and respectful dialogue and feedback are expected and valued throughout the exercise
- Today's exercise, discussions, and findings will inform future preparedness planning and actions

# Assumptions

- If a tribe requests medical countermeasures directly from the federal government, the federal government will deliver medical countermeasures to one site for the entire State of Washington - the Washington State Receive Stage and Store (RSS) warehouse

(Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives)





# Early August 2018

- There have been no major public health emergencies in your region
- The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations
- The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route
- Over 7500 Native and non-Native individuals participated in the many canoe journey events



## **Day One – August 6, 2018**

The local hospital has admitted two non-Native patients (34 year old female, 19 year old male) with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# Day One Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Morning**

The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one



# Pneumonic plague

Pneumonic plague is a severe lung infection caused by the bacterium *Yersinia pestis*. Symptoms include fever, headache, shortness of breath, chest pain, and cough. They typically start about three to seven days after exposure. It is one of three forms of plague, the other two being septicemic plague and bubonic plague.

Pneumonic plague can be caused in two ways: primary, which results from the inhalation of aerosolized plague bacteria, or secondary, when septicemic plague spreads into lung tissue from the bloodstream. Pneumonic plague is not exclusively vector-borne like bubonic plague; instead it can be spread from person to person.

Pneumonic plague symptoms often include fever, weakness, and headache as well as rapidly developing pneumonia with shortness of breath, cough, and chest pain.

<https://emergency.cdc.gov/agent/plague/factsheet.asp>

<https://www.cdc.gov/plague/faq/index.html>



# **Day Three Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 8, 2018 Afternoon**

A tribal clinic has had two patients (58 year old female, 66 year old male) present with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



## **Day Three Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?

# Day Four – August 9, 2018

- A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of:
  - high fever
  - severe weakness
  - bloody sputum
  - shortness of breath
  - possible pneumonia
- One of the patients participated in the annual canoe journey
- Both tribal patients who presented on Day Three are critically ill
- All 5 tribal patients that have presented with symptoms are ages 55 and older





# Day Four Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Morning**

- Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington
- Washington State Emergency Management Division (EMD) is now activated – Mission Number has been issued
- DOH Incident Management Team (IMT) is now activated

# Day Five – August 10, 2018

## Morning

- Three local health jurisdiction employees have called in sick and have been referred to the hospital for care
- Two nurses from the hospital have become ill with the same symptoms
- The two initial tribal clinic patients were diagnosed with pneumonic plague
- Both initial tribal patients attended the canoe journey
- Centers for Disease Control and Prevention (CDC) Director publishes a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment; the initial shipment to Washington State will be sufficient to administer prophylaxis to 80% of the 25 and younger population in Washington; more will be available in 10-14 days
- Tribal and nontribal health jurisdictions need to request medical countermeasures





# **Day Five Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS
- A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 10, 2018 Afternoon**

- A local health jurisdiction needs to request use of tribal staff to dispense medical countermeasures
- A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



**Centers for Disease Control (CDC)  
Strategic National Stockpile  
"Push Pack"**

## **Day Six – August 11, 2018**

The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse



# Day Six Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



# Hotwash, Findings and Self-Evaluation

# Next Steps

- AIHC will provide each jurisdiction with their compiled notes and after-action report (AAR)
- Tribes and LHJs complete the Partner Profile Form and return to AIHC ASAP
- Other?



## Appendix C: TABLETOP SIGN-IN SHEET

REGION 6

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

June 1, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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REGION 6

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

June 1, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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# 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise

After Action Report and Improvement Plan

**Region 7**



**American Indian Health Commission  
for Washington State**

*In partnership with*



## Acronyms

Acronym	Definition
AAR	After Action Report
ASPR	Office of the Assistant Secretary for Preparedness and Response
CDC	Center for Disease Control
COOP	Continuity of Operations Plan
DOH	Washington State Department of Health
LHJ	Local Health Jurisdiction
MCM	Medical Countermeasures
POD	Point of Dispensing
PPE	Personal Protective Equipment
RSS	Receive, Stage and Store Warehouse

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## PREFACE

An After Action Report and Improvement Plan (AAR/IP) provide actionable insights for building community preparedness by documenting strengths and areas for improvement that participants identify during a simulated response to an emergency.

This report is tangible evidence of the valuable partnerships that exist between tribes, local governments and Washington State to improve public health preparedness in our communities. It serves as a collection of lessons learned, outlines recommended actions, and provides the basis for planning future exercises. This AAR/IP will contribute to improving future incident responses, training, exercises, equipment prioritization, plan effectiveness and overall preparedness.

The tabletop exercise this AAR documents was part of the American Indian Health Commission's Cross-Jurisdictional Collaboration Project of 2018. The project was facilitated by the American Indian Health Commission for Washington State (AIHC) with funding from the Washington State Department of Health (DOH).

### STRENGTHS

Strengths identified by participants from the Colville Tribes, Indian Health Service and Chelan-Douglas Health Department include:

- Colville Tribes great expertise and experience in responding to emergencies
- Strong commitment by all partners to work together

### AREAS FOR IMPROVEMENT

Areas for improvement identified by participants from the Colville Tribes, Indian Health Service and Chelan-Douglas Health Department include:

- Increasing coordination between all partners on Communications, Public Messaging and Response Operations
- Increasing opportunities for the Tribe and Counties to exercise together

The American Indian Health Commission for Washington State wishes to express gratitude and appreciation for the many tribal, local and state partners that participated in this project and invested significant time and effort in support of our shared commitment to protecting the lives of all Washington State citizens.

## SECTION 1: EXERCISE OVERVIEW

Exercise Name	2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise
Exercise Dates	May 29, 2018
Scope	This exercise was a discussion-based tabletop exercise for Region 7, to address coordination and collaboration between the 1 tribe and 5 local health jurisdictions regarding the distribution of medical countermeasures.
Mission Area(s)	Response
Core Capabilities	PHEP Capability 06: Information Sharing PHEP Capability 09: Medical Materiel Management and Distribution
Overarching Objectives	<p>PHEP Capability 06 Information Sharing: Test the ability of federal, state, local, and tribal governments to exchange information and situational awareness data in preparation for, and response to, a plague outbreak.</p> <p>PHEP Capability 09 Medical Materiel Management and Distribution: Test the ability to coordinate logistical operations and medical material requests among federal, state, local, and tribal jurisdictions.</p>
Threat or Hazard	Pneumonic plague
Scenario	The exercise scenario included an outbreak of plague shortly after the annual Omak Stampede that draws the participation of thousands of Natives and non-Natives from Washington, Idaho, Oregon, Canada and other countries.
Participating Organizations	A total of 11 individuals participated in the exercise. Confederated Tribes of the Colville Reservation Chelan-Douglas Health Department Indian Health Service Washington State Department of Health

## SECTION 2: EXERCISE DESIGN AND SCENARIO SUMMARY

### Exercise Purpose and Design

On May 29, 2018, the American Indian Health Commission for Washington State (Commission) in partnership with the Washington State Department of Health (DOH) conducted a public health tabletop exercise where the DOH's Incident Management Team (IMT) was activated, and tribes, DOH, and LHJs coordinated on the distribution of medical countermeasures to tribes.

The exercise was conducted to strengthen the response capabilities of tribal, state, and local governments and to assure the appropriate amount and type of medical countermeasures and materiel reach every tribe quickly during public health emergencies. This exercise was developed and conducted by the Commission, in cooperation with representatives from DOH and various tribal and local governments and organizations.

The exercise was designed to test tribal, state, and local health jurisdiction plans, policies and procedures and provide an opportunity to evaluate current operations concepts, plans, and capabilities in response to a public health incident. The exercise was developed and evaluated utilizing objectives that were identified by tribal, state, and local government representatives.



### Exercise Planning Process

The Commission facilitated a planning meeting at each of the nine public health emergency planning regions for representatives from DOH, tribes and local health jurisdictions. The purpose of the planning meetings was for each region to: (1) increase partners' understanding of the various jurisdictions' capacity, organization, resources, etc; and (2) plan a tabletop exercise. Participants' suggestions were incorporated into the exercise design. The Commission designed the exercise, with technical assistance from DOH on epidemiological and logistical details.

## Exercise Objectives

### Objective 1: PHEP Capability 09 Medical Materiel Management and Distribution

Test the state and region’s ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### Objective 2: PHEP Capability 06 Information Sharing

Test resource and information-sharing between tribal and non-tribal jurisdictions

## Scenario Summary

The scenario for this exercise utilizes a public health incident that involves a population exposure to pneumonic plague. Cascading events require the incident managers and responders to take steps to identify, mitigate the effects of, protect the community from, and respond to the hazard and to acquire prophylaxis through the state medical countermeasures distribution system.

## Assumptions

If a tribe requests medical countermeasures directly from the federal government, the federal government will coordinate with the State and deliver medical countermeasures the Washington State Receive Stage and Store (RSS) warehouse in Tumwater.<sup>1</sup>

## Major and Detailed Events

- **Early August 2018:** There have been no major public health emergencies in the region. The mild winter and the hot and dry summer have caused many of Washington’s regions to experience flea infestations. The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route. Over 2500 Native and non-Native individuals participated in the many canoe journey events.
- **Day One August 6, 2018.** The local hospital has admitted two non-Native patients (34-year-old female, 19-year-old male) with symptoms of: (1) high fever; (2) severe weakness;

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<sup>1</sup> Based on CDC’s guidance “Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11” and discussion with CDC representatives on a March 15, 2018 webinar.

(3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.

- **Day Three August 8, 2018 Morning.** The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one.
- **Day Three August 8, 2018 Afternoon.** A tribal clinic has had two patients (58-year-old female, 66-year-old male) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.
- **Day Four August 9, 2018.** A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia. One of the patients participated in the annual canoe journey. Both tribal patients who presented on Day Three are critically ill. All 5 tribal patients that have presented with symptoms are ages 55 and older.
- **Day Five – August 10, 2018 Morning.** Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington. Washington State Emergency Management Division (EMD) is now activated and a Mission Number has been issued. DOH Incident Management Team (IMT) is now activated.
- **Day Five – August 10, 2018 Morning.** Three local health jurisdiction employees have called in sick and have been referred to the hospital for care. Two nurses from the hospital have become ill with the same symptoms. The two initial tribal clinic patients were diagnosed with pneumonic plague. Both initial tribal patients attended the canoe journey. Centers for Disease Control and Prevention (CDC) Director published a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment. The initial shipment to Washington State will be insufficient to administer prophylaxis to the entire target population. More supplies will be available in 10-14 days. Tribal and nontribal health jurisdictions need to request medical countermeasures.



- **Day Five-August 10, 2018 Afternoon.** A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS. A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle.
- **Day Five-August 10, 2018 Afternoon.** A local health jurisdiction has requested use of tribal staff to dispense medical countermeasures. A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts.
- **Day Six-August 11, 2018.** The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse.

## SECTION 3: KEY FINDINGS

The 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise was developed to assess the capability of tribes, the Washington State Department of Health (DOH), and the local health jurisdictions (LHJs) to coordinate distribution of medical countermeasures to tribal nations during a public health incident. A tabletop exercise was held in each of Washington State's nine (9) public health emergency preparedness regions.

The following objectives that were exercised align with the Centers for Disease Control (CDC) Public Health Emergency Preparedness Capabilities (PHEP):

<b>Exercise Objective</b>	<b>Objective Description</b>	<b>Related PHEP Capability Number/Description</b>
Objective 1	Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.	C09 Medical Materiel Management and Distribution
Objective 2	Test resource and information-sharing between tribal and non-tribal jurisdictions	C06 Information Sharing

This section of the After Action Report (AAR) presents strategic findings as they relate to the tabletop objectives and key issues that were identified as a result of the exercise.

## **MEDICAL MATERIEL MANAGEMENT AND DISTRIBUTION (RELATES TO PHEP CAPABILITY 09).**

Objective 1 of this tabletop exercise tested the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### **Major Strengths**

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** The DOH and almost all LHJs recognized the sovereign authority of tribes to determine who their priority populations are in the dispensing of medical countermeasures, even if that determination may conflict with CDC guidelines. As a result, the DOH and most LHJs stated they will distribute medical countermeasures to the tribe regardless of the tribes' internal decisions regarding priority populations.
- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Most LHJs stated they have the capacity to deliver medical countermeasures to tribes.

### **Primary Areas for Improvement**

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** Not all LHJ representatives understand that their role is limited to transporting and/or handing over tribes' medical countermeasures allocations, unless a tribe specifically requests additional coordination or assistance. Some LHJ participants believe they have legal obligations to ensure that tribes follow CDC recommendations. This lack of understanding resulted in some tribes in Washington State not receiving vaccine and antivirals during the 2009 - 2010 H1N1 pandemic response and can produce catastrophic consequences during future public health incidents, unless corrected.



- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Some LHJs stated they may not have the capacity to deliver medical countermeasures directly to tribes.

- 3. Identification of Tribal Service Population.** Tribal service population numbers can vary greatly from one public health incident to another, due to large events like the annual Canoe Journey, Omak Stampede, pow wows, concerts, tourism, etc. Some LHJs noted the need for a system to inform the LHJs, during a response, specifically which population the tribe will be serving to avoid duplication or gaps.
- 4. Medical Countermeasures Plans.** Most local health jurisdictions' medical countermeasures planning documents do not address processes for distribution of medical countermeasures to tribes. Most tribes need to develop and adopt medical countermeasures plans, including a clear process for making decisions during public health incidents regarding how they want their medical countermeasures delivered.
- 5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.** There is no clearly documented system in place for including tribes in communication, decision-making, and coordination of efforts during public health incidents and responses.

## Recommendations

### 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.

- a) DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing.
- b) The United States federal government should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an agency consultation with tribes on these



guidelines.

- c) DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government.
- d) DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes.

**2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.

**3. Identification of Tribal Service Population.** DOH should develop and document a streamlined process for tribes to inform DOH of the population they will serve for each specific public health incident.

**4. Medical Countermeasures Plans.** Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.

**5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.**

- a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
- b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.
- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
- d. DOH and the Commission should continue to work with tribes to sign on to the "Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State" so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.
- e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the

MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.

- 6. Pharmacy Memorandum of Understanding.** DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU). This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.
- 7. Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State.** DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.
- 8. Ability to Receive, Manage and Store Medical Countermeasures.** Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.
- 9. Staff Training.** Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.



**INFORMATION SHARING BETWEEN JURISDICTIONS (RELATES PHEP CAPABILITY 06).** Objective 2 of this tabletop exercise tested resource and information-sharing between tribal and non-tribal jurisdictions.

### Major Strengths

- 1. Reporting Public Health Incidents to State.** Once the LHJs received notice from the hospitals and/or clinics, all LHJs immediately contacted DOH during the exercise. DOH immediately began coordinating with the LHJs, the hospitals, and the tribes to begin an investigation to share information, determine where the disease originated and initiate response actions.
- 2. Reporting Public Health Incidents to Indian Health Care Providers.** Many LHJs maintain healthcare provider notification systems that include Indian health care providers and other tribal representatives. Tribal partners are eligible to register for the Washington State Department of Health's (DOH's) SECURES health alert system and receive notifications.

### Primary Areas for Improvement

- 1. Reporting Public Health Incident to Indian Health Care Providers.** Not all LHJs have a system in place to ensure all Indian health care providers and other tribal contacts are notified of a public health incident. Also, not every tribe is registered on the Washington State Department of Health's (DOH's) SECURES health alert system.
- 2. Accuracy and Maintenance of Contact List.** There is no system in place for maintaining accurate and current partner contact lists for individuals with key roles during responses. DOH's "Yellow Book" and "Red Book" are published in paper format, and thus not updated in real time. DOH has plans to convert the books to an online system, to be updated quarterly.

### Recommendations

- 1. Reporting Public Health Incidents to Indian Health Care Providers.**
  - a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
  - b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the correct tribal contacts are registered and kept current.

- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
  - d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 2. Accuracy and Maintenance of Contact List.** DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.

## **EMERGENCY PUBLIC INFORMATION AND WARNING (RELATES TO PHEP CAPABILITY 04):**

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.

### **Major Strengths**

- 1. LHJ Public Information Officers.** Some LHJs have public information officers who can quickly manage public information dissemination and provide technical assistance to other jurisdictions in the region that do not have this capability.
- 2. DOH Public Information Resources.** DOH has resources to provide technical assistance to LHJs and tribes regarding public information sharing and messaging.
- 3. Tribes' Knowledge Access to Communicating With Tribal Community Members and Expertise.** Tribes have comprehensive systems in place to communicate with their community members. They also have the knowledge to develop messaging that is respectful of culture and history, and appropriate for their community members.

### **Primary Areas for Improvement**

- 1. Inclusion of Tribes in State and Local Public Information Sharing.** There is no clearly documented system in place for coordination and collaboration on public information and messaging for the tribal communities. It is imperative for LHJs to coordinate with tribes on messaging, to assure respect for culture and history and assure message efficacy. Many tribal community members will disregard or distrust public health messages that do not originate from tribal council or other tribal officials. Health literacy is a critical factor to consider in ensuring community members understand alerts and notices. A strong understanding of the community's culture and historical context are also key. Messages should provide tribal community members with clear guidance on reasonable action steps they can take to protect themselves and others.



2. **Controlling Spread of Misinformation within Tribal Communities.** Tribes voiced concern about controlling information to the public in small communities where information spreads quickly and inaccurately through word of mouth and on social media. This spread of misinformation could result in tribal clinics being overwhelmed. Tribes expressed interest in receiving technical assistance in this area.

## Recommendations

1. **Inclusion of Tribes in State and Local Public Information Sharing.**
  - a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses.
  - b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.
2. **Controlling Spread of Misinformation within Tribal Communities.** The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.

**PUBLIC HEALTH SURVEILLANCE AND EPIDEMIOLOGICAL INVESTIGATION (RELATES TO CAPABILITY 13):** Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

### Major Strengths

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** All LHJs coordinate on some level with tribes when they must go on tribal lands to conduct epidemiological investigations that involve tribal community members. One LHJ partners with a tribe on conducting communicable disease investigations by including a tribal employee to serve as a community liaison. Several participants recognized the importance of having a tribal community liaison available during investigations, since tribal members may be hesitant to communicate with non-tribal members. The tribal community liaison can also be an especially valuable asset, given their knowledge of the community.

### Recommendations

- 1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.



**RESPONDER SAFETY AND HEALTH (RELATES TO PHEP CAPABILITY 14):** The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

### Major Strengths

- 1. Access to Training and Personal Protective Equipment (PPE).** Many tribes and LHJs have access to training and personal protective equipment (PPE) necessary to safely respond to a public health incident.
- 2. Notification of Risk of Exposure to EMS Personnel.** Many tribes and LHJs have a system in place to notify emergency medical services (EMS) personnel before they transport a patient that can expose them to a communicable disease or other potential risk.

### Primary Areas for Improvement

- 1. Access to Training and Personal Protective Equipment (PPE).** Some tribes stated their law enforcement staff (and other potential responders) do not have access to PPE and training on PPE and other precautions needed to safely respond to incidents that may expose them to communicable diseases or other risks.
- 2. Notification of Risk of Exposure to EMS Personnel.** Some tribes and LHJs need to develop and implement standard operating procedures to ensure that EMS and other emergency responders are not exposed to communicable diseases or other potential risks.

### Recommendations

- 1. Access to Training and Personal Protective Equipment (PPE).**
  - a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.
  - b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.
- 2. Notification of Risk of Exposure to EMS Personnel.** All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other

emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.

**MEDICAL SURGE (RELATES TO PHEP CAPABILITY 10):** 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.

### Major Strengths

- 1. Tribal Clinic Capacity and Expertise.** Many tribal clinics are well equipped and staffed to respond to a public health incident, and plan to continue serving their patient population for the duration of most public health incidents.



### Areas for Improvement

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Most tribal clinics do not have Continuity of Operations (COOP) Plans or Crisis Standards of Care to clearly guide their operations during a public health incident.

### Recommendations

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.

## Appendix A: IMPROVEMENT PLAN

The Improvement Plan (IP) specifically details what actions will be taken to address each recommendation presented in the After Action Report (AAR), who or what entity will be responsible for taking the action, and the timeline for completion.

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Medical Materiel Management and Distribution</b> (Relates to PHEP Capability 9)	1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes	a. DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing	a. DOH	10/30/19
		b. The United States federal government (CDC/ASPR) should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an	b. CDC and ASPR	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>agency consultation with tribes on these guidelines.</p> <p>c. DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government</p> <p>d. DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes</p>	<p>c. DOH and Commission</p> <p>d. DOH and Commission</p>	<p>10/30/19</p> <p>12/30/19</p>
	2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.	The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.	DOH and Commission	10/30/19
	3. Identification of Tribal Service Population.	DOH should develop and document a streamlined process for tribes to inform DOH	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		of the population they will serve for each specific public health incident.		
	4. Medical Countermeasures Plans.	Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.	LHJs and Tribes	04/30/19
	5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.	<ul style="list-style-type: none"> <li>a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.</li> <li>b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.</li> <li>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g.</li> </ul>	<ul style="list-style-type: none"> <li>LHJs and Tribes</li> <li>LHJs and Tribes</li> <li>DOH</li> </ul>	<ul style="list-style-type: none"> <li>04/30/19</li> <li>04/30/19</li> <li>06/30/19</li> </ul>

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH and the Commission should continue to work with tribes to sign on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.</p> <p>e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH and Commission</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	6. Pharmacy Memorandum of Understanding	DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU).	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.		
	7 Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State	DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.	DOH and Commission	06/30/19
	8. Ability to Receive, Manage and Store Medical Countermeasures	Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.	Tribes and LHJs	04/30/19
	9. Staff Training	Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.	Tribes and LHJs	04/30/19
Information Sharing between Jurisdictions (Relates to PHEP Capability 6)	1. Reporting Public Health Incidents to Indian Health Care Providers	a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.	Tribes and LHJs	04/30/19
		b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>correct tribal contacts are registered and kept current.</p> <p>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	2. Accuracy and Maintenance of Contact List	DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Emergency Public Information and Warning</b> (Relates to PHEP Capability 4)	1. Inclusion of Tribes in State and Local Public Information Sharing	a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses. .	LHJs and Tribes	04/30/19
		b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.	DOH and Commission	06/30/19
	2. Controlling Spread of Misinformation Within Tribal Communities	The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.	DOH and Commission	6/30/19
<b>Public Health Surveillance and Epidemiological Investigation</b> (Relates to PHEP capability 13)	LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.	LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.	LHJs and Tribes	6/30/19
<b>Responder Safety and Health</b> (Relates to PHEP capability 14)	1. Access to Training and Personal Protective Equipment	a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and	LHJs and Tribes	6/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.</p> <p>b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.</p>	DOH and Commission	06/30/19
	2. Notification of Risk of Exposure to EMS Personnel.	All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.	LHJs and Tribes	6/30/19
<b>Medical Surge</b> (Relates to PHEP capability 10)	Continuity of Operations (COOP) Plans and Crisis Standards of Care	Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.	Tribes	4/30/19

Appendix B: TABLETOP EXERCISE SLIDES

# **Cross-Jurisdictional Collaboration Project Medical Countermeasures**

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## **Tabletop Exercise**

**May 2018**



**American Indian Health Commission**  
for Washington State

# Agenda



**Introductions and Overview**



**Unfolding Situation → Decisions and Responses**



**Break**



**Later Developments → Decisions and Responses**



**Break and Photos**



**Hotwash, Findings and Self-Evaluation**



**Next Steps**

# **Introductions and Overview**





# **Introductions**

- **What is your job title?**
- **How long have you worked in your current position?**
- **What responsibilities do you have related to community emergency preparedness?**

# What are Medical Countermeasures (MCM)?

- Medical treatments or prophylaxes for public health threats
- Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



# Medical Countermeasures and Tribes

- Each time an incident occurs, a tribe has the sovereign authority to choose how medical countermeasures are distributed to their community by federal, state, and or local governments
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for each incident, ensuring the fastest response and protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE and LHJ**  
coordinate  
conveyance of  
MCMs to **TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

## Option 4 → Tribe Contacts Federal Government

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity; **\*SEE FEDERAL REFERENCES BELOW.**

### \*Version 11

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”

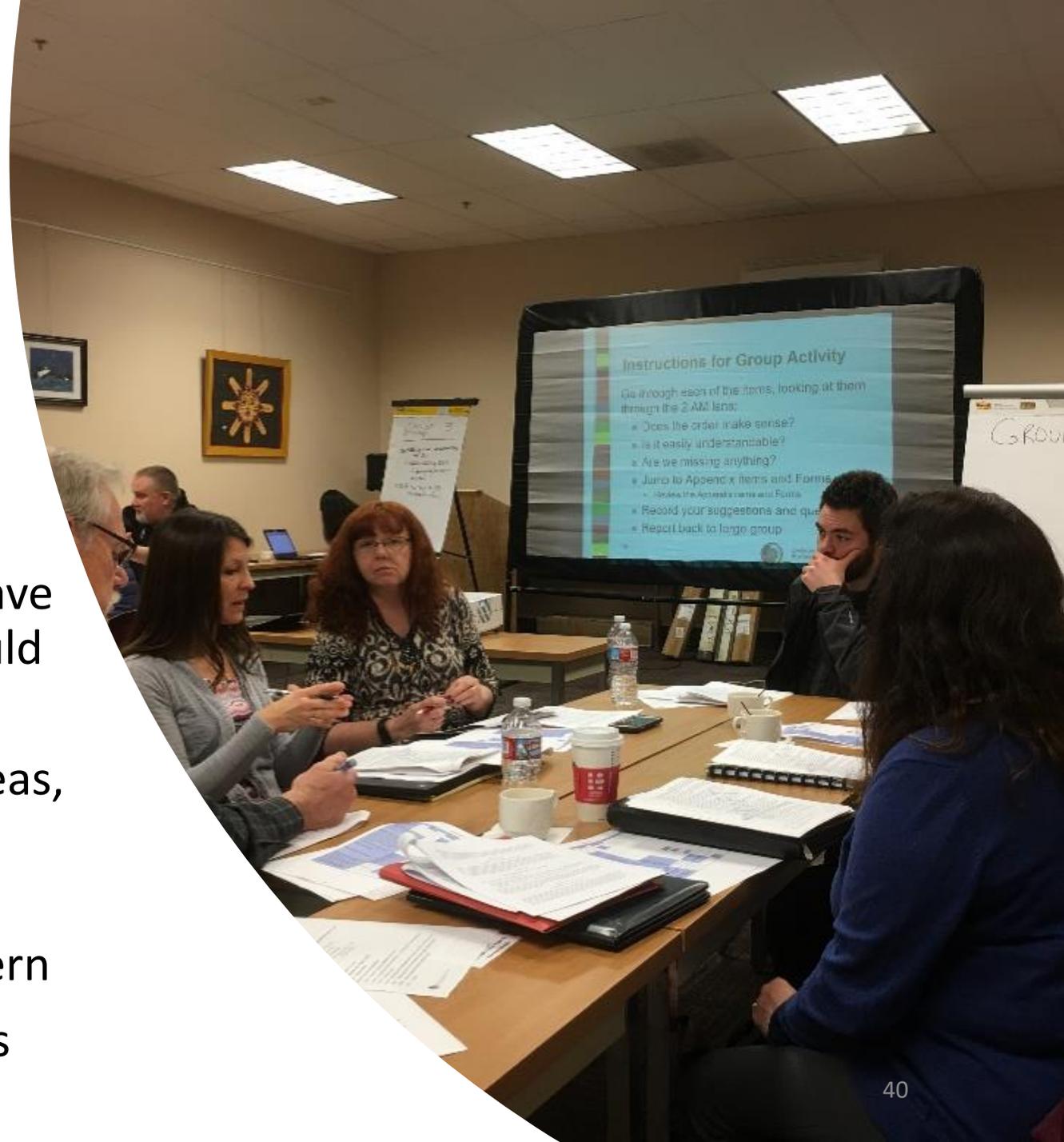
See CDC’s “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5.

“the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.” Version 11, p. 6

**Regardless of the dispensing option chosen, MCMs will be distributed through the system developed by the state health department once an emergency is declared** and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the community has access to MCMs. Version 11, p. 6. *Emphasis added.*

# What is a Tabletop Exercise?

- An informal discussion using a scripted scenario as a catalyst
- Identifies gaps in our plans, issues we have not yet thought about, changes we should make to our plans
- Promotes free and open exchange of ideas, no time pressures
- Opportunity to discuss issues in depth, collaboratively examining areas of concern
- There are no “right” or “wrong” answers



# Purpose of the Tabletop Exercise

Testing communication and MCM distribution processes through a tabletop exercise will increase:

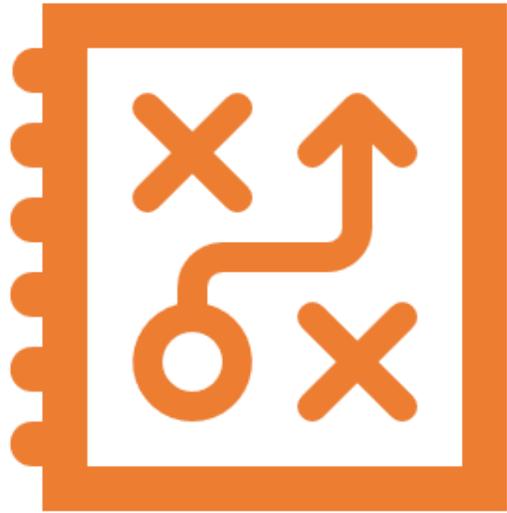
- tribes' understanding of how the different options will work for their communities and strengthen their decision-making at the time of an incident
- tribal, local, and state partners' understanding of how they will interact during MCM distribution



# Specific Objectives

1. Test the region's ability to effectively coordinate distribution of MCM across tribal and nontribal jurisdictions
2. Identify strengths and areas for improvement
3. Identify potential legal issues
4. Test resource- and information-sharing between tribal and non-tribal jurisdictions
5. Have each tribe make an informed analysis of what will be the most likely option for MCM distribution to its jurisdiction





# Tabletop Scenario



# Assumptions

- The purpose of this exercise is to identify gaps and vulnerabilities
- No jurisdiction is fully prepared for this type of public health emergency
- Open, honest and respectful dialogue and feedback are expected and valued throughout the exercise
- Today's exercise, discussions, and findings will inform future preparedness planning and actions

# Assumptions

- If a tribe requests medical countermeasures directly from the federal government, the federal government will deliver medical countermeasures to one site for the entire State of Washington - the Washington State Receive Stage and Store (RSS) warehouse

(Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives)





# Early August 2018

- There have been no major public health emergencies in your region
- The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations
- The annual Omak Stampede has brought together participants from around the state from August 9 to August 12
- Over 8500 Native and non-Native individuals participated in the many Omak Stampede events from across Washington, Idaho, Oregon and Canada



## **Day One – August 16, 2018**

The local hospital has admitted two non-Native patients (34 year old female, 19 year old male) with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# Day One Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 18, 2018 Morning**

The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one



# Pneumonic plague

Pneumonic plague is a severe lung infection caused by the bacterium *Yersinia pestis*. Symptoms include fever, headache, shortness of breath, chest pain, and cough. They typically start about three to seven days after exposure. It is one of three forms of plague, the other two being septicemic plague and bubonic plague.

Pneumonic plague can be caused in two ways: primary, which results from the inhalation of aerosolized plague bacteria, or secondary, when septicemic plague spreads into lung tissue from the bloodstream. Pneumonic plague is not exclusively vector-borne like bubonic plague; instead it can be spread from person to person.

Pneumonic plague symptoms often include fever, weakness, and headache as well as rapidly developing pneumonia with shortness of breath, cough, and chest pain.

<https://emergency.cdc.gov/agent/plague/factsheet.asp>

<https://www.cdc.gov/plague/faq/index.html>



# **Day Three Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 18, 2018 Afternoon**

A tribal clinic has had two patients (58 year old female, 66 year old male) present with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# **Day Three Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?

# Day Four – August 19, 2018

- A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of:
  - high fever
  - severe weakness
  - bloody sputum
  - shortness of breath
  - possible pneumonia
- One of the patients participated in the Stampede
- Both tribal patients who presented on Day Three are critically ill
- All 5 tribal patients that have presented with symptoms are ages 55 and older





# Day Four Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Morning**

- Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington
- Washington State Emergency Management Division (EMD) is now activated – Mission Number has been issued
- DOH Incident Management Team (IMT) is now activated

# Day Five – August 20, 2018

## Morning

- Three local health jurisdiction employees have called in sick and have been referred to the hospital for care
- Two nurses from the hospital have become ill with the same symptoms
- The two initial tribal clinic patients were diagnosed with pneumonic plague
- Both initial tribal patients attended the Stampede
- Centers for Disease Control and Prevention (CDC) Director publishes a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment; the initial shipment to Washington State will be sufficient to administer prophylaxis to 80% of the 25 and younger population in Washington; more will be available in 10-14 days
- Tribal and nontribal health jurisdictions need to request medical countermeasures





# **Day Five Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Afternoon**

- A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS
- A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Afternoon**

- A local health jurisdiction needs to request use of tribal staff to dispense medical countermeasures
- A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Six – August 21, 2018**

The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse



# Day Six Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



# **Hotwash, Findings and Self-Evaluation**

# Next Steps



- AIHC will provide each jurisdiction with their compiled notes and after-action report (AAR)
- Tribes and LHJs complete the Partner Profile Form and return to AIHC ASAP
- Other?

## Appendix C: TABLETOP SIGN-IN SHEET

REGION 7

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 29, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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REGION 7

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 29, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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# 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise

After Action Report and Improvement Plan

**Region 8**



**American Indian Health Commission  
for Washington State**

*In partnership with*



## Acronyms

Acronym	Definition
AAR	After Action Report
ASPR	Office of the Assistant Secretary for Preparedness and Response
CDC	Center for Disease Control
COOP	Continuity of Operations Plan
DOH	Washington State Department of Health
LHJ	Local Health Jurisdiction
MCM	Medical Countermeasures
POD	Point of Dispensing
PPE	Personal Protective Equipment
RSS	Receive, Stage and Store Warehouse

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## PREFACE

An After Action Report and Improvement Plan (AAR/IP) provide actionable insights for building community preparedness by documenting strengths and areas for improvement that participants identify during a simulated response to an emergency.

This report is tangible evidence of the valuable partnerships that exist between tribes, local governments and Washington State to improve public health preparedness in our communities. It serves as a collection of lessons learned, outlines recommended actions, and provides the basis for planning future exercises. This AAR/IP will contribute to improving future incident responses, training, exercises, equipment prioritization, plan effectiveness and overall preparedness.

The tabletop exercise this AAR documents was part of the American Indian Health Commission's Cross-Jurisdictional Collaboration Project of 2018. The project was facilitated by the American Indian Health Commission for Washington State (AIHC) with funding from the Washington State Department of Health (DOH).

### STRENGTHS

Strengths identified by Region 8 participants include:

- Experience working together on emergency responses, including Rattlesnake Ridge, H1N1
- Strong commitment by partners to work together

### AREAS FOR IMPROVEMENT

Areas for improvement identified by Region 8 participants include:

- Increasing coordination between all partners on Communications, Public Messaging and Response Operations
- Increasing opportunities for the Tribe and other partners to exercise together

The American Indian Health Commission for Washington State wishes to express gratitude and appreciation for the many tribal, local and state partners that participated in this project and invested significant time and effort in support of our shared commitment to protecting the lives of all Washington State citizens.

## SECTION 1: EXERCISE OVERVIEW

Exercise Name	2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise
Exercise Dates	May 31, 2018
Scope	This exercise was a discussion-based tabletop exercise for Region 8, to address coordination and collaboration between the 1 tribe and 2 local health jurisdictions regarding the distribution of medical countermeasures.
Mission Area(s)	Response
Core Capabilities	PHEP Capability 06: Information Sharing PHEP Capability 09: Medical Materiel Management and Distribution
Overarching Objectives	<p>PHEP Capability 06 Information Sharing: Test the ability of federal, state, local, and tribal governments to exchange information and situational awareness data in preparation for, and response to, a plague outbreak.</p> <p>PHEP Capability 09 Medical Materiel Management and Distribution: Test the ability to coordinate logistical operations and medical material requests among federal, state, local, and tribal jurisdictions.</p>
Threat or Hazard	Pneumonic plague
Scenario	The exercise scenario included an outbreak of plague shortly after the annual Omak Stampede that draws the participation of thousands of Natives and non-Natives from Washington, Idaho, Oregon, Canada and other countries.
Participating Organizations	A total of 19 individuals participated in the exercise. Yakama Nation Toppenish School District, Yakima County, Yakima County Emergency Management, Yakima County Fire District 5, Astria Health, Virginia Mason Memorial Hospital, White Swan Ambulance Washington State Department of Health
Point of Contact	Lou Schmitz, Consultant for American Indian Health Commission, <a href="mailto:lou.schmitz.aihc@outlook.com">lou.schmitz.aihc@outlook.com</a>

## SECTION 2: EXERCISE DESIGN AND SCENARIO SUMMARY

### Exercise Purpose and Design

On May 31, 2018, the American Indian Health Commission for Washington State (Commission) in partnership with the Washington State Department of Health (DOH) conducted a public health tabletop exercise where the DOH's Incident Management Team (IMT) was activated, and tribes, DOH, and LHJs coordinated on the distribution of medical countermeasures to tribes.

The exercise was conducted to strengthen the response capabilities of tribal, state, and local governments and to assure the appropriate amount and type of medical countermeasures and materiel reach every tribe quickly during public health emergencies. This exercise was developed and conducted by the Commission, in cooperation with representatives from DOH and various tribal and local governments and organizations.

The exercise was designed to test tribal, state, and local health jurisdiction plans, policies and procedures and provide an opportunity to evaluate current operations concepts, plans, and capabilities in response to a public health incident. The exercise was developed and evaluated utilizing objectives that were identified by tribal, state, and local government representatives.



### Exercise Planning Process

The Commission facilitated a planning meeting at each of the nine public health emergency planning regions for representatives from DOH, tribes and local health jurisdictions. The purpose of the planning meetings was for each region to: (1) increase partners' understanding of the various jurisdictions' capacity, organization, resources, etc; and (2) plan a tabletop exercise. Participants' suggestions were incorporated into the exercise design. The Commission designed the exercise, with technical assistance from DOH on epidemiological and logistical details.

## Exercise Objectives

### Objective 1: PHEP Capability 09 Medical Materiel Management and Distribution

Test the state and region’s ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### Objective 2: PHEP Capability 06 Information Sharing

Test resource and information-sharing between tribal and non-tribal jurisdictions

## Scenario Summary

The scenario for this exercise utilizes a public health incident that involves a population exposure to pneumonic plague. Cascading events require the incident managers and responders to take steps to identify, mitigate the effects of, protect the community from, and respond to the hazard and to acquire prophylaxis through the state medical countermeasures distribution system.

## Assumptions

If a tribe requests medical countermeasures directly from the federal government, the federal government will coordinate with the State and deliver medical countermeasures the Washington State Receive Stage and Store (RSS) warehouse in Tumwater.<sup>1</sup>

## Major and Detailed Events

- **Early August 2018:** There have been no major public health emergencies in the region. The mild winter and the hot and dry summer have caused many of Washington’s regions to experience flea infestations. The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route. Over 2500 Native and non-Native individuals participated in the many canoe journey events.
- **Day One August 6, 2018.** The local hospital has admitted two non-Native patients (34-year-old female, 19-year-old male) with symptoms of: (1) high fever; (2) severe weakness;

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<sup>1</sup> Based on CDC’s guidance “Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11” and discussion with CDC representatives on a March 15, 2018 webinar.

(3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.

- **Day Three August 8, 2018 Morning.** The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one.
- **Day Three August 8, 2018 Afternoon.** A tribal clinic has had two patients (58-year-old female, 66-year-old male) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.
- **Day Four August 9, 2018.** A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia. One of the patients participated in the annual canoe journey. Both tribal patients who presented on Day Three are critically ill. All 5 tribal patients that have presented with symptoms are ages 55 and older.
- **Day Five – August 10, 2018 Morning.** Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington. Washington State Emergency Management Division (EMD) is now activated and a Mission Number has been issued. DOH Incident Management Team (IMT) is now activated.
- **Day Five – August 10, 2018 Morning.** Three local health jurisdiction employees have called in sick and have been referred to the hospital for care. Two nurses from the hospital have become ill with the same symptoms. The two initial tribal clinic patients were diagnosed with pneumonic plague. Both initial tribal patients attended the canoe journey. Centers for Disease Control and Prevention (CDC) Director published a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment. The initial shipment to Washington State will be insufficient to administer prophylaxis to the entire target population. More supplies will be available in 10-14 days. Tribal and nontribal health jurisdictions need to request medical countermeasures.



- **Day Five-August 10, 2018 Afternoon.** A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS. A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle.
- **Day Five-August 10, 2018 Afternoon.** A local health jurisdiction has requested use of tribal staff to dispense medical countermeasures. A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts.
- **Day Six-August 11, 2018.** The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse.

## SECTION 3: KEY FINDINGS

The 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise was developed to assess the capability of tribes, the Washington State Department of Health (DOH), and the local health jurisdictions (LHJs) to coordinate distribution of medical countermeasures to tribal nations during a public health incident. A tabletop exercise was held in each of Washington State's nine (9) public health emergency preparedness regions.

The following objectives that were exercised align with the Centers for Disease Control (CDC) Public Health Emergency Preparedness Capabilities (PHEP):

<b>Exercise Objective</b>	<b>Objective Description</b>	<b>Related PHEP Capability Number/Description</b>
Objective 1	Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.	C09 Medical Materiel Management and Distribution
Objective 2	Test resource and information-sharing between tribal and non-tribal jurisdictions	C06 Information Sharing

This section of the After Action Report (AAR) presents strategic findings as they relate to the tabletop objectives and key issues that were identified as a result of the exercise.

## **MEDICAL MATERIEL MANAGEMENT AND DISTRIBUTION (RELATES TO PHEP CAPABILITY 09).**

Objective 1 of this tabletop exercise tested the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### **Major Strengths**

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** The DOH and almost all LHJs recognized the sovereign authority of tribes to determine who their priority populations are in the dispensing of medical countermeasures, even if that determination may conflict with CDC guidelines. As a result, the DOH and most LHJs stated they will distribute medical countermeasures to the tribe regardless of the tribes' internal decisions regarding priority populations.
- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Most LHJs stated they have the capacity to deliver medical countermeasures to tribes.

### **Primary Areas for Improvement**

#### **1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.**

Not all LHJ representatives understand that their role is limited to transporting and/or handing over tribes' medical countermeasures allocations, unless a tribe specifically requests additional coordination or assistance. Some LHJ participants believe they have legal obligations to ensure that tribes follow CDC recommendations. This lack of understanding resulted in some tribes in Washington State not receiving vaccine and antivirals during the 2009 - 2010 H1N1 pandemic response and can produce catastrophic consequences during future public health incidents, unless corrected.



- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Some LHJs stated they may not have the capacity to deliver medical countermeasures directly to tribes.

- 3. Identification of Tribal Service Population.** Tribal service population numbers can vary greatly from one public health incident to another, due to large events like the annual Canoe Journey, Omak Stampede, pow wows, concerts, tourism, etc. Some LHJs noted the need for a system to inform the LHJs, during a response, specifically which population the tribe will be serving to avoid duplication or gaps.
- 4. Medical Countermeasures Plans.** Most local health jurisdictions' medical countermeasures planning documents do not address processes for distribution of medical countermeasures to tribes. Most tribes need to develop and adopt medical countermeasures plans, including a clear process for making decisions during public health incidents regarding how they want their medical countermeasures delivered.
- 5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.** There is no clearly documented system in place for including tribes in communication, decision-making, and coordination of efforts during public health incidents and responses.

## Recommendations

### 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.

- a) DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing.
- b) The United States federal government should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process



- for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an agency consultation with tribes on these guidelines.
- c) DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government.
  - d) DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes.
- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.
- 3. Identification of Tribal Service Population.** DOH should develop and document a streamlined process for tribes to inform DOH of the population they will serve for each specific public health incident.
- 4. Medical Countermeasures Plans.** Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.
- 5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.**
- a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
  - b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.
  - c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
  - d. DOH and the Commission should continue to work with tribes to sign on to the "Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State" so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.

- e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 6. Pharmacy Memorandum of Understanding.** DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU). This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.
- 7. Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State.** DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.
- 8. Ability to Receive, Manage and Store Medical Countermeasures.** Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.
- 9. Staff Training.** Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.



**INFORMATION SHARING BETWEEN JURISDICTIONS (RELATES PHEP CAPABILITY 06).** Objective 2 of this tabletop exercise tested resource and information-sharing between tribal and non-tribal jurisdictions.

### Major Strengths

- 1. Reporting Public Health Incidents to State.** Once the LHJs received notice from the hospitals and/or clinics, all LHJs immediately contacted DOH during the exercise. DOH immediately began coordinating with the LHJs, the hospitals, and the tribes to begin an investigation to share information, determine where the disease originated and initiate response actions.
- 2. Reporting Public Health Incidents to Indian Health Care Providers.** Many LHJs maintain healthcare provider notification systems that include Indian health care providers and other tribal representatives. Tribal partners are eligible to register for the Washington State Department of Health's (DOH's) SECURES health alert system and receive notifications.

### Primary Areas for Improvement

- 1. Reporting Public Health Incident to Indian Health Care Providers.** Not all LHJs have a system in place to ensure all Indian health care providers and other tribal contacts are notified of a public health incident. Also, not every tribe is registered on the Washington State Department of Health's (DOH's) SECURES health alert system.
- 2. Accuracy and Maintenance of Contact List.** There is no system in place for maintaining accurate and current partner contact lists for individuals with key roles during responses. DOH's "Yellow Book" and "Red Book" are published in paper format, and thus not updated in real time. DOH has plans to convert the books to an online system, to be updated quarterly.

### Recommendations

- 1. Reporting Public Health Incidents to Indian Health Care Providers.**
  - a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
  - b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the correct tribal contacts are registered and kept current.

- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
  - d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 2. Accuracy and Maintenance of Contact List.** DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.

## **EMERGENCY PUBLIC INFORMATION AND WARNING (RELATES TO PHEP CAPABILITY 04):**

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.

### **Major Strengths**

- 1. LHJ Public Information Officers.** Some LHJs have public information officers who can quickly manage public information dissemination and provide technical assistance to other jurisdictions in the region that do not have this capability.
- 2. DOH Public Information Resources.** DOH has resources to provide technical assistance to LHJs and tribes regarding public information sharing and messaging.
- 3. Tribes' Knowledge Access to Communicating With Tribal Community Members and Expertise.** Tribes have comprehensive systems in place to communicate with their community members. They also have the knowledge to develop messaging that is respectful of culture and history, and appropriate for their community members.

### **Primary Areas for Improvement**

- 1. Inclusion of Tribes in State and Local Public Information Sharing.** There is no clearly documented system in place for coordination and collaboration on public information and messaging for the tribal communities. It is imperative for LHJs to coordinate with tribes on messaging, to assure respect for culture and history and assure message efficacy. Many tribal community members will disregard or distrust public health messages that do not originate from tribal council or other tribal officials. Health literacy is a critical factor to consider in ensuring community members understand alerts and notices. A strong understanding of the community's culture and historical context are also key. Messages should provide tribal community members with clear guidance on reasonable action steps they can take to protect themselves and others.



2. **Controlling Spread of Misinformation within Tribal Communities.** Tribes voiced concern about controlling information to the public in small communities where information spreads quickly and inaccurately through word of mouth and on social media. This spread of misinformation could result in tribal clinics being overwhelmed. Tribes expressed interest in receiving technical assistance in this area.

## Recommendations

1. **Inclusion of Tribes in State and Local Public Information Sharing.**
  - a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses.
  - b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.
2. **Controlling Spread of Misinformation within Tribal Communities.** The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.

**PUBLIC HEALTH SURVEILLANCE AND EPIDEMIOLOGICAL INVESTIGATION (RELATES TO CAPABILITY 13):** Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

### Major Strengths

**1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** All LHJs coordinate

on some level with tribes when they must go on tribal lands to conduct epidemiological investigations that involve tribal community members. One LHJ partners with a tribe on conducting communicable disease investigations by including a tribal employee to serve as a community liaison. Several participants recognized the importance of having a tribal community liaison available during investigations, since



tribal members may be hesitant to communicate with non-tribal members. The tribal community liaison can also be an especially valuable asset, given their knowledge of the community.

### Recommendations

**1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.

**RESPONDER SAFETY AND HEALTH (RELATES TO PHEP CAPABILITY 14):** The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

### Major Strengths

- 1. Access to Training and Personal Protective Equipment (PPE).** Many tribes and LHJs have access to training and personal protective equipment (PPE) necessary to safely respond to a public health incident.
- 2. Notification of Risk of Exposure to EMS Personnel.** Many tribes and LHJs have a system in place to notify emergency medical services (EMS) personnel before they transport a patient that can expose them to a communicable disease or other potential risk.

### Primary Areas for Improvement

- 1. Access to Training and Personal Protective Equipment (PPE).** Some tribes stated their law enforcement staff (and other potential responders) do not have access to PPE and training on PPE and other precautions needed to safely respond to incidents that may expose them to communicable diseases or other risks.
- 2. Notification of Risk of Exposure to EMS Personnel.** Some tribes and LHJs need to develop and implement standard operating procedures to ensure that EMS and other emergency responders are not exposed to communicable diseases or other potential risks.

### Recommendations

- 1. Access to Training and Personal Protective Equipment (PPE).**
  - a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.
  - b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.
- 2. Notification of Risk of Exposure to EMS Personnel.** All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other

emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.

**MEDICAL SURGE (RELATES TO PHEP CAPABILITY 10):** 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.

### Major Strengths

- 1. Tribal Clinic Capacity and Expertise.** Many tribal clinics are well equipped and staffed to respond to a public health incident, and plan to continue serving their patient population for the duration of most public health incidents.



### Areas for Improvement

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Most tribal clinics do not have Continuity of Operations (COOP) Plans or Crisis Standards of Care to clearly guide their operations during a public health incident.

### Recommendations

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.

## Appendix A: IMPROVEMENT PLAN

The Improvement Plan (IP) specifically details what actions will be taken to address each recommendation presented in the After Action Report (AAR), who or what entity will be responsible for taking the action, and the timeline for completion.

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Medical Materiel Management and Distribution</b> (Relates to PHEP Capability 9)	1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes	a. DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing	a. DOH	10/30/19
		b. The United States federal government (CDC/ASPR) should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an	b. CDC and ASPR	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>agency consultation with tribes on these guidelines.</p> <p>c. DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government</p> <p>d. DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes</p>	<p>c. DOH and Commission</p> <p>d. DOH and Commission</p>	<p>10/30/19</p> <p>12/30/19</p>
	2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.	The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.	DOH and Commission	10/30/19
	3. Identification of Tribal Service Population.	DOH should develop and document a streamlined process for tribes to inform DOH	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		of the population they will serve for each specific public health incident.		
	4. Medical Countermeasures Plans.	Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.	LHJs and Tribes	04/30/19
	5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.	<ul style="list-style-type: none"> <li>a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.</li> <li>b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.</li> <li>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g.</li> </ul>	<ul style="list-style-type: none"> <li>LHJs and Tribes</li> <li>LHJs and Tribes</li> <li>DOH</li> </ul>	<ul style="list-style-type: none"> <li>04/30/19</li> <li>04/30/19</li> <li>06/30/19</li> </ul>

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH and the Commission should continue to work with tribes to sign on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.</p> <p>e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH and Commission</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	6. Pharmacy Memorandum of Understanding	DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU).	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.		
	7 Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State	DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.	DOH and Commission	06/30/19
	8. Ability to Receive, Manage and Store Medical Countermeasures	Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.	Tribes and LHJs	04/30/19
	9. Staff Training	Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.	Tribes and LHJs	04/30/19
Information Sharing between Jurisdictions (Relates to PHEP Capability 6)	1. Reporting Public Health Incidents to Indian Health Care Providers	a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.	Tribes and LHJs	04/30/19
		b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>correct tribal contacts are registered and kept current.</p> <p>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	2. Accuracy and Maintenance of Contact List	DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Emergency Public Information and Warning</b> (Relates to PHEP Capability 4)	1. Inclusion of Tribes in State and Local Public Information Sharing	a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses. .	LHJs and Tribes	04/30/19
		b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.	DOH and Commission	06/30/19
	2. Controlling Spread of Misinformation Within Tribal Communities	The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.	DOH and Commission	6/30/19
<b>Public Health Surveillance and Epidemiological Investigation</b> (Relates to PHEP capability 13)	LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.	LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.	LHJs and Tribes	6/30/19
<b>Responder Safety and Health</b> (Relates to PHEP capability 14)	1. Access to Training and Personal Protective Equipment	a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and	LHJs and Tribes	6/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.</p> <p>b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.</p>	DOH and Commission	06/30/19
	2. Notification of Risk of Exposure to EMS Personnel.	All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.	LHJs and Tribes	6/30/19
<b>Medical Surge</b> (Relates to PHEP capability 10)	Continuity of Operations (COOP) Plans and Crisis Standards of Care	Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.	Tribes	4/30/19

## Appendix B: TABLETOP EXERCISE SLIDES

# **Cross-Jurisdictional Collaboration Project Medical Countermeasures**

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## **Tabletop Exercise**

**May 2018**



**American Indian Health Commission**  
for Washington State

# Agenda



**Introductions and Overview**



**Unfolding Situation → Decisions and Responses**



**Break**



**Later Developments → Decisions and Responses**



**Break and Photos**



**Hotwash, Findings and Self-Evaluation**



**Next Steps**

# **Introductions and Overview**





# **Introductions**

- **What is your job title?**
- **How long have you worked in your current position?**
- **What responsibilities do you have related to community emergency preparedness?**

# What are Medical Countermeasures (MCM)?

- Medical treatments or prophylaxes for public health threats
- Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



# Medical Countermeasures and Tribes

- Each time an incident occurs, a tribe has the sovereign authority to choose how medical countermeasures are distributed to their community by federal, state, and or local governments
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for each incident, ensuring the fastest response and protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE and LHJ**  
coordinate  
conveyance of  
MCMs to **TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

\*"Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5-6.

## Option 4 → Tribe Contacts Federal Government

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity; **\*SEE FEDERAL REFERENCES BELOW.**

### \*Version 11

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”

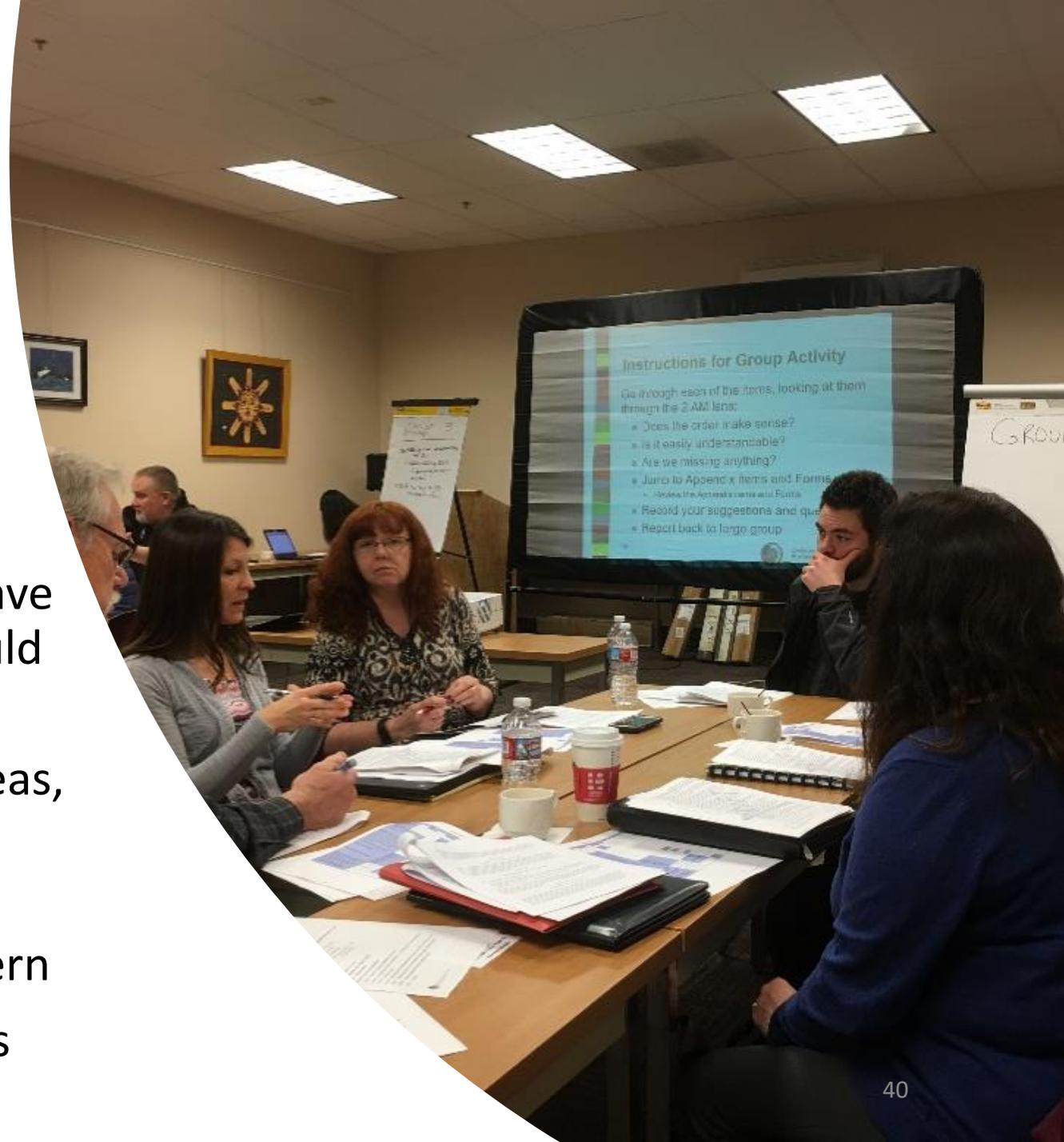
See CDC’s “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5.

“the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.” Version 11, p. 6

**Regardless of the dispensing option chosen, MCMs will be distributed through the system developed by the state health department once an emergency is declared** and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the community has access to MCMs. Version 11, p. 6. *Emphasis added.*

# What is a Tabletop Exercise?

- An informal discussion using a scripted scenario as a catalyst
- Identifies gaps in our plans, issues we have not yet thought about, changes we should make to our plans
- Promotes free and open exchange of ideas, no time pressures
- Opportunity to discuss issues in depth, collaboratively examining areas of concern
- There are no “right” or “wrong” answers



# Purpose of the Tabletop Exercise

Testing communication and MCM distribution processes through a tabletop exercise will increase:

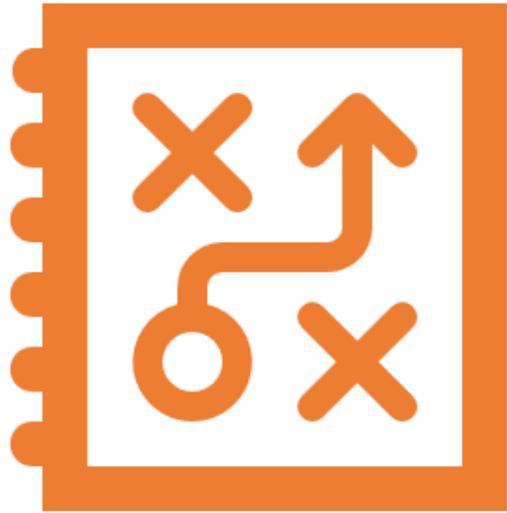
- tribes' understanding of how the different options will work for their communities and strengthen their decision-making at the time of an incident
- tribal, local, and state partners' understanding of how they will interact during MCM distribution



# Specific Objectives

1. Test the region's ability to effectively coordinate distribution of MCM across tribal and nontribal jurisdictions
2. Identify strengths and areas for improvement
3. Identify potential legal issues
4. Test resource- and information-sharing between tribal and non-tribal jurisdictions
5. Have each tribe make an informed analysis of what will be the most likely option for MCM distribution to its jurisdiction





# Tabletop Scenario



# Assumptions

- The purpose of this exercise is to identify gaps and vulnerabilities
- No jurisdiction is fully prepared for this type of public health emergency
- Open, honest and respectful dialogue and feedback are expected and valued throughout the exercise
- Today's exercise, discussions, and findings will inform future preparedness planning and actions

# Assumptions

- If a tribe requests medical countermeasures directly from the federal government, the federal government will deliver medical countermeasures to one site for the entire State of Washington - the Washington State Receive Stage and Store (RSS) warehouse

(Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives)





# Early August 2018

- There have been no major public health emergencies in your region
- The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations
- The annual Omak Stampede has brought together participants from around the state from August 9 to August 12
- Over 8500 Native and non-Native individuals participated in the many Omak Stampede events from across Washington, Idaho, Oregon and Canada



## **Day One – August 16, 2018**

The local hospital has admitted two non-Native patients (34 year old female, 19 year old male) with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# Day One Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 18, 2018 Morning**

The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one



# Pneumonic plague

Pneumonic plague is a severe lung infection caused by the bacterium *Yersinia pestis*. Symptoms include fever, headache, shortness of breath, chest pain, and cough. They typically start about three to seven days after exposure. It is one of three forms of plague, the other two being septicemic plague and bubonic plague.

Pneumonic plague can be caused in two ways: primary, which results from the inhalation of aerosolized plague bacteria, or secondary, when septicemic plague spreads into lung tissue from the bloodstream. Pneumonic plague is not exclusively vector-borne like bubonic plague; instead it can be spread from person to person.

Pneumonic plague symptoms often include fever, weakness, and headache as well as rapidly developing pneumonia with shortness of breath, cough, and chest pain.

<https://emergency.cdc.gov/agent/plague/factsheet.asp>

<https://www.cdc.gov/plague/faq/index.html>



# **Day Three Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 18, 2018 Afternoon**

A tribal clinic has had two patients (58 year old female, 66 year old male) present with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



## **Day Three Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?

# Day Four – August 19, 2018

- A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of:
  - high fever
  - severe weakness
  - bloody sputum
  - shortness of breath
  - possible pneumonia
- One of the patients participated in the Stampede
- Both tribal patients who presented on Day Three are critically ill
- All 5 tribal patients that have presented with symptoms are ages 55 and older





# Day Four Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Morning**

- Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington
- Washington State Emergency Management Division (EMD) is now activated – Mission Number has been issued
- DOH Incident Management Team (IMT) is now activated

# Day Five – August 20, 2018

## Morning

- Three local health jurisdiction employees have called in sick and have been referred to the hospital for care
- Two nurses from the hospital have become ill with the same symptoms
- The two initial tribal clinic patients were diagnosed with pneumonic plague
- Both initial tribal patients attended the Stampede
- Centers for Disease Control and Prevention (CDC) Director publishes a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment; the initial shipment to Washington State will be sufficient to administer prophylaxis to 80% of the 25 and younger population in Washington; more will be available in 10-14 days
- Tribal and nontribal health jurisdictions need to request medical countermeasures





# **Day Five Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Afternoon**

- A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS
- A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Afternoon**

- A local health jurisdiction needs to request use of tribal staff to dispense medical countermeasures
- A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Six – August 21, 2018**

The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse



# Day Six Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



# **Hotwash, Findings and Self-Evaluation**

# Next Steps



- AIHC will provide each jurisdiction with their compiled notes and after-action report (AAR)
- Tribes and LHJs complete the Partner Profile Form and return to AIHC ASAP
- Other?

## Appendix C: TABLETOP SIGN-IN SHEET

REGION 8

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 31, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
Wil Badonie	Environmental specialist Spill Response / Hazmat Team	wil - Badonie @yakama.com
Bryan Bauer	Yakima County Fire Dist 5 Bat. Capt	Bryan.Bauer@YCFDS.org
Darren King	White Swan Ambulance EMS Dispatcher	ddsquince@aol.com
MIKE McMULLEN	VIRGINIA MASON MEMORIAL HOSP EMERGENCY PREPAREDNESS COORD	MikeMcMullen@yxmlt.org
Cory Partner	DOH - MCM COORDINATOR	cory.Partner@doh.wa.gov
Ted Fischer	DOH MCM support	ted.fischer@doh.wa.gov
Jack Follansbee	Director of Public Health - IHS	jack.follansbee@IHS.gov
Terra Palomarez	Chief Nursing Officer	terra.palomarez@astria.health



American Indian Health Commission  
For Washington State

## REGION 8

### Cross-Jurisdictional Collaboration Project

#### TABLETOP EXERCISE

May 31, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Eric Jensen	CEO	eric@astria.health
Ryan Ibach	COO / LERC	ryan.ibach@co.yakima.wa.us
Theresa Wallahee	Homeland Security	Theresa-Wallahee@yakama.com
Shawn Blackshear	Environmental Health Officer	shawn.blackshear@hs.gov
Horace Ward	Senior Planner	horace.ward@co.yakima.wa.us
Jason Clapp	EM Planner	jason.clapp@co.yakima.wa.us
J. Eligio Jimenez	Director of Safety	jejimenez@toppuish.wednet.edu
Gary R. Peters	Prevention Officer	gary-peters@yakama.com

REGION 8

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 31, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
Sgt Alexander	Police Sgt	james_alexander@yakama.com
Courtney Whitefoot	YN Homeland Security Theresa's assistant	courtney-whitefoot@yakama.com
Tino Alonso	Loss Control Specialist	tino_alonso@yakama.com



# 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise

After Action Report and Improvement Plan

**Region 9**



**American Indian Health Commission  
for Washington State**

*In partnership with*



## Acronyms

Acronym	Definition
AAR	After Action Report
ASPR	Office of the Assistant Secretary for Preparedness and Response
CDC	Center for Disease Control
COOP	Continuity of Operations Plan
DOH	Washington State Department of Health
LHJ	Local Health Jurisdiction
MCM	Medical Countermeasures
POD	Point of Dispensing
PPE	Personal Protective Equipment
RSS	Receive, Stage and Store Warehouse

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## PREFACE

An After Action Report and Improvement Plan (AAR/IP) provide actionable insights for building community preparedness by documenting strengths and areas for improvement that participants identify during a simulated response to an emergency.

This report is tangible evidence of the valuable partnerships that exist between tribes, local governments and Washington State to improve public health preparedness in our communities. It serves as a collection of lessons learned, outlines recommended actions, and provides the basis for planning future exercises. This AAR/IP will contribute to improving future incident responses, training, exercises, equipment prioritization, plan effectiveness and overall preparedness.

The tabletop exercise this AAR documents was part of the American Indian Health Commission's Cross-Jurisdictional Collaboration Project of 2018. The project was facilitated by the American Indian Health Commission for Washington State (AIHC) with funding from the Washington State Department of Health (DOH).

### STRENGTHS

Strengths identified by Region 9 participants include:

- Some of the tribes and local health jurisdictions in the region have developed strong, collaborative relationships over the years
- The tribes have great established systems to communicate with tribal community members

### AREAS FOR IMPROVEMENT

Areas for improvement identified by Region 9 participants include:

- Increasing coordination between all jurisdictions on Communications, Public Messaging and Response Operations
- Increasing opportunities for the Tribe and other partners to exercise together
- Engaging ALL tribes and counties in the region

The American Indian Health Commission for Washington State wishes to express gratitude and appreciation for the many tribal, local and state partners that participated in this project and invested significant time and effort in support of our shared commitment to protecting the lives of all Washington State citizens.

## SECTION 1: EXERCISE OVERVIEW

Exercise Name	2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise
Exercise Dates	May 30, 2018
Scope	This exercise was a discussion-based tabletop exercise for Region 9, to address coordination and collaboration between the 3 tribes and 8 local health jurisdictions regarding the distribution of medical countermeasures.
Mission Area(s)	Response
Core Capabilities	PHEP Capability 06: Information Sharing PHEP Capability 09: Medical Materiel Management and Distribution
Overarching Objectives	<p>PHEP Capability 06 Information Sharing: Test the ability of federal, state, local, and tribal governments to exchange information and situational awareness data in preparation for, and response to, a plague outbreak.</p> <p>PHEP Capability 09 Medical Materiel Management and Distribution: Test the ability to coordinate logistical operations and medical material requests among federal, state, local, and tribal jurisdictions.</p>
Threat or Hazard	Pneumonic plague
Scenario	The exercise scenario included an outbreak of plague shortly after the annual Omak Stampede that draws the participation of thousands of Natives and non-Natives from Washington, Idaho, Oregon, Canada and other countries.
Participating Organizations	A total of 12 individuals participated in the exercise. Confederated Tribes of the Colville Reservation, Kalispel Tribe Northeast Tri County Health District, Spokane Regional Health District, Whitman County Health Department Washington State Department of Health
Point of Contact	Lou Schmitz, Consultant for American Indian Health Commission, <a href="mailto:lou.schmitz.aihc@outlook.com">lou.schmitz.aihc@outlook.com</a>

## SECTION 2: EXERCISE DESIGN AND SCENARIO SUMMARY

### Exercise Purpose and Design

On May 30, 2018, the American Indian Health Commission for Washington State (Commission) in partnership with the Washington State Department of Health (DOH) conducted a public health tabletop exercise where the DOH's Incident Management Team (IMT) was activated, and tribes, DOH, and LHJs coordinated on the distribution of medical countermeasures to tribes.

The exercise was conducted to strengthen the response capabilities of tribal, state, and local governments and to assure the appropriate amount and type of medical countermeasures and materiel reach every tribe quickly during public health emergencies. This exercise was developed and conducted by the Commission, in cooperation with representatives from DOH and various tribal and local governments and organizations.

The exercise was designed to test tribal, state, and local health jurisdiction plans, policies and procedures and provide an opportunity to evaluate current operations concepts, plans, and capabilities in response to a public health incident. The exercise was developed and evaluated utilizing objectives that were identified by tribal, state, and local government representatives.



### Exercise Planning Process

The Commission facilitated a planning meeting at each of the nine public health emergency planning regions for representatives from DOH, tribes and local health jurisdictions. The purpose of the planning meetings was for each region to: (1) increase partners' understanding of the various jurisdictions' capacity, organization, resources, etc; and (2) plan a tabletop exercise. Participants' suggestions were incorporated into the exercise design. The Commission designed the exercise, with technical assistance from DOH on epidemiological and logistical details.

## Exercise Objectives

### Objective 1: PHEP Capability 09 Medical Materiel Management and Distribution

Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### Objective 2: PHEP Capability 06 Information Sharing

Test resource and information-sharing between tribal and non-tribal jurisdictions

## Scenario Summary

The scenario for this exercise utilizes a public health incident that involves a population exposure to pneumonic plague. Cascading events require the incident managers and responders to take steps to identify, mitigate the effects of, protect the community from, and respond to the hazard and to acquire prophylaxis through the state medical countermeasures distribution system.

## Assumptions

If a tribe requests medical countermeasures directly from the federal government, the federal government will coordinate with the State and deliver medical countermeasures the Washington State Receive Stage and Store (RSS) warehouse in Tumwater.<sup>1</sup>

## Major and Detailed Events

- **Early August 2018:** There have been no major public health emergencies in the region. The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations. The annual tribal canoe journey has brought together participants from around the state between mid-July and August 4, for events along the route. Over 2500 Native and non-Native individuals participated in the many canoe journey events.
- **Day One August 6, 2018.** The local hospital has admitted two non-Native patients (34-year-old female, 19-year-old male) with symptoms of: (1) high fever; (2) severe weakness;

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<sup>1</sup> Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives on a March 15, 2018 webinar.

(3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.

- **Day Three August 8, 2018 Morning.** The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one.
- **Day Three August 8, 2018 Afternoon.** A tribal clinic has had two patients (58-year-old female, 66-year-old male) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia; and (5) rapidly deteriorating condition.
- **Day Four August 9, 2018.** A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of: (1) high fever; (2) severe weakness; (3) bloody sputum; (4) shortness of breath; (5) possible pneumonia. One of the patients participated in the annual canoe journey. Both tribal patients who presented on Day Three are critically ill. All 5 tribal patients that have presented with symptoms are ages 55 and older.
- **Day Five – August 10, 2018 Morning.** Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington. Washington State Emergency Management Division (EMD) is now activated and a Mission Number has been issued. DOH Incident Management Team (IMT) is now activated.
- **Day Five – August 10, 2018 Morning.** Three local health jurisdiction employees have called in sick and have been referred to the hospital for care. Two nurses from the hospital have become ill with the same symptoms. The two initial tribal clinic patients were diagnosed with pneumonic plague. Both initial tribal patients attended the canoe journey. Centers for Disease Control and Prevention (CDC) Director published a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment. The initial shipment to Washington State will be insufficient to administer prophylaxis to the entire target population. More supplies will be available in 10-14 days. Tribal and nontribal health jurisdictions need to request medical countermeasures.



- **Day Five-August 10, 2018 Afternoon.** A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS. A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle.
- **Day Five-August 10, 2018 Afternoon.** A local health jurisdiction has requested use of tribal staff to dispense medical countermeasures. A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts.
- **Day Six-August 11, 2018.** The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse.

## SECTION 3: KEY FINDINGS

The 2018 Tribal-State-Local Government Medical Countermeasures Distribution Tabletop Exercise was developed to assess the capability of tribes, the Washington State Department of Health (DOH), and the local health jurisdictions (LHJs) to coordinate distribution of medical countermeasures to tribal nations during a public health incident. A tabletop exercise was held in each of Washington State's nine (9) public health emergency preparedness regions.

The following objectives that were exercised align with the Centers for Disease Control (CDC) Public Health Emergency Preparedness Capabilities (PHEP):

<b>Exercise Objective</b>	<b>Objective Description</b>	<b>Related PHEP Capability Number/Description</b>
Objective 1	Test the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.	C09 Medical Materiel Management and Distribution
Objective 2	Test resource and information-sharing between tribal and non-tribal jurisdictions	C06 Information Sharing

This section of the After Action Report (AAR) presents strategic findings as they relate to the tabletop objectives and key issues that were identified as a result of the exercise.

## **MEDICAL MATERIEL MANAGEMENT AND DISTRIBUTION (RELATES TO PHEP CAPABILITY 09).**

Objective 1 of this tabletop exercise tested the state and region's ability to effectively coordinate distribution of medical materiel for the public and public health partners across tribal and nontribal jurisdictions.

### **Major Strengths**

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** The DOH and almost all LHJs recognized the sovereign authority of tribes to determine who their priority populations are in the dispensing of medical countermeasures, even if that determination may conflict with CDC guidelines. As a result, the DOH and most LHJs stated they will distribute medical countermeasures to the tribe regardless of the tribes' internal decisions regarding priority populations.
- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Most LHJs stated they have the capacity to deliver medical countermeasures to tribes.

### **Primary Areas for Improvement**

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.** Not all LHJ representatives understand that their role is limited to transporting and/or handing over tribes' medical countermeasures allocations, unless a tribe specifically requests additional coordination or assistance. Some LHJ participants believe they have legal obligations to ensure that tribes follow CDC recommendations. This lack of understanding resulted in some tribes in Washington State not receiving vaccine and antivirals during the 2009 - 2010 H1N1 pandemic response and can produce catastrophic consequences during future public health incidents, unless corrected.



- 2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.** Some LHJs stated they may not have the capacity to deliver medical countermeasures directly to tribes.

- 3. Identification of Tribal Service Population.** Tribal service population numbers can vary greatly from one public health incident to another, due to large events like the annual Canoe Journey, Omak Stampede, pow wows, concerts, tourism, etc. Some LHJs noted the need for a system to inform the LHJs, during a response, specifically which population the tribe will be serving to avoid duplication or gaps.
- 4. Medical Countermeasures Plans.** Most local health jurisdictions' medical countermeasures planning documents do not address processes for distribution of medical countermeasures to tribes. Most tribes need to develop and adopt medical countermeasures plans, including a clear process for making decisions during public health incidents regarding how they want their medical countermeasures delivered.
- 5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.** There is no clearly documented system in place for including tribes in communication, decision-making, and coordination of efforts during public health incidents and responses.

## Recommendations

- 1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes.**
  - a) DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing.
  - b) The United States federal government should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an agency consultation with tribes on these guidelines.
  - c) DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government.
  - d) DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes.

2. **LHJ Capacity to Deliver Medical Countermeasures to Tribes.** The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe’s allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.
3. **Identification of Tribal Service Population.** DOH should develop and document a streamlined process for tribes to inform DOH of the population they will serve for each specific public health incident.
4. **Medical Countermeasures Plans.** Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.
5. **Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.**

Camas Center for Community Health

- a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
- b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.
- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
- d. DOH and the Commission should continue to work with tribes to sign on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.
- e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the



MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.

- 6. Pharmacy Memorandum of Understanding.** DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU). This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.
- 7. Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State.** DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.
- 8. Ability to Receive, Manage and Store Medical Countermeasures.** Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.
- 9. Staff Training.** Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.



**INFORMATION SHARING BETWEEN JURISDICTIONS (RELATES PHEP CAPABILITY 06).** Objective 2 of this tabletop exercise tested resource and information-sharing between tribal and non-tribal jurisdictions.

### Major Strengths

- 1. Reporting Public Health Incidents to State.** Once the LHJs received notice from the hospitals and/or clinics, all LHJs immediately contacted DOH during the exercise. DOH immediately began coordinating with the LHJs, the hospitals, and the tribes to begin an investigation to share information, determine where the disease originated and initiate response actions.
- 2. Reporting Public Health Incidents to Indian Health Care Providers.** Many LHJs maintain healthcare provider notification systems that include Indian health care providers and other tribal representatives. Tribal partners are eligible to register for the Washington State Department of Health's (DOH's) SECURES health alert system and receive notifications.

### Primary Areas for Improvement

- 1. Reporting Public Health Incident to Indian Health Care Providers.** Not all LHJs have a system in place to ensure all Indian health care providers and other tribal contacts are notified of a public health incident. Also, not every tribe is registered on the Washington State Department of Health's (DOH's) SECURES health alert system.
- 2. Accuracy and Maintenance of Contact List.** There is no system in place for maintaining accurate and current partner contact lists for individuals with key roles during responses. DOH's "Yellow Book" and "Red Book" are published in paper format, and thus not updated in real time. DOH has plans to convert the books to an online system, to be updated quarterly.

### Recommendations

- 1. Reporting Public Health Incidents to Indian Health Care Providers.**
  - a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.
  - b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the correct tribal contacts are registered and kept current.

- c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)
  - d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.
- 2. Accuracy and Maintenance of Contact List.** DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.

## **EMERGENCY PUBLIC INFORMATION AND WARNING (RELATES TO PHEP CAPABILITY 04):**

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.

### **Major Strengths**

- 1. LHJ Public Information Officers.** Some LHJs have public information officers who can quickly manage public information dissemination and provide technical assistance to other jurisdictions in the region that do not have this capability.
- 2. DOH Public Information Resources.** DOH has resources to provide technical assistance to LHJs and tribes regarding public information sharing and messaging.
- 3. Tribes' Knowledge Access to Communicating With Tribal Community Members and Expertise.** Tribes have comprehensive systems in place to communicate with their community members. They also have the knowledge to develop messaging that is respectful of culture and history, and appropriate for their community members.

### **Primary Areas for Improvement**

- 1. Inclusion of Tribes in State and Local Public Information Sharing.** There is no clearly documented system in place for coordination and collaboration on public information and messaging for the tribal communities. It is imperative for LHJs to coordinate with tribes on messaging, to assure respect for culture and history and assure message efficacy. Many tribal community members will disregard or distrust public health messages that do not originate from tribal council or other tribal officials. Health literacy is a critical factor to consider in ensuring community members understand alerts and notices. A strong understanding of the community's culture and historical context are also key. Messages should provide tribal community members with clear guidance on reasonable action steps they can take to protect themselves and others.



2. **Controlling Spread of Misinformation within Tribal Communities.** Tribes voiced concern about controlling information to the public in small communities where information spreads quickly and inaccurately through word of mouth and on social media. This spread of misinformation could result in tribal clinics being overwhelmed. Tribes expressed interest in receiving technical assistance in this area.

## Recommendations

1. **Inclusion of Tribes in State and Local Public Information Sharing.**
  - a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses.
  - b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.
2. **Controlling Spread of Misinformation within Tribal Communities.** The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.

**PUBLIC HEALTH SURVEILLANCE AND EPIDEMIOLOGICAL INVESTIGATION (RELATES TO CAPABILITY 13):** Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes, as well as to expand these systems and processes in response to incidents of public health significance.

### Major Strengths

**1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** All LHJs coordinate on some level with tribes when they must go on tribal lands to conduct epidemiological investigations that involve tribal community members. One LHJ partners with a tribe on conducting communicable disease investigations by including a tribal employee to serve as a community liaison. Several participants recognized the importance of having a tribal community liaison available during investigations, since tribal members may be hesitant to communicate with non-tribal members. The tribal community liaison can also be an especially valuable asset, given their knowledge of the community.



### Recommendations

**1. LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.** LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.

**RESPONDER SAFETY AND HEALTH (RELATES TO PHEP CAPABILITY 14):** The responder safety and health capability describes the ability to protect public health agency staff responding to an incident and the ability to support the health and safety needs of hospital and medical facility personnel, if requested.

### Major Strengths

- 1. Access to Training and Personal Protective Equipment (PPE).** Many tribes and LHJs have access to training and personal protective equipment (PPE) necessary to safely respond to a public health incident.
- 2. Notification of Risk of Exposure to EMS Personnel.** Many tribes and LHJs have a system in place to notify emergency medical services (EMS) personnel before they transport a patient that can expose them to a communicable disease or other potential risk.

### Primary Areas for Improvement

- 1. Access to Training and Personal Protective Equipment (PPE).** Some tribes stated their law enforcement staff (and other potential responders) do not have access to PPE and training on PPE and other precautions needed to safely respond to incidents that may expose them to communicable diseases or other risks.
- 2. Notification of Risk of Exposure to EMS Personnel.** Some tribes and LHJs need to develop and implement standard operating procedures to ensure that EMS and other emergency responders are not exposed to communicable diseases or other potential risks.

### Recommendations

- 1. Access to Training and Personal Protective Equipment (PPE).**
  - a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.
  - b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.
- 2. Notification of Risk of Exposure to EMS Personnel.** All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other

emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.

**MEDICAL SURGE (RELATES TO PHEP CAPABILITY 10):** 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.

### Major Strengths

- 1. Tribal Clinic Capacity and Expertise.** Many tribal clinics are well equipped and staffed to respond to a public health incident, and plan to continue serving their patient population for the duration of most public health incidents.



### Areas for Improvement

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Most tribal clinics do not have Continuity of Operations (COOP) Plans or Crisis Standards of Care to clearly guide their operations during a public health incident.

### Recommendations

- 1. Continuity of Operations (COOP) Plans and Crisis Standards of Care.** Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.

## Appendix A: IMPROVEMENT PLAN

The Improvement Plan (IP) specifically details what actions will be taken to address each recommendation presented in the After Action Report (AAR), who or what entity will be responsible for taking the action, and the timeline for completion.

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Medical Materiel Management and Distribution</b> (Relates to PHEP Capability 9)	1. LHJ and DOH Role in Distribution of Medical Countermeasures to Tribes	a. DOH should draft amendments to Annex 9 of the State Emergency Response Plan to clearly explain the role and responsibility of DOH and LHJs in the distribution of medical countermeasures, and conduct an agency consultation with tribes on these amendments. All partners must understand that the role of LHJs and DOH is limited to transporting and/or handing over the tribes' allocations. Unless a tribe specifically requests coordination or assistance, LHJs and DOH have no role regarding the tribes' decisions and actions regarding dispensing	a. DOH	10/30/19
		b. The United States federal government (CDC/ASPR) should: draft clear guidance outlining the roles and responsibilities of the federal government, state, local and tribal jurisdictions in the distribution of medical countermeasures to tribes; draft clear guidance outlining a process for tribes that choose to request and receive medical countermeasures directly from the federal government; and conduct an	b. CDC and ASPR	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>agency consultation with tribes on these guidelines.</p> <p>c. DOH, the Commission, and tribal representatives should continue to request the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) to provide detailed guidance on the process for tribes to request and receive medical countermeasures directly from the federal government</p> <p>d. DOH should continue to collaborate with the Commission to assure that all local health jurisdictions understand their limited role in the distribution of medical countermeasures to tribes</p>	<p>c. DOH and Commission</p> <p>d. DOH and Commission</p>	<p>10/30/19</p> <p>12/30/19</p>
	2. LHJ Capacity to Deliver Medical Countermeasures to Tribes.	The Partner Profile form should be amended to collect from each LHJ confirmation on whether they have the capacity to deliver medical countermeasures to tribes, if a tribe chooses to have DOH deliver the tribe's allocation to the LHJ. This is key information for the tribe to make plans to pick up the MCM from the LHJ, or to choose an alternate option for delivery.	DOH and Commission	10/30/19
	3. Identification of Tribal Service Population.	DOH should develop and document a streamlined process for tribes to inform DOH	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		of the population they will serve for each specific public health incident.		
	4. Medical Countermeasures Plans.	Tribes and LHJs should develop medical countermeasures plans that clearly outline processes for distribution of medical countermeasures to tribes; inclusion of tribes in communication, decision-making and public information messaging; requesting, receiving, distributing and dispensing medical countermeasures; and other critical response actions.	LHJs and Tribes	04/30/19
	5. Ongoing Public Health Incident Communication and Coordination between Tribes, DOH, and LHJs.	<p>a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.</p> <p>b. Each region should develop an Emergency Coordination Center or similar system to support the coordination of response actions and decision-making.</p> <p>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g.</p>	<p>LHJs and Tribes</p> <p>LHJs and Tribes</p> <p>DOH</p>	<p>04/30/19</p> <p>04/30/19</p> <p>06/30/19</p>

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH and the Commission should continue to work with tribes to sign on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can more efficiently coordinate and share resources during distribution of medical countermeasures.</p> <p>e. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH and Commission</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	6. Pharmacy Memorandum of Understanding	DOH should continue to work with tribes who have a pharmacy to see whether they would like to sign the statewide Pharmacy Memorandum of Understanding (MOU).	DOH	10/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		This option may be another avenue for tribes to receive medical countermeasures quickly, by having a large distributor such as McKesson deliver directly to their pharmacy.		
	7 Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State	DOH and the Commission should continue to support tribes and LHJs in signing on to the “Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State” so tribes and LHJs can quickly and effectively share resources in the distribution of medical countermeasures.	DOH and Commission	06/30/19
	8. Ability to Receive, Manage and Store Medical Countermeasures	Tribes and LHJs should make an internal assessment regarding their ability to receive, manage, and store medical countermeasures.	Tribes and LHJs	04/30/19
	9. Staff Training	Tribes and LHJs should make sure all relevant staff receive training on medical countermeasures and understand their roles and responsibilities during a response.	Tribes and LHJs	04/30/19
Information Sharing between Jurisdictions (Relates to PHEP Capability 6)	1. Reporting Public Health Incidents to Indian Health Care Providers	a. Each region should develop a Joint Information System to strengthen coordination and communication among tribes and LHJs during public health incidents.	Tribes and LHJs	04/30/19
		b. DOH and the Commission should continue to coordinate the SECURES registration process for tribes to assure that the	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>correct tribal contacts are registered and kept current.</p> <p>c. DOH should assure that tribes are included in the regular conference calls convened by DOH during public health incidents to address ongoing issues (e.g. points of contact, public messaging, disease investigation, etc.)</p> <p>d. DOH, in collaboration with the Commission, should continue its work with the tribes and LHJs to ensure that key information is maintained current and shared using the MCM Partner Profile form, including: the most likely option for medical countermeasures delivery for each tribe, whether each LHJ has the capacity to deliver directly to a tribe(s), resources available and resources needed, primary contacts, etc. Tribes and LHJs should have access to this information.</p>	<p>DOH</p> <p>DOH and Commission</p>	<p>06/30/19</p> <p>04/30/19</p>
	2. Accuracy and Maintenance of Contact List	DOH and the Commission should develop a system that provides tribes and local health jurisdictions with current and accurate contact information for individuals from all jurisdictions with key roles during responses. A single, official point of access that is restricted to authorized users is preferred.	DOH and Commission	04/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
<b>Emergency Public Information and Warning</b> (Relates to PHEP Capability 4)	1. Inclusion of Tribes in State and Local Public Information Sharing	a. The LHJs and tribes in each region should collaborate to develop plans that clearly outline processes to coordinate on unified public messaging during public health incidents and responses.	LHJs and Tribes	04/30/19
		b. DOH and the Commission should work together to develop ways of strengthening coordination and communication among tribes, DOH, and LHJs to address public health messaging.	DOH and Commission	06/30/19
	2. Controlling Spread of Misinformation Within Tribal Communities	The Commission and DOH should identify and provide opportunities for tribes to access training and technical assistance in this area.	DOH and Commission	6/30/19
<b>Public Health Surveillance and Epidemiological Investigation</b> (Relates to PHEP capability 13)	LHJ-Tribes-DOH Coordination of Communicable Disease Investigations.	LHJs should continue to coordinate with tribes in conducting epidemiological investigations involving tribal community members and identify a tribal community liaison to assist with those investigations. The tribal community liaisons can expedite investigations, given their knowledge of the community and assist with tribal members who may be hesitant to communicate with non-tribal members.	LHJs and Tribes	6/30/19
<b>Responder Safety and Health</b> (Relates to PHEP capability 14)	1. Access to Training and Personal Protective Equipment	a. Tribes and LHJs should ensure their plans address protection of law enforcement, EMS and other emergency responders. Tribes that have not had preparation and	LHJs and Tribes	6/30/19

Objective/Key Issue	Recommendation	Improvement Action Description	Primary Responsible Entity	Recommended Completion Date
		<p>training on use of PPEs for law enforcement and other tribal emergency responders should work with their clinics to implement necessary personal protective equipment preparation, adoption of standard precautions and relevant training.</p> <p>b. The Commission and DOH should identify and provide opportunities for tribes and LHJs to access training and technical assistance in this area.</p>	DOH and Commission	06/30/19
	2. Notification of Risk of Exposure to EMS Personnel.	All tribes and LHJs should develop and implement standard operating procedures to ensure that law enforcement, EMS, and other emergency responders are provided appropriate information to prevent exposure to communicable diseases and other potential risks.	LHJs and Tribes	6/30/19
<b>Medical Surge</b> (Relates to PHEP capability 10)	Continuity of Operations (COOP) Plans and Crisis Standards of Care	Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care to support their ability to continue serving their patients during most public health incidents and to guide their operations during these events.	Tribes	4/30/19

## Appendix B: TABLETOP EXERCISE SLIDES

# **Cross-Jurisdictional Collaboration Project Medical Countermeasures**

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## **Tabletop Exercise**

**May 2018**



**American Indian Health Commission**  
for Washington State

# Agenda



**Introductions and Overview**



**Unfolding Situation → Decisions and Responses**



**Break**



**Later Developments → Decisions and Responses**



**Break and Photos**



**Hotwash, Findings and Self-Evaluation**



**Next Steps**

# **Introductions and Overview**





# **Introductions**

- **What is your job title?**
- **How long have you worked in your current position?**
- **What responsibilities do you have related to community emergency preparedness?**

# What are Medical Countermeasures (MCM)?

- Medical treatments or prophylaxes for public health threats
- Supplies, equipment, pharmaceuticals and other items needed to treat or protect against public health threats



# Medical Countermeasures and Tribes

- Each time an incident occurs, a tribe has the sovereign authority to choose how medical countermeasures are distributed to their community by federal, state, and or local governments
- Tribes should have detailed information about the MCM distribution options that exist
- Having detailed information on the different options will allow a tribal nation to make the analysis as to which option will be best for each incident, ensuring the fastest response and protecting their community



# Federal Government (SNS) → Washington State

**OPTION 1**  
**Tribe → State**

**TRIBE**  
sends staff  
and vehicle  
to pick up  
MCM at  
STATE RSS  
location

**OPTION 2**  
**State → Tribe**

**STATE**  
delivers  
directly to  
**TRIBAL**  
location

**OPTION 3**  
**State → LHJ → Tribe**

**STATE** delivers Tribal  
allocation to Local  
Health Jurisdiction (LHJ)

**TRIBE and LHJ**  
coordinate  
conveyance of  
MCMs to **TRIBE**

**OPTION 4**  
**Tribe**  
**Contacts**  
**Feds (CDC)**

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity\*

\*"Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5-6.

## Option 4 → Tribe Contacts Federal Government

Delivery of MCMs to tribes will occur, dependent upon the facts and circumstances of the incident, through federal coordination with the State or other entity; **\*SEE FEDERAL REFERENCES BELOW.**

### \*Version 11

“For state and local jurisdictions that include military installations, tribal nations, and federal agencies, a unique set of challenges can arise for coordinating the receipt, distribution, and dispensing of MCMs. ***While planners sometimes mistakenly believe that these unique jurisdictions are autonomous or will be covered by federal agencies during an emergency, responsibility for these entities actually falls to the state and local jurisdictions in which they are located.***”

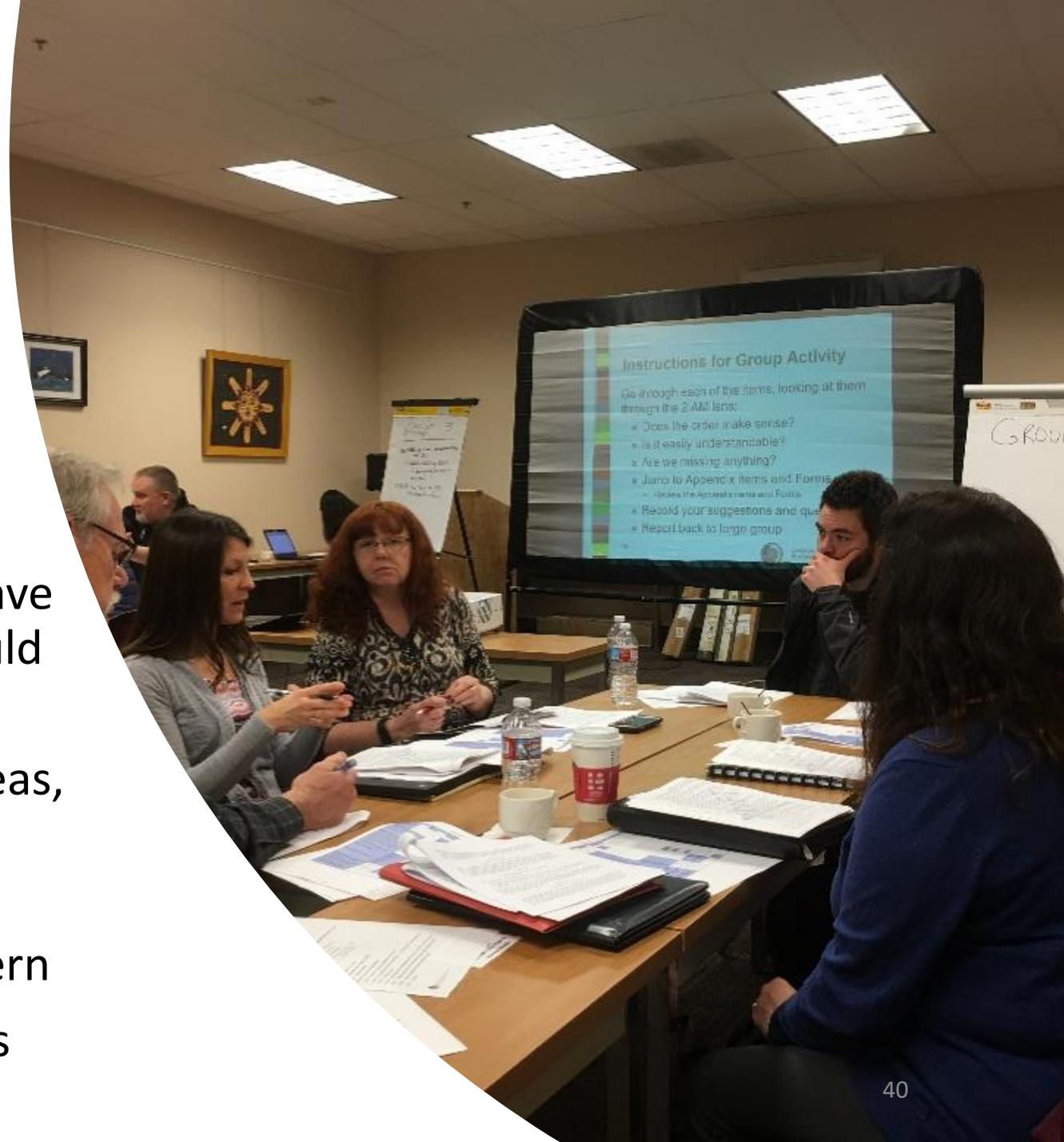
See CDC’s “Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, Version 11, p. 5.

“the state is responsible for developing the MCM distribution system and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the affected communities has access to MCMs during an incident.” Version 11, p. 6

**Regardless of the dispensing option chosen, MCMs will be distributed through the system developed by the state health department once an emergency is declared** and it is vital that state and local planners coordinate with their tribal populations to ensure everyone in the community has access to MCMs. Version 11, p. 6. *Emphasis added.*

# What is a Tabletop Exercise?

- An informal discussion using a scripted scenario as a catalyst
- Identifies gaps in our plans, issues we have not yet thought about, changes we should make to our plans
- Promotes free and open exchange of ideas, no time pressures
- Opportunity to discuss issues in depth, collaboratively examining areas of concern
- There are no “right” or “wrong” answers



# Purpose of the Tabletop Exercise

Testing communication and MCM distribution processes through a tabletop exercise will increase:

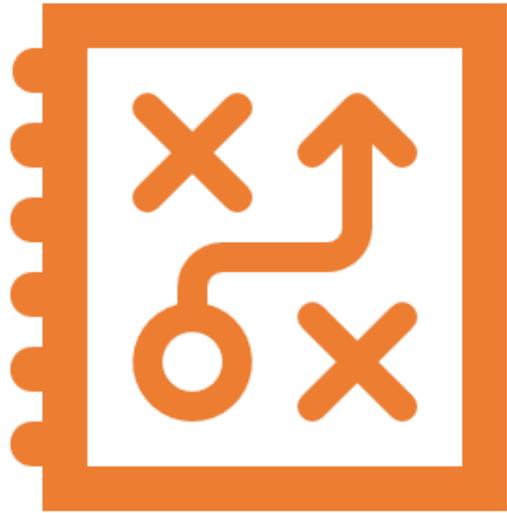
- tribes' understanding of how the different options will work for their communities and strengthen their decision-making at the time of an incident
- tribal, local, and state partners' understanding of how they will interact during MCM distribution



# Specific Objectives

1. Test the region's ability to effectively coordinate distribution of MCM across tribal and nontribal jurisdictions
2. Identify strengths and areas for improvement
3. Identify potential legal issues
4. Test resource- and information-sharing between tribal and non-tribal jurisdictions
5. Have each tribe make an informed analysis of what will be the most likely option for MCM distribution to its jurisdiction





# Tabletop Scenario



# Assumptions

- The purpose of this exercise is to identify gaps and vulnerabilities
- No jurisdiction is fully prepared for this type of public health emergency
- Open, honest and respectful dialogue and feedback are expected and valued throughout the exercise
- Today's exercise, discussions, and findings will inform future preparedness planning and actions

# Assumptions

- If a tribe requests medical countermeasures directly from the federal government, the federal government will deliver medical countermeasures to one site for the entire State of Washington - the Washington State Receive Stage and Store (RSS) warehouse

(Based on CDC's guidance "Receiving, Distributing, and Dispensing SNS Assets – A Guide to Preparedness Version 11" and discussion with CDC representatives)





# Early August 2018

- There have been no major public health emergencies in your region
- The mild winter and the hot and dry summer have caused many of Washington's regions to experience flea infestations
- The annual Omak Stampede has brought together participants from around the state from August 9 to August 12
- Over 8500 Native and non-Native individuals participated in the many Omak Stampede events from across Washington, Idaho, Oregon and Canada



## **Day One – August 16, 2018**

The local hospital has admitted two non-Native patients (34 year old female, 19 year old male) with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



# Day One Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 18, 2018 Morning**

The hospital has made initial diagnosis of pneumonic plague for both non-tribal patients who presented on day one



# Pneumonic plague

Pneumonic plague is a severe lung infection caused by the bacterium *Yersinia pestis*. Symptoms include fever, headache, shortness of breath, chest pain, and cough. They typically start about three to seven days after exposure. It is one of three forms of plague, the other two being septicemic plague and bubonic plague.

Pneumonic plague can be caused in two ways: primary, which results from the inhalation of aerosolized plague bacteria, or secondary, when septicemic plague spreads into lung tissue from the bloodstream. Pneumonic plague is not exclusively vector-borne like bubonic plague; instead it can be spread from person to person.

Pneumonic plague symptoms often include fever, weakness, and headache as well as rapidly developing pneumonia with shortness of breath, cough, and chest pain.

<https://emergency.cdc.gov/agent/plague/factsheet.asp>

<https://www.cdc.gov/plague/faq/index.html>



# **Day Three Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Three – August 18, 2018 Afternoon**

A tribal clinic has had two patients (58 year old female, 66 year old male) present with symptoms of:

- high fever
- severe weakness
- bloody sputum
- shortness of breath
- possible pneumonia
- rapidly deteriorating condition



## **Day Three Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?

# Day Four – August 19, 2018

- A tribal clinic has had three more patients (female 59, male 64, male 72) present with symptoms of:
  - high fever
  - severe weakness
  - bloody sputum
  - shortness of breath
  - possible pneumonia
- One of the patients participated in the Stampede
- Both tribal patients who presented on Day Three are critically ill
- All 5 tribal patients that have presented with symptoms are ages 55 and older





# Day Four Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Morning**

- Governor Jay Inslee has issued a proclamation of emergency for the entire State of Washington
- Washington State Emergency Management Division (EMD) is now activated – Mission Number has been issued
- DOH Incident Management Team (IMT) is now activated

# Day Five – August 20, 2018

## Morning

- Three local health jurisdiction employees have called in sick and have been referred to the hospital for care
- Two nurses from the hospital have become ill with the same symptoms
- The two initial tribal clinic patients were diagnosed with pneumonic plague
- Both initial tribal patients attended the Stampede
- Centers for Disease Control and Prevention (CDC) Director publishes a letter including recommendations which identify individuals ages 25 and younger as priority population for receiving prophylactic treatment; the initial shipment to Washington State will be sufficient to administer prophylaxis to 80% of the 25 and younger population in Washington; more will be available in 10-14 days
- Tribal and nontribal health jurisdictions need to request medical countermeasures





# **Day Five Morning Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Afternoon**

- A tribe has requested use of a local health jurisdiction's truck to pick up medical countermeasures from the Washington State RSS
- A local board of health member raises concerns about liability if the LHJ allows the tribe to use their vehicle



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



## **Day Five – August 20, 2018 Afternoon**

- A local health jurisdiction needs to request use of tribal staff to dispense medical countermeasures
- A tribal council member raises concerns about liability if the tribe allows tribal staff to assist the LHJ in the LHJ's response efforts



# **Day Five Afternoon Discussion**



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



**Centers for Disease Control (CDC)  
Strategic National Stockpile  
"Push Pack"**

## **Day Six – August 21, 2018**

The federal government has delivered Strategic National Stockpile (SNS) assets to the Washington State Receive Stage and Store (RSS) warehouse



# Day Six Discussion



- **What actions (if any) will you take at this time?**
- **Who will you communicate with?**
  - Within your jurisdiction
  - Outside of your jurisdiction
- **What is the nature of the communication?**
  - How do you communicate?
  - What information do you share?
  - Do you have contact information immediately available to you?



# **Hotwash, Findings and Self-Evaluation**

# Next Steps



- AIHC will provide each jurisdiction with their compiled notes and after-action report (AAR)
- Tribes and LHJs complete the Partner Profile Form and return to AIHC ASAP
- Other?

## Appendix C: TABLETOP SIGN-IN SHEET



American Indian Health Commission  
For Washington State

REGION 9

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 30, 2018  
SIGN-IN SHEET



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REGION 9

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 30, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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## **APPENDIX H: SIGN-IN SHEETS**



American Indian Health Commission  
For Washington State

## REGION 1

### Cross-Jurisdictional Collaboration Project

Meeting 1

February 6, 2018  
SIGN-IN SHEET



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American Indian Health Commission  
For Washington State

REGION 1

Cross-Jurisdictional Collaboration Project

Meeting 1

February 6, 2018

SIGN-IN SHEET



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REGION 1

Cross-Jurisdictional Collaboration Project

Meeting 1

February 6, 2018

SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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American Indian Health Commission  
For Washington State

REGION 2

Cross-Jurisdictional Collaboration Project

Meeting 1

January 30, 2018

SIGN-IN SHEET



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REGION 2

Cross-Jurisdictional Collaboration Project

Meeting 1

January 30, 2018

SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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REGION 2

Cross-Jurisdictional Collaboration Project

Meeting 1

January 30, 2018

SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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American Indian Health Commission  
For Washington State

REGION 3

Cross-Jurisdictional Collaboration Project

Meeting 1

February 1, 2018

SIGN-IN SHEET



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REGION 3

Cross-Jurisdictional Collaboration Project

Meeting 1

February 1, 2018

SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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American Indian Health Commission  
For Washington State

## REGION 4

### Cross-Jurisdictional Collaboration Project

Meeting 1

February 2, 2018

SIGN-IN SHEET



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American Indian Health Commission  
For Washington State

## REGION 4

### Cross-Jurisdictional Collaboration Project

Meeting 1

February 2, 2018

SIGN-IN SHEET



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American Indian Health Commission  
For Washington State

REGION 5

Cross-Jurisdictional Collaboration Project

Meeting 1

May 21, 2018  
SIGN-IN SHEET



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REGION 5

Cross-Jurisdictional Collaboration Project

Meeting 1

May 21, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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American Indian Health Commission  
For Washington State

## REGION 6

### Cross-Jurisdictional Collaboration Project

Meeting 1

May 4, 2018

SIGN-IN SHEET



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REGION 6

Cross-Jurisdictional Collaboration Project

Meeting 1

May 4, 2018

SIGN-IN SHEET



American Indian Health Commission  
For Washington State



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American Indian Health Commission  
For Washington State

REGION 7

Cross-Jurisdictional Collaboration Project

Meeting 1

April 10, 2018  
SIGN-IN SHEET



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RANDY AUGUST	<del>Emergency</del> EMERGENCY PLANNER	randy.august2@colvilletribes.com
Ted Fischer	Emergency Preparedness Specialist	Ted.fischer@doh.wa.gov
Cory Partner	EMERGENCY PREP. SPECIALIST	cory.partner@doh.wa.gov
Ryan Buckner	Pharmacist, IHS Omak Clinic Coordinator	Ryan.Buckner@ihs.gov



American Indian Health Commission  
For Washington State

## REGION 8

### Cross-Jurisdictional Collaboration Project

Meeting 1

April 12, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Horace Ward	Senior Planner	horace.ward@co.yakima.wa.us
Ryan Ibach	Chief operating officer Local Emergency Response Coordinator Yakima Health District	ryan.ibach@co.yakima.wa.us
Ted Fischer	WA. DOH EPR	Ted.fischer@doh.wa.gov
Cory Portner	WA DOH EPR	cory.portner@doh.wa.gov
Theresa Wallahee	YNHS	Theresa-Wallahee@yakama.com
Courtney Whitefoot	YNHS	courtney-whitefoot@yakama.com
Sgt. Alexander	YN Police	james_alexander@yakama.com
Tino Alonso	Loss Control Specialist	tino_alonso@yakama.com

REGION 8

Cross-Jurisdiction Collaboration Project

Meeting 1

April 12, 2018

SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
John Pulsipher	IHS Facility Manager/Safety	john.pulsipher@ihs.gov



American Indian Health Commission  
For Washington State

## REGION 8

### Cross-Jurisdictional Collaboration Project

Meeting 1

April 12, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS

Name                      Number                      Email  
Jason Clapp              (509) ~~547~~574-1907              jason.clapp@co.yakima.wa.us

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Jackie Follansbee              (509) 865-1753              jackie.follansbee@IHS.gov

Horace Ward              509-~~731-9447~~ ~~6653~~              horace.ward@co.yakima.wa.us

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Gary R. Peters              509-865-6653              gary-peters@yakama.com



American Indian Health Commission  
For Washington State

## REGION 9

### Cross-Jurisdictional Collaboration Project

Meeting 1

April 11, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Cory Porter	EMERGENCY PREP. SPECIALIST DOH	cory.portner@doh.wa.gov
Ted Fischer	WA DOH OEPR Emergency Readiness Specialist	ted.fischer@doh.wa.gov
Ron Poplawski	CANAS BUSINESS MGR	rpoplawski@canashealth.com
DEL OSTENBERG	CCT Emergency MGR, EMS FIRE & <sup>ambulance</sup>	-
Kathy Desautel	operation Manager	kathy.desautel2@Colvilletribes.com
Tom Ling	OPERATIONS SPECIALIST/EMT	tling@kalispeltribe.com
Matt Schanz	Administrator, Northeast Tri Co. Health District	mschanz@netchd.org
Cindy Thompson	Health Program Specialist	cathompson@srhd.org

REGION 9

Cross-Jurisdictional Collaboration Project

Meeting 1

April 11, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
Summer Warfield	PHEPR / MRC	swarfield@srhd.org
Ben Stone	Environmental Health / PHEPR	ben.stone@co.whitman.wa.us



American Indian Health Commission  
For Washington State

REGION 1

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 24, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Heather Thomas	Public & Gov't Affairs Mgr	hthomas@snohd.org
Nancy Furness	Division Director ISHD	nfurness@snohd.org
Kate Curtis	Assistant Div Dir	kcurtis@snohd.org
Robert Taylor	Training + Exercise	RTaylor@snohd.org
Therese Quinn	MRE Coordinator	TQuinn@SNOH.org
Vickie Fontaine	Emergency Mgmt Coordinator	vickief@co.skagit.wa.us
Cristin Corcoran	PHEPR Coordinator	Cristinc@co.skagit.wa.us
Bob Hicks	Operations Manager	bobhicks@co.skagit.wa.us

REGION 1

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 24, 2018

SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
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Mitch MARKOVICH	SAMISH PUBLIC HEALTH	M MARKOVICH@SAMISHTRIBES.WA.US
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REGION 1

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 24, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
Lisa Hainey	Environmental Scientist, Upper Skagit Indian Tribe	lisaha@upper-skagit.com
Troy L. George	PHEP Coordinator NWN IHB	troy@indianhealthboard.org
Stephanie Coffey	Environmental Health Officer NWN IHB	stephanie@indianhealthboard.org
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Andrea Garcia	RN, Clinic Manager	andrea.garcia@nooksack-nsn.gov
Caroline Lorkins	Public Health Emergency Planning and Response Coord. ICBPH	carolinel@co.island.wa.us
Quintina Bowen	Swinomish tribal Health programs manager	qbowen@Swinomish.nsn.us
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REGION 1

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 24, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
MARK RAKA	EMERGENCY PREPAREDNESS SPEC.	mraaka@co.whatcom.wa.us
Chalice Dew-Johnson	Coordinator, WCSO- Division of <sup>Emergency Management</sup>	cdjohnso@co.whatcom.wa.us
Soni Hensley	PHN Supervisor / <sup>Whatcom Co</sup> Health	jhensley@co.whatcom.wa.us
Cindy Hollinsworth	Communicable Disease Manager, Whatcom Co. Health Dept	chollins@co.whatcom.wa.us
Melissa Morin	Communications Specialist Whatcom Co. Health Dept.	mmorin@co.whatcom.wa.us
Julie Rose	Public Health Nurse - immunizations whatcom Co. Health Dept	jrose@co.whatcom.wa.us
David H. Owens	Emergency Prep Specialist WA DOH	david.owens@doh.wa.gov
Carrie Corder	Emergency Preparedness Specialist WA. Dept. of Health	Carrie.Corder@doh.wa.gov



American Indian Health Commission  
For Washington State

# REGION 1

## Cross-Jurisdictional Collaboration Project

### TABLETOP EXERCISE

May 24, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
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Barbara Juarez	Ex Director NWWIHB	barbara@indianhealthboard.org

REGION 2

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 1, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
Misty Eves	HR Representative Neo-Kayet Development Corp.	mives@pgst.nsn.us
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Adele Stokes	Health prevention specialist PGST Health Services	adeles@pgst.nsn.us
Kerstin Powell	Health SVCS Mgr	kerstin@pgst.nsn.us
John J Folz	Facilities Manager	john@Neo-Kayet.com
SAM WHITE	PGST-CHIEF OF POLICE	SWHITE@PGST.NSN.US
Renee Veregge	Special Projects/SEA Coordinator & Tribal Council	reneev@pgst.nsn.us
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American Indian Health Commission  
For Washington State

REGION 2

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 1, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Jordan Calder	Maintenance	calderjordan@yaknas.com
ROBERTO COX	(STORES OPERATIONS MANAGER	fito@glidingeaglemarket.com
Kelly Sullivan	Exec Director PGST	sullyk@pgst.nsn.us
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Amy Anderson	Training & Exercise Specialist - PHEPR KPHD	amy.anderson@kitsappublichealth.org
Susan Turner MD	Health Officer	susanturner@ " "
Cherrie May	Emerg. Mgt. Coordinator	cmay@Squamish.nsn.us
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American Indian Health Commission  
For Washington State

REGION 2

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 1, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
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Andy Brastad	Clallam Co HHS Director	abrastad@co.clallam.wa.us
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Cindy Lowe	Deputy Director of Health	clowe@jamestowntribe.org
Thomas Locke	Public Health & Safety Officer	tlocke@jamestowntribe.org
Glen Roggenbuck	Emergency Mgmt Coordinator Lower Elwha Klallam	glen.roggenbuck@elwha.org
Jessica Latourelle	Chief Pharmacist Muck Tribe	jessica.latourelle@gmail.com
Ted Fischer	Emergency Preparedness Specialist	Ted.Fischer@doh.wa.gov
David Owens	Emergency Prep Spec	david.owens@doh.wa.gov



American Indian Health Commission  
For Washington State

### REGION 3

## Cross-Jurisdictional Collaboration Project

### TABLETOP EXERCISE

May 8, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Carrie Corder	Emergency Specialist WA. DOH	Carrie.corder@doh.wa.gov
Ted Fischer	Emergency Specialist WA DOH OEPK	ted.fischer@doh.wa.gov
Dan Houchick	Emergency Preparedness Coord. with	dhouchick@co-grays-harbor.wa.us
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Denise Walker	Health Director CTWC	dwalker@chehalistribe.org



American Indian Health Commission  
For Washington State

### REGION 3

## Cross-Jurisdictional Collaboration Project

### TABLETOP EXERCISE

May 8, 2018

SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Jennifer Dixon	Emergency Prep Thurston Co. PH	dixonjm@co.thurston.wa.us
Sue Poyner	Emergency Prep Mgr. Thurston Co PH	poyners@co.thurston.wa.us
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Mary Goetz	Director - Pacific Co. Public Health & Human Services	mgoetz@co.pacific.wa.us.
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Ed Mund	Lewis County Public Health Emergency Preparedness Coord.	ed.mund@lewiscountypuwa.gov

REGION 3

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 8, 2018

SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
CAL BRAY	EMERGENCY MGMT. COORDINATOR	CBRAY@CHEHALIS TRIBE.ORG
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Lisa Hall	EMS Chief / Coroner	lhall@quinault.org
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Kim Thompson	Health Director	Kzillyett@shoalwaterbay-nsn.gov
Robin Souvenir	Chief of Police	rsouvenir@shoalwaterbay-nsn.gov



American Indian Health Commission  
For Washington State

## REGION 4

### Cross-Jurisdictional Collaboration Project

#### TABLETOP EXERCISE

May 7, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
ALAN MELNICK	PUBLIC HEALTH DIRECTOR / HEALTH OFFICER (CLARK COUNTY)  HEALTH OFFICER SKAMANIA	alan.melnick@clark.wa.gov
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Robin Albrandt	Regional E.R. Coordinator Clark County PH/RIV	robin.albrandt@clark.wa.gov
RICH KONRAD	EM. PREPAREDNESS COORDINATOR CLARK / RIV PUBLIC HEALTH	richard.konrad@clark.wa.gov
Lianne Martinez	Emerg Prep Coord Region IV PH	Lianne.Martinez@clark.wa.gov
Stephen Kutz	Exec. Dir. HHS Cowlitz Tribe	skutz@cowlitz.org
William Elliott	Emergency Management Coordinator, Cowlitz Tribe	belliot@cowlitz.org
Alyssa Fine	Diabetes Educator / RN PHS officer Cowlitz Tribe	afine@cowlitz.org



American Indian Health Commission  
For Washington State

REGION 4

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 7, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
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Ted Fischer	E.P.R.S. DoH OEPR	Ted.fischer@doh.wa.gov
Cory Portner	DoH EPR	cory.portner@doh.wa.gov
ERNIE SCHNABLER	DEM Director / Cowlitz Sheriff's Office	schnablere@co.cowlitz.wa.us
Michelle Ashby	Community Health Manager @ cowlitz HHS	ashbym@co.cowlitz.wa.us
Carole Harrison	Deputy Director Cowlitz County HHS	harrisonc@co.cowlitz.wa.us
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Kay Culbertson	Cowlitz Tribal Health Director	Kculbertson@ cowlitz.org



American Indian Health Commission  
For Washington State

REGION 5

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

June 13, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Carrie Corder	Specialist - Emergency Preparedness	carrie.corder@doh.wa.gov
Khamla MARTIN	interim	KKM1303@doh.wa.gov
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Wigd Turner	DIVISION DIRECTOR	nturner@tpchd.org
Cindy Miron	Program Manager - PITEP	cmiron@tpchd.org
Rebecca Baron	Training & Exercise Coordinator	rbaron@tpchd.org
TERESA Mathews	Puyallup Tribe EMERGENCY Management	Teresa.l.mathews@PuyallupTribe.com
JASON Dillon	Puyallup Tribe EMERGENCY MANAGEMENT COOR.	JASON.Dillon@puyallupTribe.com



American Indian Health Commission  
For Washington State

## REGION 5

### Cross-Jurisdictional Collaboration Project

#### TABLETOP EXERCISE

June 13, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Danelle Reed	KCC Director	danelle@eptha.com
Alan Shelton	clinical Director PPHA	alan@eptha.com
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Will Jones	Compliance & Technology Director	wjones@eptha.com
Marian Ogden	member Services Liaison	marian@eptha.com
DOBBIE BAILEY	Mitigation Coordinator/ GIS	dbailey@co.pierce.wa.us
Sue Smith	Emergency Preparedness Specialist	sue.smith@doh.wa.gov
KRISTEN BAIRD ROMERO	Community Preparedness Supv	KRISTEN.BAIRD@DOH.WA.GOV

REGION 6

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

June 1, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
Ada McDaniel	EM Director - MIT	ada.mcdaniela@muckleshoot.nsn.us
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Kenny Jones	Medical Assistant Lead	Kenny.jones@muckleshoot-health.com
CARINA EISENBASS	PREP Director	carina.elsenbass@kingcounty.gov
Meredith Li-Vollmer	Risk Communication Specialist	meredith.li-vollmer@kingcounty.gov
NICK Solari	Response Planning.	nicholas.solari@kingcounty.gov
Greg Lezard	Community Health Rep	Greg.Lezard@muckleshoot-Health.com

REGION 6

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

June 1, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
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Dale Alexander	DOH Supervisor operations in EPR	dale.alexander@doh.wa.gov

REGION 7

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 29, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
Ted Fischer	Emergency Preparedness Specialist	Ted.fischer@doh.wa.gov
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DEL OSTENBERG	CTEAS Engng Mnglr	del.ostenberg.org@clulinkhs.com
Will Moore	ColvilleHS Maint / Safety officer	William.moore@ths.gov
Dennis Whitman	IHS / Facility	denuwhite@ihs.gov
Ryan Buckner	IHS - Clinical Pharmacist	ryan.buckner@ihs.gov
Amber Seymour	Tribal Health Educator <sup>PHEPR Coord</sup>	amber.seymour.thp@colvilletribes.com

REGION 7

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 29, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
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REGION 8

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 31, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
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Bryan Bauer	Yakima County Fire Dist 5 Bat. Capt	Bryan.Bauer@YCFDS.org
Darren King	White Swan Ambulance EMS Dispatcher	ddsquince@aol.com
MIKE McMULLEN	VIRGINIA MASON MEMORIAL HOSP EMERGENCY PREPAREDNESS COORD	MikeMcMullen@yxmlt.org
Cory Partner	DOH - MCM COORDINATOR	cory.Partner@doh.wa.gov
Ted Fischer	DOH MCM support	ted.fischer@doh.wa.gov
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Terra Palomarez	Chief Nursing Officer	terra.palomarez@astria.health



American Indian Health Commission  
For Washington State

## REGION 8

### Cross-Jurisdictional Collaboration Project

#### TABLETOP EXERCISE

May 31, 2018  
SIGN-IN SHEET



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Horace Ward	Senior Planner	horace.ward@co.yakima.wa.us
Jason Clapp	EM Planner	jason.clapp@co.yakima.wa.us
J. Eligio Jimenez	Director of Safety	jejimenez@toppuish.wednet.edu
Gary R. Peters	Prevention Officer	gary-peters@yakama.com

REGION 8

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 31, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
Sgt Alexander	Police Sgt	james_alexander@yakama.com
Courtney Whitefoot	YN Homeland Security Theresa's assistant	courtney-whitefoot@yakama.com
Tino Alonso	Loss Control Specialist	tino_alonso@yakama.com



American Indian Health Commission  
For Washington State

REGION 9

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 30, 2018  
SIGN-IN SHEET



NAME	JOB TITLE	E-MAIL ADDRESS
Cory Partner	DOH-MCM COORDINATOR	cory.Partner@doh.wa.gov
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Bob Lutz	Health offe - Spokane County	blutz@scwd.org
Joshua Pahang	Medical Student - Spokane County	j.pahang@wsu.edu
Tom Ling	EMT - Kalispel Tribe	tling@kalispeltribe.com
Kathy Desautel	CFU	Kathy.desautel@colvilletribes.com
Ben Stone	Environmental Health Specialist	ben.stone@co.whitman.wa.us

REGION 9

Cross-Jurisdictional Collaboration Project

TABLETOP EXERCISE

May 30, 2018  
SIGN-IN SHEET



American Indian Health Commission  
For Washington State



NAME	JOB TITLE	E-MAIL ADDRESS
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Cindy Thompson	Preparedness Specialist	cathompson@srhd.org