Tribal Medical Countermeasures Distribution and Dispensing Planning Project

June 30, 2019

In partnership with

aihc
AMERICAN INDIAN HEALTH COMMISSION FOR WASHINGTON STATE

Washington State Department of Health

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ACKNOWLEGMENTS

The Commission wishes to acknowledge and thank all the individuals who participated in this project and who dedicate their life's work to protecting the health and safety of all the citizens in our communities.

1. INTRODUCTION

Medical countermeasures (MCM) are life-saving pharmaceuticals and medical supplies used to protect the individuals, families and communities during public health emergencies. The AIHC has engaged tribes in planning for requesting, receiving and dispensing medical countermeasures to tribal community members from 2018 to 2019.

During the 2009 H1N1 influenza pandemic, some tribes did not receive their allocations of MCM, as a result of systemic problems. Key contributors to this failure were the lack of clear federal guidance; the lack of documented processes in Washington State and local health jurisdiction (LHJ) plans to ensure proper distribution to tribes; a general lack of knowledge and understanding of roles and authority by the State and LHJs; and the absence of cross-jurisdictional coordination and exercises prior to 2009.

Strengthening tribal capacity and partnerships with the Washington State Department of Health (DOH) and the local health jurisdictions is critical to assure that tribal community members are protected during future public health emergencies. In 2018, the Commission hosted 9 regional planning meetings for tribes, LHJs and DOH, and 9 regional tabletop exercises with tribes, LHJs and DOH.

In 2019, as part of the Tribal Medical Countermeasures Distribution and Dispensing Project, the Commission hosted 9 regional planning meetings for tribes, LHJs and DOH, and 2 mass medication dispensing training workshops for tribes and urban Indian health programs. Additionally, the AIHC facilitated a webinar for tribes to review draft MCM guidance and the Model Tribal Medical Countermeasures Plan, and presented at the 2018 National Tribal Emergency Management Council Conference, and at the 2018 and 2019 Northwest Tribal Public Health Emergency Preparedness Conference.

During the Project, the Commission developed key work products including:

- Proposed revisions to federal guidance
- Proposed revisions to the Washington State MCM plan documents
- Proposed wording for LHJ plans to address tribal issues
- Model tribal MCM plan for tribes to use as a template
- Tribe and Urban Indian Health Program Mass Medication Dispensing Training Curriculum

Working with DOH, the Commission conducted outreach to engage tribes in the 2019 T-Rex full-scale statewide exercise held on May 6, 2019, designed to test the distribution of MCM to all parts of Washington. Fourteen tribes chose to participate in T-Rex. Seven tribes chose to

exercise picking their MCM up from their neighboring LHJ, 2 chose to pick up from DOH and 5 chose to have their MCM delivered to a tribal location.

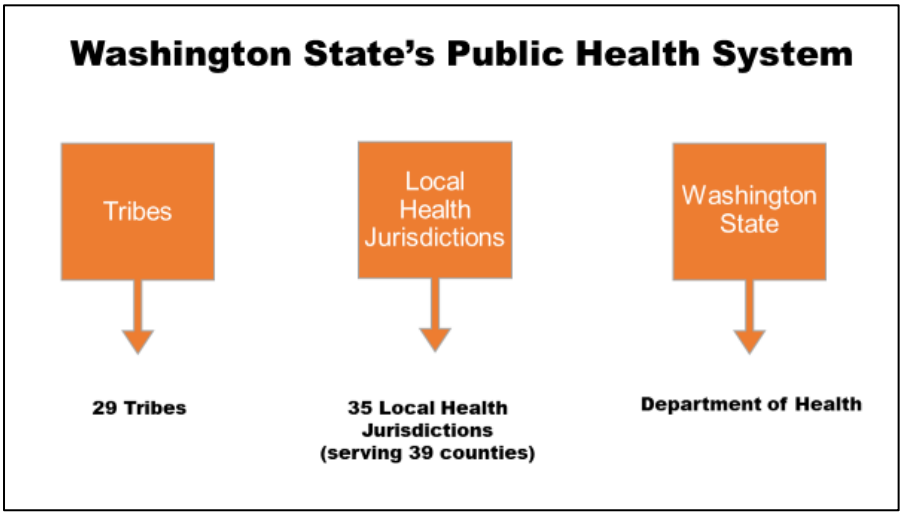
The exercise was very useful in identifying gaps in plans and needed corrective actions. Some tribes encountered no problems during the exercise. However, some tribes had their MCM delivered to a location different from the one they requested, and others did not receive notice that their MCM were ready for pickup. These findings will be used to develop and implement corrective actions.

Continued work is necessary to strengthen key areas, including: clear written guidance for all jurisdictions, effective processes for communication across jurisdictions before and during responses, strengthening tribal and LHJ capabilities.

2. TRIBAL MEDICAL COUNTERMEASURES

The United States' Strategic National Stockpile (SNS) holds large quantities of life-saving pharmaceuticals and medical supplies to protect the public in the event local supplies cannot meet the immediate needs of a public health emergency. Each time a public health incident occurs that requires these medical countermeasures (MCM), a Tribe has the sovereign authority to choose how those medical countermeasures are distributed to their community.

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



Collaboration among the twenty-nine (29) tribes, thirty-five (35), and the State of Washington are vital to the effective distribution of medical countermeasures to tribes. The CDC's, "Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, *Version 11,* does provide limited guidance, however, on the responsibility of state and local governments to ensure the delivery of medical countermeasures to 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."[1] The CDC recommends that jurisdictions "coordinate and collaborate with American Indian and Alaska Native (AI/AN) tribes through a memorandum of

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

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

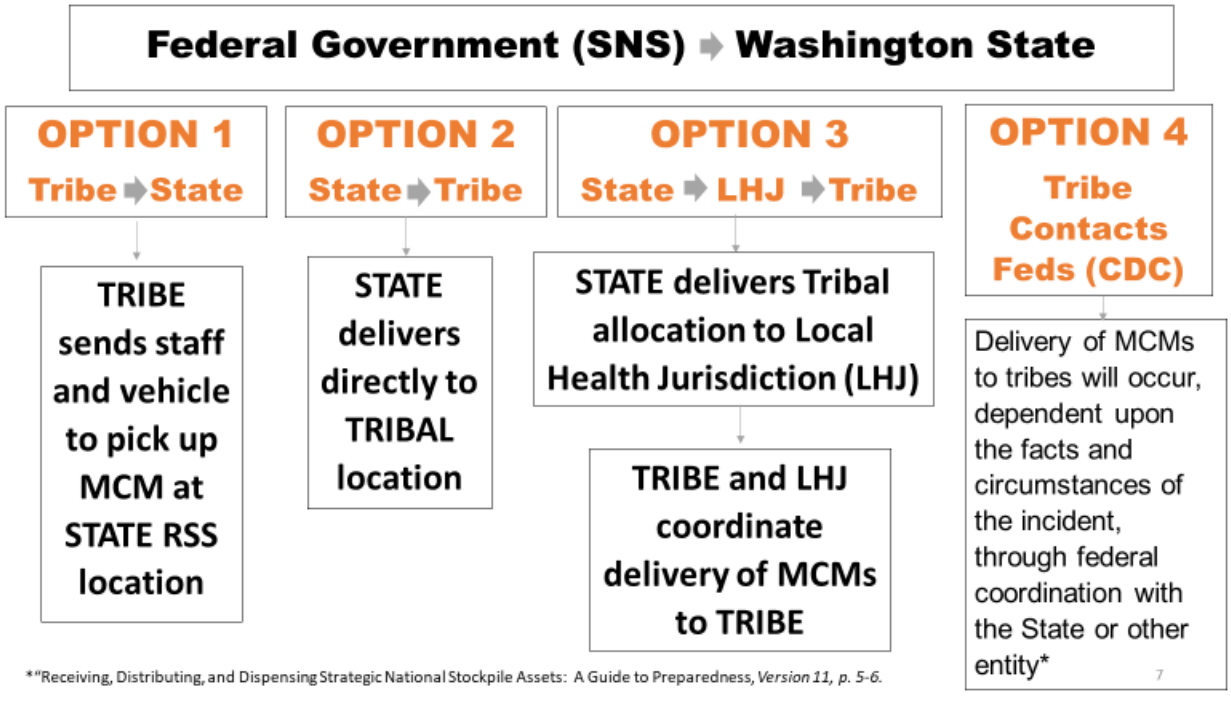
In the State of Washington, tribes have four primary options for the delivery of medical countermeasures to their tribal nations:

Option #1: The Tribe can choose to coordinate with the Washington Department of Health and have Tribal representatives travel to Washington State's distribution hub and pick up the Tribe's supply of medical countermeasures.

Option #2: The Tribe can choose to coordinate with the Washington State Department of Health and have the Washington Department of Health deliver medical countermeasures directly to the Tribe.

Option #3: The Tribe can choose to have the Washington Department of Health deliver the Tribe's allocation of medical countermeasures to its local health jurisdiction. The Tribe will then coordinate with the local health jurisdiction for the delivery of medical countermeasures to the Tribe.

Option #4: The Tribe can choose to coordinate with Center for Disease Control Strategic National Stockpile for the distribution of medical countermeasures to the Tribes. Delivery of medical countermeasures 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.*

TRIBAL MEDICAL COUNTERMEASURES DISTRIBUTION AND DISPENSING PLANNING PROJECT

Tribal Medical Countermeasures Planning in Washington State

Medical countermeasures distribution and dispensing is one of the most critical functions for preserving life and safety during public health emergencies. In 2018, the AIHC facilitated a project to strengthen distribution of medical countermeasures to tribal nations in Washington. The project included cross-jurisdictional planning meetings and tabletop exercises for the tribes and LHJs in each of Washington State's 9 public health emergency planning regions to test each region's ability to distribute medical countermeasures to the tribal nations.

A key finding from the 9 tabletop exercises in 2018 is the lack of clear, documented guidance on the role and responsibilities of federal, state, local and tribal governments in the distribution of MCM to tribes. Also, none of the tribes in Washington have a written Medical Countermeasures Plan.

Tribes and LHJs noted the need for continued work in each region to develop systems for including tribes in communications, decision-making, and operational coordination during responses. Additionally, present there was not a system in place for tribes and LHJs in each region to maintain and share current information regarding contacts at each jurisdiction and other MCM management details.

Finally, tribes expressed the need for training on dispensing MCM.

AIHC's Medical Countermeasures Distribution and Dispensing Planning Project was designed to address the key gaps identified by tribes, local health jurisdictions and Washington State in 2018. Primary deliverables for this project include:

- Model Tribal Medical Countermeasures Plan
- Proposed Policy Language for CDC/ASPR Medical Countermeasures Guidance
- Proposed Policy Language for Washington State Department of Health Medical Countermeasures Plan (Annex 9)
- Model Tribal Provisions for Local Health Jurisdictions' Medical Countermeasures Plans
- Engagement of Partners: Tribes, Urban Indian Health Programs, Indian Organizations, Local Health Jurisdictions, Counties, Healthcare Coalitions, State Agencies
- Facilitated Cross-Jurisdictional Medical Countermeasures Planning Meetings
- System for Jurisdictions to Share Medical Countermeasures Information
- Facilitated Participation of Tribes in T-Rex Statewide Medical Countermeasures Distribution Full-Scale Exercise
- Point of Dispensing Training for Tribes and Urban Indian Health Programs

3. MODEL TRIBAL COUNTERMEASURES PLAN

Drafting medical countermeasures plans for tribal nations presents unique legal and policy planning issues. Perhaps for this reason, no existing tribal medical countermeasures plans were found despite making direct inquiries with the twenty-nine tribes in Washington State. Unlike local health jurisdictions, tribal nations are not referenced in key planning assumptions of existing federal, state, and local guidance and plans. For example, what is the federal role in distributing and dispensing medical countermeasures to tribes? Do local health jurisdiction plans indicate they are responsible for delivery of medical countermeasures to tribes if so requested? And finally, do state and local health jurisdictions acknowledge in their plans that they possess no authority over how a tribe receives or dispenses medical countermeasures?

The model tribal medical countermeasures plan in Appendix A answers these key questions and outlines processes for requesting, receiving, distributing, and dispensing MCM during a public health emergency. The following planning assumptions were included in the plan:

- **Responsibility for Distributing and Dispensing MCM to Tribe.** The State and local health jurisdictions (LHJs) are responsible for distributing and dispensing MCM to tribal nations in accordance with the National Response Framework and Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness Version 11.
- **State and Local Governments Lack of Authority.** The State and local health jurisdictions do not possess legal authority over how a tribe receives MCM or dispenses MCM.
- **Federal Role in Distributing and Dispensing MCM to Tribe.** In most circumstances, the federal government (including IHS, the Centers for Disease Control and Prevention (CDC), and the Office of the Assistant Secretary for Preparedness and Response (ASPR)) will not distribute medical countermeasures to a tribe directly. Instead, the federal agencies will likely coordinate the delivery of the tribe's medical countermeasures with Washington State.
- **Tribal Activation of Incident Command System**. Tribes will operate under the Incident Command System (ICS) and in adherence to the National Incident Management System (NIMS). Tribes will activate their Emergency Operations Centers (EOCs) or Emergency Coordination Centers (ECCs) and Emergency Response Teams (ERTs), when responding to an incident that requires mass dispensing.

In addition to tribal specific issues, the model tribal medical countermeasures plan incorporates best practices for medical countermeasures planning. These best practices include addressing at-risk populations such as individuals with functional and access needs. See Model Tribal Medical Countermeasures Plan in Appendix A.

4. PROPOSED POLICY LANGUAGE FOR CDC/ASPR MEDICAL COUNTERMEASURES GUIDANCE

During the 2009 H1N1 outbreak, many local health jurisdictions failed to recognize or understand their lack of jurisdiction over a tribe's dispensing of medical countermeasures to their community members. This lack of understanding left some tribes (who planned to use priority populations slightly different from CDC's recommendations) without the medical countermeasures they were entitled to receive from local health jurisdictions. Unfortunately, no federal guidance existed to provide direction to local health jurisdictions regarding tribal authority. In addition, the tribes had no guidance regarding the federal role in dispensing and distribution of medical countermeasures to tribes. The current federal guidance on medical countermeasures, "Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, *Version 11,"* (hereinafter referred to as "Version 11") requires significant revisions to sections addressing coordination with tribal governments.

The American Indian Health Commission for Washington State (AIHC) held a webinar on March 15, 2018 with the CDC and twenty-six (of the State's twenty-nine) tribes to discuss revising Version 11. Compiling feedback from tribes in Washington State, the AIHC drafted proposed Version 11 revisions and a letter to the CDC and ASPR. These documents were reviewed and approved by the tribal delegates of the Commission on February 2019. See Appendix B. The Commission presented the draft language at the 2019 regional medical countermeasures planning meetings for further feedback from local health jurisdictions and the DOH representatives.

Implementing the following revisions to Version 11, in consultation with tribal nations, will greatly reduce the occurrence of legal and policy disputes between tribes and their neighboring local governments:

- **Federal Role in Medical Countermeasures Dispensing and Distribution to Tribes**
    - Tribal governments who wish to deal directly with the [CDC OR ASPR] in distribution of medical countermeasures should contact [CDC or ASPR representative] at [contact method and information].
    - In most emergencies, the federal government will delegate responsibility of MCM distribution to the state in which the tribal nation is located.

- **Medical Countermeasures Distribution**
    - Tribal governments may choose to receive MCM directly from the state or the local jurisdiction in which they are located. In some circumstances, a tribe may choose to receive MCM directly from a federal agency.
    - For each distinct public health emergency, tribal governments determine the population they choose to serve. Upon determination of the service population, tribal governments should coordinate with state and local jurisdictions to assure the appropriate type and quantity of MCM are allocated.
- **Medical Countermeasures Dispensing**
    - Each tribal nation has the sovereign authority to provide for the welfare of its people and, therefore, has the authority to dispense MCM.
    - Each tribal nation has the sovereign authority to establish priority groups when there are not enough resources to provide mass dispensing to 100% of the tribal nation's service population.
    - Tribal governments, and not state or local jurisdictions, determine priority populations in dispensing of medical countermeasures to their tribal communities.
    - Issues regarding a tribal nation dispensing of MCM shall be addressed by the tribal nation and the federal agency responsible for the MCM. While state and local jurisdictions are responsible for distributing MCM to tribal nations, state and local jurisdictions do not possess legal authority over tribal nations' dispensing of MCM.

5. PROPOSED TRIBAL POLICY LANGUAGE FOR DOH MEDICAL COUNTERMEASURES PLAN

Since the 2009 H1N1 pandemic, the Washington State Department of Health (DOH) has worked with the Commission to improve state and local coordination with the twenty-nine tribes on medical countermeasures. Improvements include revisions to Washington's medical countermeasures plan referred to as Annex 9 in the DOH's Emergency Management Plan. Annex 9 reflects a multijurisdictional approach and defines the department's "capacity to support local health jurisdictions, military installations, and tribal governments."

Annex 9 requires further clarity and guidance to address issues regarding the jurisdiction and authority of local health jurisdictions (LHJs) and tribes. The American Indian Health Commission (Commission) drafted revisions to address these gaps and presented the draft language at the nine regional medical countermeasures planning meetings for further feedback from tribal, LHJ, and DOH representatives. After incorporating tribal, LHJ and DOH input, the Commission drafted the following proposed revisions to Annex 9 (see Appendix C):

- **Responsibility for Distribution and Dispensing of Tribal Medical Countermeasures**. The state and local health jurisdictions are responsible for distribution and dispensing of MCM to tribal nations in accordance with the National Response Framework and Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness Version 11.

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

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

6. MODEL TRIBAL PROVISIONS FOR LHJ MEDICAL COUNTERMEASURES PLANS

In accordance with CDC guidance, responsibility for the distribution and dispensing of medical countermeasures to tribes falls to the state and local jurisdiction in which they are located.[2] Local health jurisdiction medical countermeasures plans should detail how their jurisdiction will coordinate with tribal nations in the distribution and dispensing of medical countermeasures.

Current Gaps in Local Health Jurisdiction Plans: The American Indian Health Commission (AIHC) requested each LHJ in Washington to share its medical countermeasures plan. Thirteen of the thirty-five LHJs shared their plans. Most plans did not address coordination with tribal nations for the distribution and dispensing of medical countermeasures. Even worse, some local health jurisdiction plans incorporated tribes into their plans in a manner that failed to understand the tribes' sovereign status and the local health jurisdiction's lack of authority over tribes. Kitsap County, on the other hand, provided the best language of the reviewed plans. Although Kitsap County's plan was the most accurate in addressing medical countermeasures coordination with tribes, it lacked sufficient detail regarding coordination processes between the local health jurisdiction and neighboring tribes.

Based on the Commission's review of LHJ medical countermeasures plans and feedback from tribal and local partners, the Commission drafted model tribal policy language and a tribal MCM distribution guidance chart for local health jurisdictions to adopt and incorporate into their existing plans. See Appendix D. Key provisions of the model language include:

- **Recognition of Tribal Sovereignty.** [LHJ] recognizes the sovereignty of Tribes. This plan does not supplant Tribes' emergency plans and processes for distributing emergency medications and vaccines to their Tribal members, employees, and others.
- **Responsibility for Distribution and Dispensing of Tribal Medical Countermeasures.** The State and Local Health Jurisdictions are responsible for distribution and dispensing of MCM to tribal nations in accordance with the National Response Framework and Receiving,

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

Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness Version 11.

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

7. PARTNER ENGAGEMENT

To assure broad participation and engagement in this work, the Commission presented and requested input and participation in the project activities from a broad range of partners, including tribes, Washington Department of Health Office of Emergency Preparedness staff, CDC staff, tribal organizations and local health jurisdictions. The following is list of some of the meetings where the Commission provided information on the project:

1. Washington State Tribal and State Leaders Health Summit, November 6, 2018
2. AIHC-DOH Medical Countermeasures Coordination Meeting, December 10, 2018
3. AIHC Delegates Meeting, December 13, 2018
4. AIHC-DOH Medical Countermeasures Coordination Meeting, January 17, 2019
5. Northwest Portland Area Indian Health Board Meeting, January 23, 2019
6. AIHC Delegates Meeting, February 21, 2019
7. AIHC-DOH Medical Countermeasures Coordination Meeting, February 27, 2019
8. Model Tribal MCM Plan Design Webinar, February 28, 2019
9. Washington State Partners in Emergency Preparedness Conference, April 28, 2019
10. AIHC Delegates Meeting, May 9, 2019
11. Northwest Tribal Public Health Emergency Preparedness Training & Conference, June 10-14, 2019
12. DOH Program Update Call, June 17, 2019

MCM Partner Meeting Outcomes. Several key issues and themes were raised by tribal MCM partners throughout the course of this project, including, but not limited to the following:

1. When will CDC revise the tribal language in Version 11 and to what extent will the language be revised to reflect current gaps in medical countermeasures distribution and dispensing to tribes?
2. When will LHJs include language in their MCM plans to address coordination with tribes?
3. It is important for tribes to adopt medical countermeasures plans to assist tribes in preparing for public health emergencies, including situations in which a local health jurisdiction may not effectively coordinate with the tribe. Tribal plans can delineate the best course of action for each unique tribe and identify options for distribution and dispensing.
4. How can tribes develop the capability to dispense MCM to their communities?
5. How will tribes be included in the T-Rex statewide exercise? What information will the tribe need to send to DOH in order to participate in T-Rex? What will tribes need in order to participate in T-Rex?

8. CROSS-JURISDICTIONAL PLANNING MEETINGS

The American Indian Health Commission hosted nine cross-jurisdictional planning meetings; one in each of the State's public health emergency planning regions. The planning meetings were, on average, six hours long. Representatives from tribes, local health jurisdictions (LHJ), Washington State Department of Health (DOH), healthcare coalitions, hospitals, and county emergency management departments were in attendance. The following items were addressed at each of the planning meetings:

1. **Strategies to Develop a Joint Information System and Improved Communications.**

    - All nine regions expressed frustration with how to maintain contacts among tribal and LHJ representatives. Frequent changes in staff and leadership at all jurisdictions makes it a significant challenge. The Commission maintains updated contacts for each of the tribes and urban Indian health programs and provides it to DOH throughout the year. This should continue. Each region requested the Commission to maintain online share sites for maintaining contacts for each jurisdiction and public health emergency preparedness documents. One region has expressed interest in having one of the region's partners take over the share site sometime in the future. Most regions do not currently have the capacity to stand up a Joint Information System. However, all regions expressed support for holding regular partner phone calls during responses. David Owens at DOH recommended that all tribal and LHJ representatives maintain record of the DOH Duty Officer phone number. The Duty Officer can share contact information with tribal and LHJ representatives.

2. **Preparation for Participation in the Statewide T-Rex Exercise.** DOH representatives attended three of the nine regional planning meetings. In these meetings, the DOH representatives provided an overview of the T-Rex statewide full-scale medical countermeasures distribution exercise. For meetings that DOH was not present, the Commission provided the overview. The following issues and logistics were discussed:

    - Many tribes were still awaiting extent of play agreements and other documentation from DOH

- There was confusion regarding the documentation needed for tribes to participate in T-Rex

- Tribes and LHJs who planned to participate in T-Rex discussed where they planned to pick-up their medical countermeasures and walked through the logistics of coordinating at the local level.

- DOH provided information as to how many medical countermeasures they could deliver in various types of vehicles and planes.

- Some LHJs and tribes expressed interest in meeting with other partners to prepare for the T-Rex exercise including looking at the distribution options.

3. **Strategies to Develop Emergency Coordination Center.** Tribes discussed the possibility of establishing a statewide Tribal Emergency Coordination Center (ECC) to be activated during the annual Canoe Journey. This ECC could provide communications and logistical support during the weeks-long event. One example of a function for this ECC is receiving daily reports from the medic stands and clinics at each stop. This could serve a function in syndromic surveillance, to monitor potential communicable disease outbreaks. Also, the ECC could provide situational awareness information to the medic stand at the next canoe journey destination to assist in preparedness.

4. **CDC/ASPR, state, LHJ and Tribal Roles in MCM Distribution to Tribes.**

- Local health jurisdictions and tribes across all nine regions discussed a need for more exercises between tribes and local health jurisdiction in order to strengthen their understanding and competence regarding roles and coordination processes across jurisdictions.

- When a tribe chooses to coordinate with a local health jurisdiction for the distribution of medical countermeasures to the tribe, DOH will send, with the medical countermeasures, a document that specifies the amount of MCM reserved for the tribe. This process step is noted in DOH's field operation guide.

- DOH will provide security for medical countermeasures while in their possession. The security is based on three levels of threats: (1) no threat: a truck without law enforcement will be sent out; (2) a threat with unidentified source: a law enforcement officer will accompany the truck from the front and a law enforcement officer will accompany the truck from behind. Tribes will be able to pick up medical

countermeasures during a high security event if the tribe provides security to accompany the medical countermeasure to their final destination.

5. **Strategies to Develop Processes to Coordinate on Unified Public Messaging During Public Incidents and Responses.** Tribes and LHJs discussed the importance of having regular conference calls during a response, to coordinate public messaging. Some regions have started doing this, including Skagit County and the Swinomish Tribe.

6. **Actions Taken by Partners on Medical Countermeasures since the 2017-2018 DOH-AIHC Cross-Jurisdictional Project:**

    a. Department of Health: state legislation regarding foundational public health services includes funding for public health emergency preparedness. DOH has formed a new partnership with the Department of Correction for use of warehouse space, trucks, and drivers. This partnership was exercised during the T-Rex exercise.

    b. Tribes: the following are a list of actions taken by tribes. (Note: tribes are intentionally not individually identified.)

        i. through relationship built at Commission meetings, a tribe started quarterly meetings, looking at policies and procedures, and updating their codes

        ii. hired new staff

        iii. participated in MCM dispensing overview provided by DOH

    c. LHJs:

        i. Conducted periodic calls with neighboring tribes

        ii. Built internal preparedness structure and training

        iii. Worked to assure all partners are included in WA Secures

        iv. Added an emergency response coordinator

        v. Visited tribal health clinics/lands

        vi. Improved information sharing including sharing press releases and health advisories with tribes

9. MEDICAL COUNTERMEASURES PARTNER INFORMATION SHARING

Communication strategies and information sharing processes between tribes and LHJs have been identified as one of the highest priorities to assure effective coordination across jurisdictions. The AIHC developed an online password-protected document share site for each of the nine public health emergency preparedness planning regions in Washington, within the Commission's website. In 2018, the Commission began to transition its website to a new, upgraded platform. To assure tribes and LHJs did not experience a gap in access to partners' information, the Commission created interim password-protected Google Drive-based share folders for use while the new website was being built. The Commission built out new share sites on the new website which went live on February 1, 2019.

The share sites were reviewed with tribes, LHJs, DOH and other participants during the nine regional planning meetings. The Commission requested suggested edits to both format and content of the share sites. The Commission also initiated a dialogue to explore whether any of the regions would like an alternate platform for their share site. All regions stated they do not have the capacity to take on this function. Only one region expressed interest in possibly assuming this function in the future. The consensus was that these share sites are essential for cross-jurisdictional coordination and collaboration and the nine regions request the Commission to continue maintaining the sites. Each partner is responsible for submitting the information they wish to share to the Commission for posting.

The recommended medical countermeasures information for each partner to share is:

- Medical Countermeasures Partner Profile
- Local Health Jurisdiction Campus Map
- Reservation Map
- Tribal Campus Map
- LHJ Contacts
- Tribe Contacts

Additional recommended information for each partner to share is:

- For Tribal Partners
  - Public Health Emergency Laws and Codes
  - Comprehensive Emergency Management Plan
  - Pandemic Influenza Plan
- For LHJ Partners
  - Pandemic Influenza Plan

Other information posted on the share sites includes:

- Model Tribal Medical Countermeasures Plan
- Model LHJ Medical Countermeasures Plan Tribal Provisions
- Proposed Federal Guidelines Revisions
- Cross-Jurisdictional Medical Countermeasures Planning Meeting Materials

Key contacts from each tribe and LHJ have password-protected access to their regional share site. Each jurisdiction is responsible for assuring the correct individuals have password access and that information is kept up to date.

10. T-REX STATEWIDE EXERCISE

The Washington State Department of Health (DOH) conducted its largest full-scale exercise to date on May 6, 2019. The exercise was designed to test DOH's ability to receive and distribute medical countermeasures to all tribes, counties and large healthcare systems. Tribal participation in T-Rex was on a voluntary basis. Fourteen tribes chose to participate in the exercise. This was the largest participation by tribes in a statewide exercise, to date.

The Commission requested DOH to plan a joint AIHC-DOH tribes-only webinar in February to engage tribes in planning for T-Rex participation. At DOH's discretion, the tribes-only planning meeting was not held, with the expectation that tribes would participate in the general planning meetings for the exercise.

At each of the nine regional planning meetings, there was a discussion of the region's tribes' and LHJs' plans for participation in T-Rex. Attendees were encouraged to participate and to exercise cross-jurisdictional coordination of efforts. The Commission provided additional pre-exercise outreach and technical assistance to: Confederated Tribes of the Colville Reservation, Cowlitz Tribe, Makah Nation, Muckleshoot Tribe, Nisqually Tribe, Quileute Tribe, Quinault Nation, and the Spokane Tribe of Indians.

During the exercise, the AIHC staffed the position of Tribal Liaison Officer (TLOFR) in the Washington State Department of Health Incident Management Team (IMT). This position was created in 2016 to be included every time the DOH activates its IMT. The TLOFR position is designed to ensure:

- all 29 tribes in Washington have a direct and immediate contact in the IMT during an emergency response,
- tribe-specific issues are addressed as response actions are planned and implemented, and
- technical assistance and materials specific to the needs of tribes are available in a timely and proactive manner

The TLOFR served in the IMT from 7:45am until the IMT was deactivated at approximately 4:00pm. The TLOFR was in contact with representatives from several participating tribes during the T-Rex Exercise, including: Colville, Cowlitz, Lummi, Makah, Quileute, Quinault, Shoalwater Bay, Suquamish.

The TLOFR worked with the IMT's Liaison Officer LOFR to contact the tribes participating in the exercise and hold a status webinar at approximately 12:00noon. A new GoToWebinar account was used for the tribal status webinar. This caused a delay in the start time for the

webinar, so some tribes logged out before the meeting begin. Despite the delay, representatives from four tribes participated in the status update webinar: Nisqually, Samish, Shoalwater Bay, and Suquamish.

Corrective Actions. Findings from the tribes' participation in T-Rex will be used to implement corrective actions for future exercises and responses. Recommendations from tribes gathered through key information interviews and during the Tribal Public Health Emergency Preparedness Conference on June 12, 2019 include:

- Schedule two planning meetings for tribes-only at the beginning of planning for future meetings and 2-3 months prior to the exercise
- Confirm exercise details such as addresses, tribal contact cell phone numbers, desired delivery locations, etc. 1-2 months prior to the exercise
- Provide delivery drivers with a standard script or information sheet to deliver at each drop location to assure the nature of the delivery is clear to any recipient, including: what is being delivered, name of intended recipient, timing of required actions, etc.
- Assure the TLOFR position is staffed by AIHC for every IMT response and exercise to assure coordination with all 29 tribes
- Exercise often; at least every 2 years
- Provide training for the drivers; assure they have a cell phone contact for each tribal delivery; if possible have drivers drive the route ahead of time

T-Rex Tribal Participant Key Informant Interviews

TRIBE	CONTACT NAME	WHAT WENT WELL	WHAT DID NOT GO WELL	ADDITIONAL COMMENTS
Chehalis	Denise Walker		There was a communication breakdown. A message was left on Denise Walker's office landline voicemail regarding when the MCM would be delivered to the Tribe's clinic. Denise Walker was out of the office. The driver who dropped off the	For future exercises and events, it is important to assure that contact is made with a tribal representative and not just a voicemail left. Also, it is important to be clear and specific regarding what is

TRIBE	CONTACT NAME	WHAT WENT WELL	WHAT DID NOT GO WELL	ADDITIONAL COMMENTS
			MCM just said they had a delivery of medications for Denise Walker. There was no mention that they were Medical Countermeasures; no mention that they were emergency medications; no mention that it was part of the T-Rex Exercise. A tribal employee signed for it and handed it over to the Tribe's pharmacy department. The Tribe's pharmacy accepted it and held onto it.	being dropped off when the delivery is made. Drivers need to communicate clearly when they drop off the medical countermeasures.
Colville	Del Ostenberg	No problems. Colville Tribes representative picked up T-Rex MCMs at the Spokane Fairgrounds.		
Colville	Randy August	No problems. Air delivery of T-Rex MCMs arrived 15 minutes after scheduled time at the Omak Airport. Paperwork was reasonable. There were no problems unloading. Colville Tribes representative picked up T-Rex		

TRIBE	CONTACT NAME	WHAT WENT WELL	WHAT DID NOT GO WELL	ADDITIONAL COMMENTS
		MCMs at the Omak Airport.		
Cowlitz	Steve Kutz	MCM were delivered to the tribal clinic, as requested. No problems.		The street address for the tribal clinic facility is such that the street number corresponds to a back entrance. The T-Rex driver(s) figured it out quickly and delivered to the clinic front desk without a significant delay and with no problems. It could be useful to make a note regarding this address quirk in the MCM delivery plans, for future reference.
Lummi	Cristina Toledo-Cornell	DOH delivered the MCM, as requested.	Lummi Nation had incorrectly been taken off the list for deliveries. Days before the exercise, David Owens (DOH) and Lou Schmitz (AIHC) followed up and Lummi Nation was placed back on the list for deliveries. During the exercise, the delivery driver got lost and had difficulties finding the delivery location. The driver did not contact the Tribe to ask directions,	

TRIBE	CONTACT NAME	WHAT WENT WELL	WHAT DID NOT GO WELL	ADDITIONAL COMMENTS
			which could have made for a more timely delivery.	
Makah	Libby Cope	DOH drove out to Neah Bay and delivered the MCM. No problems. Makah Nation appreciated the delivery, as requested.		Makah Nation prefers to have a helicopter delivery be the mode of delivery for future events and exercises, due to frequent road closures that prevent access in and out of Neah Bay. Road closures happen often during the winter and create problematic conditions, especially during natural disasters.
Muckleshoot	Jeremy Pangelinan	Everything went well. DOH had plenty of staff at the RSS to assist with the pickup. There was not too much paperwork to complete. Muckleshoot Tribe representatives picked up the T-Rex MCMs at the RSS with no problems.		
Nisqually	Mary Szafranski	Nisqually Tribe picked up at the RSS. No problems with the pickup.	Nisqually Tribe staff were delayed at a meeting and arrived at the RSS later than planned (2:00pm).	For future events and exercises, it would be helpful to have more clear instructions regarding the type

TRIBE	CONTACT NAME	WHAT WENT WELL	WHAT DID NOT GO WELL	ADDITIONAL COMMENTS
			Nisqually Tribe sent a truck and trailer to the RSS; they did not understand they could have just sent a passenger vehicle. The MCM were not there for them to pick up.	of vehicle needed. Also, more clarity would be useful regarding the documentation needed to participate in the exercise.
Quileute	Jolene Winger		Quileute Tribe was not contacted by DOH to notify them regarding when to pick up at the Quillayute Airport for the T-Rex Exercise. Forks Community Hospital picked up the Quileute Tribe's T-Rex MCM delivery. Quileute Tribe did not find out the delivery had been made until days after the exercise.	The Quileute Tribe's 1st choice is to have MCM delivered to the Quileute Health Center, 560 Quileute Heights Loop, La Push, WA 98350. The Quileute Tribe's 2nd choice is to have MCM delivered to the Coast Guard Station in La Push, 2-24 River Drive, La Push, WA 98350. The Quillayute Airport is often not accessible due to bridges being closed down. This is NOT a preferred location for delivery of the Tribe's MCM.
Quinault	Christina Breault	Tribal staff were prepared and responded quickly. The Tribe exercised dispensing to 10	Quinault Nation had requested their allocation to be delivered to Grays Harbor County Health and Human	

TRIBE	CONTACT NAME	WHAT WENT WELL	WHAT DID NOT GO WELL	ADDITIONAL COMMENTS
		patients within 30 minutes of receipt of MCM. Despite Quinault's MCM allocation not having been delivered by DOH, as requested, to Grays Harbor County Health and Human Services, Quinault Nation staff and Grays Harbor staff were able to negotiate and work together to provide MCM for Quinault Nation to pick up and deliver to the Quinault Nation's medical clinic.	Services, but this did not happen. They had been told they would receive simulated pill bottles. On this assumption, the Quinault Tribe made plans to exercise a POD. The expected supplies were not received, so the Tribe had to improvise in order to complete its dispensing exercise.	
Samish	Nora Pederson	Tribal staff worked with Skagit County Health Department staff to plan for the exercise. The Tribe exercised picking up medical countermeasures from the Skagit County Health Department, in Hamilton. "In preparing for this exercise we built a strong partnership with our LHJ, we exercised that relationship and everything went smoothly."		

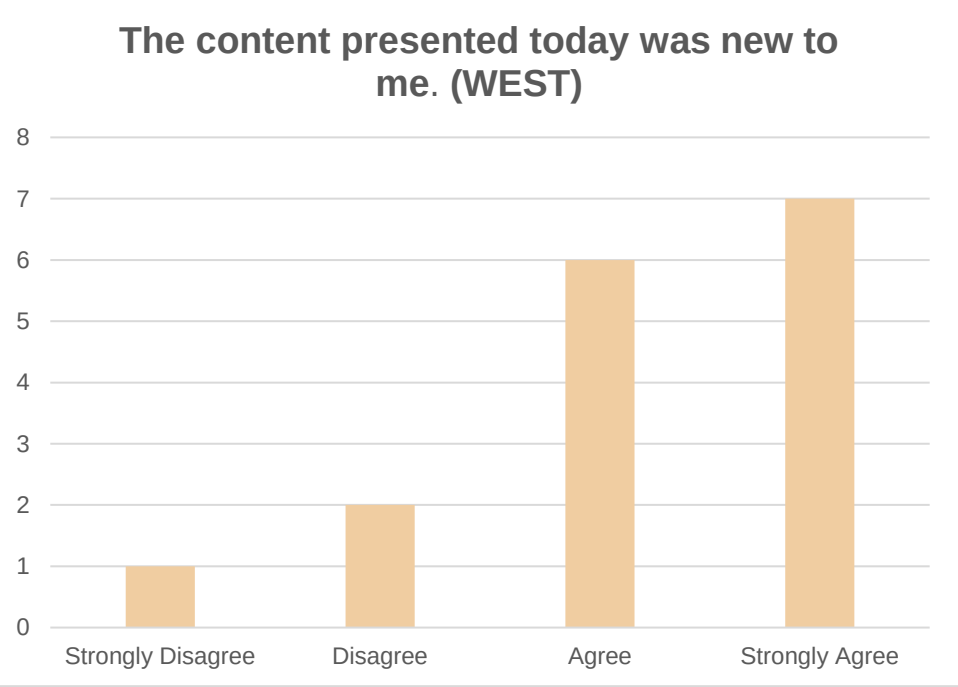
11. POINT OF DISPENSING TRAINING

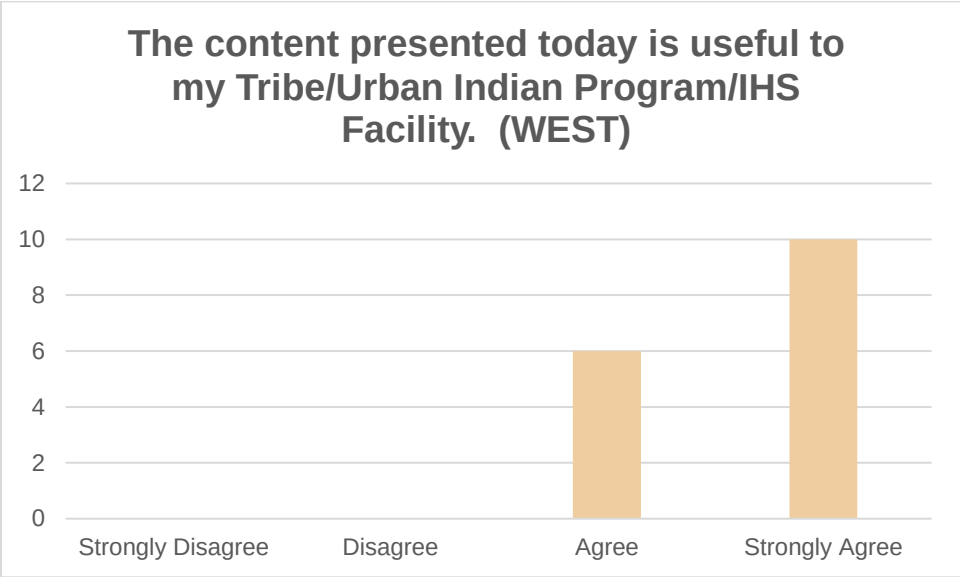
The AIHC adapted the Centers for Disease Control (CDC) “POD Essentials” curriculum to better address the needs of tribes and urban Indian health programs. The Commission scheduled two training workshops for the tribes and urban Indian health programs one Washington; one on the West side of the Cascades, the other on the East side.

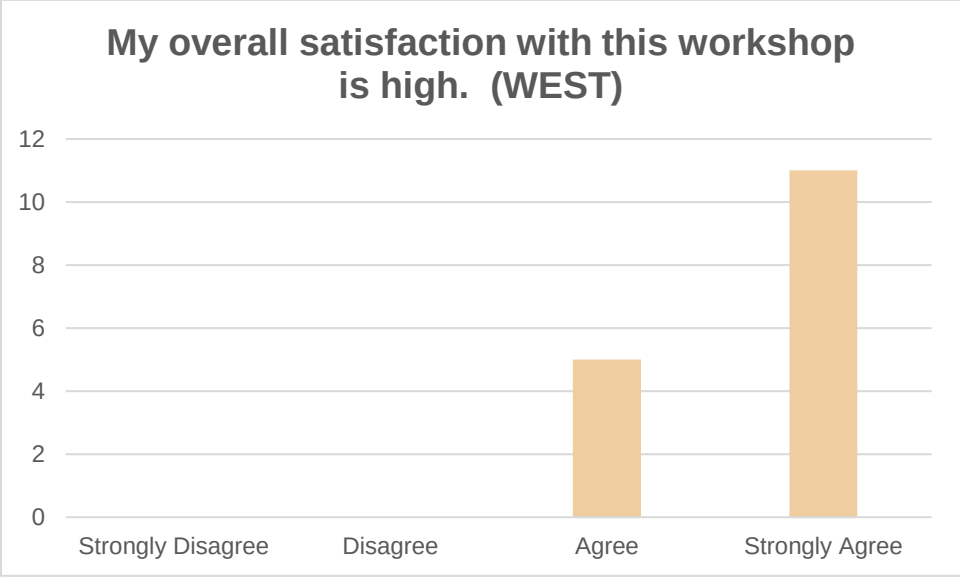
The West side workshop was hosted by the Muckleshoot Tribe and attended by 16 participants. Thirteen attendees were from 7 tribes. Some tribes invited partner counties to participate. Three participants from 2 counties attended the West side workshop. The East side workshop was hosted by the NATIVE Project of Spokane, and attended by 2 tribes, 1 IHS service unit, and 1 urban Indian health program.

Workshop evaluations demonstrated a high level of satisfaction regarding the quality of the workshop by attendees.

West Side Workshop Evaluations







What did you like most about today's workshop? (WEST)

Great steps. Simple to follow. Very hands-on.
Tribal-centered. Benefited from how to set up a POD.
Role play. Group exercise.
Learning about the differences between tribes and local LHJs.

Content was clear and well presented
Hands-on, Clear
I liked the focus/emphasis on tribal PODs
I liked the new name/title for PODs (Medication Dispensing Centers – MDCs)
Filling out the dosing sheets and following the algorithm
Easy to understand new information
Going over each main function step by step
Hands on activities
New concepts for things we have already trained on
I enjoyed learning about setting up the POD – previous trainings only covered the screening form and dispensing section – role playing the greeter was also very helpful
Key essential definitions and explanations were addressed
Good interactive scenarios
Hands-on
Role play
Materials were easy to use
Point of Dispensing is a new training
Activities
Very informative and useful

What can we do in the future to make this workshop better? (WEST)

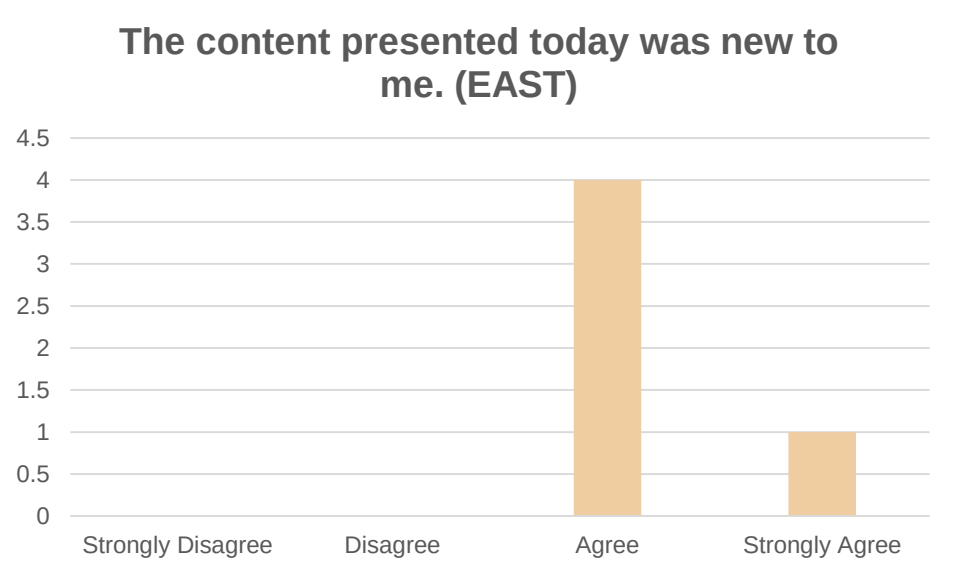
Name tents with tribe/jurisdiction so as people spoke, I could put a name with a face.
Nothing
Maybe incorporate the volunteers to act in the scenarios
It would be nice to use sample medical bottles for the exercise
N/A
A little more focus on how to set up POD – who gets notified and by who – this would be interesting information to go over
More training scenarios
Come out to present to tribal leaders and run a POD
Additional information for medical providers (for example, what to do if patient is allergic to all the meds available) as this is not easily found online
N/A

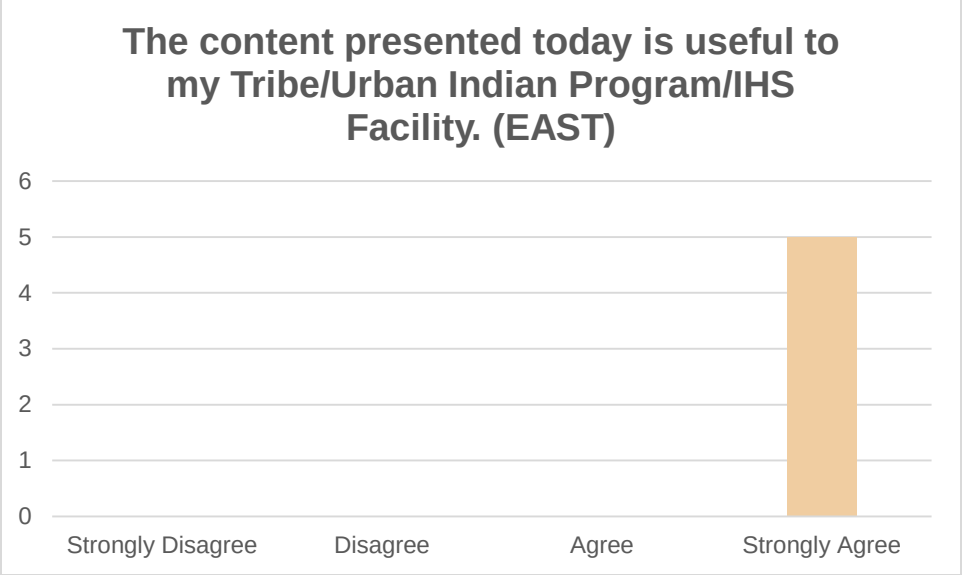
Operate a simulated POD at end of training? Exercise on greeting and client roles

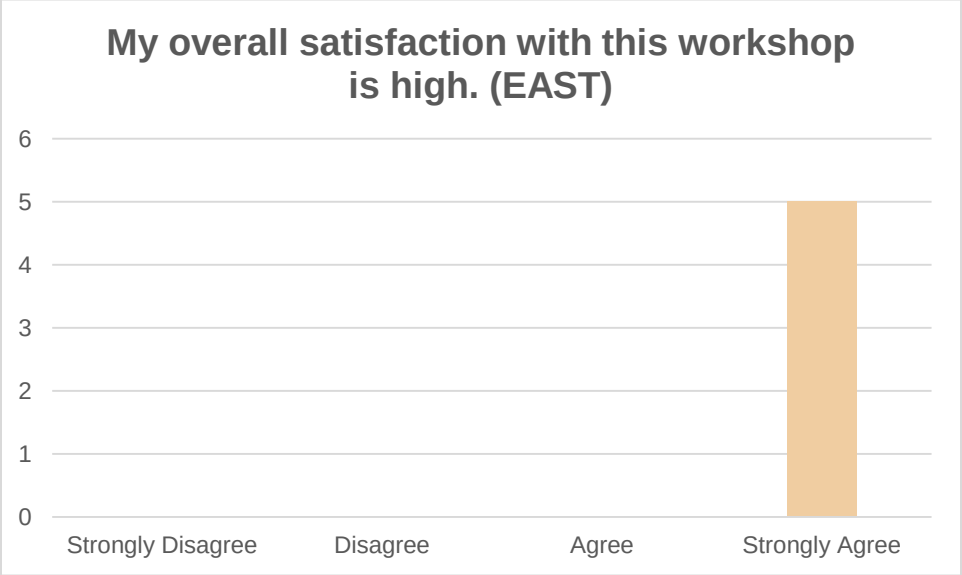
Other comments (WEST)

Very helpful for other disasters and events this can and will be used for. Thanks for a great breakfast and lunch! Re-birth tribal MRC for Washington Thank you! I was glad to see so much tribal representation ☺ Thank you! Thanks Thank you, and I really enjoyed this training The workshop was very useful in going through all 3 stages

East Side Workshop Evaluations







What did you like most about today's workshop?

Step by step instruction
Gave a framework to bring back to the facility
Going through the scenarios with the other trainees
POD
Worked through each function step by step individually and as a team

What can we do in the future to make this workshop better?

Get more people/tribes here
Incorporate with specific emergency preparedness training
If we had more of the other tribes show up and participated
It was just right
N/A

Other comments

Great food!
Great job!
Really enjoyed training and learned how different things worked
N/A
Useful and well presented information

12. RECOMMENDATIONS AND NEXT STEPS

1. **Provide continued technical assistance to tribes for creating and finalizing their medical countermeasures plan.** Many tribes are beginning to review their model medical countermeasures plan with the intent to seek adoption of the plan. Additional support for tribes as they go through the process of drafting and finalizing their plans will greatly improve tribal emergency preparedness.

2. **Provide continued technical assistance to local health jurisdictions for creating and finalizing tribal provisions within their medical countermeasures plans.** The American Indian Health Commission received positive feedback from a number of local health jurisdictions that intend to incorporate the model tribal provisions into their current medical countermeasures plans. Additional meetings to follow-up on the progress of local health jurisdictions in adopting tribal provisions will be helpful in strengthening medical countermeasures coordination among multiple jurisdictions.

3. **Conduct a DOH Tribal Consultation on the Proposed Revisions to Annex 9.** Pursuant to the RCW 43.376 and the DOH Consultation Policy, DOH should request a tribal consultation on proposed revisions to Annex 9. The American Indian Health Commission can provide assistance with outreach to tribal delegates and compiling tribal feedback.

4. **Request a Tribal Consultation with the CDC and ASPR** The American Indian Health Commission should conduct outreach with tribal leaders to request a tribal consultation with the CDC and ASPR on the Commission's recommended policy revisions to the "Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide to Preparedness, *Version 11."*

5. **Review and Update DOH Annex 9 Operational Guides/Attachments.** The American Indian Health Commission had the opportunity to review Annex 9. Several of the operational guides referenced in the list of attachments for Annex 9 are in the process of being amended or created by DOH. Once these drafts are available for review, the the Commission should review these and provide any suggested edits. Key coordination issues have not been finalized, such as the manner in which DOH will separate and clearly identify the portion of a MCM delivery that is a tribe's requested allocation, for tribes that choose to have their MCM delivered to a partner LHJ.

6. **Conduct Regular Cross-Jurisdictional Exercises, Including "Mini" or "Virtual" Tabletop Exercises and Conference Calls between Tribal, DOH, and Local Health Jurisdictions.** Tribes and LHJs want more tabletop exercises and regular meetings to

discuss coordination of joint response efforts, communication strategies, and maintenance of updated contacts.

7. **Personal Protective Equipment (PPE) Training.** Several tribes requested training and technical assistance on PPE and N-95 fitting.

8. **COOP Training.** Continuity of Operations Planning (COOP) is an area that was identified as a significant gap for tribal and urban Indian health programs clinics. Of specific concern is surge capacity during public health emergencies, the lack of crisis standards of care, and the lack of specific planning to manage ongoing primary care services while simultaneously managing a Point of Dispensing (POD).

9. **Schedule Opportunities for DOH, AIHC, LHJs and All Tribes Meeting to Discuss Corrective Actions Implemented as a Result of T-Rex Exercise Findings.** To assure corrective actions are properly implemented to address T-Rex findings, AIHC should facilitate regional meetings with participation from DOH, AIHC, LHJs, and Tribes.

10. **Develop and Draft Model Tribal-LHJ-DOH Medical Countermeasures Communication Processes and Procedures that Can Be Incorporated in Tribal, LHJ, and DOH MCM Plans.** Most of the gaps and failures identified during tribal participation in T-Rex were the result of ineffective communication processes and procedures. Specific forms and processes for tribes to communicate with DOH and LHJs during medical countermeasures responses are needed to prevent delivery of tribal MCM to incorrect locations, inability of drivers to contact the correct contact at tribal jurisdictions, etc.

11. **MODEL Tribal Isolation and Quarantine Plan.** At present, none of the Washington tribes has a plan for isolation and quarantine measures. These plans will require careful drafting to assure issues of authority and jurisdiction are clearly addressed.

12. **MODEL Tribal Pandemic Influenza Plan.** At present, very few tribes have a pandemic influenza plan. Those that are in place were mostly drafted quickly, in response to the H1N1 pandemic of 2009. Pandemic influenza is a very likely threat to our communities. Developing and implementing these plans are a priority for tribes in Washington.

13. **Opportunities to Exercise Distribution and Dispensing of Vaccine Medical Countermeasures, Including Cold Chain Storage.** Tribes requested opportunities to exercise requesting, receiving, managing, and dispensing MCM vaccines, including cold chain storage.