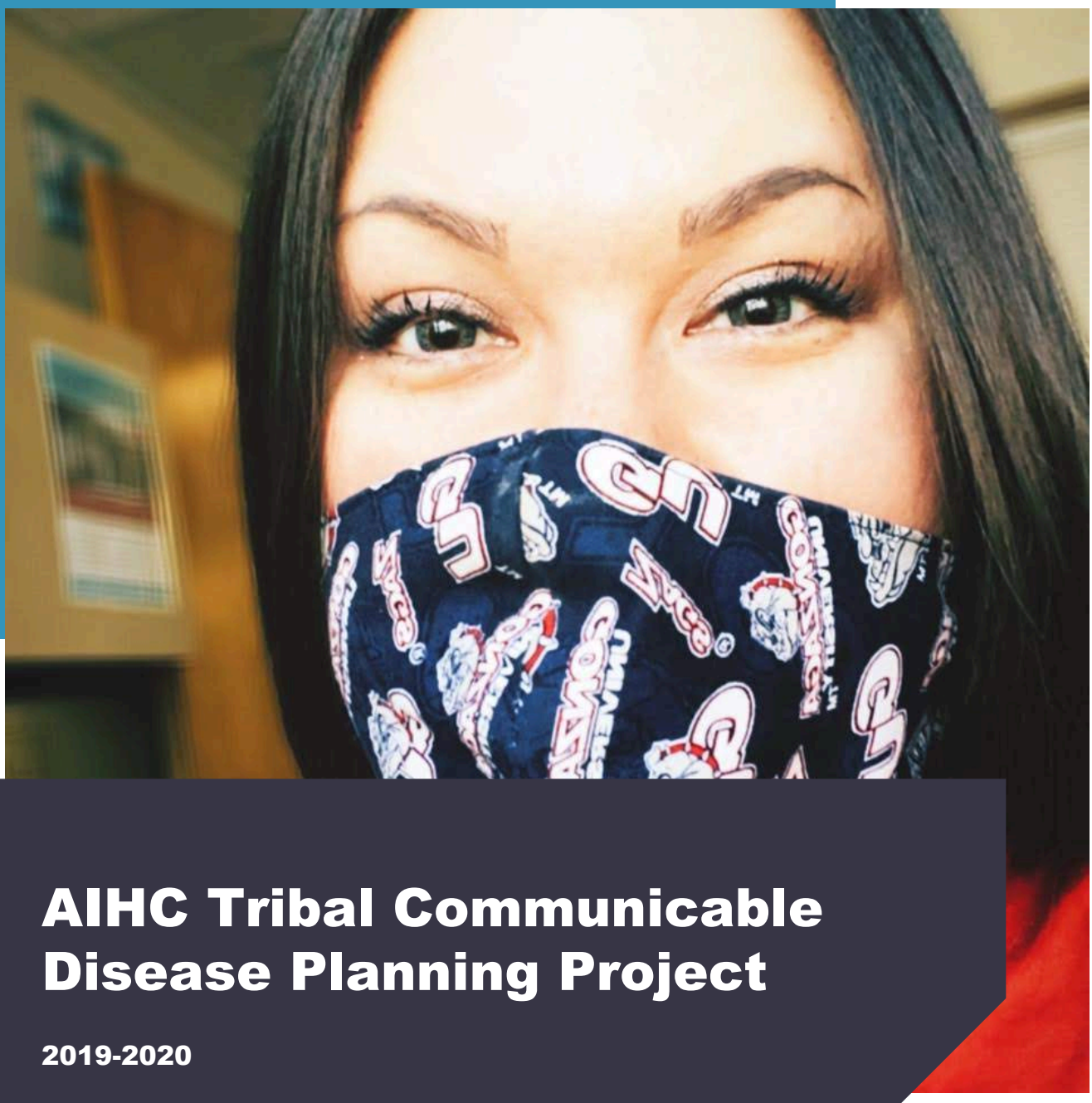

AIHC Tribal Communicable Disease Planning Project

2019-2020

American Indian Health Commission for Washington State

www.aihc-wa.com
Vicki Lowe, Executive Director

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ACKNOWLEDGMENTS

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ABOUT AIHC

The American Indian Health Commission for Washington State is a Tribally-driven non-profit organization in Washington State. Established in 1994, the AIHC's mission is to improve the overall health of American Indians and Alaska Natives through advocacy, policy, and programs to advance best practices at the Washington State level. AIHC works on behalf of the twenty-nine federally-recognized Indian Tribes and two Urban Indian Health Programs (UIHPs) in the state. Delegates, appointed by resolutions from the Tribes and Urban Indian Health Programs (UIHPs) lead the work of the Commission.

AIHC serves as a forum where a collective Tribal government voice is shaped regarding shared health disparity priorities. Tribes and UIHPs work collaboratively with Washington State health leaders, the Governor's office, and legislature to address these priorities. The Commission's policy work improves access for individual Indian people to state-funded health services, enhances reimbursement mechanisms for Tribal and UIHP health programs to deliver their own culturally-appropriate care, and creates an avenue for Tribes and UIHPs to receive timely and relevant information about state health regulations, policies, funding opportunities, and health-specific topics. The AIHC brings together state, Tribal, and UIHP partners to collaboratively address health disparity priorities across multiple systems, pooling resources and expertise for improved health outcomes.

The AIHC serves as liaison between the Washington State Department of Health's (DOH) Office of Emergency Preparedness and Response (OEPR) and the federally recognized Indian Tribes and UIHPs within Washington's geographic borders and staffs the Tribal Liaison Officer position during Washington State emergencies. The AIHC's goal is to assist Tribes and UIHPs in developing, building, and improving community, health and medical systems that are well prepared to effectively respond to threats and disasters.

Under the leadership of Tribal and UIHP delegates, the Commission provides training and technical assistance, contributes to regional efforts that strengthen Tribal and urban Indian communities' response capabilities, and promotes effective partnerships and mutual aid.

EXECUTIVE SUMMARY

The American Indian Health Commission for Washington State (AIHC), with funding from the Washington State Department of Health (DOH), began work in November 2019 to produce a specific list of resources for tribes and urban Indian health programs (UIHPs) to strengthen communicable disease emergency response capabilities. The emergence of the COVID-19 pandemic in January 2020 prompted urgency for these resources and amplified the scope of work to support the response efforts of tribes and urban Indian health programs.

During the COVID-19 response, tribal nations and UIHPs within Washington State again demonstrated why they have earned national recognition as leaders and innovators in public health emergency preparedness and response. Although at the beginning of the pandemic tribes lacked plans and infrastructure to respond to communicable disease emergencies, they quickly stood up capabilities to address community needs and overcome challenges never before encountered. Tribal governments' commitment, resilience, culture, knowledge, and community strength allowed them to swiftly and effectively take measures to protect not just tribal citizens, but all Washington residents. As of this writing, many tribal nations in Washington have had no COVID-19 cases.

Tribes and UIHPs are uniquely qualified to protect their communities. In keeping with their history of resilient governance since time immemorial, tribal governments firmly exercised sovereignty and implemented response strategies based on cultural intelligence and principles of shared responsibility for the safety of all community members. With knowledge of their community's specific circumstances, many tribes stood up to external pressures to open their lands to non-residents, loosen stay at home orders, and reopen services. Tribes also demonstrated the ability to quickly identify and reach out to all contacts of individuals who tested positive for COVID-19. In contrast, the state and local health jurisdictions took months to develop contact tracing capacity. Through these self-determined contact tracing efforts, tribes delivered a more familiar and culturally competent message about quarantine and isolation. Tribes were also able to immediately identify the resources and wraparound services community members needed to comply with distancing guidelines.

Native Project of Spokane Staff

The AIHC developed essential response resources for tribes and UIHPs in real time during the COVID-19 pandemic. Resources included model plans, model codes, model resolutions, and training workshops. States, tribes, and local health jurisdictions across the United States utilized these resources and participated in AIHC's trainings. The resources were designed to be adapted by each tribal nation and UIHP to meet their unique government structure, culture, geography, economy, and population needs. Most tribes adapted and adopted the Model Tribal Communicable Disease Emergency Response Plan within a week of it being available. The Model Stay Home Directive was implemented within days.

The pandemic showed that not every partner, including the federal government, is able to fulfill its responsibilities during times of crisis. Sovereignty and self-reliance are the foundations of effective tribal

public health emergency responses. Although it is essential for tribes to build strategic partnerships with other tribes, local governments, Washington State, and the federal government, tribal plans must be designed to maximize self-reliance during public health emergencies. For example, much of the personal protective equipment (PPE) provided by the Indian Health Service (IHS) was expired and unusable. Tribes processed resource requests for PPE through the state, traded supplies between tribes, and shared supplies acquired by AIHC through donations.

Partnerships were essential to respond quickly and effectively to the COVID-19 pandemic. Tribes that had pre-established relationships with neighboring counties were able to readily coordinate efforts on issues like testing, contact tracing, and isolation and quarantine. Tribes found that taking time to share resources, lessons learned, and best practices weekly with other tribes was invaluable. Weekly meetings between the tribes and UIHPs and Washington State agency tribal liaisons allowed for direct communication between tribes and state agencies to resolve emergent issues. Having the AIHC Tribal Liaison Officer (TLOFR) position within Washington State's Incident Command structure allowed for timely communication with tribes and UIHPs, inclusion of tribal concerns in day to day decisions, and opportunities for tribes to meaningfully engage in the state's response.

Effective collaboration and coordination of public health emergency response efforts between tribal and non-tribal jurisdictions protects the health and safety of all Washington residents. Cooperation has increased over recent years. This progress is the result of great efforts by tribal nations, urban Indian health programs, the American Indian Health Commission for Washington State (AIHC), support from the Washington State Department of Health (DOH), and positive actions by several counties. Although, some state and local partners have gained general knowledge of tribal sovereignty, much work is needed to increase understanding of tribal jurisdiction and roles and responsibilities of each government during emergency responses. Also, additional investment is needed to continue developing resources to support response capabilities in tribes and UIHPs.

> "We should not have to wait until a pandemic happens to make important changes. Tribes can submit reports and make requests in meetings, but unless the State comes to our reservation, we are not likely to see the State take action. It takes someone willing to see and listen to make changes happen."
>
> -Marilyn Scott, Vice Chair of the Upper Skagit Tribe

AIHC looks forward to collaborating with DOH to continue strengthening life-saving cross-jurisdictional partnerships and public health emergency response capabilities. May the many lessons learned and the resulting recommendations documented in this report enhance the ability of all tribal nations, states, and local governments to protect their citizens.

INTRODUCTION

Tribal nations possess the inherent authority to protect and serve their people during public health emergencies. The extent to which state and local actors recognize and support this fundamental principle significantly affects a tribal nation's ability to respond effectively. For over two decades, the American Indian Health Commission for Washington State (AIHC) has advocated for policies and laws that strengthen tribal sovereignty and self-sufficiency. In 2019, the State of Washington codified its formal recognition of tribal nations and urban Indian health programs (UIHPs) as public health entities in Substitute Senate Bill 1497: "the Washington State public health system is comprised of the state department of health, state board of health, local health jurisdictions, sovereign tribal nations, and Indian health programs."

Since 2012, the AIHC has facilitated forums and developed resources for Washington tribes, UIHPs, and local health jurisdictions to advance tribal public health emergency response readiness. During past work completed by AIHC on public health emergency response planning, tribes and UIHPs identified the need for resources to strengthen their communicable disease emergency response capabilities. The AIHC developed a project workplan for 2019-2020 to produce the following deliverables with funding support from DOH:

Mask making at the Jamestown S'Klallam Tribe

1) Model Tribal Communicable Disease Emergency Response Plan
2) Model Tribal Isolation and Quarantine Plan
3) Model Tribal Isolation and Quarantine Code
4) Training to Tribes and UIHPs on the Model Tribal Communicable Disease Emergency Response Plan
5) Training to Tribes and UIHPs on the Model Tribal Isolation and Quarantine Plan
6) Training to Tribes and UIHPs on the Model Tribal Isolation and Quarantine Code
7) Proposed Wording for Washington State Local Health Jurisdictions' (LHJs') Communicable Disease Response Plan
8) Proposed Wording for DOH Communicable Disease Emergency Response Plan
9) In-Person Meetings for the Tribes and LHJs in each of the Nine Public Health Emergency Preparedness Regions to Plan for Cross-Jurisdictional Coordination and Collaboration Before, During and After a Communicable Disease Emergency

Work on these deliverables began in late November 2019. As the world watched the COVID-19 pandemic emerge in early January 2020, the urgency to complete these resources became evident. AIHC staff and consultants worked around the clock. Given the severity and scale of the pandemic, a much larger body of work was produced than originally planned. Work products were posted on the AIHC website, shared via email, and reviewed during regular meetings with the tribes and UIHPs.

Tribes across the state quickly made use of these resources by appointing tribal public health officers, adopting communicable disease emergency response plans, standing up isolation and quarantine facilities, conducting drive through testing, and managing case investigations and contact tracing. State, local health jurisdictions,

and tribes across the nation as well as the CDC recognized the timeliness and comprehensive scale response of the Washington tribes' response efforts.

This report documents the deliverables completed and honors the innovation and competence of the twenty-nine tribes and two urban Indian health programs in Washington State. The report includes best practices developed and shared by the tribes and UIHPs to respond to this historic public health crisis. Also included are recommendations for future efforts based on insights and suggestions provided by leaders and staff from the tribes and UIHPs.

Section 1: Tribal Communicable Disease Emergency Response Planning

Model Tribal Communicable Disease Emergency Response Plan

In previous planning efforts, tribal representatives identified the need for a Model Tribal Communicable Disease Emergency Response Plan for tribes to adapt and adopt. To begin developing the model plan, AIHC requested the twenty-nine (29) tribes and thirty-nine (39) counties to share their communicable disease response plans and pandemic response plans. None of the tribes had a communicable disease response plan. Three tribes shared outdated pandemic influenza response plans which were developed in 2009 using a template provided by the Indian Health Service (IHS).

The model tribal plan developed by AIHC (See Appendix A) outlines the processes and actions a tribe will implement to contain a communicable disease emergency and protect individuals and families. Many tribes quickly adapted the model plan to fit their community and jurisdiction and activated their plans. Tribal health officers reported that having access to the model emergency response plan was critical to the timeliness and effectiveness of their response efforts for COVID-19. Some smaller tribes reported that the extent and scope of the plan challenged their ability to adapt and implement it while operating with limited staff and resources as a result of the pandemic.

The Model Tribal Communicable Disease Emergency Response Plan was posted on the AIHC website and made available to tribes on March 11, 2020.

Planning Assumptions. The Model Tribal Communicable Disease Emergency Response Plan includes key planning assumptions based on lessons learned over the years of collaborating with tribal, federal, state, and local public health partners, including:

1) coordination with other jurisdictions is essential;
2) resources and assistance may come from multiple jurisdictions and agencies;
3) the tribe possesses authority over communicable disease emergency responses;
4) the tribe will operate under the Incident Command System (ICS);
5) the plan is flexible to accommodate for the fact that each incident is unique;
6) the tribe will use culturally based and compassion approaches;
7) significant disruption and impact to the community may occur;
8) vaccines and other preventive prophylaxes may not be available;
9) supplies, equipment, and other resources may be scarce;
10) the tribe may need to determine priority groups for receiving prevention and/or treatment;
11) non-pharmaceutical interventions may be necessary;
12) tribal health services may be limited and/or understaffed;
13) every community member plays an important role in preventing the spread of disease; and
14) there may be an increased need for counseling and spiritual support.

Concept of Operations. The plan's detailed concept of operations outlines basic steps and actions that apply to all communicable disease emergency responses. One of these is the requirement to designate a tribal

health officer if the tribe has not already done so. Also included are processes for declaring a public health emergency, setting up an emergency operations center, coordinating with other jurisdictions, establishing community based public health surveillance, implementing non-pharmaceutical interventions, submitting resource requests to other jurisdictions, and post-incident activities.

Model Tribal Communicable Disease Emergency Response Plan Training

On March 11, 2020, AIHC delivered a three-hour training via webinar on the model plan. Sixty-one (61) participants from Washington State tribes attended. The webinar recording was posted on the AIHC's website and watched by a total of twenty-nine individuals from:

- Washington tribes (12)
- Tribes in other states (15)
- Colorado Department of Public Health and Environment (1)
- National Institutes of Health (1)

Lessons Learned and Best Practices

Appointment of a Tribal Public Health Officer. Most tribes prior to the COVID-19 pandemic did not have a tribal public health officer. Simultaneously declaring an emergency and adopting a communicable disease emergency response plan, tribes appointed a tribal public health officer for the first time. Tribes reported that having an official health officer was the most critical step in the pandemic response. This consequential exercise of tribal sovereignty allowed the tribes to effectively engage their community members in the response and coordinate with outside jurisdictions.

Native Project COVID-19

Early Activation of Plan. Tribes noted the importance of activating their plans early in the response. Jurisdictions that were able to activate early felt it helped prepare their organizations to manage the large volumes of information and the challenging workload of such a large-scale response.

Stay at Home Orders. Within days of the State of Washington declaring a stay-at-home order, the AIHC developed a Model Tribal Stay-at-Home Order. Many tribes quickly adopted this stay-at-home order or drafted their own. Most tribes incorporated unique provisions that allowed for exceptions such as treaty fishing and hunting, as long as specific precautions were taken. Tribes reported the stay-at-home orders appeared to be effective in reducing cases or preventing them altogether. Many tribes had few or no cases, as of this writing, especially during the time stay-at-home orders were in place.

Reservation Lockdown. Several tribes reported that individuals who are not tribal members and do not reside on the reservation were going onto tribal lands, especially during the early days of the pandemic. One possible reason for this was a misunderstanding that by being on tribal lands, individuals could violate state mandated non-pharmaceutical interventions without consequence. To protect the health and welfare of their people, many tribes took steps to prohibit nonmembers from entering tribal lands. These prohibitions exempt essential workers, such as delivery truck drivers, postal workers, and others. Other actions included signage or barricades and stationing

tribal law enforcement at reservation boundaries. Tribal communicable disease emergency response plans should address the potential need for limiting access to tribal lands.

Establishing a Strong and Clearly Defined Unified Command. Tribes reported that having a strong unified command structure, where the tribal public health officer and the emergency manager share the role of incident commander, was key to an effective response. This approach allowed for the response leadership to include subject matter expertise in public health as well as emergency management.

Food Security. The AIHC conducted a weekly survey in the early days of the pandemic to assess tribes' and UIHPs' unmet needs and challenges. Through the month of April between nine and thirteen tribes consistently reported food insecurity was a problem in their community.

During AIHC's weekly response planning meetings, tribes shared strategies implemented in their communities to address food insecurity. The Confederated Tribes of the Colville Reservation delivered meals to households experiencing food insecurity. By June 11, Colville Tribes had delivered over 35,000 meals to tribal members, more than 500 meals per day. The Port Gamble S'Klallam tribal casino froze over one thousand meals for distribution to tribal members. Quinault Tribe produced and delivered over 850 meals each week at Taholah Village and 300 each week at Queets Village. Other actions to address food insecurity included: expanded efforts on tribal community gardens, tribal casino food donations to tribal members; distribution of tribal frozen fish stock; and prepaid gift cards for tribal members to purchase groceries. As of June 25, many tribes remained concerned that food insecurity presents a significant problem. Tribal communicable disease emergency response plans should include strategies to address food insecurity.

Quinault Tribal members prepare meals during COVID-19 pandemic

Other Community Needs. Disruptions to supply chains and stay-at-home orders created numerous unmet needs for tribal individuals and families, tribal governments, and business enterprises. Many tribes had to source and provide tribal members with a broad variety of essential goods, including: diapers and formula, food supplements, toilet paper, vitamins and over the counter medications, elderberry syrup for boosting the immune system, cleaning supplies, tissues, thermometers, and indoor activities such as coloring books, large font books for their elders, and puzzles. One tribe reported delivering blankets to elders to reduce anxiety.

Upper Skagit Tribe Honors Students at End of School Year

Cultural and Social Support Needs During Stay-at-Home and Physical Distancing. Tribes reported significant challenges in meeting the cultural and social support needs of their community members. Tribal communities are bound together by strong relationships. Gatherings represent an integral part of cultural expression. Stay-at-home and physical distancing orders required the cancelation of essential ceremonies, gatherings, and celebrations. Upper Skagit Tribe Vice Chair, Marilyn Scott, shared that many young adults in her community

were despondent and showing feelings of hopelessness. Her tribe provided community households with supplies to decorate their porches in honor of their students and conducted a community car parade. Several tribes prepared and delivered culturally based care packages to community households. Other tribes connected their members with virtual drumming sessions via video conferencing platforms.

Funerals in Washington tribal communities are usually attended by several hundred people, many who travel from other reservations to honor those who have passed. This presented significant challenges to balance respecting cultural traditions with protecting the health of community members. Tribal communicable disease emergency response plans should address funerals.

Reopening Tribal Government Workplaces, Business Enterprises, and Other Community Entities. Tribes as sovereign nations have the authority to reopen government workplaces, business enterprises, and other community entities independent of other jurisdictions. Washington tribes developed and adopted their reopening plans with unique timeframes and criteria for reopening. In many cases, tribal councils worked closely with their tribal health authorities in making critical decisions such as when and how to reopen a tribal casino or whether to cancel the sale of fireworks. Tribal communicable disease emergency response plans should include basic guidance for shutting down and reopening and define the role of the tribal health authority in advising tribal council on these decisions.

Recommendations

1. AIHC should update the Model Tribal Communicable Disease Emergency Response Plan to incorporate best practices shared by tribes and lessons learned throughout the COVID-19 response. Additions to the plan may include:
    - Tribal Declaration of Emergency
    - Stay-at-Home Order
    - Reservation Lockdown Procedure
    - Telecommuting Policies for Staff
    - Workplace Safety Guidelines
    - Continuity of Operations Planning
    - Process for Maintaining a Cache of PPE (that is rotated to prevent expiration)
    - Template for Weekly Communication with Tribal Community (e.g. Facebook post)
    - Funeral Guidelines
    - Strategies to Prevent and Plan for Food Insecurity
    - Template Tribal Community Messaging Flyers
    - Cultural and Recreational Support During Social Distancing

Kalispel Tribe Employee

2. AIHC should emphasize in model plans and policies and at tribal meetings the importance of activating communicable disease emergency response plans early during an event. If tribal resources are not exceeded or the event does not increase in severity, the response can always be demobilized.
3. AIHC should update model plans to address the role of tribal council in coordinating with and supporting the tribal health officer.

4. AIHC should update model plans to include a unified command approach with clear delineation of responsibilities between the emergency operations center and the tribal public health authority.
5. AIHC should provide technical assistance for smaller tribes in need of drafting and finalizing a communicable disease emergency response plan.
6. AIHC should provide technical assistance to tribes and UIHPs to develop continuity of operations plans for public health and healthcare services.

Section 2: Testing and Screening

Early detection of contagious individuals is critical to implementing isolation and quarantine measures in a timely manner. To effectively respond to a pandemic, tribes must have the capacity to screen their community and workforce rather than relying on outside entities or jurisdictions. The Model Tribal Communicable Disease Emergency Response Plan did not include a section on screening. Tribal plans should include strategies for testing and screening.

Drive-Through Testing Training

The American Indian Health Commission for Washington State (AIHC) collaborated with Washington State Department of Health (DOH) to develop and deliver a two-hour Drive-Through Testing Workshop for Tribes and UIHPs on May 28, 2020. Twenty-six (26) participants from Washington State tribes and UIHPs attended. The webinar recording was posted on the AIHC's website and watched by one (1) tribe from Canada.

Jamestown S'Klallam Tribe
Drive Through Testing

Lessons Learned and Best Practices

Testing Supplies. Early in the pandemic, the lack of testing supplies, personal protective equipment (PPE), and limited lab capacity prevented many tribes from testing at all. For several months, tribes reported having access to five or fewer test kits at any given time. CDC and state guidelines limited testing to symptomatic and high-risk individuals only.

Laboratory Capacity. Another factor limiting testing efforts was laboratory capacity. Most tribes reported a ten-day turnaround time for test results during the first months of the response. One tribe reported driving specimens three hours roundtrip to a lab that would provide results in forty-eight hours compared to the local lab's seven to ten-day turnaround time. Approximately two months into the response, a local laboratory in Region 1 was able to stand up capacity more quickly than others. As a result, tribes in Region 1 reported access to adequate quantities of testing supplies and forty-eight-hour turnaround for results.

Testing Locations. For infection control during testing, tribes used standalone locations separate from their clinics or a designated area of their clinic. Testing sites included outside tents, a repurposed trailer, the rear entry to the clinic, and parking lots. Although most tribes have a primary care clinic on tribal lands and were able to conduct testing onsite, one tribe reported having to drive community members forty minutes each way to be tested. Tribal communicable disease emergency response plans should include pre-identified locations that may be used as testing sites.

Mass Testing. Prior to 2020, most tribes had never conducted mass screening operations. Once testing supplies became available in larger quantities, several tribes instituted strategies to conduct mass testing. One tribe reported successfully conducting a series of drive-through testing clinics. One tribe that does not have a medical clinic partnered with another tribe and a local health jurisdiction to conduct a drive-through testing clinic and stated: "What worked well for us in this response was knowing we had the capability to do our own testing. We would have tested sooner if we knew that." Tribal communicable disease emergency response plans should address mass testing.

> "What worked well for us in this response was knowing we had the capability to do our own testing. We would have tested sooner if we knew that."
> -Tribal Public Health Representative

Other Screening. By the third month of the response, many tribes had implemented standardized screening protocols for individuals to qualify for entry to tribal public buildings. These included temperature checks and questions about symptoms and contacts with COVID-19 cases. Screenings were conducted in tribal healthcare facilities, tribal government buildings, and business enterprises. Some tribes installed thermal cameras at entries of clinics and tribal enterprises.

Frequency of Testing and Populations Tested. As testing supplies became available, some tribes initiated asymptomatic testing for essential workers and first responders. One tribe reported conducting serial testing of healthcare workers every two weeks and testing all staff before they returned to the workplace.

Point of Care Testing. At least six tribes acquired Abbott ID Now® testing devices from the Indian Health Service (IHS) or elsewhere. These tests have limited use due to problems with false negative results, which led the U. S. Food and Drug Administration (FDA) to recommend that negative results from the ID Now ® device be confirmed with follow-up PCR testing. Tribes have expressed great interest in acquiring high quality point of care testing capability to support the timeliness of case investigation and contact tracing efforts. Turnaround time for receiving test results remained at up to ten days for some reference labs as of this writing. In addition to rapid results, access to high quality point of care testing would eliminate the need for tribes in remote locations to transport samples to a reference laboratory.

Shoalwater Bay Tribe Drive Through Testing

Coordination with Other Jurisdictions on Testing. Many tribes partnered with other jurisdictions to assure access to testing for their community members. One tribe provided medical staff to assist a neighboring county during a mass testing clinic. A tribe that does not have a primary care clinic on tribal lands partnered with another tribe and the Washington National Guard to test their community. Another tribe facing a significant outbreak partnered with the neighboring county and the National Guard to stand up a series of mass testing clinics in several tribal locations. For the first of these clinics, the intake form did not include a question regarding tribal membership and descendancy. This caused a delay in the tribe receiving information on positive test results and conducting timely contact tracing because the reference laboratory was hesitant to disclose test results to the tribal health jurisdiction. The intake form was edited for subsequent clinics to ask whether the individual is a tribal member, descendant, or tribal clinic

patient and a notice that test results would be reported to the tribal clinic for follow-up.

Access to Test Results and Data. Early in the pandemic, AIHC asked each tribe and UIHP to designate a single point of contact (SPOC) to receive notice of COVID-19 cases within their community. This was important because tribes had no access to information on cases tested outside the tribe's healthcare facility, and therefore, would not be able to conduct case investigations and contact tracing for those individuals. The SPOC list was provided to DOH and local health jurisdictions. Some tribes developed processes for sharing data with a neighboring local health jurisdiction to support case investigation and contact tracing.

AIHC also worked with DOH to provide the tribal and UIHP SPOCs access to the Washington Disease Reporting System (WDRS). This state database is the repository for COVID-19 case data. Complex issues including historical misclassification of American Indians and Alaska Natives (AI/AN), small numbers, data ownership, and lack of health information technology infrastructure, limit tribes' access to complete and accurate information. AIHC has established a Data Sovereignty Workgroup to address policy and practical issues related to tribes' access to and use of health data. This workgroup should serve through the pandemic and beyond to develop statewide processes consistent with tribal data sovereignty.

Recommendations

1. AIHC should update model plans to include testing and screening strategies and collect existing tribal testing protocols to inform the model plans. Tribal protocols and strategies may include:
    - pre-identified locations to serve as testing and screening sites, including specific buildings, tents, trailers, mobile units, etc.
    - drive-through testing protocols
    - mass testing protocols
    - decision trees for when to test community members, essential staff, and patients or clients in residential facilities
    - identification of labs likely to conduct testing
    - identification of governmental or private entities likely to furnish testing supplies
    - mobile testing units
2. AIHC should continue to support the efforts of the Data Sovereignty Workgroup.

Section 3: Case Investigations and Contact Tracing

Case Investigation and Contact Tracing Training

The American Indian Health Commission (AIHC) partnered with the Washington State Department of Health (DOH) to conduct three training workshops via webinar on case investigations and contact tracing. The workshops were designed specific to tribes in Washington State and included a review of practices used by DOH and local health jurisdictions. Workshop objectives included developing capability within each tribe and UIHP to conduct case investigations and contact tracing in their communities and reviewing the practices and information needs of the state and local health jurisdictions. The goal was for each tribe and UIHP to have a group of individuals prepared to quickly conduct case investigations and contact tracing.

Case Investigation and Contact Tracing Webinars

On March 27, 2020, AIHC delivered a two-hour training via webinar on case investigations and contact tracing. One hundred and sixty-nine (169) participants from Washington State tribes attended. The webinar recording was posted on the AIHC's website and watched by a total of one hundred and ninety-three (193) individuals from:

- Washington tribes (51)
- Tribes in other states (114)
- Centers for Disease Control (6)
- Colorado Department of Public Health and Environment (1)
- New Jersey State Department of Health (1)
- Colleges and Universities (14)
- Tribal Consortiums in other states (6)

On May 15, 2020, AIHC delivered a three-hour training via webinar on case investigations and contact tracing. Sixty-two (62) participants from Washington State tribes attended. The webinar recording was posted on the AIHC's website and watched by a total of sixty-three (63) individuals from:

- Washington tribes and UIHPs (29)
- Tribes in other states (34)

In response to requests from Washington tribes, AIHC scheduled a third three-hour webinar on case investigations and contact tracing scheduled for July 1, 2020. At the time of this report's writing, fifty-six individuals from Washington tribes and UIHPs had registered to attend.

Lessons Learned and Best Practices

Case Investigations and Contact Tracing Conducted by Tribes. Tribes are uniquely qualified to effectively conduct case investigations and contact tracing in their communities. Cultural competence and in-depth knowledge of the community provide contextual intelligence that outsiders lack. Tribes overwhelmingly reported the advantages of conducting their own case investigations and contact tracing. Some tribes initially relied on the state or local health jurisdiction to conduct such investigations but found they could complete them more quickly and with better results. The tribes reported that community members felt more comfortable communicating with someone they knew. One tribe shared their perspective on why they were better equipped to conduct their case investigations and contact tracing: "We knew we could do our own tracing quickly because we know everybody and all the families in our community. Within 2 hours we reached all the contacts of our first positive test."

> "We knew we could do our own tracing quickly because we know everybody and all the families in our community. Within 2 hours we reached all the contacts of our first positive test."
>
> -Tribal Public Health Representative

Collaboration Between Tribes and Other Jurisdictions on Contact Tracing. In meetings facilitated by the AIHC for each of the state's nine public health emergency preparedness regions, two local health jurisdictions noted the sizable impact that tribes' case investigation and contact tracing efforts had on controlling the spread of disease in their counties. These local health jurisdictions were overwhelmed and unable to adequately fulfill the great need for case investigations and contact tracing in their counties.

Some tribes that do not have a clinic or have limited staff relied on Washington State Department of Health (DOH) or the local jurisdiction to conduct case investigations and contact tracing for their tribal community members. Several tribes that conducted case investigations and contact tracing for their tribal communities reported they coordinated with the local health jurisdiction. For example, when a tribal member case reported contacts in the county outside reservation boundaries, the tribe shared the information needed by the local health jurisdiction to conduct contact tracing in the county.

Recommendations

1. AIHC should develop model processes for tribes and local health jurisdictions to coordinate case and contact investigations consistent with tribal jurisdiction and authority. This will reduce duplicative efforts and lead to faster response times.
2. AIHC should develop model policies, procedures and agreements for tribes and local health jurisdictions to share data regarding cases and contacts.
3. DOH should modify WDRS and CREST to include functionality that notifies tribes of cases within their communities and provides tribal users the ability to note whether the tribe will conduct case and contact investigations or delegate them to the local health jurisdiction.
4. AIHC should provide regular case investigation and contact tracing workshops for tribes and UIHPs to strengthen skills and share lessons learned and best practices.
5. DOH, in coordination with tribes and AIHC, should revise the Washington Administrative Code 246-101 to include notification to tribal health authorities.

Section 4: Isolation and Quarantine

Model Tribal Isolation and Quarantine Plan

None of the 29 tribes in Washington had an isolation and quarantine plan prior to 2020. The American Indian Health Commission (AIHC) developed a Model Tribal Isolation and Quarantine Plan to address issues specific to tribal communities (See Appendix B).

Many tribes reported adapting and adopting the Model Tribal Isolation and Quarantine Plan. One tribe that experienced COVID-19 cases early in the pandemic reported the plan was essential to their ability to quickly and effectively support isolation and quarantine in their community.

Planning Assumptions. The Model Tribal Isolation and Quarantine Plan outlines key planning assumptions, including:

1) isolation and quarantine slow the spread of communicable diseases;
2) tribes have authority over isolation and quarantine;
3) tribes will use culturally based and compassionate approaches to implement isolation and quarantine;
4) the individual's home is the preferred location for isolation or quarantine;
5) individuals in isolation must be properly separated from individuals in quarantine;
6) isolation and quarantine can cause significant stress to individuals and their families;
7) unexpected circumstances will occur during isolation and quarantine; and
8) every member of the community plays an important role in preventing the spread of disease and protecting other community members.

Quinault Nation elder "okay" sign

Concept of Operations. The concept of operations provides criteria to determine the best location for isolation or quarantine for each individual, criteria to evaluate facilities for their adequacy to house individuals who cannot isolate or quarantine at home safely, and processes to admit and monitor individuals in an isolation or quarantine facility.

Model Isolation and Quarantine Plan Training

On March 25, 2020, AIHC delivered a three-hour training via webinar on the model plan. Forty-seven (47) participants from Washington State tribes attended.

The webinar recording was posted on the AIHC's website and watched by a total of forty-seven (47) individuals from:

- Washington Tribes (12)
- Tribes in Other States (28)
- Michigan State Department of Health (2)
- Consulting Firms (2)
- Tribal Consortium (1)

- California Rural Indian Health Board (1)
- The International Association of Chiefs of Police (1)

Model Tribal Isolation and Quarantine Code

None of the twenty-nine tribes in Washington had an isolation and quarantine code prior to 2020. The AIHC developed a comprehensive Model Tribal Communicable Disease Code to address issues specific to tribal jurisdictions (See Appendix D). The code includes a section on the legal mechanisms for implementing isolation and quarantine.

Model Tribal Isolation and Quarantine Code Training

On April17, 2020, AIHC delivered a three-hour training via webinar on the model code. Members of the Washington State Bar Association were eligible for three Continuing Legal Education (CLE) credits. Forty-three (43) participants from Washington State tribes attended. The webinar recording was posted on the AIHC's website and watched by a total of five (5) individuals from tribes in other states.

Request for Isolation and Quarantine Training Webinar from California Rural Indian Health Board (CRIHB)

AIHC received a request from the California Rural Indian Health Board to deliver a training webinar for their member tribes. On April 28, 2020, AIHC delivered a three-hour training webinar on "Isolation and Quarantine on Tribal Lands." (DOH funds were not used for this activity.) Representatives of the Quinault Indian Nation and the Makah Tribe presented on their experiences adapting and adopting the Model Tribal Isolation and Quarantine Plan, identifying and preparing isolation and quarantine facilities for their communities, and challenges enforcing isolation and quarantine on tribal lands.

Lessons Learned and Best Practices

Isolation and Quarantine at Home. Many tribal community homes are multigenerational households. Housing on tribal lands is in short supply. This creates significant challenges for tribes to support their members who need to isolate or quarantine at home. Some tribes made efforts to separate a household if not all members were sick. Other tribes focused on providing households with education, technical support, and resources to maximize infection control and protect non-infected household members. Strategies included assigning the sick household member their own room and bathroom if possible, delivering meals to the sick person's bedroom, special handling of laundry and garbage, and instructions for sanitizing areas of the home. Some tribes reported utilizing their community health representatives (CHRs) to deliver supplies and medications or assist with transportation to medical care. One tribe purchased meals and laundry services at cost from their tribal casino resort for individuals under isolation or quarantine. Tribal isolation and quarantine plans should address how the tribe will provide wraparound services for individuals in isolation or quarantine at home.

Tribal Isolation and Quarantine Facilities. Several tribes stood up isolation and quarantine facilities on tribal lands. These facilities included recreation vehicles (RVs), repurposed administrative buildings or tribal hotels, trailers, tiny homes, and cabins. Tribes acquired cots, hospital beds, and other supplies to set up the facilities. One tribe stood up its quarantine facility early in the pandemic and experienced problems with a quarantined individual who did not comply with requirements and invited visitors to the facility. In addition to creating a safety risk for the exposed individuals and their contacts, the facility was damaged and required repairs. This tribe changed its quarantine strategy to a home-based approach and found it easy to monitor community members' compliance, symptoms, and need for resources through daily check-ins by phone. Another tribe

accessed technical assistance from the Washington State Department of Health and the Army Corps of Engineers and made modifications to a tribal hotel to use as a temporary isolation and quarantine facility. This tribe noted it was important to have a plan for supporting isolation and quarantine housing during the time the tribal facility was being prepared, as the need arose before the facility was ready. To meet this need, the tribe arranged with the neighboring county to provide isolation and quarantine housing to tribal members until the tribal facility was ready. The tribe also offered to provide space in the tribal facility should the county need additional space for county residents.

Tribal Coordination with Local Health Jurisdictions. Some tribes worked with their local health jurisdictions to coordinate access for tribal members at isolation and quarantine facilities managed by the county. Examples of preplanning included: documenting items individuals need to bring, items that are prohibited, process for requesting occupancy, transportation options, etc. Not all tribes have developed processes to facilitate access for tribal members to county facilities. This process is important for tribes to complete and include in their isolation and quarantine plan. Tribes located in geographically isolated areas noted transportation to off-reservation facilities presented a challenge in identifying a transporter and ensuring safety for the driver and individual transported. However, due to the nature of COVID-19, it is essential for individuals to isolate within twenty (20) minutes of a hospital with intensive care facilities and tribes made this proximity a priority.

Recommendations

1. Tribal health authorities and local health jurisdictions should develop processes to facilitate access for tribal community members to county isolation and quarantine facilities and wraparound services.
2. Tribal Isolation and quarantine plans should consider the role community health representatives (CHRs) may serve in supporting isolation or quarantine such as delivery of food, medicines and cleaning supplies.
3. AIHC should provide continued training on isolation and quarantine training and opportunities to share best practices.
4. AIHC should collect existing tribal isolation and quarantine protocols to inform and enhance the AIHC model isolation and quarantine plan.

Section 5: Surveillance

Data sovereignty is foundational to tribal self-governance and self-determination. In a pandemic, access to accurate community-specific data is critical to responding quickly and effectively.

Data Usage and Reporting

Early in Washington's COVID-19 pandemic response, the State Emergency Operations Center (SEOC) collected data on tribal response actions and case numbers from tribal social media sites and published them in the daily Situation Reports (SitReps). Tribal leaders requested these data not be published unless provided and vetted by the tribal governments. A foundational principle of data sovereignty is for tribes to control the use of their data. Much work is needed to develop systems and legal mechanisms to assure the collection and usage of tribal data is conducted in ways that uphold tribal sovereignty.

Data Accuracy

The historical problem of racial misclassification typically results in undercounting of American Indians and Alaska Natives (AI/AN) in state, federal, and local databases. Additional factors hindered surveillance efforts in AI/AN populations and assessing the burden of disease of COVID-19 among AI/AN. Racial data was not collected consistently as part of testing for COVID-19. Additionally, tribal affiliation is not collected and likely should not be collected in state databases due to problems with small numbers. As a result, a tribe of membership is unknown in these databases.

The best source of case numbers for any tribe is the tribal government. Upon reviewing limited state data published during the response, tribal leaders expressed concerns regarding the accuracy of the AI/AN numbers. Tribes proposed the following language to be included with any State of Washington Department of Health information that includes AI/AN data: "Due to significant racial misclassification of AI/AN in state databases and the lack of inclusion of data from tribal, urban Indian and other AI/AN data sources, the accuracy, adequacy, completeness, reliability or usefulness of this information is not assured." Additional funding is needed to develop capability and infrastructure in tribal governments to support assessment functions.

Tribal and Urban Indian Health Program Access to Data

Tribes and urban Indian health programs (UIHPs), as public health entities within the Washington State public health system (Substitute Senate Bill 1497), must have access to public health data. Prior to 2020, tribes and UIHPs in Washington State did not have access to the Washington State Disease Reporting System (WDRS). This system holds information on COVID-19 positive cases and other reportable conditions. Access to the COVID-19 data is critical for tribes to identify COVID-19 cases within their jurisdiction and support case and contact investigations. AIHC worked with DOH to secure access to WDRS for each tribe and UIHP. DOH provided view-only access, limited to COVID-19 data. Tribes, as public health authorities, are interested in accessing all other WDRS data regarding their tribal citizens. AIHC is working with DOH to discuss expanded access and modifications to the WDRS system and the newly created Case, Risk and Exposure Surveillance Tool (CREST) system for case and contact investigations. These efforts must continue to assure tribes and UIHPs have timely access to data.

Recommendations

1. AIHC should continue to support the efforts of the Data Sovereignty Workgroup. The Data Sovereignty Workgroup should work with DOH to modify state health databases to better support the needs of tribal governments and urban Indian health programs.

2. DOH should work with AIHC and the Data Sovereignty Workgroup to build functionality into state databases (WDRS and CREST) to notify tribal government designees when a COVID-19 positive case occurs within a zip code area that includes tribal lands. This will serve as a pilot to determine the applicability of this approach to other reportable conditions and state health databases.

Section 6: Continuity of Operations

Continuity of Operations Strategies

Within one week of Washington State's declaration of emergency, many tribal governments made their own declarations and began limiting workplace attendance. Only essential staff who could not perform work functions from home reported to tribal facilities. Many tribes and UIHPs placed healthcare providers and responders on rotating schedules to prevent burnout. Some tribal and urban clinics expanded their hours of service to seven days per week, with providers working four ten-hour shifts.

Tribes reported significant challenges managing the large volume of information related to the pandemic, staffing numerous critical daily meetings, and keeping up with funding opportunities and reporting requirements. One tribal clinic physician reported in the fourth month of the response that 70% of his time was still spent on COVID-19 related matters. Some tribes reported adopting digital team collaboration platforms, such as Microsoft® Teams during the response.

Tribes and UIHPs have reported burnout, turnover and an increased need for behavioral health care among staff, due to the size, intensity, and gravity of pandemic response work. Tribes and UIHPs provided resources through employee assistance programs (EAPs) and by leveraging their tribal behavioral healthcare programs.

Regional Reliance

"PPE nationally is a mess, and it won't get better anytime soon. In a normal pandemic response, we could look to the CDC. It started out that way but soon went off the rails. We have to substitute the state government for the federal government. We will increasingly regionalize things. This experience emphasizes how we have to depend on each other."

-Tribal Public Health Officer and Physician

Personal Protective Equipment (PPE)

Access to Personal Protective Equipment (PPE). Most tribes and UIHPs did not have a system in place to maintain a current cache of PPE. Tribes and UIHPs had difficulty accessing personal protective equipment (PPE) beginning early January, weeks before the first COVID-19 case in the United States. The second week in February, AIHC worked with Washington State to develop a written process for tribal nations to request resources, including PPE, directly from the state, local health jurisdictions, or from healthcare coalitions (see Appendix N). This document served to inform tribes, as well as responders at the state and local health jurisdictions.

Native Project of Spokane Staff

Initially, tribes and UIHPs were not included in the tier one priority level of the state's system for distribution of PPE. Tribes' and UIHPs' resource requests languished in the state's WebEOC queue, while local health jurisdiction requests were filled. Some tribes were told they were required to request PPE through a county. This was contrary to the official resource request process

document. During the response, the State Emergency Operations Center (SEOC) changed processes and timelines for requesting resources repeatedly. These changes caused frustration and confusion among tribes and counties. In early April, the state acknowledged it had failed to consider several compelling issues, including that tribal communities provide care for elders in very different ways. The state then classified tribes and UIHPs as tier 1 requesters. Following these changes, fulfillment of tribal requests improved in timeliness and completeness.

Not until late May did tribes and UIHPs begin to have access to workable amounts of PPE. Indian Health Service (IHS) provided a limited supply of PPE initially, but quantities were not sufficient and much of what was received was expired and unusable. Some tribes produced homemade masks and gowns for their healthcare providers while waiting for proper PPE. Several tribes shared or traded PPE through the weekly AIHC planning calls.

As of this writing, tribes and UIHPs remain concerned that access to PPE will once again become a serious problem, given the current rise in cases in Washington and nationally. One tribal clinic physician and tribal public health officer stated: "PPE nationally is a mess, and it won't get better anytime soon. In a normal pandemic response, we could look to the CDC. It started out that way but soon went off the rails. We have to substitute the state government for the federal government. We will increasingly regionalize things. This experience emphasizes how we have to depend on each other."

Workplace Infection Control

Tribes and UIHPs quickly instituted measures to protect employees, patients, and service recipients, including:

- using separate entrances for individuals who may be contagious
- scheduling patients who may be contagious at the end of the day
- modifying workspaces to allow for physical distancing
- installing desk shields
- installing no-touch door opening and other touchless services
- providing services in the parking lot with patients or clients in their cars
- cleaning every two hours
- creating separate rooms for telehealth patients who need access to technology
- hiring deep cleaning contractors
- implementing face covering policies for employees and visitors
- installing thermal cameras

Native Project of Spokane Deep Cleaning

Access to cleaning supplies, including sanitizing wipes, has been very limited for tribes throughout the response and remains a challenge. Some tribal casinos and other enterprises helped by providing supplies to tribal government entities until they depleted their stock.

Continuing Delivery of Healthcare Services During the COVID-19 Pandemic

Continuing Delivery of Primary Care and Behavioral Health. All tribal and urban Indian health programs

remained in operation throughout the pandemic. The quick adoption of telehealth services was perhaps the greatest factor that allowed tribes and UIHPs to continue providing critical healthcare services. The Washington State Health Care Authority (HCA) coordinated with tribes to provide thousands of laptops and cell phones for clinics and their patients to have access to technology. Some tribal citizens live in areas with no access to cell phone service or broadband. However, the HCA's devices allowed access to care to many who would have otherwise gone without or would have had to risk exposure by going in person to a facility. Indian healthcare providers reported significant improvement in their no-show rates, as a result of telehealth.

Other practices implemented by Indian healthcare providers to continue delivering care include:

- expanding services to seven days a week
- reducing the number of participants in group therapy visits
- separating visits into morning well visits and afternoon sick visits
- setting up a tent to treat sick patients
- setting up a mobile unit to provide mobile medical visits for elders
- setting up a Saturday pediatric clinic (see below)
- standing up an alternate care site
- instituting daily check-ins with behavioral health patients who may be at risk for relapse
- providing patients with at-home blood pressure and glucose monitoring kits
- providing home delivery of prescription medications by tribal community health representatives (CHRs)
- setting up drive through pharmacies
- purchasing phone cards for behavioral health services
- distributing phones for telehealth patients
- installing Wifi hotspots

Seattle Indian Health Board Staff Social Distancing

Many Indian healthcare providers reported that patients needing care avoided visiting the tribal or UIHP clinic and other healthcare facilities. These patients went for long periods of time without important screenings and other preventive care services such as regularly monitoring Hemoglobin A1c (HbA1c). Many children and adults fell behind on recommended immunizations and other preventive screenings such as mammograms and colonoscopies. One tribal representative noted, "We need more resources to highlight the importance of going to the hospital or clinic when you need attention."

Dental Clinic Closures. Due to the nature of dental care, tribal and UIHP dental clinics closed soon after the state declaration of emergency and provided only emergency services to patients. Although some started offering care again, as of this writing, many still cannot resume operations. It has been difficult or impossible to acquire essential infection control supplies and PPE. Items noted to be especially scarce include: extraoral suction systems, HEPA filters, aerosol injector equipment, and N95 respirators.

Challenges to Delivering Healthcare Services During a Pandemic:

- increased relapses in behavioral health patients
- decrease in immunization rates
- decrease in rates of gender and age-appropriate screenings
- decrease in maintenance care visits by people with chronic condition
- lack of face-to-face care/groups for behavioral health patients
- limited access to dental care
- lack of broadband access to access telehealth
- patients' lack of devices to access telehealth

Recommendations

1. AIHC should develop model patient outreach and education on the importance of not delaying preventive and chronic disease care.
2. AIHC and DOH should develop telehealth best practices and staff training.
3. AIHC should continue to support efforts to expand broadband access on tribal lands.
4. AIHC should continue to facilitate tribal workgroups to help facilitate the completion of grant funding applications and federal disaster reimbursement requirements.
5. AIHC should update model plans to address telecommuting.
6. AIHC should develop model systems for tribes to maintain a current cache of PPE.

SUCCESS STORY

The Seattle Indian Health Board (SIHB) had great success implementing a Saturday pediatric clinic. As COVID-19 case numbers surged in King County, SIHB recognized their pediatric relatives (patients) and pregnant relatives had ongoing critical needs for routine care, including immunizations and prenatal checks. SIHB clinical teams quickly mobilized to open Saturdays exclusively for well-child visits and prenatal care. Clinics were staffed by residents, medical providers, dental providers, case managers and WIC. Without these clinics, many children would have fallen dangerously behind in critical preventive services and pregnant women and their babies would have been at higher risk for poor outcomes.

Section 7: Intertribal and Cross Jurisdictional Coordination

Intertribal Mutual Support and Coordination

The American Indian Health Commission for Washington State (AIHC) facilitated weekly response planning webinar meetings for the twenty-nine tribes and two urban Indian health programs of Washington State, beginning March 19. The meetings were designed as a forum to:

1) Identify tribes' and UIHPs' unmet needs;
2) Provide an update on their COVID-19 response; and
3) Share lessons learned, best practices and provide mutual aid.

> "We lost our emergency management person. If not for the collaboration with the Commission, this would not have gone as smoothly. The AIHC has been a huge help to have one place to go for resources."
>
> -Tribal Health Director

Despite the sizable workload and time demands facing tribal leaders and staff, attendance at these weekly meetings remained between forty-five and sixty participants each week. During these calls, tribes and UIHPs shared best practices and traded resources with other tribes such as personal protective equipment. One tribal health clinic director stated, "We lost our emergency management person. If not for the collaboration with the Commission, this would not have gone as smoothly. The AIHC has been a huge help to have one place to go for resources."

Coordination Between Washington State and Tribes and UIHPs

Tribal Liaison Officer Position. AIHC staffed the Tribal Liaison Officer (TLOFR) position within the state's Incident Command structure during the COVID-19 response. The TLOFR position was created in 2016, during a measles outbreak to improve coordination between the state's response and tribes and UIHPs. Having the position staffed by the AIHC is critical, since the Commission is governed by the twenty-nine tribes and two UIHPs.

Through the Commission, the TLOFR has quick access to tribal leaders and key staff. Participating within the state's Incident Command structure allows the TLOFR to assure tribes' interests are considered during response activities and provides the tribes and UIHPs with timely information and opportunities to engage.

The Washington State Department of Health (DOH) Incident Commanders provided respectful and responsive access to the TLOFR position throughout the response. This access assured enhanced communication and coordination between the state's response efforts and tribes and urban Indian health programs.

Washington State Department of Health. The DOH has been an invaluable partner to tribes and UIHPs during the COVID-19 response. On February 19, at the request of the TLOFR, Kathy Lofy, MD the State Health Officer and Scott Lindquist, MD, MPH, State Epidemiologist for Communicable Diseases, met with tribes and UIHPs to discuss the unfolding spread of COVID-19 and the expected path forward. This meeting, early in the pandemic, was an important demonstration of government-to-government partnership and respect.

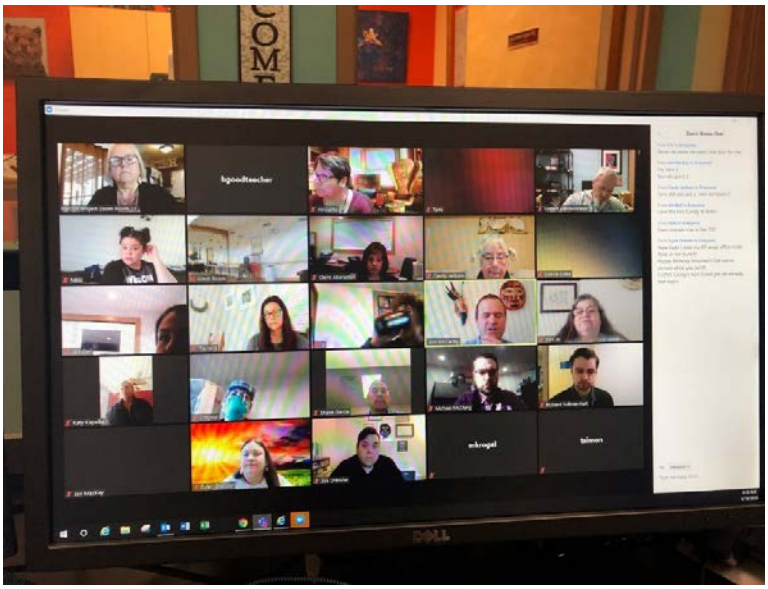
During the response, subject matter experts from DOH worked with the TLOFR to develop and present webinar workshops for tribes and UIHPs on key response capabilities, including case investigations and contact tracing and drive-through testing. DOH strike teams provided technical assistance to tribes in standing up isolation and quarantine facilities, and the Office of Communicable Disease Epidemiology worked with AIHC to

provide access to state databases to tribes and UIHPs.

Weekly State Agency Tribal Liaison Meetings. AIHC, in collaboration with the Governor's Office of Indian Affairs (GOIA), established weekly online meetings between the state agency tribal liaisons and tribes and UIHPs, beginning March 23. The purpose of these meetings was to provide a forum for state agency tribal liaisons to update tribes on their agencies' status of operations and resources available to tribes and UIHPs during the pandemic. The meetings were also intended for tribes to report unmet needs and challenges.

The following state agencies were in regular attendance:

- Department of Commerce
- Health Care Authority
- Department of Transportation
- Department of Agriculture
- Department of Health
- Department of Social and Health Services
- Department of Financial Institutions
- Office of the Insurance Commissioner
- Office of Minority and Women's Business Enterprises
- Department of Agriculture
- Department of Natural Resources
- Emergency Management Department
- Department of Corrections
- Department of Ecology
- Washington State Gambling Commission
- Liquor and Cannabis Board
- Office of the Attorney General
- Department of Labor and Industries
- Department of Children, Youth, and Family Services
- United States Substance Abuse and Mental Health Services Administration (SAMHSA)



Native Project of Spokane Online Meeting

The state agency tribal liaison meetings have expedited solutions to various challenges during the pandemic. For example, one tribe reported challenges preventing tourists and other visitors from entering reservation boundaries during lockdown and stay-at-home orders. The Washington Department of Transportation was able to immediately coordinate with the tribe and provide signage and barricades. Tribes reported many food insecurity challenges, and AIHC coordinated with the Washington State Department of Agriculture to develop strategies for addressing these. One tribe reported that lack of internet access was a crippling barrier to the tribe's governmental response and to tribal citizens, excluding them from telehealth services, schooling, and other internet-based resources. The Department of Commerce quickly responded to this need. A microwave internet access project is underway as of this writing, to be completed in the coming weeks. This is a problem

the tribe had tried to solve for decades.

While Washington State has been a leading example of tribal-state coordination in a pandemic response, Marilyn Scott, Vice Chair of the Upper Skagit Tribe emphasized the importance of not waiting until a crisis occurs to respond to the critical needs of the tribes: "We should not have to wait until a pandemic happens to make important changes. Tribes can submit reports and make requests in meetings, but unless the State comes to our reservation, we are not likely to see the State take action. It takes someone willing to see and listen to make changes happen." The meetings between state agency tribal liaisons and tribal leaders and staff should continue throughout and after this response.

Coordination Between Local Health Jurisdictions and Tribes

AIHC conducted webinar-based regional coordination and planning meetings with eight of the nine regions in the state. The meeting for Region 8 was postponed due to a dramatic surge of COVID-19 cases in Yakima County. Meeting objectives were:

1) Review lessons learned thus far from the COVID-19 response;
2) Share each jurisdiction's plans for the response going forward; and
3) Identify opportunities for collaboration across jurisdictions on response activities.

> "Having them [the tribe] do our contact tracing has been a life saver."
>
> -Local health jurisdiction representative

Positive working relationships between tribes and local health jurisdictions built over the years and through regional cross-jurisdictional planning meetings facilitated by the AIHC had a significant positive impact on the COVID-19 response. Most tribes reported they coordinated with their neighboring local health jurisdictions on activities including accessing PPE, drive-through testing, case and contact investigations, and isolation and quarantine. Many tribes were able not only to receive support from local health jurisdictions, but also to provide support to local health jurisdictions. A local health jurisdiction representative shared that "having them [the tribe] do our contact tracing has been a life saver." A tribal representative commented that "other jurisdictions have realized what a partner they can have in the tribe. It feels like there has been a change from previous years."

A small number of regions reported a lack of coordination between the tribes and local health jurisdictions. Some local health jurisdictions reported that no one from their staff had reached out or coordinated with the tribe in their region. Almost all local health jurisdictions reported they could have done more to include tribal public health officers in the response.

During the regional meetings, tribes and local health jurisdictions shared best practices, including:

- Standing up a unified command with tribe and county representatives
- Having strong prior relationships and trust with other jurisdictions and establishing relationships early on in the response. As one local health jurisdiction staff member stated, "We realized early on we can't do this by ourselves. A lot of people stepped up to help. We learned to accept help."
- Holding weekly cross-jurisdictional coordination meetings between tribes and local health jurisdictions
- Coordinating local health jurisdiction and tribal public health messaging
- Coordinating tribe and local health ordering of resources and supplies
- Daily sharing of situation reports

- Establishing agreements and processes between tribe and local hospital for the hospital to notify the tribe when individuals from the reservation test positive
- Activating the Mutual Aid Agreement for Tribes and Local Health Jurisdictions in Washington State

Recommendations

1. AIHC should facilitate a workgroup for tribal public health officers in Washington to build additional capability among tribal public health entities.
2. AIHC should continue to provide technical assistance to assure that the state and all local health jurisdiction communicable disease emergency plans recognize tribal public health officers and tribal public health departments.
3. AIHC should facilitate monthly meetings for each of the nine (9) regions to share updates and public health emergency response resources and maintain strong working relationships between local health jurisdictions and tribes.
4. AIHC should draft a model agreement between a hospital and a tribe for the hospital to notify the tribe when individuals who reside on tribal lands test positive for COVID-19 and other notifiable conditions.
5. AIHC should continue to maintain the nine regional document share sites.
6. AIHC should facilitate a process for local health jurisdictions and tribes to share and discuss after action reports (AARs) in each region.
7. Local health jurisdictions should invite tribes to serve on their incident command structure and other public health emergency response teams.
8. Local health jurisdictions should incorporate the AIHC's proposed wording to address coordination with tribes in their communicable disease response plans (See Appendix L).
9. DOH should incorporate the AIHC's proposed wording to address coordination with tribes in their communicable disease response plans (See Appendix K).
10. DOH should modify WDRS and CREST to include functionality that notifies tribes of cases within their communities and provides tribal users the ability to note whether the tribe will conduct case and contact investigations or delegate them to the local health jurisdiction.
11. AIHC, in coordination with tribes and DOH, should develop suggested policies and procedures for local health jurisdictions to coordinate with tribes on case and contact investigations. This includes a policy that tribes shall be the decisionmakers as to which jurisdiction conducts case investigations and contact tracing for individuals who live on tribal lands and individuals who receive care from a tribal clinic.
12. DOH should finalize their tribal medical countermeasures coordination guidance within Annex 9.
13. AIHC should maintain and expand its broad range of online resources to continue serving as a hub for tribes and UIHPs for resources on communicable disease emergency response and COVID-19.
14. The AIHC, in coordination with the Governor's Office of Indian Affairs, should continue conducting regular state agency tribal liaison meetings throughout the pandemic response and after.
15. AIHC should conduct a hotwash of the COVID-19 response to identify systemic problems that hinder tribes' response efforts and an assessment of how various local, state, and federal entities support tribes during responses.
16. The State Emergency Management Division (EMD) and DOH should include the role of the AIHC TLOFR within their emergency response plans.

17. Counties and local health jurisdictions should update their emergency response plans to address early inclusion of tribes on their emergency response teams and meetings.
18. AIHC should create an Emergency Response Plan that defines the operations of the AIHC during a public health emergency that impacts multiple tribes and Indian health care providers. This plan should formalize the practices developed during the COVID-19 response. The AIHC should seek approval of the Governor's Advisory Health Council for the plan. State and local jurisdictions should incorporate the function of the AIHC into their emergency plans.

APPENDICES

A. Model Tribal Emergency Communicable Disease Emergency Response Plan
B. Model Tribal Isolation and Quarantine Plan
C. Model Tribal Communicable Disease Code
D. Model Tribal Stay-at-Home Order
E. Proposed Wording for Washington State DOH Communicable Disease Emergency Response Plan
F. Proposed Wording for Local Health Jurisdiction Communicable Disease Emergency Response Plan
G. Model Resolution for Tribal Declaration of Emergency
H. Summary of Recommendations