American Indian Health Commission
2026 Novel Bird Influenza Tabletop Exercise: After-Action Report



American Indian Health Commission

2026 Novel Bird Influenza Tabletop Exercise

After-Action Report

Report Contributors:

Jessica McKee, PhD, MPH

Tribal Public Health Programs Administrator

Heather Erb, JD

Lead Policy Advisor

Contact the American Indian Health Commission:

info@aihc-wa.com

https://aihc-wa.com

PO BOX 483, Port Angeles, WA 98362

Table of Contents

ACKNOWLEGMENTS 4

TRIBES AND NOTIFIABLE CONDITIONS 5

AMERICAN INDIAN HEALTH COMMISSION NOVEL BIRD INFLUENZA TABLETOP EXERCISE 7

KEY FINDINGS 10

RECOMMENDATIONS 14

NEXT STEPS – AMERICAN INDIAN HEALTH COMMISSION 18

APPENDIX A – IMPROVEMENT PLAN 19

APPENDIX B – TABLETOP EXERCISE SLIDES 26

ABOUT AMERICAN INDIAN HEALTH COMMISSION 45

American Indian Health Commission

2026 Novel Bird Influenza Tabletop Exercise

ACKNOWLEGMENTS

The American Indian Health Commission wishes to thank and acknowledge the individuals who participated in this exercise and who dedicate their life's work to protecting the health and safety of our communities.

Aimee McKinney
Alex Dingess
Amanda Tjemsland
Amber Arndt
Andy Wilson
Angel Cortez
Angela Bennet
Apple Martine
Barbra Villona, MD
Carrie Parker
Cartina Gonzalez
Chelsea Krouse
Dana Roberts
Daphne Devlin
Dave Atteberry, MD
Dylan Dressler
Eli Owens
Eric Brooks
Frank James, MD
Gabby Hadly
Heather Hill
Hollianne Bruce
Hope Clark
Jaime Bodden
James Lewis, MD
Jay Miller
Jeff Hodson
Jennifer Reid
Jennifer Repin
Jenny Oppelt
Jessica Pankey
Juan Gutierrez, Jr.
Katie Curtis
Kelly Guy
Kim Van Pelt
Kristin Peterson
Lara Cittadini
Lara Gaasland-Tatro
Liz Henry
Mary Hardison
Matthew Feist
Megan Roorda
Melissa Sixberry
Michelle Campbell
Nate Weed
Ocean Mason
Sephora Privat
Sherman Pruitt
Stacey Anderson
Steve Kutz
Takiah Lamebull
Tom Locke, MD
Tom Schemm
Tori Ball
Vivan Hawkins

TRIBES AND NOTIFIABLE CONDITIONS

Current Notification Landscape

Communicable diseases do not obey jurisdictional boundaries. Successful collaboration across the twenty-nine (29) Tribes, thirty-five (35) local health jurisdictions (LHJs), and the Washington State Department of Health (DOH) is vital to the prevention and control of communicable diseases. Effective public health prevention and outbreak response efforts require that public health authorities respond quickly to minimize the spread of communicable diseases.

In Washington state, health care providers, health care facilities, laboratories, food service establishments, child day care facilities, and schools are legally required to notify public health authorities at their LHJ of suspected or confirmed cases of notifiable conditions under WAC 264-101. Once notified, the LHJ adds the case to the Washington Disease Reporting System (WDRS), the state's electronic disease surveillance system that allows public health staff in Washington State to enter, receive, manage, process, track, and analyze disease-related data. Reporting under WAC 246-101 is determined by location of residence. Then, based on the zip code of the patient, LHJs are assigned to conduct any necessary case and contact investigation for cases within their county.

Unfortunately, the WDRS does not allow more than one "owner" of a case which, by default, is the LHJ and there is no requirement that cases who have identified as Tribal members, or who reside on Tribal land, be reported to the Tribe. This gap in the notification process poses a significant and ongoing threat to the health and safety of the public. Additionally, Tribes do not have read/write access to the WRDS to add and manage cases for Tribal members or those who reside on Tribal land. This issue was noted during the COVID-19 After-Action Reports when Tribes reported their medical staff having to work after-hours to fax test results and cases to LHJs, who then input the information in the WDRS, essentially doubling the work. The monetary investment required to modernize data systems is significant and, in the current political environment, unlikely to happen soon. A new process is needed to ensure that cases are reported to Tribes so they can take the appropriate next steps until such a time as a notifiable conditions system can be built to include them.

Tribal Public Health Authority

In Washington, Tribes are recognized as part of the governmental public health system under RCW 43.70.512. Public health authorities are responsible for protecting their communities from disease, and timely notification allows public health officials to get

ahead of outbreaks and minimize spread. Timely reporting of notifiable conditions is crucial for the control of infectious disease, and this is only possible when the jurisdiction where the patient resides is notified.

Systemic barriers to Tribes' ability to access the systems, which are responsible for notifying public health authorities of instances of notifiable conditions within their jurisdiction, put everyone at risk. Tribes must be granted data access that is, at the very least, equitable to the access granted to local health jurisdictions. To date, there is no consensus for guaranteeing that Tribal public health authorities are notified when cases that involve someone resides within a Tribe’s jurisdiction are reported to the WDRS.

AMERICAN INDIAN HEALTH COMMISSION
NOVEL BIRD INFLUENZA TABLETOP EXERCISE

The American Indian Health Commission (AIHC) receives Foundational Public Health Services (FPHS) funding to complete foundational public health work. Work is approved during a Tribal Consultation as part of the FPHS concurrence process. This approved scope of work includes public health emergency preparedness activities, such as regional meetings, creating model codes and plans, training, and exercises. Recent events, such as COVID-19, MPOX, novel bird influenza, and Marburg virus have highlighted the lack in notification to Tribes. Despite attempted legislative fixes, there remains no formal path for reporting infectious disease cases to Tribes. The goal of this exercise is to highlight the importance of all public health authorities who have jurisdiction over people in their lands being informed of notifiable conditions impacting their people.

Objectives of the 2026 Novel Bird Influenza Tabletop were to:

- Clarify legal authorities including emergency powers, reporting requirements, and response roles;
- Assess ability to effectively coordinate novel bird influenza outbreak across Tribal and non-Tribal jurisdictions;
- Identify strengths and areas for improvement;
- Identify potential legal issues;
- Identify gaps in policy; and
- Assess resource- and information-sharing between Tribal and non-Tribal jurisdictions.

Outreach and Engagement

At AIHC's public health and emergency preparedness meetings the exercise was briefly described, and calendar invites were sent with a focus on inviting AIHC Delegates, emergency managers, and public health and clinic staff. AIHC encouraged recipients to share the event with anyone in the Tribe who should be included. Tribal participants included Tribal Chairs, AIHC Delegates, Health Directors, Heath Officers, Medical Directors, Emergency Managers, Clinic Managers, Public Health Officers, Public Health Emergency Coordinators, Emergency Managers, and Public Health Coordinators.

AIHC worked with the Washington State Association of Local Public Health Officials (WSALPHO) to identify a range of local health jurisdictions (LHJs) to invite to participate, including LHJs from each region of Washington State and of various sizes. WSALHPO assisted in sending calendar invites to participating LHJs and encouraged recipients to

share the event with anyone within their organization who should be included. Local health jurisdiction participants included Public Health Officers, Health Department Administrators/Directors, Public Health Emergency Response Staff, Local Emergency Response Coordinators, and the Director of WSALPHO.

AIHC worked with the DOH Office of Tribal Public Health and Relations to identify key policy staff and those who oversee programs directly related to notifiable conditions reporting or outbreak response. Participants from DOH included the Chief of Policy, Chief of Resilience, State Public Health Officer, Chief Data Officer, and Tribal Policy Director.

Participants by Breakout Room

Room 1: Region 1

Tribes: Lummi, Sauk-Suiattle, Samish, Swinomish, and Tulalip (8 participants)

Counties: Skagit and Snohomish (10 participants)

DOH: (1 participant)

Room 2: Region 2

Tribes: Jamestown S'Klallam, Suquamish (2 participants)

Counties: Clallam and Jefferson (10 participants)

DOH: (1 participant)

Room 3: Regions 3, 5, and 6

Tribes: Squaxin Island, Chehalis, and Snoqualmie (3 participants)

Counties: Thurston and Pierce (2 participants)

DOH: (1 participant)

Room 4: Regions 4, 7, 8 and 9

Tribes: Cowlitz, Yakama, and Kalispel (4 participants)

Counties: Yakima and Benton-Franklin (6 participants)

DOH: (2 participants)

WSALPHO: (1 participant)

The NATIVE Project: (1 participant)

Assumptions

Assumptions for the exercise were:

1. The purpose of the exercise was to identify gaps and vulnerabilities;
2. No jurisdiction is fully prepared for this type of public health emergency;
3. Open, honest, and respectful dialogue and feedback are expected and valued throughout the exercise; and
4. The exercise, discussions, and findings will inform future preparedness planning and actions.

Scenario

The exercise built on a local incidence of novel bird influenza and as the exercise progressed, questions were posed to encourage discussion among participants within their breakout rooms.

The exercise scenario began with a patient presenting to a local hospital emergency room with shortness of breath and other symptoms common for respiratory illnesses. Hospital staff collected and sent samples from the patient to the public health laboratory. A day later the test results return positive for a strain of the novel bird influenza. The scenario progresses over a two-week timeline. See tabletop exercise slides attached in **APPENDIX B.**

Questions

Each "day" of the scenario timeline was paired with "discussion" prompts related to legal authorities, reporting requirements, response roles, communications, coordination, and resource sharing. The questions asked in their respective place in the tabletop exercise are detailed in the slides attached in **APPENDIX B.**

KEY FINDINGS

This tabletop exercise provided opportunities for new and strengthened relationships between individuals and entities that will need to work closely in public health emergencies. It established a path forward to improve the public health response around notifiable conditions in Washington.

The following are key findings from the tabletop exercise:

1. **No clear communication pathway.** Participants noted no clear communications pathway to report notifiable conditions impacting individuals residing within Tribal jurisdictions. In most discussions, there was not a clear point of contact at the Tribe for notifications.

    a. Participants in some counties reported that if there was a positive case, and that person identifies as a Tribal member, said individual would reach out to the Tribe. It was not clear whether some counties would report if the individual was not a Tribal member.

    b. Others assumed that the Department of Health would notify the Tribe.

    c. The Yellow Book maintained by the Department of Health was discussed but the Tribal contact updates have not been consistent.

    d. Participants also noted that many Tribes do not have 24/7 staff available to contact should a positive test result come in on the evening or weekend, save for law enforcement.

2. **Need for increased information sharing between Tribal and local health jurisdictions.** Participants had different understandings of what information could be shared between Tribal and local health jurisdictions.

    a. A Tribal health officer noted that Tribes' access to both clinical and medical records makes them strong partners in response efforts.

    b. Some local health jurisdictions suggested they would be hesitant to share certain information with Tribes because of the Health Insurance Portability and Accountability Act (HIPAA) and raised questions about disclosure of Tribal membership and cases involving non-Tribal members residing on Tribal lands.

3. **Tribes lack access to WDRS.** Tribes are still lacking access to the Washington Disease Reporting System (WDRS).

    a. This was a major barrier during the COVID-19 pandemic. It created double the work for both Tribes and the LHJs because Tribal staff were having to send case

information to LHJs to be uploaded to WDRS rather than uploading information directly.

b. DOH requires a signed Data Sharing Agreement (DSA) for read/write access to WDRS.

c. At the time of this exercise, only one Tribe had completed the DSA process.

4. **Significant staff turnover.** There has been significant staff turnover in response roles at Tribes, LHJs, and DOH since the COVID-19 pandemic. This has led to a loss of historic knowledge regarding roles and responsibilities, as well as issues related to jurisdiction.

   a. Continued training exercises are needed to ensure that cross-jurisdictional collaboration in emergencies is smooth and that response relationships are strong.

   b. Staff turnover is a particularly salient concern as several jurisdictions in Washington have signed a Mutual Aid Agreement, setting up a framework for them to help one another during emergencies, but new staff were not familiar with the agreements.

4. **Greater awareness needed about Tribal sovereignty and jurisdiction.** Many participants had little to no experience working with Tribes and therefore did not have a good understanding of Tribal sovereignty.

   a. Tribal participants noted that most Tribes have designated health officers and emphasized the value of standardizing notification processes, while acknowledging the complexity of Tribes having both political and medical leadership structures. Tribes may require notification to council and/clinic.

   b. Some participants shared that they are not located near a Tribe but were eager to learn about the best ways to work with Tribes.

   c. Other staff were new and had not had the opportunity to work with a Tribe during an emergency, and thus, were unfamiliar with Tribal sovereignty and jurisdiction.

   d. A common quote working in Indian Country came up in the hotwash to help DOH and LHJ staff understand how unique each Tribe is. “If you have worked with one Tribe, you have worked with one Tribe.”

   e. Training for staff at all levels of governmental public health regarding these topics is needed.

5. **Cross-jurisdictional coordination and collaborations are key.** Participants noted that cross-jurisdictional collaboration and opportunities to learn together are more important than ever.

a. Participants also noted that opportunities to work together in person should be prioritized because relationships need to be built before emergencies occur.

b. A local health jurisdiction noted that maintaining close coordination and early communication, including coordination with county and Tribal communications teams, helps reduce the spread of misinformation.

6. **Gaps in distribution of information identified.** Local health jurisdictions identified that Indian health care providers may not be included in their distribution lists for local provider alerts in their counties.

7. **Better understanding needed for response roles and responsibilities.** With staff turnover at all levels of government following the COVID-19 pandemic, participants agreed there were opportunities to better understand response roles and responsibilities both internally as well as the response roles and responsibilities at various agencies and levels of government.

8. **Experienced Tribal staff shared valuable lessons learned during COVID-19 pandemic.** Tribes who retained staff following COVID-19 gave more detail into clinical infection prevention and control procedures to implement in clinics, case and contact investigation, as well as preparedness to order and distribute medical countermeasures during the exercise compared to those who experienced staff turnover.

9. **Call for increased seasonal influenza vaccination.** Participants consistently included increased seasonal influenza vaccination as part of their plan following the community exposures, even if the jurisdictions were not the ones doing the vaccinating.

10. **Call for regular meetings between LHJs and Tribes.** Regular meetings between LHJs and Tribal health jurisdictions were identified as helpful to strengthen relationships, build a better understanding of Tribal sovereignty, and develop clearer response plans, roles, and responsibilities.

11. **Clarity needed on roles of WDFW, WSDA, and USDA.** Participants agreed that it was unclear what roles and responsibilities Washington Department of Fish and Wildlife (WDFW), Washington State Department of Agriculture (WSDA), and United States Department of Agriculture (USDA) would serve amid a public health emergency.

    a. Both Tribal and local health jurisdictions discussed when, within the scenario, it would be appropriate to notify said agencies of sick/dead birds.

    b. Understanding varied across breakout rooms/regions.

12. **Need for clarity regarding "full activation" vs. "readiness group".** The exercise revealed that there were inconsistencies as to progressing from a readiness group to full activation.

a. Participants were comfortable moving to a readiness group as the situation evolved but when there was uncertainty around human-to-human spread.

b. Participants were unclear what response posture other levels of government would be in or what would need to occur for all levels of government to be in active response.

13. **Call for increased awareness of Mutual Aid Agreements.** Since Mutual Aid Agreement work occurred before the COVID-19 pandemic and, considering significant staff turnover following COVID-19, few participants were familiar with Mutual Aid Agreements during the exercise.

RECOMMENDATIONS

Centers for Disease Control and Prevention (CDC) and Indian Health Services (IHS)

1. CDC and IHS should support evidence-based vaccine recommendations, including those for seasonal influenza.

    a. High vaccination rates of the seasonal influenza vaccine minimize the risk of co-infection with novel bird influenza and seasonal influenza strains. Co-infection creates opportunities for bird influenza to mutate and potentially become spreadable from person to person.

    b. Higher vaccination rates also lighten the load on health professionals across LHJs and Tribes in the event of a novel bird influenza exposure incident.

2. The CDC should develop and distribute a standardized template for assessing suspected cases of novel bird influenza.

Administration for Strategic Preparedness and Response (ASPR)

1. ASPR should support evidence-based seasonal influenza vaccination efforts as part of their pandemic and respiratory disease planning. Maintaining high rates of seasonal influenza vaccination would reduce the stress on the healthcare system should exposure to novel bird influenza occur.

Washington State Department of Health (DOH)

1. DOH should continue to support opportunities for DOH Office of Resilience and Health Security and Office of Tribal Public Health and Relations staff; local health jurisdictions; Tribes; healthcare coalitions; and other key preparedness partners to meet in person.

2. DOH should establish and maintain a notifiable conditions workgroup to:

    a. Identify and maintain a reliable pathway for reporting notifiable conditions cases to Tribes when there are positive cases in Tribal jurisdictions;

    b. Review and update their notifiable conditions policies and procedures to ensure that notifiable conditions cases are reported to Tribes; and

    c. Evaluate whether a standardized template for assessing suspected novel influenza cases exists and guarantee local and Tribal public health staff are aware of the resource so it can be shared with providers and included in planning documents.

3. DOH should prioritize meeting with Tribes one-on-one to:

    a. Discuss the DSA requirement to access their data systems; and

b. Identify any barriers or issues that may be preventing Tribes from signing a DSA.

4. DOH should share information with Tribal health jurisdictions on the same basis they share information with other state and local health jurisdictions since HIPAA includes Tribes among the public health authorities who can receive "protected health information without authorization…" for the purpose of preventing or controlling disease, injury, or disability." See 45 C.F.R. § 164.512(b)(1)(i) and 45 C.F.R. § 164.501. See also "Public Health Data Exchange between Tribal, Federal, State, and Local Jurisdictions: A Legal Overview."

5. DOH should not limit the share of information based on the Tribal status of the individual. Washington's notifiable conditions reporting is not based on the race or political status of the individual but upon where the patient resides. See WAC HIPAA does not require such a limitation. See Chapter 246-101 WAC.

6. DOH should review and update Appendix 4 – Pandemic Influenza and Viral Respiratory Disease Plan to:

   a. Ensure that notifiable conditions are reported to Tribes.

   b. Include assumptions around activation and readiness levels. For example, if there is no human-to-human transmission and no request from locals, DOH would remain in readiness group.

   c. DOH should also indicate what factors would contribute to full activation.

7. DOH should collaborate with the AIHC to:

   a. Develop a solution that provides Tribes and local health jurisdictions with current/accurate contact information for individuals with key roles during responses.

      i. A single, official point of access restricted to authorized users is preferred.

      ii. Solution may include changes to how the Yellow Book is managed.

   b. Continue its work with the Tribes and LHJs to ensure that Tamiflu is well stocked in the Logistics Center for distribution.

Local Health Jurisdictions

1. LHJs should continue to reach out to Tribes and participate in opportunities to collaborate with Tribes on public health matters.

2. LHJs should share information with Tribal health jurisdictions on the same basis they share information with other local health jurisdictions since HIPAA includes Tribes

among the public health authorities who can receive "protected health information without authorization" for the purpose of preventing or controlling disease, injury, or disability." See 45 C.F.R. § 164.512(b)(1)(i) and 45 C.F.R. § 164.501.

3. LHJs should not limit the share of information based on the Tribal status of the individual. Washington's notifiable conditions reporting is not based on the race or political status of the individual but upon where the patient resides. See WAC HIPAA does not require such a limitation. See Chapter 246-101 WAC.

4. LHJs should coordinate with Tribes to amend their communicable disease/pandemic planning documents and identify processes for reporting to Tribes during case and contact investigations.

5. Communicate with the Tribes, and other partners in their region, to develop plans that clearly outline processes for:

    a. Including Tribes in communication, decision-making, and coordination of response actions during response efforts; and

    b. Coordinating unified public messaging.

6. Ensure leadership and response staff have a good understanding of Tribal sovereignty, authority, and jurisdiction. The AIHC provides training in this regard, however local health jurisdictions should be made aware that state agencies often receive priority on the training schedule, so it is recommended to request training as soon as possible. Possible resources include the Washington Department of Health guidance, "Understanding Washington's Public Health System."

7. Update provider alert contact lists to include healthcare providers at Tribes and nearby Urban Indian Health Programs.

8. Build relationships, at the leadership level, with the clinical director and/or public health officer at nearby Tribes.

Tribes

1. Tribes should engage, or continue to coordinate, with LHJs and other relevant partners to:

    a. Participate in opportunities to collaborate on public health matters.

    b. Develop processes to ensure that notifiable conditions impacting Tribal members or on Tribal land have been reported to the Tribe.

    c. Engage in planning around case and contact investigation. Tribes have the authority to order isolation and quarantine on Tribal land. During the COVID-19 pandemic

many Tribes reported it was more effective to do their own case and contact investigation.

d. Develop plans that clearly outline processes for including Tribes in communication, decision-making, and coordination of response actions during responses.

e. Develop plans that clearly outline processes for coordinating unified public messaging.

2. Tribes should develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care. This will guide their operations and support their ability to continue serving their patient population during most public health incidents.

3. Tribes, if they haven't already, should explore the possibility of registering with state to obtain access to the state laboratory ordering system.

4. Tribes should work to ensure that they can quickly assess Tamiflu stock available to them within the Tribe and discuss the possibility of maintaining a small stockpile if they do not already.

NEXT STEPS – AMERICAN INDIAN HEALTH COMMISSION

1. AIHC will continue to support and facilitate opportunities for Tribes and LHJs to collaborate on notifiable conditions and other public health matters.

2. AIHC will continue to collaborate with the DOH by:

    a. Participating in the Notifiable Conditions Workgroup and helping to identify paths for reporting notifiable conditions to Tribes.

    b. Developing a solution for providing Tribal and local health jurisdictions with current and accurate contact information for individuals with key roles during responses.

3. The AIHC will seek funding to:

    a. Assist local health jurisdictions in amending their communicable disease/pandemic planning documents to clearly address processes for reporting notifiable conditions to Tribes.

    b. Assist the nine (9) public health emergency planning regions in engaging Tribal and local health jurisdictions to develop plans that clearly outline processes for including Tribes in communication, decision-making, public information messaging, and coordination of response actions.

    c. Update model communicable disease plans/codes developed before COVID-19 to assist Tribes in their planning.

    d. Assist Tribal clinics in developing Continuity of Operations Plans (COOPs) and Crisis Standards of Care to clearly guide their operations during a public health incident.

4. To build on the progress made by this tabletop exercise, the AIHC will:

    a. Plan a larger version of this exercise and include more partners;

    b. Plan an in-person version of this exercise for regions that requested it; and

    c. Make the materials for this exercise available so Tribes can adapt it for internal use.

5. The AIHC will work to establish a relationship with the Washington Department of Agriculture and include them in future exercises.

6. The AIHC will continue to work on legislation to ensure that notification to Tribes occur

APPENDIX A – IMPROVEMENT PLAN

Responsible Entity	Recommendations and Next Steps	Support for Recommendations	Recommended Completion Date
Centers for Disease Control (CDC) and Indian Health Services (IHS)	1. Support evidence-based vaccine recommendations, including those for seasonal influenza. 2. The CDC should develop and distribute a standardized template for assessing suspected cases of novel bird influenza.	High vaccinate rates of the seasonal influenza vaccine minimizes the risk of co-infection with novel bird influenza. Higher vaccination rates also lighten the load on health professionals across Tribal and local health jurisdictions in the event of a novel bird influenza exposure incident.	
Administration for Strategic Preparedness and Response (ASPR)	1. Support evidence-based seasonal influenza vaccination efforts as part of their pandemic and respiratory disease planning.	Maintaining high rates of seasonal influenza vaccination would reduce the stress on the healthcare system should exposure to novel bird influenza occur.	
Washington State Department of Health (DOH)	1. Continue to support opportunities for DOH Office of Resilience and Health Security and Office of Tribal Public Health and Relations staff, LHJs, Tribes, healthcare coalitions, and other key preparedness partners to meet in person. 2. Establish and maintain a notifiable conditions workgroup to: a. Identify and maintain a reliable pathway for reporting notifiable conditions cases to Tribes; b. Review and update their notifiable conditions policies and procedures to ensure that notifiable conditions cases are reported to Tribes; and c. Evaluate whether a standardized template for assessing suspected novel influenza cases	If this resource exists, local and Tribal public health staff should be made aware	

Responsible Entity	Recommendations and Next Steps	Support for Recommendations	Recommended Completion Date
	exists and guarantee local and Tribal public health staff are aware of the resource. 3. Prioritize meeting with Tribes one-on-one to: a. Discuss the data sharing agreement (DSA) requirement to access their data systems; and b. Identify any barriers or issues that may be preventing Tribes from signing a DSA. 4. Review and update their Appendix 4 – Pandemic Influenza and Viral Respiratory Disease Plan to: a. Ensure that notifiable conditions are reported to Tribes. b. Include assumptions around activation and readiness levels. c. Indicate what factors would contribute to full activation. 5. Collaborating with the AIHC to: a. Develop a solution that provides Tribal and local health jurisdictions with current/accurate information for individuals with key roles during responses. b. Continue its work with the Tribal and local health jurisdictions to ensure that Tamiflu is well stocked in the Logistics Center for distribution. 6. Provide training, support, and education on the exchange of public health data with Tribal jurisdictions including the following understandings: a. State and local health jurisdictions should share information with Tribal health jurisdictions on the same basis they share	so they can share it with providers and include it in planning documents. For example, if there are no human-to-human transmission cases and no request from locals, DOH would remain in readiness group. A single, official point of access restricted to authorized users is preferred. Solution may include changes to how the Yellow Book is managed.	

Responsible Entity	Recommendations and Next Steps	Support for Recommendations	Recommended Completion Date
	information with other state local health jurisdictions since HIPAA includes Tribes among the public health authorities who can receive "protected health information without authorization" for the purpose of preventing or controlling disease, injury, or disability." See 45 C.F.R. § 164.512(b)(1)(i) and 45 C.F.R. § 164.501. b. State and local health jurisdictions should not limit the share of information based on the Tribal status of the individual. Washington's notifiable conditions reporting is not based on the race or political status of the individual but upon where the patient resides. See WAC HIPAA does not require such a limitation. See Chapter 246-101 WAC.		
Local Health Jurisdictions (LHJs)	1. Continue to reach out to Tribes and participate in opportunities to collaborate with Tribes on public health matters. 2. Provide staff training, support, and education on the exchange of public health data with Tribal jurisdictions including the following understandings: a. State and local health jurisdictions should share information with Tribal health jurisdictions on the same basis they share information with other state local health jurisdictions since HIPAA includes Tribes among the public health authorities who can receive "protected health information without authorization" for the purpose of preventing or	AIHC offers training in this regard. LHJs should be made aware that state agencies often receive priority on the training schedule. It is recommended to request training as soon as possible. Training resources can include the "Public Health Data Exchange between Tribal, Federal, State, and Local Jurisdictions: A Legal Overview" and Washington Department of Health guidance, "Understanding Washington's Public Health System."	

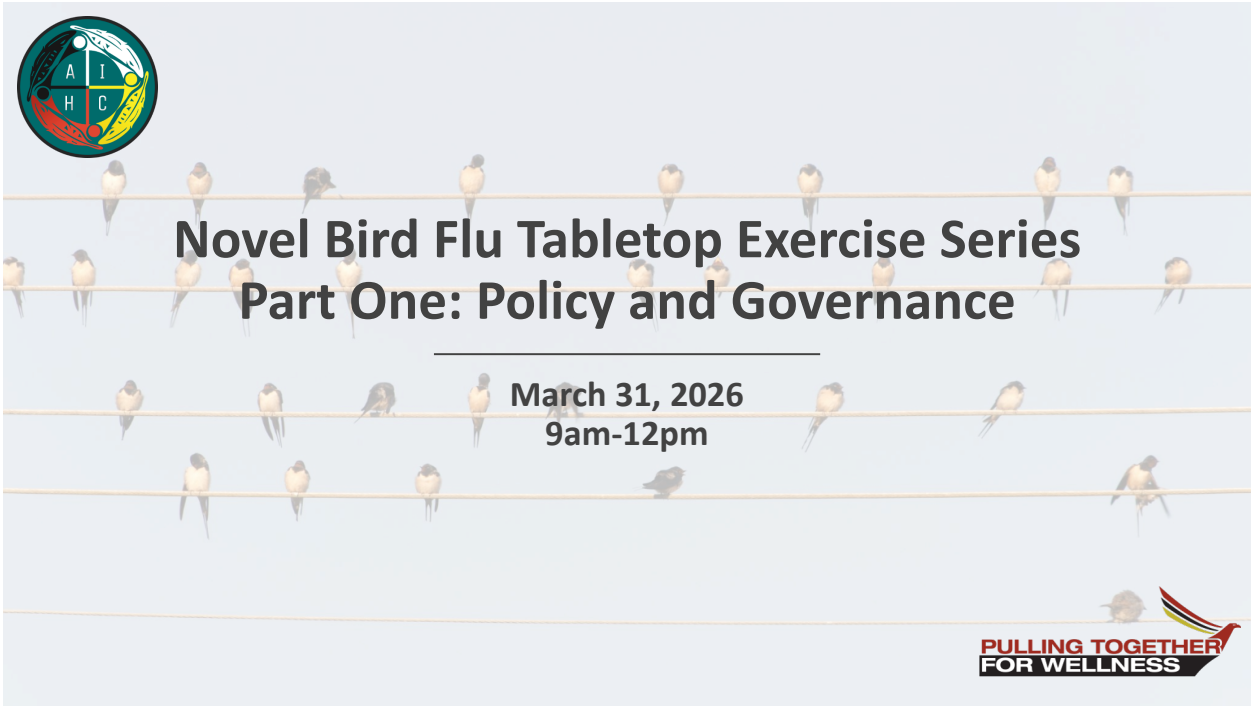
Responsible Entity	Recommendations and Next Steps	Support for Recommendations	Recommended Completion Date
	controlling disease, injury, or disability." See 45 C.F.R. § 164.512(b)(1)(i) and 45 C.F.R. § 164.501. b. State and local health jurisdictions should not limit the share of information based on the Tribal status of the individual. Washington's notifiable conditions reporting is not based on the race or political status of the individual but upon where the patient resides. See WAC HIPAA does not require such a limitation. See Chapter 246-101 WAC. 3. Coordinate with Tribes to amend their communicable disease/pandemic planning documents and identify processes for reporting to Tribes during case and contact investigation. 4. Communicate with the Tribes, and other partners in their region, to develop plans that clearly outline processes for: a. Including Tribes in communicating, decision-making, and coordination of response actions during response efforts; and b. Coordinating unified public messaging. 5. Ensure leadership and response staff have a good understanding of Tribal sovereignty and jurisdiction. 6. Update provider alert contact lists to include healthcare providers at Tribes and nearby Urban Indian Health Programs. 7. Build relationships, at the leadership level, with the clinical director and/or public health officer at nearby Tribes.		

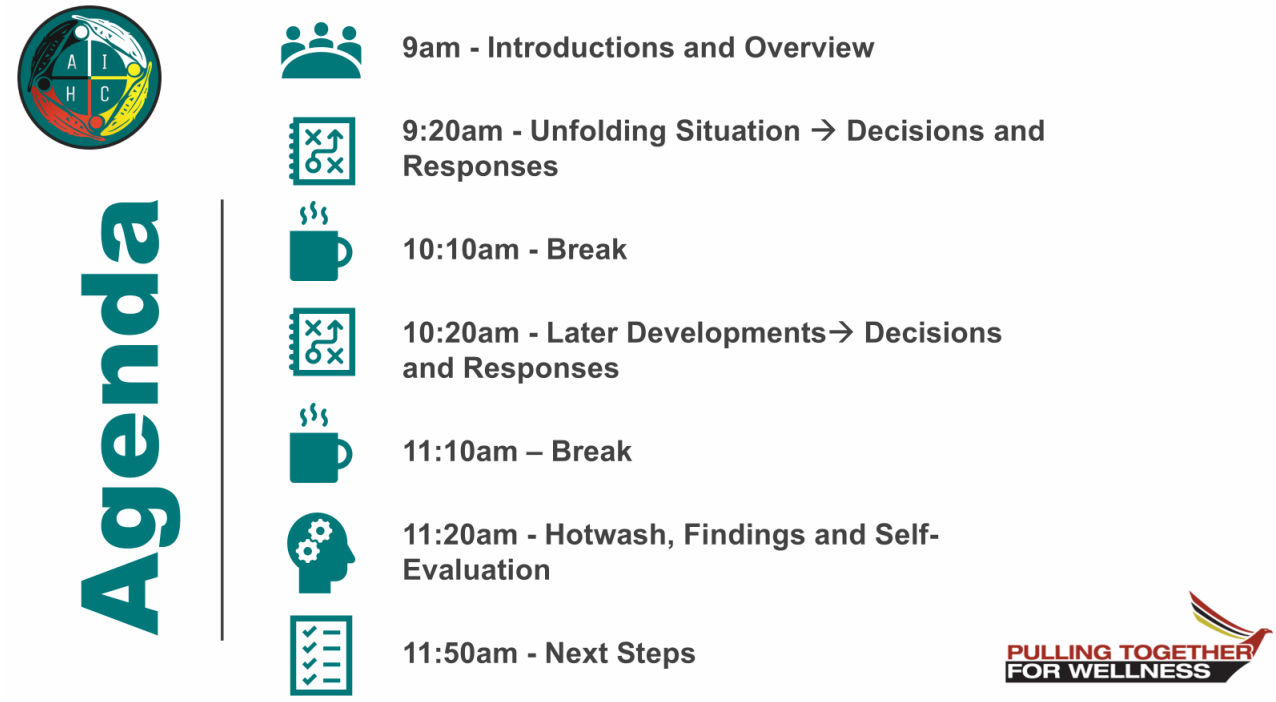
Responsible Entity	Recommendations and Next Steps	Support for Recommendations	Recommended Completion Date
Tribes	1. Engage, or continue to coordinate, with LHJs and other relevant partners to: a. Participate in opportunities to collaborate on public health matters. b. Develop processes to ensure that notifiable conditions impacting individuals residing in a Tribal jurisdiction have been reported to the Tribe. c. Engage in planning around case and contact investigation. d. Develop plans that clearly outline processes for including Tribes in communication, decision-making, and coordination of response actions during responses. e. Develop plans that clearly outline processes for coordinating unified public messaging. 2. Develop and implement Continuity of Operations Plans (COOPs) and Crisis Standards of Care. 3. Tribes, if they have not already, should explore the possibility of registering with state to obtain access to the state laboratory order system. 4. Work to ensure they can quickly assess Tamiflu stock available to them within the Tribe. Discuss the possibility of maintaining a small stockpile, if they do not already.	Tribes have the authority to order isolation or quarantine on Tribal land. During the COVID-19 pandemic many Tribes reported it was more effective to do their own case and contact investigation. This will guide operations and support their ability to continue serving their patient population during most public health incidents.	
American Indian Health Commission (AIHC)	1. Continue to support/facilitate opportunities for Tribal and local health jurisdictions to collaborate on notifiable conditions and other public health matters. 2. Continue to collaborate with the DOH by:		

Responsible Entity	Recommendations and Next Steps	Support for Recommendations	Recommended Completion Date
	a. Participating in the Notifiable Conditions Workgroup and helping to identify paths for reporting notifiable conditions to Tribes. b. Developing a solution for providing Tribal and local health jurisdictions with current/accurate contact information for individuals with key roles during responses. 3. Seek funding to: a. Assist LHJ in amending their communicable disease/pandemic planning documents to clearly address processes for reporting notifiable conditions to Tribes. b. Assist the nine (9) public health emergency planning regions in engaging Tribal and local health jurisdictions to develop plans that clearly outline processes for including Tribes. c. Update model communicable disease plans/codes developed before COVID-19. d. Assist Tribal clinics in developing Continuity of Operations Plans (COOPs) and Crisis Standards of Care. 4. The AIHC will: a. Plan a larger version of this exercise and include more partners; b. Plan an in-person version of this exercise for regions that requested it; and c. Make the materials for this exercise available so Tribes can adapt it for internal use. 5. Work to establish a relationship with the WDSA and include them in future exercises.	To adequately serve their communities, Tribes must be included in communication, decision-making, public information messaging, and coordination of response actions. This will support Tribes in their planning for future responses. This will guide their operations during a public health incident. Greater outreach will build on the progress made by this tabletop exercise.	

Responsible Entity	Recommendations and Next Steps	Support for Recommendations	Recommended Completion Date
	6. Continue to work on legislation to ensure that notification to Tribes occurs.		

APPENDIX B – TABLETOP EXERCISE SLIDES





Introductions and Overview

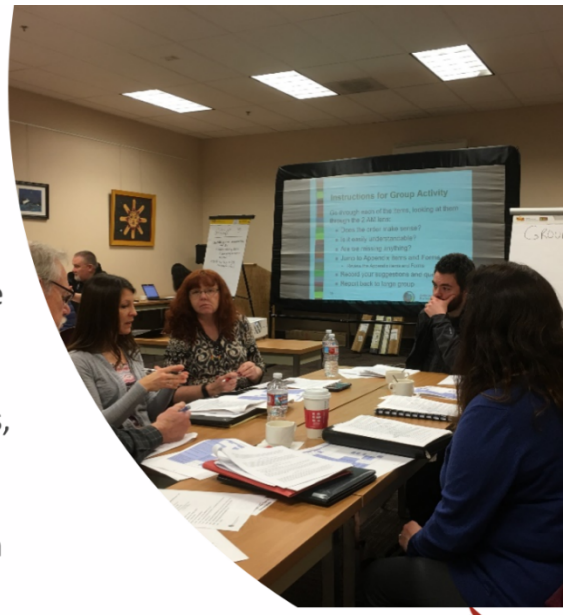
Introductions

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



What is a Tabletop Exercise?

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



PULLING TOGETHER FOR WELLNESS

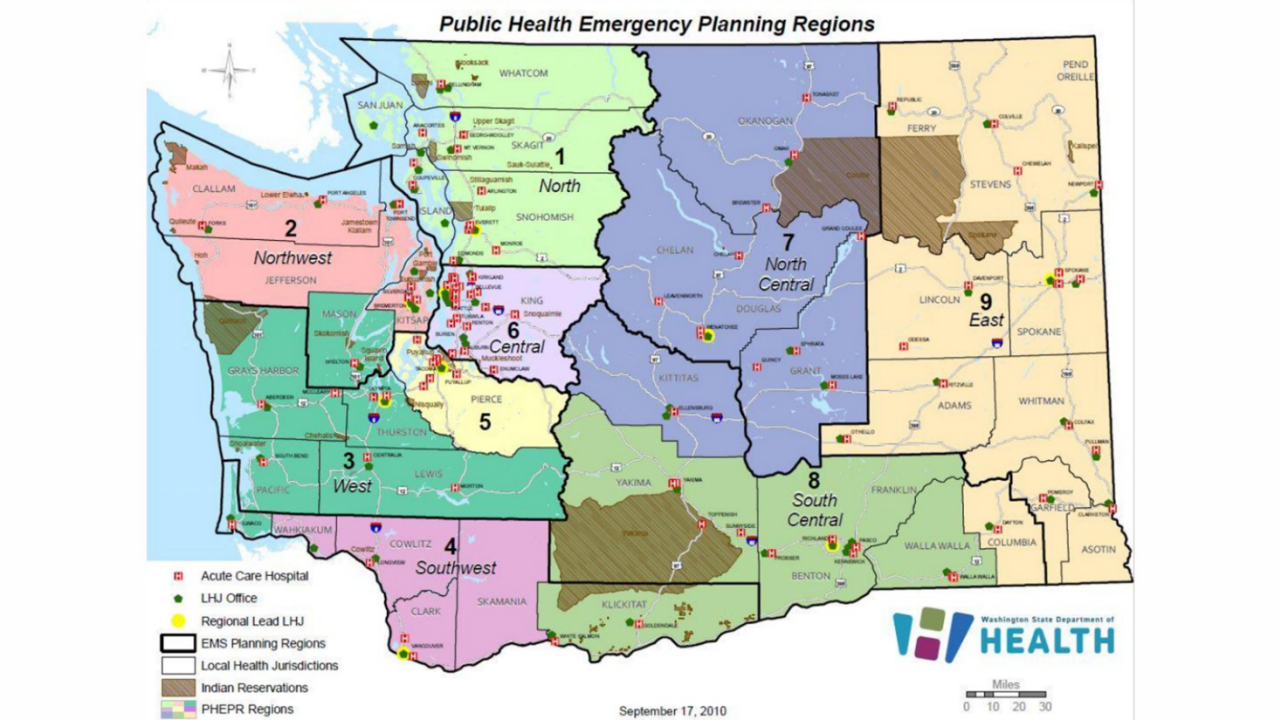
Purpose of the Tabletop Exercise



Testing communication and notification processes through a tabletop exercise will increase:

- Tribes' understanding of the flow of outbreak notification within the governmental public health system
- Tribal, local, and state partners' understanding of how they will interact during a notifiable condition outbreak

PULLING TOGETHER FOR WELLNESS



Specific Objectives

- Clarify legal authorities including emergency powers, reporting requirements, and response roles.
- Assess ability to effectively coordinate novel bird influenza outbreak across Tribal and nontribal jurisdictions.
- Identify strengths and areas for improvement.
- Identify potential legal issues.
- Identify gaps in policy.
- Assess resource- and information-sharing between Tribal and non-Tribal jurisdictions.

PULLING TOGETHER FOR WELLNESS

What are Medical Countermeasures (MCM)?

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

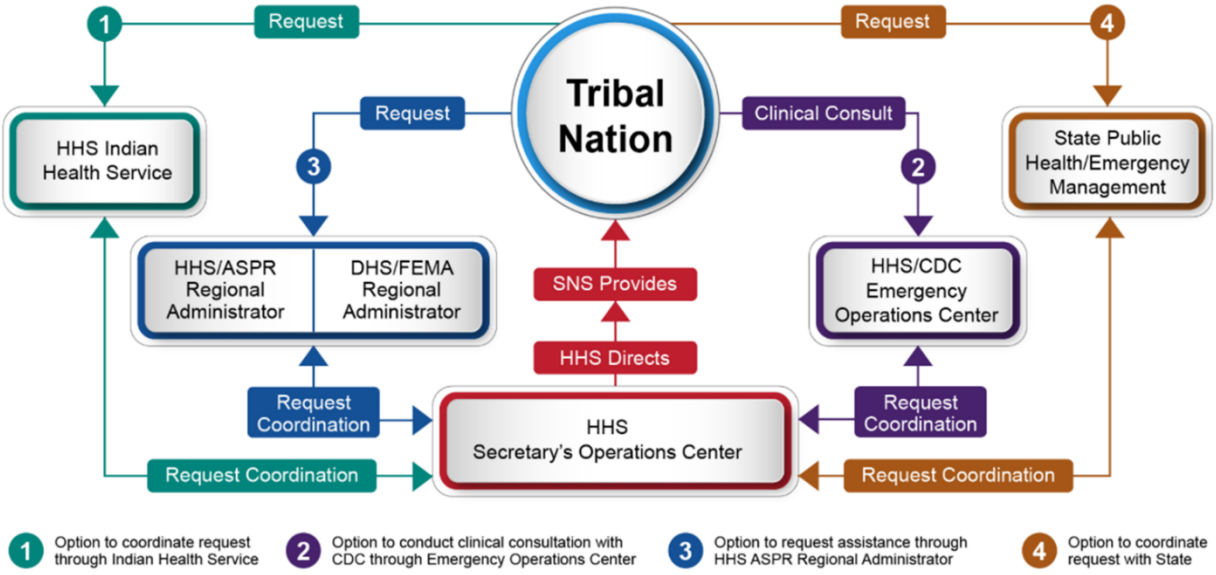


PULLING TOGETHER FOR WELLNESS

Medical Countermeasures and Tribes

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

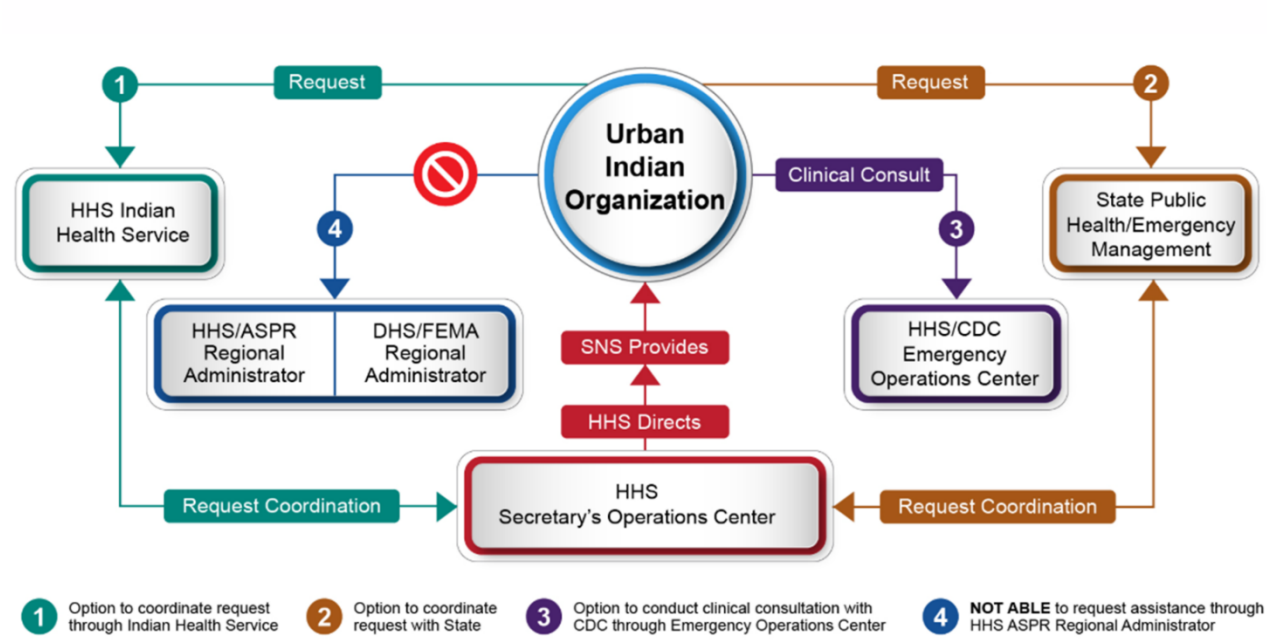
PULLING TOGETHER FOR WELLNESS



Medical Countermeasures and Urban Indian Health Programs

- Urban Indian Health Programs (aka Urban Indian Organizations/UIOs) do not have the authority to make direct requests for federal assistance from FEMA or ASPR regional administrators.
- Like Tribal nations, UIOs may request access to SNS medicines, supplies and equipment through the EMPOC for their IHS area office.
- UIOs typically rely on their relationships with states to access federal resources. Requests for SNS assets and other support are made through state public health and emergency management authorities.

PULLING TOGETHER FOR WELLNESS


1
Request
Request
2
Urban Indian Organization
HHS Indian Health Service
Clinical Consult
State Public Health/Emergency Management
4
3
HHS/ASPR Regional Administrator
DHS/FEMA Regional Administrator
SNS Provides
HHS/CDC Emergency Operations Center
HHS Directs
Request Coordination
HHS Secretary's Operations Center
Request Coordination
1 Option to coordinate request through Indian Health Service
2 Option to coordinate request with State
3 Option to conduct clinical consultation with CDC through Emergency Operations Center
4 NOT ABLE to request assistance through HHS ASPR Regional Administrator


Tabletop Scenario
PULLING TOGETHER FOR WELLNESS

Assumptions



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

PULLING TOGETHER FOR WELLNESS

Assumptions

- Washington State has adequate supply of the influenza antiviral Tamiflu stored in their warehouse
- No supply shortages to hamper other avenues of access to Tamiflu



PULLING TOGETHER FOR WELLNESS

Assumptions

- For Tribes – You are Tribe X in the scenario
- For LHJs – You are the LHJ in the scenario
- For Urban Indian Health Programs – Assume Tribe X is near your program



PULLING TOGETHER FOR WELLNESS

Late October 2026



- There have been no major public health emergencies in your region
- Fall rain began in late September and rainfall has been average
- No major events scheduled during the season
- As in years past, bird flu continues to circulate in the wild bird population

PULLING TOGETHER FOR WELLNESS

Day One – November 5, 2026

- A 6-year-old reports to your local hospital emergency room with fever, cough, sore throat, body aches, and difficulty breathing.
- Upon examination, the child is diagnosed with pneumonia. The physician orders an RT PCR to be sent to the state public health lab and admits the child to the hospital to begin treatment for pneumonia.



PULLING TOGETHER FOR WELLNESS

Day One Discussion

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

PULLING TOGETHER FOR WELLNESS

Day Three – November 7, 2026



- Lab results positive for novel bird flu
- Local public health and DOH are notified
- Case and contact investigation at the LHJ finds:
  - Patient is AI/AN and lives within Tribe X's jurisdiction
  - Family keeps backyard birds (chicken and quail; recently had a few birds get sick and isolated them from the flock, those birds passed away and were buried on property)
- DOH releases press statement

PULLING TOGETHER FOR WELLNESS

Novel Bird Flu

- A new (novel) flu virus is one that causes human infection but is different from the seasonal flu viruses that spread among people each year. People usually do not have immunity to novel flu viruses and a vaccine may not be quickly available.
- Novel flu viruses usually come from animal flu viruses. Animal flu viruses do not normally infect people, but in rare cases, especially when people have close contact with animals, infections occur.
- Novel flu viruses are concerning because they could impact public health if they change to spread easily from person to person. This could cause a pandemic.
- There are two types of novel flu viruses that are most concerning to public health officials -- avian flu and swine flu viruses.

Influenza - Novel

PULLING TOGETHER FOR WELLNESS

Novel Bird Flu Symptoms

- Cough
- Headache
- Eye redness or irritation
- Sore throat
- Fever or Chills
- Fatigue
- Congestion or runny nose
- Muscle or body aches
- Other symptoms include shortness of breath or difficulty breathing, diarrhea, nausea or vomiting, rash, and sneezing.

Influenza - Novel

Day Three Morning Discussion

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

Day Four – November 8, 2026



- A child (4), and an elder (55) report to the Tribe X's clinic experiencing fever, cough, shortness of breath, and conjunctivitis
- Both are sent to local hospital with low blood oxygen level
- Hospital sends RT PCR sent to state lab
- News about the first confirmed case has created some panic in the Tribe X's community

PULLING TOGETHER FOR WELLNESS

Day Four Discussion

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

PULLING TOGETHER FOR WELLNESS



Day Five – November 9, 2026 Morning

- Positive tests for the elder and one child
- Genetically linked to first case
- Local public health notified
- News about new cases has created some panic throughout the county



PULLING TOGETHER FOR WELLNESS

Day Five Morning Discussion

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

PULLING TOGETHER FOR WELLNESS

Day Five – November 9, 2026 Afternoon



- Case and contact interview finds that these patients are Tribal members from Tribe X in one family who are not living on the reservation but out in the county
- All attended a community trunk or treat event held at Tribe X

PULLING TOGETHER FOR WELLNESS

Day Five Afternoon Discussion

- **What does your response structure look like at this point?**
  - declare emergency
  - Taskforce
  - readiness group
  - Tribal Council's involvement?
- **If you have not declared an emergency, how will you determine whether/when to declare one?**

PULLING TOGETHER FOR WELLNESS

Day Six – November 10, 2026

- Community is concerned
- Increase in worried well hospital visits
- Misinformation spreading on social media
- CDC and State issue guidance that Tamiflu can be given to patients with suspected or confirmed bird flu and that seasonal influenza vaccine may provide some protection and should be prioritized
- No vaccine currently exists for this strain of influenza



PULLING TOGETHER FOR WELLNESS

Day Six Discussion

- How will your jurisdiction assess if local supply of Tamiflu will meet your needs?
- How would this impact your seasonal influenza vaccination activities?

PULLING TOGETHER FOR WELLNESS

Days Seven – Fourteen
November 12-19, 2026

- No additional suspected cases identified in the state



PULLING TOGETHER FOR WELLNESS

Days 7-14 Discussion

- If you activated for response, what factors influence your demobilization?
- What protective measures and public health efforts will stay in place through the rest of flu season?



Hotwash, Findings and Self-Evaluation



PULLING TOGETHER FOR WELLNESS

Next Steps



- AIHC will provide participants compiled notes and after-action report (AAR)
- Tribes and LHJs – check the Yellow Book to ensure it is up to date and if not, send corrections to ORHSPartnerEngagement@doh.wa.gov
- Look to schedule a larger, in-person version of this tabletop

PULLING TOGETHER FOR WELLNESS

ABOUT AMERICAN INDIAN HEALTH COMMISSION



The American Indian Health Commission is a Tribally driven non-profit that focuses on American Indian and Alaska Native health in Washington State. Our membership includes the 29 federally recognized Tribes whose traditional lands and territories included parts of Washington, and 2 Urban Indian Health Organizations (UIHOs). Our goal is to bring wellness to our communities and honor the sovereignty of our ways. We work with Washington State government agencies to develop policies that reflect and support our resilience. Our ways are resilient.