Navigating the Distribution and Dispensing of Medical Countermeasures to Sovereign Tribal Nations

October 25, 2023

aihc
AMERICAN INDIAN HEALTH COMMISSION FOR WASHINGTON STATE

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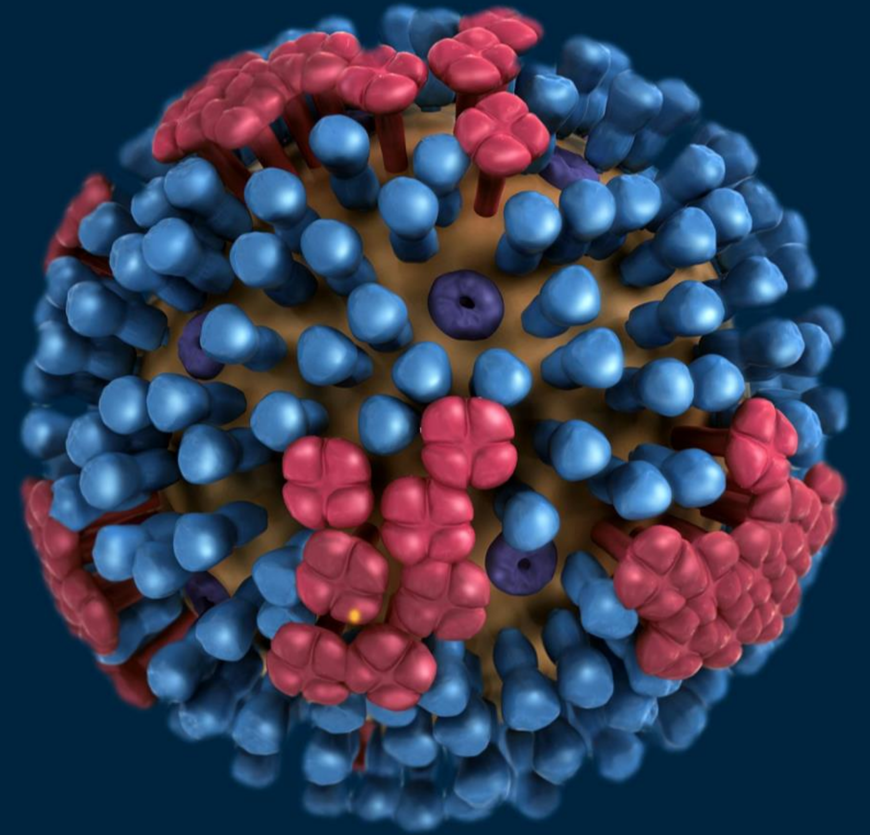
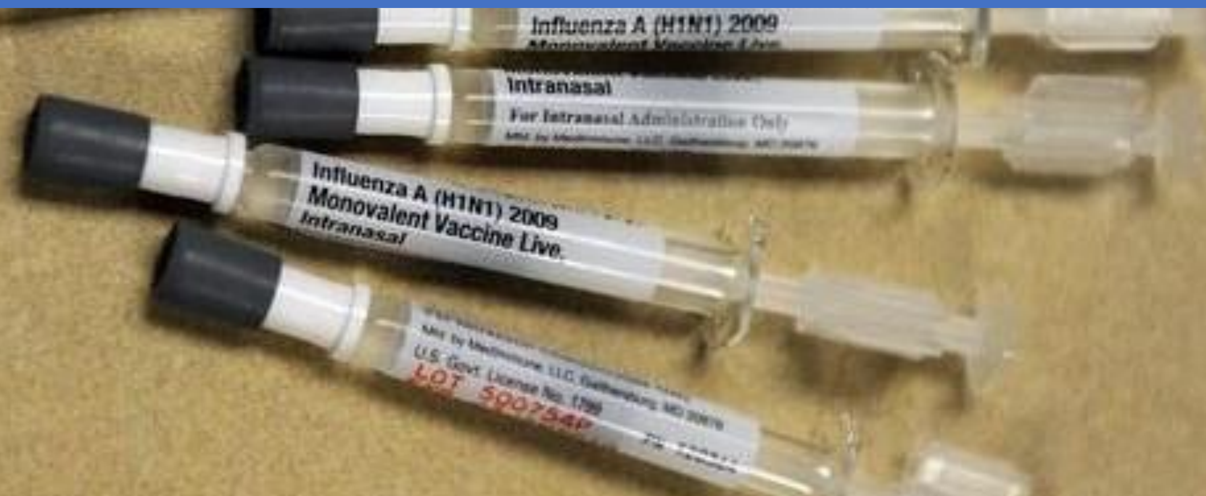
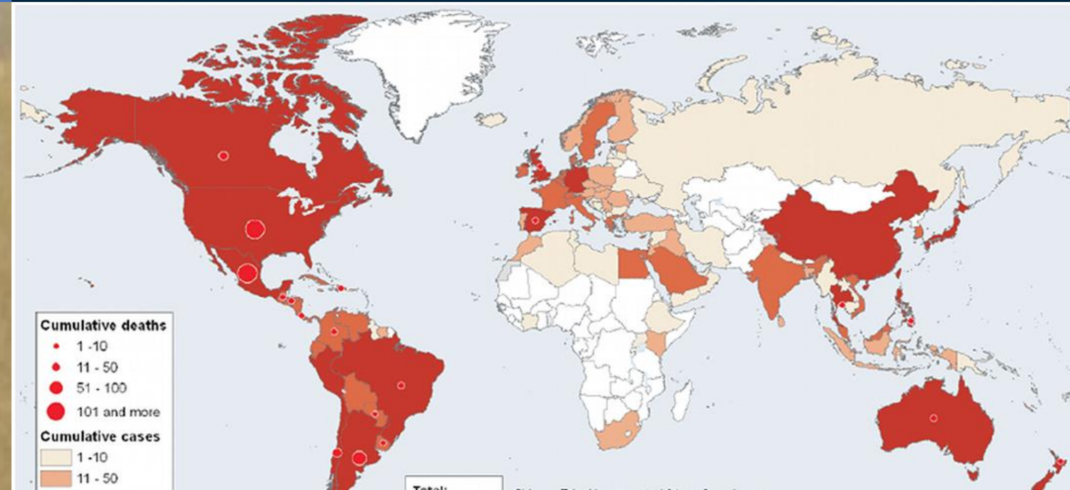
Presentation Overview

Introduction	H1N1
Part One	Understanding Tribal Public Health Jurisdiction and Authority
Part Two	Development of Federal and State Policies on Distribution of Medical Countermeasures to Tribes
Part Three	5 Key Components for Tribal Medical Countermeasures Policies
Part Four	Best Practices

H1N1







- In 2009, during the H1N1 outbreak, a small number of Washington Tribes made plans to immunize elders first.
- Some local health jurisdictions (LHJs) responsible for coordinating delivery of vaccines to Tribes argued this approach conflicted with CDC guidelines and withheld vaccine from Tribes.

CDC Intervenes

Shortly after this occurred, CDC Director Thomas Frieden issued a letter informing state health officers that all American Indians and Alaska Natives should receive the vaccine on a priority basis regardless of age.

By the time the letter was issued, however, the problem had become too entrenched, and **many Tribes never received the vaccines needed to protect their citizens.**

Why Did this Failure Happen?

LACK OF UNDERSTANDING

Of a Tribal government's sovereign right to decide their vaccine priority groups

LACK OF POLICY AND GUIDANCE

No clear federal or state guidance

LACK OF TRUST

Between Jurisdictions

Part One

Understanding Tribal Public Health Jurisdiction and Authority

Lack of understanding of federal Indian law and respect for Tribal sovereignty can have detrimental impacts to Tribal governments and to American Indians and Alaska Natives.

Public Health Governmental Powers: Jurisdiction, Jurisdiction, Jurisdiction

Federal Public Health Powers

Under the "Doctrine of Implied Powers," the federal government can exercise authority to act in the interest of public health and safety[3]

Federal Trust Responsibility

To protect Tribal Sovereignty and Health of AI/AN and Tribes[1]

Government-to-Government

Tribal Public Health Powers

*Inherent.** Not derived from the federal government[2]

The Three Sovereigns[4]

State Public Health Powers

Derived largely from sovereign powers via the 10th Amendment[3]

Local Public Health Powers

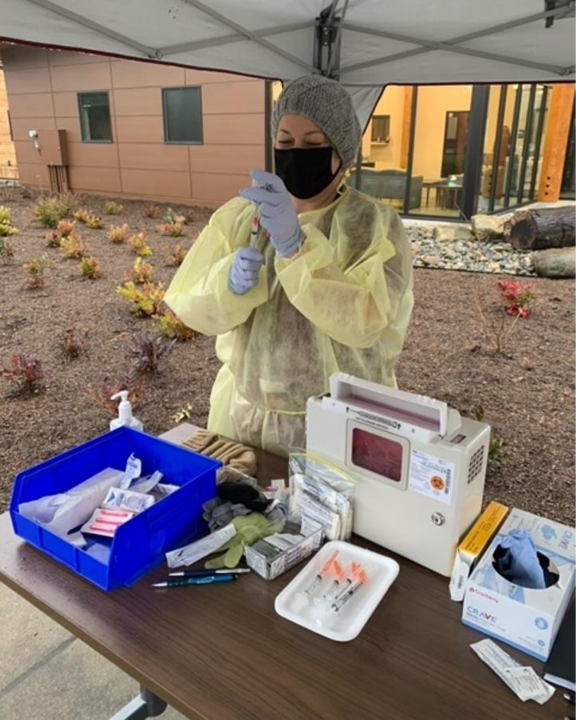
Derived largely from state police powers via state constitutional, legislative, or executive means.[3]

[1] *Cherokee Nation v. Georgia*, 30 U.S. (5 Pet.) 1 (1831); Indian Health Care Improvement Act, Pub. L. 94–437 (25 U.S.C. 1601 et seq.)

[2] *Worcester v. Georgia*, 31 U.S. (6 Pet.) 515, 559 (1832; Aila Hoss, *Toward Tribal Health Sovereignty*, 2022 WIS. L. REV. ONLINE 413, 420 (2022)

[3] James G. Hodge Jr., PUBLIC HEALTH IN A NUTSHELL, 54-60 (3d ed. 2018).

[4] RESTATEMENT OF THE LAW OF AMERICAN INDIANS, Ch. 1, intro. note (Am. L. Inst. 2022) (citing to Sandra Day O'Connor, *Lessons from the Third Sovereign: Indian Tribal Courts*, 33 U L.J. 1, 1 (1997)).



Tribal Public Health Jurisdiction

CAPACITY + CAPABILITY

Tribal governments are public health jurisdictions with inherent legal authorities and powers equal to or greater than state and local governments.*

**Worcester v.*
Georgia, 31 U.S. (6 Pet.) 515, 559 (1832); *See also*, *Cherokee Nation v. Georgia*, 30 U.S. (5 Pet.) 1 at 16 (1831).

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Tribal Public Health Powers

Tribal jurisdictions exercise a wide range of governmental public health powers including, but not limited to, the following functions:

Declare	Order	Close	Establish	Investigate	Surveil
Declaring public health emergencies	Ordering mandatory isolation and quarantine	Closing businesses and off-reservation borders	Establishing priority groups and service populations for dispensing vaccines	Performing case and contact investigations	Conducting data surveillance

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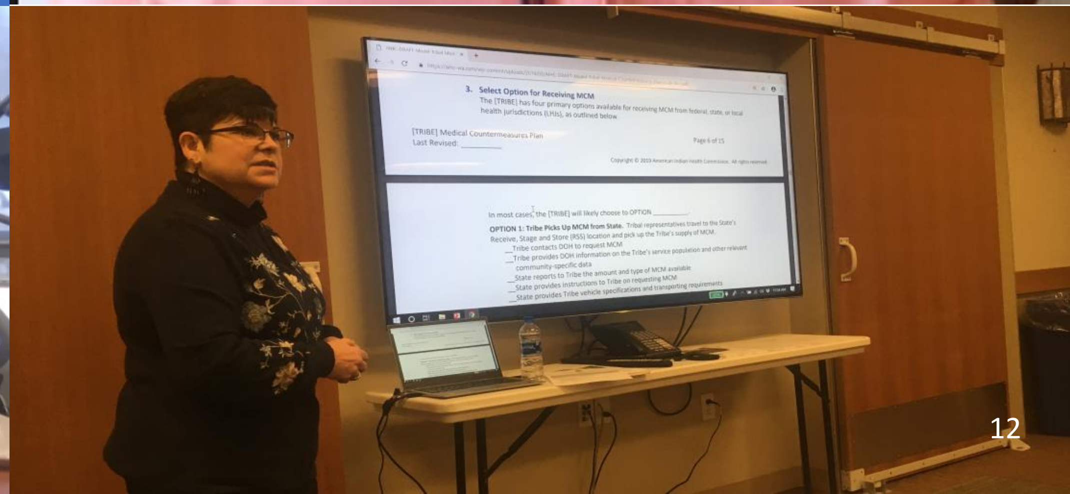
Part Two

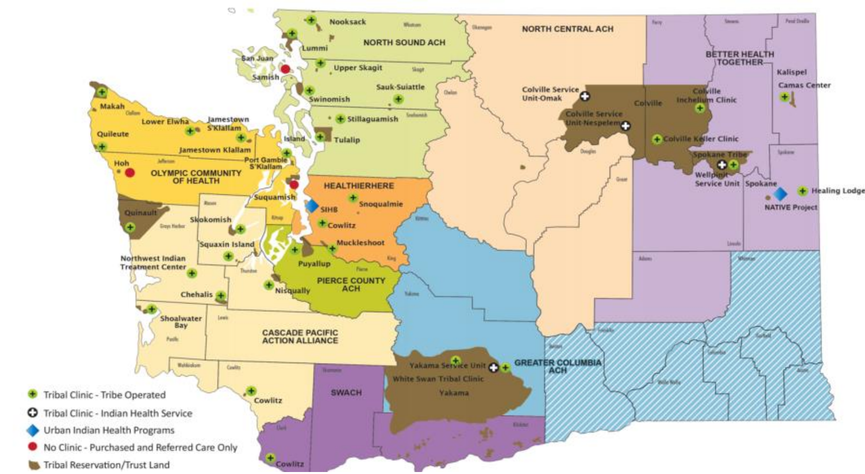
Development of Federal and State Policies on Distribution of Medical Countermeasures to Tribes



Never Again

American Indian Health Commission Goal:

Assure the appropriate amount and type of medical countermeasures (MCM) reach every Tribe **quickly** during every public health emergency

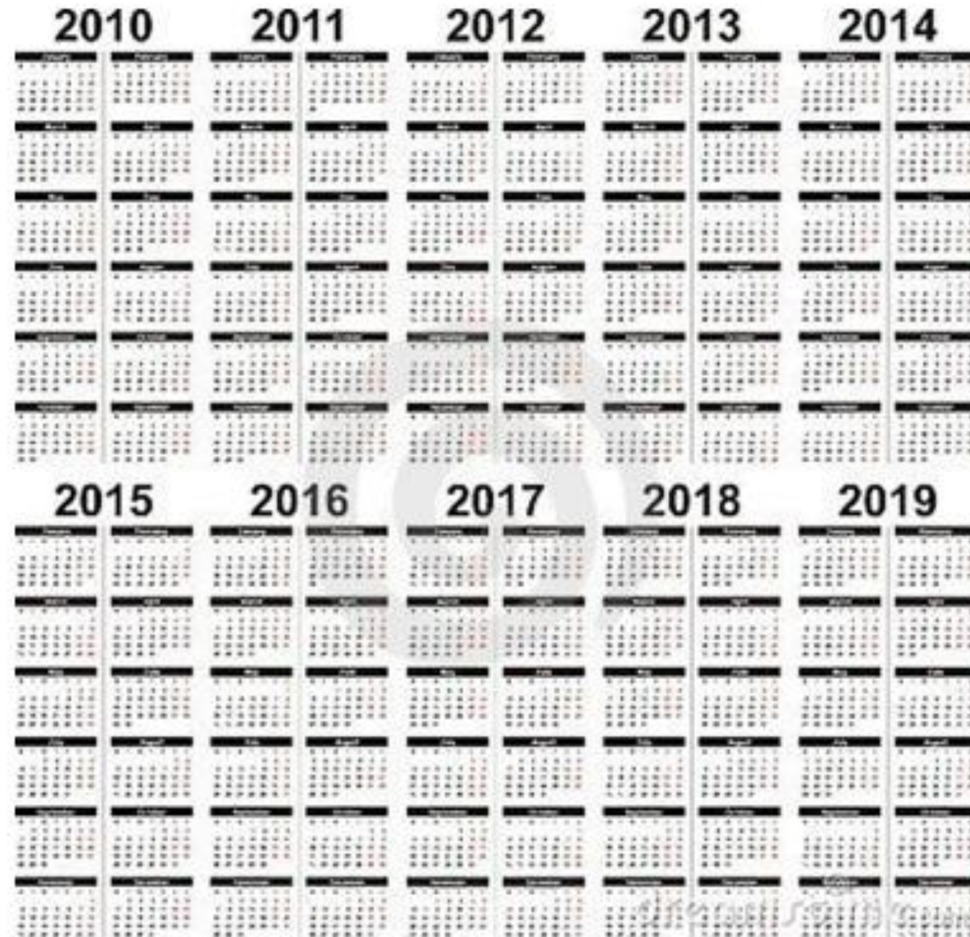


Development of Washington State Tribal Medical Countermeasures Policy

American Indian Health Commission facilitated cross jurisdictional collaboration meetings over several years.

- 29 Tribes, WA Department of Health, 35 LHJs, and 2 urban Indian health programs
- MCM Tabletop Exercises
- Mutual Aid Agreement Development

Trust and Relationships Take Time and Commitment



Part Three

5 Key Components for Tribal Medical Countermeasures Policies

Key Components for Tribal Medical Countermeasures Policies

1. Choosing Vaccine Source and Distribution

- Each Tribal nation has the sovereign authority to choose among the jurisdiction (e.g. the state where Tribe is located) or federal agency options for accessing vaccine.[1]
- State and local health jurisdictions do not possess legal authority over how a Tribe receives MCM.[2]

[1] *COVID-19 Vaccination Program Jurisdiction Operations Interim Operational Guidance, Centers for Disease Control and Prevention (CDC) October 29, 2020 Version 2.0.*

[2] *Washington State Department of Health Medical Countermeasures Plan, Annex 9.*

Key Components for Tribal Medical Countermeasures Policies

2. Determining Service Populations

- Each Tribal nation has the sovereign authority to determine the population(s) it chooses to serve.[1]
- Neither local health jurisdictions nor states have the authority to determine the population the Tribe will serve in providing medical countermeasures. [2]

[1]*COVID-19 Vaccination Program Jurisdiction Operations Interim Operational Guidance, Centers for Disease Control and Prevention (CDC) October 29, 2020 Version 2.0.*

[2]*Washington State Department of Health, Medical Countermeasures Plan, Annex 9.*

Key Components for Tribal Medical Countermeasures Policies

3. Distributing and Dispensing Vaccine within the Tribe

- Each Tribal nation has the sovereign authority to choose how MCM are distributed to its community.[1]
- The State and local health jurisdictions do not possess legal authority over how a Tribe dispenses MCM.[2]

[1]*COVID-19 Vaccination Program Jurisdiction Operations Interim Operational Guidance, Centers for Disease Control and Prevention (CDC) October 29, 2020 Version 2.0.*

[2]*Washington State Department of Health, Medical Countermeasures Plan, Annex 9.*

Key Components for Tribal Medical Countermeasures Policies

4. Establishing Priority Groups

- Each Tribal nation has the sovereign authority to establish priority groups when there is a vaccine or other accompanying resources.[1]

[1] *COVID-19 Vaccination Program Jurisdiction Operations Interim Operational Guidance, Centers for Disease Control and Prevention (CDC) October 29, 2020 Version 2.0.*

[2] *Washington State Department of Health, Medical Countermeasures Plan, Annex 9.*

Key Components for Tribal Medical Countermeasures Policies

5. Coordinating with Tribal Jurisdictions

- **Vaccine Planning.** Jurisdictions should reach out to Tribal nations within their respective areas for involvement in planning efforts and include Tribal engagement procedures in their vaccination plans.[1]
- **Vaccine Distribution.** States are responsible for ensuring that medical countermeasures are distributed to Tribes when requested.[2]

COVID-19 Vaccination Program Jurisdiction Operations Interim Operational Guidance, Centers for Disease Control and Prevention (CDC) October 29, 2020 Version 2.0.

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

Federal Government (SNS) ➡ Washington State

OPTION 1

Tribe ➡ State

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

OPTION 2

State ➡ Tribe

STATE delivers directly to TRIBAL location

OPTION 3

State ➡ LHJ ➡ Tribe

STATE delivers Tribal allocation to Local Health Jurisdiction (LHJ)

TRIBE and LHJ coordinate conveyance of MCMs to TRIBE

OPTION 4

Tribe Contacts Feds (CDC)

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

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

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STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47890 • Olympia, Washington 98504-7890
Tel: 360-236-4030 • 711 Washington State Relay

September 3, 2020

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

Dear Chairman Kutz:

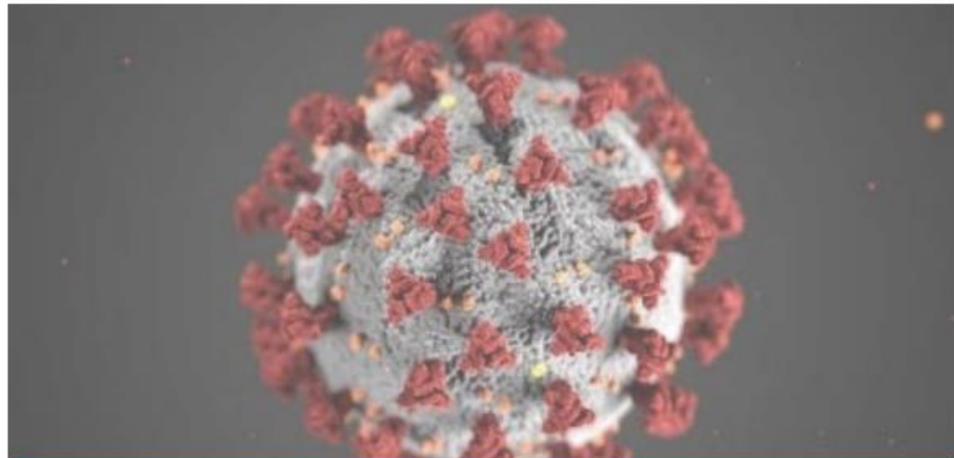
SUBJECT: Medical Countermeasures Tribal-State-LHJ Coordination Plan

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

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

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

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



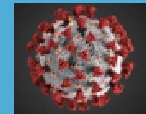
COVID-19 Vaccination Program Interim Operational Guidance Jurisdiction Operations

Centers for Disease Control and Prevention (CDC)

October 29, 2020

Version 2.0

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



Tribal Nations and Tribal Communities

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

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

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

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

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

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

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

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

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

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

A Special Thanks

CDC Public Health Law Program

What Happens When Federal and State Governments Respect Tribal Sovereignty…

Health | Local News | Northwest | Puget Sound

Huge response to a mass COVID-19 vaccination site in Sequim is likely preview of what's to come

Jan. 14, 2021 at 6:54 pm | *Updated Jan. 19, 2021 at 10:32 am*

"The clinic vaccinated about **500** people in four hours...."

Hundreds of Sequim residents waited for a drive-through clinic operated by the Jamestown S'Klallam Tribe. Clallam County is starting to vaccinate residents who are 70 and older ahead of the state's vaccination schedule. (Courtesy of James Castell)

https://www.seattletimes.com/seattle-news/health/huge-response-to-a-mass-covid-19-vaccination-site-in-sequim-is-likely-preview-of-whats-to-come/

Education | Education Lab | Health

Teachers crying tears of gratitude as Washington tribes help speed COVID-19 vaccines to them

March 18, 2021 at 6:00 am | *Updated March 18, 2021 at 9:39 am*

The Seattle Times

https://www.seattletimes.com/education-lab/Tribal-governments-in-washington-help-speed-teacher-vaccination-effort/

Health | Local News | Puget Sound

How a Native American COVID-19 vaccine rollout is a model for community-centered approaches

Feb. 1, 2021 at 6:00 am | Updated Feb. 1, 2021 at 7:04 pm

The Seattle Times

https://www.seattletimes.com/seattle-news/health/we-take-it-for-our-community-how-a-native-american-survey-and-vaccine-rollout-models-a-community-centered-approach/

BEST PRACTICES

1. **Advocacy.** Advocate for federal and state policies that are consistent with the 5 Key Components for Tribal MCM Policies.

2. **Training and Awareness.** Ensure state and local staff are regularly trained and aware of Tribal MCM state and federal policy.

3. **Cross Jurisdictional Meetings.** Establish regular meetings between Tribes, state, and local health jurisdictions that include reviewing each other's plans, capabilities, and resources and developing collaborative relationships.

4. **MCM Exercises.** Conduct regular MCM exercises between Tribal, state, and local health jurisdictions that include identifying and addressing gaps.

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THANK YOU

COVID-19 Vaccine Distribution Planning for Tribal Nations: The CDC Perspective

Jillian Doss-Walker, DrPH, MPH
Public Health Advisor/Deputy Branch Chief
Centers for Disease Control and Prevention

Public Health Law Conference
October 24, 2023

Overview

- Background on AI/AN Health Care System
- Lessons from H1N1
- COVID-19 Tribal Consultations for Vaccine Planning
- Vaccine Distribution Planning Process
- Vaccine Implementation
- Lessons Learned

AI/AN Health Care System

- IHS Funded “I/T/U” system (37 states)
  - Indian Health Services facilities
  - Tribal health facilities (PH-638 facilities)
  - Urban Indian health facilities
- IHS is not insurance
  - Patients can receive care provided at the site if eligible, but can’t go elsewhere and have IHS billed
- Other federal, state, and private organizations are also important sources of care for AI/AN people

I/T/U Facilities

- Serve predominately AI/AN population
- Usually located in remote/rural AI/AN communities
  - Reservations, Tribal trust lands
  - Often the only source of care
- Level of care provided varies
  - AI/AN beneficiaries may receive additional services through contract care with other health systems, contingent on funding
    - Limited for members of that facility's tribe
- IHS is not insurance

Lessons from H1N1

- Vaccine distribution through states for tribal members, IHS received vaccine for employees and "hot spots"
- Inconsistent consideration of high-risk medical conditions for AI/AN communities when determining vaccine allocations
- Tribal sovereignty was not well understood by states, resulting in vaccine being withheld from tribal nations
- Parallel distribution systems for IHS employees and beneficiaries

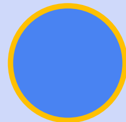
Trust needed to be repaired and distribution systems needed to be reconsidered

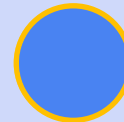
COVID-19 Vaccine Distribution Planning and Implementation Timeline

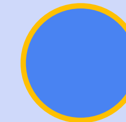
August: CDC stood up a Vaccine Planning Unit for Tribal Nations

October-December: Coordination with IHS/states/Tribes/ OWS to prepare for distribution

2020







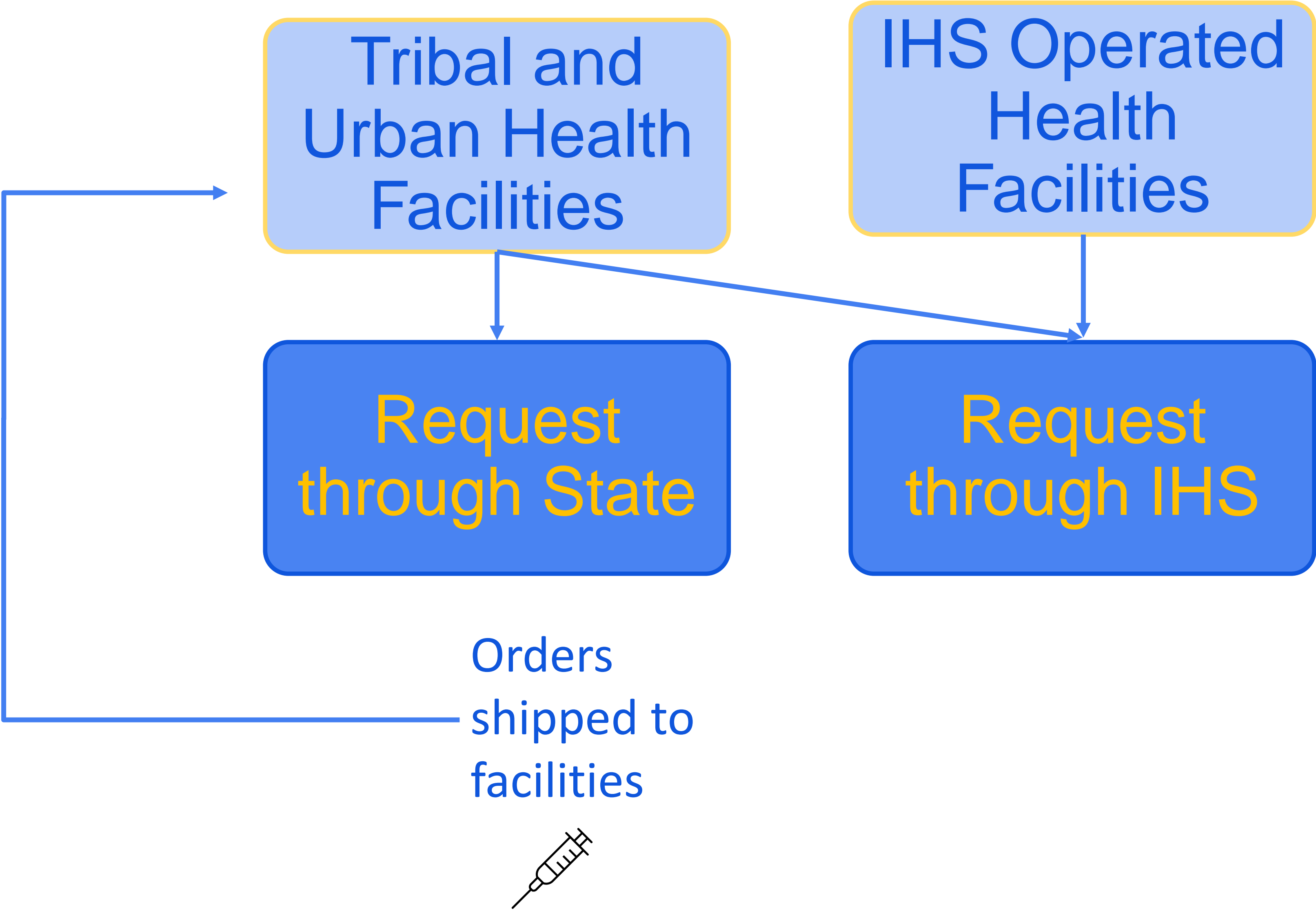
September: Engagements with Tribal organizations, including Emergency Tribal Consultations and Urban Confer

December 14: Vaccine distribution to Tribal Nations begins

Emergency Tribal Consultations

- Purpose: to understand concerns regarding vaccine distribution to tribal communities and to ensure an agreed upon process to honor tribal sovereignty
  - Proposal: Tribal nations to decide their preference for vaccine allocation and distribution–whether to receive vaccine at the facility level through a state/local immunization program or through IHS

Proposed Program Design



Tribal Consultation Feedback and Program Development

Feedback	Impact to program design
Preference for vaccine distribution system	-Tribal health units had the ability to choose how they wanted to receive vaccine: the state or IHS
Authority to determine who should receive vaccine	-Modified provider agreement to state that tribal nations do not need to follow ACIP guidelines -Communicated decision authority to partners
Authority to determine their service population	-Population numbers (including tribal members and non-tribal community members) determined by health facility

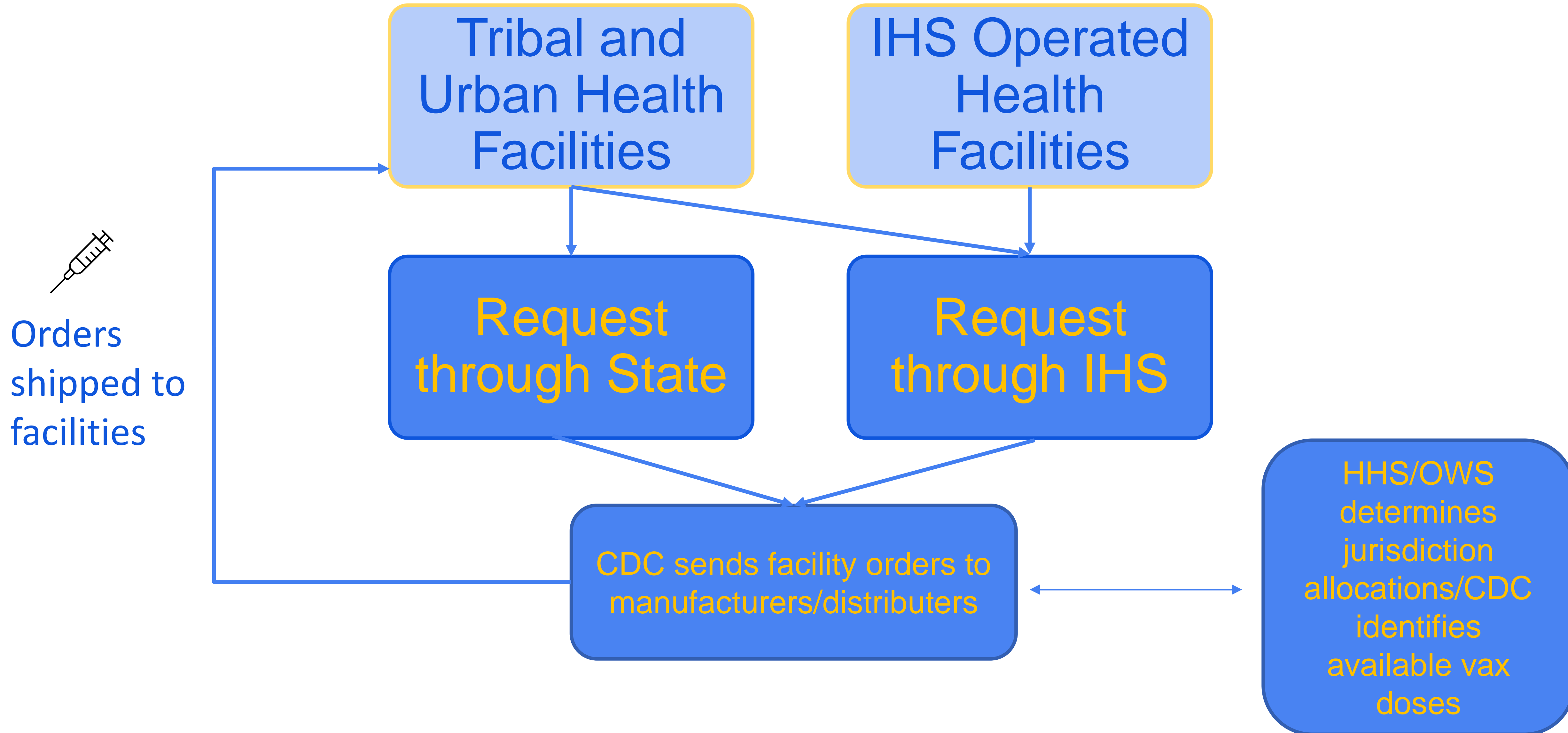
Tribal Consultation Feedback and Program Development

Feedback	Impact to program design
Ability to determine which vaccine to receive	-Health facilities requested vaccine as it became available
Request culturally appropriate communication materials	-Regular communication and updates to partners -Disseminated culturally appropriate information

Program Implementation

- State and IHS coordination with tribal health facilities
  - Planning for distribution roll-out
  - Population enumeration
- Vaccine distribution, handling, and training for all healthcare facilities
  - Hub-and-Spoke models
- Communication to partners
- Data systems: data collection, analysis, and sharing

Final Program Design



Roll Out

- Vaccine implementation in I/T/Us began December 2020, facilities began to receive vaccine based on population estimates
- 699 IHS, Tribal, and Urban health facilities had been enrolled in the IHS or state vaccine program to receive COVID-vaccine
  - 338 I/T/U facilities through IHS (approx. 2 million people)
  - 361 I/T/U facilities through the state (approx. 500,000 people)

December 14, 2020 Navajo Nation (Chinle, AZ)

"This vaccine was made for a purpose, to be used to protect us from the COVID-19 virus. We can't waste this opportunity. Everyone will have their chance to be vaccinated and everyone has to make their own choice. For me, I chose to be vaccinated because I know people- other medicine men- that have been exposed to the virus. Some have lost loved ones. I've listened to stories of people that were sick with the virus. I thought about my own priorities- my family, my loved ones. I was given this opportunity and I'm so grateful."

– Mr. Roland Begay, Chinle Comprehensive Healthcare Facility

Challenges and Lessons Learned

- Distribution
  - Cold chain vaccine delivery to health facilities
  - Clear coordination on distribution of vaccine to tribal health facilities between states and IHS
  - Tribes advocated for dual enrollment and ability to directly receive vaccine
- Access, availability, and ownership of vaccine administration data
- Concerns about vaccine safety and hesitancy
- Unexpected issues:
  - Cross-border vaccine sharing was initially undefined for tribal land that crossed into Mexico or Canada
  - Tribes wanted to modify vaccine cards to show their support

Recommendations

- Clearly message and train staff on giving deference to tribes determining their service populations and priority groups
- Recommend to ACIP to prioritize AI/AN populations for future pandemics
- Need for better coordination between IHS and states on vaccine distribution
- Retrospective review of immunization data systems
  - Develop a working group to review how data was collected and analyzed for AI/AN
  - Identify how to improve our data systems and processes for future pandemics
- Cross-border vaccine sharing policy gaps should be identified and established
- Modifications to the vaccine card should be allowed by the tribal nation

Acknowledgements

- Tribal leaders
- Tribal health facility leadership, clinicians, and nurses
- American Indian Health Commission
- State Health Department Immunization Programs
- CDC Federal Entities Team
- IHS Vaccine Distribution Task Force
- HHS Intergovernmental and External Affairs Team
- National Indian Health Board and other Indian Area Health Boards
- Many, many other tribal organizations and members that voiced their concerns and helped with implementation

Thank you!

Questions??

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.