[DRAFT]

Proposed Strategy for Improving Tribal and Urban Indian Organization Access to Federal Resources During a Pandemic Response

Introduction

The analysis contained in this document will outline current request processes for tribal nations and Urban Indian Organizations (UIOs) to access Strategic National Stockpile (SNS) and other federal public health response supplies under a variety of legal instruments and emergency response authorities, and will describe the factors driving both the request processes themselves and the methods through which SNS distributes medications and materiel during a response. From that analysis, this document will outline recommended guidance for facilitating the tribes' and UIOs' ability to directly access federal public health emergency response supplies when needed during a public health emergency.

Background

The Administration for Strategic Preparedness and Response (ASPR) mission, and the Strategic National Stockpile's place in it:

ASPR leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies. ASPR collaborates with state, local, tribal, and territorial governments and other partners across the country to improve readiness and response capabilities. ASPR also serves as the principal advisor to the Secretary of the U.S. Department of Health and Human Services (HHS) on all matters related to federal public health and medical preparedness and response, and oversees the Secretary's Operations Center as the central hub for health emergency response operations.

The SNS has been in existence since 1999, when it was created as the National Pharmaceutical Stockpile. Since then, the SNS has grown into a $14 billion dollar repository of medical countermeasures, such as pharmaceuticals, medical supplies, and medical equipment. These countermeasures are held to guard against an array of biological threats and serves as a backstop to commercial and governmental capabilities in large-scale emergencies such as pandemic response. The SNS transferred from the Centers for Disease Control and Prevention (CDC) to ASPR in 2018. Since the transition from CDC to ASPR, the SNS has been a key element in ASPR's health security mission.

To ensure that it meets the nation's medical and public health needs before, during, and after a disaster or public health emergency, ASPR is focusing on three key areas: Respond, Restore, and Prepare.

1. Respond well and emerge stronger from the COVID-19 pandemic - ASPR leads the ongoing coordination of the COVID-19 response across HHS. To make sure ASPR doesn't lose the capability developed during COVID, ASPR is extending capabilities in the areas of logistics, public health and medical surge operations, and medical countermeasure development and distribution.

2. Restore resources and capabilities diminished during the pandemic - ASPR is actively restoring and strengthening capabilities depleted during the pandemic such as the SNS and securing the public health supply chain.

3. Preparing for future emergencies - ASPR is constantly scanning the horizon to prepare for future emergency incidents, whether natural or manmade. In collaboration with partner organizations, ASPR is leading the development of policies and frameworks that guide operations to enable its organization and partners to better prepare for, respond to, and recover from disasters and emergencies.

E.O. 14001, "A Sustainable Public Health Supply Chain"

The Tribal Access Working Group was convened to develop, expand, and refine processes for the Indian Health Service (IHS), tribal, and UIO providers to request federal assistance to locate critical medical supplies.

The source of the Tribal Access Working Group's charge was Executive Order (EO) 14001, "A Sustainable Public Health Supply Chain:"

- Shortly after taking office in January 2021, President Biden issued EO 14001 to direct various multiple actions to secure supplies necessary to respond to the COVID-19 pandemic as well as future large-scale public health emergencies.

- The overall goal of EO 14001 is to "ensure critical medical supplies are available to public health authorities when local supplies or commercial sources are overwhelmed."

The Tribal Access Working Group was specifically convened to address section 5 of the EO, "access to Strategic National Stockpile," which directed HHS to "consult with tribal authorities and take [appropriate] steps . . . to facilitate access to the SNS for federally recognized tribal governments, Indian Health Service healthcare providers, tribal health authorities, and Urban Indian Organizations."

Why was a specific direction to ensure tribal and UIO access to federal public health emergency supplies deemed necessary?

- During public health emergencies, the SNS and other federal and military stockpiles serve as an essential supply chain buffer to meet state and local demand for medical supplies and equipment when commercial supply is strained or insufficient.

- The COVID-19 pandemic revealed vulnerabilities in the global supply chain for medical countermeasures, Personal Protective Equipment (PPE) and other supplies.

- These supply chain vulnerabilities, and the shortages and delays that resulted, uniquely impacted tribal and Urban Indian Organization entities during the COVID response.

The work of the Tribal Access Working Group - to develop, expand and refine processes for IHS, tribal and UIO providers to access SNS and other federal medical supplies during a public health emergency - fits squarely within ASPR's mission focus to emerge stronger from the COVID-19 pandemic, restore and enhance mission capabilities, and prepare for future public health emergencies.

Organization of the Tribal Access Working Group

The Tribal Access Working Group was organized under SNS leadership, with collaboration from other HHS entities including:

- The Indian Health Service
- CDC's Center for Preparedness & Response (CPR)
- Administration for Community Living (ACL)
- Office of the Chief Information Officer (OCIO)

During initial planning meetings the original working group recognized that additional subject matter expertise was needed in providing technical assistance, training, and exercise support to our state, local, tribal, and territorial (SLTT) partners. The members recognized that enhanced SNS support to tribal nations and UIOs would have Public Health Emergency Preparedness funding and oversight implications. Consequently, subject matter experts from CDC's Division of State & Local Readiness (DSLR) were engaged to assist. To facilitate the outreach to the tribes and UIOs, the working group also added subject matter experts from the HHS Office of Intergovernmental and External Affairs and IHS Office of Urban Indian Health Programs with extensive experience in coordinating formal tribal consultations and Urban confer sessions.

As It has proceeded, the working group has continued to incorporate additional stakeholders with relevant subject matter expertise, including from the CDC Center for State, Tribal, Local, and Territorial Support (CSTLTS)/ Office of Tribal Affairs and Strategic Alliances (OTASA), for potential assistance with communications and technical assistance outreach to the tribes and UIOs and from FEMA's Tribal Liaison Office, for potential assistance with providing detail and context on current tribal and UIO request processes under different declaration authorities. Through its outreach efforts, the working group has assembled an array of federal stakeholders from ten different offices and agencies, and two different departments

Developing the Plan of Action

With those observations in mind, the working group set out to build the work plan and associated milestones:

- The working group focused effort around PHEP capabilities for MCM dispensing and administration, and medical material management and distribution.
- The working group also concentrated on developing communications and technical assistance plans to support the tribes' and UIOs capability to access federal resources.

Based on these discussions, the working group developed a four-prong work plan (also referred to as the four milestones):

- First, the working group proposed to review current ways that tribal nations could request pandemic response materiel from SNS, IHS, FEMA, and other federal support entities.

    The working group purposely chose not to limit the inquiry solely to resources available from the SNS. Early on, it became clear that tribes and UIOs were looking to, and receiving

support from, the IHS National Supply Service Center (NSSC), from the Federal Emergency Management Agency (FEMA), and from other avenues in addition to the SNS

- Second, the working group proposed to develop tiered, coordinated request processes to facilitate tribal nations' and UIO access to available federal medical supplies and materiel resources. This presentation focuses on the proposed processes for the requests from tribal nations and UIOs to the federal entities.
- Once that is complete, the working group proposes to develop a plan to communicate those revised request processes for federal support to tribal and UIO entities.
- And finally, the working group proposes to develop guidance and technical assistance to states, to assist them in supporting tribal nations' pandemic response.

Conducting the Analysis

Executing the first milestone required the working group to identify the known issues with the tribes' and UIO's access to federal resources during the COVID response. The working group needed a mechanism to obtain comprehensive feedback and recommendations from the tribal leaders and UIO leaders themselves on their experiences during the COVID response. The solution was to initiate tribal consultation and urban confer and conduct formal national listening sessions with tribal and UIO leaders and health care providers, to gather comments and observations from a broad range of tribal entities, of all sizes and shapes, from across the country.

The working group conducted three 90-minute national listening sessions via Zoom - two tribal consultations with tribal leaders and one urban confer session with UIO leaders - led by the SNS Director and featuring a panel of SMEs from SNS and IHS. Introductory "Dear Tribal Leader" and "Dear UIO Leader" letters outlined the focus of the sessions, and presented the three questions that the sessions would address:

- To identify the gaps in the processes used by tribal and UIO providers to request federal assistance for medical supplies during the COVID-19 pandemic
- To develop recommendations on how to close those specific gaps
- And, more generally, to develop recommendations to improve the request processes for federal assistance to access supplies held in the SNS and other Federal stockpiles

The three listening sessions drew over 280+ participants from tribal entities and UIOs from across the country, including self-identified leaders from ~32 tribes. Participants provided verbal observations and recommendations during the Zoom meetings and submitted written comments via the associated chat function and in separate memos. From the three sessions, the working group compiled over 170 pages of transcribed comments from tribal/UIO leaders, and SNS planners distilled them into a five-page summary. The working group then scrubbed the comments further to synthesize them into the process analysis required, combining like comments together by subject matter area, and grouping and prioritizing them by their effect on potential SNS pandemic response support.

The working group identified five primary themes in the tribal and UIO leaders' comments specific to COVID response medical supply support from SNS or other federal entities (FEMA, etc.):

- Comments reflecting the inscrutability and changeability of the various request processes the tribes and UIOs had to follow, and how they affected the costs the tribes and UIOs would incur
- Comments and questions on the timing and mechanics of requests
- Suggestions for visibility on what is available in the Stockpile
- Comments reflecting on the accuracy of items received, and
- Comments on the tribes' ability to access HHS Regional Emergency Coordinators for their assistance

Based on the insights gleaned from the three listening sessions, the working group completed its review of current processes through which the tribes and UIOs can request pandemic response materiel from SNS, IHS, FEMA, and other federal support entities in December 2021.

Summary of Analysis and Recommendations

The analysis and recommendations contained in this document outline current request processes for tribal nations and UIOs to access SNS and other federal public health response supplies under the following authorities:

- The Stafford Act (through FEMA),
- A declared Public Health Emergency (through HHS), or
- Other emergency response authorities

Additionally, the analysis and recommendations contained in this document provide guidance for facilitating the tribes' and UIOs' ability to directly access federal public health emergency response supplies.

It is important to note that the SNS request process varies depending on the threat and number of people affected. These factors also result in SNS using a variety of distribution methods:

- In some cases, the SNS is the only repository of certain medications used to treat rare conditions (e.g., for those with reactions or exposures to smallpox vaccine). In such cases, the SNS might deploy this materiel to treat a single person.
- For large-scale incidents, the SNS can distribute materiel in containerized or palletized configurations or by using its rapid purchasing power.
- For other events, the SNS may be the only source of large quantities of required materiel or may be the only source able to move materiel rapidly enough to meet the needs of the jurisdiction and affected population.
- Because of the need for immediate administration of some MCM (e.g., antidotes to chemical agents or CHEMPACK), some materiel are pre-positioned in states and localities to allow for immediate use following an incident in which local supplies are depleted or do not exist.

Pathways for a tribal nation or Urban Indian Organization request for pandemic resources:

In the following section, we outline the draft results of the analysis conducted in Milestone #2. We provide the recommended pathways for a tribal nation to submit a request for pandemic resources. These pathways apply more broadly to any health and medical resources needed to address a tribal nation public health or medical resource shortfall during a public health emergency.

This is a summary of the pathways, with an understanding that there will likely be distinct nuances in any future public health emergency.

In our analysis, we have identified that tribal nations may request federal resources through the Indian Health Service, through consultation with the CDC, through the FEMA Regional Administrator (particularly in cases where there is a Stafford Act declaration) or the HHS Regional Administrator, and finally, tribal nations may choose to coordinate through the states for resources.

Through Indian Health Service (IHS)

- The IHS National Service Supply Center (NSSC) can receive support from SNS
- Request flows from IHS through HHS Secretary's Operations Center to ASPR/SNS
- IHS facilities and UIOs may receive support from the IHS NSSC

Through the CDC Emergency Operations Center (EOC)

- Tribal nation consultation with CDC may be held for a range of needs, from small outbreaks to environmental health needs and to more complicated responses
- Urban Indian Organizations may confer with the CDC; however, the statutory relationship is different for UIOs and requests for support through IHS or the state health departments should be considered first
- Request flows from CDC EOC through HHS Secretary's Operations Center to ASPR/SNS

Through Federal Regional Administrators (FEMA and HHS)

For tribal nations seeking nation-to-nation assistance in larger scale responses (when approaching the threshold for a Stafford Act declaration), the recommended primary coordination point is the FEMA Region or the HHS Regional Administrator's office

- Provides consistency between Stafford Act guidance and events that do not meet that threshold
- HHS Regional Emergency Coordinator (REC) staff have coordination role and contacts for handling event escalation
- IHS Emergency Management Point of Contact (EMPOC) should be in the coordination loop with tribal nation and HHS REC to deconflict and reduce duplication of effort with IHS actions to resolve support requirements

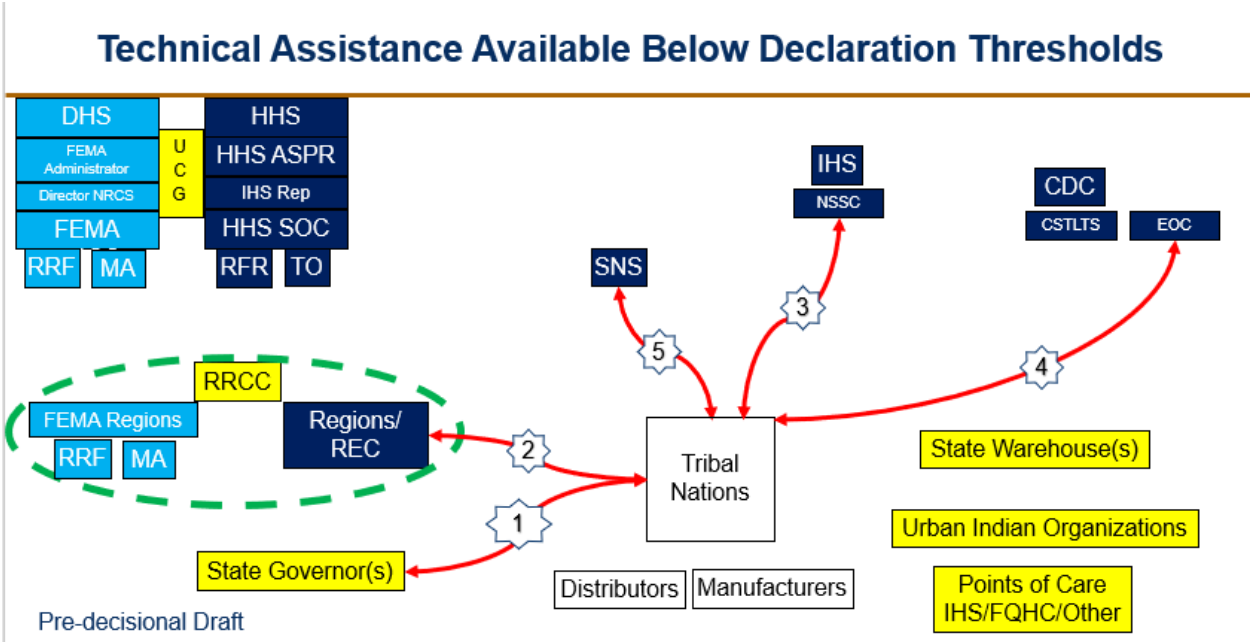
Nation-to-nation requests may be made directly to FEMA NRCC/SOC/White House, but the recommended request coordination point is at the Federal Region FEMA Regional Administrator or HHS Regional Administrator

- Consistent with FEMA Regional Administrators as tribal nation contact
- Request flows from HHS Region through the HHS Secretary's Operations Center
- Nation-to-Nation

Through States

- Tribal nations and UIOs may choose to use existing relationships with states to request federal pandemic resources and access SNS assets
- Tribal nation and UIO access to SNS assets through states can occur concurrently with IHS requests for SNS assets or with direct nation-to-nation requests. These requests should be deconflicted with/by the IHS Emergency Management Point of Contact (EMPOC) and the HHS Regional Emergency Coordinator (REC) in coordination with tribal leadership.
- Example: Tribal nation or UIO requests PPE for individuals through state, IHS facility requests ventilators directly through HHS REC and the HHS Secretary's Operations Center (SOC) rather than through the state.

Sources of Technical Assistance for Tribal Nations



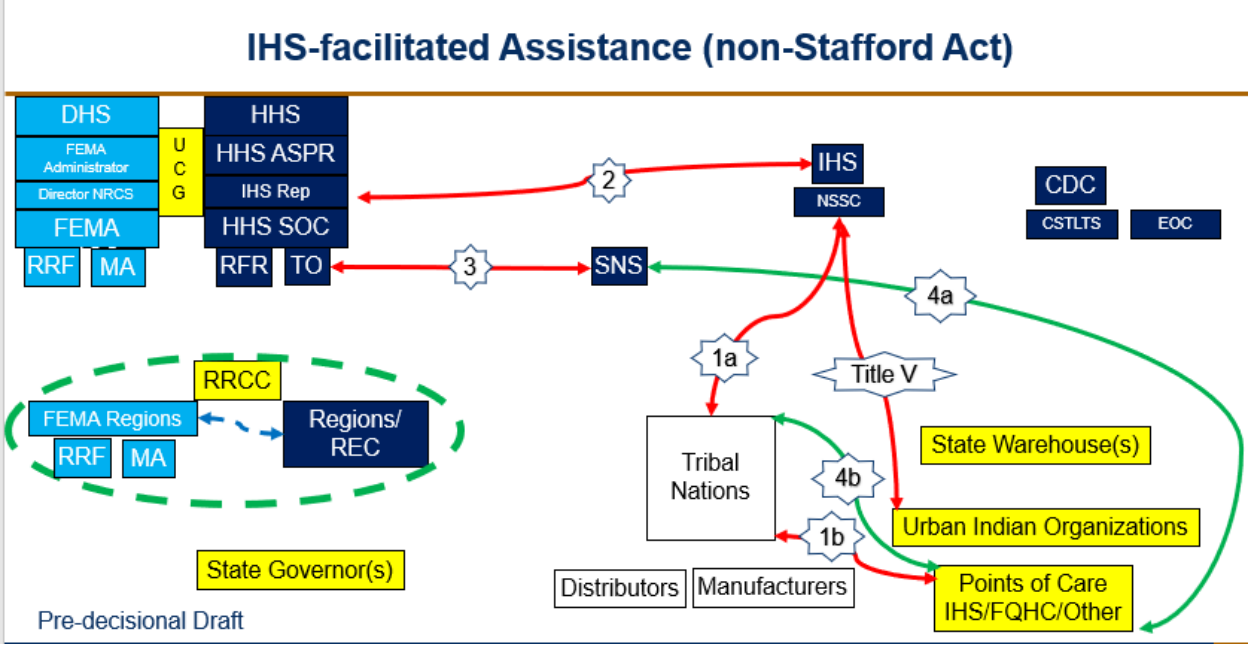
Red arrows indicate request flow or information flow in the above diagram.

For technical assistance, if the emergent situation does not meet the threshold for either a formal Major Disaster Declaration, or a Public Health Emergency declaration, the tribal nation may still seek assistance or support from the:

1. State governor or state agencies
2. HHS Regional Emergency Coordinator
3. IHS Regional Representatives including EMPOC
4. CDC EOC (consultations or MCM for individual patients, as an example)
5. SNS Operations Center

Additional Details Regarding the Request Flow for Requests from Tribal Nations:

Through Indian Health Service (IHS)



IHS-facilitated Assistance (non-Stafford Act):

Red arrows indicate request flow and green arrows indicate flow of resources.

1. A. Request from the tribal nation to IHS or IHS facility request to NSSC (Need to get process flow clarity from IHS for 1) Direct Service Tribes 2) Title I Tribes 3) Title V Tribes. Request from the tribal nation to/through the IHS facility or EMPOC

   B. Submits request to the HHS Regional Emergency Coordinator (REC) (Green dashed oval shows that RRCC is not activated; however, coordination between REC and FEMA regional staff occurs as shown with dashed blue arrow).

2. IHS sends requirements to IHS Rep in SOC to generate a Request for Resources (RFR).

3. For SNS-held assets, SOC generates a Task Order and issues it to the SNS Operations Center.

4. A. SNS provides support to IHS on behalf of the tribal nation as specified in the Task Order. B. IHS supports the tribal nation, as requested.

Through the CDC Emergency Operations Center (EOC):

(No flow chart provided)

1. A. Request from the tribal nation to CDC through clinical consultation

   B. CDC EOC submits request to HHS Regional Emergency Coordinator (REC) (Green dashed oval shows that RRCC is not activated; however, coordination between REC and FEMA regional staff occurs as shown with dashed blue arrow).

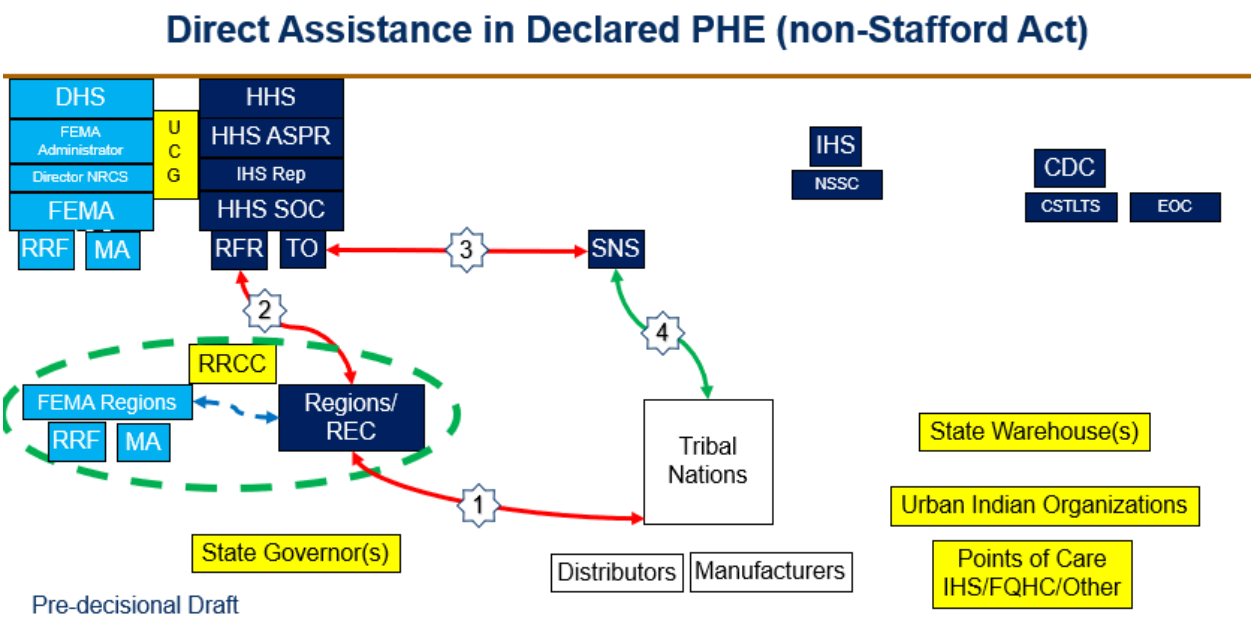
2. CDC EOC sends requirements to HHS SOC to generate a Request for Resources (RFR).

3. For SNS-held assets, SOC generates a Task Order and issues it to SNS Operations Center.

4. A. SNS provides support to tribal nation as specified in the Task Order.

   B. CDC supports tribal nation, as requested.

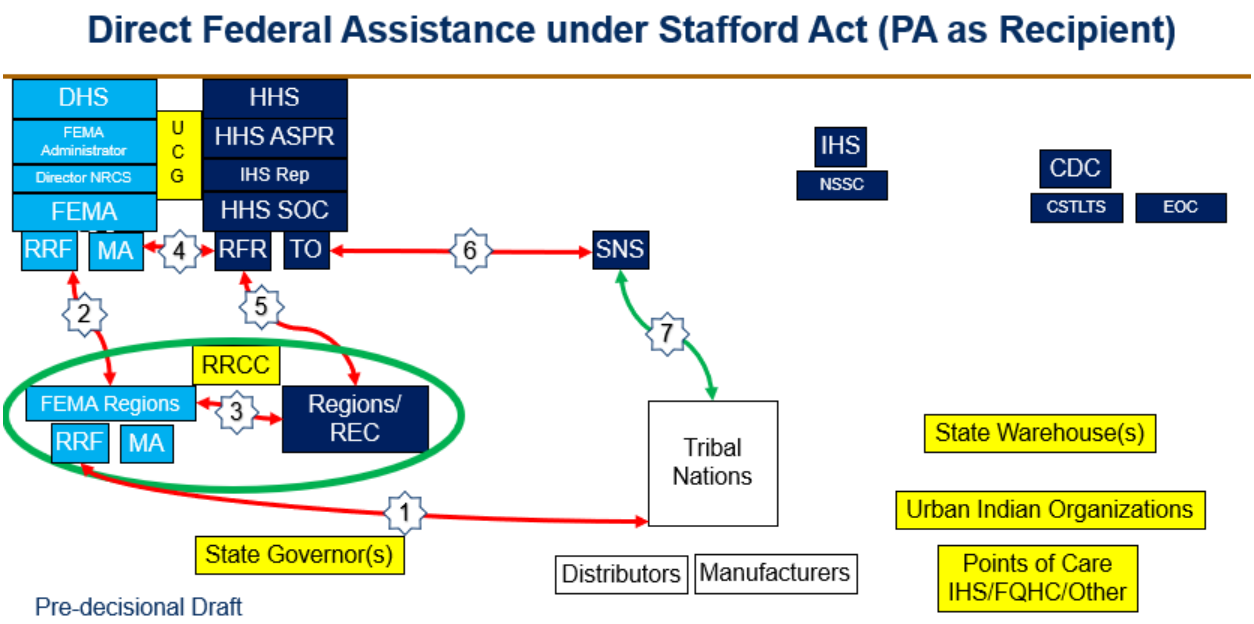
Through Federal Regional Administrators (FEMA and HHS)



Red arrows indicate request flow and green arrow indicate flow of resources.

Direct Assistance in Declared PHE (non-Stafford Act):

1. Request from the tribal nation to the HHS Regional Emergency Coordinator (REC) (Green dashed oval shows that RRCC is not activated; however, coordination between REC and FEMA regional staff occurs as shown with dashed blue arrow).
2. REC sends up region-level requirements to SOC as a Request for Resources (RFR).
3. For SNS-held assets, SOC generates a Task Order and issues it to SNS Operations Center.
4. SNS provides support to tribal nation as specified in the Task Order.



Red arrows indicate request flow and green arrows indicate flow of resources.

Direct Federal Assistance under Stafford Act (PA as Recipient):

1. Request from the tribe to the FEMA Region
2. FEMA RRCC coordinates with NRCC as needed
3. RRCC-level coordination with REC (ESF-8 and ESF-6)
4. Mission Assignment, whether issued at RRCC or NRCC is sent to SOC for generation of Task Order
5. REC can send up FEMA Region-level requirements to SOC as a Request for Resources (RFR)
6. For SNS-held assets, SOC generates a Task Order and issues it to SNS Operations Center
7. SNS provides support to tribal nation as specified in the Task Order

Tribal Nation Access to Public Assistance (PA) (Stafford Act) – notes from "Tribal Declarations Pilot Guidance" - FEMA, January 2017

- Can be cost reimbursement to tribal government
- If tribal government is unable to do the work themselves, can be DFA
- Direct Federal Assistance (DFA) is tasked to other agencies, such as HHS, by FEMA through Mission Assignment (MA) process
- DFA through MA is subject to same cost share as other PA-eligible work, billed back to tribal government once the DFA is complete
- In a state declaration, tribal government can choose to receive assistance as a recipient or a subrecipient

        - Subrecipient coordinates through state
        - Recipient signs a FEMA-Tribe Agreement

Additional requirements:

- Financial and grants management requirements
- Compliance with the Stafford Act
- Compliance with FEMA's regulations
- Monitor any subrecipients
- Meet non-federal cost share requirement
- Have an approved Tribal Mitigation Plan

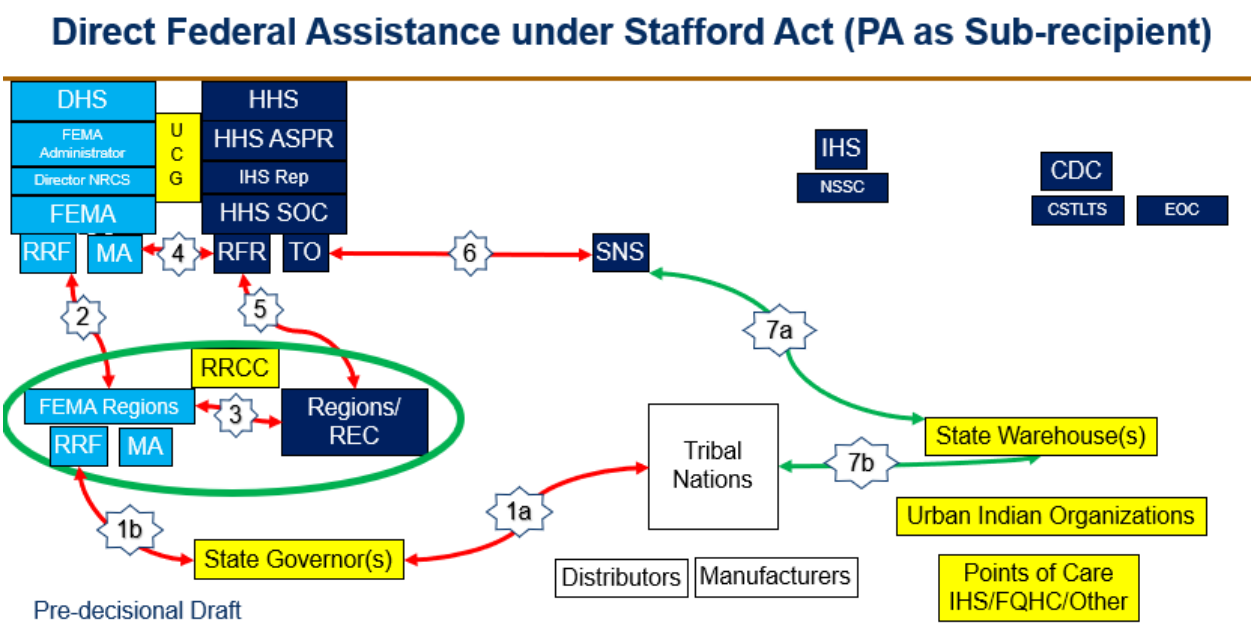
Steps for request:

- Emergency Plan Activation
- Initial Damage Assessment for PHE Public Health Assessment
- Joint Preliminary Damage Assessment (PDA)
    - Tribal government may request a Joint PDA concurrent with or separate from a state's request for a Joint PDA
    - The two governments may combine damage to support a single declaration request, even if the two governments requested separate Joint PDAs

Declaration Request – Chief Executive submits to the President through the appropriate FEMA Regional Administrator

Through States

Assistance coordinated through the states may come under multiple authorities. One is under a Stafford Act Major Disaster Declaration through PA as a sub-recipient.



Red arrows indicate request flow and green arrows indicate flow of resources.

Direct Federal Assistance under Stafford Act (PA as Sub-recipient):

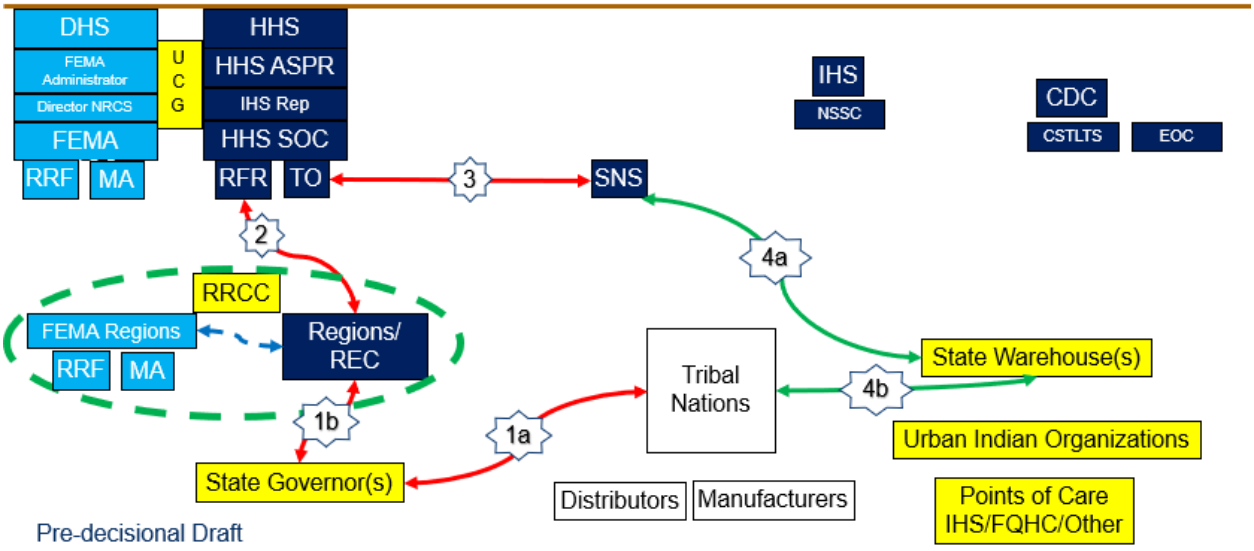
1. A. Request from the tribal nation to the state governor or state emergency management

   B. State submits request to FEMA Region on behalf of the tribal nation
2. FEMA RRCC coordinates with NRCC, as needed
3. RRCC-level coordination with REC (ESF-8 and ESF-6)
4. Mission Assignment, whether issued at RRCC or NRCC is sent to SOC for generation of Task Order
5. REC can send up FEMA Region-level requirements to the SOC as a Request for Resources (RFR)
6. For SNS-held assets, the SOC generates a Task Order and issues it to SNS Operations Center
7. A. SNS provides support to state for benefit of tribal nation as specified in the Task Order.

   B. State supports tribal nation as sub-recipient of the Public Assistance

For Public Health emergencies that do not meet the threshold of a Major Disaster Declaration, Tribal Nations may choose to request State-facilitated Assistance in Declared PHE (non-Stafford Act)

State-facilitated Assistance in Declared PHE (non-Stafford Act)



Red arrows indicate request flow and green arrow indicate flow of resources.

1. A. Request from the tribal nation to the Governor or state EM or state or local health agency which

   B. Submits request to HHS Regional Emergency Coordinator (REC) (Green dashed oval shows that RRCC is not activated; however, coordination between REC and FEMA regional staff occurs as shown with dashed blue arrow).

2. REC sends region-level requirements to the SOC as a Request for Resources (RFR)
3. For SNS-held assets, the SOC generates a Task Order and issues it to the SNS Operations Center
4. A. SNS provides support to state on behalf of tribal nation as specified in the Task Order.

   B. State supports the tribal nation, as requested

This is also a mechanism for tribal nations which are not federally recognized to receive assistance through the state.

In the pages that follow, we have provided an annotated summary of the findings from the Tribal Consultation and Urban Confer Sessions and the "Dear Tribal Leader" letter replies.

Summary of Findings from the Consultation and Confer Sessions:

Identified gaps for support from ASPR or SNS:

(ASPR/SNS) Lack of awareness of request process and understanding authority for requests.

(ASPR/SNS) Question about allocation and planning numbers for tribal access to countermeasures.

(ASPR/SNS) Need for better communication of changes in process for requests (my question – is it partly that there were different processes for different commodities? Drugs / Ventilators / PPE / Vaccine / …).

(ASPR/SNS) Tribal distribution times should be considered for SNS resource allocation planning.

(ASPR/SNS) Requests for SNS assistance when tribal supplies are nearly exhausted. Tribes should be able to order with more lead time.

(ASPR/SNS) Tribal access to consultation with RECs was limited for some tribes

(ASPR/SNS) Need for listing or catalog of what's available (online) and what's coming to tribe with tracking for follow-up

(ASPR/SNS) Received items (gowns, gloves) that were not requested and concern for taking away what others might have needed.

Identified gaps related to COVID vaccine:

(vaccine) Tribes were forced to choose one source for the vaccine (through state or direct from federal govt) and their experience was variable. Some who went through state did not receive enough to meet tribal needs. There was also a reluctance to go through the state due to issues in H1N1 response.

(vaccine) HHS/CDC established priority groups do not match tribes' ability to establish their own priority groups, which challenged "ordering" countermeasures by priority group.

Identified gaps related to contract and procurement capabilities:

(contracting/procurement) Tribal entities would like access to medical supplies on existing agreements and contracts

Identified gaps related to COVID testing and diagnostics:

(testing and diagnostics) Issue with considering purchasing a type of testing device (Cepheid) and then receiving Abbot ID now (with delays and limited supply)

Broader issues and some proposed solutions/strategies:

IHS was treated as a health jurisdiction and distributed/allocated resources that came through Congress.

Navajo set up a Joint Structure (Unified command) with FEMA/IHS/AZ

Proposal to have IHS representative in the SOC and at other key locations to serve as advocate for tribal entities.

(Medical staffing) Tribes would prefer access to staffing contracts for temporary medical personnel at reasonable contract rates

(exercise) Recommendation to include tribal nations in National Level Exercises

(Federal deployers) Several federal agencies deployed to tribal reservations were not aware of tribal sovereignty (Training gap for federal responders / FEMA IS / NDMS Training / SNS Training)

(infrastructure) Peripheral issues such as access to air conditioning and water in California tribes

From the letters sent in response to the Dear Tribal Leader

Identified gaps:

(SNS) Currently, tribes can request supplies from SNS through either state health officials or IHS officials. While it may seem helpful to have two avenues to request supplies, both options add an extra level of cumbersome red tape, which is extremely detrimental in times of emergency. When SNS works through states or IHS, rather than with tribes directly, we are not getting the information we need.

(SNS) The tribe took over the Winnebago Hospital from IHS because IHS was failing. We know we can provide more timely and efficient care to our tribal members. We need the tools and access to be able to do that. As sovereign nations, we are not to be made subservient to states. Tribes should be able to make SNS requests directly.

(overarching) Data sharing

(overarching) Transportation support to reach remote tribal areas

(testing and diagnostics) We received supplies not knowing where they came from and addressed to the wrong department. For example, Pharmacy was given Viral Transport Media (VTM) that could have been used by the Laboratory. The VTM media went unused for several months because no one knew what it was or who could use it.

(vaccine) Tribes that opted to receive their supply from IHS often received significantly less vaccine than tribes who selected the state for vaccines. Some states were able to meet or exceed the vaccine needs of the tribes within their jurisdiction, while other states were not able to distribute at least 100 vaccines each week for tribes.

(vaccine) Additionally, the Biden Administration had announced the retail pharmacy program for COVID-19 vaccinations based on selections of pharmacies by states and territories. This program excluded tribal pharmacies and excluded many AI/AN peoples from participating because they live up to 90 minutes from the closest pharmacy chain that was administering the vaccines.

(overarching) Too often, we are overlooked when it comes to supply chain distribution for supplies and medical countermeasures (MCMs). With respect to tribal requests for National Disaster Medical Systems (NDMS) assistance, often our requests are unnecessarily being routed through the state. Moreover, our requests for Disaster Medical Assistance Teams usually go through the Regional Emergency Coordinators, but tribes usually do not have direct access to the Regional Emergency Coordinators. Tribal governments should have direct access to SNS, ASPR, NDMS, and all federal resources.

Broader issues and some proposed solutions/strategies

Allow dual access to federal and state supply chains.

HHS should also consider including the topic of access to the public health supply chain in the annual HHS regional consultations held with tribes.

Every regional ASPR office should have a tribal liaison. In addition to access to the SNS, the federal government needs to notify tribes of policies and the process to request supplies and ensure that tribes have technical assistance to secure access.

SNS needs to establish a federal-tribal working group to address tribal issues and come up with solutions to problems. Tribal communities are particularly hard hit by the COVID-19 pandemic, and the effects of "long covid" are still unknown. Having an active working group can help tribes respond to the unknown that remains to be seen.

The Administration needs to change any guidance that ASPR and the SNS have received that directs them to work with states that would then be required to account for tribes' interests. Such guidance is inconsistent with the federal trust responsibility and the United States' treaty obligations. The guidance should direct ASPR and SNS to work with tribes and tribal health programs directly.

Relatedly, pursuant to the HHS' responsibilities to monitor the availability of national supply levels, HHS must be more proactive in engaging with tribes by collecting data on their current levels of resources. This will better illustrate for HHS the extent of tribal needs, the barriers to acquisition caused by the state pass-through process, and the delay between requests and order fulfillment.

Additionally, along the lines of the aforementioned, and considering many tribes' locations being remote and rural (like ours), tribal governments should also be included in all talks about how to get supplies distributed in our communities. We know the lay of our lands. Thus, we can help with logistical work of effective distribution and storage of items.

Additionally, a September 2020 GAO report noted that ASPR officials were seeking new legal authority to enter into joint acquisition agreements with states to enable greater supply acquisition coordination. ASPR should also seek new legal authority to enter such agreements directly with tribes. (GAO-20-701, p. 19)

There is no national public health emergency plan to clearly support tribal sovereignty. Develop a national public health emergency plan incorporating tribal sovereignty. Allocate federal resources and funding to develop a national plan for Indian Country.

Federal, state, and local agencies should work together to address tribal needs. During this pandemic it was evident that communication across all levels of government was a problem.

Federal agencies should revise the public health emergency plans to address issues and gaps reported by tribal nations. Is there a different public health emergency model that bridges HHS and FEMA as well as inclusion of tribal perspectives?

Establish regional stockpiles on tribal land with tribal consent.

Specific Comments from Urban Indian Organization leaders from the urban confer sessions

Topic/issue areas are identified in parenthesis and any reply provided by IHS or HHS during the urban confer session is shown with indent.

(Tracking System) Before having access to the Strategic National Stockpile (SNS), it would have been helpful to know what supplies were available. As a matter of follow up, a tracking system to notify UIOs how long it would take for the requests to be addressed and for updates should have been implemented. In the midst of the programs coordinating to assist, multiple attempts to reach out for guidance were made from the UIOs. This was not an optimal approach because not knowing how much Personal Protective Equipment (PPE) the UIOs were eligible to receive took away from other UIOs that may have needed it more during this process with no communication. For this reason, having a point of contact (POC) updated annually is important in order better coordinate for functionality purposes not only for a pandemic but for other issues such as imminent natural weather disasters. Communication becomes a barrier when UIOs do not know the IHS POC.

(Unnecessary Supplies) As an outreach referral site, there was concern about receiving unnecessary supplies such as gowns or gloves from the Area Office and the National Supply Service Center (NSSC). Understanding what types of services the UIOs provide would have been appropriate to better equip them with the necessary supplies so that there was no deprivation of the same supplies at another UIO site.

> [Response from] Indian Health Service (IHS) – The IHS will keep this recommendation in mind in terms of what facility IHS is working with, whether it is an Ambulatory, Limited Ambulatory, Residential Treatment center, or Outreach and Referral site. Different scopes of services mean different supplies.

(Unnecessary Supplies) Receiving random supplies that were not needed versus what was requested became an issue. Receiving supplies through the state of Washington was fluid and there was a tracking system involved with receiving their supplies. The weekly IHS communication provided support, which was helpful but what was the determination factor in priority when it came to requests for supplies or equipment such as an Abbott BinaxNOW machine?

> [Response from] HHS - These decisions were made with IHS. It involved many people where products were quickly pushed out rather than relying on requests. All the relevant departments were involved, and decisions were often based on the user population.

(Communication) Accolades to Captain Hayes for the effort in providing supplies. When NSSC had supplies, they accommodated. But when they were out of stock, there was no feedback or response from them regarding requests.

> [Response from] HHS - We were not prepared for this pandemic. It was challenging. The infrastructure communication was challenging. To push notifications at industry standard to contact individuals to let them know their products were coming was difficult. But we had success in working with people at the Area Office that were intimate with the UIOs.

(Effective Strategies Future Preparedness) UIOs could not access federal supplies, but IHS secured equitable resources. During the pandemic, the UIOs experienced receiving unnecessary medical supplies

and improper PPE not consistent with specific needs. No proper assessments and no data were evident, because there was no proper distribution. No direct access to the SNS meant receiving random shipments of PPE not aligned with current needs, which left the UIOs with an abundance of supplies. The UIOs then self-shared or distributed supplies to support one another. The distribution implementation needed to be addressed especially during heightened demand in the global medical supply chain. There were delays in receiving testing equipment and the UIOs were unable to maintain use of supplies, which caused an offset to their finances. All federal agencies engaged in emergency responses should have an established operational order regarding where to access the necessary equipment to ensure maximum protection. Finally, the UIOs must be recognized as community level first responders and have equitable access to all appropriate stockpiles.

Acronyms and abbreviations used in this document:

ACL	Administration for Community Living
AI/AN	American Indian and Alaska Native
ASPR	Administration for Strategic Preparedness and Response
CDC	Centers for Disease Control and Prevention
CPR	Center for Preparedness and Response
CSTLTS	Center for State, Tribal, Local, and Territorial Support
DHS	U.S. Department of Homeland Security
DSLR	Division of State and Local Readiness
EM	Emergency Management
EMPOC	Emergency Management Point of Contact
EO	Executive Order
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
FQHC	Federally Qualified Health Center
GAO	Government Accountability Office
HHS	U.S. Department of Health and Human Services
HQ	Headquarters
IHS	Indian Health Service
IS	Independent Study
MA	Mission Assignment
MCM	Medical Countermeasure
MRC	Medical Reserve Corps
NDMS	National Disaster Medical System
NRCC	National Response Coordination Center
NSSC	National Supply Service Center
OCIO	Office of the Chief Information Officer
OTASA	Office of Tribal Affairs and Strategic Alliances
PA	Public Assistance

PDA	Preliminary Damage Assessment
PHE	Public Health Emergency
PPE	Personal Protective Equipment
REC	Regional Emergency Coordinator
RFR	Request for Resources
RRCC	Regional Response Coordination Center
SME	Subject Matter Expert
SNS	Strategic National Stockpile
SOC	Secretary's Operations Center
TO	Task Order
UCG	Unified Coordination Group
UIO	Urban Indian Organization
VTM	Viral Transport Media
WG	Working Group