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REPUBLICAN STAFF DIRECTOR

U.S. House of Representatives
Committee on Natural Resources
Washington, DC 20515

March 18, 2020

Rear Admiral Michael D. Weahkee
Principal Deputy Director, Indian Health Services
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Dear Rear Admiral Weahkee,

I am writing to express my deep concern about the Indian Health Services (IHS) response to the Novel Coronavirus (COVID-19) and the impacts this world pandemic will have on Indian Country.

On March 6, 2020, the president signed H.R. 6074 – the *Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020* – into law. This new law provides grants or cooperative agreements to tribal organizations, urban Indian health organizations or health service to tribes, and allocates $40 million to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes.

On March 13, 2020, the Subcommittee for Indigenous Peoples of the United States staff held a conference call with several members of your staff to discuss various issues suggested to us by tribal leaders and organizations about federal COVID-19 response and prevention in Indian Country.

On March 14, 2020, the House of Representatives passed H.R. 6201 – the *Families First Coronavirus Relief Act* – which provides IHS with $64 million for diagnostic COVID-19 testing. Testing availability was identified by tribal leaders as one of the most immediate issues in dealing with COVID-19. Other key concerns include long wait times for testing results, the importance of providing emergency funding directly to tribes rather than through state intermediaries, quarantine concerns related to multi-generational housing, and the lack of clear federal guidance for IHS and tribal facilities.

Based on the IHS call with congressional staff late last week, I am concerned about your agency's COVID-19 response and a number of related issues that have arisen since the initial spread of the pandemic. To assist the Committee's oversight of this issue, please provide the following documents and information as soon as possible, but no later than March 27th:

Pandemic Funding for Tribes and Urban Indian Organizations

- Congress recently provided $40 million for tribes and urban Indian organizations through the Center for Disease Control (CDC). How is IHS working with the CDC to allocate funding to tribes?
- What criteria is IHS using to determine the amount of funding given to tribes and urban Indian health organizations?
- What is your timeline for disbursing critical funds and implementing comprehensive policies to tribes and urban Indian organizations?

Pandemic Supplies

- How do IHS facilities order materials necessary for COVID-19 testing? How many are able to test for COVID-19 on site, and for those that cannot, how do they order test results? What IHS policies are currently in place to order pandemic testing for IHS patients?
- How many respirators are currently available to IHS facilities, tribally operated 638 programs and urban Indian health organizations, respectively?
- How many Intensive Care Unit beds are currently available to IHS facilities, tribally operated 638 programs and urban Indian health organizations, respectively?
- Do IHS facilities, tribally operated 638 programs and urban Indian health organizations have direct access to the Strategic National Stockpile of Medical Supplies during pandemics? If not, is it your position that the administration could establish that access unilaterally, or that Congress would need to approve such access?

Pandemic Training – General

- What types of training have Indian Health Services hospital staffers received in preparing for and responding to COVID-19?
- What type of pandemic training information specifically related to COVID-19 has been shared with tribes and urban Indian programs?
- How does IHS utilize Tribal Epidemiology Centers (TECs) during pandemic responses and training?
- What is the current guidance for patient benefit coordinators regarding patient billing for COVID-19 testing?
- Please provide an overview of IHS' current public health surveillance system. How is pertinent information and positive case data transmitted from IHS to the CDC?

- What type of resources are provided to IHS facilities and urban Indian organizations to prepare for pandemics more generally?

Reporting and Testing

- How many IHS facilities, tribally operated 638 programs and urban Indian health organizations are certified to test for COVID-19? For those that are not certified, why are they not certified?
- What is the reporting and testing process for IHS facilities, tribally operated 638 programs and urban Indian health organizations?
- Will testing kits be available to all urban Indian organizations?
    - If not, what is the test distribution process? If this is this a need-based distribution, what are the criteria for assessing need and prioritizing sites?

Communication and Outreach During Pandemics

- What systems are in place to notify tribes and nearby cities about positive COVID-19 cases on tribal lands or found through urban Indian health programs?
- What is the IHS outreach and communication plan for tribes and urban Indian centers to provide prevention training?

Tribal Quarantines During Pandemics

- What steps is IHS taking to ensure that housing shortages identified by IHS facilities or urban Indian health centers are met with alternative housing methods for quarantines?
- How will IHS work with other agencies to ensure quarantine areas are readily available for potential outbreaks?

Transportation of Positive Pandemic Cases

- What are your agency's recommendations to tribes or urban Indian health centers for providing transportation to potential or positive COVID-19 cases?
- What is IHS' policy for transporting patients during pandemics?
- What is the average distance, respectively, for transporting patients at IHS and urban Indian health centers to sufficiently equipped health care facilities?

Protecting Vulnerable Populations During Pandemics

- What is IHS' policy to protect vulnerable populations during pandemics?
- How will IHS develop culturally competent policies to address health issues related to tribal elders?

During the conference call, my staff received assurances that your agency would readily respond to any correspondence with additional questions following the call. Please consider this letter a response to that invitation. Alternatively, considering the changing nature of this pandemic, I would welcome a follow-up conference call with Members of my Committee as soon as feasible. Please contact Naomi Miguel with the Subcommittee for Indigenous Peoples of the United States staff at Naomi.Miguel@mail.house.gov or (202) 225-6065 with any questions about this request.

Thank you for your attention to this matter. I look forward to a timely response.

Sincerely,

Raúl M. Grijalva
Chairman
Committee on Natural Resources

Enclosures:

- National Indian Health Board Letter to U.S. Department of Health and Human Services Secretary Alex M. Azar II
- National Council of Urban Indian Health Letter to U.S. Department of Health and Human Services Secretary Alex M. Azar II
- Confederated Tribes of Umatilla Indian Reservation Presumptive Coronavirus Press Release
- Oglala Sioux Tribe State of Emergency Declaration
- Navajo Nation State of Emergency for COVID-19

National Indian Health Board

Submitted via email: Secretary@HHS.gov

March 7, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Azar:

On behalf of the National Indian Health Board (NIHB) and the 574 federally recognized American Indian and Alaska Native (AI/AN) Tribes we serve, we write to strongly urge you to implement the recommendations outlined in this letter to ensure Tribes, Tribal organizations, and urban Indian organizations quickly receive necessary resources to prevent, prepare, and respond to the domestic presence of the 2019 novel coronavirus (COVID-19).

Indian Country is pleased that Congress included, and the President signed into law, $40 million in direct funding to Tribes, Tribal organizations, and urban Indian organizations under H.R. 6074, Coronavirus Preparedness and Response Supplemental Appropriations Act. We are also pleased that H.R. 6074 authorizes reimbursements to federal agencies like the Indian Health Service (IHS), and to Tribes, Tribal organizations, and urban Indian organizations that have expended funds since January 20, 2020 on COVID-19 preparedness and response activities.

On Thursday March 5, 2020, NIHB held a national All-Tribes call with over 200 Tribal leaders and health officials participating. NIHB held the call to seek input and guidance on how the set-aside funding for Indian Country under H.R. 6074 for COVID-19 response efforts should be managed. We write today to outline Indian Country's priorities and perspectives on how these funds should be delivered to Tribes, Tribal organizations, and urban Indian organizations and we stand ready to work with you to achieve the full implementation of these recommendations.

To that end, Indian Country puts forth the following recommendations to ensure a robust and comprehensive response to COVID-19 in Tribal and urban Indian communities:

1. **Authorize an interagency transfer of the $40 million in set-aside funds for Tribes, Tribal organizations, and urban Indian organizations from the Centers for Disease Control and Prevention (CDC) to the Indian Health Service (IHS) for dissemination**
2. **Triple the set-aside funds for Tribes, Tribal organizations, and urban Indian organizations to $120 million**
3. **Provide additional funds to cover related Tribal and urban Indian expenses for COVID-19 outside of strictly clinical care**

March 10, 2020

The Honorable Alex M. Azar II
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Submitted electronically via Secretary@HHS.gov

Re: Allocation of Coronavirus Preparedness and Response Supplemental Appropriations Act Funds to Urban Indian Organizations

Dear Secretary Azar:

On behalf of the National Council of Urban Indian Health (NCUIH) and the urban Indian organizations (UIOs) we represent,[1] we write to inform you of the method of expeditious distribution and amount of resources necessary for UIOs under the Coronavirus Preparedness and Response Supplemental Appropriations Act, supported by data collected from a national call for information from UIOs on their facility needs, incurred costs, and suggested mechanisms for funding. NCUIH urges you to implement the funding distribution recommendations outlined in this letter to ensure UIOs promptly receive the necessary resources to prevent, prepare, and respond to the domestic presence of the 2019 novel coronavirus (COVID-19). Any contrary action or delay in the distribution of funds to areas of significant need will impact lives.

NCUIH is the national representative of UIOs receiving grants under Title V of the Indian Health Care Improvement Act and the American Indians and Alaska Natives (AI/ANs) they serve. Founded in 1998, NCUIH is a 501(c)(3) organization created to support the development of quality, accessible, and culturally sensitive health care programs for AI/ANs living in urban communities. NCUIH fulfills its mission by serving as a resource center providing advocacy, education, training, and leadership for Urban Indian health care providers. NCUIH strives to improve the health of the more than 70%[2]

[1] NCUIH represents 41 urban Indian organizations which operate 74 facilities spanning 22 states.
[2] The American Indian and Alaska Native Population. U.S. Census Bureau. Accessed January 12, 2012, at: http://www.census.gov/prod/cen2010/briefs/c2010br-10.pdf.

percent of the AI/AN population living in urban settings, supported by quality, accessible health care centers and governed by leaders in the Indian community.

BACKGROUND

On March 6, 2020, H.R. 6074, Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Act) became law. The Act provides $8.3 billion in emergency funding for federal agencies to respond to the COVID-19 outbreak, including $2.2 billion for the Centers for Disease Control and Prevention (CDC), of which *not less than* $950,000,000 will be distributed via grants or cooperative agreements to states, localities, territories, tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes, and a proviso that "*not less than* $40,000,000 of such funds shall be allocated to tribes, tribal organizations, urban Indian health organizations, or health service providers to tribes." Grants or cooperative agreements with urban Indian health organizations will provide these funds to carry out surveillance, epidemiology, laboratory capacity, infection control, mitigation, communications, and other preparedness and response activities to prevent, prepare for, and respond to COVID-19, as well as to *reimburse costs* expended for these purposes incurred between January 20 and March 6, 2020.

RECOMMENDATIONS

In order to formulate an adequate, reasonable, and accurate national request regarding the distribution of this funding, NCUIH reached out to all 41 UIOs for input on their facilities' needs, estimated reimbursement costs, and their suggested mechanism to receive funding from the supplemental appropriations.

A. HHS Must Ensure $120 Million Is Distributed to Indian Health Care Providers

NCUIH's outreach demonstrated that significant need exists. Many UIOs have already begun planning for local outbreaks, with some already in the midst of local epidemics. Although the federal government has a trust obligation to provide health care services to AI/AN people regardless of their place of residence, UIOs, who serve AI/ANs residing in urban areas, operate on extremely low margins and suffer from chronic underfunding. Currently, the IHS budget provides a mere $57,684,000 for 41 facilities to operate 74 health facilities in 22 states. UIOs must look to grants and other supplemental funding sources to provide additional services and serve more patients. However, UIOs

have been left out of previous spending packages that address epidemics, like Zika. It is imperative that these funds reach UIOs expeditiously as these low margins will make it extremely difficult for these facilities to adequately plan for and address the COVID-19 epidemic. For instance, the 2018-2019 partial government shutdown had dire impacts on UIOs and caused, among other things: facilities closures, staff layoffs, reduced hours, and canceled programs/services. It is imperative that adequate supplementary funding reach these providers promptly to ensure they may continue to provide high quality care to their patients while also managing local outbreaks and minimizing risks to their communities. In addition, COVID-19 could have devastating impacts on AI/ANs in light of the health disparities they face.

For these reasons, NCUIH supports the request of the National Indian Health Board (NIHB) to provide $120 million (of the $2.2 billion appropriated to CDC) to tribes, tribal organizations, and urban Indian organizations. It is imperative that these funds not only reach Indian Health Care Providers quickly but also enable them to provide clinical care, as well as support the necessary supplies and resources to isolate and treat patients while mitigating the risk of spread to the community.

B. Funds Must Support Clinical Care and Supplies Including PPE

Among priorities identified in responses from UIOs were the needs for funding to support supplies, including adequate sterilization and sanitation supplies like hand soap, hand sanitizer, hospital-grade cleaning supplies; PPE including surgical and N95 masks, gloves, gowns, etc.; and administrative costs including the need for additional temporary staff to account for staff illness and additional internet access for remote staff. These costs quickly add up and UIOs report significant difficulty in obtaining adequate supplies as well as price hikes cutting into their already limited funding. Therefore, we support the request of NIHB to enable the funds to provide the necessary clinical support but also ensure funds can be utilized for these purposes.

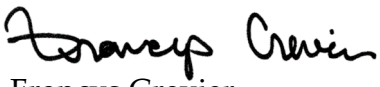
C. Suggested Mechanism to Distribute the Federal Funding

The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 states that the Director of CDC "may satisfy the funding thresholds outlined [regarding funding to urban Indian health organizations] by making awards through other grant or cooperative agreement mechanisms" and each grantee "shall submit a spend plan to the CDC not later than 45 days after [March 6, 2020]." However, not all of the 41 UIOs have existing cooperative agreements with CDC. NCUIH notes the extreme

sense of urgency in disseminating these funds given the rapid spread of COVID-19 and that facilities are necessarily already preparing for the epidemic. Therefore, any unnecessary delay is unacceptable – including delay caused by a novel grant or application process. To that end, NCUIH supports an inter-agency agreement with IHS, as outlined in NIHB's request, for prompt distribution from IHS to Indian Health Care Providers (including UIOs), to the extent that such distribution can occur expeditiously. In the event this would create unforeseen delays in funds distribution, NCUIH recommends CDC work expeditiously with IHS and stakeholders to ensure Tribes, tribal organizations, and UIOs can have access to the resources they need to protect their patients.

Communications on this matter may be directed to Julia Dreyer, Federal Relations Director for NCUIH at jdreyer@ncuih.org.

Sincerely,



Francys Crevier
Executive Director
National Council of Urban Indian Health

cc: Robert R. Redfield, Director, Centers for Disease Control and Prevention
Captain Carmen Clelland, Director, Office of Tribal Affairs and Strategic Alliances, Centers for Disease Control and Prevention
RADM Michael D. Weahkee, Principal Deputy Director, Indian Health Service
P. Benjamin Smith, Deputy Director for Intergovernmental Affairs, Indian Health Service
Rose Weahkee, Ph.D., Acting Director, Office of Urban Indian Health Programs, Indian Health Service
The Honorable Roy Blunt, U.S. Senate
The Honorable Patty Murray, U.S. Senate
The Honorable Rosa DeLauro, U.S. House of Representatives
The Honorable Tom Cole, U.S. House of Representatives
The Honorable Lisa Murkowski, U.S. Senate
The Honorable Tom Udall, U.S. Senate
The Honorable Betty McCollum, U.S. House of Representatives
The Honorable David Joyce, U.S. House of Representatives
The Honorable Richard Shelby, U.S. Senate
The Honorable Patrick Leahy, U.S. Senate
The Honorable Nita Lowey, U.S. House of Representatives

The Honorable Kay Granger, U.S. House of Representatives

4. **Minimize deployments of Commission Corps officers stationed at IHS, Tribal and urban Indian sites**
    - **<u>We urge you to deem all IHS Commission Corps officers as mission critical</u>**
5. **Clarify the process by which Tribes, Tribal organizations, and urban Indian organizations can receive reimbursements authorized under H.R. 6074**

<u>Background</u>

Each department and agency of the United States federal government has trust and treaty responsibilities to AI/AN Tribes and Peoples. These responsibilities were established through over 350 Treaties between sovereign Tribal Nations and the United States, and reaffirmed in the United States Constitution, Supreme Court case law, federal legislation and regulations, and presidential executive orders.

Congress further reaffirmed the federal trust responsibility under the permanent reauthorization of the Indian Health Care Improvement Act (IHCIA) when it declared that "… *it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians… to ensure the highest possible health status for Indians and urban Indians and to provide all resources to effect that policy*."[1] It is essential to remember that these obligations exist in perpetuity. As such, the federal government must honor its obligations to Tribes and AI/AN Peoples in the COVID-19 response and we believe the best way to do that in this scenario is to transfer the $40 million in Tribal and urban Indian COVID-19 funds to IHS for immediate distribution.

Further, Section 601 of IHCIA established IHS as an agency under the U.S. Public Health Service (USPHS), making it an integral part of the federal public health emergency response apparatus. Relatedly, Section 218 of IHCIA authorizes IHS to award funds to Indian Country for communicable and infectious disease prevention, control, and elimination measures. This is important, as the Indian health system has a large federal footprint nationwide with 605 hospitals, clinics, and health stations managed by IHS, Tribal, and urban Indian health programs (the I/T/U system) stretching over 37 states. IHS also has the most efficient mechanism in place to ensure funding swiftly reaches the I/T/U system with the added strength of the statutory authority under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) to award funds to Tribes under self-determination or self-governance contracts and compacts.

Despite the large footprint of the Indian health system and inclusion of IHS as an agency under the USPHS, the Service is frequently excluded from federal public health emergency response efforts. In addition, IHS is not even included in the White House Coronavirus Task Force led by the Vice President – a situation which Tribes would like to see corrected. IHS also is not able to directly access pharmaceuticals, supplies, and other medical countermeasures (MCMs) from the Assistant Secretary for Preparedness and Response (ASPR) Strategic National Stockpile (SNS). This needs to be corrected, as well.

[1] 25 U.S.C. 1601 et seq.

The most recent version of CDC's report on how state, local, and Tribal entities can access SNS resources acknowledges that, "…*Many planners mistakenly believe that* [AI/AN] *communities will receive MCMs from the Indian Health Service (IHS) or another federal agency. However, CDC's guidance calls for state and local health departments to coordinate with these communities, develop written agreements, and ensure those living on tribal lands will receive MCMs.*[2]

It is entirely unacceptable that IHS has to face restrictions in accessing SNS resources, and that the only recourse for sovereign Tribal governments to access SNS resources is by working with local and state entities when the trust responsibility lay solely with the federal government, and not with the states. It is equally unacceptable that a state governor must request a presidential disaster declaration on behalf of a Tribal Nation under the Stafford Act in order for a Tribe to directly access resources. In light of the COVID-19 health emergency, these federal structural failures are once again placing AI/AN lives at increased risk of disease and death.

AI/AN Health Disparities and Increased Risk for COVID-19

AI/AN Tribal and urban Indian communities are disproportionately impacted by health conditions that the Centers for Disease Control and Prevention (CDC) has specifically identified increase the risk of a more serious COVID-19 illness. Among these are heart and lung disease, diabetes, and respiratory illnesses.[3] Among AI/ANs 18 years of age and over, rates of coronary heart disease are 1.5 times the rate for Whites[4], while rates of diabetes among AI/ANs in the same age group are nearly three times that of Whites.[5] Studies have shown that AI/ANs are also at increased risk of lower respiratory tract infections,[6] and in certain regions of the country are twice as likely as the general population to become infected and hospitalized with pneumonia, bronchitis, and influenza.[7]

Health disparities in Indian Country are exacerbated by the chronic underfunding of the Indian health system, and statutory restrictions in access to federal public health funding streams. For instance, per capita medical expenditures within Indian Health Service (IHS) in FY 2017 were $4,078, compared to $9,726 in national per capita spending that same year. Tribes, Tribal organizations, and urban Indian organizations remain ineligible to apply for CDC Public

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[2] Centers for Disease Control and Prevention. Receiving, Distributing, and Dispensing Strategic National Stockpile Assets: A Guide for Preparedness, Version 11. Retrieved from https://www.orau.gov/sns/v11/ReceivingDistributingDispensingSNSAssets_V11.pdf

[3] *See* https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html

[4] CDC 2020. Summary Health Statistics: National Health Interview Survey: 2018. Table A-1a. http://www.cdc.gov/nchs/nhis/shs/tables.htm

[5] CDC 2019. Summary Health Statistics: National Health Interview Survey: 2018. Table A-4a. http://www.cdc.gov/nchs/nhis/shs/tables.htm

[6] Santiago Manuel Cayetano. Lopez, MD, Zachary Weber, Medical Student, Geralyn Palmer, Medical Student, Travis Kooima, Medical Student, Fernando Bula-Rudas, MD, Archana Chatterjee, MD, PhD, Archana Chatterjee, MD, PhD, 2615. Increased Severity of Lower Respiratory Tract Infection Among Native American Compared with Non-Native American Children, *Open Forum Infectious Diseases*, Volume 6, Issue Supplement_2, October 2019, Pages S909–S910, https://doi.org/10.1093/ofid/ofz360.2293

[7] Groom, A, et al. Pneumonia and influenza Mortality among American Indian and Alaska Native People, 1990-2009. Am J Public Health. 2014 June; 104. Supplement 3: S460–S469. Published online April 2014. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035860/.

Health Emergency Preparedness (PHEP) grants, and historically receive very little CDC funds for public health.

In fact, the $21 million per year Good Health and Wellness in Indian Country (GHWIC) program is the largest source of dedicated public health funding for Indian Country, and it has been proposed for elimination in the last three President's Budget requests. This is a compelling reason why Indian Country does not believe CDC has the organizational commitment to champion and protect public health resources for Tribal and urban Indian organizations. Further, CDC has historically expressed very little cultural competency to address Tribal and urban Indian needs, and the current COVID-19 emergency requires swift and appropriate action. That is why Indian Country is asking for their set-aside emergency COVID-19 funding to be administered through IHS, which possesses both cultural and structural competency to ensure these resources reach Indian Country in alignment with Tribally informed methods.

In conclusion, to effectuate more robust and comprehensive access to COVID-19 prevention, control, and response efforts across Indian Country, we ask that the following recommendations be implemented:

1. **Authorize an interagency transfer of the $40 million in set-aside funds for Tribes, Tribal organizations, and urban Indian organizations from CDC to IHS for immediate dissemination**
    - The IHS has direct access to and relationships with Tribes, Tribal organizations, and urban Indian organizations in a way that CDC does not.
    - Authorizing an interagency transfer of funds from CDC to IHS would assist in guaranteeing that the entire Indian health system is included in response efforts.
    - In addition, transferring the funds to IHS would allow funds to be distributed according to IHS rules and regulations, thus allowing self-governance Tribes to receive COVID-19 funds under P.L. 93-638 self-determination or self-governance contracts and compacts.

2. **Triple the set-aside funds for Tribes, Tribal organizations, and urban Indian organizations to $120 million**
    - Tribes, Tribal organizations, and urban Indian organizations urgently need COVID-19 funds. If the $40 million in set aside funds were to be equally distributed across all of Indian Country, it would amount to only $65,000 per Tribal Nation and Urban Indian Organizations, which is entirely inadequate.
    - H.R. 6074 established $40 million as the baseline Tribal set-aside, with the opportunity to receive additional funding. We urge you to consider tripling the set-aside to $120 million for Tribes, Tribal organizations, and urban Indian organizations to ensure that Indian Country is more appropriately resourced.
    - We urge the federal government to identify additional resources and reallocate them to Indian Country for this purpose.

It would be wholly unacceptable for the federal government to fail to sufficiently fund all 50 states in the COVID-19 response – why then should it be acceptable to fail to sufficiently fund all of Indian Country, to which the federal government holds trust and treaty obligations?

3. **Provide additional funds to cover related Tribal and urban Indian expenses for COVID-19 outside of strictly clinical care**
    - Most IHS and Tribal facilities lack the necessary laboratory infrastructure to test for COVID-19, and also lack the supplies and resources to isolate or quarantine patients experiencing symptoms, provide personal protective equipment to providers and first responders, and connect patients to care services. As a result, Tribal and urban Indian entities have faced additional ancillary expenses such as for transportation, lodging, patient referrals, and other expenditures.
    - While H.R. 6074 authorizes reimbursements for activities directly related to coronavirus preparedness and response, it does not explicitly outline reimbursements for related expenditures such as transportation and other expenses.

4. **Minimize deployments of Commission Corps officers stationed at IHS or Tribal sites**
    - **<u>We urge you to deem all IHS Commission Corps officers as mission critical</u>**
    - The Indian health system faces severe and chronic provider shortages. In a 2018 Government Accountability Office (GAO-18-580) report, provider vacancies across eight IHS Areas with substantial direct care responsibilities were at an average 25%, but stretched as high as 31%.
    - The Indian health system relies on Commission Corps officers to fill its widespread provider vacancies. In fact, the IHS is the largest recipient of Commission Corps officers nationwide.
    - IHS and Tribal sites have reported that dozens of Commission Corps officers have already been deployed, and an additional 100 have been authorized for deployment.
    - Taking Commission Corps officers from IHS, Tribal and urban Indian sites not only adversely impacts patient care, <u>it also poses a significant financial burden on the I/T/U system</u>. This is because I/T/U sites are still required to cover salary and benefits of Commission Corps officers, *even when they are on deployment*.

5. **Clarify the process by which Tribes, Tribal organizations, and urban Indian organizations can receive reimbursements authorized under H.R. 6074**
    - It remains unclear how Tribes, Tribal organizations and urban Indian organizations can submit reimbursement requests for expenditures related to COVID-19 between January 20, 2020 and the date of enactment of H.R. 6074.

- We ask that you work with IHS and CDC to issue guidance to all Tribes and urban Indian health entities clarifying the process for itemizing and submitting reimbursement requests.

As more and more cases are announced and as availability of medical supplies remains scarce, we urge your prompt consideration of these requests to ensure that necessary COVID-19 resources are delivered to Indian Country as expeditiously as possible. We stand ready to work you to ensure the Indian health system is fully prepared to address this health emergency.

Yours in Health,

Victoria Kitcheyan

Victoria Kitcheyan
Chairwoman
National Indian Health Board

cc: Robert R. Redfield, Director, Centers for Disease Control and Prevention
RADM Michael D. Weahkee, Principal Deputy Director, Indian Health Service
The Honorable Roy Blunt, U.S. Senate
The Honorable Patty Murray, U.S. Senate
The Honorable Rosa DeLauro, U.S. House of Representatives
The Honorable Tom Cole, U.S. House of Representatives
The Honorable Lisa Murkowski, U.S. Senate
The Honorable Tom Udall, U.S. Senate
The Honorable Betty McCollum, U.S. House of Representatives
The Honorable David Joyce, U.S. House of Representatives

For immediate release: March 2, 2020

Contact: Chuck Sams, (541) 215-9666

Presumptive Coronavirus Affects CTUIR

Mission, OR – The Confederated Tribes of the Umatilla Indian Reservation Board of Trustees has been informed by the Governor's Office via the Oregon Health Authority that a staff member of Wildhorse Resort and Casino has tested presumptive positive for Novel Coronavirus (COVID-19). The Board of Trustees has ordered an Incident Command be stood up. The Incident Command will consist of staff from Yellowhawk Tribal Health Center and the Tribal Government. The Board of Trustees has ordered that Nixyaawii Community School, Head Start, Daycare and Senior Center to be closed until all facilities have been fully sanitized. Wildhorse Resort and Casino will be temporarily closed in order to sanitize the facilities. Closures will take effect at 12:00 PM March 2, 2020. In addition, all community events on the Umatilla Indian Reservation are cancelled for the week of March 2 to 8, 2020.

The Novel coronavirus (2019-nCoV) is a virus strain that has only spread in people since December 2019. The virus is spread from one person to another through the air by coughing and sneezing, close personal contact, such as touching or shaking hands and touching an object or surface with the virus on it, then touching your mouth, nose, or eyes.

To help prevent the spread of this virus, the flu and common cold please:

- wash hands often with soap and warm water for at least 20 seconds. If not available, use hand sanitizer
- avoid touching your eyes, nose, or mouth with unwashed hands
- avoid contact with people who are sick
- stay home while you are sick and avoid close contact with others by not attending large events
- cover your mouth and nose with a tissue or sleeve when coughing or sneezing

The Confederated Tribes is coordinating the response to this event with the State of Oregon and Umatilla County. Public safety is a primary concern of the CTUIR. All efforts are being taken to ensure the health and safety of the community and will be providing information as it becomes available. Additional information about the virus and how to take necessary precautions can be found at https://www.oregon.gov/oha (https://www.oregon.gov/oha). A hotline has been established to answer questions and concerns by dialing 211.

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Tribal Service: Communications (/departmentprogram/communications) Topics:
virus (/general-tags/virus)
corona (/general-tags/corona)
coronavirus (/general-tags/coronavirus)
closures (/general-tags/closures)

Oglala Sioux Tribe
Office of the President
P.O. Box #2070
Pine Ridge, South Dakota 57770
1(605) 867-5821 Ext. 8420 (O) / 1(605) 867-6076 (F)

Julian Bear Runner

DECLARING A STATE OF EMERGENCY OF CORONAVIRUS DISEASE 2019 (COVID-19) ON THE PINE RIDGE RESERVATION

Declaration by the President of the Oglala Sioux Tribe, Julian R. Bear Runner

On this date, March 10, 2020 at 5:00 p.m. (MST), I am declaring a State of Emergency for the Pine Ridge Reservation based on the rising number of COVID-19 victims which directly affects the Lakota way of life and balance of society.

WHEREAS, the Pine Ridge Reservation covers more than 3 million acres in a remote and rural area, and has more than 45,000 enrolled citizens; and

WHEREAS, the Oglala Sioux Tribe is one of 16 sovereign nations in the Great Plains Region and a part of the Oceti Sakowin (Seven Council Fires, known as the Great Sioux Nation) with Treaty Rights, the United States' obligations to us, and our unique political relationship with the United States set forth in a series of Treaties through 1868, including the Fort Laramie Treaty of 1851 (11Stat. 749) and the 1868 Sioux Nation Treaty (15 Stat. 635); and

WHEREAS, the Great Sioux Nation, along with its allies, the Northern Cheyenne and Arapaho Nations, defeated the 7th Calvary Regiment of the United States Army at the Battle of the Little Big Horn, also known as the Battle at Greasy Grass, and the victory, along with capturing the United States flag that day on June 25, 1876 has been made a huge part of why the United States entered into peace Treaties with the Great Sioux Nation and its allies, however it is the belief of the Oglala Lakota that to this day we will continue to be punished by the United States for this act; and

WHEREAS, the United States Treaty obligations and trust responsibility to the Oglala Sioux Tribe call for efforts to ensure peace and property on the Pine Ridge Reservation; and

WHEREAS, despite the United States Treaty obligations and trust responsibility to our Tribe, our Pine Ridge Reservation suffers from unordinary high rates of deaths, along with unemployment and extreme poverty, within Oglala Lakota County alone, which is entirely within our Reservation and consistently one of the highest in negative statistics counties in the United States; and

WHEREAS, our Tribal citizens face many social challenges associated with generational and historical grief, compounded with real-time grief over the continual loss of loved ones due to all the negative statistics associated with the high rate of deaths, suicides, as well as homicides; and

WHEREAS, many of our Tribal citizens continue to face historical intergenerational trauma issues and horrific acts committed against Indigenous Nations, and are still reeling in the shock waves from the onslaught of christianity which seeks to eradicate our Lakota way of life and beliefs; and

WHEREAS, many of our Tribal citizens are pushing forth for the restoration of traditional lifeways and laws by understanding and practicing Lakota lifeways and laws in order to combat the extreme poverty, alcohol, drug abuse/addiction, and high crime rates as well as the imminent threat of the current COVID-19 Virus affecting our country and state.

WHEREAS, within the past week, the State of South Dakota and the Pan Handle of Nebraska, there has been 6 confirmed victims of the coronavirus, resulting in one deceased possibly related to the virus, now,

THEREFORE, I, JULIAN R. BEAR RUNNER, PRESIDENT OF THE OGLALA SIOUX TRIBE, DO HEREBY DECLARE A STATE OF EMERGENCY OF THE SARS-CoV-2, THE DISEASE THAT CAUSES COVID-19 ON THE PINE RIDGE RESERVATION; AND

BE IT FURTHER DECLARED, I, JULIAN R. BEAR RUNNER, President of the Oglala Sioux Tribe, remind the United States of America of its Treaty obligations and trust responsibilities to the Oglala Sioux Tribe and request immediate assistance from the United States Department of Health and Human Services and/or any other resources available in the form of immediate deployment of appropriate Supplies, Equipment and other related resources to the Pine Ridge Reservation to assist the Tribe with Medical Assistance, Prevention and Education as well as provide test kits for the associated disease/virus.

BE IT FURTHER DECLARED, I, JULIAN R. BEAR RUNNER, President of the Oglala Sioux Tribe, demand test kits for COVID-19 be provided to Pine Ridge Indian Health Service (IHS) due to their lack of ability to definitely test and diagnose for the virus, demand funding from the United States government for education and prevention of the Coronavirus (COVID-19), demand immediate action & protocol to be set as priority for I.H.S. to order and receive medical equipment and supplies.

BE IT FURTHER DECLARED, I, JULIAN R. BEAR RUNNER, President of the Oglala Sioux Tribe, demand protection measures for the Oglala Lakota Nursing Home and Cohen Home by restricting visitation to our elders and persons with heart disease, diabetes, and lung disease as they are at higher risk of getting very sick with this illness. Demand all schools to develop protocols for protective measures against COVID-19 and implement them. Demand Oglala Sioux Tribe to implement safety protocols and procedures against COVID-19 to ensure the safety of the general public. Demand Parks and Recreations to develop and implement protective measures and cease off reservation sales of the Buffalo to include the Buffalo at Pe Sla.

BE IT FURTHER DECLARED, I, JULIAN R. BEAR RUNNER, President of the Oglala Sioux Tribe, demand the ceasing of any stores attempting to price gouge during this time of emergency. Demand churches and non-profit organizations develop and implement quarantine procedures immediately for incoming donations and volunteer personnel. Demand all District Executive Boards develop and implement quarantine procedures immediately for incoming Native American Heritage Association (NAHA) donations prior to distribution.

BE IT FURTHER DECLARED, I, JULIAN BEAR R. RUNNER, President of the Oglala Sioux Tribe, demand all agencies and organizations report their protocols and procedures to the Executive Board of the Oglala Sioux Tribe immediately.

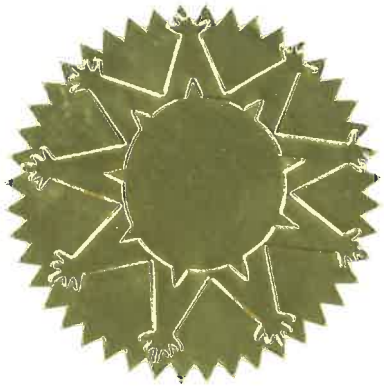
BE IT FINALLY DECLARED, I, JULIAN R. BEAR RUNNER, President of the Oglala Sioux Tribe, demand that the State of Emergency Declaration be fully supported to develop and implement protective measures against Coronavirus Disease (COVID-19) for the Pine Ridge Reservation.

By:

OGLALA SIOUX TRIBE

Julian R. Bear Runner, President

IN WITNESS WHEREOF, I have hereunto set my hand and cause to be affixed the Great Seal of the Oglala Sioux Tribe on this 10th day of March, 2020



The Navajo Nation
Office of the President and Vice President

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FOR IMMEDIATE RELEASE
March 11, 2020

Navajo Nation declares Public Health State of Emergency for COVID-19 coronavirus

WINDOW ROCK, Ariz. – On Wednesday, Navajo Nation President Jonathan Nez and Vice President Myron Lizer declared a Public Health State of Emergency for the Navajo Nation in response to the growing spread of the COVID-19 coronavirus, also known as "Diko Ntsaaígíí-Náhást'éíts'áadah" in the Navajo language. There are no confirmed cases of the COVID-19 coronavirus on the Navajo Nation, however the declaration is a proactive measure to help ensure the Navajo Nation's preparedness and the health and well-being of the Navajo people.

At the request of President Nez and Vice President Lizer, the Navajo Nation Commission on Emergency Management held a meeting on Wednesday to consider the growing concerns related to the COVID-19 coronavirus. The commission voted 4-0 in support of the declaration.

President Nez and Vice President Lizer also issued travel restrictions on Wednesday for all Executive Branch employees, which requires all divisions, departments, and programs to restrict all off-Nation work-related travel until further notice. They also directed employees who recently traveled to "hot spots," or areas known to have confirmed cases of the virus, to self-quarantine for approximately 14 days. All Executive Branch offices are either canceling or postponing conferences, summits, and events that draw large numbers of people from off the Navajo Nation.

"For several weeks, we've been planning and preparing while we monitor the growing spread of the virus. We have a large population of Navajo people that reside in many states including Utah, Arizona, New Mexico, and Colorado, which now have confirmed cases, so it's very important that we remain proactive and continue to provide outreach and information to the public. We don't want to create a sense of panic, but we want our Navajo people to plan and prepare in the event that the virus reaches our communities," said President Nez.

On Feb. 27, President Nez and Vice President Lizer established the Navajo Nation COVID-19 Preparedness Team to monitor, plan, prepare, and coordinate precautionary efforts to address the COVID-19 coronavirus. A Health Command Operations Center is also established within the Department of Health, which is made up of five function areas including Command, Operations, Planning, Logistics, and Finance/Administration.

President Nez and Vice President Lizer sent letters to members of Congress and the White House to ensure that Indian Health Service facilities and other hospitals receive financial support and resources from the recent $8.3 billion appropriations by Congress and President Trump to fight the spread of the COVID-19 coronavirus. In late February, President Nez also sent a letter to Indian Health Service requesting a mandatory 45-day quarantine for IHS commissioned officers that are deployed to high-risk areas and return to the Navajo Nation. IHS notified President Nez that they are complying with President Nez's request to ensure the well-being of IHS commissioned officers before returning them to service on the Nation.

As another proactive measure, the Division of Human Resources is also tasked with finalizing an "alternative work schedule" and a "tele-work policy" for Navajo Nation employees. In addition, the Community Health Representatives program and the Health Education Program are going door-to-door to educate and inform Navajo individuals with underlying conditions, including heart, lung, kidney disease, diabetes, and conditions that suppress the immune system. They also provide information and presentations at chapters, schools, and various worksites.

"Our command center officials and health professionals are doing everything they can to inform the public and to provide as much education as possible, but it's also up to us as individuals to do our part to prevent the spread of the virus in our communities. Please continue to check on your elders to ensure their well-being and to take precautionary measures to reduce risks," said Vice President Lizer. "With many students on spring break, it's imperative that parents keep their children safe by practicing good hygiene to prevent exposure to the virus."

Symptoms of the COVID-19 coronavirus include mild to severe respiratory illness with fever, cough, and shortness of breath. It can take up to 14 days for the virus to become active after exposure. Currently, there is no vaccine available for the virus, according to the Centers for Disease Control and Prevention.

The public is encouraged to take the following precautionary actions to help prevent the spread of the virus:

- Washing your hands with warm water and soap often for at least 20 seconds
- Cover coughs and sneezes
- Avoid touching your eyes, nose, and mouth
- Staying home if you are sick
- Avoiding contact with people with sicknesses/symptoms
- Cleaning/sanitizing common areas and "high-touch" surfaces
- Avoiding large gatherings and crowds

The coronavirus has the potential to become severe. Severe cases can also lead to pneumonia, kidney failure, and in some cases, death. The most vulnerable are the elders, young children, and those with compromised immune systems. Health care officials also advise that if a person has shortness of breath or has difficulty breathing, to report to your local physician and/or emergency room hospital and to call ahead to allow the facility to prepare for your arrival.

“Our Navajo people are strong and resilient. In times like this, we need to remember the challenges that our elders overcame. We will continue to pray for the safety and well-being for all people as we continue to be proactive. We will persevere through this,” added President Nez.

A list of established hotlines for the public to call with questions or concerns includes:

- Navajo Nation Health Command Operations Center: (928) 871-7014
- Chinle Comprehensive Health Care Service Unit: 1 (800) 242-9271
- Gallup Indian Medical Center Service Unit: (505) 726-5888
- Tséhootsooí Medical Center: 1 (800) 232-4342
- Winslow Indian Health Care Center: (928) 289-8143
- Sage Memorial Hospital: (928) 755-4500
- Tuba City Regional Health Care: (928) 283-2501

The Navajo Nation COVID-19 Preparedness Team will hold its third radio forum on Thursday, March 12th beginning at 6:00 p.m. on KTNN 660AM and 101.5FM to provide information and receive questions. The Navajo Nation Department of Health is offering to provide presentations to communities and other groups. Please send requests by email to coronavirus.info@nndoh.org or visit their website for additional information: http://www.ndoh.navajo-nsn.gov/COVID-19.

The Navajo Nation COVID-19 Preparedness Team will continue to coordinate with the county, state, and federal officials to monitor the evolving impacts of the coronavirus and continue to encourage the public to take precautions.

# # #

For the latest news from the Office of the President and Vice President,
please visit http://www.opvp.navajo-nsn.gov/ or find us on Facebook, Twitter, and Instagram.

THE NAVAJO NATION

JONATHAN NEZ | PRESIDENT MYRON LIZER | VICE PRESIDENT

CEM-20-03-11

RESOLUTION OF THE COMMISSION ON EMERGENCY MANAGEMENT

DECLARING A PUBLIC HEALTH STATE OF EMERGENCY FOR THE NAVAJO NATION DUE TO THE CONFIRMATION OF THE CORONAVIRUS DISEASE ("COVID-19") IN REGIONAL AREAS SURROUNDING THE NAVAJO NATION.

WHEREAS:

1. Pursuant to 2 N.N.C., § 881 the Navajo Nation Council established the Commission on Emergency Management, authorizing it to assess, verify, recommend and declare states of emergency with the concurrence of the President of the Navajo Nation; and

2. Pursuant to 2 N.N.C., § 883 (A) and (C) the Commission is empowered to coordinate immediate emergency and disaster relief services with Navajo Nation and non-tribal entities in conjunction with the Department of Emergency Management to recommend and deploy appropriate resources regarding natural and man-made emergencies; and

3. Pursuant to 2 N.N.C., § 884 (B), (2) the Commission on Emergency Management may seek assistance from federal, state, other tribal governments, and local and private agencies to address emergency and disaster related situations; and

4. The nature of the Coronavirus Disease ("COVID-19") is such that it has spread and increased globally, as indicated by the Centers for Disease Control & Prevention ("CDC"), the World Health Organization ("WHO"), and other public health organizations within the U.S. and regionally; and

5. In the U.S. the number of positive and presumptive positive cases have grown, with the rise in COVID-19 confirmed cases in Arizona, New Mexico, Utah, Colorado; and

6. No confirmed COVID-19 cases have been verified on the Navajo Nation and area Public Health Services are closely monitoring the situation; and

7. The Navajo Nation, in collaboration with various entities such as the U.S. Public Health Services Area Offices (Albuquerque, Navajo, Phoenix), CDC, state departments of health, Navajo Nation 638 Tribal Health Organizations and various other multi-agency groups, have organized an incident command approach to mitigate COVID-19 transmission on the Navajo Nation; and

8. In partial response to addressing the spread of COVID-19 on the Navajo Nation, a Navajo Department of Health ("NDOH") Command Operations Center has been established with an infrastructure to maintain situational awareness, conduct daily communication briefings among NDOH and key collaborative partners and, disseminate information to the public; and

9. The Navajo Department of Emergency Management (NDEM) Emergency Operation Center (EOC) shall be activated to support the Navajo Department of Health Command Center.

10. Locally, it is acknowledged and understood that the threat of transmission of COVID-19 needs to be mitigated to reduce risk of exposure to the Navajo People and the resultant consequential public health impacts.

NOW, THEREFORE, BE IT RESOLVED THAT:

1. The Navajo Nation Commission on Emergency Management hereby declares a Public Health State of Emergency for the Navajo Nation due to the confirmation of the Coronavirus Disease ("COVID-19") in regional areas surrounding the Navajo Nation.

2. To address increased concerns of potential public health impacts due to risk and exposure to the COVID-19, especially to our older population, the Navajo Nation must encourage independent responsibility and action by the Navajo People in practicing recommended preemptive measures to minimize, prevent and reduce risk of exposure to and from the COVID-19.

3. The Navajo Nation population receives timely, consistent and correct information needed on the COVID-19 on preventive measures against contracting and spread of the virus, signs, symptoms and contacting local hospitals and clinics for reporting.

4. In declaring the Public Health State of Emergency, all Navajo Nation Branches, programs, departments will comply with and adhere to directives, instructions, and/or policies forthcoming from the Navajo Department of Health as related to addressing COVID-19.

5. The needs of the Navajo Nation are to be addressed in a manner so as to provide the necessary resources required to address said Declared Public Health State of Emergency. This includes, but not limited to, resources of personnel, medical supplies and equipment, monetary funding, and other resources as may be required to protect the health, safety and welfare of citizens of the Navajo Nation.

CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the Navajo Nation Commission on Emergency Management at a duly called meeting at Window Rock, Navajo Nation, Arizona, at which a quorum was present and that same passed by a vote of 4 approved, 0 opposed, and 0 abstained this 11th day of March 2020.

Herman Shorty, Chairperson
Commission on Emergency Management

Motion by: Dicky Bain
Second by: Ben Bennett

CONCURRENCE:

Jonathan Nez, President
THE NAVAJO NATION

Myron Lizer, Vice President
THE NAVAJO NATION