NPAIHB Quarterly Board Meeting
Public Health Committee Meeting
January 19, 2021

Agenda

- Introductions
- Review of 2021 Policy Priorities
- Public Health Improvement Updates
- Data Access Update
- Other

Ali Desautel, Kalispel
Andrew Shogren, Digwalic/Swinomish
Ashley Hoover, NPAIHB
Bridget Canniff, NPAIHB
Celeste Davis, NPAIHB
Christina Diego, SIHB
Dawn Rae Bankson, CDC Foundation/NPAIHB
Karen Hanson, Kootenai
Lauren Sawyer, NPAIHB intern
Lona Johnson, Nooksack
Marilyn Scott, Upper Skagit
Nancy Bennett, NPAIHB
Nickolaus Lewis, Lummi
Obinna Oleribe, Klamath
Tam Lutz, NPAIHB
Tempest Dawson, North Sound Accountable Community of Health
Ticey Mason, NPAIHB
Tyanne Connor, CDC Foundation/NPAIHB
Victoria Warren-Mears, NPAIHB

Review of 2021 Policy Priorities – Public Health

For any corrections changes:

- COVID-19 Vaccine - none
- Public Health
    - Andrew Shogren: Add COVID-19 response – lack of PH infrastructure has hurt tribes in the response, underline that in addition to carrying the existing priorities forward. Example in #2 – where we didn't have the capacity and had to create it. But perhaps it should have its own number.
    - Obinna Oleribe – look at it as part of PH emergency response, as an example. Celeste Davis, suggested wording: "The COVID-19 pandemic has laid bare the

structural inequities that lead to health disparities. This includes inadequate public health infrastructure."
    - Victoria: Includes GHWIC support – important to expand that to include the TPWIC (Tribal Practices for Wellness in Indian Country) CDC funding?
    - #7 not just about funding, but inequity in general – in vaccine distribution, for example. (Ali)
    - For #5, update language "through CDC" rather than "to CDC"
    - Dr. Oleribe: Who defines what is appropriate in No 1? Victoria: each tribe defines what adequate PH infrastructure looks like for them (add tribal determination language)
    - Coordination between NPAIHB, states, tribes in determining needed public health infrastructure
    - Introductory sentence about current pandemic, enhance equity in PH response?
    - Victoria: Is this panel of topics what NPAIHB should put forward?
    - In #5, including other non-communicable disease, where asthma is specifically called out – bring up leading causes of morbidity/mortality, MV injury, for example, COVID-19, etc. (HCV and HIV called out specifically in next section, due to potential for loss of funding in previous cycles)
        - Unintentional injuries 3rd leading cause of death, all ages
        - For ages 1-44, number 1 leading cause of death
        - Specific to Motor Vehicle Injury: AI/AN aged 1-19 years, MV injury is the leading cause of unintentional injury death. Among infants less than one year of age, the motor vehicle traffic death rate among AI/AN is 8 times higher than that of non-Hispanic whites.
    - How can we strengthen public health infrastructure, especially for emergency purposes?
- HCV/HIV Treatment and Funding – no comments, may need some rewording for clarity

VWM general comments: Wordsmithing needed, broadening categories to take into account additional health conditions of public health concern. Not limiting ourselves to any one particular disease, although COVID-19 is all-encompassing right now.

Leg and policy team will incorporate out changes this evening, and present a more final document tomorrow. Will try to broaden some of this and capture concept of generic public health readiness.

Public Health Improvement Updates
Two upcoming initiatives/opportunities:

- Oregon Survey Modernization workgroup recruitment, to review how BRFSS and Oregon Health Teen survey data can be best used for decision making by the tribes and AI/AN communities, and identify and address limitations or gaps. Contact Bridget Canniff at bcanniff@npaihb.org or respond to our recruitment survey at https://www.surveymonkey.com/r/ORSurveyModRecruit
- Washington tribal data partners meeting: February 3, 10-1 PM, virtual meeting

- Agenda:
  - Introduction to the WA Tribal Public Health Improvement Program
  - Data Linkage presentation
  - Communicable Disease Data Briefs overview
  - Facilitated discussions
- Register at: https://www.surveymonkey.com/r/DataPartnersMtg

Data Access Update

The NWTEC has a data sharing MOU with the state of Idaho for COVID-19 data. This MOU is the broadest of any state and allows us to link the NW Tribal Registry with the State of Idaho COVID-19 data to correct for missing or incorrect AI/AN individuals. The state will then correct their records and provide them to CDC. This will make Idaho's AI/AN data very accurate. We feel that this MOU is a proof of concept and will be expanded to other data the state has that we can perform linkages with.

COVID-19 Discussion

- Ticey Mason: Concerns about mixing households, gatherings, parties, etc. where people are not social distancing, masking, or taking other precautions
- Chairman Lewis: high positivity, people who are positive out and about violating quarantine, but there is pushback at the tribe. Concerns about HIPAA as related to public health, where maybe our health team, under public health emergency declaration, could share more with law enforcement, casino, etc. – people aren't listening about COVID-19 risk, not just here at Lummi.
- Celeste Davis: The tribe, as public health authority, does have ability to make certain info known to public safety officials, or gaming commission probably as well, to share info about cases. This applies to public health authority in public health emergency. In different places, tribes have exercised this authority with non-compliant HIV patients, and in cases in the NW with TB patients not being compliant, which is highly infectious. Tribes made names and addresses, etc. available, not to the public, but other agencies and programs within the tribe to ensure quarantining and appropriate care, medication compliance, etc. Probably the best examples of laws/ordinances are from county health depts templates. Fines could also be implemented as a means to ensure compliance, even imposing fines after the fact.
- AIHC isolation and quarantine resources online:
  - COVID-19 model plans, policies, codes: https://aihc-wa.com/aihc-emergency-preparedness/incident-responses-and-other-news/covid-19-model-docs/
  - AIHC Model Communicable Disease Code is here: https://secureservercdn.net/50.62.172.232/tvl.3bf.myftpupload.com/wp-content/uploads/2020/03/AIHC-Model-Tribal-Communicable-Disease-Code-03-30-2020.doc
  - Communicable disease code example https://aihc-wa.com/covid-19-isolation-and-quarantine/
  - Involuntary Detention: https://secureservercdn.net/50.62.172.232/tvl.3bf.myftpupload.com/wp-

content/uploads/2020/03/Appendix-Q-Court-Order-Granting-Involuntary-Detention.doc

- Chairman Lewis: The tribe does have some control over employees who are deliberately going against policies, so what can we do for corrective action? There are policies in place, but a lot of people think they're not going to get it and when they do and have been out and about, and get COVID, they feel remorseful. But there are also concerns that people won't tell the truth in contact tracing if they risk reprimand or firing. Casinos/businesses staying open is another issue. When they initially closed, it leveled off COVID-19 spread, but with reopening, there are many challenges. There are also issues with what's happening on reservation vs. in Bellingham. Some tribes closed their borders early on, are there current or planned border closures?
- VWM example: Shoalwater Bay put in place, on the honor system, around the holidays, had employees agree to go into quarantine and be tested before going back to work if they might have been exposed in social settings. This is a little bit of a different approach that might work better in small clinic to ensure enough workforce would be available, but is an innovative solution. We encourage you to discuss with one another; there are some promising practices that allow people a break from COVID fatigue but also allow for a measure of control in the community.