

# Tribal Testing and Contact Tracing in New England

A REGIONAL STRATEGY for COVID-19

June 29, 2020

## Purpose

Create a regional Tribal Testing and Contact Tracing Strategy informed by assessments and dialogue with Tribal leadership and representatives. This strategy will meet leadership's intent, align resources with priorities, and provide courses of action for creating or improving Tribal Nation COVID-19 testing and contact tracing programs. This strategy will be shared as a resource for the ten Tribal Nations in New England, with the understanding that each has the option to adapt or modify the strategy to meet their Nation's unique needs.

## Problem Statement

### *Current state:*

The 10 Tribal Nations in New England have unique geographies, demographics and requirements for effective COVID-19 testing and contact tracing. Some Tribes are leading effective response internally, while others are receiving support from the state and some federal agencies. For the first time ever in Region I, four Tribal Nations are receiving federal support as direct recipients, working closely with FEMA to complete the required plans and documentation. Six Tribes have decided to be sub-recipients of the state and a team of three Tribal Liaison Officers is supporting all ten Tribes in the region. As we have progressed together through this global emergency, Tribes have collaborated with state and federal partners to develop creative solutions for immediate and critical needs. For example, one Tribe satisfied a critical testing gap through facilitation and coordination with the Federal Emergency Management Agency (FEMA), U.S. Dept. of Health and Human Services Office of the Assistant Secretary for Preparedness and Response (HHS ASPR), Indian Health Service (IHS), the State, and United South and Eastern Tribes (USET). Another Tribe worked directly with the State to obtain resources to meet their critical testing need. Yet another Tribe reached out to the Centers for Disease Control and Prevention (CDC) Tribal Support Unit to request assistance with the pandemic response and future planning.

### *Impact:*

Some Tribes are not able to effectively test or perform COVID-19 contact tracing at the level they would like. Compounding the testing and tracing gaps within some Tribes, *none* has direct access to testing and tracing data collected by non-Tribal public health facilities and other authorities for their respective populations. This information is essential to not only maintain visibility on disease burden in the community but affects Tribal leaderships' ability to properly plan for and inform actions to allocate scarce resources to protect their communities. Compounded by challenges to funding for necessary life-sustaining emergency activities, along with internal staffing shortfalls and nationwide shortages of PPE and other resources, the response to COVID-19 has stretched all available capabilities.

### *Desired state:*

Each of the 10 Tribal Nations in New England has a sustainable and effective testing, contact tracing, and mitigation strategy that is comprehensive and supportive of the unique needs of their communities. All federal and state agencies are synchronized and appropriately supportive of the Tribes' testing and contact tracing requirements. New collaboration can lead future, nationwide improvements and mitigate challenges for second-wave and future public health emergencies.

## Methodology

Joint Region I HHS ASPR and FEMA leadership have identified and supported the provision of COVID-19 testing and contract tracing for the ten federally recognized Tribal Nations in New England. To effectively provide federal support and ensure collaboration among ASPR, FEMA, CDC, IHS, and Tribal partners, the Region I Tribal Testing and Contact Tracing planning group was formed. The goal of this interagency planning group was to engage with the Tribes to assess their needs and support requests for testing and tracing activities. This document is the product of that collaboration.

Over the course of two and a half weeks, the planning group convened to research and analyze available resources and guidance, review self-reported Tribal assessments, and develop this strategy. The planning group participants included representatives from IHS, CDC, HHS/ASPR, FEMA, and the United South and Eastern Tribes (USET), benefitting from regional and national subject matter experts. The Planning Group met twice weekly, and performed an extensive review of existing guidance, technical assistance documents, and available resources.

This strategy presents two courses of action, each including information, policy guidance, technical assistance, resources, and funding opportunities meant to increase capacity for effective COVID-19 testing and contact tracing for

Tribal communities. It also presents considerations for additional opportunities for collaboration between Tribal Nations and their associated states, specifically to share information and ensure access to testing opportunities outside of the immediate Tribal jurisdiction.

To assess needs and collect information from the Tribes, Region I's COVID-19 response team leveraged relationships and access through the FEMA and HHS Tribal Liaison Officers who have developed and continue to maintain effective relationships with Tribal leaders and emergency management personnel. In late May 2020, the FEMA Tribal Liaison Officers requested feedback from the Tribes about their *current* testing and tracing capacity, their desired *ideal* capacity, and the resources they would need to reach that ideal. Responses were received from seven of the ten federally recognized Tribes in the region. The survey questions are provided in **Appendix A**.

## Findings

Many Tribes stated they had the testing capacity necessary for their community's current needs, however, they would need support with testing and contact tracing if they were to experience an increased incidence of disease or "outbreak" of positive cases. Some Tribes reported the need for an increase in the number of test kits (in some cases hundreds more than they currently have) for the Abbott ID Now machine, and swabs and viral transport media in order to regularly test their public-facing staff. Two Tribes reported implementation of a contact tracing program within their respective jurisdictions.

The majority of respondents identified the need for federal support, including:

- Continued Tribal Liaison Officer support
- Technical assistance (experts and/or field assistance teams)
- Contact Tracing (technology, applications, personnel)
- Antibody testing
- Access to testing materiel and related PPE
- Coordination with Federal and State partners for testing access, information sharing, and resource sharing
- Financial, equipment and human resource support

## Challenges and Successes

### Information Management

Existing limitations on Tribal Nation access to American Indian/Alaskan Native (AI/AN) health data are a significant barrier to even a basic understanding of the burden of many diseases facing Indian Country. Despite the treaty and trust obligations of the United States to ensure for overall health and wellbeing, Tribal Nations and the Indian Health System have been chronically underfunded for generations. This underfunding has played a significant role in preventing the development of a robust public health infrastructure. Simultaneously, individual states have cultivated extensive public health infrastructure, including the establishment of reportable disease and vital statistics reporting mechanisms, outbreak investigation, contact tracing, data collection, and quarantine measures for all residents, including AI/AN people. High rates of inaccurate racial classification within state datasets and the suppression of AI/AN data due to small numbers, leave Tribal Nations without accurate statistics regarding the overall health of our populations.

In recognition of these deficits, the 1996 reauthorization of the Indian Health Care Improvement Act (IHCA) established 12 Tribal Epidemiology Centers (TECs) across Indian country. In 2010, the permanent reauthorization of IHCA designated TECs as Public Health Authorities and further compelled the Secretary of HHS to share any and all health data with Tribal Nations. However, Tribal Nations and TECs continue to experience frequent challenges in access to data on both the federal and state level. HHS will, in coordination with host states, make appropriate Tribal data available to Tribal Nations and TECs as expeditiously as possible in accordance with Congressional intent under IHCA. To enhance Tribal Nations' efforts to monitor and address disease in their respective communities, States that receive federal dollars to assist in the execution of public health services will be required to share identifiable and appropriate data in their possession, consistent with state law and the requirements of the federal funding appropriated to support COVID-19 pandemic measures.

There have been a few stopgap measures, that although successful in the interim, require further effort to remain sustainable solutions in the long term. The successes shared below are from Tribal Nations that did not receive Abbott ID Now machines from IHS, and therefore had no point-of-care testing capability at their Tribal health clinics.

- One Tribe, through facilitation by HHS ASPR and FEMA, in coordination with IHS and USET, developed an agreement with their partner State to perform COVID-19 viral testing. The State public health lab agreed to test all specimens received from the Tribe at no cost, leaving the Tribe responsible only for the cost of testing material and shipping. This arrangement ensured the Tribal health authority would receive test results, as the orders for testing originated from the Tribe.
- Another Tribe, after requesting and being denied an Abbott ID Now machine from IHS and unsuccessfully attempting to procure one directly from various suppliers and Abbott laboratories, reached out to their partner State's department of health, which provided an analyzer and several test kits. The State agreed to provide more test kits as the Tribe uses their initial allotment, and the Tribe has the option to enter into an agreement with IHS for the provision of further test kits.

Although these agreements are appreciated and have addressed immediate, critical needs, the data sharing challenges remain. Without a lasting agreement between State and Tribe, Tribal health authorities will not have knowledge of results and disease incidence when their community members are tested and treated at non-Tribal facilities. At least one State has expressed support for this effort and recognizes the value of a data sharing agreement with Tribes. FEMA and HHS ASPR continue to engage the State to determine a long-term solution.

***The FEMA Tribal Liaisons and FEMA and ASPR leadership are available to coordinate discussion and advocate for synchronized and comprehensive solutions with State and external partners. If a Tribe would like assistance with this coordination, please reach out to your Tribal liaison.***

## Courses of Action

Based on feedback received from seven Tribal Nations, two courses of action are identified to achieve their self-reported ideal: 1) increase testing capacity, and 2) implement or enhance a contact tracing program. Each course of action (COA) is discussed below and includes the following sections: informational overview, options, and resources. The content of each COA is intended to serve as a guide that Tribes may use or modify to fit their unique needs.

### 1. Increase Testing Capacity

Two types of tests are available for SARS-CoV-2, the virus that causes COVID-19: viral tests and antibody tests. In general, a viral test identifies if an individual has a current infection and an antibody test shows if an individual had a previous infection. An antibody test may not be able to show if a person has a current infection, because it can take 1-3 weeks after infection to make antibodies. At this point, research has not identified if having antibodies to the virus can protect someone from being infected with the virus again, or how long that protection might last. Viral testing is considered *diagnostic* when conducted in individuals with symptoms consistent with COVID-19 or among asymptomatic individuals with known or potential recent exposures to SARS-CoV-2. Testing is considered *surveillance* when conducted among asymptomatic individuals without known or suspected exposure to SARS-CoV-2.

When using testing to help control disease spread, consider these guidelines for high priority COVID-19 viral testing:

- Hospitalized patients with symptoms
- Individuals with symptoms consistent with COVID-19
- Healthcare facility workers, workers in congregate living settings, and first responders with symptoms
- Residents in long-term care facilities or other congregate living settings, including correctional and detention facilities and shelters, with symptoms or exposures to individuals with COVID-19
- Persons identified by public health officials or clinicians as high priority, including:
  - Persons with symptoms of possible infection with COVID-19, including fever, cough, shortness of breath, chills, muscle pain, new loss of taste or smell, vomiting or diarrhea, and/or sore throat

- Asymptomatic individuals with recent known or potential exposure to SARS-CoV-2 to control transmission
- Persons without symptoms who come from racial and ethnic minority groups disproportionately affected by adverse COVID-19 outcomes: African Americans, Hispanics and Latinos, some American Indian Tribes
- Persons without symptoms who are prioritized by health departments or clinicians, including but not limited to: public health monitoring, sentinel surveillance, presence of underlying medical condition or disability, residency in a congregate housing setting such as a homeless shelter or long term care facility, or screening of other asymptomatic individuals according to state and local plans

## COVID-19 Testing Options

### a. *Viral Testing at Tribal Health Clinics*

Most Tribes reported this as the ideal option for the Tribal health authority to maintain ongoing awareness and implement efforts for control over disease incidence within the community. Whether a Tribe has an Abbott ID Now or other point of care testing capability, or they collect specimens to send to a reference lab for testing, the ordering clinician will receive the results for the tests they order.

Many Tribes reported an insufficient number of test kits and/or challenges to keeping their clinics supplied with testing material and necessary personal protective equipment (PPE). Tribes have a few options for ordering testing resources:

- 1) Through their regular health clinic ordering process and supplier;
- 2) Through IHS (for those with an Abbott ID NOW analyzer). Tribes who received their Abbott machine from a non-IHS source may also order test kits through IHS, although an agreement must be developed;
- 3) Tribes who are direct recipients of FEMA support may order testing supplies and PPE directly from FEMA through the Resource Request Form (RRF) process. (Note: the Tribe may be responsible for a 25% cost share);
- 4) Tribes who are sub-recipients of the state may submit RRFs directly to the state, who will try and source the need directly. If they are unable to source the need, the request will be routed to FEMA. (Note: the Tribe may be responsible for a 25% cost share).

***Tribes can, at any time, reach out to their FEMA Tribal Liaison who can then work with operations and logistics staff, State liaison officers, voluntary agency liaisons, and other federal partners to exhaust all options for fulfillment, for the needs of the whole community.***

A note about the Abbott ID Now machine: Negative results may need to be confirmed with a high sensitivity authorized molecular test in the event a negative test result is not consistent with a patient's clinical signs and symptoms, or if it is necessary for patient management. For more information on concerns about false negatives, see this [FDA news release](#).

### b. *Viral Testing at non-Tribal, External Facilities*

Some Tribes refer their community members to outside medical facilities for testing. Although testing can occur at local hospitals, clinics, laboratories, and community-based test sites, the challenge with data control and information management exists. Unless an agreement has been struck between the Tribe and the state public health authority, the state has no obligation or method to report test results to the Tribe. If a patient tests positive, the Tribe has no way of receiving the results, and Tribal leadership has no way of maintaining awareness of disease incidence, making contact tracing impossible and hindering the ability to further protect the greater community. If a Tribe decides to augment testing capacity by utilizing non-Tribal test sites, they might consider coordinating with the health facilities and/or the state public health authority to determine how results will be reported back to the Tribe. FEMA and HHS ASPR partners are willing and ready to facilitate those discussions upon request.

Testing sites available to the general public throughout New England may be located [here](#).

**c. *Antibody Testing***

Unfortunately, there is limited science on how to best interpret serology and what it means to long term immunity for an individual. Until more is known, particularly about whether antibody production confers immunity, antibody testing for SARS-CoV-2 has limited usefulness in the clinical setting. This is a rapidly evolving field so recommendations may change. Results of any antibody testing must be considered along with other evidence, such as patient symptoms, known exposure history, and the statistical performance of the test. See the [Recommendations for Antibody Testing](#) provided by USET's Tribal Epidemiology Center for further uses and cautions on antibody testing. The U.S. Food and Drug Administration (FDA) provides a [summary of the expected performance](#) of the tests it has authorized under Emergency Use Authorization, which may be of interest to the Tribal Health Director and medical staff as they determine whether to order antibody tests for their patients.

In order to meet the needs of all Tribal community members including elders and people with disabilities and chronic health conditions, considerations for physical accessibility to testing sites and strategies to provide effective and accessible communications in multiple formats are strongly recommended.

**2. Implement or Enhance a Contact Tracing Program**

Case investigation and contact tracing are fundamental activities that involve working with a case patient (symptomatic and asymptomatic) who has been diagnosed with an infectious disease to identify and provide support to people (contacts) who may have been infected through exposure to the patient. This process prevents further transmission of disease by separating people who have (or may have) an infectious disease, from people who do not. It is a core disease control measure that has been employed by public health agency personnel for decades. Case investigation and contact tracing are most effective when part of a multifaceted response to an outbreak.

Case investigation is the identification and investigation of patients with confirmed and probable diagnoses of COVID-19, and contact tracing is the subsequent identification, monitoring, and support of their contacts who have been exposed to, and possibly infected with SARS-CoV-2. Prompt identification, voluntary self-quarantine and monitoring of these COVID-19 contacts can effectively break the chain of disease transmission and prevent further spread of the virus in a community. While case investigation and contact tracing for COVID-19 may be new, health departments and frontline public health professionals who perform these activities have experience conducting these activities for tuberculosis, sexually transmitted infections, HIV, and other infectious diseases.

**Developing a Contact Tracing Program**

Planning for contact tracing involves hiring and training staff, determining how individuals will be quarantined and isolated, implementing testing strategies, and using testing results data to inform continued case investigation and contact tracing efforts.

Accurate collection and tracking of data are essential parts of outbreak response. Some jurisdictions have adapted their existing laboratory and surveillance reporting systems to manage their COVID-19 response, while others are using recently developed or adapted contact tracing software and applications, such as those offered by: [REDCap](#), [CHEXOUT](#), [Sara Alert](#), [Microsoft ARIAS](#), Salesforce, MAVEN COVID-19, [CommCare](#).

Contacts need to be monitored at the onset of symptoms. While some health departments use staff to contact individuals daily to see if they have developed symptoms, others enroll contacts in technology solutions such as the CDC's free Text Illness Monitoring System (TIMS).

***Planning and Technical Assistance Resources***

- CDC's COVID-19 Tribal Support Unit works with Tribes and Tribal-serving organizations to identify technical assistance needs and provide critical technical assistance that would be of most benefit. Teams may be deployed or support remotely. Support may include epidemiological/data support, contact tracing, infection prevention and control, risk communication and community mitigation engagement, or improvement of a pandemic response plan. Contact the Tribal Support Unit at [eocevent362@cdc.gov](mailto:eocevent362@cdc.gov) or visit the [CDC's Tribal Communities](#) page for more information or to request support.



- [State Approaches to Contact Tracing during the COVID-19 Pandemic](#). An interactive map featuring each state's contact tracing program model, workforce, lead agencies, funding, and technology.

#### *Training Resources*

- For general guidance on contact tracing, the CDC's [contact tracing resource page](#) compiles a variety of resources for contact tracers, case investigators, and team leads. CDC also has a detailed reference [Interim Guidance on Developing a COVID-19 Case Investigation & Contact Tracing Plan](#).
- There are multiple online contact tracing resources being introduced. Two that seem to be the most commonly used among tribal, state and local health departments, are free, and have similar content are:
  - The Association for State and Territorial Health Officers ([ASTHO training](#)) - an interactive learning environment with some downloadable guides
  - The John Hopkins University [online contact tracing training](#) which is in webinar format
- CDC funded [Disease Intervention Services Training Centers](#) are currently developing a training program that should soon be free and available to tribal organizations.

#### *Staffing Resources*

- [AmeriCorps](#)
  - A few States are using this option for contact tracing. The most developed process is in Texas with the OneStar Foundation. Funding may be provided from the Corporation for Community Service or might be supplemented by a FEMA Mission Assignment directly through the Tribe (note: there may be an associated 25% cost share with this option).
  - Senior Corps and VISTA volunteers are being used in addition to AmeriCorps volunteers in Colorado.
  - Please reach out to the FEMA Tribal Liaison Officer or Voluntary Agency Liaison (VAL) for coordination if this is a resource you'd like to pursue.
- US Census Bureau
  - Current survey staff may be a good option for this initiative. FEMA is investigating this option further and will provide more detailed information as it becomes available.
- [Medical Reserve Corps](#)
  - Each state has a medical reserve corps consisting of local medical and public health volunteers. The capabilities of the medical reserve corps differ state to state; however, these organizations are all established to strengthen public health and improve response and recovery capabilities in their communities.

## Other Resources

#### *Testing Strategy Resources*

- CDC [Overview of Testing for SARS-CoV-2](#)
- CDC [Testing General Information](#)
- CDC [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens](#) for COVID-19
- CDC [Priorities for COVID-19 Testing](#)
- CDC COVID [Tribal Communities](#) links
- CDC [Testing Guidance for Nursing Homes](#)
- CDC [Testing Strategy for COVID-19 in High Density Critical Infrastructure Workplaces after a COVID-19 Case Is Identified](#)
- FDA [comparison of current serology tests](#) with Emergency Authorization Use
- CDC [PPE Guidance](#)
- CDC [Cleaning and Disinfection for Community Facilities](#)
- White House [Testing Blueprint Addendum](#)

*Possible Grant Writing and Management Assistance*

- [National Indian Health Board](#)
- [GovGrantsHelp](#)
- First Nations Development Institute, [Grant Seeker Resources](#)
- Association of Indian Physicians, [Tribal Grant Writing Training](#)
- FEMA's [Grants Management Technical Assistance \(GMTA\) Program](#) administers this resource center for state, tribal, territorial, and local governments receiving Federal financial assistance. The site contains practical information and resources on all aspects of grants management, from laying the foundations for project development to preparing an application for a FEMA award to evaluation and closeout.



## COA 1: Increase Testing Capacity

See the *Potential Funding Opportunities* chart at the end of this document for fiscal resources to support this COA.

Activity	Considerations	Requirements	Potential Resources
Determine resources needed to enhance testing capacity	<ul style="list-style-type: none"> <li>Ordering and availability of testing material and PPE</li> <li>Available personnel</li> <li>Physical accessibility to testing sites and effective and accessible communications</li> </ul>	<ul style="list-style-type: none"> <li>Trained personnel to collect and perform testing</li> <li>Effective ordering process to acquire testing material and PPE</li> </ul>	<ul style="list-style-type: none"> <li>FEMA or State RRF process</li> <li>IHS</li> <li>Regular clinic ordering and supplier</li> <li>Donations</li> </ul>
Determine who receives priority testing	<ul style="list-style-type: none"> <li>Symptomatic patients</li> <li>Asymptomatic patients</li> <li>Staff</li> <li>Others</li> </ul>		Ample guidance available online from CDC, IHS, USET, and others as provided in the strategy narrative.
Determine information management process	<ul style="list-style-type: none"> <li>Where is testing occurring?</li> <li>Are agreements in place for reporting from non-Tribal facilities?</li> </ul>	<ul style="list-style-type: none"> <li>If testing in-house, information management is controlled</li> <li>If testing at non-Tribal facilities, agreements will be necessary to receive results</li> </ul>	<ul style="list-style-type: none"> <li>Tribes are encouraged to reach out to the state public health authority to discuss reporting.</li> <li>FEMA and HHS/ASPR leadership are willing and able to facilitate data sharing agreement discussion between state public health authorities and Tribes in the region.</li> </ul>

## COA 2: Implement or Enhance a Contact Tracing Program

See the *Potential Funding Opportunities* chart at the end of this document for fiscal resources to support this COA.

Activity	Considerations	Requirements	Potential Resources
Determine staff needed to perform contact tracing	<ul style="list-style-type: none"> <li>Are there enough staff in-house?</li> <li>Will the Tribe need to hire/contract with support personnel?</li> </ul>	Sufficient staff to support contact tracing needs	<ul style="list-style-type: none"> <li>AmeriCorps</li> <li>Medical Reserve Corps</li> <li>Volunteer organizations</li> </ul>
Determine what system, software, or application the Tribe will use	<ul style="list-style-type: none"> <li>Can the Tribe purchase a program?</li> <li>Will the no-cost options provide the service and security required?</li> <li>Is training available?</li> </ul>	<ul style="list-style-type: none"> <li>A contact tracing program, software, or app that can provide leadership with accurate, immediate information, and meets whatever privacy requirement is required by the Tribe</li> </ul>	<ul style="list-style-type: none"> <li>CDC's COVID-19 Tribal Support Unit</li> <li>Various software and applications available to purchase and at no cost</li> </ul>
Determine training needed to perform contact tracing	<ul style="list-style-type: none"> <li>Is training accessible?</li> <li>How quickly can staff be trained?</li> </ul>	Staff trained in contact tracing requirements	<ul style="list-style-type: none"> <li>Various training resources through the chosen program or online. See COA 2 narrative for a list of options with links</li> </ul>
Determine support to community members who have tested positive and/or who are self-isolating	<ul style="list-style-type: none"> <li>If a community member tests positive or has been exposed, do they have the ability to self-isolate?</li> <li>Is there support for their children, grocery shopping, meals, medication, etc.?</li> <li>How will the Tribe enforce isolation requirements?</li> </ul>	Community member and their household needs are met and supported while they are in isolation	

## Potential Funding Opportunities

This table contains funding opportunities mostly made available due to passage of the CARES Act. As such they are new appropriations and the contours of the grant programs and associated application dates are not yet established. Real time updates will be provided as additional information becomes available and we encourage the tribes to bookmark the informational websites.

Funding Opportunity	Total Funding	PPE	Facilities	Staffing	Contact Tracing	Housing	Other
<a href="#">DOI/BIA - CARES Act: FY20-21 Operation of Indian Education Programs</a>	\$69,000,000						X
<a href="#">DOI/BIA - CARES Act: FY20-21 Operation of Indian Programs</a>	\$453,000,000	X	X				X
<a href="#">DOI/Office of the Secretary - CARES Act: FY20-21 Departmental Operations</a>	\$158,400,000	X	X	X			
<a href="#">HHS/CDC - CARES Act: FY20-24 Infectious Diseases Rapid Response Reserve Fund</a>	\$300,000,000				X		
<a href="#">HHS/Office of the Secretary - CARES Act: FY20-24 Public Health &amp; Social Services Emergency Fund</a>	\$11,014,500,000						X
<a href="#">HUD/Management &amp; Administration - CARES Act: FY20-21 Program Offices</a>	\$15,000,000					X	
<a href="#">HHS/NIH - Coronavirus Preparedness &amp; Response Supplemental Appropriations Act: FY20-24 National Institute of Allergy &amp; Infectious Diseases</a>	\$826,000,000						X
<a href="#">HHS/CDC - Coronavirus Preparedness &amp; Response Supplemental Appropriations Act: FY20 Infectious Diseases Rapid Response Reserve Fund</a>	\$1,500,000,000				X		
<a href="#">HHS/NIH - Coronavirus Preparedness &amp; Response Supplemental Appropriations Act: FY20-24 National Institute of Environmental Health Sciences</a>	\$10,000,000						X
<a href="#">HHS/IHS - Families First Coronavirus Response Act: FY20-22 Medical Services</a>	\$64,000,000	X					X
<a href="#">HHS/IHS - CARES Act: FY20-21 Indian Health Facilities</a>	\$125,000,000	X					X
<a href="#">USDA/FS - CARES Act: FY20-21 National Forest System</a>	\$34,000,000	X	X				
<a href="#">HHS/IHS - CARES Act: FY20-21 Indian Health Services</a>	\$1,032,000,000						X
<a href="#">HHS/CDC - CARES Act: FY20-24 CDC-wide Activities &amp; Program Support</a>	\$2,500,000,000				X		
<a href="#">HUD/PIHP - CARES Act: FY20-24 Indian Community Development Block Grants (ICDBG- CARES)</a>	\$100,000,000					X	
<a href="#">HUD/CPD - CARES Act: FY20-22 Homeless Assistance Grants (ESG-CV)</a>	\$4,000,000,000	X				X	
<a href="#">HHS/CDC - Coronavirus Preparedness &amp; Response Supplemental Appropriations Act: FY20-22 CDC-wide Activities &amp; Program Support</a>	\$2,200,000,000				X		
<a href="#">HUD - CARES Act: FY20 Indian Housing Block Grant Program (14.867)</a>	\$200,000,000					X	
<a href="#">The Harvard Project on American Indian Economic Development</a>	N/A						X
<a href="#">Rural Health and Safety Education</a>	\$4,000,000 Deadline: 7/1/2020						X
<a href="#">STATE ENVIRONMENTAL JUSTICE COOPERATIVE AGREEMENT PROGRAM (SEJCA) / COVID-19 PROJECTS</a>	\$1,000,000 Deadline: 6/30/2020						X
<a href="#">HHS/CDC - Paycheck Protection Program &amp; Health Care Enhancement Act: FY20 Epidemiology &amp; Laboratory Capacity for Testing Cooperative Agreements (93.323)</a>	\$10,250,000,000	X			X		X

## Appendix A: Tribal Questionnaire

1. How do you feel your Tribe is doing with testing? Do you have all the testing you need to reopen?
2. What is your current testing capacity (how many people per day/week)?
  - a. Does this include repeat/serial testing for medical or other personnel?
3. What is your desired testing capacity (people per day/week)?
  - a. Does this include critical staff only or the entire population?
  - b. Does this include widespread testing of asymptomatic community members?
4. Do you feel you have the appropriate PPE to meet your testing goals?
  - a. If not, what do you need?
5. Do you feel you have the appropriate staffing to meet your testing goals?
6. What efforts, if any, is the Tribe taking to increase testing?
7. How is the Tribe collecting testing data (total numbers tested, positive and negative results, diagnoses, hospitalizations, etc.)?
8. Is the Tribe conducting contact tracing?
  - a. If yes, how is this carried out? Do you feel you have the appropriate staffing to meet your contact tracing needs?
  - b. If no, please share why and what support you might need to implement contact tracing in your community.
9. What are the challenges, if any, standing between your current testing capability and where you'd like to be?
10. What type of support, if any, could you use from FEMA and other federal agencies to increase testing?

# Approval Signatures

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Approved by: Capt. Russ Webster, FEMA Region I  
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