Senate Committee on Indian Affairs
Oversight Hearing

COVID-19 Pandemic Impact in Native Communities

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Good afternoon Chairman Schatz, Vice Chairman Murkowski, and Members of the Committee. Thank you for the opportunity to testify on the Indian Health Service's (IHS) continued efforts to respond to and mitigate the impact of the Coronavirus in Native communities and vaccinate Native communities during the Coronavirus pandemic.

Responding to and Mitigating the Impact of the Coronavirus Pandemic

Over the past year, the IHS has worked closely with our Tribal and Urban Indian Organization (UIO) partners, state and local public health officials, and our fellow Federal agencies to coordinate a comprehensive public health response to the pandemic. Our number one priority has been the safety of our IHS patients and staff, as well as Tribal community members.

The IHS continues to play a central role as part of an all-of-nation approach to prevent, detect, treat, and recover from the COVID-19 pandemic. We are partnering with other Federal agencies, states, Tribes, Tribal organizations, UIOs, universities, and others to deliver on that mission. We protect our workforce through education, training, and distribution of clinical guidance and personal protective equipment (PPE). We also protect our Tribal communities through supporting Tribal leaders in making their decisions about community mitigation strategies that are responsive to local conditions, and to protect the health and safety of Tribal citizens as those communities make plans to safely open and return to work.

While the Indian health system is large and complex, we realize that preventing, detecting, treating, and recovering from COVID-19 requires local expertise. We continue to participate in regular conference calls with Tribal and UIO leaders from across the country to provide updates, answer questions, and hear their concerns. In addition, IHS engages in rapid Tribal Consultation and Urban Confer sessions in advance of distributing COVID-19 resources to ensure that funds meet the needs of Indian Country.

I am grateful to Congress for supporting our efforts through the passage of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020; the Families First Coronavirus Response Act; the Coronavirus Aid, Relief, and Economic Security (CARES) Act; the Paycheck Protection Program and Health Care Enhancement Act, the Coronavirus Response and Relief Supplemental Appropriations Act, and now the American Rescue Plan Act. These laws have provided additional resources, authorities, and flexibilities that have helped the IHS workforce continue to provide critical services throughout the pandemic and also permitted the IHS to administer over $9 billion to IHS, tribal, and urban Indian health programs to prepare for and respond to Coronavirus. These resources have helped us expand vaccinations, available testing,

public health surveillance, and health care services. Moreover, they support the distribution of critical medical supplies and PPE in response to the pandemic. The American Rescue Plan Act in particular makes a historic investment in Indian Country. The Act provides $6.1 billion in new funding to support IHS, Tribal, and urban Indian health programs to combat COVID-19, expand services, and recover critical revenues.

It has been over a year now that IHS and our dedicated workforce has been responding to the COVID-19 Pandemic. Over the last year, the IHS has marked considerable achievements. The IHS COVID-19 Incident Command Structure was stood up to establish communication protocols to ensure comprehensive situational awareness and efficient deployment of resources. We instituted reporting mechanisms to become a central information repository for the IHS COVID-19 response. We developed a COVID-19 data surveillance system and the IHS COVID-19 website to share critical health information, important COVID-19 vaccine information and updates, and we disseminate clinical guidance, training, and webinars. We provide assistance to the IHS and Tribal facilities through Critical Care Response Teams and Tele Infection Control Assessment and Response assessments.

We are detecting COVID-19 through screening and state-of-the-art lab testing. We have distributed a total of 830 Abbott ID NOW rapid point-of-care analyzers, as well as 1.9 million rapid COVID-19 tests. The IHS National Supply Service Center (NSSC) has also distributed over 84 million units of PPE and other Coronavirus response related products to IHS, Tribal, and UIO (I/T/U) health care facilities at no cost, including 2.6 million testing swabs and transport media. As of April 4, 2021, we have performed 2,215,027 tests in our American Indian and Alaska Native communities. Of those tests, 190,810 (9.3 percent, cumulative data) have been positive.

The IHS increased coordination with Federal partners to streamline access for I/T/U supply requests to the Strategic National Stockpile. A PPE request tracking system was developed and IHS staff were placed in liaison functions to ensure oversight on I/T/U requests. The IHS burn rate calculator for tracking PPE has been implemented to improve the data quality. A guide on ordering/requests process for Emergency Management Points of Contact has been completed and posted for ongoing strategic purposes. NSSC has supplied testing kits to all Area requests, a new contract with AbbottID has started, and they are shipping directly to sites.

The IHS has a sufficient supply of therapeutic agents currently authorized or approved by the FDA for the treatment of COVID-19, including remdesivir and the combination monoclonal antibody products, and is distributing them to I/T/U health care facilities upon request. The IHS National Pharmacy and Therapeutics Committee provides clinical guidance to Areas and facilities regarding COVID-19 emerging treatments and, through its Pharmacovigilance program, also monitors medication safety in our service population.

During the pandemic, the IHS faced life-threatening medical surges that required additional acute care and Intensive Care Unit beds. The IHS and U.S. Department of Veterans Affairs (VA), Veterans Health Administration, signed an Interagency Agreement that set forth certain terms and conditions governing the arrangement for the standardized coordination and delivery of health care and other services between VA and IHS during disasters, public health incidents, and other emergencies.

We are treating each and every patient with culturally competent, patient-centered, relationship-

based care. As we look to recovery from COVID-19, the IHS is supporting the emotional well-being and mental health of its workforce and the communities we serve, providing training, education, and access to treatment that draws from the faith and traditions of American Indians and Alaska Natives, as well as their long history of cultural resilience.

In April 2020, IHS expanded the use of an Agency-wide videoconferencing platform that allows for telehealth on almost any internet-connected device and in any setting, including patients' homes. Around the same time IHS also permitted the emergency use of certain commonly available mobile apps to enable the provision of services remotely while minimizing exposure risk to both patients and staff. These authorities, along with the actions taken by the Centers for Medicare and Medicaid Services to allow payment for previously non-billable services, made it possible for IHS to dramatically increase our use of telehealth from an average of under 1,300 visits per month in early 2020 to a peak of over 40,000 per month in June and July of that year. More recent data suggests a plateau of around 30,000 monthly telehealth visits. It is important to note that on average, about 80 percent of telehealth encounters across IHS are conducted using audio only, largely related to the limited availability of technologies and bandwidth capacity in the communities we serve across the country. IHS is currently in the process of procuring an additional cloud-based telehealth platform to complement our existing solutions and distribute telehealth funds to sites for equipment and devices to improve access for more interactive telehealth encounters.

EHR and Facilities Modernization

As we, the IHS, expanded our use of technology in the telehealth area, the pandemic also highlighted the challenges and risks posed by the decentralized and distributed health information technology architecture currently in use at IHS. While our facilities use a capable, nationally certified electronic health record (EHR) system, the fact that it is internally developed by IHS and is installed separately at hundreds of locations nationwide created significant barriers to the rapid response needed for COVID-19. We are extremely proud of how our informatics and technology staff made changes to the system to support COVID-19 testing, diagnosis, and vaccination documentation and reporting, and how the field was able to implement these changes into clinical workflows. However, we know that those activities would have been much more streamlined in an updated technology environment.

This experience has validated and reinforced IHS' commitment to the modernization of our EHR system and health information technology infrastructure. IHS is grateful for the funding for EHR modernization provided by Congress in the CARES Act, the FY2021 appropriation, and the American Rescue Plan Act, which will allow us to proceed with the foundational steps in this important multi-year effort. In accordance with the language of the FY2021 appropriation, IHS plans to inform the appropriate Congressional committees in the near future to outline our planned approach to EHR modernization.

The IHS effort to improve the EHR system underscores the need to replace outdated facilities. Aging medical facilities impede medical innovation. Modern hospitals are packed with complex equipment with high electrical requirements. Contemporary hospitals are designed to provide clean, reliable power to ensure that patient care is uninterrupted. The difficulty in retrofitting older hospitals with modern technology is that the massive concrete structure tends to absorb Wi-Fi signals, representing a significant challenge to wireless equipment.

In addition, the pandemic highlighted some of the difficulties that older facilities pose to delivering health care services. It is the IHS' policy to use the physical environment to help prevent and control the spread of infection. This past year has shown that outdated facilities' patient flow often did not allow for social separation and that waiting areas are not sized or structured for social distancing. Optimally, the infected and non-infected would be separated, and patients would flow in one direction through the facility. This is not possible in some IHS facilities, which resulted in limiting appointments, renovation of space, or providing temporary space outside of the facility to separate patients.

Vaccinations – Allocations and Administration

IHS developed a vaccine strategy led by the IHS Incident Command Structure and the designated IHS Vaccine Task Force. This effort was informed by the Federal Vaccine Response Operation (FVRO) and aligned with the Centers for Disease Control and Prevention (CDC), FVRO, and Tribal stakeholder input. HHS and IHS participated in Tribal consultation and urban Indian confer in development of the plan, and a final IHS Vaccine Plan was published on November 18, 2020.

Working with tribal communities, I/T/U health programs receiving vaccines for distribution through the IHS jurisdiction have administered 1,029,647 doses as of April 5. This achievement is despite the challenges IHS faces in terms of the predominantly rural and remote locations we serve and the infrastructure challenges those communities face. The IHS reached its goal to administer 1 million COVID-19 vaccines by the end of March (administering 1,007,002 doses as of March 31, 2021) after surpassing its goal of administering 400,000 vaccines by the end of February. In February and March, 260,000 supplemental vaccine doses were sent to Indian Country. IHS remains committed to vaccine availability for all individuals within our health system. This Federal vaccination effort is possible because of strong partnerships with tribal and urban Indian health facilities.At IHS, we know that Tribal Nations are in the best position to determine the needs of their citizens.

Information on the number of COVID-19 vaccines administered across the IHS can be found at https://covid.cdc.gov/covid-data-tracker/#vaccinations, and there is a Federal entities section under the map. The IHS is working diligently with our CDC partners to report and validate vaccine administration data as quickly as possible. IHS estimates the current number of people vaccinated may be higher than reflected in the validated data on the CDC COVID Tracker. Communicating accurate and timely information remains a priority for the IHS.

Since mid-December 2020, the IHS has distributed 1,562,837 vaccine doses of the Food and Drug Administration authorized Pfizer-BioNTech, Moderna, and Johnson & Johnson/Janssen COVID-19 vaccines. IHS has shipped vaccine directly to 293 I/T/U facilities and used a hub and spoke model to ensure all 352 facilities that are coordinating vaccine through the IHS jurisdiction receive vaccine. The table below shows the total number of vaccine doses distributed and administered per IHS Area as of April 5, 2021.

COVID-19 Vaccine Distribution and Administration by IHS Area

Area	Total Doses Distributed*	Total Doses Administered**
Albuquerque	112,155	97,271

Area	Total Doses Distributed*	Total Doses Administered**
Bemidji	118,105	85,214
Billings	51,015	32,565
California	179,285	83,254
Great Plains	107,150	62,750
Nashville	74,867	45,197
Navajo	246,065	183,651
Oklahoma City	432,410	268,566
Phoenix	155,500	109,095
Portland	77,285	55,874
Tucson^	9,000	6,210
TOTAL	**1,562,837**	**1,029,647**

*Distributed Data Source: IHS National Supply Service Center, includes total doses ordered and anticipated to be delivered by April 2, 2021.

**Administered Data Source: CDC Clearinghouse data from Vaccine Administration Management System (VAMS) and IHS Central Aggregator Service (CAS). Data in the CDC Clearinghouse reflects prior day data. Data may be different than actual data as there are known CDC data lags and ongoing quality review of data including resolving data errors.

^The Tucson Area vaccine administration data is currently being validated.

Note: Alaska Area – all tribes chose to receive COVID-19 vaccine from the State of Alaska.

COVID-19 related data are reported from I/T/U facilities, though reporting by Tribal and UIOs is voluntary. The table below shows the number of cases reported to the IHS through 11:59 pm on April 4, 2021.

COVID-19 Cases by IHS Area

IHS Area	Tested	Positive	Negative	Cumulative percent positive *	7-day rolling average positivity *
Alaska	565,977	11,566	480,985	2.3%	0.8%
Albuquerque	91,714	8,079	62,838	11.4%	5.2%
Bemidji	152,191	10,576	138,064	7.1%	7.0%
Billings	96,601	7,360	85,879	7.9%	3.3%
California	76,191	7,784	65,310	10.6%	2.9%
Great Plains	138,161	14,096	123,535	10.2%	3.8%
Nashville	73,823	5,980	66,956	8.2%	4.0%
Navajo	238,530	31,389	163,002	16.1%	3.0%
Oklahoma City	473,229	60,186	408,007	12.9%	3.0%
Phoenix	172,323	23,559	147,923	13.7%	2.9%
Portland	110,752	7,491	102,925	6.8%	5.7%
Tucson	25,535	2,744	22,638	10.8%	5.4%
TOTAL	**2,215,027**	**190,810**	**1,868,062**	**9.3%**	**2.9%**

* Cumulative percent positive and 7-day rolling average positivity are updated three days per week.

<u>Access to Clean Water</u>

Supporting Tribes to ensure they are able to supply water to their communities during the COVID-19 outbreak is an important aspect of the IHS COVID-19 response. Access to water is critical for hand washing and cleaning environmental surfaces to help break the virus' chain of infection and reduce the pressure on the IHS health care delivery system, which is a critical concern.

To address this concern, the IHS over the past year deployed nine teams of 40 U.S. Public Health Service Commissioned Corps Officers in support of the Navajo Nation to improve access to safe water points. This work included surveying the availability of safe water points across 110 Chapters over 27,000 square miles. The survey identified 59 locations where additional water points were needed. Following the survey, the teams completed water points site installation designs, construction/beneficial use inspections, and operation and maintenance trainings at these locations. The installation of these water points resulted in a reduction in round trip travel distance from 52 miles to 17 miles and was completed within 6 months.

In addition to increasing the number of water points, the mission helped ensure a means to safely transport water for in-home drinking and cooking. This was achieved by providing 107 Chapters over 37,000 water storage containers to be distributed to each resident living in a home with no piped water. Water disinfection tablets, to boost water disinfection levels in the water storage containers, were also provided to Chapters as needed based on the field team measured water point disinfection levels. These innovative actions will help to improve the stored water quality and reduce the risk of gastrointestinal illness to water point users.

The teams also worked to increase public awareness of water service availability and developed creative public health outreach materials describing the importance of the water service use through a multimedia campaign (online, print newspaper, and radio) broadcast across the Navajo Nation. This included assisting the Navajo Nation in developing a website, which includes an interactive map of the water points, to communicate the location, hours of operation, and Chapter contact information. Officers developed outreach materials highlighting the importance of accessing water at regulated water points and promotion of safe water storage practices.

We look forward to continuing our work with Tribal and Federal partners. As we work towards recovery, we are committed to working closely with our stakeholders and understand the importance of working with partners during this difficult time. We strongly encourage everyone to continue to follow CDC guidelines and instructions from their local, state, and Tribal governments to prevent the spread of COVID-19 and protect the health and safety of our communities. Thank you again for the opportunity to speak with you today.