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" VA Response to COVID-19 Pandemic and VA Fourth Mission"

U.S. House of Representatives
Committee on Veterans' Affairs

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Good afternoon, Chairman Takano, Ranking Member Bost, 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 COVID-19 in Native communities and vaccinate Native communities during the COVID-19 pandemic.

Responding to and Mitigating the Impact of the COVID-19 Pandemic

Since the start of the pandemic, 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, distribution of clinical guidance and personal protective equipment (PPE), and physical modifications within IHS health care facilities (e.g., installation of high efficiency air filtration units, adjustments with patient flow, and use of tele-health services). We also protect our Tribal communities by supporting Tribal leaders in making locally-responsive decisions about community mitigation strategies, and in protecting the health and safety of Tribal citizens as those communities safely re-open and return to in-person 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 COVID-19

Preparedness and Response Supplemental Appropriations Act, 2020; the Families First COVID-19 Response Act; the COVID-19 Aid, Relief, and Economic Security (CARES) Act; the Paycheck Protection Program and Health Care Enhancement Act, the COVID-19 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 $8 billion to IHS, tribal, and urban Indian health programs to prepare for and respond to the COVID-19 pandemic. These resources have helped us expand vaccinations, available testing, public health surveillance, and other health care services. Moreover, they support the distribution of critical medical supplies, personnel, and PPE in response to the pandemic. The American Rescue Plan Act, in particular, made a historic investment in Indian Country. The Act provided $6.1 billion in new funding to support IHS, Tribal, and urban Indian health programs to combat COVID-19, expand health care services, and recover critical revenues.

It has been almost three years now that IHS and our dedicated workforce has been responding to the COVID-19 pandemic. Over this period, the IHS has marked considerable achievements. The IHS COVID-19 Incident Command Structure continues to ensure comprehensive situational awareness for all IHS Areas nationally and for the efficient deployment of resources. We updated reporting mechanisms to include automatic data transfer rather than manual data entry, where the Resource and Patient Management System (RPMS) is used. We maintain a COVID-19 data surveillance system and the IHS COVID-19 website to share critical health information and important COVID-19 vaccine information and updates, and we disseminate clinical guidance, training, and webinars as our understanding of COVID-19 evolves. We continue to 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 1105 Abbott ID NOW rapid point-of-care analyzers, as well as 66.6 million rapid COVID-19 tests. The IHS National Supply Service Center (NSSC) has also distributed over 100 million units of PPE and other COVID-19 response related products to IHS, Tribal, and UIO (I/T/U) health care facilities at no cost, including 33.2 million testing swabs and transport media. As of November 22, 2022, we have performed 44,967,434 tests in our American Indian and Alaska Native communities. Of those tests, 553,405 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 of 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 was completed and posted for ongoing strategic purposes. NSSC has supplied testing kits to all Area requests, and has a contract in place with Abbott, which provides

testing capabilities for I/T/U health care facilities through the end of FY 2023.

The IHS has a sufficient supply of therapeutic agents currently authorized or approved by the FDA for the treatment of COVID-19and 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, at the height of the initial pandemic surge.

For the first time, IHS clinicians could provide services in patients' homes. This allowed continued access to care while protecting patients and health care workers. The current average is approximately 11,000 telehealth visits per month. 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. Beginning October 31, 2022, IHS clinicians and support staff at Federal facilities can use AA RingMD, a secure, cloud-based solution that enables patient-to-provider and provider-to-provider telehealth meetings. This platform is available across multiple devices and allows for expanded tele-video visits in settings such as homes or schools with low broadband availability. AA RingMD is the

first telehealth-focused platform that IHS has deployed and will complement Webex, the existing IHS telehealth solution, giving IHS two secure options to use when providing telehealth care, both now and when the COVID-19 public health emergency ends.

EHR and Facilities Modernization

As 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 FY 2021 and FY 2022 appropriations, and the American Rescue Plan Act, which will allow us to proceed with the foundational steps in this important multi-year effort.

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. The past three years have shown that outdated facilities' patient flow often did not allow for social separation and 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 COVID-19 Pandemic 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 22,331,165 doses as of November 2022. 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 2021 (administering 1,007,002 doses as of March 31, 2021) after surpassing its goal of administering 400,000 vaccines by the end of February 2021. These early achievements contributed to the growing momentum of utilized vaccination as one of the most effective tools protecting our service population and communities from severe illness and poor outcomes due to COVID-19 infection. American Indian and Alaska Natives were recognized by the CDC throughout 2021 and well into 2022 as having the highest vaccination rates of all ethnicities for a first dose of COVID-19 vaccine and were second highest for completion of vaccination series. IHS continues to encourage staying up to date with COVID-19 vaccines and has administered over 111,000 bivalent boosters as of November 27, 2022.

IHS remains committed to vaccine availability for all individuals within our health system. Since February 2021, IHS has had ample supply of COVID-19 vaccines with I/T/Us having the ability to order the brand and quantity desired to meet their local needs. 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-November 2022, the IHS has distributed 33,856,630 vaccine doses of the Food and Drug Administration authorized or approved Pfizer-BioNTech, Moderna, and Johnson & Johnson/Janssen and Novavax 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 November 20, 2022.

COVID-19 Vaccine Distribution by IHS Area

Area	Total Doses Distributed*	Total Doses Administered**
Albuquerque	261,990	198,980
Bemidji	312,720	184,842
Billings	178,730	86,664
California	454,730	233,485
Great Plains	344,430	180,818
Nashville	200,140	115,233
Navajo	613,880	419,382
Oklahoma City	831,865	528,575
Phoenix	431,605	263,090
Portland	206,550	113,204
Tucson^	19,990	14,254
TOTAL	**3,856,630**	**2,338,527**

*Distributed Data Source: IHS National Supply Service Center, includes total doses ordered and anticipated to be delivered by November 20, 2022.
**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 November 30, 2022.

COVID-19 Cases by IHS Area

IHS Area	Tested	Positive	Negative	Cumulative percent positive *	7-day rolling average positivity *
Alaska	1,124,082	55,972	918,334	5.7%	4.4%
Albuquerque	182,199	17,353	140,880	11.0%	2.6%
Bemidji	324,791	33,815	289,434	10.5%	6.9%
Billings	161,819	14,292	142,620	9.1%	9.6%
California	202,804	23,212	169,588	12.0%	8.3%
Great Plains	302,376	32,862	265,736	11.0%	6.9%
Nashville	201,064	21,799	168,908	11.4%	9.8%
Navajo	588,687	87,787	421,243	17.2%	19.1%
Oklahoma City	1,234,987	186,278	1,037,408	15.2%	8.9%
Phoenix	334,854	51,167	281,142	15.4%	21.8%
Portland	255,777	22,630	232,534	8.9%	16.7%
Tucson	84,297	9,568	74,449	11.4%	0.0%
TOTAL	**4,995,737**	**556,735**	**4,142,276**	**11.8%**	**12.5%**

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

Access to Clean Water

Supporting Tribes to ensure they are able to supply water to their communities during any infectious disease public health 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, in 2020 and leading into early 2021, the IHS 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 Navajo Nation 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 six 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. Presently, the IHS continues to coordinate Navajo Water Access Coordination Group virtual meetings with Navajo Nation, Environmental Protection Agency, Centers for Disease Control, non-governmental organizations, and other officials on a monthly basis to support completion, prioritization, and communication on Navajo Nation clean water access projects and activities.

Working with the Department of Veterans Affairs

In addition to supplying water to tribal communities, many IHS Areas have examples of working with VA on mitigating the impacts of the COVID-19 pandemic. For instance, the Phoenix Area IHS leveraged the IHS/VA inter-agency agreement (IAA) to augment IHS staffing at the Whiteriver Indian Hospital and Hopi Healthcare Center through multiple VA staff deployments, including: 24 registered nurses and 2 x-ray technicians for time periods ranging between 15 and 60 days.

In a similar fashion, the same inter-agency agreement was employed in the Navajo Area IHS during a major COVID-19 surge in the spring of 2021. As a result, VA deployed 14 emergency department and medical-surgical registered nurses to Gallup Indian Medical Center (GIMC) in Gallup, NM for clinical staffing support. The VA team was able to provide care at GIMC from 03/11/2021 to 03/26/2021, until such time that a private sector contract could be executed for additional contract nurses. This VA support occurred at a time when available nurses were extremely difficult to find, especially in rural areas, and contract nurse compensation rates were skyrocketing. The deployed VA nurses remained on-site at the GIMC until the contract nurses arrived, which allowed for a smooth transition of patient care.

During the COVID-19 pandemic, the Navajo Area IHS and VA entered into five separate inter-agency agreements to reserve intensive care unit and medical-surgical patient beds at VA medical facilities in the following U.S. cities: Albuquerque, NM, Grand Junction, CO, Salt Lake City, UT, Phoenix, AZ, and Tucson, AZ. The inter-agency agreements authorized the Navajo Area IHS to transfer non-veteran American Indian and Alaska Native COVID-19 patients to the listed facilities limited to a pre-determined number of reserved beds at each VA facility. The Albuquerque-based VA Medical Center was particularly helpful with receiving COVID-19 patients from Gallup Indian Medical Center during some of the most challenging times during the pandemic.

VA was an important Phoenix Area partner in our strategy to assure hospital bed capacity. VA identified bed availability for our patients with less acuity to assure our facilities had the bed capacity to treat patients with COVID-19. For example, in January 2021, an inter-agency agreement (IAA) was developed with VA to accept non-veteran IHS patients during the pandemic. This proved important for Phoenix Indian Medical Center (PIMC), who utilized the IAA for several patients during its operating room closure when regional bed capacity was limited due to a COVID-19 surge.

VA loaned one of our sites, the Parker Indian Hospital Center, two transport ventilators for 6 months when our procurement was delayed due to supply chain disruptions. VA also provided to the Area, at no charge, 16 powered air purifying respirators, 8,500 gowns, and 6 high flow nasal cannula kits. During the January 2022 COVID-19 surge, there was a national shortage of sterile water. VA provided PIMC with sterile water to support the care of COVID patients requiring high flow oxygen and ventilation. The PIMC and the Phoenix VA pharmacy teams have collaborated on a number of items throughout the pandemic, including the development of a new process for curbside pharmacy service; development of a contingency plan for chemotherapy services; transfer of vaccine in times of need or excess; and establishment of an MOU for Sterile Compounding to allow each site to access the other site's sterile compounding facilities for compounding sterile (hazardous and non-hazardous) products.

In September of 2021, at the peak of the Delta COVID-19 surge, the Oklahoma City Area (OKC) had a 48-year old female patient at one of our Federal hospitals with severe COVID who required intubation and intensive care. With no intensive care unit, we tried to find a facility with an intensive care bed. The only available intensive care bed was in Connecticut, but the patient would not remain stable enough for transport. Fearful that this patient would die, we reached out to the Oklahoma City VA hospital administrator and inquired if they would accept our American Indian patient who was not a veteran. The administrator assisted in connecting the clinical teams and the patient was transferred. Initially, the patient was so ill that she was a candidate for extracorporeal membrane oxygenation (ECMO) but none was available in the region. The OKC VA continued to give care and the patient began to improve. Eventually, she was discharged to outpatient rehab. This patient would not have survived if the OKC Area office and the OKC VA hospital administrator had not developed a working relationship.

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.