INDIAN HEALTH SERVICE

COVID-19 RESPONSE, 100 DAY REVIEW

PLANNING SECTION

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Introduction

The Indian Health Service (IHS) provides comprehensive health care services for approximately 2.6 million American Indians and Alaska Native (AI/AN) people who are citizens of 574 federally recognized tribes in 37 states. The outbreak of the novel coronavirus disease (COVID-19) is impacting health systems around the world causing health systems to rethink and redesign their traditional approaches to providing health care. The IHS is rapidly redesigning service delivery methods and is leveraging local, tribal, state and federal resources and guidance to safely and efficiently rethink health care delivery models to meet new challenges and health care needs of AI/AN people while maintaining a commitment to the mission of the IHS: to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.

This report covers actions taken by the IHS to support federal, tribal, and Urban Indian Organizations (UIOs) (I/T/U, Indian Health System) in the first 100 days, a period covering March 6, 2020 through June 14, 2020.

Executive Summary

During the first 100 days of formal IHS response, the IHS has implemented over 250 activities across six aims and 14 strategic objectives (see Figure 1 IHS COVID-19 Action Plan Aims and Strategic Objectives). Key outcomes from those activities (see Appendix 2 for the IHS Major Response Activity Summary) include:

Expedited critical funding distribution to I/T/Us.

> The IHS distributed $1.9 billion to I/T/Us in an unprecedented manner. Once funding was announced, IHS coordinated and conducted tribal consultation and urban confer in a short timeframe. With a concentrated effort on alerting tribes and UIOs of funding opportunities, the average turnaround time from enacted bill to consultation and confer was 5 days. After consultation and confer occurred, funding was distributed within 8 days on average By June 2, 2020, 11 areas reported that Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security CARES Act funding had been awarded to 39 UIOs.

Communicated regularly and shared critical information with I/T/Us.

> The IHS instituted efficient reporting mechanisms to become a central information repository for the Indian Health System and other federal agencies. The Incident Command Structure (ICS) was stood up in an efficient manner with communication protocols established to ensure comprehensive situational awareness and efficient resource development. The IHS also established a surveillance system for COVID-19 related data and developed and maintained an IHS COVID-19 website. These functions allowed for the sharing of critical health information to patients, IHS staff, and other stakeholders. In addition, the IHS participated in federal partners and White House coordinated calls and supported regular communication with IHS staff on administrative concerns.

Streamlined IHS Area and facility access to supplies through process improvement with the Strategic National Stockpile (SNS) and internal National Supply Service Center (NSSC) functions.

> The IHS increased coordination with federal partners to streamline access for I/T/U supply requests to the SNS. A personal protective equipment (PPE) request tracking system was developed and IHS staff were placed in liaison functions to ensure oversight on I/T/U requests.

Summary of activities by aim:

1) To prevent the spread of COVID-19 the IHS developed and distributed guidance and recommendations, including those on efficient treatment and prevention of COVID-19 and safety best practices; issued approval process guidance for IHS Payment for Quarantine or Isolation Space; coordinated with Johns Hopkins University (JHU) on community prevention materials; and established a website that provides COVID-19 related information, including IHS's daily surveillance numbers as well as frequently asked questions (FAQ) and other resources. In addition, the IHS supported ongoing federal collaborations with the Centers for Disease Control and Prevention (CDC), Federal Emergency Management Agency (FEMA), and Veterans Health Administration (VHA); held rapid consultation and confer with Tribes and UIOs on funding from the Provider Relief Funds, Paycheck Protection Program and Health Care Enhancement Act; and, has worked closely with the Navajo Nation to increase access by collecting site information for the completion of site layout drawings of 37 transitional water points.

2) To detect cases of COVID-19 the IHS stood up a data surveillance system to track the detection of cases and assist in planning IHS response with I/T/Us performing 193,348 COVID-19 tests, of which 15,218 were positive for a total IHS percent positive rate of 8.8 percent (as of June 14, 2020, see Table 1). To complement testing strategies, the IHS has begun work on developing contact tracing programs and a strategic testing plan. In addition, early identification of potential COVID-19 cases is being addressed in partnership with the CDC by securing the new Text Illness Monitoring Systems, of which, 350 new channels for tribes are available to use which bypasses tribes having to go through the State for access. The IHS distributed a medical counter measures survey of need to I/T/U facilities, assessing the level of need for materials, supplies, and equipment. The IHS also received 250 Abbott-ID analyzers and distributed them to 214 IHS and tribal locations.

3) To treat COVID-19 cases and sustain regular operations the IHS expanded telehealth across federal facilities to provide patients with the opportunity to stay home and reduce their risk of infection and also keep health care workers safe; developed a contract to establish a Critical Care Response Team to provide urgent lifesaving medical care to stabilize and treat patients with suspected or confirmed COVID-19, and to train frontline health care staff at IHS and tribal facilities using evidence-based/best practices; and assisted the deployments of CDC tribal support through the deployment of 4-5 member teams for onsite support to Areas in critical need of assistance. IHS also issued over 40 clinical and administrative guidance and recommendation documents to support the delivery of timely, quality, and safe care; offered webinars in partnership with the University of New Mexico; and developed interim guidance on dental clinical operations, telehealth use, coding for visits, and produced COVID-19 hiring guides for human resource directors.

4) To support the Indian Health System in the recovery from COVID-19 the IHS developed and offered a series of webinars on various topics including mental health of health care workers and child and adolescent mental health; shared respectful and safe burial practices, and collaborated on a fact sheet on children and grief and a story book for AI/AN people on dealing with COVID-19. The IHS also distributed guidance for dental clinic operations and re-opening; maintained situational awareness of COVID-19 related employee adverse events through the IHS electronic reporting system; submitted funding requests for continued health community messaging, and contributed to men's health blog on COVID-19 for National Men's Health Week.

5) To manage resources the IHS developed, issued, and implemented a number of initiatives and flexibilities to adapt to the COVID-19 operating environment. IHS wrote and distributed numerous agency-wide guidelines pertaining to hiring, leave, and pay authorities received from Office of Personnel Management through the CARES and FFCR Acts. The IHS implemented Hazard Pay

Differential (HPD) and Environmental Differential Payments (EDP) to support recruitment and retention of our workforce at IHS direct service sites. To track the IHS workforce on a national level, IHS monitors the workforce by tracking Commissioned Corps deployments. The IHS federal employees testing positive for COVID-19, and agency telework numbers. In addition, IHS implemented significant changes in logistical operations to manage the emerging situation, including developing a PPE tracking system, implemented facility level PPE expenditure rate planning tools, detailing staff to liaise with the SNS, established interagency agreements with FEMA and developed guidance for I/T/Us on requesting PPE through the SNS. The IHS NSSC modified its operations to provide daily information and distribute critical supplies to most critical Areas. Critical equipment was distributed to I/T/Us; including Abbott ID Now analyzers and testing media as well as reusable cloth masks, along with large amounts of health care PPE. Guidance was also developed providing information on billing for expanded services, Tribal guidance for applying for Health Resources and Services Administration (HRSA) grants on COVID-19 related grants, and a guide to assist with Resource and Patient Management System (RPMS) configuration options to optimize for COVID-19 operations. Finally, funding distributions were developed and payments were tracked. Funding was distributed, on average, within 8 days after consultation and confer occurred

6) To provide comprehensive situational awareness of COVID-19 activities the IHS implemented an ICS; required daily situation reports from Areas and Headquarters (HQ) elements, including supply needs; developed and distributed daily situation reports and common operating pictures; prepared a Concept of Operations (CONOPS) to guide agency activity, established regular meetings and coordination processes, including ensuring public communications and area safety communications were effective.

Indian Health Service Response to COVID-19

On January 31, 2020, the Secretary of HHS, undersection 319 of the Public Health Service Act (42 U.S.C 247d), declared a public health emergency in response to COVID-19. Since late February 2020, IHS senior leadership worked collaboratively with the Department of Health and Human Services (HHS) to prepare for our role and response to COVID-19 across AI/AN communities. As part of preparedness, IHS participated in a Pandemic Influenza Exercise: Operation Crimson Contagion, between January 2019 and August 2019, in collaboration with the HHS. Operation Crimson Contagion moved through a severe influenza pandemic scenario from activation of the disaster simulation through devolution. In addition, IHS Areas and Service Units participate in disaster preparedness exercises to test their disaster response plans based on local and tribal all hazard vulnerability analysis results. The IHS was able to leverage the planning exercises, including the pandemic influenza planning, to begin to address the COVID-19 pandemic.

In early March 2020, IHS senior leadership activated the HQ ICS to respond to COVID-19 using the IHS pandemic response plan and disaster plans in IHS healthcare facilities. Subsequently, IHS drafted the IHS COVID-19 Response CONOPs aligning with the US COVID-19 Response plan. The initial IHS HQ ICS team worked collaboratively in person and spent time around a marker board sketching out the plan. The IHS HQ ICS team is comprised of incident command leadership, Facilities/Area Coordination Group, Liaison Section, Public Information Officer, Systems Support Section, Operations Section, Planning Section, and Safety Officer (See Appendix 1 for summary of ICS Sections). With the evolution of the COVID-19, stay at home/shelter in place orders, and the closing of the IHS HQ Parklawn building in Rockville, MD; the ICS moved to virtual operations in late March 2020.

COVID-19 Funding

In total, from March 6, 2020 through June 14, 2020, the IHS received a total of $1.9 billion in COVID-19 related resources.

Overview of Funding Provided by COVID-19 Supplemental Bills:

Four supplemental appropriations were enacted to address the COVID-19 Public Health crisis. The Coronavirus Preparedness and Response Supplemental Appropriation Act of 2020 was enacted on March 6, 2020. Through authorities in this Act, HHS provided $70 million to the IHS from the Public Health and Social Services Emergency Fund. These funds were made available to I/T/Us to prevent, prepare for, and respond to COVID-19. The Families First Coronavirus Response Act (FFCRA) was enacted on March 18, 2020; providing $64 million to support testing for COVID-19 among AI/AN people. The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was enacted on March 27, 2020; providing a total of $1.032 billion to the IHS for COVID-19 preparedness and response activities. The bill language specifically identified the following additional purposes: public health support, electronic health record (EHR) modernization, telehealth and other information technology upgrades, Purchased/Referred Care, Catastrophic Health Emergency Fund, UIOs, Tribal Epidemiology Centers, Community Health Representatives, and other activities to protect the safety of patients and staff. The bill also set forth the following requirements for these funds that a minimum of $450 million must be used for distribution to the IHS directly operated programs, tribal health programs, and UIOs; a maximum of $65 million may be used for EHR stabilization and support; and, up to $125 million may be transferred to the IHS's Facilities account for COVID-19 related activities. The Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA) was enacted on April 24, 2020 providing $750 million to the HHS Public Health and Social Services Emergency Fund for testing and testing related activities in IHS, tribal, an UIO facilities. The PPPHCEA funds can be used for necessary expenses to purchase, administer, process, and analyze COVID-19 tests.

Release of Funds – $134 million on March 27, 2020

The IHS conducted immediate Tribal Consultation and Urban Confer during the week of March 23, 2020 to inform agency decisions on funding allocations for the $70 million for COVID-19 response in Public Health and Social Services Emergency Fund resources, along with the $64 million for COVID-19 testing received in the FFCRA. On March 27, 2020, the IHS announced the release of all $134 million in a Tribal and UIO Leader Letter. These funds were allocated as follows:

- $64 million for COVID-19 Testing from the FFCRA:
  - $3 million for UIOs and
  - $61 million for IHS and tribal health programs.

- $70 million from the Public Health and Social Services Emergency Fund for COVID-19 Response:
  - $30 million for IHS direct service programs and
  - $40 million for the NSSC to purchase medical supplies and PPE free of charge for the I/T/U.

Release of Funds – $600 million on April 3, 2020

For the release the CARES Act funds, the IHS conducted a second round of Tribal Consultation and Urban Confer the week of March 30, 2020 to inform agency decisions on funding allocations for the $1.032 billion provided in the CARES Act. On April 3, 2020, the IHS announced the release of $600 million for COVID-19 response activities in a Tribal and UIO Leader Letter. These funds were

allocated as follows: $30 million for UIOs; and $570 million for IHS and tribal health programs. Of the remaining $432 million provided in the CARES Act, the IHS will use $65 million for EHR stabilization and support.

Release of Funds – $750 million on May 19, 2020

On April 29th, 2020, the IHS held Tribal Consultation and Urban Confer calls to inform agency decisions on the implementation of support for testing and testing related activities, part of the PPPHCEA. The PPPHCEA provided $750 million that can be used to for necessary expenses to purchase, administer, process, and analyze COVID-19 tests, including support for workforce, epidemiology, and use by employers or in other settings. In addition, these funds can be used to scale up testing by public health, academic, commercial, and hospital laboratories, and community-based testing sites, health care facilities, and other entities engaged in COVID-19 testing. Funds may also be used to conduct surveillance, trace contacts, and perform other related activities related to COVID-19 testing. The IHS established the following funding allocations:

- For the purposes of the PPPHCEA:
  - $50 million to support UIOs and
  - $550 million to IHS Federal health programs and THPs
    - This includes $50 million PRC distribution formula for new PRC funds,
- $100 million to purchase tests, test kits, testing supplies, and related personal protective equipment through the IHS National Supply Service Center and
- $50 million for nation-wide coordination, epidemiological, surveillance, and public health support to bolster the expansion of testing across Indian Country.

Aims and Strategic Objectives of the IHS Action Plan

The Action Plan supports the planning and monitoring of the IHS response to COVID-19. The aims: to Prevent, Detect, Treat, and Recover are supported by two more administrative aims; to manage resources and provide comprehensive situational awareness. The strategic objectives were developed through review of IHS priority activities at the beginning of the response. The refinement of those activities into larger buckets of work allowed for the Agency to identify critical streams of activity to guide development and implementation of additional activities.

Figure 1: IHS COVID-19 Action Plan Aims and Strategic Objectives

AIMS					
PREVENT Spread of COVID-19	**DETECT** Cases of COVID-19	**TREAT** COVID-19 Cases and Sustain Regular Operations	SUPPORT the Indian Health System in the **RECOVERY** from COVID-19	**MANAGE** Resources	**PROVIDE** Comprehensive Situational Awareness of COVID-19 Activities
STRATEGIC OBJECTIVES					
Objective 1.1: To enable employees, communities, and the service population to protect themselves. **Objective 1.2:** To conserve critical resources to ensure a sustained response. **Objective 1.3:** To inform Tribes, urban Indian organizations, tribal organizations, IHS staff, and federal agencies.	**Objective 2.1:** To execute a surveillance and testing strategy. **Objective 2.2:** To support decision making and communication through data analysis.	**Objective 3.1:** To provide safe and effective care. **Objective 3.2:** To sustain the Indian Health System functioning.	**Objective 4.1:** To address the impacts of COVID-19 among employees. **Objective 4.2:** To facilitate community support resources for COVID-19. **Objective 4.3:** To support the emotional and spiritual well-being of American Indian and Alaska Natives. **Objective 4.4:** To return to pre-COVID operations.	**Objective 5.1:** To provide resources for safe and effective care.	**Objective 6.1:** To uniformly report on situational awareness across all IHS Areas to inform decision making and guide planning. **Objective 6.2:** To monitor the IHS response to COVID-19.

Aim 1: To Prevent the Spread of COVID-19

Objective 1.1: To enable employees, communities, and the service population to protect themselves.

This objective focuses on ensuring AI/AN communities have the essential means to practice COVID-19 prevention practices is the focus of this objective.

The IHS, in collaboration with the Navajo Nation, identified access to clean water sources as a critical issue. The IHS Navajo Area Office worked in partnership with the Navajo Nation to identify acute needs surrounding sanitation concerns around the lack of clean water. The field operations section has coordinated with the Navajo Nation, Navajo Area IHS, and the CDC to provide clean water sources across the Navajo Nation. This includes coordination efforts with an IHS team of 5 IHS engineers who are onsite working with the Navajo Nation collecting site information for the completion of site layout drawings of the 37 transitional water points.

To support the prevention of COVID-19 spread, the system support section of the ICS provided approval process guidance for IHS Payment for Quarantine or Isolation Space for individuals who have been exposed to COVID-19, but are not yet sick, or where the individual is sick, but does not require hospitalization, and isolation or quarantine is medically indicated. Allowable funding sources include Health Services appropriations, CARES Act funds and Purchased/Referred Care (PRC) funding.

The IHS reviewed and distributed guidance and recommendations that primarily fall within increasing capacity for efficient treatment. However, a number of guidance documents developed increased preventive measures including: 1) appropriate use and conservation of PPE for staff and patients; 2) prescreening of staff and patients for fever or symptoms prior to entrance into a health care facility; 3) the reduction of elective and/or non-urgent health care services to limit exposure of patients to potential infectious patients in a health care facility; 4) changes to patient flow or service delivery to reduce exposure/promote social distancing in a health care facility; and, 5) development of capacity for and promotion of telehealth options for care delivery.

Objective 1.2: To conserve critical resources to ensure a sustained response.

This objective focuses on ensuring the Indian health system plans for a sustained response is the focus of this objective.

The Safety Officer has provided ongoing support to IHS HQ and Area staff and leadership. This includes compiling and sharing current safety information and management tools so staff are supported to work in the safest environment possible. Incident Command and Section Chiefs have regularly reminded and encouraged staff to use leave as needed to keep personnel refreshed and alert throughout the response.

Objective 1.3: To inform Tribes, urban Indian organizations, tribal organizations, IHS staff, and federal agencies.

This objective focuses on providing the I/T/Us and Indian health system stakeholders with current and critical information to ensure a common understanding of the current situation is the focus of this objective.

The ICS supported the notice and ongoing development federal collaborations with the CDC, FEMA, and VHA. The CDC supported a tribal help desk which the IHS assisted coordination with tribes on. In addition, the ICS coordinated with federal facilities to assist in their formula for determining tribal resource support. The IHS also staffed liaisons to the National Response Coordination Center (NRCC) tribal advisory desk, the FEMA Task Force Liaison Officer, FEMA Legal Liaison Officer, and a Secretary's Operation Center (SOC) Liaison Officer.

The IHS established and maintained a COVID-19 website which serves as the primary location for sharing IHS COVID-19 specific information. On March 19, 2020 the website was launched and is now updated daily with IHS COVID-19 surveillance data and links to IHS Global Information System data. The site includes frequently asked questions and resources which cover topics from accessing PPE to availability of telehealth services.

A large component of communication activities include Consultation and Confer for COVID-19 related funding. Rapid Consultation and Confer was held the weeks of March 23, 2020, and March 30, 2020. On April 29, 2020 Consultation and Confer was held on funding from the Provider Relief Funds, Paycheck Protection Program and Health Care Enhancement Act. Tribes and UIOs were alerted on the rapid Consultation and Confer and final decisions on funding were shared through tribal and UIO leader letters.

The HQ Operations section coordinated with JHU on a community prevention materials. Topics included elder mental health, a general COVID-19 Fact Sheet, how to prevent the spread of COVID-19, tips for elders and their caregivers, and what tribal members need to know about COVID-19. The materials are accessible on the IHS COVID website.

Aim 2: To Detect Cases of COVID-19

Objective 2.1: To execute a surveillance and testing strategy.

This objective focuses on establishing and maintaining an AI/AN data system to provide population specific information to inform decision making is the focus of this objective.

The IHS stood up a data surveillance system to track the detection of new COVID-19 cases and assist in planning IHS response. The surveillance system collects facility level data on COVID-19 related

outcomes, such as ventilator use and hospital bed capacity, along with aggregated testing data from all federal sites and participating tribal and UIO facilities. The data surveillance system aggregates data nationally and by IHS Area and helps to inform response activities.

Table 1. Aggregate COVID-19 tests submitted from federal and participating tribal and UIO sites to the IHS surveillance system (Date: June 14, 2020).

IHS Area	Tested	Positive	Negative	Percentage Positive
Alaska	29,348	68	22,970	0.3%
Albuquerque	15,256	876	10,424	7.8%
Bemidji	10,108	295	9,262	3.1%
Billings	17,141	263	14,030	1.8%
California	3,437	143	2,782	4.9%
Great Plains	14,264	702	12,421	5.3%
Nashville	7,126	948	5,935	13.8%
Navajo	35,339	7,442	25,422	22.6%
Oklahoma City	34,952	703	33,262	2.1%
Phoenix	16,510	3,102	12,329	20.1%
Portland	7,891	581	7,304	7.4%
Tucson	1,976	95	1,770	5.1%
Total	**193,348**	**15,218**	**157,911**	**8.8%**

Tracking of COVID-19 tests across the Indian health system is a critical accomplishments for the IHS. In the first 100 days, I/T/Us performed 193,348 COVID-19 tests, of which 15,218 were positive for a total IHS percent positive rate of 8.8percent (computed as Percent Positive = Positive / (Positive + Negative)).

At the 100 day mark, the Indian health system reported an AI/AN per capita testing rate of 116.3 per thousand population (compared to United States all per capita testing rate of 71.2). This not only shows the hard work being done by IHS employees providing the testing, but demonstrates the hard work and collaborative effort by FEMA and the NSSC to obtain the testing capability (with Abbott ID Now Analyzers, Cepheid Analyzers and other methods of testing) and testing medium.

To complement testing strategies, the IHS has begun work on developing contact tracing programs and a strategic testing plan. Coordination began with support for the State of New Mexico and the Navajo Area IHS. In addition, early identification of potential COVID-19 cases is being addressed by securing new Text Illness Monitoring Systems, of which 350 new channels for tribes are available to use which allows tribes access to data without having to go through the States.

IHS also promoted effective communication through participation on weekly coordination calls with the CDC. Agenda topics included CDC support and response to the Navajo Nation, data and analysis, dashboarding, potential linkage to correct AI/AN death data reported to CDC, and designation of IHS and CDC liaison officers.

Objective 2.2: To support decision making and communication through data analysis.

This objective focuses on providing timely data analysis to the Indian health system to inform and support decision making is the focus of this objective.

With the data surveillance system and improved National Healthcare Safety Network (NHSN) reporting from all direct service hospitals, the IHS has improved its capability to make informed decisions through data analysis. At the outset of developing the surveillance system, a medical counter measures survey of need was distributed to I/T/U facilities. This survey assessed the level of need at each I/T/U facility (materials, supplies and equipment) and informed planning activities for the initial ICS response.

Aim 3: To Treat COVID-19 Cases and Sustain Regular Operations

Objective 3.1: To provide safe and effective care.

This objective focuses on developing and distributing critical guidance documents, recommendations, and activities to inform the adaptation of the health care delivery system to meet the urgent needs of providers, patients, communities, and stakeholders is the focus of this objective.

The IHS HQ ICS sent out over 40 clinical and administrative guidance and recommendation documents to support the delivery of timely, quality, and safe care. Examples include clarification on Emergency Medical Treatment and Labor Act (EMTALA) requirements, credentialing disaster and emergency procedures, and recommendation for PPE optimization and planning strategies. A full list of guidance and recommendations can be found in Appendix 3.

The IHS announced expansion of telehealth across IHS federal facilities to provide patients the opportunity to stay home and reduce their risk of infection and also keep healthcare workers safe. The IHS also offered a variety of COVID-19 Extension for Community Healthcare Outcomes (ECHO) webinars in partnership with the University of New Mexico. Topics included homeless population partnership, alternative care sites, and adapting ambulatory care to COVID-19.

To support the delivery of care, the IHS worked on the development of a contract to establish a Critical Care Response Team (CCRT). The CCRT will deploy on an as needed basis to provide urgent lifesaving medical care to stabilize and treat patients with suspected or confirmed COVID-19 and will prepare and train frontline health care staff at IHS and tribal facilities using evidence-based/best practices. The IHS also assisted the deployments of CDC tribal support through the deployment of 4-5 member teams for onsite support to Areas in critical need of assistance.

Objective 3.2: To sustain the Indian Health System functioning.

This objective focuses on ensuring the sustained provision of health care services outside of COVID-19 care is the focus of this objective.

The IHS focused on sustained care in the Indian health system through developing interim guidance on dental clinical operations, telehealth use, coding for visits, and produced COVID-19 hiring guides for human resource directors.

Aim 4: To Support the Indian Health System in the Recovery from COVID-19

Objective 4.1: To address the impacts of COVID-19 among employees.

This objective focuses on providing emotional and physical support to IHS employees through the COVID-19 response is the focus of this objective.

The IHS instituted regular staff calls to provide COVID-19 updates and resources. COVID-19 webinar sessions were offered on fostering provider resilience and supporting the mental health of healthcare workers. In total, over 260 attendees attended the webinars to increase their ability to address staff health.

The IHS has maintained situational awareness of COVID-19 related employee adverse events through the IHS electronic reporting system. Ongoing, regular review of COVID related adverse events between HQ ICS sections and Areas will increase the Agency's ability to establish and monitor best practices to reduce the number of COVID-19 positive employees.

Objective 4.2: To facilitate community support resources for COVID-19.

This objective focuses on developing and disseminating AI/AN specific information to promote community resilience is the focus of this objective.

To develop and distribute community resources, the IHS submitted funding requests for continued health community messaging and contributed to Men's Health Blog on COVID-19 for National Men's Health Week.

Objective 4.3: To support the emotional and spiritual well-being of American Indian and Alaska Native people.

This objective focuses on maintaining emotional and spiritual support for a sustained AI/AN community response is the focus of this objective.

To increase behavioral health services, the IHS supported connection of Area behavioral services and Area behavioral health programs with HQ Operations to increase awareness among providers and community members of technical assistance available.

The HQ Operations sections provided topic specific tele education opportunities, including Provider Mental Health Series Webinars as part of the initiative to support IHS employee well-being in the recovery phase through a cooperative agreement with Sister Sky Inc. HQ Operations also supported the IHS Telebehavioral Health Center of Excellence on the launch of a series of webinars focused on culture and resilience during COVID-19 and supporting the mental health of healthcare workers during COVID-19, which was done in partnership with Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Technology Transfer. With a focus on adolescents, two behavioral health webinars with Casey Family Programs were provided on supporting child and adolescent mental health during a pandemic and supporting parents and caregivers of children and adolescents.

IHS also shared burial practices to ensure the practice of respectful and safe burial practices. To foster increased communication on recovery, a collaboration with JHU developed a Children and Grief fact sheet and a COVID-19 storybook for AI/AN Children "Our Smallest Warriors, Our Strongest Medicine: Overcoming COVID-19," book adapted from the "My Hero is You" storybook.

Objective 4.4: To return to pre-COVID operations.

This objective focuses on facilitating the resumption of core IHS services while maintaining COVID-19 activities is the focus of this objective.

To begin resumption of clinical activities during May 2020, the IHS Division of Oral Health (DOH) distributed Interim Guidance for Dental Clinic Operations Beyond Emergency Care, New Dental Guidance regarding CDC released updates to the Interim Infection Prevention and Control Guidance for Dental Settings, and Interim Guidance for Re-Opening Dental Clinic Operations (see Appendix 3 for dates). In addition, FAQs for dentists on reopening dental clinic operations were developed and posted at the COVID-19 website.

Aim 5: To Manage Resources

Objective 5.1: To provide resources for safe and effective care.

Complementing Objective 1.2, this objective focuses on ensuring the Indian health system plans for a sustained response with specific attention to facilitating efficient administrative functions.

Securing adequate staffing levels and ensuring effective management of human resources is a primary role of the IHS HQ ICS. The Office of Human Resources (OHR) supported this by obtaining or implementing a variety of new hiring, compensation, and leave authorities/flexibilities. IHS received the following authorities from the OPM to support the COVID-19 response efforts: Direct Hire Authority for 32 occupations, dual compensation salary off-set waiver authority 74 occupations, and COVID-19 Schedule A Excepted Service hiring authority. OHR produced guidance and fact sheets on these hiring authorities. IHS instituted interim procedures for onboarding personnel and temporary deployments during the COVID-19 pandemic. This interim procedure streamlined the vetting process for Federal personnel from multiple organizations, including the HHS National Disaster Medical System (NDMS), the Veterans Administration, CDC, and the PHS Commissioned Corps, to rapidly deploy and immediately begin their work. IHS implemented Hazardous Pay Differential and Environmental Differential Pay for employees in IHS direct service facilities performing hazardous duty, including physical hardship and job-related exposure to COVID-19. Over 10,000 IHS employees have received these payments since implementation. IHS also implemented premium pay flexibilities for employees responding to COVID-19 as authorized in the CARES Act. OHR issued guidance and implemented the FFCRA that allows employees to receive up to two weeks of emergency paid sick leave. OHR has continuously maintained current staffing information by tracking Commissioned Corps Deployments, federal employees testing positive for COVID-19, and employee telework numbers.

To assist in providing essential information to the Areas, the OHR provided OHR- Emergency Paid Sick Leave Act (EPSLA)/FFCRA Guidance Emergency Paid Sick Leave Act guidance, FAQ, and forms. The IHS remains committed to providing a safe work environment, ensuring employee access to benefits for which they qualify, and using IHS resources efficiently. Hazardous pay differential and environmental differential pay eligibility risk assessment recommendations were created, and implementation is coordinated with Area staff.

To develop and facilitate a streamlined PPE logistics process for I/T/Us the IHS has taken a number of actions. To provide PPE supplies to I/T/U, the System Support section developed a PPE request tracking system. At the outset of the response, IHS identified a liaison to FEMA for the SNS on March 27. On April 4, guidance was issued to I/T/Us on how to request PPE through the SNS or the FEMA WebEOC. To improve the supply process, Interagency Agreements (IAA) were drafted with FEMA. The IAA develops an improved resource request process. To assist in comprehensive PPE tracking, training

sessions were offered to Area Emergency Management Point of Contacts (EMPOCs) on entering SNS requests and to respond to any issues, concerns or questions. The IHS also maintained tracking of contracting actions and reported weekly to HHS.

The NSSC monitored supply requests through review of daily Area Situational Reports (SITREP) and requests shared through daily ICS calls. Using allocation methodologies, as well as good communication with EMPOCs, these products are staged in the Oklahoma City Area. This coordinated effort also complemented the FEMA request for IHS to change process for SNS requests to all requests being sent to NSSC.

The IHS distributed a recommendation for PPE Planning and Optimization for Healthcare Facilities during the COVID-19 Pandemic. The use of the PPE Burn Rate calculator from the CDC was used after review of PPE estimators and identified advantages with the CDC tool. The CDC tool was later modified to accommodate IHS burnrates.

A Guidance to Accessing Medical Supplies was released for ventilator requests. FEMA issued an advisory concerning ventilator requests and in order to ensure consistency with the FEMA Advisory and IHS process, additional steps were identified that tribes and UIOs could follow in order for IHS ICS to have visibility on ventilator requests to provide tracking, assistance, and support to ensure requests are fulfilled.

As part of the HHS national contract, IHS received Abbott ID Now analyzers and testing medium. In the first allotment from HHS, IHS received 250 analyzers that were initially distributed by NSSC on April 14 to rural and remote IHS and tribal health program locations through a plan that was developed taking into consideration clinical requirements, legal/contract requirements, and training. HHS approved a 2nd allotment to IHS for an additional 100 analyzers, and through June 14, 53 of the 100 analyzers were distributed to IHS, tribal health programs as well as UIO health programs. The remaining 47 analyzers from the 2nd allotment are expected to be received in the coming weeks. HHS continues to allocate test kits on a weekly basis in support of I/T/U health programs testing efforts. NSSC worked through the Area EMPOCs to determine I/T/U facility needs for distribution of the weekly allocation of the test kits. The safety officer assisted in managing face covering requests to FEMA and the HHS Assistant Secretary for Preparedness and Response (ASPR) for Area and tribal health program staff. HHS distributed of more than 380,000 reusable cloth masks was coordinated with HHS, with each washable mask being used up to 15 times.

To support expansion of service, the system support section developed a guide to assist I/T/U sites with RPMS Configuration and Data Capture options to support and address expanded services during the pandemic. To provide guidance on COVID-19 related Medicare billing, temporary billing guidance was developed and distributed. In April, IHS began tracking third party revenue collections on a weekly basis to track the trend of loss revenue throughout the Indian health system.

To provide COVID-19 funds specifically for the PRC program, the IHS PRC distribution formula was utilized. The System Support section prepared funding tables for $50 million distribution of Paycheck Protection Program and Health Care Enhancement Act funds using the PRC distribution formula for new funds and submitted to the IHS Office of Finance and Accounting (OFA). To ensure IHS tracks COVID-19 related payments for services through the PRC program, the Fiscal Intermediary (FI) contractor developed a weekly report to monitor PRC related payments made using COVID-19 specific codes. At the onset of the pandemic, the IHS issued a directive identifying COVID-19 testing and treatment as Medical Priority I for PRC related services.

The IHS enhanced communication with external partners. Specifically, the IHS offered support to federal agencies providing guidance on tribal COVID-19 funds, including HRSA grants. After working with HRSA on notice of funding opportunity language and providing feedback to their staff during the grant application process, IHS worked closely with HRSA to assure that applicants selected through the review process were eligible tribal governments, tribal organizations (i.e. tribal clinics, Alaska Native Corporations) or UIOs. HRSA's list of grantees has a geographic distribution that includes at least one award in each of the 12 IHS Areas. The IHS also assisted in developing a methodology of the Provider Relief Funds to be distributed from HRSA.

IHS personnel are performing hazardous duty involving physical hardship and job-related exposure to the COVID-19 virus. IHS must identify civilian employees who are eligible for HPD and EDP. OHR consulted with the 12 Area Directors, and recommended to the IHS Director to approve a broad application of HPD and EDP to cover any civilian employee performing work at an IHS healthcare facility, and to authorize Areas the option to provide retroactive HPD and EDP supplemental payments beginning back to March 15. RADM Weahkee approved this recommendation, signed the decision memo on April 15, and made distribution to the Area Directors.

On May 22, Systems Support sent out to Area Directors the Implementation Guidance for HHS's return to normal operations that has been sent to each Operating Division from the Assistant Secretary for Administration. The guidance provides a three-phased transition to normal operations after meeting national gating criteria at the local level, is applied HHS-wide, and puts the health and safety of employees and their families at the very center. IHS is required to follow the three phases after the national gating criteria is met in a state or county before a local jurisdiction may proceed to a phased return to normal operations. The gating criteria includes a downward trend for 14 days of illness and COVID-19 cases, as well as local hospital capacity to treat patients. Staff composition, types of facilities, programs and services carried out, and available resources will influence how IHS can carry out an orderly phased transition. For the initial plan submission to HHS, IHS has accepted this Implementation Guidance for the overall IHS plan that was submitted on June 1. Area Offices may elect to use the guidance as written for their respective plan, or may choose to make specific additions to address unique situations while still being aligned with the principles of the guidance. IHS must consider how to minimize and control the impact of COVID-19 in the workplace as phased return to normal operations is conducted. IHS staff must maintain healthy operations and work environment for all staff, visitors, and patients.

Aim 6: To Provide Comprehensive Situational Awareness of COVID-19 Activities

Objective 6.1: To uniformly report on situational awareness across all IHS Areas to inform decision making and guide planning.

Complementing Objective 1.3, this objective focuses on developing and sharing comprehensive situational awareness for the management the IHS response.

Early on, Areas were requested to submit Area situational reports to highlight critical activity and identify supply needs. The Planning Section reviewed Area SITREPs daily and included their information in daily reports.

A Concept of Operations (CONOPS) was developed and shared within the agency to assist in preparedness and response activities. And, as previously reported, IHS publishes daily testing surveillance data on the website. IHS continues to provide various data displays to inform decision making, guide planning, and for public awareness.

Objective 6.2: To monitor the IHS response to COVID-19.

Complementing Objective 1.3, this objective focuses on monitoring the IHS response through documentation and review of activities.

To facilitate coordination with and support Area Planning Activities, the Planning section met with Area Planning staff to discuss alignment of action plans and critical needs.

To maintain progress on the Action Plan, the Planning section monitors the IHS Emergency Response Coordination Center SharePoint site and implementation of key activities. The IHS Action Plan informs leadership and Areas on the IHS response and assists in planning for future action.

The Public Information Office holds weekly Public Affairs Liaison calls to discuss COVID-19 updates and media requests. The Safety Officer holds bi-weekly calls with Area Safety Officers to provide information and to open the flow of communication from the Areas to HQ as it pertains to safety challenges.

Appendix 1 IHS Incident Command Structure (ICS)

Incident Commander (IC) – Deputy Director
The Incident Commander has overall responsibility for the incident, sets objectives for the response.

Deputy Incident Commander – Chief of Staff

Field Operations Coordination Group – Chief – Deputy Director for Field Operations
The Field Operations Coordination Group ensures coordination of response activities and communications across the 12 IHS Area Offices and the IHS Office of Environmental Health & Engineering. Major responsibilities of the Field Operations Coordination Group include:

- Ensure Area Office and OEHE compliance with ICS reporting requirements
- Facilitate Area Office and OEHE communication with ICS and other partner entities
- Assist Area Offices and OEHE to gain access to money, materiel and human capital necessary to perform COVID-19 response
- Liaison between Area ICS and IHS ICS
- Support as needed, Area Office communications with internal and external customers

Liaison Section – Chief – Deputy Director for Intergovernmental Affairs

- Act as a point of contact for IHS representatives.
- Maintain a list of assisting and cooperating agencies and their respective agency representatives.
- Assist in setting up and coordinating interagency contacts.
- Monitor incident operations to identify current or potential inter-organizational problems.
- Participate in planning meetings, providing current resource status, including limitations and capabilities of IHS resources.
- Provide IHS-specific demobilization information and requirements.

Public Information Officer – Director, Public Affairs

- Determine, according to direction from the IC, any limits on information release.
- Develop accurate, accessible, and timely information for use in press/media briefings.
- Obtain IC's approval of news releases.
- Conduct periodic media briefings.
- Arrange for tours and other interviews or briefings that may be required.
- Monitor and forward media information that may be useful to incident planning.
- Maintain current information, summaries, and/or displays on the incident.
- Make information about the incident available to incident personnel.
- Participate in planning meetings.

Systems Support Section -- Chief – Deputy Director for Management Operations
The Systems Support Section Chief is responsible for logistics, finance, and administration. Coordinates the HQ response to incoming requests from the Areas for incident support needs, provides resources, and other relevant services. Manages all HQ related financial aspects of an incident, monitors incident related costs, and provides overall fiscal guidance. The Systems Support Section Chief may identify branches within the section to facilitate scope of authority.

Operations Section – Chief – Chief Medical Officer
The Operations Section Chief is responsible for managing all tactical operations at an incident. The Incident Action Plan (IAP) provides the necessary guidance. The need to expand the Operations Section is generally dictated by the number of tactical resources involved and is influenced by span of control

considerations. The Operations Chief may identify branches within the section to facilitate scope of authority.

Major responsibilities of the Operations Section Chief are to:

- Assure safety of tactical operations.
- Manage tactical operations.
- Develop the operations portion of the IAP.
- Supervise execution of operations portions of the IAP.
- Request additional resources to support tactical operations.
- Approve release of resources from active operational assignments.
- Make or approve expedient changes to the IAP.
- Maintain close contact with IC, subordinate Operations personnel, and other agencies involved in the incident.
- Staff in the Operations Section are responsible for executing tactical activities.

Planning Section – Chief – Deputy Director for Quality Healthcare
The Planning Section Chief is responsible for providing planning services for the incident. Under the direction of the Planning Section Chief, the Planning Section collects situation and resources status information, evaluates it, and processes the information for use in developing action plans. Dissemination of information can be in the form of the IAP, in formal briefings, or through map and status board displays.

Major responsibilities of the Planning Section Chief are to:

- Collect and manage all incident-relevant operational data.
- Supervise preparation of the Incident Action Plan (IAP).
- Provide input to the IC and Operations in preparing the IAP.
- Incorporate Medical and Communications Plans and other supporting materials into the IAP.
- Conduct and facilitate planning meetings.
- Reassign personnel within the ICS organization.
- Compile and display incident status information.
- Establish information requirements and reporting schedules for units.
- Determine need for specialized resources.
- Assemble and disassemble Task Forces and Strike Teams not assigned to Operations.
- Establish specialized data collection systems as necessary.
- Assemble information on alternative strategies.
- Provide periodic predictions on incident potential.
- Report significant changes in incident status.
- Oversee preparation of the Demobilization Plan.

Planning Section are responsible for gathering and analyzing operational information and sharing situational awareness. Staff in the Operations Section are responsible for executing tactical activities.

S**afety Officer –** Technical Advisor to the Designated Agency Safety and Health Official
The Safety Officer is responsible for providing technical guidance and leadership on employee health and safety in collaboration with the Deputy Safety Officer and the Infection Prevention and Control Coordinator in the IHS Office of Quality. The Safety Officer is a resource for the HQ ICS as well as Area and Service Unit safety staff facilitating communication between stakeholders, and monitoring employee adverse events.

Appendix 2 IHS Major Response Activity Summary

January-February 2020

- IHS CMO sent Areas reports on the Corona Virus (COVID-19).
- IHS CMO sent IHS facilities and providers information on COVID-19.

March 6-20, 2020

- March 5: Launch of weekly Indian Country COVID-19 Update calls with tribal and Urban Indian Organization leaders call hosted by the White House Office of Intergovernmental Affairs and Federal partners.
- March 6: IHS HQ ICS Activated to mitigate negative impacts of the COVID-19 outbreak using our existing pandemic influenza plan as a base.
- March 6: The Coronavirus Preparedness and Response Supplemental Appropriation Act of 2020 was enacted.
- March 6: HHS provided $70 million to the IHS from the Public Health and Social Services Emergency Fund.
- March 18: The Families First Coronavirus Response Act was enacted ($64 million to IHS for testing).
- March 18: PRC Directive issues (directed all IHS PRC Programs to assign COVID-19 testing and treatment as Medical Priority 1).
- March 19: Official launch of the IHS.gov Coronavirus (COVID-19) website.

March 21-April 3, 2020

- March 20: Navajo Nation-Request for Information from Service Providers (assistance in assessing resources and ability to combat COVID-19)
- March 23: Tribal Consultation and Urban Confer for Public Health and Social Services Emergency Fund and Family First Coronavirus Response Act.
- March 27: The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) was enacted.
- March 27: Release of funds ($134 million).
- March 30: Tribal Consultation and Urban Confer for CARES Act funding ($1.032 billion).
- April 1: Approximately 4 million N95 masks distributed.
- April 3: Release of Funds ($600 million) for response activities (CARES Act).
- April 3: COVID-19 Schedule A Government-wide Hiring Authority from OPM.

April 4-17, 2020

- April 6: Billing Guidance for COVID-19.
- April 7: Launch of weekly series of COVID-19 Update calls for UIO Leaders.
- April 8: Posting of IHS COVID-19 Guidance on the Quality Portal.
- April 8: Telehealth services expansion across the agency announced.
- April 9: June 4: Abbott ID Analyzer (first distribution) and tests.
- April 14: NSSC distributes the 250 Abbott ID NOW analyzers and test kits to rural and remote IHS and Tribal health programs.
- April 14: PRC allocation formula developed for CARES Act distribution.
- April 15: IHS Surveillance Dashboard rolled out.
- April 15: Implementation of Hazardous Pay Differential and Environmental Differential Pay at IHS direct service sites.

April 18-May 1, 2020

- April 23: Final CARES Act allocation announced.
- April 23: Direct Hire Authority from OPM to support COVID-19 national emergency.

- April 24: Paycheck Protection Program and Health Care Enhancement Act (PPPHCEA) was enacted.
- April 25: Emergency Dual Compensation Waiver Authority for Reemployed Annuitants from OPM to support COVID-19 response.
- April 29: Tribal Consultation and Urban Confer for PPPHCEA ($750 million).
- April 30: Approximately 4 million pairs of gloves distributed.
- April 21 to May 1: 327,000 masks distributed.

May 2-15, 2020

- May 4-May 8: Approximately 36 million pairs of gloves distributed.
- May 15: Expansion of Specialty Care in the Billings Areas announced.

May 16-29, 2020

- May 18: $750 million for testing capacity expansion and testing related activities announced.
- May 18: Approximately 31,000 coveralls distributed.
- May 18: 51,000 swabs/utm distributed.
- May 19: PPPHCEA $750 million distribution decision announced to Tribal and Urban Indian Organization leaders.
- May 22: $500 million distribution announced for tribal hospitals, clinics and urban health centers.
- May 28: 185,000 masks distributed.
- May 28: IHS distributes COVID-19 Testing Plan template that corresponds with the distribution of PPPHCEA funds to Tribal Leaders and UIO Leaders.
- May 29: 101,000 swabs/utm distributed.

May 30-June 12, 2020

- June 1: 15,000 bottles of hand sanitizer distributed.
- June 1: 750,000 masks distributed.
- June 2: Critical Care Response Team formed and announced.
- June 5: 4,240 thermometers distributed.
- June 8: NSSC distributes 53 additional Abbott ID NOW analyzers and test kits to I/T/Us health programs.

Appendix 3 IHS Major Guidance and Resources Shared

March 6-20, 2020

- March 6: IHS COVID-19 Interim Guidance for Risk Stratification and Return-to-Duty for Officers Returning from Deployment
- March 10: Interim Infection Prevention and Control Recommendations CDC COVID-19
- March 12: Workforce Flexibilities
- March 15: IHS COVID-19 Interim Guidance on OSHA Enforcement Memorandum on Respirator Annual Fit Testing
- March 17: Recommendations for Sharing OAA Disaster Relief FAQs
- March 18: PRC Directive issued (directed all IHS PRC Programs to assign COVID-19 testing and treatment as Medical Priority 1).
- March 18: IHS COVID-19 Interim Guidance for Conservation of Medical Resources
- March 18: IHS COVID-19 Interim Guidance for Triaging of Patients and Visitors Prior to Entry of IHS Healthcare Facilities
- March 18: IHS COVID-19 Interim Guidance for Optometry Clinics
- March 19: Guidance to the field in regards to IHS staff use of respirators vs. facemasks when in close contact (6 feet or less) of patients with known or suspected COVID-19.
- March 19: Recommendation for Grace Period for Renewal of AHA Provider Cards
- March 20: Interim Guidance for Telehealth use in IHS for Responding to COVID-19
- March 20: IHS COVID-19 Interim Guidance for Care Services to Non-Beneficiaries
- March 20: IHS COVID -19 Interim Guidance for Telehealth use in IHS for Responding to COVID-19

March 21-April 3, 2020

- March 25: CMS EMTALA Requirements and Implications Re: COVID-19
- March 25: Recommendation for PPE Planning and Optimization for Healthcare Facilities during COVID-19 Pandemic
- March 25: Recommendation for Evaluation of Options for Laboratory Testing During the COVID-19 Pandemic
- March 27: Guidance on Diagnostic Testing for COVID-19
- March 27: IHS COVID-19 Interim Guidance for Dental Clinic Operations
- March 27: IHS COVID-19 Interim Guidance for Emergency Medical Services Regarding Nebulizer Therapy and Other Aerosol-Generating Procedures
- March 27: IHS COVID-19 Interim Guidance for Use of Technology for Telehealth
- March 27: IHS Temporary Procedures on Fingerprinting New Employees during COVID-19 Public Health Emergency
- March 29: IHS COVID-19 Interim Guidance on Flu Surveillance System Reports
- March 31: IHS COVID-19 Interim Guidance for Coding Teledentistry Events
- April 1: IHS Fact Sheet on Emergency Dual Compensation Waiver Authority for Hiring Reemployed Annuitants during COVID-19
- April 2: IHS COVID-19 Interim Guidance for Personal Protective Equipment Optimization and Planning Strategies for Healthcare Facilities during COVID-19 Pandemic
- April 3: Recommendation for PPE Optimization and Planning Strategies for Healthcare Facilities during COVID-19 Pandemic
- April 3: IHS Fact Sheet on COVID-19 Schedule A Government-wide Hiring Authority

April 4-17, 2020

- April 6: Billing Guidance for COVID-19
- April 7: FTCA Coverage for Volunteer non-Service health care practitioners at IHS direct care facilities for physicians, physician assistants, and advance practice nurses

- April 8: Ventilator Request - Addendum 1 to I/T/U Guidance to Accessing Medical Supplies
- April 8: IHS Fact Sheet on Evacuation Pay
- April 9: IHS COVID-19 Interim Guidance for Dental Clinic Operations
- April 10: IHS COVID-19 Interim Guidance to Virtual Check-in and Visit for Adults with Diabetes during the COVID-19 Pandemic
- April 14: IHS COVID-19 Interim Guidance for Coding Teledentistry Events
- April 15: IHS COVID-19 Recommendation for Interim Infection Prevention and Control Screening Recommendations for Coronavirus Disease 2019 in Healthcare Settings
- April 15: IHS COVID-19 Interim Clinical Guidance for Testing of Patients for COVID-19 Using the Abbott ID NOW™ Analyzer

April 18-May 1, 2020

- April 18: IHS COVID-19 Interim Recommendation for Utilization of Temporary Privileging for IHS Medical Staff Hired during the COVID-19 Pandemic
- April 20: IHS Fact Sheet on Hazardous Pay Differential and Environmental Differential Pay
- April 23: IHS Guidance on COVID-19 Direct Hire Authority Approval from OPM
- April 29: Maintaining Essential Well Child Care during the COVID-19
- May 1: IHS Guidance on Implementation of the Families First Coronavirus Response Act, Emergency Paid Sick Leave Act

May 2-15, 2020

- May 3: IHS COVID-19 Interim Guidance for Dental Clinic Operations Beyond Emergency Care.
- May 6: IHS COVID-19 Interim Guidance for the Role and Response of Community Health Representatives/Community Health Workers during COVID-19 Pandemic
- May 7: COVID-19 Emerging Treatments Update - Remdesivir (GS-5734™) -EMERGENCY USE AUTHORIZATION
- May 12: IHS COVID-19 Interim Guidance for Community Health Representatives/Community Health Workers Virtual Home Visits during the COVID-19 Pandemic
- May 13: IHS COVID-19 Interim Guidance for Re-Opening Dental Clinic Operations - Date Implemented
- May 13: IHS Interim Guidance on Personnel Security Pre-clearance Requirements for Short-term Deployments during COVID-19 Pandemic
- May 15: IHS Interim Guidance Regarding Medications Under FDA Emergency Use Authorization During COVID-19 Pandemic
- May 22: IHS Guidance on the Implementation of Premium Pay Flexibilities during COVID-19