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SUBMITTED VIA *ELECTRONIC TRANSMISSION:* *testimony@indian.senate.gov*

March 28, 2018

Chairman John Hoeven (R-ND)
Vice Chairman Tom Udall (D-NM)
Senate Committee on Indian Affairs
838 Hart Senate Office Building
Washington, DC 20510

Re: Testimony for the Record to the Senate Committee on Indian Affairs March 14, 2018 Oversight Hearing on "Opioids in Indian Country: Beyond the Crisis to Healing the Community"

Dear Chairman Hoeven and Vice Chairman Udall,

On behalf of Northwest Portland Area Indian Health Board (NPAIHB), I write to submit testimony for the record to the Senate Committee on Indian Affairs on the March 14, 2018 Oversight Hearing on "Opioids in Indian Country: Beyond the Crisis to Healing the Community." The NPAIHB is a Public Law 93-638 Tribal organization that advocates on health care issues for the forty-three federally-recognized tribes in the states of Idaho, Oregon, and Washington.[1] I would like to thank the Senate Committee on Indian Affairs for holding this important hearing and soliciting input from tribes and other key stakeholders in Indian Country.

Impacts of the Opioid Crisis on Portland Area Tribes

Over 353,000 American Indian and Alaska Native (AI/AN) people reside in Idaho, Oregon, and Washington, representing 6.8% of the nation's AI/AN population. This figure includes urban AI/AN people, as well as tribally-enrolled AI/ANs. The 43 federally-recognized Tribes in the Pacific Northwest are diverse in terms of their population size, culture, geographic location, infrastructure, and economic and health opportunities.

Opioid prescriptions have risen dramatically over the past 15 to 20 years and the annual incidence of opioid overdose and deaths have also risen nationally. People in rural counties are nearly twice as likely to overdose on prescription painkillers as people in big cities and many tribal communities are located in rural areas. AI/AN communities experience disparities in many health outcomes, including opioid overdose deaths. In 2008, the year for which opioid analgesics accounted for over 40% of all drug poisoning deaths, the drug overdose death rate for AI/ANs was greater than all other races/ethnicities in the U.S. The opioid pain reliever-related

[1] A "tribal organization" is recognized under the Indian Self-Determination Education Assistance Act (P.L. 93-638; 25 U.S.C. § 450b(1)) as follows: "[T]he recognized governing body of any Indian tribe; any legally established organization of Indians which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the Indian community to be served by such organization and which includes the maximum participation of Indians in all phases of its activities."

overdose death rate for AI/AN was 6.2 per 100,000 population in 2008. In 2010, the opioid overdose death rate among AI/AN women was 7.3 per 100,000 population, compared with a rate of 5.7 among white women and 4.2 among all U.S. women.

Prescription overdoses impact every family member in tribal communities throughout the Portland IHS Area (Idaho, Oregon, and Washington). Tribal elders are often raising their grandchildren, while fighting to help their child suffering from addiction. In the Portland IHS Area a race-corrected analysis found the age-adjusted drug overdose death rate for AI/ANs for opioid, prescription drug, and all drug overdoses to be twice that of non-Hispanic whites. This disparity in opioid and drug overdoses has persisted in Idaho, Oregon, and Washington since 1997. Drug overdose deaths from opioid misuse are of significant concern to tribal communities. From 2006 to 2012, a total of 10,565 deaths occurred among AI/AN residents in the states of Idaho, Oregon, and Washington. There were 584,070 deaths among non-Hispanic White (NHW) in the three-state region. Drug overdoses accounted for 4.3% (450) of all deaths among Northwest AI/ANs and 1.7% (9,868) of all deaths among NHWs. Of the drug overdose deaths, 65.3% (294) of AI/AN deaths and 69.3% (6,837) of NHW deaths were from prescription drugs. Of the prescription drug overdose deaths, 77.2% (227) of AI/AN deaths and 75.4% (5,157) of NHW deaths were from opioid overdoses.[2]

Misuse of prescription opioids commonly leads to the use of other drugs, such as heroin in tribal communities. The National Institute of Drug Abuse noted that 21 to 29 percent of patients prescribed opioids for chronic pain misuse them, and 4 to 6 percent who misuse prescription opioids transition to heroin. Furthermore, the death rate for heroin overdoses among AI/ANs have dramatically increased, rising 236 percent from 2010 to 2014.[3]

Federal Trust Responsibility to Tribes

The Committee must take into consideration the unique status of AI/ANs as well as the unique health care system that serves AI/ANs. Legislation must assist in expanding access to integrated services and reach critically underserved AI/AN people. The federal government has an obligation to provide Indian health services through numerous treaties, court cases, and laws. Tribes are sovereign governments with a unique trust relationship with the United States. It is important to note that Congress has funded IHS at a level far below patient needs since the creation of the agency in 1955. For example, in FY 2017, national health expenditure spending was $9,207 per capita, compared to IHS spending was $3,332 per patient.

Healthcare Delivery in the Portland Area

AI/ANs face barriers to receiving quality medical and behavioral health care, due in part to chronic underfunding of IHS, tribal, and urban Indian clinics, and stigma associated with accessing behavioral health care in some communities. Limited access to specialized health care services contributes to and exacerbates disparities in nonfatal and fatal opioid overdose among AI/ANs.

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[2] Northwest Portland Area Indian Health Board IDEA-NW Project. 2016. Unpublished death certificate data from Idaho, Oregon, and Washington.
[3] Dan Nolan and Chris Amico, How Bad is the Opioid Epidemic?, PBS.org (Feb. 23, 2016), available at https://www.pbs.org/wgbh/frontline/article/how-bad-is-the-opioid-epidemic/

Tribal reservations are often located far from urban centers where specialized health services for opioid addiction treatment are available. Health care delivery for federally recognized tribes is provided either through a directly operated IHS clinic, a tribally operated but IHS-funded clinic (tribal health clinic), or urban Indian clinics, which receive some IHS funding. Federally recognized tribes, as sovereign nations, can elect to have IHS provide all health care services for their tribes, including substance abuse treatment and mental health services, or they can choose to take the funding for all or part of these services and deliver health care services themselves. Although the rules governing health care delivery for federally recognized tribes are uniform across the U.S., there is significant heterogeneity within and between IHS Areas regarding services administered by IHS, tribes, and urban Indian health clinics. In 2014, there were only eight tribal health facilities with medication assisted treatment (MAT)/office-based opioid treatment (OBOT) services, and six tribal programs with MAT/OBOT policies and procedures. Additionally, tribal patients experience a lack of easy access to methadone clinics to receive opioid treatment, which limits tribal ability to provide expanded services in the future. NPAIHB recommends that Congress consider ways to facilitate construction and operation of methadone clinics in locations accessible to tribal and rural communities.

The majority of Northwest tribal clinics have limited resources and health care providers; therefore, they do not have their clinics set up to provide MAT services for the opioid use disorder (OUD) and substance use disorder (SUD) patients. Portland Area Tribes are heavily dependent on their purchased and referred care (PRC) program funds to refer patients outside of the community, which can take too much time and distance for tribal patients. The general purpose of PRC is for IHS and tribal facilities to purchase services from private health care providers in situations where: 1) no IHS or tribal direct care facility exists; 2) the existing direct care element is incapable of providing required emergency and/or specialty care; 3) utilization in the direct care element exceeds existing staffing; and 4) supplementation of alternate resources (e.g., Medicare, Medicaid, or private insurance) is required to provide comprehensive health care to eligible AI/ANs.

It is a significantly expensive venture for tribal programs to provide OUD and SUD services. Numerous Portland Area Tribes have had issues with their treatment numbers being compared to the city-wide health programs that have satellite programs. Tribes are constantly competing for specialized unique population funding.

Portland Area tribal healthcare facilities experience healthcare workforce shortages, which has pushed more opioid prescriptions to treat health conditions that would have successfully been treated with non-opioid therapies. Furthermore, opioid addiction and abuse has led to a constant need to staff new substance abuse positions and additional trainings for physicians to provide MAT with drugs such as naltrexone.

Lack of Opioid Funding and Resources for Tribes

There is a drastic need for more funding and resources to address this crisis in tribal communities. The opioid epidemic impacts scarce resources and funding priorities throughout all tribal government departments in tribal communities due to the lack of funding and resources from the federal government. Section 10003 of the 21st Century Cures Act provides grant funding for the

State response to the opioid abuse crisis, however no grant funding was set-aside for tribes.[4] Therefore, tribes are left out of statewide public health initiatives, such as prevention and intervention efforts created through the state opioid crisis grants. Eligibility for the state targeted response to the opioid crisis grants (STR) was statutorily limited to single state agencies, thus tribes are not eligible to apply. The grant directed states to identify communities of focus at highest risk for OUD. States are also expected to address differences in access, service use and outcomes for their population of focus. Of the 35 states that have federally recognized tribes, 16 states acknowledged tribes as a population of focus and/or specified actions being taken to combat opioids in tribal communities. In the Portland Area, only tribal clinics in Oregon applied to the state and received limited STR funds to combat the opioid epidemic and only the state of Washington included tribes as a high-risk population of focus for STR funds. All our tribes need as much financial assistance from federal healthcare programs as well as direct funding and programs to address the opioid epidemic in their communities.

There is an inherent underlying problem with the process of requiring tribes to access federal funding through states. Federal trust responsibility is with the federal government and any federal dollars that flow down to states should require state-tribal meaningful consultation. Therefore, tribes and tribal members are not always included in the current process of combatting the opioid epidemic. Forcing tribes to go through states and compete with states for funds diminishes the federal trust responsibility. Tribes are sovereign nations and have a government-to-government relationship with the federal government and should not be subjected to request funds from the states.

Direct Access to Adequate Funding and Resources

The major barrier for tribes to combat the opioid crisis is adequate funding for on-the-ground efforts. Portland Area tribal law enforcement, health care facilities, and social services programs are overwhelmed and not resourced sufficiently to meet the needs of the tribal communities to combat the opioid epidemic. Tribes are in need of additional resources directly from the federal government for funding, personnel and authorities to combat the multitude of problems through a comprehensive approach. NPAIHB and our member tribes strongly encourage Congress to create direct funding sources to tribes.

Tribes are in need of funding to provide naloxone HCL (Narcan), a nasal administered overdose reversal drug, as well as training to all law enforcement personnel in tribal communities. Collaboration between law enforcement and all sectors in tribal communities needs to be represented in the process to combat the crisis as a whole.

NPAIHB and our member tribes support the Mitigating Methamphetamine Epidemic and Promoting Tribal Health Act (METH Act) (S.2270), introduced by Senator Steve Daines (R-MT). This legislation would make tribes eligible for direct funding under the 21st Century Cures Act, which provides states with funding for opioid prevention and response. The bill would also allow for the funds to be used for prevention and response to other substances, such as methamphetamines. NPAIHB and our member tribes also support the Tribal Addiction Recovery Act of 2018 (TARA Act) (H.R. 5140). This legislation also makes tribes and tribal organizations

[4] Public Law 114-255, December 13, 2016

eligible for direct funding under the 21st Century Cures Act and extends the use of the funds to also address other addictive substances such as alcohol, heroin and methamphetamine, including by providing mental health services.

NPAIHB appreciates the inclusion of $4 billion to fight the opioid crisis in fiscal year (FY) 2018, particularly the $50 million set-aside for tribes and tribal organizations in the recently passed Consolidated Appropriations Act of 2018 (H.R.1625). The $5 million in FY 2018 appropriations specifically for tribes under the Medication-Assisted Treatment (MAT) for Prescription Drug and Opioid Addiction program is also crucial for tribal clinics to implement the MAT program and administer the life-saving treatment. Direct funding to tribal programs is vital as it ensures funding to tribal governments to utilize for culturally appropriate programs. Furthermore, we are very grateful for the increased funding of $5.4 billion for IHS.

Physician Access to Medical Records

42 CFR Part 2 in relation to the privacy of substance abuse treatment records, prevent tribal primary care and mental health providers from accessing patient records from dependency providers. This is a barrier to coordinated medical care and could lead to a provider treating a patient with an opioid prescription without being aware that the patient has a substance use disorder. NPAIHB is in support of the Overdose Prevention and Patient Safety (OPPS) Act (H.R. 3545), which allows access by physicians to patients' full medical records with HIPAA safeguards.

Best Practices for Tribes

Despite numerous challenges that tribes experience with the opioid epidemic, tribes in the Portland Area have developed multifaceted response efforts that connect prevention, treatment and interdiction. Tribes cannot be limited to the types of services they provide due to the lack of reimbursement for services or financial assistance. There are no actual resources for tribes to provide OUD and SUD services, especially with the high costs associated with the capitol construction of an OUD and SUD clinic and no certainty to get reimbursed. Additionally, there is a need for wrap around services and a full continuum of care including daily monitoring of dosages. Portland Area Tribes are interested in or actively working to align substance use disorder treatment with primary care. However, most tribal healthcare facilities are not near SUD services. NPAIHB believes that co-location of health services on tribal reservations could improve behavioral health integration. We recommend that Congress support funding for tribes to integrate comprehensive behavioral health into primary care.

Portland Area Tribes have established several innovative model programs:

The Swinomish Indian Tribal Community in Washington (Swinomish) is a model for tribes to provide a continuum of integrated behavioral health and primary care. Swinomish could no longer wait for federal or state entities to assist or supplement OUD and SUD treatment services because in their county the opioid overdose mortality increased by 42% in the last decade. In response, Swinomish developed a treatment model and built a new tribally-financed, tribally-owned, and tribally-managed opiate outpatient treatment facility that opened at the end of 2017. The projected service population for the first year is 200 patients, 350 patients in the following years as well as a need a minimal of 20-25 staff.

The Port Gamble S'Klallam Tribe in Washington, partnered with tribal agencies and Kitsap County officials to develop a cross-government response to the opioid crisis in their community. The tribe created the Tribal Healing Opioid Response (THOR) with goals of prevention of opioid misuse, prevention of deaths from overdose by educating the community, and expansion of access to treatment by training health providers.

The Muckleshoot Tribe in Washington has been operating a successful behavioral health program for the past few years. The behavioral health program includes a medication-assisted treatment branch where tribal members are able to receive Suboxone or Vivitrol for treatment of opioid use disorder. The program has proven successful in July 2017, reaching 94% compliance with the program. As of August 2017, Muckleshoot has distributed close to 4,000 kits of Naloxone, and also operates a syringe service program to help reduce the risk of co-occurring health conditions such as HIV and Hepatitis C.

In addition, in Washington, the Centers for Medicare and Medicaid Services (CMS) recently approved State Plan Amendment (SPA) 17-0042 for the state of Washington to allow the outpatient all-inclusive rate for Medicaid beneficiaries to be paid for up to five outpatient visits per Medicaid beneficiary per calendar day for professional services.[5] The increase in allowing up to five outpatient visits in a day is very beneficial for OUD and SUD patients who are in need of various types of services in a day.

Financial assistance and incentives are needed to develop and sustain an integrated continuum of care for OUD patients. Washington Tribes have opted for all Indian Medicaid patients to be opted out of managed care organizations (MCOs) and behavioral health organizations (BHOs), but if patients are in need of more intensive treatment they may access care at BHOs, not preferred for AI/ANs. An integrated continuum of care example is that Swinomish utilizes a unique whole-person treatment model with a full-service approach unlike what clinics have traditionally offered. The Swinomish opiate treatment facility will offer outpatient treatment services, primary medical care, mental health counseling, medication assisted therapies, shuttle transportation, on-site childcare, as well as case management and referrals. However, federal and state funding does not cover all of these services.

Culturally Appropriate Health Care

NPAIHB and our member tribes recommend that the Committee support through legislation the traditional healing practices, cultural beliefs regarding approaches to treatment, and differences in interpersonal communication that contribute to significant variances in effectively meeting the healthcare needs of AI/ANs. Tribes are focused on providing culturally appropriate treatment to members suffering from addiction, including wellness activities such as talking circles. While evidence-based care has many advantages in opioids treatment, these approaches do not solely work in Indian Country. Tribes often utilize traditional, culturally appropriate and promising practices in addition to evidence-based practices. Culturally-based programming helps tribes tailor initiatives to the specific needs of their community, while also honoring tribal sovereignty and the right to self-determination. Many tribal public health programs – including the well-known and

[5] Washington Health Care Authority State Plan Amendment (SPA) 17-0042

highly successful Special Diabetes Program for Indians (SDPI) – combine tribal best practices with evidence-based practices.

In addition, federal health care programs should include resources for non-pharmaceutical therapies and alternative methods to treat pain. There are limited types of non-pharmaceutical therapies that are reimbursable, therefore, tribes must rely on the ability to use PRC program funds. Physical therapy, oral health services, and acupuncture are examples of additional therapies and services that OUD patients need.

Prevention, Identification, and Education of Health Professionals

A best practice for prevention and identification is the inclusion of culturally responsive and community relevant prevention, treatment, and aftercare practices for OUD patients. Additionally, NPAIHB recommends more outreach, education and training on opioid use disorder (OUD), especially pharmacy education curtailed towards culture and community.

The *Centers for Control and Disease Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain* describes how opioid prescriptions should not be the first treatment for acute or chronic pain management. Although, many tribes report that opioids are some of the only options available to tribal patients to address their pain, non-opioid therapies, traditional medicine and other alternatives could be a solution but there is a lack of reimbursement and access.

Lastly, the various federal and state Prescription Drug Monitoring Programs are helpful, but there is a need for more comprehensive monitoring programs (for example, across states and ensuring all providers have access) because of the large number of prescribers who are still over-prescribing which may be due to holes in the current systems.

Public Health Infrastructure

Tribes remain behind in public health infrastructure, capacity, and workforce capabilities. Our tribes have asked for funding and resources directly to tribes for tribal public health infrastructure. Too often population density is often a primary consideration in the allocation of resources. It is important to recognize that public health emergencies can and do occur on Indian reservations and in rural areas in proximity to tribes, and that the impact of public health emergencies can be felt on all Americans regardless of geography.

Tribes need funding for public health surveillance infrastructure. In 2017, the CDC noted that the drug overdose death count among AI/ANs may be underestimated by as much as 35% due to racial misclassification on death certificate data. That is truly unacceptable. Without adequate data for tribal public health systems, tribes and IHS are unable to maintain accurate records of vital statistics, to quantify disparities in health outcomes between AI/ANs and other populations, and to ultimately make true assessments of need.

Modernization of IHS Health Information Technology

There is a need to modernize the health information technology infrastructure within IHS and tribal health facilities as well as streamline data sharing and reporting. The current electronic

health record (EHR) system that IHS and tribes utilize is the Resource and Patient Management System (RPMS), which is an integrated public health information system based on the Department of Veterans' Affairs (VA) VistA system. Tribes constantly experience issues with interoperability when referring a patient to another clinic that uses another EHR system. Many tribes in the Portland Area have purchased and utilize different EHR systems that work better with the needs of their tribal clinics. There is a need to better streamline the RPMS with other EHRs that other tribes utilize. Congress must take into consideration that for some smaller tribal health facilities have a limited bandwidth to fully operationalize RPMS. Tribes have limited support and training to do case management through their EHR system. Tribes also experience barriers to integration within the IHS health information system. For tribes who have purchased a different EHR system, there are still limitations to integrate mental health and substance use and legal restrictions under 42 C.F.R. Part 2. NPAIHB recommends that Congress provide adequate support, funding, and oversight toward a more integrated EHR platform for IHS and tribes.

PDMPs are state-run electronic databases that track controlled substance prescriptions. PDMP regulations for providers to update the system differ by state. IHS requires that federally funded IHS opioid prescribers check their state PDMP database prior to prescribing and dispensing opioids for pain. However, access to state and federal PDMP databases varies across IHS/tribal facilities. NPAIHB recommends that Congress direct states to consult with tribes on state-run PDMPs and ensure access to Indian health programs.

Conclusion

We appreciate the opportunity to provide this testimony to the Senate Committee on Indian Affairs and welcome any follow-up questions by the Committee. You may direct any further questions to the attention of Laura Platero, Director of Government Affairs/Policy Analyst, Northwest Portland Area Indian Health Board, lplatero@npaihb.org.

Sincerely,

Andy Joseph, Jr., NPAIHB Chairperson
Colville Tribal Council Member