



**Testimony of the National Indian Health Board
to the Committee on Energy and Commerce, Health Subcommittee**
Legislative Hearing on Opioid Public Health and Prevention Efforts
March 22, 2018

Introduction

Chairman Burgess, Ranking Member Green and Members of the Subcommittee, the National Indian Health Board (NIHB) thanks you for holding this Legislative Hearing on Opioid Public Health and Prevention Efforts.” On behalf of NIHB and the 573 federally-recognized Tribes we serve, I submit this testimony. My name is Stacy A. Bohlen and I am the Chief Executive Officer of the National Indian Health Board.

NIHB is a 501(c)3, not for profit, national Tribal organization founded by the Tribes in 1972 to serve as the unified, national voice for American Indian and Alaska Native (AI/AN) health in the policy-making arena. Our Board of Directors is comprised of distinguished and highly respected Tribal leaders in AI/AN health. They are elected by the Tribes in each region to be the voice of all 573 Tribes at the national level.

Since 1972, NIHB has advised the U.S. Congress, Indian Health Service (IHS), and other federal agencies about health disparities and service issues experienced in Indian Country. The current opioid epidemic represents one of the most pressing public health crises affecting Tribal communities. While this epidemic is affecting many communities throughout America, it has disproportionately impacted Tribes and has further strained the limited public health and healthcare resources available to Tribes. The federal government must take concrete action to ensure Indian Country has the tools it needs to address opioid abuse and heal Tribal communities.

Trust Responsibility

The federal promise to provide Indian health services was made long ago. Since the earliest days of the Republic, all branches of the federal government have acknowledged the nation’s obligations to the Tribes and the unique trust relationship between the United States and Tribes.

The Indian Health Service is the primary agency by which the federal government meets the trust responsibility for direct health services. IHS provides services in a variety of ways: directly, through agency-operated programs and through Tribally-contracted and operated health programs; and indirectly through services purchased from private providers. IHS also provides limited funding for urban Indian health programs that serve AI/ANs living outside of reservations. Tribes may choose to receive services directly from IHS, run their own programs through contracting or compacting agreements, or they may combine these options based on their needs and preferences.

Today the Indian healthcare system includes 46 Indian hospitals (1/3 of which are Tribally operated) and nearly 630 Indian health centers, clinics, and health stations (80 percent of which are Tribally operated). When specialized services are not available at these sites, health services are purchased from public and private providers through the IHS-funded purchased/referred care (PRC) program. Additionally, 34 urban programs offer services ranging from community health to comprehensive primary care. To ensure accountability and provide greater access for Tribal input, IHS is divided into 12 geographic Service

Areas, each serving the Tribes within the Area. It is important to note that Congress has funded IHS at a level far below patient need since the agency's creation in 1955. In FY 2017, national health spending was \$9,207 per capita while IHS spending was only \$3,332 per patient.

Overview of the Opioid Epidemic in Indian Country

The national opioid epidemic represents one of the great public health challenges of the modern era. The Centers for Disease Control and Prevention (CDC) noted over 64,000 drug overdose deaths in 2016 alone, largely driven by prescription and illicit opioids.¹ Among AI/ANs, the rate of drug overdose deaths is twice that of the general population, according to the IHS. Deaths from prescription opioid overdoses increased four-fold from 1999 to 2013 among AI/ANs.² The CDC reported that AI/ANs consistently had the highest drug overdose death rate by race every year from 2008-2015, and the highest percentage increase in drug overdose deaths from 1999-2015 at 519%.³ Deaths from prescription opioid overdoses increased four-fold from 1999 to 2013 among AI/ANs, with an opioid overdose death rate of 9.6 per 100,000 in 2015 – second only to whites.

Regional data trends further demonstrate the high burden of the opioid epidemic within Tribal communities. According to the State of Alaska Epidemiology Center, AI/ANs had the highest overdose death rate by race from 2009-2014 at 20.2 deaths per 100,000 population. Similarly, the Washington State Department of Health reported that from 2011-2015, the opioid overdose death rate was highest among AI/ANs at a rate of 29 deaths per 100,000 compared to 12 deaths per 100,000 for Whites.

The Indian Health system is chronically underfunded, understaffed and overextended. Limited Tribal and IHS public health and healthcare resources have been further inundated by this highly deadly and superbly costly epidemic. While the treatment and recovery costs are certainly great, the human toll of the epidemic on our Tribal communities is even greater. The state of Minnesota reported that pregnant AI/AN women were 8.7 times more likely to be diagnosed with maternal opioid dependency, and that AI/AN infants were 7.4 times more likely to be born with neonatal abstinence syndrome (NAS) – meaning that the repercussions and trauma of this crisis are intergenerational. Other secondary impacts include the undue burdens imposed on many AI/AN families struggling with opioid and substance use disorders, the children forced into foster care, and the kinship care networks that are strained beyond their ability.

While Tribal communities are certainly in need of expanded treatment resources, public health prevention must not be forgotten. This includes upstream prevention activities such as comprehensive substance use education in youth, expanded substance and alcohol use education and training for our providers, prevention of adverse childhood experiences, healing from historical and intergenerational trauma, and investment in culturally appropriate and Tribally-driven programming.

Bolstering Tribal public health surveillance infrastructure is also a major need. The CDC noted in 2017 that the actual 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. Data is the backbone of any public health system, and without it the Tribes and IHS are unable to maintain accurate records of vital

¹ National Institute on Drug Abuse. 2017. Overdose Death Rates. Retrieved from <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

² Indian Health Service. New effort targets drug overdoses in Indian Country. Retrieved from <https://www.ihs.gov/newsroom/pressreleases/2015pressreleases/new-effort-targets-drug-overdoses-in-indian-country/>

³ Mack KA, Jones CM, Ballesteros MF. Illicit Drug Use, Illicit Drug Use Disorders, and Drug Overdose Deaths in Metropolitan and Nonmetropolitan Areas — United States. MMWR Surveill Summ 2017;66(No. SS-19):1–12.

DOI: <http://dx.doi.org/10.15585/mmwr.ss6619a1>

statistics, to quantify disparities in health outcomes between AI/ANs and other populations, and to ultimately make true assessments of need. More importantly, Tribal leaders must have this information to make informed policy decisions and implement targeted programs. For instance, for the last 12 years, United South and Eastern Tribes Tribal Epidemiology Center (TEC) has been conducting a mortality analysis, and now has a limited amount of data that speaks to opioid abuse among AI/ANs in the eastern United States. From that data, they have learned that 9% of all deaths among their member Tribal Nations were somehow related to substance abuse between 2002 and 2012. Almost one in five substance use deaths were attributable to opioids, including heroin, with the vast majority of opioid deaths, 93%, prescription drug related. These statistics illuminate the critical need for more comprehensive interventions in Tribal communities to improve prevention and treatment measures.

Tribes also remain behind many other communities in their public health infrastructure, capacity, and workforce capabilities as a result of being largely left behind when the United States was modernizing its public health infrastructure. These obstacles have made it particularly difficult for Tribal communities to assemble a coordinated and comprehensive defense against major health emergencies, including the opioid epidemic.

At IHS, and indeed even at many Tribal facilities, deferral of care due to funding and workforce shortages has pushed more and more Tribal members towards prescription opioids to treat health conditions that would otherwise successfully be treated with non-opioid therapies. For instance, limited funding resulted in nearly 80,000 Purchased/Referred Care (PRC) services (an estimated total of \$371 million) being denied in FY 2016 alone. This endless cycle of deferral and opioid dependency is a direct result of the underfunding of the IHS system, and must be stopped.

The CDC Guideline for Prescribing Opioids for Chronic Pain describes how opioid therapy should not be the first line of treatment for acute or chronic non-cancer related pain management, and should rarely, if ever, be prescribed with other medications such as benzodiazepines. Nevertheless, many Tribal members still report that opioids are some of the only options available to them to address their pain symptoms. Lack of reimbursement and access to non-opioid therapies, traditional medicine and other alternatives leaves both providers and patients in a catch-22 that ultimately leads to more harm.

Tribes throughout the country are finding that lack of adequate funding for the IHS exacerbates some of the systemic challenges currently afflicting the Indian health system and is further restricting their ability to confront the opioid crisis. The Bay Mills Indian Community, a Tribe located on the Upper Peninsula in Michigan, has capacity issues so severe that, even if that Tribe received federal funds to operate an opioids treatment outpatient program, the Tribe reports that their facilities are too small and outdated to be able to operate such a program on-site. NIH has noted in previous testimony to Congress that IHS's facilities construction budget is so underfunded that a facility built today would not be able to be replaced for 400 years. These chronic funding issues have limited the ability of Tribes to confront the opioid crisis without additional, sustained Congressional support.

The Red Cliff Tribe of Chippewa Indians in Wisconsin lacks resources to keep up with the latest training practices available to healthcare providers. While the Tribe has started a Harm Reduction Program to provide access to Naxolone, lack of substance abuse and addiction training among Tribal providers limits the program's reach and uptake in the community. The Red Cliff Police Department reported 346 investigations on drug use in 2016, an increase of almost 100 from the year prior. The total population of the reservation is under 1,000.

Policy Solutions

A) *Access to Federal Opioid Resources*

Addressing the opioid epidemic is a nationwide priority; however, access to critical opioid prevention and treatment dollars are not reaching many of the Tribal communities that are in serious need of these funds. As the federal, state, and local governments are working together to ensure a coordinated, comprehensive response, Tribal Nations are frequently excluded from these efforts. Failure to include Tribal Nations when seeking solutions to the opioid epidemic will result in major gaps in the ability of the United States to eradicate opioid addiction in this country. These gaps in coordination are detrimental not just from a healthcare and treatment perspective, but from a law enforcement perspective, as well. As the trustee to Tribal Nations and in pursuit of a more comprehensive response to this crisis, the federal government must facilitate and require collaboration between Tribal governments and other units of government. Outreach from the Committee, as well as future legislation, should promote and require this necessary intergovernmental collaboration.

H.R. 5140 – Tribal Addiction Recovery Act (TARA)

The CURES Act provided \$1 billion in funding over a two-year period to states and territories to combat the opioid crisis. Tribes were not eligible entities for this critically important funding. Although a small number of states subsequently allocated CURES funds to Tribes, access was not at the level of need, nor was it equitably distributed. Furthermore, as the trust responsibility is exclusive to Tribal Nations and the federal government, Congress must not circumvent this sacred duty by forcing Tribes to go through state agencies for these funds. In addition, many Tribes have historically had complicated relationships with state governments as a result of having to compete for limited dollars. Providing direct funding to Tribes, as outlined in H.R. 5140, would solve this issue.

Forcing Tribes to go to states diminishes the federal trust relationship for health and means that little, if any, funding reaches the Tribal communities. It also erodes Tribal sovereignty and the constitutional relationship set up between the Tribes and the federal government. Tribes are not subservient to the state governments, but exist as equal, sovereign partners with the federal government, and H.R. 5140 would correct an error in the law that erroneously left Tribes of the direct funding pool.

An example of the current funding structures can be seen in Ho-Chunk Nation in Wisconsin. Like many Tribes, Ho-Chunk has seen an increased number of infants born with substance addiction and NAS, as well as an increase in opioid-related overdose deaths in the community. The Tribal government declared a State of Emergency regarding the opioid crisis and is in the process of developing a Tribal Action Plan within their departments. A major problem for the Tribe is that the grant money the state receives and distributes to the Tribes is not sufficient to meet the added burden the Tribe's behavioral health facility is experiencing.

In Minnesota, the Department of Human Services reported that the age-adjusted death rate due to drug poisoning is four times higher among AI/ANs compared to whites. Further, despite representing roughly 1.1% of the population for the state, AI/ANs accounted for 15.8% of those who entered treatment for opioid use disorder. Yet, when the state passed through funding under the STR program, it gave Tribes funding far below the needed 15 percent.

H.R. 5140 would also help get resources to Tribal communities in a more efficient way. Forcing Tribes to go to states diminishes the federal trust relationship for health and means that little, if any, funding

reaches the Tribal communities. Tribes should be put in charge of their own funding because they will know the strategies that will help challenges in their own communities. Time and again, we have seen that when Tribes are given funding directly outcomes are better and funds are used more efficiently. When state priorities are driving the programming decisions, the unique needs of Tribal communities are often left out.

We are also encouraged to see that TARA includes an extra \$25 million for the program. However, we also recommend that H.R. 5140 include a specific 10 percent set-aside for Tribes and be distributed on a non-competitive basis. This will make sure that the funds are actually reaching the communities in need. Legislation has been introduced in the Senate – S. 2437, the Opioid Response Enhancement Act – that would provide this set-aside.

In short, H.R. 5140 is a critical piece of legislation that will be an important first-step in getting funding to Tribal communities. NIHB urges that the Committee swiftly act on H.R. 5140.

Discussion Draft of a Bill to Improve Fentanyl Testing and Surveillance

The Committee's consideration of the bill to improve fentanyl testing and surveillance would provide grants to federal, state, and local agencies for the establishment or operation of public health laboratories to detect fentanyl, its analogs, and other synthetic opioids. NIHB suggests that Tribes and Tribal organizations (as defined in section 4 of the Indian Self-Determination and Education Assistance Act) be added to the list of eligible grantees. Tribal health programs have needs similar to other health providers, so it is essential that they are included in this type of funding. Fentanyl-related overdoses have been on the rise in Tribal communities in recent years, but Tribal resources to tackle the crisis have been limited. Improving fentanyl surveillance and testing will help Tribes target their prevention, treatment and intervention efforts to the communities that need it most.

Discussion Draft of a Bill to Enhance and Improve State-run Prescription Drug Monitoring Programs

Prescription Drug monitoring programs (PDMPs) can be an important tool in tracking opioid abuse or misuse. However, integration between IHS and Tribal health providers with state-level PDMPs has been mixed at best. In order to fully overcome this crisis, it is critical that Tribes be included in the development and implementation of state PDMPs. Therefore, we request that the legislation statutorily require states to conduct meaningful consultation with the Tribes on the implementation of any PDMP in the state about how to better track, report and assess Tribally-specific prescriber and dispenser practices.

Additionally, the draft bill would authorize “Evidence-Based Prevention Grants” and “Enhanced Surveillance of Controlled Substances grants.” In both of these cases, Tribes and Tribal organizations should be allowed to receive this funding. Tribal public health systems, including Tribal Epidemiology Centers (TECs), are at the frontlines of treating and preventing the opioid crisis, but, as discussed above, are often not included in state-level initiatives. Therefore, direct funding will enable this important work to reach Tribal communities.

NIHB also recommends including language that would allow the technical assistance authorized to states (Sections 399V-7 (a)(1)(B) and 399V-7(b)(1)(B)), also be authorized to Tribes, Tribal organizations and Tribal Epidemiology Centers. Again, it is critical to ensure that this funding reaches the Indian health

system so that we can close gaps in opioid abuse disorder disease surveillance and prevention. The requirement for routine technical assistance to Tribes, Tribal organizations and Tribal Epidemiology Centers is also statutorily required under Section 214 (C) of the Indian Health Care Improvement Act.

The Eliminating Opioid-Related Infectious Diseases Act

The Eliminating Opioid-Related Infectious Diseases Act will authorize the CDC to undertake an injection drug use-associated infection elimination initiative and work with states to improve education, surveillance and treatment of injection drug-use associated infections, like human immunodeficiency virus (HIV) and hepatitis. The legislative language notes that “public and private entities” would receive the available grant funding. However, we believe that this should also clearly state that Tribes and Tribal organizations are eligible for funding. In addition, NIHB recommends adding “Tribes and Tribal Epidemiology Centers” to Section 317N(a)(1). It is critical that this funding reach Indian Country. AI/ANs have the highest rates of hepatitis C by race (twice the national average) and recently there have been spikes in cases linked to injection drug use.

In addition, we call upon Congress to:

- Establish Tribally-specific funding streams such as a Special Behavioral Health Program for Indians, modeled off the very successful Special Diabetes Program for Indians, so that Tribes can develop their own programs to address substance misuse and dependence in their communities. NIHB supports legislation that has been introduced for this purpose, H.R. 3704 the Native Health Access Improvement Act.
- Ensure parity between states and Tribes in any new opioid-related legislation advanced in Congress. This means not only including Tribes as eligible entities, but also requiring Tribal consultation, information and data sharing, and funding set asides, where applicable. For example, the Senate is considering the “Comprehensive Addiction and Recovery Act (CARA) 2.0” (S. 2456) legislation should include Tribes and Tribal organizations in several sections of the bill. This includes **Section 6** which establishes funding for regional technical assistance centers to focus on addiction recovery and naloxone training/dissemination; **Section 7** which allows states to increase the 3-day limit on first time opioid prescriptions found in Section 3 if the state passes a law or implements a statewide regulation should include Tribal law as well; and **Section 10** which provides funding to states for addiction treatment programs targeted toward pregnant and post-partum women. Finally, we recommend adding language to **Section 13** that would require states to consult with Tribes on the implementation of prescription drug monitoring programs.
- Establish trauma-informed interventions in coordination with Tribes to reduce the burden of substance use disorders including those involving opioids.
- Include set asides for Tribes within the \$6 billion in opioid program funding for Fiscal Years 2018 and 2019 authorized in the Bipartisan Budget Act of 2018 (P.L. 115-123).

FY 2019 Budget Proposal

NIHB and Tribes were glad to see that the FY 2019 President’s budget request proposed \$150 million in funding to “provide multi-year competitive grants based on need for opioid abuse prevention, treatment,

and recovery support in Indian Country.”⁴ Tribes are supportive of this additional funding, but many Tribes have expressed concerns that competitive grant programs are not the solution to long-term, broad-based funding. Competitive grants erode Tribal sovereignty and do not honor the federal trust responsibility. Furthermore, when Tribes are forced to apply for grants it takes away scarce staff and resources from other program-oriented work leading to diminished program effectiveness across the board. We look forward to working with Congress as this policy is developed to ensure that the proposed funds truly reach the areas with greatest need and fully honor the promises made to our ancestors. In addition, we note that other federal agencies – such as the Substance Abuse and Mental Health Services Administration and the Centers for Disease Control and Prevention – should have funding made directly available to Tribes.

B) Supporting Traditional Healing Initiatives

Tribal communities have been healing their people for thousands of years, and these strategies are highly effective in the communities where they are employed and engaged. Yet, it is often the case that traditional healing practices are not do not meet mainstream criteria for data collection under federal grants, which puts Tribes at a disadvantage when applying for and administering federal programs. It is critical that Congress support these traditional practices by providing funding – including Medicaid reimbursement— for traditional healing methods.

H.R.5272, the Reinforcing Evidence-Based Standards under Law in Treating Substance Abuse (RESULTS) Act

H.R.5272, the Reinforcing Evidence-Based Standards under Law in Treating Substance Abuse Act, requires entities applying for federal grants and cooperative agreements for mental health or substance use disorder (SUD) treatment to demonstrate how their program is evidence-based. NIHB requests an amendment to this bill that would permit Tribes and Tribal organizations to also utilize traditional, culturally-based and promising practices as well as 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. Evidence-based programs that do not integrate traditional Tribal practices are often not be as effective at improving health outcomes as programs that do. Many Tribal public health programs – including the well-known and highly successful Special Diabetes Program for Indians (SDPI) – combine Tribal best practices with evidence-based practices. It has worked. As a result of SDPI, A1C levels among American Indians and Alaska Natives nationwide are down by an entire percentage point, and End Stage Renal Disease – one of the biggest contributors to Medicare costs – has decreased by 54%. SDPI demonstrates that using a combination of Western medicine with traditional healing practices can make major, positive gains when it comes to treating and preventing disease in Tribal communities. The same approach will help ensure the highest possibility for success in reducing mental health and SUD health disparities in Tribal communities.

Tribal Healing to Wellness Courts

In addition to traditional healing practices, we urge Congress to support innovative, culturally-appropriate Tribal restorative justice models through sustained funding. Established as alternatives to conventional

⁴U.S. Department of Health and Human Services. “FY 2019 Budget in Brief.” February 12, 2018. Pg. 28.

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sentencing for non-violent individual offenders, Tribal Healing to Wellness Courts promote long-term recovery through treatment, community healing resources, and the Tribal justice process by using a multi-disciplinary approach to achieve the physical and spiritual healing of participants.

For example, the Penobscot Nation, has operated a Healing to Wellness Court (HTWC) since 2011. Any individual Penobscot Nation citizen who is charged with a non-violent crime can petition to participate in the HTWC program. Once accepted into the program, the individual must agree to enter a guilty plea for the crime charged against him/her, but his/her sentence is “deferred” to allow the individual to go through the program. Then, a comprehensive, holistic plan is developed in collaboration between 10 Tribal government departments to address the individual’s treatment needs in four phases:

- Phase I: Introduction/Education. This phase is focused on detoxification and beginning treatment and generally lasts 180 days.
- Phase II: Personal Responsibility. This phase is focused on stabilization and treatment and generally lasts 120 days.
- Phase III: Cooperation/Accountability. This phase is focused on maintenance and treatment and generally lasts 120 days.
- Phase IV: Completion/Continuing Wellness. This phase is focused on graduation and aftercare and generally lasts 120 days.

Successful completion of the program results in a dismissal of the participant’s guilty plea. Over two dozen individuals have gone into the program since 2011. Recidivism is extremely low. The biggest problem that the Penobscot Nation has is that they do not have sufficient resources to accommodate all the individuals who are interested in participating in the program. While, the program is funded mainly through the Bureau of Indian Affairs, with supplemental funding from the Indian Health Service, the Department of Justice, and the Department of Housing and Urban Development, this is administratively burdensome and unlikely to result in additional resources for the Court. Similarly, while some grants offered by the Substance Abuse and Mental Health Services Administration (SAMHSA) could possibly be used for this purpose, SAMHSA’s application requirements and standards often serve to preclude smaller, less resourced Tribal Nations from applying. The recovery model offered by Tribal Healing to Wellness Courts should be supported by this Congress, as it seeks to incentivize long-term sobriety and reduce criminal recidivism among drug offenders. In order to accomplish this, NIHB urges this Committee to consider dedicated, sustained funding for this infrastructure in Indian Country.

C) Health Information Technology (IT) within the Indian Health System

The federal government has not met its trust responsibility as it relates to updating and modernizing the physical and technological infrastructure within IHS and Tribal health facilities and health IT systems. The current primary Electronic Health Record (EHR) system IHS uses is the Resource and Patient Management System (RPMS), an integrated public health information system based on the U.S. Department of Veteran’s Affairs (VA) VistA system. It is a comprehensive suite of applications that supports virtually all clinical and business operations at IHS and most tribal facilities, from patient registration to billing. RPMS is comprised of over 80 software applications and is designed to track patient and population based clinical and practice management applications. However, various concerns and challenges have been cited regarding RPMS. Some notable issues are:

- Many Tribes utilize different EHR systems instead of RPMS;

- Smaller Tribal health facilities do not have the bandwidth to fully operationalize RPMS, and would benefit from the ability to share new components such as files that contain all available drugs instead of just some;
- Some smaller Tribal health clinics are in need of greater training and technical assistance on how to utilize the system most efficiently;
- There is a need to further streamline the system and align it with other EHRs utilized by Tribes;
- Robust and timely IT support is not routinely available;
- Interoperability is incomplete, meaning that if a patient is referred to another clinic that utilizes a different system, the patient records are more than likely not cross-referenced which leads to inconsistencies in patient records.

Issues also exist in terms of RPMS interactions with Prescription Drug Monitoring Programs (PDMPs). PDMPs are state-run electronic databases that track controlled substance prescriptions. Across the board, utilization of PDMPs is inadequate. A national survey of primary care physicians found that 86% of the time, physicians did not check their statewide PDMP prior to prescribing an opioid, despite the fact that 72% of primary care physicians are aware of their state's PDMP.⁵

It is important to note the limitations of the PDMP system, both generally and in its usefulness for IHS and Tribal providers, pharmacists and public health practitioners. One, PDMP laws and regulations differ by state. In other words, whereas one state may require providers to update the system within a 24 hour period, other states only require updating the system every few days, or even over a longer period of time. Further, interstate sharing of PDMP data is not streamlined, which creates gaps in monitoring especially for individuals living in border towns, or for reservations that traverse multiple state boundaries. Additionally, to NIHB's knowledge, only the state of Alaska decreed a special consideration for IHS providers to access the PDMP system, which may explain why IHS established memorandums of understanding (MOU) with state agencies to permit IHS access and reporting. Also, there is currently no Tribally-specific PDMP system. The FY 2017 House Appropriations Bill authorized \$1 million to IHS to establish such a system; however, to NIHB's knowledge, this system has not yet been implemented. Finally, no PDMP system collects racial demographics, limiting its value as a tool for public health monitoring for Tribes and Tribal Epidemiology Centers.

Due to budgetary constraints, IHS has not been able to support operations and maintenance for the certified RPMS site. Other federal agencies, like the Veterans' Administration, are in the process of moving away from RPMS-like systems toward more integrated software platforms, where EHRs and PDMPs can communicate under an interoperable platform. Unless Congress intervenes, this will create a disconnect between IHS and other agencies.

NIHB supports E-prescribing, especially given its potential to reduce the spread of prescription opioid abuse, and encourages IHS to utilize it where practicable. However, most IHS and Tribally run health facilities are in rural areas where limited broadband make widespread adoption of E-prescribing unrealistic without Congressional intervention. To ensure that E-prescribing is a viable tool in the Indian health system, Congress must first continue, and expand, its investment in rural broadband to incorporate rural Tribal communities.

Telehealth is a much-needed and successful innovation in rural areas. For example, the Eastern Aleutian Tribes, a healthcare provision organization serving 8 Alaska Native communities, has begun using

⁵ Office of Management and Budget. Circular A-130. Appendix III. *Security of Federal Automated Information Resources*.
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telemedicine to diagnose conditions, prescribe treatment, and conduct follow up examinations. Many Tribes in remote Alaska communities, often disconnected by the road system and only accessible by plane or boat, do not have access to medical providers regularly and have come to rely on telemedicine to fill a gap in healthcare provision. However, this was only accomplished through sustained investment in rural broadband. Greater network bandwidth and broadband access is a critical need, demonstrated by a 2018 FCC report that found as many as 35% of individuals living in Tribal lands lack broadband access, while in some Tribal communities as much as 80% lack broadband access.

To ensure Tribes are able to utilize Health IT to the greatest extent possible in confronting Indian Country's opioid epidemic, Congress should:

- Provide adequate support, funding, and oversight as IHS moves away from the RPMS system toward a more integrated platform that can better interact with E-prescriptions and EHRs.
- Provide oversight to IHS to implement a Tribally-specific PDMP system than can interact with state PDMPs.
- Review and support IHS's list of Tribal broadband projects, and also include direct funding to Tribes to improve their broadband and telehealth infrastructure.
- Mandate State-Tribal consultation on changes to state PDMPs.
- Incentivize providers to adopt E-prescription as a way to reduce the needless and harmful spread of opioids.
- Eliminate the requirement for Tribal providers to obtain the Secretary's authorization to be designated as an Internet Eligible Controlled Substances Provider, as it imposes an undue burden that delays the delivery of much-needed treatment resources, especially given that no other providers are subject to this requirement.⁶

Tribal Response to Opioids

Despite these challenges, Tribes across Indian Country have engaged in multifaceted response efforts that traverse the prevention, treatment and interdiction landscape. For instance, after declaring a state of emergency on the opioid epidemic in March 2016, the Mashpee Wampanoag Tribe in Massachusetts partnered with the IHS to assemble more resources to address the growing number of overdose deaths in their community. The Tribe worked towards establishing an integrated community intervention model, implementing the CDC Guideline for Prescribing Opioids for Chronic Pain, and developing an opioid response grounded in the social determinants of health. The Tribe worked with Tribal Police and Homeland Security to create prescription drug drop boxes, developed a 24-hour call line for crisis intervention, and established a Tribal Coordinating Committee to create a 5 year Tribal Action Plan to address alcoholism and substance abuse issues.

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

In Oklahoma, the Chickasaw Nation launched the "Define Your Direction" campaign, which is an education initiative encouraging Tribal youth to make healthy choices and be positive role models when

⁶ (21. U.S.C. 829) Section 311(g)(2)

it comes to resisting prescription drug misuse and underage drinking in their communities. Some outcomes of the program thus far include equipping all Chickasaw Nation Lighthorse officers with Naloxone; distributing more than 400 medication lockboxes to Elders; recording significant reductions in prescription drug misuse within the past 30 days among 6th, 8th, 10th and 12th graders; and reductions in risk factors such as early drug use initiation and low neighborhood attachment among Tribal youth.

NIHB encourages the Committee Members to connect with the Tribes in your home states to learn more about current initiatives and gain further insight into technical assistance and funding needs, so that programs such as these are replicated in more and more Tribal communities.

Conclusion

Again, NIHB would like to thank the Committee for holding this hearing and soliciting input from a variety of stakeholders. Indian Country has seen over the past several years that opioids do not face barriers in entering Tribal communities. To truly address this problem, Congress must ensure that Tribes receive direct funding, and are included any type of national-level opioid legislation moving forward. For any follow up questions, please contact Stacy Bohlen, NIHB's Chief Executive Officer, at sbohlen@nihb.org or 202-507-4070.