



Statement By

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Before the

**Committee on Indian Affairs
United States Senate**

**Oversight Hearing
“Opioids in Indian Country:
Beyond the Crisis to Healing the Community”**

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Chairman and Members of the Committee:

Good afternoon, Chairman Hoeven, Vice-Chairman Udall, and Members of the Committee. I am Dr. Michael Toedt, Chief Medical Officer, Indian Health Service (IHS). I earned my Doctorate of Medicine from the Uniformed Services University of the Health Sciences in Bethesda, Maryland. I am board certified in family medicine and I am a fellow of the American Academy of Family Physicians. I have served as a Commissioned Officer for 26 years in both the National Health Service Corps and the Indian Health Service. Today, I appreciate the opportunity to provide information on the work that IHS has been doing to address the opioid crisis, which is a top priority for the Department of Health and Human Services (HHS).

IHS is a distinct agency in HHS, established to carry out the responsibilities, authorities, and functions of the United States to provide health care services to American Indians and Alaska Natives. It is the only HHS agency whose primary function is direct delivery of health care. The mission of IHS, in partnership with American Indian and Alaska Native people, is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level. The IHS system consists of 12 Area offices, which oversee 170 Service Units that provide care at the local level. Health services are provided through facilities managed by the IHS, by Tribes and tribal organizations under authorities of the Indian Self-Determination and Education Assistance Act (ISDEAA), and through contracts and grants awarded to urban Indian organizations authorized by the Indian Health Care Improvement Act.

The impact of the opioid crisis on American Indians and Alaska Natives is immense. The Centers for Disease Control and Prevention (CDC) reported that American Indians and Alaska Natives had the highest drug overdose death rates in 2015 and the largest percentage increase in the number of deaths over time from 1999-2015 compared to other racial and ethnic groups.¹ During that time, deaths rose more than 500 percent among American Indians and Alaska Natives. In addition, because of misclassification of race and ethnicity on death certificates, the actual number of deaths for American Indians and Alaska Natives may be underestimated by up to 35 percent.¹

Addressing the Opioid Crisis in Indian Country

IHS recognizes the importance of collaborating and consulting with tribes to develop a comprehensive plan for addressing the opioid crisis in Indian country. IHS partners with its tribal advisory committees, including the Tribal Self-Governance Advisory Committee, the Direct Service Tribes Advisory Committee, and the National Tribal Advisory Committee on Behavioral Health to gather input on critical next steps to address the opioid crisis. The opioid crisis has been a priority on recent meeting agendas for the advisory committees and will be a topic for future meetings as well.

IHS strengthened and prioritized efforts to address the opioid crisis in 2012 and developed a number of recommendations focused on six areas: patient care, policy development/implementation, education, monitoring, medication storage/disposal, and law enforcement. In March 2017, IHS chartered the National Committee on Heroin, Opioids and Pain Efforts

¹ <https://www.cdc.gov/mmwr/volumes/66/ss/pdfs/ss6619.pdf>

(HOPE). The HOPE committee, which consists of multidisciplinary health care professionals across IHS, works to advance the Department's multifaceted plan to combat opioid abuse: 1) better prevention, treatment, and recovery services; 2) better targeting of overdose reversing drugs; 3) better data on the epidemic; 4) better pain management; and 5) better research. To address better research, IHS partners with the National Institutes of Health on research addressing health disparities and health priorities within Indian communities.

The HOPE committee is reviewing and updating IHS policies to ensure they are aligned with the most current national guidelines and addressing the most urgent needs. For example, the IHS "Chronic Non-Cancer Pain Management" policy, originally published in 2014, was re-released earlier this year to align with the 2016 CDC Guidelines for Prescribing Opioids for Chronic Pain. This policy also requires mandatory opioid training for all Federal controlled substance prescribers with required refresher training every three years.

The IHS Prescription Drug Monitoring Programs (PDMP) policy strengthens the monitoring and deterrence of prescription misuse and diversion by requiring IHS providers to check state PDMP databases prior to prescribing opioids for longer than seven days. IHS has partnered with all states where IHS federal facilities are located and has successfully connected with 17 out of the 18 state PDMP databases, allowing access for 82 of the 83 IHS facilities offering pharmaceutical services. The IHS PDMP policy also requires IHS practitioners to conduct peer reviews of prescriber activity. Additionally, under the IHS policy, pharmacies must report opioid prescribing data to state PDMPs - a proactive requirement not currently required by law. IHS is also working to establish two additional policies to expand access to medication assisted

treatment (MAT), and to standardize how first responders in American Indian and Alaska Native communities are provided naloxone, a medication for reversing opioid overdoses.

To address the shortage of specialists who can provide MAT in rural tribal communities, IHS is training its current workforce to provide these specialty services. Over the last two years, IHS partnered with the Substance Abuse and Mental Health Services Administration (SAMHSA) to train nearly 70 physicians to obtain their Drug Addiction Treatment Act waivers to treat opioid use disorders, which increases access to treatment services in American Indian and Alaska Native communities. In 2008, IHS established the Telebehavioral Health Center of Excellence (TBHCE) which provides, clinical services, provider education and technical assistance throughout the Indian health system. The TBHCE was developed to support remote and isolated American Indian and Alaska Native communities and areas with limited access to behavioral health services. These services directly equip IHS staff to reduce morbidity and mortality surrounding the opioid epidemic. Currently, the TBHCE is providing training on MAT for opioid use disorder, which uses Food and Drug Administration approved pharmacological treatments, in combination with psychosocial treatments and social supports.

Additionally, IHS offers weekly continuing education on pain and addiction as well as consultation on complex cases to further train primary care clinicians to provide these specialty MAT services. Consultation is offered through virtual clinics hosted by the University of New Mexico to connect primary care clinicians with expert teams to share knowledge and elevate the level of specialty care available to patients. There are some promising signs of the positive outcomes as a result of these efforts. For example, a preliminary analysis of available IHS data

indicates a 13 percent decrease in the average number of opioid prescriptions per 100 of all IHS users from FY 2013 – 2016.²

The Tribal Law and Order Act requires HHS, the Department of Justice, and the Department of Interior to coordinate efforts on alcohol and substance use issues in Indian country. IHS is actively involved in interagency coordination and collaboration on tribal alcohol and substance use programs. As part of this effort, tribes are encouraged to develop Tribal Action Plans (TAP) to address substance use and opioid use in their communities. IHS is an integral part of the TAP workgroup that works with tribes to help them gain access to government resources and coordinate efforts in order to achieve our shared goals of preventing and treating substance use disorders.

IHS partners with the Bureau of Indian Affairs (BIA) to train and equip law enforcement officers (LEOs) to recognize signs and symptoms of overdoses and intervene when the overdose is occurring. As of December 2017, the IHS trained and provided naloxone at no cost to BIA for more than 300 LEOs and certified 47 BIA LEOs as naloxone trainers. In direct care facilities, IHS has also been providing naloxone supplies, training and tool kits to tribal law enforcement. IHS encourages its pharmacists to co-prescribe naloxone to patients who are at higher risk for opioid overdose based on criteria developed with primary care clinicians, and as a result the number of naloxone prescriptions has increased by 518 percent from FY 2013 to FY 2017.

² IHS– National Data Warehouse

IHS has developed a data reporting system that will provide prescribing data on national, regional, and local levels. We will track data focusing on the overall improvements and monitoring of prescribing practices and procurement. Regional data will be used for comparison with state-level data from the CDC and among other facilities in their region, as well as nationally. We will use the information to identify areas of improvement, monitor trends, intervene early and effectively, and enhance efforts to train medical providers.

IHS Behavioral Health and the Alcohol and Substance Abuse Program

Addiction is complex, but treatable. Unfortunately, there is no single treatment that is right for everyone. The IHS Alcohol and Substance Abuse Program (ASAP) provides funding, policy, training, and technical assistance to local IHS, tribal, and urban Indian programs to ensure a variety of treatment options exist. Approximately 90 percent of the FY 2017 ASAP budget of \$205 million is contracted or compacted by Tribes enabling those programs to deliver treatment services tailored to meet their local needs. These programs provide services at all stages of recovery from detoxification, behavioral counseling, outpatient and residential treatment, and long-term follow up to prevent relapse.

IHS also targets suicide and substance use and misuse prevention through the Substance Abuse and Suicide Prevention (SASP) program. As of FY 2017, SASP funds approximately \$30 million to 175 IHS, Tribal, and Urban Indian Health organizations to develop and implement culturally appropriate, evidence-based and/or practice-based, community driven models. We fund 19 projects that focus specifically on methamphetamine and substance abuse prevention, treatment, and recovery programming. The majority of the SASP projects focus on prevention

and early intervention strategies to reduce risk factors for suicidal behavior and substance use among American Indian and Alaska Native youth. A total of 108 funded projects work with Native youth to increase resiliency, teach coping skills, promote family engagement, and hire behavioral health providers who specialize in treating children, youth, and families. The SASP program is currently in its third year and IHS will evaluate SASP data to better understand the full impact of the program, what is working in tribal communities, disseminate best practices, and share lessons learned.

IHS is addressing the need to assist youth with substance use disorders including opioid dependency through twelve Youth Regional Treatment Centers (YRTCs). The YRTCs provide a range of clinical services to provide treatment rooted in culturally relevant, holistic models of care.

IHS actively solicits feedback and works with the tribes to develop and implement models of care that are sustainable to combat the opioid crisis. We focus on treatments that are evidence-based and culturally effective that will have a significant impact on the prevention, treatment and recovery efforts. To sustain this strategy, IHS is collaborating with key stakeholders to develop viable reimbursement models for services provided, while advocating for reimbursement for traditional and culturally based practices, a critical approach to opioid recovery in tribal communities. This comprehensive strategy will allow for a more unified approach with tribal communities and also afford IHS the time to evaluate the impact of these interventions. IHS will continue to work with Tribes to develop coordinated responses using every available resource possible to battle the opioid crisis in tribal communities.

Thank you for your commitment to improving health care for American Indians and Alaska Natives by addressing the opioid crisis as a top priority. I will be happy to answer any questions the Committee may have.