

Opportunities to Improve Health through National Initiatives, Medical Progress, and Partnerships

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What Determines Health?



Source: McGinnis et al, 2002

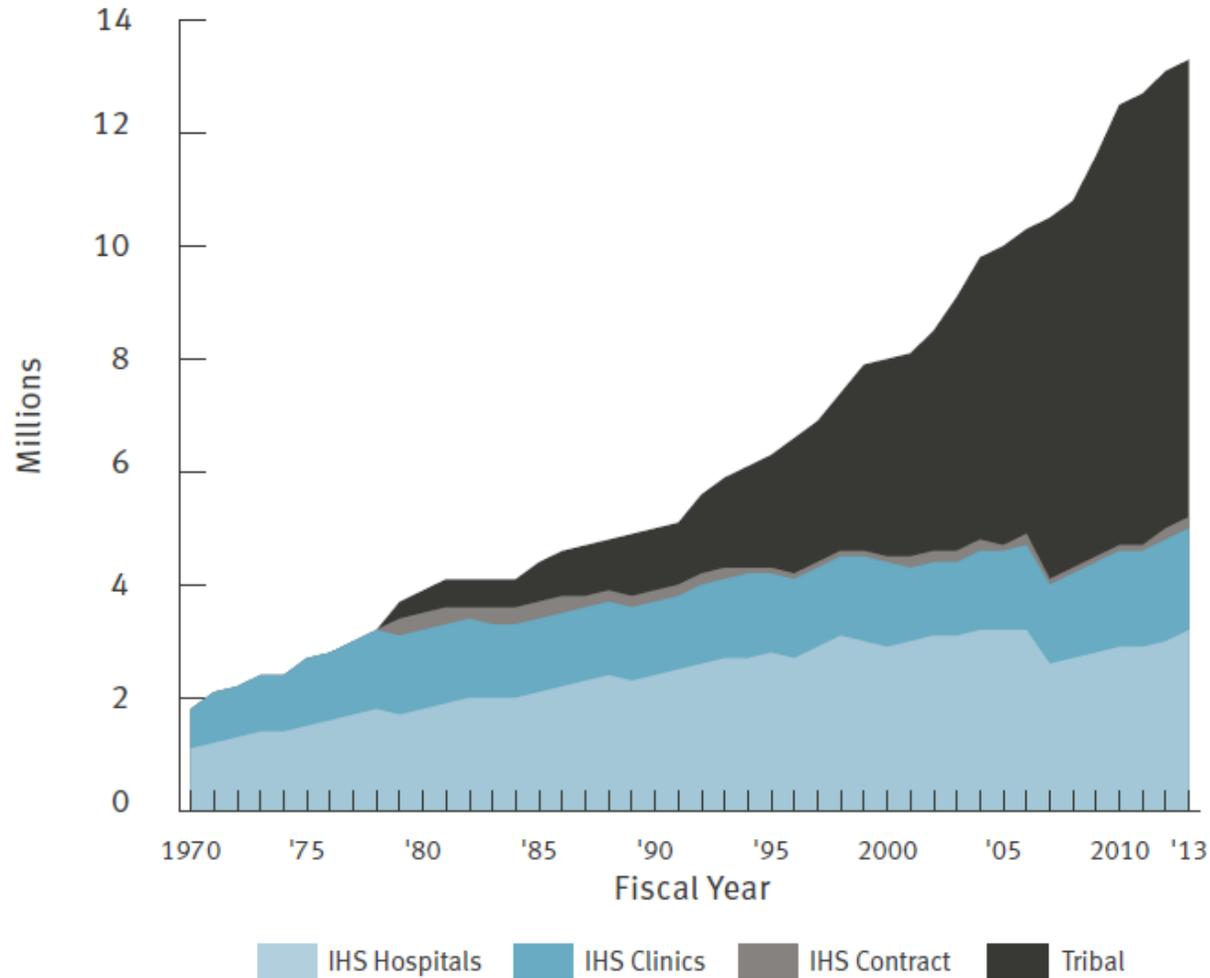
Rural Health Challenges

- About **20%** of the US population—more than 50 million people—**live in rural** areas, but only 9% of the nation's **physicians** practice in **rural** communities.
- 60% of trauma deaths occur in rural America



Chart 5.20 Number of Ambulatory Medical Visits

IHS and Tribal Direct and Contract Facilities



Source: Trends in Indian Health, 2014 edition.

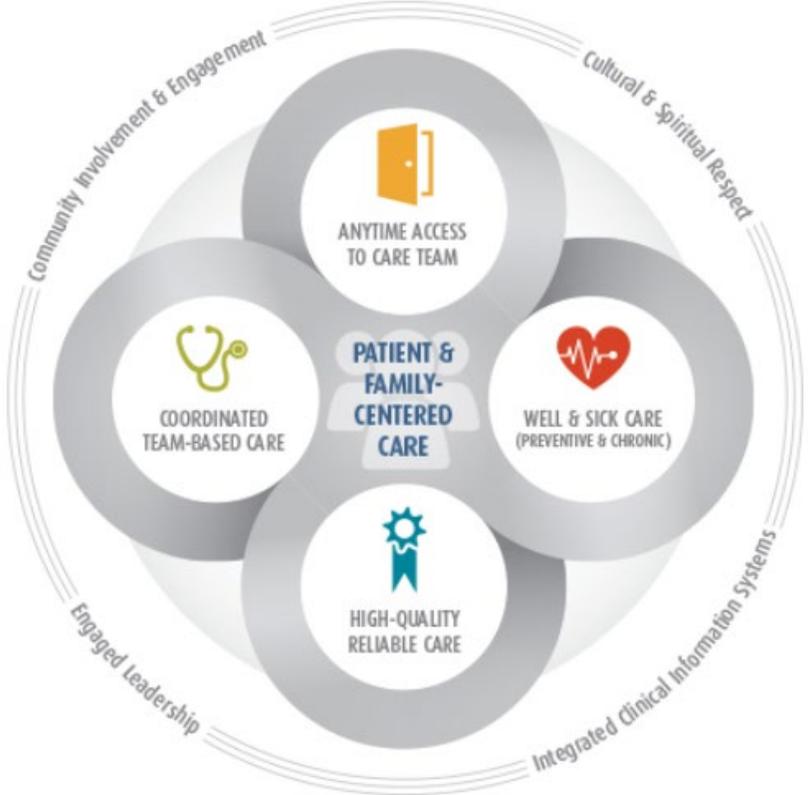
Most service is outpatient-based.

Ambulatory medical visits to Indian Health Service and Tribal direct and contract facilities have increased 660 percent since FY 1970. In FY 2013, there were nearly 13.6 million visits.

Physician Vacancy Rates

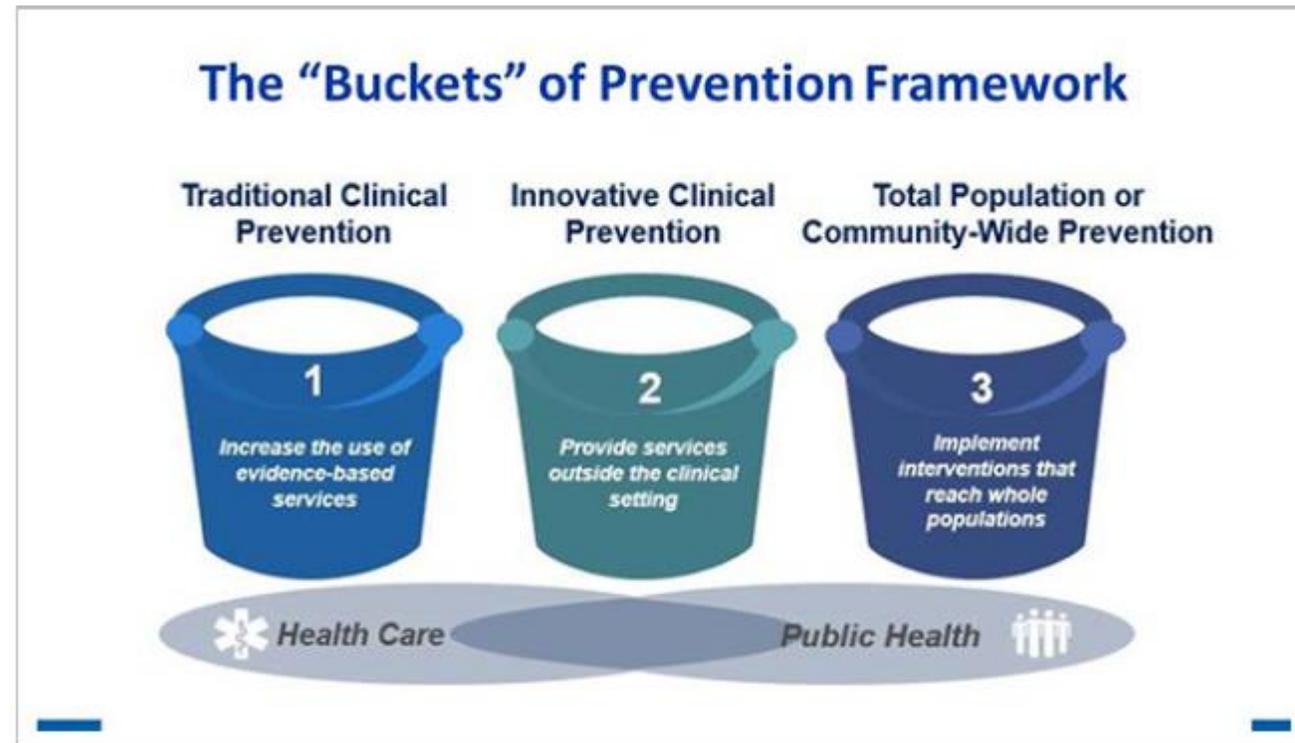
Apr-19								
Vacancy Rate Overall	Medical Officers Vacancy Rate	Nurse Vacancy Rate	Nurse Practitioner Vacancy Rate	Vacancy Rate for Certified Registered Nurse Anesthetists (CRNAs)	Vacancy Rate for Nurse Midwives	Dentist Vacancy Rate	Pharmacist Vacancy Rate	Physician Assistant Vacancy Rate
23%	28%	32%	30%	15%	28%	27%	18%	29%

IHS Model of Care



A comprehensive solution is necessary – a new model alone isn't enough.

Buckets of Prevention



Opportunities to Improve Health Through National Initiatives, Medical Progress, and Partnerships

Opioids

HIV

Hepatitis C

Patient Centered Medical Home

HHS 5-POINT STRATEGY TO COMBAT THE OPIOIDS CRISIS



Better addiction prevention, treatment, and recovery services



Better data



Better pain management

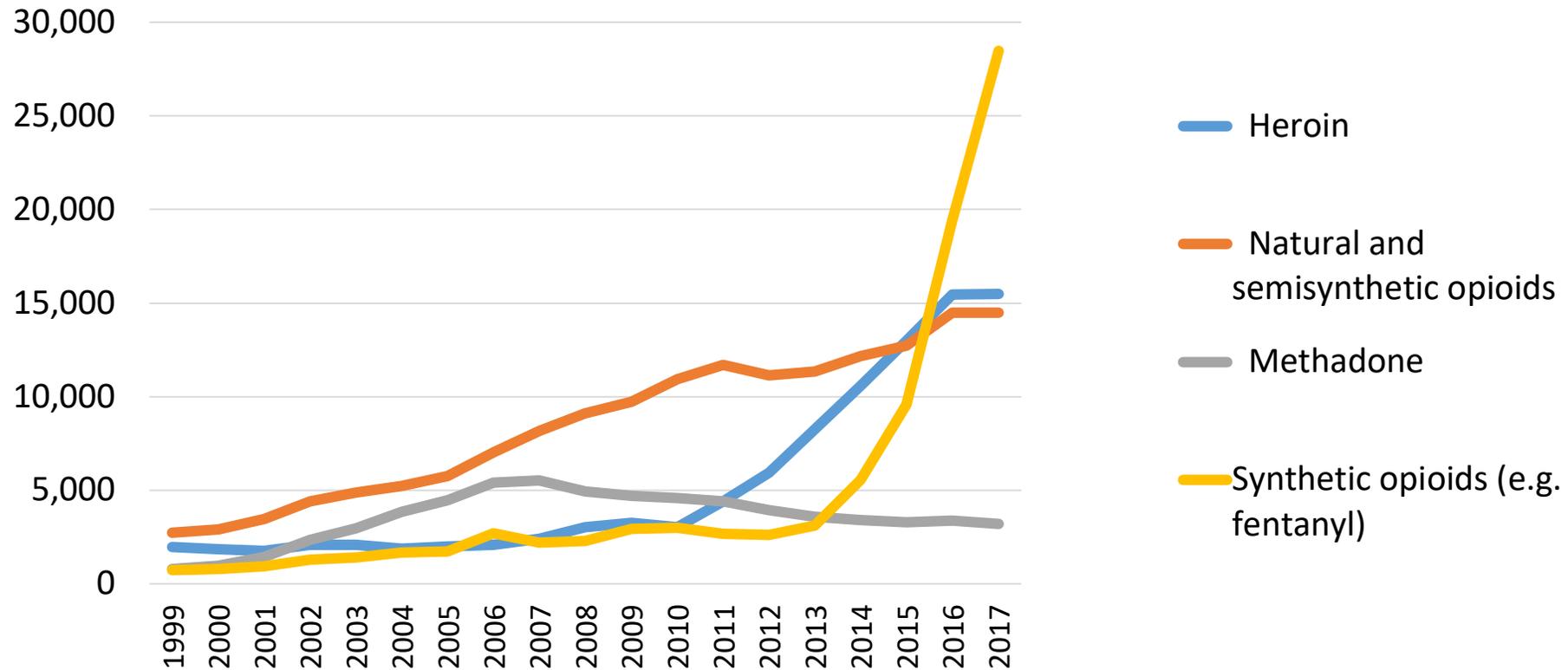


Better targeting of overdose reversing drugs



Better research

US drug overdose deaths: Opioid categories



SOURCE: NCHS, National Vital Statics System, Mortality



Opioid Overdose Death Rates

CDC data indicates that American Indians and Alaska Natives (AI/AN) had the second highest overdose death from rates from all opioids in 2017 (15.7 deaths/100,000 population) among racial/ethnic groups in the US

AI/AN had the highest overdose death rate for prescription opioids (7.2)

AI/AN had the second highest overdose death rates from heroin (5.2)

AI/AN had the third highest from synthetic opioids (6.5)

The overall rate of overdose deaths for AI/AN has increased by **13%** between 2015-2017

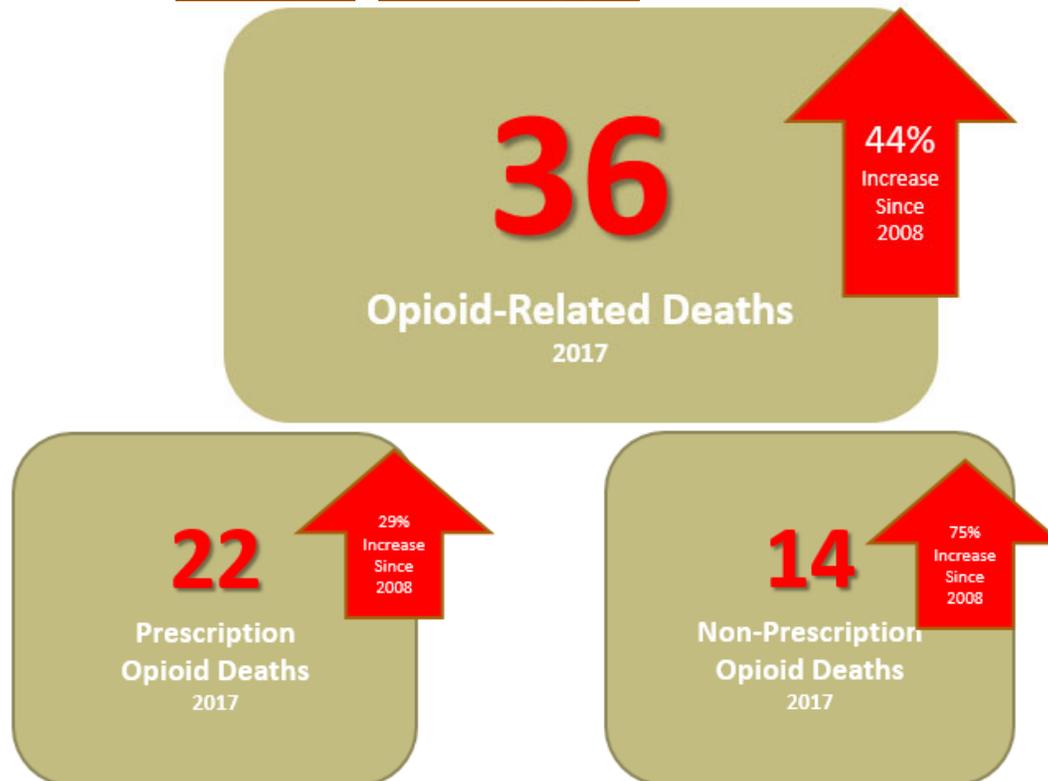
Scholl L, et. al., Drug and opioid involved overdose deaths- United States, 2013-2017, *MMWR*, Vol 67 (51 & 52) Jan. 4, 2019, pp 1419-1427.



Arizona American Indian/Alaskan Native **Opioid**-Related Deaths: 2008-2017

Overdose Facts	Naloxone Statistics	Medical Assisted Therapy	Neonatal Abstinence Syndrome	Phoenix Area Strategic Plan
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Overdose Facts [Overdose Trends](#) [Overdose Demographics](#)



Source: Arizona Department of Human Services

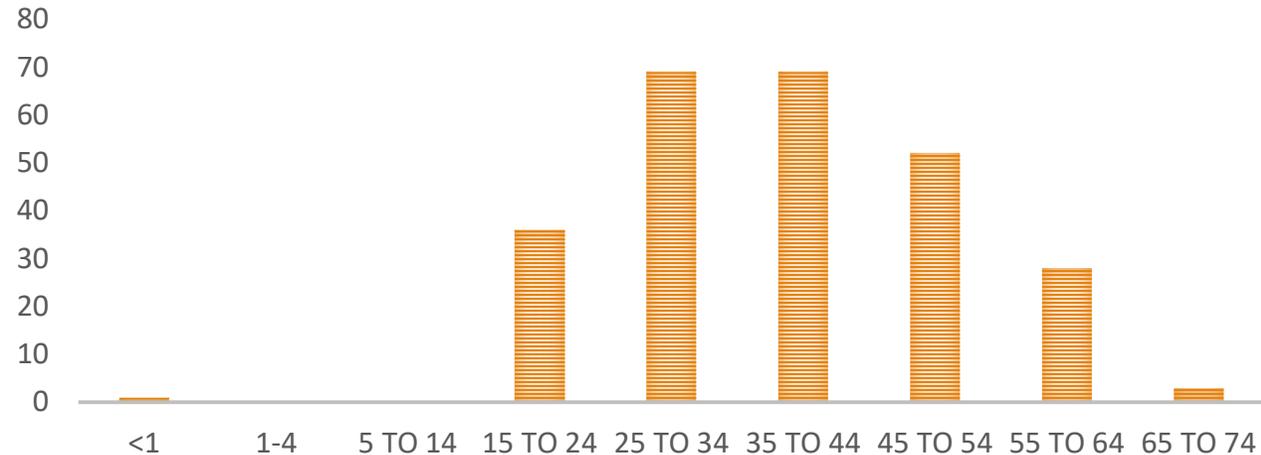


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Overdose Facts [Overdose Trends](#) [Overdose Demographics](#)

AI/AN OPIOID POISONING DEATHS BY AGE ARIZONA; 2008-2017



N=258 (M=168; F=90) | Min=0; Max=72; Ave.=38



Chronic Non-Cancer Pain Management Policy

[IHM Part 3, Chapter 30](#)

Provides best practice guidelines surrounding management of chronic non-cancer pain

- Current version aligns with [CDC Guideline for Prescribing Opioids for Chronic Pain-United States, 2016](#)
- Policy Administrative Requirements:
 - Establish and implement local chronic non-cancer pain protocols and procedures
 - Complete training on appropriate and effective use of controlled substance medications
 - Respect and support the patient's right to optimal pain assessment and management
 - Co-prescribe naloxone with MME>50 or other risk factors
- **Good pain management IS prevention**



Prescription Drug Monitoring Programs (PDMP)

[IHM Part 3, Chapter 32](#) - *State Prescription Drug Monitoring Programs*

- Establishes requirement for IHS Federal prescribers to:
 - register with State PDMP
 - request reports for new patients
 - request reports when prescribing opiates for acute pain (>7 days of treatment)
 - request at least quarterly reports when managing chronic opioid therapy for chronic pain
- Establishes requirement for IHS Pharmacies to:
 - report dispensing data
 - conduct PDMP queries prior to dispensing outside prescriptions



Maternal Child Health Interventions



American College of Obstetricians and Gynecologists (ACOG) *Recommendations to IHS on American Indian/Alaska Native Pregnant Women and Women of Childbearing Age with Opioid Use Disorder*

1. Enhanced screening for substance use disorders in women of childbearing age, paired with
2. Education and
3. Broad access to treatment services and harm reduction strategies can improve outcomes for both mothers and newborns as well as help to keep the family unit together.

American Academy of Pediatrics (AAP) *Recommendations to IHS on the Prevention and Treatment of Neonatal Opioid Withdrawal Syndrome*

- Pending release
- IHS response to Protecting Our Infants Act and GAO 18-32: *Newborn Health: Federal Action Needed to Address Neonatal Abstinence Syndrome*
- Emphasizes the importance of:
 - prenatal recovery engagement
 - NOWS detection and management
 - aftercare



Managing Acute Dental Pain

Recommendations for the Management of Acute Dental Pain

- Published August 2018
- Provides pain management recommendations and best practices for general dentistry procedures
- Contains treatment recommendations for special populations
- Prescriber implementation seminar was hosted in October 2018
- Recent webinar on Naloxone & Dentistry



Medication Assisted Treatment (MAT)

Medication Assisted Treatment (MAT) involves:

- The use of medications
- In combination with counseling and behavioral therapies
- Holistic "whole patient" individualized approach

The goal of MAT is to support recovery and prevent relapse with medication and psychosocial therapy. Medication in support of recovery is one part of a comprehensive approach toward achieving long-term recovery.

MAT allows a person to regain a normal state of mind, free of drug-induced highs and lows



Assuring Access to Medication Assisted Treatment for Opioid Use Disorder

[SGM 19-01](#) – Published June 11, 2019

Goal: To improve access to Medication Assisted Treatment (MAT) for patients with an Opioid Use Disorder (OUD) diagnosis.

Policy: All Federal Indian Health Service Facilities are required to create an action plan to identify local MAT resources and coordinate patient access to these services when indicated.

Action Plan Requirements:

- To identify local MAT resources and create a plan to coordinate access to these services, regardless of the patient's eligibility for PRC or other 3rd party resources;
- Use broad screening protocols to assist with the early identification and referral to treatment for OUD;
- Increase provider training and capacity to encourage and support patient long-term recovery efforts;
- Increase staff proficiency in managing acute opioid withdrawal; and,
- Improve access to naloxone for patients at risk for overdose.



Indian Health Service Opioid Grant Program- Behavioral Health

In FY 2019 The Consolidated Appropriations Act, 2019 (Public Law 116-6), provided a \$10 million increase in the Alcohol and Substance Abuse Program budget line to better combat the opioid epidemic by creating a Special Behavioral Health Pilot Program (SBHPP), modeled after the Special Diabetes Program for Indians. Program to be coordinated with SAMHSA.

June 21 - Tribal Consultation and Confer on development of an Opioid Grant Program via Behavioral Health

- ***Tuesday, September 3, 2019 – comment submissions due***
- If you need additional information, please contact Dr. Tamara James, Acting Director, DBH, IHS, by telephone at (301) 443-1872 or by email at tamara.james@ihs.gov.



SAMHSA Opioid Grant- Interagency Coordination Efforts:

In FY18 SAMHSA received \$50 million in appropriations for the Tribal Opioid Response (TOR) Grant

Awarded 136 grants ranging from \$50,000 to \$3.5 million (depending on the tribe)

SAMHSA's New FY19 Tribal Opioid Response (TOR) Grant Applications were due 8/6/2019

Up to 163 awards anticipated between \$50,000 and \$5.9 million (depending on the tribe)



Medication lockbox pilot project update

- Goal: 1) identify an acceptable locking box ; 2) measure its use among project participants; and 3) determine a distribution method
- Inclusion factors: High-risk (55+, prior RX theft, chronic pain opioid Rx)
- Key partners: DEHS, Pharmacy, CHRs, Housing Depts., & tribal first responders

■ Results

- 9 Participating tribal communities (8 in AZ and 1 in NV)
 - 55 boxes installed
 - 30 and 60 day follow-up evaluations
 - 30 day results = 89% of the lock boxes were used to secure meds
 - 60 day results = 95% of the lock boxes were used to secure meds
- Prior to implementation, **only 1%** of individuals secured their medications*
- Reported loss/theft of medications went from 31% at implementation to 0% at the 60-day follow-up
 - 4 Phoenix Area tribes considering sustaining the program locally
 - Project is being replicated by 3 IHS Areas



Community-based Opioid Poisoning Prevention Activities

Environmental Health Service



Medication disposal

Connect tribes to IHS and state programs for the resources to remove expired/unused medications from the home environment

Medication drop boxes

- 3 active drop boxes in the Phoenix Area
- 571 lbs. of medications dropped in the boxes in the first 6 months

Medication neutralization pouches

- Acquired 1,300 pouches from AZ Dept. of Human Services
- To date, 575 prescription medications disposed of in the home environment from 2 tribal communities



Overdose-reversing drugs (Naloxone)

Connect tribal first responders to resources for Naloxone and its recommended training

- Partnered with the state Health Depts. in AZ and NV
- 670 doses of Naloxone distributed to first responders in 15 tribal communities



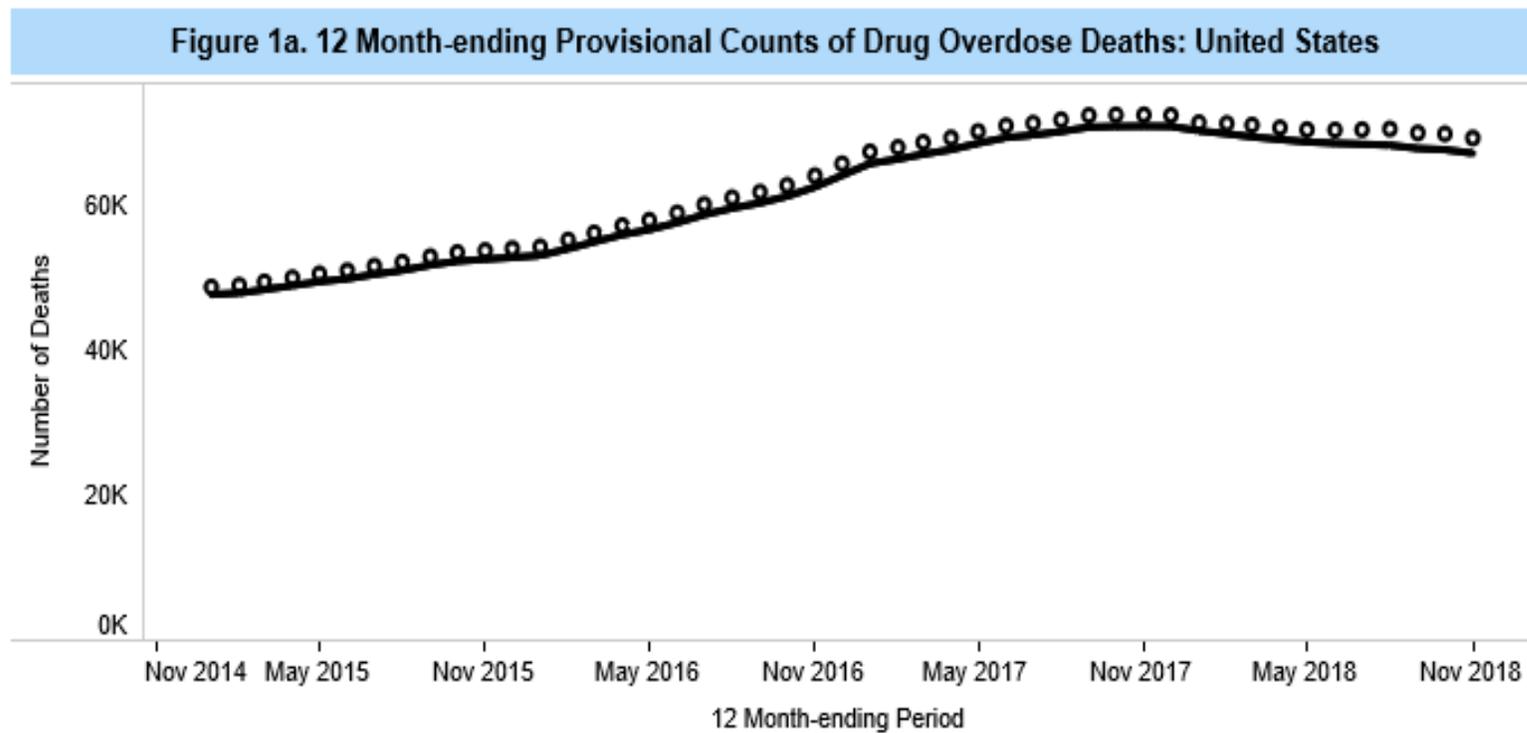
Policy Efforts

[IHM Part 3, Chapter 35](#) - Prescribing and Dispensing of Naloxone to First Responders

- Operationalizes the terms of an IHS-BIA Memorandum of Understanding (12/2015, renewed 6/2017)
- Requires IHS Federal pharmacies to provide naloxone to Tribal law enforcement agencies and other trained first responders.
- Local policies must include procedures for:
 - training
 - prescribing
 - dispensing naloxone to tribal entities



There is hope...



Ahmad FB, Escobedo LA, Rossen LM, Spencer MR, Warner M, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2019.

Ending the HIV Epidemic: A Plan for America

GOAL:

75%
reduction
in new HIV
infections
in 5 years
and at least
90%
reduction
in 10 years.



Our goal is ambitious and the pathway is clear – employ strategic practices in the *places* focused on the right *people* to:



Diagnose all people with HIV as early as possible after infection.

Treat the infection rapidly and effectively to achieve sustained viral suppression.



Protect people at risk for HIV using potent and proven prevention interventions, including PrEP, a medication that can prevent HIV infections.

Respond rapidly to detect and respond to growing HIV clusters and prevent new HIV infections.



HIV HealthForce will establish local teams committed to the success of the Initiative in each jurisdiction.

HIV in Indian Country



From 2005 to 2014, the CDC reported 63% increase in HIV rates among gay and bisexual AI/AN men;

The overall HIV rate of AI/AN increased by 19% during that period of time

The undiagnosed rate for AI/AN living with HIV hovers at 18%

The national undiagnosed rate is 13%

According to 2013 data from the CDC, 53% of all AI/AN diagnosed with HIV were receiving continuous HIV care compared to 58.2% in Whites

About 52% AI/AN were virally suppressed compared to 62% for Whites

HIV in Indian Country



The largest burden of HIV is among AI/AN men who have sex with men, who accounted for 78% of all HIV cases among AI/AN in 2013

AI/AN women show a rate of HIV diagnosis that is three times the rate of White women

AI/AN had the lowest survival rate after an AIDS diagnosis of any race

Survival rates between 2010 and 2014 were lowest among AI/AN

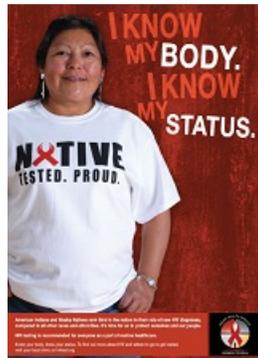
AI/ANs have the third highest rate of HIV transmission of any race

Diagnose as early as possible

Opt-out testing in pregnancy

Opt-out testing ages 13-65

Those at high risk for HIV infection should be screened every year





Treatment is prevention

U = U

Undetectable = Untransmittable

- People living with HIV on ART with an undetectable viral load in their blood have a negligible risk of sexual transmission of HIV.

www.preventionaccess.org

Pre-Exposure Prophylaxis (PrEP)



Tenofovir disoproxyl fumerate/emtricitabine (Truvada®)

- Reduces risk of getting HIV from sex by more than 90%
- Reduces risk of getting HIV by injection drug use by more than 70%
- On IHS Core Formulary

Treat HIV infections rapidly



Change in paradigm to treat as quickly as possible

- Utilize pharmacists to provide extensive education to new start patients and follow-up between medical appointments
- HIV Treatment options are now on the IHS core Formulary

Rapidly detect and **Respond** to emerging clusters of HIV

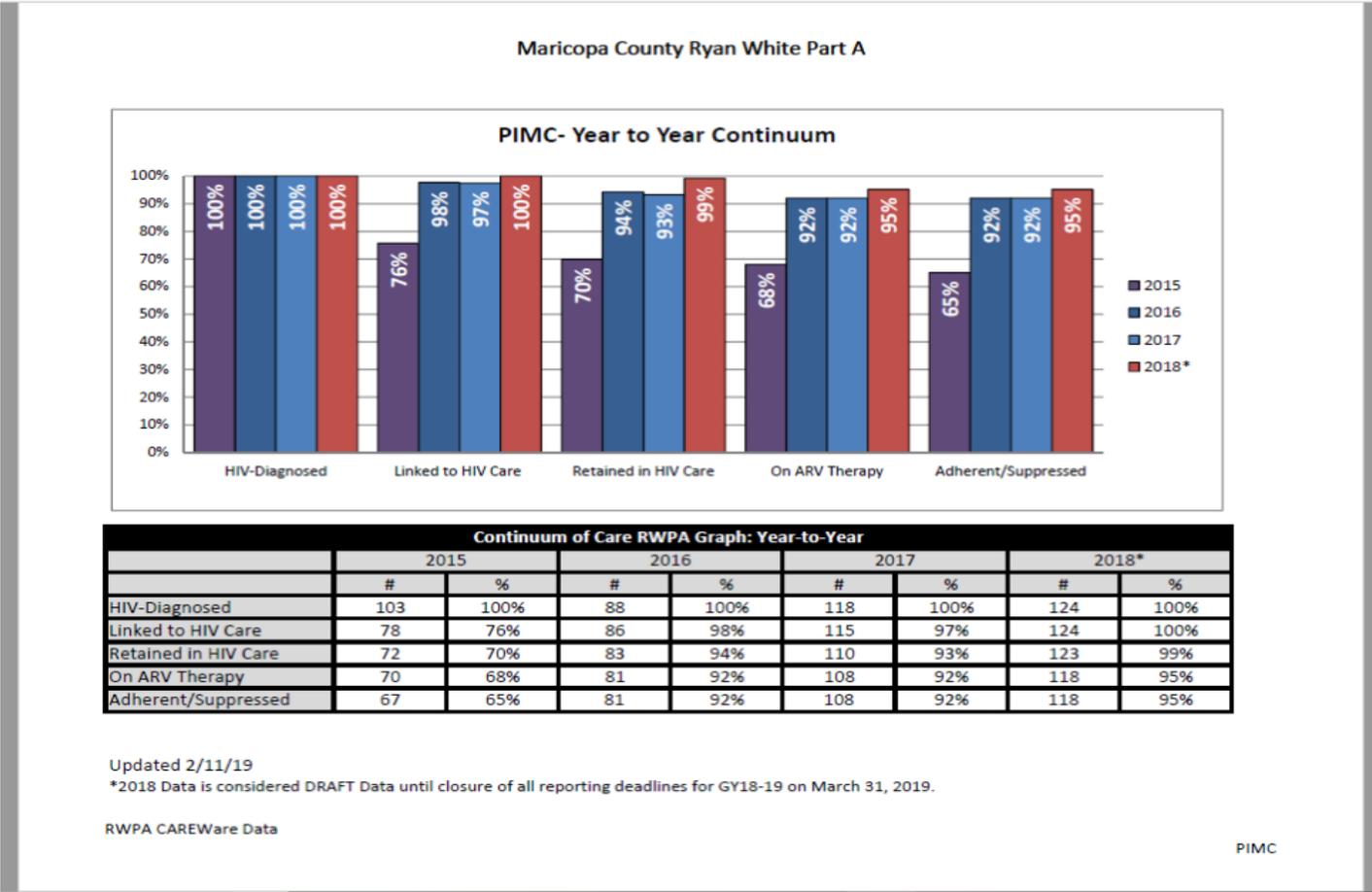


Increase screening with syphilis or other Sexually Transmitted Infection (STI) outbreaks

Ensure that states and communities have the technological resources to investigate all related HIV cases to stop chains of transmission

Partner with Tribes, State and County Departments of Health, and the CDC

Maricopa county Ryan white Part a HIV continuum for PIMC HIVCOE



Hepatitis C

May 2019 – IHS Special General Memorandum to expand universal screening for Hepatitis C to all patients over the age of 18 years at least once in their lifetime.

Universal screening supplements and does not replace more frequent risk based testing

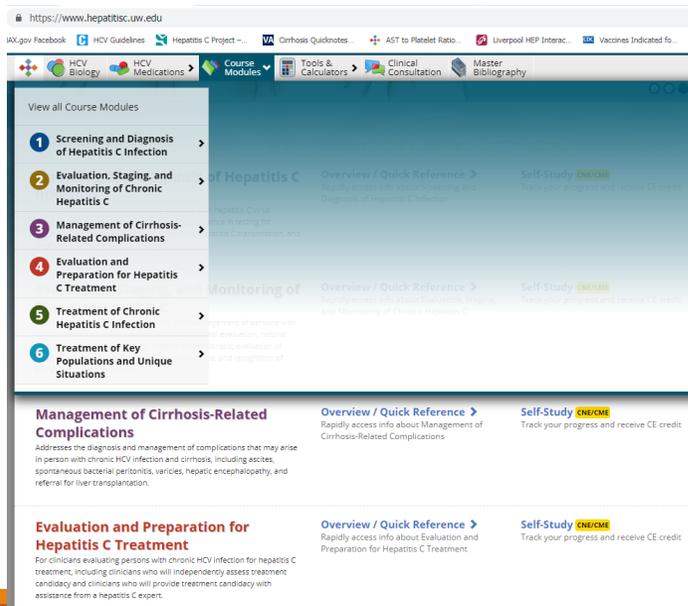
HCV in AI/AN remains more than double the national rate

Early diagnosis and treatment can reduce HCV morbidity and mortality

Provider-related barriers

Perception that they need special training to treat

- Very easy to treat and manage
- Multiple **FREE** resources such as UCSF Clinical Consultation Line and Project ECHO
- Online, comprehensive HCV training (with CE credits!) available **for FREE** through the University of Washington at: <https://www.hepatitisc.uw.edu/>



Indian Health Services HCV and HIV Consultation Service

9 am – 8 pm EST, Monday - Friday

Hepatitis C mono- and co-infection consultation: (844) 437-4636
HIV consultation: (800) 933-3413

The Clinician Consultation Center (CCC) provides free, confidential, and timely expert HCV and HIV consultation to IHS clinicians of all experience levels and training backgrounds.

Advice is based on Federal treatment guidelines, current medical literature, and clinical best practices.



Cost (yes, that elephant in the room)



Medication Cost

Decreased significantly since added to the IHS core formulary

90% of patients (non cirrhotic, treatment-naïve) will only need 8 weeks of medication

A **liver transplant** typically **costs** up to **\$575,000** or more for the procedure, including follow-up care and medications for the first six months after the procedure.¹

Cost of treating a non-cirrhotic, treatment naïve patient is ~ **\$11,500**

- *Free to facility if covered by insurance!*

1. <https://health.costhelper.com/liver-transplant.html>

Facility-related barriers

Perceived cost of medication

- Engage pharmacy to assist with Prior Authorizations for medication

Lack of providers qualified to treat HCV

- Any Primary Care provider can manage / prescribe with basic training

Availability of appointment slots/rooms

- Minimal follow up required; patients typically seen only 5 times total (over 6 months)

Potential Solutions

IHS sites: HCV medications on National Core formulary

Tribal Sites: Consider adding the drug benefits far outweigh costs

Facilities: Encourage interested providers to dial in to a few ECHO sessions (IHS HCV ECHO every 1st and 3rd Wednesday of the month) to see the level of support available

Everyone: Educate patients on ease & availability of treatment through community radio, CHRs, signage in healthcare facilities

Prevalence of Trauma

Mental Health Population - US

- **90% of public mental health clients have been exposed to trauma**

Muesar et al., 2004. Muesar et al., 1998

- **51-98% of public health clients have been exposed to trauma**

Goodman et al., 1997. Muesar et al., 1998

- **Most have multiple experiences with trauma**

Muesar et al., 2004. Muesar et al., 1998

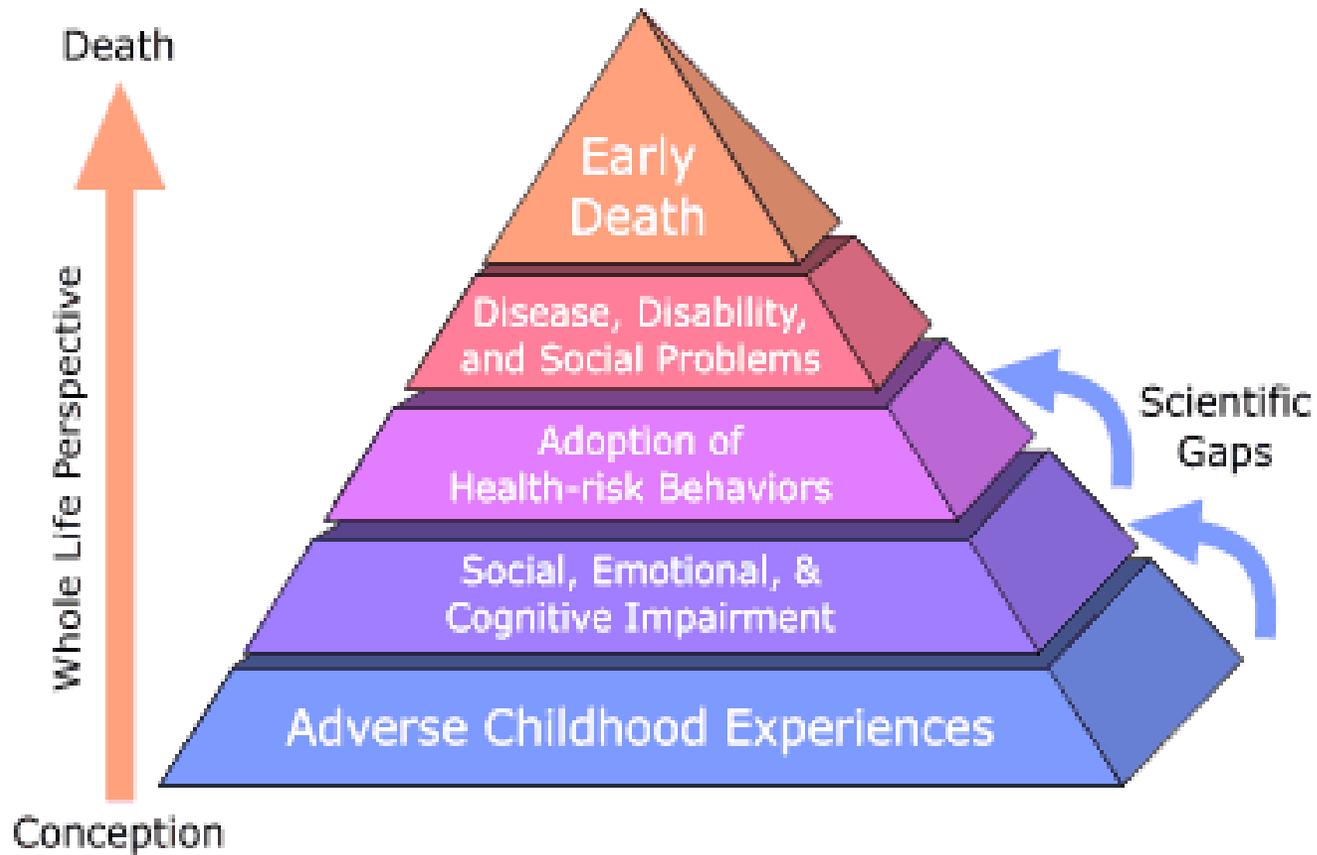
- **97 % of homeless women with SMI have experienced severe physical & sexual abuse, and 87% experience this abuse both in childhood and adulthood**

Goodman et al., 1997

Critical Trauma Correlates

**Adverse Childhood Events (ACE's)
have serious health consequences.**

- Adoption of health risk behaviors as coping mechanisms (eating disorders, smoking, substance abuse, self-harm, sexual promiscuity)
- Severe medical conditions: heart disease, pulmonary disease, liver disease, sexually transmitted infections, cancers
- Early death



The Adverse Childhood Experiences study of the effects of trauma on future health was result of collaboration of CDC and Kaiser Permanente. They wanted to find out if there were any commonalities in the backgrounds of high users of healthcare services, chronic illnesses, and early deaths.

They asked participants about trauma in their childhood - about recurrent physical or emotional or sexual abuse, family substance abuse or incarceration, depression, or other mental health issues.

The study revealed the following information pictured here in this pyramid.

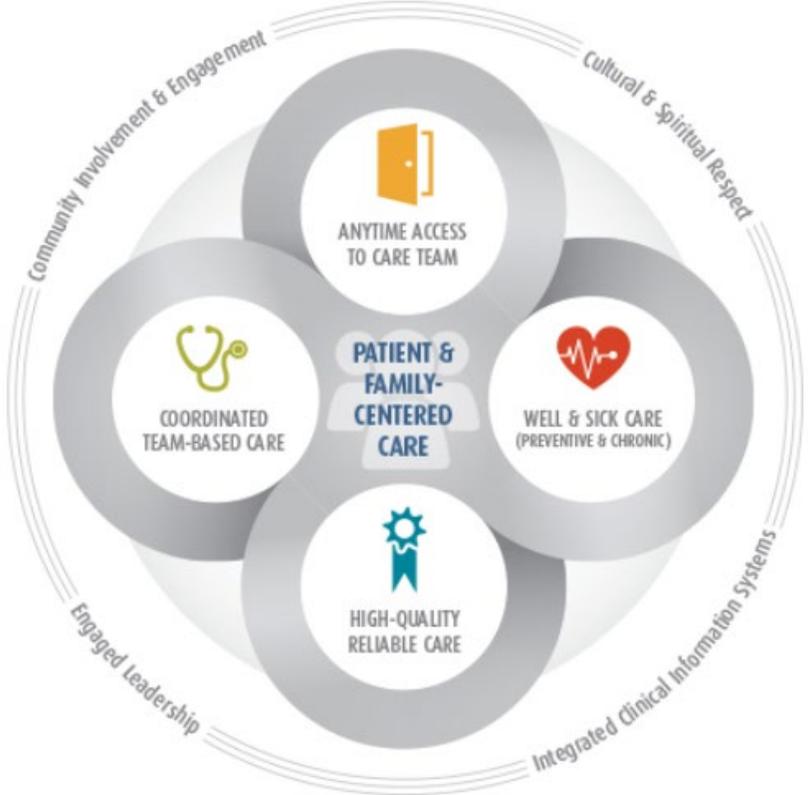
<http://www.acestudy.org/>

Trauma-Informed Care

- Recipient is center of his/her own treatment
- Recipient and family are empowered
- Wellness and self management are the goal
- Transparent and open to outside parties
- Power/control are minimized
- Staff are trained and understand function of behavior

**TIC respects and empowers the individual
as the center of their own wellness!**

IHS Model of Care



Accreditation

In 2017, IHS leadership signed a Special General Memorandum (SGM) 2017-1, which requires Patient Centered Medical Home (PCMH) designation for all IHS ambulatory care facilities by Dec. 31, 2021.

Organizations Providing Accreditation

- The Joint Commission (TJC)
- Accreditation Association for Ambulatory Health Care (AAAHC)
- National Committee for Quality Assurance (NCQA)

Why Accreditation?

Validate quality of care; engage patient and staff

Reinforce risk management efforts

Help meet certain states' regulation requirements

Enhanced payer reimbursements

Phoenix Area PCMH Accreditation Status

Facility	Accreditation Body	Status
Phoenix Indian Medical Center	The Joint Commission	Accreditation Pending
Hopi Health Care Center	The Joint Commission	Accredited
Whiteriver Service Unit	The Joint Commission	Accredited
Colorado River Service Unit	The Joint Commission	In Progress
Elko Service Unit	AAAHHC	Accredited
U+O Service Unit	AAAHHC	Accredited
Ft Yuma Service Unit	AAAHHC	Accredited

American Indian Medical Home

The American Indian Medical Home (AIMH) Program is for American Indian/Alaska Native (AI/AN) members enrolled in the American Indian Health Program (AIHP) through AHCCCS (Arizona Health Care Cost Containment System).

The AIMH Program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for its AIHP enrolled members.

Current Phoenix Area Sites Participating:

- PIMC
- Whiteriver

IHS Model of Care

