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National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
4770 Buford Highway NE.
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Atlanta, GA 30341

Re: Docket CDC-2015-0112: USET Comments on the CDC Proposed 2016 Guideline for Prescribing Opioids for Chronic Pain

The United South and Eastern Tribes, Inc. (USET) is pleased to offer the following comments on the Center for Disease Control and Prevention's (CDC) draft 2016 Guideline for Prescribing Opioids for Chronic Pain (the Guideline). USET supports the aims of the Guideline, as we believe these clinical recommendations will be a first step in reducing the harmful effects opioid abuse in the United States. However, USET is disappointed that the architects of the Guideline excluded the Indian Health Service (IHS), and Tribally Operated Clinics from the consultative process that included other federal agencies like the U.S. Department of Veteran's Affairs (VA), as both agencies provide direct health care to vulnerable patient populations. Furthermore, American Indian/ Alaska Natives (AI/AN) have unique treatment needs based on: the traditional practices incorporated into their health care, belonging to communities with high burdens of substance abuse disorders as a result of historical trauma, and access to care via the complex network of providers in the Indian Health Care Delivery System. These considerations are clearly omitted in the clinical recommendations in the Guideline. USET offers the following recommendations to initiate further collaboration and consultation with the CDC's National Center for Injury Prevention and Control on matters that are very important to public health in Indian Country and to the health and wellness of AI/AN patients.

USET is a non-profit, inter-tribal organization representing 26 federally recognized Tribal Nations from Texas across to Florida and up to Maine.[1] Both individually, as well as collectively through USET, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the IHS, which contains 36 IHS and tribal health care facilities. Our citizens receive health care

[1] USET member Tribes include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

services both directly at IHS facilities, as well as in Tribally Operated facilities operated under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

I. Failure to Initiate Meaningful Consultation with Tribal Nations and the Indian Health Service

Executive Order 13175[2], issued on November 6th, 2000 by President Clinton, requires regular and meaningful consultation and collaboration among Tribal Nation officials and the federal government, in recognition of the special legal and trust relationship between the United States and Tribal Nations. The CDC, an agent of the federal government, and steward of the Federal Trust responsibility, missed several opportunities for meaningful engagement of Tribal Nations and Tribal Nation organizations. Below, we highlight several areas where input from Tribal Nations was overlooked, and explain how this weakens the partnership between the Federal Government and Tribes in their mission to elevate health outcomes for AI/AN patients.

Notably, USET is unaware of any effort on the part of the CDC to initiate consultation with Tribal Nations during development the Guideline. As the CDC may know, opioid abuse is a growing problem in Indian Country. Moreover, CDC's own Tribal Consultation policy requires the agency to consult with Tribal Nations in the development of policies that have Tribal implications. The CDC's failure to initiate consultation undercuts the Government-to-Government relationship between the U.S. and Tribal Nations and fails to address the needs of AI/AN patients. Before CDC finalizes the Guideline, USET contends that it must actively and meaningfully consult with Tribal Nations.

Additionally, in the introduction to the Guideline, a section titled "Federal Partner Engagement" explains the CDC's interest in soliciting information from various federal partners given the magnitude and scope the guideline, and need for interagency collaboration for implementation of the recommendations. Visibly absent from the list of federal partners is the IHS. Based on 2015 data, care was delivered to 2.2 million eligible AI/AN patients through approximately 13,180,754 outpatient visits to IHS and Tribally Operated clinics[3]. To omit the agency is to ignore a critical access point for many AI/AN patients and undermines the Indian Health System's role as a partner in implementing the Guideline, particularly in Indian Country.

The Guideline also delineates that it is intended "for Primary Care providers (e.g., Family physicians and internists) who are treating patients with chronic pain". By excluding the IHS from the consultative process, the CDC is overlooking over 750 physicians, 700 pharmacists and 2,480 nurse employees, all of whom have a major role in coordinating primary care services and chronic pain treatment to AI/AN patients. These Indian Health Care Providers (IHCPs) are on the frontlines of AI/AN care and their input to any suggested clinical guidelines would be essential to treating the unique needs of this patient population.

Another section of the Guideline describes an opportunity for stakeholder engagement which included, "representation from community organizations with interests in pain management and opioid prescribing." USET, which houses one of the 12 regional Tribal Epidemiology Centers (TEC) in Indian Country, was not notified nor aware of the formulation of the Guideline. Under the Indian Health Care Improvement Act (IHCIA), Tribal Epidemiology Centers (TEC) are designated as Public Health Authorities and have access to data sets through data sharing agreements with our Tribal Nations. An analysis of mortality and other diagnostic data substantiates the prevalence of opioid abuse within Indian Country. In addition, providing technical support to member Tribal Nations in conducting community health assessments further underscores prescription drug abuse as a major health threat. The technical expertise that TECs provide is essential to promoting positive public health outcomes

[2] Exec. Order No. 13175, 3 C.F.R. 3 (2000).
[3] Indian Health Service: Year 2015 Profile Fact Sheet.

and implementing policy in Indian Country. The CDC should confer with TECs regarding any major regulations or guidelines, in order to minimize unintended consequences of poor policy making in Indian Country and to assist the agency in fulfilling the requirements described in Executive Order 13175.

II. Unique Challenges facing the Indian Health Care Delivery System, and the Chronic Pain Treatment of AI/AN Patients

i) Indian Health Professional Workforce Considerations

Some of the challenges that the IHS faces when combatting opioid abuse in Indian Country are specific to the way the IHS provider networks are set up and limitations in accessing patient prescription drug information. In addition to accessing IHCPs, who are typically IHS or Tribal direct hires, AI/ANs gain access to primary and specialty care services through the Purchased Referred Care (PRC) program. PRC allows IHS and Tribally Operated Facilities to refer patients out, purchasing health services outside of the "four walls" of their clinic. PRC is a critical extension of the Indian Health Care Delivery System, allowing much-needed care to be provided and filling a major gap between patient needs and the services available at the IHS/Tribal level. The sharing of patients between PRC providers and IHCPs can, however, make it challenging to coordinate care effectively, and make it easy for patients to "doctor shop." The Guideline, as it is written, assumes the patient sees one provider for primary care services. This misses the unique organization of providers in the Indian Health Care Delivery System. Stakeholder engagement with providers that operate across the Indian health landscape is essential to coordinating care for AI/AN and eliminating opportunities for opioid abuse.

Another challenge that is unique to the Indian Health Care Delivery System is the unintended complications of IHCIA, which established special licensure laws to combat the health profession workforce shortages that are rampant in Indian Country. Section 134 of IHCIA allows physicians, pharmacists and other providers with licensure from any state to practice medicine in the state where their employing Tribal Nation is located. Although this is beneficial for recruiting qualified providers, it means that many are not able to access the Prescription Drug Monitoring Program (PDMP) in their state of practice, and as result, cannot access essential information about patients' use of prescription drugs. The exclusion of IHCPs from PMDP is a major issue for prescription drug monitoring and surveillance of drug use and abuse within the community. This reality is in conflict with Recommendation 9 of the Guideline which suggests, "Providers should review PDMP data when starting opioid therapy for chronic pain and periodically throughout the ongoing course of therapy, ranging from every prescription to every 3 months." CDC should acknowledge the limitations of IHCPs' access to this information and offer viable alternatives for these providers to ensure proper surveillance of drug use among AI/AN patients. Supporting an initiative to build a technology bridge between IHS' electronic medical record system (Resource and Patient Management System) and PDMP would greatly strengthen the drug monitoring effort in Indian Country.

ii) Clinical & Treatment Considerations: Traditional Healing, Historical Trauma, and Provider Trust

AI/AN populations are also distinctive in that most programming related to substance abuse and mental health is operated under ISDEAA agreements, which allow Tribes more ownership and autonomy in designing community-directed programming. According to IHS, approximately 50 percent of mental health programs and over 80 percent of alcohol and substance abuse programs, are Tribally-operated[4]. Fundamental to many of the Tribally-

[4] Indian Health Service: Behavioral Health Fact Sheet.

operated programs is the incorporation of traditional healing practices and a holistic approach to health care. The Guideline misses these critically important concepts in AI/AN behavioral health care. Additionally, due to challenges arising from historical trauma and high rates of substance abuse, providers serving AI/AN patients need to be trained in trauma-informed care. Many providers do not realize that many of the root causes of opioid abuse are the result of the historic losses that AI/AN communities have endured. Any CDC guidance related to the treatment of chronic pain for AI/AN patients need to acknowledge historical trauma and be inclusive of culturally appropriate interventions, including smudging, sweat lodges, and talking circles. Through further engagement with Tribal Nations, CDC can build on their existing guidance to have more practical application in Indian Health settings.

iii) Assessment of Risks: Inadequate Access to Detox Facilities.

When assessing the risks of opioid treatment in chronic pain management consideration that providers working in rural Indian communities must consider access to detox facilities. In rural areas where many Tribal Nations are located, there is often only one local detox facility. These facilities are often at capacity and do not have enough beds to meet the demand. Additionally, hospital emergency rooms, which can be 40 or more miles away, routinely deny patients for detox. When patients do finally find access to care for chemical dependency, outside of the Indian Health Care Delivery System, they receive less culturally appropriate care and often take their primary care services away from their IHS or Tribal clinic. This complicates case management for patients, and if a patient has health insurance, redistributes resources in a way that is detrimental to the Indian Health Care Delivery System.

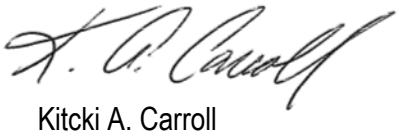
Conclusion

USET appreciates the opportunity to provide comments on the CDC draft 2016 Guideline for Prescribing Opioids for Chronic Pain. We look forward to further collaboration and meaningful consultation with the CDC in order to implement public health policy that is cognizant of the unique needs of AI/AN patients and congruous within the Indian Health Care Delivery System.

Should you have any questions or require additional information, please do not hesitate to contact Ms. Liz Malerba, USET Director of Policy and Legislative Affairs, at (202) 624-3550 or by e-mail at lmalerba@usetinc.org.

Sincerely,

Brian Patterson
President



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"Because there is strength in Unity"