



U.S. Department of Justice

Washington, D.C. 20530

**Indian Health Care Improvement Act
Report Required by 25 U.S.C. 1680q(b)(2)
October 2011**

According to a recent report from the National Institute on Drug Abuse, “approximately 7.0 million persons were current users of psychotherapeutic drugs taken nonmedically (2.8 percent of the U.S. population). This class of drugs is broadly described as those targeting the central nervous system, including drugs used to treat psychiatric disorders.”¹ The medications most commonly abused are pain relievers, tranquilizers, stimulants and sedatives. Among adolescents, prescription and over-the-counter medications account for most of the drugs, excluding tobacco and alcohol, frequently abused by high school seniors. Rates of other high risk behaviors, including abuse of other drugs and alcohol, are reported among individuals abusing prescription drugs. Unfortunately, Indian country is not immune from prescription drug abuse. Accordingly, the Indian Health Care Improvement Act, effective March 23, 2010, addresses the issue of prescription drug monitoring.

Pursuant to 25 U.S.C. 1680q(b)(2), the Attorney General is required to submit to the Senate Committee on Indian Affairs and the House Committee on Natural Resources a report that describes the following:

- The capacity of Federal and tribal agencies to carry data collection and analysis and information exchanges as described in the Act;
- The training conducted for Indian health care providers, tribal leaders, law enforcement officers, and school officials regarding awareness and prevention of prescription drug abuse and strategies for improving agency resources for addressing prescription drug abuse in Indian communities;
- Infrastructure enhancements required to carry out the activities described in the Act; and
- Any statutory or administrative barriers to carrying out the activities required by the Act.

DEA Certificate of Registration

A lawful dispenser of controlled substance prescription drugs must have a Certificate of Registration issued by the Drug Enforcement Administration (DEA). The DEA Certificate of Registration is a required reporting element for all PDMP databases. Therefore, Indian Health Service (IHS) providers will each need to acquire a Certificate of Registration. The Controlled Substances Act currently allows officers of the U.S. Public Health Service, along with other uniformed services, to use a facility specific internal tracking number. IHS is now in the process of obtaining a Certificate of Registration for all their providers. Application for a DEA registration may be submitted either online through the use of the interactive DEA 224 form, available at the Office of Diversion Control’s website (www.DEAdiversion.usdoj.gov), or a DEA 224 paper application. All applications submitted are electronically transmitted to the appropriate DEA field office based upon the business address of the applicant. The application, background checks, and any other relevant information, are reviewed by the local DEA field office. Once the various checks are completed by the local DEA field office, barring any derogatory findings, the application is approved and the new DEA Certificate of Registration (DEA 223) is automatically mailed to the address the applicant provided. Currently, there are approximately 1.4 million DEA registrants. This figure represents the entire DEA registrant population, including researchers, manufacturers, distributors, etc. There are 1,307,203

¹ National Institute on Drug Abuse, Topics in Brief, *Prescription Drug Abuse*, May 2011.

individual practitioners registered with DEA to dispense controlled substances. The phrase “individual practitioner” includes all individual persons (i.e., not institutions such as hospitals or pharmacies) who are registered to dispense or administer controlled substances. Of that number, 66,436 are fee exempt. And, of the fee exempt prescribers, approximately 0.08% is an Indian Tribe, IHS, tribal hire or a contractor working on a reservation.

Bureau of Justice Assistance’s Harold Rogers Prescription Drug Monitoring Program

Advancing the Use of Prescription Drug Monitoring Programs

Background

Beginning in FY 2002, Congress appropriated funding to the U.S. Department of Justice to support the Harold Rogers Prescription Drug Monitoring Program (HRPDMP). Prescription drug monitoring programs (PDMPs) help prevent and detect the diversion and abuse of pharmaceutical controlled substances, particularly at the retail level where no other automated information collection system exists. States that have implemented prescription monitoring programs have the capability to collect and analyze prescription data much more efficiently than states without such programs, where the collection of prescription information requires the manual review of pharmacy files, a time-consuming and invasive process.

The purpose of the HRPDMP is to enhance the capacity of regulatory and law enforcement agencies to collect and analyze controlled substance prescription data. The program focuses on providing help for states that seek to establish and enhance prescription drug monitoring. Program objectives include:

- Building a data collection and analysis system at the state level;
- Enhancing existing programs’ ability to analyze and use collected data;
- Increasing the usage of PMDP data among authorized users within the states;
- Facilitating the exchange of collected controlled substance prescription data among states; and
- Assessing the efficiency and effectiveness of the programs funded under the initiative.

The grant program, which is administered by the Department of Justice’s Bureau of Justice Assistance (BJA) was created by the Department of Justice Appropriations Act, 2002 (Public Law 107-77) and has received funding under each subsequent year’s Appropriations Act. To date, grants have been awarded to 49 states and 1 U.S. territory under this program. PDMPs collect, monitor, and analyze electronically transmitted prescribing and dispensing data submitted by pharmacies and dispensing practitioners. The data are used to support states’ efforts in education, research, enforcement and prescription drug abuse prevention. PDMPs are managed under the auspices of a state, district, commonwealth, or territory of the United States.

Several state PDMPs have established relationships with IHS facilities and/or tribes to share dispensed controlled substance data with the PDMP. These relationships have occurred on an ad-hoc basis and are not consistent from state to state. In some cases, these relationships

effectively ended because the tribes or IHS facilities involved did not have the legal authority to share data with the PDMP per the state law. North Dakota approached BJA in the fall of 2010 with a proposal to use some HRPDMP enhancement grant funding to collaborate with IHS to enable them to report their controlled substance dispensing data to select states' PDMPs.

With approval from BJA, the North Dakota Board of Pharmacy proceeded with a pilot and contracted with a vendor to develop and implement software to detect and export controlled substance dispensing data at IHS and tribal health care facilities in the states of North Dakota, South Dakota, and Minnesota. Under this model, data is exported from the Resource and Patient Management System (RPMS) Pharmacy System, in operation at the local facilities, to the PDMPs operated by the participating states.

Conceptual Framework

DOJ envisions that this technical solution will be available to all IHS facilities who wish to report their data to PDMP programs, whether they reside in North Dakota or other states. The implementation of this initial reporting is taking place through the first test site at the Spirit Lake, North Dakota IHS facility. The North Dakota Board of Pharmacy has collaborated with Spirit Lake Health Center clinical leadership to launch this effort. The vendor selected for this project is Cimarron Medical Informatics, LLC.

The pilot plan includes an initial exchange model piloted by the Spirit Lake Health Center, and then subsequent implementation at additional IHS facilities (some of which are listed below). This approach allows these facilities to report to the North Dakota, Minnesota, and South Dakota PDMPs.

North Dakota

- Spirit Lake Health Center
- Quentin Burdick Hospital
- Standing Rock Hospital

South Dakota²

- Cheyenne River Service Unit
- Fort Thompson Health Center
- Lower Brule Health Center
- Pine Ridge Service Unit
- Rapid City Service Unit
- Rosebud Service Unit
- Sisseton Service Unit

² For the facilities with the designation "Service Unit," all facilities within the Service Unit will be included in this project if those facilities all operate on the same RPMS computer system. If multiple facilities in the Service Unit operate on separate RPMS computers, the Export System will be implemented as part of this project only at the parent, or main, facility.

Yankton/Wagner Service Unit

Minnesota

Cass Lake Hospital
White Earth Service Unit
Red Lake Hospital

IHS has also pursued the establishment of data sharing between IHS facilities in Arizona and the state PDMP, and has requested additional assistance from BJA's TTA providers to move this initiative forward.

Status of the Project

- Programming was completed by the end of April 2011.
- IHS now has dispenser reporting participation within the Aberdeen Area (South Dakota and North Dakota) to the North Dakota PDMP. Additionally, Bemidji Area Federal sites are reporting to the Minnesota PDMP.
- IHS has identified Arizona as a high priority state for implementation of PDMP data sharing due to its large population of Native Americans who are eligible for IHS and Tribal health services. Arizona has signed a letter of agreement with the Integrated Justice Information Systems Institute (IJIS) institute to take the preliminary technical steps required to move forward in this information sharing initiative.
- BJA has authorized the IJIS institute to develop a translational utility to address software differences among states and enable data sharing to come to fruition in spite of these differences.

Challenges to Implementation of PDMP Programs

- This IHS data sharing initiative is being developed using the American Society of Automation in Pharmacy (ASAP) 4.1 Standard. Not all states operate using this standard. BJA believes that the proposed translational utility will resolve this issue.
- IHS has designated Arizona as a key state in its PDMP reporting strategy. However, there are financial and technological constraints that may make its participation difficult. For example, the state of Arizona does not have the resources to upgrade their ASAP 1995 to ASAP 4.1.
- For a number of reasons, practitioners do not always use PDMPs. Reasons cited include that using a PDMP is not yet a part of their daily practice, practitioners cannot get reimbursed for using the service and general lack of education and knowledge about PDMPs. Accordingly, IHS is looking to revise its educational materials for distribution to practitioners.
- As with many programs, resources – both personnel and financial – pose challenges to full implementation of PDMPs in Indian country. It takes significant time to develop the necessary linkages for a robust PDMP. Considerable time is necessary to work with providers in tribal communities to develop interest on their part to send information to

state for full state information. The Office of National Drug Control Policy (ONDCP) has provided money to BJA to assist in the development of state-to-state linkages (which could include tribes). Given that many Indian people obtain prescription medications from non-tribal or non-IHS providers, it is most effective to aggregate controlled substance prescription data at the state level rather than to develop a separate IHS PDMP system.

The Way Forward

- BJA has authorized the Alliance of States with Prescription Drug Monitoring Programs (The Alliance) and the PMP Center of Excellence at Brandeis University, its two PDMP Training and Technical Assistance Providers, to work with IHS and the IJIS Institute to create interoperability between IHS, its pharmacies and PDMPs. This includes several steps:
 - Assist IHS in sending controlled substance prescription data from all IHS pharmacies to the state PDMP in which each IHS pharmacy is located. In addition, BJA has introduced IHS to the State PDMPs through the Alliance of States with Prescription Monitoring Programs (ASPMP) and setting IHS up as a test organization for the Prescription Monitoring Information Exchange (PMIX).
 - Develop a single, unified method for PDMPs to collect controlled substance prescription data from all IHS pharmacies (i.e., work with PDMPs to collect the same data elements from the IHS pharmacies using the same ASAP data transmission standard). The foundation for these unified data elements already exists in the Alliance's PDMP Model Act.
 - Resolve issues, such as identification numbers for federal controlled substance prescribers, in order to permit IHS prescribers and pharmacists to establish PDMP accounts through which they can request state PDMP data and interstate PDMP data.
 - In recognition of the responsibility of IHS to supervise and assure the quality of care within their health care system, conduct a review of state laws and regulations to determine what changes are needed to permit IHS clinical care supervisors to access PDMP data regarding the prescriptions issued and patients treated by their prescribers and pharmacies.
- BJA supports coordinating with IHS and expanding the pilot to include engaging self governance and 638 contracting tribes in controlled substance prescription data collection sharing to improve the information available to prescribers and dispensers of controlled substances.

Outreach and Training

The Department of Justice has a number of components involved in providing outreach, training and technical assistance to Indian country concerning illegal drugs. While not all of these programs specifically address PDMPs, many address issues connected to prescription drug abuse. Given the problems with prescription drug abuse in Indian country, such outreach, training and technical assistance provides a valuable service to tribal communities and can save

lives. A sampling of DOJ funded and/or led outreach, training and technical assistance efforts follows.

Drug Endangered Children Task Force

According to a 2008 Bulletin prepared by the Indian Health Service, almost 1 million of the Native people in the United States are under the age of 18. Twenty percent are at risk of abuse and 40,000 suffer substantiated abuse and neglect based on 2004 Child Welfare League of America data. Of these abused/neglected children, 65-85 percent is thought to be substance abuse related. Native youth are also at increasing risk for using drugs. In 2006, the Bureau of Indian Affairs found that 35 percent of high school seniors at the Navajo Nation reservation reported trying methamphetamines at least once in 2006.

The *2010 National Drug Control Strategy* mandated the formation of a Drug Endangered Children Interagency Task Force (DECTF), which was established May 2010 and is chaired by the Justice Department's Deputy Attorney General. The DECTF has three primary goals: (1) establishment of an infrastructure to support Federal, State, local, and tribal efforts; (2) identification of model protocols and promising practices related to assistance for drug endangered children; and (3) development of a national training program to better serve drug endangered children. The DECTF has a number of subcommittees including one for tribal issues. The Tribal Subcommittee was formed in order to take into consideration the unique and special issues involving implementation of federal initiatives in tribal communities. The Tribal Subcommittee has been focused on developing a DEC training curriculum specific to Indian country. The curriculum development working group is being spearheaded out of the Justice Department's Office of Legal Education's National Indian Country Training Project. The initial curriculum development meeting was conducted July 6-8, 2011. In addition, the National Indian Country Training Project, the Office for Victims of Crime and BJA are working together so that limited resources may be used as efficiently as possible. Also, a collaborative effort ensures that any product developed by one component complements the efforts of the other two components.

The Tribal Subcommittee has also reviewed existing federal, state and tribal partnerships focused on DEC issues. One such example is the Native American Drug and Gang Initiative in the Eastern District of Wisconsin. This effort is a collaboration between Tribal law enforcement agencies and the Wisconsin Department of Justice's Division of Criminal Investigation. The initiative is intended to combat drug and gang activity on the reservations. The project includes both PL 280 and non-PL 280 tribes³. To date, all eleven tribes in Wisconsin have participated in a two-day training. Subsequently, four of the tribes have completed DEC policies and procedures documents with two of these tribes currently operating successful DEC programs. Lessons learned as part of the Wisconsin project will inform recommendations of the Tribal Subcommittee.

The National Alliance for Drug Endangered Children (National DEC)

³ Jurisdiction for investigating and prosecuting crimes in Indian country depends on, among other factors, the nature of the crime, location of the crime, and Indian/non-Indian status of the defendant and victim. The federal government has concurrent criminal jurisdiction with tribes in non-PL 280 jurisdictions. However, Public Law No. 83-280 gave six states criminal jurisdiction over crimes by or against Indians in Indian country.

National DEC, funded by BJA and the Office of Community Oriented Policing Services (COPS), provides leadership, strategic planning, training, and technical assistance to DEC alliances and network members to assist in the building of State DEC Alliances, Tribal DEC Alliances and community collaboratives. Over the past few years, National DEC has trained thousands of professionals to better recognize the risks faced by drug endangered children and to develop effective responses. Recently, the organization conducted an eight hour Core DEC Training to the Navajo Nation in Farmington, New Mexico. Since launching the Core DEC Community Awareness Training, National DEC has certified one-hundred and six trainers from all over the country to include three trainers who are Native American, can take the training into Indian country and can help spread the DEC message. National DEC also conducts an annual national conference, which includes a tribal component, and it hosts professional development webinars. The webinars include topics that are specific to prescription drug abuse as well as topics specific to tribal communities. A partial list of the thirty-five free webinars offered to date by National DEC is as follows:

- *Law Enforcement Perspectives on Building a Local DEC Collaborative*, presented by Lieutenant Eric Nation
- *Rescue, Restoration, and Reclamation – the Three “Rs” in Protecting Our Children*, presented by James Copple
- *Prescription Drugs and Drug Endangered Children*, presented by Special Agent Vic Routh
- *National Medical Guidelines for Children Removed from Meth Labs*, presented by Dr. John Martyny and Dr. Penny Grant
- *Impact of Trauma and Addiction on Drug Endangered Children*, presented by Carol Ackley
- *Treating Marijuana Disorders: Science and Practice*, presented by Denise Walker
- *The Role of Prevention in DEC Efforts*, presented by Loretta Wyrick Severin, Becky Swift, and Kendra Dunn
- *Drug Courts Primer*, presented by Meghan Wheeler, National Association of Drug Court Professionals
- *Prescription Drug Abuse*, presented by Dr. Steve Freng, Northwest HIDTA
- *Drugs of Abuse in Pregnancy and the Effect on the Fetus and Child*, presented by Dr. Jennifer Lowry
- *Identifying Drug Endangered Children from Law Enforcement and Child Protective Services*, presented by Betsy Dunn and Mitch Brown

- *Engaging Families with Children Affected by Substance Abuse in Tribal Communities*, presented by Nadja Jones, National Indian Child Welfare Association (NICWA)

National DEC's Online Resource Center features a searchable library of hundreds of research reports, articles, training presentations, protocols, and more. Currently, eighty-five reports, articles, and presentations relevant to DEC efforts in Indian Country are housed in the National DEC Online Resource Center. In addition to the online library, the National DEC Web site offers technical assistance to practitioners and community members through our "Ask an Expert" service.

Lamar Associates

In 2009, Lamar Associates partnered with the National Association of Drug Diversion Investigators (NADDI) to create the nation's first and only prescription abuse drug prevention training program for tribes. In 2011, the COPS program awarded Lamar Associates a grant to offer 22 additional training opportunities, both on-site and online, in partnership with NADDI and the National Indian Child Welfare Association (NICWA). The curriculum provides participants—including tribal leaders, law enforcement, health professionals, educators and high-risk youth ages 15-20—with culturally-appropriate training to restructure or realign existing resources, improve community policing strategies, and enhance capacity of tribes to prevent prescription drug diversion and abuse. Strategies for improving prescription drug monitoring in cooperation with IHS facilities and state PDMPs are critical to preventing prescription drug abuse in Indian country, and Lamar Associates covers this essential component extensively in the training.

By the completion of the COPS-funded training and technical assistance program, Lamar Associates expects to have trained an estimated 2,500 participants from over 100 tribes. Each participant completing the training is provided with materials to share with colleagues and community members. Lamar Associates also established social media sites to improve ongoing collaboration among tribes and with state and federal agencies. According to post-training evaluations, and participants' comments, participants find the training highly useful and relevant. Many commented that they planned to share the materials with schools, colleagues, governing bodies and offenders, and to apply the strategies and methods learned to better monitor prescription drugs and to prevent abuse and diversion among tribal members.

National Congress of American Indians (NCAI)

BJA is supporting NCAI in its efforts to improve the ability of tribal law enforcement to combat methamphetamine and pharmaceutical crime investigation through improved training on this topic. Specifically, NCAI's goals are to improve the ability of tribal law enforcement agencies to combat methamphetamine use and production, as well as pharmaceutical drug fraud and diversion in their communities. NCAI is tailoring existing training to address methamphetamine and pharmaceutical drug abuse, and is planning to hold 10 regional trainings. NCAI will also provide follow up technical assistance to assist agencies in changing policies as necessary and developing advisory groups on these issues.

PACT 360

BJA is supporting outreach initiatives to educate the public on the dangers of drug abuse and on take-back programs to reduce the availability of prescription drugs to those who would use them for non-medical purposes. Through a project with the Partnership for a Drug-Free America (herein referred to as “the Partnership”), law enforcement agencies across the nation are collaborating with other stakeholders to educate their communities about the dangers of substance abuse and to provide information and resources to empower parents, teens and concerned citizens to address these threats.

PACT360, a Partnership drug abuse prevention program, invites teams of local law enforcement personnel, drug treatment specialists, and drug abuse prevention experts to educate communities on local drug problems and provide tools to address substance abuse locally. BJA is currently exploring the possibility of adapting the PACT360 module in order to provide tribal communities with a prevention program that meets their needs.

DEA National Take Back Initiative

National Prescription Drug Take Back Days address a vital public safety and public health issue. Millions of Americans currently abuse prescription drugs. And, studies show that a majority of abused prescription drugs are obtained from family and friends, including the home medicine cabinet. The DEA has scheduled another National Prescription Drug Take Back Day for Saturday, October 29, 2011; this event will provide a venue for persons who want to dispose of unwanted and unused prescription drugs. Persons wanting to reduce the amount of unwanted controlled substances in their homes currently have few disposal options beyond discarding or flushing the drugs, which are not appropriate disposal methods. The DEA is doing significant outreach in Indian country for the October event, and they are working with tribal law enforcement to develop drop-off sites on reservations. Earlier events in September 2010 and April 2011 involved nearly 4,000 state, local and tribal law enforcement agencies throughout the nation with more than 309 tons of pills collected. Therefore, it is expected that the October 2011 National Take Back Day will serve to reduce homes in Indian country of unused and unwanted prescription drugs.

DEA’s leadership on the Take Back Initiative is critical as Congress passed the Safe and Secure Drug Disposal Act of 2010. This legislation amended the Controlled Substances Act and required DEA to develop a process for people to safely dispose of their prescription drugs. Per Section 2 of the Safe and Secure Drug Disposal Act of 2010, “take-back programs often cannot dispose of the most dangerous pharmaceutical drugs – controlled substance medications – because Federal law does not permit take-back programs to accept controlled substances unless they get specific permission for the Drug Enforcement Administration and arrange for full-time law enforcement officers to receive the controlled substances directly from the member of the public who seeks to dispose of them.” The goal of the Safe and Secure Drug Disposal Act of 2010 is to encourage the Attorney General to “set controlled substance diversion prevention parameters that will allow public and private entities to develop a variety of methods of collection and disposal of controlled substances, including some pharmaceuticals, in a secure, convenient, and responsible manner.” DEA has been actively involved in the drafting of federal

regulations to implement the law for nearly a year now. Until that process is complete, the DEA will continue to hold Take Back Days.

The Justice Department looks forward to continued collaboration with IHS, ONDCP and grant-funded training and technical assistance providers to heighten consumer and provider knowledge about the dangers of prescription drugs and the benefits of PDMPs.