2021 Update: COVID-19 & the Pivot to Telehealth

An Environmental Scan of Tribal Opioid Overdose Prevention Responses: Community-Based Strategies and Public Health Data Infrastructure

October 2021

SEVEN DIRECTIONS
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Acknowledgments

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1. Introduction: An Update of Seven Directions' 2019 Environmental Scan of Tribal Opioid Overdose Prevention Responses

Since the publication of the Environmental Scan in 2019, tribal and urban Indian communities have been significantly impacted by the collision of the ongoing opioid crisis and the COVID-19 pandemic. The COVID-19 pandemic has represented changes and challenges for tribal opioid overdose prevention programs, and at the same time, created new opportunities and pathways to prevention, treatment, recovery and support care coordination. This brief updates the Environmental Scan (2019) and the Models of Tribal Promising Practices brief (2020) with COVID-19-induced and telehealth-specific programmatic pivoting for opioid use disorder (OUD) services that many tribes, tribal programs, tribal epidemiology centers (TECs) and urban Indian health programs undertook in 2020 and 2021.

This report is intended to provide an overview of the pandemic's impact on American Indian and Alaska Native (AIAN) communities and substance use disorder (SUD) and OUD programming. While information is still limited, the challenges, successes, and stories shared here reveal adaptations that began for most tribal communities in March 2020.

2. Sources Consulted to Update Scan

Information was gathered from four diverse sources for this environmental scan update:

1. Review of existing peer reviewed literature, grey literature, and web-based publicly available information;
2. Key informant interviews with the CDC's Center for State, Tribal, Local, and Territorial Support (CSTLTS) tribal recipients (CDC-RFA-OT18-1803) and the Project Manager for the Tribal ECHO Opioid Response Projects at Northwest Portland Area Indian Health Board;
3. Presenters and participants in a dozen virtual Seven Directions' Gathering Grounds Indigenous Community of Practice sessions from March 2020 to July 2021; and
4. Seven Directions' 13-member Opioid Technical Advisory Group's meeting on June 22, 2021.

As the COVID-19 pandemic continues, its impact on SUD/OUD and behavioral health services is substantive and constantly changing. Available research and evaluation literature still contain major gaps, but in combination with key informant interviews and peer sharing sessions, we are able to provide a thorough picture of the current landscape.

* Tribal in this report includes American Indian and Alaska Native communities on reservations, Alaskan villages, and urban areas.

3. Literature Review

COVID-19 Impact in AIAN Communities

The COVID-19 pandemic has had a disproportionate impact on AIAN communities across the country with high death rates and severe economic consequences stemming from closed reservation borders and lockdowns. Tribes and tribal communities experienced high numbers of deaths early in the pandemic: CDC data show that between January and June 2020, AIAN were 3-5 times more likely to be diagnosed with COVID-19 than non-Hispanic whites [1,2]. Other estimates show the COVID-19 death rate for AIAN between the ages of 30-49 was ten times higher than whites [3].

As of August 2021, the age-adjusted infection rate for AIAN was 1.7 times higher compared to non-Hispanic whites; age-adjusted death rate was 2.4 times and age-adjusted hospitalization rate was 3.5 times higher [4]. This high rate of loss of life represents the loss of cultural knowledge, language, and history with the deaths of many elders [3]. Tribes are also facing the cost of closures: the shutdowns through early May 2020 cost $4.4 billion in lost economic activity and almost $1 billion in lost wages [5].

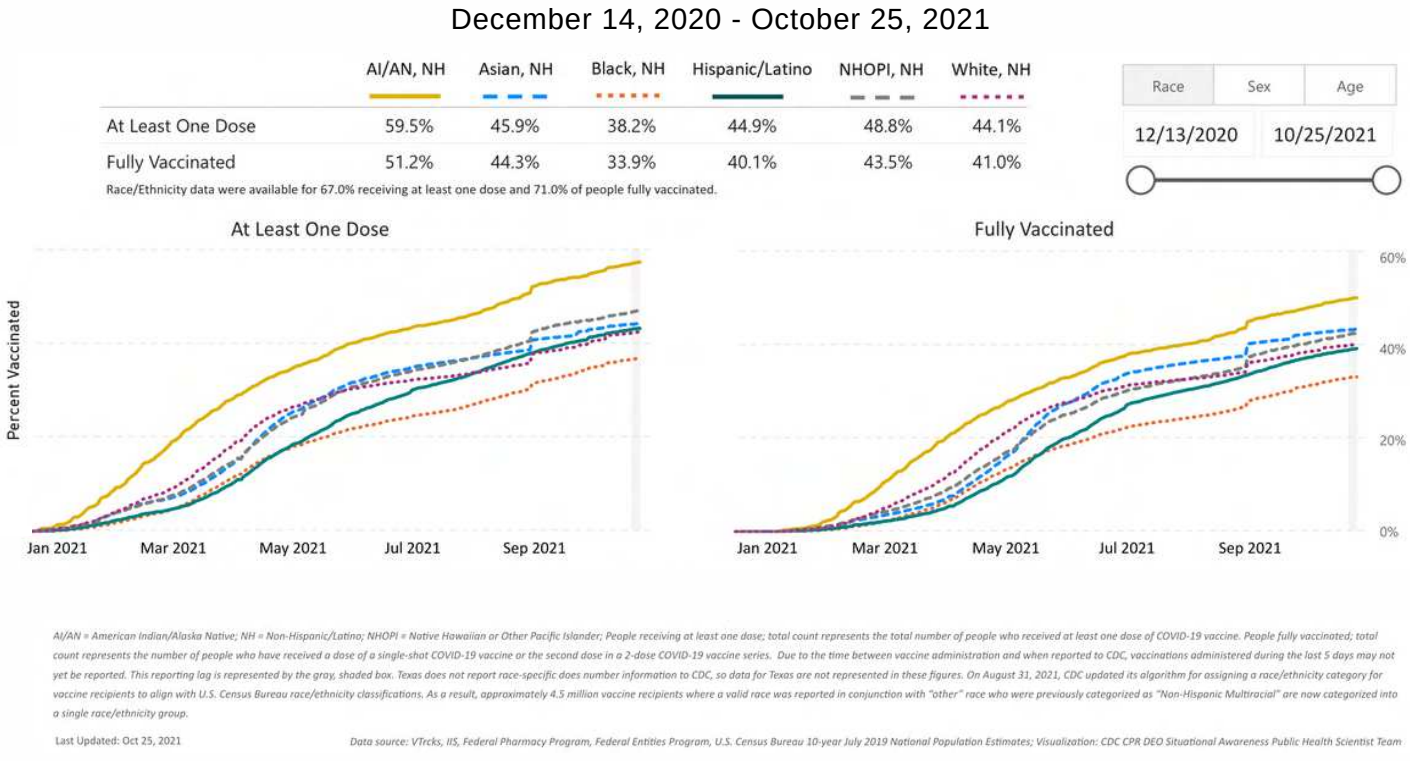
In anticipation of COVID-19 vaccines becoming available during Winter 2020-2021, tribal leaders, tribal health programs, and communities continued efforts at protecting tribal citizens from the virus with an eye toward recovery and rebuilding from the pandemic. They also strengthened their public health infrastructure to facilitate vaccination communications, access, and delivery. As a result, when the vaccines became available in phases, AIAN communities were among the first to take advantage of and achieved high rates of vaccination [6].

But like the rest of the country, vaccine rates have slowed (Figure 1). The American COVID-19 Vaccine Poll surveyed over 12,000 Americans to understand their vaccine access, opinions and reactions to vaccine messaging (AIAN sample size 1,921, margin of error +/-2.2%). Overall 39.9% of AIAN participants were hesitant to get the vaccine. Unvaccinated AIAN were concerned that:

- the Johnson & Johnson Janssen vaccine causes blood clots (38.3%);
- President Biden distributed unproven vaccines (30.5%);
- the vaccine makes people sick (30.5%);
- a belief in a personal right to opt out (28.6%); and
- Former President Trump rushed to unproven vaccines (26.8%) [7].

Respondents identified “Getting a COVID-19 vaccine can protect the lives of my family, friends, and those I love” as the most convincing message to get vaccinated (34% effective) [7]. This aligns with the results from the Urban Indian Health Institute’s January 2021 COVID-19 vaccine survey which identified a “strong sense of responsibility to protect the Native community and preserve cultural ways” as the primary motivator for AIAN to get the COVID-19 vaccine [8].

Figure 1. Percent of People Receiving COVID-19 Vaccine by Race/Ethnicity and Date Reported to the CDC, United States



Source: Center for Disease Control. Provisional Drug Overdose Death Counts. Retrieved October 20, 2021 from: https://covid.cdc.gov/covid-data-tracker/index.html#vaccination-demographics-trends

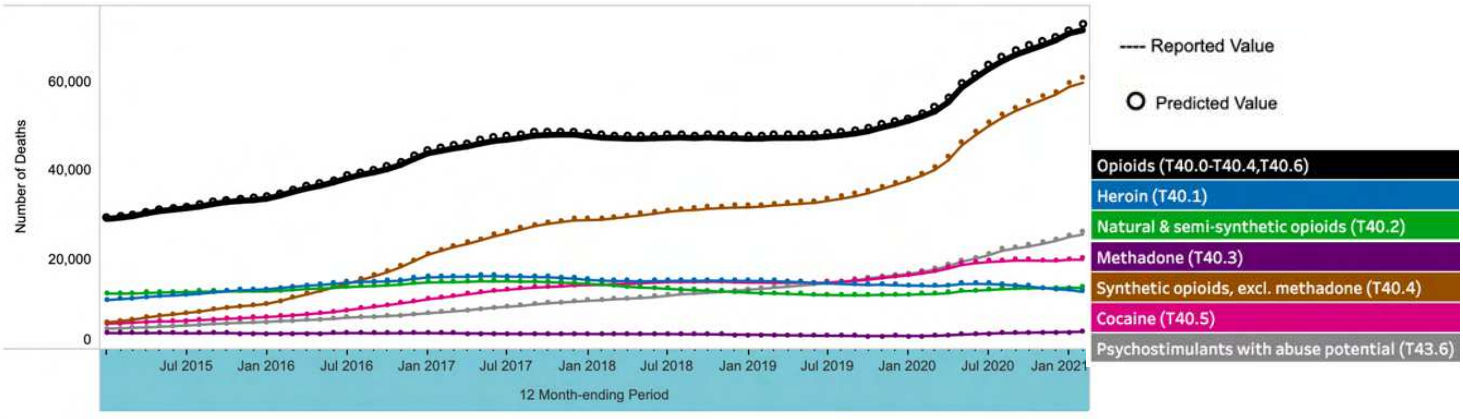
By September 2021, vaccine rates began to rise again, perhaps partly due to the highly contagious Delta variant making up an estimated 99% of COVID-19 variants circulating in the U.S. [9,10]. Even before President Biden's vaccine mandate on September 9, 2021, some states, employers, and tribes began enforcing vaccine mandates. The federal mandate requires all federal employees, contractors, and all employers with more than 100 employees to demonstrate vaccination or implement weekly COVID-19 testing. A recent Kaiser Family Foundation poll found that the emergence of the Delta variant and hospitalizations and deaths was the biggest motivator of the increase in vaccinations, while vaccine mandates and FDA approval were less influential [11]. But by October 2021 it is clear that vaccine mandates are working and workplaces implementing them are achieving high vaccination rates [12].

A Collision of Two Epidemics: COVID-19 & Opioid Use Disorder & Overdose

Pre-pandemic data collected between 2016 and 2019 indicate that opioid use disorder remains stable across all ages in the AIAN population (approximately 1-2%) and access to medication assisted treatment has increased [13]. However, recently released provisional national data across all races and ethnicities show an increase of 29.7% in drug overdose deaths, with reported overdose deaths totaling 95,133 in February 2021, up from 73,344 in February 2020 at the start of the pandemic [14]. This is the highest recorded increase in drug overdose deaths in a single year, and the highest number of recorded deaths in a 12-month period.

Deaths due to opioid overdose continued to increase during the pandemic (Figure 2). The isolation wrought by pandemic restrictions in combination with reduced treatment options and an increase in illicitly manufactured fentanyl meant people were facing more challenges and less able to get the support they needed [15]. In addition to restricted support services, care-seeking might have been lower due to concerns about COVID-19 [16].

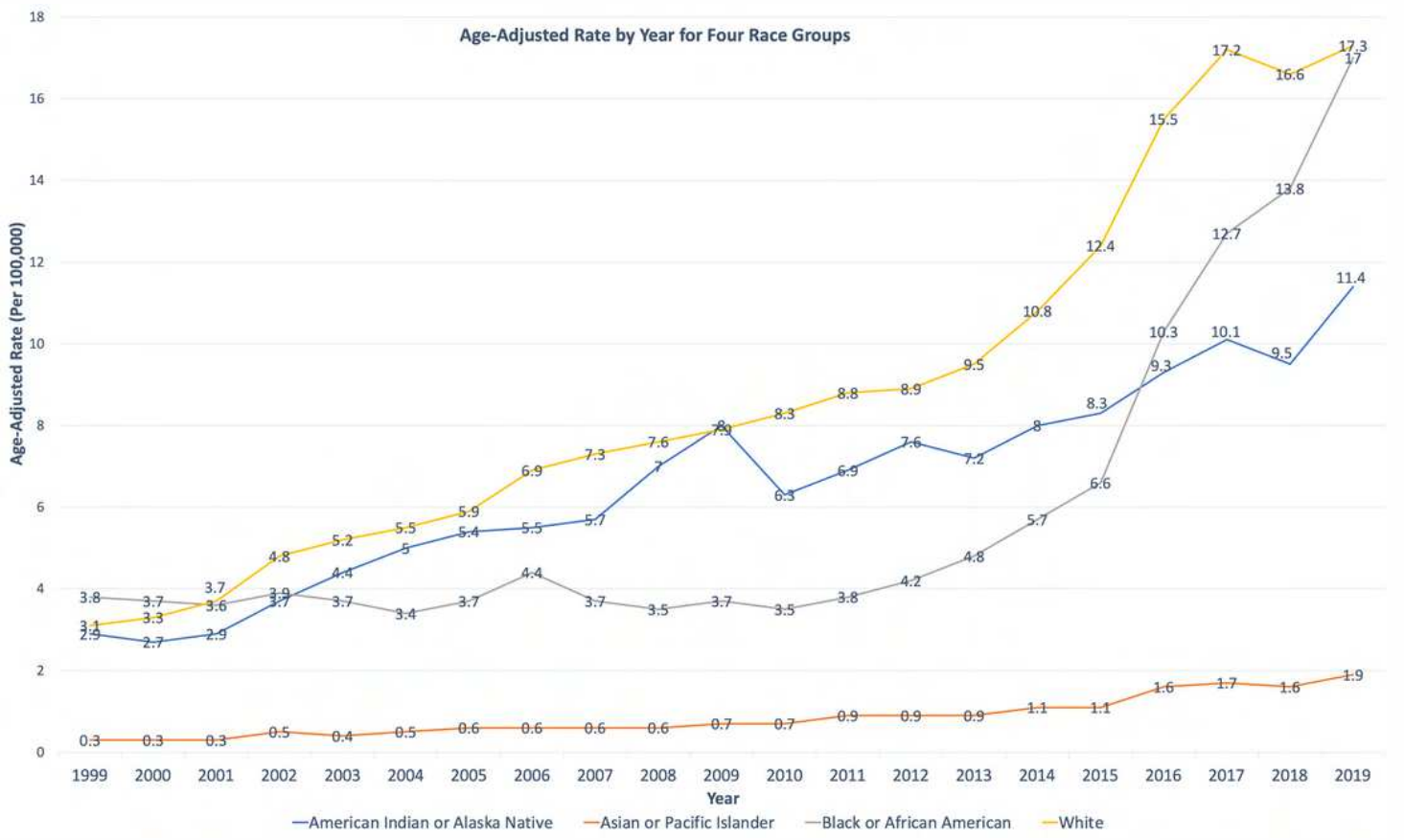
Figure 2. 12 Month-ending Provisional Number of Drug Overdose Deaths by Drug or Drug Class



Source: Center for Disease Control. (September 5, 2021). Provisional Drug Overdose Death Counts. Retrieved September 30, 2021. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Available data (Figure 3) suggest that AIAN people experienced one of the largest increases in drug and opioid-involved overdose mortality rates between 2018 and 2019 compared with other racial/ethnic groups.

Figure 3. Opioid Overdose Mortality in the US, 1999-2019 by Race/Ethnicity



Source: Death 1999-2019 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999-2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. MCOD codes include T40.0 (Opium); T40.1 (Heroin); T40.2 (Other opioids); T40.3 (Methadone); T40.4 (Other synthetic narcotics); and T40.6 (Other and unspecified narcotics). Retrieved July 29, 2021. http://wonder.cdc.gov/mcd-icd10.html

Though the available data are compelling, racial misclassification of AIAN people continues to present a barrier to an accurate picture of the true crisis [17]

For example, the Washington State June 2021 Behavioral Impact Statement noted a 26.8% misclassification rate of hospital visits for AIAN people from May 15 - September 15, 2021 (9,443 hospital visits in Washington were classified as another race) [18].

Telehealth During the Pandemic

With behavioral health services pivoting to telehealth during the pandemic, the limited options for AIAN experiencing SUD/OUD changed. Some populations experienced an increase in care options via telehealth while many, especially Elders, discovered even more barriers to care with technological challenges, lack of internet access to support telehealth, and transportation challenges. According to the Center for Medicare and Medicaid Services (CMS), telehealth rates increased from February through April 2020 and remain higher than before the pandemic. Services delivered via telehealth were highest among working age adults, followed by children, and then older adults [19].

Although minimal information is available to assess how well telehealth is working for tribal communities, a few states with high AIAN populations provide some insight into the impact of telehealth services. Washington State's June 2021 COVID-19 Behavioral Health Impact Situation Report for all people living in Washington provides an overview of telehealth usage for behavioral health services among Medicaid clients. Beginning in March 2020, there was a significant increase in telehealth usage than before the start of the pandemic (237.6%) which may have been impacted by Washington's "Stay Home, Stay Healthy" order. December 2020 (the most recent reporting period) showed a 12% increase of telehealth behavioral health services use claims compared to November 2020 [18]. When the data are stratified by age, usage is highest among the 19- 44 (14%) and 45-65 (13%) age groups, and lowest among 18 and younger (8%) and 65 and older (5%) [18].

Other states with high AIAN populations reported similar telehealth usage. When Medicaid expanded coverage for telehealth services during the pandemic in Montana, behavioral health visits increased by 1,400% [20]. In New Mexico, therapists have noted improved appointment attendance: 90% of patients continued treatment and the no-show rate dropped from around 40% to less than 10% [21].

In Minnesota, providers said that telehealth [22]:

Made it easier for patients to access services and involve family members.

Gave providers more time to serve more clients/patients by eliminating the commute between provider sites.

Decreased the number of patient/client "no-shows" and late arrivals.

Increased access to services for patients who would otherwise not access care due to travel barriers, including their illness, lack of transportation, lack of child/senior care, or level of motivation.

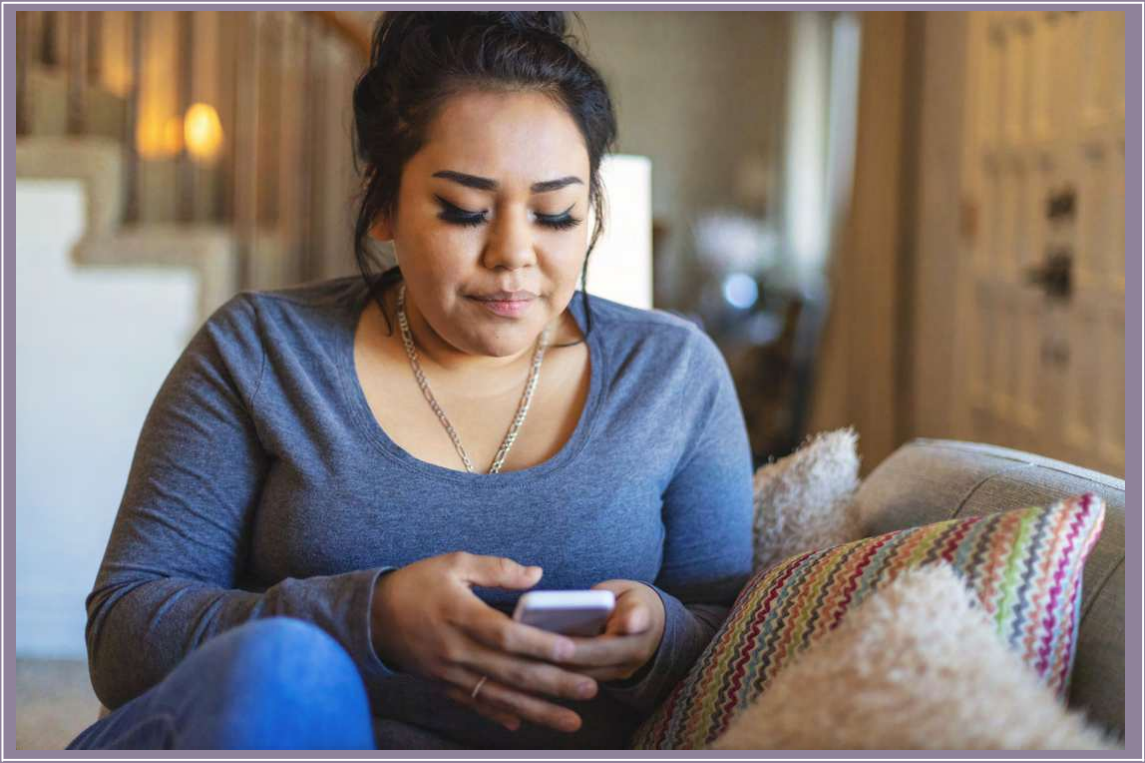
Received positive feedback from metro county ethnic minority groups and rural tribal recipients, who noted that telehealth improves "equity in access to healthcare" and that it was preferable for telehealth via telephone rather than the internet.

A review of Minnesota Medicaid claims data showed that 30% of patients utilized telehealth for behavioral health resources during the pandemic, an increase of 6% from March 2020. Focus group data showed that telemedicine appeared to work well for young to middle aged adults but presents challenges for seniors (barriers to technology) and children (difficult to engage) [22].

Preliminary reports suggest that COVID-19 safety measures present opioid treatment programs with the opportunity to restructure outdated methods of care [23]. In particular, patients receiving medication assisted treatment (MAT) have historically encountered tight regulations in regards to daily face-to-face prescription fills and complicated pre-authorization requirements. While these requirements are in part grounded in necessary overdose prevention precautions for medications like methadone, they also represent the stigma and procedural inflexibility associated with MAT. Recent articles suggest that the following COVID-19 adaptations should be considered as permanent changes to MAT: utilize telehealth in place of required in-person initial evaluation and follow-up approval visits; co-prescribe naloxone, an opioid reversal agent, to mitigate overdose for those at high risk; and utilize newer, long-acting injectable formulations of buprenorphine [23,24].

Three national organizations focused on tribal health stepped forward early in the pandemic to provide guidance and support to tribal communities as they transitioned from in-person behavioral health services to telehealth. The Indian Country ECHO Substance Use Disorder Program, run by the Northwest Portland Area Indian Health Board, offers didactic and case presentations as well as information sharing by peers and topical experts and has been very involved in telehealth training and support [25]. The National AIAN Addiction and Technology Transfer Center Network, as well as the Prevention Technology Transfer Center, acted quickly to train the AIAN behavioral health workforce, offering virtual learning guides, webinars, a short training series as well as peer examples [26,27]. Their websites are kept up-to-date with new resources and information on ongoing training and webinar opportunities.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act includes funding to increase access to and support for telehealth SUD/OUD services with $200 million appropriated to the COVID-19 Telehealth Program at the Federal Communications Commission. This funding is intended to help providers (including healthcare providers on tribal lands, associated with an Indian Tribe, or part of the Indian Health Service) to offer telehealth services. An additional $249.95 million was appropriated in June 2021 [28].



4. Emerging Themes from COVID-19's Impact on Opioid Overdose Prevention

As Seven Directions connected with tribal communities regarding OUD work during the pandemic, four areas were consistently impacted due to the COVID-19 pandemic: (1) provision of services, (2) changing projects and priorities, (3) rebuilding and strategic planning, and (4) the shift to telehealth and use of technology.

COVID-19's Impact on the Provision of Services

AIAN-serving organizations report that the opioid crisis has worsened during COVID-19. As the opioid crisis grows, health services in general are overwhelmed. There have been reductions in staff and turnover due to COVID-19. Practitioners have difficulty identifying people at risk since they are no longer sending outreach workers inside homes. At the same time, there has been reduced provision of, and access to, health care. There is an increased need for SUD/OUD services but there are shortages of counseling and mental health staff in rural areas as well as concurrent COVID-19 related challenges such as the lack of childcare. Some of these challenges existed prior to the pandemic, such as the lack of behavioral health providers and stressful working environments.

As resources shifted to COVID-19 mitigation, OUD programs were often moved to the back burner. OUD staff became frontline workers responding to basic needs. Many prevention activities, especially youth activities, were put on hold to limit the spread of COVID-19. Disinformation became prevalent during COVID-19 pandemic and mistrust of both official and unofficial sources grew. There is a great need for public relations and improved health communication especially around complex subjects, such as MAT. On many occasions, hard-won partnerships were negatively impacted as communication and interactions decreased across departments, task forces, and coalitions.

Project & Priority Changes

Many tribal OUD programs moved in-person programming to virtual platforms. This included both service-oriented work such as wellbriety meetings (a term coined by AIAN sobriety group White Bison to mean sober and well) and administrative functions like site visits and sub-awardee meetings [29]. While some programs delayed programming or put it on hold (see below), others shifted away from manualized interventions to web-based interventions, recognizing the opportunity for permanent change. With limited availability from outside partners, some programs repositioned their focus from external collaboration to internal infrastructure and capacity building.

Some services continued in-person which necessitated changes in patient and provider flow, along with clinic policies and procedures, in order to adhere to COVID-19 safety protocols including reduced capacity guidelines. Transportation services were adjusted to lower the number of people in each vehicle and patient schedules were spaced out so that fewer people were in the clinic at the same time.

Tribal communities have been creative in connecting their opioid education efforts to COVID-19 support including combining OUD informational materials and activities with giveaways of hand sanitizer and food bags. One tribe distributed naloxone at vaccination sites and another began discussing naloxone as prevention, similar to vaccine education. Broadly, COVID-19 has initiated community conversations about the need to communicate, seek opportunities, and take action. There has been an increase in data-informed decision making, data and health communications, and an increased investment in integrating new information into programs and priorities. One tribe conducted a COVID-19 community health survey, including behavioral health needs, through a drive-through community recruitment strategy.

Rebuilding & Strategic Planning

By October 2021, eighteen months after the first major pandemic response implementation across a wide swath of the United States, many tribal communities are still focusing on vaccination efforts, general recovery and rebuilding, and prevention and protection from variants of the coronavirus. Some tribes, namely, the Coeur d'Alene Tribe, have exercised their sovereignty and public health authority to pass vaccine mandates for all employees in an effort to prevent the cycle of infection due to new variants (i.e., Delta, Delta-plus, Lambda, and Gamma). Others are working to implement federal and state requirements and guidelines. Safety concerns persist with new variants and a significant percentage of the population unwilling to be vaccinated. The constantly mutating coronavirus has necessitated several updates in public health guidelines, which has led to time lags or differences between local and federal guidelines.

Despite these challenges, AIAN people have the highest vaccination rate in the country [6].

Some programs, including tribal behavioral health programs, are beginning to transition back to full staffing levels and providing support. They are beginning to rebuild and assess their next move as OUD programmatic priorities or tribal priorities may have shifted.

Shift to Telehealth & the Use of Technology

As tribes and tribal communities went into lockdown or restricted interactions in 2020, tribal clinics and programs increased their telehealth options. Tribal members and program staff had to quickly learn ways to maximize technology to provide accessible services. Tribes began conducting virtual training and/or online community engagement activities and provided funding for technological tools (laptops, iPads, cell phones). In small tribal communities where privacy may be an issue, both clients and service providers had to be creative in maintaining confidentiality during telehealth sessions. While the CARES Act and other similar legislation have the potential to improve internet availability, many structural inequities remain. Lack of cell phone service coverage and limited broadband access pose significant challenges to accessing telehealth services and cannot be overcome simply by purchasing technological tools. Rural, remote tribal communities may benefit the most from telehealth resources, yet the continued lack of access remains a substantial barrier to fully realizing these benefits.

Highlight: Tulalip Tribes

In 2020, the Tulalip Tribes in Washington State introduced **Overdose Detection Mapping & Application Program (ODMAP)** to track real-time overdoses and treatment and send outreach workers with follow-up resources. It is part of their overall initiative to address SUD/OUD that includes reducing barriers to recovery and virtual community naloxone trainings, which are followed by a doorstep delivery to participants.

Much of the programming has been designed to overcome COVID-19 related barriers. For example, the naloxone dispersal initiative was created to not only make naloxone more accessible, but to allow Tulalip to distribute naloxone while still abiding by COVID-19 safety measures and keeping vulnerable populations safe, especially the Elders in the community. It allowed the team to bring the naloxone to doorsteps rather than coming to a central location. During this time, Tulalip also shared naloxone training videos via Zoom with community members, instead of meeting in-person.

The overdose mapping tool has been a critical resource for the ODMAP team to identify hotspots and trends in the community, especially with the potential increase in overdose due to the fentanyl crisis and multi-level COVID-19 impact to individuals, families, and health service systems. The vital data embedded in the mapping tool assists the team in coordinating resource deployment in areas of most need.

This tool has also allowed the team to analyze the data and make conclusions regarding the fentanyl crisis that continues to devastate many communities. For example, among the fatal overdoses documented by the overdose mapping tool in Tulalip, all have fentanyl listed as the primary suspected substance. The team is using the data and responding with an educational campaign that will align with a community event and candlelight vigil for National Overdose Awareness Day.

Visit https://www.tulaliptribalcourt-nsn.gov/ProgramsAndServices/NarcanTraining for more details.

5. Conclusion & Recommendations

This COVID-19 and telehealth update to the Seven Directions Environmental Scan (2019) is a reflection of tribal communities' efforts to simultaneously address the two epidemics of COVID-19 and drug overdoses since March 2020. Tribal OUD programs have put numerous programs and activities on hold, shifted to providing emergency services, developed strategies to maintain programming, and pivoted to telehealth. We acknowledge the losses and hardship of the past 18 months and at the same time, recognize the strength, resilience, and innovation that has carried tribal communities so far.

Through Technical Assistance, Gathering Grounds (a virtual Indigenous Community of Practice), and our OTAG, we are continuously assessing how we can best support our tribal partners and best practices in OUD programming and care coordination. We anticipate addressing the following areas of interest in the upcoming year:

1. Strategic planning;
2. Data opportunities, visualization and cross-sharing including national, regional and community-level AIAN OUD data;
3. Culturally-anchored public health communications;
4. Supporting telehealth needs;
5. Rebuilding relationships;
6. Expanding models of OUD tribal promising practices; and
7. Ensuring OUD programs are prepared for new funding opportunities.

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7. Resources

Self-Care

Tips for Managing Stress

- SAMHSA Wallet Card for stress management and phone helplines.
- Resource List for COVID-19 fatigue.

Compassion Fatigue/Provider Burnout

- Recommendations for addressing physicians' pandemic stress.
- Free support for physicians, front line/healthcare workers, and essential worker seeking mental health assistance.

Coping with Loss & Grief

- Native Spirituality: Creating Time and Space for Trauma Recovery and Wellness by the Mental Health Technology Transfer Center (MHTTC) Network.
- Children and grief during COVID-19.

Telehealth

Integrating telehealth service in the current clinic workflow to ensure a consistent patient experience.

- Indian Health Service Toolkit for establishing telehealth services is a useful starting point to begin mapping the clinic environment and identifying issues of telehealth compatibility and processes that may need alignment.
- Project ECHO provides online training on the adoption of telehealth across several topics.
- The Institute for Healthcare Improvement offers many free trainings and a list of COVID and telehealth specific resources. For example, they link to sites like the Center for Care Innovations, which has free clinic flow guides, as well as several online events, including a conference the week of Nov. 11.
- The Rural Health Information Hub offers a telehealth toolkit.

Indigenizing Communications During COVID-19

- **Seven Directions Gathering Grounds**: Resource Handout for indigenizing resources referred to in the Gathering Grounds session with Apryl Deel-McKenzie and Pearl Walker-Swaney. Handout identifying organizations, examples of indigenized communications and downloadable COVID-19 related resources.

- **Native Governance Center**: Indigenized Communication During COVID-19 with Native Governance Center Apryl Deel- McKenzie (Diné, MSW) and Pearl Walker-Swaney (White Earth Nation and Standing Rock Sioux Tribe, MPH) from Native Governance Center share five Indigenous values to hold when developing communications during COVID-19.

- **Johns Hopkins Center for American Indian Health**: Indigenized communications for COVID-19 including: Q&A social media toolkits, radio transcripts, and educational materials for a range of topics that can be circulated by print or web.

- **Harvard**: COVID-19 Resources Toolbox This toolbox features a "tip of the day," radio transcripts, fact sheets, community resource, policy briefs, and examples of Tribal-led COVID-19 response.

- **Albuquerque Area Southwest Tribal Epidemiology Center:** COVID-19 Educational Materials Breaking news, public health alerts, and indigenized communications for COVID-19 educational materials for all ages - coloring pages included!

- **National Indian Health Board:** Vaccine Information & Tribal Support The National Indian Health Board is leading a national effort to advocate and secure resources for Tribes to respond to COVID-19. NIHB seeks to ensure that the Tribes remain informed on COVID 19, have the resources and assistance needed to respond to the pandemic, and that the Congress and Administration understand and address Tribal needs and priorities.

Medication-Assisted Treatment (MAT) Program Implementation

Using in-person or telehealth, or a combination, AND determining whether to provide induction and/or micro- dosing.

- SAMHSA provides broad technical assistance free to federally-recognized tribes on behavioral health program development and implementation.

- The Northwest Addiction Technology Transfer Center offers multiple online training videos addressing the use of telemedicine to support opioid addiction recovery.