

Models of Tribal Promising Practices

Tribal Opioid Overdose Prevention Care Coordination and Data Systems

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SEVEN DIRECTIONS

A CENTER FOR INDIGENOUS PUBLIC HEALTH

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About Seven Directions

We are a public health institute committed to the health & wellness of Indigenous communities.

We are the first national public health institute in the United States to focus solely on improving Indigenous health and wellness. We are committed to cultivating and sharing knowledge, connecting communities and resources, and working to achieve shared goals for future generations.

We are dedicated to transforming Indigenous public health practice through culturally grounded, innovative programs and services that will:

- Honor Indigenous knowledge and understandings of public health.
- Remain active, and enthusiastically seek and share knowledge with others.
- Build relationships with those who share passion for public health.
- Contribute to innovation and creativity within the field.
- Seek opportunities to understand what improves Indigenous health.
- Generate resources – models, tools, and information – to develop our practice.

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Purpose

The purpose of this brief is to feature four models of Tribal Promising Practices addressing Opioid Use Disorder (OUD) and opioid overdose prevention. These models are derived from the frameworks of broader approaches which are also described here. A review of key elements of tribal care coordination and data infrastructure development strategies implemented by these models is included. Addressing the opioid epidemic requires removing barriers to prevention in American Indian and Alaska Native (AI/AN) communities through culturally-relevant, comprehensive, and holistic approaches led by tribes and supported by access to data, funding, and resources. Many tribes and urban Indian organizations have led such efforts while utilizing empirically supported prevention and treatment strategies.

Highlighting Tribal Promising Practices to reduce OUD and prevent opioid overdose is a necessary first step towards healing and wellbeing. As such, this brief serves both as a resource and dissemination tool for four models of Tribal Promising Practices with a goal to reach other tribal and urban Indian communities of practice who may be exploring approaches to incorporate into their own programs. Oftentimes tribal approaches are not covered in peer-reviewed literature or other publications, limiting the opportunities to learn from practice-based evidence and the experiences of those implementing adapted versions of evidence-based practices. The intended audience for this brief includes federal, state and local agencies, funders, researchers, evaluators, and any organization or individual interested in Tribal Promising Practices that address AI/AN OUD and Opioid overdose prevention, treatment, recovery, healing, and wellbeing. Other models will be highlighted in future briefs.



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Introduction

The COVID-19 pandemic exacerbates and underscores the detrimental impact of the opioid epidemic on American Indian and Alaska Native (AI/AN) communities. The opioid epidemic is an on-going public health crisis in AI/AN communities across reservations and urban areas. The result of intersecting and cumulative impacts of social and health inequities, the opioid epidemic requires a multi-level, multi-pronged, social determinants of health approach that includes evidence-based practices (EBPs) with a focus on prevention, treatment, and recovery strategies. These EBPs should be based on a care coordination and data decision framework. The evidence suggests that existing EBPs that have been found to be effective in mainstream populations and applied in AI/AN communities without cultural contextualization do not offer similar successful outcomes. Therefore, in the last three years, several federally coordinated tribal opioid response efforts that include service delivery, capacity building, and research specifically call for integration of culturally responsive strategies.

Tribal leaders and AI/AN communities, however, recognized the opioid crisis in their communities long before the U.S. federal government declared the opioid epidemic a national emergency (Magarati et al., 2019). Tribes have been at the forefront of developing, testing, and evaluating innovative, strengths-based, culturally-responsive, and contextually-relevant promising strategies in combination with EBPs in the last 20 years. These Tribal Promising Practices were developed using an Indigenous lens to meet the needs of AI/AN individuals, families, and tribal and urban Indian communities. They include an Indigenous Harm Reduction approach, a Peer Support approach, an Indigenous Integrated Healthcare approach, and a combination Mixed Harm Reduction and Integrated Healthcare approach.

This document is written for community members, tribal and organizational leaders, and healthcare professionals at the forefront of the opioid epidemic to better inform the development and application of culturally-relevant opioid prevention, treatment, and recovery practices. It is the first document to delve into and compare “promising practices” of programs that include three critical components: tribal care coordination, data management, data infrastructure, or a combination of these.

Our research included a review of scientific literature, publicly available web-based information on many innovative programs that tribal health departments are undertaking, and interviews with leaders of four programs. Our analysis of these programs revealed that efforts are operationalized under three key domains of practice-based and health care system-based tribal care coordination: (a) Indigenous-centered praxis; (b) relationships; and, (c) capacity development, which include the following ten tribal promising practice themes: (1) cultural fit, (2) innovative practice, (3) knowledge sharing, (4) cross-sector collaboration, (5) meeting community needs, (6) community investment, (7) leadership, (8) professional and cultural development, (9) sustainability, and (10) data infrastructure. We provide definitions and descriptions of how these domains drive OUD treatment and opioid overdose prevention efforts among four tribal communities.

This document examines how the four models of Tribal Promising Practices: Harm Reduction, Peer Support, Service Integration, and mixed Harm Reduction and Service Integration rely on tribal program components of tribal care coordination, data management, and data infrastructure. This brief is designed to support knowledge sharing across tribal communities to address the opioid epidemic in AI/AN communities.

Methods

The following section provides the methods used to identify four approaches of Tribal Promising Practices in OUD and overdose prevention. We relied on a series of information gathering steps that included: (1) a scientific and grey literature review which culminated in the first national environmental scan of Tribal opioid response (Seven Directions, 2019); (2) consultation with and feedback from our Tribal Opioid Advisory Group (OTAG) consisting of national, tribal and university experts; (3) consultation with local, regional, and national experts in OUD and opioid overdose prevention and, (4) two series of semi-structured key informant interviews.



Interview Data Collection

Given the gap in the scientific and grey literature, we completed an exploratory, qualitative study of tribal opioid approaches to better understand how tribal contexts, cultures, and communities informed decision making in OUD treatment / opioid overdose prevention program development and implementation. Our aim was to establish common approaches and to describe the frameworks tribes relied on to achieve positive outcomes.

Series 1. In Fall 2019, we interviewed ten individuals representing tribal community leaders, service providers, and public health professionals serving on regional health boards and in tribal epidemiology centers (see list in Acknowledgment on p.2). The ten participants were selected based on their involvement in opioid overdose prevention work in tribal communities, the geographic region of the U.S. within which they work, and the tribal community served. This includes individuals serving on or who were referred by the project's OTAG. Interviews of 30 to 45 minutes were audio recorded with the interviewees' permission and transcribed using the Temi mobile application. The interviews focused on goals, cultural relevance, successes, barriers, and future needs regarding these four areas: programs and services, data infrastructure and systems, strategic planning, and communities of practice (see Appendix A). The Seven Directions team analyzed the transcripts via a discussion process called affinity mapping, in which similar or related insights are grouped together in order to identify overarching themes. This process, in combination with the literature review, resulted in the identification of ten key practice-based and health care system-based themes that underlie Tribal Promising Practices in OUD Care Coordination.

Series 2. We developed a revised interview guide to include these findings (see Appendix B), and conducted a second series of interviews in the first half of 2020 during the COVID-19 pandemic. Directors of four tribal opioid overdose prevention programs participated. These interviews lasted from one to three hours, and focused on the ten tribal practices themes within the care coordination framework. In particular, we were interested in uncovering culturally-responsive strategies and data systems related to OUD treatment and opioid overdose prevention. The analysis supported the description of approaches of Tribal Promising Practices in this brief. The content describing the tribal model was confirmed by participating interviewees. OTAG members provided an additional review.

The following section describes the care coordination framework, the essential components of successful tribal opioid treatment /overdose prevention programs. We then describe the OUD models select tribes have applied, using the care coordination framework as a means of describing the instrumental adaptations and enhancements tribes adopted to successfully carry out the models in their communities.



Tribal Care Coordination Framework

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines **care coordination** as “the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery. Care coordination involves managing personnel and the resources needed to carry out all required patient care activities, and often includes the exchange of information among participants responsible for different aspects of care” (SAMHSA, 2019). Care coordination activities can help achieve systematic service coordination, improve the overall delivery of health care, and facilitate the coordination of services and improve patient outcomes (SAMHSA, 2019). As such, use of data (collection, management, analysis, interpretation, dissemination, application) and data system infrastructure become the cornerstone of an effective care coordination framework within programs.

Several tribes have applied the care coordination framework within their substance use disorder (SUD), OUD treatment and recovery, and opioid overdose prevention programs and services. These programs address issues that are unique among AI/AN populations and negatively impact mental health, including the effects of colonialism,

discrimination, historical trauma, and adverse childhood experiences. Other successful SUD and OUD prevention initiatives include drug take-back programs, safe prescribing practices, and efforts to reduce stigma through community outreach and education. In addition, programs that apply culturally-grounded interventions specific to the AI/AN community support improved patient functioning in all areas of wellness (Rowan et al., 2014). In other words, in the AI/AN context, care coordination includes designing a culturally-responsive continuum of care where Indigenous values incorporate cultural strengths, honor tribal sovereignty, and offer key support to community members seeking treatment for OUD and opioid overdose.

The CDC has identified this approach as a strategy that can be deployed at the practice- and system-level of care delivery. Studies have demonstrated that services require collaboration to ensure delivery to patients, and patient support must continue beyond the care institutions to the community, home, and other local settings (AHRQ, 2014; CDC, 2018; Hajewski et al., 2014; Hodgins et al., 2014; Neven et al., 2016; Quinn et al., 2017; SAMHSA, 2019). Tracking outcomes and successes are essential for ensuring care is tailored to a patient’s needs.

In the interviews conducted by Seven Directions, participants expressed the importance of relationships within and between healthcare, social services, and other key stakeholders as a necessary component/domain of the tribal care coordination framework. These partnerships ensure that services are readily available, responsive, and tailored to the community receiving services. These internal relationships strengthen the communication within organizations, raise awareness around the availability of services, and how to access them, while improving community ownership and trust in the services provided. These relationships at the system level ensure essential support to facilitate access to care for individuals and families. External collaborations with federal, state, and county partners are valuable in the development and

institutionalization of data sharing agreements and Health Information Exchanges. Coordination among providers, support services, and community-based supports further assist in prevention, intervention, and treatment efforts. Studies emphasize that OUD service delivery requires a collaborative effort with support within the community, home, and other settings to ensure healing (Hodgins, et al., 2019; SAMHSA, 2019). Figure 1 illustrates the key partnerships identified in tribal OUD scientific and grey literature as instrumental in ensuring program success through care coordination collaboration.

Key Partnerships Necessary for Tribal Care Coordination Implementation

		
Community-Based Supports	Support Services	Providers
<ul style="list-style-type: none"> • Tribal leadership / Governance • Schools • Community organizations • Urban Indian Centers / Organizations • Non-Profit organizations • Youth organizations • Worksites • Cultural / Traditional healers 	<ul style="list-style-type: none"> • Law enforcement • Courts and corrections facilities • Emergency departments • Emergency services / First responders • Transient housing • Transportation • Child care • Federal, state, county, city agencies • Tribal Epi Centers • Tele-medicine 	<ul style="list-style-type: none"> • Primary care providers • Behavioral health providers • Opioid prescribers • Health educators • Social workers • Recovery specialists • Pharmacies

Figure 1



Tribal Promising Practices in OUD Care Coordination

This section provides a description of the care coordination framework from an Indigenous perspective. Three domains of tribal care coordination models emerged from the literature review and our qualitative analysis of our interview transcripts: (1) Indigenous centered praxis, (2) relationships, and (3) capacity development. Within each of these domains, themes have emerged that center specific tribal practices which strengthen opioid treatment and support. These promising practice themes include: (1) cultural fit, (2) innovative practice, (3) knowledge sharing, (4) cross-sector collaboration, (5) meeting community needs, (6) community investment, (7) leadership, (8) professional and cultural development, (9) sustainability, and (10) data infrastructure. (AHRQ, 2014; CDC, 2018; Hajewski et al., 2014; Hodgins et al., 2014; Neven et al., 2016; Quinn et al., 2017; SAMHSA, 2019)

Table 1 provides definitions for each of the ten tribal practice themes within each of the three care coordination domains.

Care Coordination Domains and Tribally-Grounded Promising Practices

DOMAIN	PROMISING PRACTICE / DEFINITION
<p>Indigenous Centered Praxis</p> 	<p>Cultural Fit: The model appropriately coincides with community needs, values, and beliefs (i.e., culturally-based practices in programs, healing stories, storytelling, cultural curricula for prevention and recovery, cultural wellness approaches, integrated cultural values for prevention and treatment services, and multigenerational in scope.</p> <p>Innovative Practice: The method, actions, or activities that were developed had not happened before or were adapted from another model to better fit their needs.</p> <p>Knowledge Sharing: Provides bi-directional opportunities, and co-learning approaches to share lessons learned with staff, outside agencies, and community members.</p>
<p>Relationships</p> 	<p>Cross-sector Collaboration: Relationships (e.g., MOAs, MOUs, MUAs) were established with others to support services and resources to implement the model.</p> <p>Meeting Community Needs: Services were developed in response to gaps in care or needs experienced within and across the tribal community.</p> <p>Community Investment: Tribal governance bodies, leadership, and key community stakeholders support the model.</p> <p>Leadership: Strong champions supportive of rapid decisions and able to gather essential resources, including establishing teams that assess the quality of services and health outcomes on an ongoing basis.</p>
<p>Capacity Development</p> 	<p>Professional and Cultural Development: Staff receive training to enhance knowledge and skills to implement the model.</p> <p>Sustainability: The model has continued resources including workforce development and training, and/or billing capability to ensure longevity.</p> <p>Data Infrastructure: The tribal approach has identified means of data collection, analysis, and reporting to inform care coordination decision making, establish quality or performance improvement measures, and tailor individual care.</p>

Table 1

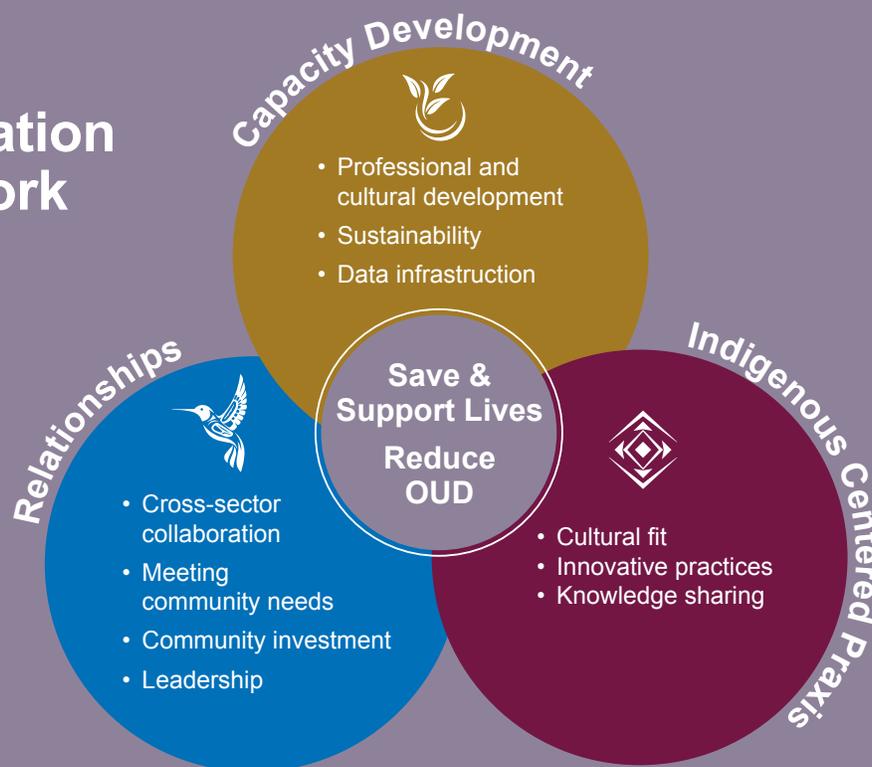
Approaches to Tribal Care Coordination Promising Practices



Tribes apply the care coordination framework (Figure 2) in a variety of ways. Many tribal programs employ a blend of methods adapted to fit the needs of the community. Several tribal opioid response programs coordinate resources to provide services. Treatment and recovery are frequently implemented together or combined with overdose prevention efforts. SUD and OUD prevention outreach and education often go hand in hand with harm reduction strategies, as does stigma reduction. Each program utilizes aspects of Care Coordination that rely on the 10 tribal practices (Table 1) across the three domains (Indigenous Centered Praxis, Relationships, and Capacity Development).

Care Coordination Framework

Figure 2





Harm Reduction Approach

Harm Reduction Approach

Indigenous Centered Praxis

- Include culturally-grounded care.
- Link to community-centered prevention groups.
- Build in cultural activities.
- Share meals or other culturally meaningful moments of connection.

Relationships

- Ensure meaningful access to care.
- Build partnerships within and external to American Indian or Alaska Native community.
- Consider systems integration to ensure harm reduction is realized (e.g., courts, housing, etc.)
- Identify ways to reduce financial burdens to obtain treatment.
- Include administrative practices needed to maintain quality and scope of services needed.
- Implement training and community education efforts to reduce discriminatory practices and address stigma.

Capacity Development

- Review assessment measures to ensure fit.
- Develop a patient tracking system that will allow practitioners to extract longitudinal data to see how individual patients do over time.
- Provide descriptions of how patient information will be protected and who has access.
- Include qualitative assessments of program participants to tell the story.



Harm Reduction Overview

▶ **What it is.** The harm reduction approach, a public health approach developed in the 1980s, originated in the development of psychological treatments to address alcohol use disorder. The approach meets an individual “where they are at” (Marlatt & Witkiewitz, 2002, p. 867), while supporting client-led development of treatment strategies based on the client’s motivation, strengths and limitations (Stancliff, Medley, and Matthews, 2019; Witkiewitz, 2005).

In the context of OUD, harm reduction approaches include syringe exchange programs, supervised consumption sites, and naloxone distribution, as well as provider education toward maximizing harm reduction (e.g., naloxone co-prescribing in the context of pain treatment) (Lavalley et al., 2018; Mancher, Leshner, & National Academies of Sciences, Engineering, and Medicine, 2019).

▶ **Effectiveness.** This approach has often met resistance from individuals, practitioners, and communities who espouse abstinence as the only appropriate goal for substance users (Marlatt & Witkiewitz, 2002), though research demonstrates that harm reduction approaches are effective in reducing the risk of death and other harmful outcomes of opioid use (Bukten et al., 2012; Chimbar & Moleta, 2018; Ng, Sutherland, & Kolber, 2017).

▶ **Why it’s important.**

Indigenizing Care for Opioid Use. Within AI/AN communities, researchers have identified the need to ensure that AI/AN community health providers have “a commitment to Indigenizing harm reduction and addiction treatment policies, practices and supports by incorporating traditional Indigenous values... [and a recognition that] the impacts of colonialism and institutional racism [continue to affect AI/AN individuals and communities], while acknowledging the strengths, abilities, and inherent rights of Indigenous Peoples, [as well as developing an approach to address] the underlying conditions that drive high rates of overdose, such as those related to family, housing and access to health care” (Lavalley et al., 2018, p. E1466; Leston et al., 2020).

Access to Care. SUD morbidity and mortality rates remain major public health issues among tribal and urban Indian communities. Access to opioid treatment and harm reduction services represent major challenges to addressing opioid overdose prevention within AI/AN communities (National Congress of American Indians, 2018; Fisher, Cahill, Broyles, Rorke, & Robinson, 2017). Ensuring opioid treatment meets community-grounded approaches to care can support improved access to care and reduce opioid related harm. In addition, three main issues serve as barriers to opioid harm reduction approaches: (1) the limited access to and availability of opioid data; (2) the stigma associated with accessing opioid treatment and other services; and, (3) contextual issues such as access to care, financial burden of care, and other needs (Lavalley et al., 2018; Leston et al., 2020).

▶ Harm Reduction Approaches: Key Components in AI/AN Settings

Data collection and access to data remain critical limitations for fully implementing harm reduction approaches. In particular, AI/AN enrollment and identity inform, and necessarily limit, how data on Indigenous people are collected. In addition, some non-tribal treatment settings fail to collect data on AI/AN individuals. These limitations likely disguise the depth and breadth of the opioid overdose crisis among AI/AN individuals and communities. Addressing this issue within the framework of tribal self-governance and self-determination, means that the data on overdoses and related outcomes among AI/AN populations must be owned, controlled, and/or accessible by AI/AN communities and programs aimed at addressing the opioid epidemic (Lavalley et al., 2018; Leston et al., 2020).

Stigma-free access to opioid treatment services represents an essential component to harm reduction approaches within AI/AN communities (Leston et al., 2020). Providing education and training in tandem with harm reduction efforts supports the reduction of stigma among individuals, program staff, providers, and community members. Clarifying the specific harm reduction support offered helps individuals and providers make informed decisions about treatment regimes.

The use of health fairs, lifting bans on purchasing syringes with federal dollars, and removing punitive sanctions for people who use drugs while in treatment are some of the approaches that could be added to existing harm reduction

efforts. Tribally-specific services, educational supports, and Indigenous-centered strategies are important as every community is different and faces unique challenges.

Meaningful solutions to contextual barriers, such as delays in receiving care, limitations in accessing harm reduction services, limited education on harm reduction options by both providers and patients, financial burdens, and preventing unnecessary hospitalizations are important elements in ensuring successful harm reduction approaches in Indian Country (Leston, 2020). Some of these barriers may be related to discrimination clients face in accessing services. Identifying and eliminating discriminatory processes will institutionalize an equitable approach and address client challenges in access to care (Pro & Zaller, 2020). Moreover, ensuring clients have access to the full array of harm reduction approaches can ensure client success, as well as satisfaction and engagement in the overall treatment approach. This would include offering needle exchange programs, in addition to medically assisted treatment (MAT), or providing clients with information about local needle exchange opportunities or alternatives to ensure safe needle use. Diabetic needles often require prescriptions, and also serve as a deterrent to purchasing new needles. Further, clients find providing personal information a deterrent, as they are often unclear about whether or not law enforcement will be involved or if their information will be used to deny them access to other services.

“**Harm reduction services intervention and policies must be designed to fit individual and community needs by listening, respecting, and meeting [clients] where they are at, instead of leaving them where they are at**” (Leston et al., 2020, p. 78).



The White Earth Nation Health Model



This section describes the Indigenous harm reduction approaches of White Earth Nation of Minnesota. The White Earth Nation relies on a combination of traditional tribal approaches with EBPs from Western medicine.

Why was it developed?

Twenty years ago, an elder from the White Earth Nation stood up at a community forum and asked how the Nation was going to address HIV and injection drugs. This was the beginning of the movement to develop an approach aimed at reducing overdose deaths. Over the course of the program, compassion within the community for those dealing with OUD has increased. With American Indians in Minnesota experiencing an overdose rate six times higher than the national average, data-driven strategies and community engagement have provided essential support to inform White Earth Nation's approach. They are assessing social determinants of health, with the intent to address them through other avenues of individual and community support systems.

How was it developed?

The White Earth Nation's collaboration and coalition-based approach focuses on how to ensure an integrated approach to harm reduction, allowing for comprehensive treatment of multiple substances as needed. They have taken harm reduction to the

systems level, developing essential partnerships with law enforcement, emergency medical services (EMS), local counties adjacent to tribal lands, the state of Minnesota, and federal partners to ensure the continued sustainability and effectiveness of the harm reduction program. Program staff partner with cultural groups to enhance the client experience, support community and cultural connectedness through cultural activities, build an active recovery community, and provide key follow-up to those clients new to care to ensure engagement and ongoing success. At the point of Naloxone refill, recipients are asked to complete a survey assessing demographics, their current drug use, the effectiveness of Naloxone administration, and the quality of law enforcement and EMS response. These data are analyzed over time to inform program strategies with community partners. Clinton Alexander, the Interim Director of White Earth Nation Behavioral Health, routinely reviews fatality, overdose, and drug use data to determine next steps in prevention efforts. These efforts continue to deepen the White Earth Nation's comprehensive systemic harm reduction approach through ongoing capacity building for program staff and partners.

Indigenous Centered Praxis



The White Earth Nation's innovative approach includes incorporating traditional healing methods (i.e., use of traditional medicines such as tobacco and sweetgrass) and values with a harm reduction approach that evolved through Western science. The success of harm reduction also heavily relies on the program's integration of the community's cultural values.

Relationships



Accountability represents a core component, which informs both data collection and the strategic network of partners. Key community partnerships among behavioral health, law enforcement, and EMS ensure access to these data in real time. These essential program elements have combined to form a "systemic harm reduction" approach, which has successfully reduced the number of fatal overdoses among participants.

Capacity Development



White Earth has a comprehensive sustainability plan, which allows for third party billing, includes 638 supplemental income, and ensures cost recovery for appropriate services at Federal encounter rates.



*So when I think of harm reduction for White Earth Nation, the mandate came from the community. It came from elders almost 20 years ago demanding that we do something, and that there was an acknowledgement that the services and systems are in place to keep people alive. **The driving force behind harm reduction comes from the community, the permission from the community to move in that direction.** That mandate to the work around overdose came from our community individuals who were tired of seeing others in their community die of overdose, knowing that they're preventable. So I think it really is rooted in the community. The work was initiated through the community and tribal programs saw and understood their responsibility to support these efforts."*

- Clinton Alexander, Interim Director of White Earth Nation Behavioral Health

COMPONENTS OF THE White Earth Nation's Health Model

Cultural Fit	<p>Cultural values integrated</p> <p>Provide access to traditional medicines, herbs, tobacco, sage, and sweet grass</p> <p>Sobriety feasts</p>	Innovative Practice	<p>MAT program for pregnant women with a focus on the whole family</p>	Knowledge Sharing	<p>Harm Reduction Coalition</p>
Cross Sector Collaboration	<p>Federal, State, County partners</p> <p>EMS and law enforcement</p> <p>Cultural groups</p> <p>University of Minnesota School of Medicine</p>	Meeting Community Needs	<p>Integrated care across systems</p> <p>Community outreach and education to reduce stigma</p>	Community Investment	<p>Peer recovery support</p> <p>Pre-arrest Diversion Framework</p> <p>Elder Support</p>
Leadership	<p>Elected officials value this work</p> <p>Elders help to remind community of the values and guide the work</p> <p>Cultural authorities are supportive</p>	Professional & Cultural Development	<p>Use of multidisciplinary teams</p> <p>Quality improvement</p>	Sustainability	<p>Cultural authorities are supportive</p> <p>Comprehensive sustainability plan</p>
Data Infrastructure	<p>Taking bold steps and using data to identify intersections within a person's life</p> <p>Established comprehensive data sharing agreements</p>	<p>The White Earth Nation harm reduction approach combines culture, community, and context with Western medicine, meeting with patients and partners where they are at, and relying on data to inform a systemic harm reduction approach that integrates health, behavioral health, and social services.</p>			

Summary

In summary, tribal harm reduction approaches reflect best practices evidenced in the literature. Integrating an Indigenous approach, developing solutions to address contextual challenges, working to reduce discriminatory practices, improving the collection, management and use of data in decision making, and actively dismantling stigma of opioid treatment represent approaches evidenced in the White Earth Nation Harm Reduction model. Addressing these pressing issues has led to the engagement of those tribal members with an OUD. As a result, those able to effectively engage with the program have seen successes, including reintegration in the community, a system of support available in case of relapse, and cultural supports that reaffirm community connectedness. These elements are possible through the exercise of tribal sovereignty, along with the commitment to community wellness and the power of community support.





Integrated Health Care Approach

Integrated Approach

Indigenous Centered Praxis

- Integrate tribe's language into signs and resources in the facility, and train staff on the basics of local language.
- Incorporate pictures of the traditional tribal lands in the facility to connect patients and staff to the history of the site.
- Incorporate tribal elders or other valued community members into the facility, such as in the lobby to greet patients, in order to ensure comfort for anyone entering the facility.
- Include spirituality, holistic healing, and community and family traditional practices alongside MAT and other Western medicine approaches.



Relationships

- Create a “clinical team” for each patient - a team that consists of all of the staff and providers that are supporting the patient. Ensure this team meets regularly (ex. two times a week) to coordinate and support the patient's recovery plan.
- Establish a partnership with another SUD treatment center to provide care to each other's patients in the event of an emergency.
- Educate community members on the Integrated health care approach, and foster relationships with community groups to increase acceptance of this effort in the community.

Capacity Development

- Provide all services in one facility building. Eliminate referrals to other locations.
- Ensure services provide both the clinical support - psychiatrists, therapists, social workers, and SUD counselors - and the social support - support with insurance, housing, food, and community building.
- Bring together people with diverse community perspectives or training (ex. medical staff, mental health staff, and prosecutors) into a task force that collaborates on their approach to provide seamless integrated care to patients.
- Incorporate all programs into the same EHR system to provide a centralized data system to review patient and facility-wide progress.
- Provide extensive and consistent training, and provide these training to all staff, even if the training subject is not directly related to their role.
- Coordinate or provide transportation to and from the facility, and child care while the patient is at the facility.

Integrated Health Care Overview

- ▶ **What it is.** The World Health Organization defines “integrated care” as a health care system that is “designed according to the multidimensional needs of the population and the individual, and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care (World Health Organization, 2016).

Integrated care is person-focused and does not focus solely on the condition of the individual (a condition-centric approach) (Mann et al., 2020). The approach supports the variety and complexity of the patient’s needs and aligns care towards “community-based, comprehensive, and preventive care” (Mann et al., 2020). An integrated approach allows for both generalist and specialist care to be in the same location, also known as vertical integration, which improves the quality of care accessible to patients and the capacity to meet the volume and diversity of needs in a community. This approach has been used internationally for various needs, such as oral care, geriatrics, and behavioral and mental health.

- ▶ **Effectiveness.** The Integrated approach in the context of OUD helps to potentially improve clinical care and decrease cost (Fanucchi et al., 2019). A review of health care quality discovered that “significant disparities in the quality of healthcare for AI/ANs exist in all dimensions of quality, including the structure, process, and outcomes of care. Existing systems are not designed to reduce health disparities (Lewis & Myhra, 2018), making the Integrated approach attractive to AI/AN communities as it has been demonstrated to reduce health disparities. A meta-analysis on outcomes of integrated care in AI/AN communities has demonstrated positive results, including improved physical and mental health symptoms, reduced substance use, improvements in education and employment status, decreased involvement with the criminal justice system, and improved access to comprehensive care and quality of care. (Lewis &

Myhra, 2017; Lewis & Myhra, 2018). For behavioral health in particular, outcomes include improved “patient health outcomes, provider satisfaction, and cost-offset” (Lewis & Myhra, 2017).

- ▶ **Why it’s important.** An Integrated approach helps address key barriers to supporting patients with OUD in the AI/AN population.

Culturally Appropriate Treatment. For AI/AN communities, an Integrated approach has the potential to support the implementation of practices that align with a community’s values towards health and well-being.

An Integrated community-based approach has the potential of bridging and integrating the current separation of treatment delivery and culturally appropriate care (Lewis & Myhra, 2017). The lack of inclusion of cultural adaptation, spirituality, or holistic healing has made MAT implementation and use less attractive to tribal programs (Venner et al., 2018). A study by Rieckmann et al. (2017) found that treatment culture and organizational fit is key to uptake of MAT implementation. Specifically, “alignment between culturally relevant interventions...and organizational perspectives... that support specific services” facilitate MAT use (Rieckmann et al., 2017).



Standard treatment for OUD usually focuses on the individual, but Native peoples often approach health and wellness more holistically. This disconnect makes it challenging to incorporate aspects of community and family traditional practices—essential and strengthening elements of Native culture—into mainstream medical treatment . . . We need a more holistic view that goes beyond a person’s biology. We must integrate culture, societal factors, and even spirituality, when appropriate, into mainstream medical institutions and education” (NIH, 2020)

▶ **Uptake of MAT Implementation.** Currently, patient acceptance of traditional residential facilities for MAT is relatively low, with one study noting that only 19% of patients accepted a discharge to a SUD residential treatment (Rieckmann et al., 2017). Distance from home, program restrictions, and previous negative experiences were mentioned as reasons to not accept further care (Fanucchi et al., 2019). These referrals to separate locations for care, and the lack of support provided to patients during that transition, discourage patients from receiving the care they need. An Integrated approach eliminates the referral to care in a different location by centralizing its services.

▶ **Addressing Co-Occurring Issues.** People with OUD often have “one or more co-occurring medical, psychological, social, familial, and spiritual problems that negatively impact their quality of life” (Harfield et al., 2018). An Integrated approach is effective in part because the approach incorporates treatment and management, prevention and health promotion, all while addressing the social determinants of health (Harfield et al., 2018).

▶ **Reducing Prolonged Stays in Hospital.** The ability to go home in-between treatments and adhere to the prescribed dose are effective components of an Integrated approach. The practice of keeping people in a hospital setting for prolonged periods of time is costly and unpleasant for patients; and hospitals sometimes offer limited addiction treatment. “We assert that patients with OUD who are engaged in treatment can participate in and take responsibility for complex aspects of their own medical care” (Lewis & Myhra, 2017).

▶ **Financial Barriers and Insurance Coverage.** Limited coverage for AI/AN treatment services poses a barrier for patients to receive appropriate treatment (Venner et al., 2018). “Indigenous people are three times less likely to have health insurance compared with other Americans, while 57% use [the] Indian Health Service (IHS) . . . The average amount spent for an IHS enrollee per year is \$1,900 compared with \$5,200 for Veterans and \$6,000 for Medicaid recipients” (Lewis & Myhra, 2018). Additionally, “access to physicians is particularly important for MAT use because most insurance companies will not reimburse for services that are not overseen by a licensed physician” (Rieckmann et al., 2017). In this study, 42% of programs providing MAT relied on an outside provider to have prescribing authority. Limited insurance can prevent a patient from being covered with an outside provider, posing a significant barrier to patients needing prescriptions (Rieckmann et al., 2017).



▶ **Access to Care.** “Urban AI/AN may also face difficulties navigating the health care system, based in part on mobility, enculturation, and lack of formal tribal affiliation” (Venner et al., 2018). Integrated care has an opportunity to consider the patient’s specific needs to be able to travel to the health facility and be provided care regardless of tribal affiliation status.

▶ Integrated Health Care Approaches: Key Components in AI/AN Settings

In summary, an Integrated healthcare approach is an effective strategy to improve outcomes for patients with OUD. In AI/AN communities, a few key components can maximize effectiveness:

Include a variety of services

To address the holistic health and comorbidities of patients, an Integrated approach can include a wide variety of health providers and care modalities to serve the unique needs of the patient.

Ensure proximity of services

To address the barriers posed by referrals and limited insurance coverage, it is important for services to be in the same or close physical location with providers covered by the same insurance.

Integrate a Western medicine approach (i.e., MAT) with AI/AN healing

Integration of local Indigenous culture, health beliefs and practices is necessary for an effective Integrated system of care for Indigenous peoples (Lewis & Myhra, 2017; Harfield et al., 2018).

Community participation

It is important to include the community's practices, knowledge, and perceptions of SUD. Integrating traditional practices, such as beading, drum making, and sweat-lodge ceremonies weave in community values, norms, and world views ('To Walk in the Beauty Way,' 2020).

Ensure care is accessible



Transportation. Visiting the health center often requires transportation which may pose a financial or logistical challenge. It's important the program either provides or supports the transportation of patients to the facility (Fanucchi et al., 2019; Venner et al., 2018).



Insurance. Lapses in insurance coverage limit accessibility of care. The program should consider how to support patients in signing up for insurance and financially supporting the care of those who do not qualify for insurance (Fanucchi et al., 2019; Venner et al., 2018).



Childcare. It's important to provide childcare so patients can still come to the facility when needed (Fanucchi et al., 2019).



Telephone assistance. "Research suggests telephone assistance is a key element of integrated programs" (Fannuchi et al., 2019). A program should consider this limitation in their model to ensure patients can be supported remotely and reach the facility for support when needed.

Swinomish Tribal Health Model

The didg^wálič Wellness Center in Anacortes, Washington is an exemplary model of an Integrated health care approach for the treatment of people with a SUD. The Center not only serves the Swinomish Indian Tribal Community, but all AI/AN members and non-tribal members ages 18 to 78. The goal is to provide treatment and view the patient's needs holistically to best address the underlying factors that contribute to wellbeing and the use of substances.

Why the Swinomish Tribe developed the didg^wálič Wellness Center

The didg^wálič integrated treatment model combines MAT with counseling, primary medical care, dental care, outpatient psychiatric care, harm reduction practices, and social support services within the same clinic. The Swinomish Indian Tribal Community developed this model over the course of several years in answer to the mainstream models of OUD treatment that were failing to meet the needs of the Tribal community during the early years of the opioid epidemic. The Tribe recognized that its decades-old counseling program for alcoholism could not adequately meet the challenge of this complex new disease, opioid use disorder, that was devastating the Tribal community.

How the didg^wálič Wellness Center was developed

Dawn Lee, now the Chief Operating Officer (COO) of didg^wálič Wellness Center, observed multiple barriers faced by Tribal members in accessing OUD treatment and was instrumental in developing and advocating for this integrated approach to care. The model evolved by testing new approaches over the course of four years and integrating new

therapies one at a time, starting with MAT. Ms. Lee developed a model for office-based Suboxone treatment that closely tied medication administration with intensive counseling and partnered with a local pharmacy to administer medication. Next, the Tribe developed a practice called a “warm hand-off” to reduce failure rates of patient referrals to other services, such as primary care and psychiatric care. But limitations continued to impede patient access to care, especially the lack of transportation for patients to get to and from treatment; lack of safe childcare during treatment; lack of insurance coverage; and persistent lack of referral fulfillment. In 2016, Ms. Lee went to Swinomish Tribal leadership and proposed to build a new treatment facility.

Ms. Lee and her team provided extensive community education to small and large groups across the community to garner community support. This effort ensured community members knew what to expect and offered opportunities to provide their input.

In response, Tribal leaders invested in the development of a new, under-one-roof health care center that delivers fully integrated OUD treatment services with primary care, dental care, outpatient psychiatric care, harm reduction, and social support services such as free transportation and childcare for patients.

COMPONENTS OF THE

Swinomish Tribe's didg^wálic Wellness Center Model

Cultural Fit	<p>Use of Tribal language on signs and on walls of facility</p> <p>Tribal Elder Coach</p> <p>Talking circles, Pow-wow, Sweat lodge</p>	Innovative Practice	<p>Having all services in one location</p> <p>Offering holistic services</p> <p>Supporting patients to get insurance or financial sponsorship</p>	Knowledge Sharing	<p>Providers and staff meet and collaborate to support patient journey</p>
Cross Sector Collaboration	<p>MOU with another site for emergencies</p> <p>Partner with law enforcement and jails</p>	Meeting Community Needs	<p>Provide transportation and child care</p> <p>Community education and involvement</p>	Community Investment	<p>Received support from community members</p> <p>Support from tribal council, the County commissioners, and the City of Anacortes</p>
Leadership	<p>Swinomish Opiate Task Force</p>	Professional & Cultural Development	<p>Ongoing training that every staff takes, even if not directly related to their role</p> <p>Basic training for staff on tribal language</p>	Sustainability	<p>Medicaid funding supports costs</p>
Data Infrastructure	<p>Individual successes</p> <p>EHR for all services/ departments</p> <p>Client satisfaction survey</p>	<p>The Swinomish Indian Tribal Community practices an Integrated Model that centralizes medical treatment and social support in one physical location, and creates a welcoming and accessible space by including traditional language and practices into the facility.</p>			



Elaborating on the didgʷálič Wellness Center Model: Mapping to the Domains of Tribal Care Coordination Promising Practices

The Center provides all substance use services in one building. Patients without insurance can access support to sign up or to request funding to purchase insurance coverage. With all providers co-located, providers and staff meet regularly, gaining a holistic view of the patient. This ensures providers can assess the treatment needs of patients, along with essential supports needed. Mental health, detoxification and rehabilitation, and SUD counselors are available. In addition, patients may be referred to social workers, case workers, and elder coaches. The services provided include counseling, medication provision and support, individual and group sessions, acupuncture, and support with food banks, shelter, and housing from social and case workers.

Indigenous Centered Praxis



The Clinic integrates the Lushootseed language, spoken by the Swinomish Tribe. For example, all signs include information in both Lushootseed and English, the staff has learned basic Lushootseed, and the Lushootseed alphabet is displayed on the wall, ensuring patients see their local language as soon upon entering the Center. The Center has placed historical pictures of traditional tribal lands in prominent locations, connecting patients and staff to the site. Creating a communal, connected, and family feel reflects the values of the Swinomish people. A Tribal Elder Coach spends time in the lobby, greeting patients and families, giving out snacks, and encouraging them on their journey to ensure a welcoming, supportive environment for patients, their families, and community members.

Relationships



The Center has an MOU with another SUD treatment center to provide care to each other's patients in the event this is necessary. The Center established a relationship with the local police department to ensure that when police encounter someone with a mental health or substance use issue they are connected to mental health staff. This evolved into a program in which the department hired an advocate that supports mental health or substance-use related calls. Through a partnership with detention centers, the Center provides methadone daily to the prisoners enrolled in treatment. This facilitates relationships with the Clinic to ensure they seek continued care upon release. The Center engaged in long-term education effort and established communications with detention center staff to facilitate this partnership.

Capacity Development



A 25-member Swinomish opiate task force coordinates community and tribal opioid response. Members include medical, mental health, and court staff, along with prosecutors, and representatives of various SUD programs and casinos. This group also promotes a collaborative approach. The Integrated model incorporates multiple social services, which the task force supports through facilitating discussions to confirm tribal strategies.

The Center celebrates patient success. All progress is celebrated, demonstrating the Center's community connectedness. All departments can access the Swinomish Electronic Health Record (EHR), a centralized data system used to review patient progress, update treatment plans, and extract statistics when needed. Client satisfaction surveys are used to understand a patient's experience at the Center. Important indicators to measure success include: ensuring stability of individual patients' medication response, assessing the program retention rate, and assessing changes in number of take-home doses.



We have a team environment here. *We do a treatment team with the patient where we bring members from all of our different departments together in the same room monthly. We look at what we can do to help the patient, which department needs to do what. And we really wrap our arms around that patient, and we don't give up on them. We talk about some of the challenges, and about the successes of our clients every week. That is what's really helpful because everybody is engaged in that client's process and the client knows it."*

- Dawn Lee, Chief Operating Officer, didg'álic Wellness Center



How the Integrated Care Model Addresses Barriers to Care

Key services are co-located, reducing the number of patients who fail to complete referrals. With everything in one location, patients can easily access an array of services, removing referral follow-up as a barrier. Moreover, co-location eliminates transportation issues. The Center provides transportation to the clinic and child care, ensuring access to care. The Center provides support with insurance which contributes to sustainability and continuity of care. Co-location of services also allows providers to meet and discuss the care of patients in a holistic and coordinated approach.

Summary

Currently, health care services still suffer from a system of care that fails to connect care across sectors. Historical approaches to the provision of care and provider training reinforce these silos. The Integrated health care model requires envisioning a mode of care that addresses the complexities of wellbeing and the many underlying factors that contribute to substance use or pose barriers to accessing or remaining in care. The Integrated health model, as developed and implemented by the Swinomish Tribe, provides patient-centered support, respecting the unique context, life experience, and challenges of each patient who enters the facility.



Peer Support Approach

Peer Support Approach

Indigenous Centered Praxis

- Incorporate cultural practices unique to tribal beliefs and ways.
- Focus on the journey of healing instead of the addiction.
- Include the community in the awareness of OUD.
- Balance healing with treatments to reduce the stigma of OUD.

Relationships

- Work collaboratively with tribal departments and services providers.
- Include key programs as the communities' needs change.
- Inform tribal leadership on OUD and trends that are occurring in the community.
- Keep leadership updated on successes and challenges of OUD.
- Bring in key stakeholders for added support from governments, agencies and organizations.

Capacity Development

- Provide training opportunities to staff/ providers for up-to date information on OUD.
- Allow staff to attend conferences/trainings to engage with others in their field.
- Train tribal members that are able to act as peer supports and advocate for others.
- Ensure a data infrastructure is in place that is able to interface with established data systems.

Peer Support Overview

Peer support is increasingly found in post-overdose programs to engage high risk individuals and improve the likelihood of starting medical treatment, accessing social services, and addiction recovery programs (Samuel et al., 2018; Waye et al., 2019). The standard response to mitigate opioid overdose is access to MAT and naloxone (overdose recovery drug) (Bagley et al., 2019; Scott, et al., 2020). There is a critical time in the emergency department, after a near fatal overdose, to engage patients in treatment and harm reduction, and reduce the risk of another potentially life-threatening overdose (Bagley et al., 2019; Eddie et al., 2019; Samuel et al. 2019; Waye et al., 2019). Peer support programs offer a crucial opportunity to enroll patients in post-overdose response programs whether initiated in the emergency room, facilities, home, or a combination. They vary in style and outreach, there are no standards of care, and gaps remain in understanding their effectiveness (Bagley et al., 2019).

▶ **Effectiveness.** Peer support and navigation have proven effectiveness in HIV outreach and chronic disease prevention and/or management (Bagley et al., 2019; Scott et al., 2020). There is growing evidence that peer support increases engagement and retention of high-risk individuals in care (Samuel et al., 2018; Waye et al., 2019). Shared lived experience of peers increases levels of trust, credibility, and comfort among individuals (Bagley et al., 2019; Powell, et al., 2019). One qualitative study with postpartum women identified accountability as an individual protective factor with peer support (Goodman, Saunders, & Wolff, 2020).

Peer support programs are moving toward standardization, and certification for training, which opens opportunities for reimbursement. A shared sense of collective responsibility represents one domain that allows for cross program comparison (Bardwell et al., 2018). This study focused on a peer witness injection program. Collective responsibility offers one area in which peer support programs may identify a unified approach and application to assess effectiveness and potentially support future reimbursement (Bardwell et al., 2018; Eddie et al., 2019).

▶ **Importance of peer support to overcome barriers to opioid prevention.** The shared experience between program staff and patients represents a central attribute of peer support. Shared experiences lay the foundation for trust, help to alleviate stigma, and offer the promise of future self-efficacy for patients. This relationship building, which may include cultural connections provided by peers, extends from the individual to their personal and larger social network, offering opportunities to establish a support network.

Additionally, peer support may support collaboration across first responders, fire departments, police, and medical services. Data sharing represents a critical barrier to overcome, as peer support has yet to be demonstrated to be effective. The type of information shared, and in what networks, may jeopardize the connection between peer support staff and patients. At the same time, loss of privacy could undermine the trust peers establish with high-risk individuals.

Using peer support in opioid overdose prevention holds promise especially for highest risk individuals, such as those who recently had a near fatal overdose. Peer based programs offer an opportunity for intervention in the emergency room setting when patients are provided links to other critical services, such as addiction treatment. By including peer support in the array of post-overdose services, tribes aim to ensure continuity of care within the health system.

Pascua Yaqui Tribe's Peer Support Model

The Pascua Yaqui Tribe is a federally recognized tribe located in Southern Arizona that established its own medication-assisted treatment (MAT) program within the Pascua Yaqui Health Services Division. This allowed tribal members to stay in their community while accessing services. With care coordination, health care, and behavioral health services work together to support their tribal members. The Pascua Yaqui Tribe also utilizes traditional healers, alternative medicine, and peer supports workers to assist those healing from their opioid use.

Why was it developed?

The Pascua Yaqui Tribe's New Beginning (NB) program is part of the Pascua Yaqui Health Services division (PYTHSD). Developed over 20 years ago, the aim was to establish a tribal harm reduction program that would provide treatment for substance misuse/abuse disorders and mitigate overdose. The PYTHSD NB program emerged as a response to concerns raised by community members and tribal council. Individuals with SUD were unable to obtain necessary treatment, and as a result, suffered relapses, and in some cases, died as a result of overdose. At this time all treatment was provided off tribal lands, disconnected to family and culture. Tribal leaders and community members were concerned about the impact opioids were having on individuals, families, and the overall community.

How was it developed?

The PYTHSD NB program was originally a stand-alone harm reduction program. Over the years it has evolved into a centralized care coordination program for OUD and prevention of opioid

overdose. The program uses a peer support model and provides services, programs and treatment within the Tribe. Initially, this type of effort had not been attempted, and there was a necessary cycle of learning and improving. The PYT found that steady, thoughtful changes, implemented over time, helped to build a sustainable, effective program. Keeping open lines of communication internally was an essential component to ensure coordination across providers and departments. Providing management personnel ensured implementation was successfully achieved. Development of data infrastructure supported tracking of outcomes. Connecting with tribes across the country provided opportunities to learn what worked from others. Ensuring sufficient time to obtain feedback from staff, providers, and community members ensured buy-in and tailoring. Hiring flexible teams able to navigate both the clinical and administrative sides of the program provided the knowledge and content expertise necessary for success. Engaging in data infrastructure development from the beginning offered the opportunity to measure changes over time, key indicators of quality and patient progress.

COMPONENTS OF Pascua Yaqui Tribe's Peer Support Model

Cultural Fit	<ul style="list-style-type: none"> Equine therapy and cultural leaders Traditional Healing Program The Alternative Medicine Program 	Innovative Practice	Provide MAT with individual/group counseling with cultural healing with traditional healthers, and/or alternative medicine	Knowledge Sharing	<ul style="list-style-type: none"> Presentations at local and national conferences and training Staff are on local and national advisory boards
Cross Sector Collaboration	<ul style="list-style-type: none"> Partner with behavioral health, language dept., social services and the police dept. Working on agreements with the city 	Meeting Community Needs	Care coordination	Community Investment	Tribal Council approved MAT as service on the reservation
Leadership	<ul style="list-style-type: none"> Community meetings which tribal council members attend Tribal Council and Elder engagement 	Professional & Cultural Development	<ul style="list-style-type: none"> Training focused on resilience, community-based training and other therapeutic approaches Board certified providers for Addiction Medicine 	Sustainability	Funding to start up the peer support program and to get Narcan from the state
Data Infrastructure	<ul style="list-style-type: none"> Monthly chart reviews Access to data by all involved in care Data infrastructure development from Day 1 Data sharing and governance 	<p>The PYTHSD peer support model is strength based and draws on Indigenous-centered praxis, relationships, and capacity building to support a coordinated care approach with the New Beginnings program. A major challenge for the program's performance and success is tribal data capacity and infrastructure development.</p>			

“

We lose something when we don't have that data and tracking abilities.
I feel there are a whole lot of ways that tribes could do more to support each other . . . wish we could talk to other tribes regarding standards and learn more from each other. I would love just to talk to other tribal sites and share what we do and what is working for them.”

- Dr. Christina Arredondo, Medical Director, Pascua Yaqui Tribe

Elaborating on the Pascua Yaqui Peer Support Model: Mapping to the Domains of Tribal Care Coordination Promising Practices

Indigenous Centered Praxis



PYTHSD ensures programs include a high level of cultural fit. The peer support model is implemented primarily by tribal members who share cultural and lived experience with program clients. They facilitate clients' navigation of services and engagement in Yaqui healing practices to support overall health. Access to traditional healers, participation in cultural ceremonies, alternative medicine modalities, equine therapy, and engaging with cultural leaders in the community represent the hallmarks of the peer support program. Peer support staff support patient navigation to assist in integrating primary care and social services. For example, PYTHSD peer support connects with pregnant women, following their progress over the course of their care.



Relationships



The tribal council of the Pascua Yaqui Tribe approved use of MAT and peer support on tribal lands. They are invested in the program's aim to reduce the number of tribal and community members with OUD and ensure opioid overdose prevention. At the same time, some leaders and elders feel it is not necessary and would rather support abstinence as an approach to treatment for OUD. To address these concerns, the PYTHSD hosts community meetings, attended by tribal council members, as part of an ongoing process to build and maintain relationships for the benefit of the whole community.

Relationships play a central role for Indigenous centered praxis. Within the PYTHSD NB program, relationships are established and maintained through responsiveness to community needs, investment in collaboration, and tribal leadership. PYTHSD works closely with tribal programs like Child Protective Services, Behavioral Health, Tribal Policy Department, the Nursing program (community health nurses and representatives), and other healthcare and wellness services. Recently the NB program started working with the Pascua Yaqui Tribe's Language and Culture program to support clients' reconnection with the culture. This type of cross sector collaboration improves program fit, and is made possible through the relationships nurtured across programs.

PYTHSD has long standing relationships with the state and county public health departments and board membership within regional American Indian organizations. These relationships, in particular with tribal organizations and entities, have created a peer support network that offers opportunities to share and communicate with one another on an ongoing basis. Formal agreements with support services like Peoples' HealthCare Connection and the judicial system ensure patients receive the treatment and services they need to heal and maintain recovery. It is through ongoing communication and sharing of knowledge that PYTHSD NB is maintaining relationships within and outside the Tribe to respect the community and tribal leadership while best serving clients.

Capacity Development



PYTHSD NB prioritizes capacity building among staff, which aligns with the value placed on knowledge sharing. All providers are board-certified in addiction medicine. This establishes a strong foundation for capacity within the program. Professional and cultural development opportunities are provided to staff. Staff may attend resiliency and therapeutic training. Staff share presentations after returning from conferences to continue capacity building within the program.

Sustainability of the PYTHSD NB program requires strong data capacity and infrastructure development. Improving tracking of provider performance, patients' reasons for use, overdose data, and establishing data sharing agreements with EMS to track indicators remain priorities. Qualitative follow up would provide additional insight into patient needs. For example, PYTHSD NB tracks how much Narcan is distributed and if it is used, but not why the client needs more. Tribal governance over data sharing and management of data is well established; the PYT will not participate in state level tracking until data use is clearly defined. This is necessary to prevent release of information without tribal consultation, as the release of tribally specific data can potentially harm and perpetuate stigma for patients and the Tribe as a whole. However, data sharing could help clarify overall OUD prevalence, as the tribal data may not capture all instances of emergency care and use of treatment services.

Overcoming barriers to care using peer-support-based programs

The PYTHSD NB program overcomes barriers to OUD and overdose prevention by maintaining a centralized, community-led, and peer-based program. The program provides medical care and other services, allowing it to focus on overall health and wellbeing. This approach increases access to care, and ensures patients' engagement in their treatment regime. Peer support builds and maintains trust with clients through shared culture and lived experiences. It is through these trust relationships and the creation of community that peer support programs work to help at-risk clients navigate the services needed for their health and wellbeing. The PYTHSD NB program also provides services to non-tribal members who are part of the community because of their close connections to the Tribe. Peer support will be increasingly important as the program incorporates additional providers with specialties not currently available onsite.

Summary

The peer support model is considered an effective way to support the PYTHSD NB clients. The program helps clients navigate health care services and supports attendance in other PYTHSD programs. The program offers treatment by Yoeme traditional healers, visits to the PYT Ranch, and equine therapy. The peer support staff offer understanding and compassion through shared experiences and cultural values, establishing trusting relationships and a sense of belonging in a community of recovery. The PYTHSD NB program uses Indigenous-centered praxis, relationships and capacity building as core elements of its care coordination. The peer support model is embedded in this coordination, supporting program effectiveness, efficiency and equity.



Rosalie Scott, Program Director, Lummi Counseling Services

A Multi-Pronged Harm Reduction & Integrated Health Care Approach

Multi-Pronged Approach

Indigenous Centered Praxis

- Cultural therapist to teach spirituality embodied by cedar, with weaving, beading, drawing, and carving.
- Canoe clubs offer cultural and spiritual connections: being on the water as a connection to the Creator.
- Meetings and community events with traditional prayers, ceremonial dance, and drumming.



Relationships

- Community-wide buy-in prior to launching OTP off the ground, and continued community involvement.
- Training collaborations with municipal fire department and technical college.
- Holistic collaborations and wrap-around services with tribal and non-tribal agencies addressing housing, justice system, jobs placement, counseling, etc.

Capacity Development

- Upgrading of skills and certifications of personnel required by the program.
- Adapt EHRs with local tribal college to understand population health needs.
- Continuous QI driven by client surveys.

Multi-Pronged Model of Harm Reduction and Integration

Integrating OUD care coordination and treatment offers a combination of key supports to address the complexities inherent in OUD and the multifaceted nature of the challenges that people face when dealing with addiction (Crummy et al., 2020). MAT has successfully incorporated a mixture of approaches tailored to their communities' needs, including harm reduction, various therapies, and support within their program. Research confirms that integrating the management of OUD with primary care, psychological needs, and other medical supports represents a promising practice in OUD treatment (Crummy et al., 2020, p. 39)

▶ **Why It Is Important.** The high frequency of comorbidities and polysubstance use among patients experiencing OUD suggests a multi-pronged approach to treating all types of SUD may be most effective (Crummy et al., 2020). Some models explicitly integrate OUD treatment within the larger context of primary care (McCarty et al., 2017), and integration of early treatment and treatment services into general primary care has increased (US Surgeon General, 2016).

▶ **Effectiveness.** MAT has been found to be more effective in reducing the quantity and frequency of opioid use when compared to treatments that do not use medication. The most promising MAT models of care included four components: (1) pharmacological therapy; (2) provider and community educational interventions; (3) coordination / integration of SUD treatment and other medical / psychological needs; and (4) psychosocial services / interventions (Chou et al., 2016). These components are generally integrated into individual, patient-centered programs coordinated by providers.

▶ **How the Multi-Pronged Approach Addresses Barriers to Care.** Barriers to implementing an integrative approach include the necessity for collaboration between support services such as health departments, social services, health care clinics, and other community-based services. Challenges include the lack of personnel representing these sectors; the low numbers of physicians authorized to prescribe MAT; ensuring HIPAA-compliant, SUD-specific EHRs; financial reimbursement from third-party payers; stigma from both providers and community members; staff training; and transportation. Addressing these barriers include strategies such as setting up web-based learning networks, telemedicine, using nurses or social workers to coordinate treatment, and community outreach efforts (Chou et al., 2016).



Lummi Nation's Healing Spirit Model

The Lummi Nation is located 100 miles north of Seattle, and 30 minutes south of the Canadian border in Northwest Washington State. The Lummi Nation began to see misuse of prescribed and illicit pain pills, particularly Oxycontin. When those became less available, use shifted to heroin, which was cheap and accessible to people already dependent on pain pills. As tolerance increased, use shifted to heroin, and some began to use intravenously. This contributed to increasing overdoses and deaths, and the spread of bloodborne pathogens. Community members, meeting weekly, advocated for more treatment services. The foundation of the Lummi CARE program, an abstinence-based AUD program, started more than 50 years ago. In 2007, Dr. Ron Horn was recruited to prescribe Suboxone (buprenorphine/naloxone). In this “office-based opioid treatment” (OBOT) program, MAT may be prescribed. The federal Drug Enforcement Administration’s then-100 patient per provider limit of allowed patients was quickly reached.

Why the Healing Spirit Clinic Developed

With a waiting list of over 100 patients seeking recovery services with the assistance of medication, community members and tribal leaders, led by Chairman Darryl Hillaire, supported the expansion of both Narcan distribution which had just been legalized in Washington State (2010) and the creation of an Opiate Treatment Program (OTP). In 2013, Lummi created a unique OTP using Suboxone instead of Methadone. This allowed the Lummi Healing Spirit Clinic OTP to treat more people than had previously been allowed under OBOT rules, and Lummi’s client numbers increased to over 300. It also allowed mid-level practitioners, PA-Cs & ARNPs, to work with doctors. The tribe saved money switching from prescribed buprenorphine under the OBOT rules to direct-to-patient-dispensed buprenorphine/naloxone under the OTP rules, and was able to treat three times as many clients for the same cost.

The decision to implement MAT for opiate use disorder started as a grassroots effort by tribal elders and family members who saw their relatives

dying from lack of treatment or inadequate treatment. Prior to 2013, Lummi clients had to seek care at another tribe’s methadone clinic one hour away. Some Lummi tribal members noted that patients taking methadone would nod out or act over-medicated. Many tribal members said they felt “more normal on Suboxone, than they did on Methadone.” Tribal leaders were aware that it was much easier to overdose on Methadone than on buprenorphine/naloxone. They were particularly concerned that a child could accidentally overdose on a family member’s methadone and die. Because of these reasons, tribal leaders preferred that the Lummi OTP only carry buprenorphine / naloxone, mono-buprenorphine (for pregnant women), naltrexone, oral and injection (Vivitrol).

One major element of the effectiveness of the Lummi Healing Spirit treatment is the availability of counseling, both chemical dependency and mental health, in a culturally appropriate environment. Additionally, clients have access to many support services. These wrap-around services, all run by the Lummi Nation or Tribal members, include homeless shelters, temporary housing, job placements, and educational opportunities.

How the Healing Spirit Clinic Developed

Using a community-based approach, Lummi tribal leaders and Lummi Counseling Services (formerly CARE Program) personnel, directed by Rosalie Scott, Program Director, Josie Jones, Program Assistant, and Matt Magrath, Program Sponsor provided information about various methods of opiate treatment to the community. The majority favored the MAT harm reduction model of treatment with Suboxone despite the high cost and limited availability.

To address the Suboxone treatment shortage, the tribe hosted multiple Tribal Council meetings, health commission meetings, General Council meetings, as well as grassroots sessions. Given the controversy surrounding addiction and addiction treatment, it was essential to get buy-in from residents before opening an OTP. But in Lummi's case, the need was voiced from the community, so Tribal Council support followed. With community and Tribal Council approval provided in 2011 and 2012, the Healing Spirit Clinic opened in 2013.



The Healing Spirit Model and Care Coordination Domains

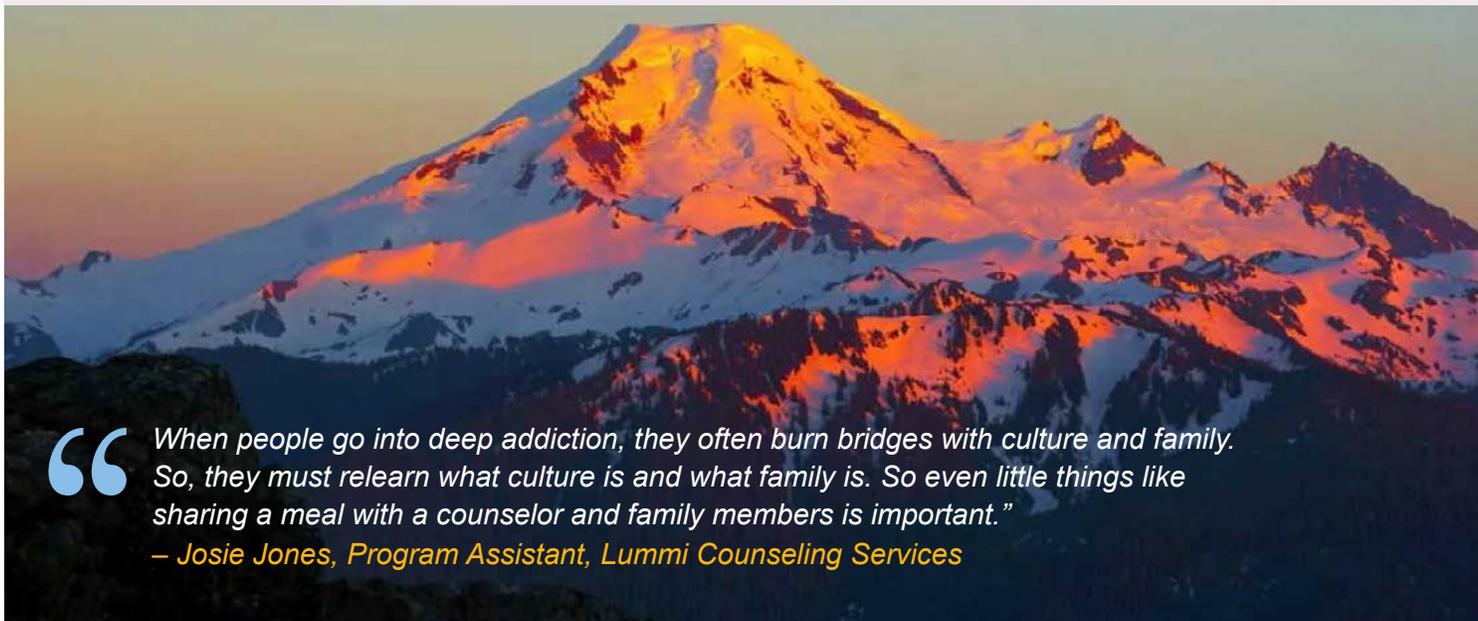
Indigenous Centered Praxis



The Healing Spirit Center maintains a Culture Room with a cultural therapist and cultural assistant, who help clients learn about the spirituality embodied by cedar, with weaving, beading, drawing, and carving.

On the prevention side, canoe clubs offer both cultural and spiritual connections, as being on the water is viewed traditionally as supporting a connection to the Creator.

Lummi meetings start with a prayer, and holiday or community events start off with traditional prayers, ceremonial dance, and drumming. These practices center spiritual practices and support ongoing cultural connectedness.



“When people go into deep addiction, they often burn bridges with culture and family. So, they must relearn what culture is and what family is. So even little things like sharing a meal with a counselor and family members is important.”

— Josie Jones, Program Assistant, Lummi Counseling Services

Relationships



The Lummi OTP hosts paramedic trainees, from the Bellingham Fire Department and the Technical College's paramedic training program, to learn more about addiction medicine and the positive outcomes that can occur from first responders' hard work.

On the prevention side of substance use, the Lummi Tribe participates in annual Regional/ International Canoe Journeys. Last year, the Lummi Tribe hosted tribes throughout the Northwest. The Lummi Counseling Services is exploring adding the Jamestown S'Klallam Canoe Journey curriculum / model for prevention, to expand cultural services already provided.

One of the hallmarks of the Lummi Healing Spirit Clinic is its integration with other tribal health and human services departments, as well as collaboration with local, non-tribal administrative agencies. Lummi's Drug Court Program, Housing Authority, Counseling Services, and homeless shelters coordinate with the Healing Spirit Clinic to support patient's needs. The Lummi Counseling Services program operates two transitional housing units that help those early in their recovery have a safe place to live. The homeless shelters are run by tribal members and offer another avenue for people in recovery to have a safe place to sleep.

The Behavioral Health Department has mental health counselors and a psychiatrist. In addition, funding from the Washington State Health Care Authority supports transitional job placements and phones to meet technology needs for clients. Patients may avail themselves of multiple tribally managed wrap-around services.

Capacity Development



The chemical dependency program includes certified counselors, and the OTP has physicians, mid-levels (PA-C & ARNP), and nurses.

Lummi has been training Recovery Coaches, grant-funded positions that cannot be billed through a third party, to become Peer Support Counselors. Peer support counselors with a SUD specialty can now bill services through a third party. This has an added benefit of providing opportunities for community members that have recovered from addiction to help others overcome the same struggles.

The Lummi clinic uses "Methasoft," an electronic health record which was specifically designed for OTPs. At the individual level, data collected includes client history, dosing & medication information from the pharmacy, physician, and counselors. There are annual physical records, as well as every-three-months follow-up records. (At the beginning of treatment, clients are seen weekly, and those visits are part of the record, as well.) Lummi added counseling assessments to adapt to individual patient needs, which include psycho-social, biomedical, and chemical dependency metrics. Group counseling sessions, and reports to various agencies/departments (i.e. drug-court, Child Protective Services, Indian Child Welfare, Vocational Rehab, etc.) are also included in the EHR.

At the systems level, the Lummi OTP employs continuous quality improvement, overseen by the Director of Healthcare Compliance and providing backend internal reviews. Client surveys are included in performance reviews to ensure the program meets client needs. Healthcare Compliance also reviews program data, ensuring adherence to federal and state guidelines.

The two most important takeaways from the Lummi OTP's experience with data systems are: (1) EHRs are limited, as their purpose is to record individual health outcomes, and they are not designed to assess population health trends. The clinic is working with Northwest Indian College to adapt the EHR to support understanding population health trends. (2) Survey Monkey and other free software can be used to assess client satisfaction and for other needs not captured in the EHR.



Summary

Within 2-3 years after the launch of the Lummi Healing Spirit Clinic in 2013, there was less stigma towards MAT in the community. Family members saw the positive results of MAT, affirming the community's initial acceptance of the program.

“ *With stigma, there was not much sharing, but with success, there was less judgment. Over time people got into a better space, and wanted to share their stories saying, 'I am very proud of where I am. I needed help, and was able to get it through the Suboxone program. I have my home, children and life back, and it is going to stay that way'*

– Rosalie Scott, Program Director, Lummi Counseling Services

Lummi's Healing Spirit Clinic is an effective model of an OTP that emphasizes a harm reduction approach with wrap-around services backed by community support. Community and council buy-in was achieved through thorough and transparent dissemination and discussion of promising practices at numerous community meetings. The EHR have been supplemented with other data collection efforts to assess client satisfaction and obtain qualitative data to elicit stories of success. Wrap-around services involving agreements and coordination with other tribal departments increase the likelihood of successful outcomes for OTP clients.

Moreover, leveraging partnerships and knowledge sharing with community partners has led to program growth and sustainability, while Lummi's quality improvement activities ensure the cultural match developed continues to meet community needs.

COMPONENTS OF Lummi Nation's Healing Spirit Clinic Model

Cultural Fit	Offers a Culture Room with a cultural therapist and cultural assistant to teach about spiritual aspects of traditional practices and traditional arts	Innovative Practice	Opened the first MAT using Suboxone in Indian Country	Knowledge Sharing	Meetings were held to discuss as a Nation the concerns regarding OUD in the community and how to best address the issues
Cross Sector Collaboration	Integrate services already offered by the tribal government w/ MAT Providers work together to support the Opiate Treatment Program	Meeting Community Needs	Syringe Service Program Naloxone kits distributed "door to door" Wrap-around services	Community Investment	OUD services started by the efforts of tribal elders and family members
Leadership	Tribal leaders supported the community's efforts Directors of different programs work together to meet the needs of clients	Professional & Cultural Development	Culturally focused curriculum is available for staff Agreements with the local college for paramedic training and internships	Sustainability	Funds are provided through a third-party billing agreement with the state
Data Infrastructure	Data systems integrated with existing EHRs Q1 for internal reviews Client satisfaction surveys	<p>The Lummi Nation harm reduction and integrated care approaches combines traditional Lummi values to individualize care with Western medicine, and provides integral contextual and cultural supports to ensure engagement and participation in chartering a tailored recovery journey.</p>			

Conclusion



This brief describes the tribal OUD and overdose prevention care coordination framework and illustrates Tribal Promising Practices by providing an overview of four tribal models to address OUD. Interviews with directors and managers of several tribal OUD and overdose prevention programs highlighted that Indigenous centered praxis, internal and external relationships, and organizational capacity undergird the tribal care coordination framework. These three domains of care coordination appear to be critical in addressing the opioid epidemic within tribal settings. They are operationalized through ten practice themes, which in turn, vary by the needs, priorities and the resources of tribal and urban Indian communities. The 10 promising practices include: (1) cultural fit, (2) innovative practice, (3) knowledge sharing, (4) cross-sector collaboration, (5) meeting community needs, (6) community investment, (7) leadership, (8) professional and cultural development, (9) sustainability, and (10) data infrastructure.

Providing a variety of supports and tailoring approaches to align with community priorities represent key features of tribal promising practices. The primary goal of care coordination is to save lives by preventing and reducing OUD and opioid overdose. Multiple approaches may be applied in the same community to best support tribes' OUD prevention, intervention, treatment, and recovery efforts.

The four successful models of OUD Tribal Care Coordination Promising Practices highlighted include: (1) a Harm Reduction model (White Earth Nation), an Integrated Healthcare model (Swinomish Tribe), a Peer Supports model (Pascua Yaqui Tribe), and a Mixed multi-pronged model (Lummi Nation). As Indigenous communities look towards their own cultures, community strengths and the type of support their people need to address OUD, other innovative approaches will likely emerge.

Despite important successes achieved in the past 20 years in addressing OUD using evidence-based, culturally-informed prevention, treatment and recovery approaches, some tribal communities find data management, infrastructure systems, and development and/or identification of data tools major challenges. While tribal data sovereignty provides the basis for opioid use data collection, management, and analysis, issues of data sharing across jurisdictions and departments, the lack of standard definitions of key variables, racial misclassification, and the paucity of OUD measures tested and confirmed within AI/AN populations remain barriers to the full realization of a data system that accurately reflects tribal population health needs and outcomes.

The CDC has identified Health Information Technologies (HIT) as a possible approach to addressing these issues. HIT may include EHR from one or more health organizations and other care coordination partners such as law enforcement and court records, PDMPs, telehealth information, personal health records (PHR), and external health information exchanges (HIE). While many tribal settings continue to utilize Indian Health Service,

which has begun implementing HIE to facilitate the exchange of information across internal and external organizations, others have developed their own systems for data collection, management, and analysis. Care Coordination is improved with strong data / data Infrastructures. Data systems such as HIT use technology to improve care coordination (CDC, 2018), and may be an important resource moving forward.

Barriers to Success

- **Stigma** related to SUD, MAT, mental health, and behavioral health may be an issue that could hinder progress.
- **Economic barriers and lack of resources** could prevent some programs from building capacity and improving infrastructure.
- **Key metrics for measuring success** are evolving and not currently well-defined in substance use disorder treatment. It may therefore be difficult to generate evidence for practice.
- **Racial misclassification and the lack of AI/AN specific data** present key challenges in obtaining data to identify trends and priorities for specific communities and regions.
- **Terminology used to describe OUD** can be confusing or misapplied. For example, the terms opiate and opioid are often used without clear definitions. An opiate is a natural substance that comes from opium (from a plant) – morphine, codeine, etc. Opioids are synthetic or semi-synthetic drugs (medications) – oxycodone, hydrocodone, methadone, fentanyl, etc.

Diversity of Tribes

- While AI/AN communities might share a history of trauma from colonization, they each have a distinct culture, context, and needs. Some interview participants noted that many substance use treatment approaches lump all indigenous communities together and treat them as one group, which can result in poor uptake or delivery of care if cultural and contextual characteristics are not aligned with a given substance use treatment approach.
- Some tribes in rural communities feel isolated and require additional connections, such as peer support, to provide additional guidance and advice.
- Tribes surrounded by large non-Native populations and urban Indian communities may have specific needs or require strategies that account for majority group interaction and lack of culturally tailored substance use treatment options.
- Some interview participants made a distinction between tribal and urban Indian programs / organizations, recognizing that these two types of AI/AN communities may have unique considerations that inform how OUD programs are developed and implemented.

Alcohol and Other Drugs

Opioids may not be the only substance misused in tribal communities. OUD programs and supports need to be flexible enough to include treatment for additional substances such as methamphetamine or alcohol.

Improving management and coordination of long-term opioid therapy requires not only a refined approach to the clinical care of patients but also strategies that can be deployed at the practice- and system-level of care delivery. These strategies include establishing or revising internal opioid policies, developing registries and using panel management, employing team-based approaches, and effectively using technology to strengthen care coordination and data infrastructure (AHRQ, 2014; CDC, 2018; Hajewski et al., 2014; Hodgins et al., 2014; Neven et al., 2016; Quinn et al., 2017; SAMHSA, 2019)



Fighting for the Future: Recommendations

1. Hold on to cultural teaching and relationships.

Tribal communities share a history of losses due to epidemics that have swept through tribal communities over the past 500 years. As Indigenous communities respond to the coronavirus pandemic, the challenges of providing services and support to those who struggle with OUD have rapidly become more challenging and complex. Issues such as ability to purchase the supplies and tools necessary to prevent transmission of this highly contagious novel virus have consumed many tribal communities. Taking the time to reflect on tribal cultures and relationships may seem difficult given the emergency response tribal communities and practitioners must also mount to address COVID-19. However, community values, priorities, and needs represent crucial guides in how to best address the added risk and urgent response needed to protect vulnerable community members.

2. Exercise data sovereignty by investing in data infrastructure.

By establishing a comprehensive data collection and management system that addresses both clinical care objectives along with implementation and process goals, as well as offers opportunities to track changes in health outcomes over time, tribes will have the opportunity to fully realize tribal sovereignty in this area of care delivery. As the experts that contributed to this report point out, data systems require careful planning and ongoing maintenance and review to ensure continued relevance and accessibility of data. Financial and human resources, including time and expertise, are needed to bring this about.

3. Tribal promising practices offer an opportunity to establish quality of care and fidelity indicators specific to tribal settings.

Actual tribal practices in OUD care coordination may look different across tribal communities as the tribal promising practices are likely implemented in ways that best fit a given community. Reviewing how these ten promising practices are operationalized within the three domains of (1) Indigenous centered praxis, (2) relationships, and (3) capacity development in programs represents a first step towards identifying best practices within tribal nations. Clarifying how each practice is implemented can provide a basis for assessing fidelity and quality of care.

TRIBAL PROMISING PRACTICES



Indigenous Centered Praxis

1. Cultural fit
2. Innovative practice
3. Knowledge sharing



Relationships

4. Cross-sector collaboration
5. Meeting community needs
6. Community investment
7. Leadership



Capacity Development

8. Professional and cultural development
9. Sustainability, and
10. Data infrastructure

References

- Altekruse, S., Cosgrove, C., Altekruse, W., Jenkins, R., & Blanco, C. (2020). Socioeconomic risk factors for fatal opioid overdoses in the United States: Findings from the mortality disparities in American communities study (MDAC). *PLoS One*, *15*(1), E0227966.
- Bagley S. M., Schoenberger S. F., Wayne K. M., & Walley A. Y. (2019). A scoping review of post opioid-overdose interventions. *Preventive Medicine*. 2019;128:105813. doi:10.1016/j.yjmed.2019.105813
- Bardwell, G., Kerr, T., Boyd, J., & Mcneil, R. (2018). Characterizing peer roles in an overdose crisis: Preferences for peer workers in overdose response programs in emergency shelters. *Drug and Alcohol Dependence*, *190*, 6-8.
- Bukten, A., Skurtveit, S., Gossop, M., Waal, H., Stangeland, P., Havnes, I., & Clausen, T. (2012). Engagement with opioid maintenance treatment and reductions in crime: A longitudinal national cohort study. *Addiction*, *107*(2), 393-399.
- Centers for Disease Control and Prevention. (2018). *Quality improvement and care coordination: Implementing the CDC guideline for prescribing opioids for chronic pain*.
- Centers for Disease Control and Prevention. (2017). *Prevent opioid use disorder*. <https://www.cdc.gov/drugoverdose/prevention/opioid-use-disorder.html>
- Chimbar, L., & Moleta, Y. (2018). Naloxone Effectiveness: A Systematic Review. *Journal of Addictions Nursing*, *29*(3), 167-171.
- Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., Hoepfner, B., Weinstein, C., & Kelly, J. R. (2019). Lived experience in new models of care for substance use disorder: A systematic review of peer recovery support services and recovery coaching. *Frontiers in Psychology*. doi:10.3389/fpsyg.2019.01052
- Fanucchi, L., Walsh, S., Thornton, A., & Lofwall, M. (2019). Integrated outpatient treatment of opioid use disorder and injection-related infections: A description of a new care model. *Preventive Medicine*, *128*, 105760.
- Goodman, D., Saunders, E., and Wolff, K. (2020). In their own words: a qualitative study of factors promoting resilience and recovery among postpartum women with opioid use disorders. *BMC Pregnancy and Childbirth*. doi:10.1186/s12884-020-02872-5
- Hajewski, C. J., & Shirey, M. R. (2014). Care coordination: a model for the acute care hospital setting. *JONA: The Journal of Nursing Administration*, *44*(11), 577-585.
- Harfield, S. G., Davy, C., McArthur, A., Munn, Z., Brown, A., & Brown, N. (2018). Characteristics of Indigenous primary health care service delivery models: A systematic scoping review. *Globalization and Health*, *14*(1), 12.
- Hodgins, F. E., Lang, J. M., Malseptic, G. G., Melby, L. H., & Connolly, K. A. (2019). Coordinating outpatient care for pregnant and postpartum women with opioid use disorder: Implications from the COACH program. *Maternal and Child Health Journal*, *23*(5), 585-591.

Indian Health Service. (n.d.). *Opioid crisis data: Understanding the epidemic*. <https://www.ihs.gov/opioids/data/>

Lavalley, J., Kastor, S., Valleriani, J., & Mcneil, R. (2018). Reconciliation and Canada's overdose crisis: Responding to the needs of Indigenous Peoples. *CMAJ: Canadian Medical Association Journal = Journal De L'Association Medicale Canadienne*, 190(50), E1466-E1467.

Leston, J., Crisp, C., Lee, M., & Rink, E. (2020). Interviews with American Indian and Alaska Native people who inject drugs. *American Indian and Alaska Native Mental Health Research (Online)*, 27(1), 64-85.

Lewis, M., & Myhra, L. (2017). Integrated care with Indigenous populations: A systematic review of the literature. *American Indian and Alaska Native Mental Health Research: The Journal of the National Center*, 24(3), 88-110.

Lewis, M., & Myhra, L. (2018). Integrated Care with Indigenous populations: Considering the role of health care systems in health disparities. *Journal of Health Care for the Poor and Underserved*, 29(3), 1083-1107.

Magarati, M., Ignacio, M., Crowder, R. Brown, C., Diego, C., Egashira, L. & Parker, M. (2019). *An Environmental Scan of Tribal Opioid Overdose Prevention Responses: Community-Based Strategies and Public Health Data Infrastructure*. Seven Directions, A Center for Indigenous Public Health, University of Washington, Seattle, WA. https://assets.website-files.com/5d68735d677c2aa989f0317b/5da8c57dcbc040a41d532331_ENV.SCAN_TribalOpioidOverdosePrevent_Sep2019-compressed.pdf

Marlatt, G., & Witkiewitz, K. (2002). Harm reduction approaches to alcohol use: Health promotion, prevention, and treatment. *Addictive Behaviors*, 27(6), 867-886.

Mancher, M., Leshner, Alan I., & National Academies of Sciences, Engineering, Medicine. Committee on Medication-Assisted Treatment for Opioid Use Disorder, issuing body. (2019). *Medications for opioid use disorder save lives* (Consensus study report). Washington, DC: National Academies Press.

Mann, J., Quigley, R., Harvey, D., Tait, M., Williams, G., & Strivens, E. (2020). OPEN ARCH: integrated care at the primary–secondary interface for the community-dwelling older person with complex needs. *Australian Journal of Primary Health*. doi:10.1071/PY19184

National Institutes of Health HEAL Initiative. (2020). *'To Walk in the Beauty Way': Treating Opioid Use Disorder in Native Communities*. <https://heal.nih.gov/news/stories/native-cultures>

Neven, D., Paulozzi, L., Howell, D., McPherson, S., Murphy, S. M., Grohs, B., Marsh, L., Lederhos, C., & Roll, J. (2016). A randomized controlled trial of a citywide emergency department care coordination program to reduce prescription opioid related emergency department visits. *The Journal of Emergency Medicine*, 51(5), 498-507.

Ng, J. R., Sutherland, C., & Kolber, M. (2017). Does evidence support supervised injection sites? *Canadian Family Physician*, 63(11), 866.

Powell K. G., Treitler P., Peterson N. A., Borys S., & Hallcom D. K. (2019) Promoting opioid overdose prevention and recovery: An exploratory study of an innovative intervention model to address opioid abuse. *International Journal of Drug Policy*, 64:21-29. doi:10.1016/j.drugpo.2018.12.004

- Pro, G., & Zaller, N. (2020). Interaction effects in the association between methadone maintenance therapy and experiences of racial discrimination in U.S. healthcare settings. *PLoS One*, *15*(2), E0228755.
- Quinn, A. E., Rubinsky, A. D., Fernandez, A. C., Hahm, H. C., & Samet, J. H. (2017). A research agenda to advance the coordination of care for general medical and substance use disorders. *Psychiatric Services*, *68*(4):400-404. doi: 10.1176/appi.ps.201600070
- Rieckmann, T., Moore, L., Croy, C., Aarons, G., & Novins, D. (2017). National Overview of Medication-Assisted Treatment for American Indians and Alaska Natives with Substance Use Disorders. *Psychiatric Services*, *68*(11), 1136-1143.
- Rowan, M., Poole, N., Shea, B., Gone, J. P., Mykota, D., Farag, M., Hopkins, C., Hall, L., Mushquash, C., & Dell, C. (2014). Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study. *Substance Abuse Treatment, Prevention, and Policy*, *9*, 34. <https://doi.org/10.1186/1747-597X-9-34>
- Samuels, E. A., Bernstein, S. L., Marshall, B. D. L., Krieger, M., Baird, J., & Mello, M. J. (2018). Peer navigation and take-home naloxone for opioid overdose emergency department patients: Preliminary patient outcomes. *Journal of Substance Abuse Treatment*, *94*:29-34. doi:10.1016/j.jsat.2018.07.013
- Scott C. K., Dennis M. L. Grella, C. E., Kurz, R., Sumpter, J., Nicholson, L., & Funk, R. (2019). A community outreach intervention to link individuals with opioid use disorders to medication-assisted treatment. *Journal of Substance Abuse Treatment*, *108*:75-81. doi:10.1016/j.jsat.2019.07.001
- Stancliff, S., Medley, B., Matthews, W. (2019). Harm reduction: Caring for people who misuse opioids. In Compton, M., Manseau, M. W., & American Psychiatric Association Publishing, issuing body. (Eds). *The American opioid epidemic: From patient care to public health* (pp. 337-359). Washington, D.C: American Psychiatric Association Publishing.
- Substance Abuse and Mental Health Services Administration. (2019). *Intensive care coordination for children and youth with complex mental and substance use disorders: State and community profiles*. SAMHSA Publication No. PEP19-04-01-001. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Venner, K., Donovan, D. M., Campbell, A., Wendt, D., Rieckmann, T., Radin, S., Momper, S. L., & Rosa, C. (2018). Future directions for medication assisted treatment for opioid use disorder with American Indian/Alaska Natives. *Addictive Behaviors*, *86*, 111-117. doi: 10.1016/j.addbeh.2018.05.017
- Waye, K.M., Goyer, J., Dettor, D., & Marshall, B. D. L. (2019). Implementing peer recovery services for overdose prevention in Rhode Island: An examination of two outreach-based approaches. *Addictive Behaviors*, *2019 Feb*;89:85-91. doi:10.1016/j.addbeh.2018.09.027
- Witkiewitz, K. (2005). Defining Relapse from a Harm Reduction Perspective. *Journal of Evidence-Based Social Work*, *2*(1-2), 191-206.
- World Health Organization. (2016). Integrated Care Models: an Overview. http://www.euro.who.int/__data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf

A. Series 1 Interview Guide

Opioid Interview Semi-Structured Interview Guide	
Participant domains: Data, Program, Admin, OD Prevention, Recovery, Pain Management (n=9)	
Intro	<p>Introduce self and 7D at the start of the call.</p> <p>“Hello, this is [name] calling on behalf of Seven Directions to discuss your opioid prevention programming. Is now still a good time to talk?”</p> <p>If YES: “Great. Our purpose is to gain a better understanding of opioid prevention activities across AI/AN communities. We are asking for your participation in a one-time interview to obtain a better understanding of opioid-related programming as it relates to: organizations, service delivery, data infrastructure, and community. We will use the data to supplement our findings in the environmental scan report we have developed around tribal responses to opioid use and death prevention and care, and possibly for reports to CDC and tribal programs. Your identity (name/position), however, will be kept confidential. We may use direct quotes; however, we will not use any identifiers except for the name of your organization/tribe. Do we have your permission to audio record? Do we have permission to list your organization and the community and tribe(s) you work with?”</p> <p>If YES, begin recording using Temi app and additional backup recording device. (Let them know you are about to start recording. This may take you a few seconds, or a bit longer. If you tell them, then they will be fine waiting for you to make sure that the recorder is on. Make sure the app is on.)</p>
Contact Information	<p>Name:</p> <p>Organization:</p> <p>Community:</p> <p>Program: (Behavioral Health/Human Services etc.)</p> <p>Phone:</p> <p>Email:</p>
A. Program-related	<ol style="list-style-type: none"> 1. What are the goals of your program specific to opioids and wellness? 2. Who are your target populations? (e.g. all community members or those who are referred to) 3. What cultural values guide your program if any? For example, some programs emphasize Indigenous “relationship building” or “community” input from clients, which could also be faith-based values as well. 4. What types of evidence-based practices do you use or recommend in your program? (Or best practices) (e.g., incentives, integration of case management, and health information system improvements). 5. What culturally-specific services do you offer or recommend as part of your program? 6. What are the barriers to the success of your program?

B. Series 2 Interview Guide

Best Practices/Promising Practices Care Coordination and Data Infrastructure Interview Guide

n=4

Intro

Before the call: Email and schedule a time for an hour call for an interview regarding Best/Promising Practices focused on **OUD and Opioid Overdose Prevention, Treatment, Recovery**.

At the time of the call:

Introduce yourself and your role at Seven Directions at the start of the call.

“Hello, this is [name] calling on behalf of Seven Directions to ask you some questions regarding [PROGRAM/MODEL].

Your program was identified as a promising/best practice by...

We emailed you on [date] to request a call to complete this questionnaire. There are [#] sections which will take about 45 - 60 minutes to go through.

We are identifying three models of Tribal Best/Promising Practices for Care Coordination, Systems of data collection, and Evaluation to measure success that focused on OUD and Opioid Overdose Prevention, Treatment, Recovery, Seven Directions will summarize these Models of Tribal Promising/Best Practices with the aim to disseminate broadly for other tribal communities to learn from your work. We intend for other tribal communities to learn from your work. We intend for these Models to serve as resources for other indigenous communities looking for successful examples of how to approach opioid overdose prevention and data infrastructure development.

Is this a good time to talk?

If NO...Ask to reschedule.

If YES...

Great. Before we begin, I want to make sure I am capturing the correct information. I would like to go back to review our conversation after we are done. Do you mind if I record our discussion?

If NO...don't record and take good notes. Start the interview.

If YES...before starting the interview. Ask...

C. Reflection

Reflections of Care Coordination and Data Infrastructure and Tribal Applications

The stories provided below as “Reflections of Care Coordination” are depictions of how Care Coordination domains could be applied in a tribal community. All these scenarios are a combination of possible situations and are only used as examples. They are not based on real people.

A Day in a Life: Story #1

A 20-year-old woman is in need of housing after successfully leaving an abusive relationship. Four months pregnant, she has been able to lean on her network of relatives and friends for temporary shelter, but is usually asked to leave after a few weeks. She continues to “shoot up” (inject) opioids, and has not been able to see a doctor. This is her second child and she knows Child Protective Services will be involved. She has been in the behavioral health system since she was a teenager and she feels nothing has helped her. She has been in and out of group homes and substance abuse programs. However, she has a positive relationship with her therapist and continues to stay in touch when she is around the reservation. Her therapist has been working with her around enrolling in the tribe’s MAT.

Today she decided to go to the MAT since she stopped by the tribe’s WIC program (Special Supplemental Nutrition Program for Women, Infants, and Children) and they helped her with some food and provided some resources for her to call. Seeing the pictures on the wall with mothers and babies gets her thinking about her life. She decided to visit the Traditional Healers that were at the MAT clinic that day as a walk-in appointment. While leaving the Healer’s room, the psychiatrist walks over to greet her. She is aware of her situation and asks if there is anything she could help her with. She is able to do a physical examination and treat her abscesses on her arms and legs; however, she encourages her to see her primary care provider which she agrees with, too. Together, they walk down the hall to the healthcare facility where they are able to fit her in for an appointment. While she waits for her doctor’s appointment, the psychiatrist runs back to her office to order her medications to the on-site pharmacy as she completed her notes in their electronic health system so her primary doctor gets the most updated information.

Reflection Questions to Consider:

What are some Care Coordination domains you can identify in this “Day in a Life?”

- Cultural Fit
- Innovative Practice
- Community investment
- Cross-sector collaboration
- Knowledge Sharing
- Meeting community needs
- Leadership
- Data Infrastructure

What are some possible “care coordination” types of support needed?



Indigenous Centered Praxis:

- What cultural aspects are important to my community and organization?
- What type of services could be incorporated into our cultural beliefs and practices?
- What does traditional healing mean in our community and what can be supported?
- What would our elders say and recommend?



Relationships:

- What are my community's needs in OUD?
- How does my community view OUD?
- How are we educating leadership and the community?
- How are tribal leadership views of OUD?
- What partnerships have been established and which are needed?
- How do care coordination practices help providers with "meeting clients where they are at?"
- What cultural aspects or practices might help build supportive relationships with the client?



Capacity Development:

- How does "care coordination" look in our organization?
- Define "care coordination" in your setting:
- What aspects of "care coordination" are important in your program?
- What steps can you take to develop your "care coordination" approach?
- What type of trainings are needed for staff, other support service staff including the community?
- How are health information systems connected or integrated for data sharing within the organization?
- What data exchanges and data agreements are currently in place or are needed outside the organization?
- What type of data is collected to support services and track progress?
- How does care coordination utilize a strengths-based approach to working with clients?

A Day in a Life: Story #2

A single, middle-age, father of two young children currently lives in a residential treatment home. Through the generations of his family, there has been a struggle of addictions and abuse. The tribe's Child Protection Services has been overseeing his situation since the tribe's housing authority found his children alone in the home while he was at work. The man's elderly mother is able to care for the children now, but she has serious health conditions, and due to a lack of childcare is unable to make her doctor's appointments. It's the clinic's policy that minors cannot be left alone in the clinic's waiting room.

Today the residential treatment's caseworker drops him at the tribe's MAT program for his daily dose and services. If their van was not available, he would have had to schedule for the non-emergency transportation service covered by his Medicaid plan; otherwise, he would miss his dosing. As he checks-in with the front office worker, she pulls up his EHR and sees he is not due for his urinalysis until next week. She marks him as "Show" in their patient management system to alert his therapist that he has arrived so they can meet and update his treatment plan.

As the father turns to sit down, he sees his Peer Support worker, who stops to greet him. They both have been cultural participants since they were young so they know each other's families and circle of friends. His Peer Support lets him know that the Traditional Healers are in today and encourage him to see them for a "cleansing." His Peer Support worker knows he has been missing his family and has been worried about finding a job to help out his mother with some bills. He thanks him with a head nod and walks into the dosing room.

Reflection Questions to Consider:

What are some Care Coordination domains you can identify in this "Day in a Life?"

- | | |
|--|---|
| <input type="checkbox"/> Cultural Fit | <input type="checkbox"/> Cross-sector collaboration |
| <input type="checkbox"/> Innovative Practice | <input type="checkbox"/> Sustainability |
| <input type="checkbox"/> Knowledge sharing | <input type="checkbox"/> Leadership |
| <input type="checkbox"/> Meeting community needs | <input type="checkbox"/> Data Infrastructure |
| <input type="checkbox"/> Community investment | |

What are some possible "care coordination" types of support needed?



Indigenous Centered Praxis:

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- What type of services could be incorporated into our cultural beliefs and practices?
- What does traditional healing mean in our community and what can be supported?
- What would our elders say and recommend?



Relationships:

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