Northwest Tribes Opioid Response Strategic Agenda
General Opioid Response Categories

A. Major Goal #1: Prevention
1. Community Education
2. Medication Safety

B. Major Goal #2: Clinical Treatment and Recovery
1. Provider Education
2. Expand OUD Treatment Services – MAT
3. Improve Access to OUD Treatment
4. Behavioral Health
5. Recovery Services

C. Major Goal #3: Perinatal Opioid Use Disorder and Neonatal Opioid Withdrawal Syndrome
1. Prevent Neonatal Opioid Withdrawal Syndrome (NOWS)
2. Enhance Care for Neonatal Opioid Withdrawal Syndrome (NOWS)

D. Major Goal #4: Harm Reduction
1. Naloxone
2. Improve Health Outcomes Among People Who Use Drugs
3. Law Enforcement
4. Harm Reduction Policy

E. Major Goal #5: Data and Surveillance
1. Surveillance
2. Data Improvement
3. Data Dissemination

F. Major Goal #6: Research

G. Major Goal #7: Organizational Development
1. Leadership
2. Relationships
3. Workforce Development
4. Advocacy

GOALS, STRATEGIES AND METRICS

A. Major Goal #1: Prevention

1. Community Education

a. Increase AI/AN community awareness of opioid response in Indian Country.
b. Design and launch an educational campaign (both print and web-based media and marketing) to address one or more of the following:
    i. Targeted and culturally appropriate public education campaigns on the potential harms of prescription medication misuse and abuse and secure home storage of medication.
        1.
    ii. Science-based education campaigns to improve the public's understanding of OUD, as well as evidence-based and culturally-based treatments, historical and intergenerational trauma, prevention strategies, and to eliminate stigma associated with the disease.
    iii. Decreasing stigma, protective factors influencing health outcomes.
c. Increase and support the use of school- and community-based prevention programs that are evidence-based to prevent misuse of opioids and other substances.
d. Provide education on adverse childhood experiences, trauma, suicide prevention, tobacco prevention, mental health, and the spectrum of care for OUD to community.
e. Adopt best practice prevention curriculum in pre-K and K-12 schools, such as It's Your Game, Keep it Real, Native STAND, Healing of the Canoe, WeRNATIVE Teacher's Guide, White Bison, Pulling Together in Wellness, etc.
f. Work with community coalitions and school districts to implement strategies to prevent misuse of opioids and other substances among youth.
g. Provide presentations and training to school staff and administration about opioid prevention strategies.
h. Identify and allocate resources for culturally relevant evidence-based programs for families and caregivers of youth with or at risk for OUD, including tribal-based practices, (traditional medicine and medicine people, ceremonies, etc.).
i. Engage community and faith-based organizations to use evidence-based messages on prevention, treatment, and recovery.
j. Encourage and lead conversations beyond abstinence as a means to recovery.
k. Discuss the impacts of colonization, including historical and inter-generational trauma, on OUD and incorporate into education and prevention campaigns.
l. Expand culturally appropriate primary prevention and awareness activities for Tribal youth to reduce the risk of substance use initiation.
m. Adapt curriculum to target priority populations that include Two Spirit/LGBTQ, sex workers, and homeless youth, felons, etc.

2. Medication Safety

a. Provide lock boxes for medication storage and promote safe use, storage, and disposal of prescription medications, including opioids and partial-agonists, to prevent misuse, and illicit acquisition and distribution.
    i. Identify and promote other, more secure methods of medication storage rather than relying on child locks and child-proof medication containers.

b. Educate medical staff, patients, and consumers on safe consumption of prescription medications and drug-drug interactions.
c. Educate patients about best practices for managing acute pain, including the risks and benefits of opioids and opioid alternatives.
d. Locate and share medication disposal and take-back programs at police stations and other central locations with community members.
e. Implement and promote medication disposal programs and take-back at local pharmacies, clinics, and hospitals.
f. Facilitate proper home disposal of unused opioid prescription medications and other prescription drugs such as benzodiazepines and gabapentin.
g. Develop patient education tools to implement at clinics and pharmacies and limit the number of pills prescribed at once.
h. Discuss potential new policies to eliminate paper prescriptions.
i. Educate dental providers and clinics on medication safety, prescribing best practices, and how to recognize OUD in patients.

B. Major Goal #2: Clinical Treatment and Recovery

1. Provider Education

a. Provide health care providers and other staff working in native communities with ongoing training on harm reduction and OUD treatment best practices, policies, and interventions.
b. Educate and build capacity of health care providers to recognize signs of opioid misuse, effectively identify patients misusing opioids and other substances, and link patients to appropriate treatment resources in a non-stigmatizing way.
c. Build skills of health care providers to have supportive patient conversations about problematic opioid use and treatment options.
d. Offer and raise awareness of educational opportunities (virtual and in person) on evidence-based practices associated with pain management, prescribing, alternative therapies, addiction, and treatment.
e. Ensure tribal health clinics are aware of opioid prescribing indicators available in EHR and encourage review of the prescribing practices of their staff and patient level risk.
f. Work to include information on opioid and other SUD evidence-based treatment in I/T/U Clinics.
g. Develop and disseminate toolkit and repository of resources for healthcare providers on best practices associated with opioid prescribing, pain management, addiction, and patient education.
h. Assess clinic adoption of standard opioid prescribing and pain management best practices.
    i. Include traditional ways of understanding and managing pain.
i. Develop guidelines and policies, as needed, to manage patients on high dose chronic opioids, tapering strategies, use of non-opioid alternatives, and pain self-management education.
j. Increase the use of the Prescription Drug Monitoring Program (PDMP) among health care providers to help identify opioid use patterns, opioid/sedative co-prescribing, and indicators of poorly coordinated care.
k. Educate prescribers on available reports to understand their prescribing practices, including compliance with opioid prescribing standards, acute pain, if their practices significantly differ from other prescribers in their specialty.
l. Increase the number of health systems that adopt screening and prescribing guidelines to reduce the number of patients receiving >90 mg morphine-equivalent doses per day.
m. Educate healthcare professionals regarding drug-drug interactions between opioids and other medications, including the interactions between opioids and benzodiazepines, alcohol, and gabapentin.
n. Encourage the use of multidisciplinary team models for the management of pain.
o. Explore options for passive and active overdose follow up with health care providers.
p. Educate dental providers and clinics on safe prescribing practices and how to recognize OUD.
q. Promote OUD treatment education in medical, nursing, and other healthcare professional schools.
r. Adopt practices that promote trauma informed care including safety, choice, collaboration, trustworthiness, and empowerment.

2. Expand OUD Treatment Services – MAT

a. Engage and retain people with OUD in treatment and recovery services. Focus areas include:
    i. Expanding services to help those with OUD find stable housing.
    ii. Seek funding for patient transportation, including transportation to and from I/T/U clinics.
    iii. Incorporate childcare options for parents receiving MAT and OTP services to increase retention rates.

iv. Expanding the use of case managers and care navigators to help patients reduce illicit drug use and improve health by accessing the appropriate level of care and ancillary services for their OUD, (e.g., OTP or office-based opioid treatment, OUD/ SUD counseling, mental health services, suicide prevention, tobacco cessation, contraception, or medical care);
v. Expanding recovery support/coach programs, evaluating their impact, and developing financial sustainability models.

b. Increase the number of AI/AN patients with OUD receiving MAT, by increasing organizational linkages and professional learning opportunities for providers who work in I/T/U clinics and OTPs.
c. Increase participation, enrollment, and retention of people with OUD in treatment services.
d. Advance telehealth direct care and consultation approaches to MAT, including project ECHO, UCSF Warmline, etc.
e. Strengthen acceptance of OUD medications in housing and residential programs serving persons with OUD.
f. Follow best practices related to MAT and companion psychosocial treatment, such as coordinated, holistic, culturally appropriate, person- and family-centered treatment of OUD, including the utilization of a broad range of providers, ancillary professionals, and team-based care.
g. Increase the number and/or capacity of Treatment Programs and encourage them to offer all medications approved by the FDA for the treatment of OUD.
h. Increase the number of DATA 2000-Waivered providers I/T/U clinics.
i. Develop model for sustainable funding for MAT or OTP programs.
j. Adopt treatment and care models for co-occurring conditions and related factors that influence health outcomes (alcohol and other drugs, sexual assault, suicide, LGBTQ 2 Spirit and mental health).
k. Cultivate a learning community that will contribute to best practice guidelines and policy templates addressing opioid misuse in AI/AN communities.
l. Assess need for family-centered in-patient treatment facility and/or in-home outpatient treatment.
m. Develop ER-based MAT induction programs.

3. Improve Access to OUD Treatment

a. Determine the location, treatment capacity, and patient load of active waivered buprenorphine prescribers and identify areas with lack of prescribers.
b. Provide co-located OUD and behavioral health services.
c. Scale up jail to community MAT programs.
d. Work with jails and prisons to initiate and/or maintain incarcerated persons on medications for OUD.
e. Address housing and transportation needs of those with OUD to support successful recovery.
    i. Including addressing the need for housing for people in recovery with past criminal involvement.
f. Establish access to the full continuum of care for persons with OUD to include low barrier access to medication, office-based OTPs, OTPs, SUD treatment programs, mental health services, pain management, healthcare, recovery support services, service programs, emergency rooms and hospitals.
g. Pilot new models of care to support primary care in accepting patients who have been induced in low-barrier settings, including SSPs, whose care needs are complicated by mental illness, polysubstance abuse and/or living homeless.
h. Develop a response strategy to respond to disruptions to OTPs during natural disasters.
i. Ensure medically-managed withdrawal (“detoxification”) facilities are accessible.
j. Create a resource guide to include validated resources, and make available to all stakeholders.

k. Work with hospital ERs regarding referrals post-discharge for OUD.
l. Track, screen, prevent, and refer to treatment patients with OUD and SUD who have infectious complications, including HIV, viral hepatitis, and endocarditis, particularly among persons who inject drugs. This can be done through SSPs, other culturally-based and evidence-based strategies.

4. Behavioral Health

a. Increase the number of behavioral health providers knowledgeable about SUD/ OUD, including psychiatrists, primary care providers with specialized addiction training, peer recovery specialists, social workers, and others.
b. Strengthen the education process demonstrating the value of peer and recovery supports through Recovery Community Centers and other recovery-oriented systems and services.
c. Follow best practices related to MAT and companion psychosocial treatment, such as coordinated, holistic, culturally appropriate, person- and family-centered treatment of OUD, including the utilization of a broad range of providers, ancillary professionals, and team-based care.
d. Encourage medical and behavioral health providers to screen all patients with OUD for depression, suicide, tobacco use, etc.
e. Develop guidance on how to maintain HIPPA compliance for cross-sectional communication between medical, behavioral health, social services, mental health services, etc.

5. Recovery Services

a. Enhance discharge coordination for people leaving inpatient treatment facilities who require linkages to home and community-based services and social supports, including:
    i. Housing
    ii. Sober/transitional living facilities
    iii. Transportation
    iv. Case management
    v. Medical and behavioral health services
    vi. Food assistance
    vii. Employment
    viii. Faith-based organizations
b. Increase family recovery support services, (e.g., Narcotics Anonymous and Nar-Anon Family Groups, etc.).
c. Enable family-centered treatment that endeavors to keep families and caregivers together in their homes and communities, including utilizing out of home care only when in the best interest of the child.
d. Provide culturally and linguistically appropriate education and support to individuals, families, and caregivers to understand the importance of recovery and to find and access a range of evidence-based services.
e. Identify innovative ways to expand recovery services as part of a continuum of services to support stable and long-term recovery.
f. Support the development of recovery communities, recovery coaches, and recovery community organizations to expand the availability of and access to recovery support services.
g. Increase cultural curriculum for healing through sweat lodges, traditional dance, drumming circles, elders teaching (guidance), traditional art practices, and other ceremonies.

C. Major Goal #3: Perinatal Opioid Use Disorder and Neonatal Opioid Withdrawal Syndrome

1. Prevent Neonatal Opioid Withdrawal Syndrome (NOWS)

a. Create an accessible range of culturally relevant treatment options to support pregnant and parenting women with OUD.
b. Increase access to MAT for pregnant women using substances
c. Increase the number of designated women's and family treatment centers.
d. Educate maternity care providers to identify and treat (or rapidly refer) women with SUD, including OUD, who are pregnant or parenting.
e. Link pregnant and post-partum women to appropriate services with the goal of keeping mom and baby together, (e.g., Parent and Child Assistance Program, Maternity Support Services, Behavioral Health Organizations, Nurse Family Partnership).
f. Expand wrap around services for pregnant and parenting women that address the social determinants of health, (housing, employment, food security, etc.).
g. Build clinical expertise around treating pregnant women with OUD, potentially using telehealth or regional experts.
h. Increasing access to family planning and preconception care among women who use opioids, including in SSPs.
i. Reduce stigma and other barriers to care, and to support the long-term recovery of women.
j. Educate tribal and non-tribal community members about the effects of OUD before and during pregnancy.
k. Provide community education regarding MAT for pregnant and parenting women.

2. Enhance Care for Neonatal Opioid Withdrawal Syndrome (NOWS)

a. Improve management of infants born with NOWS.
b. Enhancing the care of affected babies and mothers through the implementation of clinical best practices, including supporting mothers rooming in with babies with NOWS.
c. Provide education to staff regarding NOWS and clinical best practices to reduce stigma and promote standardized care.
d. Educate clinicians on guidelines, culturally-based and evidence best practices for breastfeeding while on MAT.
e. Implement a respite program for women, including post-partum support coaches.
f. Integrate Behavioral Health services in perinatal clinics.
g. Ensure access to affordable housing for pregnant and parenting women with OUD.
    i. Include long term supportive housing for mothers who are not capable of independent living.

D. Major Goal #4: Harm Reduction

1. Naloxone

a. Distribute naloxone to tribal and non-tribal community members.
b. Develop partnerships with community agencies and provide targeted overdose education (including prescription and non-prescription) and naloxone distribution to:
    i. Individuals who use opioids and those mostly likely to witness an overdose
    ii. People who access syringe services program
    iii. People with opioid prescriptions
    iv. People who access MAT services
    v. Law enforcement, EMT and other first responders
    vi. Jails, prisons and drug courts
    vii. People recently released from incarceration
    viii. Residential treatment and Recovery Housing
    ix. Emergency rooms
    x. Homeless communities
    xi. Schools
c. Ensure widespread availability of naloxone, including through standing orders, co-prescription with other opioids, collaborative practice agreements, pharmacist prescriptive authority.

2. Improve Health Outcomes Among People Who Use Drugs

a. Provide education to tribal communities on harm reduction to increase community buy-in in relation to PWID.
b. Collaborate and work with people with lived experience in meaningful roles with upward mobility (vs token roles for peer recovery workers).
    i. Include peers/persons with lived experience in the conversation in a good way, creating a safe space to uphold the peer voice.
c. Develop a program to monitor the presence of fentanyl in drugs supplies, for instance promoting fentanyl testing strips for people who use drugs.
d. Educate law enforcement, prosecutors, people who use drugs and the public about the Good Samaritan Overdose Laws.
e. Identify and promote new models, evidence-based and culturally-based best practices of post-overdose follow up to support long-term overdose prevention.
f. Regularly collect survey and interview data to document current health needs of individuals who use drugs, including people who inject drugs and use other opioids.
g. Map SSP services to determine critical gaps and unmet needs among people who inject drugs
h. Expand access to syringe services programs (SSPs). Consider targeting:
    i. Family planning and sexual health services in SSPs
    ii. People who are homeless
    iii. People recently released from incarceration
    iv. Youth
    v. Improve linkages between SSPs and the above.
i. Explore integration of harm reduction practices with:
    i. Individuals who use opioids and those mostly likely to witness an overdose
    ii. People who access syringe services program
    iii. People who access MAT services

iv. Law enforcement, EMT and other first responders
v. Jails, prisons and drug courts
vi. People recently released from incarceration
vii. Residential treatment and Recovery Housing
viii. Emergency rooms
ix. Homeless communities
x. Two-Spirit/LGBTQ
xi. Sex workers
xii. Youth

j. Expand diversion of people with SUD from the criminal justice system to substance (mis)use treatment.
k. Support people in recovery in obtaining jobs, including those with past criminal involvement.
l. Reduce barriers and provide education on safe consumption for people who use drugs.
m. Develop and distribute indigenous-focused harm reduction best practices, education (specifically education on safe consumption), and materials.
    i. Peer education on safe consumption should include addressing issues like discouraging consumption alone, not consuming in a locked bathroom, having naloxone on hand, etc.
n. Consider creating an opioid overdose task force to respond to non-fatal overdoses in the community.

3. Law Enforcement

a. Training:
    i. Increase awareness, availability, and use of Naloxone within law enforcement.
    ii. Offer in person and online training opportunities for law enforcement trainees and personnel, topics include:
        1. Signs and symptoms of an opioid overdose, recognizing impairment, how to investigate the scene of an opioid-related incident, and how to recognize substances.
        2. Emergency opioid antagonist (naloxone) training – administration, benefits, storage, policies, reporting requirements, and statutory requirements.
        3. Treatment Referral resources at the state, regional, and local level.
        4. Opioid-related crime data.
        5. Data on opioid-related hotspots and trends.
        6. Safe medication storage and disposal.
        7. Harm reduction and SSP
b. Strengthen link between community and criminal justice-involved treatment services.
    i. Build collaboration with local healthcare providers, hospitals, Emergency Medical Services (EMS), and treatment providers to monitor and alert each other of new threats and resources available in the community.
    ii. Encourage communication between tribes and state/federal (such as DEA and Customs/Border Protection) to collaborate on drug trafficking prevention efforts on tribal land
    iii. Encourage local law enforcement to participate in National Drug Take-Back days or provide an option for safe medication disposal in the community.

4. Harm Reduction Policy

a. Work with Tribes and tribal law enforcement to address several legal issues, including:
    i. Fewer requirements to start harm reduction programs.
    ii. Decriminalize use of substances on reservations.

1. Begin shifting jail and incarceration to rehabilitation structure
2. Offer restorative services, such as background expungement, reconsideration, legal assistance, etc.

iii. Decriminalize maternal substance use.
iv. Change laws for syringe programs and increase access to syringe services.
v. Reform drug laws with attention to rural tribal realities.
vi. End drug-related banishment practices and policies.

b. Indigenize harm reduction practices in response to OUD to ensure safety of all AI/AN people and reduce the risk of everyday harms.
c. Assess prevalence and content of Good Samaritan laws in tribal communities, and consider enacting a 911 Good Samaritan Law or a policy.
    i. A Good Samaritan law protects an individual from arrest in seeking emergency services for themselves or someone else who may be experiencing an overdose.)
    ii. Good Samaritan laws prevent fatal drug and alcohol overdoses by protecting bystanders who seek medical attention from prosecution.

E. Major Goal #5: Data and Surveillance

1. Surveillance

a. Conduct a comprehensive assessment of available and relevant opioid and overdose data sources, including exploring access to, developing data sharing agreements with, and/or obtaining the most up-to-date data from:
   i. State Prescription Drug Monitoring Programs (PDMPs)
   ii. State death certificates
   iii. State hospitalization/hospital discharge records
   iv. State emergency department visit/Syndromic Surveillance/ESSENCE systems
   v. State emergency medical services (EMS) systems
   vi. Enhanced State Opioid Overdose Surveillance (ESOOS)
   vii. State Unintentional Drug Overdose Report System (SUDORS)
   viii. CDC Web-based Injury Statistics Query and Reporting System (WISQARS)
   ix. CDC Wide-ranging Online Data for Epidemiologic Research (WONDER)
   x. National Violent Death Reporting System (NVDRS)
   xi. Fatality Analysis Reporting System (FARS)
   xii. CDC Youth Risk Behavior Surveillance System (YRBSS)
   xiii. State Healthy Youth/Teen Surveys
   xiv. State Medicaid Data
   xv. Behavioral Risk Factor Surveillance System (BRFSS)
   xvi. Epi Data Mart (IHS National Data Warehouse)
   xvii. Pregnancy Risk Assessment Monitoring System (PRAMS)
   xviii. Drug treatment programs, including inpatient, MAT, and OTP
   xix. Tribal clinic electronic health records (EHR, RPMS)
   xx. Tribal/county police and illicit drug seizure data on/near tribal lands
   xxi. Jails/drug incarcerations
   xxii. Community-incidents and syringe clean-up programs
   xxiii. SSPs and Naloxone programs
   xxiv. Overdose tracking resources (such as ODMAP or other overdose reporting systems)
b. Conduct a comprehensive assessment of key overdose and opioid metrics attainable through available data sources, such as:
   i. Number of non-fatal opioid-related hospitalizations, emergency department visits, and emergency medical service calls/visits
   ii. Number of fatal opioid overdoses
   iii. Incidence of neonatal abstinence syndrome (NAS)
   iv. Prevalence of substance use in pregnancy
   v. Prevalence of youth and adult opioid use disorder
   vi. OUD treatment metrics, such as number of tribes that have or have access to MAT/OTP programs and patient load data
   vii. Opioid related arrests, incarcerations, and drug seizures on tribal lands
   viii. SSP evaluation metrics, such as number of participants served, syringes distributed and returned, naloxone distribution, infectious disease screening, and referrals and linkages to healthcare and social services.
   ix. Gender identity/ Two spirit/ Native LGBTQ
c. Develop a sustainable plan for ongoing surveillance of established metrics.

d. Address issues related to data ownership, storage and access.

2. Data Improvement

a. Perform AI/AN race correction linkages with datasets to improve AI/AN statistics.
b. Work with states to incorporate AI/AN opioid/overdose linkage results into their systems.
c. Work with states and medical examiners/coroners to improve overdose cause of death reporting, race collection, and tribal affiliation.
    i. Assess need for a native-specific overdose fatality review panel.
d. Assess challenges with behavioral health data collection and analysis including undercounting of AI/ANs in state and national surveillance systems, racial misclassification of AI/ANs, and shortages in tribal public health surveillance infrastructure and capacity to make accurate and comprehensive assessments of need.
e. Support or perform linkages between disparate datasets to enhance overdose/opioid analysis, such as:
    i. Linking overdose death records to PDMPs (prescriptions prior to overdose), state hospitalization records (prior non-fatal overdoses, OUD diagnosis, etc.), recently released incarcerated individuals (overdose mortality in the year after release).
    ii. Link hospital discharge data to birth certificates for NAS.
f. Develop uniform data sharing agreements with other state agencies, local and tribal justice system, prison and jails.
g. Work with state partners to recognize TECs as a Public Health entities similar to local health jurisdictions for streamlined data access.
h. Assess if there are regional or clinic/tribal level metrics that are not attainable through available data sources and develop data collection plan if needed.
i. Support making overdose a reportable condition (to the tribe) and develop a way to effectively disseminate the information.
    i. Encourage first responders to adopt and actively use of the Overdose Detection Mapping Application Program (ODMAP) for overdose reporting, tracking and updates.

3. Data Dissemination

a. Identify key partners and community members who need to know opioid/overdose data findings.
b. Develop a plan to disseminate data findings, key points, and get feedback on tribal data needs, such as:
    i. Online overdose/opioid data dashboards for on-demand regional and tribal use.
    ii. Occasional webinars to present new or updated data.
c. Coordinate with programs and tribes to disseminate a newsletter of prevention and treatment efforts alongside data products, as well as tribal opioid-related policies.
d. Effectively communicate the meaning of opioid and overdose data and its implications to tribal communities and external partners, including protective factors and successes, not only “the problems.”
e. Decolonize data by developing reports and materials to inform tribal community, ensuring materials are culturally appropriate.
f. Develop materials and trainings for tribes to understand opioid data, including data sources, limitations, and how to use it for monitoring, developing interventions, and evaluations.
g. Develop reports to promote evidence-based policymaking and service planning, on topics such as:
    i. Substance use and pregnancy

ii. Infectious disease consequences of OUD, including HIV/ HCV, MRSA, etc.
iii. Opioid-related deaths
iv. Non-fatal overdoses
v. Opioid prescriptions
vi. New drug patterns
vii. NAS incidence
viii. Updates on opioid response efforts, including prevention efforts
ix. Rates, prevalence, and location of homeless population
x. Evaluation of Wellness/Drug Courts
xi. Polysubstance use and co-occurring disorders
xii. Urban Indian communities

h. Convene stakeholder meetings to address emerging opioid and overdose issues and community solutions based on data

F. Major Goal #6: Research and Evaluation

1. Assess barriers to OUD prevention and treatment (e.g., bias/stigma, quality of patient-provider communication, concerns regarding addition and 'replacing one drug with another'.)
    a. Investigate the different barriers for urban and rural community treatment programs
    b. Identify components of racism and other structural determinants of health that affect treatment and recovery
    c. Seek to understand the unique needs of and barriers for priority populations
2. Develop and examine efficacy of culturally appropriate prevention and intervention strategies to reduce opioid misuse and support OUD treatment
3. Understand the acceptability and effectiveness of Distance Collaborative Patient Management, (e.g., tele-health, ECHO), for MAT.
4. Develop resource guide that identifies easily accessible MAT programs, OTPs, other drug treatment programs, prevention efforts, and resources for people living throughout Indian Country
5. Identify tribally driven research needs, which could possibly include:
    a. Methods for utilizing PDMP data to evaluate relationships between prescribing, patient risk behaviors, and overdoses; include examining buprenorphine metrics and analyzing prescribing differences between tribes.
    b. Examining the prevalence of AI/AN substance use during pregnancy and Neonatal Abstinence Syndrome (NAS).
    c. Conduct an analysis on the current use and capacity for OUD treatment services for pregnant women.
    d. Identifying causes, risk and protective factors, comorbidities, and disparities of opioid misuse and addiction that can be used to devise solutions to the underlying causes, inform prevention efforts, and monitor trends
    e. Identify protective factors, (e.g., family support, community support, etc.), that promote healthy behaviors among patients with documented OUD.
    f. Determine the effectiveness of MAT in AI/AN communities.
    g. Determine the impacts of Tribal Syringe Services Programs (SSPs).
    h. Assess the impact of historical, intergenerational and current trauma in Tribal communities on behavioral health outcomes related to drug misuse, addiction and overdose.
    i. Research and define high-value treatment for OUD options for Indian Country.
    j. Review and synthesize new and emerging research on OUD and best practices associated with safe and effective chronic pain management
6. Map available resources, including Narcan distribution sites
7. Increase community based participatory research
    a. Develop client surveys to better understand priorities of people who use drugs
    b. Train people who use drugs or are in recovery to administer surveys
8. Collect qualitative data through talking circles, digital stories, and storytelling
9. Increase Native-led research
10. Assess and evaluate resiliency of tribal communities
11. Assess and evaluate the impact of crisis and trauma in AI/AN communities in relation to OUD
12. Develop studies on the role of native medicine in both OUD and trauma
13. Measure the effect of cultural identity on treatment and recovery services
14. Determine the feasibility of supervised drug consumption sites in AI/AN communities
15. Identify native scholars/professionals to develop a comprehensive literature review on prevention, treatment, and best practices, and dissemination materials for AI/AN communities

G. Major Goal #7: Organizational Development

1. Leadership

a. Support holistic, faith-based, and culturally driven approaches to tribal opioid response.
b. Identify local policy gaps and barriers to implementing a tribal opioid response, including MAT programs, SSPs, etc.
c. Implement policies to increase provider buy-in for MAT, such as incentive programs, allocated time for training and participation in tele-ECHO sessions, etc.
d. Work to ensure all patients have access to MAT, including working with different payers to reduce and remove coverage limitations.
e. Identify and leverage diversified funding for SSPs to provide adequate levels of supplies, case management, health engagement services, infectious disease screening (including HIV and HCV), and comprehensive overdose prevention education.
f. Utilize local, state and federal grants to develop specific strategies to prevent opioid misuse
g. Develop and implement a tribal level naloxone procurement and distribution plan.
h. Develop tribal laws that decriminalize maternal and prenatal opioid use, taking into consideration best practices that demonstrate a fair and unbiased attitude towards women with OUD who are pregnant and promote keeping mother and child together.
i. Develop tribal laws that decriminalize OUD and support alternatives such as drug court and OUD treatment instead of incarceration.
j. Exercise tribal sovereignty by supporting tribes in developing their own policies and programs related to tribal opioid response, including decriminalizing and legalizing SSPs and SUSs.
k. Adopt tribal harm reduction policies and practices focused on destigmatizing OUD, moving away from abstinence only, and including culturally sensitive considerations.
l. Educate tribal council and leadership on the spectrum of care for OUD, effects on the family and community of those with OUD, harm reduction best practices, and OUD data to increase awareness and allow them to make informed decisions on tribal policies.
m. Provide tribal council and delegates with talking points for SAMHSA, CDC, HHS and other state and federal tribal advisory groups to assist in developing consensus, exchanging views, share information, provide advice and/ or recommendations.
n. Promote knowledge sharing between tribes and local, regional, and national organizations
    i. Regional representatives should promote two-way information sharing from and to tribes
    ii. Knowledge sharing should support policy change and reform
o. Include youth in tribal government to share their concerns and needs
p. Recruit individuals from priority populations to share their stories and ensure their voices are heard by leadership

2. Partnerships

a. Non-traditional partnerships in health
b. Work with local, state and federal partners to implement a coordinated tribal opioid response strategy.
c. Collaborate with organizations serving tribal and urban AI/AN populations, including tribal epidemiology centers, area health boards, IHS and national tribal organizations.
d. Partner with IHS to incorporate traditional healing practices into the IHS health care delivery system model (per the Tribal treaty agreements).

e. Collaborate with the BIA to incorporate the Tiwahe Initiative into health care and behavioral health services, focusing on delivering holistic treatment and services for individuals with OUD and their families.
    i. Work with Jails to create new regulations for PRC coverage.
f. Enhance collaboration and partnerships between health care system and:
    i. SSPs
    ii. Law enforcement, EMT and other first responders
    iii. Jails, prisons and drug courts
    iv. Victims Assistance Program
    v. Hospitals
    vi. Dental Clinics
    vii. Universities (research and graduate students)
g. Develop a national network of those working on opioid response in AI/AN communities to encourage exchange of information and resource sharing

3. Workforce Development

a. Develop and implement a comprehensive educational plan for physicians, advanced practice nurses, pharmacists, and other healthcare professionals and providers in training, to improve the national professional expertise in their identification and treatment of addiction as well as safe pain management, treatment, and recovery.
b. Provide training to existing and new providers, other healthcare professionals, and external program support staff to ensure that they have the information and skills appropriate to their professional role(s) in responding to prevention and treatment of OUD. Training may draw from existing resources and adapted or new training developed to meet the needs of tribal health programs and clinics.
c. Increase staffing levels by seeking additional funding, and/or restructuring staffing profiles to ensure adequate workforce to implement effective opioid response.
d. Implement innovate strategies to address staffing shortages, including use of telehealth and teleECHO, to complement existing workforce and expertise at tribal health clinics and health programs
e. Support recruitment of existing staff and potential applicants who are interested in providing OUD care and provide access to new or upgraded skills training.
f. Include consideration of previous opioid response experience, and/or demonstrated/stated willingness to work with persons with OUD, as part of hiring, on-boarding, and new staff training.
g. Recruit job candidates with lived experience, including those in recovery, people with a history of OUD/SUD, and those with past criminal justice involvement
h. Provide ongoing professional development and educational opportunities pertaining to OUD for behavioral health service providers
    i. Develop and encourage mentorship programs.
i. Encourage staff to use designated time for wellness and stress management activities to promote staff retention and avoid staff turnover and burn out.
j. Provide cultural competency training to staff working directly with AI/AN communities, including traditional practices, language, and values.
k. Encourage Native youth to pursue careers in the health care, behavioral health, and public health fields by providing opportunities for internships, scholarships, etc.
    i. Raise awareness of tribal and TEC career opportunities for new graduates

ii. Develop internships for youth involved in treatment programs or youth with past criminal justice involvement

l. Create a network of indigenous harm reduction champions, including train the trainer models.

4. Advocacy

a. Encourage a full funding plan for IHS as recommended by the National Tribal Budget Formulation Workgroup to ensure that health care needs of AI/AN people are being addressed in honor of the federal trust and treaty responsibility.
b. Advocate for sustainable funding for health systems services beyond short term funding opportunities to ensure long term success.
c. Advocating for increased, sustainable funding to provide housing and transportation to services for:
    i. Families and individuals with OUD
    ii. People with criminal backgrounds
    iii. Youth
    iv. Other priority populations
d. Create more meaningful and timely tribal consultation to determine distribution pathways for funding, respond to proposed regulatory changes, and to advance the government-to-government relationship between tribes and the federal government.
e. Enhance communication and formal feedback from state, tribal, and local providers, officials, and other stakeholders to continually improve federal funding, programs, and services, for example:
    i. Community-based organizations and coalitions to promote safe storage products and community use of secure medicine disposal sites.
    ii. Cultural-based programs that address OUD.
f. Explore Medicaid reinstatement policies and procedures to increase the ability of offenders to access benefits upon release, such as suspension of benefits rather than termination upon incarceration.
g. Advocate for closing gaps in mental health and behavioral health services for individuals with OUD and their families.
h. Advocate for policies and practices to destigmatize opioid use and move away from abstinence only.
i. Encourage tribes to remove barriers and change attitudes towards individuals and families accessing OUD services by addressing negative connotations and stigma
j. Expand the use of traditional medicines and cultural practices to prevent and treat addiction
k. Support tribal participation in state PDMPs by integrating PDMPs into EHRs
l. Advocate for communication between state PDMP programs to assist tribes whose service areas span state borders.
m. Remove limits on who can prescribe MAT to address rural infrastructure and workforce barriers
n. Advocate for direct, non-competitive and formula-based funding to tribes to address tribal opioid response.
o. Encourage and support tribal leaders in advocating for the use of traditional and cultural practices as recognized and reimbursable forms of treatment
p. Work toward adding community health worker visits as a billable service
q. Encourage the development and adoption of tribal resolutions to address the spectrum of care for OUD, including supporting wraparound services for families and individuals with OUD.
r. Support tribal efforts to address pharmaceutical companies' role in the opioid crisis

s. Advocate for all prescribers to be able to provide medications for OUD
t. Increase funding for tuition waivers and loan repayment for behavioral health and medical providers in AI/AN communities
u. Make sure all those working in the health and behavioral health fields (including harm reduction) earn a competitive living wage