Medication Assisted Treatment Toolkit

Empowering Recovery from Substance Use Disorders in Rural Alaska

Alaska Native Tribal Health Consortium
Behavioral Health Department
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Section 1: Getting Started

This toolkit was developed by a team at the Alaska Native Tribal Health Consortium (ANTHC), a statewide, non-profit tribal health organization whose purpose is to provide for the unique health needs of Alaska Native and American Indian people living in Alaska. ANTHC is located in Anchorage, Alaska and we would like to acknowledge the land on which we reside. We acknowledge the Dena'ina people, on whose traditional lands we work and live on. We also acknowledge the Creator and all Indigenous people of Alaska. Thank you for your past and present stewardship of the waters, plants, animals and spiritual practices of this place.

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This guide was developed to complement the State of Alaska Medication Assisted Treatment (MAT) Guide.[1] This guide is focused on providing services in rural areas with Alaska Native people. This guide was developed with the assistance of people across the breadth of fields and disciplines of people that provide services to people with substance use disorders. As such, below there is more specific information for people with prescribing privileges, however, most of the information is intended for any person providing MAT services in rural areas. Throughout the guide resources relevant to that section are hyperlinked, meaning you can click (for some computers you may need to hold the 'Ctrl' key on the keypad and simultaneously click) on the resource to open it in an online web browser. For printed versions, you can find more information on where to find the hyperlink in the references following each section that correspond with the number superscript following the hyperlink.

In tandem with the development of this toolkit, ANTHC Behavioral Health[2] partnered with Project ECHO[3] to develop a virtual learning network focused on improving delivery of addiction medicine and medication-assisted treatment called the Addiction Medicine ECHO. This partnership aims to: enhance best practices relevant to rural Alaska needs, troubleshoot and overcome barriers, support and resources to empower providers, and inform providers on the latest policies and practices. The training series is intended for health care providers who want to learn more about addiction medicine, providers interested in starting a medication-assisted treatment program, and current practitioners of addiction medicine looking to support a community of practice. The program launched January 28th, 2021 occurring the second and fourth Thursday of the month from 12:00 – 1:00 p.m. AKST. Contact behavioralhealth@anthc.org or visit our website[4] to learn more.

In addition, ANTHC has two consultation service networks available to you at no-cost to your organization. First, ANTHC consultation services for providers around medication assisted treatment. This consultation service is intended for both providers seeking consultation around client care, but also the development and growth of MAT services in an organization. Secondly, ANTHC contracts with Sonosky, Chambers, Sachse, Miller & Monkman, LLP to provide confidential legal consultation for Tribal Health Organizations (THOs) in the Alaska Tribal Health System (ATHS). To learn more about 42 CFR requirements please reference the ANTHC 42 C.F.R. Part 2 Training Resources[5], including a summary, toolkit, and training video. To request either of these consultation services please contact behavioralhealth@anthc.org.

These guidance tools have been prepared for educational purposes only. Nothing in these documents is intended as or should be relied upon as legal advice. These tools are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the U.S. Department of Health and Human Services.

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Section 1 References

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Section 2: Billing Insurance Coverage and Telehealth

2.1. Billing

This section will provide information about billing, considerations for a state of public health emergency, telehealth service recommendations and resources for finding more information. In Appendix E and F, you will find a reference table for 1115 waiver that identifies the type of service that can be billed by certain health professional groups for substance use treatment and behavioral health services as of January 2021.

April 28, 2021 the Department of Health and Human Services published a federal register notice[1] for changes in practice guidelines for the administration of buprenorphine for treatment of opioid use disorder. These changes are intended to increase access by removing some of the requirements for prescribers under certification requirements under r 21 U.S.C. § 823(g)(2) of the Controlled Substances Act (CSA) for physicians licensed under State law and who possess a DEA registration. These changes remove the requirement for-prescribers to take a waiver course or attest to ability to refer for counseling to obtain a waiver to treat no more than 30 clients with buprenorphine for opioid use disorder. Prescribers are still required to file a notice of intent to SAMHSA to obtain their X-DEA number, which can be filed with a brief online application here.[2]

2.1.1. Centers for Medicare & Medicaid Services (CMS) Covered Services

Under Medicaid, medication assisted treatment (MAT) can be billed by medical professionals under the health professional group similarly to other medical services. If a medical provider works in an outpatient or primary care setting, then MAT can be billed as a part of those services. As long as a facility (i.e., outpatient, primary care, etc.) does not "hold itself out" as a substance use treatment provider, then they are not obligated to fall under 42 CFR Part 2. Simply put, if a family medicine doctor has been prescribing MAT to support someone with a substance use disorder, then they are not required to meet 42 CFR Part 2 standards because that provider is working under the health professionals' groups and is not identified as a substance use treatment provider. For services billed under Medicaid or Medicare, the Administrative Service Office (ASO) is responsible for managing claims adjudication.

The state of Alaska has the 1115 federal waiver, which indicates permission for the state to deliver care differently. Under the 1115 waiver, some CMS requirements are waived to allow for changes in service delivery. Clinic services remain the same but rehabilitation services fall under the 1115 waiver. In Appendix E and F, you will find a chart of billable services under the 1115 waiver, service description, procedure code/modifier, and type of provider for that service. Appendix E is for substance use disorder services while Appendix F is for mental health services. In the chart, community health and behavioral health aids are also listed under services they are eligible to bill.

2.1.2. Non-Insured Indian Health Services Beneficiaries

Outside of the Alaska Tribal Health System (ATHS) individuals with no insurance will be charged the fee for that service. On the other hand, each regional ATHS varies on what is allowed for "purchased and referred care" for substance use treatment (SUT). Namely, SUT is not necessarily covered under "purchased and referred care." Historically, SUT has not been covered by the ATHS, but there has been movement towards approval. Therefore, it is important to inquire based on the region if that service is accepted as a "purchased and referred care" which means that service is at no cost to the individual. In the case of an emergency room visit, an individual can take the invoice to their hub, like Southcentral Foundation, to see if it will be covered.

2.1.3. Non-Insured Beneficiaries

For tribal members that do not have access to employer sponsored health insurance or Medicaid/Medicare, it is strongly advised to reach out to your Tribal Sponsored Health Insurance Program (TSHIP) to request eligibility for health insurance. The ANTHC Tribally-Sponsored Health Insurance Program website[3] offers information to commonly asked questions and how to get started with this process.

2.1.4. Billing outside the Clinic

There are special considerations for billing outside of the clinic in a different facility, such as in a shelter, inpatient treatment facility or other facility you may want to provide a service to your client. Reimbursement for time outside the clinic in an outside facility falls under the "four walls rule." As part of COVID-19, there are exceptions to this rule until the U.S. is no longer in a state of public health emergency. Traditionally, if you deliver services outside the "four walls" of a clinic you should not bill for that service. For telehealth services, there is increased flexibility at this time because there has been no clear definition under telehealth about clinic walls as both provider and client may not be located inside of the clinic while providing a service. Additionally, certain groups are exempt from the "four walls rule" such as 1115 waiver services, federally qualified health centers (FQHC), and health professional group rules (i.e., providers, BHA, anchorage neighborhood health center). Plus, "this CIB[4] explains the steps Tribal facilities and states will need to take before the extended grace period expires in order for Tribal facilities to continue to receive Medicaid reimbursement for services provided outside the four walls of the facility after October 31, 2021" (p. 1).

2.2. State of Public Health Emergency Considerations

Under the state of public health emergency, the State of Alaska has new guidelines to improve access to services under the restrictions of COVID-19. This expanded services that are covered using teleconferencing platforms with audio and video (i.e., Zoom, Skype, FaceTime, etc.) as well as audio only platforms such as services provided over the phone or in cases where video is not available on the teleconferencing software. On March 31, 2020, the DEA[5] increased prescription flexibilities to allow buprenorphine initiation and continuation over the phone. For more resources and guidance about providing services during COVID-19 please see SAMHSA's resources and information website.[6] The Center for Medicaid Services[3] outlines considerations for telehealth on their website[7], as well as provides several guides including: State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth,[8] and Rural Health Care and Medicaid Telehealth Flexibilities and Guidance[9] informational bulletin. For further guidance on telehealth for Medicaid recipients in Alaska during COVID-19 please reference the Medicaid Behavioral Health Telehealth Emergency Response Policy Guidance.[10] This guidance provides the hierarchy of billable services that providers should follow for individual and group services, as well as a list of appropriate billing codes.

Another concise resource can be found on the American Psychiatric Association website[11] which provides links to relevant updates from national organizations, as well as *commercial payer information* and state specific resources.[11] Lastly, the Department of Health and Human Resources has provided guidance for the use and disclosure of client health information in response to COVID-19 public health emergency on their website.[12] For guidance currently waived restrictions on telehealth and licensing during COVID-19 see this reference.[13] During the public health emergency, CMS has approved Alaska's request for an 1135 Medicaid waiver[14] suspends FFS prior authorization requirements and allows more flexibility in reimbursement for services offered in alternative settings.[15]

The next section will review Alaska specific resources relevant to changes under the state of a public health emergency. On the 16th of March 2020, Governor Dunleavy signed HB 29 into law[16] requiring health care insurers to provide coverage for telehealth benefits in Alaska for both physical and mental health services. Additionally, the Governor signed bill[17] SB 241 waiving licensure and telehealth requirements for the duration of the public health emergency; and waives the requirement for in person physical examination to deliver telehealth services. For more specific information about the telehealth regulations for opioid use disorder treatment please reference the state medical board and the newest requirements removing waiver requirements for MAT prescription for providers: The State Medical Board Announces Telehealth Regulation for OUD Treatment.[18,19]

2.3. Telehealth

Alaska Senate Bill 74 was signed into effect 11 July 2016 establishing a registry for telemedicine businesses related to mental and physical health services.[20] Registering as a telehealth provider is the first step to providing telehealth services.[21,22] Click here[23] to register with the state of Alaska. As many remote villages have no access to MAT prescribers locally, telemedicine is a critical tool in increasing access to treatment for clients who live in remote villages. ANTHC has a well-established telehealth system already in place, with most village clinics having

equipment (such as AFHCAN carts) that can connect via secure video conferencing software to another clinic or hospital in the state. Most secure telemedicine conferencing applications can also be used with laptops, tablets and smartphones.

2.3.1. Benefits of Telehealth

Telehealth increases access and availability to services. Telehealth means that clients living in rural areas are no longer required to sacrifice days of their time and coordinate finding child care in order to leave their home village to attend a medical appointment. Telehealth improves access to specialists and can reduce dual relationships when the provider and client both live in a small town. However, there are times it is beneficial for clients to come to their hub and other times that a telehealth appointment is more appropriate. Important questions to ask when deciding how to see a client in person or through telehealth are:

- What are the reasons to consider telehealth with this client?
- Are there reasons the client needs to be seen in person (i.e., monitoring complex medical issues)?
- Do they have access or means for videoconferencing or are there barriers to telehealth?
- Are there ways to improve access to telehealth tools at home or in their community?
- How will the provider and client best maintain confidentiality?

2.3.2. Telehealth Prior to COVID-19

For a brief outline of the requirements for providing MAT and telehealth prior to the expansion of services of COVID-19, please see the Diversion Control Divisions handout.[24,25,26,27]

2.3.3. Telehealth Expectations

It is important to communicate with the client about what telehealth looks like and requirements there may be for them. Generational differences and barriers to accessing technology are possible. Telehealth can be stressful for some clients and become even more so if technical difficulties arise that they cannot troubleshoot. Further, leaving more space for silence is important to ensure no one is talking over the other and leaves more time to respond. The first time a client is using a telehealth platform it may be beneficial to have a practice session or to review how to navigate the system to ensure the client and provider can see and hear one another.

2.3.4. Migration

There are seasonal considerations for people dependent on subsistence hunting or commercial fishing which may take them away from home for extended periods of time. Also, those employed in oil, gas, or mining may have non-traditional work hours and prolonged absences from home, which limits their access to services. These barriers can be overcome by asking about these considerations and making adjustments based on the client's needs.

2.3.5. Lack of Human Connection

Telehealth has improved much of the services we are providing. However, telehealth for some clients can feel cold and removed because of the lack of human connection. It is important to weigh the benefits of telehealth with the clients own experiences and potential limitations when considering telehealth; reference the bullets outlined under Section 2.3.1.

2.3.6. Telehealth Services Coverage

Telehealth services are covered as part of the emergency CMS extension. It is recommended that individuals with private insurance seeking reimbursement should reach out to their own health insurance provider as to whether services will be covered and/or copays waived during the national emergency and after the state of emergency is lifted.[15]

2.3.7. Platforms for Telehealth Services

Two major considerations for a telehealth platform are HIPAA compliance and connection barriers. The system should offer secure communication to protect the integrity of protected health information and requires a business associate agreement from service providers to be used to conduct telehealth services. Information on business associate contracts can be found on the HHS website.[28] Although President Trump waived HIPAA requirement to authorize the use of Skype and FaceTime during the state of emergency, these are not considered HIPAA compliant platforms.[29,30]

Internet. Not all communities have access to the internet, and not all communities have the internet with connectivity requirements for a given videoconferencing software. These factors are important to consider.

Phone Calls and HIPAA Compliance. At the time of the creation of this toolkit, special billing was authorized as part of COVID-19 state of public emergency. Part of these changes is authorization for services over the phone that otherwise would be required over videoconferencing. There is debate on whether phone calls are HIPAA compliant, and one important factor is the use of PHI under HIPAA and the associated technology (i.e., landline, mobile device, Voice over Internet Protocol (VoIP)). It is important to note informed consent limitations based on technology that cannot guarantee privacy and confidentiality. Further, ensure the client understands the importance of physical privacy to protect their information and do not to use public locations offering free Wi-Fi given the potential risk for hacking. [8] Clients that do not have a computer or phone are encouraged to work with local health clinics to assist with attending appointments.

Group Sessions via Videoconference. Similar to individual sessions, it is important to outline the expectations and rules for group sessions. Confidentiality can become more difficult depending on an individual's limitations to physical privacy and connectivity. Therefore, it is important to outline with group members the potential for loss of confidentiality and troubleshoot alternatives, such as wearing headphones or going to the local health clinic to ensure privacy.

2.3.8. Prescribing New Medications by Telehealth

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 regulates the prescription of controlled substances through online video conferencing platforms and is enforced by the Drug Enforcement Agency. The Act required an in-person medical evaluation for new clients being prescribed a controlled substance; however, under the public health emergency this regulation is suspended. For more information please reference the APA reference on the Ryan Haight Act[31] and the State of Alaska Medical Board[32] for more information and a link to register as a telehealth provider. Before proceeding, there are several technology considerations providers and their clients should be aware of:

- The technology platform should be HIPAA compliant
- The client knows how to log in and use the technology
- A Business Associate Agreement is required between service provider and the vendor
- Adequate internet connectivity for video conferencing which is password protected and not public access.
- Educate client about increase risk for being hacked when using public and unsecured Wi-Fi
- Up to date anti-virus/anti-malware protection on the device being used to prevent being hacked[15]

The initial visit between the MAT prescriber and the client should be in person when possible, to establish a client-prescriber relationship, per federal and state telemedicine regulations. If an initial in-person visit is not possible, see telemedicine regulations on prescribing without an in-person visit Internet Eligible Controlled Substance Provider Designation[33] for IHS facilities. A licensed provider is not required to be physically present with the client at a follow-up visit. At the follow up visit for prescribing MAT, the client would go into the village clinic for their telemedicine appointment. The local medical assistant or community health aide/practitioner (CHA/P) collects vital signs, urine for drug screening and other labs as indicated, and performs medication counts. The CHA/P may also administer medications and injections if they have been trained in the procedure and authorized by their medical director. The client is connected via video conference (i.e., Vidyo, Zoom, or similar application) to the MAT provider at the distant site. Concluding the telemedicine session, with the client's permission, the MAT prescriber communicates with the local provider regarding the client's progress in their treatment plan and sends a copy of the visit note to the village clinic. Prior to leaving the clinic, follow-up appointments should be coordinated and scheduled with both the prescribing and remote clinics. For more information about providing MAT with telemedicine in the IHS system, see IHS Tele-MAT Toolkit.[34]

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Section 3: Program Development

3.1. Barriers to Implementation

Historically many barriers have prevented the implementation of MAT programs. These barriers have included, but are not limited to state regulations, restrictions from funders, staff expertise, stigma, and concerns related to client needs.[1] Each community has unique barriers therefore it is important to brainstorm the barriers within your own community based on feedback from clients, providers, administrators, and the community at large. This toolkit contains recommendations for many barriers, including stigma, staff capacity, and many other concerns. Additionally, the Community Toolbox contains information on Developing and Increasing Access to Health and Community Services[1]. Finally, other potential resources can be found within Alaska, by partnering with another organization for mentorship, or participating in a Project ECHO to build a community of support.[2]

3.2. Key Champions

A champion is an individual that serves as an advocate for your program. This can be anyone in the community: an elder, a tribal leader, youth, pastor, educator, provider, people in recovery, and many more. The right champion(s) are people that are devoted to the work your program is doing and are dedicated to ensuring the success of the program, from implementation to long term sustainability. Champions can serve as an advocate at community events and provide testimony at council and board meetings. When identifying champions, consider specifically targeting at least one person in each of the following categories: community members, people in recovery, and providers. Community members understand local concerns and can help grow community support. People in recovery have experience receiving services and understand the needs of those in recovery. Providers are able to communicate best practices and serve as an advocate within the clinical setting. Involving these champions early in planning stages and engaging them in the long term will significantly strengthen your program.[3]

Acknowledging champions in a public setting can be advantageous on many fronts. Most importantly, reflecting on the contributions of champions honors the hard work and dedication. It also highlights the work the champion has done, centering the issues, encouraging others to take on a similar role, and providing an opportunity for community dialogue.[3]

3.3. Supportive Leadership

Like champions, supportive administrative leadership is crucial for programs. Organizational leadership should be on board with the process early in program development. It is important to spend time understanding concerns and misconceptions in order to garner support. Supportive leadership sees value in the program and advocates on its behalf during council and board meetings. Supportive leadership is also engaged in high level policy discussions to ensure your program is able to continue operating and able to provide the best services possible to clients.

3.4. Client-Centered Care

When developing a program, considering everything from the client's viewpoint will aid in developing programs that are client-centered. The image to the right displays considerations for client-centered care.

Client-centered care is a concept that the client is the most important part of care, therefore treatment should work follow the goals and values of the client.[4] Providers will establish a personal connection with both the client and family, communicating frequently. Within the tribal health system this also means respecting traditional practices and approaches to medicine. It also means keeping a client in their community when possible, so they have access to their support network, traditional foods, and cultural needs.

Part of client-centered care is meeting clients where they are at and helping them improve their quality of life within their own bounds. Using a harm reduction approach is helpful, as is the use of low threshold care. High threshold care can create barriers that make it less likely that clients receive the care they desire. For example, requiring wrap around services may be an approach a program believes is most effective, but a client may not want to receive all services and may forgo care if so required. Some programs require clients to maintain complete abstinence, which serves as another barrier. Instead, a low threshold approach considers barriers and identifies ways to increase access to care as needed and with consistency.[5] See the table below for more on care thresholds and rationale.

Low Threshold	Higher Threshold	Rationale for Lower Threshold
Same-Day Treatment Entry		
▪ Prescription at first visit ▪ Home-induction available	▪ Two or more visits before prescription ▪ Office-based induction required	▪ Uncertain clinical benefit from delayed prescription ▪ Home-induction is safe and effective
Harm Reduction Approach		
▪ Patients' goals prioritized ▪ Nonjudgmental attitude ▪ Reduction in illicit opioid use as acceptable goal ▪ Use of other substances does not result in treatment cessation	▪ Programmatic rules prioritized ▪ Abstinence as primary treatment goal ▪ Buprenorphine discontinuation for use of other substances	▪ Patient-centered approach improves provider-patient relationship ▪ Non-judgmental attitude reduces stigma ▪ Improved quality of life and reduced HIV, HCV, and overdose risk with medication continuation
Flexibility		
▪ Reduced visit frequency based on clinical stability ▪ Intensive counseling offered but not required ▪ Mutual aid meetings encourage but not required ▪ Rapid re-initiation of treatment if missed visit	▪ Medication pick-up or visit frequency based on rigid protocol ▪ Intensive counselling required to receive buprenorphine ▪ Mutual aid meetings required ▪ Induction required to restart medication	▪ High overdose risk for untreated OUD. Buprenorphine only treats OUD. ▪ High patient burden may prevent engagement ▪ Clinical trials do not support required intensive counseling vs routine medical management. ▪ Mutual aid meetings helpful for some but not others. MAT use may be stigmatized.
Availability in Nontraditional Settings		
▪ Buprenorphine prescribed from emergency department, syringe exchange program, mobile units, etc.	▪ Eligible patients referred to medical office or opioid treatment program	▪ Improved access to treatment. Low rates of referral completion

3.4.1. Drug Subculture

To understand the client it is important to spend some time understanding drug subculture. Each drug has its own subculture and this often further varies by region. Two notable examples of mainstream drug subculture include alcohol and marijuana. Alcohol is a prime example of how subculture can vary significantly. For instance, wine and beer have distinct cultures that vary by country, age, and specialized events and rituals. SAMHSA shares more information in *Chapter 6: Drug Cultures and the Culture of Recovery* in its Treatment Improvement Protocol: Improving Cultural Competence[6]. Erowid[7] and PsychonautWiki[8] are two online resources that are targeted towards people experimenting with substances, so it contains information clients are more likely to access. Additionally there are numerous YouTube channels that discuss drug subculture, like PsychedSubstance[9].

Section 3 Resources

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Section 4: Community Partnerships

Nearly half of all federally recognized tribes in the United States are located in Alaska[1]. Many of these tribes in Alaska are remote villages accessible only by plane. The geographic situation of Alaska presents unique challenges to health care delivery for people who reside in rural areas. It is imperative that health programs and organizations foster strong relationships with communities to provide quality services. Maintaining communication with communities puts organizations in a position to improve dissemination of health resources.

4.1. Community Engagement and Improving Relationships

4.1.1. Connection to Hub Teams

The connection between a hub community and smaller villages can be pivotal in the delivery of services. For example, if a tribal health organization receives funding to help address a certain health issue, often the funding and program development will be housed in the regional hub. Still, smaller villages must be involved in order for the program to be successful. For example, program staff can invite key champions in the village tribes such as council members, to offer feedback and input in the development of such programs. What's more, to involve youth and elders in the development of programs can be a great asset to the value and quality of such programs. To have the input of various voices and demographics can be powerful. After all, creating programing with the collaboration of communities improves the programming, fosters connection to the hub and engages members from outlying villages to participate in the final product.[1]

Coalitions. Coalition means an alliance working together towards a specific goal. A coalition typically would involve stakeholders from various fields. For MAT, a coalition might involve stakeholders from public health, social services agencies, school district faculty and staff (i.e., teachers, school principals), public safety (municipal safety officers, state troopers), tribal offices, city offices, general store management, and faith organizations (i.e., local pastors, faith leadership). To establish an interdisciplinary network means everybody can offer input and add their voice to the conversation. Additionally, coalitions allow people to develop the same knowledge and language around the topic to be disseminated more widely. Therefore, everyone is aware that individuals will receive MAT services.

Listening sessions. Listening sessions provide members of the general public an opportunity to offer valuable input on the issues of MAT. Also, this is an opportunity to learn about concerns from the public around MAT. Listening sessions can inform the development of educational materials, program materials, and can be worked into the MAT curriculum to share with providers. What's more, the act of listening can show genuine interest in the needs of the public. To offer a space for the public to have a voice in their concerns and needs may improve openness to the implementation of MAT in rural communities.

4.1.2. Education

Community education is key to addressing barriers around MAT. For example, education around stigma (see Section 5.1: Reducing Stigma), the efficacy of MAT (see Section 8: Opioid Use Disorder Medications and Section 9: Overview of Alcohol Use Disorder and Pharmacotherapies), and more. Education can occur through community presentations, community panel discussions, community dialogues, and promotional materials (i.e., handouts, flyers).

4.1.3. Traditional Practices

Importantly, it is recommended that health educators and programs incorporate traditional practices in the development of community education materials. For example, *storytelling* is a vital component to passing on knowledge in Alaska Native and American Indian (ANAI) cultures. One creative way to provide education to communities in a culturally sensitive manner is to invite an individual with lived experience around substance misuse and recovery, to share their story. This story could be used for a video, a story in a news article, social media, website, or other venue.

One other example of educating communities in a culturally sensitive manner might be to incorporate traditional Alaska Native values[2] in community education materials and presentations. For instance, "Believe in them and keep them going through time" is a traditional value of the Unangan/Unangax people. To offer MAT to individuals

means to promote health and well-being and to support individuals in a manner that is considerate of cultural values.

4.1.4. Community Readiness

Communities vary in readiness for MAT. It is important to meet communities where they are at. Readiness can be measured through readiness assessments. Specifically, community readiness assessments conducted in Alaska should take into consideration cultural factors. MAT, if offered to rural Alaska, should be delivered with cultural considerations. For example, cultural sensitivity training and training around Alaska Native cultures can help enhance MAT delivery and overall practice for providers (See Section 12: Holistic Healthcare in Rural Alaska).

On another note, community readiness can be influenced by education around MAT. Many people are cautious or skeptical of something they know little to nothing about. For example, offering a presentation can help start an important conversation to find ground for MAT program developers, stakeholders, and community members. Below are a few resources when considering assessing community's readiness for change:

- SAMHSA, Center for the Application of Prevention Technologies, Tools to Assess Community Readiness to Prevent Substance Misuse[3], 2016
- The Tri-Ethnic Center for Prevention Research on the Community Readiness Model, Community Readiness: Handbook for Successful Change[4], 2006
- SAMHSA Tribal Training and Technical Assistance Center, Community Readiness Manual on Suicide Prevention in Native Communities[5], 2014
- NIDA Publications, Preventing Drug Use among Children and Adolescents (In Brief): Is the community ready for prevention?[6] 2020

4.2. Community in Recovery

The concept of wrap-around services is to offer a variety of resources and services that can aid in the recovery of addiction. Another way to think about it is offering a "menu." To have a variety of options of resources and services can put someone in a great position to recover in the way that works for them. For example, someone may choose to engage in mental health services while also being prescribed MAT. Others may try to use 12-step programs alone to support their recovery. To have the option of these is important in supporting someone in healing in their own way. Below include various communities to consider referring clients to for support in recovery.

4.2.1. Housing Programs

There are various levels of care and programs when it comes to substance misuse, including prevention and education, interventions, and responding to emergencies. To have residential housing and a place designed to meet the needs of people suffering from severe cases of substance use disorder (SUD) is an important resource. Residential housing and services provides an opportunity to help with severe and crisis needs, including detoxification, de-escalation, and offering short term services and care to help people get back on their feet. Housing programs are a vital to promote long term recovery for individuals that experience SUD.

A few websites to start looking for housing programs are the Alaska Housing Finance Corporation[7], Program Summaries[8], Halfway Housing[9], and Transitional Housing[10].

4.2.2. Sober Social Environments and Outreach

Part of recovery is having a safe space for healthy activity. For example, many successful MAT programs offer an outreach office and a space for community members and individuals receiving addiction medicine services to thrive. This space will also offer an alternative activity and place to previous environments where substance misuse happened.

4.2.3. 12-Step Programs

Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups offer what we know as a "12 step programs" to recovery. For decades AA and NA have offered a safe place for individuals to gather in a group setting. The significance of such a group can help people meet others with shared experiences and to offer them a safe place to share as well.

4.2.4. Al-Anon

Al-Anon is a support group for concerned significant others who have someone in their life that suffers from SUD. Al-Anon has offered a group style similar to 12-step program to connect those with loved ones who suffer from SUD to receive support.

4.2.5. Community Reinforcement Approach and Family Training

Community Reinforcement Approach and Family Training (CRAFT) helps family members improve their personal well-being and learn specific skills to motivate their loved one toward substance use treatment. In CRAFT, a clinician helps family members strengthen their communication and problem-solving skills, increase their use of effective helping behavior, improve their personal well-being, and learn how to effectively invite their loved one to treatment. These aspects help strengthen the relationship between family members and their loved ones and help motivate the loved one to enter substance use treatment.

Research shows that 7 out of 10 loved ones enter substance use treatment after their family member has attended CRAFT sessions.[11,12] This success rate is more than double that of Al-Anon and Johnson Intervention models.[13] Regardless if the loved one enters treatment, family members' exhibit increased wellbeing following their engagement in CRAFT.[12,13] Visit the ANTHC website to learn more information about where CRAFT is currently offered[14], or contact your local Tribal Health Organization (THO).

4.3. Establish Partnerships with Systems

As stated earlier in this section, establishing and strengthening relationships with communities is key to successful MAT programs. Systems to consider to partner with include but are not limited to Office of Children's Services (OCS)[15], Domestic Violence and Sexual Violence Service (DV/SV) Agencies, judicial, housing, and law enforcement. For more information about wrap around services, special populations and co-occuring disorders see Section 12.3 Treating the Whole Person.

4.3.1. Office of Children's Services

As we may understand, adults experiencing SUD may be involved in court cases. Clients may have dealt with child protective services while struggling with SUD. To engage Office of Children's Services (OCS) in a MAT partnership can help them understand essential services that community members are receiving. They may consider a positive correlation between engagement in MAT services and the improvement of child welfare and safety. They may also see MAT as an available resource for people struggling in SUD and can be an important referral and entry point into treatment programs for their clients.

To have a partnership with OCS may look like updating OCS workers about MAT services in the state. Promotional materials such as brochures with MAT information can be distributed to OCS offices throughout Alaska. One important example to demonstrate is that you promote de-stigmatizing language according to best practices with MAT. To partner with OCS and similar child welfare services means that you are inspiring and promoting similar affirming and sensitive language with community partners around substance misuse.

4.3.2. Domestic Violence and Sexual Violence Service Agencies

Partnering with domestic violence and sexual violence (DV/SV) agencies as you develop your MAT program can strengthen community engagement. According to the Administration for Children and Families (ACF) and Substance Abuse and Mental Health Services Administration (SAMHSA), there is a connection between substance misuse and intimate partner violence.[16] If you have the capacity and outreach resources to involve DV/SV agencies in the development of your program, it can be a valuable asset to your MAT program. DV/SV professionals can provide trauma informed insights from the specific perspective of their role and the services they provide.

What's more, DV/SV agencies and professionals can be a resource in providing information to clients about availability of MAT providers and programs, and some clients engaged in MAT may be in need of batterer intervention services. To have a partnership with DV/SV agencies can provide a platform to offer wrap-around services to clients receiving MAT.

One other possibility is to offer DV/SV advocates and other employees the chance to learn about Narcan® (*see Section 10: Harm Reduction*). Narcan is a nasal spray for emergency prevention of an opioid overdose and is available to many Alaskans free of charge through various programs. Access a list of DV/SV services in Alaska here.

4.3.3. Shelters and People Experiencing Homelessness

In 2010, SAMHSA cited about 34.7% of all sheltered adults who were homeless had chronic substance use issues in the United States.[17] Shelters for people experiencing homelessness and other similar places can offer a venue to share information about MAT services. Additionally, if partnered with shelters around the development of MAT services, shelter employees and volunteers have the opportunity to learn about services available to people in need of housing. For example, if there are residential programs available for people in crisis situations around SUD, homeless shelters can offer referrals to available programs. Shelters can work to promote dignity, health and safety by offering referrals to MAT and available residential treatment.

4.3.5. Criminal Justice System

Sixty eight percent of people involved in the U.S. criminal justice system have misused alcohol or drugs, and 66% met diagnostic criteria for a substance related disorder.[18,19] Similar to partnering with DV/SV service agencies and OCS, to involve judicial systems in MAT partnerships can help provide safe communities to individuals that are engaged in MAT services. SUD are linked with DV/SV issues and other social problems, and providing education to the judicial systems about MAT services can provide the context to maladaptive and disruptive behaviors, and can highlight the benefits on MAT in reducing criminal activity and recidivism. It is critical to provide information to jails, prisons and re-entry programs on how to provide a warm handoff to MAT programs upon release, as overdose rates in the first 2 weeks following release from incarceration is 120 times higher for clients not on MAT. Access to MAT prior to or immediately upon release has been shown to reduce overdose rates by 70%.[20] Judicial systems have their own language to describe issues such as SUD and crimes that involve substance use. To engage judicial systems can bring the community together to understand the context of SUD and to influence a framework of the best supportive environment possible to individuals. Developing relationships with judges, therapeutic courts, probation officers and pre-trial enforcement officers can increase the likelihood that they will refer individuals to MAT providers when appropriate. The Alaska criminal justice system is working towards offering MAT to incarcerated individuals, however not all clients will have access to MAT while incarcerated. SAMHSA provides a comprehensive resource for medication assisted treatment in the criminal justice system here. [20]

4.3.6. Law Enforcement Services

Law enforcement professionals often are first responders to crisis situations. Crisis situations might involve SUD, such as an opioid overdose. A partnership with law enforcement services with MAT programs can help strengthen community engagement. When officers respond to drug related crisis situations, they can provide information about SUD treatment services. For example, MAT providers and program managers can offer MAT informational handouts to State Troopers and municipal police, who can share them with people who need services. We recommend setting up a time to meet with law enforcement agencies to discuss partnerships.

4.3.7. Where to Begin

To establish a partnership with any recommended agencies can happen in a number of ways. You can offer to provide them with an educational talk about SUD treatment and overdose response. You can request letters of support from them when applying for MAT funding. If granted funding, and with permission from agency policies, you can offer their leaders and administrative staff honorarium payments if they offer time for key stakeholder meetings for the development of MAT programs. You can also invite them to participate in a community coalition to meet regularly about any community needs and issues around addiction and MAT.

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Section 5. Client Communications

5.1. Reducing Stigma

Medications for substance use treatment and people with substance-related disorders face high levels of discrimination and stigma which result in a decrease in access to services and treatment.[1] "A social sigma is the disapproval of, or discrimination against, a person based on perceivable social characteristics that serve to distinguish them from other members of a society; social stigmas are commonly related to culture, gender, race and health".[2]

For more general information on addiction basics see Section Six and the resources listed below:

- Video on reducing stigma: Taking Care of Each Other: Reducing Stigma[3]
- Anti-Stigma Toolkit: A Guide to Reducing Addiction-Related Stigma[4]

5.1.1. Self-Stigma

The high rates of stigma towards people with opioid use disorder (OUD) has detrimental results on their psychological wellbeing, including shame or self-stigma.[5,6] Self-stigma is characterized as the internalization of negative public opinion leading to association of negative addiction stereotypes.[6] Self-stigma results in reduced treatment seeking and negative attitudes towards accessing medication assisted treatment (MAT) and treatment.[7,8]

5.1.2. Intervention Stigma

Stigma towards MAT is rooted in the misconception that methadone and buprenorphine is substituting one drug for another and also stems from substance-related diagnosis stigma.[9] Madden described the prejudice towards MAT as 'intervention stigma'.[9] A national public opinion study showed low awareness of the evidence for MAT to treat OUD and over half reported a belief that there is no effective treatment for OUD.[10] People with OUD confirm stigmatization related to their use of methadone when interacting with the public and health care professionals.[11]

It is important to normalize MAT. MAT remains underutilized largely due to stigma.[12] The largest barrier to the use of medications like methadone and buprenorphine is the belief that it is replacing one drug with another. Simply put, it is viewed as substitution and not treatment. Methadone and buprenorphine are opioids (full and partial opioid agonists) that are prescribed and administered under monitored and controlled conditions which are safe and effective treatment for opioid use disorder. The effects of MAT differ from the effects of misused substances, like heroin. For instance, the short half-life of heroin use leads to a rapid cycle of euphoria, crash and craving often several times a day, resulting in behavioral and emotional disruption. On the other hand, MAT is designed to create a steady effect that reduces withdrawal effects like craving and crash, minimal to no euphoric effects, while still offering analgesic effects and maintaining biological homeostasis that allow people to function fully in their lives. Thus, incorporating MAT allows the client to stabilize the parts of their brain changed by their addiction allowing improved engagement in treatment. MAT allows clients to hold jobs, avoid a return to substance use and criminal behavior, and reduce risk for exposure to HIV by reducing injection drug use.[12]

5.1.3. Reduce Stigmatizing Language

One area for combating stigma is changing the way people communicate about substance use by reducing language that reinforces negative views.[13] Terms such as "substance abuser" or "addict" have been shown to increase stigmatization and reinforce blaming of individuals relative to person-first language such as "person with an opioid use disorder".[14,15] The use of the term 'substance abuser' over 'person having a substance use disorder' was found to be associated with a belief that a person was less likely to benefit from treatment, more likely to benefit from punishment, perceived as socially threatening, believed to have control over their substance use without help and continued use was a result of an innate dysfunction.[14,16] Even the term "medication assisted treatment" has a more negative association than the term pharmacotherapy or medication for addiction treatment.[15] Simply changing the language people use have been found to decrease stigma associated with MAT and substance misuse.[17] In short, language should be used that respects the dignity and worth of all people by using person-first language, focuses on the medical nature of SUD and treatment, promotes recovery and avoids

stereotypical and biased language and slang.[18] The table below provide suggestions for language to use or avoid to reduce stigma.

Use person first language: Words to use, words to avoid and why we use them		
Words to use	**Words to avoid**	**Because…**
Person who uses drugs (PWUD)	Drug user	Use person-first language. The change shows that a person "has" a problem, rather than "is" the problem. The terms avoid elicit negative associations, punitive attitudes, and individual blame.
Person with non-problematic drug use	Recreational, causal or experimental user	
Person with substance use disorder Person with drug dependence Person with problematic drug use	Drug abuser, junkie, dope head, crackhead, druggie, stoner	
Person with alcohol use disorder	Alcoholic	
Person in recovery	Former addict/alcoholic	
Person who injects drugs	Injecting drug user	
Substance use disorder	Drug problem	Inaccurately implies that a person is choosing to use substances or can choose to stop, while "habit" undermines the seriousness of the disease.
Problematic drug use	Drug habit	
Drug misuse, harmful use *For illicit drugs*: use *For prescription medications*: misuse or used other than prescribed	Drug abuse	The term "abuse" was found to have a high association with negative judgments and punishment. Legitimate use of prescription medications is limited to their use as prescribed by the person to whom they are prescribed. Consumption outside these parameters is misuse.
Abstinent, not actively using, person who has stopped using drugs	Clean	Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions. Set an example with your own language when treating clients who might use stigmatizing slang. Use of such terms may evoke negative and punitive implicit cognitions and may decrease clients' sense of hope and self-efficacy for change.
Actively using	Dirty	
Testing negative for substance use	A clean drug screen	
Testing positive for substance use	A dirty drug screen	
Opioid agonist therapy, Medication for treating opioid use disorder, Medications for addiction treatment, Pharmacotherapy	Opioid substitution or replacement therapy, Medication assisted treatment	It is a misconception that medications merely "substitute" one drug or "one addiction" for another. It is a misconception that medications are ineffective without the addition of counseling services
Baby born to mother who used, drugs while pregnant, Baby with signs of withdrawal from prenatal drug exposure, Newborn exposed to substances	Addicted baby	Babies cannot be born with addiction because addiction is a behavioral disorder—they are simply born manifesting a withdrawal syndrome. Using person-first language can reduce stigma.

Note: Created from National Institute on Drug Abuse[19] and ANTHC Harm Reduction Toolkit[20].

5.2. Talking to Clients

Decreasing stigma begins with providers taking the opportunity to educate clients about MAT. Misinformation from providers that perpetuates stigma is often damaging and can hurt the client and provider relationship. Stigma about MAT is perpetuated by low awareness and misinformation about the effectiveness of MAT in treating substance-related disorders.[21,22] SAMHSA[23] highlighted the importance of providing education about medication and evidence of benefits and correcting misconceptions in reducing illicit opioid use and increasing MAT prescription. Research findings indicate education of stakeholders (i.e., participants, corrections staff, community providers, clinicians, etc.) has the potential to break down systemic barriers and stigma to increase access and utilization of treatment services.[23]

For more information see the Provider Clinical Support System[24] for evidence-based training and resources for working with clients with opioid use disorders. Or watch the video Tell Me What to Say: How to Approach Challenging Patient Conversations.[25]

5.2.1. Motivational Interviewing

Motivational Interviewing (MI)[26] is considered an appropriate and effective intervention for American Indians and Alaska Native (AI/AN) people. MI is a way of structuring a conversation to engage a person in a discussion where they weigh the advantages and disadvantages of change to create their own argument to change their behavior. MI respects sovereignty and self-determination which is consistent with decolonizing methodologies, and potentially raises awareness of the impact of intergenerational trauma and cultural genocide. The spirit of MI allows for

culturally appropriate adaptations of reflective listening and open-ended questions to guide a client through the process of change. For more information about adapting MI for AI/AN communities see the resource section, click this link.[26]

5.2.2. Family Involvement

Substance use disorders do not affect just those who are misusing the substance, but also their family and other significant people in their lives. [27] Families are complex entities and do not necessarily contain only blood relatives. Each family is complex and varies greatly. Some common characteristics families often possess are rules, roles, boundaries and communication styles. Integrating a client's family and community can have numerous benefits and potential challenges. Providing the support system a better understanding of how their interactions can contribute to behavior and learning to best support the client. Families can greatly improve treatment engagement and retention, improve outcomes, and motivate clients to receive/continue treatment, improve family functioning, foster healing from addiction, and reduce risk in family members of developing substance use or mental health disorders. Level of family involvement may vary across different settings (i.e., residential versus outpatient care). It is important to discuss this with a client and the family involved in their care. There are various pathways for integrating families in service delivery, such as parallel, sequential and integrated approaches. These different pathways mean treatment can be tailored depending on family structure, way of functioning, and dynamics.[27]

There are several empirically supported targets for treatment for clients and their support systems.[28] To begin, treatment should address skills to improve the function of the system including communication, conflict resolution, parenting skills, cohesiveness, and attitudes towards substance use. Secondly, support systems often maintain homeostasis, or balance, within the system to keep things consistent. Thus, families should work together to redefine that balance of healthy behaviors and dynamics. Thirdly, there may be gender-specific family dynamics that need to be taken into consideration. For example, women socialized as caretakers may struggle with confrontation and feel it is not their place to criticize substance use behavior. Fourth, research suggests a person with a substance use disorder is at high risk for interpersonal violence, neglect, mistreatment and even abuse. It is important to screen for all forms of abuse, including children taking on the role of parent inappropriate for their developmental stage. Additionally, do not overlook the effects on adult children and ensure to approach all families with sensitivity. Take the time to understand the family dynamic and the negative and/or positive effects experienced by different family members. [28]

It is also important to identify the role that family may play in inadvertently stigmatizing medications for addiction treatment. Well intentioned family members may press clients to stop taking their medications due to a misconception that they are replacing one drug for another. It can be helpful to bring a family member in for a co-visit to discuss the importance of continuing MAT for the long-term treatment of the chronic disease of addiction.

Below are resources for clients and their families about substance use treatment and more:

- SAMHSA, Resources for Families Coping with Mental and Substance Use Disorders[29]
- PCSS, Addiction Impacts the Entire Family: Pearls for Providers[30] [Video], 2020
- PCSS, MAT Handouts for Patients and Family Members[31], 2020
- SAMHSA, Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends[32], 2020
- Recovery Research Institute, Guide for Family Members[33]
- SAMHSA, Decisions in Recovery: Treatment for Opioid Use Disorders[34], 2016
- ASAM, Opioid Addiction Treatment: A Guide for Patients, Families and Friends[35], 2016
- SAMHSA, Helping a Loved One Dealing with Mental and/or Substance Use Disorders[36]
- SAMHSA, Supporting a Loved One Dealing with Mental and/or Substance Use Disorders[37]

Substance Use Disorder Treatment for American Indian and Alaska Native Families. Overall, there is lack of research on culturally appropriate substance use disorder treatment for AN/AI populations, However, existing studies of family focused interventions have found an array of positive outcomes including: improved abstinence maintenance, greater number of days of abstinence, higher perceived support, decline in immediate substance use, decreased stress/emotions/activities related to substance use, increased employment rates, decrease in criminal involvement, and a wide variety of improvement across mental health outcomes (i.e., decrease in self-reported depression, anxiety, concentration, hallucinations, suicide attempts and problems controlling violent behavior).[38]

Significance of Community. American Indian and Alaska Native clients and their communities must be given opportunities to offer input on the types of services they need and how they receive them. The interconnectedness of community should be understood and acknowledged by including not only the family, but a systems approach that incorporates the community (for more information on how to put this into action please see Section 4: Community Partnerships). The input of community helps match services to clients, increase community use of services, and use agency and tribal financial resources efficiently. Providers must involve themselves in native community events and encourage Indigenous community involvement in treatment services. Four specific dynamics have been found to serve an important focus for intervention for AI/AN families: (1) presence of grandparents or other valued others (i.e., community elders, spiritual leaders), (2) open communication about substance use, (3) importance of forgiveness, and (4) use of cultural and spiritual practices in promoting recovery.[38]

5.3. Confidentiality

There are heightened confidentiality standards for SUD clients regulated by state statutes (AS 47.30.590), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and by 42 CFR Part 2. 42 CFR Part 2 are federal substance use disorder confidentiality regulations issued by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). They were developed to protect clients from unintended bias associated with SUDs. The 42 CFR Part 2 non-disclosure requirements are stricter than HIPAA; in cases where statutes differ, providers should use the strictest guidelines. Communication should be effective and timely while ensuring proper documentation and confidentiality in line with regulations and organizational practices.

ANTHC contracts with Sonosky, Chambers, Sachse, Miller & Monkman, LLP to provide confidential legal consultation for THOs in the ATHS. To request this consultation at no-cost to your organization, contact behavioralhealth@anthc.org. To learn more about 42 CFR requirements:

- Alaska Native Tribal Health Consortium, 42 C.F.R. Part 2 Training Resources[39]
- Department of Health and Human Services, 42 CFR Part 2[40], 2017
- ASAM, Confused by Confidentiality? A Primer on 42 CFR Part 2[41], 2013
- SAMHSA, Fact Sheet: SAMHSA 42 CFR Part 2 Revised Rule[42], 2020
- SAMHSA, Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to me?[43]
- SAMHSA, Disclosure of Substance Use Disorder Patient Records: How Do I Exchange Part 2 Data?[44]

5.3.1. Confidentiality in Small Communities

Small communities pose dilemmas for professionals and their clients given the overlapping relationships and familiarity between clients and communities. In small communities, relationships may overlap with personal and professional roles, unlike urban or suburban settings where professionals are like strangers to their clients at their initial meeting; ethical relationships are different between strangers and close-knit relationships. Trouble may arise for a provider when their standards of professional conduct do not fit or are at odds with the nature of connection in a small community. The familiarity in small communities can enhance the trusting relationship with professionals. Still, confidentiality issues arise because clients and professionals know the details of each other's lives. Potential conflicts that can arise when addressing privacy and confidentiality include: (1) clarify confidentiality and privacy policy with clients, (2) conduct informative discussions about confidentiality and privacy with the community in general, and (3) review medical record management for potential privacy breaches. [45]

A few examples of potential exceptions to maintaining confidentiality are listed below for consideration:

- Testifying in court, or responding to a court order to release medical records
- Reporting potentially impaired drivers
- Reporting in workers' compensation cases
- Reporting communicable disease (and notifying partners)
- Reporting gunshot or other suspicious wounds if criminality is questioned
- Warnings by physicians to persons at risk, when there is a legally recognized duty to warn
- Reporting of child abuse, domestic violence, or elder abuse[45]

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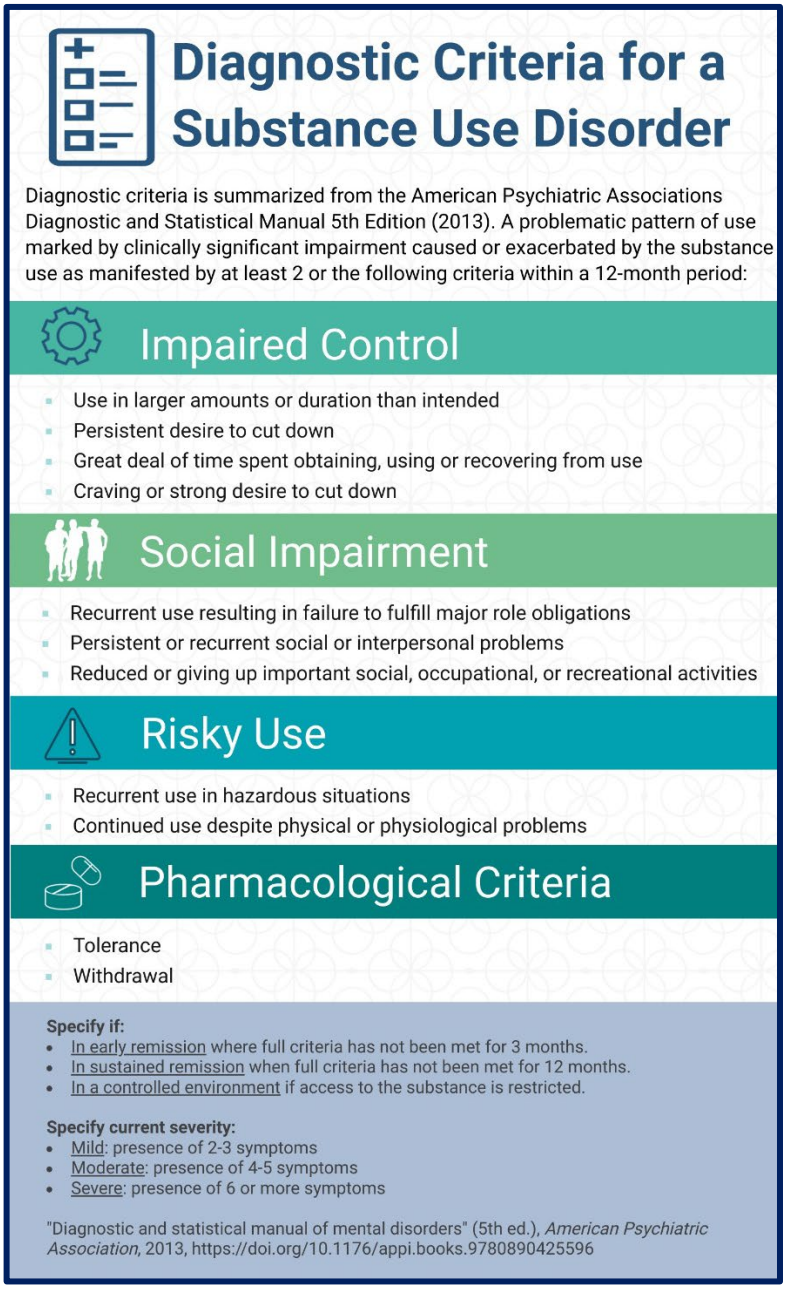
Section 6: Addiction Basics

6.1. Addiction

In 2019, ASAM defined addiction as a, "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences; prevention efforts and treatment approaches for addiction are generally as successful as those for other chronic diseases." (p. 3).[1] In the past, terms like 'addict' or 'drug abuse' were used to describe people who use drugs. Instead, it is recommended to use terms such as people who use drugs or other substances. Specifically, drug abuse is an older diagnostic term marked by unsafe use leading to role failures, potential legal issues, and persistent interpersonal issues. "Addiction is a lot like other diseases, such as heart disease; both disrupt the normal, healthy functioning of an organ in the body, both have serious harmful effects, and both are, in many cases, preventable and treatable" (p. 4).[2]

6.1.1. Substance-Related Disorder

A substance use disorder (SUD) differs from addiction in that it must meet specific diagnostic criteria from the American Psychiatric Association (2013) fifth edition of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) contained in the substance-related and addictive disorders section. Substance use diagnostic criteria fall into four clusters of symptoms: "impaired control, social impairment, risky use, and pharmacological criteria (i.e., tolerance and withdrawal)" (p. 1).[2] Severity ranges from mild to severe; two or more criteria must be present to meet criteria for a SUD. SUDs are marked by clinically significant impairment or distress across several domains of functioning. The specific criteria is outlined in this table.



6.1.2. Physical Dependence

Physical dependence is different from a substance use disorder, and in fact is only one criteria for a SUD. Dependence occurs with regular use of a substance. In fact, physical dependence can occur with the daily or almost daily use of any substance like caffeine or a prescription medication. The human body naturally adapts to the regular exposure. Dependence is marked by withdrawal symptoms when the substance is stopped. Dependence alone does not indicate an addiction, but can be an element leading to it.[3]

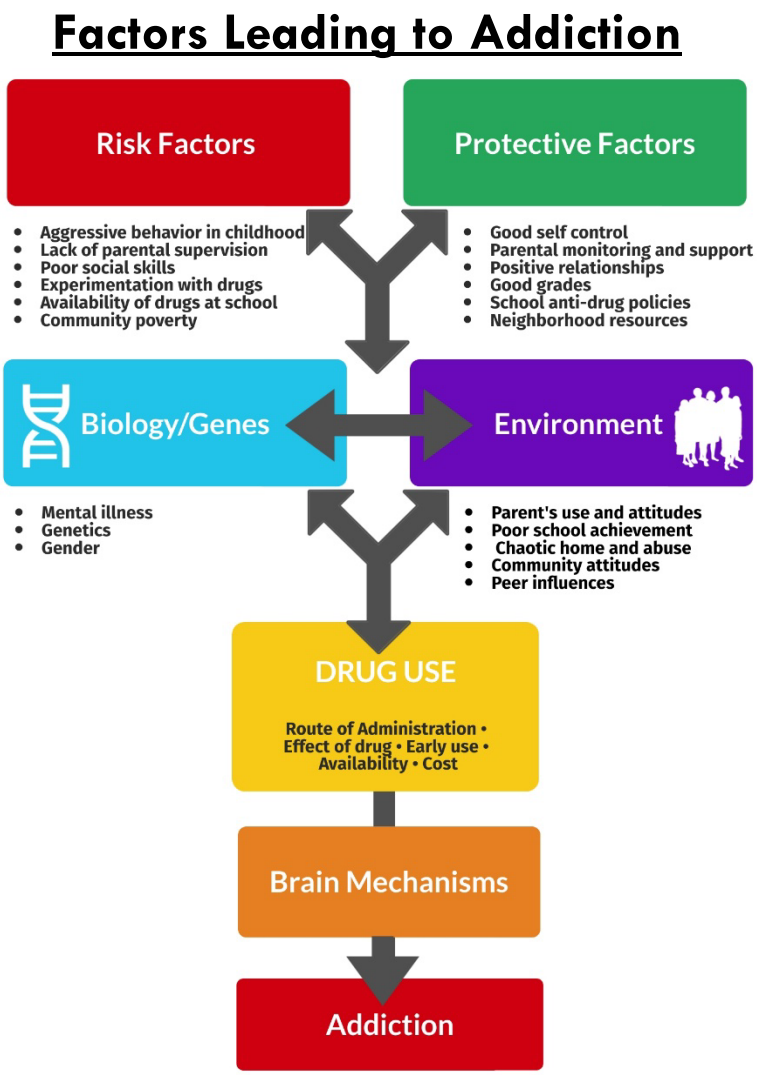
6.2. How to Use Different Terms

With changes in diagnostic terminology and working towards reducing stigmatizing language, the terms we use in the field of addiction continue to change. Here is a brief discussion on how to use terms; for more information reference Section 5.1 Reducing Stigmatizing Language or the National Institute of Drug Abuse glossary[4]. To begin with, NIDA defines how to use the terms drug use, misuse and addiction. Most people who use substances will not develop an addiction. Substance use is the broadest term indicating the use of any substance, legal and illegal, at any level of use ranging from periodic to regular use. Drug use is differentiated from the more general substance use to refer to the use of illegal drugs explicitly, such as the use of heroin, cocaine, and methamphetamine. On the other hand, drug misuse refers to not following a doctor's direction for use of a prescription medication, use of another person's prescription, or alcohol in moderation. The reason some professionals revert to the more general terms like substance use or substance misuse is because drug use/misuse fails to account for harmful patterns of use for legal substances, like tobacco, cannabis, and alcohol.[5]

The term addiction is intended to refer to the most severe end of the spectrum of substance use disorders. Addiction is marked by compulsive substance use and impulsivity despite negative consequences. Additionally, addiction is accompanied by changes in brain functioning, specifically chances in brain regions around inhibition and reward system. Similarly, the terms physical dependence and tolerance express physical changes from substance use. Dependence causes changes in the body from regular use; physical dependence can lead to cravings to relieve withdrawal symptoms. Tolerance occurs over time as a person needs to take higher doses to get the same effect, and often accompanies dependence making it difficult to differentiate.[5]

6.3. Brain Disease Model of Addiction

There exists strong scientific evidence for the brain disease model of addiction. Research has shown how chronic exposure to alcohol and drugs alter critical brain structures and in turn behavior. Affected brain areas associated with addiction are loss of control, compulsivity, impulsivity, inflexible behavior and negative emotional states.[6] Due to this, addiction is caused and influences a combination of behavioral, psychological, environmental, and biological factors. Most notably, substances cause changes in the reward, motivation and memory system in the brain. Even when substance use stops, the brain changes take time to find new equilibrium in the absence of a substance. These changes leave people vulnerable to physical and environmental cues, increasing risk for relapse. This research underpinned that will power is not enough because the brain has been changed by substance use. Thus, the brain disease model posits that addiction is perpetuated by the biological changes from substance use, which with time causes the substance to be a very strong positive and negative reinforcement.[7]



6.4. Substance Use and Behavior

There are several reasons that lead people to their initial use of a substance.[8] NIDA outlined five primary explanations that lead to voluntary initiation: (1) to feel good, (2) to feel better, (3) to do better, and (4) curiosity and (5) social pressure. With continued use after the initiation of use, a person's ability to exert control over use becomes impaired, which is a hallmark of addiction. Given that substances make people feel good or better, the problem arises as the substance takes over the person's life and increased amounts are required just to feel 'normal'. Like other diseases, the likelihood of developing an addiction differs from person to person. There is no single factor predisposing people to addiction. Below is a figure of general risk factors and protective factors, with no single factor determining if a person will become addicted to a substance.[8]

The image on the previous page highlights the various elements that increase risk for addiction.[6] To begin with, there are biological and genetic factors that increase the risk of addiction. For instance, a person's gene expression accounts for 40-60% of a person's risk of addiction. Early use has been found to increase risk because of the effect of a substance on the developing brain. However, early use is a mixture of biology and environment that impact risk for developing a substance-related disorder. Environmental factors related to risk of addiction include family and home environment, peers and school, and neighborhood. Further, route of administration, specifically injection drug use significantly increases the addictive potential because the effect is more intense and rapid than other routes, like smoking.[8]

6.5. Multiple Routes to Recovery

SAMHSA[9] defined recovery as "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." Recovery is not a linear process and is highly personalized. Individuals contain within them unique needs, strengths, preferences, goals, culture and backgrounds that impact their pathway to recovery. Each individual's recovery path is built upon their multiple capacities, strengths, talents, resources, coping skills, and community. Recovery is not a set trajectory, rather SAMHSA outlined ten guiding principles of recovery: hope, person-driven, many pathways, holistic, peer support, relational, culture, addresses trauma, strengths/responsibility, and respect.[9]

Recovery is characterized by continual growth and improved functioning that may involve setbacks. Setbacks are a natural part of the recovery process and are essential in fostering resilience for individuals and their support networks.[9] It is important to note addiction is described as a chronic condition, and has relapse rates similar to other chronic conditions. The relapse rates for drug addiction are similar to other chronic illnesses; namely, research has found relapse rates for the following are 30-50% for Type 1 Diabetes, 40-60% for drug addiction, 50-70% for hypertension, and 50-70% for asthma. Like other chronic conditions, addiction can be managed effectively and a relapse serves to indicate the need for renewed intervention. Due to this, it is important to know that a return to substance use does not indicate treatment failure, rather signifies a need to adjust or reinstate alternate treatment approaches.[10]

One conceptualization of the multiple pathways to recovery breaks it down into three pathways[11]: clinical services, non-clinical services and self-management. First, clinical services involve a healthcare provider, clinician or other credentialed professional who aids in the recovery process. It may involve referral to a substance use treatment program based on the ASAM levels of care (see Section 7.3. Assessment and Referral for Care). Clinical services may include medication assisted treatment (MAT), holistic-based recovery services, an array of behavioral health interventions, contingency management (CM), relapse prevention (RP/MBRP), motivational interviewing and motivational enhancement therapies (MI/MET), family therapy, etc. Secondly, non-clinical services do not have to involve a trained clinician, but rather are peer or community lead. A few examples of non-clinical services are recovery community centers or residencies, peer-based recovery support, education-based recovery services, employment services, and faith-based support services. Lastly, not all people need aid from formal services and may effectively engage in self-management pathways without formal services, sometimes referred to as "natural recovery." This may be as simple as developing and implementing a plan to moderate use, and can be enabled by creating a supportive environment.[12,13]

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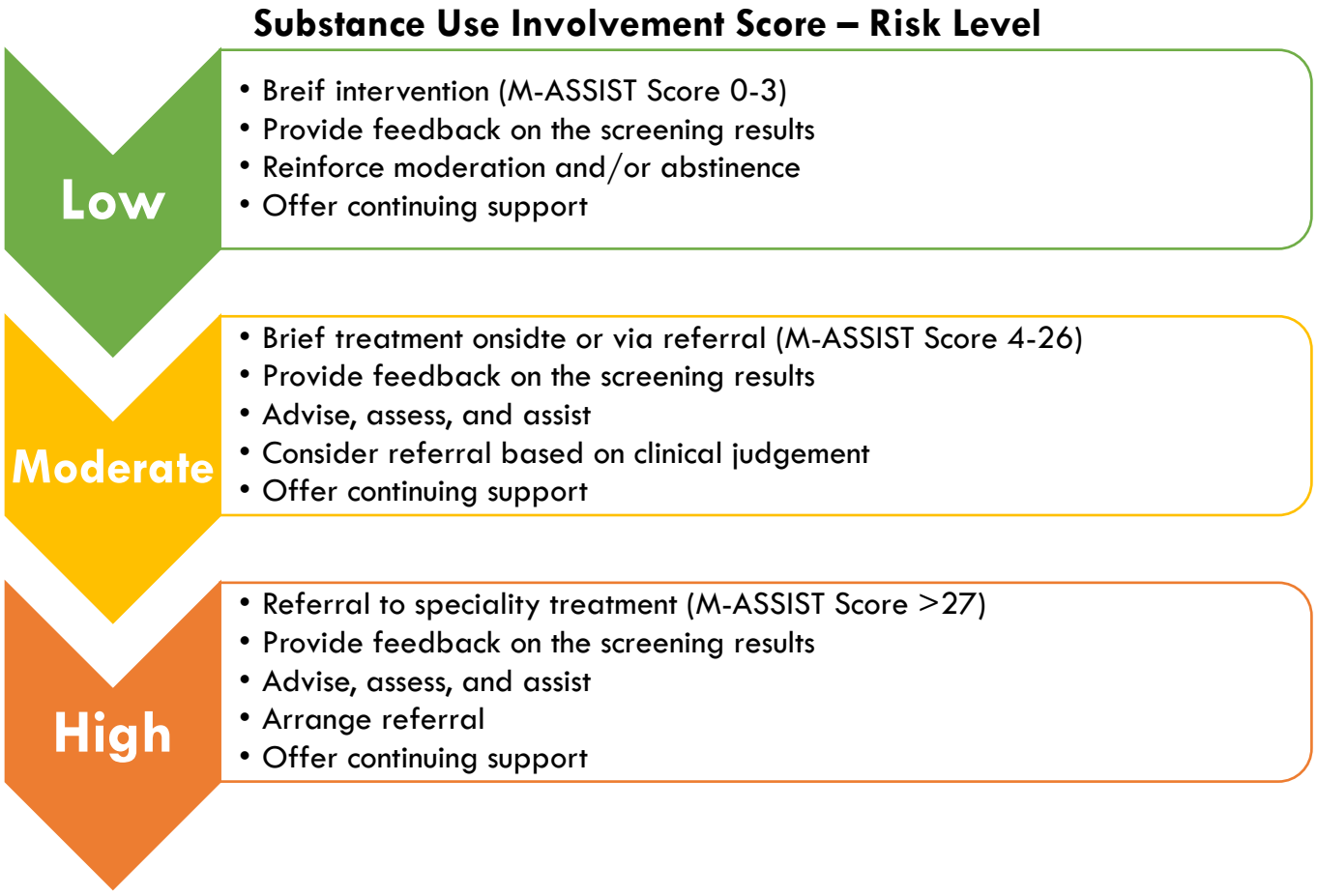
Section 7: Screening, Assessment and Treatment

When meeting with a client, it is essential to screen for substance use. If indicated, it is recommended to implement a more comprehensive assessment to diagnosis and develop a plan for treatment or referral. If the client has co-occurring mental or physical health disorders, the provider should consider referral or integration of additional services such as psychosocial and/or medical services.

7.1. Screening

SAMHSA recommended that all providers screen for the use of alcohol, tobacco, prescription drugs, and illicit drugs at least annually.[1] Screening is intended to identify if a client may misuse a substance and may indicate a more comprehensive assessment of their use and potential substance-related diagnosis. Often, screening involves using an evidence-based tool to detect potentially problematic use. Some screening tools may include the AUDIT, DAST, NIAAA, TAPS, and more.[1] For a quick reference of evidence-based screening tools and assessment resource materials, see NIDA chart[2] or NIAAA chart.[3] If the client screens positive for harmful substance use, it is recommended they receive a more in-depth assessment.[4]

In addition, NIDA offers an online version of Modified ASSIST[5] for screening drug and alcohol use in general medical settings. The M-ASSIST begins with screening for a range of substances a person may use and then will move into assessment tools based on scores on screening items. After completing the assessment, the tool will provide a risk rating, treatment recommendations, and vulnerabilities. Below provides an idea of how using the M-ASSIST determines a risk rating which then suggests the next step for the provider.[6]



7.2. Screening, Brief Intervention, and Referral to Treatment Model

The Screening, Brief Intervention and Referral to Treatment (SBIRT) model has a substantial evidence which supports effective prevention for harms associated with alcohol and tobacco use, and potential effectiveness in addressing harmful drug misuse, depression, trauma, or anxiety problems.[6,7] When meeting with a client, it is essential to screen for alcohol and tobacco use, and provide brief intervention and referral to treatment as needed. "SBIRT is a comprehensive, integrated public health model designed to provide universal screening, secondary prevention (detecting risky or hazardous substance use before the onset of abuse or dependence), early intervention, and timely referral and treatment for people who have SUDs" (p. 1).[4] If screening indicates misuse of alcohol, a more comprehensive assessment should be completed to determine a treatment plan and offer for referral for other treatment options.[6,7]

Screening is the first stage in the SBIRT process. Screening is intended to identify if a client may misuse alcohol and may indicate a more comprehensive assessment of their use harms, and potential substance-related diagnosis. Often, screening involves asking about use or using an evidence-based screening tool. [6,7] For example, an SBIRT approach to alcohol use would begin by asking about alcohol use: "Do you sometimes drink beer, wine, or other alcoholic beverages?" If the answer is NO, then the screening is complete. If the answer is YES, show clients the standard drinks chart and then follow up to inquire more about use: "How many times in the past year have you had: (*for men*) 5 drinks or more in a day / (*for women*) 4 drinks or more in a day?" The AUDIT[8] or another screening tool may be used in place of this question. A more in-depth assessment is recommended if the client indicates 1 or more heavy drinking days or has an AUDIT score of ≥ 8 for men or ≥ 4 for women because this indicates risky or potentially harmful alcohol use. If the client does not have risky or harmful use, then recommend lower limits or abstinence as medically indicated based on the client's medications and health conditions while expressing openness in talking about alcohol use and concerns. Rescreen for alcohol use annually.[9]

Brief intervention using the SBIRT should begin with education on definitions of a standard drink depending on the type of alcohol and provided information about recommended alcohol use based on age and gender.[7] "In the U.S., a standard drink is any drink that contains about 14 grams of pure alcohol (about 0.6 fluid ounces or 1.2 tablespoons)".[9] Click here[10] for a visual of a standard drink. Depending on the level of risk, clients may be recommended for brief intervention or brief treatment. SAMHSA defined brief intervention as " program involves 1-5 sessions lasting 5 minutes to an hour… brief treatment as part of SBIRT involves 5-12 sessions, lasting up to an hour" (p. 4).[11]

For screening and brief intervention, the 5 A's are consistent with the SBIRT model for alcohol and tobacco use. The 5 A's are as follows:

1. **Ask** about substance use and/or using a screening tool.
2. **Advise** about moderation for recommended use.
3. **Assess** willingness to abstain/moderate use and interest in support and/or recovery services.
4. **Assist** to abstain through services like pharmacotherapies.
5. **Arrange** follow-up, referral, and support.

Clients who meet moderate to severe substance use disorder should be considered for referral to more comprehensive services or a higher level of care.[11,12] For more comprehensive information on SBIRT, you can reference the SAMHSA Screening, Brief Intervention and Referral to Treatment (SBIRT) in Behavioral Healthcare[13] and TAP 33 Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment[14].

7.3. Assessment and Referral for Care

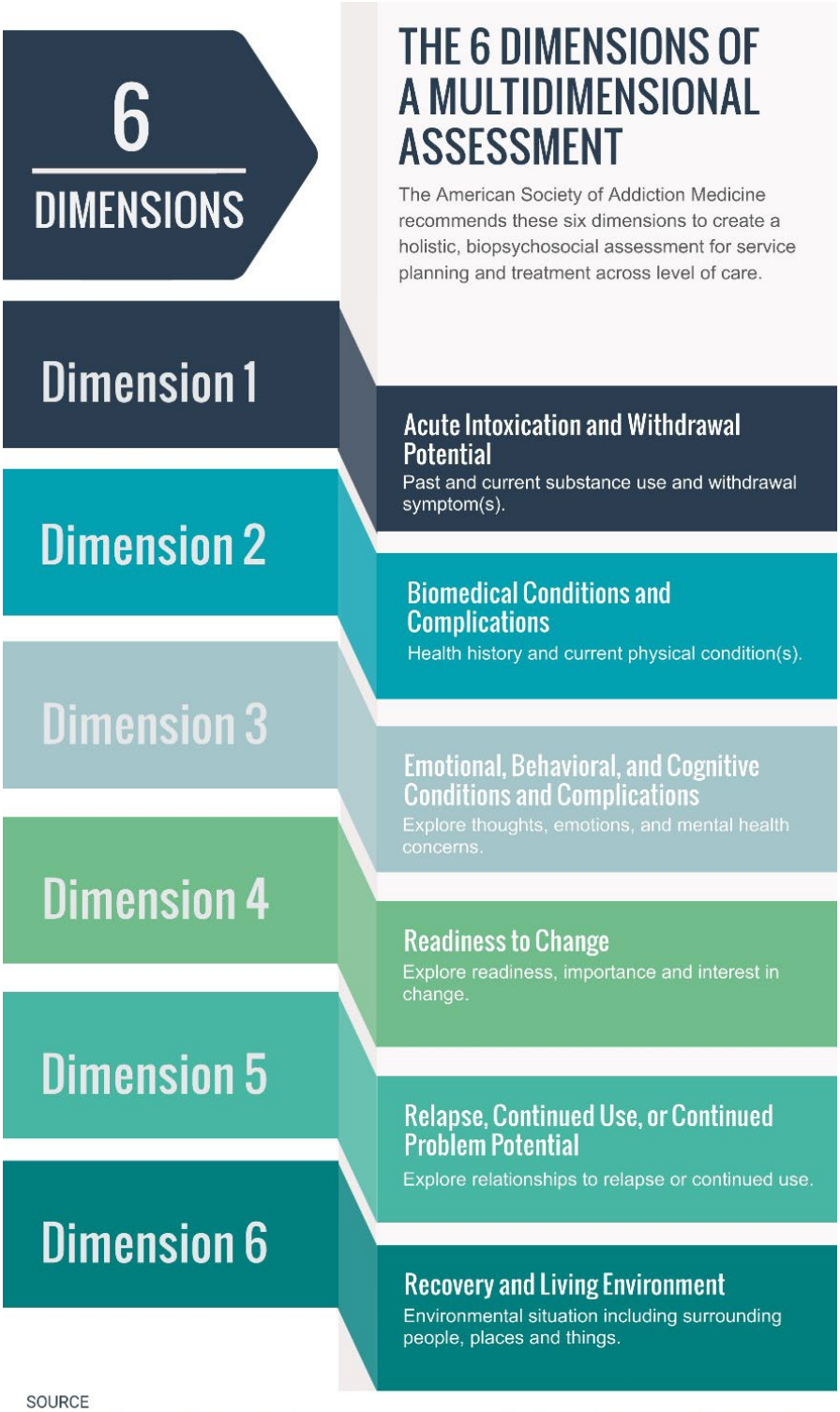
An assessment is defined as a process to determine substance-related conditions and needs associated with medical, psychological, and social domains. An assessment is conducted if any of the following are present: screens or discloses substance use, signs or symptoms of substance use, or the client asks for an assessment or treatment. The extent of an assessment depends on a medical provider's ability to treat clients directly: (1) if a provider does not offer pharmacotherapy, the focus is on medical assessment, making a substance-related diagnosis, client safety, and a referral and/or warm hand-off to a medical provider that offers pharmacotherapy (2) if the provider

offers pharmacotherapy, a comprehensive assessment is initiated, and (3) completion of the assessment should not delay or preclude initiating medication assisted treatment. In fact, stabilizing a client on pharmacotherapy for OUD prior to the completion of the assessment can facilitate client engagement by relieving the physical discomfort associated with withdrawal and cravings which can interfere with obtaining an accurate and complete assessment.[15] The State of Alaska MAT Guide[16] reviews important elements of a comprehensive assessment includes: proper diagnosis of existing substance use, mental health, and physical disorders; obtain comprehensive history, physical examination, laboratory testing, querying the Prescription Drug Monitoring Program (PDMP), and developing a plan for treatment or referral.

If the assessment indicates a referral to substance use treatment, then a qualified addiction professional (typically a licensed behavioral health clinician or certified chemical dependency counselor) will complete a SUD assessment using the ASAM Criteria. The client will be assessed on the six dimensions and then the professional will make a recommendation for level of care. The ASAM explores six different dimensions to create an all-inclusive and comprehensive assessment used for service planning and treatment as outlined in the following section.[17]

7.3.1. Alaska Levels of Care for Referral

When a provider determines a client is in need of substance use treatment, the client is evaluated for their recommended level of care. The Alaska Levels of Care are defined in the Alaska Behavioral Health Provider Service Standards and Administrative Procedures for SUD Provider Services. Alaska uses the *American Society of Addiction Medicine (ASAM) Criteria* for determining levels of care. The ASAM criteria is a universal standard for insurance companies, meeting the following criteria: it has a holistic, biopsychosocial approach for determining individualized client plans, it uses a common language for assessing needs and a spectrum of assessment levels for treatment referral. The ASAM criteria is a multidimensional assessment that takes into account a client's strengths, assets, resources and support structure as well as needs, obstacles and limitations. A comprehensive assessment utilizing the ASAM criteria will explore six different dimension listed in the figure below used to develop the treatment plan and recommended level of care.[17]



SOURCE
https://www.asam.org/asam-criteria/about?gclid=EAIaIQobChMIzPD-tbzw6gIVWR-tBh2e2A2CEAAYASABEgJQ7_D_BwE

The six dimensions are then used to recommend placement on a continuum for treatment services, increasing in intensity from level 1 outpatient services to level 4 medically managed intensive inpatient services. Each level of care refers to a broad category of services and treatment formats offered to clients.[17] To learn more about the ASAM criteria click here[17], and to learn more about services available at each Level of Care click here[18].

The continuum of care levels are as follows:

- Level 0.5 Early Intervention
- Level 1: Outpatient Services
- Level 2: Intensive Outpatient (IOP)/ Partial Hospitalization (PHP) Services
- Level 2.1: Intensive Outpatient Services
- Level 2.5: Partial Hospitalization Services
- Level 3: Residential/Inpatient Services
- Level 3.1: Clinically Managed Low-Intensity Residential Services
- Level 3.3: Clinically Managed Population Specific High-Intensity Residential Services
- Level 3.5: Clinically Managed High-Intensity Residential Services
- Level 3.7: Medically Monitored Intensive Inpatient Services
- Level 4: Medically Managed Intensive Inpatient Services[18]

7.4. Substance Use Treatment

Successful substance use treatment depends on the person and often includes a variety of services and resources. [11] Pharmacotherapies should be the first line of treatment, usually combined with some form of behavioral therapy or counseling. Often, treatment begins with treating withdrawal to reduce the negative effects of withdrawal to help the person successfully stop using the substance. However, treatment varies greatly depending on the individual needs of a client. Pharmacotherapy is often combined with other treatment and support services to enhance treatment efficacy and remission outcomes. Studies have found that programs providing regular, structured, SUD-focused counseling had better outcomes than programs providing little or no counseling.[19] The image below shows the array of components in a comprehensive substance use treatment program.[20]

7.4.1. Treatment Plan

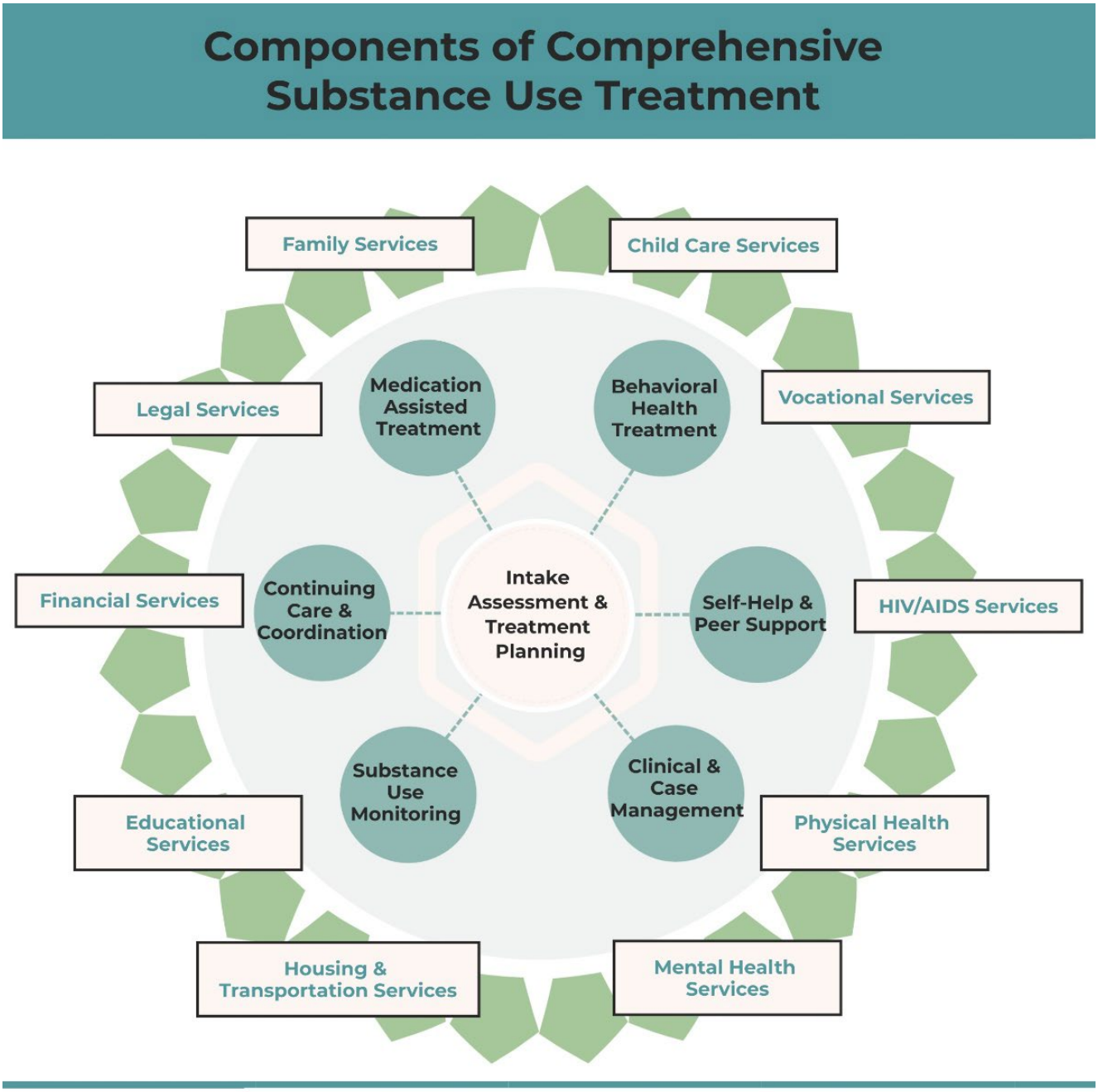
The first step following an intake assessment for services is to develop a plan for treatment. The development of the treatment plan should be a collaborative process that is educational and informative to the client to promote engagement. The treatment plan should clearly identify the goals of treatment, expectation and any therapeutic contingencies for non-adherence, and any conditions for changing or stopping treatment. A collaborative treatment plan is the first step in establishing a strong working relationship. The treatment plan should be a living document that is updated together to review progress and changes made to better treat the whole person as they progress through treatment.[21,22,23,24]

Specifically related to pharmacotherapy, the State of Alaska MAT Guide[25] outlines guidelines for treatment planning, progress monitoring and indicators, and discontinuation related to addiction medicine.

7.4.2. Psychosocial Treatment

Psychosocial treatment encompasses counseling and/or psychotherapy that is offered to an individual, group, and/or family. All levels of care offer psychosocial treatment to support clients in attaining and maintaining recovery and behavioral changes to support their recovery.[26] Some of these may include motivational interviewing and motivational enhancement therapy[27], contingency management[28], cognitive-behavioral therapies (CBT)[29], behavioral couple's therapy (BCT)[30], community reinforcement approach and family therapy (CRAFT)[31], and/or family therapy[32].

Co-facilitated groups with a medical provider and behavioral health counselor after which clients are offered individual medical appointments to offer therapeutic discussion and education. For more information about group visits[33], the care innovations website has a section on group visits and refill visits. Referral to psychosocial services and SUD treatment will be covered more in depth in the State of Alaska MAT Guide[34].



SOURCE: "Principles of Drug Addiction Treatment: A Research-Based Guide" (Third Eds.) National Institute on Drug Abuse, 2018. https://www.va.gov/HOMELESS/nchav/resources/docs/interventions/contingency-management/NIDA-principles-of-drug-addiction-treatment-a-research-based-guide-third-edition-508.pdf

7.4.3. Recovery Support Services

Another important element involves a recovery community as outlined in Section 4.2: Communities in Recovery. Community support services may include housing, peer support, traditional healing services, sober social environments, vocational and educational services, child care, legal services, financial services, transportation, outreach, HIV/AIDs services, Al-Anon, and 12-step programs. (i.e., alcoholics anonymous and narcotics anonymous). Recovery support services are a crucial part of treatment in helping a person build a life worth living without substances.[35,36] Other services may be accessed at specific organizations that offer recovery community centers or recovery community organizations like Recover Alaska and Recovery Support Alaska.[37,38,39]

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Section 8: Pharmacotherapy for Opioid Use Disorder

8.1. Opioids and Opioid Use Disorder

Opioids are a class of drugs that include the illicit drug heroin, synthetic opioids such as fentanyl, and prescription pain relievers such as oxycodone, hydrocodone, codeine, and morphine. Opioids enter the body and rapidly bind to the opioid receptors in the brain areas affecting many processes. Opioids impact the parts of the brain that are associated with pain, pleasure, that control the heart rate, sleeping patterns and breathing. This makes opioids ideal for prescription for relaxing the body and relieving pain; however, the euphoric effects can lead to misuse and addiction. It is important to note that there are key differences between taking opioids as prescribed, physical dependence, misuse of a prescription opioid, illicit opioid use, addiction and a substance use disorder. Specifically, opioid use disorder is a treatable chronic brain disease marked by problematic or harmful patterns of opioid use, causing changes in neural structure, function and clinically significant impairment or distress over time.[1,2]

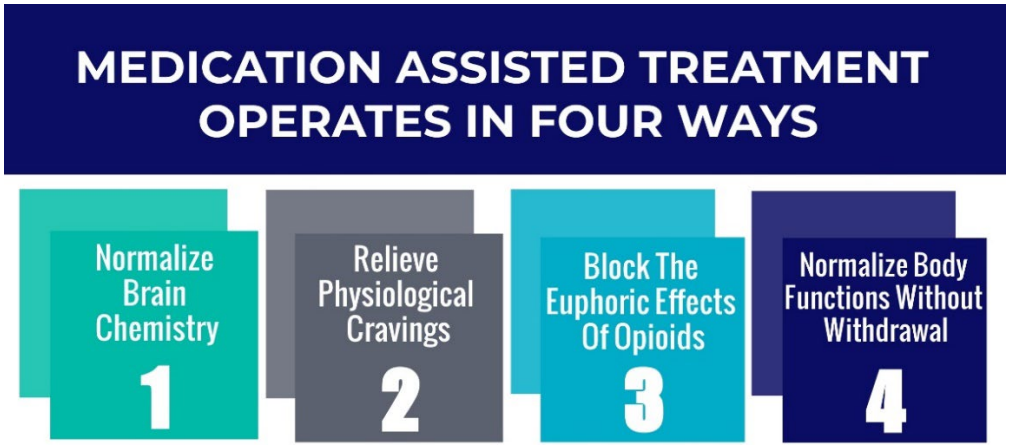
8.2. Medication Assisted Treatment for Opioid Use Disorder

SAMHSA[3] defined medication assisted treatment (MAT) as "the use of Food and Drug Administration (FDA) approved medication for the treatment of a specific substance use disorder in combination with clinically indicated behavioral or cognitive behavioral counseling and other indicated services" (p. 4). There exists MAT to treat tobacco, alcohol, or opioid use disorders as defined by the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5); this section will provide a brief overview of MAT to treat opioid use disorder (OUD). A few references are listed below:

- For more in-depth information about different medication-assisted treatments, prescribing and regulatory information please reference the State of Alaska MAT Guide[4]
- SAMHSA: Medication-Assisted Treatment of Opioid Use Disorder Pocket Guide[5]

The research over the past 50 years underscores the benefits of long-term retention of MAT which is associated with improved outcomes. [6] Discontinuation often leads to returning to use (or relapse) and overdose. There are numerous positive outcomes associated with the utilization of MAT. MAT has been found to reduce risk for premature death, fewer fatal overdoses, improve treatment retention, lower rates of opioid use, reduce injection drug use, reduce transmission of infectious disease, improve quality of life, increase rates of employment, improve social functioning, improve birth outcomes for pregnant women, decrease criminal behavior, and enhance reintegration of individuals within their communities.[6,7]

MAT is intended to normalize brain function and structure that has been altered by prolonged opioid use.[6] MAT restores healthy brain function leading to reduced compulsive behaviors and enhanced recovery. MAT has been found to reduce opioid cravings and withdrawal symptoms, and to decrease response to future drug use.



8.2.1. Overview of Medications to Treat Opioid Use Disorder

The three FDA approved MATs in the U.S. for OUD are ***methadone, buprenorphine,*** and ***naltrexone***. The table below briefly outlines how each medication works, frequency of administration, route of administration and who can prescribe the medication.

Pharmacotherapy for Opioid Use Disorder				
Medication	**How it Works**	**Frequency of Administration**	**Route of Administration**	**Who May Prescribe or Dispense it**
Methadone	Full agonist: binds to and activates opioid receptors in the brain that were activated by the drug, but in a safer and more controlled manner. Reduces the symptoms of withdrawal and cravings.	Daily	Orally: liquid concentrate, tablet, or powder	SAMHSA-certified outpatient treatment programs dispense methadone for daily administration onsite or at home for stable clients.
Buprenorphine	Partial agonist: binds to and activates opioid receptors but with less intensity than full agonists.	Daily tablet or film	Oral tablet or film dissolved under the tongue	Physicians, nurse practitioners, and physician assistants with a federal waiver. Any pharmacy can fill prescriptions, there are no special requirements for staff to dispense.
Sublocade (buprenorphine injection)		Monthly	Injection for moderate to severe opioid use disorder	
Vivitrol (extended-release injectable naltrexone)	Antagonist: binds to and blocks the activation of certain receptors on cells, preventing a biological response.	Monthly	Intramuscular injection into the gluteal muscle by a physician or other healthcare professional	Any individual who is licensed to prescribe medicine (i.e., physician, physician assistant, nurse practitioner) may prescribe and order administration by qualified staff.

Note: From Foney and Mace[8], National Council for Behavioral Health.

8.2.2. Methadone

Methadone[9] is "a long acting opioid agonist medication used for the treatment of opioid addiction and pain" (p. 27). An opioid agonist binds to and activates opioid receptor sites in the brain.[10] Methadone is an effective and most commonly used opioid replacement treatment. Methadone is a longer lasting opioid with less abuse potential, so it is used to replace habit forming opioids.[10,11] Methadone is most often used for long term maintenance rather than short term detoxification.[11] Methadone is used to minimize withdrawal symptoms, reduce cravings, and reduce opioid use. As well as reducing side effects of withdrawal, methadone produces less euphoria than other opioids.[9] Methadone can be accessed when admitted to the hospital for treatment or emergencies.[12] However, methadone is most commonly administered in outpatient opioid treatment programs (OTPs), also known as methadone clinics. No special training is required of physicians in OTPs to prescribed methadone.[12] Typically, people are required to go to a methadone clinic daily for their dosage, but later they may be offered the incentive of take-home dosages.[11]

8.2.3. Buprenorphine

The goal of buprenorphine is to suppress cravings and minimize symptoms of withdrawal and risks for overdose.[9] Additionally, buprenorphine produces less respiratory depression, has a lower overdose risk than methadone or other opioids, and reduces rewarding effects of opioid use while taking buprenorphine.[12] Buprenorphine is a partial opioid agonist which means it produces a partial activation of the opioid receptor so it doesn't cause intoxication in an opioid tolerant client, and it has a ceiling effect, meaning taking additional dosages above those prescribed will have little additional effect.[12,13] Buprenorphine also blocks the opioid receptor so that other opioids such as heroin will have little effect if taken. Buprenorphine is available in tablets or films absorbed under the tongue, and extended-release subcutaneous formulations created to improve treatment adherence.[12,13] The trade name for buprenorphine is Subutex; and the combination of buprenorphine and naloxone is trade names Suboxone, Zubsolv and Bunavail.[14,15] In the Suboxone formulation, buprenorphine is mixed with naloxone, an opioid antagonist, which discourages injection but does not alter the effects of sublingual buprenorphine. Since both the combo and mono products work equally well, the combo product (buprenorphine/naloxone) is preferred because it is 6 times less likely to be injected or diverted.[15,16] Buprenorphine may be used for treating opioid withdrawal because it diminishes symptoms of withdrawal and cravings.[16,17] Withdrawal from discontinuation of buprenorphine is less severe than with other opioids.[16] The most common risk for initiation buprenorphine is

precipitated withdrawal if the first dosage is taken too soon after last opioid use. Precipitated withdrawal is uncomfortable but treatable and only lasts about 6 hours. Buprenorphine can be provided by an OTP or prescribed in a primary care clinic and filled at a regular pharmacy. In the primary care setting, individuals are often seen weekly at the beginning of treatment and then visits are less frequent as the client stabilizes. To prescribe buprenorphine, a physician or physician's assistant must obtain a waiver[17] from the Drug Enforcement Administration by filing a notice of intent with SAMSHA.[16]

8.2.4. Extended-Release Injectable Naltrexone

Naltrexone is an opioid antagonist that selectively blocks opiate receptors in the brain which decreases and prevents the euphoric and analgesic effects of opioids.[18,19] Antagonists bind to and block the activation of opioid receptor sites, preventing physical dependence and positive and negative opioid responses.[20,21,22] Oral naltrexone was approved by the FDA in 1984 and was available in a daily oral formation to treat OUD; however, it was found to be no better than placebo for eliminating opioid use and treatment retention. In addition, individuals on oral naltrexone were at increased risk for overdose. So it is not appropriate to use oral naltrexone to treat OUD.[22,23,24] In 2010, extended-release injectable naltrexone (XR-NTX, trade name Vivitrol) was approved by the FDA to treat opioid misuse and was approved previously to treat alcohol use disorder.[25] There is no specialized training required to prescribe naltrexone, however naltrexone requires full detoxification before the initiation of treatment to prevent precipitated withdrawal. Thus, treatment initiation requires medically supervised detoxification 5-7 days free of short acting opioids (such as heroin or oxycodone), and 10-14 days free of long acting meds (such as methadone or buprenorphine).[26] The requirement for complete detoxification prior to induction is a significant barrier given the undersupply and cost of services for detoxification, as well as client hesitancy. Even with supervised inpatient medically supervised withdrawal management, up to 1/3 of clients will fail to tolerate the symptoms long enough to receive their naltrexone injection.[27]

Risks	Benefits
Methadone	
• More abuse potential • Strict protocol requires daily visits, transportation and may lead to feelings of lack of control in treatment. • Prolongs QTC interval. • Significant drug to drug interactions with psychiatric medications and antiretroviral agents. • More difficult to treat neonatal abstinence symptoms in infants compared to buprenorphine. • Increased stigma around methadone clinics.	• Improved retention in treatment as compared to buprenorphine. • More effective for severe dependence. • Oral liquid less risk of injection. • Daily visits provide structure. OTP programs offer comprehensive services beyond MAT. • Effective in treating withdrawal; lasts 24 hours. • Affordable and covered under Medicaid. • L2 rating for breastfeeding. Gold standard for OUD treatment in pregnancy.
Buprenorphine	
• Not as good at retaining clients in treatment compared to methadone so may return to heroin use. • Less psychosocial support available in outpatient settings. • Somewhat more difficult to induce with small risk of precipitated withdrawal. • Shortage of local providers accepting new clients can cause difficulty in accessing treatment.	• Treatment provided outpatient clinics thus is less restricting. • Less abuse potential and has a ceiling effect reducing risk for respiratory depression. • Less severe NAS, improved neurobehavioral and biometric outcomes for infants. • Fewer drug interactions than methadone. • Effective at treating withdrawal; lasts 36-48 hours. • Affordable and covered under Medicaid. • L2 rating for breastfeeding, lower RID. • Along with methadone, it is first line choice in pregnancy
Extended-Release Injectable Naltrexone (i.e., Vivitrol)	
• More difficult to initiate because it requires full detoxification. • More difficult to engage and retain clients.	• No diversion value or overdose potential. • No special waiver needed to prescribe

Note: Created from SAMHSA MAT for Opioid Use Disorder Pocket Guide.[28]

8.2.6. Choosing the Most Appropriate Medication

For more information reference the State of Alaska MAT Guide (page 37-38)[29]. Elements to consider when choosing the most appropriate medication include:

- Screening and assessment
- Client treatment goals
- Chronic pain
- History of substance use and co-occurring substance use
- Mental health considerations
- Availability
- Rural limitations for availability or dispensation
- Detoxification status[29]

8.3. Barriers to Medication Assisted Treatment in Rural Areas

Lister, Weaver, Ellis, Himle & Ledgerwood[30] provided a systematic review of MAT barriers specifically in rural areas. A brief review of their findings are in the table below which highlights the barriers commonly experienced by clients and providers of MAT in rural areas.

	Most Common Barrier Type	Other Barriers
Client-Focused Barriers Domains in Rural Areas		
Availability	Rural areas were more likely to lack available MAT clinics and waivered practitioners than urban areas	Rural areas were less likely to offer concurrent psychosocial services with MAT
Accessibility	Rural clients were more likely to travel further, longer and across states than urban areas	Rural providers believed rural clients viewed MAT as a cost burden
Acceptability	Rural clients were offered MAT less often than urban due to concerns that it would not work well in rural areas	Rural providers perceived their clients would see MAT as unsatisfactory
Provider-Focused Barrier Domains in Rural Areas		
Availability	Rural providers cited limited capacity and infrastructure such as lack of staff, office space, etc.	Lack of coordination with rural clinics
Accessibility	Lack of time for rural providers to deliver MAT	No other findings
Acceptability	Negative provider attitudes including lack of belief in MAT, too complex, and negative views of people with SUD	Regulatory concerns around providing MAT, including inability to meet DEA regulations, and audit issues

Note: Created from Lister et al.[30]

Systemic barriers to substance use treatment and MAT include (1) inadequate training in MAT and substance use treatment, (2) insufficient number of DATA 2000 waivered providers for buprenorphine treatment, (3) limited knowledge, training and experience within the workforce, and (4) gaps in access to MAT.[31] One study ranked the priority barriers to address to improve evidence-based treatment:

1. Eliminate stigma
2. Build provider capacity
3. Improve payment options and service availability
4. Increase access to MAT
5. Workforce development and training
6. Improve care coordination or transitions to care
7. Development of standards of care
8. Client reluctance to seek or engage in treatment[31]

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Section 9: Pharmacotherapy for Alcohol Use Disorder

9.1. Alcohol Use in Alaska

Compared to the U.S. in 2017, Alaska had a slightly higher self-reported current alcohol use (57% vs. 54%). Alaskans experience higher rates of alcohol-attributable mortality compared to most other states.[1] Alcohol-attributable mortality[1] is defined as the "rate of death due to the direct effects of acute intoxication or withdrawal from alcohol per 100,000 population; the definition includes ICD10 mortality codes F10 and X45; this definition excludes unintentional injuries (vehicle accidents, drownings, and other injuries) where alcohol use was a contributing factor in the death" (p.1). Specifically, Alaska had the 3rd highest rate in the U.S. of alcohol-attributable mortality in 2016. In the same year, the rate of alcohol attributable mortality within the Alaska Native population was 7 times higher than in non-Indigenous people in Alaska.[1]

Among Alaska Native people, alcohol misuse is the seventh leading cause of death. [1] These rates have not significantly decreased between 1980 and 2015; however, rates have been lower since a peak from 2000 to 2007. Additionally, rates of alcohol misuse mortality among Alaska Native people vary by location: the Arctic Slope region experiences rates of 99.4 versus Yukon-Kuskokwim region's rate of 17.7 per 100,000 people.[1,2]

9.2. Evaluating Clients for Pharmacotherapies

SAMHSA[3] developed a checklist for prescribing medication to treat alcohol use disorder. Below is a concise overview of the checklist: for full resources click here[3].

- Begin with the SBIRT approach for screening for risky use, brief intervention and referral to treatment for people needing more extensive care (see Section 6.2).[4,5]
- Assess the need for medication-assisted treatment and current level of use, abstinence, experience of craving, and stage in recovery. Evaluate for severity of substance use and co-occurring disorders, including other substance use or mental or physical health needs. Clients who have moderate to severe alcohol use disorder consider psychosocial approaches or referral into substance use treatment.
- Educate the client on the risk and benefits of the recommended medication and obtain informed consent. Evaluate for stage of withdrawal; consider a rating instrument such as the Clinical Institute Withdrawal Assessment for Alcohol Scale, Revised (CIWA-Ar).[6]
- Integrate pharmacological and non-pharmacological therapies and refer clients for higher levels of care, as needed, for clients that would benefit from more intensive or specialized services.[7,8,9]

9.3. Overview of Alcohol Use Disorder Medications

There are three FDA approved medications to treat alcohol use disorder: Acamprosate, disulfiram, and naltrexone. First, ***acamprosate*** reduces symptoms of protracted withdrawal (i.e., insomnia, anxiety, restlessness, and dysphoria) by normalizing brain systems disrupted by chronic alcohol consumption in adults. It is thought to be more effective in clients with severe alcohol use disorders. Secondly, ***disulfiram*** inhibits an enzyme involved in the metabolism of alcohol, causing an unpleasant reaction (i.e., flushing, nausea, and heart palpitations) if alcohol is consumed after taking the medication. Compliance can be a problem, but among motivated clients this can be very effective. Lastly, ***naltrexone*** blocks receptors involved in the rewarding effects of drinking and in the craving for alcohol similarly to how it blocks the effects of opioids. It reduces relapse of heavy drinking behavior and is highly effective in most clients. However, there is a genetic variability that renders naltrexone ineffective in specific people Naltrexone is available in both oral tablet and long-acting injectable preparations.[10] For more information see the table below:

Disulfiram	Naltrexone	Acamprosate
DOSAGE AND FREQUENCY OF ADMINISTRATION		
Oral: 250 to 500 mg Daily	*Oral:* 50 to 100mg Daily *Extended-release injectable:* 380mg per month - Monthly	*Oral:* 666 mg- Three times per day
PRINCIPAL ACTION		
When taken in combination with alcohol, it causes a significant negative physical reaction (i.e., nausea/vomiting, flushing, and heart palpitations) intended to deter drinking. Given sufficient amounts of alcohol in the client's system, more severe reactions may occur.	Blocks opiate receptors that are involved in the rewarding effects of drinking and craving for alcohol. Extended-release injectable naltrexone is administered every 4 weeks, thereby minimizing opportunities for non-adherence and produces a more consistent and predictable blood level of the drug.	Intended to reduce symptoms of protracted abstinence by counteracting the imbalance between the glutamatergic and GABAergic systems associated with chronic alcohol exposure and alcohol withdrawal.
CLINICAL USES/IDEAL CANDIDATES		
Candidates include clients dependent on alcohol who have completed alcohol withdrawal. Ideally, candidates are committed to abstinence and willing to take disulfiram under the supervision of a family member or treatment program.	Indicated for the treatment of alcohol dependence in clients who can abstain from alcohol in an outpatient setting before the initiation of treatment. Full detoxification is not required, but the greatest benefit is to discontinue drinking several days before treatment initiation.	Indicated for the maintenance of abstinence in clients who are dependent on alcohol and are abstinent at treatment initiation. The efficacy of Acamprosate in promoting abstinence has been shown in people who have completed detoxification.
CONTRAINDICATIONS		
Contraindicated in the presence of severe myocardial disease or coronary occlusion, psychoses, pregnancy, and in those with high levels of impulsivity, suicidality, and hypersensitivity to disulfiram or to other thiuram derivatives used in pesticides and rubber vulcanization. Clients who are taking or have recently taken metronidazole, paraldehyde, alcohol, or alcohol-containing preparations (e.g., cough syrups, tonics) should not be given disulfiram. See the package insert for specific precautions for drug to drug contraindications.	Contraindicated in Clients currently dependent on opioids or receiving opioid analgesics because it could precipitate a severe opioid withdrawal or block opioid analgesia; clients in acute opioid withdrawal; have failed the naloxone challenge test or whose urine tests positive for opioids. Contraindicated in clients with a history of sensitivity to polylactide-co-glycolide, carboxymethyl cellulose, or any components of the diluent used for the injectable medication. It should not be given to people whose body mass precludes intramuscular (IM) injection with the 2inch needle provided. Use should be avoided in clients with serum aminotransferase levels greater than five times the upper limit of normal, except where the benefits outweigh the risks.	Indicated for the maintenance of abstinence in clients who are dependent on alcohol and are abstinent at treatment initiation. The efficacy of Acamprosate in promoting abstinence has not been demonstrated in subjects who have not completed detoxification or who have not achieved alcohol abstinence before beginning treatment.
USE IN PREGNANT AND POSTPARTUM WOMEN		
Pregnancy: The FDA has not assigned a pregnancy category. The safe use of this drug in pregnancy has not been established. Therefore, disulfiram should be used during pregnancy only when, in the judgment of the physician, the probable benefits outweigh the possible risks. *Nursing*: Do not give disulfiram to nursing mothers.	*Pregnancy*: FDA Pregnancy Category C‡ *Nursing*: Transfer of naltrexone and 6ß-nal-trexol into human milk has been reported with oral naltrexone. Because animal studies have shown that naltrexone has a potential for tum-origenicity and other serious adverse reactions in nursing infants, an individualized treatment decision should be made whether a nursing mother will need to discontinue breastfeeding or discontinue naltrexone.	*Pregnancy*: FDA Pregnancy Category C‡ *Nursing*: It is not known whether Acamprosate is excreted in human milk.

Note. Developed from SAMHSA & NIAA Pocket Guide.[11] This table highlights some properties but does not provide complete information and is not intended as a substitute for other sources used by clinicians (see http://www.dailymed.nlm.nih.gov for current package inserts). For client information, visit the National Library of Medicine's MedlinePlus.[12]

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Section 10: Harm Reduction

10.1. Principles of Harm Reduction

Harm reduction is a public health philosophy that refers to policies, programs, and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and laws.[1] In the context of substance use, harm reduction disentangles the notion that drug use equates to harm. Harm reduction targets interventions at the negative consequences of drug use rather than drug use itself. Substance use can be complex and can impact an individual's social, emotional, spiritual and physical health and well-being. Harm reduction focuses on positive change, safety and working with people without judgement, discrimination, coercion, or requiring that they stop using drugs as a precondition for support.[1,2]

According to the ANTHC Harm Reduction Toolkit from iknowmine[2], harm reduction utilizes evidence-based strategies focused on reducing harms associated with substance use.[2] Harm reduction strategies may include:

- Interventions that decrease an individual's risk of Hepatitis C, HIV, other blood-borne viral and bacterial infections, as well as injury and death,
- Programs that offer free harm reduction supplies for people who use drugs,
- Tobacco smoking reduction and e-cigarette substitution programs,
- Connecting people who use substances to health care services,
- Opioid substitution treatment,
- Safe injection facilities,
- Peer support services, including hiring and engaging with peer support staff and individuals with lived experiences and/or who have been successful in the recovery process to help others experiencing similar situations.

Harm reduction is grounded in justice and human rights. It encompasses health and social services that apply to illicit and licit drugs, including many different interventions and approaches to treatment around substance use disorders. According to the National Harm Reduction Coalition, harm reduction "incorporates a spectrum of strategies that includes safer use, managed use, abstinence, meeting people who use drugs 'where they are at' and addressing conditions of use along with the use itself".[3,4] People who use substances and those with a history of drug use often experience marginalization, which is a compounding factor to substance use. Along with offering practical supplies and tools, harm reduction interventions create a platform for healthcare professionals to treat individuals with dignity and respect; to allow people who use substances to be their own primary agent of reducing the harms of their drug use; and to empower and support individuals with strategies which meet their actual conditions of use.

Using harm reduction principles, health care professionals can advocate that drug use is complex and encompasses a continuum of behaviors from severe to complete abstinence.[4,5] They can also promote "people-first language", avoid perpetuating negative stereotypes and biases through the use of slang and idioms, and focus on the medical nature of substance use disorders and treatment[5] (See Section 5: Client Communication for more information).

Harm reduction is a public health alternative to disease models of drug use and addiction. It recognizes abstinence as an ideal outcome but accepts alternatives that reduce harm. This approach is also grounded in principles that aim to protect human rights and improve public health. Furthermore, ANTHC has several programs and interventions with a harm reduction focus for Indigenous communities and incorporates culture and traditional ways of healing at the heart of their efforts.

Learn more or order free educational materials, safe medication disposal and harm reduction supplies from ANTHC's iknowmine program[6]. Additionally, access the Harm Reduction Webinar Series from https://www.iknowmine.org/harm-reduction-trainings/[7] or an informative video from the First Nations Health Authority: Indigenous Harm Reduction[8].

10.2. Evidence Based Practices

10.2.1. Screening, Brief Intervention, and Referral to Treatment

Refer to Section 6.2 for more information on Screening, Brief Intervention, and Referral to Treatment (SBIRT) Model.[9]

10.2.2. Motivational Interviewing

See Section 5.2.1 in Patient Communications for information about Motivational Interviewing.

10.2.3. Syringe Access and Disposal

Access to new syringes and disposal supplies is a crucial harm reduction intervention, to help decrease HIV, Hepatitis C, and other blood-borne viral and bacterial infections.[10] Syringe exchange programs have been shown to be cost-effective in reducing HIV transmission and increase access to other medical and social support services.[11,12]

Syringe assess and disposal services across Alaska:

- Anchorage: Alaskan AIDS Assistance Association with 4A's[13]
- Fairbanks: Interior AIDS Association[14]
- All Alaska: Alaska Native Tribal Health Consortium (ANTHC) HIV/STD Prevention Program[15]
- See Safe Syringe Disposal handout on iknowmine.org[15]

The HIV/STD Prevention Program (home of iknowmine.org) and the Substance Misuse Prevention Program offer a rural Harm Reduction Toolkit for rural Alaskan providers and programs. Additionally, they offer free mailing services for Safe medication disposal supplies, condoms, safer injection kits that contain syringes, disposal supplies, and more. Learn more at iknowmine.org.[15]

The Centers for Disease Control and Prevention has recently launched the Syringe Services Programs: A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation.[16]

10.2.4. Naloxone for Overdose Prevention

Narcan® nasal spray is a nasal formulation of naloxone that is FDA approved for the treatment of a known or suspected opioid overdose. Narcan is prefilled, needle free and requires no assembly to spray into one nostril while the person suspected of an opioid overdose lays on their back. Narcan rapidly reverses an opioid overdose by binding to the opioid receptors, reversing respiratory depression and blocking the effects of other opioids. Narcan should not be used to replace emergency services but can reverse overdose long enough to allow time for emergency medical staff to respond to crisis. It is important to remain with the person suspected of an opioid overdose who has been administered Narcan until emergency services arrive because the person may need a second dosage of Narcan.

Opioid overdose is a growing public health issue that is impacting communities all over the United States and has increased exponentially in Alaska over the past couple of decades. In response, the State of Alaska signed into law ***Senate Bill 23***, "an act relating to opioid overdose drugs and to immunity for prescribing, proving or administering opioid overdose drugs."[17] Under the authority of AS.17.20.085 and a February 14, 2017 Declaration of Disaster Emergency, a medical standing order authorized and approved the Department of Health and Social Services Project HOPE Overdose Response Program (ORP) "to maintain supplies of opioid overdose rescue kits for the purpose of distributing and administering to a person at risk of experiencing an opioid overdose or a family member, friend, caregiver, or other person in a position to administer the opioid overdose drug naloxone (i.e., Narcan Nasal Spray) to a person at risk of experiencing an opioid overdose."[18]

Project HOPE works with community organizations to distribute or administer Narcan in Alaska. In addition, the Alaska Native Tribal Health Consortium and other statewide partners[19] offer Narcan and training to administer opioid overdose medication on the iKnowMine website.[20] Supplies can be ordered on the website and shipped, all free of charge. For questions about opioid overdose prevention supplies and educational opportunities, contact ANTHC at saprevention@anthc.org.

10.3. Medication Assisted Treatment as Harm Reduction

Medication assisted treatment (MAT) aligns with the principles of harm reduction. According to SAMHSA MAT[21] have been approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to meet each patient's needs.[22] MAT treats the neurological and physiological changes caused by regular substance use. Many Indigenous people consider holistic health and well-being to be more than mental, emotional and physical health. It also includes connection to community, culture, land, Indigenous practices and spirituality. MAT reduces cravings and physical symptoms, allowing an individual to focus on healing the spirit and engaging themselves in ways that allow healing in their own way. MAT along with cultural practices such as hunting, berry picking, Native dancing, caring for family members and participating in community activities can all play a valuable part in the recovery process. [23]

10.3.1. Using Research in Practice

Data and research are great places to begin identifying the latest best practices in the delivery of health care services. MAT is an evidence-based practice for treating substance use. If there is little time for research, a great way to stay on top of the latest best practices is to attend training for the treatment of substance misuse. Additionally, provider consultation is a great way to be connected to a specialist that can help assist with treating patients with complex situations.

For resources related to MAT, visit the SAMHSA website[24], access the CDC Framework for Opioid Overdose Response[25]. For data in Alaska, visit the State of Alaska Opioid dashboard[26] and the Alaska Native Epidemiology Center[27] websites. For nationwide data visit the CDC website[28].

10.3.2. Information Dissemination

Dissemination of information about evidence-based treatments, best practices and toolkits like this one have grown. For more resources about harm reduction, safe medicine disposal, Narcan, or related substance misuse from ANTHC contact saprevention@anthc.org. For access to the ANTHC Harm Reduction toolkit and harm reduction supplies visit iknowmine.org. In addition to harm reduction, the iknowmine website[29] contains educational materials for youth around substance misuse prevention, safety in relationships, mental health, and more.

For a harm reduction ECHO training visit the Northwest Portland Area Indian Health Board website[30]. For the Medication Assisted Treatment ECHO series, including topics related to harm reduction, visit the Addiction Medicine ECHO website[31]. Lastly, more resources can be found at the Substance Abuse and Mental Health Services Administration: Evidence-Based Practices Resource Center.

10.3.3. Using Community Data

The use of community data can help inform how you see your clients and their needs. Community data that is available can be found from the Alaska Native Epidemiology Center[32], the State of Alaska Section of Epidemiology[33] and youth data from AK Adolescent Tribal Action Plan for a Strategic Planning[34,35] guide. Data can highlight the health disparities that communities may face. It can also support grants that can provide funding opportunities for the health needs within your community, including building capacity for MAT. However, as a tribal health organization dedicated to promoting the health, well-being and dignity of AN/AI people, we recognize that, sometimes, the consistent acknowledgement of health disparities plaguing AN/AI communities can be harmful and shameful. It is recommended to review data with caution and the consideration that, although problems do exist, there are many strengths to communities that are often marginalized. It is important to see people as people in the context of their communities, in the context of their families, and in their perspective. For example, AN/AI people in Alaska are disproportionately are affected by high rates of opioid misuse, domestic violence, and suicide. On the other hand, we know that AN/AI people are resilient and hold sacred knowledge of self-care, physical, emotional and mental healing, and more. One recommendation is to communicate that there are important traits of resilience that AN/AI communities carry, which can help create a buffer for the damaging effects of high rates of health problems. For more see Section 12: Holistic Healthcare in Rural Alaska.

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Section 11: Medication Assisted Treatment in Rural Alaska

As a provider in rural Alaska, you are probably familiar with presenting challenges and unique needs that people in rural Alaska face. For example, this MAT toolkit covers information about secure storage for MAT, types of medications to consider, harm reduction services and supplies, telemedicine procedures, and more.

Photo credit: Alaska Native Tribal Health Consortium

11.1. Service Delivery and Clinical Considerations

First things first, we will discuss how health care providers in Alaska can begin to prescribe medication assisted treatment (MAT) for opioid use disorder. Then we will further explore special considerations for MAT delivery in Alaska. For State of Alaska statutes and federal policy please see the Medication Assisted Treatment (MAT) Guide[1] by the State of Alaska Department of Health and Social Services, Office of Substance Misuse and Addiction Prevention[1]. In addition to policy, the State of Alaska MAT Guide also includes recommended models of prescriber care based on setting of clinical site and medication. In summary, the setting you choose to initiate MAT for your patients may be limited by your resources. Whether you are located in a hub or a village, your relationship with your patient, and patient comfort and support system may impact how you should approach implementing MAT with your patient. Wherever you are initiating MAT, there are recommendations and guidelines for you. Please reference the State of Alaska MAT Guide[1] for the complete information.

11.1.1. Federal and State Regulations

Federal statutes, regulations, and guidelines oversee MAT for opioid use disorder. The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment Division of Pharmacologic Therapies (DPT)[2] manages oversight of activities to ensure compliance with federal regulations to address substance use disorder medications, including methadone and buprenorphine.

Under the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities or SUPPORT for Patients and Communities Act of 2018 (SUPPORT Act)[3], health care providers can prescribe medication assisted treatment with flexibility, offering the ability to provide more tailored health care services based on individual need around opioid use disorder. The SUPPORT Act provides providers the ability to prescribe MAT to 100 patients or more if they meet certain criteria. Click this link to learn more about how to become a buprenorphine waivered practitioner[4].

11.1.2. The Role of Community Health Aides

Community health aides (CHA) are limited in the scope of work pertaining to MAT, but with proper training and authorization from the providers are able to assist with procedures related to MAT, including the following:

- Collection of urine for drug screening,
- Medication counting,
- Calculation of COWS scores,
- Administer SUD screening tools,
- Taking medical and SUD intake history,
- If trained to do so, administer Sublocade and Vivitrol with permission from THO medical director.

Typically, the main primary care provider would administer the first injection to monitor side effects such as precipitated withdrawal. However, authorized CHAs can administer follow up injections

CHAs have an important role in the healing and recovery of Alaska Native people suffering from SUD. Often, their cultural and community knowledge can empower support the healing of community members suffering from substance misuse. Also, MAT can be delivered closer to home, allowing individuals to participate in subsistence and other cultural activities and to stay connected to their communities while healing.

11.2. Policy, Regulatory & Organizational Change

The following section is focused on how to start and maintain a MAT program. First, we will review client intake and clinical flow, relevant policies and procedures, telemedicine considerations, initiation of MAT in different settings (i.e., office based, at home), and special considerations for starting naltrexone and buprenorphine. Next, treatment agreements, ways to reduce diversion, and discontinuation.

Furthermore, implementing policies that align with the No Wrong Door[5] approach have many benefits. Below highlights current sources of referrals into substance use treatment and the no wrong door approach.

"No Wrong Door" is a person-centers approach to human services that views any community or government program as the gateway or door to services and resources, especially in regards to accessing substance use treatment. The concept is based on the idea that a single application should be used to determine eligibility for and enroll in programs and resources to streamline systems and increase efficiency.1 In 2015, among treatment episode admissions aged 12 and older the most common referral source to least common were as follows: (1) self-referral, (2) criminal justice system, (3) other community referral, (4) substance use care provider, (5) school/educational, and (6) employer/EAP. 2 For more information see the resources below.

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11.2.1. Patient Intake and Policies and Procedures

Clinical Flow and Intake. Patients often self-refer to MAT programs seeking treatment, but may be referred from other medical providers, behavioral health, the emergency room, residential treatment, child protective services or the criminal justice system. Regardless of the referral source, it is critical to have an established clinic workflow in place to ensure that patients are able to access treatment quickly and efficiently. A few examples of workflows can be found below:

- Center for Care Innovations, Primary Care Resource Hub[6]
- Alliance Medical Center, Sample Medication Assisted Treatment Workflows[7], 2019
- Jefferson Healthcare, Medication Assisted Treatment (MAT) Workflow[8], 2018
- New Hampshire Department of Health and Human Services, Guidance Document on Best Practices[9]: Key Components for Delivering Community-Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire, 2018

The clinic should designate an employee (often a case manager or a behavioral health provider, but could be a front desk or other ancillary staff) to perform the initial intake screening for all new referrals. This initial screening is typically done over the phone to determine the patients' needs and the level of urgency required. Information gathered may include current drug use, current withdrawal status, insurance information, access to transportation/clinic, pregnancy status, etc. A few examples of intake forms can be found here.[10]

The person performing the intake screening would then present the information to the medical provider to verify appropriateness and urgency of referral, then the patient should be scheduled for initial intake appointment in the clinic. Rapid access to intake appointments (less than 1 week) is ideal for high risk patients to reduce no-show rates and to capture patients while their motivation level is high, however this is not possible in all clinical settings. Telemedicine may allow for more rapid access to intake (see Section 2.3: Telehealth). It is important to remember that no-show rates can be very high for new patient intakes, and patients may require multiple rescheduling attempts prior to successfully following through with induction. Case management services are critical to assist patients with planning and transportation to get to their appointments.

If onsite behavioral health (BH) is available, then scheduling should also be coordinated with the BH provider or BHA to perform BH intake screening and schedule SUD/BH assessment. Assessments are generally best performed after the patient is medically stable as intoxication or acute withdrawal make it difficult for the patient to participate. Although BH assessment is important, medication initiation should never be delayed due to the patient's inability or resistance to complete their assessment. If possible, reduce barriers to BH care by offering BH appointments on the same day as medical appointments if co-located, or utilize telemedicine when possible.

Initial medical intake appointments should be scheduled for a long enough block of time (typically 60-90 minutes) to allow for screening, diagnosis, medical history gathering, physical exam, labs and patient education and review of consent forms and treatment agreements and create a treatment plan with the patient. Whenever possible, MAT should be started at this first appointment (administered, dispensed or prescribed), because of high no-show/missed follow-up rates early in treatment and the high risk of overdose death off MAT. All patients should be given overdose response training and a naloxone rescue kit at their first visit. Much of the screening and history taking may be performed by support staff such as a nurse, case manager, CHA/P or medical assistant. Verified SUD screening tools (such as AUDIT, DAST-10 and DSM-5 OUD checklist) should be used, which are widely available and quick to administer. Resources can be found here.[11]

The prescribing provider can then review this information to verify the diagnosis, perform the exam and develop a treatment plan. An example of forms for medical history and physical for intake can be found here.[12] On the first medical visit, basic labs should be performed, which include at a minimum a urine drug test and pregnancy test. If available HIV, hepatitis, STD and liver function tests should be performed as well, at the first visit or shortly thereafter. Rapid CLIA-waived HIV/Hep C tests utilizing oral fluid or capillary puncture can be useful to increase screening rates when blood draw is not available.

During the initial medical visit, the provider will discuss treatment options with the patient and then they can choose together which medication is the best fit for the patient and then develop a treatment plan. For more information on choosing the best medication, see the State of Alaska MAT Guide[13] (pp. 37-38).

Partnering with Tribal Health Organizations. THOs who do not have providers that offer MAT prescribing may choose to partner with another THO to provide these services to their patients. A memorandum of agreement (MOA) can outline expectations of each parties' roles and responsibilities in providing patient care. MOAs may include details on frequency of visits, random urine drug screens, medication counts and behavioral health services expectations. Both parties should understand the billing of telemedicine services for the provider clinic and the remote clinic, including plans for billing ancillary lab services and CHA/P services at the remote clinic. Coordination of provider and support staff schedules between the two clinic sites is very important. It is helpful to designate a specific champion at each clinic site who will be responsible for coordinating the schedules and the flow of patient information between the sites. Standing lab and medication administration orders created by licensed providers/medical directors at the remote clinic may be required if the distant consulting provider is not credentialed to provide direct patient care at the remote clinic.

Medication Delivery Rural Communities and Secure Storage. Prior to offering MAT services, multiple considerations must be made to plan for access to medications needed to treat OUD as well as medications to manage withdrawal symptoms and common side effects. Whether a patient is presenting for treatment of withdrawal symptoms, or to start on MAT, most patients will need some supportive medications to relieve unpleasant symptoms. Most medications to treat withdrawal symptoms are commonly used, inexpensive, generic medications which are not controlled substances, thus making them relatively easy to keep in stock at a clinic for as needed use. These medications may be ordered from any private pharmacy or from the ANMC pharmacy, and do not require any special storage requirements. Comfort medications can be administered by medical staff during office visits, they can be dispensed in small take home amounts from the clinic by a licensed prescriber, or they can be prescribed to the patient and filled by a pharmacy for pick up or mail order delivery directly to the patient.

Common medications used in the treatment of opioid withdrawal symptoms:

- Restlessness, sweating and cravings: Clonidine 0.1-0.3 mg tid
- Nausea: Ondansetron 4 mg tid, promethazine 25 mg tid
- Insomnia: Trazodone 50-150 mg qhs, doxepin 6-10 mg qhs
- Anxiety: Hydroxyzine 25-50 mg tid
- Pain: Ibuprofen 800 mg tid, Acetaminophen 1000 mg tid
- Muscle Spasm: Tizanidine 4 mg tid
- Diarrhea: Imodium 1-2 caps tid

It is discouraged to use controlled substances (such as benzodiazepines) to treat withdrawal symptoms in the outpatient setting. It is useful to discuss with the patient which symptoms have bothered them most in the past so that the provider can plan which medications the patient is likely to need prior to their planned induction. A clinic may also want to create medication order sets to provide commonly needed comfort medications to all patients.

Buprenorphine commonly causes nausea, so some providers will co-prescribe ondansetron for all patients. This common side effect typically resolves within 2 weeks. Mono-buprenorphine products have similar incidence of nausea as buprenorphine/naloxone products, so nausea is generally not an indication to switch to the mono-product.

Short buprenorphine tapers can also be used by experienced providers for withdrawal management in patients who need to complete opioid withdrawal in order to enter incarceration or residential treatment, or who plan to switch to naltrexone after withdrawal is complete. These tapers typically utilize lower doses of buprenorphine with daily dose reductions and discontinuation of the medication over 1-2 weeks. Complete opioid withdrawal is best performed in the inpatient setting as there is a high rate of failure to complete and high return to use, which poses a risk of the patient beginning to lose follow up and increases overdose risk. Opioid withdrawal (also known as detoxification or detox) should never be performed in a patient without a plan to start them on MAT upon completion or to admit the patient to a controlled, secure environment.

Pharmacy Availability and Delivery of Buprenorphine and Naltrexone. Because buprenorphine is a controlled substance, the in-office ordering, storing, administration and dispensing of sublingual buprenorphine comes with a number of logistical hurdles. Some village clinics within the ANTHC system may be able to store small amounts of buprenorphine used for in-office inductions supplied by their THO's overseeing pharmacy in their pic-point (or

other pharmacy machine) so that the dispensing is controlled by the pharmacy to avoid certain DEA paperwork. For in-office induction, mono-product (plain buprenorphine, 2+8mg tabs) are sufficient, but if the medication will be dispensed the combination product is preferred.[14,15]

Resources for dispensing and storing controlled substances:

- Quick Tips: DEA Requirements for MAT Storage[16], 2020
- American Society of Addiction Medicine, DEA Office Inspection Tips[17]

Most offices choose instead to have all patient prescriptions filled at a local or mail order pharmacy and then picked up by or mailed directly to the patient. It is important to contact the local and mail order pharmacies that the clinic is likely to utilize to ensure that they carry the most common formulations of buprenorphine (the 2 and 8 mg mono-product tablet and the 2/0.5 and 8/2mg combo strips). Most ANTHC pharmacies carry all of these formulations. For patients who get their prescription through the mail, it is important to order sufficient medication for the patient to avoid too frequent mailings that may be subject to delay, and to order refills early enough that the patient does not run out of medication and experience withdrawal. It is important to educate patients on monitoring the status of their refills and mail delivery to watch for delays, so that plans can be made to ration medication if needed to avoid withdrawal symptoms.[18]

Monthly injectable buprenorphine (i.e., Sublocade) is not carried at local private pharmacies. For patients with Medicaid, this medication is ordered through Magellan Pharmacy (phone: 866-554-2673 / fax: 866-364-2673). For patients with private insurance contact their insurance's prior-authorization department to determine their specialty pharmacy of choice or utilize Invidor's in Support program to do the benefits investigation for you using this enrollment form.[19] For uninsured Native beneficiaries, Sublocade is available through RASU pharmacy to high-risk patients who meet certain criteria, but can only be initiated through specialty care with addiction medicine, addiction psychiatry or inpatient/residential substance use treatment programs, for more information on Alaska Levels of Care for Referral see Section 6.3.1. Regardless of the pharmacy utilized, the injection is mailed to the clinic for storage and in-office administration. Sublocade is not allowed to be in the patient's possession at any time and should be stored in the clinic in a locked box, in a locked fridge in a locked room.[20]

Monthly injectable naltrexone (i.e., Vivitrol) can be ordered from any pharmacy and can be mailed directly to the clinic or to the patient. It should be stored in the refrigerator until use, and patients should be counseled on the dangers of self-administering the medication at home due to risk of precipitated withdrawal with the first dose.[20]

11.2.2. Induction Setting and Procedures

Starting Buprenorphine. Induction (also called initiation) of buprenorphine can occur in the patient's home, in the outpatient clinic, in the Emergency room or in residential/inpatient treatment settings. Choosing the best setting for induction involves balancing the needs and comorbidities of the patient, along with the experience level of the provider and availability of local resources. For patients who reside in remote areas with limited clinic, provider and pharmacy access, several factors may influence the plan for induction setting.[20]

Factors Influencing Induction Plan:

- If the patient needs to travel to get to the provider's clinic, a multi-day in-office intake/induction may require multiple trips which may be difficult to arrange or disrupted by weather. Some patients may find it difficult to be away from home, work and childcare responsibilities for multiple days of medical appointments. On the other hand, patients who are able and willing to come into a treatment facility for the week or stay locally and come into the clinic for multiple daily appointments will have access to more intensive medical care and psychosocial support.
- Timing of withdrawal can be difficult to coordinate with the clinic visit. The patient may arrive too early in withdrawal to start medications or feel too sick with severe withdrawal if their travel is delayed.
- If there is no local pharmacy, then in-office induction will require either the use of clinic stocked buprenorphine or for the provider to prescribe a mail-order prescription and for the patient to return to the clinic with their medication for a future scheduled induction appointment. If clinic administered medications are utilized, the patient may need to return to the clinic for multiple consecutive days of dosing to allow time for their prescription to be mailed to their home.

- If at-home induction is planned, the patient is provided with all the education on how to start taking their buprenorphine at home during their intake visit. The prescription is then mailed to the patient's home (for the first 1-2 weeks of medication needed), and the patient is able to start their medication on the day and time that they are ready. Daily phone contact with the patient is required to check on their symptoms, cravings and doses of medications taken and to address any concerns. In-person or telemedicine follow up visit should occur within 1 week.
- For patients who start taking their buprenorphine at home, it is important for them to have comfort medications on hand to treat any withdrawal symptoms that arise as previously listed above.[20]

11.2.3. Office Based Initiation

To initiate MAT in a doctor's office provides the ability to monitor a patient's response to medicine. Office based initiation may be beneficial for clients who are nervous about withdrawal or MAT initiation, or who are at increased risk for precipitated withdrawal. For example, medication can be administered if a patient experiences precipitated withdrawal. This is especially helpful if a patient is feeling nervous or is at risk for precipitated withdrawal. For example, patients may need to travel to receive the initial medication, away from their home communities. For more comprehensive information about office based initiation, please reference the State of Alaska MAT Guide.[20]

Below are a few of the benefits and costs of starting buprenorphine in the doctor office for consideration:

Pros	Cons
• Medical team is available to check on the patient and provide comfort medications • Medical team verifies the client's readiness to start and ensure medication is taken properly • Reduced risk of precipitated withdrawal	• Patients may have to make multiple visits to the office the first week • Patients may have transportation issues • Patients may not be as comfortable as they would be at home

11.2.4. At-Home Initiation

Clients with adequate support systems may be able to initiate MAT in their home communities and regular clinic sites. In these cases, the patient would most likely be evaluated via telemedicine (see telemedicine section). In most cases, the patient would be required to have an in-person exam and evaluation prior to starting telemedicine.) See policies and procedures in the telemedicine section for more). For more information, please reference the State of Alaska MAT Guide.[20]

Below are a few of the benefits and costs of starting buprenorphine at home for consideration:

Pros	Cons
• More flexibility in timing patient's first dose • Patient may be more comfortable at home • Patient doesn't need to drive anywhere	• Waiting to be experiencing enough withdrawal to start buprenorphine may be difficult • Medical team is unavailable to assist patient in person

Resources for at home initiation:

- For more information access the It MATTTRs clinical checklist[21] for providers to help guide providers in home initiation procedures.
- Consider providing your patient an instruction guide that explains at-home instructions and procedures such as the one found on the ASAM website: A Patient's Guide to Starting Buprenorphine at Home. [22]

11.2.5. Starting Naltrexone

Starting naltrexone for OUD generally always needs to occur in the clinic or hospital setting, due to the requirement for a patient to be abstinent from opioids for 7-14 days prior to administration. Although starting naltrexone can be straightforward in a patient with an extended period of abstinence (such as those recently released from incarceration or residential treatment), naltrexone is difficult to initiate in a patient who is actively using opioids. Most patients are not able to tolerate or complete opioid withdrawal at home, and even with intensive medication management in the hospital setting, up to 1/3 of patients leave before completing withdrawal

and receiving naltrexone. If a patient who is actively using opioids desires to start naltrexone, they should be referred to inpatient withdrawal management (See Section 6.3.1: Alaska Levels of Care for Referral). Liver function tests should be tested prior to the first injection, after 1 month and then every 6 months. Naltrexone is contraindicated in patients with transaminase levels that are 5 times higher than normal.

If a patient who has already completed withdrawal presents to the clinic for naltrexone (i.e., Vivitrol) induction, a urine drug screen as well as a naloxone challenge test should be performed prior to the first injection to verify that the patient is not physically dependent on opioids. Due to the risk of precipitated withdrawal, the first dose of naltrexone should be given in a clinic with a medical provider present. Subsequent doses may be given during telemedicine visits by village nursing staff or CHA/Ps that have been trained in the procedure and have doctor authorization (See Section 11.1.2 above) to reduce patient travel if needed. Oral naltrexone is occasionally used for the treatment of alcohol use disorder, but it is not effective in opioid use disorder, so only monthly injectable naltrexone (i.e., Vivitrol) should be used.

Naloxone Challenge Test (Clinical Opiate Withdrawal Scale[23]: COWS)

1. Obtain baseline COWS; if 4 or less proceed with challenge
2. Administer naloxone 0.4 mg (1 cc) IM or 0.8 mg SQ to deltoid and observe for 20 minutes
3. If no change in COWS, administer additional 0.8 mg (2 cc) to the other deltoid or SQ and monistor for additional 20 minutes
4. If the test is negative, proceed with extneded-release injectable naltrexone

11.2.6. Treatment Agreements

A treatment agreement, also known as a treatment plan, is intended to be educational and informational while promoting engagement in treatment. The treatment agreement should identify the *goals* of treatment, *conditions* to be met for changing or stopping treatment, *contingencies* for non-adherence or not meeting goals, and the *expectations* for client and provider. Treatment agreements should adapt and develop with the client depending on the type and duration of the treatment. An excellent sample was developed by the American Society of Addiction Medicine: Sample Treatment Agreement. [24]

Because every clinic is unique in its location, resources, strength, challenges and philosophies of care, there is no "one-size-fits-all" set of policies and procedures. It is important to customize P&P to address local challenges and to outline an agreed upon framework so that clinicians and support staff have consistency when addressing commonly encountered challenges.

For more information about treatment agreements and the common challenges that present during MAT treatment, please see the State of Alaska MAT Guide[25] and the list below for common challenges encountered in providing MAT:

- No-shows/late arrivals
- Requests for early refills
- Refusal to comply with drug testing or unexpected results on drug test
- Polysubstance use
- Medication non-compliance
- Lack of BH participation
- OCS/Probation involvement
- Billing/collection concerns

11.2.7. Considerations when Formulating Clinic Policies

No-Shows and Late Arrivals. A patient with substance use disorders may struggle with keeping their scheduled medical appointment and arriving on-time. It is important to remember that these behaviors are consistent with the diagnostic criteria for SUDs: "failure to fulfill major obligations" and "having persistent and recurring social and interpersonal problems" related to their drug use. No show rates for first appointments may approach 50% in some populations, however appointments scheduled less than 48 hours in advance have much lower no-show rates. If possible, schedule blocks of appointment time each week designated for MAT patients, to allow for more open access scheduling. These set blocks of time can also function as walk-in hours for patients who need urgent appointments or fail to attend their scheduled appointments. Group visits that occur at the same time every week can allow for consistency that may simplify attendance for some patients. Afternoon appointment times are better suited to many patients, especially those struggling with sleep disturbances. Intensive case management for patients with severe SUD is often required, to make frequent reminder calls, reschedule appointments and arrange transportation. Patients who face transportation or other home obligation challenges may benefit from the use of telemedicine when possible. Patients who repeatedly miss appointments resulting in lapses of medication and frequent cycles of drug use and abstinence may benefit from a switch to monthly XR formulations of medications. Policies must clearly outline expectations for schedule adherence and consequences for non-adherence. Policies must prioritize keeping the patient on MAT whenever possible, as overdose death is greatly increased in patients who stop taking their medications.[25]

Requests for Early Refills and Trouble with Medication Compliance. Most treatment agreements include a clause that early refills will not be issued. When a patient requests an early refill, it is important to determine why they ran out early. If they are having uncontrolled cravings, and taking more than prescribed, it is important to re-evaluate the patient frequently to adjust the dose. Inquire what triggered the cravings. Insomnia, anxiety and acute or chronic pain are common causes of increased cravings. Treating these comorbid conditions may reduce medication overuse. Increased outreach by and engagement in BH or peer support services may help manage psychosocial stressors. Keeping prescriptions short early in treatment can reduce the amount of medication a patient has to manage, and also reduce the number of days of withdrawal a patient has to manage if they run out early. Inquire if a patient is sharing their medication with a friend, family member or partner, and if so, working to recruit their loved one into treatment can be very helpful. If medication is reported stolen, providing basic lock-boxes to patients can improve medication security. If a patient still has some medication left, help them to make a plan to ration it to reduce withdrawal symptoms (cutting dose in half for the last few days before fill is due). If the patient is completely out of medication for 3 days or more before their refill date, providers may choose to refill as a "one time emergency" while simultaneously increasing the level of support a patient is receiving. Multiple episodes of running out of medication early despite dose increases, short prescriptions and adequate management of comorbid conditions may mean that the patient would benefit from directly observed dosing of their medications (typically done via video chat or via secure apps such as E-Mocha). Failure to reach successful medication compliance with the above tactics may mean that the patient would benefit from switching to a Monthly injectable form of MAT. All patients should be offered a referral to a higher level of care (see Section 6.3.1: Alaska Levels of Care for Referral) when appropriate and patients should always be offered comfort medications for withdrawal symptoms.[25]

Drug Test Refusal or Unexpected Results. Medical visits for MAT monitoring and prescribing typically include obtaining a urine or oral fluid drug test. Drug testing may also be performed randomly, especially for patients that have drug-related legal or OCS cases. See the Drug Testing section below for more details on understanding the use of drug testing in MAT. Inability or refusal to give a drug testing sample, tampering with a sample and

unexpected results on a drug test, are common problems that providers encounter in everyday practice. Even long-term, stable patients can occasionally show aberrance in test results, and this may be one of the first indicators of return to use. Clinics should create treatment agreements that clearly outline expectations for drug testing compliance, and what changes might be made in their treatment plan if they refuse to give a sample or tamper with their sample. Witnessed urine collection is invasive and embarrassing for patients, can be uncomfortable for staff, and may not be possible if same gender staff is not present to witness. It is best reserved for patients with legal issues who are likely to have medical records subpoenaed, and is best performed in a laboratory that has staff trained to perform the procedure. A simpler alternative for witnessed collection is oral fluid testing, which may also be performed randomly in the clinic or at home via video chat. Treatment agreements should emphasize the importance of honesty about drug use and the use of testing as a therapeutic tool. When illicit drug use is revealed by testing this is an indication that increased patient support and monitoring is required, such as increasing frequency of visits and shorter prescriptions, offering more BH support and addressing underlying comorbid conditions and stressors that are triggering use. Aberrancy in a drug test result should almost never be a trigger to withhold medication from a patient, but may guide decisions to change dose, formulation or type of medication utilized. Drug testing policy should always prioritize keeping patients on MAT whenever possible.[25]

Polysubstance Use. Polysubstance use is common in patients with OUD, however, patients that continue to use other substances can still be successful in stopping or reducing opioid use and reducing their risk of overdose death. It is important to remember that MAT for OUD does not treat other substance use disorders, so treatment specifically directed at the comorbid SUD is required. It is not recommended to withhold buprenorphine from patients that are using alcohol or other sedatives, but it is important to warn them of the risk of overdose and to provide naloxone rescue kits. In patients who continue to use other illicit drugs, the clinic must decide whether their policy will be to continue to prescribe sublingual buprenorphine with weekly visits and close monitoring, or to require a switch to monthly injectable buprenorphine if diversion and medication compliance are a concern.[25]

Lack of Behavioral Health Participation. MAT can be effective to reduce drug use and associated morbidity and mortality even without psychosocial support, so MAT should never be withheld for patients due to lack of participation in behavioral health care. A wide variety of psychosocial support should be continually offered to patients to find an option that best suits their needs. Many modalities of psychosocial support may be helpful outside of the traditional individual and group counseling, including mutual support groups (NA/AA) which can be attended virtually, tele-behavioral health, peer support and motivational interviewing. Rather than punish a patient for not engaging in behavioral health, participation should be incentivized through rewards/contingency management. Motivational interviewing should be offered at every patient interaction and can be provided by medical staff, BHA's and case managers. It may take patients several months in treatment before they become interested in and motivated to engage in psychosocial support. Group visits, where a patient receives their medical appointment and prescription during a mutual support group meeting can increase engagement, as can scheduling a medical and BH visit at the same time if collocated or available via tele-med. Peer support workers and BHA's can also meet briefly with patients before or after their medical appointment to provide support.[25]

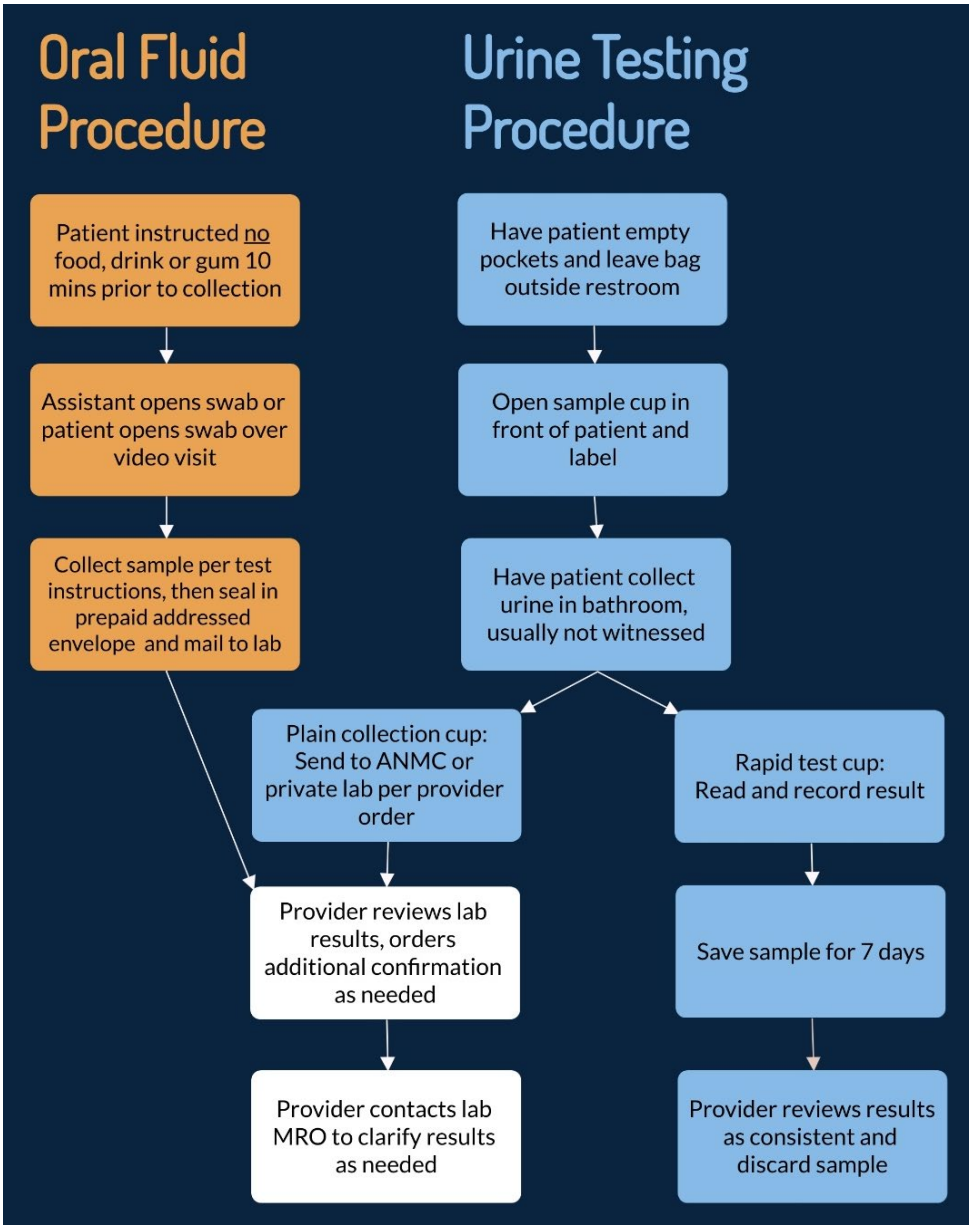
- For resources on the group visit model of care reference Care Innovations: Resource Hub[26]

Patients with Criminal Justice or Child Protective Services Involvement. Clinics may wish to create special policies and treatment plans for patients who are referred to treatment through probation, OCS or other court order. Patients with legal issues should be offered a highly structured treatment plan with more frequent visits and drug testing. More random testing and more confirmatory testing should be offered to show proof of compliance. Monthly injectable medication is preferred when possible to show proof of compliance, or alternatively offering directly observed dosing of sublingual products (via video chat, in person or by secure DOT app such as E-mocha). Monthly injectable buprenorphine is preferred to daily dosing for patients who are at risk for return to incarceration, to reduce risk of acute withdrawal due to medication interruption. Patients with legal cases are often court ordered to receive BH assessment and support. All patients should be asked to sign releases of information to allow communication with probation/parole/OCS/lawyers on patients level of engagement with treatment, but it is also critical to remember that no records (such as drug testing result) can be shared with any outside entity without the patients explicit written consent or by court order. Regular communication between the state agencies and the medical case manager are critical to ensure that medical and BH treatment plans align with any legal requirements of court ordered treatment. The referring state agency has protocols in place to perform their own random forensic drug testing for monitoring compliance. Patients who fail to meet the high standards of

court ordered treatment should still be offered low threshold and harm reduction care to reduce morbidity and mortality.[25]

Billing and Collection Concerns. Treatment agreements should clearly outline plans should patients fail to pay their bill at the clinic. All possible social service assistance should be offered to assist patients in obtaining insurance and to enroll in grants that can help to cover the cost of medical and BH services. Withholding medication increases risk of overdose death and is not recommended.[25]

Drug Testing. Drug testing is covered extensively in the State of Alaska MAT Guide[25] (pp. 26-28), please reference the guide for information. Drug testing is an important clinical tool used to monitor abstinence and medication compliance and detect return to use. It should be used as a therapeutic tool used to guide discussions with patients and provide information to guide treatment planning, not as a punitive measure.



Alaska Medicaid covers urine drug testing with limitations on quantities. Currently Medicaid covers 20 presumptive (screening) tests and 20 definitive (confirmatory) tests per calendar year. For more information on coverages and billing codes read the Alaska Medicaid Policy Update on Drug Screening/Testing.[27] There are many commercial labs that offer to send out confirmatory testing and will bill Medicaid directly, clinics can typically customize testing panels based on patient need. The ANMC lab currently offers a variety of confirmatory drug panels to choose from; please reference the ANMC Laboratory.[28]

Drug test samples are usually collected at medical visits and sometimes at the patients' home. Urine and oral fluids sample drug levels are stable for extended periods of time, so that delays in shipping the samples generally do not affect test results. The process of collecting samples, ordering and performing the appropriate test is summarized in the algorithm to the left.[29]

The most common drug test used is an on-office rapid urine screening test. This is typically a cup or a dipstick that provides rapid results at the time of clinic visit. CLIA waived rapid urine drug screening tests and have easy to read instructions that are included in the packaging.[29]

False positive results are very common, so it is important to send the sample out for laboratory confirmation testing if there is a discrepancy between test results and client report that would affect clinical decision making.

The State of Alaska MAT Guide[29] provides more information about the following:

- Use of confirmatory testing: Understanding drug testing results can be challenging, always consider calling the confirmatory labs, medical review officer or an addiction specialist to get assistance in interpreting test results.
- Responding to drug test results: Presenting results in an objecting manner, reassessing and revising treatment plans, and addressing refusal.

Sample staff training protocol for UDS collection procedures:

Competency	Method of Verification	-	+	Date Completed
Perform POCT	Is able to state storage temperature: (35.6-82.4 F)			
	Is able to gather supplies for POCT UDS procedure: UDS cups – timer			
	Is able to identify client and obtain two or more identifiers: Name – DOB - MRN			
POCT UDS Prep.	Open UDS cup in front of client: Is able to write two identifiers on the cup label:			
	Is able to instruct client: • Empty pockets with all valuables on exam room table • Hang coat or jacket in exam room. • Instruct to open the cut but DO NOT TOUCH the inside of the cup. • Void into the cup. • Close the lid and tighten securely. • Give the cup to tech.			
Reading and Recording	Is able to read urine temperature on the temperature strip provided in the cup: Is able to run full 5 minutes before reading the result: (See attached document on how to read results) Is able to document result to HER.			
Note:	DO NOT RUN TEST on POCT UDS without performing external controls first.			

11.2.8. Reducing Buprenorphine Diversion

A sample ASAM policy to reduce diversion can be found here[30] and several recommendations are listed below:

- Use buprenorphine/naloxone combination products when cost is not an issue and medically indicated. The mono-product is much more likely to be diverted.
- Counsel clients on safe storage of, and non-sharing of medications
- Counsel clients on taking medication as instructed and not sharing medication. Explicitly explain to clients definitions of diversion and misuse with examples
- Check PDMP for new clients and check regularly thereafter
- Prescribe a therapeutic dose that is tailored to the client's needs.
- Make sure the client understands the practice's treatment agreement and prescription policies
- Request random urine/oral fluid tests
- Perform confirmatory testing for nor buprenorphine metabolite on samples
- Schedule unannounced pill/film counts (in person or over video)
- Directly observe ingestion (in person or over video)
- Limit medication supply
- Consider changing to injectable XR forms for clients who continue to be at risk for diversion. See more information about diversion in the State of Alaska MAT Guide.[31]

11.2.9. Discontinuation of Medication Assisted Treatment

All forms of MAT are intended for long term treatment periods. In fact, rates of relapse and risk for overdose are greater for clients that discontinue MAT within the first year. There are no recommended limits to MAT duration, and for some clients, MAT may be a lifelong treatment. The Surgeon General has recognized that clients who are treated for at least 3 years have lower rates of relapse. See more information about discontinuation of MAT in the State of Alaska MAT Guide[31] (pp. 23, 44 & 47).

When the client expresses a desire to discontinue MAT, the provider should have a conversation about their reasons for discontinuation, medically appropriate considerations, and exploring the best way for that client to taper and/or work towards discontinuation. As part of discontinuation counseling, it is recommended that clients be provided education about overdose prevention and a naloxone rescue kit. The following criteria should be discussed with the client and met before discontinuation:

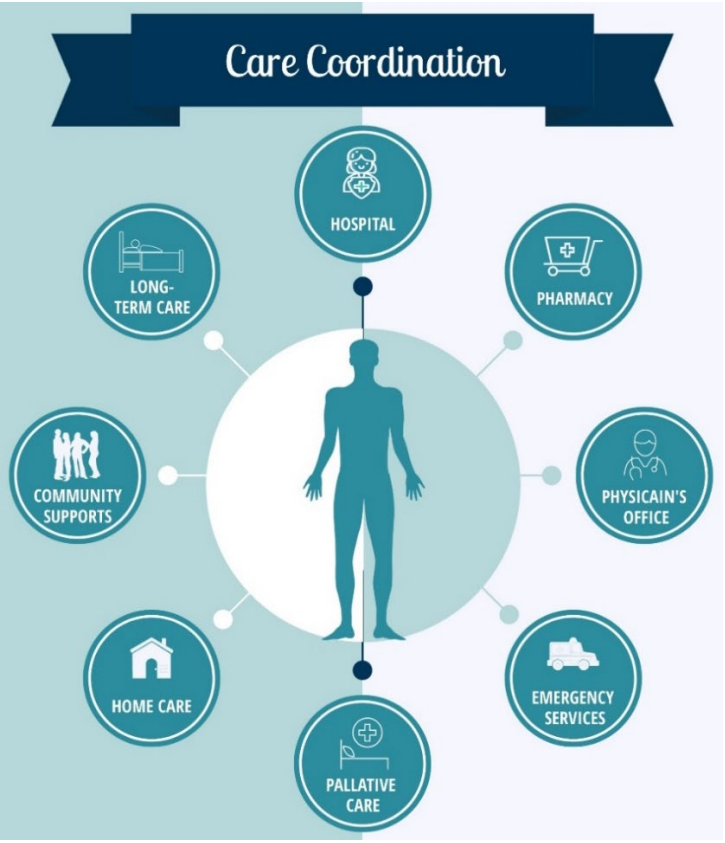
- Relapse free for a year
- Stable housing, job, family life
- No major stressors (legal, financial)
- Stable mental health
- Actively engaged in strong recovery support system

For more information about tapering long-term opioid use reference the Department of Health and Human Services, HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics[32], 2019.

If a rapid taper is unavoidable, the safest avenue is to have this occur with inpatient withdrawal management. Mark and Parish (2019)[33] found clients who had opioid tapers over less than 21 days had a 50% chance of needing hospital care to manage withdrawal symptoms. Another option for clients that stops their buprenorphine treatment and is abstinent from opioids, is to transition to monthly naltrexone injections to support their treatment goals and act as a safety net from overdose.

11.3. Care Coordination and Communication

Care coordination is defined as the organizing of client care and sharing information between all care providers to achieve safer and more effective care based on the client's needs and preferences. Then, communicating these needs to the *right people at the right time*. Care coordination is broader and more comprehensive than care navigation. Effective care coordination can result in fewer emergency department visits, lower medication costs, higher survival rates, and reduce costs by avoiding unnecessary hospital admissions.[34] The triple aim of care coordination is to improve client experiences, lower overall costs, and improve community health. Care coordination enables providers to work at the top of their credentials, improve service utilization, engage clients in their own care and enter into value-based contracts with greater confidence.[35]



A few comprehensive resources on care coordination:

- Integrated Behavioral Health Project: Partners in health: Mental health, primary care and substance use interagency collaboration toolkit.[36]

- AMHSA: A quick start guide to behavioral health integration for safety-net primary care providers: Decision tree.[37]
- SAMHSA: A Standard Framework for Levels of Integrated Healthcare.[38]

11.3.1. The Nuka System of Care

Southcentral Foundation's (SCF) Nuka System of Care is an exemplary example of care coordination effectively improving access to a full continuum of quality health care services, including medical, dental, behavioral, support, and traditional healing services.[39] SCF provides services to 65,000 Alaska Native people who are part of 227 federally recognized tribes who live in Anchorage, Matanuska-Susitna Valley and additional 55 rural villages within 108,000-square miles, which is three times the size of Texas.[11] In the Nuka System of Care, clients are recognized as "customer-owners" who have an ownership stake in the organization and a role in decision making.[39,40] The key features of the Nuka System of Care[39] that separate it from existing systems are:

- "A system built for and accountable to clients (known as "customer-owners" within the Nuka system);
- An emphasis on prevention, behavioral health, primary care, and supportive services;
- Multidisciplinary care teams with robust communication among team members;
- Full redesign of how behavioral health is delivered, including the integration of behavioral health into primary care;
- Significant investments in staff training and development to reduce turnover, enhance quality of care, provide opportunities for career advancement, and perhaps most importantly, ensure commitment to an organizational culture grounded in customer service;
- Facility and workflow design that promotes relation-building and improves interactions with and among providers; and
- Continuous performance monitoring based on sophisticated information technology and data management" (p. 1)

The first stage of transforming the system began by asking for input from the customer-owners; Salinsky[39] stated their key message was: "customer-owners wanted to have long-term, trusting relationships with their primary care provider, they wanted to be treated with respect and dignity, and they wanted to be able to access services when they needed them" (p. 2). Developed from this message, panels of teams were created that serviced 1,200 customer owners who selected their own panel; families were encouraged to be treated by the same panel but not required. The second phase of transformation focused on developing a multidisciplinary model where panels of general practitioners, nurse case managers, medical assistants, and administrators all worked together. To maximize efficiency, panel members worked at the top of their license allowing them to bring in administrators and case managers to take over administrative tasks while nurses could focus on panel management and chronic disease management. The third stage of development brought in providers of other disciplines (i.e., midwives, health educators, dieticians, pharmacists, etc.) to rotate and integrate into panels; while specialists (i.e., cardiologists, endocrinologists, pulmonologists, etc.) spend more time offering consultation to primary care providers rather than seeing clients directly. Behavioral health was integrated into primary care clinics improving the choices for customer owners on what services to utilize and even allowed customer-owners to have same day appointments with a psychiatrist and outpatient behavioral health consultants.[39]

The evidence speaks for itself. The Nuka System of Care has drastically improved access to and quality of care for customer owners since implementation. From 1999 to 2016, the number of empanelment to primary care providers has increased from 6,447 to 65,661. SCF now offers same-day access, when prior to Nuka the average wait time for a primary care appointment was up to two weeks. Between 2000 and 2015 there has been a 36% decline in hospital emergency department admissions. SCF exceeds the 90th percentile in several Healthcare Effectiveness Data Information Set (HEDIS) measures. Finally, customer-owners have a 96% satisfaction level and 93% among employees.[39,41,42,43,44] For more information please reference Salinsky.[39]

Gottlieb[40] outlined the key to SCF Nuka System success can be distilled down to customer ownership and relationships. Relationships are not only about building connections between customer-owners and providers, but are also the operating principles that guide strategic planning, hiring process, facility design, support systems, financing, workflow, and quality improvement.

RELATIONSHIPS[40] stands for:

- "**R**elationships between the customer-owner, the family, and provider must be fostered and supported
- **E**mphasis on wellness of the whole person, family, and community including physical, mental, emotional, and spiritual wellness
- **L**ocations that are convenient for the customer-owner and create minimal stops for the customer-owner
- **A**ccess is optimized and waiting times are limited
- **T**ogether with the customer-owner as an active partner
- **I**ntentional whole system design to maximize coordination and minimize duplication
- **O**utcome and process measures to continuously evaluate and improve
- **N**ot complicated but simple and easy to use
- **S**ervices are financially sustainable and viable
- **H**ub of the system is the family
- **I**nterests of the customer-owner drive the system to determine what we do and how we do it
- **P**opulation-based systems and services
- **S**ervices and systems build on the strengths of Alaska Native cultures" (p. 4).

Teamwork. The core of coordinated care is the team work of medical providers, behavioral health, specialty care, community resources, support services, and even people beyond a typical clinic such as the criminal justice system and first responders. Teamwork creates another blanket of support around the client as they work towards their wellness goals. Teamwork should attempt to integrate the operating principle of RELATIONSHIPS focused on fostering support, whole person wellness and integration of the whole system to optimize care.

MAT Team. It is recommended to have a MAT team with dedicated staff. Positions to consider integrating to the MAT team are providers, prescribers of MAT, pharmacists, counselors (i.e., behavioral health, vocational, family, etc.), peer support specialist, case managers, psychiatrists, and more. Due to the chronic and ongoing nature of substance use, clients will likely need a variety of different services at different points. The MAT team should integrate relevant services in a given area to provide wrap around services relevant to substance use treatment. This way there are multiple available services that a client may choose to engage in depending on their self-determination.[45]

Pain Management Working Group. Pain is a crucial element in selecting and maintaining MAT. A pain committee can be critical in developing a multi-modal approach to pain management and offer varying perspectives to pain management. A pain committee ensures individualized, client-centered care that offers safe opioid use and risk assessment to ensure a balance of managing the pain and integrating complementary services such as education, restorative movement therapies, traditional healing, intervention procedures, acupuncture, behavioral health, and more.[46]

11.3.2. Addressing Gaps in Transitions of Care

Given the distance of travel people must make to get certain levels of care, transitions of care are important to ensure the client does not experience a gap in services. A gap could have adverse effects for clients on therapeutic regimens especially those with complex health issues. Three key elements to ease the process are knowledge, resources and self-efficacy. Clients can take charge of parts of their transition, especially if provided with the knowledge to do so and resources to reach out to in chance of hiccups.[41] Pollack et al.[47] discusses how to empower both systems and individuals to ensure a successful transition in care.

Communication. Communication is crucial across the teams serving the client and the client themselves especially in care coordination. An integral part of care coordination is consistent communication between a client and their team of providers. Clients should be provided information about the level of communication to be expected from providers and expected of them. Care teams should maintain a realistic and negotiated standard of communication with the client. While phone calls and telehealth continue to grow as means of communication; alternative forms of communication methods should be considered to reach higher risk audiences, like youth and elders.

- **Texting.** Texting is a form of communication to consider given proper consent from the client. Texting allows clients to reply in their own time and have a record of the conversation. On the other hand, there are higher confidentiality risks associated with texting that should be discussed with the client prior to their consent.
- **Social media**. Social media is not an appropriate medium to communicate with a client. However, it is a powerful outreach medium especially for youth and younger generations born in the boom of technology. Social media offers a concise way to spread information about services.

11.3.3. Logistics

Below are some important considerations when coordinating care, especially with rural communities.

Scheduling. When providing services to rural communities, scheduling is not as simple as when the client is available. Rather is complex considerations based on transportation options for a given community, weather and time of year, employment, childcare and more. Case managers and/or care coordination requires a conversation looking to the future on how to schedule a client. For instance, if the client must be seen again in six months' time, do they need to be scheduled earlier to take into consideration subsistence hunting?

Childcare. Childcare is an important consideration for clients. Clients lacking childcare will either not attend appointments or bring along their children; as such, the clinic should develop a policy for family member presence at appointments. For clients that travel from rural communities to come to a hub for medical services it is important to consider if it is possible to schedule a family to reduce travel. Additionally, it may behoove hubs to offer childcare services while adults attend appointments.[48] One potential barrier to this would be health insurance only covering travel fare for the client receiving medically necessary services.

Client Transportation. There are several travel barriers from rural areas. Health insurance requires transportation to be medically necessary. Depending on the location, there are limitations on types of transportation such as no vehicle transport except during the winter when the waters are frozen over, requiring air or boat transport depending on the time of year. Another barrier is weather; winter poses another set of barriers to air transport.

11.3.3. Medication Considerations

Planning how the client will receive their medication will depend on the location. Regardless, it is important to assess the available means and plan for delivery of medication whether that involved in person or mail. If the medication is mailed, coordinate shipping of the medication with the village clinic or client. Part of medication is tracking and ensuring clients receive their medication. As well as flowsheets of clients due for the next step in the medication process depending on the type of medication.

11.3.4. Case Management

The case manager is the first line of contact for many clients in not only coordinating care but also managing the clients concerns. Case managers are crucial in navigating resources, services, and between other systems. When navigating systems, case managers begin with a signed release of information which is crucial in assisting clients navigate resources and other systems. A key feature of case management is ensuring initiation and maintenance of eligible benefits. A case manager should be aware of various benefits and resources and assist the client in navigating these services including signing up for insurance, applying for benefits, applying for higher levels of care, and getting other services such as housing, food stamps, food banks, etc. Additionally, case manager can act as a bridge between the care team and other systems like Office of Children Services, DV, criminal justice system, and more.[49]

Community Treatment Resources. Community partnerships are the best place to start when considering a referral to higher levels of care such as residential substance use treatment or considerations for recovery communities (See Section 4: Community Partnerships). Section 6: Screening, Assessment and Treatment outlines the levels of care from outpatient to residential substance use treatment. Continuity of care is important in referring clients to higher levels of care and with a transfer home.

Section 11 References

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Section 12: Holistic Healthcare in Rural Alaska

12.1. Holistic Health in Rural Alaska

This section of the toolkit is focused on understanding health and wellness in the context of Indigenous communities. Although the bulk of research about holistic health and wellness in Alaska Native and American Indian communities has been conducted with Indigenous communities outside of Alaska, we believe that many of these findings and principles can be helpful to understanding the context of wellness for Alaska Native people. We recognize important differences between Indigenous communities, but we also recognize similarities in cultural strengths and resilience across tribes.

Mi'kmaw Elders Albert and Murdena Marshall proposed the concept of "two-eyed seeing," which integrates two worldviews in healthcare and related settings.[1,2] The two perspectives include western science and Indigenous knowledge systems. There is nothing "right" or "wrong" about either of these perspectives and both hold power in healing and the promotion of health for Indigenous people. However, it is important to consider traditional indigenous knowledge and perspectives of well-being to effectively serve indigenous communities. According to Fijal and Beagan, western science is focused on reductionism (i.e., reducing problems), empiricism, objectivism, and treating specific problems. By contrast, Yup'ik leader and Elder Harold Napoleon argued that Indigenous wellness involves interdependency, environmental epistemology, spirituality, family relations, and community involvement.[2] Similarly, the Cultural Resources for Alaska Families Traditional Health and Wellness Guide[3] recognizes two key concepts to Alaska Native health: "balance and connection, to nature and each other; these are fundamentally simple, but require culture to be built around them to work" (p. 29). Additionally, the guide recognizes several domains of health: physical, mental, emotional, spiritual, relational intertwined with participation of traditional activities.

12.2. Traditional Healing and Knowledge

Traditional Indigenous knowledge, in Alaska Native cultures, has been passed down through generations by modeling and storytelling.[4] Traditional healers have held a special place in Alaska Native communities as they are well respected for their healing roles. They have knowledge of natural elements such as plants as medicine and foods that can provide remedies to ailments, aches, pain, and disease. In a more general sense, elders have shared how plants, food and other resources can be used to treat ailments. Previously mentioned, the use of traditional healing practices can be helpful on a profound level, including spiritually, mentally and physically.

When implementing MAT, we urge health care providers and other professionals to consider offering referrals to traditional healing clinics and medicine to supplement MAT. We know the implications of substance misuse impact an individual on many levels, including relationships, job security, mental health, and physical health. Traditional healing can address issues if stigma is a factor in the health and well-being for someone suffering from substance misuse through decolonization (See Section 12.2.1 Decolonization for more information).

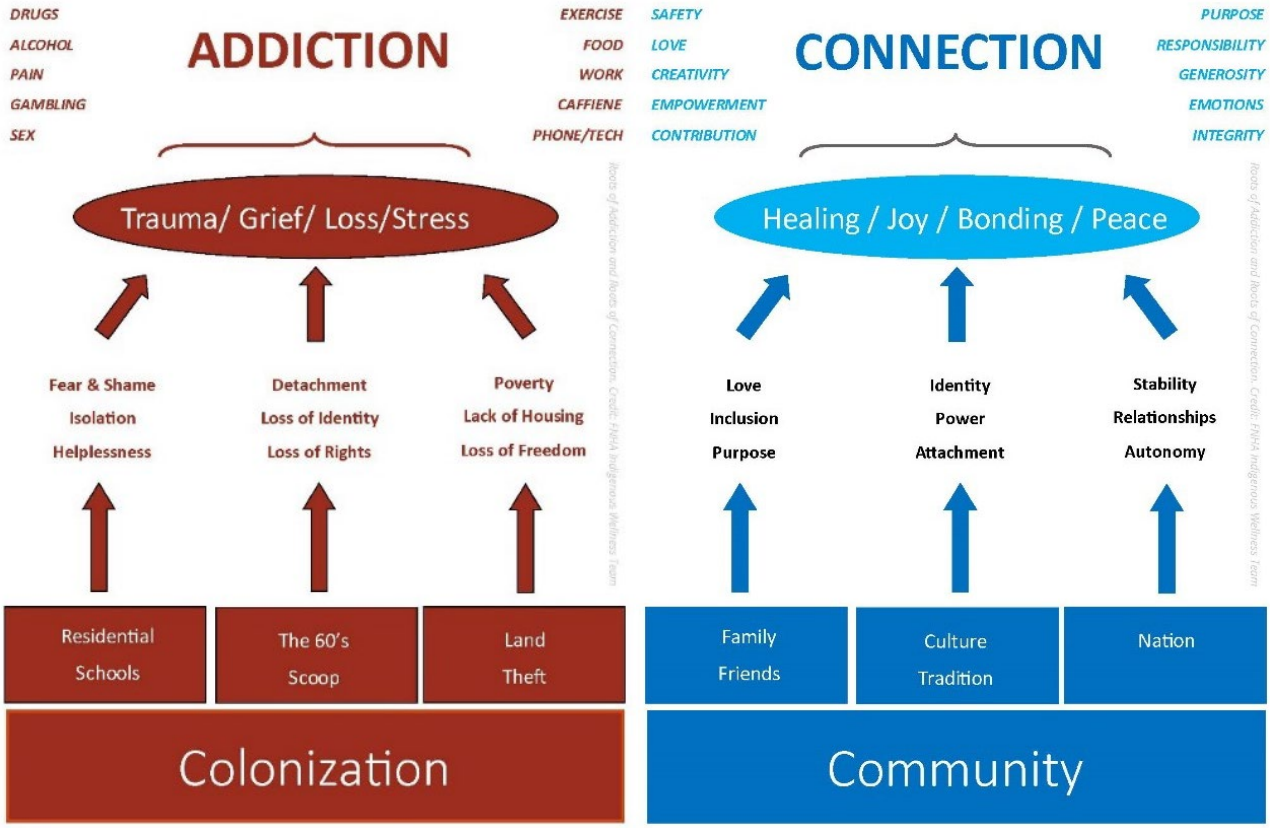
The Northwest Portland Area Indian Health Board (NPAIHB) and Alaska Native Tribal Health Consortium (ANTHC) have partnered, under the guidance of Elders Doug (Tsimshian) and Amy Modig (Deg Hit'an Athabascan), to develop the 49 Days of Ceremony curriculum. The curriculum is based on a holistic framework for health and wellness that incorporates Alaska Native and American Indian (AN/AI) Indigenous knowledge, teachings and practices. The 49 Days of Ceremony framework represents a journey of becoming a good or "real" human being that involves the *individual* (connection to ourselves through volition or will power), the c*ommunity* (connections with others through the mental, emotional, physical and spiritual aspects of life) as well as *Mother Earth* (connection to the natural world) and *Father Sky* (connection to our ancestors). This project-based curriculum is still in development, but will be implemented through Aunties and Uncles as traditional teachers while engaging in culturally relevant activities and practices. For more information contact Connie Jessen with ANTHC at cmjessen@anthc.org.

12.2.1. Decolonization and Cultural Resilience

For thousands of years, Alaska Native people have thrived off of a subsistence lifestyle, with activities such as hunting, fishing and gathering food.[5,6] Throughout history, Alaska Native people have endured a series of targeted violence (see Section 12.2.3 below, Historical and intergenerational trauma). Currently, Alaska Native communities are reclaiming Indigeneity working to heal from past trauma. One powerful way to heal from the effects of colonization is decolonization. Decolonization refers to the practice of undoing colonialism by incorporating Indigenous ways of knowing and culture in work. We will focus on decolonizing addiction to promote overall health and well-being.

12.2.2. Decolonizing Addiction

Many researchers associate the high rates of substance misuse problems plaguing Alaska Native communities as an effect of colonialism.[7,8] On the other hand, connection to community, culture and land sets a space for healing for Alaska Native people in recovery. Previously mentioned, individuals in recovery are needing to heal not just from physical harms of substance misuse, but the spiritual, mental, emotional, and cultural aspects of their being should be addressed as well. The figures below from the First Nations Health Authority[9] considers addiction to involve trauma, grief, loss and stress.



Self-Care for Providers and Staff. In the "giving" professions, including social services, health care, mental health, and related areas, we often hear of compassion fatigue and burnout. This is especially true for providers. Research suggests that "normal" stress (stress that is manageable) often boosts performance, whether it is leading a team meeting for the first time or tackling your first day on the job. On the other hand, excessive stress activates the normal "fight, flight, or freeze" response in the body, which can cause the physical presentations of digestive problems, having difficulty eating or sleeping, and further physical symptoms and mental health problems.[10,11] We also know that practicing skills such as mindfulness, breathing, and knowledge of the physical presentations of stress and learning techniques to help regulate the body (for example, deep breathing, box breathing, and meditation) can build a buffer against the effects of stress.[12] Additionally, a 2015 study by Finlay-Jones, Rees and Kane[13] found that having compassion for oneself in times of stress serves as a buffer to emotional and physiological presentations of stress.

It is recommended to practice self-care. This can look like:

- Taking a vacation from work;
- Asking for help from coworkers;
- Reaching out to a network of friends for support;
- Getting out on the land;
- Incorporating self-regulation techniques into your day (mindfulness, breathing, stretching, and more);
- And whatever self-care looks like for you!
    - Please see resources at the end of this section for ways to cope with stress.

Cultural Training. So far, this section has covered Indigenous perspectives in healthcare, decolonization, and traditional healing. We know that health care providers are tasked with helping clients navigate their care and sometimes providing the best quality care can be difficult when working with clients of a different cultural background than providers. "Culture" can have different meanings, including ethnicity, having a disability, age (being a youth or elder), being lesbian, gay, bisexual, transgender, queer/questioning, or Two Spirit (LGBTQ2S+). What's more, it is rare that someone only carries one of these cultural identities. Being a member of several minority groups' impacts how someone is treated in the world. American Indian and Alaska Native people and LGBTQ2S+ people are at higher risk of health problems such as substance misuse and suicide because of their cultural backgrounds.[14,15] There are also cultural differences between being a rural or urban Indigenous person.

It is recommended to seek cultural training to help you navigate addiction medicine with your clients by providing a safe environment that is culturally sensitive. Like the Cultural Resource for Alaska Families, miscommunications and misunderstandings can happen between providers and Indigenous people if they are of different cultural backgrounds. Being Indigenous means more than differences in diet and language, but also different social norms, differing ways of thinking, and different ways of living in the world each day. Please see cultural resources at the end of this section.

Incorporating Personal Stories of Resilience. We briefly touched on increasing resilience for providers and healers. For people suffering from substance misuse, each individual can be at many different parts of their journeys. Some might feel remorseful and want help to change their using behavior but are not sure where to start. Others may have gone several years without using it to find themselves experiencing a return to substance use. Some may have stopped using and are feeling hopeful in their recovery and roles in their families and communities. No matter where someone is at in their journey, sharing and listening to these stories of recovery can leave hope and understanding for someone in different ways. For one thing, they can feel that they are not alone in their struggles but someone else has been there. Also, they can feel hopeful about their own path to healing and wellness.

Community and Cultural Resilience. Building on the aspects of personal stories of resilience, we move to consider resilience on the community and cultural level. Research has demonstrated that connection to community and culture for many Indigenous people has increased capacity for resilience.[16,17] On the previous page, we featured the First Nations Health Authority concepts of "Addiction" and "Connection". Essentially, the opposite of addiction is not recovery; the opposite of addiction is connection. A person's connection to land, culture, and a network of community are key components to setting up an individual for success in recovery.

Moreover, we know that people use substances for many reasons. The younger someone uses substances, the more likely they are to develop a substance use disorder. [18] For Indigenous youth, to have a strong sense of cultural identity is associated with higher levels of psychological health, self-worth, self-efficacy, connectedness, and purpose.[18,19,20] Putting these concepts together, we believe that a strong connection to culture and community is a huge asset in prevention but also recovery for Indigenous people that suffer from substance misuse. Moreover, we know that racism and discrimination experienced can be a part of the picture. Having connection to community members that share the same cultural identity, language, and stories can provide a buffer to issues such as discrimination.

We encourage providers to consider health in the context of their client's perspective, with history and culture in the picture. Many Indigenous people are part of a collective group and maintaining these connections is critical to recovery. A few training and resources:

- Indian Health Services, Culturally Relevant Best Practices[22]
- SAMHSA, American Indian and Alaska Native Culture Card[23]: A Guide to Build Cultural Awareness, 2009
- The Alaska Native Heritage Center, Cultural Awareness Workshops[24]
- The Alaska Training Cooperative[25]
- First Alaskans Institute[26]

12.2.3. Historical and Intergenerational Trauma

According to the State of Alaska Cultural Resources for Alaska Families guide[27], "historical trauma is the total collective emotional and psychological wounding over the lifespan and across generations, stemming from massive group trauma" (p. 22). For centuries, many Indigenous communities have endured targeted oppression and assault, including child removal via residential school policies, epidemics due to lack of immunity to new diseases, and the forced suppression of cultural practices.[28,29] Research evidenced that historical trauma is linked to several negative health outcomes such as substance misuse, suicide, domestic violence, and other behavioral issues.[30,31]

According to Wexler, DiFluvio and Burke[32], Indigenous communities face persisting marginalization and oppression in the forms of racism and discrimination. Racism and discrimination leave minority groups at risk of several health problems, including substance misuse, suicide and other behavioral health problems. Alaska Native people are striving to heal from historical trauma. In support of their efforts to address social and behavioral health problems, it is recommended that providers understand the complexities that are associated with substance misuse. Previously mentioned, we know that people use substances for many reasons. We recommend going back to principles of harm reduction: to de-stigmatize and respect individuals. A few resources on historical trauma below:

- University of New Mexico, Historical Trauma and Cultural Healing[33], 2020
- Indian Health Service, Trauma Informed and Historical Trauma[34]: Informed Care Training for Non-Provider Staff, 2017
- Alaska Public Media, Historical Trauma podcast[35], 2016
- Sitkans against Family Violence, Historical Trauma Page[36]
- SAMHSA, Tribal Families and Trauma Exposure[37]

12.3. Treating the Whole Person

Substance use does not occur in a vacuum. Although some people may initiate substance use as part of experimentation, often the continued use is the result of complex physiological, psychological and social factors. Therefore, substance use treatment strives to make changes within various domains of a person and the community within which they are embedded while building upon the person's inherent strengths and resilience. Especially for people who may experience a variety of chronic illnesses, they are at increased risk for depersonalized and over medicalized care. A whole-person model of care has been shown to improve client experiences, ensure person-focused treatment, and focus on relationships between the client and across domains of his care team.[38]

12.3.1. Integrated Wrap Around Services

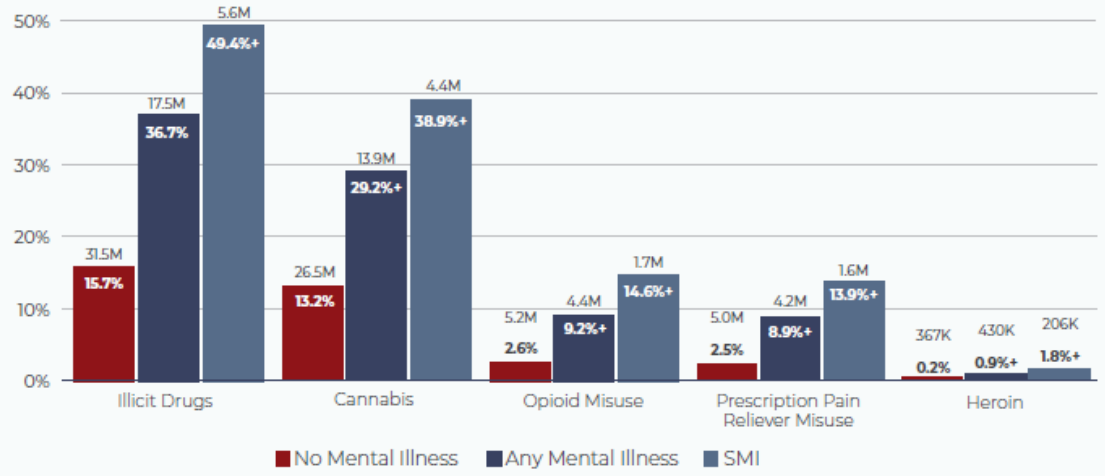
Previously, we have discussed care coordination (Section 11.3) and the elements to consider for substance use treatment (Section 6.4). As part of integrated treatment, substance use treatment should involve not only substance use and mental health treatment but also medical and other recovery support services. When possible, it is helpful to have cross-trained professionals that treat both substance use disorders and serious mental illness. Part of integrated treatment is offering stage-wise treatment services so people can be matched with services appropriate to their stage in recovery. Further, behavioral health elements should be integrated such as motivational interviewing to assist clients in identifying and pursuing personal goals, cognitive behavioral therapy to target co-occurring disorders, and more. Having services available across multiple formats (i.e., individual, group, self-help and family) is beneficial.[39] Other wrap around services to consider are additionally services that the client may benefit from focused on treating the whole person such as housing, recovery support, education and other services related to community partnerships (Section 4). Given the complexity of integrated wrap around services, a case

manager or other similar care coordinator is beneficial to ensure the clients continue to receive services relevant to their needs as they transition in the recovery process. A good video on talking to clients about potentially challenging topics is Tell me what to say: How to approach challenging patient conversations.[40]

12.3.2. Addressing Co-Occurring Disorders

"Comorbidity is important because it is the rule rather than the exception with mental health disorders".[41] Within the general adult population, national surveys found that mental illness and substance misuse commonly co-occur and remain untreated. Of the 2 million adults in the U.S. between 2015 and 2017 a national survey found in the past year: 77% of people had a co-occurring substance use disorder or nicotine dependence; and 64% experienced a co-occurring mental illness, of which, 27% experienced a comorbid severe mental illness. Comprehensive treatment for co-occurring disorders is rare, and people most often receive care for their mental health.[41]

EXHIBIT 1.2. Co-Occurring Substance Misuse in Adults Ages 18 and Older With and Without Any Mental Illness and SMI (in 2018)



Source: McCance-Katz (2019). Adapted from material in the public domain.

SAMHSA[41] outlined the six guiding principles in treatment client with co-occurring disorders:

1. "Use a recovery perspective.
2. Adopt a multi-problem viewpoint.
3. Develop a phased approach to treatment.
4. Address specific real-life problems early in treatment.
5. Plan for the client's cognitive and functional impairments.
6. Use support systems to maintain and extend treatment effectiveness" (p. 14).

Completing a full assessment is the first stage to providing an appropriate level of care (Section 6.3.1: Alaska Levels of Care for Referral). The treatment plan should adapt depending on the client's stage in recovery and include a variety of services that address specific real-life problems early in treatment, use support systems to maintain and extend effective treatment (i.e., building community, mutual support, reintegration with family and community, and/or peer support services).[41,42]

A few comprehensive resources about co-occurring disorders are listed below:

- SAMHSA: TIP 42: Substance Use Treatment for Persons with Co-Occurring Disorders[41], 2020
- SAMHSA: Evidence-based resource guide series: Treatment of stimulant use disorders[42], 2020
- SAMHSA: First-Episode Psychosis and Co-Occurring Substance Use Disorders[43], 2019
- SAMHSA: Pharmacologic Guidelines for Treating Individuals with Post-Traumatic Stress Disorder and Co-Occurring Opioid Use Disorders[44], 2012

12.3.3. Special Populations

The community of people in recovery from substance misuse are diverse. People experiencing homelessness, involved in the criminal justice system, women, and people from historically underserved diverse groups often face multiple barriers, have unique needs and presenting concerns. Special populations who experience co-occurring disorders are especially vulnerable to challenges to treatment that may result in poor outcomes. SAMHSA developed Chapter 6: TIP 42: Substance Use Treatment for Persons with Co-Occurring Disorders[41] which provides information about the treatment of special populations with co-occurring disorders.[41]

People Experiencing Homeless. Housing is not just a physical shelter, it is a social determinant of health essential for the physical, emotional, and socioeconomic wellbeing of people. "According to the US Department of Housing and Urban Development's June 2010 Annual Homeless Assessment Report to Congress (2010 AHAR), on a given night in January 2010, 407,966 individuals were homeless in shelters, transitional housing programs, or on the streets (this number does not include persons in family households)."[45] Data conducted from 2006 to 2011 indicated that approximately 30% of people who are chronically homeless have experience a mental health condition, of which 50% have a co-occurring substance use problem.[45] Housing is a crucial step in recovery; without stable housing the likelihood of achieving and maintained long-term recovery reduces drastically. Due to this, housing is a crucial initial step in a flexible, multifactorial, integrating treatment focused on providing diverse services, resources and treatment options.[46,47,48]

When working with people who experience homelessness and co-occurring disorders, a few recommendations are:

1. Address the housing needs of the client by assisting in obtaining housing and teaching skills to maintain housing based on the client's needs and resources.
2. Collaborate with workers in shelters and other services providers for people who are homeless.
3. Address the real-life concerns in addition to housing, which may including food and nutrition, legal and financial concerns, insurance and health care, problems related to children and family, and application for eligible benefits/resources.[46]

Resources for working with people who are homeless:

- SAMHSA: Homelessness Programs and Resources[47], 2019
- SAMHSA: TIP 55: Behavioral Health Services for People Who Are Homeless[48], 2015
- SAMHSA: Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States[49], 2011

People Involved in the Criminal Justice System. Rates of mental health and substance use disorders vary depending on the population involved in the criminal justice system. Among U.S. state prisons, prevalence is approximately 48% had a history of mental illness, 29% had a severe mental illness, and 26% had a substance use disorder. Successful treatment of SUD is associated with reducing risk for violence by disrupting the link between substance misuse and re-incarceration. Ideally, treatment begins within a criminal justice facility and then continues post-release into community services and follow-up care.[50,51]

Resources for working with people involved in the criminal justice system:

- SAMHSA: Substance Abuse Treatment for Adults in the Criminal Justice System A Treatment Improvement Protocol TIP 44[51], 2014
- SAMHSA: Medication-Assisted Treatment (MAT) in the Criminal Justice System[52]: Brief Guidance to the States, 2019
- SAMHSA: Guidelines for Successful Transition of People with Mental or Substance Use Disorders from Jail and Prison[53]: Implementation Guide, 2017
- SAMHSA: GAINS Center for Behavioral Health and Justice Transformation[54], 2020

Special Considerations for Women and Pregnancy. Although rates of SUD are lower for women, they face disproportionate barriers related to children and child care. Women can be served in mixed-gender treatment programs that account for differences as well as increased barriers to initiating treatment. Women experience different initiation and participation needs and most often enter treatment through the route of the criminal justice

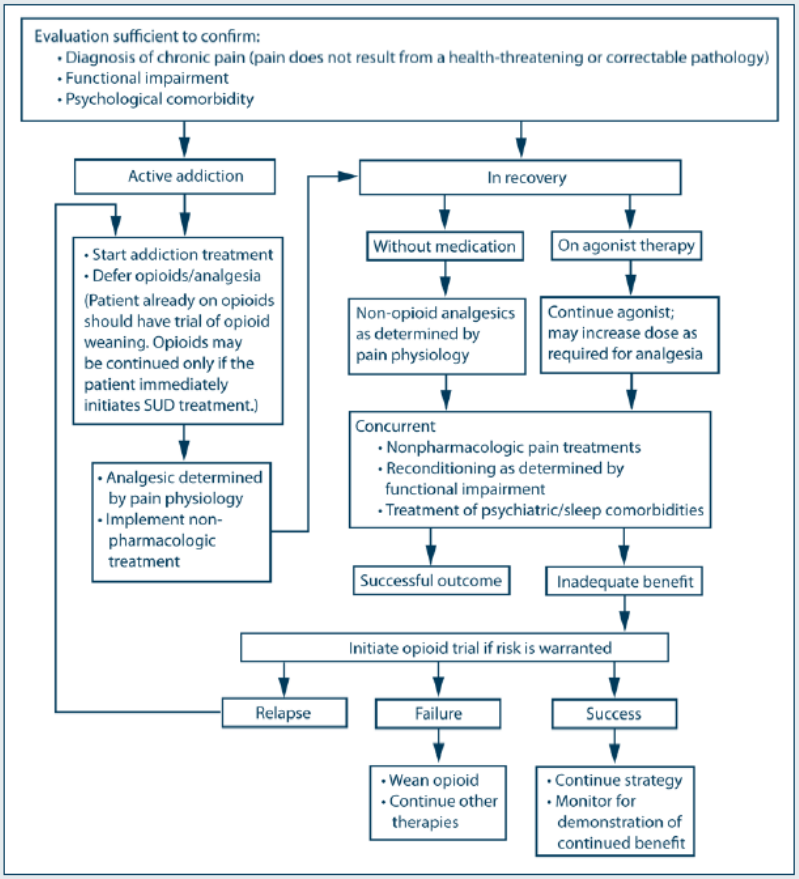
system. While male counterparts report more trouble in functioning, women often report more difficulty in emotional problems. Furthermore, women with a SUD are more likely to experience a co-occurring mental health disorder and history of physical or sexual abuse posing increased challenges to recovery and increase risk of relapse. SAMHSA[55] outlined: "positive outcomes are especially likely in programs that include residential treatment with in-house accommodations for children, outpatient treatments that incorporate family therapy, and comprehensive services that address women-specific needs (e.g., case management, pregnancy-related services, parenting training/classes, child care, job training, and continuing care)" (p. 174). Women benefit from trauma-informed approaches and incorporating resources or services that address disparities.[55]

Resources for working with women:

- SAMHSA: Trends in Substances of Abuse among Pregnant Women and Women of Childbearing Age in Treatment[56], 2014
- SAMHSA: A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorder[57], 2016
- SAMHSA: Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants[58], 2018

Treating Pain in Clients with a Substance Use Disorder. Addiction and chronic pain share many of the same neurophysiological patterns. Both are not static conditions but fluctuate in intensity depending on circumstances and ongoing management. They involve overlapping areas of the central nervous system which can have harmful consequences when untreated and require multifaceted treatment. The development and course of addiction and chronic pain are both influenced by genetic and environmental factors.

Exhibit 3-1 Algorithm for Managing Chronic Pain in Patients With SUD



Treating pain should begin with an evaluation of the pain itself, diagnosis of pain and other co-occurring disorders, functional impairment and psychological comorbidities. This figure outlines two trajectories depending on active engagement in substance misuse or in recovery services.[59]

SAMHSA[59] outlined the goals for treating pain within clients with a substance use disorder are as follows:

1. Treat with a "non-opioid analgesics as determined by pathophysiology.
2. Recommend or prescribe non-pharmacological therapies (e.g., cognitive–behavioral therapy, exercises to decrease pain and improve function).
3. Treat comorbidities.
4. Assess treatment outcomes.
5. Initiate opioid therapy only if the potential benefits outweigh risk and only for as long as it is unequivocally beneficial to the patient" (p. 35).

To begin with, SAMHSA[59] outlined several options for non-opioid analgesic pharmacological options including: acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs), tricyclic antidepressants, anticonvulsants, topical analgesics, antipsychotics, and muscle relaxants (see exhibit 3-2, pp. 35-37). A provider may decide to use one of these over another depending on existing psychiatric comorbidities so the medication could address both the pain and comorbidities. Benzodiazepines and cannabinoids have been found to have analgesics properties but were not recommended given their addictive properties for someone with SUD.[59]

Non-pharmacological treatments are beneficial partners to pharmacological therapies. Non-pharmacological treatments pose no relapse risk, may be more consistent with the client's values and preferences, improve quality of life and reduce pain, and should be included in most pain treatment plans. Common examples of non-pharmacological therapies are therapeutic exercise, physical therapy, cognitive behavioral therapy, complementary and alternative medicine (i.e., chiropractic, massage, acupuncture, relaxation, and other mind-body therapies). Multimodal treatment plans have been found to have both short and long term benefits.[59,60]

For clients undergoing major surgery, clients on an existing MAT regime have a tolerance for opioids so higher doses of opioid agonists may be required for effective pain control. Discontinuation of MAT likely would lead to a disengagement in treatment. Past research has not shown benefit of discontinuing methadone or buprenorphine, rather suggested long-term MAT maintenance to minimize risk for relapse.[62] See State of Alaska MAT Guide[61] for management of pain for clients on MAT (pp. 53-54).[62]

A comprehensive resource for treating people with chronic pain:

- Department of Veterans Affairs: Transforming the Treatment of Chronic Pain Moving beyond Opioids[63]: A VA Clinician's Guide, 2017

Human Immunodeficiency Virus and Viral Hepatitis Treatment. Approximately 4.4 million people live with chronic viral hepatitis in the United States. Often the signs and symptoms of viral hepatitis are only evident when the disease has caused severe liver damage. Due to people often being unaware, they do not seek treatment. Between 2010 and 2020, an estimated 150,000 people died of liver cancer or viral hepatitis -related disease. People who use or have used illicit drugs, have engaged in injection drug use are at increased risk for contracting hepatitis C virus (HCV)and other forms of viral hepatitis.[64]

SAMHSA[47] cited symptoms for viral hepatitis may include one or more of the following: "fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, gray-colored bowel movements, joint pain, and jaundice (yellow color in skin or eyes)" (pp. 1-2). If a person experiences any of these symptoms, they should contact their healthcare provider to get tested. The CDC recommends that all adults get tested once HCV regardless of risk, and then tested as needed if ongoing risk persists. If a person may have been exposed to HCV in the past six months, it is recommended they get tested for HCV antibody (ribonucleic acid) commonly known as the HCV RNA.[65]

"Treatment for an acute HCV infection consists of antivirals and supportive treatment. If the illness is chronic, regular monitoring for signs of liver disease progression is necessary and treatment with antiviral drugs may be recommended" (p. 2). Engagement strategies are especially beneficial in retaining clients in care and considering MAT for treatment of co-occurring substance use disorders. With treatment and monitoring of HCV, people with co-occurring mental health and substance use disorders have comparable adherence rates to HCV treatment as those without a substance use or mental health disorder.[47] Previous requirements for eligibility for HCV antiviral treatment included prolonged(6+ months) of abstinence from illicit drugs. These requirements have been removed as studies have shown that appropriately counseled clients who are using IVD have low rates of re-infection with HCV. Providers must counsel clients on avoiding sharing contaminated injection equipment, and ensure clients know how to access clean injection supplies.

Nearly 50,000 people become infected with Human Immunodeficiency Virus (HIV) every year in the United States. Left untreated, HIV can lead to Acquired Immune Deficiency Syndrome (AIDS). In 2011, about 14% of the 1.2 million people living with HIV did not know they had contracted the disease. Further, about 50% to 90% of people with HIV who inject drugs also have HCV.[65]

Symptoms of HIV include one or more of the following: "fever, fatigue, loss of appetite, nausea, vomiting, abdominal pain, gray-colored bowel movements, joint pain, and jaundice (yellow color in skin or eyes)" (p. 2). Initial symptoms of HIV are similar to those of influenza, and as the disease progresses, HIV progresses to AIDS and other infections are common such as tuberculosis, pneumonia, severe weight loss, and certain types of cancer. If a person experiences any of these symptoms, they should contact their healthcare provider to get tested. Additionally, a person should be tested every year who shares needles/syringes or other equipment for injecting drugs, has a history of sexually transmitted infections, or have had unprotected sex with multiple or anonymous partners. Clients at high risk for HIV exposure due to local disease incidence or multiple high risk behaviors should be offered PrEP (pre-exposure prophylaxis) medications to reduce risk of becoming infected with HIV.[65]

Similar to treatment for hepatitis, HIV treatment consists of antiretroviral treatment (ART). Optimal treatment for HIV consists of coordinated substance use and mental health treatment during or before treatment for HIV and HCV. With treatment and monitoring of HIV, people with co-occurring mental health and substance use disorders have comparable adherence rates to HIV treatment as those without a substance use or mental health disorder.[65]

Providers should focus on the following goals when working with people with a substance use disorder, HIV or viral hepatitis[66]:

1. "Reduce and eliminate alcohol and drug use
2. Provide evidence-based treatment for substance use disorders
3. Assist patients to get tested for HIV and viral hepatitis
4. Educate about prevention of substance use disorders and infectious diseases
5. Assure that those with substance use disorder(s) and/or infectious diseases get treatment
6. Provide post-exposure prophylaxis where clinically indicated
7. Encourage patients to practice safer sex every time" (p. 2).

Comprehensive Resources for Staff and Clients about HIV and Hepatitis:

- SAMHSA: Screening and Treatment of Viral Hepatitis in People with Substance Use Disorders[67], 2021
- SAMHSA: Take Action Against Hepatitis C Education Session Guide[68], 2016
- SAMHSA: Addressing Viral Hepatitis in People with Substance Use Disorders: Quick Guide for Clinicians and Administrators[69]. Based on TIP 53, 2013
- SAMHSA: Take Action against Hepatitis C: For People in Recovery from Mental Illness or Addiction[70], 2014

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Appendix A: General Resources

Center for Substance Abuse Treatment

The Center for Substance Abuse Treatment (CSAT), a part of the Substance Abuse and Mental Health Services Administration (SAMHSA), is responsible for supporting treatment services through a block grant program, as well as disseminating findings to the field and promoting their adoption. CSAT also operates the 24-hour *National Treatment Referral Hotline* (1-800-662-HELP), which offers information and referral services to people seeking treatment programs and other assistance. CSAT publications are available through SAMHSA's Store (store.samhsa.gov). Additional information about CSAT can be found on SAMHSA's Web site at https://www.samhsa.gov/about-us/who-we-are/offices-centers/csat.

Four A's Syringe Service Program

The Alaskan AIDS Assistance Association - Four A's Syringe Access Program (FASAP) provides access to sterile syringes and other safer injection supplies for Injection Drug Users. Four A's Syringe Access Program is a safe, legal, non-judgmental place to collect free injection supplies confidentially. Non-identifying information (gender, age range, race and zip code) is recorded for funding purposes. Bring in your used syringes, receive new syringes and works. All clients have access to free condoms, safe sharps disposal, HIV testing, risk reduction counseling, referral to STI/STD clinic, and referrals to addiction treatment and recovery programs.

FASAP has three locations: Anchorage offers various hours Monday through Friday located at 1057 W Fireweed Lane Suite #102, Anchorage, AK 99503. Juneau location is open Monday through Friday 2:00 – 5:00 p.m. located at 225 Front Street Suite #103-A, Juneau, AK 99801. Mat Su Valley has a Four A's Mobile Health Unit located at the Park & Ride on Trunk Road on Friday afternoon. For more specific information call or text 907-744-6877 with questions or visit their website at https://www.alaskanaids.org/prevention/syringe-exchange.

Homer Syringe Exchange

The Homer Exchange is a safe and confidential resource on the first and third Tuesdays of each month from 5:00 - 7:00 p.m. at the South Peninsula Hospital Training Center to safely dispose of used sharps and obtain clean needles. Free naloxone (overdose response) kits are available, as well as information about how to get free HIV & Hepatitis C testing. South Peninsula Hospital Training Center is located at 4300 Bartlett Street, Homer, AK 99603. You can call (907) 235-3436 or email homerexchange@gmail.com for more information.

National Council for Behavioral Health

The National Council for Behavioral Health is a not-for-profit association and advocacy organization whose mission is to advance the delivery of integrated health care through health care organizations that deliver mental health and addictions treatment and services. The National Council is committed to increasing access to comprehensive, high-quality care that affords every opportunity for recovery. For more information see their website at: https://www.thenationalcouncil.org/. Additionally, the NCBH has a *provider locator* at the top left of website.

National Institute on Alcohol Abuse and Alcoholism

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) provides leadership in the national effort to reduce alcohol-related problems by conducting and supporting research in a wide range of scientific areas, including genetics, neuroscience, epidemiology, health risks and benefits of alcohol consumption, prevention, and treatment; coordinating and collaborating with other research institutes and Federal programs on alcohol-related issues; collaborating with international, national, State, and local institutions, organizations, agencies, and programs engaged in alcohol-related work; and translating and disseminating research findings to healthcare providers, researchers, policymakers, and the public. Additional information is available at https://www.niaaa.nih.gov/ or by calling 301-443-3860.

National Institute on Drug Abuse

The National Institute on Drug Abuse (NIDA) is a federal scientific research institute under the National Institutes of Health, U.S. Department of Health and Human Services. NIDA is the largest supporter of the world's research on drug use and addiction. NIDA-funded scientific research addresses the most fundamental and essential questions about drug use, including tracking emerging drug use trends, understanding how drugs work in the brain and body, developing and testing new drug treatment and prevention approaches, and disseminating findings to the general public, researchers, policymakers, and others. NIDA offers various resources for providers and clients in plain language. For more information see their website at https://www.drugabuse.gov/.

National Institute of Mental Health

The mission of National Institute of Mental Health (NIMH) is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. In support of this mission, NIMH generates research and promotes research training to fulfill the following four objectives: (1) promote discovery in the brain and behavioral sciences to fuel research on the causes of mental disorders; (2) chart mental illness trajectories to determine when, where, and how to intervene; (3) develop new and better interventions that incorporate the diverse needs and circumstances of people with mental illnesses; and (4) strengthen the public health impact of NIMH-supported research. Additional information is available at https://www.nimh.nih.gov/ or by calling 301-443-4513.

Seven Directions

Seven Directions is pleased to announce the publication of "Models of Tribal Promising Practices: Tribal Opioid Overdose Prevention Care Coordination & Data Systems." The interview and insights you provided were invaluable to the compilation of this brief, and we thank you for sharing your experience and expertise. We are also providing users the option of downloading each of the four highlighted approaches as stand-alone sections from the National Indian Health Board's Tribal Opioid Overdose Prevention webpage.

Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA provides many resources for providers and clients; for instance, recommendations for MAT treatment can be found in the TIP 63: Medications for Opioid Use Disorder Full Document at: https://store.samhsa.gov/product/TIP-63-Medications-for-Opioid-Use-Disorder-Full-Document/PEP20-02-01-006

Appendix B: Culturally Relevant Resources

I Know Mine

The I Know Mine website www.iknowmine.org/ is a trustworthy health resource for you(th) and their allies like providers, parents, teachers, aunties and uncles and other trusted adults. The Alaska Tribal Health Consortium (ANTHC) HIV/STD Prevention Program established iknowmine.org to provide Alaska Native and rural Alaska youth holistic health education and additional resources to promote healthy lifestyle choices. The website distributes educational materials and harm reduction resources, condoms, NARCAN® kits, safe medicine supplies and offers STI self-testing. I Know Mine also offers a Rural Harm Reduction Toolkit and the opioid puzzle will be available soon.

Cultural Resources for Alaska Families

The Cultural Resources for Alaska Families is a guide designed for use by the Office of Children's services (OCS) in the case planning process with Alaska Native parents and children involved in the child welfare system but is open

to use by any programs and partners who may benefit from its content. Find the full resource online at: http://dhss.alaska.gov/ocs/Documents/Publications/pdf/CulturalResourcesGuide.pdf.

Introduction to Motivational Interviewing For American Indian and Alaska Native Communities

The Urban Indian Health Institute created a two-page introduction to motivational interviewing and adaptation recommendations for American Indian and Alaska Native communities. Full resource can be found online at: http://www.uihi.org/wp-content/uploads/2013/08/Final-Resource-Guide-082213-CS_CO.pdf.

Appendix C: Provider Resources

American Society of Addiction Medicine

The American Society of Addiction Medicine (ASAM) was founded in 1954, is a professional medical society representing over 6,000 physicians, clinicians and associated professionals in the field of addiction medicine. ASAM is dedicated to increasing access and improving the quality of addiction treatment, educating physicians and the public, supporting research and prevention, and promoting the appropriate role of physicians in the care of clients with addiction. For more information go to their website: https://www.asam.org/.

Foundation for Opioid Response Efforts

The Foundation for Opioid Response Efforts (FORE) is a national, private, grant making foundation focused on inspiring and accelerating action to end the opioid crisis founded in 2018. FORE offers provider education, payer strategies, policy initiatives, and public awareness key to ending the opioid crisis. More information on opportunities for partnership and collaboration can be found on their website: https://forefdn.org/.

Opioid Response Network

The Opioid Response Network (ORN) is SAMHSA funded collaborative coalition created to provide training and address the opioid crisis. The Opioid Response Network has local consultants in all 50 states and nine territories to respond to local needs by providing free educational resources and training to states, communities and individuals in the prevention, treatment and recovery of opioid use disorders and stimulant use. More information about ORN and requesting training or education material can be found on their website: https://opioidresponsenetwork.org/.

Northwest ATTC Webinar Series

The ATTC Network is an international, multidisciplinary resource for professionals in the addictions treatment and recovery services field. The Northwest ATTC's monthly webinar series, which began with our first installment, January 31, 2018, will feature presentations on a wide range of topics of interest to the region. To register for a training or sign up for the ATTC mailing list go to their website at: https://attcnetwork.org/centers/northwest-attc/northwest-attc-webinar-series.

Provides Clinical Support System

The Providers Clinical Support System (PCSS) is a program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) created in response to the opioid overdose epidemic to train primary care providers in the evidence-based prevention and treatment of opioid use disorders (OUD) and treatment of chronic pain. The project is geared toward primary care providers who wish to treat OUD. PCSS is made up of a coalition, led by American Academy of Addiction Psychiatry (AAAP), of major healthcare organizations all dedicated to addressing this healthcare crisis. Through a variety of trainings and a clinical mentoring program, PCSS's mission is to increase healthcare providers' knowledge and skills in the prevention, identification, and treatment of substance use disorders with a focus on opioid use disorders. For more information go to their website at: https://pcssnow.org/

Regional Alcohol and Drug Abuse Counselor Training

The Regional Alcohol and Drug Abuse Counselor Training (RADACT) is dedicated to providing training opportunities for chemical dependency certification & behavior health counselor certification, clinical supervision and administration. RADACT strives to increase the educational level of individuals entering, or working in, the substance abuse counseling field by providing courses to meet the various degrees of experience and expertise found within our target populations. RADACT holds classes throughout Alaska and also offers correspondence courses. For more information go to their website: https://www.radact.com/.

Appendix D: Client Resources

Buprenorphine Practitioner Locator

Find practitioners authorized to treat opioid dependency with buprenorphine by state at SAMHSA buprenorphine provider locator: https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator.

Opioid Treatment Program Directory

The SAMHSA offers an opioid treatment program directory where you can view the opioid treatment programs in a State at their website: https://dpt2.samhsa.gov/treatment/directory.aspx

Substance Use Treatment Locator

The SAMHSA Substance Use Treatment Locator can be found at https://findtreatment.gov/. The Substance Abuse and Mental Health Services Administration (SAMHSA) collects information on thousands of state-licensed providers who specialize in treating substance use disorders, addiction, and mental illness. Results can be narrowed by location, types of treatment, medication assisted treatment availability, payment methods, age, language, and more.

SAMHSA's National Helpline – 1-800-662-HELP (4357)

SAMHSA's National Helpline is a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families facing mental and/or substance use disorders.

Behavioral Health Treatment Services Locator

The SAMHSA offers a Behavioral Health Treatment Services Locator, a confidential and anonymous source of information for persons seeking treatment facilities in the United States for substance use and/or mental health problems at https://findtreatment.samhsa.gov/. Results can be narrowed by location and services with more information for each service center including type of care, level of care, treatment approach, emergency services, license, payment options, ages accepted at that program, and more.

Opioid Fact Sheet

The Alaska Native Tribal Health Consortium developed the Opioid Fact Sheet in June 2021. The fact sheet provides information about opioids in the brain. By using the Schol-AR app available for free on iOS or Android app stores, you can view an image on the fact sheet through an augmented reality. You can find the three page Opioid Fact Sheet below (pp. 81-83).

Opioids and the Brain

Opioid use can change how a person's brain works. A doctor can prescribe medicine that reduces cravings and helps people with opioid use disorder stay in recovery.

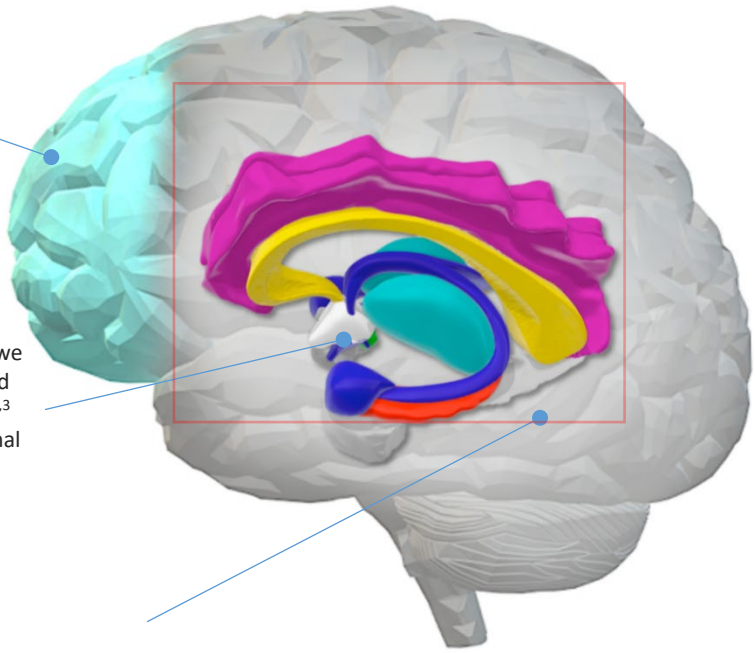
- Opioid use can reduce size of the prefrontal cortex – the cover on the front part of the brain. The prefrontal cortex does our long-term thinking and analysis.
- Opioid use can reduce size of the amygdala. The amygdala is important for emotional health. It helps us react the right way to family, friends, and situations.
- Brain changes from opioids can make it harder to see how risky things could hurt us.
- Brain changes from opioids can make it harder to make good long-term decisions.
- Brain changes from opioids can last many years, even after a person stops using opioids.
- What are opioids? Opioids include pain medicine like oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and fentanyl. Opioids include illegal drugs like heroin.
- For patients with opioid use disorder, Medication-Assisted Treatment (MAT) can block some of the effects of opioids. MAT can reduce cravings. Patients on MAT are less likely to die of overdose. They are more likely to stay in recovery.

PREFRONTAL CORTEX

This is the analytic part of our brain. Opioid use has been associated with decreased size in parts of the prefrontal cortex.[1] Damage to this part of the brain can change how a person analyzes situations.[2]

AMYGDALA

The amygdala is an almond-shaped structure. There's one on each side of the brain. The amygdala helps us process emotion and how we react to things. Opioid use has been associated with decreased size in parts of the amygdala.[1,3] Opioid use can make it harder for the emotional part of the brain to talk to the analytic part of the brain. That could change how a person processes information and makes decisions.[4]



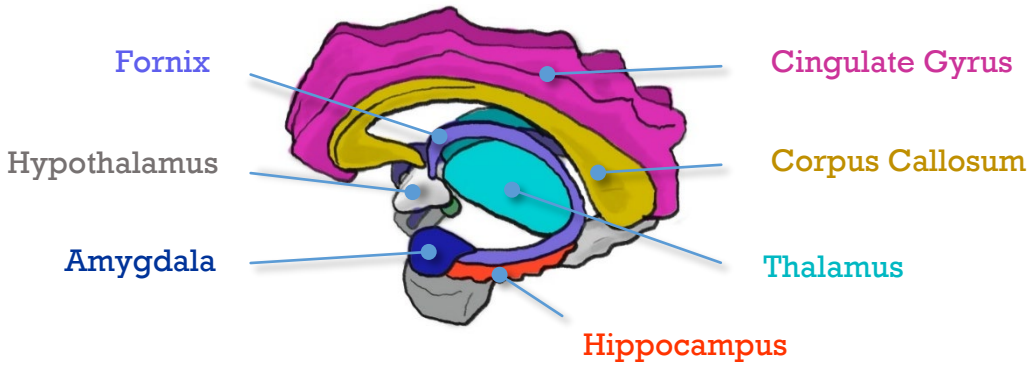
LIMBIC SYSTEM

The amygdala is part of the limbic system. The limbic system is group of brain structures that process emotion, sensory input, and memory. Opioids can change these structures.[4,5]

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

This is in your head. Here's what it does.

Your limbic system helps keep you happy, healthy, and safe from things that could hurt you.



FORNIX

- The fornix looks like a little cable attached to the hippocampus (the memory part of the limbic system).
- The fornix helps the hippocampus talk to other parts of the brain.

HYPOTHALAMUS

- The hypothalamus controls hunger, thirst, and the release of adrenaline. It helps us react fast to things that can hurt us.
- Opioid use can turn down the body's production of adrenaline, at least short-term.
- When someone stops using opioids, the hypothalamus may tell the body to make too much adrenaline. That can make a person feel nervous or sick.

HIPPOCAMPUS

- The hippocampus helps us learn and remember things.
- A person using opioids may not remember as well as they used to.[4]

THALAMUS

- The thalamus monitors everything we see, hear, smell, taste, and experience.
- The thalamus helps decide what combinations of things are important to remember and how to remember them.
- Some drugs can act on the thalamus to make sensory cues to addiction stronger.[6]

CORPUS CALLOSUM

- The corpus callosum manages the flow of information between the left and right sides of the brain.
- Studies have shown decreased functionality in parts of the corpus callosum in people who are opioid-dependent.[3]

CINGULATE GYRUS

- Connects the limbic system to parts of the brain that help us feel compassion and decide what's important.
- Opioid use can "rewire" the cingulate gyrus to make a person prioritize drug use, even when it hurts them and others.[3]

Make this 3D model with your cell phone.

1. Print this fact sheet OR display it on your computer screen.
2. Aim your iOS or Android phone camera at the above QR code. Install the Schol-AR app.
3. With the app open, aim your phone camera at the drawing of the limbic system on the previous page.
4. Use your phone screen to view the 3D model. Swipe the screen to rotate. Pinch to make the model bigger or smaller.

How to get Medication Assisted Treatment

Four Directions Medication Assisted Treatment (MAT) program in Anchorage involves prescribed medication(s) that can help customer-owners maintain abstinence from harmful drugs, alcohol, and tobacco.

Southcentral Foundation administers the treatment of opioid use disorder in the form of Suboxone and Naltrexone.

MAT is also available for alcohol and tobacco use disorders. MAT, in combination with recovery treatment in Four Directions, has been shown to increase the chance of sustained recovery.

CONTACT

Four Directions Outpatient Treatment Center
4000 Laurel St, Anchorage, AK, 99508
Tel. (907) 729-6300

For a complete list of MAT providers in Alaska,
see the Substance Abuse and Mental Health Services Administration,
U.S. Department of Health and Human Services, directory at:
https://www.samhsa.gov/medication-assisted-treatment/find-treatment

1. Lin, J. C., Chu, L. F., Stringer, E. A., Baker, K. S., Sayyid, Z. N., Sun, J., Campbell, K. A., & Younger, J. W. (2016). One month of oral morphine decreases gray matter volume in the right amygdala of individuals with low back pain: Confirmation of previously reported magnetic resonance imaging results. *Pain Medicine*, 17(8), 1497–1504.

2. Bechara, A., Damasio A.R., Damasio H., Anderson S.W. (1994). Insensitivity to future consequences following damage to human prefrontal cortex. *Cognition*, 50, 7-15.

3. Upadhyay, J., Maleki, N., Potter, J., Elman, I., Rudrauf, et al (2010). Alterations in brain structure and functional connectivity in prescription opioid-dependent patients. *Brain: A Journal of Neurology*, 133(Pt 7), 2098–2114. https://doi.org/10.1093/brain/awq138

4. Biernacki, K., McLennan, S., Terrett G, et al. (2016). Decision-making ability in current and past users of opiates: A meta-analysis. *Neuroscience and Behavioral Reviews*, 71:342-351.

5. Kutlu, M. G., & Gould, T. J. (2016). Effects of drugs of abuse on hippocampal plasticity and hippocampus-dependent learning and memory: contributions to development and maintenance of addiction. Learning & Memory (Cold Spring Harbor, N.Y.), 23(10), 515–533. https://doi.org/10.1101/lm.042192.116

6. Huang, A. S., Mitchell, J. A., Haber, S. N., Alia-Klein, N., & Goldstein, R. Z. (2018). The thalamus in drug addiction: from rodents to humans. *Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences*, 373(1742), 20170028. https://doi.org/10.1098/rstb.2017.002

Appendix E: Chart of 1115 Substance Use Disorder Medicaid Waiver Services

Chart of 1115 Medicaid Waiver Services: SUD (Substance Use Disorder) Services Descriptions

Unit	SUD Service Description	Procedure Code/Modifier	Provider
15 minutes	Outpatient Services ASAM 1.0 Individual	H0007 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Outpatient Services ASAM 1.0 Individual (Telehealth)	H0007 VI GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Outpatient Services ASAM 1.0 - Group (Adolescent)	H0007 HQ HA VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Outpatient Services ASAM 1.0 - Group (Adolescent) (Telehealth)	H0007 HQ HA VI GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Outpatient Services ASAM 1.0 - Group (Adult)	H0007 HQ HB VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Outpatient Services ASAM 1.0 - Group (Adult) (Telehealth)	H0007 HQ HB VI GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses

			• Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Intensive Case Management	H0023 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Intensive Case Management (Telehealth)	H0023 VI GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Ambulatory Withdrawal Management 1 WD	H0014 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
	ASAM 2-WM: Ambulatory Withdrawal Management Services with Extended On- site Monitoring - Adolescents and Adults		• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Daily	Clinically Managed Residential Withdrawal Management 3.2 WD	H0010 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians,, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Daily	Medically Monitored Inpatient Withdrawal Management 3.7 WD	HOOIO TG VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides

			• Peer Support Specialist
Daily	Medically Managed Intensive Inpatient Withdrawal Management 4.0 WD	H0011 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Daily	Medically Monitored Intensive Inpatient Services 3.7	H0009 TF VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Daily	Medically Managed Intensive Inpatient Services 4.0	H0009 TG VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Community & Recovery Support Services - Individual	H2021 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Community & Recovery Support Services - Individual (Telehealth)	H2021 VI GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Community & Recovery Support Services - Group	H2021 HQ VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist

15 minutes	Community & Recovery Support Services - Group (Tele health)	H2021 HQ VI GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Monthly	SUD Care Coordination	H0047 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Monthly	SUD Care Coordination (Telehealth)	H0047 VI GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Peer-Based Crisis Services	H0038 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates or behavioral health aides • Peer support specialists
Hourly	23 Hour Crisis Stabilization Observation	59484 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Psychologist • Mental Health Professional Counselor • Bachelors Behavioral Health Clinical Associate • Substance Use Disorder Counselor • Behavioral Health Aides • Peer Support Specialist
Per Call Out	Mobile Outreach and Crisis Response Services	T2034 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Licensed psychologists • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates • Behavioral health aide • Peer support specialist
Daily	Crisis Residential Stabilization	59485 VI	• Licensed physicians • Licensed physician assistants

			• Advanced registered nurse practitioners • Licensed registered nurses • Community health aide • Licensed psychologists • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates • Behavioral health aide • Peer support specialist
15 minutes	Intensive Outpatient ASAM 2.1 • Individual	HOOIS VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Community health aide • Licensed psychologists • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates • Behavioral health aide • Peer support specialist
15 minutes	Intensive Outpatient ASAM 2.1 - Individual (Telehealth)	HOOIS VI GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Community health aide • Licensed psychologists • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates • Behavioral health aide • Peer support specialist
15 minutes	Intensive Outpatient ASAM 2.1 - Group	H0015 HQ VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Community health aide • Licensed psychologists • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates • Behavioral health aide • Peer support specialist
15 minutes	Intensive Outpatient ASAM 2.1 - Group (Telehealth)	HOOIS HQ VI GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Community health aide • Licensed psychologists • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates • Behavioral health aide • Peer support specialist
	ASAM 2.1 Intensive outpatient services – adolescents and adult		• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
	ASAM Level 2.5 Partial hospitalization (PHP - Adult)		• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 138.250 • Substance Use Disorder Counselors

			• Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Per Assessment	Per Assessment Treatment Plan Development/Review	T1007 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community health aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral health clinical associates • Behavioral health aides • Peer support specialist
Per Assessment	Per Assessment Treatment Plan Development/Review (Telehealth)	T1007 VI GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community health aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral health clinical associates • Behavioral health aides • Peer support specialist
Daily	Partial Hospitalization	H0035 VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community health aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral health clinical associates • Behavioral health aides • Peer support specialist
	SUD Partial Hospitalization Program - Adolescents (PHP- Adolescents)		• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Daily	SUD Residential 3.1 (Adolescent)	H2036 HA VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Daily	SUD Residential 3.1 (Adult)	H2036 HF	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates

			• Behavioral Health Aides • Peer Support Specialist
Daily	SUD Residential 3.3	H0047 HF	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Daily	SUD Residential 3.5 (Adolescent)	H0047 HA VI TF	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Daily	SUD Residential 3.5 (Adult)	H0047 TG VI	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses supervised • Mental health professional clinicians • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
	ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services - Adolescents and Adults		• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
	ASAM Level 3.7 Medically Monitored Intensive Inpatient Services for Adults and Medically Monitored High Intensity Inpatient for Adolescents		• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
	ASAM Level 4.0 Medically Managed Intensive Inpatient Services - Adolescents and Adults		• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistant • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist

**Developed from the 4-Aug-2020 Chart of 1115 Medicaid Waiver Services AND the State of Alaska – Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services.

Appendix F: Chart of 1115 Behavioral Health Medicaid Waiver Services

Chart of 1115 Medicaid Waiver Services: Behavioral Health (BH) Service Descriptions

Unit	BH Service Description	Procedure Code/Modifier	Staff Qualifications
15 minutes	Home based Family Treatment Level 1	H1011 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Community Health Aide • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Home based Family Treatment Level 2	HI011 TF V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistance • Community Health Aide • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Home based Family Treatment Level 3	H1011 TG V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assist a nee • Community Health Aide • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Daily	Therapeutic Treatment Homes	H2020 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistance • Community Health Aide • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Assertive Community Treatment	H0039 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Behavioral Health Clinical Associates • Employment/Vocational Specialists • Behavioral Health Aides • Peer Support Specialists
Daily	Adult MH Residential Treatment Level 1	T2016 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners

			• Licensed registered nurses supervised by a physician or advanced nurse practitioner • Licensed practical nurses supervised by a physician or advanced nurse practitioner • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates • Behavioral health aides • Peer support specialists
Daily	Adult MH Residential Treatment Level 2	T2016 TG V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates or behavioral health aides • Peer support specialists
Daily	Children's MH Residential Treatment Level 1	H2033 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistance • Community Health Aide • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Daily	Children's MH Residential Treatment Level 2	H2033 TF V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Mental health professional clinicians 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistance • Community Health Aide • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Peer-Based Crisis Services	H0038 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates or behavioral health aides • Peer support specialists
Hourly	23 Hour Crisis Stabilization Observation	59484 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Psychologist . Mental Health Professional Counselor • Behavioral Health Clinical Associate • Substance Use Disorder Counselor • Behavioral Health Aides • Peer Support Specialist
Per Call Out	Mobile Outreach and Crisis Response Services	T2034 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses

			• Community Health Aide • Licensed psychologists • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates • Behavioral health aide • Peer support specialist
Daily	Crisis Residential Stabilization	59485 V2	• Licensed physicians • Licensed physician assistants • Licensed advanced nurse practitioners • Licensed registered nurses • Community health aide • Licensed psychologists • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates • Behavioral health aide • Peer support specialist
15 minutes	Intensive Case Management	H0023 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Intensive Case Management (Telehealth)	H0023 V2 GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Community **&** Recovery Support Services - Individual	H2021 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Community **&** Recovery Support Services - Individual (Telehealth)	H2021 V2 GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Community **&** Recovery Support Services• Group	H2021 HQ V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Behavioral Health Clinical Associates • Behavioral Health Aides

			• Peer Support Specialist
15 minutes	Community **&** Recovery Support Services• Group (Telehealth)	H2021 HQ V2 GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
Daily	Partial Hospitalization	H0035 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistance • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Intensive Outpatient 2.1- Individual	HOOIS V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistance • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Intensive Outpatient 2.1 - Individual (Telehealth)	HOOIS V2 GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistance • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Intensive Outpatient 2.1- Group	H0015 HQ V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistance • Behavioral Health Clinical Associates • Behavioral Health Aides • Peer Support Specialist
15 minutes	Intensive Outpatient 2.1- Group (Telehealth)	H0015 HQ V2 GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community Health Aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance Use Disorder Counselors • Certified Medical Assistants/Certified Nursing Assistance • Behavioral Health Clinical Associates • Behavioral Health Aides

			• Peer Support Specialist
Per Assessment	Treatment Plan Development/Review	T1007 V2	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community health aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates • Behavioral health aides • Peer support specialist
Per Assessment	Treatment Plan Development/Review (Telehealth)	T1007V2 GT	• Licensed physicians • Licensed physician assistants • Advanced registered nurse practitioners • Licensed registered nurses • Licensed practical nurses • Community health aide • Mental health professional clinicians, 7 AAC 70.990 (28) • Substance use disorder counselors • Behavioral health clinical associates • Behavioral health aides • Peer support specialist

**Developed from the 4-Aug-2020 Chart of 1115 Medicaid Waiver Services AND the State of Alaska – Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services.