Indian Health Service Program Evaluation Services

Community Opioid Intervention Pilot Projects FY 2021-2022 Report

Table of Contents

List of Figures

List of Abbreviations

Term	Abbreviation
American Indian and Alaska Native	AI/AN
Annual Progress Report	APR
Community Opioid Intervention Pilot Project	COIPP
Coronavirus Disease 2019	COVID-19
Full-time Equivalent	FTE
Indian Health Care Improvement Act	IHCIA
Indian Health Service	IHS
Intensive Outpatient Program	IOP
Kauffman & Associates, Inc.	KAI
Medication-assisted Treatment	MAT
Medication for Opioid Use Disorder	MOUD
Opioid Use Disorder	OUD
Syringe Exchange programs	SEP
Syringe Service Programs	SSP
Substance Use Disorder	SUD

Executive Summary

The Community Opioid Intervention Pilot Project (COIPP) program was first established by the Consolidated Appropriations Act of 2019, (Pub. L.116–6) and the accompanying Conference Report (H. Rpt. 116–9). IHS received this new appropriation of $10 million in FY 2019 to better combat the opioid epidemic by creating a pilot program to address the opioid epidemic in Indian Country and award grants that support the development, documentation, and sharing of locally designed and culturally appropriate prevention, treatment, recovery, and aftercare services for opioid use disorders in AI/AN communities.

This evaluation report provides insights into grantee sites' program efforts and achievements utilizing data obtained through IHS COIPP Program first year (April 1, 2021 – March 31, 2022).

The evaluation used a mixed-method design to collect summative data to address the evaluation questions aligned with the goals and objectives of the program. The evaluation plan aimed to address key program objectives:

- Increase public awareness and education about culturally-appropriate and family-centered opioid prevention, treatment, and recovery practices and programs in AI/AN communities.
- Create comprehensive support teams to strengthen and empower AI/AN families in addressing the opioid crisis in Tribal or urban Indian communities.
- Reduce unmet treatment needs and opioid overdose related deaths through the use of MAT.

This report is organized by the evaluation questions and provide a summary of supported activities, accomplishments, challenges and recommendations among COIPP grantees. The findings are also meant to inform the IHS COIPP grant program team of areas that may warrant further development and support to ensure success of the overall COIPP grant program.

The findings from this evaluation highlight the successes achieved by grantee sites through use of their IHS COIPP funding, but also revealed valuable insights in service capacity, challenges, and opportunities for IHS to revise behavioral health programs and inter-agency goals for AI/ANs impacted by opioid use disorder.

Introduction

The Indian Health Service (IHS) Department of Health and Human Services Grant Program Year 1 (April 1, 2021 – March 31, 2022) addressed the opioid crisis in AI/AN communities through the development of local projects that sought to expand community education and awareness of opioid misuse and opioid use disorder. In addition, these activities are to increase local knowledge and use of culturally appropriate interventions in the prevention, treatment and recovery for opioid use disorder including increased use of medication assisted treatment (MAT) for opioid use disorders. While the 2021 IHS Notice of Funding Opportunity included the term medication assisted treatment (MAT), more recently, the field has shifted to the use of medications for opioid use disorder (MOUD). This document will include use of MAT and MOUD to remain consistent with grantee responses to questions presented in the 2021 COIPP Annual Progress Report (APR).

This report presents findings from an evaluation of the 35 grantees who built and expanded their work to address the opioid crisis in their communities. While activities conducted among grantees are based on project objectives, the purpose of the COIPP evaluation is to:

- Understand how funding is being targeted to address the range of programmatic objectives of the grant.
- Discern grantee capacity for evaluation.
- Evaluate grantee's annual progress reporting.

The findings from this evaluation will highlight the successes achieved by grantee sites through use of their IHS COIPP funding. The findings are also meant to inform the IHS COIPP grant program team of areas that may warrant further development and support to ensure success of the overall COIPP grant program.

Background

The COIPP program was first established by the Consolidated Appropriations Act of 2019, (Pub. L.116–6) and the accompanying Conference Report (H. Rpt. 116–9). IHS received a new appropriation of $10 million in FY 2019 to better combat the opioid epidemic by creating a pilot program to address the opioid epidemic in Indian Country and award grants that support the development, documentation, and sharing of locally designed and culturally appropriate prevention, treatment, recovery, and aftercare services for opioid use disorders in AI/AN communities. In Fiscal Year 2021, the notice of funding availability was published and a release of awards was completed, resulting in 35 grantees. Under the funding opportunity, grantees are required to address the following objectives:

- Increase public awareness and education about culturally-appropriate and family-centered opioid prevention, treatment, and recovery practices and programs in AI/AN communities.

- Create comprehensive support teams to strengthen and empower AI/AN families in addressing the opioid crisis in Tribal or urban Indian communities.
- Reduce unmet treatment needs and opioid overdose related deaths through the use of MAT.

Thirty-five grantees were awarded through a competitive process in which grantees were selected from Tribal communities represented in rural and urban areas across the country. IHS attempted to prioritize projects focused on maternal and child health however, they did not receive applications with this as a primary focus.

From 1999 to 2009, the death rates involving opioid pain medications were higher among AI/AN populations than among any other racial or ethnic minority group. Drug overdoses have continued to trend upward for all races, but particularly among AI/AN, Black and White populations. During March to August 2021, overall drug overdose rates were highest among non-Hispanic Black or African American (hereafter Black) men
(61.2; 95% CI, 59.4-62.9) and AI/AN men (60.0; 95% CI, 52.8-67.2), and fentanyl-involved death rates were highest among Black men (43.3; 95% CI, 41.8-44.8).[1]

Results from the National Survey on Drug Use and Health, conducted annually by SAMHSA,[1] indicate that AI/AN adults have rates of illicit drug use, binge alcohol use, and substance misuse that are higher than the national average. Although this population demonstrates a greater need for substance abuse intervention, AI/AN people often fail to receive treatment because of a lack of health insurance,[2] a lack of community awareness of treatment options, shame that discourages them from seeking substance abuse treatment, or a lack of available treatment facilities or programs.[3, 4, 5, 6, 7, 8]

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[1] JAMA. (2022). *Racial and Ethnic Disparities in Drug Overdose Deaths in the US During the COVID-19 Pandemic.* Retrieved from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796547

[2] Results from the 2014 National Health Interview Survey, Table P-11a.

[3] Burrage, R., Gone, J., & Momper, S. (2016). Urban American Indian community perspectives on resources and challenges for youth suicide prevention. American Journal of Community Psychology, 58(1-2), 136-149. doi: 10.1002/ajcp.12080

[4] The Henry J. Kaiser Family Foundation. (2013). *Health coverage and care for American Indians and Alaska Natives* [Policy Brief]. Retrieved from http://kff.org/disparities-policy/issue-brief/health-coverage-and-care-for-americanindians-and-alaska-natives/

[5] IHS. (2011). *American Indian/Alaska Native Behavioral Health Briefing Book.* Washington, DC: U.S. Department of Health and Human Services. Retrieved from http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/2011_Letters/AIANBHBriefingBook.pdf

[6] Ibid: The NSDUH Report: Need for and receipt of substance use treatment among American Indians or Alaska Natives

[7] Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *The N-SSATS Report: Substance Abuse Treatment Facilities Serving American Indians and Alaska Natives*. Retrieved from https://roar.nevadaprc.org/system/documents/536/original/070909.pdf?1294418602

[8] U.S. Department of Health and Human Services. (2010). *To Live to See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults*. Rockville, MD: Center for Mental Health

Evaluation Methodology

The IHS conducted an evaluation of the COIPP Grant Program Year 1 (April 1, 2021 – March 31, 2022). This evaluation incorporated analyses of key quantitative and qualitative data including grantee applications and the grantee annual progress report (APR).

Evaluation Plan, Data Sources, and Analysis

The evaluation used a mixed-method design to collect summative data to address the evaluation questions aligned with the goals and objectives of the program. The evaluation plan aimed to address five key evaluation questions that included:

- How can COIPP grantees be described and categorized?
- How are grantees increasing public awareness and education about culturally appropriate and family centered opioid prevention, treatment, and recovery practices and programs in the AI/AN communities?
- How have grantees strengthened their comprehensive support teams to empower AI/AN families in addressing the opioid crisis in Tribal or urban Indian communities?
- How have grantees reduced unmet treatment needs and opioid overdose related deaths through MAT?
- What implications do the findings of this evaluation plan have on the sources of data used?
- To support answering the aforementioned evaluation questions, data from the COIPP grantee applications and from the IHS APR form were analyzed.

Specific to the COIPP applications, a qualitative narrative analysis was conducted to complete the inventory of grantee-identified measures and to categorize grantees by evaluation capacity needs to undertake program evaluation. Frequency analyses were conducted to support summarizing grantee measures and grantee evaluation capacity categorization. For APR data, frequency analysis of quantitative data was conducted and exploratory thematic analysis of open-ended qualitative data was conducted to identify themes and sub-themes.

Services, Substance Abuse and Mental Health Services Administration. Retrieved from http://www.sprc.org/sites/sprc.org/files/library/Suicide_Prevention_Guide.pdf

Logic Model

The logic model was informed by the IHS COIPP funding opportunity, as well as grantee sites' applications. Aspects of grantees' applications that were reviewed included grantees' summary of evaluation and logic models to discern the breadth of evaluation activities and measures across each of the three priority areas. The result, as seen in Figure 1, is a logic model designed to represent the shared system of values and how every element feeds into another. Sun, water, land, mountains, plants, trees are significant elements within all communities, with the tree representing life and growth as a result of the COIPP program.

Mother Earth cares for and supports the growth of everything we need to sustain life. The roots of the tree represent the reinforcements that drive priority areas of the COIPP whereby: 1) our family and the transfer of opioid prevention, treatment and recovery knowledge that is culturally-appropriate and family-centered; 2) the support systems we need to establish or strengthen and empower our families in addressing the opioid crisis; and 3) efforts that address unmet treatment needs and opioid overdose related deaths in our communities and may require innovative approaches and possibly new partnerships.

The trunk of the tree is important because it is the culmination of all resources and stakeholders that gather together to make the tree strong (i.e., community, family, external organizations—local, regional, state, federal).

As the tree grows, reaching upwards into the sky towards the sun, the sunshine represents culturally-responsive approaches to healing. The three shades of the sunlight are the short-, intermediate-, and long-term Native community change (outcomes). As with the journey of each passing day, the sun rising and setting is symbolic of the process in making lives better through the thinking, planning, progress and successes of every day toward making long healthy lives.

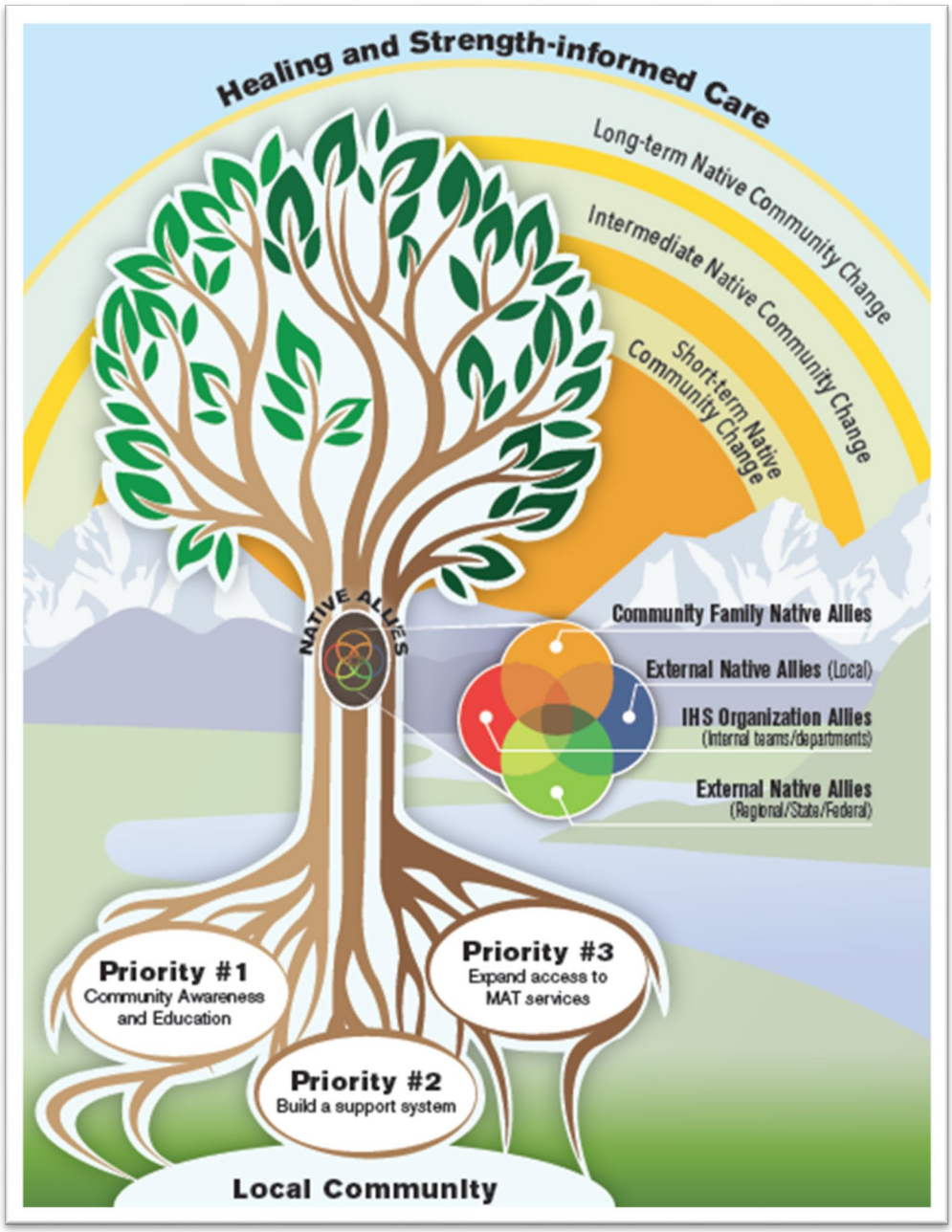


Figure 1: IHS COIPP Program Logic Model

Evaluation Findings

The evaluation findings provide a snapshot based on the analyses of qualitative and quantitative data sources gathered for the current program year (April 1, 2021 – March 31, 2022). This section provides an overview of the grantee sites, as well as how grantee sites increased public awareness and education, strengthened and empowered their support teams and AI/AN families in Tribal or urban communities, and reduced unmet treatment needs and opioid overdose-related deaths through MAT.

Overview of Grantee Sites

Overall, 35 grantee sites received IHS COIPP funding. This section of the report will provide an overview of the service population and services provided among all grantees, followed by an overview of each grantee's organizational and evaluation capacity to support their COIPP.

Organizational Capacity

During the current COIPP reporting period (April 1, 2021 – March 31, 2022) an average of 2.74 full-time equivalent (FTE) hours with a range of 0 to 9.6 FTE were allocated for the IHS COIPP program. A total of 92.5 FTE staff members were employed across all sites. In terms of hiring, an average of 4.2 staff were hired with a range of 0 staff to 18 staff hired per site. A total of 147 staff members were hired across all sites. Within staffing, 31 grantees reported having a long-term coordinator or director with an average of 0.77 FTE.

In the current reporting period, 21 grantee sites reported staff turnover. Common reasons for turnover included:

- Impacts due to the COVID-19 pandemic.
- Staff sought alternative employment, including remote work.
- Family and or personal reasons unrelated to COVID-19.

As a result of staff turnover, grantee sites reported various challenges that included:

- Inability to meet program goals or underspent funds.
- Additional time spent on training new staff.
- Delay in programming due to filling positions and or staff coverage.
- Decrease in participation and or services offered.

Out of the 35 grantees, 10 grantees were unaffected by the staff turnover.

Grantee Sites' Organizational and Evaluation Capacity

Overall, the majority of grantee sites established strong organizational and evaluation capacity. Specific to organizational capacity, the COIPP grant enabled grantee sites to maintain and hire staff members to support their efforts in their communities. However, the impacts of the COVID-19 pandemic affected the ability to maintain staff, which in turn resulted in more limited capacity to support and/or provide programming and services.

In terms of evaluation capacity, just under half of grantee sites were categorized as needing minimal support with developing and undertaking their program evaluation. However, the remaining grantees were categorized as requiring a moderate or high level of support. Finally, to support data collection, the majority of grantees use both manual and electronic health record systems.

Recommendations

- Include professional trainings in local logic model as measures of activities with short and long term outcomes.
- Grantee sites to understand their individual evaluation plans and evaluation capacity to better understand their support needs.
- Increase data collection plans that address gaps in current reporting, data on intake forms, baselines for interventions, and identify cross-site measures to understand other reportable observed changes at the macro/national level in opioid prevention and community awareness and education around substance misuse.
- Provide grantee sites with technical assistance to develop evaluation plans and tools to support their overall evaluation plans.
- Provide resources to grantee sites to support their evaluation needs (e.g. methods, tools, approaches, etc.) across each priority area of the COIPP grant program.

Increasing Public Awareness and Education

In alignment with objective one of the COIPP program, grantee sites aimed to increase public awareness and education about culturally-appropriate and family-centered opioidprevention, treatment, and recovery practices and programs in AI/AN communities. To support this priority, grantee sites conducted community educational events as well as professional trainings to support health care and non-health care professionals. This section provides an overview of the activities, and a summary of observed changes in the communities.

General Community and Educational Events

Among the 33 sites reporting on community and educational events funded by the program, an average of 19 events were conducted with a range of 0 to 193 events during the reporting period. The majority of grantees conducted events focused on education and prevention of opioid use disorder (n=32) followed by events focused on recognizing opioid overdose and administering Narcan. Less than half of all grantees focused on safeguarding controlled prescription medications (Figure 2).

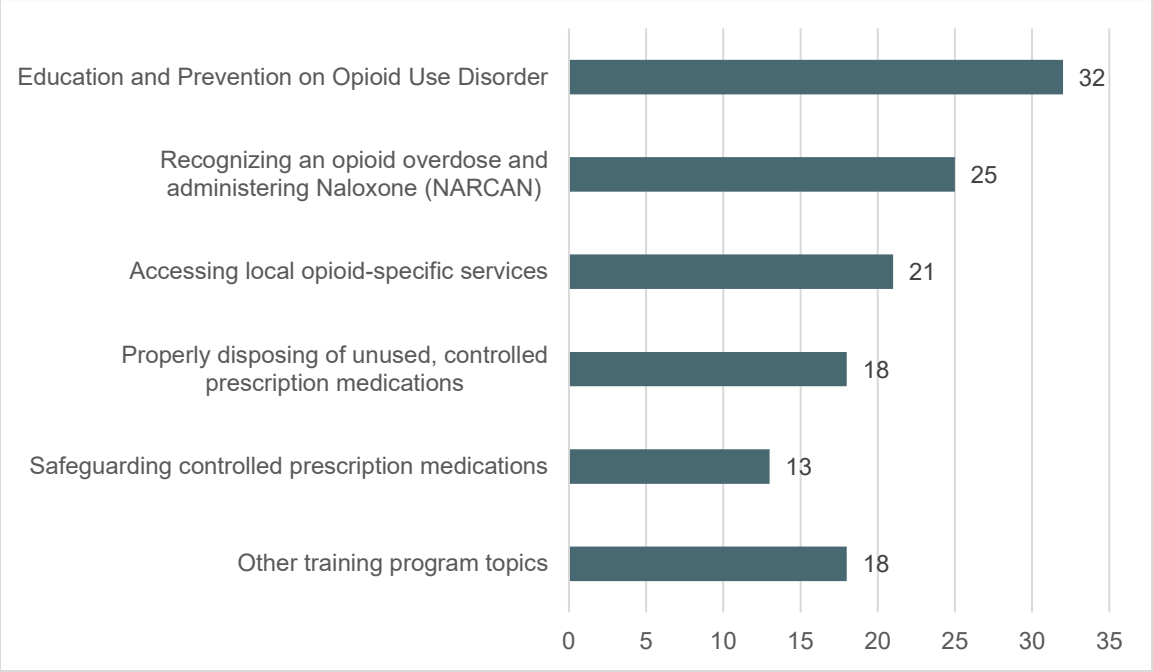


Figure 2: Number of grantee sites that performed activities by activity type

Grantees conducted a variety of events meant to increase public awareness around opioid prevention, treatment and recovery. The majority of these events were centered around providing education and prevention on OUD to the community, as well as education on Narcan administration and recognizing the signs of an overdose. In particular, there was a concentrated effort in the area of de-stigmatization and the necessity for harm reduction efforts; programs were aware that improvement in these areas was needed to impact substance use and overdose deaths. Program sites also conducted media campaigns around awareness, utilizing a combination of social media and traditional media (e.g., television ads) to reach their population.

Of the five types of listed community educational events, a total of 23,612 participants attended. Forty-seven percent of these participants attended education and prevention on opioid use disorder events (n=11,114; Figure 3).

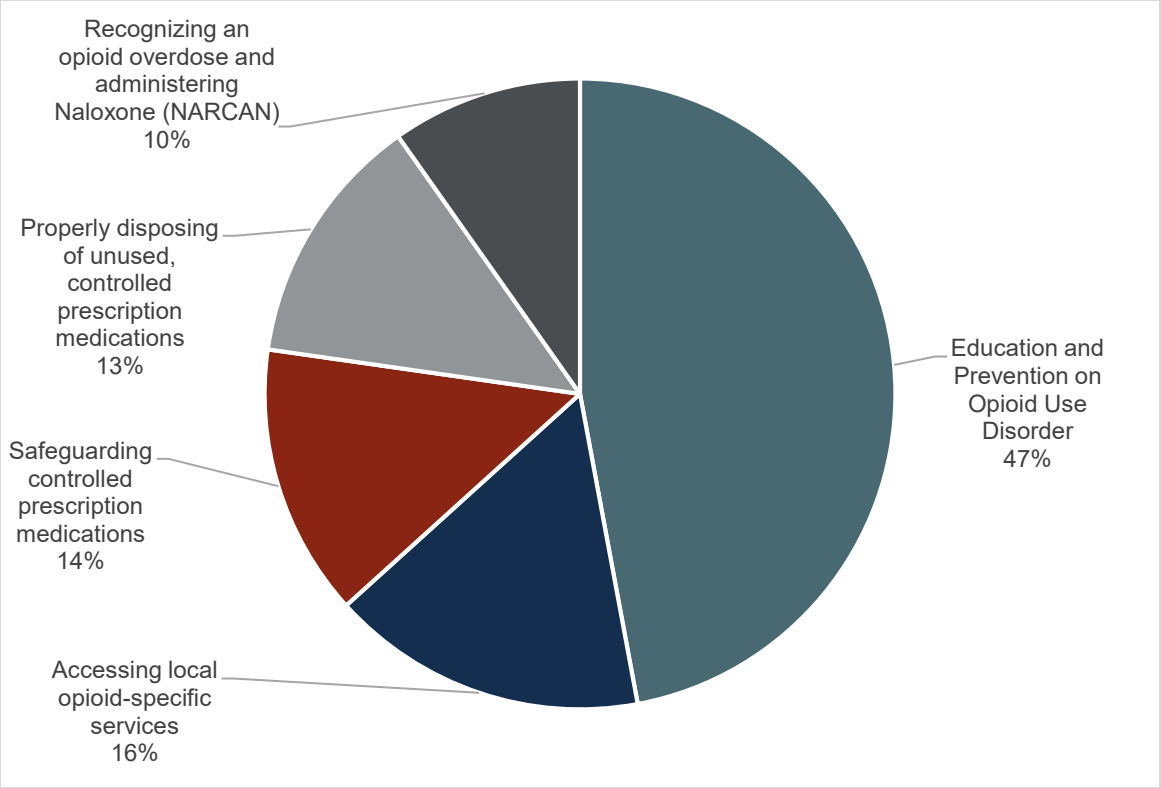


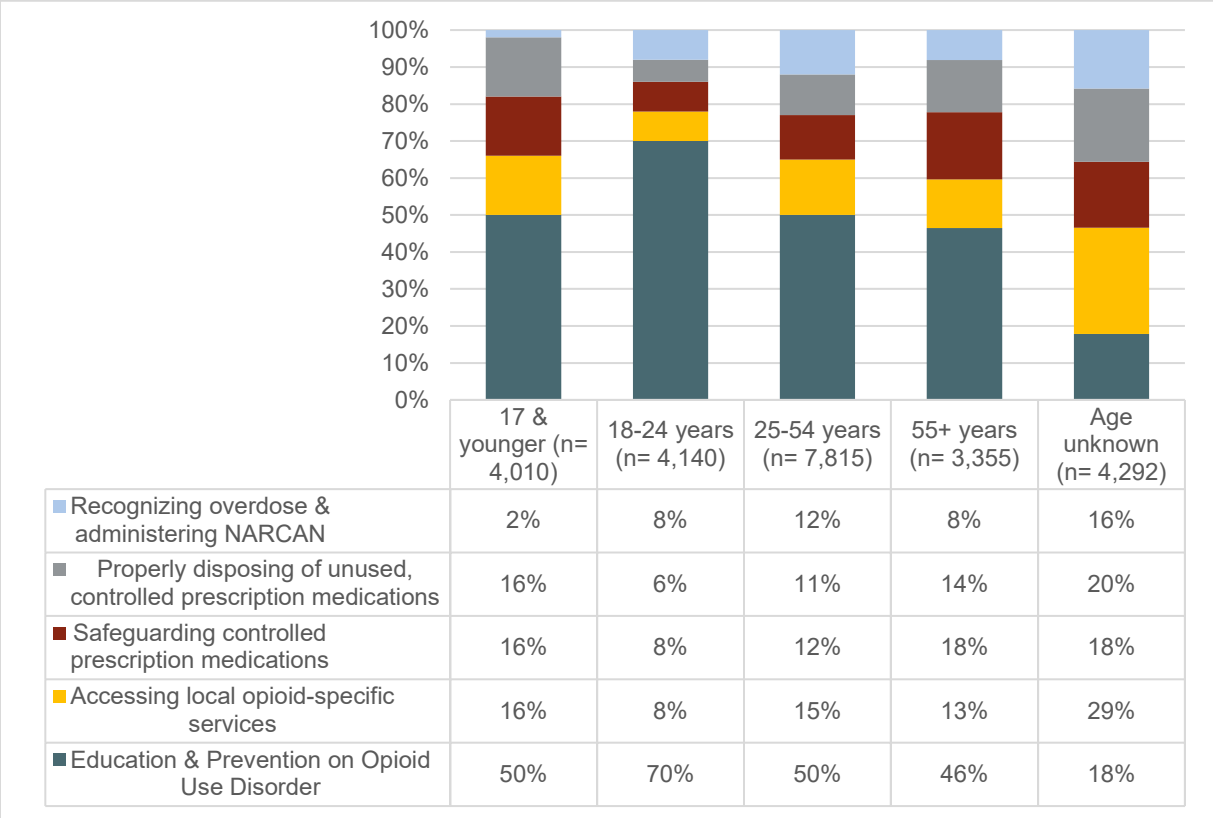
Figure 3: Participation by community educational event type

Equally important to understanding the types of trainings supported through the COIPP is learning about the participants. This report asked each grantee to report attendance for community trainings by program area. Attendance was examined by the following age cohorts:

- ≤17 years
- 18 to 24 years
- 25 to 54 years
- ≥ 55 years

A fifth category labeled “Age unknown” was used to recognize variances in the way age data are collected and recorded, as well as non-reporting by participants which may reflect a personal choice to remain anonymous. The greatest number of participants were those 25 to 54 years (n=7,815, 33%). As seen in Figure 4, across all age categories, the most attended community educational event was education and prevention on opioid use disorder, except where participants’ age was unknown, and

the most attended event was accessing local opioid-specific services. The least attended across all age categories was recognizing opioid overdose and administering Narcan, except for those 18-24 years, where the least attended event was properly disposing of unused, controlled prescription medications.



	17 & younger (n= 4,010)	18-24 years (n= 4,140)	25-54 years (n= 7,815)	55+ years (n= 3,355)	Age unknown (n= 4,292)
Recognizing overdose & administering NARCAN	2%	8%	12%	8%	16%
Properly disposing of unused, controlled prescription medications	16%	6%	11%	14%	20%
Safeguarding controlled prescription medications	16%	8%	12%	18%	18%
Accessing local opioid-specific services	16%	8%	15%	13%	29%
Education & Prevention on Opioid Use Disorder	50%	70%	50%	46%	18%

Figure 4: Participation in community/educational events by age

Eighteen grantees indicated they had conducted other community educational event topics. An extensive list of topic themes are listed below:

- Accessing Treatment
- Art Therapy
- Awareness & De-Stigmatization of Substance Use Disorder
- Crisis Stabilization
- Cultural Activities
- Current Drug Trends
- Drug Concealment Trends
- De-Escalation Training
- Drug Takebacks
- Mindfulness
- Motivational Interviewing
- Narcan Utilization Training
- Nutrition
- Outreach
- Peer and Family Support Groups
- Polysubstance Use
- Prison Reintegration
- Protective Factors

- Botvin Life Skills Training for Middle Schools
- Drug safety training for Middle Schools
- Fentanyl Education
- Grief Education
- Harm Reduction
- Historical Trauma
- Homelessness and COVID-19
- Mental Health First Aid
- Mental Health Trainings
- Question, Persuade, Refer (QPR) Training
- Social Media Trends and Drugs
- Science of Addiction and Addiction Medicine
- Substance Misuse
- Suicide Prevention Trainings
- Traditional Teachings
- Trauma-Informed Care
- Vaping Education
- Violence

To further understand the population served, grantee sites indicated the number of individuals who self-reported as homeless and received services or participated in program activities. Across all grantees, 484 individuals self-reported as homeless. Figure 5 depicts this group of individuals by age. The majority of this group of participants were between 25 and 54 years of age (62%). Recognizing variances in the way age data are collected and recorded, an “unknown age” category was included and accounted for 2% of those who reported being homeless. This is an important factor to understand as it may be the only point of entry to such services for homeless participants.

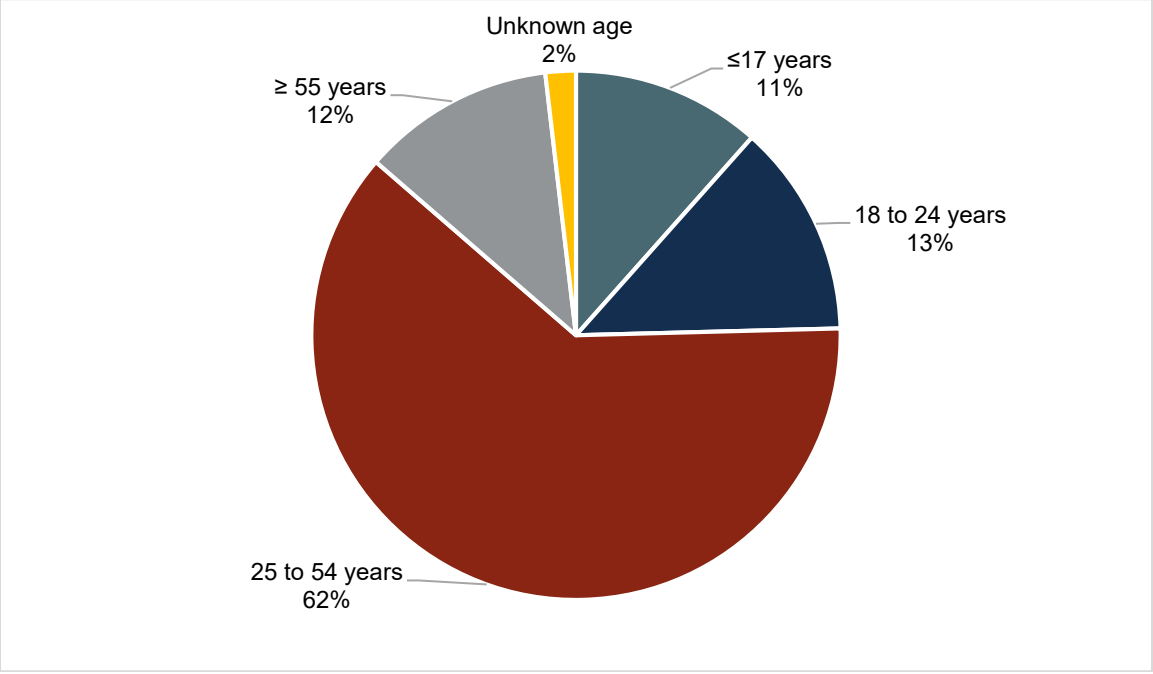


Figure 5: Participants self-reported as homeless by age category (n=484)

Homelessness is an enormous problem in the United States. The most recent Annual Homelessness Assessment Report to Congress reports substantial racial disparities: AI/AN compose 2.8 percent of people experiencing homelessness but are only 1 percent of the U.S. population. A prevalence study of Native American adults found that one-third had experienced homelessness (Whitbeck, Crawford, and Sittner Hartshorn 2012); and Morton, Chavez, and Moore (2019) found a 12.2 percent prevalence rate among AI/AN young adult, three times the rate of their White peers. Indigenous people are three to four times more likely to experience homelessness than their White counterparts (C.Garcia, Sept. 2022)

Homelessness is a risk factor for many other preventable health conditions. There are three types of ways health and homelessness relate to one another: 1) health problems that occur before but lead to homelessness, 2) health problems resulting from homelessness, and 3) failed or deterred treatment due to homelessness thus exacerbating the health condition(s). (Committee on Health Care for Homeless People, 1988)

Professional Trainings

Although most awareness efforts centered on the community, trainings were also provided in the same areas for healthcare and non-healthcare professionals, including law enforcement, teachers, and crisis response volunteers. Grantee sites also provided trainings to health care professionals and non-health care professionals to support increasing public awareness and education about culturally-appropriate and family-centered opioid prevention, treatment, and recovery practices and programs in AI/AN communities.

Among health care professionals, 21 grantee sites reported conducting trainings across four main health care professions, reaching a total of 1,979 professionals. As seen in Figure 6, the majority of participants who attended these trainings were non-licensed staff (65%) followed by behavioral therapists (19%). Of the 12 grantees who indicated “other,” the following additional categories of participants were identified:

- General health care professionals and medical facilities
- Program Manager
- White Bison Traditions Men
- Pharmacists
- Volunteer crisis response teams
- Family nurse practitioners
- Physician Assistants

Three grantees indicated they did not conduct COIPP-related trainings for health care professionals in Year one.

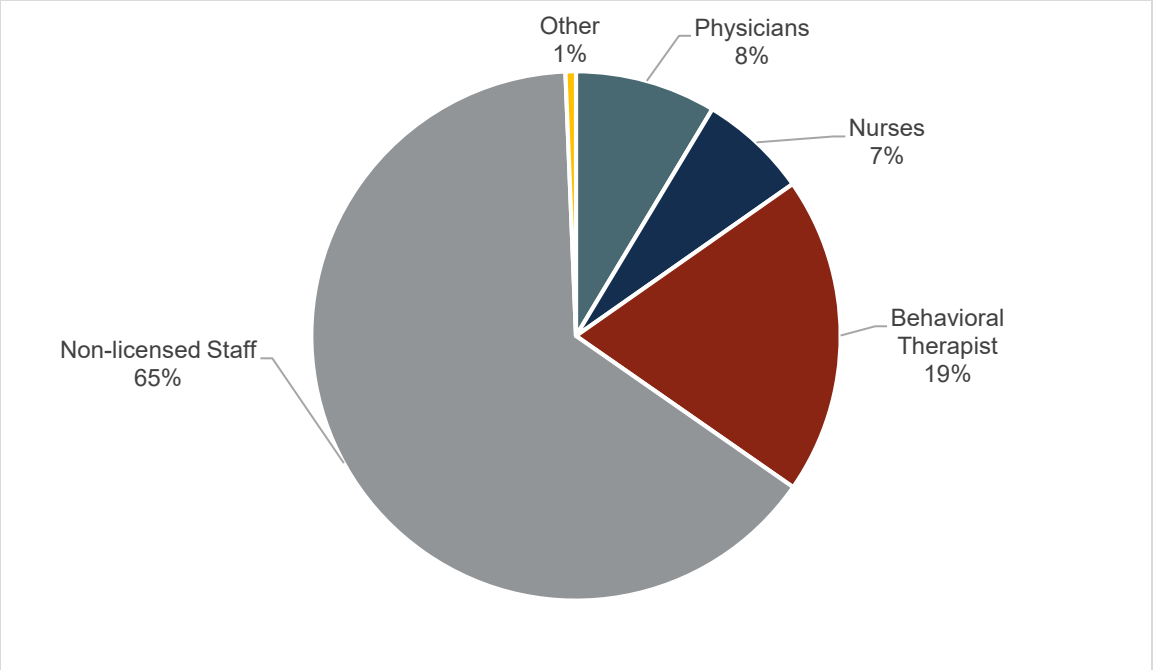


Figure 6: Attendance of healthcare professional trainings by profession (n= 1,979).

Twelve grantee sites indicated training of non-health care professional trainings conducted in their community. Figure 7 provides an overview of the total number of trainings conducted across four main location types. The majority of trainings were conducted within partner agencies (39%), followed by social-cultural gathering settings (28%).

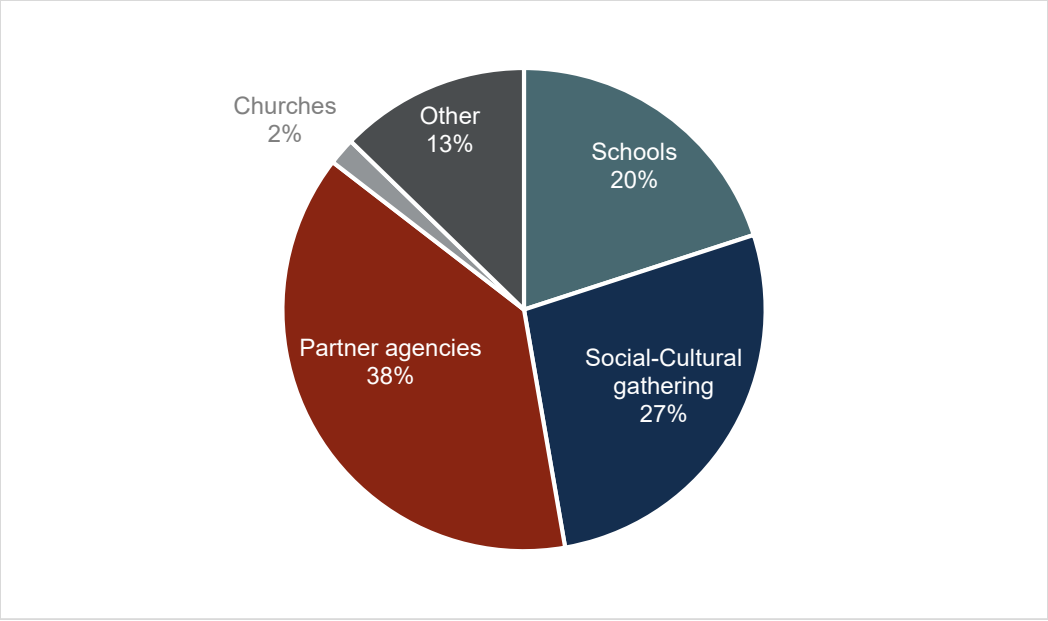


Figure 7: Number of non-health care professional trainings conducted by setting (n=54)

Six grantee sites indicated trainings conducted in other settings, which included:

- Online or telehealth recovery staff and Tribal workers
- Other Tribal communities
- Tribal coalitions
- County-level project teams
- Virtual health fairs
- General public offerings
- Opioid task forces
- Community health partners

Observed Changes in Community Education Events and Professional Trainings

Community awareness can be a difficult phenomenon to measure. Despite this, many grantee sites were able to rely on a range of creative indicators to gain an idea of the impact of their outreach efforts. Most used quantitative measures, including surveys, community readiness assessments, and attendance numbers. Social media analytics and verbal feedback also provided some grantee sites insights indicative of a shift in awareness among the community. In particular, the increase in help-seeking behaviors from those seeking services for family or friends, shows an increase in knowledge of the signs of substance use and addiction, as well as awareness of local available services.

As a result of community education events and professional trainings, 29 grantee sites reported numerous observed changes in opioid prevention and community awareness and education around substance misuse. The remaining six grantee sites reported that they did not observe any changes yet or had limited capability to conduct activities due to the COVID-19 pandemic.

Specific to changes in opioid prevention, grantee sites observed positive changes including:

- Greater interest in substance abuse prevention.
- An increase in outreach efforts to vulnerable communities (e.g., street outreach efforts, homeless camps and shelters).
- Emergence of community-based opioid prevention activities (e.g., new prevention planning committee with community partners, more non-health care professionals, including law enforcement, involved in trainings).
- Increase in medication disposal kiosks, naloxone, and fentanyl test strips.
- Increase in referrals for opioid use disorder.

Some grantee sites observed an increase in substance use among intensive outpatient program clients and a lack of opioid-specific programs conducting outreach in their

communities as a result of the COVID-19 pandemic and limited access to services. As described by one grantee:

> *"During the COVID-19 pandemic there has been an increase of utilization of opioids and fentanyl, which not only us, but other agents within our community have responded to by increasing the outreach, educational materials, and distribution of Narcan at very diverse events where we can reach the most vulnerable communities."*

For education and events, grantee sites observed a range of positive influence across their communities. First, there was an increase in educational materials distributed and interest in services and events provided also increased. Examples include: Narcan education and training, opioid education webinars (e.g., de-stigmatization, historical and intergenerational trauma, and community readiness), opioid crisis and prevention, youth prevention activities, and drug takeback events. Events supported an increased understanding and use of traditional medicines, while also fostering an opportunity to engage and educate non-Natives in Tribal practices. Furthermore, these activities increased education of local agencies on services offered, while also increasing accessibility.

With each education and event, grantees also saw increased interest in education and support materials, as well as services for youth and guardians, and for those who know someone living with SUD.

Public engagement to build community awareness was also fostered through social media. Many grantees used social media to support prevention and educational awareness and experienced greater reach and traffic to their page engagements and posts, as well as increased followers. Primarily, grantees used social media analytics to measure community awareness and interest. Increasing social media interactions, television campaign ad clicks, and online opioid overdose response kit requests provided a glimpse into growing awareness of opioid and substance misuse within the community.

Through the many efforts of grantee sites, a shift in community awareness was also observed. More specifically, grantee sites reported an increase in community engagement and awareness of substance use, as well as a shift in recognizing and using cultural-specific prevention efforts throughout a community. As a result, gradual shifts in attitudes and stigma towards opioid use were observed. As quoted by one grantee site:

> *"There is still stigma regarding mental health and substance abuse however, the community is becoming increasingly more willing to openly talk or ask about options. Because of the efforts that [grantee site] is making, the non-Tribal community is becoming more conscious of the practices of the tribe which they share a community with."*

Some grantees also measured this shift in a variety of ways, including using before and after surveys for community awareness events. In addition, grantees gathered participation and attendance numbers, with several noting the increase in participation as a sign of the success of the awareness events.

Grantees indicated that verbal feedback was an often-used indicator of whether community members were benefiting from such training. Many reported that there was not only much positive verbal feedback following training events, but there was also an increase in help-seeking behaviors in the community. Current patients were requesting new services they had recently learned about, and family and friends were calling to discuss service options for family members or friends suffering from substance use.

With increased community awareness of opioid use and prevention, comes increased understanding of the signs of overdose. This is illustrated by another grantee site who stated:

> *"Within the community there has been an increase in recognizing the signs of overdose and how Narcan can potentially prevent death. Because of events and media, community members are more actively reaching out for help."*

Among professionals, trainings supported professional development and individual growth. In fact, some grantee sites observed more non-healthcare professionals (e.g., law enforcement and local opioid task forces) participate in trainings. Grantee sites also observed an increase in self-esteem, a deeper understanding of historical trauma from both native and non-native professionals, and increased sense of AI/AN pride. To illustrate this, one grantee shared the following:

> *"During this debrief session it['s] common to hear people make connections between historical events and their own family systems and communities. It's also common for non-Indigenous participants to express a deeper understanding of how trauma has impacted Alaska Native communities. Evaluation results indicate that the exercise instills Alaska Native pride, including pride from non-Indigenous participants. Non-Indigenous participants expressed pride in serving Alaska Natives. Furthermore, many people felt like the exercise helped them grow as professionals and individuals."*

Finally, although many grantee sites reported an increased interest in Narcan training, as well as an increased distribution harm reduction efforts (e.g., Narcan kits, fentanyl test strips, suboxone treatment, etc.) across their communities, some grantees were still working to build awareness in their communities. To illustrate this grantee's situation:

> *"It has come to our attention that Fentanyl is making its presence known in the community and surrounding areas. There has been an increase on overdoses and overdose death, as well as a Narcan shortage. Another observation is the*

extent of how many community members are unaware that Narcan exists. Many people state they do not know what Narcan is when they approach our booth."

However, only two programs mentioned the use of culturally-informed programmatic activities in this section: a "Culture is Healing" presentation on harm reduction, and the use of the Alaska Blanket Exercise for trauma. While many programs incorporate culturally-tailored methods throughout their treatment and services, it appears that this was less incorporated into public awareness events. Recognizing that each grantee site and community is unique, grantees identified their innovative approaches to provide education and training below:

- Integration of culturally relevant colors, logos, images in branding
- Participant handbook with cultural and local resources
- Created a Recovery Support Application
- Medicine Wheel Wellness training for teachers
- Monthly Red Road event with community speakers
- "Addicted America": monthly live interviews
- White Bison Wellbriety training
- Healing through Painting sessions
- Alaska Blanket Exercise groups
- Youth Mindfulness sessions
- Culturally-appropriate clinic name
- Drive-thru health fairs and community meals
- Equinox and Solstice celebrations
- Elder Box Project

Media Campaign Approaches

Media campaign tools were used by 33 grantee sites to support building awareness and education in their communities. As depicted in Figure 8, the most used media campaign used was Facebook (n=32), followed by Tribal website (n=19) and Instagram (n=14).

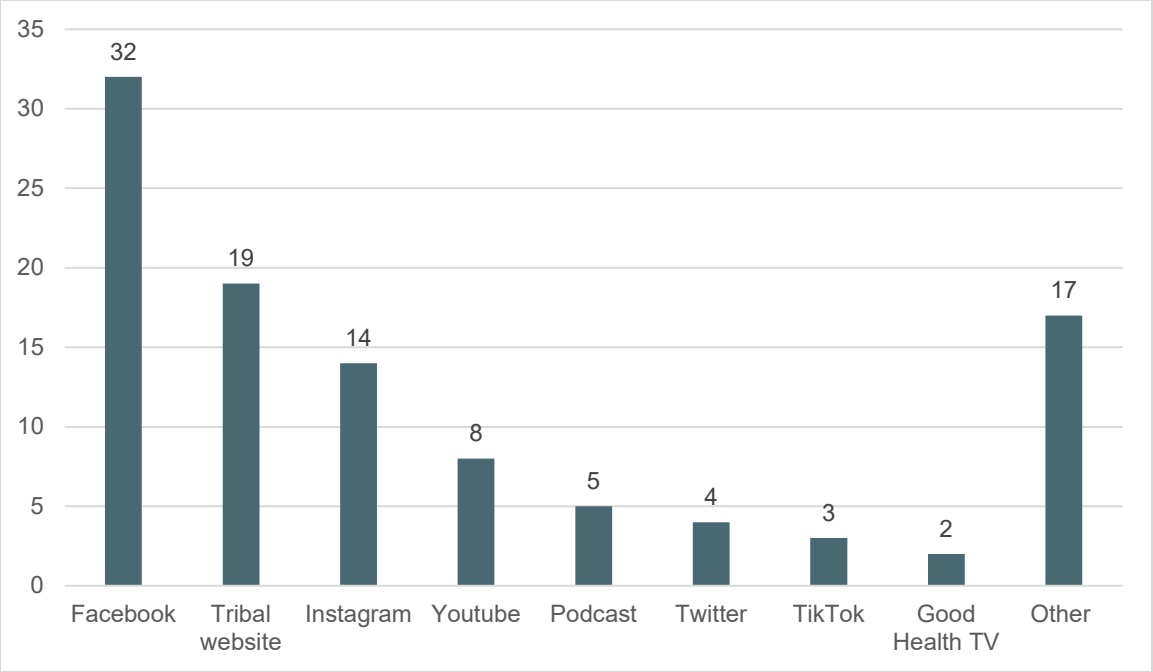


Figure 8: Media campaign tools used by grantee sites to build awareness of their program.

Seventeen grantees indicated the use of other media campaign tools and included:

- Brochures
- Factsheets
- Website (internal and external partners)
- Billboards
- Publications, posters, flyers, newsletters
- Community Panel
- Local Presentations, events (in-person or virtual)
- Videos
- Local radio
- Newspaper ads
- Email distribution lists
- Local television news station
- Lummi TV

Grantee sites were further asked to report on the use of IHS COIPP funds for radio, television, or billboard ads focused on opioid use prevention, disorder, and/or treatment messages. Only 8 grantee sites reported using these media methods. Figure 9 summarizes the total number of ads created and the total number of times ads were aired by media type for all 8 grantee sites. Specific to radio, 6 ads were created and

were aired 77 times. A total of 21 TV ads were created and were aired 97 times. Finally, a total of 15 billboards were created.

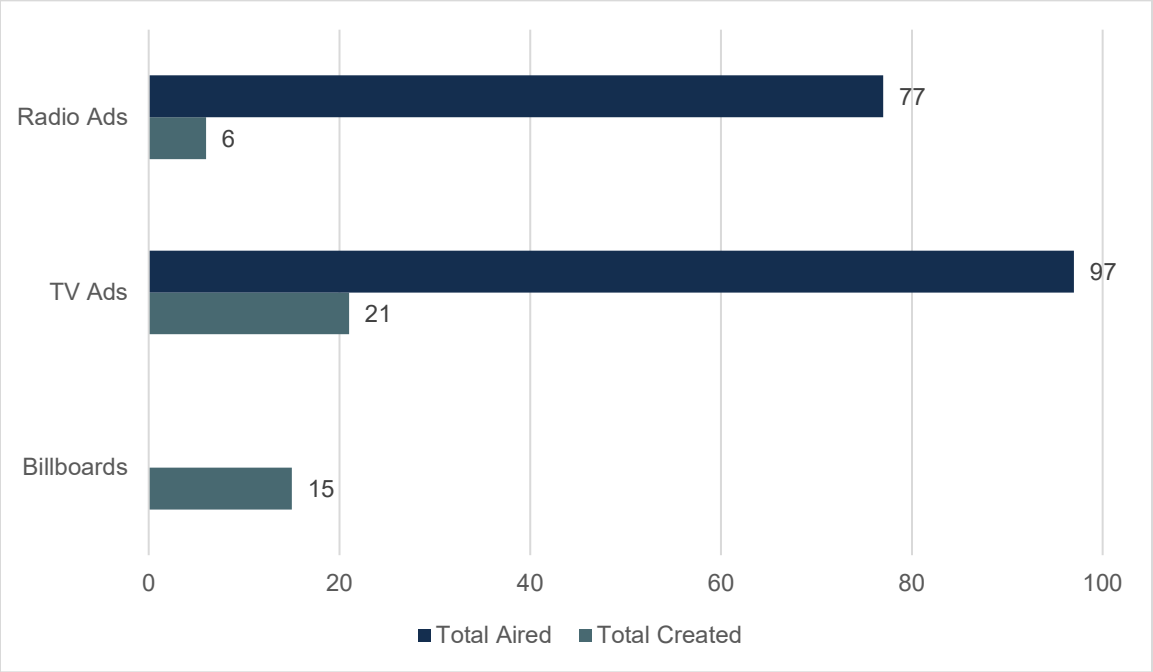


Figure 9: Number of radio, TV, and billboard ads created and aired

Accomplishments and Challenges

Overall, 31 grantee sites reported on their accomplishments. Major accomplishments identified were providing adolescent, youth, and family centered programs and activities, and expanding community partnerships with tribes, local public health departments, community-based organizations, public schools, and higher education institutions. Such partnerships led to greater engagement with youth to support substance use prevention and outreach, including developing life skills training and awareness information. Much of this work was reported to have been grounded in a cultural-community framework. New partnerships led to expansion of community outreach with different target audiences. In addition, partnerships increase opioid prevention and treatment awareness with health care providers, community members, behavioral health and mental health professionals, medical personnel, and non-licensed staff.

Some grantee sites were successful in expanding their program reach and adapted their curriculum to continue to meet change in needs and engage with youth and their families. Examples of youth and family centered curriculum, programs, and activities include:

- Healing of the Canoe Projects' Culturally Grounded Life Skills Youth curriculum

- Youth Gathering of Native Americans (GONA) training
- Youth safety camps
- Education and prevention booths at school events
- Little Earth youth and family empowerment programs
- Youth-focused integrated model for prevention, treatment, and recovery
- Youth representation
- Creators Game
- Youth and family listening sessions to better understand their needs
- Youth representation on Opioid Concerns Community Advisory Board

Through thematic analysis of the open-ended survey question responses from 32 grantees about challenges and barriers revealed, the primary theme of the continued impact of COVID-19. Due to the unpredictability of the COVID-19 pandemic, grantees were challenged with the following:

- Providing patient access to facilities and care
- Adapting in-person patient care for virtual settings
- Hiring and staff retention
- Changing healthcare policies and safety protocols, (5) communication and outreach strategies, and (6) decrease of patient visits.

Recommendations to increase public awareness and education about culturally-appropriate and family-centered opioid prevention, treatment, and recovery practices and programs in AI/AN communities.

- Develop a community of learning on culturally-tailored initiatives that integrate Tribal values and cultural practice to support awareness and education regarding opioid use disorder, prevention, intervention, treatment, and recovery.
- Increase the number activities that bring community awareness and education to safeguard prescription medications, for safe disposal of prescription medications, especially among adults 18-24 years of age.
- Prioritize health education activities among individuals 17 years or younger to recognize overdose and administration of NARCAN.
- Increase the number of COIPP grantees that provide opioid use disorder prevention, treatment, and recovery related trainings for health care professionals.
- Disseminate educational and training materials and information about services for youth and guardians, living with SUD.
- Establish and disseminate local, Tribal and regional plans to access naloxone supplies.

- Identify best-practices for engaging and improving delivery of services for opioid use disorder for special populations such as youth and people who are homeless.
- Identify and share best practices in developing comprehensive support teams including critical roles identified by position, responsibilities, and full or part-time status.
- Implement local evaluations to characterize observed changes reported by grantees in the prevention and community awareness and education around substance misuse.
- Increase local grantee technical assistance to developing metrics and data collection sources on awareness/education to evaluate activities and trainings. As an example, future data collection may consider cross-tabs analysis to understand differences across organizations.
  Establish program guidance and communication protocols between program official and grantee to enhance data collection activities and the quality of reported data.
- Explore impact, target, and penetration for use of radio, television, or billboard advertisements focused on opioid use prevention, disorders, and/or treatment messages.

Strengthening and Empowering Support Teams and AI/AN Families

The COIPP aims to develop and strengthen comprehensive support teams that address the negative health effects and social burden of opioid use disorder. In alignment with priority two, this section reports on efforts to strengthen comprehensive teams in addressing the opioid crisis in Tribal or urban Indian communities. This section highlights the partnerships and support teams established, group therapies and activities undertaken, as well as any trauma-informed care and support services provided across grantee sites.

Partnerships and Support Teams

Critical to this effort, is a cross-system collaboration with other community sectors to provide appropriate and timely screenings and services—especially with law enforcement, emergency departments, social services, legal services, education, health care providers, behavioral health, shelters, and advocacy groups. In pursuit of this priority area, grantees focused on capacity building in order to provide comprehensive support teams to AI/AN families. This is particularly evident through the establishment of many new MOUs/MOAs, as well as numerous new and continuing partnerships with, primarily local, organizations. A total of 68 Memorandum of Understanding (MOU) or Memorandum of Agreements (MOA) were established to support the programs across all grantee sites. On average, each grantee site established two MOU/MOAs. Of programs that reported establishing any MOU/MOAs, the lowest reported amount was one, and the highest number established was 10.

Only eight grantee sites provided information on the new and existing partnerships that they formed in support of their programs. Out of a total of 56 partnerships, 16 were new partners and 40 were existing partners. The services offered through the partnerships encompassed a broad range of needs, including recovery support services, intensive outpatient treatment (IOP), and cultural activities.

Within the first year, grantees primarily focused on three key activities; establishing new partnerships, expanding support services (crisis intervention, mental health, outpatient and wrap around services), and finally cultural activities. A full list is provided below:

- Council Collaboration
- Cultural Activities
- Family Support
- Intensive outpatient programs
- Medications for Opioid Use Disorder
- Opioid Prevention
- Outreach
- Professional Development
- Recovery Services
- Referrals
- Resources and Technical Assistance
- Shelter/Housing
- Support Services
- Syringe Service Program
- Training/education
- Youth Services

Support groups consisted of crisis response teams, advocacy/prevention groups, multidisciplinary coordination groups, and elder and youth advisory councils. Of all grantee sites, 10 reported facilitating the establishment of youth advisory councils, while six reported establishing elder advisory councils. More than half (19) of the programs established multidisciplinary coordination groups, with 16 grantee sites also establishing advocacy/prevention groups. Twelve of the programs established crisis response teams, with a total of 23 individual entities involved and 127 group members (Figure 10).

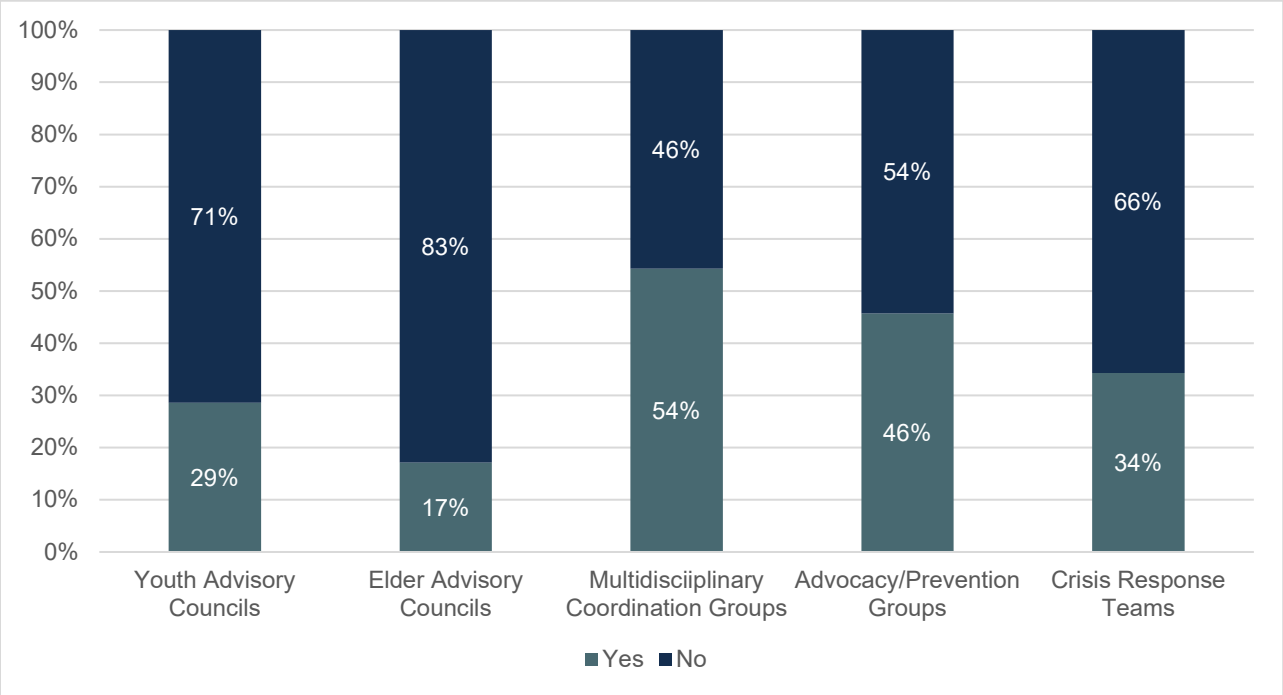


Figure 10: Percent of grantee sites with support groups by group type (n=35)

Grantee sites were also asked to report on the number of meetings held with each group/team they facilitated Figure 11. Multidisciplinary coordination group meetings were most held meetings, with over half (53%) of total meetings reported as this group type. Elder advisory councils met about half as frequently as multidisciplinary coordination groups, representing about 23% of all meetings. Youth advisory councils made up 14% of meetings, while crisis response team meetings were 9%. There were no reported meetings of advocacy/prevention groups.

While the majority of grantees reported establishing multidisciplinary coordination groups, who the groups consist of remains unclear.

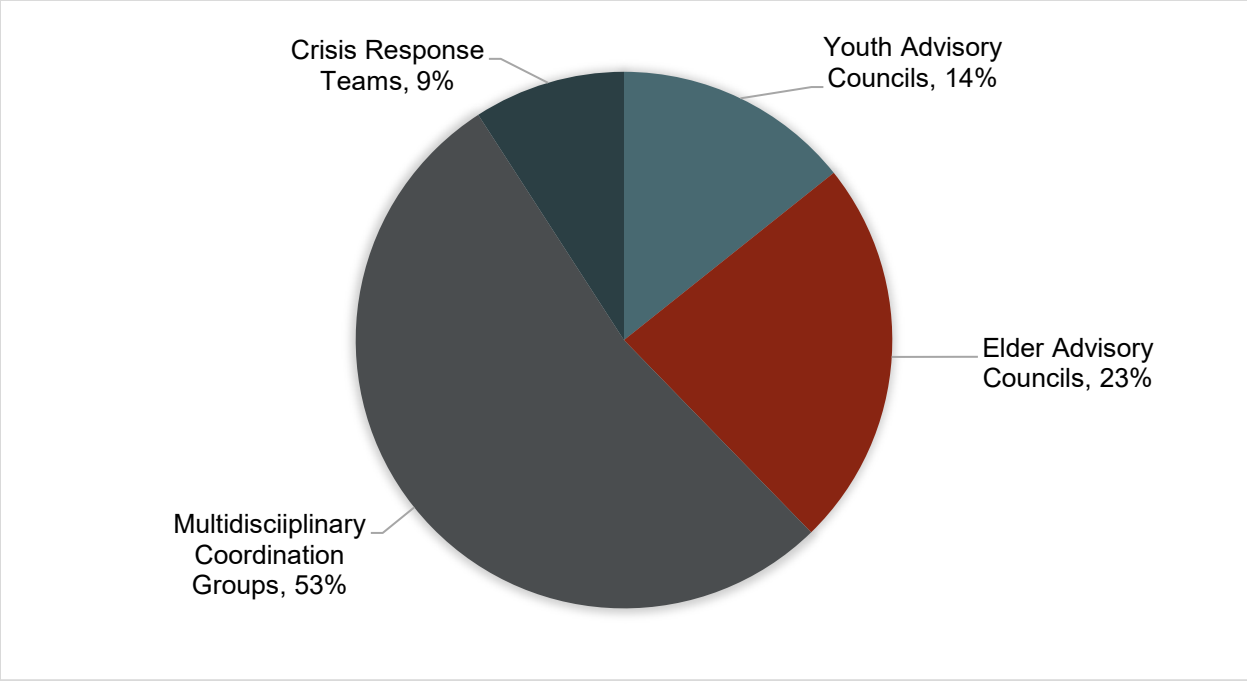


Figure 11: Meetings held by group/team (n=175)

Behavioral Health Services

Through these partnerships, programs were able to offer many additional services, such as recovery support services, intensive outpatient treatment and cultural activities.
Group Therapies

To support AI/AN families in addressing the opioid crisis in Tribal or urban Indian communities, 27 grantee sites reported offering group therapy sessions. In the current program year, a total of 2,622 group therapy sessions were hosted. In terms of participation, 22 grantee sites reported a total of 1,362 community members participated in the sessions.

Referral Management
The 20 grantee sites (57%) that provided programs of support services for family members of individuals experiencing or diagnosed with opioid use disorder were mostly for access and referral to counseling and resources. Other services included cultural activities and support groups.

Grantee sites described their program's approach and method to coordinate and refer family members of individuals experiencing or diagnosed with opioid use disorder, with most indicating referral to resources within their organizations and to external resources. Referral to peer support specialists, recovery coaches and counseling were described most. Counseling was another approach described by the grantees. One grantee had a specific program, "CRAFT", which is designed for families.

"*We have several staff members trained in Community Reinforcement and Family Training (CRAFT). This therapy is for loved ones of those experiencing a SUD to motivate their loved one to reduce their use, motivate their loved one to seek treatment, and to improve their own qualities of life*."

"…*providing capacity building services to Tribal communities in building and strengthening services for families of individuals with an opioid use disorder*."

Family-based care, including roles of mentors and volunteers were described by the grantees, of their program's innovative approaches. Most grantee sites recognized community events or activities for innovative approaches, with trained peer support specialists, recovery coaches, and staff coordinating the activities and working with families. Some of the programs are planning, or conducting family days, nights or group sessions.

"*Indigenous services provides activities for families that revolve around culture and spirituality, such as winter storytelling and spring, summer, fall garden prep and harvest. Opioid intervention and prevention is interwoven whether through providing educational materials at such events or access to staff who can facilitate enrollment in services*."

"… *utilizes Peer Mentors to guide families and individuals impacted by the opioid crisis. Their roles vary including teacher, encourager, support, and cultural mentor.*"

Peer Support Specialists

Engaging peer support specialists throughout the continuum of care for the programs were also valued by patients. In addition to community and resource navigation, the peer support specialists conduct cultural practices to assist with addressing opioid crisis in their communities. As highlighted by one grantee site: *"Through the use of recovery coaches and peer support specialist, the Tribe has been able to connect with clients within their own community and home through in person visits."*

Integration of Culture and Tradition in Programs and Activities

Integrating culture and Tribal values into programs is one strategy to ensure programs and activities are appropriate for the community served. Majority of grantees reported integrating Tribal values and culture within their treatment/sobriety efforts (34 grantees). Figure 12 depicts the types of cultural activities grantee sites' support teams used to integrate Tribal values and culture into their treatment/sobriety efforts. The top three used Tribal traditions or cultures included Equine Therapy (n=25) followed by traditional games (n=17), and dancing (n=13).

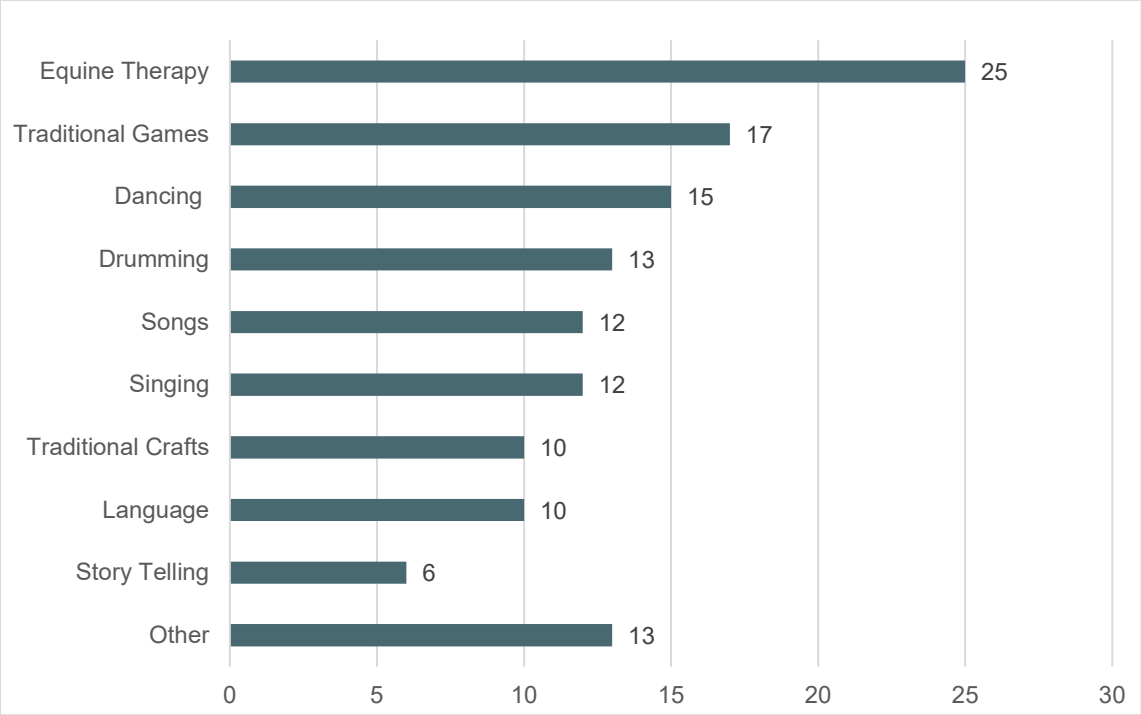


Figure 12: Cultural activities offered by program with treatment/sobriety efforts (n=133)

Thirteen grantee sites reported other Tribal values and cultural approaches they integrated into their treatment/sobriety efforts. These other activities included:

- Alaska blanket exercise
- Craft-making (e.g., medicine bags, drums, beadwork)
- Concept of kinship
- Cultural healing library
- General traditional and cultural practices and ceremonies (e.g., spearing, plant gathering, birch bark gathering; gourd-dance, Native hymn singing, etc.)
- History education
- Including elders
- Language speakers
- Medicine Wheel Perspective
- Opening blessings
- Red Road material
- Sweat lodge ceremonies
- Sharing a meal
- Talking Circles
- Traditional medicine
- Wellbriety meditation
- White Bison Program
- 12 Step programs

As quoted by one grantee site, some Tribal values and cultural resources are being adapted and incorporated to support their patients:

"White Bison, Red Road educational material are used to support our patients in their desires to achieve sobriety through native traditional practices. As well we incorporate wellbriety meditation of the day during each group session."

"[Grantee] offers culture is prevention to not only our MAT participants but to patients and community members as a whole. Where beading, drumming and other traditional practices are taught and shared."

To illustrate another way Tribal values and cultural approaches are integrated, another grantee site described the following:

"In the spring our clients are to take part in spearing, plant gathering, and birch bark gathering. In the Summer we able to fish, camp, and medicinal plant gathering. In the fall we are able to harvest wild rice, and plant gathering. In the winter we able to fish, and share our traditional stories."

The impact of providing culturally-tailored activities to their Tribal or urban communities was described by the grantees as "integral for participants' recovery," and has shown in research to be a protective factor for health and social outcomes among AI/AN people.[9] Many grantees observed these approaches to be popular and serve as tools to build connection and trust, while also making culture accessible. As quoted by one grantee site:

"Being able to provide culturally tailored services to our clients is huge. Many of our clients have little to no knowledge on lots of our cultural practices though they live on the reservation. Being able to give them access to those cultural pieces they want is vital to our program growth."

Having staff members who were also Tribal members brought cultural awareness to services provided and improved connectedness and trust with participants. Moreover, the benefit was described as mutual for both patient and provider whereby:

"Having these experiences, for the client demonstrates a desire of the provider to understand and be part of the community. Providers who use culturally tailored services are able to gain client trust and better help them succeed in their programs."

At the same time, one grantee site indicated that the integration of Tribal values and culture into programs is similar to, "walking the fine line of how the activities should be

[9] Journal of Primary Prevention. 2017 Apr;38(1-2):5-26. doi: 10.1007/s10935-016-0455-2. Identifying Protective Factors to Promote Health in American Indian and Alaska Native Adolescents: A Literature Review, Henson M1, Sabo S2, Trujillo A3, Teufel Shone N4.

presented, when trying to serve many Tribal nations, who are all very diverse in their practices."

Although the COVID-19 pandemic interrupted in-person services, many grantees continued to support their communities through virtual programming. Finally, some grantee sites reported they are just beginning to integrate Tribal values and culture into their programs. One grantee site indicated that they are working with local Native healers and practitioners to develop ways of integrating Tribal values and culture into their programming.

Religious, Spiritual, and/or Faith-based Services Linked to Program Activities

Faith-based programs have demonstrated effective partnerships for SUD recovery offering both spiritual and peer support recovery groups that offer faith-based approaches and principles to prevent relapse. The majority of COIPP grantee sites (n=31) reported religious, spiritual, and/or faith-based services link to their program activities. The top three used by grantee sites as depicted in Figure 13 were traditional practices (n=27), prayer (n=23), and therapy/counseling that was not spiritually informed (n=22).

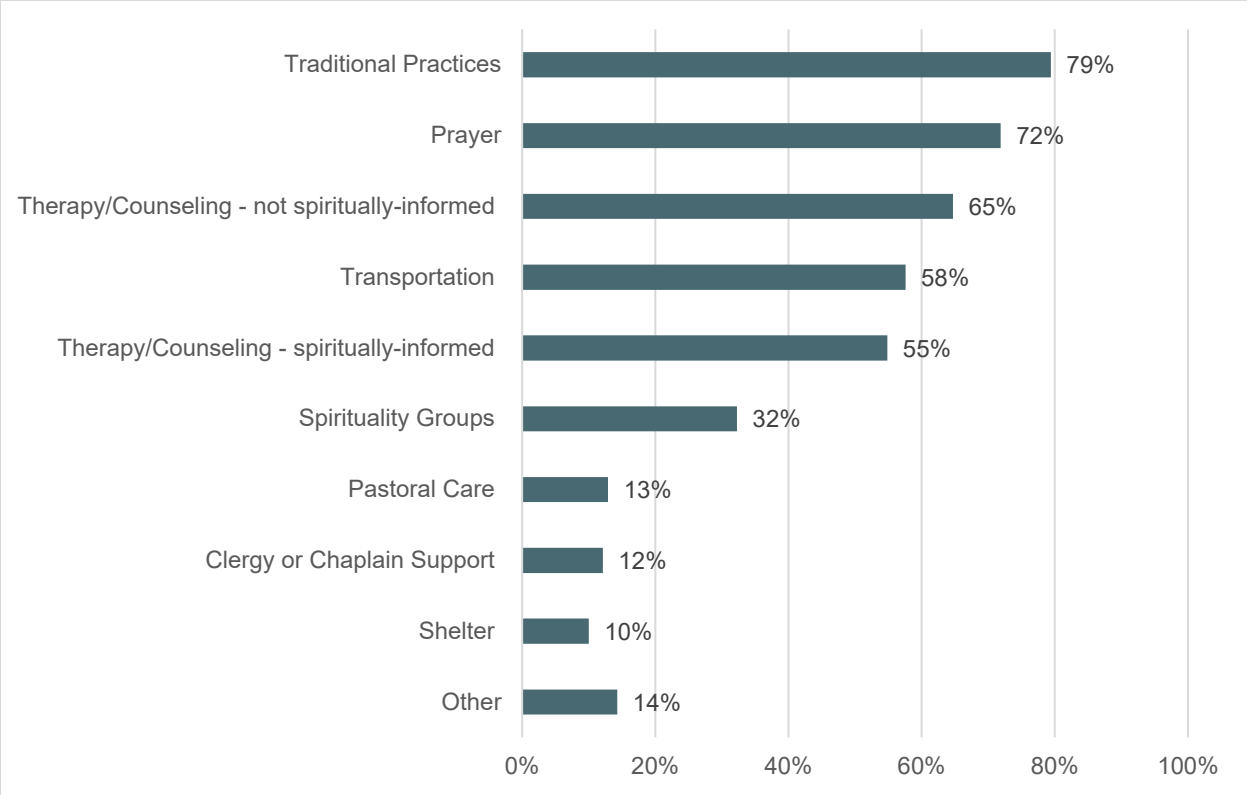


Figure 13: Grantee sites with religious, spiritual and/or faith-based services linked to programmatic activities (n= 31)

Three grantees identified other types of religious, spiritual, and/or faith-based services used in their programmatic activities, which included:

- Wellbriety meditations
- Sage de la Pena healing
- Culture is prevention program
- Chief traditional health officer
- Sweat lodges
- Traditional fasting
- Wellness activities
- Cultural art activities

As reported by grantee sites, providing religious, spiritual and/or faith-based services had a positive impact for the client's treatment and recovery. . As quoted by one grantee site:

"Participants who are involved in some form of faith-based services display more optimistic behaviors and a higher resilience to stress which can help in the overall recovery process."

Linking spiritual services with activities also helps with maintaining sobriety. Most of the grantee sites stated they make the services available, and clients can use the services if they choose.

Trauma-informed Care and Support Services

Developing and implementing a trauma informed approach to address trauma, including historical trauma, is necessary to comprehensively address the root causes of SUDs. In addition, organizations that are trauma informed will not only ensure its system understands the prevalence and role of trauma in patient care but will promote self-care to prevent secondary traumatic stress, which can lead to compassion fatigue and burnout. Of the 35 grantees, 28 consider their organizations as being trauma-informed in terms of policies, procedures, rules and practices. A total of 801 individuals in the communities served were trained on trauma-informed care. As depicted in Figure 14, 38% were health care professionals, 37% were program staff, and 25% were community members.

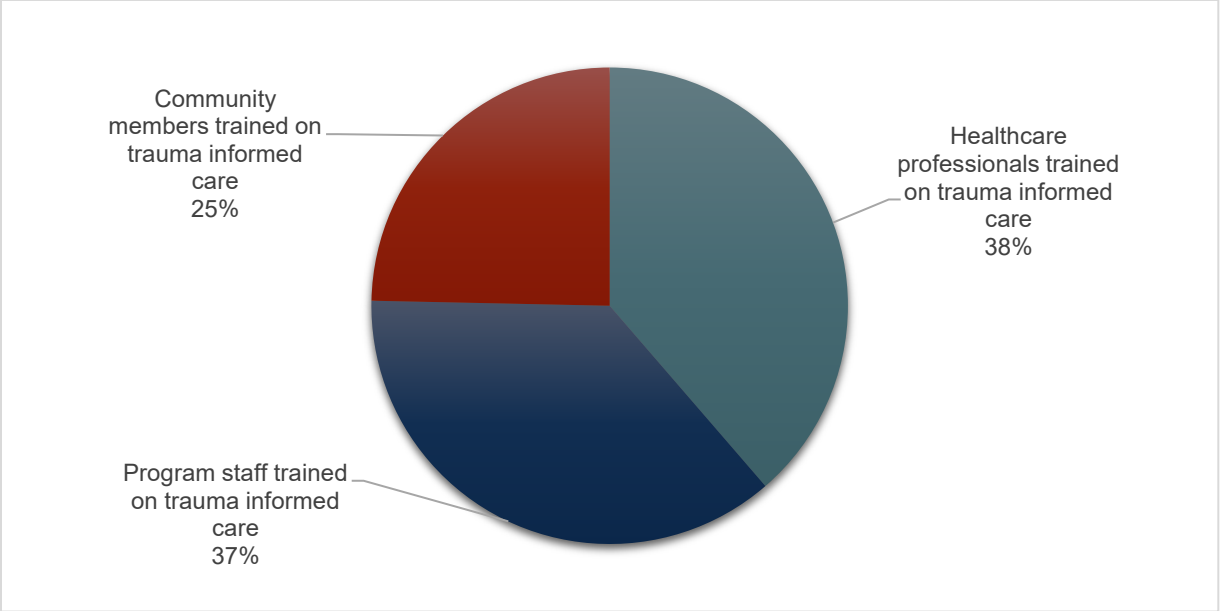


Figure 14: Individuals trained in trauma-informed care (n=2,072)

Grantee sites had various support services in place that addressed provider burnout numbered (n=22) and efforts to address compassion fatigue (n=20). For family members of individuals experiencing or diagnosed with opioid use disorder, 20 grantee sites reported offering support services for them as shown in Figure 15.

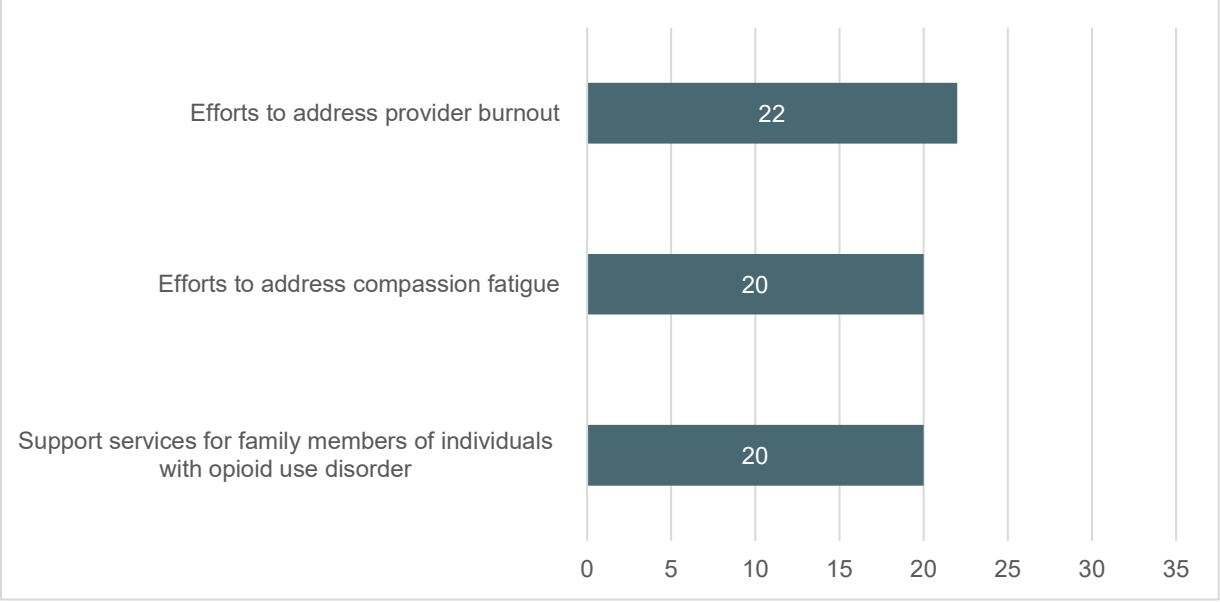


Figure 15: Grantee sites with support services (n=35)

In addition to the reported 801 community members trained on trauma-informed care, grantees reported that 63% of all programs had support services in place for their team

with efforts to address provider burnout and compassion fatigue. Most programs included wellness activities, which includes, what one grantee described as “Wellness Wednesdays”, where employees are treated to a free workout class. Another program offered a work/life balance program,

“The Work/Life Balance Program reaches out to specialists to help with balancing work and life issues for providers and all staff. These experts are available 24/7 providing short term help and referrals available for additional care.”

Other activities to address provider burnout included mindfulness and team activities. Personal time off was listed as a support service, with one grantee including 6.5 weeks of personal leave for their providers. Another service was staff check-ins where burn out was addressed.

Grantee sites described similar efforts to address compassion fatigue of their staff, with many of the same responses identified from provider burnout above. In fact, many of the grantees did not separate provider burnout from compassion fatigue. Another grantee, stated that they used “practice peer-supervision to address compassion fatigue.” Employee assistance programs were used to address compassion fatigue along with burn out, for several of the programs. The 20 grantee sites (57%) that provided programs of support services for family members of individuals experiencing or diagnosed with opioid use disorder were mostly for access and referral to counseling and resources. Other services included cultural activities and support groups.

Grantee sites described their program’s approach and method to coordinate and refer family members of individuals experiencing or diagnosed with opioid use disorder, with most indicating referral to resources within their organizations and to external resources. Referral to peer support specialist, recovery coaches and counseling were described most. Counseling was another approach described by the grantees. One grantee had a specific program, “CRAFT”, which is designed for families.

“We have several staff members trained in Community Reinforcement and Family Training (CRAFT). This therapy is for loved ones of those experiencing SUD to motivate their loved one to reduce their use, motivate their loved one to seek treatment, and to improve their own qualities of life.”

“…providing capacity building services to Tribal communities in building and strengthening services for families of individuals with an opioid use disorder.”

Family-based care was mentioned by most grantee sites, with family events offering activities that revolved around culture and spirituality. Family-based care, including roles of mentors and volunteers were described by the grantees. Most grantee sites recognized community events or activities for innovative approaches, with trained peer support specialists, recovery coaches, and staff coordinating the activities and working

with families. Some of the programs are planning, or conducting family days, nights or group sessions.

"Indigenous services provides activities for families that revolve around culture and spirituality, such as winter storytelling and spring, summer, fall garden prep and harvest. Opioid intervention and prevention is interwoven whether through providing educational materials at such events or access to staff who can facilitate enrollment in services."

"… utilizes Peer Mentors to guide families and individuals impacted by the opioid crisis. Their roles vary including teacher, encourager, support, and cultural mentor."

Qualitative responses indicated that these activities, particularly those that are culturally-tailored, can be extremely helpful to clients and their family/friends during their recovery process and throughout their journey of sobriety.

Recommendations

- Expand resources and tools to identify and develop best practices for coordination of care among patients impacted by opioid use disorder.
- Provide resources (e.g., materials, workshops, toolkits) and opportunities to grantee sites to learn more about diverse Tribal and cultural practices that can be incorporated into their activities and programming.
- Use qualitative evaluation methods, such as key informant interviews or focus groups to explore COIPP staff challenges and barriers faced from the perspective of program delivery and personal support services needed when working in this field of work.
- Develop data collection plans with longitudinal data from grantee sites to document trends and changes in the unique Tribal, cultural, evidence-based, and practice-based activities used to strengthen and empower support teams and AI/AN families.
- Determine key characteristics of effective multidisciplinary groups including partners, responsibilities, functions, activities and services.
- Catalogue behavioral health services offered by COIPP sites alone or in conjunction with paraprofessional services.
- Increase resources and tools to expand Trauma Informed Care policies, procedures, and trainings.
- Share successfully implemented prevention activities addressing staff burnout and compassion fatigue.

Reducing Unmet Treatment Needs and Opioid Overdose-related Deaths through MAT

The impact of the opioid crisis on AI/AN populations is immense. The rate of drug overdose deaths among AI/ANs is above the national average. A purpose of the COIPP is to expand access to and encourage an increased use of medication-assisted treatment (MAT). MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. Medications used in MAT are approved by the Food and Drug Administration (FDA) and MAT programs are clinically driven and tailored to meet each patient's needs. Research shows that a combination of medication and counseling/therapy can successfully treat OUD. MAT can help sustain recovery and is also used to prevent or reduce opioid overdose.

The 2021 COIPP Notice of Funding Opportunity included the term medication assisted treatment (MAT), but more recently, the field has shifted to the use the term, medications for opioid use disorder (MOUD). This document will include use of MAT and MOUD to remain consistent with grantee responses to questions presented in the 2021 COIPP Annual Progress Report (APR), In alignment with Objective three of the COIPP, grantee sites were asked to describe how they had reduced "unmet treatment needs and opioid overdose related deaths through MAT". This section of the report provides an overview of the methods used by grantee sites that include:

- Reducing unmet treatment needs and opioid overdose related deaths through MAT,
- MAT population screening, referral and treatment services
- Established partnerships, policies and procedures. This section culminates with grantee sites' perceived accomplishments and challenges.

Evidenced-Based Practices

Twenty-eight grantees described their use of evidence-based practices to reduce unmet treatment needs and opioid overdose related deaths. Five themes emerged that included:

- Use of MAT
- Screening/assessment tools
- Program model/services
- Behavioral and mental health therapies
- Trained and certified staff

Screening/Assessment Tools

Several different screening and assessment tools were mentioned, including intake interviews, patient needs assessments, and more specific assessments such as an Adverse Childhood Experiences (ACE) assessment.

Program model/services
Programs were described as being evidence-based in their approach to client services with several specific models (e.g., Opioid Health Home, Canoe curriculum) mentioned.
.

Behavioral and mental health therapies
A wide variety of behavioral/mental health therapies and treatment modalities are used, including dialectical behavioral therapy, cognitive behavioral therapy, eye movement desensitization and reprocessing, general individual/family therapy, and recovery support groups.

Trained and certified staff
Staff described to support these services included licensed clinical social workers, SUD counselors, opioid health educators, and peer recovery support specialists.

Innovative Approaches
The COIPP was designed to encourage Tribes to develop unique and innovative community interventions that will address the opioid crisis at a local level.

Twenty-six grantees reported on the innovate approaches to self-care that they employed in their programs. Four themes emerged:

- Cultural activities and traditional healing
- Patient services
- Technology
- Complimentary therapeutic activities

Cultural activities and traditional healing
Cultural activities were most frequently expressed by grantee sites. They focused on cultural practices that supported client recovery and connection to culture. Examples of cultural activities included cultural arts, such as beading, fishing, and gardening, as well as healing practices including sweat lodges and talking circles. One grantee site described their use of a cultural advisor as someone, “participants get to meet […] to develop goals for regaining or learning new skills that promote a Wabanaki way of living.”

Patient services
Patient services offered by grantee sites included a variety of support groups, both in person and online.

Technology
Grantee sites also encouraged the use of third-party apps for recovery support, such as apps that focused on mindfulness. Some grantee sites also provided other technological services, such as noise machines and sun lamps. One grantee site

mentioned they were currently underway in developing culturally appropriate data collection processes to inform future programming.

Complimentary therapeutic activities

Finally, many grantee sites incorporated the use of therapeutic activities to compliment treatment including mindfulness, meditation, and other centering practices (journaling, stress management, breathing techniques). Additional practices mentioned focused on general health and wellness, such as physical activity, sleep, hygiene, and self-care.

Evidence-Based Practices Used to Treat SUD

Of the 35 grantee sites, 32 grantees reported on evidence-based practices they used in their program to treat substance use disorder in the current reporting period. The top two most used evidence-based practices used were motivational interviewing (n=26) and cognitive behavioral therapy (n=26). The second most used practices used were contingency management (n=17) and dialectical behavior therapy (n=17) (Figure 16).

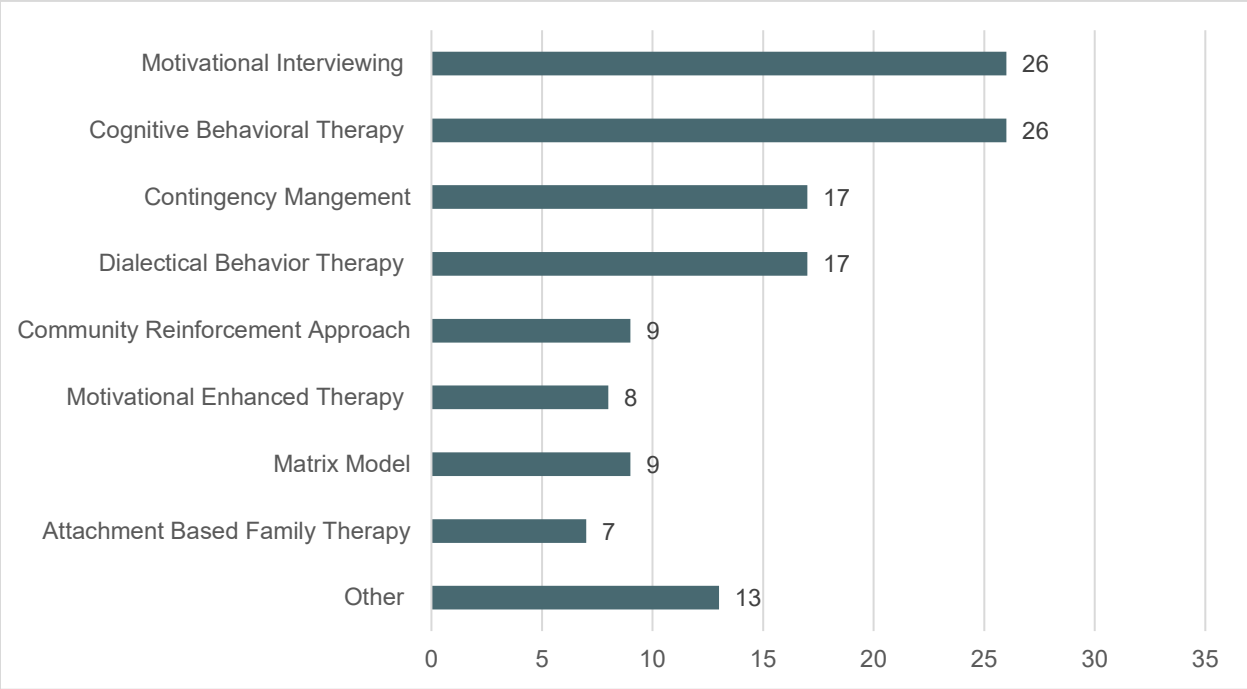


Figure 16: Number of grantee sites utilizing evidence-based practices to treat substance use disorder by type (n=32)

Thirteen grantee sites indicated the use of a variety of practices, evidence-based (EB), best practices (BP), culture-based (CB), Promising Practice, and experiential therapies (ET) to treat substance use disorder in the current reporting period. These included:

- Botvin Life Skills - EB
- Complementary and Alternative Medicine Sessions (Including Massage, Acupuncture, Chiropractic, Yoga, Mindfulness) - BP
- Culturally Driven Mindfulness - CB
- Experiential Group Therapy - ET
- Eye Movement Desensitization and Reprocessing Psychotherapy - EB
- Harm Reduction - EB
- MAT - EB
- Mental Health First Aid - BP
- Oregon 9 Tribes' Best Practices - BP
- Path to Wellness App - EB
- Psychotherapeutic Support – EB
- QPR (Question, Persuade, Refer) Gatekeeper Training - EB
- Spiritual Care and Wellness - CB
- Traditional Healing Practices - CB
- Warrior Down - CB
- Wellbriety - PP
- White Bison Mending Broken Hearts - CB
- 12-Step Facilitation - EB
- Mind Body Medicine - PP
- Opioid Health Home Model - EB

Prescribers vs Providers/Trained & Access

Thirty-two grantee sites indicated that there were 181 prescribers in their catchment area. Figure 17 below displays the number of prescribers who are trained on opioid related trainings, have obtained a waiver that meets the Drug Addiction Treatment Act of 2000 (DATA 2000) requirements, or had attended a MAT training. Overall, the majority (81%) of prescribers had completed opioid prescription training, while 69% had obtained a DATA waiver, and a 60% had also attended a MAT training event.

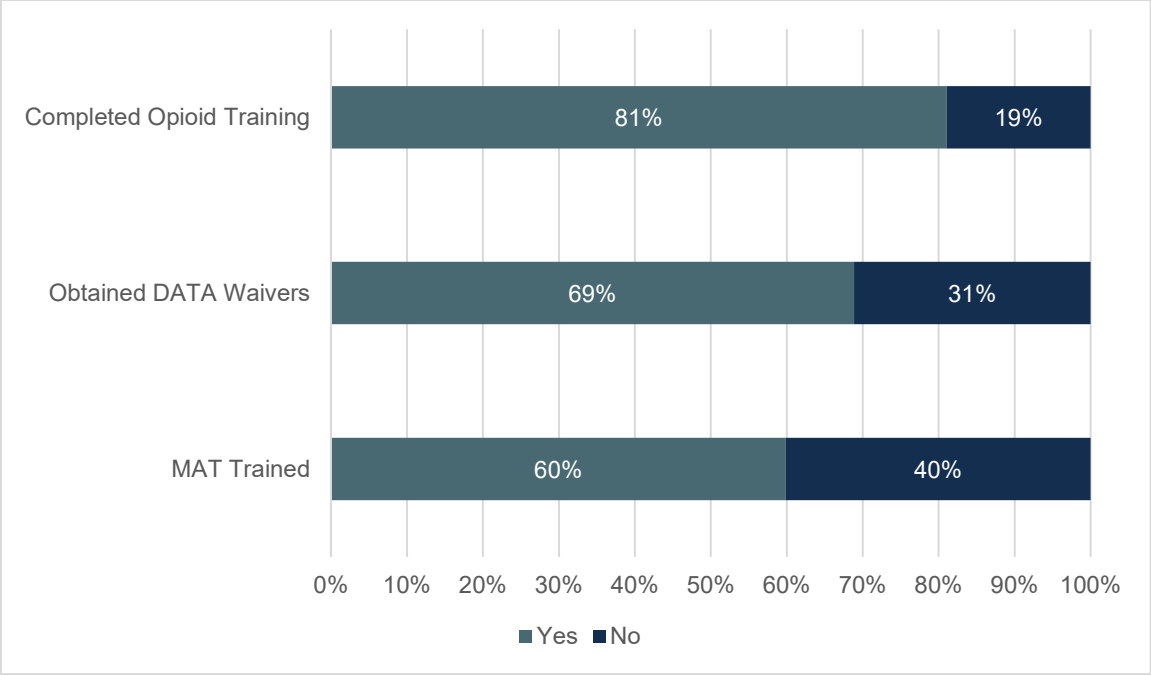


Figure 17: Prescribers in Catchment Area with Opioid-related Training (n=181)

Use of Telehealth Services

Tele-MAT has the ability to increase access to patient assessment opportunities and prescribing services in order to further expand access to FDA-approved medications for OUD in areas and communities where this practice has been difficult to establish or maintain. Tele-MAT can also be used to augment existing recovery resources in rural communities. Grantee sites reported the use of general telehealth/medicine services, including Tele-MAT. Most sites began the telehealth services due to the COVID-19 pandemic and continued their use due to the flexibility it offered patients.

Outreach and Education

Grantee sites also discussed the use of expanding outreach and education about MAT services in the community, through sharing resources, holding Extension for Community Healthcare Outcomes (ECHO) trainings, and community gatherings such as powwows.

Innovative Support Services

Finally, there were a variety of innovative support services provided by the programs, with several mentioning curbside services. Other grantee sites provided home-based medication inductions, or employed integrative behavioral health staff.

Screenings & Referrals in the General Population

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a comprehensive, public health approach to the delivery of early intervention and treatment services for persons with SUDs, as well as those who are at risk of developing SUDs. IHS has broadly promoted SBIRT as an integral part of a sustainable, primary care-based activity that aims to support and integrate the prevention of SUD into overall care. In FY

2021, IHS reported 15.8 percent of patients were screened using SBIRT, exceeding the proposed target of 14.3 percent of IHS patients ages 9 through 75 years. Likewise, COIPP projects conducted screenings for opioid-use, substance-use, and alcohol-use disorders, as well as suicidal risk.

Across all COIPP grantee sites, a total of 323,583 screenings including suicidal risk screenings, universal alcohol screenings, and SBIRT were conducted. However, these numbers may not represent unique encounters. As depicted in Figure 18, the majority conducted were universal alcohol screenings (54%), followed by suicidal risk screenings (41%). Only 5% of screenings fell in the SBIRT category. It is worth noting that of all 35 grantee sites, 32 reported to suicidal risk and universal alcohol screenings, as 31 grantee sites reported on SBIRT.

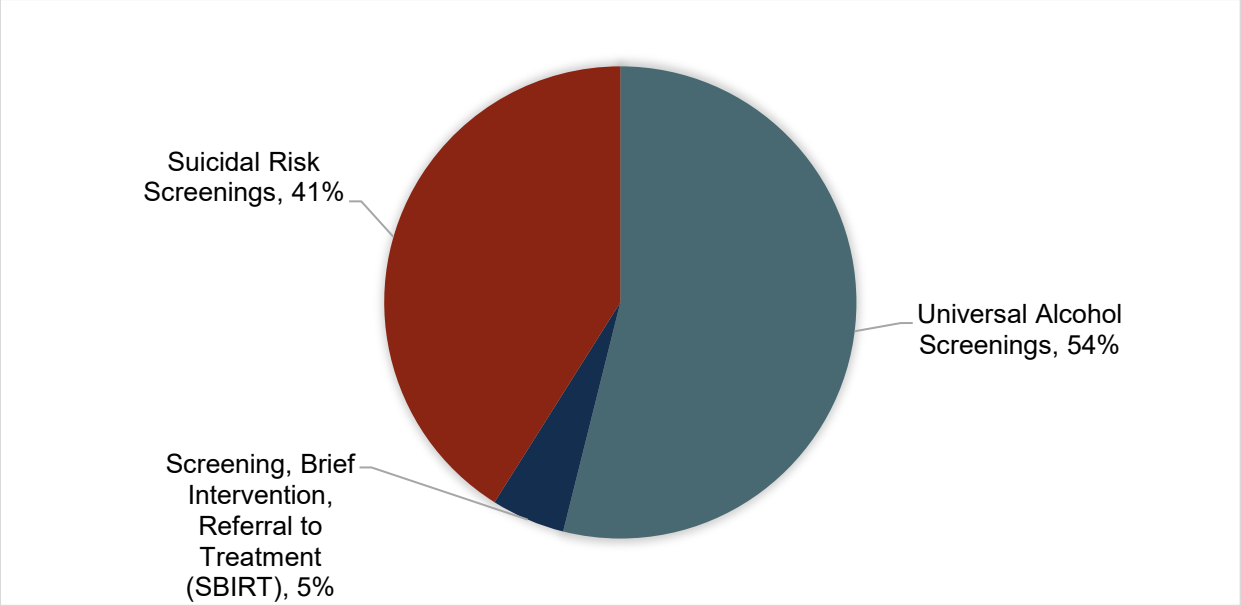


Figure 18: Number of screenings conducted by type (n=323,583)

Opioid, Substance, and Alcohol Use Disorder Screenings and Support Services Provided

Across 33 grantee sites, a combined 11,993 patients were screened for OUD, which equates to an average of 363 individuals screened per grantee site in Year one with one site alone screening 5,673 individuals. Figure 19 depicts the number of individuals screened and the services provided to them. Out of the 11,993 individuals screened, 11% were referred for OUD treatment. Out of those referred for treatment, 64% entered treatment for OUD. From those who completed treatment, 83% were provided with recovery support services by the program.

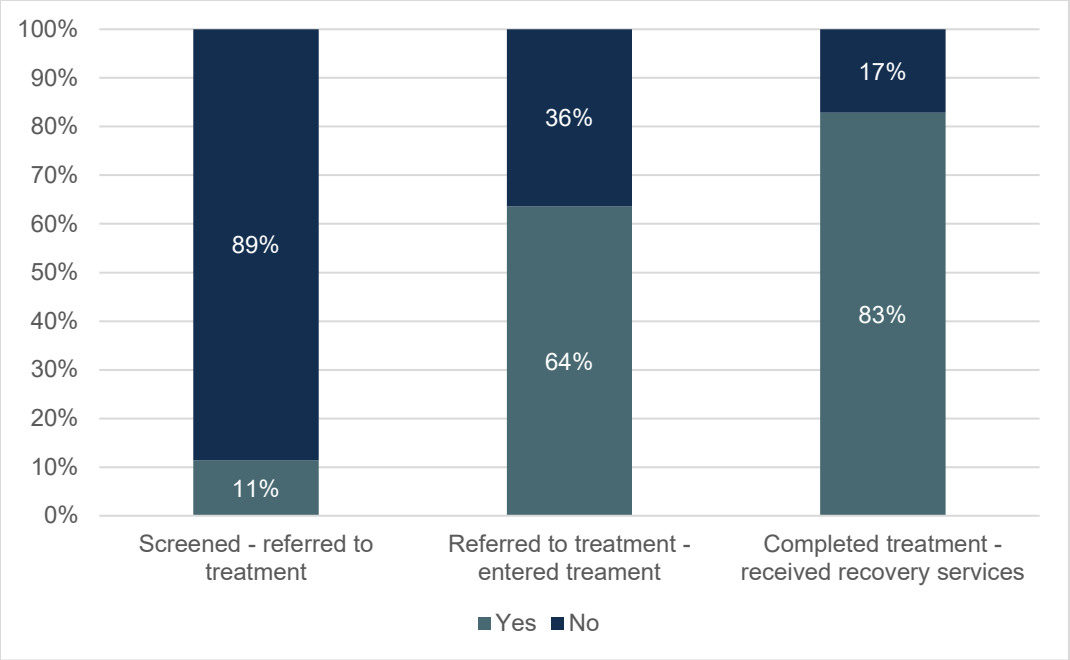


Figure 19: OUD screenings and services (n=11,993)

Figure 19. Twenty-eight percent of the 11,993 individuals screened for OUD were referred to support services. In addition, there were 170,403 individuals screened for Alcohol Use Disorder (not shown below).

Partnerships, Policies, Procedures

The majority of grantees indicated that they had partnerships, policies, and procedures in place to support their COIPP efforts. As seen in Figure 29, 79% of grantee sites have a written policy and/or procedure established for opiate prescribing and 71% indicated that either their organization or a healthcare organization they partner with had access to resources that could help providers self-monitor opioid prescriptions, including those for chronic non-cancer pain.

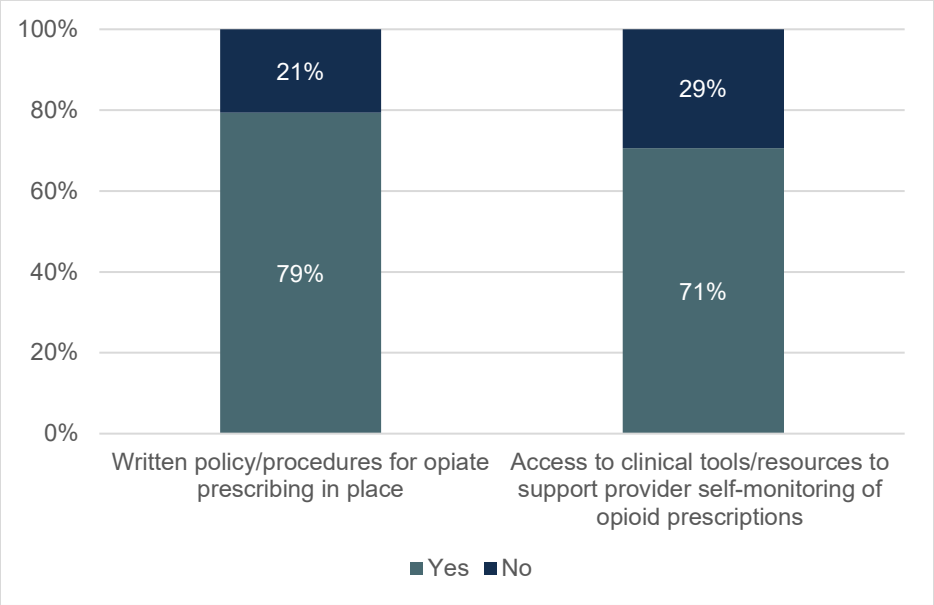


Figure 20: Opiate prescription policies/procedures in place (n=34)

All grantee sites reported on the type of policies/procedures in place to support substance use harm reduction efforts, which is depicted in Figure 20. The top three policies/procedures reported were for OUD referral process (n=31), MAT (n=30), and naloxone distribution (n=29) (Figure 21).

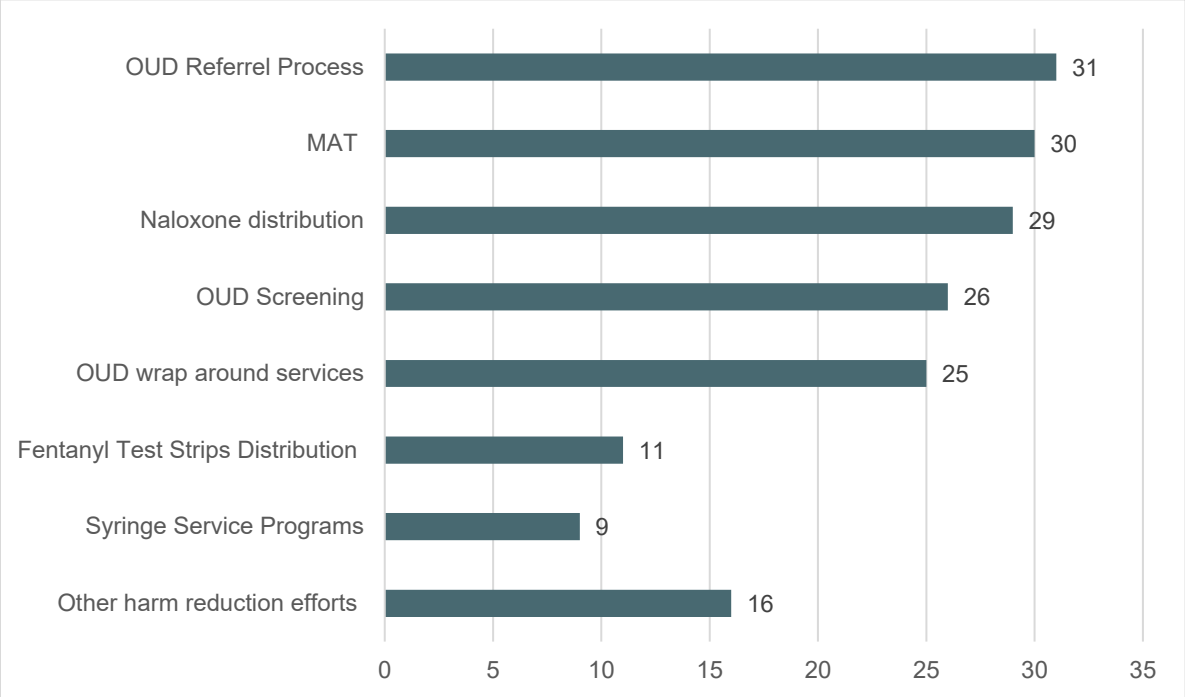


Figure 21: Harm reduction policies and procedures (N=35)

Sixteen grantee sites stated that they had policies/procedures in place for other harm reduction efforts which focused on:

- Drug disposal and provision of lockboxes (e.g., Deterra bags and Dispose RX)
- STI prevention and educational materials
- Alternative pain management
- Harm reduction kits
- Cultural healing

Even though grantee sites have policies/procedures in place to support their COIPP work, 31% indicated that they needed more resources in order to develop written policies/procedures/protocol for naloxone distribution, syringe service programs, and fentanyl test strips.

Harm Reduction Efforts

Grantees engaged in a wide range of harm reduction efforts, in particular, almost 100% reported offering naloxone distribution. All grantee sites reported on specific harm reduction efforts each were able to provide which included Narcan, fentanyl test strips, and syringe service programs. As seen in Figure 22, the majority of programs (91%) offered some form of Narcan distribution, while 40% of programs were also able to distribute fentanyl test strips. Syringe Services Programs were also offered by 37% of programs.

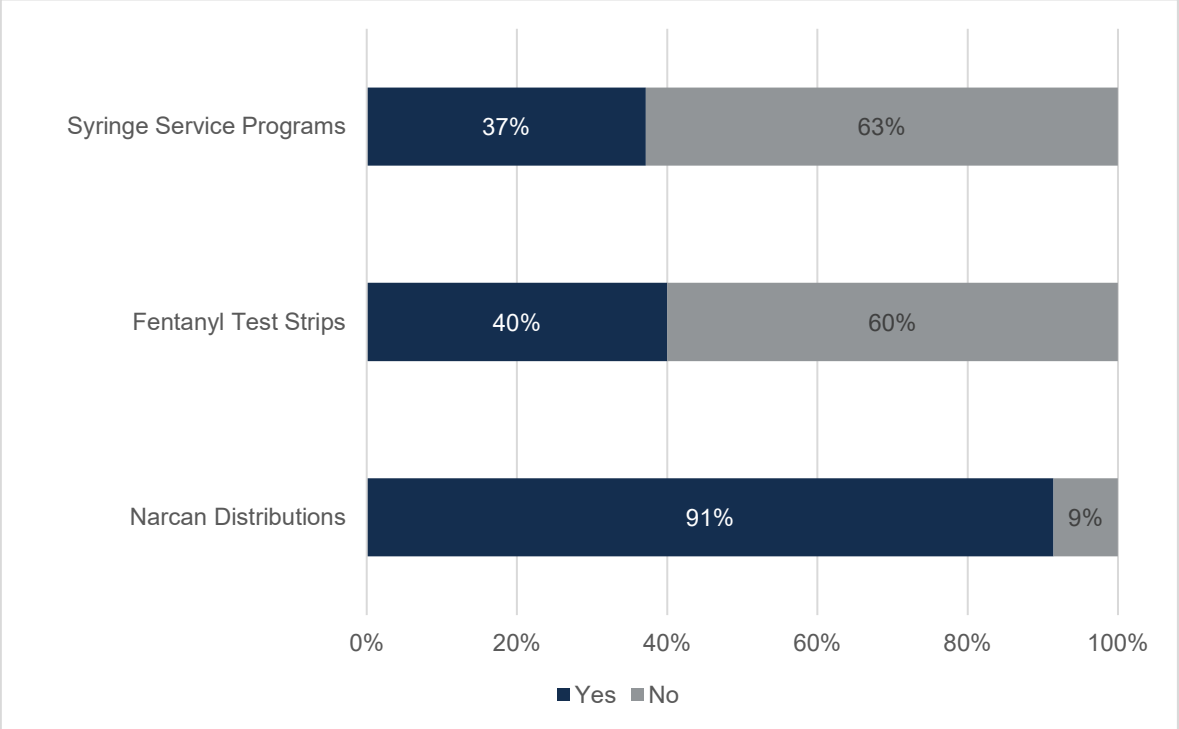


Figure 22: Harm reduction services provided by grantee sites (n=35)

Grantee sites shed insight on a variety of other harm reduction methods they used. The most commonly mentioned were naloxone and syringe services programs.
At the same time, grantee sites expressed the barriers they experienced in pursuit of harm reduction efforts. While many programs were able to distribute naloxone and provide training on its use, several programs mentioned they had issues due to limited access to naloxone or the procurement process. Only one program mentioned an onsite syringe exchange program, which was grant funded and ended when the funding ran out. Other grantee sites either had made progress towards establishing a syringe exchange program, or had ties to local organizations that had an existing program. Accessing and disbursing fentanyl test strips was another common barrier, as there is stigma surrounding its access and use, as well as FTS is also still illegal in some states as they are considered to be drug paraphernalia. To illustrate this, one grantee stated that, "*We need to reduce the stigma of harm reduction techniques. It is believed to be enabling the user rather than reducing harm to the user."* Similarly, another grantee highlighted that, "*due to varying opinions on the use of Fentanyl test strips we are still evaluating the implementation of their use here at our facility.*"

Reducing stigma and negative bias when talking about addiction encourages persons who use drugs or with a SUD to receive treatment. In addition, expanding harm reduction efforts such as establishing syringe services programs reduces infectious diseases and link patients to care; naloxone availability provides overdose reversals; fentanyl test strips help identify fentanyl and synthetic opioids in drug supplies; and medication lock-boxes keep prescription drugs safe from persons who use drugs - all of which are vital to reducing overdoses and overdose deaths in the AI/AN population.

The COVID-19 pandemic also created a challenge causing delays in the development of harm reduction programs and services in the communities they served, while at the same time creating changes in use patterns that impacted the well-being of community members. Finally, lack of disbursement policies, limited harm reduction funding, and a lack of capacity to offer such services have created challenges for grantee sites to offer harm reduction services.

Accomplishments and Challenges

Program accomplishments were reported by 27 grantees. One grantee site reported that they were able to double the rate of individuals treated for OUD (from 5 to 10 individuals), while others reported high screening rates between 50-100%. Most grantee sites had distributed harm reduction materials and listed this as a major accomplishment. Many grantee sites expanded their support services for patients and family/friends, working to overcome systemic barriers such as transportation. Capacity building was another major accomplishment, with programs hiring new key staff members, getting employees trained and certified in MAT and harm reduction, and beginning needed certification and/or licensure processes for their programs.

All themes found are listed below:

- Establishment of new partnerships
- Patients screened and receiving treatment
- Work towards capacity building and program expansion
- Distribution of harm reduction materials
- Improvement in community awareness/understanding
- Provision of support services for patients and family/friends

While there were many accomplishments achieved across the grantee sites, many challenges were faced. Prominent among these were the challenges posed by the ongoing COVID-19 pandemic. Many grantee sites expressed that the restrictions on in-person services was a severe limitation to the treatment that they could provide, especially for MAT services. While some programs found success through telehealth and TeleMAT services, this was not without further technological challenges. Other challenges faced regarded social norms. As one grantee site reported, their community has a "*more reserved stance as to harm reduction efforts*", and the lack of awareness and support for harm reduction was reported by many. In addition, patients themselves expressed mistrust towards engaging with services, and grantee sites reported that it was particularly difficult to reach at-risk populations, such as the unhoused and younger users. The various structural challenges, including grantee site that experienced catastrophic challenges and numerous staffing issues, also presented a barrier to program success. Some programs also reported that their success was simply restricted due to their limited program capacity to provide MAT and support services. A full list of themes is provided below:

- Community attitudes towards harm reduction
- Staffing challenges
- Structural barriers
- Limited culturally-appropriate treatment
- Limited program capacity and support services
- Restrictions due to COVID-19
- Mistrust/disinterest toward services
- Technology challenges
- Systemic/sociodemographic barriers to access
- Lack of current data to drive program development

Recommendations

- Understand challenges in the expansion of MAT services to improve program support resources.
- Provide grantee sites with resources in order to develop written policies/procedures/protocols for harm reduction efforts such as naloxone distribution, syringe services programs, fentanyl test strip distribution, and others.
- Identify with grantee sites how and if overdose and overdose-related death data, particularly among the AI/AN population, are collected, tracked and reported to establish challenges and barriers, and strategies to overcome for evaluation and to inform practices.
- Provide grantee sites resources to support their work to destigmatize opioid-use, substance-use, and alcohol use disorders, as well as harm reduction efforts, particularly around naloxone administration, syringe services programs and fentanyl test strips.
- Explore age- and gender-specific resources that could support grantee sites with the variances in MAT service outcomes.
- Explore types of staff training and certification.
- Understand grantee SUD screening efforts and protocols that include best practices, screening follow-up and coordinated care activities, referral management and services, and training needs including billing and reimbursement business models among grantees.
- Explore grantee non-SUD screening efforts and protocols that support the prevention of risky behaviors that lead to increased diseases, infections, and trauma (i.e., Hepatitis C, HIV, STI, SV/IPV)
- Document grantees' barriers and successes to expanding MAT services including model systems and examples.

Summary of Recommendations

Grantee Sites' Organizational and Evaluation Capacity

Overall, the majority of grantee sites established strong organizational and evaluation capacity. Specific to organizational capacity, the COIPP grant enabled grantee sites to maintain and hire staff members to support their efforts in their communities. However, the impacts of the COVID-19 pandemic affected the ability to maintain staff, which in turn resulted in more limited capacity to support and/or provide programming and services.

Increasing Public Awareness and Education

Gaps in public awareness and education efforts include the lack of culturally-tailored initiatives, the limited focus on education about prescription medication disposals, and the need for continued outreach efforts. As discussed above, most programs did not mention integrating cultural practices into their efforts, and this is an area that should be explored further to improve community engagement. Safe disposal of prescription medications was the least frequently provided type of community education, so further events or campaigns around this topic may be needed. Finally, while programs overall reported improvement in their community's awareness of OUD, prevention, and treatment, there still remains a need for a greater focus on harm reduction efforts.

Strengthening and Empowering Support Teams and AI/AN Families in Tribal or Urban Indian Communities

Although most grantee sites incorporated cultural values or activities into their programming, grantees expressed difficulty in tailoring activities when serving citizens of diverse Tribal Nations. In addition, while the majority of sites had support services in place for their staff, they were often limited or required the individual to seek help themselves, such as employee assistance programs. In order to prevent burnout in the context of high staff turnover and staff shortages, more creative efforts to offer support to staff should be explored.

Reducing Unmet Treatment Needs and Opioid Overdose-related Deaths through MAT

Over the reporting period, more than half of grantees provided MAT services and many were also able to expand access to existing MAT services, including through TeleMAT. Programs offered medications including buprenorphine (Suboxone), naltrexone (Vivitrol), and naloxone (Narcan). Most programs offered referrals to other services including inpatient treatment options and syringe services programs. In addition, a majority of prescribers across catchment areas had obtained DATA waivers for buprenorphine subscribing, which may have a positive impact on MAT expansion in the

future. Across grantee sites, there was a wide variety of therapy modalities offered, including dialectical behavior therapy, cognitive behavioral therapy, and eye movement desensitization and reprocessing, family therapy, and support groups. Grantee sites also made an effort to have staff trained and licensed in many behavioral health areas, including recovery/peer support specialists. Grantee sites also supplemented treatment with support services including cultural activities and traditional healing, health and wellness support, and services such as transportation to overcome barriers to access.

Grantees engaged in a wide range of harm reduction efforts, in particular, almost 100% reported offering naloxone distribution. Syringe services programs and fentanyl test strip distribution were less frequently offered; however, this is at least somewhat due to the barriers the sites experienced in pursuit of these efforts: many discussed the stigma surrounding these specific harm reduction approaches among the community, and even among their own organizations.

Based on the findings, there are several gaps in reducing the unmet treatment needs and opioid overdose related deaths through MAT. Grantees reported the need for continued expansion of MAT services, both treatment and support services, through capacity building and improved outreach to hard-to-reach populations such as unhoused individuals and younger users. In addition, when asked to report on overdose incidents and deaths in their catchment area, several grantee sites indicated that the statistics for overdoses and overdose deaths were unknown, not specific to Tribal citizens, or had not been updated in recent years, which made it difficult or impossible for them to use this data for programming or evaluation purposes. Thus, a need for improved access to more accurate and appropriate overdose morbidity and mortality data, particularly among AI/AN individuals is necessary to drive evidence-based programs and evaluate program success. Finally, destigmatizing and expansion of harm reduction efforts, especially syringe services programs and fentanyl test strips, are vital to reducing overdose deaths among the AI/AN population.

Recommendations for Evaluation of the COIPP

The first year of this pilot project evaluation provided many insights into the progress the COIPP grantee sites are making towards their programs. Recommendations to support improvements in subsequent years of the COIPP include:

- Use qualitative evaluation methods, such as key informant interviews, to further explore the challenges and barriers grantees experience with the IHS COIPP APR form completion, understanding, and submission. This is especially important in areas where grantees did not complete specific questions (see Appendix B).
- Provide grantees with the technical assistance they need to use the IHS COIPP APR form to better describe the types of information requested and how best to complete and submit the report. This can include an overview of the reporting form,
- Condense the APR form to reduce survey fatigue across grantee sites completing the form. This can include removing or altering questions with the fewest responses, identifying questions asking similar aspects about a program, and restructuring the response option layout.
- Across all grantees, there is a need to gather more contextual narrative information about their programs including strengths of their program, challenges/barriers, next steps/future planning, and unmet needs for the program and for patients.
- Across all grantees, there is need to understand program approaches including practice- or evidence-based approaches and cultural/traditional approaches, including: Type; How grantees learned about the approach; How grantees integrated the approach into practices/programs; and how integrating the approach has made a difference or had an impact on community.
- Address opportunity to gather information on special population groups (e.g., homeless, older adults, pregnant women, etc.) including total served, types of services, and any unmet needs.
- Work with grantee sites to identify ways to gather and collect data to support the APR form. For example, several programs indicated that the statistics for overdoses and overdose deaths were unknown, not specific to Tribal citizens, or had not been updated in recent years.
- Develop measures to understand the various ways grantees assess changes in community perspective as a result of their community awareness campaigns.
- Develop measures to support quantifying grantees' community awareness/education efforts (e.g., duration, changes in community awareness measures, change in knowledge, attitudes, beliefs, etc.).
- Identify measures that grantees may already be reporting through other database systems (e.g., GPRA) to avoid duplication of reporting efforts, but to also enrich the overall evaluation of the IHS COIPP.
- Develop additional ways to capture grantee sites' program evaluation accomplishments throughout the year, such as a bi-annually or quarterly reporting form to track grantees progress and identify successes/challenges throughout the year. The information gathered could support the IHS COIPP program team make decisions on how best to support grantee sites with their work.

Appendix

Appendix A: Evaluation Plan

Purpose

The purpose of the COIPP evaluation is to guide a comprehensive study of the COIPP grantees to understand how funding is being targeted to address programmatic objectives of the grant, to discern grantee capacity for evaluation, and to evaluate grantee's annual progress reporting. The results of this evaluation plan will surface current gaps in grantee data and limitations to complete the annual progress report. The findings can also be used for formative purposes to build grantee capacity to effectively use the new template.

Evaluation Design

The evaluation uses a mixed-method design to collect summative data to address the evaluation questions aligned with the goals and objectives. The evaluation questions, data collection instruments, timelines, and analysis methods are outlined below.

1. **How can COIPP grantees be described and categorized?**

Evaluation Questions	Data Source and Collection Instruments	Timeline	Methods
1.1) What are grantees' evaluation capacity needs to undertake their program evaluation? **High (grantee will need help to plan and organize program evaluation and total data collection)** **Moderate (grantee may need minimal help in quality and completeness of program evaluation and data collection)** **Minimal (grantee needs minimal support limited to coordinating receipt of evaluation and data information to IHS)**	Grant applications	December 2021–February 2022	Document review Frequency analysis

2. How are grantees increasing public awareness and education about culturally appropriate and family centered opioid prevention, treatment, and recovery practices and programs in the AI/AN communities?	**Data Source and Collection Instruments**	**Timeline**	**Methods**
2.1) What types of public awareness educational programs, events and media campaigns are being conducted by grantees within their community? **2.2) How are cultural or traditional practices incorporated into awareness educational programs, events, and media campaigns?** **2.3) What population groups are being targeted and tracked by grantees (e.g., youth, adults, elders, families)?** **2.4) What type of activities have grantees conducted to assess change in participants' knowledge, attitudes, and beliefs?** **2.5) What are the known gaps in increasing public awareness and education about culturally appropriate and family centered opioid prevention, treatment, and recovery practices and programs in the AI/AN communities?**	Grant applications IHS Annual Progress Report (APR) Form	December 2021– February 2022 July 2022 – September 2022	Document reviews Frequency analysis Qualitative narrative analysis

3. How have grantees strengthened their comprehensive support teams to empower AI/AN families in addressing the opioid crisis in Tribal or urban Indian communities?	Data Source and Collection Instruments	Timeline	Methods
3.1) How many community partnerships and MOU/MOAs are established by grantees? **3.2) What type of trainings and how many trainings were conducted have grantees provided to support:** • **Internal staff or provider professionals** • **External professionals** **3.3) How many certified staff or providers do grantees have in place to support COIPP-related services?** **3.4) What are the known gaps in establishing comprehensive support teams to empower AI/AN families in addressing the opioid crisis in Tribal or urban Indian communities?**	IHS Annual Progress Report (APR) Form	July–September 2022	Frequency analysis Qualitative narrative analysis

4. How have grantees reduced unmet treatment needs and opioid overdose related deaths through MAT?	Data Source and Collection Instruments	Timeline	Methods
4.1) Have grantees established a MAT program? **4.2) How many outreach or office patient encounters were conducted with OUD patients?** **What specific treatment options were offered (e.g., referrals, MAT prescriptions, # of DATA waive providers)** **4.3) How many and what type of opioid-related medications were administered?** **4.4) How many SBIRT specific trainings were conducted?** **4.5) How many patients were screened for intake (SBIRT) across all programs?** **4.6) What are the known gaps in reducing unmet treatment needs and opioid overdose related deaths through MAT?**	IHS Annual Progress Report (APR) Form	July–September 2022	Frequency analysis Qualitative narrative analysis

5. What implications do the findings of this evaluation plan have on the sources of data used?	Data Source and Collection Instruments	Timeline	Methods
○ **What are common components of reported data?** ○ **What key measures are missing from the current data available?** ○ **What additional tools and existing databases do grantees' report to that can inform the COIPP evaluation and track changes in outcomes?** ○ **What evaluation assistance might be helpful to increase grantees' evaluation capacity or ability to complete the APR form?** ○ **What efficiencies can be realized in gathering reporting data?**	Key data elements matrix		Comparison analysis Frequency analysis

Appendix B: Frequency of Answered Survey Questions

Table 1 displays a count of the individual responses to each survey question, as well as the reporting rate (out of a total of 35 grantees). Only main topic questions are displayed, as it was unfeasible to display the fully array of questions. Questions designated as "Avg" represent instances where there were only sub-questions, and so were calculated as the average response rate over the series of sub-questions.

Table 1: Frequency of responses to APR

Frequency of Responses to Survey

Question	A1	A2	A3	A4	A5	B1	B2	B3	B4	B5	B6	B7
Responses	35	35	35	35	22	33	21	33	35	20	35	34
Response Rate	100%	100%	100%	100%	63%	94%	61%	94%	100%	57%	100%	97%
Question	B8	B9 - Avg	B10	B11	B12	B13	C1	C2	C3 - Avg	C4	C5	C6
Responses	34	32	35	33	32	35	35	31	27	29	32	32
Response Rate	97%	92%	100%	94%	91%	100%	100%	89%	78%	83%	91%	91%
Question	C7	C8	C9	C10	C11	C12	C13	C14	C15	C16	C17	C18
Responses	32	32	34	29	33	33	31	32	31	32	30	29
Response Rate	91%	91%	97%	83%	94%	94%	89%	91%	89%	91%	86%	83%
Question	C19	C20	C21	C22	C23	C24	C25	C26	C27	C28 - Avg	C29	C30 - Avg
Responses	33	32	31	33	33	30	30	34	34	33	35	33
Response Rate	94%	91%	89%	94%	94%	86%	86%	97%	97%	93%	100%	95%

Question	C31	C32	D1	D2 - Avg	D3	D4	D5	D6	D7	D8	D9	D10
Responses	33	34	35	35	32	33	30	30	16	16	16	16
Response Rate	94%	97%	100%	99%	91%	94%	86%	86%	46%	46%	46%	46%
Question	D11	D12 - Avg	D13- Avg	D14 - Avg	D15 - Avg	D16 - Avg	D17	D18	D19	D20	D21	D22
Responses	16	20	18	21	18	16	17	15	15	16	16	15
Response Rate	46%	57%	51%	61%	51%	47%	49%	43%	43%	46%	46%	43%
Question	E1	E2	E3	E4 - Avg	E5	E6 - Avg	E7	E8	E9	E10	E11	E12
Responses	34	32	32	30	35	28	31	33	32	32	29	35
Response Rate	97%	91%	91%	86%	100%	81%	89%	94%	91%	91%	83%	100%
Question	E13	E14	E15	E16	E17	E18	E19	E20 - Avg	E21	n/a	n/a	n/a
Responses	34	34	30	34	8	30	33	24	31	n/a	n/a	n/a
Response Rate	97%	97%	86%	97%	23%	86%	94%	67%	89%	n/a	n/a	n/a