Prevention of Non-Medical Use of Prescription Opioids and Heroin Use in Alaska

Guidance Document

State of Alaska Department of Health and Social Services
Division of Behavioral Health
Section of Prevention and Early Intervention
Strategic Prevention Framework Partnerships for Success Grant Program

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Table of Contents

PREFACE .......................................................................................................................... 1
Organization of This Document ......................................................................................... 1

SECTION 1: INTRODUCTION AND OVERVIEW ................................................................ 2
Grantee Responsibilities ....................................................................................................... 2
Grant Parameters ................................................................................................................ 2
What Is NMUPO? .................................................................................................................. 3
Addressing NMUPO ............................................................................................................ 4
Selected Intervening Variables ............................................................................................. 4

SECTION 2: STRATEGIC PREVENTION FRAMEWORK .................................................. 7
Step 1: Assessment .............................................................................................................. 9
Task 1: Assess Consumption and Related Consequences .................................................. 10
Task 2: Assess Intervening Variables and Community Factors ...................................... 11
Task 3: Assess Capacity – Resources and Readiness ....................................................... 12
Task 4: Prioritize Community Factors .............................................................................. 14
Step 2: Capacity Building .................................................................................................. 17
Task 1: Build Capacity – Increase Resources and Improve Readiness ................................ 17
Step 3: Planning .................................................................................................................. 21
Task 1: Develop a Vision Statement ............................................................................... 21
Task 2: Select Strategies ..................................................................................................... 22
Task 3: Develop a Strategic Plan that Aligns with the Logic Model ................................ 23
Step 4: Implementation ....................................................................................................... 28
Task 1: Build Capacity and Mobilize Support ................................................................ 28
Task 2: Carry Out Strategies ............................................................................................. 28
Task 3: Balance Fidelity with Necessary Adaptations ..................................................... 29
Task 4: Plan for Sustainability ......................................................................................... 30
Step 5: Evaluation .............................................................................................................. 32
Task 1: Develop Evaluation Plan .................................................................................... 32
Task 2: Develop an MIS in an Excel File to Track Data Collected for Strategy Indicators . 44
Task 3: Review and Share Evaluation Findings with Targeted Audiences ....................... 47
Cultural Competence ......................................................................................................... 49
Sustainability ..................................................................................................................... 53
Glossary of Terms .............................................................................................................. 54

SECTION 3: APPENDICES ................................................................................................. 57
Appendix 1: PFS Grant Milestones, Timeline, and Deliverables ....................................... 58
Appendix 2: Community Assessment Framework ........................................................... 61
Appendix 3: Resource Assessment Worksheet .................................................................. 70
Appendix 4: Community Factor Prioritization Process .................................................... 72
Appendix 5: Capacity Building Plan - Example and Template ........................................ 75
Appendix 6: Step 1 Fidelity Checklist ................................................................................. 76
Appendix 7: Step 2 Fidelity Checklist ................................................................................ 80
Appendix 8: Strategic Plan Development Guide ............................................................... 83
Appendix 9: Logic Model Development Guide .................................................................. 87
Appendix 10: Action Plan Template .................................................................................. 89
Appendix 11: Step 3 Fidelity Checklist .............................................................................. 90
Appendix 12: Step 4 Fidelity Checklist .............................................................................. 94
Appendix 13: Evaluation Indicators for Prescription Opioid Intervening Variables, Consumption, and Consequences ......................................................................................... 97
Appendix 14: Evaluation Indicators for Heroin Intervening Variables, Consumption, and Consequences ..................................................................................................................... 99
Appendix 15: Step 5 Fidelity Checklist ............................................................................... 101
This guidance document is developed for communities funded by the Strategic Prevention Framework Partnerships for Success (PFS) grant program in Alaska who are implementing efforts to prevent and reduce non-medical use of prescription opioids (NMUPO) among 12-25 year olds and heroin use among 18-25 year olds.

The Alaska PFS initiative, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), supports a comprehensive approach to prevent and reduce NMUPO and heroin use in Alaska communities through use of the Strategic Prevention Framework (SPF). This initiative will support the implementation of evidence-informed and sustainable environmental strategies to increase prevention capacity in funded Alaskan communities and effectively address NMUPO and heroin use.

Substance abuse is a complex problem that requires coordinated, evidence-informed solutions. This document is intended to help guide PFS-funded communities in Alaska through the SPF planning process to develop and implement effective, data-driven, and culturally competent strategies that will have a measurable and sustained effect on NMUPO and heroin use at the community level.

Organization of This Document

This guidance document may be viewed as having three distinct sections that, altogether, provide the necessary information and resources to assist communities in their efforts to address NMUPO and heroin use:

- **Section 1: Introduction and Overview** provides information on NMUPO and heroin use, as well as the PFS grant program. This section includes a description of the grant and prioritized intervening variables relevant to opioid abuse for the PFS grant program.
- **Section 2: Strategic Prevention Framework** provides guidance on the use of the SPF, a 5-step model for planning, implementing, and evaluating evidence-informed, culturally appropriate, sustainable NMUPO and heroin use prevention strategies.
- **Section 3: Appendices** encompass a range of tools and resources relevant to the SPF process that are referenced throughout Section 2. These include grant-specific resources that communities will use to help plan and implement their prevention efforts.
**SECTION 1: INTRODUCTION AND OVERVIEW**

**Grantee Responsibilities**
The six PFS sub-recipient grantees in Alaska will have approximately one year from the point at which they receive funding to complete Steps 1-3 of the SPF (i.e., assessment, capacity building, and planning). This process will result in the generation of 1) a community assessment report that includes data demonstrating consumption, consequences, intervening variables, and pertinent community factors related to NMUPO and heroin use, 2) a logic model that includes a data-driven strategy selection process, 3) a capacity building plan, 4) action plans, and 5) an evaluation plan. Instructions on how to develop these deliverables appear in this document. For a timeline of deliverables for the PFS grant program, see [APPENDIX 1: PFS Grant Milestones, Timeline, and Deliverables](#).

**Grant Parameters**
- This is a prevention grant focused on preventing and reducing NMUPO and heroin use (i.e., grant priority areas).
- Urban grantees (i.e., population of 20,000 or greater) are required to address NMUPO among 12-25 year olds and heroin use among 18-25 year olds. Rural grantees (i.e., population less than 20,000) are only required to address NMUPO among 12-25 year olds.
- The primary target population is 12-25 year olds. Youth (12-17 years) can be reached both in and/or outside of school settings. Secondary target populations (e.g., prescribers, law enforcement, and parents) can be served as long as the effects of these services are likely to have an impact on the consumption and/or consequences of the primary target population of 12-25 year olds.
- All prevention activities must be limited to the communities or service areas funded through this grant.
WHAT IS NMUPO?

Data from the National Survey on Drug Use and Health (NSDUH) indicate that pain relievers (i.e., opioids) are the most commonly misused and abused type of prescription drug, far exceeding the misuse and abuse of stimulants, tranquilizers, and sedatives. The term opioid designates a class of drugs derived from opium or manufactured synthetically with a chemical structure similar to opium. Heroin is a naturally derived opioid. Other opioids—including oxycodone (OxyContin), morphine, meperidine, methadone, and codeine—are used therapeutically for the management of pain and other conditions. These products may be diverted from pharmaceutical purposes and used illicitly; they have a high potential for abuse because they can create psychological and/or physical dependence.\(^1\) The table below lists commonly diverted medications.

<table>
<thead>
<tr>
<th>Narcotic Pain Medications (Opioids)</th>
<th>Stimulant Medications</th>
<th>Barbiturate Sedatives</th>
<th>Benzodiazepine Tranquilizers</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Codeine</td>
<td>- Adderall®</td>
<td>- Amobarbital (Amytal®)</td>
<td>- Clonazepam (Klonopin®)</td>
</tr>
<tr>
<td>- Fentanyl (Sublimaze®/Duragesic®)</td>
<td>- Dextroamphetamine (Dexedrine®/Dextrostat®)</td>
<td>- Pentobarbital (Nembutal®)</td>
<td>- Diazepam (Valium®)</td>
</tr>
<tr>
<td>- Meperidine (Demerol®)</td>
<td>- Focalin</td>
<td>- Secobarbital (Seconal®)</td>
<td>- Estazolam (Prosom®)</td>
</tr>
<tr>
<td>- Methadone (Dolophine®)</td>
<td>- Methylphenidate (Methyl®/Ritalin®)</td>
<td>- Phenobarbital (Luminal®)</td>
<td>- Flunitrazepam (Rohypnol®)</td>
</tr>
<tr>
<td>- Hydromorphone (Dilaudid®)</td>
<td></td>
<td></td>
<td>- Lorazepam (Ativan®)</td>
</tr>
<tr>
<td>- Morphine</td>
<td></td>
<td></td>
<td>- Midazolam (Versed®)</td>
</tr>
<tr>
<td>- Opium</td>
<td></td>
<td></td>
<td>- Nitrazepam (Mogadon®)</td>
</tr>
<tr>
<td>- Oxycodone (OxyContin®)</td>
<td></td>
<td></td>
<td>- Oxazepam (Seraz®)</td>
</tr>
<tr>
<td>- Hydrocodone (Vicodin®)</td>
<td></td>
<td></td>
<td>- Triazolam (Halcion®)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Temazepam (Restoril®/Normison®/Planum®/Tenox®/Temaze®)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Chlordiazepoxide (Librium®)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Alprazolam (Xanax®)</td>
</tr>
</tbody>
</table>

* Trade names are in parentheses.

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ADDRESSING NMUPO

When considering how to prevent and reduce NMUPO, it is critical to identify the personal and contextual factors associated with use and consequences of use, as these factors provide opportunities for intervention. Different types of these factors, also called variables, are described below.

Intervening Variables

Intervening variables include, but are not limited to, risk and protective factors. Risk factors are characteristics of school, community, and family environments—as well as characteristics of youth and young adults and their peer groups—that are known to be related to an increased likelihood of drug use. Protective factors exert a positive influence or buffer against the negative influence of risks, and are related to reducing the likelihood that youth and young adults will engage in problem behaviors such as NMUPO.

Intervening variables fall into two categories: (1) those that cannot be modified (immutable), and (2) those that can be modified. The former category is useful for identifying the target population for prevention strategies (i.e., individuals or groups that may be at disproportionate risk). The latter category is generally the focus of prevention strategies (i.e., the setting, behavior, or characteristic that prevention activities are attempting to change).

Immutable Factors

Gender

Evidence is mixed regarding gender differences and non-medical use of prescription drugs. Some studies have found that adolescent females are more likely to report non-medical use of prescription drugs. In particular, females may be more likely to report non-medical use of opioids or sedatives/anxiolytics and are more likely to report non-medical use for the purpose of “self-treating” compared to males who tend to report more “sensation-seeking” reasons (e.g., to get high).

However, one study found that males reported more non-medical use of opioid analgesics than

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Another study examining 2006 National Survey on Drug Use and Health (NSDUH) data of all U.S. individuals age 12 or older found that males were more likely to report lifetime and past year non-medical use of prescription opioids, but there were no gender differences for rates of abuse or dependence on prescription opioids. Additionally, males and females may gain access to prescription drugs for non-medical purposes differently. Adolescent females may be more likely to obtain opioid prescription drugs for free or steal them from a friend or relative, while adolescent males may be more likely to purchase prescription opioids or to acquire them from a physician.

Race/Ethnicity
Research has consistently found higher rates of NMUPO among individuals who identify as white after accounting for other risk factors (e.g., availability, peer use). A larger percentage of white respondents reported sensation-seeking motives for NMUPO compared to non-white respondents.

Modifiable Factors Selected for the PFS Grant

Many intervening variables affect NMUPO and heroin use. Three specific variables were prioritized for the PFS grant program based on national research, having a direct causal or contributory relationship to opioids, and the ability to see change at the community level within a grant cycle. As a result, community assessments and subsequent efforts will mainly focus on these key intervening variables: social availability of prescription opioids, retail availability of prescription opioids through providers, and perceptions of risk for harm.

Social Availability of Prescription Opioids
Multiple studies have examined the relationship between access/availability and NMUPO. Many studies suggest that increased availability is a contributing factor for NMUPO. For example, one study found that a perception of prescription drugs as readily available was associated with increased levels of prescription drug misuse among a sample of middle and high school students in Tennessee. According to pooled estimates from NSDUH in 2013 and 2014, the most common source of pain relievers among 12–25 year olds during their most recent use within the past year was from a friend or relative, which they received for free (43.1% for 12–17 year olds, 50% for 18–25 year olds). Other common sources were from a single doctor (22.9% for 12–17 year olds, 16.8% for 18–25 year olds) and by buying it from a friend or relative (9.4% for 12–17 year olds, 13.6% for 18–25 year olds). No other potential sources accounted for more than 8% for either age group.

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Retail Availability of Prescription Opioids through Providers
Evidence suggests that prescribers taught best practices for prescribing opioids and provided with information regarding opioid dosing guidelines were more likely to safeguard against potential patient misuse. For example, prescribers were less likely to prescribe opioids at high dosages when they were provided opioid dosing guidelines.\(^\text{11}\) Physicians participating in educational presentations describing recommended prescribing practices also were less likely to prescribe long-acting opioids for acute pain and more likely to adopt other recommended practices.\(^\text{12}\)

Perception of Risk for Harm
Individuals’ perception of the risk associated with opioids and heroin is related to their use behaviors. A study found a protective effect of having greater perception of risk of substance abuse on prescription opioid misuse outcomes based on an analysis of NSDUH data.\(^\text{13}\) Another study found a similar relationship among college students.\(^\text{14}\) If individuals do not think they are doing anything potentially dangerous when they take prescription opioids without a doctor’s orders, then they are more likely to misuse them.\(^\text{15}\) Conversely, those who are concerned about the dangers of prescription opioids are less likely to misuse them.\(^\text{16}\) These findings mirror those from studies linking perception of harm and other kinds of substance abuse (e.g., alcohol).\(^\text{17}\)

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6 Prevention of Non-Medical Use of Prescription Opioids and Heroin Use in Alaska
SECTION 2: STRATEGIC PREVENTION FRAMEWORK

The Strategic Prevention Framework is an approach to prevention that embraces and promotes the outcomes-based prevention model and data-driven decision-making. The theory behind PFS is that there are factors that cause or have an impact on substance use and the Consequences related to use. Generally, these factors are categorized into groups called intervening variables.

The SPF framework is intended to build state and local capacity to decrease substance misuse and abuse, and it comprises these five steps:

1. Conduct a community needs assessment;
2. Mobilize and/or build capacity;
3. Develop a comprehensive strategic plan;
4. Implement evidence-informed prevention strategies and infrastructure development activities; and
5. Monitor process and evaluate effectiveness.¹⁸

The outcomes-based prevention model asks you to look at the negative substance abuse outcomes (e.g., non-medical use of prescription opioids), connect the variables that contribute to those outcomes (e.g., social availability of prescription opioids) and the community factors causing or contributing to these variables (e.g., lack of convenient disposal site), and then select strategies that specifically address those factors. Moreover, the SPF embraces the environmental approach to prevention; that is, an understanding that changes to the environment will prevent most individuals from engaging in risky substance use behaviors.¹⁹ Environmental strategies can be contrasted with programmatic efforts, which are likely to have an impact on a smaller proportion of individuals in a community. By influencing intervening variables through carefully selected policy, systems, and environmental strategies, we can achieve population-level changes in substance abuse consumption patterns and consequences.

This guide is intended to help you assess your community’s prevention needs, plan your approach, and evaluate your PFS work. It uses examples and tools that will help you determine if you are employing evidence-informed environmental prevention strategies in a manner that best addresses NMUPO and heroin use in your community. The guide is also designed to help your organization take ownership of your achievements, promote your successes, and produce materials that will help sustain your work in the future. Tips for success and questions to


consider appear throughout this guide to assist you in conducting your own needs assessment, planning, and evaluation.
STEP 1: ASSESSMENT

The first step in the SPF is to systematically gather and analyze local data related to NMUPO and heroin use. These data will help you better understand how NMUPO and heroin use manifests within your community and, ultimately, identify appropriate strategies to address the issue. Assessment is a critical first step in prevention planning; without quality assessment, communities risk selecting strategies that do not address the true problem or its community factors.

Completing a community assessment will allow your community to target its resources and maximize its impact on NMUPO and heroin use. For example, are there certain geographic areas within your community on which you should concentrate? Are you focusing on the appropriate gender group? Are there certain community conditions that are of greater concern than others? These questions are especially important given a fiscal climate in which scarce resources are often expected to produce measurable results.

The assessment process itself will also function as a tool to strengthen your community’s capacity. It is designed to be a community-wide effort rather than the sole responsibility of the fiscal agency or coalition. It will help community members to think more deeply about the specific strengths and needs within the community, and to engage in a dialogue about how best to address the issues. The process will lead your community to the evidence-informed strategies that best fit your community’s needs by either launching new initiatives or reenergizing existing efforts.

Purpose of Assessment

The data you collect as part of the assessment process will help you do the following:

• Identify the nature and extent of NMUPO and heroin use and related consequences among different groups, including those defined by age, gender, race/ethnicity, or other demographic characteristics
• Identify existing health disparities related to NMUPO and heroin use
• Determine whether your community is ready to address NMUPO and heroin use and what additional resources may be needed
• Identify community factors that contribute to social availability, retail availability, and perceived risk for harm of NMUPO and heroin use

Health Disparities Statement

Healthy People 2020 defines health disparity as “a health outcome [that] is seen in a greater or lesser extent between populations.”

Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender identity; sexual orientation; age; geographic location; or other characteristics historically linked to discrimination or exclusion.

An examination of health disparities is a priority for PFS grantees. Therefore, it will be important to consider differences in NMUPO and heroin use consumption patterns and consequences among various sub-groups within your community.
Some of the data you gather in the assessment phase will also serve as a baseline for evaluation, as described in SPF Step 5.

**Conducting an Assessment**

Conceptually, there are three main areas to examine during an assessment, as displayed below.

1. The nature and extent of NMUPO and heroin use and related consequences
2. The community factors that influence NMUPO and heroin use and their consequences
3. The existing resources and readiness of the community to address NMUPO and heroin use

During the assessment phase, it is recommended that you begin by assessing the nature and extent of NMUPO and heroin use and related consequences within your community (box 1 above). Doing so will give you a better understanding of what these problems look like in your community and, more specifically, among the target population. An important part of this process is to assess for the presence of differences among sub-groups defined by characteristics such as gender, age/grade, race, ethnicity, culture, sexual orientation, and other factors that may be differentially related to consumption patterns. Furthermore, beginning your assessment with an examination of the nature and extent of the problem(s) will help you to focus your assessment on key factors (box 2 above) and capacity (box 3 above) that are most relevant to the local manifestation of NMUPO and heroin use and, more importantly, the identified groups or sub-groups. Please see APPENDIX 2: Community Assessment Framework for further instruction on conducting a community assessment.

**Task 1: Assess Consumption and Related Consequences**

Before you begin to collect or analyze data, you should establish an assessment workgroup or committee to oversee and conduct the needs and capacity assessment for your community. Representatives from your collaborating organizations should be included on this committee. The key is to ensure that you have comprehensive geographic coverage and include members who have an array of backgrounds and experiences, so your work can be conducted in a culturally competent manner.

One of your first agenda items should be to agree on a decision-making process for the committee and to determine an acceptable timeline for assessment activities. You will also need to establish roles and articulate who will be responsible for making sure each portion of the assessment is completed. Make sure that these agreements are recorded and that everyone
understands the goals and objectives of the assessment so that the process runs as smoothly as possible. Steps should also be taken to provide this information to anyone joining the committee or workgroup later on in the process.

Since NMUPO and heroin use have already been identified as the main issues to address, the next step is to create a descriptive profile of the consumption patterns and related consequences as they manifest within your community.

Grantees should not assume that they need to collect all data using primary data collection techniques. Much of the data needed to assess consumption, consequences, and key intervening variables will be provided by state-level evaluators. Please see APPENDICES 13 and 14 for data that will be provided. Other local data may already be collected through other sources (e.g., YRBS, local hospital records) and should be accessed through those sources. For communities also addressing heroin use, follow a similar approach to assessing consumption and consequence patterns for heroin use among 18-25 year olds.

Task 2: Assess Intervening Variables and Community Factors
Intervening variables that have been specifically linked to NMUPO include social availability of prescription opioids, retail availability of prescription opioids through providers, and perceived risk for harm. Your assessment efforts should focus on these three intervening variables, considering questions such as why, how, where, when, and for whom they occur in your community (i.e., community factors). If time allows and adequate resources are available, grantees may be able to include an additional intervening variable. Doing so would require a documented need for including the variable, justification of sufficient capacity to address the variable, and Program Coordinator approval.

One thing to keep in mind as you review the literature related to these intervening variables is that studies may differ in the manner in which they define and measure NMUPO. Studies define use, misuse, non-medical use, and abuse differently, and they often use different time increments for their measurements (e.g., past month, past year, lifetime use). These differences reinforce the need to 1) have a clear outcome statement for the specific drug identified, and 2) familiarize yourself with the nuances in the literature regarding populations being studied and what exactly was measured. Ultimately, when reviewing the literature, be sure to consider the specific circumstances (e.g., substance and population being studied) for which the research was conducted.

Remember: intervening variables represent a group of factors that social scientists have identified as influencing the occurrence and magnitude of substance abuse and its consequences. The Alaska PFS project is built on the idea that making changes to these variables at the community level will, over time, cause changes in NMUPO and related consequences.

Intervening variables are broad concepts that manifest differently in different communities. It is your job to define what it is about each intervening variable that contributes to NMUPO and heroin use in your community (i.e., the community factors). A heroin example: the issue may be that in one community people who use heroin believe that they will not get caught, because
even though the police are working hard to enforce the laws, nobody hears about anyone who got caught (factor: perception about enforcement). In another community, police may not spend as much of their time enforcing laws around heroin use because other issues are considered a bigger problem (factor: focus of police enforcement). Both of these factors contribute to the intervening variable of enforcement (perceived or actual) related to heroin use. However, each of these factors requires a different community response. These community factors will then need to be prioritized using a data-driven process.

Task 3: Assess Capacity – Resources and Readiness
Assessing your community’s readiness to address the substance abuse problem and the existing resources that may be dedicated to this purpose should occur during your community assessment. This will help you prepare for strategic planning.

Assessing resources. Identifying and assessing the resources that exist to address the prevention or reduction of NMUPO and heroin use in your community will help you identify potential resource gaps, build support for prevention activities, and ensure a realistic match between identified needs and available resources.

The word resources often connotes staff, financial support, and a sound organizational structure. However, prevention resources may also include the following:

- Existing community efforts to address the prevention and reduction of NMUPO or heroin use
- Community awareness of those efforts
- Specialized knowledge of prevention research, theory, and practice
- Practical experience working with particular populations
- Knowledge of the ways that local politics and policies help or hinder prevention efforts

It is important to focus your assessment on relevant resources (i.e., those related to community factors). A well-planned and focused assessment will produce far more valuable information than one that casts too wide a net. At the same time, keep in mind that useful and accessible resources may also be found outside the substance abuse prevention system, including among the many organizations in your community that promote health and wellness. Please see APPENDIX 3: Resource Assessment Worksheet for further instruction.

Assessing community readiness. An assessment of community readiness will help you determine your community’s level of awareness of, interest in, and ability and willingness to support substance abuse prevention initiatives. There are many resources available to measure community readiness, and most of them acknowledge that readiness occurs in stages. PFS grantees are required to use the Tri-Ethnic Center’s Community Readiness Model, which has identified nine stages of community readiness:

- **Stage 1: Community tolerance/no knowledge.** Substance abuse is generally not recognized by

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the community or leaders as a problem. “It’s just the way things are” is a common attitude. Community norms may encourage or tolerate the behavior in a social context. Substance abuse may be attributed to certain age, sex, racial, or class groups.

- **Stage 2: Denial.** There is recognition by at least some members of the community that the behavior is a problem, but there is little or no recognition that it is a local problem. Attitudes may include “It’s not my problem” and “We cannot do anything about it.”

- **Stage 3: Vague awareness.** There is a general feeling among some in the community that there is a local problem and that something ought to be done, but there is little motivation to do anything. Knowledge about the problem is limited. No identifiable leadership exists, and/or leadership is not encouraged.

- **Stage 4: Pre-planning.** Many people clearly recognize that there is a local problem and that something needs to be done. There is general information about local problems and some discussion. There may be leaders and a committee to address the problem, but there is no real planning or clear idea of how to progress.

- **Stage 5: Preparation.** The community has begun planning and is focused on practical details. There is general information about local problems and about the pros and cons of prevention approaches, but this information may not be based on formally collected data. Leadership is active and energetic. Decisions are being made and resources (i.e., time, money, people, etc.) are being sought and allocated.

- **Stage 6: Initiation.** Data are collected that justify a prevention approach; however, decisions may be based on stereotypes rather than data. Action has just begun. Staff are being trained. Leaders are enthusiastic, as few problems or limitations have occurred.

- **Stage 7: Institutionalization/stabilization.** Several planned efforts are underway and supported by community decision-makers. Strategies and activities are seen as stable, and staff are trained and experienced. Few see the need for change or expansion. Evaluation may be limited, although some data are routinely gathered.

- **Stage 8: Confirmation/expansion.** Efforts and activities are in place and community members are participating. Strategies have been evaluated and modified. Leaders support expanding funding and scope. Data are regularly collected and are used to drive planning.

- **Stage 9: Professionalization.** The community has detailed, sophisticated knowledge of the magnitude and severity of the problem and related risk and protective factors. Universal, selective, and indicated efforts are in place for a variety of target populations. Staff are well-trained and experienced. Effective evaluation is routine and used to modify strategies. Community involvement is high.

Community readiness assessments must be conducted by urban communities for both NMUPO and heroin use separately as different levels of readiness may exist for each. Obtaining community readiness scores (overall and by domain) will help communities focus on needed readiness-building efforts. Community readiness assessments will be conducted again in 2019 as a requirement of SPF Step 5 (Evaluation) to determine if changes in community readiness have occurred during the project.

For funded grantees with one predominant community (Municipality of Anchorage, Sitka City and Borough, Juneau City and Borough, and Fairbanks North Star Borough) the community
readiness assessments will be relatively straightforward. For grantees with multiple communities (Mat-Su Borough and the Kenai Peninsula Borough), a slightly different approach will need to be developed. It is not reasonable to do a complete community readiness assessment in each community within the borough due to limited time and resources for the assessment process. One example solution would be to conduct a community readiness assessment with individuals in a limited but consistent set of prioritized community sectors (e.g., six versus nine sectors) in the two most populated communities. This would allow you to determine readiness for most of the population in your borough. You will not conduct as many interviews in each community but there will be enough information to determine the level of readiness and move forward with planning. As a second example, it is possible that other data collected during the assessment process will lead to a focus on specific high-need communities within your borough. In this example, including the selected high-need communities in the readiness assessments would instead be important. For Mat-Su Borough and Kenai Peninsula Borough grantees, it will be important to work closely with the Data and Evaluation Technical Assistance Liaison (DETAL) team to craft the best readiness assessment plan based on your unique approach and regional makeup.

It will be important for all grantees to maintain consistency in the approach used for both baseline and follow-up community readiness assessments in order to compare results with confidence over time.

**Task 4: Prioritize Community Factors**

Prioritizing community factors is a critical part of the SPF. It is unlikely that you will have the resources and readiness to address all community factors simultaneously, which is why prioritization and selection are important. Community factors pertaining to the required strategies of disposal sites and awareness campaigns have already been prioritized. These prioritized community factors for addressing NMUPO are: lack of knowledge about the risks of easy social access to prescription opioids; lack of knowledge about how to prevent social access to prescription opioids; and lack of a convenient and/or recognized site to safely dispose of prescription opioids.

Coalitions will prioritize other community factors identified in the needs assessment related to NMUPO and heroin use; coalitions will develop strategies for addressing these community factors later on. There are many ways to organize and compare the data you gather in order to help you prioritize them. A template is also available in **APPENDIX 4: Community Factor Prioritization Process**.

While different criteria can be used to prioritize community factors, communities often consider two criteria in particular when making this decision:

- **Importance**: The extent to which various community factors have the potential to meaningfully impact the relevant intervening variable
- **Changeability**: How easy it would be to change the community factor given existing time, resources, and readiness

Whenever possible, it is recommended that you select community factors that are high in both.
### Importance

When weighing the importance of community factors, consider the following:

- **How much does the community factor directly influence the intervening variable?** For example, it is known that easy access to prescription opioids through social sources is a problem, and local survey data show that community members would be more likely not to keep unused or expired medication in their homes if a convenient disposal site existed in the community. Therefore, the factor of lacking a convenient disposal site would be rated as high in importance.

- **Does the community factor impact other behavioral health issues or other identified problems?** For example, is there a factor that influences both NMUPO and heroin use? If so, focusing on this risk factor may impact more than one issue.

- **Do the community factors directly impact the specific developmental stage of those experiencing the problem?** For example, for the identified problem of NMUPO among high school students, the risk factor of being a member of a social fraternity or sorority would be less important for high school students than it would be for college populations.

### Changeability

When assessing the changeability of a factor, you may want to consider the following:

- Whether the community has the capacity—the readiness and resources—to change a particular community factor
- Whether a suitable evidence-informed strategy exists that has been shown to impact the community factor
- Whether change can be brought about in a reasonable time frame (i.e., changing some factors may take too long to be a practical solution within this grant cycle)
- Whether the changes can be sustained over time

<table>
<thead>
<tr>
<th>Importance</th>
<th>Changeability</th>
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<tbody>
<tr>
<td>High</td>
<td>High</td>
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<td>Low</td>
<td>Low</td>
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</table>
If the community has ample resources and sufficient readiness to address a community factor, a suitable evidence-informed strategy exists, and sustainable change can occur within a reasonable timeframe, then the factor would be considered high in changeability. If there are not adequate resources or if the community is not ready to address the factor, the changeability of the factor may be low. Such capacity considerations will be discussed in the next step, Capacity Building.

At the completion of the Assessment step, coalitions will submit their assessment report to the Program Coordinator. At the same time, coalitions will also submit their completed Step 1 fidelity checklist. Coalitions are expected to maintain as much fidelity to the SPF process as possible, and these checklists will help keep coalitions on track. For more information, see APPENDIX 2: Community Assessment Framework for a report outline and APPENDIX 6: Step 1 Fidelity Checklist.
STEP 2: CAPACITY BUILDING

Capacity building involves improving your coalition’s ability to address the prevention or reduction of NMUPO and heroin use within your community. Capacity includes all the human, technical, organizational, and financial resources you will need, as well as your community’s readiness to address the priority problem(s). Capacity is an ongoing process; it takes place throughout all steps of the SPF and requires continuous attention in order to implement and evaluate your strategies in a culturally competent and sustainable way.

Your capacity affects how (and how effectively) your group goes about every aspect of its work. Different elements of capacity become more important during different points in the SPF cycle. Your capacity needs may change as work progresses, goals are accomplished, and priorities shift or expand.

Task 1: Build Capacity – Increase Resources and Improve Readiness

It is important to continually assess your capacity and make sure that you have the resources and readiness required to carry out each stage. For example, during Step 1 (Assessment), your coalition will need to assess its cultural competence and build its capacity to integrate or infuse cultural competence into the assessment process so that participants in planning meetings, focus groups, and other assessment activities experience a safe and supportive environment. Additionally, your coalition will need to assess its capacity to successfully implement and sustain a particular strategy during the Planning phase (Step 3).

Key components of this task include the following:

- Increasing the availability of fiscal, human, organizational, and other resources
- Raising awareness of the NMUPO or heroin use problem and the readiness of stakeholders to address this issue

  Note: One way to raise awareness is to conduct a media campaign. For tips on working with the media and crafting an effective message, please refer to the Alaska PFS website.²¹

- Developing or strengthening relationships with partners and/or identifying new opportunities for collaboration

Capacity Building through Organizational Development

Part of capacity building is paying attention to the organizational infrastructure needed to plan, implement, evaluate, and sustain your strategy. Five factors are key to both organizational infrastructure development and sustainability²²:

- Creating and strengthening administrative structures and formal linkages among all organizations and systems involved
- Encouraging champions (i.e., people who speak about and promote the strategies in

²¹ See http://www.iser.uaa.alaska.edu/Projects/pfs/index.php
the community) and leadership roles for multiple supporters across organizations and systems, and making sure that these roles are distributed across different ethnic, racial, socioeconomic, and other community sub-populations

- Making plans to ensure that adequate funding, staffing, technical assistance, and materials will be in place as needed
- Developing administrative policies and procedures that support your prevention strategies and send a clear message about the desirability of and expectations for sustaining efforts
- Building and maintaining community and coalition expertise in several areas, such as effective prevention, needs assessment, logic model construction, selection and implementation of evidence-informed strategies, fidelity and adaptation of evidence-informed strategies, evaluation, and cultural competence

**Capacity Building throughout the SPF**

At each step of the SPF, it is important to document and track required assets and needs. This information will assist you in developing concrete plans for building your coalition’s capacity and tracking the implementation of your plans. For example, after completing the assessment of needs, readiness, and resources in Step 1, your coalition might do the following:

- Review the **quantitative** and **qualitative** data collected regarding your community’s capacity to prevent and reduce NMUPO and heroin use
- Identify capacity needs
- If necessary, conduct additional assessments to further define your capacity needs

Next, your coalition should develop a capacity building plan for addressing identified needs, building on the assets and resources you identified earlier in the process. It is recommended that coalitions prioritize three key needs and develop their plan around those; this will keep coalitions focused and will make effective use of limited time and resources. See **APPENDIX 5: Capacity Building Plan - Example and Template** for further guidance.

**Capacity Building through Cultural Competence**

Increasing the cultural competence of your coalition involves looking at your current practices and considering whether your written guidelines or policies reflect a culturally competent perspective.

Answering the following questions can help you assess your coalition’s strengths and weaknesses in this area:

- **Membership:** How well does your coalition reflect the communities you serve? To increase the breadth of your representation, should you add members? Should you forge partnerships with organizations that have stronger capacity for working with certain diverse groups?
- **Resources:** Do your members or partners need additional training or resources in order
to serve all parts of your community equitably? For example, do you need to build your capacity to translate materials into another language?

- **Barriers**: What is getting in your coalition’s way as you work to connect with and serve diverse communities? Without rehashing past mistakes, can you take a clear look at any problems that exist and identify how your coalition might change its practices?
- **Leadership**: Has your group publicly endorsed cultural competence and inclusivity? Does it need more leadership in this area, perhaps from a partner with more expertise?

**Capacity Building through Improved Community Readiness**

To improve community readiness, the National Institute on Drug Abuse recommends the following strategies based on the stage of community readiness a community is currently at. These recommendations coincide with the Tri-Ethnic Center’s nine stages of community readiness:

- **Stage 1: Community tolerance/No knowledge**
  - Hold small-group and one-on-one discussions with community leaders to identify the perceived benefits of substance use and how community norms reinforce use
  - Have small-group and one-on-one discussions with community leaders on the health and social costs of substance abuse in order to change perceptions among those most likely to be part of the group that initiates strategy development

- **Stage 2: Denial**
  - Offer educational outreach to community leaders and groups interested in sponsoring local strategies focusing on the health and social costs of substance abuse
  - Use local incidents that illustrate the harmful consequences of substance abuse in your one-on-one discussions and educational outreach initiatives

- **Stage 3: Vague awareness**
  - Offer educational outreach on national and state prevalence rates of substance abuse and prevalence rates in communities with similar characteristics
  - Conduct local media campaigns that emphasize the consequences of substance abuse
  - Include local incidents that illustrate the harmful consequences of substance abuse in all outreach efforts

- **Stage 4: Pre-planning**
  - Offer educational outreach to community leaders and sponsorship groups that communicate the prevalence rates and correlates or causes of substance abuse
  - Provide educational outreach that introduces the concept of prevention and illustrates specific prevention strategies adopted by communities with similar profiles
  - Conduct local media campaigns emphasizing the consequences of substance abuse and ways to reduce demand for misused or illicit substances through prevention efforts

- **Stage 5: Preparation**
  - Offer educational outreach to the general public on specific types of prevention strategies, their goals, and how they can be implemented
- Provide educational outreach for community leaders and local sponsorship groups on prevention strategies, goals, staff requirements, and other startup aspects of prevention initiatives
- Conduct a local media campaign describing the benefits of prevention strategies for reducing consequences of substance abuse

**Stage 6: Initiation**
- Offer in-service educational training for staff (paid and volunteer) on the consequences, correlates, and causes of substance abuse and the nature of the problem in the local community
- Conduct publicity efforts associated with the kickoff of the initiative
- Hold a special meeting with community leaders and local sponsorship groups to provide an update and review of initial activities

**Stage 7: Institutionalization/stabilization**
- Lead in-service educational efforts on the evaluation process, new trends in substance abuse, and new initiatives with trainers either brought in from the outside or with staff members sent to trainings sponsored by professional societies
- Conduct periodic review meetings and special recognition events for local supporters of the prevention initiative
- Publicize local efforts associated with review meetings and recognition events

**Stage 8: Confirmation/expansion**
- Lead in-service educational efforts on the evaluation process, new trends in substance abuse, and new initiatives with trainers either brought in from the outside or with staff members sent to trainings sponsored by professional societies
- Conduct periodic review meetings and special recognition events for local supporters of the prevention initiative
- Present results of research and evaluation activities of the prevention strategy to the public through local media and public meetings

**Stage 9: Professionalization**
- Provide continued in-service training of staff
- Continue to assess new drug-related problems and to reassess targeted groups within community
- Continue to evaluate efforts
- Provide regular updates on activities and results to community leaders and local sponsorship groups
- Share success stories with local media and at public meetings

Do not try to skip stages. For example, if you find that your community is in Stage 1, do not try to force it into Stage 5. Change must happen through preparation and process - not coercion.

As with the other SPF steps, coalitions will complete the Step 2 fidelity checklist and submit it to their Program Coordinator at the same time they submit their assessment report and Step 1 fidelity checklist. See [APPENDIX 7: Step 2 Fidelity Checklist](#) for further information.
STEP 3: STRATEGIC PLANNING

In this step, you will use the information you obtained during Steps 1 and 2 to develop a strategic plan and logic model for preventing and reducing NMUPO and heroin use in your community. A strategic plan is often compared to a roadmap. Continuing the metaphor, the needs and capacity assessment is akin to gathering information on potential routes, traffic patterns, the number of roads in an area, the condition of various routes, the amenities available to you along the way, and the systems in place to maintain all of the above for the duration of your journey. This planning step involves developing a comprehensive, logical, and data-driven plan to address the problems identified in Step 1 with the current and future capacity developed in Step 2. Guidelines for PFS grantees on developing a strategic plan and logic model are provided in APPENDIX 8: Strategic Plan Development Guide and APPENDIX 9: Logic Model Development Guide.

Task 1: Develop a Vision Statement
At one of your first planning meetings you will want to review the purpose of the strategic plan and review the findings of your needs and capacity assessment. The assessment report you prepared should be sufficient, but you may wish to share more detailed findings as well, particularly with new members who may have just joined the process.

While much of the work you have done so far is focused on the past and present conditions in your community, it is now time to develop a vision for the future. A vision statement is a description of that ideal end-state and it should indicate what the group is striving to achieve.

Guidelines for your vision statement:
- The vision statement should capture the dream of how coalition members want their community to be.
- It needs to be concise and clear so that the message is immediately evident.
- Vision statements are positive and often contain a collage of upbeat and positive phrases such as "healthy teens" or "drug-free youth."
- The vision statement must be general; that is, it shouldn’t indicate such specifics as how an organization will reach its goal. It also needs to be broad enough to attract support and not offend any group of people.
- A vision statement should be flexible. It should represent a “common ground” point of view so that everyone can agree with it.
- It is inspirational and adapts to fit changes in the community, needs, coalition membership, and times.
- It can apply to all people in your community and stand as a litmus test in guiding important decisions.

A vision statement should always be positive, personal, and inspirational. The vision statement paints the big picture: where the organization is now, and where it needs to be going. The statement should provide a framework for decision-making. Its inspirational nature helps to
develop team spirit and to empower the organization.

**Task 2: Select Strategies**

When developing a plan to address NMUPO and heroin use in your community, it is important to identify and select strategies that have been shown to be effective, are a good fit for your community, and are likely to promote sustained change. Although it is natural to want to jump directly to strategy selection, this step should only occur *after* your community factors have been prioritized. The community factors should drive strategy selection – not vice-versa.

**Policy, Systems, and Environmental Change.** The PFS is primarily focusing on policy, systems, and environmental (PSE) change, which is a new way of thinking about how to effectively improve health in a community. For many years, health programs have focused on individual behavior, assuming that if you teach people what will make them healthy, they will find a way to do it. Unfortunately, being healthy is not just about individual choices. Today, we are realizing that it is not enough to know how to be healthy – you need practical, readily available, healthy options around you. That is where PSE strategies come in.

PSE change is a way of modifying the environment to make health choices practical and available to all community members. By changing laws and systems, or even shaping physical landscapes, a big impact can be made with little time and resources. PSE strategies make healthier choices a real, feasible option for community members by looking at the laws, rules, and environments that impact our behavior.

**Evidence of Effectiveness.** Literature reviews, published studies, unpublished evaluation findings, and other resources may help you identify strategies with the greatest potential to affect the community factors you identified and associated intervening variables.

Despite the fact that there are few published studies yet demonstrating NMUPO prevention outcomes at the community level, there are several resources that can assist prevention practitioners in identifying evidence-informed strategies in this area. Some resources include the Office of National Drug Control Policy’s “Prescription Drug Abuse Prevention Plan,”


This is not intended to be an exhaustive list, but it does cover many of the strategies that constitute the current state of the science.
For each strategy you consider:

- Review the research evidence that describes how the strategy is related to your selected community factors and intervening variables
- Based on this evidence, present a rationale describing how the strategy addresses the community factors and intervening variable

**Note:** Be sure to discuss potential strategies with your Program Coordinator.

As described later in this section, this process will help you develop a logic model that shows how your selected strategies will lead to improvements in NMUPO and heroin use prevention outcomes.

**Conceptual Fit**

Think about how relevant the strategy is to your community and how it is logically connected to your community factors, intervening variables, and desired outcome. To determine conceptual fit, consider the following questions:

- Has the strategy been tested with the identified target population? If so, how? If not, how can it be applied to the target population?
- How will implementing this strategy in your local community help you achieve your anticipated outcomes?

**Practical Fit**

Given your community’s readiness, target population, and general local circumstances, how effectively could you implement this strategy? Consider the following:

- Resources (e.g., cost, staffing, access to target population)
- Coalition climate (e.g., how the strategy fits with existing prevention efforts, the coalition’s willingness to accept new strategies, buy-in of key leaders)
- Community climate (e.g., the community’s attitude toward the strategy, buy-in of key leaders)
- Sustainability (e.g., community ownership of the strategy, renewable financial support, community champions)

**Task 3: Develop a Strategic Plan that Aligns with the Logic Model**

At this point in the SPF process, you know your community’s priority problem(s), intervening variables, community factors, resources, and readiness. Additionally, you have identified appropriate strategies for addressing NMUPO and heroin use. The next step is to bring all these elements together to create an overall vision of what your group is attempting to do and how it will evaluate the results of its efforts.

Developing a strategic plan requires you to do the following:

- Identify resources for implementation
- Develop a logic model (see APPENDIX 9: Logic Model Development Guide)
- Develop action plans (see APPENDIX 10: Action Plan Template)
- Develop an evaluation plan

**Identify Resources for Implementation.** Specify all resources needed to implement and evaluate each selected strategy. Be sure to consider the following:

- Human resources (e.g., staffing, partnerships, volunteers, coalition membership)
- Skills (e.g., prevention and intervention knowledge and skills, data collection and analysis)
- Fiscal resources (e.g., monetary, in-kind)
- Material resources (e.g., space, equipment)
- Existing resource gaps that will limit your ability to effectively implement the selected strategies

**Develop a Logic Model.** A logic model is a chart that describes how your initiative is supposed to work and explains why your strategy is a good solution to the problem at hand. Effective logic models depict the activities that will bring about change and the results you expect to see in your community. A logic model keeps planners moving in the same direction by providing a common language and point of reference.

Logic models may be used for various purposes (e.g., planning, implementation, evaluation) and can feature different elements (e.g., inputs, activities, outputs, outcomes).

Use the information you gathered in Steps 1 and 2 of the SPF to develop a community-level logic model that links local factors, associated intervening variables, evidence-informed strategies, and anticipated outcomes.

The first figure below is a logic model for addressing prescription opioid misuse and abuse among 12-25 year olds. The logic model includes strategies to create change in key community factors that will influence the identified intervening variables, which will directly lead to a reduction in the non-medical use of prescription opioids and associated consequences. A basic heroin logic model is also provided below.

The example logic models below illustrate the required PFS community factors and strategies but do not include any additional community factors and strategies that may be chosen by communities during the SPF process. Remember that an additional PSE strategy is required for each priority area of NMUPO and heroin use.

A separate logic model will need to be created for each priority area (i.e., prescription opioids, heroin).
## Basic Logic Model for NMUPO

<table>
<thead>
<tr>
<th>Community Strategies</th>
<th>Community Factors “Why in Our Community?”</th>
<th>Intervening Variables</th>
<th>Consumption Pattern</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-level campaign</td>
<td>Lack of knowledge among adults about risks of easy social access to Rx opioids</td>
<td>Social Availability - Easy access to Rx opioids through social sources</td>
<td>RX opioid misuse and abuse</td>
<td>RX opioid hospital poisonings</td>
</tr>
<tr>
<td>Create safe disposal sites</td>
<td>Lack of knowledge among adults about how to prevent social access to RX opioids</td>
<td>Retail Availability - Easy access to RX opioids through providers or dealers</td>
<td></td>
<td>RX opioid ER visits</td>
</tr>
<tr>
<td>Multi-level campaign</td>
<td>Other Community Factors identified by communities during assessment to address: Social Availability, Retail Availability, or Perceived Risk</td>
<td>Perceived Risk of Harm from RX opioid misuse or abuse</td>
<td></td>
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Prioritized and Evaluated by Communities

Prioritized and Evaluated by the State
Develop Action Plans. An *action plan* is the detailed sequence of steps that must be taken for a strategy to succeed. They comprise one component of your larger strategic plan.

An action plan states:
- What needs to be accomplished
- Who is responsible
- The timeline for completion
- How you will measure success

Keep in mind that good planning requires a group process. Whether decisions are made within a formal coalition or among a more informal group of partners, these decisions cannot represent the thoughts and ideas of just one person; they must reflect the ideas and input of individuals from across community sectors. For a template and example of an action plan, see *Appendix 10: Action Plan Template*.

*Action plan and cultural competence.* To increase your group’s cultural competence, you will need to be open to modifying your planning and thinking processes to reflect the preferences of the target population. For example, some Alaska Native and American Indian communities
prefer planning processes that are circular, such as using a Mind Map to brainstorm, rather than a linear list or table. Faith-based organizations may believe that action-oriented plans should be tempered by other forms of spiritual guidance about the best way to move forward. Listening to and incorporating different viewpoints will help you develop a plan that is culturally competent, shows respect for participants’ values, and is, therefore, more likely to succeed.

Members of your community or coalition may come to the table with different levels of understanding regarding substance abuse and how to plan, implement, and evaluate strategies. Some may not be familiar with logic models or may not understand how a formal logic model may differ from their usual approaches. Several training sessions may be needed to get everyone to the same baseline of understanding, thereby promoting fruitful discourse and consensus building.

**Note:** The cultural competence planning process may identify several areas of discord among members of your coalition. This is a good opportunity to address these differences early on, thereby preventing the issues from resurfacing later and derailing your work.

### Increasing Cultural Competence

Cultural competence should be visibly interwoven throughout your strategy. A plan to increase your coalition’s cultural competence should do the following:

- Include measurable goals and objectives with concrete timelines. For example, you might develop an outreach goal of contacting 10 different community agencies within six months, with the ultimate goal of recruiting 5 new coalition members.
- Ensure you are involving representatives from all community sectors in your efforts. Outline the steps your coalition will take to include each sector as a full participant in your prevention efforts, rather than solely as the target of your activities.
- Indicate who is responsible for the proposed action steps, and outline some of the potential resources needed.

### Develop an Evaluation Plan

It is a common misperception that evaluation starts only at the end of a project. **Though evaluation is the focus of the last step of the SPF, it should be considered during each preceding step.** Ongoing monitoring and modifying are essential to determine whether your desired outcomes are achieved and to assess the effectiveness and impact of your strategy and the quality of service delivery. Data collection for evaluation purposes should be built into the project design and should be part of your strategic plan. Your evaluation will ultimately affect the sustainability of your strategy. See Step 5 of the SPF process for further guidance on developing evaluation plans.

Alongside the strategic plan and its relevant components, coalitions will also submit their Step 3 fidelity checklist. See [APPENDIX 11: Step 3 Fidelity Checklist](#) for more information.
STEP 4: IMPLEMENTATION

In the implementation phase, you will focus on carrying out your strategic plan, including the various components of your action plans, and identifying and overcoming any potential barriers. You will assess your capacity to carry out the strategic plan, determine what training or other assistance is needed, and decide how to engage additional community partners who have the necessary expertise.

In this phase, the role of your coalition shifts from planning to oversight, mutual accountability, and monitoring of the implementation process. You must make sure that the plan is implemented with fidelity, allowing for adaptations only when necessary. It is especially important to integrate the principles of cultural competence into the implementation phase so that the strategy is accessible to and effective with the identified target population.

At this point, it is important to make sure that all partners understand the identified goals and selected strategies, as well as their own specific contributions. All members should support the goals and strategies and understand how the activities to be implemented will lead to the desired outcome.

Task 1: Build Capacity and Mobilize Support
Assess your coalition’s capacity to implement the selected strategies by answering three questions:
- What capacity is required to implement these strategies?
- Does your coalition have that capacity?
- If not, how will you improve your capacity?

These types of questions should also be addressed in your strategic plan. Be sure to review the Capacity Building Plan you completed in Step 2 and make any necessary edits.

Partners who are involved in the assessment and planning processes may find that they lack the skills needed to carry out one or more of the selected strategies. A plan to improve capacity may include involving additional community partners who already have appropriately trained staff, hiring staff with the necessary expertise, or providing training opportunities for staff and members who will be involved in implementing the strategy. When seeking community partners, keep in mind the principles of cultural competence; ensuring diversity among your partners and developing links with community institutions are good strategies for supporting cultural competence.

Task 2: Carry Out Strategies
Everyone involved in the effort should understand his or her role in implementing the identified strategies. All too often, the tasks of implementation are handed over to a few staff members, while others sit back and expect to hear about how the work is going, without being directly involved. Staff may be able to fill a number of important roles, including preparing meeting minutes, compiling reports, coordinating meetings, facilitating communication with partners, maintaining accurate records for funding and reporting requirements, and assisting with
planning, problem-solving, and information management. However, with all these roles to fill, staff cannot also be expected to implement the selected strategies by themselves.

You may consider forming small committees that will each focus on a specific strategy. In doing so, remember to support cultural competence by ensuring diversity in your leadership. Providing additional leadership opportunities can also be an integral way to promote sustainability. The more invested your partners become, the more likely they will be to support your coalition’s activities in the long term.

Some members may be willing to become prevention champions—those who speak about and promote the strategies in the community. In addition, members can leverage resources for change in the community through their professional and personal spheres of influence. For example, a member might serve as a liaison to help implement an inter-organizational prevention effort, bringing together organizations to which he or she has connections.

**Task 3: Balance Fidelity with Necessary Adaptations**

*Fidelity* is the degree to which a strategy is implemented as its original developer intended. Strategies that are implemented with fidelity are more likely to replicate the results from the original implementation of the strategy than are those that make substantial adaptations.

Although ensuring fidelity is an important concern, at times it may be necessary to adapt the strategy to better fit your local circumstances. You may find, for example, that you are working with a target population that is in some way different from the population that was originally evaluated, or that some strategy elements must be adjusted due to budget, time, or staffing constraints. In these cases, it may be necessary to adapt the strategy to meet your needs. Balancing fidelity and adaptation can be tricky—any time you change a strategy, you may compromise the outcomes. Even so, implementing a strategy that requires some adaptation may be more efficient, effective, and cost-effective than designing a new strategy.

Here are some general guidelines for adapting a strategy:

- Select strategies with the best initial fit to your local needs and conditions. This will reduce the likelihood that you will need to make adaptations later.
- Select strategies with the largest possible *effect size*—the magnitude of a strategy’s impact. For example, policy change generally has a larger effect size than classroom-based programs.

  *Note:* The smaller a strategy’s effect size, the more careful you need to be about adapting that strategy. You do not want to inadvertently compromise any good that
you are doing. In general, adaptations to strategies with large effect sizes are less likely to affect relevant outcomes.

- Implement the strategy as written, if possible, before making adaptations, since you may find that it works well without having to make adaptations.
- When making adaptations, consult an evaluator.
- Retain the core components, because strategies that include these components have a greater likelihood of effectiveness. If you are not sure which elements are core components, refer to the strategy’s logic model, if it is available, or consult an evaluator for assistance.
- Stick to evidence-informed principles. Strategies that adhere to these principles are more likely to be effective, so it is important that adaptations are consistent with the science.
- Change your coalition’s capacity before you adapt a strategy. While it may seem easier to change the strategy, changing local capacity to deliver it as it was designed is a safer choice.

Task 4: Plan for Sustainability
The implementation of strategies to bring about significant community change rarely takes place in a short timeframe. As you build capacity to bring about change, you should be aware of the need to generate resources to sustain your strategies, beyond the expense of carrying out a strategy.

Sustaining your work includes both institutionalizing strategies and finding additional financial support for them—both of which should be planned for by the time you begin to implement activities. It is important to form a workgroup of staff and coalition partners to focus on sustainability planning, since getting key stakeholders involved from the beginning can inspire them to become advocates for your work and champions for sustaining your activities.

Planning for financial stability involves figuring out strategies and action steps to obtain and grow the diverse resources—human, financial, material, and technological—needed to sustain your efforts over time. Additional resources may include finding in-kind support, recruiting and sustaining a volunteer staff, obtaining commitments for shared resources from other organizations, or persuading another organization to take on a project begun by your group.

Institutionalizing your work is a long-term process that requires finding ways to make the policies, practices, and procedures you have established become successfully rooted in the community. This includes existing systems and frameworks relevant to your work, which can be stepping stones to eventual policy changes. This can also help extend the length of time you have to work on the issues, since it may take years to build a comprehensive solution.

Partnerships are crucial in finding ways to integrate your work into existing departments within a community or into other organizations. To do this, it is important to invest in capacity, teach people how to assess needs, build resources, and effectively plan, implement, and evaluate prevention strategies to create the systems necessary to support these activities going forward.
After the first year of implementation, coalitions will submit their Step 4 fidelity checklist to the Program Coordinator to ensure they are meeting fidelity requirements of the SPF. See APPENDIX 12: Step 4 Fidelity Checklist for further information.
STEP 5: EVALUATION

Evaluation Part I: Evaluation Basics

SPF Step 5 involves the evaluation of your PFS efforts. This section provides you with a brief overview of how evaluation fits into the SPF process, describes the ways in which different types of evaluation methods can be useful for your PFS efforts, and then walks through the required evaluation components of the Alaska PFS Project. Evaluation templates specific to the project and additional evaluation resources will be available on the PFS website.26

Please note that one-on-one technical assistance and trainings will be provided throughout the project to assist you with your evaluation efforts. If you have any technical assistance questions related to PFS evaluation requirements, please contact the DETAL team. They will be providing technical assistance and trainings, where necessary, related to the evaluation requirements outlined in this section created by UAA Center for Behavioral Health Research and Services (CBHRS) evaluators.

Why evaluate?
Program evaluations are systematic investigations that assess how well a project or strategy is working and why (or why not). Knowing whether a strategy works provides important information about whether or not to use it again in the future. Understanding why a strategy works and what specific details promote or inhibit its effectiveness allow for informed modifications to improve effectiveness.

The five functions of evaluation, described below, are accomplished when you provide the needed information to the appropriate stakeholders so that they make better choices (improvement), work more closely with coalition partners (coordination), demonstrate that outcomes have been met (accountability), honor a team’s work (celebration), and show community leaders why they should remain invested in coalition efforts (sustainability).

Improvement. Evaluation efforts can help to improve the ways in which strategies are implemented—both efficiently and effectively. Improvement is the most important function of an evaluation.

Coordination. Since it takes multiple partners to implement the various strategies selected by the coalition to address local substance abuse issues, evaluation efforts can help these partners and activities point in the same direction. Evaluation efforts should help members know what others are doing, how this work fits with their own actions and goals, and what opportunities exist for working together in the future.

There is no such thing as a “perfect” evaluation design. Evaluation efforts must be prioritized within the context, timeframe, and resources available (e.g., skills, data, expertise, budget). For this project, there are state and federal evaluation requirements that must also be met. Doing less but doing it well is better than trying to do too much. Keep it manageable!

26 See http://www.iser.uaa.alaska.edu/Projects/pfs/index.php

Prevention of Non-Medical Use of Prescription Opioids and Heroin Use in Alaska
**Accountability.** Evaluation efforts allow the coalition to describe its contribution to important population-level change and decide if progress has been made in changing outcomes.

**Celebration.** This function is all too often ignored. The path to reducing substance abuse at the community level is not easy, so a stated aim of any evaluation process should be to collect information that allows the coalition to celebrate genuine accomplishments.

**Sustainability.** A thorough evaluation can assist a coalition in providing important information to the community and various funders, which promotes the sustainability of both the coalition and its strategies.

**Process Evaluation**
When reading and talking about program evaluation, two types of evaluations are used and discussed most frequently – process evaluation and outcome evaluation. A *process evaluation answers questions such as who, what, when, why, and how about your efforts.* The results from a *process evaluation* should help you decide how you could adjust your implementation efforts to be more effective, such as when or where those adjustments should occur in your implementation process. Capacity building goals are best measured by process evaluations, as are strategy implementation efforts. Below are some specific examples of the types of questions that a process evaluation may answer.

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<thead>
<tr>
<th>Types of process evaluation questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who…</strong></td>
</tr>
<tr>
<td>• planned to undertake each action?</td>
</tr>
<tr>
<td>• actually completed each action?</td>
</tr>
<tr>
<td>• were the planned participants?</td>
</tr>
<tr>
<td>• were the actual participants?</td>
</tr>
<tr>
<td><strong>What...</strong></td>
</tr>
<tr>
<td>• action steps were planned?</td>
</tr>
<tr>
<td>• action steps were actually taken?</td>
</tr>
<tr>
<td><strong>When...</strong></td>
</tr>
<tr>
<td>• was each action planned?</td>
</tr>
<tr>
<td>• was each action actually initiated and completed?</td>
</tr>
<tr>
<td><strong>Why...</strong></td>
</tr>
<tr>
<td>• was each action taken?</td>
</tr>
<tr>
<td>• were any adjustments made?</td>
</tr>
<tr>
<td><strong>How...</strong></td>
</tr>
<tr>
<td>• was each action actually implemented?</td>
</tr>
<tr>
<td>• well does the strategy match community needs?</td>
</tr>
</tbody>
</table>

*A process evaluation compares the work that is being done to what you originally planned to do.* It allows you to see what you did differently and begin to think about why you strayed from the plan, whether intentionally or unintentionally, when you did. A process evaluation also considers the quality and the strengths and weaknesses of both the plan and the actual
implementation, and it considers how well the strategy addresses community needs, matches your organization’s available resources (both financial and in terms of staffing), and whether or not it seems capable of producing your desired outcomes.

**Process evaluation can also attempt to measure successes in terms of immediate reactions.** Assessing a reaction means measuring how participants perceived or felt about a strategy, service, or policy (e.g., through satisfaction surveys or satisfaction interviews). If strategies are not perceived well by community members, they are unlikely to be effective.

**Outcome Evaluation**

*An outcome evaluation tells you whether your activities are changing knowledge, attitudes, and specific behaviors among your target population in the community.* For this project, our target population comprises youth and adults 12-25 years of age. Ultimately, an outcome evaluation is trying to measure the extent to which your prevention efforts are creating changes that will help you achieve a reduction in NMUPO, heroin use, and consequences of these behaviors in the community. A good outcome evaluation can help you decide whether to expand what you are doing or terminate work and shift your resources elsewhere.

Outcome evaluations can measure short-term changes (e.g., knowledge, attitudes, or whether or not a policy was passed) or can measure longer-term changes such as a change in opioid misuse or reductions in consequences related to opioid consumption. One challenge of outcome evaluation is to know how long it will take for people to incorporate new behaviors or for policies to take effect. Another challenge is to understand how multiple variables might affect someone’s decision to change his or her behavior. For example, research shows that media publicity about enforcement activities (e.g., newspaper articles) alongside increased enforcement efforts is far more effective at changing underage alcohol consumption than enforcement efforts alone. This is because the combined approach impacts young people’s *perceptions* about being caught - not just their chances.

It is often difficult to directly link changes in outcomes to a specific strategy when conducting an evaluation (i.e., A caused B). Including a comparison group (i.e., a group of persons who did not receive the strategy) in your evaluation design for comparative purposes can help but it is often costly, time-intensive, and not practical for community-level prevention efforts such as the PFS. Another way to determine change in outcomes is through a time-series design by monitoring outcomes multiple times before and after your strategy has been implemented. The time-series approach, including graphs, will be used for the PFS project to evaluate change in the specific community factors identified during the assessment and targeted by your chosen strategies.

**For the PFS project, communities will have the most influence over carefully selected community factors.** Therefore, community-level outcome evaluation efforts will focus on the strategies implemented to directly address community factors. Below is an example of the general community logic model being used for the PFS project and expanded on by communities.
to address prescription opioids. The farther right you move in the logic model, the less likely change will be seen during the PFS grant. Yellow areas of the logic model indicate more long-term outcomes with change expected after 3-5 years. The model below also shows which components of the logic model will be evaluated by CBHRS evaluators at the state and community (borough) levels and which components will be evaluated by funded communities using local data. In terms of evaluation, the right side of community logic model is the responsibility of CBHRS evaluators and the left side of the logic model is the responsibility of funded communities.

**Example Community Logic Model for Addressing NMUPO**

<table>
<thead>
<tr>
<th>Community Strategies</th>
<th>Community Factors “Why in Our Community?”</th>
<th>Intervening Variables</th>
<th>Consumption Pattern</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-level campaign</td>
<td>Lack of knowledge among adults about risks of easy social access to Rx opioids</td>
<td>Social Availability - Easy access to Rx opioids through social sources</td>
<td>Rx opioid misuse and abuse</td>
<td>Rx opioid hospital poisonings</td>
</tr>
<tr>
<td>Create safe disposal sites</td>
<td>Lack of knowledge among adults about how to prevent social access to Rx opioids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multi-level campaign</td>
<td>Lack of convenient and/or recognized sites for adult community members to dispose of Rx opioids safely</td>
<td>Retail Availability - Easy access to Rx opioids through providers or dealers</td>
<td></td>
<td>Rx opioid ER visits</td>
</tr>
<tr>
<td>Other Community Strategies chosen by communities</td>
<td>Other Community Factors identified by communities during assessment to address: Social Availability, Retail Availability, or Perceived Risk</td>
<td>Perceived Risk of Harm from Rx opioid misuse or abuse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prioritized and Evaluated by Communities Prioritized and Evaluated by the State
## Indicators Measured by State Evaluators in the Community Logic Model Addressing NMUPO

<table>
<thead>
<tr>
<th>Community Strategies</th>
<th>Community Factors “Why in Our Community?”</th>
<th>Intervening Variables</th>
<th>Consumption Pattern</th>
<th>Consequences</th>
</tr>
</thead>
</table>

### Social Availability
- Rx opioids misused in past 30 days obtained through social sources (18-25)
- Rx opioids misused in past 30 days easy/very easy to obtain (18-25)

### Retail Availability
- % of all patients meeting Rx opioid doctor shopping threshold (18-25)
- # of Rx opioid PDMP queries per physician to assess patient doctor shopping behavior (12-25)
- Past 12-month doctor shopping for Rx opioids reported (18-25)
- Rx opioids misused during past 30 days were obtained through dealer and/or provider (18-25)

### Perceived Risk of Harm
- Perceived risk of harm from using Rx drugs without a prescription (14-18)
- Perceived risk of harm from misusing Rx opioids once or twice per week (18-25)

### Rx opioid misuse and abuse
- Past 30-day misuse of Rx opioids (18-25)
- Past 30-day non-medical use of Rx drugs (14-18)

### Rx opioid hospital poisonings
- # (%) of individuals discharged from hospital for Rx opioid poisoning compared to all poisonings (12-17, 18-25)

### Rx opioid ER visits
- # (%) of individuals discharged from the ER due to Rx opioids (12-17, 18-25)

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Prioritized and Evaluated by Communities  
Prioritized and Evaluated by the State

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Prevention of Non-Medical Use of Prescription Opioids and Heroin Use in Alaska
Evaluation Part II: Designing the PFS Evaluation

Task 1: Develop Evaluation Plan
The first step in evaluating your PFS efforts is to design your evaluation plan. Your evaluation plan, which will be developed during Step 3: Planning, will be included as part of your PFS strategic plan and submitted before the start of year two. This section outlines the required components of the PFS evaluation for each community. Communities are certainly encouraged to do more to evaluate their efforts if time and resources allow. **However, the most important thing you can do is to keep your evaluation plan manageable!** Below are the key steps in designing your PFS evaluation plan.

1. Create an evaluation team
2. Finalize community logic models (if not done already)
3. Develop strategy evaluation plans
4. Monitor action plan progress
5. Develop data collection plans for SAMHSA’s Community Level Instrument (CLI-R)
6. Write down your evaluation plan
Create an Evaluation Team

The first step in designing an evaluation is to pull together a team of people who will oversee the evaluation process and share findings with the coalition and relevant stakeholders. These individuals may or may not be the same people who were involved in your data assessment process. However, these individuals should be willing and able to provide guidance or implement the evaluation activities. In addition to paid PFS project staff, a good place to start is with coalition members and stakeholders who have evaluation skills, a vested interest in the strategies selected, or a passion in reducing NMUPO and heroin use. A combination of these attributes would be a good mix for an evaluation team.

Evaluation cannot be done in isolation. When stakeholders are not appropriately involved, evaluation findings are likely to be ignored, criticized, or resisted. People who are included in the process are more likely to feel a good deal of ownership for the evaluation plan and results. They will probably want to help develop it, defend it, and make sure that the evaluation really works. Therefore, any serious effort to evaluate your PFS efforts must consider the viewpoints of the partners who will be involved in planning and delivering strategies, your target audience(s), and the primary users of the evaluation data.

Finalize Community Logic Models

Before designing an evaluation plan, you need to identify what you are evaluating. Finalizing your community logic model(s) will help you connect all your chosen strategies to the factors in your community that contribute to the problem. Quite simply, a community logic model is a graphic representation of the work you are trying to accomplish on one page. In addition to being a good communication tool, a community logic model will also help guide and focus your strategy evaluation work. The example community logic model shown earlier includes the required PFS community strategies to address Social Availability of Prescription Opioids. Please use APPENDIX 9: Logic Model Development Guide to finalize your community logic models for prescription opioids and heroin (if required).

Develop Strategy Evaluation Plans

Strategy evaluation plans will include strategy outcomes, indicators, and measures. Examples of strategy evaluation plans are included below. The first step will be to identify 2-3 outcomes specific to the strategy. These should relate to your community factor(s) that the strategy was chosen to address. The outcomes you choose should be reasonable enough to expect change on and measure within the timeframe of the grant. Outcomes such as change in knowledge, awareness, or attitudes fall into this category; certain behaviors can also be expected to change within short timeframes. These types of outcomes will provide an indication about whether your strategy is headed in the right direction to reduce NMUPO or heroin use within the community down the road (i.e., long-term outcome).
Once the strategy outcomes have been defined, such as an increase or a decrease in certain knowledge, attitudes, and behaviors, or the establishment of certain policies, you are ready to develop indicators and determine how to measure each indicator. A good way to determine if the logic works is to create IF-THEN statements and ask yourself whether they are true. For instance,

“If we do this strategy, we will achieve these community factor outcomes, which will reduce this intervening variable, which will reduce NMUPO.”

You might be asking yourself, “Why does this matter, as long as we’re seeing the long-term results we want to see?” The answer is that if the logic is not compelling, you will not know if (and will have a hard time convincing others that) the changes you are seeing are the result of your hard work.

The following two strategy evaluation plans are examples created for required PFS strategies. Most strategies will address one community factor, but sometimes one strategy may address two community factors or two strategies will address one community factor. Strategy Evaluation Templates, which will be provided on the PFS website, can be adapted accordingly to develop your outcomes, indicators, and measures. The DETAL is available to provide further training and technical assistance as you complete the Strategy Evaluation Templates.

Developing indicators and evaluation measures for your strategy outcomes will come next. To identify indicators, a useful question would be to ask “What evidence will we use to show that this outcome has been achieved?” The answer to this question becomes the indicator that will be used to track progress and document success. Remember, the indicator is the concept or idea that will be used to determine success—how you actually measure it comes next. It is important to think about the indicator first and then figure out how to measure it. Thinking creatively about the best way to demonstrate success within the time and resources available is often a necessary part of the process. To be useful to the community, data collected for the outcome evaluation must be locally based. A plan for collecting local data must be developed that specifies the source and type of data, including data you collect yourselves (primary data) or archival data already collected by other organizations (secondary data).
### EVALUATION OF A MULTI-LEVEL CAMPAIGN TO INCREASE KNOWLEDGE ABOUT RISKS OF SOCIAL ACCESS AND WAYS TO PREVENT SOCIAL ACCESS TO RX OPIOIDS

**GOAL:** REDUCE RX OPIOID MISUSE/ABUSE

<table>
<thead>
<tr>
<th>Community Factor: Lack of community knowledge among adults about risks associated with easy access to Rx opioids</th>
<th>Intervening Variable: Social Availability of Rx opioids</th>
<th>CSAP Category: Information Dissemination</th>
<th>Strategy Target Population: Adults 18+</th>
</tr>
</thead>
</table>

#### KEY STRATEGY OUTCOMES

Multi-level campaign to:

1) Increase knowledge about risks associated with easy access to Rx opioids

2) Increase knowledge about ways to reduce social access to Rx opioids

3) Increase safe storage, monitoring, and disposal of Rx opioids

#### INDICATORS

1. # and reach of awareness products disseminated (posters, articles, etc.) \(^{(P)}\)

2. % of adults who have seen messages about safe storage and disposal of Rx opioids \(^{(P)}\)

3. % of adults reporting safe storage and monitoring of Rx opioid prescriptions (or intentions) \(^{(O)}\)

4. % of adults who report disposing of Rx opioids safely (or intentions) \(^{(O)}\)

#### METHOD / MEASURE

1. Dissemination tracking

2. Quarterly random survey of 100 adults (e.g., DMV)

3. Quarterly random survey of 100 adults (e.g., DMV)

4. Quarterly random survey of 100 adults (e.g., DMV)

\(^{(O)}\) Outcome indicators; \(^{(P)}\) Process indicators

### EVALUATION OF THE STRATEGY TO INCREASE THE NUMBER OF SAFE DISPOSAL SITES AND A CAMPAIGN TO INCREASE AWARENESS AND USE OF SAFE DISPOSAL SITES

**GOAL:** REDUCE RX OPIOID MISUSE/ABUSE

<table>
<thead>
<tr>
<th>Community Factor: Lack of convenient and/or recognized sites for adult community members to dispose of Rx opioids safely</th>
<th>Intervening Variable: Social Availability of Rx opioids</th>
<th>CSAP Category</th>
<th>Campaign to promote safe disposal sites: Information Dissemination</th>
<th>Strategy Target Population: Adults 18+</th>
</tr>
</thead>
</table>

#### KEY STRATEGY OUTCOMES

Increase safe disposal sites to:

1) Increase access to safe disposal sites

Multi-level campaign to:

2) Increase awareness of safe disposal sites

3) Increase use of safe disposal sites

#### INDICATORS

1. # of disposal sites created and # of days open \(^{(P)}\)

2. # and reach of awareness products disseminated (posters, articles, etc.) \(^{(P)}\)

3. % of adults aware of at least one local safe disposal site \(^{(O)}\)

4. # visitors of visitors and/or pounds of Rx opioid pills discarded at disposal sites \(^{(O)}\)

#### METHOD / MEASURE

1. Activity tracking

2. Dissemination tracking

3. Quarterly random survey of 100 adults (e.g., DMV)

4. Activity tracking

\(^{(O)}\) Outcome indicators; \(^{(P)}\) Process indicators
Developing strategy evaluation plans is not a cut and dry process and requires careful thought and discussion by your evaluation team. Many revisions are often necessary as you gain input from different stakeholders or coalition members. Don’t be discouraged by the process!

You will notice in the example strategy evaluation plans above that both process and outcome evaluation indicators are included. For example, while reach of awareness efforts is typically a process evaluation measure, it is useful to include in order to document progress in reaching the intended target audience over time. You cannot expect change in knowledge or behaviors from a multi-level campaign if you are not adequately reaching your target audience or having the saturation necessary. However, if your indicators show that saturation and reach are adequate but change in knowledge or behaviors are not occurring, it may signal that a change in approach or an additional approach may be necessary. Both process and outcome evaluation indicators will allow you to track different aspects of strategy progress over time and help you decide where changes may be necessary and where strategies are effective.

For the PFS project, quarterly measurement of strategy indicators will be required. Please keep these criteria in mind as you develop your measurement plan. Less frequent measurement (i.e., every 12 months) can result in delays in making necessary changes in strategy implementation. For example, if data is available or collected only annually, the coalition must wait until an entire year (or more) has passed in order to obtain key information and consider necessary modifications to efforts. We recommend that communities consider all evaluation requirements when choosing the number of community factors to address or strategies to implement. It will be important to choose a small number of meaningful strategies that can be implemented and evaluated well in order to have the most impact in the community.

While not required, it is often extremely useful to develop a data collection plan that specifies the actual measure, frequency of collection, data source(s) including necessary contacts or agreements, and other notes. The plan should also specify who is responsible for each designated measure in the Strategy Evaluation Plan. The data collected should be considered the responsibility of the community’s evaluation team and the property of the local coalition. Below is just one example of what a data collection plan for one indicator might look like. Data collection plans are particularly helpful if PFS staff or coalition turnover occurs as the project progresses, and to maintain consistency in how data is collected over time.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Indicator</th>
<th>Evaluation Measure</th>
<th>Source</th>
<th>Collection Procedure</th>
<th>Timeline/ Frequency</th>
<th>Person(s) Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-level campaign</td>
<td>% of adults who have seen messages about safe storage and disposal of Rx opioids</td>
<td>Have you seen any messages (posters, TV ads, radio ads, etc.) about storing Rx opioids safely? (same question for disposal)</td>
<td>Survey</td>
<td>Random selection of 100 adults at DMV (50 male/50 female)</td>
<td>Jan, Apr, July, Oct (each year beginning January of 2017)</td>
<td>Local Project Coordinator</td>
</tr>
</tbody>
</table>
Monitor Action Plan Progress
Monitoring your progress during implementation will allow you to determine whether you are on track during capacity building and strategy implementation efforts and where deviations occurred. Developing a systematic way to review your logic model and implementation efforts plan can help your coalition to:

- Document strategy components that work well
- Identify where improvements need to be made
- Provide feedback so that strategies may be implemented more effectively
- Make timely adjustments in activities and strategies to better address identified problems
- Assess whether enough resources have been leveraged and where you might find more
- Engage key stakeholders (e.g., community members, providers, staff) so they feel a sense of responsibility and pride in helping to ensure that your coalition’s goals and objectives are met and that the substance abuse problem in the community is reduced

Expanding your existing action plans is a useful way to go about this. Place an expected completion date and checkbox next to each activity in your action plan. Check off each activity as you complete it and document the following in a notes column:

- Activities that worked well or were particularly success
- Activities that were not implemented in the order suggested or within the timeframe identified
- Activities you tried that did not work
- New activities you created to take the place of ones that did not work

At the end of this process, you will have a good record of what you did and did not implement, the challenges you faced, and how you overcame each challenge. It will help you community with the Project Coordinator about your progress. Without ongoing documentation such as this, it is hard to recover needed information to describe what worked well and what needed to be changed to tell the full story of implementation after the fact. It is very easy for information to get lost or forgotten over a 4-year project. If there is turnover in project staff or coalition members, consistent documentation such as this provides needed context about the history of the strategy.

Develop Plans to Collect Data for SAMHSA’s Community Level Instrument (CLI-R)
The first step in developing your process evaluation plan is to become familiar with the Community Level Instrument (CLI-R) required by SAMHSA which will be entered online twice per year by communities on April 15th and October 15th. It will then be reviewed by state-level staff, approved (or returned for revisions), and submitted by state-level staff to SAMHSA by May 1st and November 1st. The CLI-R instrument, manual, and helpful resources can also be found on the PFS project website.

The CLI-R will be submitted through the following website: https://pep-c.rti.org/. Staff will be given a login and password to enter CLI-R data for their community and both webinars and one-on-one assistance will be provided to communities by the DETAL to help prepare for collecting and reporting CLI-R data.
It will also be important to identify how the CLI-R can be used to inform your coalition and stakeholders about the implementation of the SPF process and your chosen strategies. While data will be reported to SAMHSA semi-annually, much of the data specific to strategies will need to be tracked and reviewed on an ongoing basis as part of your evaluation efforts.

In particular, the CLI-R will be helpful for the community process evaluation through monitoring:

- Changes in community capacity (i.e., data, resources, partnerships)
- Gaps and strengths in involving needed sectors of the community during coalition and grant-related efforts
- Strategy characteristics (specifically, evidence of effectiveness, CSAP prevention category, intended target population)
- Frequency and reach of strategies in your service area
- Costs associated with the delivery of each strategy

*Strategy approval from the Program Coordinator will come first. Identifying which CSAP prevention category your strategy falls under will come next.* This will determine the kind of data to be collected and reported for each approved strategy in the CLI-R.

*Information dissemination.* Examples of this type of strategy include media campaigns, brochures, and radio or television public service announcements. Information dissemination strategies provide knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities and also awareness of prevention programs or services. They are characterized by one-way communication to the audience.

*Prevention education.* Examples of this type of strategy include classroom education sessions and educational programs for youth, adults, and families. This strategy involves two-way communication between the educator and participants. Activities under this strategy aim to build life and social skills, decision-making and drug refusal skills, and analysis and judgment abilities regarding substance use and abuse.

*Alternative activities.* Examples of this type of strategy include social and recreational activities, community service activities, and mentoring programs. Alternative activities provide opportunities for the target population to participate in activities that exclude substance use. The assumption is that more involvement in constructive and healthy activities offset the attraction or needs usually filled by drugs and would, therefore, minimize or reduce the use of drugs.

*Problem identification and referral.* This strategy aims to identify individuals who have indulged in illegal/inappropriate use of substances or indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through referral to an educational program. This strategy does not include activities to determine if a person is in need of treatment.

*Community-based process.* This type of strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders.
Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services, interagency collaboration, coalition building, and networking.

Environmental. This type of strategy includes changing the environment of the community to influence the incidence and prevalence of substance abuse in the general population. Environmental strategies are often sustainable beyond the end of the grant. Examples of environmental strategies include establishing or changing written and unwritten community policies, standards, codes, and attitudes. This category constitutes the primary focus for strategies implemented as part of the PFS grant.

Plan to Conduct a Second Community Readiness Assessment
Community readiness assessments will be conducted again in 2019 as a requirement of step 5 (evaluation) in order to determine if changes in community readiness have occurred during the PFS project. Community readiness assessments are discussed earlier in the Guidance Document under Step 1. Baseline community readiness scores will be included in strategic plans and follow-up readiness assessment scores will be provided directly to CBHRS evaluators to allow for analysis of data across communities over time. Ensuring consistent data collection efforts will be important for communities in order to accurately compare results over time.

Write Down Your Evaluation Plan
As mentioned above, evaluation plans will be included as part of community strategic plans. Following the guidance above and using the templates provided will help you in preparing the key components of your evaluation plan.

Evaluation Part III: Analyze and Share PFS Evaluation Data

1. Develop an MIS in an Excel file to track data collected for strategy indicators
2. Graph MIS results for strategy indicators and measures
3. Review and share evaluation findings with targeted audiences

Task 2: Develop an MIS in an Excel File to Track Data Collected for Strategy Indicators
Creating a management information system (MIS) is helpful to document changes in strategy indicators identified in your strategy evaluation plans. A local MIS is the tool to document and store all data regarding community factors in an easy format. The MIS is created using a simple Excel spreadsheet in which strategy indicators are recorded quarterly. The benefit of using Excel is that it allows you to graph your data in order to visually communicate findings over time to project staff, coalition members, and stakeholders.

It is important to start collecting data before your strategies begin in order to provide baseline information. Aiming for 2 quarters of baseline data collection is a good goal for the PFS project. All indicators should be measured over time in exactly the same way. This is where having a good data collection plan is useful. Changing to a different data collection approach midway through the project can lead to inconsistent results and can be misleading when trying to interpret the data. Below is an example of how an MIS could be set up in Excel.
**Example Local Management Information System (MIS)**

**Intervening Variable: Social availability of Rx opioids**

**Community Factor:** Lack of convenient and/or recognized sites for adult community members to dispose of Rx opioids safely

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase safe disposal sites</td>
<td>Cumulative # of disposal sites that are open for use</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Media campaign to increase awareness of and use of safe disposal sites</td>
<td>Cumulative # of TV ads seen per adult about safe disposal sites</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3.7</td>
<td>4</td>
<td>7.2</td>
<td>7.8</td>
<td>8.5</td>
<td>8.9</td>
<td></td>
</tr>
<tr>
<td>Media campaign to increase awareness of and use of safe disposal sites</td>
<td>% of adults who can identify at least one safe disposal site per quarter</td>
<td>20</td>
<td>20</td>
<td>21</td>
<td>24</td>
<td>24</td>
<td>51</td>
<td>63</td>
<td>76</td>
<td>70</td>
<td>72</td>
<td>72</td>
<td></td>
</tr>
<tr>
<td>Media campaign to increase awareness of and use of safe disposal sites</td>
<td># of people who drop off prescription at safe disposal sites per quarter</td>
<td>10</td>
<td>12</td>
<td>9</td>
<td>8</td>
<td>9</td>
<td>7</td>
<td>47</td>
<td>66</td>
<td>118</td>
<td>131</td>
<td>132</td>
<td>151</td>
</tr>
</tbody>
</table>

**Graph MIS Results for Strategy Indicators and Measures**

A graph can create a visual picture of the data collected for each strategy indicator in the MIS Excel spreadsheet. The frequency of data entered guides the type of chart chosen to display the data. Data available on a quarterly basis can be easily displayed as a time series graph, which is the intention of the PFS project. Graphs can provide information to assess strategy progress, monitor overall effectiveness of strategy efforts, and provide a useful tool for seeing patterns and trends over time. Such a tool allows your coalition and stakeholders with varying degrees of data experience to easily make sense of the information being collected. The challenge is for staff and the coalition to determine the effectiveness, strengths, and limitations of efforts based on all available data, including information included in the graphs.

Monitoring the data on a regular basis alerts staff and coalition members to unexpected challenges or lack of effectiveness that require adjustments to strategy efforts. A good practice is
for staff and the coalition to monitor all project data quarterly once implementation begins for the most up-to-date community results of local prevention strategies.

Below are some examples of graphs created from the hypothetical indicator data shown above for the community factor *Lack of convenient and/or recognized sites for adult community members to dispose of Rx opioids safely*. The red lines indicate when the strategy began.
Task 3: Review and Share Evaluation Findings with Targeted Audiences

Just as data should be collected on an ongoing basis throughout the project, the data collected should be reviewed regularly. Dissemination is a key component of the evaluation step of the SPF. Those team members involved in strategy implementation are likely to have an interest in reviewing data most regularly so any adjustments, if necessary, can be made as soon as possible. Unless the data is reviewed and discussed on a regular basis it is difficult to make any necessary changes when needed. Through presentations or brief reports, the coalition can also be kept engaged in the evaluation by hearing updates on progress and any results that are found along the way. This will allow coalition members to ask questions and also offer input as strategies proceed.

Data can also be shared with appropriate stakeholders. The format in which you choose to share the information should depend on the intended audience. A report can be as brief as an executive summary of the evaluation process and findings or a more comprehensive paper. The key in determining a report format is to ensure that it is clear, understandable, and meaningful to the intended audience in the least amount of words and space, whether it is for staff, coalition members, partners, the public, or other decision-makers.

Newsletters can be helpful to release to the general public or to your stakeholders. This type of document can be shorter and less detailed than a report. You can also narrow the focus and highlight one single topic or strategy in a newsletter. When you are creating a newsletter, avoid using jargon, acronyms, or complicated terms so that someone who has never heard of the PFS project can understand the information being presented. If you are not sure what to write, start by making some lists that answer the following questions, and then use that information to create your newsletter.

- Who is involved in the PFS and what does the project do?
- Why did we choose our strategy(s)? Why are our strategies important?
- What have we learned? What evidence suggests that our strategies work?
- What upcoming events have we planned?
- Where can people go for additional information/resources about the evaluation findings?

10 Tips for Data Reporting and Presentation

1. Keep tables simple! Too many lines, groups, or patterns can get confusing.
2. Make it black and white friendly. Could someone still understand a photocopy?
3. Give it the “glance” test. Could a casual reader understand a table or chart without explanation?
4. Highlight numbers and statistics with quotes from a focus group. Including the human angle is an effective way to convey your message.
5. Use pull quotes. Put key findings that you wish to highlight in a text box and bold them.
6. Present data in more than one way. “Two in five high school students” might hit closer to home for parents than “40%,” but it means the same thing.
7. Use section headers and “chapters.” Break up a report into themed sections for ease of reading.
8. Be consistent in formatting and fonts. Too many fonts or too much formatting can be tiring for the reader as well as confusing.
9. Use grammar- and spell-check!
10. Avoid fancy language and clichés. If there is a straightforward way to say something, do so.
You can also release information about your PFS efforts, including evaluation results, to the general public through the **media**. Many of you are already familiar with using a press release issued to local newspapers, television, and radio stations to generate a news story about your PFS efforts. Including evaluation results such as easy-to-understand graphs, tables, or quotes can make your story more powerful. You may also choose to post your results on the websites of your organization and its members, where the public may access it, or employ web-based **social media** tools like Twitter or Facebook to provide periodic updates to subscribers.

While keeping dissemination efforts short and targeted is ideal, having a full report created to summarize final project and evaluation efforts can be very helpful for project staff, coalition members, and other stakeholders. This type of report can be linked on an organization or coalition website in order to direct individuals who may wish to have more details about PFS efforts, strategies, and evaluation results and can be accessed and utilized after the grant ends for sustainability.

To ensure fidelity to the evaluation components of the SPF, grantees will be required to complete and submit the Step 5 fidelity checklist to the Program Coordinator one year after beginning implementation and evaluation. See **APPENDIX 15: Step 5 Fidelity Checklist** for more information.

As part of the final PFS project report, grantees will be expected to conduct their community readiness assessment(s) again during the final year of the project. The findings of this assessment will be included in the final report, which is due to the Program Coordinator and state-level evaluators by May 31, 2020.

*Guidance for the final PFS project report will be provided at a later time during the project. The final PFS project report will include a summary of process and outcome evaluation findings. The Program Coordinator will also ask you to reflect on your evaluation efforts quarterly in progress reports to DBH.*

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48 | Prevention of Non-Medical Use of Prescription Opioids and Heroin Use in Alaska
CULTURAL COMPETENCE

Cultural competence, which also includes linguistic competence, must be considered at each step of the SPF. Your coalition should incorporate cultural and linguistic competence into every step, as discussed throughout this document.

What is Cultural Competence?

_Cultural competence_ is the ability of an individual or organization to interact effectively with people from different cultures. Developing cultural competence is an evolving, dynamic process that takes time and occurs along a continuum. In order for your efforts to prevent substance abuse to be effective, you must understand the cultural context of your target population and have the required skills and resources for working within this context.

Although some people may think of culture solely in terms of race or ethnicity, there are many other elements to consider, such as age, educational level, socioeconomic status, gender identity, sexual orientation, language, and cognitive and physical abilities and limitations. You must be respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of the diverse population groups in your community. This means learning more about the populations; drawing on community-based values, traditions, and customs; and working with persons from these populations to plan, implement, and evaluate your strategies.

What is Linguistic Competence?

_Linguistic competence_ involves more than having bilingual staff; it refers to the ability to communicate with a variety of different cultural groups, including people with low literacy, non-English speakers, and those with disabilities. The National Center for Cultural Competence defines linguistic competence as follows:

Cultural and linguistic competence help to ensure the needs of community members are identified and addressed, thereby contributing to the effectiveness of your strategies. Consider the following examples:

- A community coalition wants to educate parents of high school students on the risks of NMUPO. As Spanish is the primary language of many parents, the group asks a teacher to translate the take-home flyer. However, the teacher’s translation does not use vocabulary and idioms that match the parents’ ethnicity, so families do not read it or do not understand it, and some are even offended by it. The flyer is revised based on input from a small group of these parents. It is now much more clear and useful to the school’s Spanish-speaking families.

- A community group hires professional outreach workers to provide support services to family members of people abusing opioids. However, the professionals do not connect well with the people they are trying to educate. The group then recruits members of the community who are in recovery, and trains them to deliver outreach education. This strategy has much greater success.

The capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing. Linguistic competency requires organizational and provider capacity to respond effectively to the health and mental health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.28

You might consider some or all of the following approaches:

- Hiring bilingual/bicultural or multilingual/multicultural staff
- Providing foreign language interpretation services
- Printing materials in easy-to-read, low-literacy, picture, and symbol formats
- Offering sign language interpretation services
- Using TTY and other assistive technology devices
- Offering materials in alternative formats (e.g., audiotape, Braille, enlarged print)
- Adapting how you share information with individuals who experience cognitive disabilities
- Translating legally binding documents (e.g., consent forms, confidentiality and patient rights statements), signage, health education materials, and public awareness materials and campaigns
- Using media targeted to particular ethnic groups and in languages other than English (e.g., television, radio, Internet, newspapers, periodicals)

Guiding Values and Principles for Language Access

The National Center for Cultural Competence identifies the following guiding values and principles for language access:

- Services and supports are delivered in the preferred language and/or mode of delivery of the population served
- Written materials are translated, adapted, and/or provided in alternative formats based on the needs and preferences of the population served
- Interpretation and translation services comply with all relevant federal, state, and local mandates governing language access
- Consumers are engaged in evaluation of language access and other communication services to ensure quality and satisfaction

National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)

The National CLAS Standards are a comprehensive series of guidelines that inform, guide, and facilitate practices related to culturally and linguistically appropriate health services. Originally developed by the HHS Office of Minority Health in 2000, the standards were updated in 2013

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50 Prevention of Non-Medical Use of Prescription Opioids and Heroin Use in Alaska
after a public comment period, a systematic literature review, and input from a National Project Advisory Committee.

The standards have been updated and expanded to address the importance of cultural and linguistic competence at every point of contact throughout the health care and health services continuum. The 15 standards, listed in the table below, are organized into one Principal Standard and three themes. Resources for implementing the National CLAS Standards are available from the Office of Minority Health’s Think Cultural Health website.\(^{29}\)

<table>
<thead>
<tr>
<th>Principal Standard</th>
<th>1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance, Leadership, and the Workforce</td>
<td>2. Advance and sustain organizational governance and leadership that promote CLAS and health equity through policy, practices, and allocated resources</td>
</tr>
<tr>
<td></td>
<td>3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area</td>
</tr>
<tr>
<td></td>
<td>4. Educate and train governance, leadership, and the workforce in culturally and linguistically appropriate policies and practices on an ongoing basis</td>
</tr>
<tr>
<td>Communications and Language Assistance</td>
<td>5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services</td>
</tr>
<tr>
<td></td>
<td>6. Inform all individuals of the availability of language assistance services, clearly and in their preferred language, both verbally and in writing</td>
</tr>
<tr>
<td></td>
<td>7. Ensure the competence of individuals providing language assistance, recognizing</td>
</tr>
</tbody>
</table>

\(^{29}\) See https://www.thinkculturalhealth.hhs.gov/Content/clas.asp
<table>
<thead>
<tr>
<th>Engagement, Continual Improvement, and Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.</td>
</tr>
<tr>
<td>9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization’s planning and operations.</td>
</tr>
<tr>
<td>10. Conduct ongoing assessments of the organization’s CLAS-related activities, and integrate CLAS-related measures into measurement and continual quality improvement activities.</td>
</tr>
<tr>
<td>11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes, and to inform service delivery.</td>
</tr>
<tr>
<td>12. Conduct regular assessments of community health assets and needs, and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.</td>
</tr>
<tr>
<td>13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.</td>
</tr>
<tr>
<td>14. Create culturally and linguistically appropriate conflict and grievance resolution processes to identify, prevent, and resolve conflicts or complaints.</td>
</tr>
<tr>
<td>15. Communicate the organization’s progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.</td>
</tr>
</tbody>
</table>
SUSTAINABILITY

Sustainability is often thought of as the ability to find another source of funding after an initial grant ends. But sustainability is not only about sustaining funds; it also means sustaining the gains you have made in addressing a health problem—in this case, preventing or reducing substance misuse and abuse. It means constantly building on your efforts by retaining and improving strategies that are shown to be effective in achieving your identified outcomes, and discontinuing or modifying those that do not seem to be working as well.

Sustainability does not mean that a strategy must continue as originally designed or must be implemented by the same people as before. Rather, you should use the findings from your evaluation to make continual, ongoing improvements. As you learn more about what works and does not work in your community, you may find it useful to bring in new partners and implement new strategies.

Planning for sustainability requires that you consider the many factors that will ensure the success of your efforts over time. For example, forming a stable prevention infrastructure, ensuring the availability of training systems, and developing a strong base of community support are critical factors in successful sustainability.

Here are some tips for increasing sustainability:

- **Think about sustainability from the beginning.** Building support, showing results, and obtaining continued funding all take time. It is critical to think about who needs to be at the table from the beginning.
- **Build ownership among stakeholders.** The more invested that stakeholders become, the more likely they will be to support prevention activities for the long term. Involve them early on and find meaningful ways to keep them involved. Stakeholders who are involved in the assessment process are more likely to support the strategies used to address the identified problems and to support this work over time.
- **Track and share outcomes.** A well-designed and well-executed evaluation will help you improve your efforts and show evidence of the effectiveness of your strategies. Share your outcomes with community members so that they can become champions of your efforts.
- **Identify champions** who are willing to speak about and promote your prevention efforts.
- **Invest in capacity** at both the individual and the systems levels. Teach people how to assess needs, build resources, plan, implement, and evaluate effective strategies, and create the systems necessary to support these activities over time.
- **Identify diverse resources,** including human, financial, material, and technological. Be sure to identify and utilize as many of these as possible.
GLOSSARY OF TERMS

**Anxiolytics** are medications that inhibit anxiety. These medications are known as minor tranquilizers.

**Benzodiazepines** are depressants generally prescribed to treat anxiety, panic attacks, insomnia, and seizures.

**Community Factors** are specific issues in a community that comprise or explain an intervening variable. They are identified locally through focus groups, surveys, observation, and other data gathering processes and are the key link to identifying strategies.

**Comparisons** determine how one group (e.g., geographic area, demographic group) compare to another. Rate ratios can be used in comparison analyses.

**Consequences** are defined as the social, economic, and health problems associated with substance misuse and abuse. Examples are things such as drug overdose deaths, crime, and car accidents or suicides related to substance misuse and abuse.

**Consumption** is the act of eating or drinking something. For PFS, consumption outcomes include overall consumption, acute or heavy consumption, consumption in risky situations (e.g., driving) and consumption by high risk groups (e.g., youth, college students, pregnant women).

**Data** are pieces of factual and tangible information from which conclusions can be drawn.

**Evaluation** of an organization’s strategies is a planned and careful use of information to understand the organization’s work and its relationship to organizational goals.

**Evidence-Informed** ensures that decision-making is conducted with understanding of the best available research evidence. It is characterized by the systematic and transparent access to, and appraisal of, evidence as an input into the decision-making process.

**Intervening Variables** are factors that affect the relationship between a causal factor and an outcome. For example, implementing a prescription drug disposal site may lead to fewer overdoses because it reduces the amount of prescription opioids in the community available (intervening variable). Disposal sites that do not succeed in reducing the amount of prescription opioids available in the community will not have the effect of reducing overdoses.

**Logic Model** is a tool for strategic planning that identifies a behavioral health outcome that the local prevention effort wishes to change, and also identifies the factors or intervening variables that have been shown to affect the outcome directly or affect other intervening variables. The logic model also specifies the strategies selected by the community coalition that have been shown to change intervening variables, and the measures to monitor changes in those variables.
Long-Term Outcomes are more distant targets of your organization’s work and include changes in substance consumption behaviors and consequences of substance use.

Magnitude indicates the size of the problem (i.e., number of people/cases, percent, rate).

Opioids are substances that bind to the opioid receptors present in many bodily tissues. They include endogenous substances such as endorphins, as well as exogenous opium-derived and synthetic drugs that interact with opioid receptors. Morphine, for example, is both an opiate and an opioid, but fentanyl and methadone are only opioids. Heroin is also an opioid.

Pain Relievers are drugs that are capable of producing analgesia, that is, relieving pain by altering the perception of painful stimuli without producing anesthesia or loss of consciousness.

Policy, Systems, and Environmental (PSE) Strategies are efforts to change or alter the conditions around people to ensure greater health, safety, and wellness. These strategies seek to change community social norms, practices, laws, or policies that are intended to influence the community environment where behavioral health conditions exist. PSE strategies are grounded in the field of public health, which emphasizes the broader physical, social, cultural, and economic forces that contribute to the problems that coalitions address. Coalitions can use these strategies to change the context in which behavioral health issues occur as opposed to seeking change solely in individuals.

Population-Level Change focuses on change for entire populations. By entire populations, we mean collections of individuals who have one or more personal or environmental characteristic in common. Information demonstrating population-level change should be measured at the same town, community, or region that the organization serves.

Pre-Test and Post-Test Method of evaluation involves comparison of data obtained before and after a prevention strategy is implemented to look for changes that might be attributable to the strategy. This method is used often in prevention evaluation.

Process Evaluation assesses how an organization carries out its planned initiatives by focusing on the “who, what, where, when, why, and how” of strategy implementation. A key component of processes evaluation is satisfaction with the strategy implementation.

Qualitative Data are detailed and descriptive but are usually not quantified in numbers, such as verbal responses in focus groups and interviews, as well as general impressions formed from observations. Qualitative data can affirm or personalize quantitative data by adding context.

Quantitative Data consist of information that can be counted or expressed numerically and can be analyzed using statistical methods. Quantitative data include numbers, percentages, rates, rate ratios and can be displayed in tables, graphs, and charts.
Rate Ratio is a relative difference measure used to compare the rates of events (i.e., prevalence, incidence) occurring at any given point in time.

Reliability refers to the degree to which a measurement procedure can be reproduced. Lack of reliability may arise from differences between observation, or instruments of measurements, or instability of the attribute being measured.

Sedatives include a variety of drugs that work by depressing the central nervous system. These drugs produce a calming effect and offer increased pain relief as compared to tranquilizers.

Severity is the extent of burden (e.g., years of potential life lost, economic cost, impact on others).

Stimulants are substances that raise levels of physiological or nervous activity in the body.

Strategic Planning is a decision-making process that carefully considers how the coalition will go about making change. A strategic plan has multiple documents including a logic model, evaluation plan, and sustainability plan. Together they are a “flight plan” that guides people to the outcome they hope to achieve.

Tranquilizers are drugs that cause a person to become very relaxed and calm.

Trends consider whether an issue is improving over time, getting worse, or remaining unchanged.

Validity is the extent to which the results are accurate and the extent to which the conclusions derived can be generalized.
SECTION 3: APPENDICES

Appendix 1: PFS Grant Milestones, Timeline, and Deliverables
Appendix 2: Community Assessment Framework
Appendix 3: Resource Assessment Worksheet
Appendix 4: Prioritization Process
Appendix 5: Capacity Building Plan - Example and Template
Appendix 6: Step 1 Fidelity Checklist
Appendix 7: Step 2 Fidelity Checklist
Appendix 8: Strategic Plan Development Guide
Appendix 9: Logic Model Development Guide
Appendix 10: Action Plan Template
Appendix 11: Step 3 Fidelity Checklist
Appendix 12: Step 4 Fidelity Checklist
Appendix 13: Evaluation Indicators for Prescription Opioids
Appendix 14: Evaluation Indicators for Heroin
Appendix 15: Step 5 Fidelity Checklist
Appendix 1: PFS Grant Milestones, Timeline, and Deliverables

The Division of Behavioral Health operates in relation to the state calendar year (July 1 – June 30), while SAMHSA follows the federal fiscal cycle (October 1 – September 30). Because of these differing schedules, not all DBH- and SAMHSA-specific deadlines will align.

Year 1

July 2016
7/1: PFS grant program begins for grantees. Coalitions begin work on assessment and capacity building activities
7/21: Mandatory introductory webinar for new grantees. At least one person from both the coalition and the fiscal agency must attend

September 2016
9/30: Grantees must submit a Memorandum of Agreement with their local school district indicating the school district’s willingness to participate in the biennial Youth Risk Behavior Survey (YRBS), or establish other means to collect youth outcome data. (See the RFP for more specific information.)
9/30: Submit DBH Quarterly Reports to Grant Administrator and Program Coordinator

October 2016
TBD: Attend the All Grantee Meeting in Anchorage, Alaska
10/15: Submit CLI-R
10/31: Submit a status update to the Program Coordinator on the status of the community assessment and capacity building activities

December 2016
12/31: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

January 2017
1/31: Submit draft of community assessment report to Program Coordinator for review and feedback

March 2017
3/15: Submit finalized community assessment report, Step 1 fidelity checklist, and Step 2 fidelity checklist to the Program Coordinator
3/31: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

April 2017
4/1: Grantees may begin implementing required strategies. Grantees may begin implementing these strategies earlier in the fiscal year if baseline data collection has been completed
4/15: Submit CLI-R

May 2017
5/15: Submit drafts of strategic plan, logic model, and evaluation plan to the Program Coordinator for review and feedback

59 | Prevention of Non-Medical Use of Prescription Opioids and Heroin Use in Alaska
Appendix 1: PFS Grant Milestones, Timeline, and Deliverables

June 2017
6/30: Coalitions must submit the final draft of their strategic plan, logic model, evaluation plan, and Step 3 fidelity checklist to the Program Coordinator. Once a coalition’s strategic plan, logic model, and evaluation plan are approved, they may begin implementing the remainder of their strategies.

6/30: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

Year 2

July 2017
7/1: Second fiscal year begins for grantees

August 2017
8/31: Any grantees who have not yet begun full implementation will begin (with Program Coordinator approval)

September 2017
TBD: Attend the All Grantee Meeting in Anchorage, Alaska
9/30: Submit DBH Quarterly Reports to Grant Administrator and Program Coordinator

October 2017
10/15: Submit CLI-R

December 2017
12/31: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

March 2018
3/31: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

April 2018
4/15: Submit CLI-R

June 2018
6/30: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

Year 3

July 2018
7/1: Third fiscal year begins for grantees
7/31: Submit Steps 4 and 5 fidelity checklists to Program Coordinator

September 2018
TBD: Attend the All Grantee Meeting in Anchorage, Alaska
9/30: Submit DBH Quarterly Reports to Grant Administrator and Program Coordinator

60 | Prevention of Non-Medical Use of Prescription Opioids and Heroin Use in Alaska
Appendix 1: PFS Grant Milestones, Timeline, and Deliverables

October 2018
**10/15**: Submit CLI-R

December 2018
**12/31**: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

March 2019
**3/31**: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

April 2019
**4/15**: Submit CLI-R

June 2019
**6/30**: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

**Year 4**

July 2019
**7/1**: Fourth fiscal year begins for grantees

September 2019
**TBD**: Attend the All Grantee Meeting in Anchorage, Alaska
**9/30**: Submit DBH Quarterly Reports to Grant Administrator and Program Coordinator

October 2019
**10/15**: Submit CLI-R

December 2019
**12/31**: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

March 2020
**3/31**: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

April 2020
**4/15**: Submit CLI-R

May 2020
**5/31**: Submit final report to Program Coordinator and CBHRS

June 2020
**6/30**: Submit DBH Quarterly Report to Grant Administrator and Program Coordinator

Return to Page 2
A community assessment is a tool that can be used to understand a community’s needs based on available resources and readiness to address community concerns, issues, problems, or challenges. In short, it tells an objective story about the conditions and characteristics of a community. By collecting primary and secondary data, the tool begins to take shape and helps to describe substance abuse within a community, as well as the consequences of such abuse, current prevention/enforcement activities already being used, and gaps in community resources. This information can be used to educate community members and stakeholders, dispel misconceptions, review current prevention efforts, and prioritize strategies to address the most pressing concerns identified during the assessment process.

The following framework is intended to be a resource to help communities think critically about data collection and how that data can be used to develop an assessment process from which appropriate strategies and actions can be identified and developed.

Urban grantees will be required to conduct community assessments for both NMUPO and heroin use. These assessments can be compiled into one assessment report; however, each priority area should have its own information on consumption, consequences, and intervening variables; community readiness; and prioritized community factors. Rural grantees will only be required to address NMUPO in their community assessments.

**Which questions should be answered in a community assessment?**

Assessments should be developed to meet the needs of the community. The following framework consists of seven key questions that can be answered by compiling primary and secondary data. Suggestions for potential sources of data are included in this framework.

**Note:** This framework is not meant to be a fill-in-the-box type of worksheet. Instead, it is meant to frame the community assessment in such a way as to guide grantees through data collection and analysis. The topic areas and examples presented here are not exhaustive but rather reflect only a handful of considerations for data collection.

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30 Primary data: data that is collected directly by those who are conducting the assessment  
31 Secondary data: data that has been collected by an outside source
**Community Assessment Guiding Questions**

1. **What are the characteristics of the community?**

   Descriptive information including the location and size of the community, demographic characteristics of residents, number of schools, employment, home ownership rates, and other information, can be used to “paint a picture” of the community.

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Examples of data that can be used</th>
<th>Data collection options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic characteristics of community residents</td>
<td>Gender, age, cultural characteristics of community residents, including trends over time</td>
<td>Secondary data review (Census/American Community Survey data, student demographic information through school districts)</td>
</tr>
</tbody>
</table>

2. **Needs Assessment: What concerns about prescription opioid misuse/abuse and heroin use have brought stakeholders to the table?**

   It is important to understand the concerns and priorities of local stakeholders. Recent local events or things highlighted in the media could have raised awareness or concern about the issue. This information is useful, not only in understanding current community concerns, but in recognizing potential priorities or biases among coalition stakeholders. Potential concerns may include: protecting the most vulnerable from harm towards self or others; the economic, political, and socio-cultural issues associated with behavioral health conditions and the impact they have in our communities; or the consequences that substance abuse has on individuals, families, and communities.

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Examples of data that can be used</th>
<th>Data collection options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local events or circumstances that have led to community mobilization around NMUPO and heroin use</td>
<td>Qualitative data describing major issues/ concerns Newspapers and electronic journals</td>
<td>Key informant interviews Facilitated discussion Review of local media reports, journal articles</td>
</tr>
</tbody>
</table>

3. **Needs Assessment: What is known about prescription opioid misuse/abuse and heroin use in your community?**

   In order to fully understand how these substances are affecting your community, it is imperative to examine local data and information that will reveal the current and historical circumstances of the condition. In your analysis, please include information on any of the following: prevalence rates, specific populations most impacted, changes in trends over time, or any other relevant information that would describe the extent of these substance abuse problems affecting your community.

<table>
<thead>
<tr>
<th>Topic area</th>
<th>Examples of data that can be used</th>
<th>Data collection options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extent of the problem in the community</td>
<td>Current consumption patterns – adults and youth</td>
<td>Secondary data review (YRBS, NSDUH) Community surveys Focus groups Community surveys</td>
</tr>
</tbody>
</table>
## Appendix 2: Community Assessment Framework

<table>
<thead>
<tr>
<th>Topic area</th>
<th>Examples of data that can be used</th>
<th>Data collection options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rates of hospitalizations related to prescription opioids</td>
<td>Secondary data review (hospitals)</td>
<td></td>
</tr>
<tr>
<td>Percent change in ER visits related to prescription opioids</td>
<td>Secondary data review (hospitals)</td>
<td></td>
</tr>
<tr>
<td>Magnitude of opioid-related substance abuse treatment admissions</td>
<td>Secondary data review (local treatment facilities)</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Needs Assessment: What are the perceptions of residents about prescription opioid misuse/abuse and heroin use in the community?

While existing data sources can provide information about these substances in the community, it is also important to understand how they are perceived by community members. Perceptions may vary based on the age, socioeconomic status, or racial/ethnic background of residents; therefore, efforts should be made to ensure feedback is gathered from a representative sample of residents and not just those who are coalition members.

#### Topic area
- Perceptions of community regarding NMUPO and heroin use

#### Examples of data that can be used
- Factors that encourage/discourage problems
- Qualitative/quantitative description of level/degree of resident concern

#### Data collection options
- Focus groups
- Key informant interviews
- Written/online surveys

### 5. Prioritization: What are the unique community factors that are contributing to prescription opioid misuse/abuse and heroin use?

In order for communities to be able to reduce prescription opioid misuse/abuse and heroin use, and to promote positive behaviors through their local prevention efforts, they must identify the key factors that are contributing to such substance abuse in their community. This prioritization process asks coalitions to identify, define, and justify specific community factors for which they can demonstrate actual effects in reducing harm.

#### Topic area
- Social availability of Rx opioids

#### Examples of data that can be used
- Where and how individuals 12-25 years old obtain Rx opioids for non-medical use
- Ease of access to Rx opioids for non-medical use
- Knowledge about the risks of Rx opioid abuse or risks of easy access to Rx opioids

#### Data collection options
- Community survey
- Focus groups

### Appendix 2: Community Assessment Framework

<table>
<thead>
<tr>
<th>Knowledge about ways to reduce social access</th>
<th>Focus groups</th>
</tr>
</thead>
</table>

#### 6. Readiness Assessment: Is the community ready to make change?

Community readiness is important to consider before identifying potential prevention/intervention strategies. When considering readiness, it is critical to consider whether the community is prepared and ready to act on the areas of concern identified through the needs assessment process. The readiness assessment should focus on each specific substance and key intervening variables.

<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Examples of data that can be used</th>
<th>Data collection options</th>
</tr>
</thead>
</table>
| Perceptions of community capacity to implement prevention activities | Descriptions of stakeholder concerns + perceptions | Written survey  
Focus group  
Key informant interview |
| Level of support among key stakeholders and community residents for prevention activities | Rating of “readiness” using the Tri-Ethnic Center Model | Readiness survey tool |

#### 7. Resources Assessment: What are the community strengths, assets, weaknesses, and challenges that should be taken into account when working on this type of initiative?

In the course of working with a community as the assessment is conducted, you may want to ask about other factors or important issues to consider when addressing prescription opioid misuse/abuse and heroin use in the community. When gathering information, consider what a reader would need to know in order to understand the community’s assets, strengths, and challenges. Describe any tools that were used in assessing community resources and why they were selected. List people involved in conducting the resources assessment and their roles.

<table>
<thead>
<tr>
<th>Topic area</th>
<th>Examples of data that can be used</th>
<th>Data collection options</th>
</tr>
</thead>
</table>
| Resources and gaps identified in the community’s prevention efforts | Number, type, and description of resources currently available to the behavioral health problem and its intervening variables  
Relationship between community-based organizations, law enforcement, school personnel, and other organizations  
Past prevention efforts and their results  
Factors in the success or failure of past or current prevention efforts, and how lessons learned might be incorporated into future prevention efforts | Asset mapping  
Interviews  
Focus groups  
Interviews  
Facilitated discussion |
### Appendix 2: Community Assessment Framework

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Current policies, environmental attributes, and social norms, and how these discourage/hinder prevention efforts</td>
<td>Review of existing policies and ordinances</td>
</tr>
<tr>
<td>Gaps to be addressed</td>
<td>Facilitated discussion</td>
</tr>
</tbody>
</table>
Appendix 2: Community Assessment Framework

Tips for Successfully Completing Your Assessment

After the data has been gathered, it is important for the coalition to step back and figure out what it means and how it applies to your community. The following questions can help interpret the results from the data that has been collected:

- What patterns and themes emerge in the results?
- Are there any deviations from these patterns? If yes, are there any factors that might explain these deviations?
- Do the results make sense?
- Are there any findings that are surprising? If so, how can these findings be explained?
- Are the results significant from a clinical or statistical standpoint? Are they meaningful in a practical way?
- Do any interesting stories emerge from the responses?
- Do the results suggest any recommendations for improving prevention efforts in the community?
- Do the results lead to additional questions about community needs, readiness, and resources? Do they suggest that additional data may need to be collected?

Report Findings

The results from the community assessment should be shared in a way that provides clear information that can be used to help guide next steps. The approach used to report key assessment findings may vary based on the desires of the coalition and community. While a PowerPoint presentation may be appropriate for some audiences, others may want to read a formal report and have opportunities for discussion. While submission of a formal report to the Program Coordinator is required, coalitions should determine the best means for reporting their assessment findings back to their own community.

Regardless of the approach, the following tips should be taken into account when reporting information:

- Share the most important take-away points and highlight key pieces of data that support these findings. If there are surprising or potentially controversial findings, it may be necessary to report additional supporting data in the appendix or an expanded section of the report.
- Consider using graphs, charts, and bulleted lists to present information in a clear, concise way. In written reports, bold font or bulleted lists can be used to clearly identify key points to the reader. Graphs and charts can be used to simplify data and may be a more meaningful way to report information to audiences who are visual learners.
- There are strengths and limitations associated with all types of data collection approaches, and some information can be challenging to gather and interpret. Be forthcoming with the limitations of the assessment so the audience can interpret the data in the appropriate context.
Appendix 2: Community Assessment Framework

Report Outline

I. Introduction

In one to three sentences, identify the purpose of the community assessment, who participated in the development of the assessment, and how this information will be used. Report any concerns that brought local stakeholders to the table to discuss the prevention of substance abuse.

Briefly describe the community, including demographic characteristics of residents and changes in community growth observed over time. It may also be useful to include the number of schools in the community, types of major employers, and other information that describes key aspects of the community.

II. Methods

Describe the methods used to collect data and information for the needs, readiness, and resources assessments, including the names of any instruments that were used. Include the response rate for written surveys or number of key informants/focus group participants, and methods used for transcribing and scoring readiness surveys. Identify limitations of the data collection methods (e.g., surveys were not translated into other languages), when necessary.

III. Key findings

Report the most important information collected through the needs, readiness, and resources assessments, highlighting key findings and important trends to consider. When necessary, describe gaps in the data or limitations that the reader should consider when reviewing this information. Some of the key questions that may be answered in this section are listed below:

What is known about prescription opioid misuse/abuse and heroin use in the community?

Using secondary and/or primary data sources, describe prescription opioid misuse/abuse and heroin use in the community. When reporting the results, consider if there are specific populations (i.e., cultural groups, age groups, genders) that are most impacted and changes in trends/patterns over time. Consider including regional- or state-level data to put local information into a larger context.

What are the perceptions of residents about prescription opioid misuse/abuse and heroin use in the community?
After reporting existing data that clearly describe prevalence and areas of community concern, include information about how residents perceive prescription opioid misuse/abuse and heroin use in the community. Consider whether the perceptions of residents align with what is indicated by the data.

**What factors encourage/discourage prescription opioid misuse/abuse and heroin use in the community?**

Describe the factors that encourage or discourage prescription opioid misuse/abuse and heroin use in the community. Areas of interest to include in this section of the report are:

- Report the level of availability or perceived ease of access to the substance
- Describe the policies that are in place (or are lacking in the community) related to substance misuse/abuse
- Describe local enforcement activities
- Describe community members’ access to services (or any barriers to accessing services)
- Discuss concerns around social norms

**Is the community ready to make change?**

Report the results from the community readiness assessment. Describe whether the coalition has appropriate multi-disciplinary representation, strong leadership, and the readiness of community members to address prevention. Consider how well the areas of readiness align with the needs of the community identified when reviewing existing data sources.

**What community strengths, gaps, assets, and weaknesses should be considered?**

Describe current and past prevention activities in the community, the results of efforts to strengthen ordinances/enforcement, the prevention resources available in the community, and the results of past coalition efforts. Describe the relationship between community-based organizations, law enforcement, school personnel, and other organizations, as appropriate.

**IV. Synthesis**

Provide a critical analysis of the data, highlighting the most important community needs and trends that should be considered by the coalition. Do not introduce new data in this section of the report, but guide the reader to help them understand how all the data (i.e., needs, readiness, resources) fits together. Describe common themes identified when multiple data collection sources were used, and provide possible explanations for differences between data sources. It may also be helpful to identify areas where additional data collection may be needed to fully understand an issue. Questions to ask when writing this section are:

- Based on the data, what concerns about prescription opioid misuse/abuse and heroin use are of greatest importance to the community? (This could be described by identifying issues that have an impact on the largest number of residents or disproportionate impacts on specific populations. Trend data may also indicate important changes in risk behaviors.)
Appendix 2: Community Assessment Framework

- How do the community’s current policies, systems, environmental attributes, and social norms encourage/hinder prevention efforts related to prescription opioid misuse/abuse and heroin use?
- What community strengths/assets can be used to address concerns?
- What challenges or areas of weakness will need to be addressed?

V. Recommendations

The synthesis section of the report points out areas of concern in the community, as well as resources and assets that can help the coalition address prescription opioid misuse/abuse and heroin use. The recommendations section should offer potential solutions that can be used to address challenges or build on strengths. The types of recommendations will vary depending on the needs and resources of the community. For example, an appropriate recommendation might be, “Focus future coalition meetings on identifying evidence-based models that can be used to address prescription opioid abuse among college students.” This section is also a place to suggest specific resources that may be helpful to the coalition as they work on prevention efforts in their community. Specific strategies for implementation should not be included in this section and, instead, will be identified and prioritized in the strategic planning step of the SPF as coalitions develop their logic model.
Appendix 3: Resource Assessment Worksheet

Resource Assessment: Part I

Purpose: The resource assessment allows you to identify community and organizational resources for each of your intervening variables and potential community factors. This process can be completed through a facilitated group discussion as well as through use of other existing information. Once Part 1 is complete, you can move on to Part 2 to identify gaps and ideas for addressing them.

Intervening Variable: _______________________________

Community Factor: __________________________

Community Factor: _________________________

Community Factor: _________________________

Resources:

Resources:

Resources:

Interacting Variables
- Retail Availability: easy access to opioids through providers or dealers
- Social Availability: obtaining opioids through social sources, such as friends, family, & relatives
- Perceived Risk for Harm: perception that misusing or abusing opioids is harmful

Resource Categories
- Workforce Skills: prevention training, education
- Personnel: people who work in opioid prevention
- Programs/Policies: community programs and policies in place to address opioid prevention
- Facilities: physical space & equipment
- Monetary Resources: funds dedicated or leveraged to support opioid prevention efforts
- Institutional/Leadership: organizational and leadership support of opioid prevention
- Partnerships: those in existence to address prevention
- Data: data availability/collection/reporting/sharing
- Cultural: Capacity in cultural competence
**Resource Assessment: Part 2**

*Purpose:* Part 2 of the Resource Assessment allows you to review the resources identified in Part 1 and identify gaps, as well as considering ideas for ways to address those gaps and what additional resources will be needed.

<table>
<thead>
<tr>
<th>Intervening Variable/Community Factor</th>
<th>Resource Gap</th>
<th>Possible Resources</th>
<th>Strategies to Address Gap</th>
</tr>
</thead>
</table>
| **Example**                          | **Prescribers** | • Medical practice owners  
                                          • Hospitals  
                                          • State Licensing | • Meet face-to-face with practice owners  
                                          • Meet with hospital administrator  
                                          • Identify expert in licensing |
| *Intervening Variable:* Retail Availability  
  *Community Factor:* Lack of clear, consistent guidelines for prescribing opioids for chronic non-cancer pain | | | |
| | | | |
| | | | |
| | | | |
Prioritization is a formalized process that helps limit your community’s focus in choosing community factors. It is impossible to address every need with limited resources. A well thought out process can help you be strategic and make the most impact.

The prioritization process is much more than a formality to identify community factors. It is important to know that the prioritization process is subjective. People will answer based on their knowledge and feelings. However, the fact that it is a subjective process does not diminish its value. It is important to include crucial leaders and decision-makers in the process in addition to ordinary citizens, as this can set the stage and create buy-in from all facets of the community. It also creates an opportunity for dialogue and can be a catalyst for community mobilization.

When using data to set prevention priorities, there are three key issues to address:

1. What criteria will be used to compare/contrast problems?

Once you’ve gathered all the data in your community, how will you start to prioritize intervening variables and community factors? It may be helpful to organize indicators by relevance. For example, clump availability/access indicators together; this will give you a more thorough understanding of what opioid availability looks like in your community.

Below are some considerations for developing primary prioritization criteria:

- Examine data source reliability, source validity, missing data, and ability to detect trends
- Examine magnitude, severity, change over time, and meaningful comparisons

Secondary criteria could include capacity, preventability, changeability, cultural factors, and existing services. These additional criteria are no less important than primary criteria. Primary criteria are more objective because the numbers clearly tell you their status. These secondary, relational criteria can be more difficult to assess because they involve relationships with people and changing political will.

2. What processes will be used to synthesize the data and define priorities?

Once you have developed your prioritization criteria, you then need to determine how you will weigh your options. Will you use categorical ratings (high, med, low), scoring, or weighting? How will you arrange the data?
Appendix 4: Community Factor Prioritization Process

Below is an example of a tool that can be used to organize your data and facilitate prioritization conversations:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Number &amp; Percent CY2015</th>
<th>Trend</th>
<th>Rate Ratio (AK vs. US) CY2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past month Rx opioid misuse from social sources</td>
<td>1,020 (64%)</td>
<td>↑</td>
<td>1.13</td>
</tr>
<tr>
<td>Past 12-month doctor shopping behavior</td>
<td>460 (18%)</td>
<td>↑</td>
<td>1.4</td>
</tr>
<tr>
<td>Perceived risk of great harm of NMUPO</td>
<td>225 (7%)</td>
<td>↑</td>
<td>0.9</td>
</tr>
</tbody>
</table>

3. Who will be involved in the prioritization process and what are their roles?

Before you can implement your prioritization process, you must first identify who will be involved. In addition to identifying participating members, you must also assign the roles and responsibilities of each member. Be sure that each member’s role is clear and appropriate for them.

Prioritization Tips
- Establish rules about criteria and process(es) first
- Be transparent about rules and process
- Keep things simple
- Acknowledge strengths and weaknesses of your data
- Organize data to match prioritization process
- Conduct the process in phases
- Document all your steps in your process
- Remember that context matters
Appendix 4: Community Factor Prioritization Process

Sample Prioritization Worksheet

Organization/Member: ___________________________________________

Factor: _________________________________________________________

Subjective rating of Intangible and Epidemiological Criteria using a four-tier scale.

<table>
<thead>
<tr>
<th>Intangible Criteria – Worth 34% of overall score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please rate the importance of the items below:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Readiness: Willingness</td>
</tr>
<tr>
<td>Readiness: Capacity</td>
</tr>
<tr>
<td>Political Will</td>
</tr>
<tr>
<td>Feasibility: Resources</td>
</tr>
<tr>
<td>Feasibility: Time</td>
</tr>
<tr>
<td>Feasibility: Changeability</td>
</tr>
<tr>
<td>Severity</td>
</tr>
<tr>
<td>Lack of Current Resources Addressing Topic</td>
</tr>
<tr>
<td>Extent of Disparate Populations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Epidemiological Criteria – Worth 66% of overall score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please rate the importance of the items below:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Magnitude (Worth 50% of Epidemiological Criteria Score)</td>
</tr>
<tr>
<td>Five-Year Trend (Worth 25% of Epidemiological Criteria Score)</td>
</tr>
<tr>
<td>National Comparison (Worth 25% of Epidemiological Criteria Score)</td>
</tr>
</tbody>
</table>
## EXAMPLE

<table>
<thead>
<tr>
<th>Area of Growth/Capacity Need</th>
<th>How It Will Be Addressed</th>
<th>Who Is Responsible</th>
<th>Timeline</th>
<th>Measure of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>We need to have a representative from Prevention Inc. participate in the needs assessment process, since that group works with one of the populations at risk for substance misuse/abuse in our community and could give us important input.</td>
<td>We will meet with Betty Leader, the director of Prevention Inc., to discuss the project and identify ways that Prevention Inc. might participate. Betty Leader and/or other staff will also be invited to future project meetings.</td>
<td>Jane Smith will contact Betty to set up a meeting. Other members who will attend include Jeffrey Jones and Allison Simpson from our group, both of whom already work with Jane on other projects.</td>
<td>Jane will contact Betty by July 11th and schedule the meeting for the week of July 18th.</td>
<td>Betty or another representative from Prevention Inc. becomes an active participant in our needs assessment process.</td>
</tr>
</tbody>
</table>

## TEMPLATE

<table>
<thead>
<tr>
<th>Area of Growth/Capacity Need</th>
<th>How It Will Be Addressed</th>
<th>Who Is Responsible</th>
<th>Timeline</th>
<th>Measure of Success</th>
</tr>
</thead>
</table>
Appendix 6: Step 1 Fidelity Checklist

Strategic Prevention Framework Partnerships for Success Grant

SPF Step 1 (Assessment)—Fidelity Checklist

This document is the first of five (5) fidelity checklists for measuring each coalition’s fidelity to the Strategic Prevention Framework (SPF). The first checklist is: Step 1 (Assessment) Fidelity Checklist. One of the goals for DBH Prevention grants is to increase coalition fidelity to each step of the SPF.

DBH believes the success of behavioral health prevention strategies depends largely on a coalition’s fidelity to the 5 steps of the SPF and that coalitions must complete the necessary activities and deliverable(s) in each step of the SPF to achieve behavioral health outcomes in substance abuse prevention. This fidelity checklist provides a tool for measuring each coalition’s fidelity to the model, helping to guide each community’s adherence to the planning process. Results from national SPF evaluation outcomes show that three criteria lead to better community change outcomes:

- Fidelity to the 5 steps of the SPF
- Strength, diversity, and ownership of the community coalition
- Selection of intervening variables that truly represent the community and the data collected and analyzed

Using this evaluation information, we will strive to meet these three conditions as we move through the next four years of this PFS grant program.

The intent of this fidelity checklist is to provide each coalition with clear parameters about how fidelity will be measured over time. Please review this document with your coalition members, note the critical elements we have identified, and use this tool to guide your process through Step 1. In the spaces provided, coalitions will list their key strengths and challenges related to each core activity within the SPF step. This document will be used both as a self-evaluation tool, as well as a tool your Program Coordinator will use to guide training, technical assistance, and support.

Once your coalition has reviewed this document, do not hesitate to work with your Program Coordinator if you have questions or would like to discuss this in more detail.
### Appendix 6: Step 1 Fidelity Checklist

#### Grantee Name:

**Step 1 - Community Assessment Core Activities**

<table>
<thead>
<tr>
<th>Management: A workgroup or individuals have been identified, including their roles and responsibilities in the following six core assessment areas: 1) priority area(s), 2) associated consequences, 3) target population/geographic differences, 4) prevention resources, 5) intervening variables &amp; community factors, and 6) community readiness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtaining, collecting, and entering data</td>
</tr>
<tr>
<td>Analyzing data</td>
</tr>
<tr>
<td>Reporting data</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requisite skills: The individuals or workgroup identified to collect data have the capacity and skills to do a data assessment (i.e., collect, store, compile, and analyze community-level data).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of local data sources</td>
</tr>
<tr>
<td>Ability to access community-level data OR Ability to collect community-level data (e.g., surveys, interviews) when access isn’t possible</td>
</tr>
<tr>
<td>Ability to summarize or analyze community-level data (e.g., create tables, graphs, conduct basic statistics)</td>
</tr>
<tr>
<td>Handling, storing, and reporting sensitive or identifying data</td>
</tr>
<tr>
<td>At least one person has received training in the community readiness tool</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data acquisition: Community-level data across the following six core areas have been obtained and are present in the data assessment report.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority area(s)</td>
</tr>
<tr>
<td>Consequences of priority area(s)</td>
</tr>
<tr>
<td>Target population / geographic differences</td>
</tr>
<tr>
<td>Prevention resources</td>
</tr>
<tr>
<td>Intervening variables and community factors</td>
</tr>
<tr>
<td>Community readiness</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Key Strengths</th>
<th>Key Challenges / Lessons Learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
## Appendix 6: Step 1 Fidelity Checklist

<table>
<thead>
<tr>
<th>4. Data quality: High quality community-level data were obtained across the six core areas: 1) priority area(s), 2) associated consequences, 3) target population/geographic differences, 4) prevention resources, 5) intervening variables &amp; contributing factors, and 6) community readiness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Trend data were included, when applicable</td>
</tr>
<tr>
<td>□ Data were comparable to national or state data, when applicable</td>
</tr>
<tr>
<td>□ <strong>Data were collected from all selected communities or entire service area</strong></td>
</tr>
<tr>
<td>□ Multiple data sources were used, when possible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Patterns and geographic/target population differences in the priority area(s), consequences, and intervening variables, and community factors were examined.</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Relationship strength between intervening variables and priority area was examined (if identifying additional variable)</td>
</tr>
<tr>
<td>□ <strong>Differences in the priority area by demographic variables were examined</strong></td>
</tr>
<tr>
<td>□ Differences in the priority area by village, region, or other geographic area were examined</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Prioritization of the target geographic area and/or target population should be based on the assessment results rather than opinions, hunches, or anecdotal evidence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ The target geographic area selected is supported by data</td>
</tr>
<tr>
<td>□ <strong>The target population selected, if further refined, is supported by data</strong></td>
</tr>
<tr>
<td>□ Data do not indicate stronger support for other geographic areas/target populations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Selected community factors are clearly linked to the associated intervening variable in the assessment results.</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Data were used to specify the community factors</td>
</tr>
<tr>
<td>□ Data do not indicate that other community factors provide stronger support for the intervening variable</td>
</tr>
</tbody>
</table>
**Appendix 6: Step 1 Fidelity Checklist**

<table>
<thead>
<tr>
<th>Step</th>
<th>Checklist</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td><strong>Prioritization of community factors</strong> is based on the needs assessment results, including resources and readiness information.</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>The community factors prioritized and selected are supported by data</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Data do not indicate stronger support for other community factors</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td><strong>Gaps in prevention resources and infrastructure</strong> are identified to address the priority area(s) in the identified geographic area and/or target population.</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>A systematic process was used to identify resources and infrastructure in addressing the priority area(s)</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>The gaps identified are supported by data</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td><strong>Community readiness</strong> to address the priority area(s) was assessed, and data were used to help specify community prevention needs and resources.</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>The Tri-Ethnic Center’s Community Readiness Assessment instrument and process were used to collect community readiness data</td>
<td></td>
</tr>
<tr>
<td>☐</td>
<td>Community readiness data were used along with other assessment data to help specify prevention needs and resources</td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Bolded items are non-negotiable and must be completed prior to advancing to the next step of the SPF. This does *not* mean that non-bolded items are any less important, and they should be considered to strengthen the fidelity to the SPF model.
Appendix 7: Step 2 Fidelity Checklist

Strategic Prevention Framework Partnerships for Success Grant

SPF Step 2 (Capacity Building)—Fidelity Checklist

This document is the second of five (5) fidelity checklists for measuring each coalition’s fidelity to the Strategic Prevention Framework (SPF). One of the goals for DBH Prevention grants is to increase coalition fidelity to each step of the SPF.

Although capacity building is assigned a specific step in the SPF, its activities and efforts are ongoing and evolving throughout the life of the project. As a coalition grows over time, the procedures, composition, activities, and focus may change as well. However, the core activities outlined below are essential to carry out this step with fidelity. The purpose of this step is to facilitate a process that authentically engages the community, equips coalition members with skills for prevention, and achieves outcomes through collaboration. By implementing this step with fidelity:

- Communities have “buy-in” for prevention goals and take ownership of the work
- Communities experience increased capacity for prevention work
- Coalitions are better positioned to create population-level change
- Project outcomes achieve a higher level of sustainability

Once your coalition has reviewed this document, do not hesitate to work with your Program Coordinator if you have questions or would like to discuss this in more detail.
## Appendix 7: Step 2 Fidelity Checklist

### Grantee Name:

#### Step 2 – Capacity Building Core Activities

<table>
<thead>
<tr>
<th>Key Strengths</th>
<th>Key Challenges / Lessons Learned</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Develop</strong> a working structure.</td>
<td></td>
</tr>
<tr>
<td>- The coalition documents infrastructure efforts in meeting notes, mission and vision statements, MOAs, policies, work plans, organization charts, or other tools.</td>
<td></td>
</tr>
<tr>
<td>- Capacity building efforts are connected to resource gaps or redundancies identified in the community assessment.</td>
<td></td>
</tr>
<tr>
<td>- The coalition’s collaboration with other organizations is reflected in written agreements and/or the project budget.</td>
<td></td>
</tr>
<tr>
<td>- The coalition provides ways to involve multiple sectors in decision-making and SPF activities.</td>
<td></td>
</tr>
<tr>
<td>- The coalition engages all members to the level of their interest and availability.</td>
<td></td>
</tr>
<tr>
<td>- The coalition establishes principles and values that lead to diverse community involvement and leadership, and documents the process.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Mobilize</strong> community capacity.</td>
<td></td>
</tr>
<tr>
<td>- The coalition uses the assessment to help identify missing partners; members are actively recruited throughout the life of the project.</td>
<td></td>
</tr>
<tr>
<td>- Plans are developed and implemented for recruitment activities to adapt to the needs of the work (e.g., during implementation the coalition may need different partners or resources than what was needed during the assessment).</td>
<td></td>
</tr>
<tr>
<td>- The coalition recognizes individual talents and contributions of its members.</td>
<td></td>
</tr>
<tr>
<td>- Formal membership procedures (i.e., level of participation, communication, attendance of meetings, committees, and/or workgroups) are established, documented, and followed throughout the SPF.</td>
<td></td>
</tr>
<tr>
<td>- Coalition efforts are supported by a diverse blend of resources.</td>
<td></td>
</tr>
<tr>
<td>- The coalition is embraced and supported by the local community, demonstrated by community involvement in workgroups, decision-making, outreach, and leadership.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 7: Step 2 Fidelity Checklist

<table>
<thead>
<tr>
<th>Grantee Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ The community has a level of awareness and knowledge about the coalition and its prevention efforts, possibly demonstrated by media coverage, attendance at coalition-led events, sharing of resources, public forums, or other means</td>
</tr>
<tr>
<td>□ The coalition directly involves the target population in its planning and efforts</td>
</tr>
</tbody>
</table>

#### 3. Nurture coalition capacity.

| □ The coalition engages broad community participation from all community sectors |
| □ The coalition documents its efforts to encourage participation of members that represent the cultural and linguistic composition of the community |
| □ The coalition builds and maintains its efforts around local environments and issues |
| □ The coalition has sufficient manpower to carry out activities of the SPF steps |
| □ Coalition members are clear about their roles and responsibilities, and consistently follow through with them |
| □ The coalition offers/coordinates skill building and training opportunities directly related to the SPF, prevention efforts, or coalition development |
| □ The coalition agrees on a plan to nurture current and emerging leaders |
| □ There is a plan for sustaining prevention efforts and outcomes for when grant funding ends |
Appendix 8: Strategic Plan Development Guide

This template provides a format for developing your community’s strategic plan. The strategic plan must not exceed 45 pages, including the information and tables outlined in this document. However, this total does not include any supporting materials or appendices that you may choose to submit.

Statement of Grant Intent
The PFS grant is intended to prevent non-medical use of prescription opioids (NMUPO) among 12-25 year olds and heroin use among 18-25 year olds across Alaska. PFS subrecipients will place the majority of their focus on the prevention/reduction of NMUPO and heroin use, if required, through the implementation or amendment of local policies, practices, systems, and environmental change. The primary target population is 12-25 year olds – which can be reached both in and/or outside of the school setting. Secondary target populations (e.g., parents, prescribers, etc.) can be served provided that the effects of any services delivered to these groups are likely to have an impact on past 30-day use of prescription opioids among 12-25 year olds and heroin use among 18-25 year olds in the community.

Urban grantees are required to include both priority areas (i.e., NMUPO, heroin use) in the strategic plan. Separate logic models and evaluation plans will need to be completed for each priority area.

Overview/Abstract
Note: The overview/abstract may not exceed one page.
Please provide a one-page summary of your plan that includes the following:
- A brief description of your community (including any demographic information or other information related to cultural or environmental factors that is relevant to the issue)
- The intervening variables and community factors you are targeting related to the priority area
- The strategies you will implement related to the priority area
Appendix 8: Strategic Plan Development Guide

Step 1: Assessment

1.1. Assessment Data on Priority Area(s)
Briefly describe the process you used to collect data on the nature and extent of the priority area within your community:

- What data sources and techniques for data collection did you use (e.g., administrative records, surveys, focus groups, key stakeholder interviews)?
- Include numbers/rates/percentages demonstrating your best sources of evidence related to what the priority area looks like in your community.
- Health Disparities Statement: Are any subpopulations of youth disproportionately affected by NMUPO in your community? If so, please list these populations and refer to the data/evidence that were used to determine this.
  
  Note: An examination of health disparities is a priority for the PFS grant. Your Program Coordinator will be looking for evidence that the assessment considered differences in consumption patterns and/or consequences among sub-groups.
- Note any gaps in the available data on the priority area that may limit your understanding of the issue, and how you plan to address these gaps moving forward.
- How are you integrating cultural competence and sustainability into this step of the SPF process (e.g., how will data collection be sustained, how often do you plan to re-assess, what is in place to guarantee ongoing access to data, what are the established baselines that all future data will be measured against)?
- Add any additional information that you think would help the reader understand how the assessment of priority area data was conducted.

1.2. Vision Statement Related to Priority Area(s)
Based on your understanding of the priority area consumption patterns in your community, please include the vision statement for your prevention initiative.

1.3. Assessing Intervening Variables and Community Factors Linked to Priority Area(s)
Briefly describe the process you used to collect data on intervening variables and community factors as they relate to the priority area:

- What data sources and techniques for data collection did you use?
- List all intervening variables and community factors you investigated, including data (qualitative and/or qualitative) on each and the sources of evidence.
- Note any gaps in the available data that may limit your understanding of the issue, and how you plan to address these gaps moving forward.
- Add any additional information that you think would help the reader understand how the assessment of the data on these factors was conducted.

1.4. Technical Assistance Needs Related to Assessment
What assistance, if any, do you anticipate needing in the area of assessment once your strategic plan has been approved and you move into the implementation phase? Remember, it is important to reassess your community’s needs throughout the project.

Step 2: Capacity Building

2.1. Community and Key Stakeholder Involvement
Appendix 8: Strategic Plan Development Guide

- Please list the key sectors (e.g., municipal government, education, prevention, treatment, health care, law enforcement, social service) that are actively engaged with your PFS project
- Describe how you intend to collaborate with local schools located in your community
- Please explain how members of the general community will be engaged in your PFS project
- Please describe how you will engage key stakeholders and other individuals from sectors not yet represented

2.2. Structure and Functioning
Please provide an organizational chart of the governing structure of the PFS project within your community, including any subgroups.
- How are the representatives of each key sector functioning as a team? What is the decision-making process in your group?
- What challenges have you encountered so far related to the functioning of your team, and what are you doing to overcome these challenges?

2.3. Core Planning Committee
Please list the membership of the core planning committee responsible for guiding your PFS strategic planning process.
- What challenges have you encountered so far related to the functioning of your core planning committee, and what are you doing to overcome these challenges?

2.4. Capacity-Building Needs Related to Priority Area(s)
- Describe the existing strengths within your community to address the priority area.
- Describe areas of growth that will need to be addressed in order for you to more effectively address the priority area.
- Include a capacity building plan to address your identified areas of growth/capacity need that includes the following information:

<table>
<thead>
<tr>
<th>Area of Growth/Capacity Need</th>
<th>How It Will Be Addressed</th>
<th>Who Is Responsible</th>
<th>Timeline</th>
<th>Measure of Success</th>
</tr>
</thead>
</table>

- How are you integrating cultural competence and sustainability into this step of the SPF process?

2.5. Technical Assistance Needs Related to Capacity
What assistance, if any, do you anticipate needing in the area of capacity building once your strategic plan has been approved and you move into the implementation phase?

Step 3: Strategic Planning

3.1. Planning Process
Briefly describe the process that was followed to develop this plan, including who was involved.

3.2. Planning to Address Priority Area(s)
Appendix 8: Strategic Plan Development Guide

Please describe the following related to your plan:
- The final set of community factors from section 1.3 that you selected, including how this list was selected (prioritized) from among the larger list of factors considered
- Any sub-groups that are being targeted in your PFS project, based on your health disparity analysis
- The list of strategies you propose to implement to address the priority area
- The rationale for each selected strategy
- The cultural competence of the selected strategy or strategies
- The sustainability of the selected strategy or strategies

Attach your action plans.

3.3. Logic Model
Attach your logic model(s).

3.4. Technical Assistance Needs Related to Strategic Planning and Logic Model(s)
What assistance, if any, do you anticipate needing in the area of ongoing strategic planning or logic models once your strategic plan has been approved and you move into the implementation phase?

Step 4: Implementation

4.1. Implementation of Strategies
In this section, describe your strategy implementation plans in depth, using the format below. Be specific (e.g., how many training sessions will be offered, for how many participants, and how long each session will last; when the strategy will begin and end).

4.2. Technical Assistance Needs Related to Implementation
What assistance, if any, do you anticipate needing in the area of implementation once your strategic plan has been approved and you move into the implementation phase?

Step 5: Evaluation

5.1 Evaluation of Strategies
Attach your evaluation plan(s), wherein you describe what information you will collect and how you will collect it in your local evaluation.

5.2 Technical Assistance Needs Related to Strategic Planning and Logic Models
What assistance, if any, do you anticipate needing in the area of evaluation once your strategic plan has been approved and you move into the implementation and evaluation phases?
Appendix 9: Logic Model Development Guide

Developing a community-level logic model is a way of mapping out, or drawing a picture of the opioid issue in your community, the priority consequences of that issue, the intervening variables and community factors, and the strategies you will use to reduce the impact of the issue. Identifying the key elements that make up the community-level logic model is really a central component of completing the assessment and planning steps of the SPF.

The strategies selected should always be focused on the intervening variables and community factors that your community has prioritized through the assessment process to reduce NMUPO and heroin use (if applicable). Although it is easier to choose solutions you may prefer, are familiar with, or are indirectly related to the issue, using community assessment data to target your planning is essential and proven to be effective in the SPF process. Ensuring that a strategy addresses your community factors is a central part of the strategy selection process.

Intervening variables answer the general question, “What are the reasons for non-medical use of prescription opioids?”

Community factors answer the question, “Why is NMUPO happening in my community?”

Below are the overall community-level logic models for NMUPO and heroin use:

![Logic Model Diagram](image-url)
Coalitions will be selecting community factors and associated strategies to address the intervening variables, consumption pattern, and consequences identified by DBH. Once these factors and strategies have been prioritized, you can plug them into the logic model template(s) shown above.

**Note:** If there are other intervening variables that your coalition has found to be directly linked to the priority area and can feasibly be changed during this grant cycle, you may discuss the possibility of adding these to your logic model with your Program Coordinator. However, the intervening variables shown here are required and cannot be substituted.
### Appendix 10: Action Plan Template

**Strategy 1:**

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Who Is Responsible</th>
<th>Timeline</th>
<th>Measure of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Strategy 2:**

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Who Is Responsible</th>
<th>Timeline</th>
<th>Measure of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 11: Step 3 Fidelity Checklist

Strategic Prevention Framework Partnerships for Success Grant

SPF Step 3 (Planning)—Fidelity Checklist

This document is the first of five (5) fidelity checklists for measuring each coalition’s fidelity to the Strategic Prevention Framework (SPF). One of the goals for DBH Prevention grants is to increase coalition fidelity to each step of the SPF.

Planning is a process of developing a logical order of steps that lead from individual actions to community-level prevention outcomes and achievement of the coalition’s vision for a healthier community. The goal of this third step is to use data from the assessment, including resources and readiness, to identify strategies that will have the greatest impact on identified needs. During the planning phase, PFS grantees will develop a strategic plan that includes the following key products:

- Vision statement
- Capacity building plan
- Logic model
- Strategy action plans
- Evaluation plan

Together, these products will help move coalitions from planning into action. Strategic plans align the coalition work with larger, and often long-term, priorities and opportunities. A strategic plan should include policy, systems, and environmental change strategies that create a logical, data-driven plan to address the problems identified in Step 1. Developing a logic model is a collaborative process that will help coalitions link community factors to prevention strategies and activities; it will be the basis for developing the strategic plan.

When the planning step is conducted with fidelity, coalitions can expect a higher level of success from their strategies and activities, as well as more sustainable outcomes. Do not hesitate to work with your Program Coordinator if you have questions or would like to discuss this in more detail.
**Appendix 11: Step 3 Fidelity Checklist**

**Grantee Name:**

<table>
<thead>
<tr>
<th>Step 3 - Planning Core Activities</th>
<th>Fidelity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Key Strengths</td>
</tr>
<tr>
<td>1. <strong>Vision:</strong> A statement describing the overall vision for prevention efforts in the community will help guide the community activities and will serve as an anchor for prevention efforts. The statement should be clear and comprehensive in scope. The vision statement reflects the overall guiding principle that will direct the coalition.</td>
<td></td>
</tr>
<tr>
<td>☐ The strategic plan includes a coalition-developed vision statement for prevention efforts at the community level</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Community assessment results:</strong> Community assessment results provide helpful direction for identifying prevention priorities. Plan specifications should be clearly linked to assessment results.</td>
<td></td>
</tr>
<tr>
<td>☐ The strategic plan describes how the coalition used community assessment data to refine the target population to address health disparities</td>
<td>☐ The coalition used synthesized data, including readiness and resources, to develop strategies that truly represent the needs of the target population</td>
</tr>
<tr>
<td>3. <strong>Infrastructure needs:</strong> To be effective, prevention activities should be implemented by skilled community practitioners with sufficient resources. Therefore, the plan should describe the assessment of community-level capacity and infrastructure needs, and should include a description of planned activities to address identified capacity and infrastructure needs.</td>
<td></td>
</tr>
<tr>
<td>☐ The strategic plan includes strategies to address identified capacity and infrastructure needs</td>
<td>☐ Community capacity and infrastructure indicators are measurable</td>
</tr>
</tbody>
</table>

---

Prevention of Non-Medical Use of Prescription Opioids and Heroin Use in Alaska
## Appendix 11: Step 3 Fidelity Checklist

<table>
<thead>
<tr>
<th>Step</th>
<th>Checklist Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.</td>
<td><strong>Selection of strategies</strong>: Prevention activities are more likely to achieve visible results when they specifically target community prevention needs and have shown to be effective in similar circumstances.</td>
</tr>
<tr>
<td></td>
<td>- Strategies align with the priority area and the specific community factors identified in the assessment</td>
</tr>
<tr>
<td></td>
<td>- Strategies are likely to create population-level change by influencing policies, systems, and/or environments within the community</td>
</tr>
<tr>
<td></td>
<td>- PSE strategies originate from the community assessment and match the capacity, readiness, and unique conditions of the community</td>
</tr>
<tr>
<td></td>
<td>- Evidence-informed strategies are practical, relevant, and meaningful to the community and target population served, with adaptations to meet community needs implemented as necessary</td>
</tr>
<tr>
<td></td>
<td>- If evidence-informed strategies are not used, the strategic plan clearly describes how strategies are uniquely suited for the community and include a plan to document their effectiveness</td>
</tr>
<tr>
<td>5.</td>
<td><strong>Cultural responsiveness</strong>: Strategies that appropriately address specific cultural differences are likely to be more effective. The description of planned activities should clearly describe how strategies were culturally adapted and indicate how these culturally appropriate strategies will be implemented. Remember that culture is broader than race and ethnicity.</td>
</tr>
<tr>
<td></td>
<td>- The strategic plan describes how community input was incorporated into the strategic planning process</td>
</tr>
<tr>
<td></td>
<td>- Action plans reflect input and outreach by diverse populations, cultures, ethnicities, genders, and age groups</td>
</tr>
<tr>
<td></td>
<td>- The strategic plan describes how the community was involved in the selection of strategies and how the coalition intends to nurture community buy-in, support, and involvement</td>
</tr>
</tbody>
</table>
Appendix 11: Step 3 Fidelity Checklist

Grantee Name:

<table>
<thead>
<tr>
<th>6. Monitoring and evaluation: By carefully identifying and measuring the factors that will change as a result of evidence-informed strategy implementation, communities are more likely to demonstrate direct impact.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>☐ Indicators identified are measurable and can be used to monitor community-level outcomes</strong></td>
</tr>
<tr>
<td>☐ Indicators that are expected to change are clearly defined in the strategic plan</td>
</tr>
<tr>
<td>☐ The plan specifies intended tools and procedures for monitoring progress toward community-level outcomes</td>
</tr>
<tr>
<td>☐ The plan specifies the tools for evaluating the outcomes of implemented strategies and plans for revisions based on progress, obstacles, and change in environment</td>
</tr>
<tr>
<td>☐ There is a clear, defined plan for disseminating evaluation findings to coalition members and the community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Incorporating sustainability: Improvement in prevention service delivery will occur if organizational capacity is sustained.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>☐ The strategic plan includes discussion of sustainability that articulates specific, doable action steps for each strategy</strong></td>
</tr>
<tr>
<td>☐ The coalition established a structured method of regular communication among members involved in implementing the strategies</td>
</tr>
<tr>
<td>☐ The plan identifies a diverse list of resources for continued efforts beyond state funding</td>
</tr>
</tbody>
</table>

**Note:** Bolded items are non-negotiable and must be completed prior to advancing to the next step of the SPF. This does not mean that non-bolded items are any less important, and they should be considered to strengthen the fidelity to the SPF model.
Appendix 12: Step 4 Fidelity Checklist

Strategic Prevention Framework Partnerships for Success Grant

**SPF Step 4 (Implementation)—Fidelity Checklist**

This document is the fourth of five (5) fidelity checklists for measuring each coalition’s fidelity to the Strategic Prevention Framework (SPF). One of the goals for DBH Prevention grants is to increase coalition fidelity to each step of the SPF.

Implementation is a process of identifying and implementing the specific strategies that will be coordinated by the coalition. During this step grantees will:

- Identify, coordinate, and manage coalition resources (inputs) that will be harnessed for implementing strategies. Examples of resources/inputs include people (i.e., staff or volunteers), time, facilities, supplies, materials, and funding
- Implement strategies and ensure coalition members have a thorough understanding of strategies being implemented
- Monitor and review strategies on a regular basis
- Adapt strategies to fit the local context, or develop unique strategies to fit local conditions and the identified target population

Implementation planning will assist coalitions in matching people with specific tasks and responsibilities associated with the strategy, and following a timeline for activities to occur. Implementation planning and coordination may also include identifying additional resources or inputs required of the strategy such as training, travel, space and facilities, and funding.

While implementing strategies, it is expected that the core components and activities of the strategy are being monitored and regularly reviewed by the coalition. These reviews should be documented in order to track outputs (how much) and quality improvement efforts (how well).

When the implementation step is conducted with fidelity, coalitions can expect that the strategies being implemented are relevant, meaningful, and are an efficient use of coalition resources. This may require attention to specific strategy adaptations that best align the strategy with the local conditions and the coalition’s goals and outcomes. Work with your Program Coordinator if you have any questions about this document or if you would like additional implementation tools or resources.
### Step 4 - Implementation

<table>
<thead>
<tr>
<th>Core Activities</th>
<th>Fidelity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Key Strengths</td>
</tr>
<tr>
<td>1. <strong>Identify, coordinate, and manage coalition resources (inputs) that will be harnessed for implementing strategies.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coalition directs and oversees the implementation of the strategic plan</strong></td>
<td></td>
</tr>
<tr>
<td>□ Coalition addresses organizational challenges, such as access to and availability of resources to the community, as well as managing sub-contracts and services, facilities, and other operations</td>
<td></td>
</tr>
<tr>
<td>□ Fiscal agency and coalition manage agency and fiscal resources, including budgeting needs and challenges</td>
<td></td>
</tr>
<tr>
<td>□ Coalition manages human resources, including coalition and community members’ roles and responsibilities needed to carry out implementation activities</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Build capacity for effective implementation.</strong></td>
<td></td>
</tr>
<tr>
<td>□ Coalition members are trained and educated on the fundamentals of each strategy being implemented. This includes core components and activities required to maintain fidelity and evidence supporting the specific strategy</td>
<td></td>
</tr>
<tr>
<td>□ The community understands and is knowledgeable about the coalition’s strategy implementation and the intended outcome. Community input and perceptions are regularly gathered and show support for and understanding of the coalition’s strategies and implementation process.</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Regularly review strategies.</strong></td>
<td></td>
</tr>
<tr>
<td>□ Evidence-informed strategies are reviewed regularly (i.e., core components and activities that support evidence of effectiveness) to ensure fidelity is maintained and preserved</td>
<td></td>
</tr>
<tr>
<td>□ Participant-level prevention strategies are reviewed for how much, how often, how long, where strategies occur, characteristics of participants served (e.g., demographics), methods of delivery, and other issues as</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 12: Step 4 Fidelity Checklist

Grantee Name:

<table>
<thead>
<tr>
<th>identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Policy, Systems and Environment (PSE) prevention strategies are reviewed for existing and proposed policy changes, increased stakeholder engagement and involvement, and impacts to systems, settings, and populations served</td>
</tr>
</tbody>
</table>

4. Adapt strategies to fit the local context, or develop unique strategies to fit local conditions and the identified target population.

- Adaptations are made to make the strategy more ethical, practical, or culturally responsive to the community
- Adaptations do not compromise the core components and activities that maintain the fidelity of the strategy being implemented
- Once implemented, adaptations are reviewed in order to determine if they were successful within the context of the strategy and, if not, why and what needs to be changed for the strategy or activity to be successful

**Note:** Bolded items are non-negotiable and must be completed. This does *not* mean that non-bolded items are any less important, and they should be considered to strengthen the fidelity to the SPF model.
Appendix 13: Evaluation Indicators for Prescription Opioids

**Evaluation Indicators** at the State and Community Levels for Prescription Opioid Intervening Variables, Consumption, and Consequences (This data is collected by CBHRS evaluators and will be provided to communities when it becomes available)

<table>
<thead>
<tr>
<th>INTERVENING VARIABLE Indicators</th>
<th>Target population</th>
<th>Data source</th>
<th>State Level</th>
<th>Borough Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social availability of Rx opioids</strong></td>
<td>18-25</td>
<td>CBHRS YASUS</td>
<td>No</td>
<td>Yes</td>
<td>2016 2019</td>
</tr>
<tr>
<td>• Rx opioids misused during past 30 days were easy to obtain</td>
<td>18-25</td>
<td>CBHRS YASUS</td>
<td>No</td>
<td>Yes</td>
<td>2014-2015 2016-2017 2018-2019</td>
</tr>
<tr>
<td>• Rx opioids misused during the past 30 days were obtained through social sources</td>
<td>12-17 18-25</td>
<td>NSDUH</td>
<td>Yes</td>
<td>No</td>
<td>2016 2017 2018-2019</td>
</tr>
<tr>
<td><strong>Retail availability of Rx opioids</strong></td>
<td>18-25</td>
<td>PDMP</td>
<td>Yes</td>
<td>Yes</td>
<td>2016 2017 2018 2019</td>
</tr>
<tr>
<td>• # of physicians registered in PDMP</td>
<td>18-25</td>
<td>CBHRS YASUS</td>
<td>No</td>
<td>Yes</td>
<td>2016 2019</td>
</tr>
<tr>
<td>• # of Rx opioid queries per physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• % of all patients meeting doctor shopping thresholds for Rx opioids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Past 12-month doctor shopping behavior</td>
<td>18-25</td>
<td>CBHRS YASUS</td>
<td>No</td>
<td>Yes</td>
<td>2016 2019</td>
</tr>
<tr>
<td>• Rx opioids misused during past 30 days were:</td>
<td>18-25</td>
<td>CBHRS YASUS</td>
<td>No</td>
<td>Yes</td>
<td>2016 2019</td>
</tr>
<tr>
<td>• obtained through a dealer/online dealer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• obtained through a provider</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• stolen from a doctor’s office, pharmacy, clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Perceived risk of harm (physically or in other ways) from using prescription drugs without a prescription</td>
<td>14-18</td>
<td>YRBS</td>
<td>Yes</td>
<td>Yes</td>
<td>2015? 2017 2019</td>
</tr>
<tr>
<td>• Perceived risk of harm (physically or in other ways) from:</td>
<td>18-25</td>
<td>CBHRS YASUS</td>
<td>No</td>
<td>Yes</td>
<td>2016 2019</td>
</tr>
<tr>
<td>o trying Rx opioids once or twice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o using Rx opioids regularly once or twice per week</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CONSUMPTION Indicators**

<table>
<thead>
<tr>
<th>CONSUMPTION Indicators</th>
<th>Target Population</th>
<th>Data source</th>
<th>State Level</th>
<th>Borough Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rx opioid misuse/abuse</strong></td>
<td>14-18</td>
<td>YRBS</td>
<td>Yes</td>
<td>Yes</td>
<td>2015? 2017 2019</td>
</tr>
</tbody>
</table>
Appendix 13: Evaluation Indicators for Prescription Opioids

<table>
<thead>
<tr>
<th>Target population</th>
<th>Data source</th>
<th>State Level</th>
<th>Borough Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past 30–day misuse of Rx opioids</td>
<td>18-25</td>
<td>CBHRS YASUS</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Past 30–day non-medical use of prescription pain relievers</td>
<td>12-17 18-25</td>
<td>NSDUH</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

CONSEQUENCE Indicators

<table>
<thead>
<tr>
<th>ER visits due to Rx opioids</th>
<th>Data source</th>
<th>State Level</th>
<th>Borough Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of ER Visits</td>
<td>HFDR</td>
<td>Yes</td>
<td>Yes</td>
<td>Annually</td>
</tr>
<tr>
<td>% of all ER Visits</td>
<td>HFDR</td>
<td>Yes</td>
<td>Yes</td>
<td>Annually</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Poisonings due to Rx opioids</th>
<th>Data source</th>
<th>State Level</th>
<th>Borough Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Poisonings</td>
<td>HFDR</td>
<td>Yes</td>
<td>Yes</td>
<td>Annually</td>
</tr>
<tr>
<td>% of all Poisonings</td>
<td>HFDR</td>
<td>Yes</td>
<td>Yes</td>
<td>Annually</td>
</tr>
</tbody>
</table>

- The CBHRS YASUS is the Young Adult Substance Use Survey created and administered in all funded communities by CBHRS evaluators using PFS funding.
- Data from the National Survey on Drug Use and Health (NSDUH) that is useful for the project is not available through published reports and must be obtained through a special request.
- Data from the Prescription Drug Monitoring Program (PDMP) is not available publicly or through a special request as of 7/1/16. However, data access is expected in the future. As of 6/21/16 physicians and pharmacists are required to check on the status of a patient’s prescription records before prescribing or dispensing prescription opioids.
- All school districts within funded communities will take part in the Youth Risk Behavior Survey (YRBS) as a requirement of PFS funding.
- Data from the Alaska Health Facilities Data Reporting program (HFDR) is not available publicly and must be obtained through a special request annually. All hospitals are required to report into the system as of 1/1/2015.
Appendix 14: Evaluation Indicators for Heroin

Evaluation Indicators at the State and Community Levels for Heroin Intervening Variables, Consumption, and Consequences (This data is collected by CBHRS evaluators and will be provided to communities when it becomes possible)

<table>
<thead>
<tr>
<th>INTERVENING VARIABLE Indicators</th>
<th>Target Population</th>
<th>Data source</th>
<th>State Level</th>
<th>Borough Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of heroin</td>
<td>• Heroin used during past 30 days was easy/very easy to obtain</td>
<td>18-25</td>
<td>CBHRS YASUS</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• Heroin perceived to be easy/very easy to obtain</td>
<td>12-17 18-25</td>
<td>NSDUH</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Perceived risk of harm from heroin use</td>
<td>Perceived risk of harm (physically or in other ways) from:</td>
<td>18-25</td>
<td>CBHRS YASUS</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• trying heroin once or twice</td>
<td>12-17 18-25</td>
<td>NSDUH</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>• using heroin regularly once or twice/week</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONSUMPTION Indicators</th>
<th>Target Population</th>
<th>Data source</th>
<th>State Level</th>
<th>Borough Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin use</td>
<td>• Lifetime use of heroin</td>
<td>14-18</td>
<td>YRBS</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• Past 30-day use of heroin</td>
<td>18-25</td>
<td>CBHRS YASUS</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONSEQUENCE Indicators</th>
<th>Target population</th>
<th>Data source</th>
<th>State Level</th>
<th>Borough Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER visits due to heroin</td>
<td>• Number of ER visits</td>
<td>12-17 18-25</td>
<td>HFDR</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• % of all ER visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poisonings due to heroin</td>
<td>• Number of poisonings</td>
<td>12-17 18-25</td>
<td>HFDR</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>• % of all poisonings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 14: Evaluation Indicators for Heroin

- The CBHRS YASUS is the Young Adult Substance Use Survey created and administered in all funded communities by CBHRS evaluators using PFS funding.
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Appendix 15: Step 5 Fidelity Checklist

Strategic Prevention Framework Partnerships for Success Grant

SPF Step 5 (Evaluation)—Fidelity Checklist

This document is the fifth of five (5) fidelity checklists for measuring each coalition’s fidelity to the Strategic Prevention Framework (SPF). One of the goals for DBH Prevention grants is to increase coalition fidelity to each step of the SPF.

Evaluation helps coalitions understand which strategies are working or not working in a planned and organized way. The evaluation process should be participatory; just as people participate in project activities, people must also participate in project evaluation. The best evaluations value multiple perspectives and involve a representation of community members who care about and are involved in the project. The results of evaluation may be used to refine strategies to increase effectiveness or cultural responsiveness, as well as to concretely illustrate progress toward goals. Evaluation can also function as a tool in a larger effort to strengthen a coalition or community’s prevention infrastructure. It can help lead coalitions and collaborating organizations to think more deeply about the specific strengths and needs of each strategy and to engage in a dialogue about how best to address the community’s priority area(s). Evaluation can also help determine the best combination of strategies to reach the desired outcome. The goal of this step is to monitor the project’s effectiveness at creating change in the identified outcome and intervening variables, and to make modifications to the project, if needed, based on information gained throughout the evaluation process. During the evaluation step, PFS grantees will work on the following:

- An evaluation report that synthesizes the progress being tracked
- A modified logic model and strategic plan

When the evaluation step is conducted with fidelity, coalitions can expect a higher level of success from their strategies and activities, as well as more sustainable outcomes. Work with your Program Coordinator, State-level evaluators, or the DETAL if you have any questions about evaluation or if you would like additional evaluation tools.
## Appendix 15: Step 5 Fidelity Checklist

<table>
<thead>
<tr>
<th>Step 5 - Evaluation Core Activities</th>
<th>Fidelity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Key Strengths</td>
</tr>
<tr>
<td>1. Establishing an evaluation team: A team of coalition members and, if applicable, evaluators increase the impact that participatory evaluation processes can have on a project. Evaluation can become a capacity building process, where different groups in the project discover and build on their assets and skills.</td>
<td></td>
</tr>
<tr>
<td>☐ Coalition developed an evaluation team made up of coalition members, members of the focus population, evaluator(s) (if applicable), and other key stakeholders in the community</td>
<td></td>
</tr>
<tr>
<td>☐ Coalition engages members in discussion around specific obstacles to using information from the evaluation results within the coalition (e.g., concern about the time and effort involved, dysfunctional communication and information-sharing systems, unempowered members) so as to heighten understanding, support, and ownership of the evaluation process</td>
<td></td>
</tr>
<tr>
<td>☐ Coalition uses a participatory process where each team member takes responsibility for certain aspects of the process and contributes his/her perspective</td>
<td></td>
</tr>
<tr>
<td>2. Collecting evaluation data: To what extent are data collection procedures developed? Developing written data collection procedures provides guidance, expectations, and a basis for evaluation accountability.</td>
<td></td>
</tr>
<tr>
<td>☐ Timeline of data collection established</td>
<td></td>
</tr>
<tr>
<td>☐ Responsible parties identified/assigned</td>
<td></td>
</tr>
<tr>
<td>☐ Primary data collection instruments identified and/or developed</td>
<td></td>
</tr>
<tr>
<td>☐ Secondary data sources identified, including a discussion around how well this data meets the needs of the project</td>
<td></td>
</tr>
<tr>
<td>☐ Discussion around any missing data and plans to collect such data or proxy measures</td>
<td></td>
</tr>
<tr>
<td>☐ Plans include consideration of how each piece of data will be used, how it will fit with other data, how it will help answer evaluation questions, and strengths/weaknesses of each data source</td>
<td></td>
</tr>
</tbody>
</table>
### Grantee Name:

**Appendix 15: Step 5 Fidelity Checklist**

<table>
<thead>
<tr>
<th>3. Analyzing and interpreting evaluation data: After designing an evaluation and collecting pertinent data, the information must be described, analyzed, interpreted, and a judgment made about the meaning of the findings in the context of the project.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Quantitative analysis is used to draw conclusions about the focus population and the impact the project has had on the population</td>
</tr>
<tr>
<td>☐ Analyzes the data so that the qualitative findings are clear, credible, and address the relevant and priority evaluation questions and issues</td>
</tr>
<tr>
<td>☐ Coalition discusses findings, including whether they make sense, potential biases and other limitations, explanations for surprises, and how they will determine future actions taken to improve the project</td>
</tr>
<tr>
<td>☐ Results are interpreted with respect to the cultural perspectives of the focus population</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Building evaluation capacity: To what extent is evaluation capacity developed? Internal evaluation capacity is essential to improving the use of evaluation results and institutionalizing evaluation as an essential component of prevention efforts and their sustainability.</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Evaluator hired and involved (if applicable)</td>
</tr>
<tr>
<td>☐ Built internal evaluation capacity within the coalition and conducted specific intentional activities for capacity building</td>
</tr>
<tr>
<td>☐ Availability of resources for evaluation tasks is taken into consideration during evaluation planning (e.g., costs of various data collection methods, time required for data collection and analysis)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Establishing evaluation procedures: To what extent are plans developed for implementing local evaluation procedures? Developing written plans for carrying out the evaluation provides clarity in understanding, guidance on next steps, and</th>
</tr>
</thead>
</table>

---

32 Quantitative analysis: a process involving calculating basic descriptive statistics, such as frequency distributions, measures of central tendency, and measures of distribution, and/or more sophisticated statistics

33 Qualitative analysis: a process for identifying themes and patterns in the data and then coding or categorizing these themes in an effort to understand and describe the phenomenon being evaluated
### Appendix 15: Step 5 Fidelity Checklist

Grantee Name:

<table>
<thead>
<tr>
<th>the ability to later review and edit procedures that may not be working well within the project.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Evaluation procedures are agreed upon by evaluation team</td>
<td>☐ Evaluation procedures are agreed upon by the community to ensure equitable involvement of community members, thereby sharing decision making and ownership of the evaluation process</td>
</tr>
<tr>
<td>☐ Plans to carry out the evaluation are detailed (e.g., timeline, responsible parties, tasks)</td>
<td>☐ Any revisions to evaluation procedures or data collection activities are based on information gained through the evaluation process (i.e., What is working? What is not working? What data are still missing?)</td>
</tr>
<tr>
<td>☐ Coalition revisits the initial assessment to determine any changes in community conditions or if the evaluation plan is missing key elements identified in the assessment</td>
<td></td>
</tr>
</tbody>
</table>

6. Communicating and reporting evaluation processes and findings: To what extent are plans developed to communicate feedback from the evaluation team to the larger coalition and community? Communicating evaluation findings might take on different forms for different stakeholders. The critical point is to involve everyone who will need this information in discussions about how best to communicate the progress of the evaluation.

- ☐ Dashboard developed and maintained
- ☐ Timeline established for feedback with procedures, responsible parties, and topics identified
- ☐ Communicated evaluation process, including incremental progress, to larger coalition and other stakeholders in order to ensure a shared meaning and understanding of the process
- ☐ Use of a variety of techniques in evaluation reporting (e.g., visual displays, oral presentations, summary statements, etc.)
### Appendix 15: Step 5 Fidelity Checklist

<table>
<thead>
<tr>
<th>Grantee Name:</th>
<th></th>
</tr>
</thead>
</table>

7. **Utilizing the process and results of evaluation:** To what extent does the coalition intend to use feedback to inform future prevention strategies? Determining the use of evaluation feedback on strategy development and implementation provides guidance and establishes expectations for project improvement and decision making.

- ☐ Detailed method identified for using feedback, including timeline, parties involved, topics, and purpose of topics
- ☐ Priority uses of evaluation results are identified prior to beginning evaluation procedures
- ☐ Tracking which strategies and activities are supporting or hindering outcomes and overall effectiveness so as to make improvements to the project and promote sustainability
- ☐ Any modifications to logic model are data-driven and informed by contextual factors (e.g., political climate, other similar projects in the community, new or newly enforced policies/laws/regulations, etc.)

**Note:** Bolded items are non-negotiable and must be completed. This does *not* mean that non-bolded items are any less important, and they should be considered to strengthen the fidelity to the SPF model.